Employe Benefits

Canada's plan

Canadian employers and workers are enthralled with their provincial version of national health insurance, Washington associate editor Jerry Geisel found when he traveled north to see how another country has solved a pressing U.S. issue. **Page 11.** One wonders if the Canadian beneficiaries are wearing rose-colored glasses. Editorial, **page 8.**

Day care

Providing employes with day care for their children can benefit the employer too. **Page 11.** Levi's, however, says workers reject on-site centers. **Page 37.**

Trusts court small groups

Insured multiple employer trusts are falling over each other to win small group business. **Page 11.** But regulators have defused the explosion of self-insured trusts. **Page 67.**

The ultimate

What benefit will employes appreciate the most? Kwasha Lipton's Richard Sears suggests an employe savings plan is the ultimate. Perspective, **page 57.**

Cost control

Employers are determined to quell the rising tide of health care costs. Texas Instruments makes employes pay their share. **Page 28.** Others are clutching at second opinion plans, utilization and claims review and HMOs, even though their force isn't proven. **Page 30.** GM, Chrysler and Alcoa are teaching employes how to serve on hospital boards. **Page 62.**

Benefit execs unite

A fledgling group of benefit managers is speaking up in Washington against excessive regulation of benefit plans. The first group representing only the corporate bill payers preaches the tact of quiet lobbying. **Page 68.**

Flexible benefits

American Can's flexible benefit program was such a hit with 700 employes in the test group that the company is extending the program to 9,000 salaried workers. **Page 33.**

Exchange bylaws dissipate doubts

By ELLIS SIMON

NEW YORK—Insurance brokers, have discarded their reservations about the proposed constitution and bylaws for the New York Insurance Exchange and are endorsing the completed document.

"From the brokers' standpoint, I'm satisfied," said David H. Winton, senior vp at Johnson & Higgins. "It represents a reasonable consensus of everyone's views." Mr. Winton, chairman of an ad hoc committee of the Insurance Brokers Assn. of the state of New York monitoring exchange developments, sent a memorandum to members of the association endorsing the draft constitution.

Alexander & Alexander chief executive John A. Bogardus called the constitution a "non-controversial" document that seems viable. However, its success will be determined by what unfolds in the future and how the document is interpreted, he said.

Brokers earlier objected to proposed provisions that would have prevented representatives of underwriting syndicates controlled by brokerage firms from sitting on the exchange's board of governors. L. Patton Kline, chairman of Marsh & McLennan and sole broker serving on the Committee of 13 drafting the constitution, called the provision "intolerable." The committee had proposed five underwriter seats on the board and only three broker seats.

In addition, the committee was considering election of the four public members of the board of governors in such a way that they would have essentially created a permanent seven-five split between underwriters and brokers on the board.

That proposal and the one restricting who could serve as underwriting and broker representatives to the board were dropped at the committee's November meeting. However, the draft constitution now provides for six underwriting seats and two broker seats on the board of governors, instead of the five and three configuration proposed earlier.

"It looks like there has been some improvement on questions that have concerned us," said Richard Miller, president of Corroon & Black. M&M's Mr. Kline commented, "On the whole the objec-

Continued on page 102

Photo: Wide World

Southern Railway accident kills 6

Southern Railway is self-insured for more than $1 million on the passenger train accident earlier this month. Six were killed and 60 injured when seven cars and three locomotives spilled into a ravine near Shipman, Va. Excess insurance is written by U.S. and U.K. firms.

The people column
page 106

Week of December 11, 1978

business insurance

the national newsmagazine of loss prevention, risk financing and employe benefit management

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Wage board considers exempting benefit costs

By REBECCA A. FANNIN

NEW YORK—The Council on Wage and Price Stability is strongly considering changes in the wage guidelines that would add flexibility and make compliance easier.

The council is reportedly moving toward excluding from the 7% wage ceiling the increased cost of employer pension contributions and the added cost of maintaining health benefit plans.

Corporate benefit managers find it hard to believe the Carter Administration won't alter its approach to inflation controls, exempting employe benefit cost hikes from the suggested wage limit.

For, despite their best intentions to comply with the guidelines, corporations maintain they will find it hard to live with the guidelines as they're currently proposed. Noncontrollable benefit cost increases for such things as routine health insurance premiums and higher pension fund contributions would eat up too much of the allowable amount, notwithstanding any pay hikes, benefit managers explain.

Aside from the impact of general economic inflation and claims experience on benefit costs, federal and state legislation have added to corporate benefit payments, managers complained. Their conclusion: The rules aren't fair.

"They've given no consideration to the fact that maintaining benefits can increase costs overall, especially as a result of increased hospital costs," charged Nathan Smith, assistant vp and director of employe benefits for American Home Products Corp. He predicts that hospital costs alone during 1979 will add 12% to 20% to his health insurance bills.

"The government can't say that we have to provide such benefits as maternity disability and increased pension funding requirements under ERISA, and then make us include that cost under the guidelines," he grumbled.

How can the government expect corporations to play two conflicting roles—paying for rapidly escalating health care costs but holding down benefit costs so they don't erode wage increases? wondered Champion International Corp.

An indication the council may be inclined toward leniency on the benefit issue is its recent change in the rules governing accounting for deferred executive compensation. Initially, deferred executive compensation was to be included in wage increases when the money was granted. Under the new rules, deferred compensation is now calculated as part of wages only when the employe earns the right

Continued on page 100

IRS ponders 30% tax on foreign placements

WASHINGTON—The Internal Revenue Service is hungrily eyeing a 30% withholding tax on insurance placed by U.S. buyers with foreign insurers.

The proposed change, however, is so drastic and so out of line with traditional IRS thinking that experts doubt the expensive change will ever move beyond the informal proposal stage.

"I can't believe that anybody with any real understanding of how the international insurance business works would seriously consider a proposal like that," said Robert Clements, executive vp at Marsh & McLennan. "I'd be surprised if it is being taken seriously within IRS and Treasury Department circles."

At issue is a section of the tax code that says a tax of 30% of the amount received from sources within the U.S. by a non-resident alien could be imposed on various sources of income, including interest, dividends and premiums. In a 1922 ruling, though, the IRS said the term premium did not include insurance premiums.

Now, 56 years later, the IRS is considering a proposal to hit insur-

Continued on page 105

Equitable denies curbs will hurt group services

By ELLIS SIMON

NEW YORK—Equitable Life Assurance Society of the U.S. doesn't intend to change its pension or group insurance operations as part of a cost-cutting program announced in early fall, according to Coy G. Eklund, president and chief executive officer.

The cost cutting program, which will result in layoffs of as many as 10% of the mutual insurance company's executive employes, is to control across the board rapidly rising expenses and isn't in response to weaknesses in one particular area, he said.

"The Equitable intends to stay in the forefront of group life, group health and the pension business," Mr. Eklund stressed.

Equitable had been experiencing double-digit inflation in its operating costs over the past four years, with the costs rising 17% for 1978, explained Mr. Eklund. These rising costs had been offset by favorable changes in the mortality rates and increasing interest rates, he said, but Equitable expects them to level off. "How long can we expect them to continue?" Mr. Eklund pondered.

New business had been increasing at an even pace with operating costs, but the bottom line results had not been improving as fast, he admitted.

The cost-cutting measures should improve Equitable's profitability, he added. Under the cost-cutting program Equitable's 1979 operating budget anticipates expenses of $940 million, a 5% increase above 1978. Had a 17% increase been provided for, the operating budget would have risen to $1.04 billion, $100 million greater, Mr. Eklund said.

The improved profitability should enable the company to establish a more competitive position in the market and enable Equitable to build the capital base needed to protect against emergencies and further its growth, he continued.

In an interview several weeks ago with a Wall Street Journal reporter, Mr. Eklund said. "The Equitable isn't in trouble, but if we blithely stand by and do nothing, the Equitable most certainly will be in trouble."

Mr. Eklund did not elaborate on what could have happened to the Equitable had operations been allowed to continue status quo, but he said "if I didn't do something, there'd be a new chief executive officer before long." Responding now will allow the company lead time to make adjustment for future changes.

One insurance analyst contacted by *Business Insurance* noted that Equitable was operating at a ratio of net worth and security reserves to liabilities that was well beyond the average for the insurance industry, explaining the company had "overleveraged" itself.

Other sources in the industry noted Equitable's extensive involvement with guaranteed interest pension contracts during a period of volatile interest rates and an anticipated "drying up" of quality private placement investment opportunities.

Unlike most GIC plans, the Equitable's program allows plan sponsors to put additional sums into the fund in succeeding years at the same interest rate offered in the first. In addition, the plan provides for lump sum payment of the principal at the end of the contract period if the sponsor chooses not to renew.

Mr. Eklund said Equitable contemplates "no significant changes in the pension area and continues to be interested in offering its GIC product. We're pleased with what we're doing and it looks awfully good to us.

"People wonder about how we do it, but long term interest rates actually have been stable. Since Jan. 1, 1970, we've made billions of dollars of investments with high, long term interest rates. The movement of the prime rate does not have an influence upon long term rates."

So far Equitable has not seen any diminution in the quality of investment offerings, he added. Equitable invests $25 million daily, with an average return of 9½%. ■

New staffers named to BI home office

CHICAGO—Mary Ellen McKee and John F. Maes have joined *Business Insurance* as associate editors in the Chicago office. Ms. McKee was hired to fill a newly created position, while Mr. Maes replaces Kathryn McIntyre who was promoted to news editor, as reported.

Ms. McKee joined *Business Insurance* after having worked for the National Underwriter as a staff writer and as managing editor of The Illinois Underwriter. She also had been a technical writer and editor for Peco Enterprises Inc., publisher of contractors' technical manuals. She has a BA from Augustana College in Rock Island, Ill., with emphasis in English and journalism.

Mr. Maes is returning to Chicago from Dallas, where he has worked as a reporter for the Dallas Times Herald and the Fort Worth Star-Telegram. He also has worked as a reporter for Paddock Publications in suburban Chicago, publishers of the Herald Newspapers. He has a BA in journalism from Drake University, Des Moines, Iowa. ■

Risk Manager of the Year

Nominations of corporate executives for *Business Insurance*'s Risk Manager of the Year 1979 award must be postmarked no later than **December 31**. Judging will take place prior to April, when the winner will be announced.

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Illinois rejects 36% rate hike filed by workers comp insurers

CHICAGO—The Insurance Services Office will request a hearing following the denial of a 36.8% rate hike in workers compensation premiums issued by Illinois director of insurance, Richard L. Mathias.

The rate increase was rejected, in part, because it was not in compliance with the government's new voluntary wage and price guidelines.

ISO filed for a 25% rate increase last spring, but is returning with the new request because new loss experience and inflation warrant the heftier increase, says Robert Heitzmann, executive vp of the National Council on Compensation Insurance.

A spokesman for the legislative committee of the Chicago chapter of the Risk Insurance Management Society said the rate increase request will be reviewed by all its membership. But the increase is probably justified, he added, and does not expect employers or RIMS to fight it.

Labor Dept. wants one less form

WASHINGTON—Another set of duplicative reporting requirements for pension plans will be eliminated under a Labor Department proposal announced last month.

Under the proposal, pension plan administrators no longer would be required to file a plan description form, known as EBS-1, with the Labor Department. Instead, the plan sponsor would only have to file the summary plan description, which under the pension reform law must be distributed to employes and filed with the Labor Department 120 days after a plan becomes subject to ERISA.

In calling for the elimination of EBS-1, the Labor Department said the form contained basically the same information as the summary plan description, a point benefit managers have been making for some time.

"This duplicative reporting of information may impose an unnecessary economic and administrative burden on employe benefit plans without commensurate benefits to plan participants," the Labor Department said.

Both EBS-1 and the summary plan description describe pension plan provisions and the effect of these provisions on the payment of benefits to plan participants.

Claims screening is suggested

WASHINGTON—The Justice Department next year will send to Congress a legislative proposal establishing national minimum standards for procedures to resolve medical malpractice claims.

The proposal would require states to establish panels to screen prefiled malpractice claims. The panels would try to filter out unfounded claims and provide faster payment for meritorious claims.

Under the Justice Department proposal, if a state failed to establish the required minimum standards and procedures, Attorney General Griffin Bell could intervene and require their establishment.

Underwriting profits double: III

NEW YORK—Property and casualty insurers racked up underwriting profits in the first nine months of this year. Investment income added another $4.9 billion to that total. For the same period during 1977, underwriting profits were less than half this year's results, at $355 million, with investment income adding $4.3 billion to those profits.

Combined net income for the U.S. insurers hit $4.6 billion, up 15% from $4.0 billion in the first nine months last year. Insurance company results are compiled by the Insurance Information Institute, using quarterly reports from about 500 property and casualty insurers.

Court to rule on longshore act

WASHINGTON—The Supreme Court will decide whether the federal longshoremen's act applies to all workers who handle cargo on the waterfront including those who never step foot on ships.

The court said it will review the 5th Circuit Court of Appeals ruling that land-based workers are covered by the federal act. Other appeals courts have ruled that such workers are excluded.

In 1977, the Supreme Court ruled in a landmark decision that the federal compensation law covered workers who are longshoremen by occupation even though their actual jobs may require them to work at dockside facilities, such as terminal warehouses, instead of on ships.

The court's decision in this recent appeal could further broaden the purview of the longshormen's act.

Employers favor a narrow interpretation of the federal act since compensation under federal law is substantially higher than benefits paid under state workers compensation laws.

A decision on the case is expected before the end of the court's term next June.

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the benefit beat

Philip Morris finds better travel accident plan

Philip Morris Inc. whose business travel accident insurance was canceled by its underwriter, Federal Insurance Co., and its underwriting manager, Chubb & Son, now has a non-cancellable clause with Lloyd's of London for the coverage Red Shaw Stenhouse is broker working through Boston-based Lockwood, Dipple & Green, for the new coverage. No changes in benefits were made with the move.

The travel accident policy covers salaried employes on a scheduled basis. Corporate aircraft travel is covered under a separate policy.

Death benefits range from five times salary for those earning less than $5,000 to a maximum of $400,000 for those paid $50,000 or more. Loss of two limbs and loss of eyesight is covered under the same schedule as death benefits. Likewise, the loss of one limb and loss of sight falls within the same reimbursment range. For loss of one limb or loss of sight individually, one-half the maximum death benefit is paid. One-quarter of the death benefits is paid for loss of thumb or index finger.

Life, AD&D improved

Life insurance and accidental death and dismemberment benefits for 900 members of the United Steel Workers Union at Robertshaw Control Co.'s Knoxville, Tenn., plant have been increased to $10,000 from $8,000. The increases are part of a new contract between the company and the union ending a three-week strike.

Other provisions of the contract call for increasing the weekly income insurance benefit from to $80 to $70 during the first year and to $90 from $80 in the second and increasing monthly pension benefits to $9 from $8 per year of service with a 35-year maximum.

The new contract also provides full coverage of reasonable and customary charges for obstetrical procedures and raises the maximum payment for reasonable and customary surgery charges to $1,000 from $600. Maximum benefits for miscellanous hospital charges were increased to $1,500 from $600 and the major medical deductible was changed to $100 per family from $100 per person.

Driver pensions up

Approximately 1,800 bus employes, members of the Amalgamated Transit Union, have negotiated improvements in their pensions and medical coverage and the addition of dental coverage with their employer, Baystate Development Agency in St. Louis.

Both the employe and employer contributions to pensions have increased. Workers pay $5.40 weekly toward the plan, up from $3 weekly previously. Employers contribute $20.37 per week, an increase from $17.40 per week previously.

Contribution by the employe for his dependent's medical coverage was reduced by 5%. No changes were made for the employe's own medical coverage, which is provided by Blue Cross/Blue Shield.

The new dental plan pays $500 for the individual and $1,000 for family care. The plan covers all work except orthodontic and dentures. A deductible of $25 applies for each employe, $75 for the family.

Celanese adds dental

New York-based Celanese Corp. and its affiliate Fiber Industries Inc. in Charlotte plan to introduce a dental plan to approximately 16,000 salaried and non-union hourly employes nationwide. The plan will provide a $750 annual maximum benefit for restorative and replacement work as well as diagnostic and preventive care. A $25 deductible applies to restorative work. Dependent children under 18 years of age are provided a $500 lifetime maximum reimbursement for orthodontia work. The plan will be introduced June 1, 1979, according to Hugh F. Van Deventer, director of employe benefits at Celanese. He said the company is currently soliciting bids for the coverage.

Paternity leaves

American universities, while recognizing the need to provide mothers with childbearing leaves, are not granting fathers the same privileges, a study by the American Assn. of University Women found. Out of 600 four-year colleges, 85% allow women leaves after childbirth but only 17% allow new fathers a leave of absence to care for the young child.

Standard claim forms

Physicians, dentists and hospitals in New York would be required to use standardized claims forms in submitting bills to insurance companies under a regulation proposed by the state insurance department. The specified forms would implement recently enacted legislation aimed at simplifying and reducing the cost of processing health insurance claims.

Physicians and dentists would be required to use the new form by September 1979 and hospitals would be required to adopt the Office of Health Systems Management's uniform billing form for in-patient hospital services by November 1979. The regulation is expected to be issued by the state insurance department by Jan. 1, 1979.

Improved dental plan

Employes of the Southern New England Telephone Co. will enjoy expanded coverage under the company's improved dental assistance program.

The program, effective January 1, will provide a full reimbursement for the cost of examinations and cleaning of teeth and 50% reimbursement for the cost of extractions, fillings, fluoride treatments, bridgework, dentures, and orthodontia work, subject to a $500 calendar maximum for most dental services and a $500 lifetime maximum for orthodontia. The com-

Continued on following page

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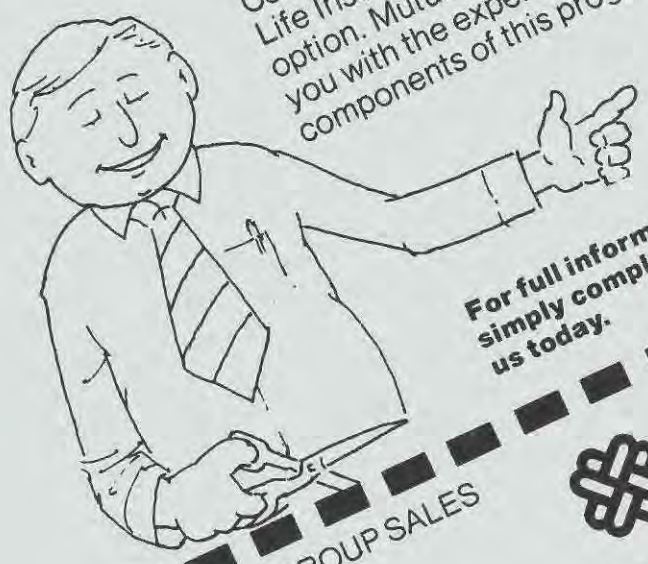

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Benefit beat . . .

Continued from preceding page
pany pays the full $2.5 million premium for its 16,000 employes.

Aetna Life & Casualty, the new insurer of the benefits, has worked some additional features into the program to improve the claims handling process. Metropolitan Life Insurance Co. previously insured the program.

SNET employes and their dentists will be able to call a toll-free number established to exclusively handle dental claims. All claims will then be processed through a totally computerized system. The insurer will also open a special claims unit in New Haven, Conn., where SNET's general offices are located.

The new program represents a 30% increase in overall dental coverage for Southern New England Telephone Co. employes.

Alcoholism benefit

Amtrol Inc. of West Warwick, R.I.,is now providing 1,600 employes and dependents with expanded coverage for alcoholism treatment by buying a new rider to the Blue Cross & Blue Shield of Rhode Island major medical program. The first Rhode Island company to buy the new rider, Amtrol is paying 70 cents a month for family coverage under the rider and 30 cents a month to provide the benefit to single employes. The benefit provides full coverage for 45 days of treatment per year in a detoxification unit for people diagnosed as suffering from alcoholism.

Canadian costs surge

The cost to Canadian employers of employe benefits surged by 30% over the last two years, primarily due to increases in pension plans and benefits required by law, preliminary results of a survey by Thorne Riddell Associates Ltd. shows.

An employer in Canada now pays on the average $5,000 each year per employe for benefits, up from $3,849 two years ago when the Canadian management consultants last surveyed benefit costs. The average hourly cost of employe benefits increased to more than $2.25 compared with $1.95 in 1976.

Because payroll costs were up across the board, the cost of benefits expressed as a percentage of gross annual payroll edged up to just over 32% from 31.11% two years ago.

Benefit costs have not slowed even under Canada's anti-inflation program regulations, partly because certain contributions to pension plans have not been restricted by the Anti-inflation Board.

Thorne Riddell's survey covered 620,000 employes, or about 7% of Canada's workforce in 157 public and private organization.

Benefit survey

Most Americans with new group major medical insurance policies have maximum benefits of $100,000 or more, a survey of 30 insurance companies by the Health Insurance Institute shows.

Of the 836,434 persons insured under group plans, 61% had their health insurance paid entirely by their employer and 35% had their premiums partially paid by employers.

More than 99% of the employes in group plans have coverage for hospital room and board charges of $50 and up and 73% have coverage for the average room and board charge, up from only 24% of the employes in a group surveyed in 1973.

The survey also identifies a trend among employers to provide more hospital days of care with 56% of the employes covered in group plans surveyed this year covered for 100 days, up from only 30% in 1973. Similarly, more employes now are covered for reasonable and customary surgical charges, 28% in 1978, compared with only 3% in 1973.

ESOP grows

Affiliated Home Centers Inc. of Kansas City, the first in the lumber industry to establish an employe stock ownership plan (ESOP) to provide for its employes' retirement, is building up the trust.

Each year the company contributes to the plan 15% of total wages, salaries and bonuses paid to full time, non-union employes who have completed one year of employment.

To date, the company has put $250,000 into the fund for 111 employes who became eligible for the program Jan. 1, 1977.

Public employes

Employes of towns and boroughs in Pennsylvania will probably demand new dental, prescription and vision care plans now that their medical benefits have caught up with the norm, predicts the Pennsylvania State Assn. of Boroughs. A recent survey of the state's townships and boroughs shows 90% of the larger municipalities provide coverage for disability, medical and surgical costs and hospitalization. On the average, Pennsylvania boroughs and townships now pay 20% of base salaries for employe benefit programs, with the larger municipalities paying as much as 40%, the survey found.

•

Benefit beat keeps insurance and employe benefit managers up-to-date on what other companies are doing and informed of current developments in the employe benefit field. We'd like to know if you've made any changes. Write Kathryn J. McIntyre, Business Insurance, *740 N. Rush St., Chicago, Ill. 60611 or call 312-649-5286.*

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errors & omissions

• Leslie Dew of Gulf Oil Corp.'s Insco subsidiary and Liberty Mutual Insurance Co. say they aren't involved in underwriting risks for CIRCL or its participants, although it was reported in the Oct. 30 issue that both of these firms had agreed to underwrite third-party business for CIRCL participants. Liberty Mutual hasn't been involved with captives, it said. Mr. Dew, underwriter for Insco's Britamco agency, said he had formally declined to participate in CIRCL business or even to participate as one of the 10 members of CIRCL's underwriting panel. Duane Allen of Hanna Mining Co., quoted as the spokesman for CIRCL's underwriting committee, responded that he had meant to indicate these companies had expressed some interest in being underwriters for CIRCL's participants and potential participants, but acknowledged they weren't currently working with any of CIRCL's members as underwriters.

• California is only charging private companies that self-insure workers compensation a licensing fee to receive the required certificate to self-insure. Public entities, recently required to also secure a certificate to self-insure workers compensation, will not have to pay the fee. The cost of administering the certificate program for public entities will be borne by general revenues. The Nov. 27 issue contained incorrect information.

HOW DO YOU PUT SAFETY TOGETHER-WHEN YOUR JOBSITES ARE SCATTERED?

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Wausau's Ed Baxa Visits WB&I Safety Van

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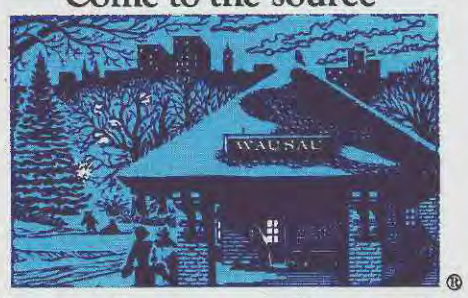

Wausau Insurance Companies
Employers Insurance of Wausau

Survey refutes impact of FASB rule

STAMFORD, Conn.—The prohibition against corporate reserves to pay future self-insured losses imposed by the Financial Accounting Standards Board has not caused companies to buy more insurance, a recently released study commissioned by the FASB shows.

A survey of major corporations by Robert C. Goshay indicates that FASB standard No. 5, which prohibits annual charges against income for a self insurance program as if the charges were insurance premiums, has had only a negligible effect on corporate risk management programs.

The survey results stand in stark contrast to complaints about the accounting standard by risk managers.

Ever since FASB No. 5 was issued in 1975, many risk managers have complained in public and to each other that the elimination of self-insurance reserves forced them to buy more insurance protecting corporate earnings from year to year.

Most recently, dozens of financial executives, responding to a request from FASB for comments on its first 12 accounting standards, asked the board to repeal the prohibition which they said barred the most economic corporate funding methods.

FASB will consider the letters, and the study that contradicts the financial executives complaints, early next year when reviewing the standard for possible amendment.

The study by Mr. Goshay, a University of California professor now on leave and serving as a vp of the broker Marsh & McLennan Inc., failed to find evidence of FASB No. 5 stifling risk management programs. But it did paint an interesting picture of corporate risk management trends over the last four years.

Mr. Goshay surveyed two separate groups: A study group representing companies that had reserved for self-insured losses prior to the release of FASB No. 5 and control group representing companies that had not reserved for self-insured losses. His findings, based on 74 responses from study group companies and 85 responses from the control group, shows:

- Corporations have maintained about the same ratio of insured to total assets over the last four years, although they are also buying new coverages.
- Corporations have increased deductibles considerably, particularly in the liability area.
- FASB No. 5 has not increased the cost to corporations of legal services or loss protection/prevention services nor has it substantially affected the operation of captive insurance companies.

In addition to presenting his survey results, Mr. Goshay included a chapter in his report of his personal observations as one in touch with risk management developments. Explaining that the maintenance of accrued reserves to pay self-insured losses made self-assumption of risk more palatable to senior management, which was concerned about year-end results, Mr. Goshay asserted, "FASB statement No. 5 affected senior managements' confidence in the risk management message."

Moreover, two risk managers have told him "that risk management decisions in their companies, after the statement, were based on a decision to avoid serious fluctuations in earnings even though the risk could more economically be borne by the company," Mr. Goshay wrote.

Researcher Robert Goshay didn't find proof FASB No. 5 stifles risk management programs.

The study's survey results, however, did not uncover such tales. Of the two corporations in the survey reporting that management had decided to insure rather than self-insure, they suggested the decision was based on "new asset configurations." Conversely, nine companies reported increased use of self-insurance.

Overall, the companies in both groups appeared to be maintaining in the last four years the same ratio of insured assets to the value of total assets. In the study group, 49 firms reported the same ratio, 18 a higher ratio and seven a lower ratio. In the control group, 52 companies reported the same ratio of insured to total assets, 21 a higher ratio and 12 a lower one.

Forty-two companies in the study group maintained the same deductible levels over the past four years. But 20 companies reported doubling deductibles. Another 11 companies increased deductible levels 25% to 50% over the same period. No one in the study group reported a lower deductible level, though three in the control group did. The control group also showed a stronger tendency toward increased self-insurance, with 48 companies reporting higher deductible levels. Both groups indicated strong growth of deductibles on liability insurance.

Twenty-eight firms which went to higher deductibles said they did so to obtain rate relief from insurers, while 19 said the increased deductible was requested by the insurance company. Decreases in deductible amounts were attributed to "risk management decisions associated with shifts to retrospective rating plans or a change in exposure base arising from merger or discontinued operations," Mr. Goshay noted.

Almost all firms reported buying higher limits of insurance over the last four years, 52 in the study group and 69 in the control group. Most agreed they were trying to maintain a ratio between exposures and deductibles, but "another company said that asset growth was a less important reason for increased limits than inflation and replacement costs," the report said.

Thirty companies use a captive insurance company, 16 (or 22%) in the study group and 14 (or 16%) in the control group. But FASB No. 5 caused only two companies to alter the operation of their captives—eliminating catastrophe reserves, which are also prohibited by the accounting standard.

The survey's captive-related questions also found continuing strong interest in these risk fund-

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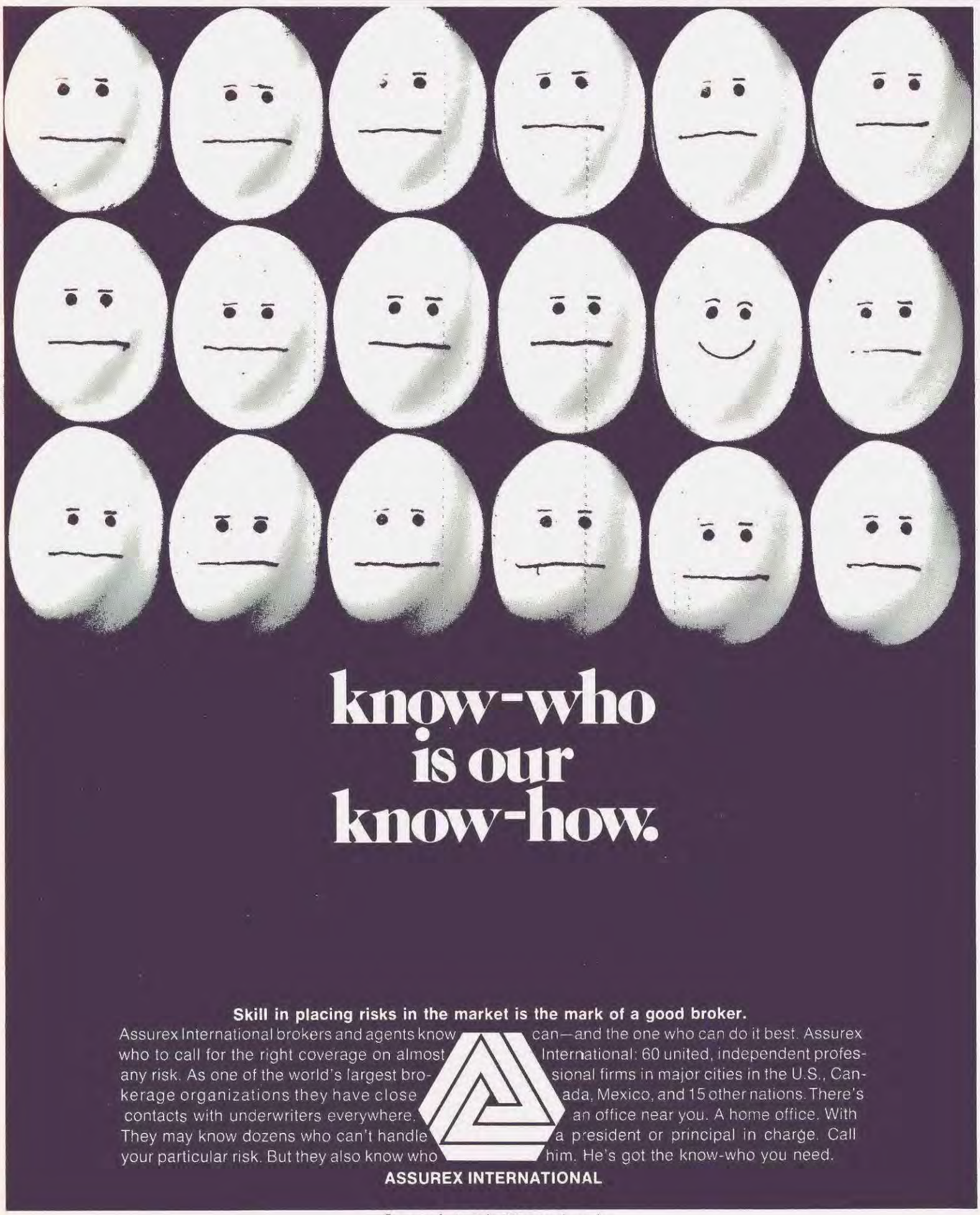

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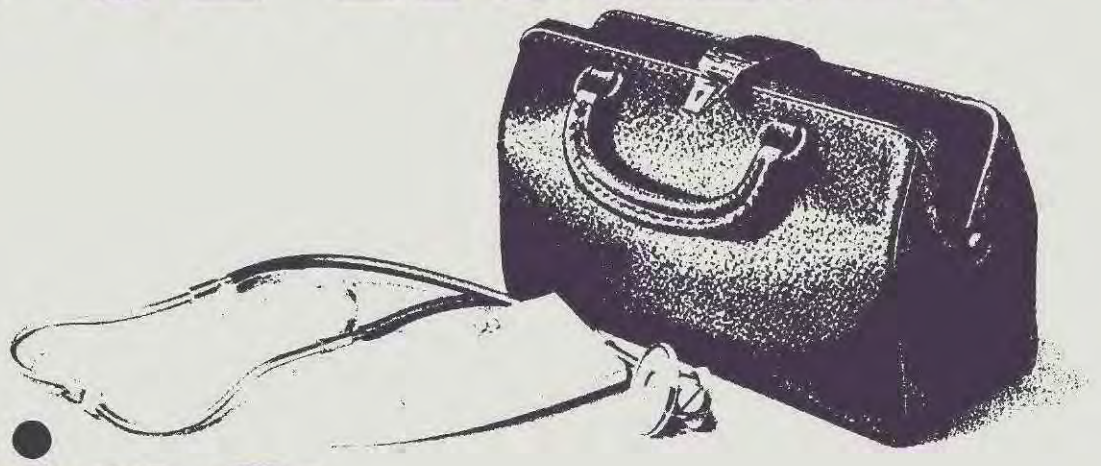
How to hold down the cost of health care claims processing



—and still be quick, fair, and accurate with settlements

For employer and insurer alike, the cost crisis is here—today. It takes more income, more profit to provide the benefits package and to process the group claims. Many cost inflators are squeezing companies now—and none is more visible than those affecting employee benefits. No longer can we be content with "explaining" these away. Many are concerned about cost containment—but MCAUTO is one of those doing something about it. Right now.

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editorial opinions

It sounds good, but . . .

DISCUSSIONS OF A U.S. national health insurance plan inevitably turn to Canada's experience with its national program. Senator Edward Kennedy, in fact, has been accused lately of shrewdly manipulating his national health insurance hearings around the country by bringing in witnesses from Canada favoring these benefits.

Senator Kennedy's idea of a national health plan, we believe, is too expensive. His solution would federalize everything, stifling what little free enterprise there is in the health care delivery system. We need more competition, not less.

But the arguments and testimony about Canada's system raise interesting questions. While the U.S. is fighting rampaging health care inflation, Canada's health care inflation rate is acknowledged to be far worse. This is, the opponents of national health insurance say, only natural, and can be expected from any government sponsored program. Moreover, inflation is exacerbated by the fact such programs encourage users to think everything is free.

It appears, from interviews with corporate insurance and benefit managers in Canada (granted, our sample was limited), that there's overwhelming support in the corporate community for national health insurance there. But it was difficult for anyone to draw a direct comparison between the employer cost of programs there versus the cost of private benefits.

Employers pay their monthly bills to the Canadian provincial governments without complaint, because the program has made life easier for them in many ways. Administratively, the plan is "a piece of cake," says vice president of a large Toronto-based firm. Employers also don't seem to mind paying most premiums for their workers.

Could it be they are merely stuck with the system, so they don't pay attention to cost?

There are other bothersome issues. On the one hand, we've heard health care providers in Canada complain that U.S. citizens living close to Canadian borders in such places as the Pacific Northwest frequently cross over to obtain medical care under the Canadian national plan in, say, Vancouver, because they can't afford the care they need in the States. Or, they may merely want a government to pay the bills. To do this, of course, they lie about citizenship and it's costing Canadians. On the other hand, we've heard tales about exactly opposite situations from U.S. health care professionals near the same borders, who contend that Canadian citizens fed up with long waits for care, doctor shortages, and filled hospitals abandon their own deteriorating system to come to the U.S. for care when they need it.

Nonetheless, several issues must be kept in mind even if there are, as Senator Kennedy contends, some 26 million Americans uncovered by health insurance. One is the inflation problem in health care, stemming substantially from government sponsored programs like Medicare and Medicaid.

Given the extensive private health insurance industry in the U.S. and its ability to administer health benefits, it would be folly to discard a resource which would cost billions to replace at the federal level. Any program should surely include a major role for the private sector, although we would actively discourage the architects from allowing any particular organization—such as Blue Cross and Blue Shield—from maneuvering itself into a position where it can virtually monopolize any private sector involvement.

Finally, employers should have the option of retaining their private health insurance benefits for employes. Corporate America should be provided with incentives, if anything, to continue sponsoring health benefit programs.

Physicals

TO OUR KNOWLEDGE, very few employers have health insurance plans that pay for annual physical exams, although such benefits are becoming popular for executives. If indeed, there is a need to shift our emphasis in this country to preventive health care (stressing health maintenance organizations, among other things) from acute care treatment for illnesses allowed to become serious, then employers should change their benefit plan provisions to pay the full cost—that's right, 100%, up to some specified ceiling such as $50, $75 or $100—of an annual physical exam for all employes.

letters

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible and we reserve the right to edit or shorten letters for clarity or space. Please send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Questions captive

To the editor: Your Oct. 30 issue containing the special risks report was of particular interest to me since I've been involved in placing and underwriting special risks since 1958. (I was a Lloyd's broker for many years before arriving here in Boston 5½ years ago to set up an agency specializing in this class of business using principally the London market.)

We presently do business with one of the best known professional athletic teams based in New York, for example, working with an underwriter at Lloyd's who's acknowledged to be the leader in this field. In my years handling insurance for various kinds of special risks, I've done business with more than a dozen of the leading pro teams and players in the U.S., through brokers.

If Bob Bradshaw is involved in about 70% of the insurance written for professional athletes, we are involved in another 20% or so, I estimate, with other firms handling the remainder, including Gordon Symons in Montreal whose firms is now part of Frank B. Hall & Co.

Aside from insurance for professional athletes, we're also insuring balloonists, actors portraying Peter Pan and swinging on wires, and other special events

Edward A. Dipple
Lockwood, Dipple & Green,
Boston, Mass.

Insures athletes

To the editor: I have read with great interest Margaret LeRoux's article in the October 30th issue regarding skateboard park liability insurance.

Lincoln Insurance Co. has been insuring skateboard parks for over two years and has made a long term commitment to provide the skateboard park industry with appropriate insurance coverages. These coverages are backed by the security and stability of an insurance company with an A.M. Best Co. rating of A "Excellent."

The Lincoln program has been structured with due consideration for the proper spread of risk and the 'tail" which will occur on liability claims. The "tail" I refer to is the time lag between the date a claim is first incurred, then reported, and the final settlement date of the claim. Unfortunately, in our judicial system this could take years and then we can only guess as to the amount which may or may not be awarded.

It is also very interesting to note

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business insurance

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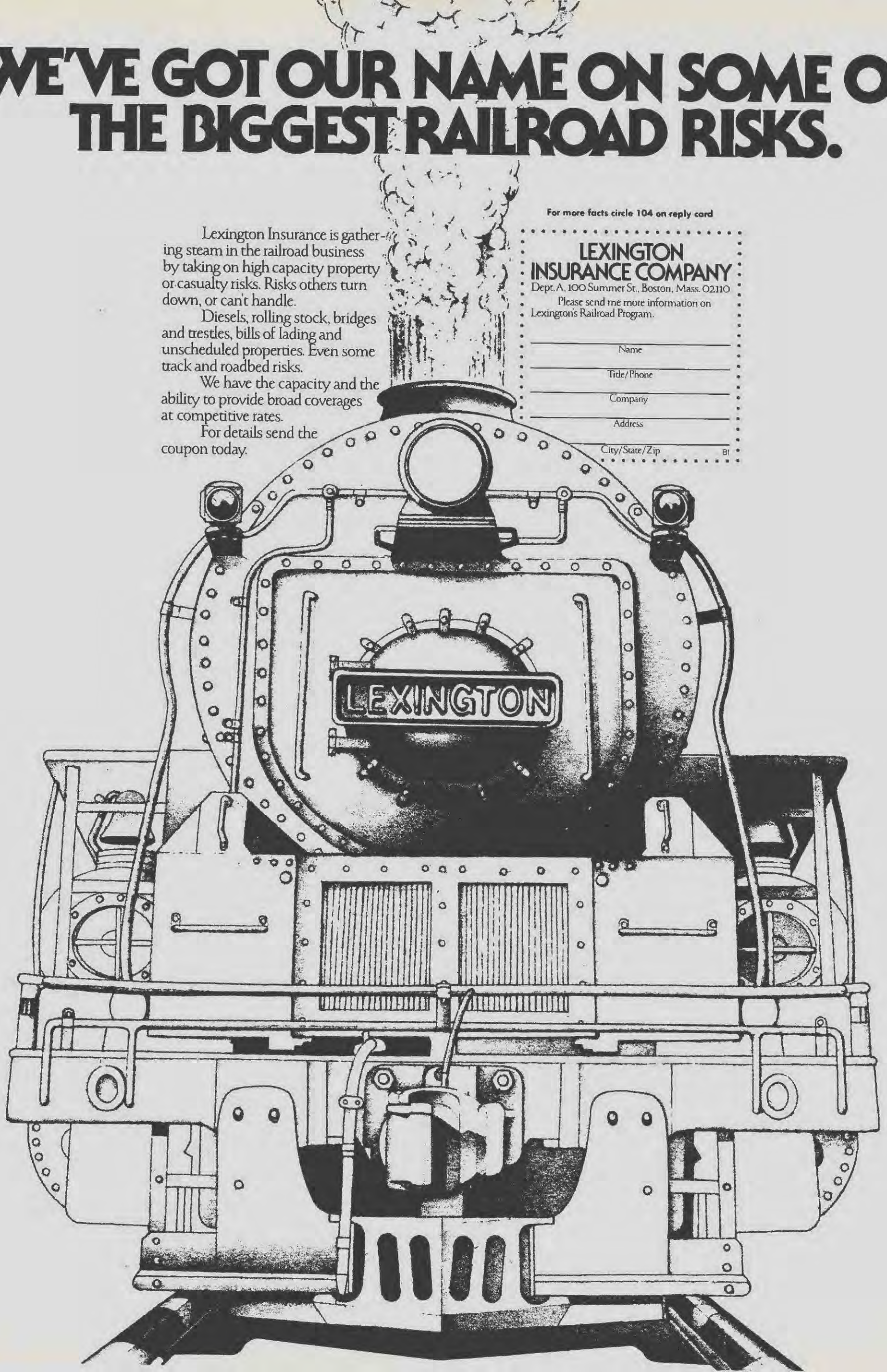

How not to be captive to your captive.

A captive program is not for everyone. But for those seriously thinking about one, an important consideration is how to operate it in a way that doesn't place you in a bind but allows you to achieve your objectives.

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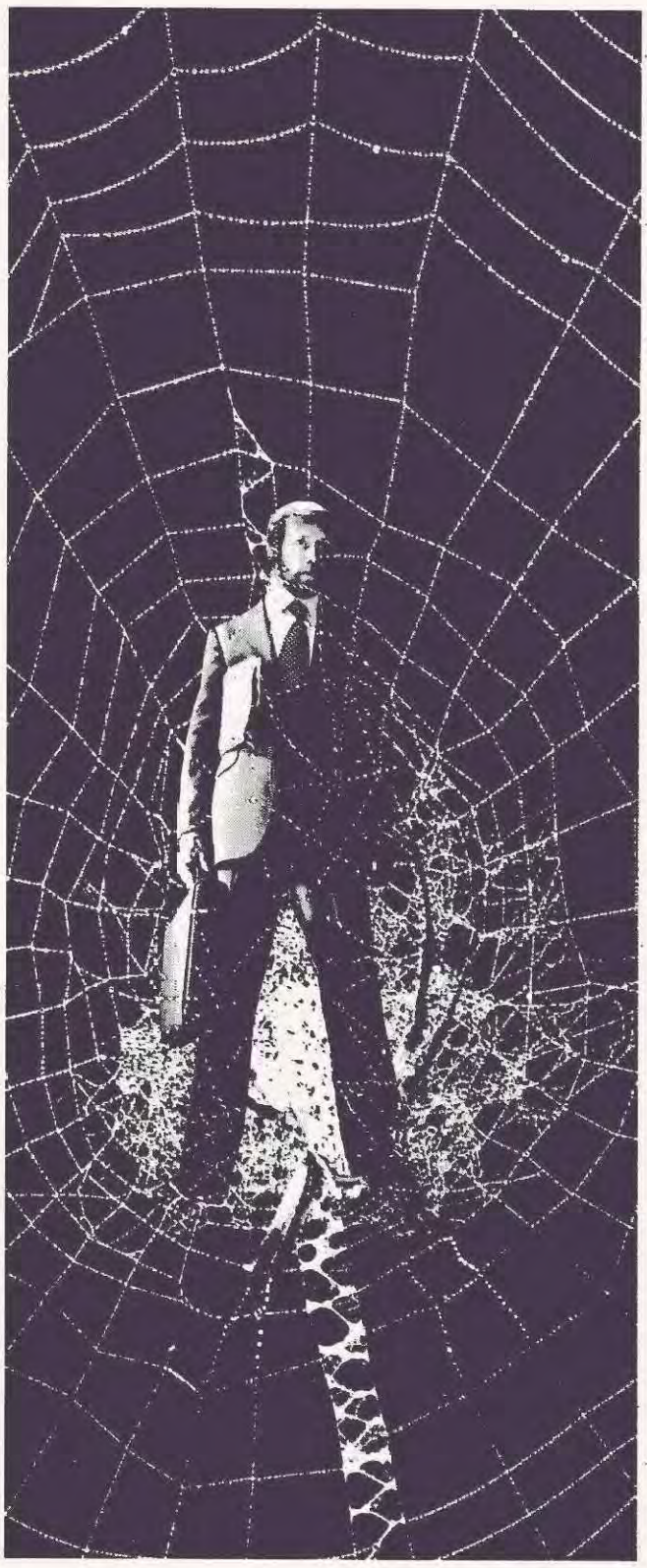

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Employe Benefits

Canadian employers, employes extol their provincial style national health

By JERRY GEISEL

TORONTO—While the U.S. talks about national health insurance, the Canadians are enjoying the fruits of government-sponsored medical and hospital insurance plans providing superior benefits at lower costs.

The plans, administered by Canada's 10 provinces and two territories with heavy federal financial contributions, enjoy such overwhelming popular support that it's inconceivable to most Canadians to return to a private system.

Evidence of that support abounds. "The people of Ontario are 100% behind the health insurance plan," a customs official told a *Business Insurance* reporter arriving at Toronto International Airport. "I don't know what I'd do without the provincial plan," added a Toronto cab driver.

Employers, too, praise Canada's public health plan.

"I could never believe that the private system could match the public programs," says David Hart, pension and insurance manager for Bata Ltd. in suburban Toronto. "I don't think there is any doubt that health care is an area for the public sector to handle."

A recent Gallup poll revealed that 84% of Canadians rate health care as a good value for their tax dollars—a higher rating than for any other public service.

The plans have retained the virtues of private systems, yet avoided the vices of many other public plans. Canadians have free choice of physicians and hospitals; long waits for elective surgery, such as in Great Britain, are unknown here. Even though the net of coverage is much broader here than in the U.S., Canadians pay less per capita for health care than their U.S. counterparts.

Why Canadians—employers and citizens alike—support their public health insurance plans becomes clear when one looks at the benefits as well as the way the plans are structured.

"Our provincial plan has dispelled the fear of a financial wipeout," says Don Elliot, manager of employe compensation services at Canada Packers Ltd., one of Canada's largest employers. "No longer can a medical disaster take away someone's life savings."

Benefit managers like Mr. Elliot agree that the provincial plans have also made life easier for them and their corporations. For, unlike most government programs, there is virtually no paperwork burden in the provincial health plans. For employers, the plans are "a piece of cake," says R. W. Quirk, vp of administration at Cadillac Fairview Corp. Ltd. in Toronto.

Under the terms of landmark legislation that the Canadian Parliament passed during the 1950s and 1960s, more than 99% of all Canadians receive comprehensive prepaid protection against the costs of medical services from doctors and surgeons, all hospital inpatient treatment and accommodations and a wide range of outpatient and extended care services. These benefits comprise the federally mandated base program.

Some provinces, at their own expense, have added extra benefits. Quebec and Prince Edward Island,

Continued on page 12

Day care: An employer benefit, too

By KATHRYN J. McINTYRE

BOSTON—A young, talented computer programmer employed by Stride Rite Corp. here turned down a federal government job she'd been waiting for because the shoe manufacturer offered her a benefit the government didn't.

Day care for her daughter was provided by the company for just 10% of her salary to a maximum of $25 a week in a center at the corporate headquarters.

This is just one example of how company-sponsored day care for employes' children can benefit a corporation, says Stride Rite Children's Center director Miriam Kertzman.

"Companies in the inner city can attract and hold onto employes. It cuts down on absenteeism. And the EEO people see it as a way to alleviate the problems of employing women," Ms. Kertzman suggests.

At the Amalgamated Clothing & Textile Workers Union day care center in Chicago, director Muriel Tuteur concurs. Day care provided in conjunction with employment "improves attendance and punctuality," she believes. The center doesn't get sick, run late in the morning or just not be there as babysitters are notorious for doing, she explains.

The two directors of the pioneer employment-related day care centers—one paid by an employer and the other paid out of union health and welfare funds collected from employers—cite the advantages of this seldom supplied employe benefit and the ease with which it can be provided.

They both agree that in addition to the tangible benefits to an employer of better employe attendance and punctuality as well as a more stable work force, day care offers employes who are parents "peace of mind that their children are safe and well cared for." Peace of mind, they note, is important to how well an employe performs her or his job.

Stride Rite's company location of its center further enhances a parent's peace of mind about his or her child's care because the parent can drop in during breaks and lunch time to visit the children. This is particularly important if the child is on medication, Ms. Kertzman noted.

Both day care centers, opened early in the 1970s in recognition of the need for day care among the employes, were and continue to be mavericks. "The company is progres-

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Photo: Kathryn J. McIntyre

Muriel Tuteur, director of the Amalgamated Clothing & Textile Workers Union's day care center in Chicago, joins in a holiday song.

Insured trusts compete for small groups

By GREG DAVID

CHICAGO—Small companies, once forgotten when it came to health insurance coverage for their employes, are the new prized market for insurance companies.

"The market of small employers is untouched," says Don Lawrenz, president of Beneficial Employers Security Trust (BEST) in Newport Beach, Calif., which insures more than 24,000 employers nationwide.

"It's a very competitive area," agrees Tom Tennant, assistant vp with Pacific Mutual Insurance Co., which expects to end the year with 20,000 employes in its multiple employer trust. Pacific Mutual, also based in Newport Beach, estimates more than two million small employers are candidates for a multiple employer trust.

"There is no way these small employers can buy good coverage without some sort of multiple employer trust or association program," adds Richard Biles, a trust administrator in Los Angeles.

Small employers are placed in the multiple employer trust to create the pooling of risks and lower costs typical of larger group insurance programs. They are often created and marketed by independent administrators, who then find an insurance company to underwrite the group.

Although the third-party administrator approach continues, more insurers like Pacific Mutual and State Mutual of Worcester, Mass., market their own trusts directly through their agent and broker networks. And the giant group insurance companies—Prudential, Aetna Life & Casualty and John Hancock—are new entrants, offering small employers having two to 25 employes some of the widest health insurance choices in years.

"The giants are coming in late, but they are applying their marketing expertise," said Mr. Tennant of Pacific Mutual.

Most of the insurance companies and third-party administrators report rapid growth in their multiple employer trusts. Pacific Mutual's 20,000-member trust is up 50% this year while State Mutual's recent annual growth rate of 3,000 to 4,000 new insureds will more than double for 1978. BEST president Don Lawrenz, who says "growth has never stopped since the trust was founded in 1970," is adding 1,000 employers a month.

The story is slightly different for Mr. Biles's National Employers Security Trust in Los Angeles. Formed in 1973, the trust grew from 1,500 persons to more than 10,000 in 1975 when the trust was underwritten by Old Republic Insurance Co. of Chicago. But Old Republic, which went from $4 million to $60 million in multiple employer trust business in one year, was forced by the Illinois insurance department to terminate the trusts it insured when the business almost bankrupted the insurer.

Mr. Biles's trust was severely hurt by the scramble following the Old Republic decision. It now insures only 5,000 persons and is growing slowly.

The National Employers Security Trust operated by Mr. Biles offers four options to small employers including a high-cost, high-benefit plan insured by Southern California Blue Cross (selected by about 75% of the employers), a lower cost plan with Continental Life & Accident Co., a health maintenance organization program with Ross-Loose Medical Group, and an optional dental plan.

Rates range from $140 a month for family coverage for an employe under 40 years of age in the Blue Cross plan to about half that amount in the Continental plan with a $500 deductible.

National Employers will accept companies with up to 50 workers, but its key area is companies with three to 25 employes.

Mr. Lawrenz's BEST operation offers eight different plans, but offers only some of the plans in each part of the country rather than have different rates for high medical cost areas and lower medical cost areas. Unlike most other

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Canada's plan . . .

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for example, provide routine dental care coverage for young children; Manitoba pays for prescription drugs used at home.

The benefits are portable from province to province and coverage also applies for Canadians who temporarily leave the country.

By contrast, about 10% of the U.S. population lacks any health care insurance and 40%, or a whopping 88 million Americans, have no insurance to pay for very large major medical bills, according to the Department of Health, Education and Welfare.

Moreover, many employer-sponsored group insurance programs in the U.S. slap participants with sizeable deductibles or require coinsurance payments. There aren't any coinsurance arrangements in Canada's provincial

Employe Benefits

plans, but a few provinces charge small fees (never more than $6 a day) for long term hospital care.

Since the plans cover routine as well as catastrophic expenses, Canadians do not have to fear that an illness or injury can result in personal bankruptcy.

Canada's provincial health insurance plans haven't spawned a huge federal bureaucracy because the role of the federal government here is limited to paying a share of the costs as well as setting basic benefit standards. Each province administers its own plan, decides how to raise its share of the costs and determines what extra benefits it will offer.

For example, federal and provincial governments together pay about two-thirds of the Ontario Health Insurance Plan's (OHIP) costs. Residents pay about one-third of OHIP costs through $19 per month premiums for individual coverage and $38 monthly premiums for family coverage. OHIP is the largest of Canada's provincial plans.

Most Ontario employers pay some or all of the OHIP premiums for their employes. Residents over 65 are exempt from paying premiums and subsidies are provided for persons receiving welfare assistance.

However, in most provinces, no premiums are charged as the full cost of the provincial plan is paid out of federal and provincial tax revenues.

By most accounts, provincial administration generally has been smooth and efficient. "From a user point of view, we really don't experience any inefficiencies," asserts Mr. Quirk of Cadillac Fairview Corp.

Only 2,300 staffers are needed to operate OHIP with its 8.5 million participants. OHIP staffers process some 60 million claims annually and pay most physician fees within six weeks of the time the bill is received, says OHIP director of data development and evaluation branch H. I. MacKillopp.

Administrative costs of operating OHIP are between 4% and 5% of benefits paid. "I doubt if private insurers could do much better than that," says Mr. MacKillopp. Even benefit administrators and consultants in the U.S. say this is a "very competitive" administrative cost structure.

While major social policy programs in the U.S., such as the pension reform law, have imposed major reporting burdens on employers, Canada's provincial health plans have relieved companies and their employe benefit managers of many administrative headaches and paperwork burdens.

In Ontario, employers simply forward a monthly check to OHIP covering the premiums of their employes. In several provinces where all the costs of the health plan are paid out of general tax revenues, employers are spared even this minor task.

The provincial health plans, because they cover all basic benefits, allow Canadian benefit and compensation managers to devote full time to administering their companies supplemental benefit programs such as vision care and paid sick leave plans. This isn't merely the government's wishful thinking; employers themselves testify that the plan has had this result.

Despite the vast array of benefits offered the entire population, Canadians pay a lot less for their health care system than Americans pay for a system in which benefits are provided largely by private insurers through employers' group insurance programs. In 1976, public and private health care costs in Canada soaked up 6.8% of the gross national product (GNP); in the U.S., on the other hand, health care expenditures amounted to 8.6% of GNP.

Americans are paying more per capita for their largely private health care system, but the average Canadian lives longer than the average American. Moreover, infant and maternal mortality rates are higher in the U.S. than in Canada.

The major reason Canadians can spend less and get more medical and hospital services than U.S. citizens is built-in cost containment controls in the provincial plans, its proponents assert.

Each year, a province's health insurance officials meet with representatives from the provincial medical association to determine physicians' fees for thousands of surgical procedures as well as for office visits.

Once an agreement is reached, physicians participating in the provincial plan must abide by this negotiated schedule. The fees which doctors can charge in Ontario are about 30% less than what U.S. physicians charge for comparable services, Mr. Mackillopp of OHIP

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How much is the cost?

TORONTO—One problem with Canada's provincial health insurance plans is that employers do not know exactly how much the plans cost because the bulk is paid out of general tax revenues.

In Ontario, however, benefit costs do vary from company to company since employers can choose to pay the plan's monthly premium charges on behalf of their employes. Canada Packers, for example, pays the entire $19 monthly premium for individual coverage or $38 premium for family coverage for its employes. On the other hand, Bata Ltd. requires its employes to pay their own full premium.

Canadian employers cannot find out what the provincial health plan would cost if they purchased the identical benefits from insurers since under Canadian law private insurers only can offer benefits not included in the provincial plans.

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Canada's plan . . .

Continued from page 12
said.

Other observers believe the differences in fees may even be greater. "I'm just flabbergasted at what they charge for certain surgical procedures in the U.S. compared to what they are here," says Ian Bray of the Bank of Nova Scotia in Toronto. In the U.S. some doctors will charge whatever the market will bear once they find out that the patient has insurance, Mr. Bray asserts. "That can't happen here."

Doctors are highly skilled professionals and they deserve equitable compensation, says Mr. MacKillopp. "That is why the provinces and the physicians negotiate first. But no one party should ever have too much power and have the right to set prices unilaterally."

Like their American counterparts, Canadians have the freedom to go to the doctor and hospital of their own choice. In most cases, a patient never even sees his doctor's bill. The physician simply fills out a form indicating the service performed as well as the patient's health insurance plan number, and the plan will reimburse him according to the negotiated fee schedule.

However, about 5% of Canadian physicians (15% in Ontario) have opted out of the provincial programs. Physicians who choose not to abide by the negotiated fee system charge their patients the fee they feel is appropriate. The patient then pays the doctor and is reimbursed by the provincial plan—but only for the amount listed in the fee schedule.

Fee schedules have limited some doctors' incomes, to be sure, but the supply of doctors has expanded substantially nonetheless. In 1965, before the provincial medical plans began, there were 128 doctors per 100,000 Canadians; by 1976, Canada had 173 doctors for every 100,000 people.

Critics of the Canadian system charge the provincial plans with failure to stem health care cost inflation. In Ontario, for example, the costs of the plan between 1970 and 1978 leaped 168%, or 13.1% a year, twice as fast as consumer goods prices. In most provinces, health care costs have been rising at a faster clip than in the U.S.

But these simple cost comparisons can be misleading, retort Canadian benefit executives. Since the provincial plans cover the entire population, annual cost increases are bound to be higher than in the U.S., where "bad risks" often lack coverage, notes one compensation manager.

"You've got to expect more costs if you provide medical and hospital care for a segment of the population that otherwise would be ignored," adds Mr. Elliot of Canada Packers.

Employe Benefits

Critics of the Canadian system also contend that public health plans lead to overuse of services. For example, hospital utilization has been consistently higher in Canada than in the U.S. In 1975, the latest year in which comparable data is available, the hospital days of care per 1,000 population were 1,830 in Canada compared to 1,284 in the U.S., a 43% difference.

But the utilization of services statistic also can be misleading, says John E. Trimble, benefit manager at Eaton's, the big Canadian retail store chain. "There are many people who couldn't afford health care services before the provincial plans. Now they are receiving those services. I don't believe that can be considered overutilization."

While there have been reports of fraud and abuse, the extent of corruption appears minor compared to the abuses that have rocked U.S. government health insurance programs such as Medicaid and Medicare.

As a check on possible fraud, Ontario health plan computers each month randomly select about 2% of physician claims to check if the doctors performed the services for which they requested reimbursement.

Some Canadians believe the government erred by not allowing employers to purchase group policies from private insurers. A less costly health care solution would have been to create a public plan to cover Canadians without access to group insurance while allowing employers to keep their group plans, maintains Gordon MacKenzie vp at William Mercer Ltd. in Toronto.

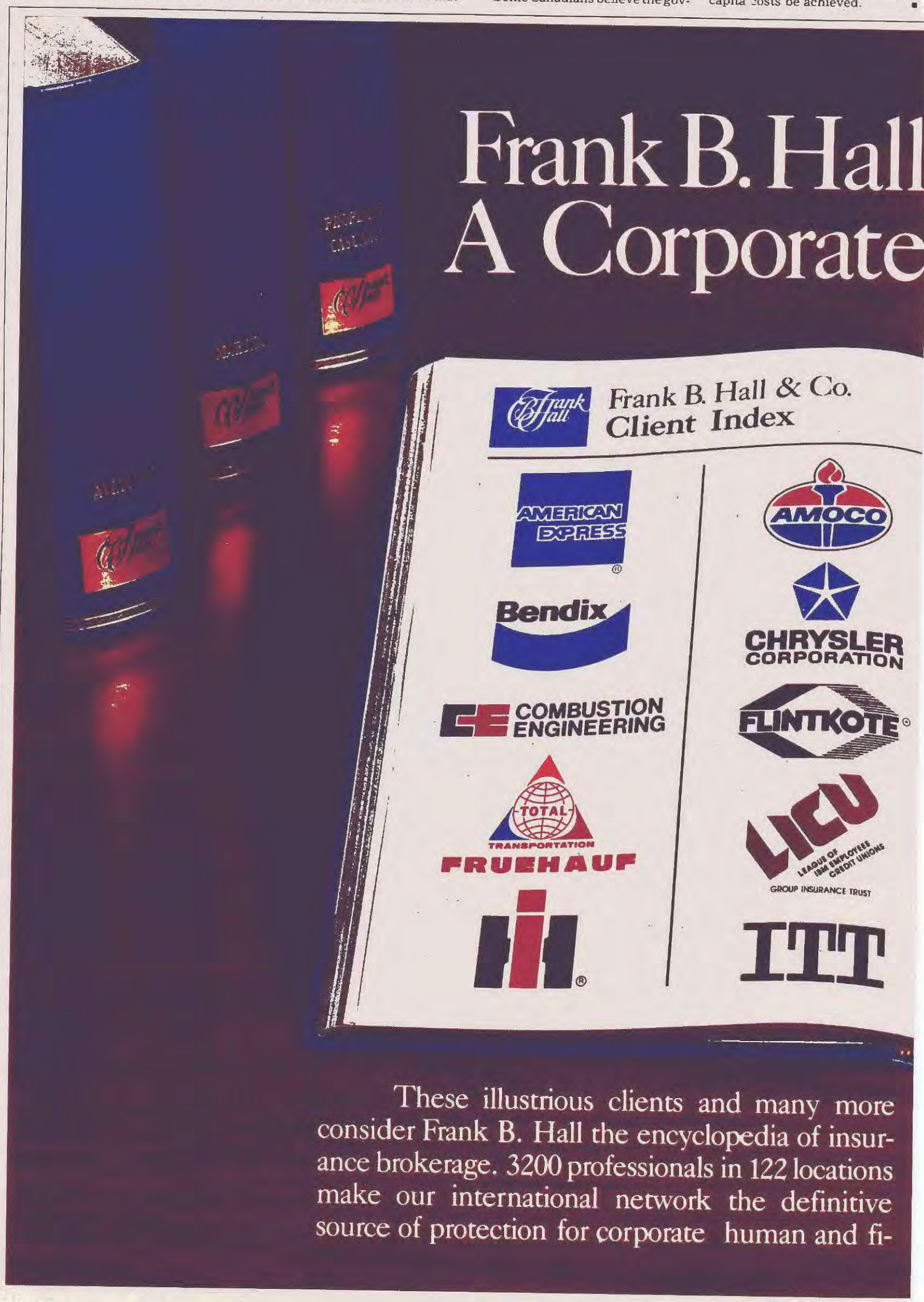
But Canadian officials observe that only by including all risks, not just persons who are not covered by group plans, can the lowest per capita costs be achieved. ■

AIG purchases Mission's stock

NEW YORK—American International Group Inc. has acquired 6.2% of the common stock in Los Angeles-based Mission Insurance Group Inc. But AIG says it doesn't have any plans to take over Mission.

In a filing with the Securities & Exchange Commission, AIG reported it acquired 282,000 of the 4.6 million shares outstanding of Mission's common stock as of Nov. 3. AIG said the purchase was for "investment purposes."

Mission president E.R. DeRosa recently told the New York Society of Security Analysts that he and AIG chief executive officer Maurice R. Greenberg see ways in which the two firms can work together, possibly exchanging business. Mr. DeRosa said reinsurance agreements would be the most likely area of cooperation. ■



employe benefit board

More employers are switching to self-funding

By SUSAN ALT

CHICAGO—Rising benefit bills have spurred a growing number of employe benefit managers to eye self-insurance as a solution to a problem that's expected to continue into 1979.

This is the picture painted by the latest Employe Benefit Board survey in which a sizeable group of participants indicated they've changed insurers in the last two years, are considering making more changes still, and hope to use a lot more self-insurance in the coming year.

Self-insurance may have helped some companies hold down their costs, evidenced by a smaller portion of benefit managers reporting cost increases during the last year than when a similar survey was done two years ago. This time around, three-fourths of the 75 benefit chiefs surveyed said their premiums and/or benefit costs have risen in the past 12 months. It's a large group, but not as large as the 87% of benefit managers who said in late 1976 they'd seen more dollars flowing out.

Most of the increases within the last year were for health and medical coverage and were in the 11% to 20% range, the survey revealed. Many companies also paid 1% to 10% more for medical benefits. In total, over half the group said increases fell in that range of 1% to 20%. Not surprisingly, only one benefit department head said medical and health costs fell last year, by 10%. These responses show increases were not quite as high as they might have been several years ago, when the Benefit Board survey revealed an average increase of 19.5% in health/medical benefit costs for the previous year.

Part of the reason for smaller increases may be an increased amount of self-insurance.

Eleven out of the 75 participants in the survey said dental benefit costs had risen substantially, usually between 11% and 25% although one manager said his plan's cost zoomed 80% last year.

Eight participants said long term disability plans are costing more, but increases have usually been in the lower ranges of 1% to 10%.

Group life insurance costs more now than it did 12 months ago for eitht companies, most of whom said premiums rose by 10% to 15%.

Travel accident coverage became much more expensive for several firms, although they represented only a tiny minority of firms that experienced any increase at all. Two firms reported premium hikes of 200% to 450%.

Self-insurance may be helping some firms to control their costs. The latest survey documented a trend evident in a number of studies done throughout this year: More companies all the time are turning to self-funding of benefit plans. Four out of five companies in our survey currently self-fund some benefit plans, compared with about 70% of the participants responding to the 1976 survey when the same question was asked.

Not only have more companies turned to self-funding, but there's

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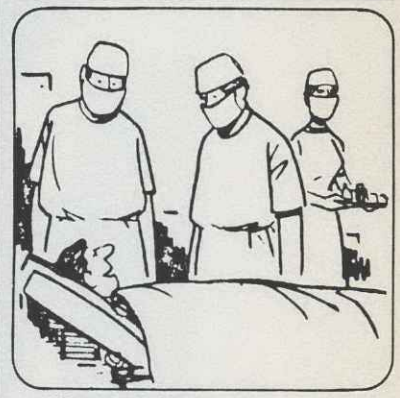

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Benefit Board . . .

Continued from preceding page
continuing interest in changing from insured to self-insured programs for other benefits, *Business Insurance* learned. Exactly half the group of benefit survey participants plans to go self-insured on more benefits in coming months, the same proportion of managers as in the 1976 survey saying they'd use self-funding more.

Long term disability benefits are the leading candidates for more self-insurance, the same finding as two years ago. Half of those who will use more self-insurance for benefits will make the move on LTD, followed by health and medical plans which are also leading candidates for self-funding methods.

One out of every three benefit managers has changed insurers on group benefit programs within the last two years, evidence of competition within the group life and health insurance industry and the shift to self-insurance, which often requires the purchase of administrative services from one of the big carriers. The share of market held by the various insurers has changed significantly, based on what the Benefit Board participants said about the companies they're using for insured programs and ASO plans.

For group life insurance programs, for example, leading insurers were Prudential, Aetna L&C, Travelers, Metropolitan Life, Connecticut General and Equitable, in that order. (Only two of the 75 participants said they were self-insured for group life benefits.)

Prudential, however, appears to have lost corporate customers for group life coverage based on *BI's* survey, compared to the survey findings of two years ago; similarly Met Life and John Hancock appear to have lost market share among the large accounts. Travelers had the same number of customers among our Benefit Board members as it had two years ago, but Aetna's customer rolls grew substantially from two years ago, with 14 group life customers on the Benefit Board now, versus half that many in 1976.

One out of every three benefit managers has changed insurers within the last two years, and equally many are considering changing insurers within the next year. Benefit chiefs overwhelmingly believe in putting their programs out for bids.

Blue Cross/Blue Shield led the field for group health and medical plans, with slightly fewer customers among participants than in 1976, while Prudential and Aetna tied for second place. This indicates a significant loss of customers for Prudential among Benefit Board members, although Aetna's share, again, nearly doubled. Travelers came in fourth, also doubling its customers among Benefit Board members. Metropolitan Life had its share of market among the 61 Board members using insurers for group health plans, sliced in half from two years ago.

Employers on the Benefit Board providing long term disability benefits most frequently use Prudential as their insurer, which also held the lead spot in the 1976 survey. Aetna was the second most-used LTD carrier, a major change since it was notably absent from the list of most-used carriers for LTD two years ago. In the number two spot in 1976 was Unionmutual, which lost customers among Benefit Board members and slipped to fifth place. Metropolitan and INA tied for third most-used carriers. INA appeared to gain a number of clients from two years ago.

Travel accident coverage is by an overwhelming margin, most frequently purchased by board members from INA, with four times more survey participants using INA than the next most popular carrier, Hartford Accident & Indemnity. INA appears to have greatly increased its customer rolls for this coverage over the last two years, based on the survey. Hartford also appeared to gain customers, while American Home Assurance appears to have lost customers. Only five board members use American Home for travel accident coverage now, versus twice that many two years ago.

Dental insurance is most frequently bought from Travelers, Prudential, Aetna, Equitable and Metropolitan. Travelers appears to have gained a share of market, while Metropolitan and Connecticut General slipped.

Travelers, Equitable, Metropolitan and Prudential are most frequently used, in that order, by companies using insurers for pension or profit sharing plans.

The number of Benefit Board members considering changing insurers within 1979 bears a close resemblance to the number of companies that have changed in the last two years. About one-third of the survey participants said they had changed insurers in the last 24 months or so, while another 30% are considering changing carriers next year or are presently reviewing their plans.

This might be expected in view of the number of benefit managers who believe strongly in going out for competitive bids on their programs. Periodically two-thirds of the group put their plans out for bids, with about one-third of those doing so only as markets or program changes necessitate. But half said they go out for bids every two to five years no matter what. ■

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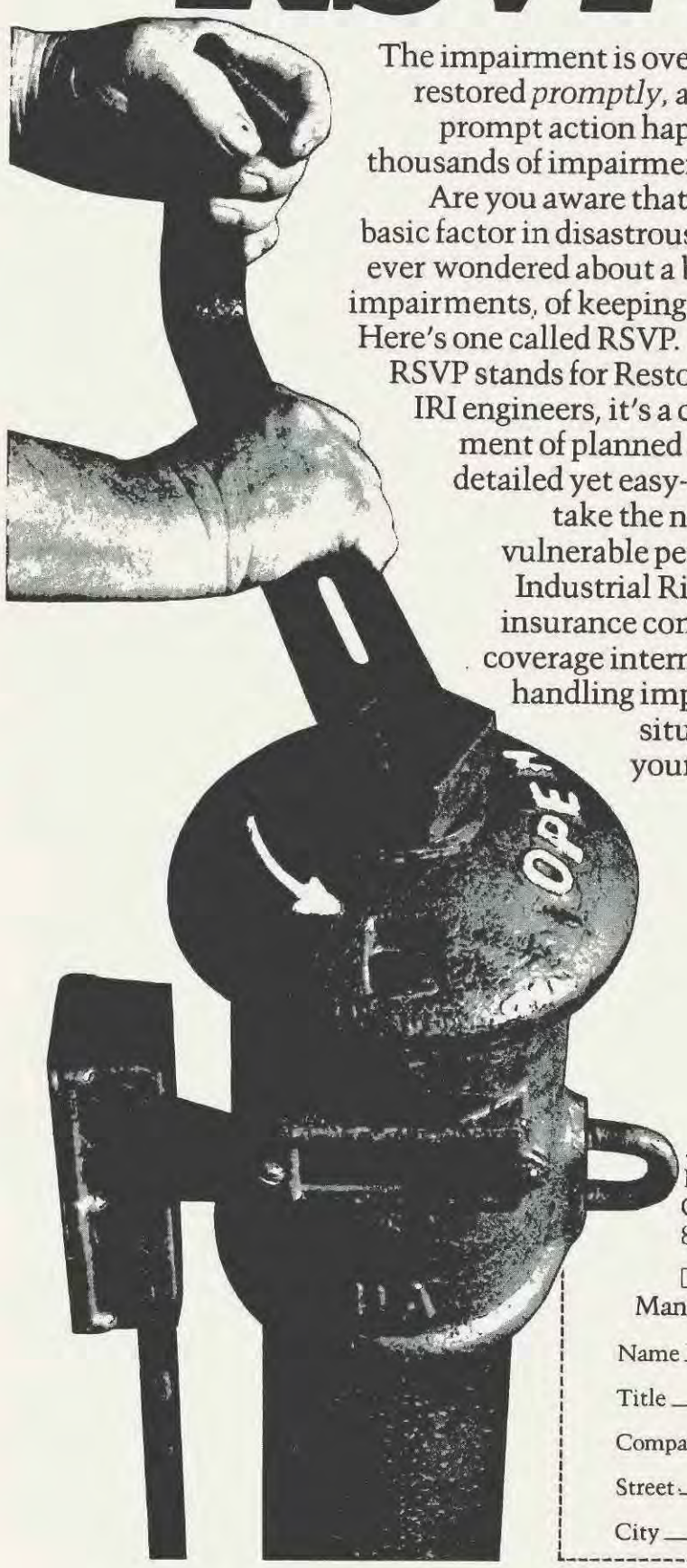

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Calif. union tests second opinion plan

By MARGARET LeROUX

STOCKTON, Calif.—A pilot program introducing a second opinion plan for elective surgery goes into effect this month for more than 7,000 cannery employes in the San Joaquin Valley.

Administrators of the plan say the cannery workers comprise the first union group to have a second opinion plan in California. Unlike New York, where group health insurers must by law offer the option of a second opinion plan, no such requirement exists in California.

A spokesman for the national office of Blue Cross in Chicago said there is no systemwide program of second opinion plans on the entire West Coast.

"We're expecting the second opinion plan to reduce surgery from 20% to 30%," said Ron Stevens, administrator of the cannery workers plan. "But even if the reduction is on the low side of 20%, it's still a savings for the plan."

The pioneer second opinion plan has already generated an enthusiastic response from physicians in the San Joaquin Valley, Mr. Stevens said. "After a single solicitation by mail two weeks ago we've already gotten 50 responses from physicians agreeing to serve as consultants for second opinions."

Employe Benefits

Mr. Stevens, vp of U.S. Administrators, which manages approximately 200 employe benefit plans, noted it would be difficult to measure the success or failure of the cannery workers second opinion plan because "we have nothing in the state to compare it to."

"It's odd that California was a leader in the health maintenance organization (HMO) movement but lags behind in second opinion plans," the benefit manager for a San Francisco Bay area corporation said.

"We've looked at second opinion plans, but there's not much information available on the West Coast," a spokesman for Crown Zellerbach said.

Among northern California companies that include a second opinion benefit for elective surgery in their group health plans are Levi Strauss & Co. and Pacific Telephone.

"The benefit is there but it hasn't been widely communicated," admitted Sara Gingrich, Levi's health and welfare plan administrator. Claims for Levi's self-insured group health plan are administered by Aetna and no statistics have been developed on the second opinion plan, she said.

Pacific Telephone introduced a second opinion benefit for some 100,000 employes in the West at the beginning of this year. A company spokesman said, "We've communicated the benefit through brochures, but have gotten no indication either favorable or unfavorable from employes about the benefit."

At the University of California in Berkeley, employe benefit personnel are discussing second opinion plans with Blue Cross of Northern California. "We're interested in them as a cost control measure, but we haven't explored the possibility thoroughly," said benefit administrator Kay Baldinelli.

Second opinion plans have been cited by health care professionals as having the potential to save millions of dollars since their introduction in New York seven years ago (*BI*, Feb. 9, 1976).

The first union group benefit plan to do so, the 12,000-member Department Store Workers, saved $1 million in 1977, according to Eleanor Tilson, union vp and administrator of the plan, when 300 of those covered chose not to have surgery after obtaining a second opinion. The plan covers a total of 25,000, including families of union members.

The savings were based on the cost of an average stay in a New York hospital, Mrs. Tilson said, an amount estimated between $1,600 and $1,700.

The 300 cases cited in the calendar year 1977 were people who did not have surgery within a year of using the second opinion benefit.

The 100,000 member Municipal Employes Union saved $1.5 million in 1977 when 376 people covered by the benefit used the second opinion and decided not to have surgery.

Rosalyn Yasser, administrator of disability and catastrophic health benefits for the union, said the savings were based on surgical and medical claims averaging $1,100 per case and an average length of hospital stay for surgery of 15 days at $210 per day.

The union has offered the second opinion benefit as an option since 1972, but only recently it was man-

Continued on page 22

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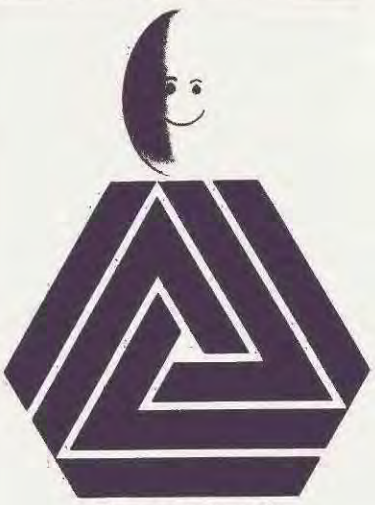

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Second opinions . . .

Continued from page 20
dated for those covered by the plan to get a second opinion for procedures in excess of $500.

"We've seen a direct impact on our disability and catastrophic medical benefits," Mrs. Yasser said. "We've seen a 25% reduction in the amount of surgery done."

Not all group experiences with second opinion plans have been as favorable as the New York unions. In Hartford a two year experiment offering the second opinion benefit as an option has been little usage.

Getting people over their hesitancy to go against their doctor's opinion is one of the major problems with second opinion plans, according to John F. Byrnes, assistant vp of Blue Cross and Blue Shield of Greater New York. As a remedy, "we offer them, complete confidentiality in obtaining the second opinion if they wish."

After deducting start up costs for the program, Blue Cross of New York estimated the second opinion plan saved $250,000 for the first 1,500 cases where the benefit was used.

"Voluntary programs aren't nearly effective enough," Department Store Workers union's Mrs. Tilson said. "But a mandatory program done with some intelligence will allow members of the health plan to perceive it as an added benefit."

According to Dr. Eugene McCarthy of Cornell Medical College in New York, a leading proponent of second opinion plans, there is too much surgery being done.

A recent survey done by the American Hospital Assn. found the rate of surgery has increased more than five times that of hospital population since 1971, he noted.

In a disturbing corollary, the American Public Health Assn. found a significant drop in the death rate in Los Angeles County in 1976 when many surgeons withheld their services during the malpractice crisis. During the slowdown period there was a 58.7% reduction in surgery and decrease in the death rate for each of the five weeks of the period.

But when surgery resumed, the death rate per 100,000 population increased to 26% from 19.2%. ■

Applying cost controls is a matter of plan design

By ELLIS SIMON

Employe Benefits

NEW YORK—Regardless of what level of benefits a medical insurance program provides, it can be designed to encourage users to be cost-effective buyers of health care services.

So say benefit consultants asked by *Business Insurance* what benefit and cost containment features should be designed into the "model" medical benefit program.

Consultants alluded to this kind of model health insurance plan as a pipedream, indicating there's not much chance any employer can succeed in implementing it.

Medical plans should be designed to reduce overutilization and encourage treatment by providers who can do it most efficiently, said James Harlow, senior vp and director at Johnson & Higgins. A well-designed plan provides for financial security, promotes good health and discourages wasteful treatment, he added.

The key is to shift the incentives in health care delivery out of hospitals and into less costly outpatient facilities, explained Frank Finkenberg, a consultant at George B. Buck & Co.

"A lot of plan sponsors talk about cost control, but there are not too many that apply it," commented Burke Leahey, a consultant with Hewitt Associates. "The problem is if you put in say, a preadmission testing feature, there may be no financial incentive for it to work. A person may choose to go into the hospital for testing just to get away from the kids."

Plan designers should include benefit differentials to make cost containment features more attractive to the employe, Mr. Leahey urged.

For instance, a plan can provide 80% reimbursement for services performed in a hospital but 100% payment for the same procedures done on an outpatient basis.

At the very least, the plan designer should assure that use of outpatient facilities won't cost the employe any more than if he went into the hospital, said Mike Reynolds, senior vp at Frank B. Hall & Co.

J&H's Mr. Harlow advocated front-end deductibles on hospitalization, even in rich plans, to discourage unnecessary hospitalization. However, outpatient testing, such as X-rays and lab work, and an annual physical should be fully covered, he suggested.

"It doesn't make much sense to put a financial barrier on something with early detection value," added J&H vp James McDonald.

Several vehicles for keeping patients out of hospitals are available to medical plan designers. On the front end, they include covering pre-admission testing, outpatient

Continued on page 26

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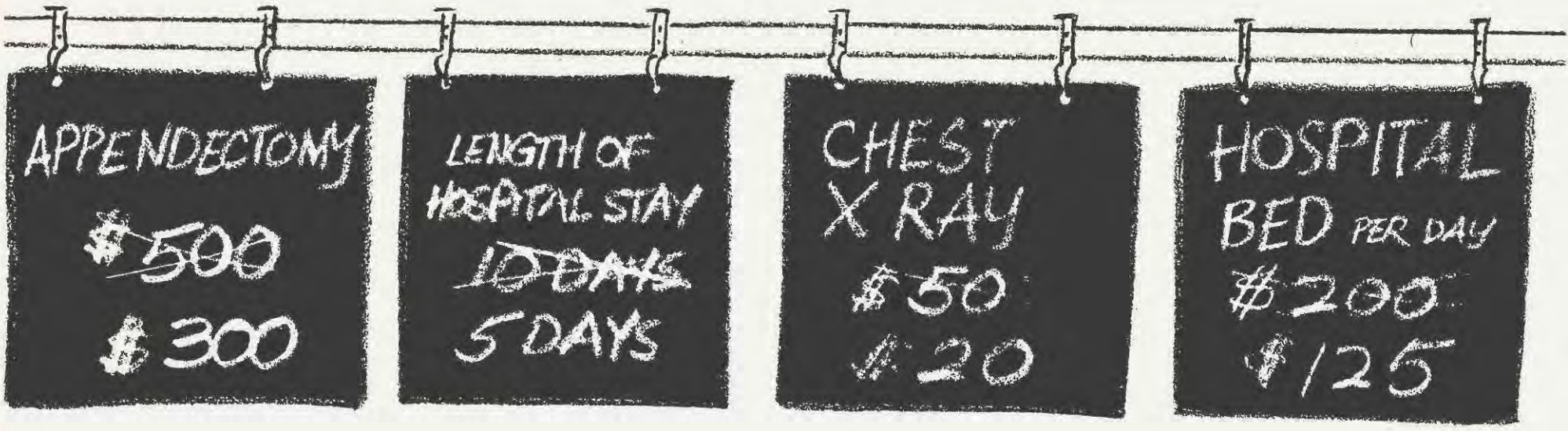
Something new of rising health care



Health care costs in this country are rising at an unacceptable rate. And Metropolitan, as one of the leading group health care insurance providers, realizes that something has to be done.

So, we've put together a medical cost containment program. It has several facets. And its basic strength is that we're involving everybody that affects, and is affected by, the rising cost of health care: users, employers, providers, insurers and regulators.

We can't sum up the whole program in one statement, but here are some of the highlights:

Designing Flexible Group Medical Plans.

We're providing plans that give our group customers more options in health care delivery, eliminating the unnecessary, and finding alternatives to the costly.

For example, we're recommending plans featuring a range of deductibles to shift some responsibility of payment to the users, giving them a greater sensitivity to the costs of medical care.

We're also advocating new types of coverage to encourage the use of effective and less costly alternatives to lengthy and costly hospital stays. Like extended care facilities, home health care, alcoholic and drug rehabilitation facilities, ambulatory surgical facilities, and on an outpatient basis, pre-admission and post release testing.

Metropolitan, in cooperation with some of our group customers, is also evaluating the long-term effects of a Voluntary Second Surgical Opinion feature that may help discourage unnecessary surgery.

What it comes down to is finding the best way to design Group Medical plans. A way that's more effective and less expensive.

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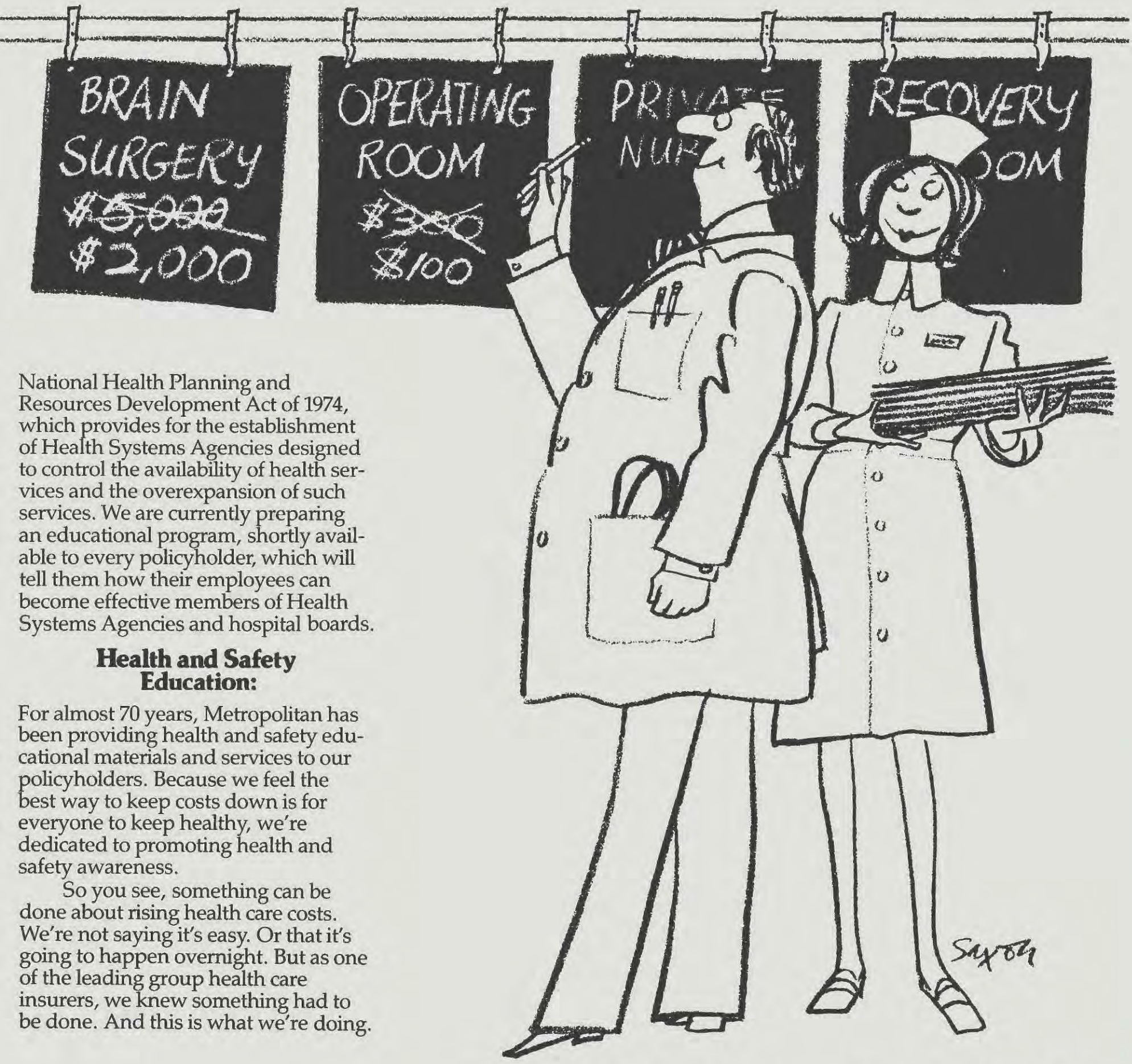

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Plan design . . .

Continued from page 22

surgical centers and second surgical opinions. Use of extended care facilities and home health care can reduce the length of a patient's hospital stay.

The effectiveness of these devices isn't fully known, although conclusive information could be available in 1979. Nevertheless, if done properly, they should all save money, said Hall's Mr. Reynolds.

John Van Steenwyk, vp at Martin E. Segal Co., said he recommends clients appoint individuals in their benefits or personnel departments to coordinate application of cost saving plan features to encourage employe use.

Plan sponsors should communicate to members the impact they can have on service rendered to them, added John Hickey, partner at Kwasha Lipton.

Employe Benefits

Mandatory second surgical opinion has been adopted by several firms, noted Segal vp Jack Goldberg. Although the concept is difficult for many persons to accept, "it's the only thing that's going to work," said James H. Brennan Jr., vp at Towers, Perrin, Forster & Crosby.

However, Frank B. Hall's Mr. Reynolds cautioned a second surgical opinion provision could result merely in operations of questionable merit being delayed until problems become more complicated and costs rise. To be successful, a second opinion program must save more money than it costs to run, added John Duffenback, also a Hall senior vp.

Consultants agreed the various cost containment features could be incorporated into all kinds of benefit plans. The basic difference between plans with varying benefit levels, they say, center primarily on at what point the patient will contribute to paying bills and how much that contribution will be.

The so-called "Cadillac" plan normally provides full payment for hospital room and board bills, complete hospital extras, reasonable and customary surgical and anesthesiology charges, X-ray and lab test costs in the base plan.

Major medical in reach plans then picks up expenses in excess of this base, in many cases without limit, but usually to a limit between $250,000 and $1 million. There is normally a small ($50 to $100 per family) annual deductible on the major medical portions with 80% coinsurance applying to the first $2,000 of major medical expenses and then full coverage for additional charges.

Under this plan, a patient is not forced to reach into his own pocket until considerable expenses have been incurred and his maximum outlay is limited, for example, to $500.

A less generous base plan may only provide coverage for a limited hospital stay and on a fixed schedule of surgical fees. Provisions for hospital extras, such as anesthesiologists and testing, would be limited or forced into the major medical plan.

Major medical would pick up a larger portion of the patient's costs under a more moderate plan and the employe would reach quicker and deeper into his own pocket. For a typical "fair" plan, an employe might pay a $200 per person annual deductible and 20% of the first $5,000 in bills. His out-of-pocket costs could then easily be in excess of $1,000.

"A low cost plan should emphasize prevention of financial disaster," said Kwasha Lipton's Mr. Hickey. "Employes would have to share in expenses that are budgetable."

Benefit consultants recommend a high limit on major medical charges in the fair plan. "A $25,000 limit destroys the principle of putting cost sharing up front," said Mr. Harlow. "The savings aren't worth it."

"In a low cost program, the philosophy is to design a plan to cover catastrophes and incorporate the deductibles up front where the employe will be aware that he's using health care resources," said Hewitt's Mr. Leahey. "You don't want to hurt the employe."

James F. O'Leary, assistant vp at William M. Mercer & Co., noted that increasing major medical coverage limits to $100,000 from $20,000 costs a mere 30 cents a month per family. ■

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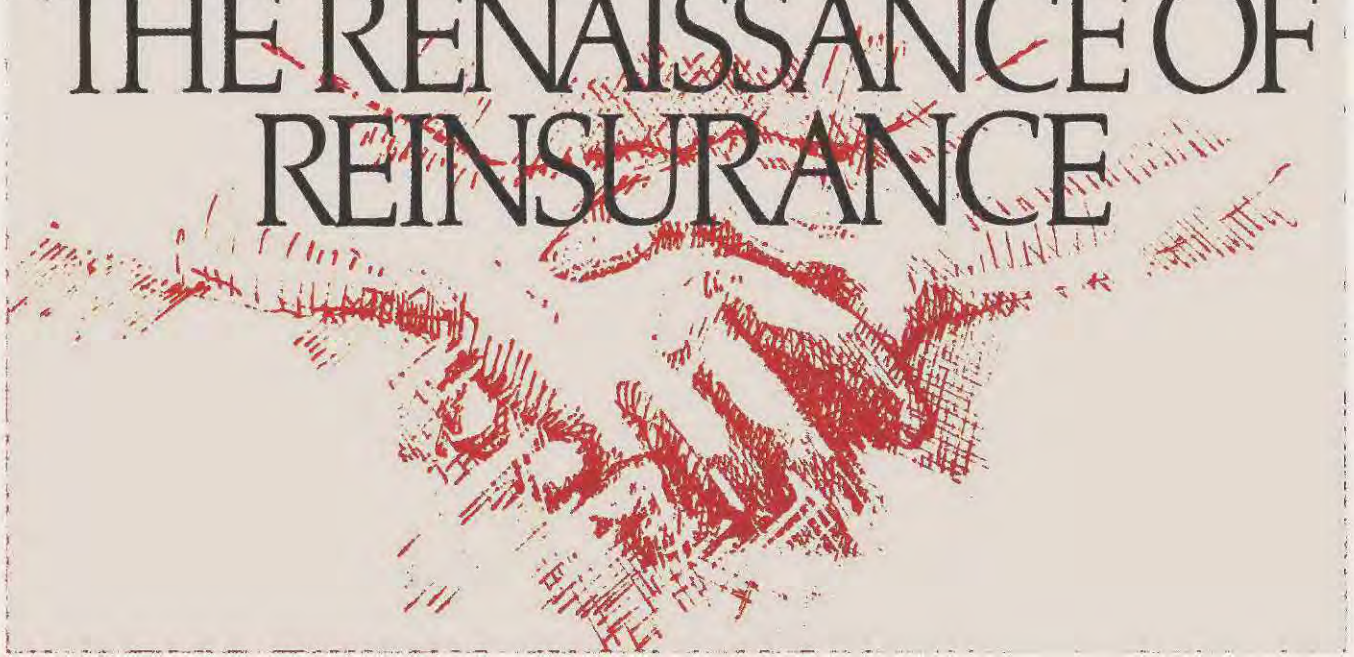

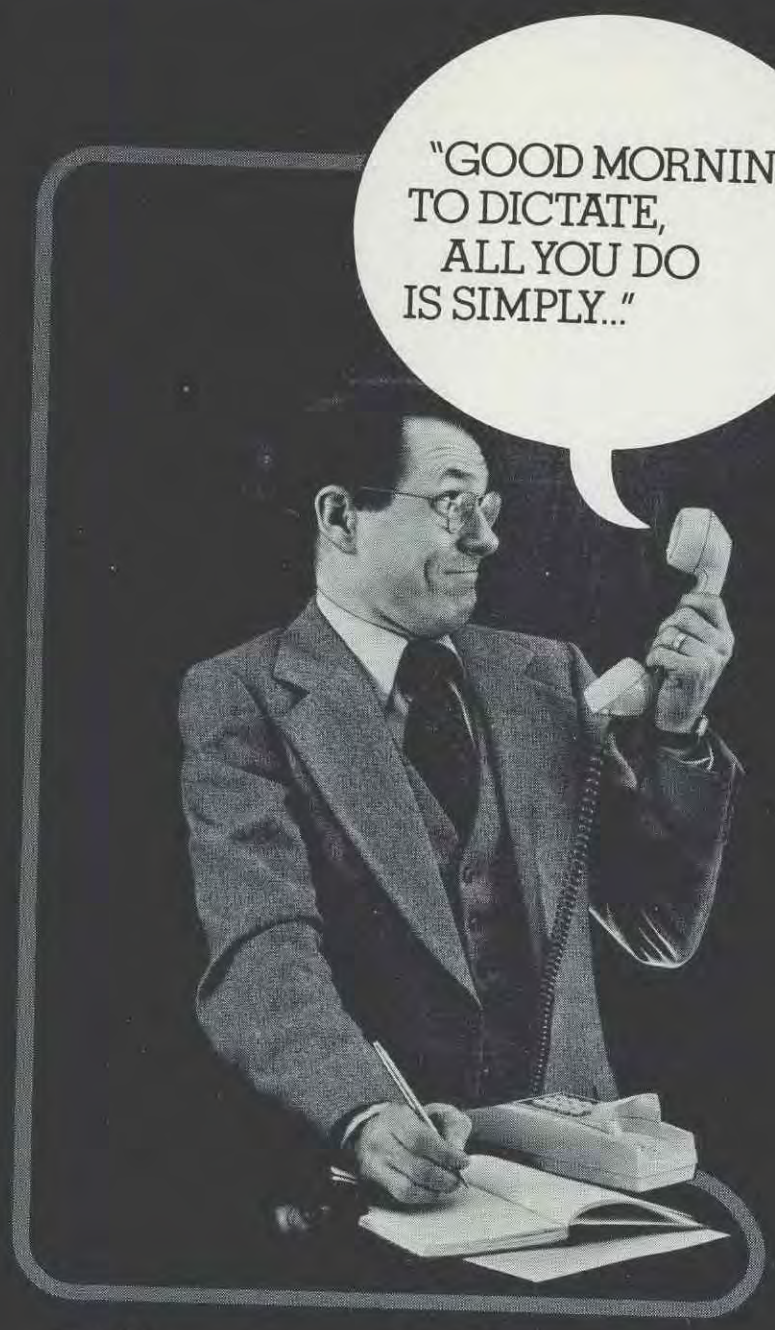

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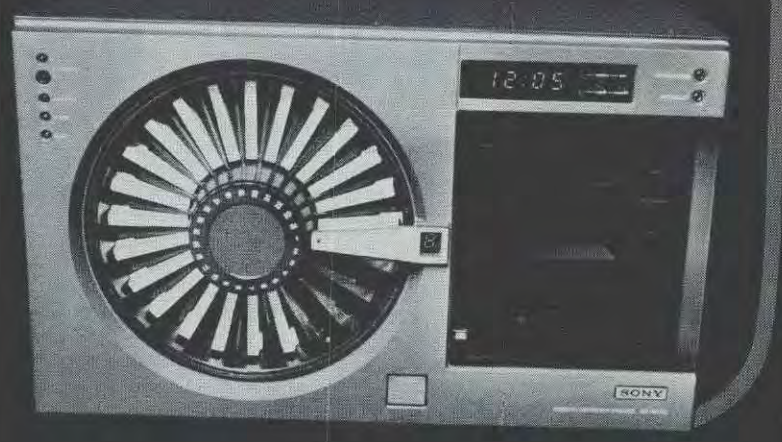

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Some different approaches to lumber exposures.

At Texas Instruments

Workers pay increases in the health plan costs

Employe Benefits

DALLAS—For many workers, rising health care costs are merely something they read about, shielded as they are from this inflation by corporate benefit plans. But Texas Instruments employes feel the sting annually, through adjustments to the employe's share of health benefit costs.

Texas Instruments has increased the employe's share of health benefit costs by ½ of 1% to 1% annually since the early 1970s, according to Gene McGarrah, corporate benefits manager. The goal is to maintain a fixed ratio of the company paying three-fourths of costs with the employe picking up the balance.

While other firms adjust the employe's share of health care benefits every few years, "I think we're the only ones who've endorsed doing this annually," Mr. McGarrah said. "Where companies share the cost with their employes they often do it as a token move.

"Many people favor the (cost sharing) concept but can't adopt it because they've gone too far in the other direction," he said.

Each year, Texas Instruments' benefit department tries to project cost increases for the coming year and then decides whether to share the increases through higher deductions, coinsurance limits or premiums. Depending upon how much costs are expected to rise, there could be increases in all of these areas or just one, Mr. McGarrah said. However, the employe share of the premium is almost certain to be affected when there are cost increases, he added.

Although higher premium costs for employes are normally applied, Mr. McGarrah prefers to have persons who use their health care benefits pay a greater share of costs than those who stay well. Yet, he added, he has yet to derive a "magic formula" for splitting up increases in the employes' portion of health care costs.

At present, Texas Instruments picks up the entire health care premium for employes after one year's service, half the premium after three months service and nothing prior to that. For dependents, the firm pays 50% after five years service, 25% for one year to five years service and nothing during the first premium year.

The plan, which is a comprehensive major medical program, has an up-front deductible of $75 per person annually and provides 80% coinsurance on the first $1,000 of expenses above the deductible, 90% coinsurance on the second $1,000 and 100% in excess of that to a limit of $200,000.

Although keeping health care costs in line is one of the plan's objectives, Mr. McGarrah said there is no way to measure whether employes have become better health care consumers as a result of cost sharing. But he believes it must have had some impact, noting that he has heard during the past two years of occasions when employes went back to health care providers to "raise hell about the price."

One drawback to the plan has been its impact on recruitment. "We get an awful lot of flack for this, but we don't make excuses for it," Mr. McGarrah said. "We have a philosophy of steering employe benefit dollars toward long service people."

The biggest complaint is with the initial cost to the employe for health care benefits, Mr. McGarrah added. ■

Claims increase

Product liability claims for automotive aftermarket and replacement items tripled between 1973 and 1976 while the average cost of liability insurance rose 45%, a survey by the Automotive Parts & Accessories Assn. shows. In some cases, liability insurance costs jumped as much as 266% over the three year period.

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As you know, Blue Cross and Blue Shield Plans are fighting a nationwide battle to keep costs from running away.

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Firms buy cost control sight unseen, with faith

Employe Benefits

By REBECCA A. FANNIN

NEW YORK—ARA Services Inc. of Philadelphia recently revamped its benefits package with an eye toward controlling medical coverage costs.

Yet the firm is "embarrassed" that it doesn't have any data to indicate the cost control effects of such measures as outpatient benefits, pre-admission testing, home health care and preventive care in reducing payments for expensive hospital care and costly medical treatments.

But ARA's manager of benefits Bruce Brodsky should not be ashamed. Among many major corporations seeking to control benefits costs, few have any figures showing how much they've saved by instituting specific cost control measures.

Inflation in the health care sector has outpaced other cost of living increases for the past several years, forcing employers paying most of the nation's health care bills through employe benefit plans to begin asserting themselves. Health insurance premiums have reflected the increasingly expensive medical bills, but self-insured employers administering internal health benefit plans and hit immediately with rising costs, have been most aggressive in controlling costs during the last two years.

"Many of the cost control programs are so new that nobody has good data," explained Willis B. Goldbeck, staff director of the Washington Business Group on Health.

"But we do know that steps taken to lower medical costs save money," Mr. Goldbeck said. "Making a commitment to cost control means switching from a passive to an aggressive position and that alone could help to control costs."

Lacking good documentation, some corporations have grown sluggish in implementing reimbursement benefits for outpatient and preventive care.

Most companies won't add on coverage for a cost control benefit unless they see the potential for significant savings, said Mr. Goldbeck.

It's debatable whether some steps being taken to control costs are effective, such as pre-admission tests and second surgical opinion programs.

In an experimental second opinion program offered by Blue Shield of New Jersey, E.I. du Pont de Nemours & Co. found that almost a quarter of the second opinions did not agree with the first opinion about whether surgery should be performed. Nonetheless, du Pont's manager of employe benefit studies, James R. Robinson, is reluctant to describe the program as a success.

Data on second opinion programs must be collected over a five-year period, he said, in order to determine whether the employe merely deferred surgery until later.

Prudential Life Insurance Co. offers coverage for second opinions on a pilot basis for 7,000 of its employes in Northern New Jersey. But the life insurer has only modest data so far about the program's effectiveness because usage has been low and experience hasn't been tracked for a long enough period.

Regardless, Prudential plans to expand the program to cover more employes.

A few people may be convinced that such programs will be worthwhile in the long run, but most companies don't see any merits to such vague efforts at controlling costs.

"We don't provide for second opinions because we haven't yet seen any successful programs," said David F. McIntire, manager of employe benefits at General Mills Inc. in Minneapolis.

Also not swayed by claims of the second opinion program's success in controlling costs are New York-based Uniroyal Inc. and Caterpillar Tractor Co. in Peoria, Ill.

A second opinion program has the potential to be cost-effective,

Continued on page 32

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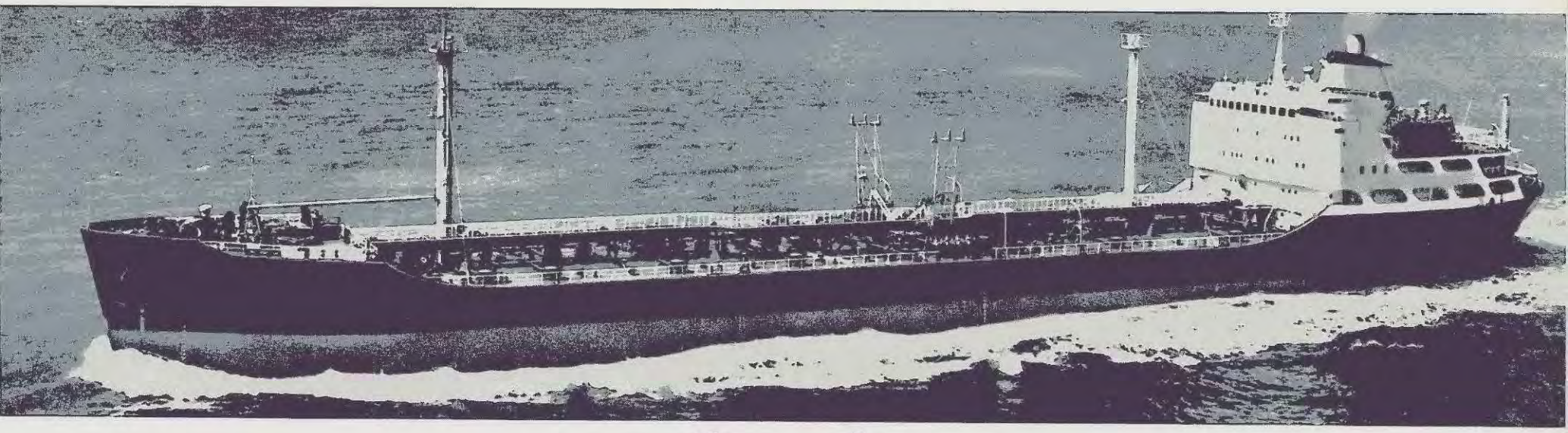

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Cost control . . .

Continued from page 30

contends InterStudy, a medical research firm responsible for preparing a comprehensive study of cost control measures for the National Chamber Foundation.

InterStudy said a study of second opinion programs carried out by Dr. Eugene McCarthy of Cornell University Medical College in the early 1970s for several New York City unions found that differing second opinions can bring about a 4.4% reduction in total surgeries performed under voluntary programs, and a 9.4% reduction under mandatory programs.

For a second opinion program to be successful, InterStudy said, employes must be educated about the program and encouraged to question their physicians' judgment.

The use of pre-admission testing benefits is more popular than second opinion plans yet isn't fully accepted among corporations. Like second opinion plans, data about its cost effectiveness is scarce.

"Pre-admission testing is about as successful as second opinions—not very," said Richard Kroczynski, manager of employe benefits for Uniroyal Inc.

The cost containment potential of pre-admission testing depends not only on equating saved testing time with shorter hospitalization but also on the willingness of physicians to suggest it to patients. Moreover, hospitals must have economic incentives to perform tests on an outpatient basis, InterStudy pointed out.

In addition, the report cited inefficiencies in the health care delivery system such as delays between admission and surgery that could offset savings from PAT.

Corporations have seen greater cost effectiveness in the use of hospital utilization reviews, particularly the concurrent type of review.

These review programs establish guidelines for appropriate admissions, hospital lengths of stay and courses of treatment. Any case falling outside the guidelines must be scutinized in greater detail to determine the appropriateness of the claim. A review board could overrule an individual physician's opinion about appropriate treatment.

International Harvester Corp. and John Deere & Co. have perceived reduced hospital occupancy with utilization review plans but have no detailed statistics to back up their feelings of success.

Goodyear Tire & Rubber Co., on the other hand, experienced a 12%

Employe Benefits

reduction in average length of stay in 1974 for its employes in Springfield, Ill., after implementing utilization review. Based on 600 hospital admissions, Goodyear calculated a savings of $30,000, according to the National Chamber Foundation report.

But the effectiveness of the utilization plan depends upon the strength of physician's and hospital's commitments to them, InterStudy said. The study also noted that any savings a company realizes may be compromised when hospitals compensate for lower occupancy rates by spreading the same fixed costs over a smaller utilization base.

Administrative review of claims, including claims review and coordination of benefits, which help companies avoid duplicate claims payments, can also produce savings. At Borden Inc., savings from coordination of benefits amounted to $1.6 million in 1976 and amounted to $2.1 million in 1977.

Claims review, identification of claims that a company is not obligated to pay, can also help control costs.

Uniroyal Inc. had limited success with a claims review plan. The company used several internal auditors to certify that all benefit payments were legitimate and found only an $80 over-payment.

Statistics on savings from paying for outpatient care, such as ambulatory surgery rather than inhospital care, are also scarce. One of the newest benefits included within outpatient benefits is home health care, a comprehensive range of health care services that can be administered at home.

Upjohn Co., which has offered home health care benefits through The Travelers Insurance Co. since 1971, estimated savings through home health care in 1973 of $316 per case for participants, according to the InterStudy report.

Corporations are most enthusiastic about potential cost-savings offered by health maintenance organizations, a prepaid form of health care that encourages cost control by providing for preventive care, outpatient care and prepayment to doctors.

The HMO gives doctors a financial incentive to control costs because they are paid a lump sum from their patients and must keep their charges below that amount to earn a profit.

International Harvester is planning to implement an individual practice association, one type of HMO. By doing so, it hopes to reduce benefits costs by 10% to 15%, said Phillip R. Lescohier, director of employe insurance.

Mr. Lescohier said he is more encouraged by the cost-savings potential of HMO's than other cost containment measures because of the financial incentives it offers. The success of other cost control features depends on doctor, hospital and employe commitment to them.

International Harvest is delaying implementation of the HMO until it gets results from an IPA type of HMO that John Deere & Co. is planning to make available to its 15,000 employes in Western Illinois and Eastern Iowa.

Michael Plunkett, director of health care at John Deere said the company chose the IPA format because it allows employes to maintain existing relationships with physicians and doesn't require a separate office in which a group of doctors practice, as in the prepaid group practice type of HMO.

John Deere's experience with the IPA may influence Caterpillar Tractor Co. to offer the IPA to its employes in the same area. ■

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American Can expands flexible benefits program

American Can chairman William F. May (right) discusses his choices under the flexible benefits program with salaried benefits director Robert B. Bogart.

By REBECCA A. FANNIN

Employe Benefits

GREENWICH, Conn.—American Can Co. has orchestrated a well-concerted effort to launch its flexible benefits program without a hitch.

In fact, if the company could begin implementing its cafeteria-type benefits program all over again, it would only make one change. "We would allow more time to do it," said Robert B. Bogart, American Can's director of salaried benefits.

That is understandable, considering the enormous task of offering a flexible benefits program that ticks. American Can invested substantial money, time and personnel to make the program succeed.

The effort has paid off so well that the company is extending its program to 9,000 salaried employes at 164 different locations Jan. 1. The program was being tested among 731 salaried employes of the consumer towel and tissue division.

American Can is the latest among only a handful of major corporations which have changed to flexible benefit plans. Its program is also on a bigger scale than other plans established in recent years.

Interest in flexible benefit plans —usually called cafeteria compensation programs—has been marginal at best, despite predictions by benefit consultants that flexible benefits are the wave of the future and would be commonplace by 1980 or soon after.

American Can's flexible benefits program grants a pre-determined core coverage of benefits for everyone in the program and allows employes to choose additional coverage to fit their individual needs (*BI*, March 6).

Included in the core coverage are 80% payment of medical expenses up to $5,000 after a $200 deductible for individuals and $400 for families, with 100% coverage beyond $5,000; life insurance of between $20,000 and $50,000 based on salary; travel accident insurance of between $50,000 and $250,000; declining retiree life insurance; one to five weeks vacation; pensions, and long and short-term disability benefits.

Employes are provided with flexible credit dollars, based on the difference between the value of the core and the value of the individual's coverage under the former benefits package, to buy back additional coverages. Payroll deductions can also be used to purchase optional benefits.

Credits for the optional benefits are generated on the basis of age, salary, service and family status.

Employes in the pilot program generally chose more expensive benefits than those offered under their former program. Medical coverage that reduces deductibles to $100 from $200 was popular. Only 14% of the employes kept the same medical coverage provided under the previous package.

Almost half the group elected to pay for new benefits covering vision, hearing and general health that American Can offered for the first time.

Life insurance selections depended upon employe age, with younger workers often selecting a plan linking rates to age and older employes choosing fixed rate plans.

To introduce flexible benefits to its employes, American Can invested approximately $100,000 in communicating the program. About $50,000 was spent to transport 120 supervisors from the company's scattered locations to two central offices where they were trained for three full days to become flexible benefits experts.

"That's one of the smartest things we've done," Mr. Bogart said. "It's important to have someone on the ground floor who knows how the program works so local employes can go to them."

Approximately $40,000 was allocated to make three videotapes introducing the program in three

Continued on following page

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EMPLOYEE BENEFITS

- Plan Design & Administration
- Employee Communications
- Third Party Claim Facilities

American Can . . .

Continued from preceding page

stages. The first, called "You Are Seven People," showed situations such as an employe who is retiring and taking retirement benefits. The tape was used to educate employes about their benefits before the flexible plan was instituted.

In the second stage, the concept of flexible benefits was introduced in a tape called "Snapshots," illustrating how six employes tailored benefits to suit their needs under the plan.

"Details," the third videotape explained how flexible credits are generated and how the different benefits can be elected.

American Can's public affairs staff shot and edited the videotapes.

To help build awareness of flexible benefits, one benefit each month was described in pamphlets inserted into paychecks. A hefty notebook containing a complete description of flexible benefits was also distributed to educate employes. In addition, a hotline was established to answer employe questions.

Employe Benefits

Some employes resent initially having to make a decision about choosing different benefits from what was automatically provided before, Mr. Bogart said.

"But the more they read and study it, the more they like having choices," he said. "The turning point is when they get their own election form and can begin choosing."

The communications program has created so much awareness of benefits that "everyone wants to play the game," Mr. Bogart added. "All the employes are talking about it."

The flexible benefits program has the potential to alleviate some administrative problems inherent in traditional plans, the company believes. If American Can wants to offer employes an additional benefit, then it just allocates more flexible credit dollars to pay for it. The company also has the option of providing the benefit without increasing the total cost of the benefit package by allowing employes to use the same amount of flexible dollars to elect the new benefit and give up a corresponding portion of benefits from another area.

Flexible benefits also help to consolidate the benefit packages of acquired firms, Mr. Bogart noted. "If the acquired company can't afford our plan, then we just give them the core benefits and improve from there by pumping in flexible dollars."

Most acquired companies have benefit levels higher than the core and lower than American Can's total benefits under the flexible benefits plan. American Can has a very high benefit level because of the number of steelworkers it employs.

One of the few options that American Can cannot offer, at least without having it taxed as income, is cash. American Can's program was carefully designed to avoid tax liabilities. Outside counsel, Dewey, Ballentine & Bushby of New York, were hired to analyze the tax aspects of the flexible benefits program.

Outside help also came from Hewitt Associates, an employe benefits consulting firm that has worked with the two other companies offering flexible benefits, TRW Inc. in Cleveland and Educational Testing Service in Princeton, N.J.

In the developmental stages, a committee was formed consisting of Mr. Bogart and representatives from Hewitt, Metropolitan Life Insurance Co. and the employe relations department. The committee met a full-day once a week for four months during the planning stages.

The flexible benefits program should also prove to be cost-effective, Mr. Bogart said. Benefits will be used more efficiently because people will opt only for benefits they really need. Casual usage of benefits, using a benefit just because it's there, will be eliminated, he thinks.

Extending flexible benefits to American Can's 28,000 hourly employes out of its total 48,000 employes could be difficult, because of union resistance. Unions could reject the plan in favor of contract bargaining. There is also the fear that union members might select the wrong benefits. ■

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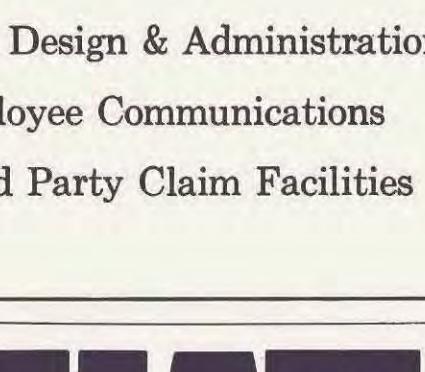

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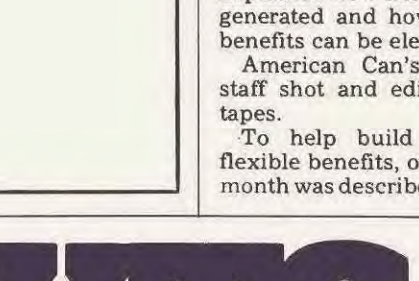

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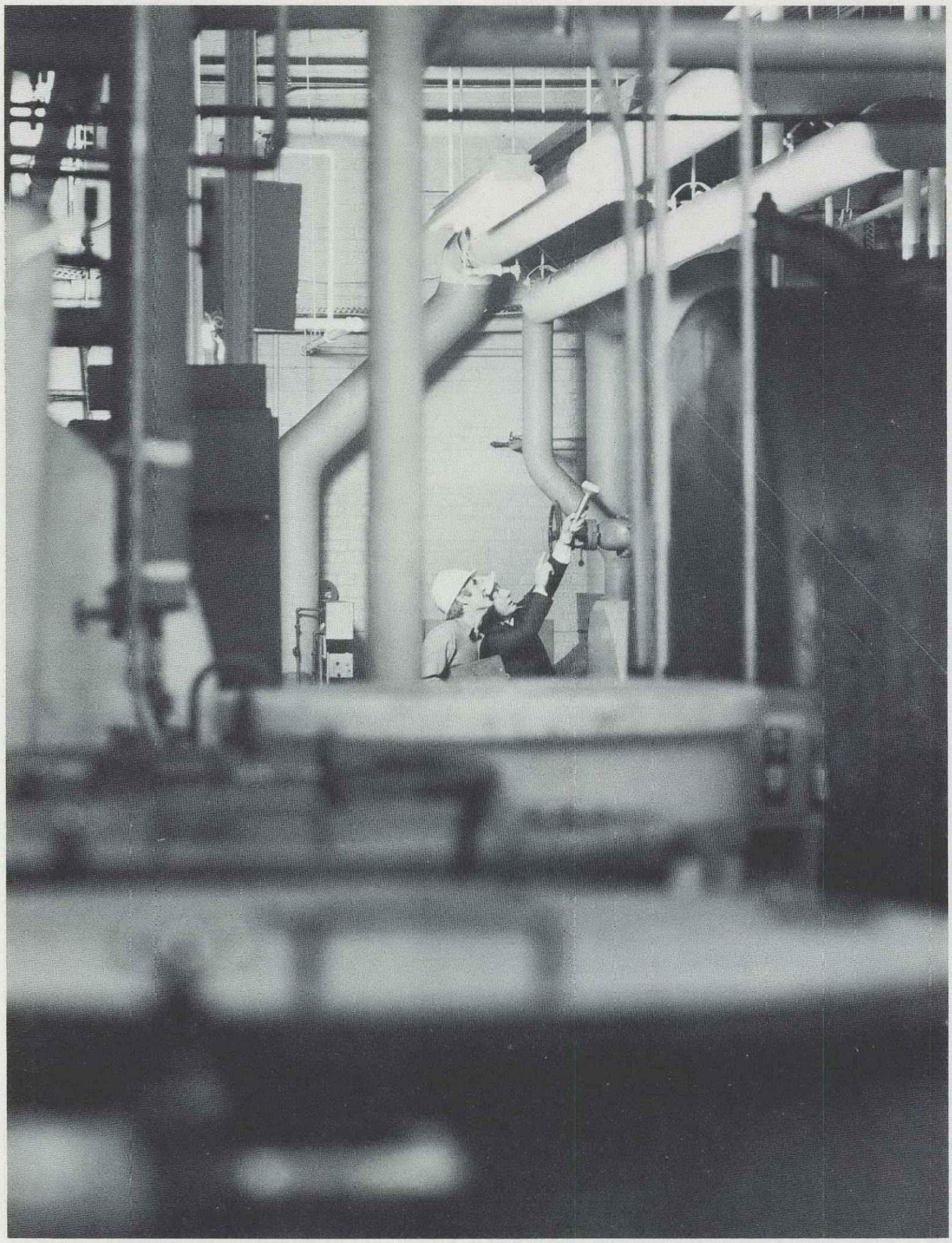

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Factory Mutual System

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Day care plans . . .

Continued from page 11

Employe Benefits

sive and socially aware," said Ms. Kertzman of Stride Rite. Work with the hard core unemployed and imprisoned in the 1960s led the company to try and effect change among children, she said. The day care center was incorporated in 1971 as a not-for-profit company by Stride Rite, with families using the center represented on the board of directors.

Picking up expenses beyond parent's contributions, Stride Rite pays about $30,000 a year to the center to care for 27 employes' children, ages 33 months to six years. In keeping with its concern for the community, the company reserved 23 spots in the center for welfare children, for which the state pays $57 a week a child for care.

The center's annual budget is $125,000, over 80% of which is spent on staff. But with the day care center on its premises, the company provides untold in-kind services including picking up the telephone, maintenance and office supply tabs as well as furnishing the services of the industrial nurse for the children's care and education and providing scrap materials for children's crafts.

"It's very cost effective to have the center here," Ms. Kertzman says.

Its Boston location also offers the day care center the services of local colleges and universities who send students to work there as interns, supplementing the nine-person full time staff.

The union-sponsored day care center in Chicago with five full time teachers on its 11-person staff enjoys the same advantages of interns from city area schools, but it receives in-kind services from the union, whose hall is down the street, instead of from a company.

"The union has a long history of providing social benefits to enrich the lives of its members," says Ms. Tuteur, explaining the union's commitment to day care, which includes maintaining six centers for 1,300 children in the Baltimore area.

As an industry which offers entry-level employment to each new wave of immigrants to America, textile manufacturers employ more women than men, making care of children a more visible issue.

When large manufacturers in Chicago turned down the union's pleas for support of a day care center, the Chicago and Central States health and welfare fund trustees decided to commit funds to a day care center: $120,000 to build a 3,500 square foot building and $15,000 for equipment.

The union paid for all the day care costs since the center opened in 1970 until this year when parents were asked for the first time to contribute $10 a week for the child care. The center spends $3,000 a year per child or $150,000 annually to care for 50 children, ages three to six years. The union's contributions to the center account for about 3% of the money in the health and welfare fund.

Tackling the issue of day care, Ms. Tuteur asserted, "I'm angry with people who say that day care is a white, middle class desire. They say children are taken care of at home or people feel more comfortable leaving their children with the lady down the street."

But the child development expert counters, "There is a growing awareness that kids need a nurturing and intellectually stimulating environment if they are going to be away from home. The kind of experience we provide here is better than any other place but the home, assuming both parents are there and are economically secure enough for the mother to stay home without climbing the walls worrying about paying the bills."

Ms. Kertzman complains that many corporations are "under the supposition women are home caring for children. It's not true. Women are working—out of economic necessity or for fulfillment—and there are single parents."

Both day care center directors believe companies and unions can meet the needs of employes for quality day care with a minimum of hassles.

"If they are willing to make a monetary commitment and get a good director, it won't be a big headache," promises Ms. Tuteur. "It's not troubling," agrees Ms. Kertzman, "and it's not expensive. It's labor intensive and there are a lot of good people available."

Consulted already by companies considering offering day care, Ms. Kertzman knows some of the management's reservations. One, she says, is a feeling that providing day care for children is somehow "intruding on an employe's personal life.

"Health care is more intrusive than day care to one's private life," Ms. Kertzman argues.

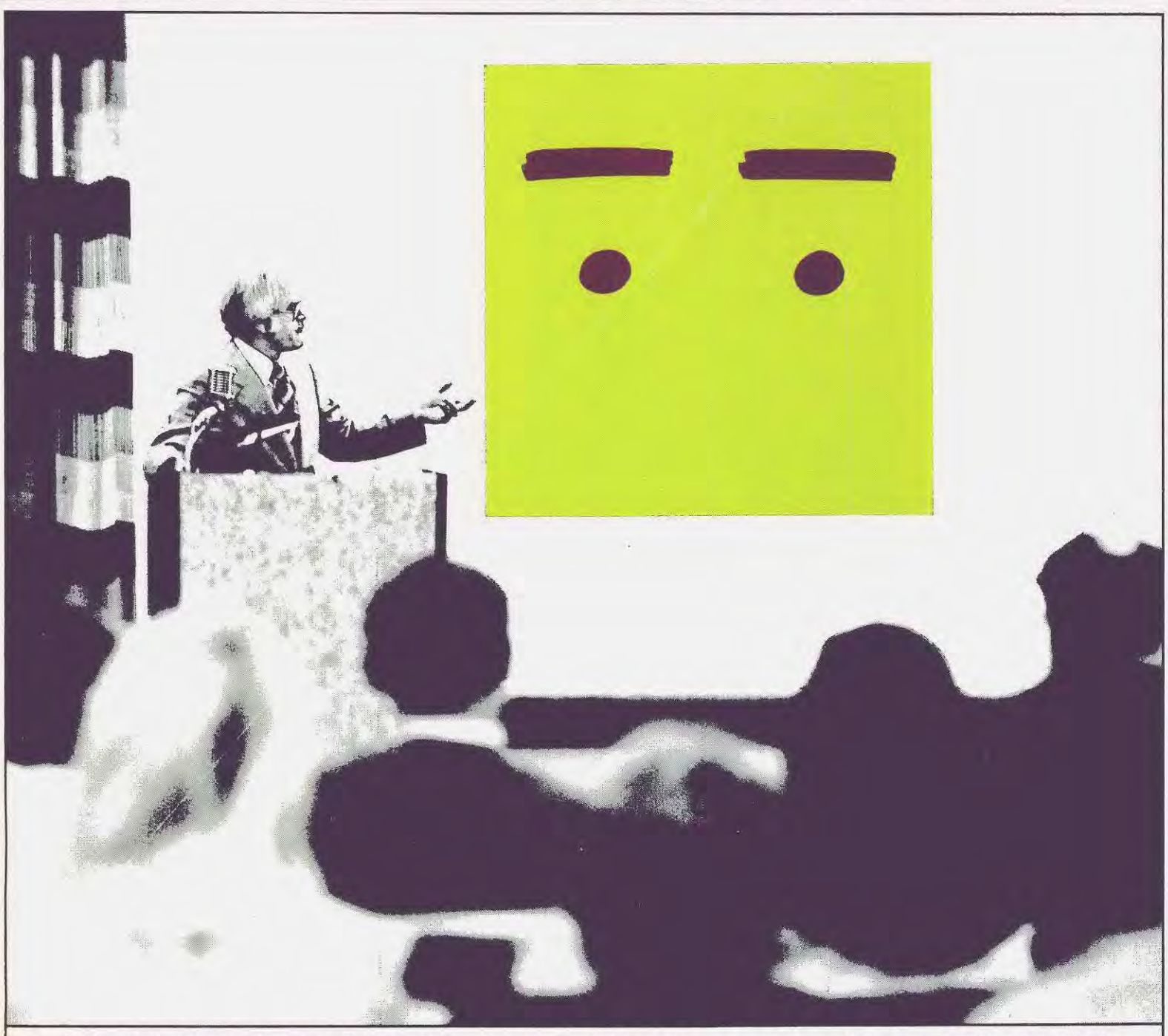
A corporation shouldn't approach day care as a profit making venture though, Ms. Kertzman believes. "A lot of comparisons can be made between for-profit day care centers and for-profit nursing homes," she said.

Instead, Ms. Kertzman suggested, "People ought to look at how they are spending a corporation's money. There isn't a corporation that doesn't contribute to charity. Some of that money can be directed to employes' families." ■

CEBS courses draw about 4,300

MILWAUKEE—More than 4,350 people have registered for employe benefit courses leading to the Certified Employe Benefit Specialist designation since the program was begun in December 1976 by the International Foundation of Employe Benefit Plans.

Registration, the foundation said, has far exceeded expectations when the program was in the formative stages. The 10 courses leading to the professional designation are being introduced progressively through 1979. ■



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Levi's touts home day care based on its own experience

Employe Benefits

SAN FRANCISCO—The future direction of day care, whether corporate sponsored or private, is toward private homes rather than large centers, according to a study by Levi Strauss & Co.

After seven years of research and experimentation with different forms of day care, Levi's concluded day care services should be close to where people live rather than where they work.

Approximately 80% of children of working parents are not cared for in day care centers, said Thomas E. Harris, director of community affairs at Levi Strauss & Co. "The vast majority of day care is being done by neighbors in private homes."

Levi's experimented with a day care center adjacent to one of its pants production facilities in Star City, Ark., only to find "this fabulous center, fully equipped and staffed, had only 12 children using it," Mr. Harris said. "Even when we opened it up for community use, the population increased to only 15."

"We have found parents are not inclined to bring their children to work with them," Mr. Harris continued. "A working mother, for example, has enough to get herself and the children ready in the morning, without having to take one or more of them along with her."

Until a few years ago, the goals of child development experts were to a system of well run day care centers. "The problem is, there's simply not enough of them," the Levi executive said.

Since 1975, Levi's has advocated the concept of home day care.

In a report on day care programs, Levi's noted advantages of family day care homes:

- The unique feature of the facility as a home, often similar to the child's own home.
- Location, usually close to where the child lives.
- Often the leader is a friend and neighbor to the families of the children who stay there.
- Many family day care homes have a multi-age group, similar to the ages of siblings in a family.

Although Levi's doesn't have a reimbursement program for employes who use family day care homes, the company has contributed to research day care. ■

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ERISA composers orchestrate fine tuning of law

By JERRY GEISEL

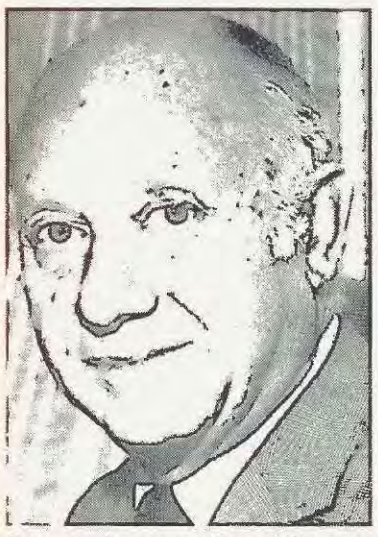
WASHINGTON—In January when the fourth anniversary of the pension reform law rolls around, the event won't be celebrated on Capitol Hill with cake and candles, but will be marked by the introduction of more pension legislation. Sen. Jacob Javits (R-N.Y.) and Harrison Williams (D-N.J.), the founding fathers of ERISA, now want to make the pension law a little easier to live with.

Meanwhile, in the House, Rep. John Erlenborn (R-Ill.) will again be proposing legislation to extend to public pension plans standards that now apply only to private programs.

At the same time, Congress will be confronted with a July 1 deadline to resolve the troubled multiemployer pension plans issue.

Debate also will be renewed on hospital cost controls and national health insurance when the Carter Administration unveils its proposals on these two politically volatile issues.

But the pension arena is where the real benefit action is expected to lie. Any changes that occur are



Sen. Javits, co-author of the pension reform law, wants to make it easier to live with.

more likely to involve fine tuning of the existing law than to make substantive changes.

Although many pension bills will be introduced in Congress next year, observers believe the Williams-Javits ERISA Improvements Act will generate the most interest because of the commanding role the two senators and their staffs have played in pension reform, as well as due to the expected strong push to pass the bill.

"The measure is a very high priority item on Sen. Williams's list," says Steve Sacher, counsel for the Senate Human Resources Committee.

The ERISA Improvements Act was introduced in the last session

Employe Benefits

of Congress, but came too late for any action. The measure now is being revised, but staff members declined to discuss specific changes being made in the bill. Some provisions likely to be retained when the measure is introduced in January, or making an appearance in other pension bills, include:

- Mandated survivor benefits for the dependants of vested employes who die before retirement.
- Tax credits for employers who start new pension plans or improve existing plans.
- Tax deductions for employe contributions into corporate pension plans.
- A single agency to administer ERISA.
- Reduced and simplified re-

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At Connecticut General, we've established a permanent task force utilizing some of our brightest minds. Their assignment: to explore ways we can contribute to lower health care costs, without affecting the quality of health care services. Here are some of the directions we're moving in:

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The idea is that members pay a flat monthly fee, whether they're sick or well. When they get sick, virtually all their medical expenses are paid by the HMO. These arrangements have acted as a real spur for HMO's to keep people well, and control unnecessary costs.

Another way we're seeking to hold down health care costs is by encouraging second surgical opinions. This feature is available to most companies covered by our health insurance. The program pays for a second opinion on non-emergency surgery, if the patient wants it. Our own work with this program gives us hope it will cut the number of these operations up to 15%.

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But one of our most far-reaching actions is the Hospital Utilization Review process we're helping set up in two communities.

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We believe that the small additional expense of this Hospital Utilization Review process will be far outweighed by the savings that come from eliminating unnecessary or overlong hospital stays.

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Even though we're working hard on a lot of new concepts, we haven't forgotten the importance of an efficient, well-managed, claim payment system.

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What does this mean to our health insurance clients? Obviously, if our costs are reduced, it will be reflected in the insurance rates for them.

And we intend to be more than a conduit for benefit dollars. The quality of health care is still uppermost. But we think quality health care need not be synonymous with escalating costs. So we're going out of our way to prove it.

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porting procesures.

Mandatory survivor benefits for vested workers who die before retirement is a provision that has already triggered a barrage of criticism from the benefit and business community.

"Mandatory survivors benefits is a horrifying proposal," says Theresa Stuchiner, a partner with consultants Kwasha Lipton in Englewood Cliffs, N.J. She thinks the proposal ignores the fact that many employers offer very good death benefits coverage through group insurance plans.

The mandatory survivor provision would cost employers more money and therefore will be harder to pass, warns George Pantos, counsel for the ERISA Industry Committee (ERIC), a benefit lobbying group that represents many of the nation's largest corporations.

David Allen, an aide to Sen. Lloyd Bentsen (D-Texas), believes there is a great deal of support for mandated survivors benefits. But the resulting higher costs at a time when the Carter Administration is urging everything be done to hold down costs means the provision faces an uphill battle, Mr. Allen acknowledged.

Proposals to permit tax deductions for employe contributions to corporate pension plans, which several congressmen are expected to introduce, also will probably find the going tough.

The Senate this year passed a measure by Sen. Robert Dole (R-Kans.) that would have allowed many workers to deduct up to $1,000 from their taxes for pension plan contributions. But the measure died when a House-Senate conference committee, under heavy Administration pressure, failed to approve it.

The Administration opposed the tax deduction for pension plan contributions because of the large potential loss of revenue to the Treasury. This opposition is unlikely to abate in view of the Administration's pledge to ease the budget deficit.

"President Carter says he wants to balance the budget. A $500 million revenue loss won't help," says Mr. Allen. In order for the tax deduction proposal to pass it is going to have to become such a high priority issue in Congress that budget considerations won't continue to defeat it, adds Russ Mueller of the House Pension Task Force.

Sen. Williams and Sen. Javits are expected to reintroduce their proposal to give tax credits to employers who improve pension plans by such means as reducing the number of years an employe must work for a firm before becoming fully vested.

Business groups representing large employers are expected to oppose the tax credit proposal. "The tax credit approach isn't fair to large corporations already having very good and costly pension plans," says Mrs. Stuchiner of Kwasha Lipton. Other benefit experts are concerned that giving tax credits for pension plan improvements might prove very difficult for the Treasury Department to administer. "How do you measure what is an improvement and what isn't?" asked one benefit consultant.

Debate over whether a new agency should be created to take over the present ERISA-related responsibilities of the Labor Department, the Internal Revenue Service and the Pension Benefit Guaranty Corp. (PBGC) will be put off another year.

That's because the Congress agreed to give the Administration more time—until Jan. 31, 1980—to come up with long term solutions to ERISA problems, including the possible creation of a single agency.

In the meantime, the Administration will be implementing a congressional-approved reorganization plan streamlining ERISA regulation by clearly dividing responsibility for the program between Labor and IRS.

Under the plan, effective this month, Treasury has primary jurisdiction for setting pension plan standards for funding, participation vesting rights and benefit pay-

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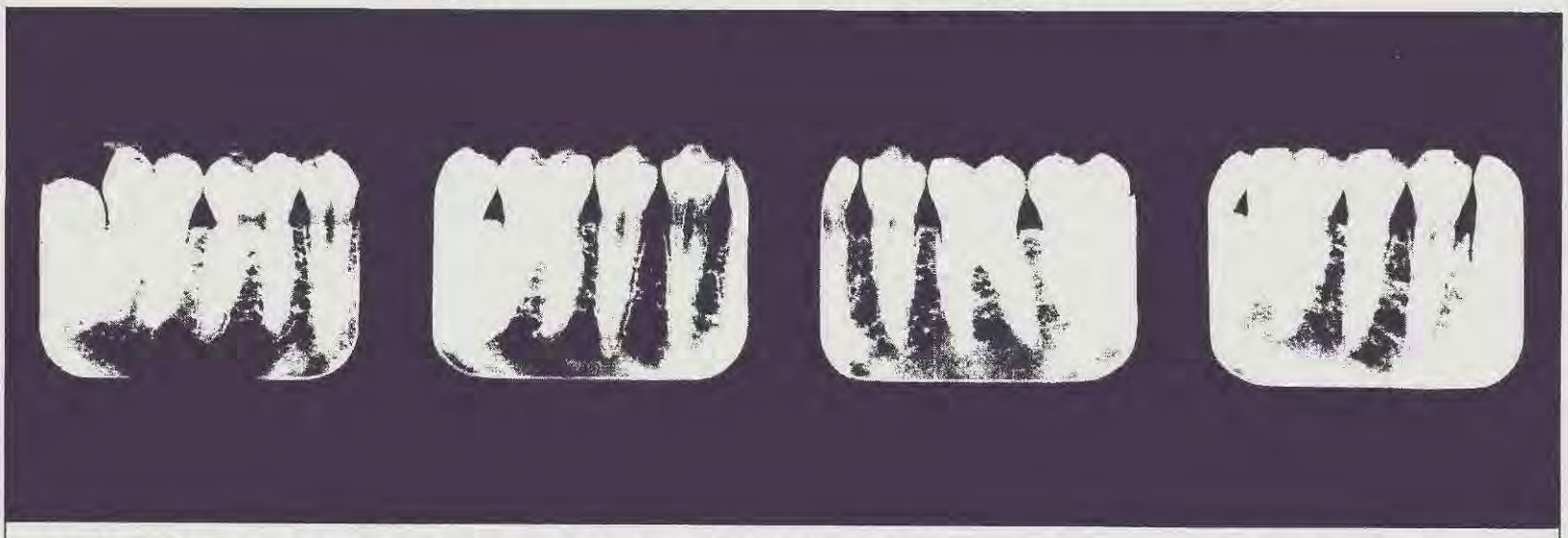
Other ways Connecticut General people come through.



How Connecticut General's pretreatment review feature helps control the cost of group dental insurance. *Before any major dental work is done, the dentist sends in an estimate of what he recommends to our claim office. We tell him exactly what's covered. That way there are no disagreeable surprises when the bill comes, for the patient, the dentist, or the employer.*

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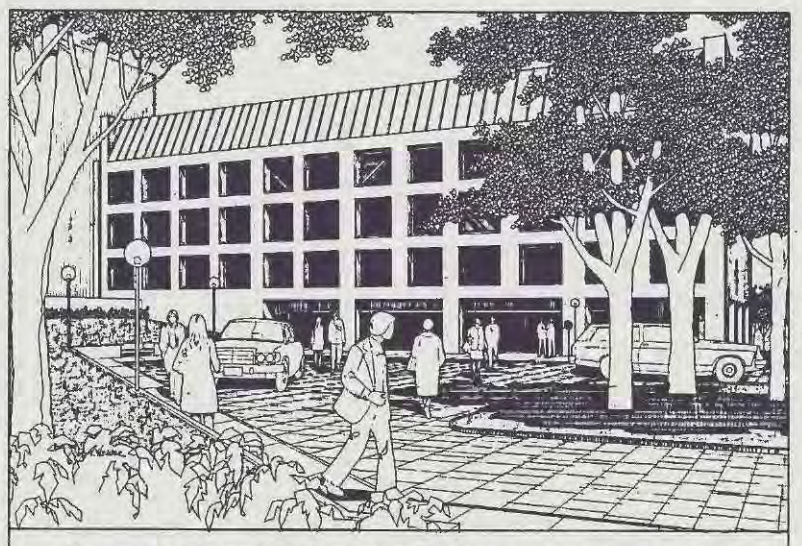

Connecticut General is taking a hard look at investments in hospitals. *As one of the leading lenders to hospitals, we're doing our part to avoid the building of unneeded hospitals or the purchase of unneeded equipment. Before we make a loan, we make sure a hospital needs new facilities and can pay for them without large increases in rates. The facilities must be approved by regulatory authorities and have acceptable planned utilization.*

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Fine tuning ERISA . . .

Continued from preceding page
ments.

On the other hand, the Labor Department will have jurisdiction over fiduciary standards for pension and welfare benefit plans. The Labor Department will continue to issue exemptions from prohibited transactions provisions of ERISA.

If the reorganization plan is successful in cutting down current ERISA problems, such as interminable waits for approval of class exemptions from various provisions in the pension reform law, it's possible the establishment of a new agency won't be needed.

Congress appears likely to sink its teeth into whether the various provisions of ERISA preempts the states from requiring employers to offer certain benefits.

"There is a good likelihood that the preemption issue will become extremely important next year," says Mr. Pantos of ERIC. The Williams-Javits bill will include a preemption provision, but staffers declined to discuss whether the bill will strengthen or weaken ERISA's preemption of state law.

Currently, Congress remains deeply divided on preemption. Rep. Cecil Heftel (D-Hawaii), for example, believes states have the right to pass laws requiring specific benefits. On the other hand, Rep. Erlenborn is concerned about the problems varying state benefit requirements have imposed on employers with multi-state operations.

Whether or not the Supreme Court decides pension plans are subject to the anti-fraud provisions of the Securities & Exchange Commission in the Daniel case, Sen. Javits and Sen. Williams are expected to introduce legislation to the contrary.

Congress is also expected to prevent a possible collapse of the multi-employer pension plan termination insurance program provided by the PBGC. Under legislation passed last year, beginning July 1, 1979, PBGC will be required to guarantee pensions of workers in multi-employer pension plans. PBGC's guarantees of such plans currently are discretionary.

In a study released this summer, the PBGC warned it could face a staggering $3.5 billion in unfunded liabilities if the hundreds of multi-employer pension plans now in financial trouble were to terminate. To pay for those huge potential losses, the PBGC might be forced to jack up the current 50-cent per worker annual premium for a multi-employer plan to as much as $80 per worker for the termination insurance.

That soaring increase could, in turn, trigger a new round of terminations by plans unable to afford skyrocketing rates.

One committee staff aide believes Congress will approve legislation postponing the July 1 deadline so PBGC has more time to work out long term solutions to the multi-employer pension plan termination problem.

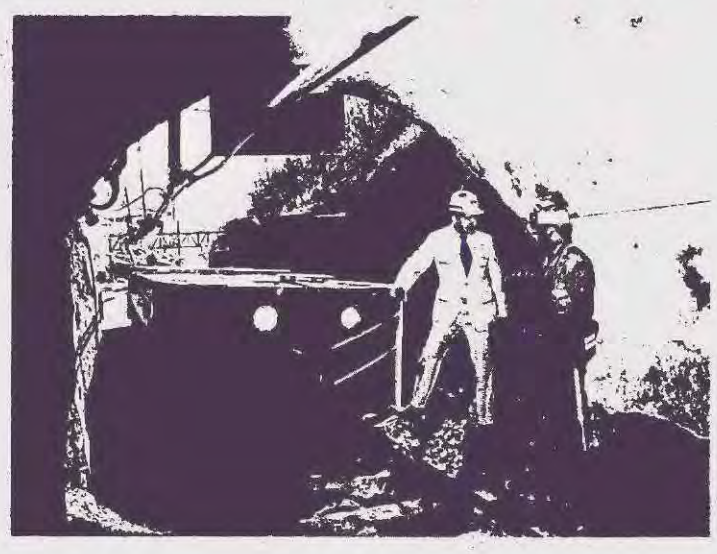
For the public sector, Rep. Erlenborn will reintroduce legislation establishing reporting, disclosure and fiduciary guidelines for the approximately 7,000 state and local government retirement plans exempted from ERISA regulation. The legislation, known as PERISA (Public Employe Retirement Income Security Act), would establish explicit reporting and disclosure requirements.

However, unlike ERISA, PERISA wouldn't set vesting standards for pension plans. Instead, an advisory council would be established to set voluntary guidelines for vesting requirements.

Mr. Mueller of the House Pension Task Force believes Congress will pass PERISA during the next session "in one form or another." Another source believes PERISA could face opposition from congressmen concerned that the legislation would result in major cost increases for public entities.

A new hospital cost containment bill will be introduced next year, according to Willis Goldbeck, director of the Washington Business Group on Health. But Mr. Goldbeck says there "is no chance of such a measure being approved."

At the same time, the Administration is expected to unveil its long delayed national health insurance plan. The outlook for approval of such a far-reaching proposal also is glum. ■



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Public workers' benefits mimic corporate programs

By MARY ELLEN McKEE

CHICAGO—The gap between employe benefits provided by private industry and the government is gradually closing, shows a *Business Insurance* survey of employe benefit packages provided by private and public sectors in Peoria, Ill., Columbus, Ohio, and Milwaukee, Wis.

Life insurance, major medical, pension and disability benefits of the public and private sectors are not too far apart in value, but state and city units are behind private industry in adding dental and vision care plans to benefit packages.

The city of Peoria, for example, has increased its life insurance coverage and added a separate maternity benefit and a dental program to the benefit package for its 1,000 employes. This doesn't even come close to the total dollar value and variety of the benefits offered to about 40,000 employes of the Peoria-area plants of Caterpillar Tractor Corp., but it does indicate a move by the city insurance coordinator to provide a more competitive benefits package.

City employes under the dental provision of their revised benefit package are covered up to $500 annually for oral examinations, teeth cleaning, dental X-rays, extractions and fillings. There is no lifetime maximum to this benefit, but orthodontia is not covered.

Meanwhile, Caterpillar covers 100% of the costs of oral examinations, fluoride treatments, dental X-rays, extractions and fillings and 50% of the costs for bridgework, dentures and orthodontia treatment for any employe with one year of service and for dependents. The benefit is subject to a $750 annual maximum and a $750 lifetime maximum for any orthodontia work.

Caterpillar also leads the city of Peoria in overall comprehensive medical benefits. Employes who have completed 60 days on the job at Caterpillar are entitled to receive 100% reimbursement for hospitalization in a semiprivate room, surgical costs, emergency care and outpatient services. Employes also receive 100% reimbursement for radiologist services and outpatient radiation therapy and chemotherapy for malignancies, diagnostic X-rays, laboratory and hemodialysis expenses.

Outpatient physical therapy costs for a maximum of 60 days are fully reimbursed, along with convalescence in a nursing home in semiprivate accommodations, nonsurgical emergency first aid and alcoholism and drug abuse treatment with a 45 day maximum for approved inpatient care and a 35 day maximum for approved outpatient care. Caterpillar offers a prescription drug plan which pays all but $2 of the cost of prescription drugs. The company also pays 90% to 100% for outpatient psychiatric care with a $1,000 yearly maximum for every person covered under the plan.

Vision care under the Caterpillar medical program includes $20 for an examination by an optometrist and $25 for an examination by an opthamologist. The company pays $20 for single lenses, $30 for bifocals, $40 for trifocals and $14 for frames. Caterpillar employes are limited to one examination, one set of lenses and one pair of frames every two years.

Peoria city employes and their dependents, on the other hand, have a more traditional major medical benefit plan. Hospitalization for semiprivate rooms, surgical costs, outpatient services and emergency care are reimbursed after a $75 deductible for single employes and $150 deductible for families at a rate of 80% up to $5,000. If costs rise above the $5,000 mark, then the insurance company will pay 100% of all hospital, medical, prescription and outpatient costs.

A separate maternity benefit, which was added to the Peoria benefit package this year, makes the Peoria program novel compared to others. Peoria employes or their spouses will be reimbursed for 80% of the total medical costs associated with a regular delivery after a $150 deductible.

Employe Benefits

Borden Inc. and Ohio State University, both major employers in Columbus, Ohio, are running neck-and-neck in the dollar value of their benefit packages.

The greatest difference between the two plans is that Borden employes contribute money each month for their benefits whereas the state pays the entire premium for all university employes' benefits.

Life insurance coverage, short-term and long term disability benefits and major medical coverage is evenly matched between the two employers. However, Borden offers a dental program; Ohio State does not. And Ohio State offers a vision care program; Borden does not.

Borden employes are insured for two times their salary if they earn under $15,000 and three times their salary if they earn over $15,000. The accidental death and dismemberment benefits match the level of life insurance. Each employe contributes five cents per thousand dollars of his salary for this benefit.

Since 30,000 Borden employes are scattered nationwide, management personnel in the company travel frequently. The company buys business travel insurance equaling another three times pay for these employes. If an employe would like more coverage he can opt for additional accident insurance up to 10 times his salary up to $300,000.

Under the Borden disability plan, the employe starts receiving

Continued on following page

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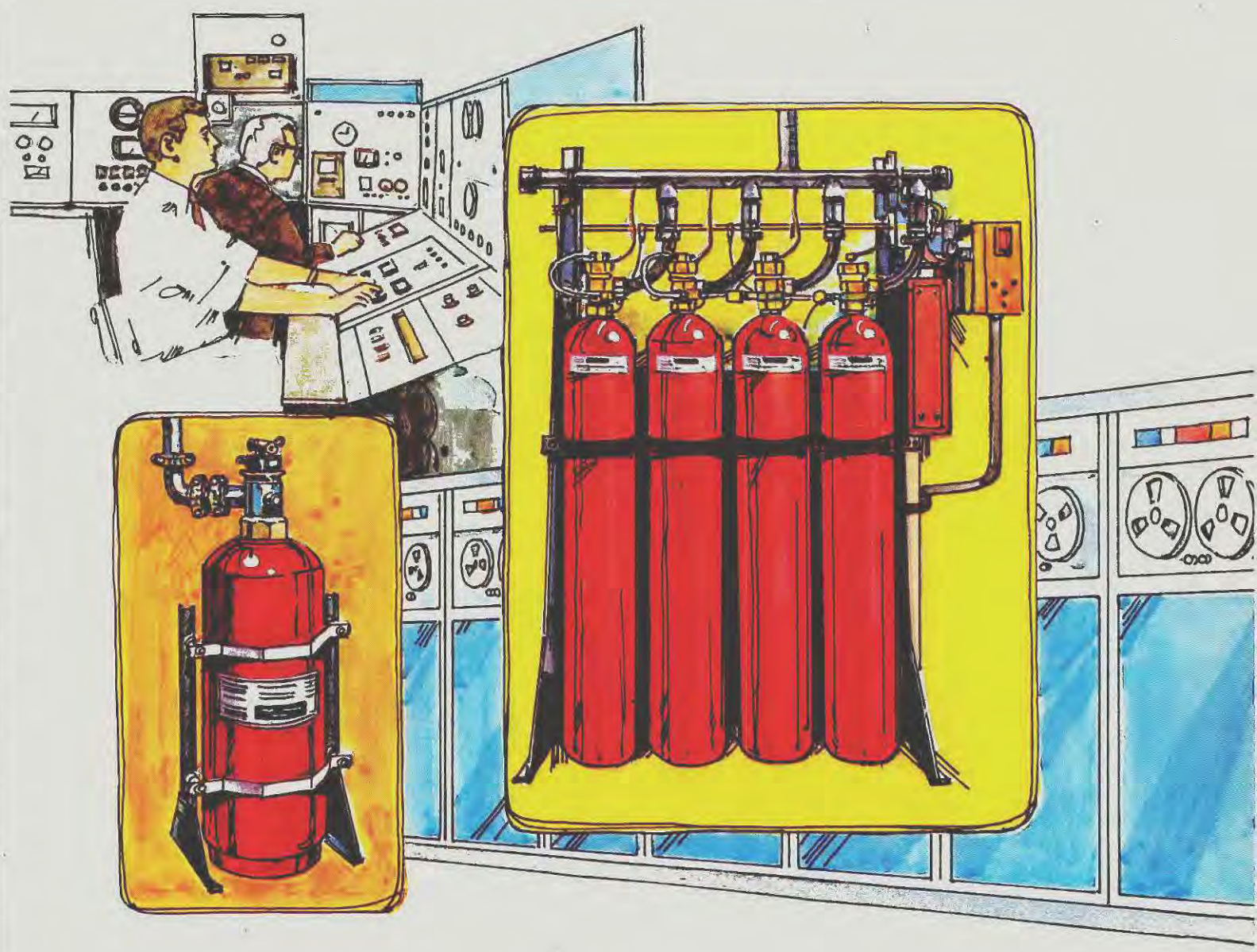

For more facts circle 111 on reply card

Public v. private . . .

Continued from preceding page

"continuance of salary" payments if he has been out of work for more than four days. He can receive this benefit up to six months depending on the length of service. For example, a Borden employe who has worked for the company for four years will receive eight weeks of full pay and another eight weeks of 75% of his salary. An employe can receive money for 27 weeks up to $3,000 per month as long as disabled.

All Ohio State employes are insured for 2½ times their salary up to age 55 when coverage starts dropping 3% each year. The program ceases when the person reaches age 70. Accidental death and dismemberment benefits match the life insurance level.

After five years with the state a person is totally vested in the state's retirement system and therefore entitled to disability payments up to 60% of salary.

For those with less than five years of service, a special fund has been established which guarantees that the employe will receive a minimum of 40% of his salary. The employes receiving disability payments are entitled to the benefits for an indefinite period of time as long as they are permanently and totally disabled.

Ohio State's vision care program is standard with the state providing $20 once every two years for an examination, $20 for frames and from $20 to $55 for lenses depending on the type of correction (bifocal, trifocal). The vision care program differs from others in that the state will pay 100% of the cost of contact lenses in cases where they are "medically necessary." In cases where they are not medically necessary the state will contribute $60 toward the total cost of the contacts.

Under its dental program, Borden pays for 90% of the total costs for twice-a-year check-ups and fluoride treatments and pays for all but $25 of total costs incurred by extractions, fillings, denture work or crowns. Borden pays 50% up to $500 for any orthodontia work. This plan imposes a $750 annual limit for each person covered under the plan with no lifetime maximum.

Since the dental program is part of the major medical plan, each single Borden employe contributes $5 every month for medical benefits and each family contributes $10 every month.

The city of Milwaukee, however, represents the most competitive race between benefits offered by private and public sectors.

The city matches the benefits of a national brewing company that employs 3,000 salaried and nonunion employes for life insurance coverage, major medical benefits, dental program and short term and long term disability benefits.

City employes as well as the brewing company's employes have life insurance coverage for two times annual salaries.

The major medical plan for the brewing company provides employes with full reimbursement for 120 days of semiprivate accommodations in a hospital and emergency outpatient care. Routine physicals, however, are not covered under the plan.

The national brewing company pays for 80% of the costs for "reasonable and customery" surgery, diagnostic X-ray, laboratory, hemodialysis and radiation and chemotherapy expenses after a $50 deductible. Under this plan, each employe is limited to a $50,000 lifetime maximum and only two people in a family are covered.

For dental care, the company pays 80% of the total cost of examinations and cleaning of teeth, 80% of costs for extractions, fillings and fluoride treatments after a $25 deductible and 50% of charges for bridgework, dentures and orthodontia treatment after a $25 deductible. An annual limit of $1,000 is placed on costs for extractions and fillings and a lifetime limit of $800 is placed on any orthodontia treatment. Only three people in a family are covered under this dental plan.

The city of Milwaukee's level of medical benefits matches the brewing company's. City employes are fully reimbursed for 120 days of hospitalization, surgery, lab fees, diagnostic testing, radiation and chemotherapy treatment. The city also pays for any extensive testing done prior to admission to a hospital and any nonsurgical emergency first aid treatment.

Under Milwaukee's dental plan, the city pays 80% of charges for examinations, extractions, fillings and cleaning of teeth with no deductible to an annual limit of $750. The city also pays for 50% of the cost of orthodontia work with no deductible to a $750 lifetime maximum.

These limits on dental and major medical coverage apply to each person covered under the city's plan, no matter how large the family and not to each family unit.

The brewing company pushes ahead in the race only because of its profit sharing plan, tuition reimbursement plan and special scholarship plan.

Under the tuition plan, employes are totally reimbursed for any course that leads to a degree or that is related to the job. Total reimbursement is given only when an employe maintains a "C" average.

Depending on the financial needs of the applicants for the scholarship funds and the amount of money available in the fund, the company will provide partial and total scholarships to any college or vocational-technical schools for children of employes. ■

Employe Benefits

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Public demands retirement plans.

WASHINGTON—Public opinion has shifted to "them" from "us" over the last eight years on who should provide retirement benefits.

Surveys by the American Council of Life Insurance show that in 1977 about 43% of the respondents said they believed employers and unions should be the major providers of retirement income. In 1969, only 28% favored reliance on employers and unions for providing retirement income. ■

Insurers avid to capture Blue Cross group dropouts

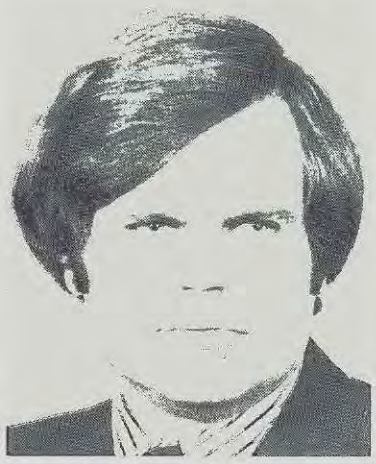
By MARY ELLEN McKEE

CHICAGO—Statistics of major health insurance companies across the nation show no appreciable shift in business between private health insurers and Blue Cross & Blue Shield plans, but changes in those market shares may be just around the corner as Blue Cross fears.

Aetna Life & Casualty, Equitable, Connecticut General and New York Life figures show Blue Cross & Blue Shield plans holding a steady share of the group market over the past three years.

Prudential sees no slippage of market share for Blue Cross & Blue Shield plans in states with a hospital discount for Blue Cross subscribers.

However, in 1978 Prudential expects to insure approximately 50,000 employes previously covered by Blue Cross & Blue Shield. Prudential snatched these Blue Cross participants from states



John Leonard of Connecticut General is watching the marketplace closely for opportunities.

without a hospital rate discount for Blue Cross and from multi-state employers, according to Dennis R. Walsh, vp of group marketing for the company.

Enrollment in Blue Cross & Blue Shield plans has declined by over one million in the past two years, Blues officials recently disclosed.

Despite insurers' assessment of the marketplace, Blue Cross & Blue Shield blames the dip in enrollment to the movement of national accounts from Blue Cross & Blue Shield plans to insurance companies.

In response, Blue Cross & Blue Shield is introducing new programs, new marketing approaches and business methods aimed at recapturing these accounts.

"The group health benefit marketplace has become very complex in recent years and some factors may pose particular difficulty for many Blue Cross & Blue Shield plans," Mr. Walsh said.

These factors are, according to Mr. Walsh:

- ERISA has spurred interest in uninsured health benefit plans and commercial insurance companies are retaining a role administering this type of plan.
- Employers have become more

Employe Benefits

actively involved in the management of their health benefit plans. Large companies are searching for funding alternatives, better service, better information and cost containment capabilities. And medium sized and small employers are moving in that direction too.

- Dental insurance is growing dramatically. Employers want medical and dental benefits serviced through a common source. Blue Cross may have difficulty controlling an account when an employer is preparing to make a major benefit addition such as dental insurance.

John K. Leonard, vp of the group insurance division for Connecticut General, says his company has won a "few" national accounts from Blue Cross & Blue Shield.

"Blue Cross has problems in coordinating large national accounts," Mr. Leonard explained. "Connecticut General stresses the service that accompanies the administration of group plans. Blue Cross & Blue Shield lost business only where service was a big issue."

Connecticut General, however, will be watching the market very closely to see if the new Blue Cross & Blue Shield products, marketing approaches and business methods geared toward the national market will have any major effect on market shares (*BI* Aug. 21).

John Goddard, senior vp of the group insurance department for Equitable, on the other hand, says

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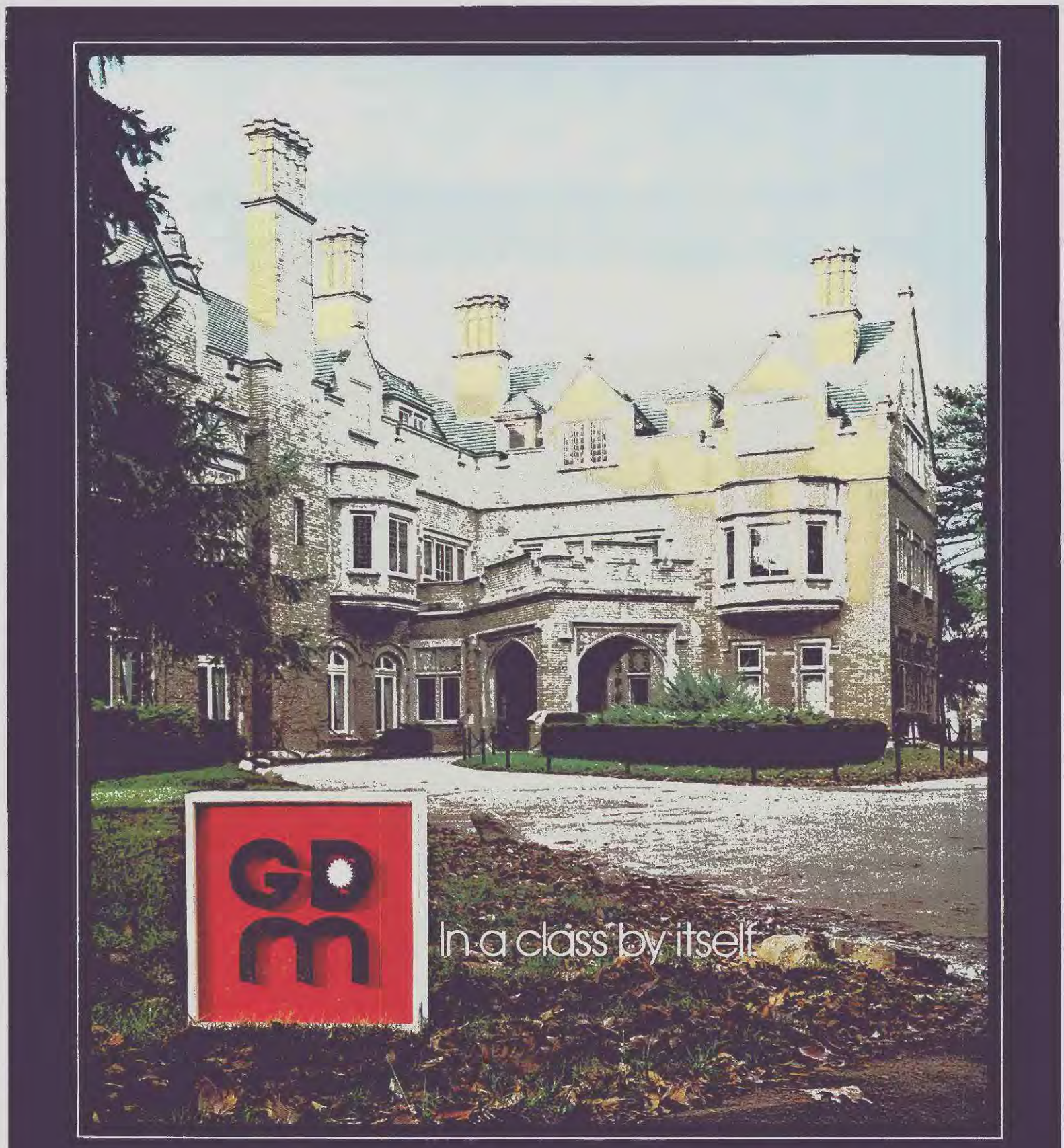

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Insurers eager . . .

Continued from preceding page
that Blue Cross & Blue Shield plans have problems handling smaller groups with employes up to 150.

"It is impossible to handle groups with 150 employes in the same manner you handle groups with 1,000 employes," Mr. Goddard noted. "Smaller groups require flexibility with simpler underwriting and issuing procedures. Economy must be worked into the process."

And Equitable, according to the group insurance vp, is working to provide that kind of economy to smaller groups.

"In the event that we capture some of the smaller accounts now administered by Blue Cross & Blue Shield plans, the marketplace will be made considerably more competitive," Mr. Goddard added.

Dennis Walsh of Prudential observes Blues market shares slipping over national accounts.

Increased legislative activity on the state level may do the most to reshape market shares, according to Mr. Leonard, group insurance vp for Connecticut General.

Last spring, bills were signed in New Jersey, New York, Illinois and Maryland requiring a study commission be formed to devise a uniform mechanism to control hospital rate discounts given to Blue Cross & Blue Shield participants.

In parts of New Jersey rate discounts run as much as 25% to 30%, with Blue Cross holding over 50% of the market share.

Rate discounts running from 40% to 45% are given to Blue Cross participants in parts of the state of New York, with Blue Cross market shares ranging from 55% up to 80% depending on the section of the state.

Connecticut General is keeping a close watch on these states, Mr. Leonard noted.

"One of the main reasons employers opt for Blue Cross & Blue Shield coverage is the discount," Mr. Leonard said. "If the rate discounting is controlled in the future, then the major attraction of a Blue Cross & Blue Shield plan is weakened—Commercial insurance companies are bound to take advantage of this."

The effects of any legislation on market shares, however, Mr. Leonard added, will not be seen until five years down the road. ■

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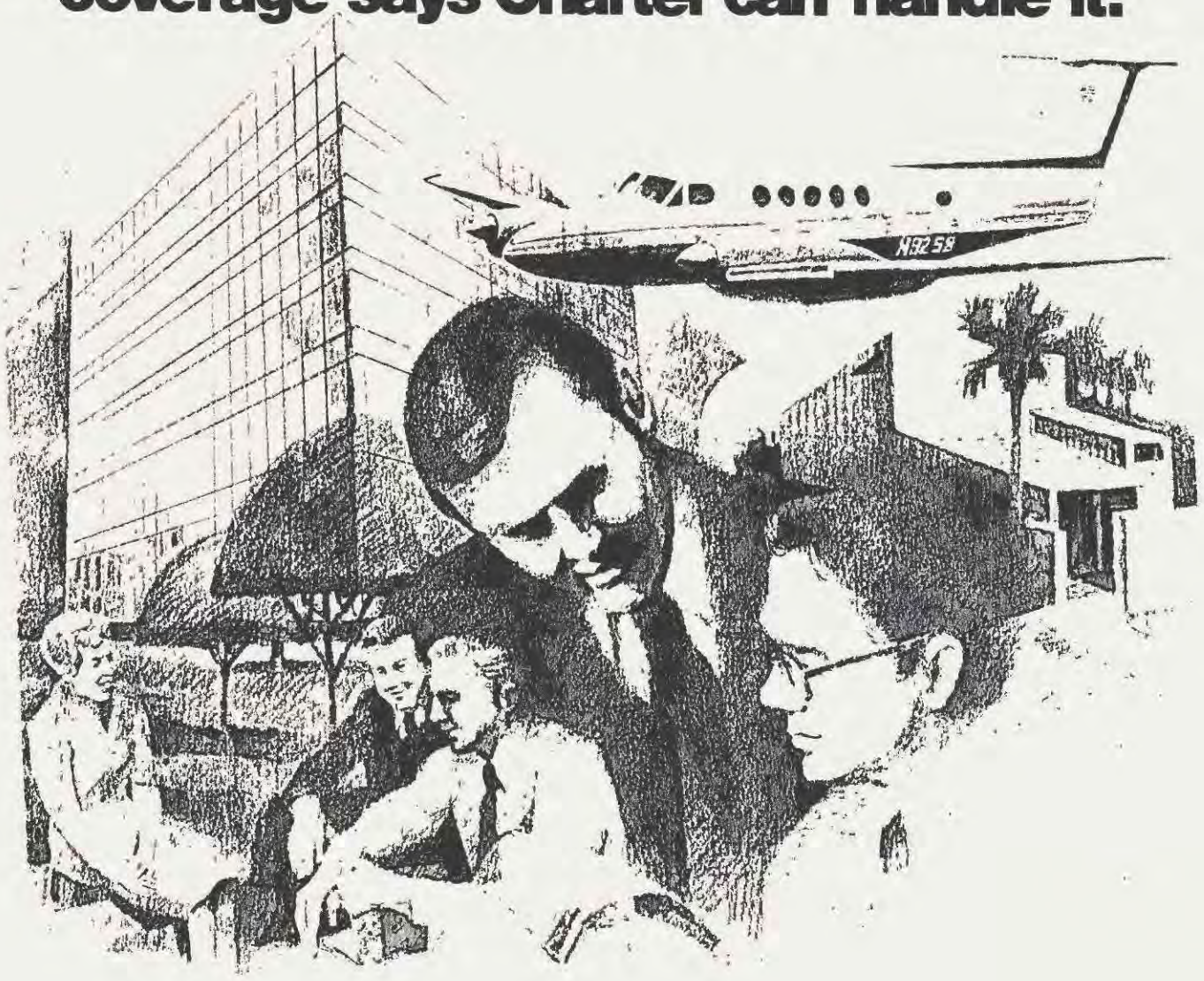

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Man creates most disasters

ZURICH, Switz.—Nearly three-quarters of the world's catastrophes in the past 10 years were "manmade," according to the Swiss Reinsurance Co. here.

The company defines a catastrophe as an event that claims more than 20 lives and/or causes financial damage exceeding $6 million in transport losses, $14 million in aviation or $17 million in fire losses.

There were over 1,300 catastrophes in the past 10 years, ranging from a low of 81 in 1968 to a high of 163 in 1971, the company's monthly publication Sigma reported. Only 27% of the catastrophes were natural events. The remaining 73% were caused by fire (20%), aviation (21%), transport (30%) and other non-classified events (2%).

Asia leads in overall frequency of catastrophes (32%), followed by Europe (27%), South America (16%), North America (14%), Africa (10%) and Oceania (1%). Europe suffered the greatest catastrophe density considering its size and more than half of all the major fire losses. ■

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Survey reveals upswing in dental, vision plans

By JOANNE GAMLIN

Employe Benefits

CHICAGO—There's been tremendous growth in the number of companies providing separate dental plans and more moderate increases in separate prescription and vision care plans, the latest Wyatt Co.'s group benefit survey of major U.S. companies reveals.

Medical plans are also increasingly basing reimbursement on "reasonable and customary" charges for such services as hospital extras, surgery, physician's calls and outpatient diagnostic benefits, the study by the employe benefit consultants found.

Long term disability plans now include more liberal benefits and definitions of benefits than they did in 1976, the last time the survey of group benefit plans was taken by Wyatt.

Finally, the survey found that 501(c)(9) trusts are being used much more often for medical and long term disability benefits than they were two years ago, although trusts are being used less often for death benefits.

The survey results are based on responses from 807 companies from the Fortune 1,000 industrials and the Fortune top 50 retailing firms, the 50 largest utilities, the 50 leading commercial banking concerns and the 50 leading transportation companies.

Forty-six percent of the responding companies reported offering separate dental plans, almost double the 28% which offered dental benefits in 1976. Of the companies now offering dental plans, 74% said they did not require any employe contribution to the plan.

Most companies with dental plans (317) impose annual limits on the plans ranging from $750 to more than $5,000, although the majority have limits falling between $750 and $2,500. Far fewer—only 40 companies—have per person dollar limits, but 29 offer limits of $5,000 or more.

Solid evidence that prescription drug and vision plans are gaining wider acceptance was provided by the survey. It reports, for example, that 164 basic medical plans have prescription drug benefit provisions and 106 cover vision care. Likewise, under comprehensive medical plan, 64 companies have prescription drug plans and 46 have vision plans. In total, 20% of the companies with basic medical plans have separate drug plans in 1978 compared with 14% two years ago and 19% of the same concerns have separate vision plans against 4% in 1976.

Coverage for 'reasonable and customary' charges is frequently supplanting strict dollar limits, and the Wyatt survey discovered that 77% of hospital extras now go under that label compared with 68% in 1976. Similarly, Wyatt reported that 52% of all surgical services are now being reimbursed under the more liberal label, up from 47% two years ago.

Employers are also becoming more generous with their definitions of long term disability, the amount of benefits provided (before offsets) and the maximum monthly benefit (before offsets). For instance, 148 plans or 21% of the total now use an "any occupation" definition of long term disability, compared with 10% in the last survey. Moreover, plans providing a benefit of 60% or more of pay have grown to 64% this year from 61% two years ago. A maximum benefit of $3,000 a month was allowed by 17% of the plans in 1976, while a full 24% permit it today.

Fifty-nine percent of the companies reported using 501(c)(9) trusts for long term disability, 57% for medical expenses and 23% for short term disability. This represents strong growth in the use of trusts compared with two years ago when only 36% of the companies surveyed used trusts for long term disability, 23% for medical expenses and 7% for short term disability.

The survey this year found only 2% of companies using trusts for standard death benefits compared with 4% two years ago, and only 7% of the companies are using trusts to fund retiree death benefits, down from 10% in 1976. ■

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IRA's appeal is still limited to small firms

By JERRY GEISEL

WASHINGTON—On the surface, the new simplified pension plan option allowing employers to contribute to employes' Individual Retirement Accounts appears to be just the solution for a company tired of the hassles associated with the pension reform law.

Beginning next year, all a company has to do is simply deposit $7,500 annually or 15% of an employe's compensation, whichever is less, into each worker's IRA in lieu of a corporate pension plan.

Under the employer-sponsored IRA system, companies can forget about expensive ERISA reporting and disclosure forms such as summary annual reports and summary plan descriptions.

Paradoxically, the IRA system's greatest virtue of simplicity is also its downfall and will generally cause all but the smallest firms to avoid the plans after scrutinizing them, according to benefit experts.

Few large companies will opt for the IRA plan because IRAs simply lack the flexibility to "do the job in terms of retirement security" as well as corporate defined benefit plans, says Theresa Stuchiner, partner at the national consulting firm of Kwasha Lipton & Co.

A shift to an IRA system could be damaging from an employe relations point of view, observes Kenneth Keene, senior vp at Johnson & Higgins in New York.

For example, under one increasingly popular type of pension plan, the benefit is based on the worker's final compensation rather than on career average compensation.

A pension plan based on final compensation rewards the "fast-track" employes who have quickly

Employe Benefits

moved up the corporate ladder, says Mr. Keene. "These are the kind of people that a corporation is most concerned about."

However, under the IRA system, in which there is a rigid limit on employer contributions and thus benefits, corporate movers and shakers would not be much better off than employes whose salaries did not rise as dramatically during their careers.

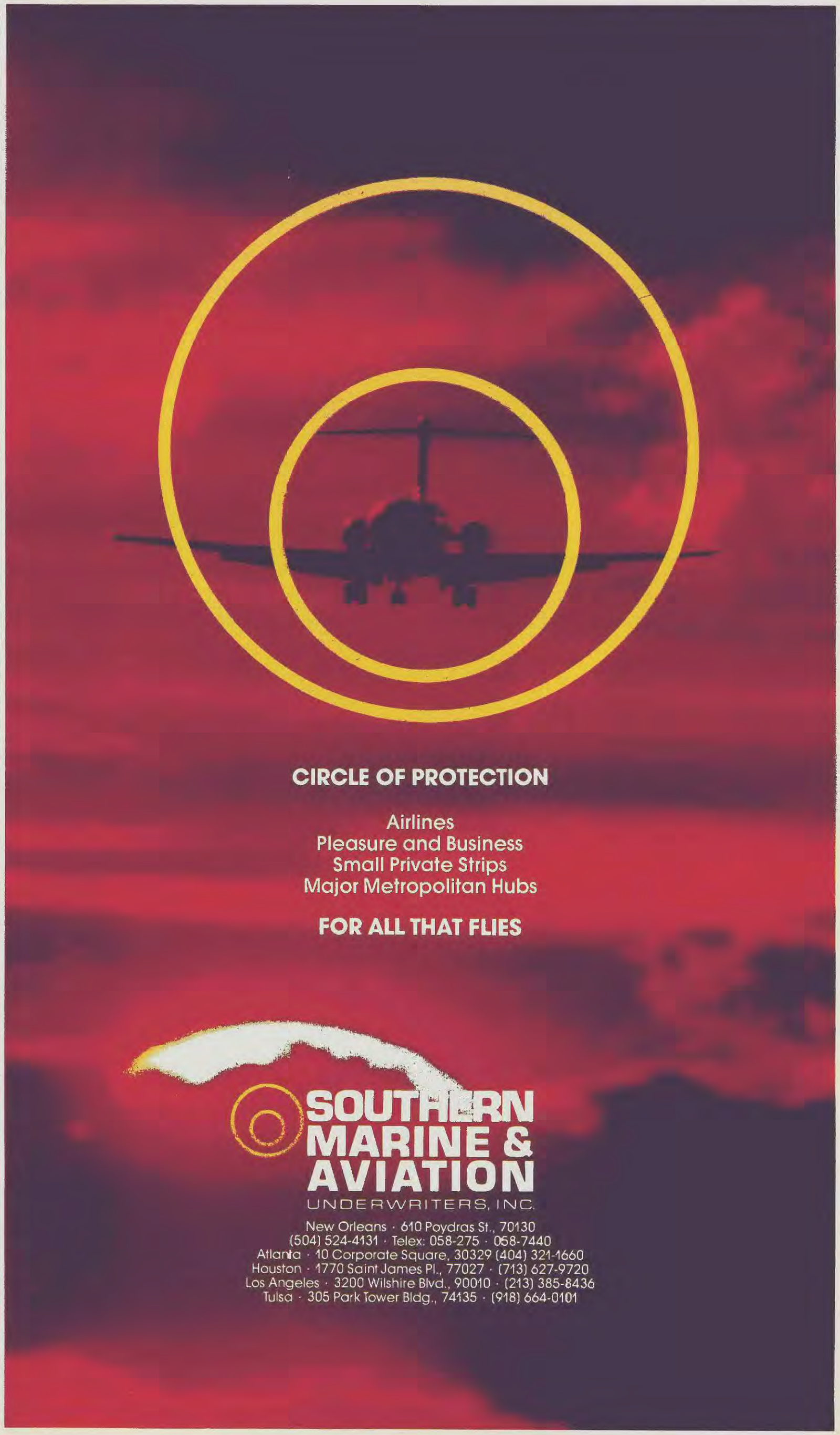
Another drawback to the IRA plan is employes would become 100% vested as soon as the employer begins funneling contributions into the IRA. By contrast, many corporate defined benefit plans don't offer 100% vesting until an employe completes 10 years of service.

By sponsoring IRAs, employers will lose their ability to hold onto workers, says Judy Diamond, president of the newly established National Assn. of Small Retirement Funds. "With an IRA and its immediate vesting provision, an employe can simply walk away when he feels like it. He no longer has to consider, 'Gee, if I stay here 10 years, I'll be vested.' "

An IRA system also could pose tough administrative problems for larger companies, says Richard Sears, partner at Kwasha Lipton. Firms with thousands of employes, for example, would have to administer thousands of IRA.

However, smaller firms—those with less than 20 employes—may find the IRA approach attractive.

"Small firms have been scared off from establishing conventional plans because of things like summary plan descriptions," says Bob Lindgren, a consultant with A.S. Hansen Co. in Lake Bluff, Ill. "The paperwork burden just isn't there (with IRAs)." ■



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DETROIT—Have you heard the one about General Motors paying more for employes' health insurance than it pays for steel? Then you've heard it told incorrectly.

To make a point, GM's director of employe benefits, Victor Zink, testified in April 1976 before a Senate health subcommittee hearing that "the Blue Cross and Blue Shield plans—if considered together—are by far our largest supplier. Metropolitan Life is second and U.S. Steel a distant third."

However, at seminars, conferences and cocktail parties, the testimony has been garbled to the assertion that GM, or the auto industry, pays more for employes' health insurance than it pays for steel to make cars.

Wrong. GM purchases steel from many steel companies in addition to U.S. Steel and the cost of steel to GM and the automobile industry as a whole is significantly greater than the cost of health care insurance, says GM.

This is not to suggest GM doesn't pay a whopping health insurance bill for employes. It paid $1.3 billion in model year 1978 toward health benefits.

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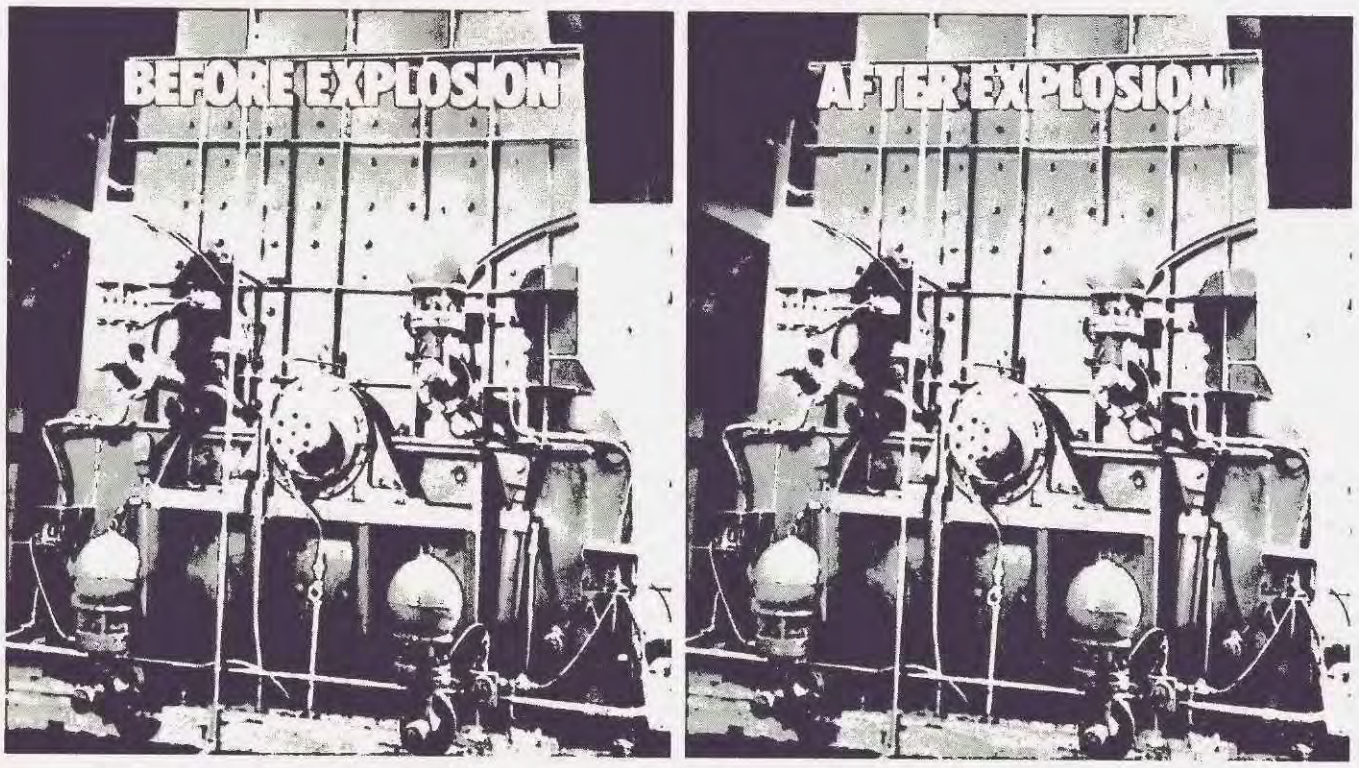

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HMOs . . .

Continued from preceding page

more awareness and support of HMOs among benefits people" already. The regional HEW offices will try to capitalize on it, with the "major thrust of their work at working with corporations to get them involved."

Conceding that "experience tells us corporations won't take the risk of starting HMOs," Mr. Veit is promoting an alliance of business, labor and community groups for starting new HMOs. Prime Health in Kansas City and a newly expanded HMO in Detroit, both the result of this type of cooperative effort, are promising examples this tact can work, he said. "This model will be the most successful in the future," Mr. Veit predicts.

Among the communities targeted for first-time or additional HMO development next year are Erie, Penn., Binghamton, N.Y., Cincinnatti, Des Moines, San Francisco, New Orleans, Anchorage, Tucson, Chicago and New York.

In conjunction with the drive for grass roots development of new HMOs, HEW is encouraging established health clinics to offer a

prepayment health plan along with their fee-for-service organization, as the Phelan Clinic in Boston has recently.

With the doctors already aligned as a group, the facilities operating and the management capability present—eliminating start-up costs and headaches—clinics such as the Lahey Clinic in Boston and the Cleveland Clinic are "prime candidates for an HMO," Mr. Veit contends.

The newly established target for HMO development, the director said, is to sustain a 20% enrollment growth rate for the next few years to reach an enrollment in HMOs of 10% of the American public by 1990. "Then you begin to have an impact on costs," Mr. Veit said.

With a 10% public participation in HMOs, "there will be significant cost savings to the HMO enrolles and there will be a competitive impact," Mr. Veit predicts.

The competition spurred by increasing HMO growth will prompt the development of other alternative health care delivery systems aiming for increased cost efficiency, he believes. Traditional health insurers, faced with competition for the consumers' health care dollar, will slow the growth of their premium increases, expand their coverage and even pick up the HMO mantle as insurers such as Prudential, CNA and INA already have, Mr. Veit says. ■

HEW readies new rules about HMOs

WASHINGTON—Enough employers have resisted offering their workers an opportunity to enroll in a health maintenance organization, circumventing the spirit of the HMO Act of 1973, that the Department of Health, Education and Welfare is finalizing new regulations to assure employer cooperation with HMOs.

The most recent draft of the regulations, which have been kicking around HEW offices for a year, has cleared the general counsel and is still being revised, said Ann Haendel of HEW.

So far, the regulations generally demand employers give the HMO a fair shake with the indemnity insurance plan offered employes. They go beyond just requiring an employer offer a federally qualified HMO if the HMO petitions.

When a federally qualified HMO petitions an employer for inclusion in his benefits program, for example, the employer will have to respond within 30 days, providing the HMO with details about his employes and the current health pro-

Employe Benefits

gram. There are no rules now on how soon an employer must answer the request of an HMO and apparently some employers were stalling the process.

The draft regulations also clearly establish that an employer is obliged to contribute toward an employe's HMO bill the same amount he spends on the most expensive indemnity plan available to the employe.

In the same vein, the draft regulations require that if the cost to an employer of the indemnity health plan increases during the contract year with the HMO, the same increase must be made in the employer contribution to the cost of the HMO. "Indemnity plans would come in low," Ms. Haendel said, "and then increase their premiums two months later and the HMO wouldn't get the higher amount."

HEW also heard of employers who were denying employes enrolled in the HMO the benefit of other health plans such as vision and dental provided to employes insured for health care. The draft regulations allow employers to exclude HMO enrollees from other health plans only if the same benefit is provided by the HMO. ■

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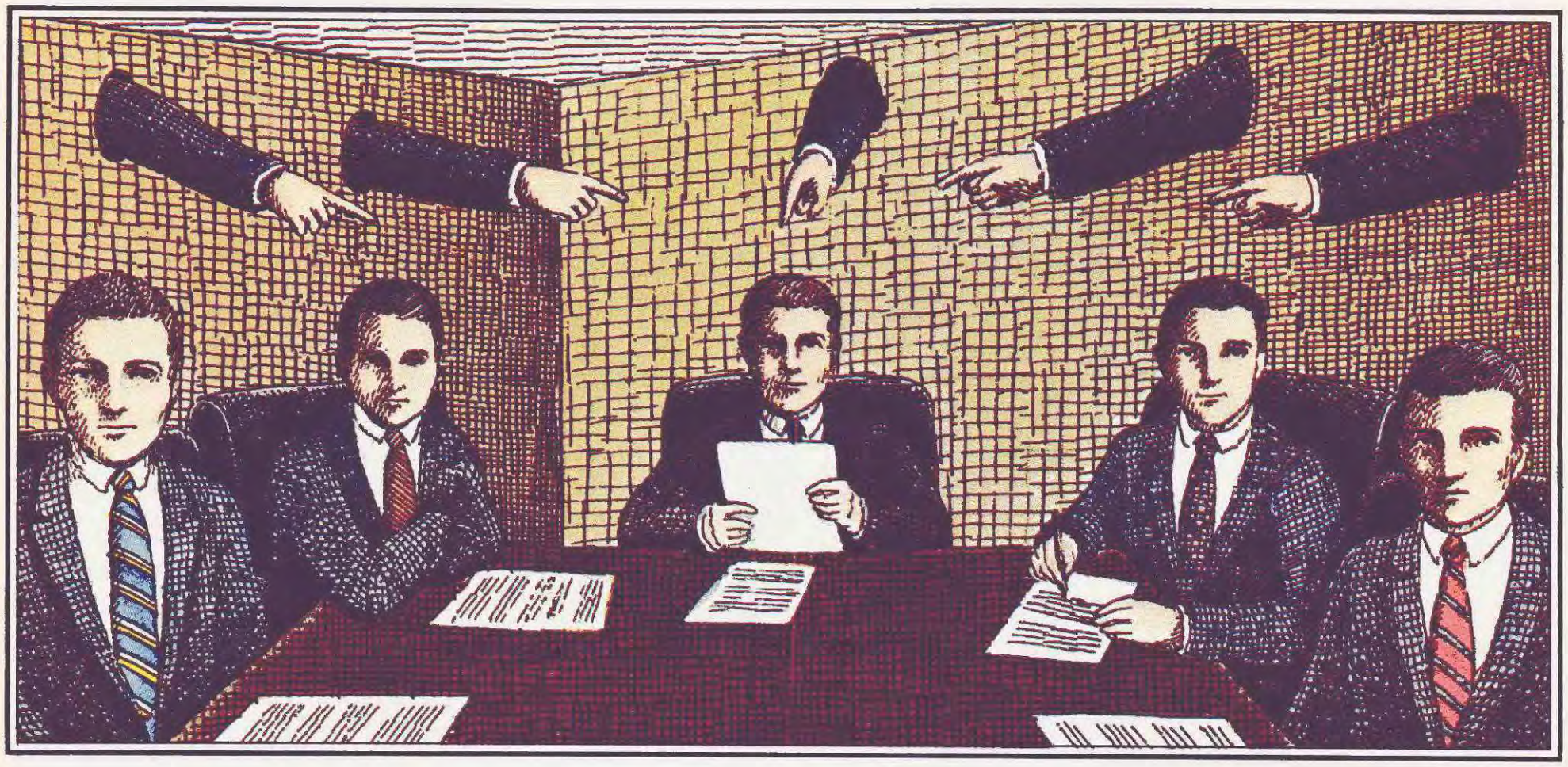


Corporate managers and directors are being held personally liable under the law for a widening range of their actions. Their greater vulnerability to claims and awards has stepped up the demand for liability insurance.

A brief review by INA of an insurance topic of interest to business executives.

If one of the officers of a company fails to obtain competitive bids for a major purchase, can he wind up being held personally responsible for a court judgment against him?

The answer is that he certainly can. In general, should a corporate director or officer act mistakenly or negligently – or should he fail to act at all when action is required – his personal assets may ultimately be at stake. Directors and officers have been held personally liable by courts for such acts as improvident investment of corporate funds in a proxy fight and failure to exercise reasonable care in the selection of a bank. And with new responsibilities resulting from closer government regulation of business, the likelihood of an executive slipup has grown considerably.

Unquestionably, officers and directors are being sued these days with increasing frequency and for ever-greater amounts. This has led to something of a run on liability insurance for directors and officers, with rates going up and coverages not always available.

Asking hard questions

To fulfill their obligations today, directors and officers should be exceptionally well-informed on the overall management of their company. In particular, a director is expected to make a reasonable investigation – at first hand, if need be – of the transactions in which he participates as a board member. This includes such matters as corporate financing and financial reporting the issuing of securities, proposed mergers and acquisitions and the like. And an officer has a specific responsibility to use reasonable care in overseeing the day-to-day activities of company employees.

But even though officers and directors may act objectively, carefully and diligently, their

Officers' Liability

management of corporate affairs is never immune from attack. Every act performed by a director or officer that results in a loss of any kind should be viewed as a potential source of a lawsuit.

Reasonable prudence

In the event of a suit, the "prudent man" rule may furnish a defense for the officer or director. If it can be shown that he did everything an ordinary prudent man would have done under the circumstances, he may well be on his way to a successful defense. And if he acted in good faith and in the best interests of the company as he saw them, he will usually be reimbursed or indemnified by his company for any legal fees and judgments incurred.

In turn, one part of a directors' and officers' insurance policy covers the company when it makes such reimbursements. And when company indemnification is not available, another part of the policy can provide for the direct reimbursement of an officer or director.

Most sizable corporations today – including over 90% of the firms listed on the New York Stock Exchange – carry directors' and officers' liability insurance in amounts ranging from $5 million to $60 million and more. The premiums paid usually reflect the company's relative vulnerability to litigation.

Corporate targets

What makes a company particularly susceptible to litigation involving directors and officers?

Aside from sheer size, a company with a number of unprofitable years is much more likely to be the object of lawsuits than is a consistently profitable one. Diversified companies are more litigation-prone than those in a single type of business, as are companies engaged in acquisitions. And publicly held companies are more vulnerable than private or closely held companies.

Stockholders and stockholder classes are frequent plaintiffs in actions brought against publicly held companies and their directors. Employees and former employees, customers, government agencies and prior owners of acquired companies are also potential plaintiffs.

Directors' and officers' liability is a specialized form of insurance. INA is one of the major carriers providing this coverage for companies of all sizes and is able to meet the specialized needs of larger companies for such protection.

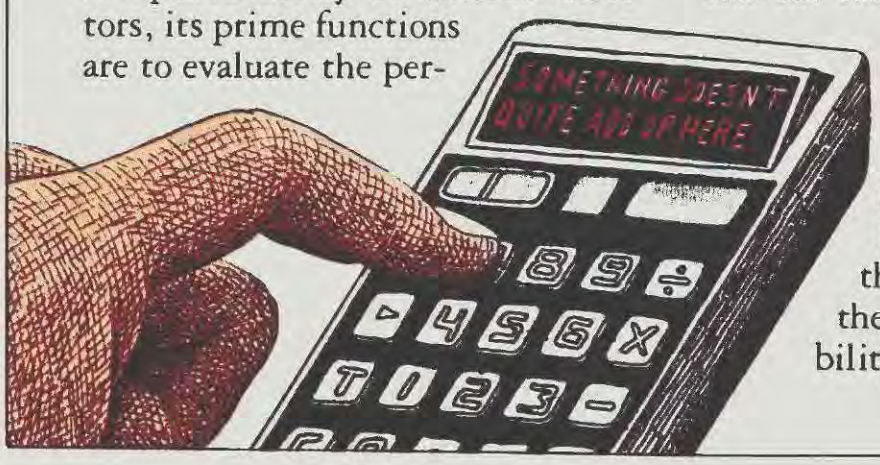
* * *

The Insurance Company of North America was founded in 1792 in Independence Hall, Philadelphia. Today it is the largest component of INA Corporation's international network of insurance and financial service companies. In property and casualty insurance and risk management services, life and group insurance, health care management, and investment banking, INA and its affiliated companies offer a unique combination of products and services to business and industry around the world.

INA insurance products and services are available through selected independent agents and brokers. For an informative booklet on current trends in directors' and officers' liability, write INA, 1600 Arch Street, Philadelphia, Pa. 19101.

The board room's "super sleuths"

One of the most effective loss-prevention measures for dealing with directors' and officers' liability is the audit committee. Usually composed solely of outside directors, its prime functions are to evaluate the performance of the company's independent auditors, assure the effectiveness of internal accounting and controls systems, and test the reliability of all financial information. If the committee successfully fulfills these obligations, it can hold down the liability exposure of the board – as well as the premiums for liability insurance.



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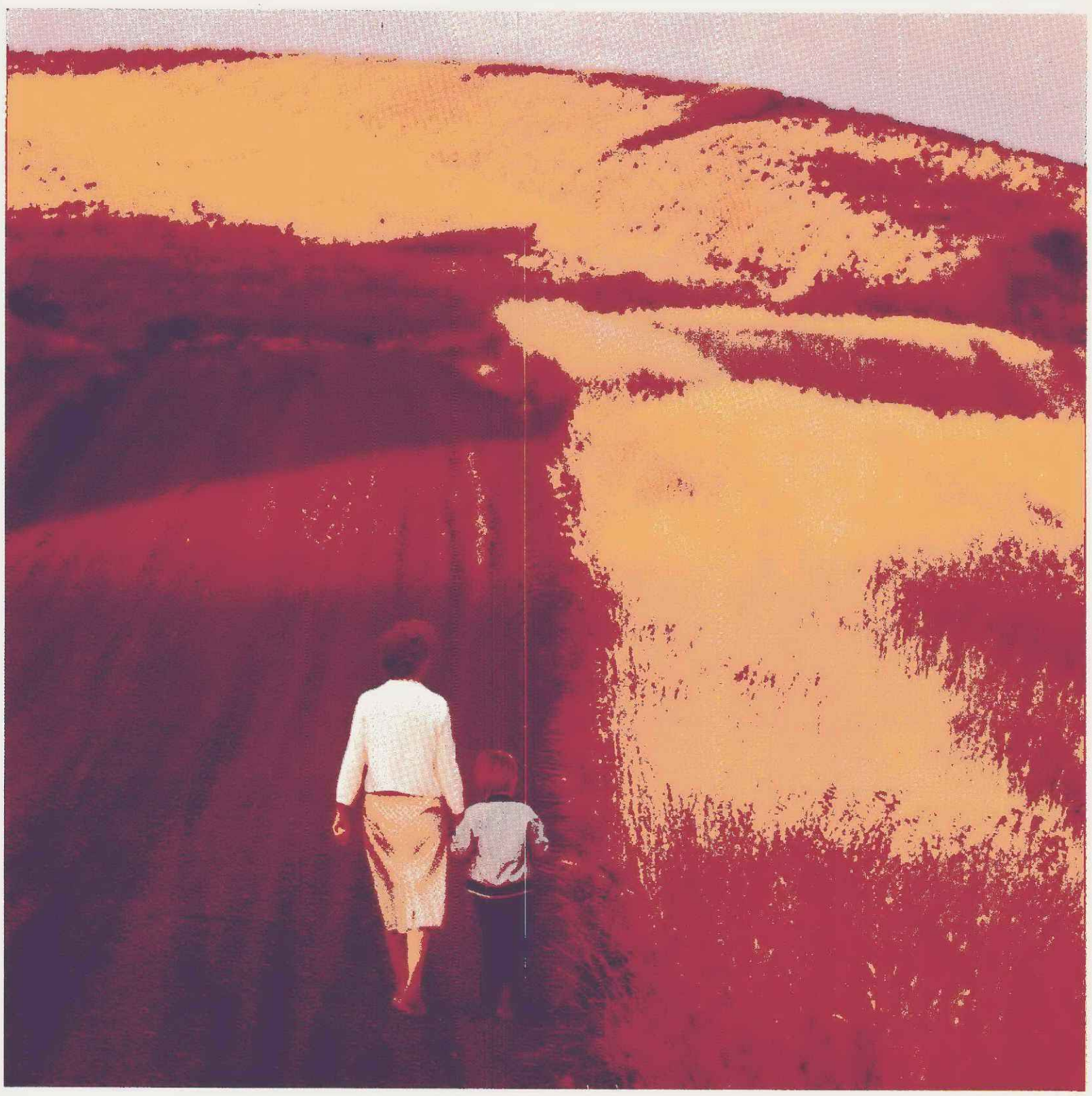

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PERSPECTIVE

'Working person's tax shelter' is also boon for employer-sponsors

By Richard C. Sears

EMPLOYE SAVINGS PLANS have been receiving a good deal of favorable press lately, and rightfully so. Their emergence from the role of supplemental benefit in the post-war years to enormously popular independence in the mid-'70s is unparalleled.

In many respects, these plans now represent the ultimate in employe benefits. For example, savings plans are active benefits, encouraging a high degree of on-going employe participation. Employes have a much greater opportunity to interact with their savings plan, and hence the employer, than they do with most other benefits. Savings plans perpetuate this interaction through regular payroll deductions, progress reports and a number of provisions which allow employes to customize the working of the plan in order to best suit their individual needs. Most other benefits are passive, representing a reservoir of assistance that is only called upon if some generally unpleasant circumstances arise. Ironically, these passively protective benefits are frequently more closely associated with the insurance carriers that manage them than they are with the company which provides them.

Savings plans are also wider in their appeal than most other benefits. Generally, all of their provisions apply equally to a broad spectrum of potential participants. There are no complicated formulas which may favor employes with either higher or lower rates of pay. There are no separate levels of coverage which might distinguish between classes of employes. And, other than the inherent virtue of accumulating savings over time, there is little premium on long service per se. For these reasons, savings plans are often the only part of the benefit program with appeal for the younger employe.

Moving from the esthetic to the pragmatic, employe savings plans are, in a sense, the working person's tax shelter. Qualified savings plans are plans which, because of their design, receive a favorable tax status from the Internal Revenue Service. At the risk of oversimplifying, although employe contributions are made with after-tax dollars, amounts which the company contributes, as well as investment growth, do not have current tax obligations. This results in employes' earning investment value on money that would have ordinarily been paid out in tax under conventional savings. As if by magic, the tax-sheltering aspects of employe savings plans result in interest compounding which can produce astounding results.

As large as these individual accumulations may potentially be, they are generally achieved at a remarkably low level of employer cost. The typical savings plan entails an employer cost of only about 2% of payroll and frequently less. But to the employe, the savings plan is usually perceived as being more valuable than other benefits, even though those other benefits may be more expensive to provide. The reason lies in the "magic" of the savings plan match: "You mean for every dollar I contribute, the company adds 50 cents? Where else could I ever find an immediate 50% return on my investment?"

Another feature which has contributed to the popularity and growth of savings plans is their inherent flexibility. In addition to helping employes accumulate meaningful savings to meet their personal goals, they can also assist the employer in meeting many of his goals. For example, they are a convenient way of increasing employe ownership of company stock. Or they can be used to incorporate a profit-sharing feature (such as an extra match based on profits), thereby encouraging employe involvement in company profitability.

"Joe, you lucky fellow, you're getting $25 from us to combine with the $50 you just deposited in the plan. Merry Christmas."

From the employe's viewpoint, a savings plan can also serve a number of distinctly different purposes. For the younger employe, it can represent a way to build up savings for buying a house, taking a special vacation, or any of the other rewards of life that are so hard to achieve. For the employe with a family, there is the potential for building up savings for college education. For the older employe, the plan may serve as a source of retirement income supplementation. In essence, each employe can use a savings plan in the manner that best suits his or her own individual circumstances, even as those circumstances change from time to time during a working career.

There is little doubt today that the vast majority of employes recognize and appreciate the value of a savings plan as an em-

Continued on page 61

Dick Sears is a partner of Kwasha Lipton, Englewood Cliffs, New Jersey, employe benefits consultants. He started his career with the John Hancock Mutual Life Insurance Company after attending Harvard College. He achieved Society of Actuaries fellowship in 1960 at the age of 23, one of the youngest fellows ever. He joined Kwasha Lipton as a Consulting Actuary in 1965 and now advises major corporate clients on all aspects of their employe benefit programs.

Should you be paying that benefit claim?

By James F. Heil

With coordination of benefits, it's wise to have a philosophy of pursue-and-then-pay, in order to avoid the difficult situation of retrieving your funds after a claim has already been paid.

—James Heil

COORDINATION OF BENEFITS has proven itself to be an effective means of reducing the cost of health care. Yet many employers are losing thousands of dollars a year because of its mismanagement.

Employers who are self-funded should gear the administration of their group medical plans to take full advantage of COB.

Our success with this approach is evidenced by the fact that our clients achieved COB savings averaging 10% of total paid claims during the first six months of 1978. The insurance industry as a whole achieved only 5%, according to a recent survey by the Health Insurance Assn. of America.

To begin proper COB investigations, the company administering the group medical plan must establish a policy of pursue-and-then-pay, rather than pay first. Deferring payment until primary payment order has been clearly established avoids the difficult and unpredictable situation when payment must be retrieved.

The policy of pursue-and-then-pay is more efficient since it avoids the duplicate process of making payment and retrieving payment.

Making payments on claims where a client's plan seems obviously primary can often turn out to be a mistake. For example, a claim was filed in our office for the unemployed spouse of a female employe. Since the spouse was unemployed and thus ineligible for most group plans, it appeared obvious that the wife's coverage would be primary. Through close scrutiny of the claim, we discovered that the spouse was an unemployed member of the Plumber's Union and still eligible for benefits under the union's welfare plan. In addition, that particular plan did not have a COB provision, so that coverage would always be primary, even on our client's employe.

Savings pursued through COB are also affected by fundamental office design. Individual accounts should be assigned to a particular claims administrator. That administrator's responsibility should be to become familiar with the provisions of your benefit plan. This kind of arrangement is also beneficial in terms of the administrator becoming knowledgeable about other localized plans.

Although many companies have corporate headquarters in large cities, the bulk of their manufacturing operations are often located in smaller communities with fewer employers. For a good number of our clients we keep logs of the coverage offered by other employers in the community where the company does business. Gathering this information can be time consuming, but we've found it's more than justified in terms of maximized COB savings.

The training of claims administrators should stress time and diligence in pursuit of COB savings. This training should include detailed and standardized procedures for determination of COB involvement.

Investigations of COB begin with a claim form filed by the employe asking questions about a working spouse, other coverage and with what company other coverage is provided.

If the questionnaire is not answered or is incomplete, a form letter should be issued asking the same questions. Following this, correspondence must be undertaken with either the spouse's employer to determine if the spouse is covered under the plan or with the spouse's carrier to determine benefits.

By aggressively investigating potential COB savings, facts often turn up that were not indicated previously. Administrators should be trained to pick up "hints" about other carrier involvements—such as partially paid hospital bills—which may have been missed.

To complete a COB investigation, details about individual claims should be recorded on computer runs. Every six months total COB savings can be calculated. Using this method, administrators whose COB savings are not at good levels can be pinpointed.

Coordination of benefits is one of the most effective weapons we have in the fight against soaring costs. But it's how you use the weapon that really counts. ■

James Heil is president of Chicago-based Self-Insurers Service Inc., administrator of self-funded group benefit plans for over 30 corporate clients.

PERSPECTIVE

Study prior claims

Revamp funding to stabilize, reduce disability plan costs

By Michael Gomez, CLU and Joseph V. Guiliana Jr.

DURING THE LAST SEVERAL years, there has been a decided trend by large firms to improve the methods used to finance their life and medical benefits. In sharp contrast to this has been the reluctance to modify the traditional insured funding and administration of their long term disability benefits, even when confronted with large rate increases which lower employe take-home pay and adversely affect plan participation.

Michael Gomez, CLU, is vp of Alexander & Alexander where he started his work career in A&A's New York group department in 1965 and is now a senior benefit consultant responsible for major group insurance accounts. Specializing in the funding methods of benefit programs, he was instrumental in the development of insurance programs without the requirement for reserves, as well as formalizing the use of pension-related methods to the funding of long-term disability benefits.

Joe Guiliana is vp and consulting actuary at A&A, joining the firm in late 1974 after seven years with the National Health & Welfare Retirement Assn.

Is this reluctance justified? The human resource management group of Alexander & Alexander and several major corporations have concluded that it isn't. Reasonable steps to stabilize and reduce costs should be taken.

In most circumstances, the impetus for considering a change in funding for the long term disability plan has been a major rate increase. The insurer expects a premium level which will cover claims plus expenses, along with an extra margin for adverse claim fluctuations. In reality, group insurance for large plans is generally a fiction. Most plans are, in fact, self-insured in a financially disadvantageous manner. The only risk an insurer assumes is cancellation with a deficit; in all other circumstances, the plan sponsor pays the claims and expenses of the program.

The long term disability reverses used to justify rate increases are truly staggering. Life and medical reserves, when related to paid claims, rarely exceed 35%. Long term disability reserves can easily be 700% to 1,000% of paid claims and still be reasonable. Many plan sponsors have questioned the magnitude of the reserves. Our various studies have usually shown that insurers are reasonable and correct in their reserve levels when the interest rate assumption is selected to reflect the portfolio rate of return for insurance companies. In one situation, there was a significant difference in total reserves set up by the insurer as opposed to our estimate. The insurer's reserve was over $11 million, while our estimate was less than $8 million. The explanation for the difference was that the insurer did not take into account future increases in the Social Security benefits which reduce plan benefits.

Recognizing that reserves are reasonable and necessary, the next question becomes . . . "What can we do?"

It is at this point that serious discussions can be held on taking action to stabilize and reduce plan costs. As noted previously, the plan sponsor has probably already assumed most of the risk, which may or may not have been a conscious decision on its part. Before more substantive discussion can be pursued, the question of risk must be thoroughly explored and reconciled. Many companies are concerned with the possibility of several major illnesses affecting the stability of the plan. Unlike life and health coverages, where one year can result in paid claims exceeding budgeted cost, the same is unlikely to happen with long term disability since benefits are paid over a number of years.

The amount of risk can be quantified by developing the likelihood of various levels of claims using statistical methods commonly used to project claims in other lines of insurance. Also, future cash flow projections can be calculated using various assumptions as to the future number of covered employes, claim levels, investment income, salary levels and other variables. Most sponsors of large plans, after reviewing the degree of risk involved with the long term disability plan, are comfortable with assuming 100% of the risk.

An important step in this entire procedure is an analysis of the prior claims history of the plan which will serve as the basis for future actions and decisions. The key to the analysis is computer programs which segment the prior disability and recovery experience of the plan by:

1. location,
2. sex,
3. age in 5 year brackets,
4. salary in $5,000 multiples,
5. union vs. non-union,
6. job classification,
7. Social Security disability approvals and,
8. any other classification which can possibly impact on plan cost.

This detailed breakdown of the claim data is then compared to expected claims using recent published insurance company experience. Abnormal patterns of utilization can then be pinpointed for more detailed analy-

Continued on page 61

LTD exposures are changing dramatically

By Robert G. Ostrander

DURING THE PAST FEW YEARS LTD as an insurance coverage has been relatively unchanged. Some larger policyholders have been increasingly aware of and interested in alternative funding methods, like self-insurance, for this volatile risk. Many state legislatures and/or insurance departments have enacted regulations affecting Social Security offsets and required coverage for complications of pregnancy.

As unemployment climbed during the early to mid-1970s and peaked at 8.7% in 1975, the number of employes filing disability claims increased sharply while those receiving benefits remained disabled for longer periods of time. This caused serious financial problems for many insurance companies.

As the economy strengthened during 1976 and 1977, the rate of new claims had demonstrated an expected improvement but there has been no significant improvement in the recovery pattern. Disabled employes are slow in returning to work.

Those insurers with a large enough portfolio of LTD business to weather the financial reverses of the middle 1970s with a minimum of discomfort are now confronted with a series of federal actions which could substantially alter the scope and basic nature of LTD insurance.

Robert G. Ostrander, product development director of the long term disability line of business, has been with Unionmutual since June 1972 after being with New York Life. He has a BA from St. John's University in New York and has done graduate work at the University of Rhode Island.

Projected LTD increases

Worker's Age	1979 Worker's Income	1978 LTD Benefit*	1979 LTD Benefit	Benefit Increase
35	$14,480	158	268	+70%
45	14,840	225	290	+29%
55	14,840	257	300	+17%
35	21,200	425	579	+36%
45	21,200	508	605	+19%
55	21,200	531	609	+15%

* Based on 1978 income $14,000 and $21 000 respectively, allowing for a 6% cost of living increase.

Three separate major changes are affecting the LTD line:

- The 1977 amendments to the Social Security Act (effective 1-1-79) which significantly reduce Social Security disability benefits.
- The proposed Department of Labor regulations interpreting the 1978 Age Discrimination in Employment Act (to be effective 1-1-79).
- The 1978 Amendment to Title VII of the Civic Rights Act of 1964 prohibiting sex discrimination on the basis of pregnancy for all employment-related purposes (effective 10-31-78).

Each of these actions is important by itself and taken together could represent a dramatic change in the nature and scope of the LTD risk.

A brief description of each and some comment on its probable impact may prove helpful in planning for 1979 benefit revisions and budgets, especially in light of the voluntary wage-price guidelines announced by President Carter in his speech of October 24.

The impact of the 1977 amendments, effective January 1, 1979, on Social Security tax rates and the maximum age base has been widely publicized and discussed. These changes serve to quickly increase revenues and to correct the drain on the trust fund's assets that occurred in 1976 and 1977.

A change in the benefit formula and a procedural change called decoupling were also made to assist in the attainment of the long-range financial solvency of the system and to reduce a long-standing area of inequity.

The major result of these changes is that disability benefits in 1979 will be considerably less than they are in 1978. This fact hasn't been fully communicated, yet it will ultimately translate to higher LTD costs for employers.

Over the past seven years (1970 to 1977) the average primary insurance award under Social Security for disabled workers increased 110.8%, almost twice as fast as the Consumer Price Index's increase of 56% for the same period. This was caused by applying cost of living increases to a table of benefits that was in fact already reflecting inflation's effects on wages. In essence, So-

Continued on page 60

ESIS Profiles: Risk management's new breed.

Russell A. Drake, Jr.
Director, Corporate Risk Management,
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PERSPECTIVE

Employer campaign to control costs can forestall government intervention

By Kenneth Keene

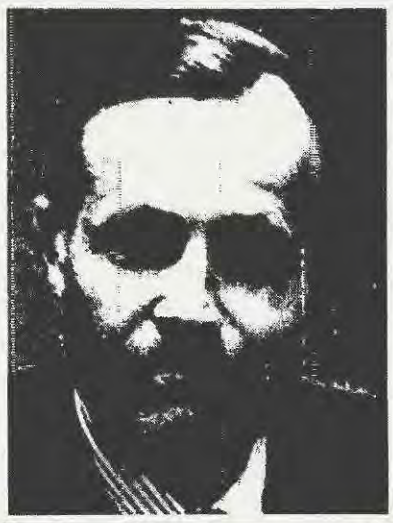
GEORGE ORWELL'S BOOK "1984," released back in 1949, depicted a time and a place then considered unrealistic and far-fetched by those readers inspired by the work ethic and freedom of enterprise code. "1984," spawning a doomsday cult, is now only half a decade away—the year, that is, not the situation depicted in the book. Or is it? Orwell wrote about a society controlled by the state, that lived by five-year plans and communicated with a vocabulary called "newspeak" which consisted of such words as Goodthink and Badthink.

The time has come for corporate planners and other organizations to adopt a five-year plan of their own to avert a doomsday scenario in 1984. And the Goodthink today has to be "Cut medical costs!"

The reasons are clear enough. In 1949, when "1984" started hitting the bookstores, medical spending in the United States was not quite $12 billion. Going into 1984, it's estimated that the figure will be more than $323 billion—a growth of 26-fold! Per capita health care costs were $78 yearly when the Fabulous Fifties began, but are expected to reach $1,360 as we approach Orwell's landmark date. Hospital cost per day was a mere $15 as 1949 came to a close, but is projected to be closer to $400 after the next five years. Bringing it nearer to home, a spokesperson for a major airline, in commenting on that corporation's increase in per-employe health insurance cost from $430 in 1973 to $850 in 1976, said: "Except for the cost of fuel, I am unaware of any single cost element which has escalated as much as medical insurance costs."

Before things get really out of hand and the federal government steps in to run the whole show ("Badthink"), employers have to get a move on to keep costs in check. And the first place for them to start is in their own back yards—their health benefit plans for employes.

There are a number of routes to control the cost of medical plans. But they should all begin with a thorough review and analysis of the whole benefit structure. Over the years, new features have been added which are too rich or duplicative or which have become overly costly. One small corrective step would be adopting a strict coordination of benefits program so that employers can provide adequate (not duplicate) coverage coupled with cost efficiency.



Effective cost control will require a combination of plan design changes and programs to keep employes healthy. Moreover, business people must be visible and vocal in their communities and on the national scene.
—Ken Keene

During the process of redesigning benefit packages, employers might want to think about involving the employes financially in the outcome through greater deductibles and higher employe contributions. The price of everything else has gone up. Has the amount of a plan's deductible or the employes' contribution followed suit? Probably not. Thus, many employers have been leveraged into higher medical costs at a rate which exceeds the rate of medical inflation. Or how about "reasonable and customary" provisions—has this blank check approach been overdone?

Emphasis can be placed on encouraging employes and their physicians to opt for less costly medical treatment. For instance, a plan can be revised to decrease or waive the deductible for medical costs arising from treatment (accident or sickness) performed on an outpatient basis or arising from home health care, same-day surgery, preventive care, etc. But a revised plan could increase the deductible or coinsurance if the employe has more expensive and lengthy treatment on an inpatient basis. At the least, a cost-conscious employer might want to adopt an in-hospital deductible consistent with Medicare—$160 starting in 1979.

In redesigning the benefit plan, an employer can incorporate any of several cost-saving features, e.g., preadmission testing—performing the laboratory and/or radiology procedures on an outpatient basis before admittance to the hospital. Second-opinion surgery is another example. A reduction in the number of unnecessary elective surgical procedures can soften the cost impact.

Of utmost importance is claims review which itemizes and analyzes how claim dollars are spent. By looking at such statistics as hospital stay, location of facilities, and the age, sex and status of a patient, an employer can tell if health dollars are being used wisely, e.g., they are at or near the norm for the particular type of claim.

All of these suggestions have to do with plan design. But cost control by no means stops here. The employer can institute programs to keep its employes healthy and to make them less likely to incur high medical expenses. These preventive care programs include:

- Disseminating information from various medical associations and societies on the identification and treatment of such things as high blood pressure, heart disease, cancer, etc.
- Encouraging and instituting immunization programs. In addition, educate employes to be more conscientious health care consumers.
- Adopting a voluntary health screening program, which can range from complete multiphasic screening to selective screening such as for hypertension.
- Instituting drug, alcohol and emotional problem assistance programs which can result in increasing productivity and reducing lost time and medical claim frequency.
- Adopting routine physical examination and on-the-job exercise programs as well as smokers workshops and weight-control programs.

The above outlines methods to bring down the cost of medical benefit plans. But employers can also look at other ways to provide medical care for employes instead of or in addition to their existing systems. One approach is prepaid medical care through a health maintenance organization (HMO). Studies of federal employe patterns have shown that those covered under prepaid group practice plans are hospitalized 50% less than those under commercially insured and the "Blues" arrangements. In a separate federal study of a prepaid group practice plan versus the Blues, the incidence of surgery was 44% to 54% higher for Blue Cross/Blue Shield. One of the HMO's biggest pluses is the emphasis on preventive and outpatient care.

The campaign to curb rising health care costs must go beyond the employer if our adaptation of Orwell's five-year plan is to be effective by 1984, or to begin to show results by 1980. Business executives must become visible and vocal in national and community affairs. They should seek representation on hospital boards and on Health Systems Agencies (HSAs). Here, their financial know-how can direct capital and energy into areas that aim for better health rather than bigger facilities. Executives are familiar with long-range planning. This is precisely what is necessary in controlling hospital spending. ■

Ken Keene, senior vp and a director of Johnson & Higgins, frequently comments on the employe benefits scene for Business Insurance.

Ostrander on LTD . . .

Continued from page 58

cial Security beneficiaries were receiving double credit for inflation. Decoupling simply means that future cost of living adjustments will be given to only those already disabled or retired. This should have a substantial impact in slowing the growth of future benefits.

Social Security was originally developed as a retirement benefit based on average wages earned during a worker's total labor force participation. As the system grew to cover more risks, like disability and more workers, primarily younger workers for disability, the calculation of "average monthly wages" on which benefits were based tended to favor younger workers who entered the labor force in the 1960s and later when covered wages were much higher. Thus, their "average" wages for Social Security purposes were greater than a comparably salaried older worker's. For example, in 1978, if a 35-year-old and a 55-year-old became disabled and both had identical earnings history and a current salary of $14,000 per year, the 35-year-old would receive a 22% greater benefit than the 55-year-old, despite the 55-year-old's greater absolute "contributions" to the system.

The 1977 amendments adjust past credited earnings based on a wage index similar to the Consumer Price Index. This average indexed wage, together with a modified benefit formula, closes the gap between younger and older workers. Continuing with our example above, the 1979 gap closes to just 8% rather than 1978's 22%.

Over the years, benefits for younger, lower paid workers tended to outstrip even pre-disability or retirement average monthly wages. For example, a 25-year-old disabled worker earning $8,000 in 1978 was entitled to a family maximum benefit of $9,504 annually, fully 118.8% of his pre-disability income.

The new formula aims for a replacement of not more than 80% of a worker's pre-disability income.

If we consider a typical LTD plan providing a 60% benefit less the primary Social Security award, the net increase in LTD benefits are evident, as shown in the chart on page 58.

As this chart suggests, younger, lower paid groups could be subject to substantial increases in the LTD rate. For budget purposes, 1979 cost increases should be estimated in the 10% to 20% range.

In summary, the proposed regulation requires that benefits may terminate for employes who become disabled prior to age 60 at the traditional age 65. If an employe becomes disabled after age 60, then benefits must continue for a minimum of five years or until age 70, whichever occurs first. The Department of Labor's philosophy is based on studies which indicate that employes who remain working after age 60 generally tend to work for an additional five years. Age 70 is the outer limit of the Age Discrimination in Employment Act.

While this may sound reliable and definitive, we understand that other legislation has already been submitted for consideration in the Congress which would tend to remove the age 70 maximum and provide that American workers will be free to continue employment for as long as they wish with no arbitrary fixed date for mandatory retirement.

It appears that the great majority of policies in force in the United States would have to be amended if this regulation stands as outlined. In addition, amendments would have to be sought in such areas as integration with pension benefits (disability or normal) so that over-insurance could be controlled. Actuarial studies have consistently evidenced a correlation between the total benefits available to an employe and the claims rate: The higher the total benefits, the higher the claims rate.

The additional cost of this protection would depend upon the population of employes over 60 and also upon the amount of offset items from sources (like pension programs) which might be available. In general, compliance with these regulations will generate cost increases of 5% to 15%. In fact, some estimates have been made by industry groups which exceed 20%.

On October 31 President Carter signed into law an amendment to Title VII of the Civil Rights Act of 1964. This amendment prohibits sex discrimination on the basis of pregnancy for all employment-related purposes, including receipt of benefits under fringe benefit programs.

It was fully effective October 31, 1978, except that plans in effect on or before October 31 have an additional 180 days (until April 30, 1979) to come into compliance.

In general, this change will have its most significant impact on employers with many younger female employes, especially when the LTD plan has a short elimination period. Older groups and plans with 180 day elimination periods should not be substantially affected.

Under the voluntary wage-price guidelines it appears that premium rate increases will be included in the calculation of the 7% wage and benefit increase. Thus, we find ourselves in somewhat of a dilemma.

In three separate actions the government has mandated benefit cost increases of up to 50% and more, in some instances.

Under the 1978 amendment to title VII of the Civil Rights Act, employers are restrained from reducing benefits or passing through the increased costs to employes for a period of one year.

Thus, the dilemma is "how does the employer balance his compliance with regulations (at a potential cost of 50% or more) with his desire to cooperate in our nation's battle against inflation?" We believe all federally mandated benefit increases should be exempt from the 7% guideline. ■

PERSPECTIVE

Filing requirements for defined benefit plans

Requirement	New	Old
1. Premium Filing		
The time available for paying premiums to PBGC has been extended for all plans. Revised PBGC-1 forms will be mailed to plan administrators about one month before the premium is due. This form is to be filed with PBGC.	**Due Date** 7 months after end of prior plan year for plan years beginning on January 1, 1978 and thereafter. Examples • Prior Plan Year Ends Dec. 31, 1977 Premium Due July 31, 1978 • Prior Plan Year Ends June 30, 1978 Premium Due Jan. 31, 1979	**Due Date** Within 30 days after beginning of plan year. Examples • Plan Year Begins Jan. 1, 1977 Premium Due Jan. 31, 1977 • Plan Year Begins July 1, 1977 Premium Due July 31, 1977
	Rates*	**Rates***
Single Employer Plans	$2.60 annually per participant for plan years beginning in 1978 and thereafter.	$1.00 annually per participant
Multiemployer Plans	Remains the same.	50¢ annually per participant
2. Annual Reporting**	**Due Date**	**Due Date**
A plan's annual reporting requirements include reportable events, closing of facilities and withdrawals of substantial employers. These events will be reported in the new, combined IRS/DOL/PBGC Annual Report Form 5500 series for plan years beginning in 1977 and thereafter. This report is to be filed with the IRS.	Combined with IRS/DOL/PBGC Annual Report Form 5500 series for plan years beginning in 1977 and thereafter; due within 7 months after end of prior plan year. (This report covers prior plan year.) Examples • Prior Plan Year Ends Dec. 31, 1977 Report Due July 31, 1978 • Prior Plan Year Ends May 31, 1978 Report Due Dec. 31, 1978	Separate report with PBGC 6 months after end of plan year. Examples • Plan Year Ends Dec. 31, 1976 Report Due June 30, 1977 • Plan Year Ends July 31, 1976 Report Due Jan. 31, 1977

* For definition of participant, see PBGC-1 instructions.

** In addition to inclusion in the Annual Report, reportable events (Section 4043 of ERISA) must be reported directly to PBGC within 30 days of the plan administrator's knowledge of the occurrence; closing of facilities and withdrawal of substantial employers, within 60 days of their occurrence.

Savings plans . . .

Continued from page 57

ployе benefit. In a recently completed national survey for a major employer, the results indicated that employes of all ages ranked the company's savings plan second (in importance) only to medical benefits. Given the immediacy (and expense) of medical care, this is an impressive testimony to the status of savings plans.

In light of current trends toward noncontributory benefits, the company savings plan is often the only benefit in which the employe has a cash investment and nothing piques concern in the minds of employes more than a personal stake. Unfortunately, savings plans do not come pre-assembled, they must be constructed individually, and proper plan administration really begins with plan design. This design seems simple—seductively simple.

The initial phase of successful plan design has little to do with the plan itself. In theory, companies construct their benefits around and in compatibility with, their corporate philosophy. Needless to say, the same should hold true when designing the savings plan. However, the real impact of successfully designing a savings plan is not in selecting major provisions; they all more or less contain the same elements—hence the seductive simplicity. More importantly, it lies in the necessary fine tuning of those provisions so that they accurately reflect the overall objectives of implementing a plan in the first place.

Designing withdrawal provisions is perhaps the trickiest area of plan development. There are several types of government requirements to deal with, including both the fact that the plan must be a deferred ("long term") compensation program and the IRS rules regarding constructive receipt of taxable money. In addition, the company's objectives for the plan must find appropriate expression in the withdrawal provisions. This is one area which will have noticeable impact on plan enrollment—employes are eager to understand their rights of withdrawal before they decide whether or not to put their money into the plan. Unfortunately, combining the company's objectives, the need for a degree of flexibility for employes and the various government requirements can lead to withdrawal provisions which are so complicated that the average employe cannot understand them.

It is possible, nevertheless, for an experienced plan designer to develop understandable withdrawal provisions which will satisfy these various criteria. However, while this is being done, many areas of significant plan administration impact must also be addressed. When a participant elects to withdraw, is he also allowed to specify from which fund the money is to be withrawn or might this lead to investment anti-selection? What penalties should be imposed for the withrawal of supplemental (unmatched) contributions? Should current period contributions be refunded as a part of, or in addition to, the amount requested, or should they remain in the plan and receive the company match? From what date is the penalty suspension period measured? These questions, and more, are often overlooked when the plan is drafted.

Next, suppose that you have just wrestled your way through government regulations and corporate philosophy to establish what you feel is a reasonable withdrawal policy. Now, you must decide how a withdrawal is to be valued. Even if you revalue investment accounts as often as monthly, it is unlikely that plan participants will make a withdrawal exactly on a valuation date. This results in your having to decide whether to delay payment of the withdrawal until the next valuation date and hope that the plan member will endure the delay peacefully, or to value the account according to the preceding valuation. The latter can result in serious investment anti-selection whenever plan investments have suffered losses since the last valuation. This decision as to how to value withdrawals becomes more acute when plan valuation dates are infrequent, such as only once each quarter. This illustrates that something as seemingly insignificant as selecting between the word "next" and "preceding," can have a major impact after the plan is implemented.

As another example, one area where adequate consideration of administration is often incomplete is the eligibility requirement. Most people automatically assume that a six-month or one-year of service waiting period will reduce administration, by eliminating distribution processing for short-service employes. This line of thinking has its basis in the high rates of turnover common during the first year of employment. However, a waiting period provision may actually be more expensive to administer than immediate eligibility would be. In the first place, there may not be as many small checks being processed for short service employes as one might think. The type of employe who leaves a company before completing one year of service is often less inclined to have joined the plan at all, so that distribution costs may be less than expected. Secondly, once employes do become eligible to join, the special effort each month (or quarter) to solicit enrollment and follow up unreturned enrollment cards can be quite expensive. Unless an audio-visual or personal explanation of the plan and its benefits is presented at that time, it is also likely that enrollment will suffer. How much easier it would be to solicit the savings plan enrollment when all the other benefits are being explained, which generally occurs during the first few weeks of employment. It would probably also be easier for the employe if he were to join the plan at the outset.

When fine-tuning a plan's design, two important considerations must always be kept in mind. These are administration and communication. While it is true that the sophistication of most record keeping systems can adapt to even the most unorthodox design, that compatibility is not without cost. It is not all that unusual for a reasonably well-informed management committee to arrive at a tightly woven plan design only to find, after the fact, that it's unaffordable.

Furthermore, it's also wise to consider that even the most reliable record keeping system is not fully automated. Savings plans, more than other benefits, must be instantly accountable. This is due in part to the fact that they owe their popularity and participation to their ability to quickly adapt to individual circumstances.

Finally, but by no means least important, the plan's design must be readily understood by the employes who are to be its potential members. A very complex or unduly restrictive design may frighten off employes to the point where enrollment suffers. ■

LTD plans . . .

Continued from page 58

sis.

Most plan sponsors realize that self-insurance usually means less cost due to the avoidance of premium taxes and insurance company administration and risk charges and the probability of a higher investment return on the reserves. The full savings available from utilizing self-insurance can only be demonstrated by calculating the cost using realistic assumptions for the interest rate, administrative expenses, claim level and other assumptions as to future employe characteristics.

A decided advantage of self-insurance is the flexibility in selecting the best person for each task. No insurer does all things well, so unbundling plan functions allows the plan sponsor a major role in selecting the persons who will best fill the various requirements. This allows negotiating for the best investment return and the lowest cost, competent claim administrator.

The following are actual examples of how costs as a percentage of covered pay can differ when using realistic assumptions:

Plan	Rate Now	Realistic Assumptions	Difference
A	.66%	.43%	(35%)
B	.45%	.25%	(44%)
C	1.09%	1.09%	0
D	1.00%	.65%	(35%)

Plan C was unique in that our analysis showed the insurer to be proposing rates that we felt to be inadequate for an insured plan. The disability and recovery rates for this plan were so poor that the existing rate, the result of a 75% rate increase, was projected to be insufficient to cover claims plus expenses. Of greater importance, our analysis pinpointed the cause of the poor claim experience. We were able to show that a certain group of employes was generating a disproportionate amount of the claims. Plan changes were recommended to solve this problem.

The realistic assumption rates are expected to remain level for long periods of time, if the assumptions adequately reflect future claims, employe characteristics, interest earnings and expenses. The stress is on adequate long term funding of the plan. Gains or losses are spread into the future so that year-to-year fluctuations in the experience of the plan need not change the contribution rate. This level cost method of financing the plan is similar to the method usually employed for pension plans.

The annual premium for insured plans is calculated to cover the claims expected to be incurred in the following year plus a margin of up to 30% for adverse experience plus any prior year deficits. This method of trying to make the plan whole each year, plus a margin, produces wide fluctuations in contributions, which can easily disrupt the budgeting process for an employer and can cause employe dissatification with possible declining participation.

If our analysis supports self-insurance and the plan sponsor agrees, implementation with or without a 501(c)(9) trust is the next step. For a noncontributory plan, a trust is needed only if the plan sponsor intends to prefund and take a current tax deduction. A trust also has the advantage of sheltering plan earnings from income taxation. A contributory plan must have a trust to hold employe monies. Some other important steps during plan implementation are the selection of a plan administrator for claims and an investment vehicle for plan assets.

The arguments for self-insurance using a level cost basis are compelling. They recognize that a large, traditionally insured long term disability plan is not insured. In fact, insurance is not necessary. Trading dollars with an insurer on such a large scale creates no advantages and definitely increases total plan costs.

At a time when companies are concerned with increased taxes and obligations on the salaries of their employes, a low-cost, level-funded method of paying long term disability is a bonus not to be overlooked. ■

Business execs train for hospital trustee service

By ELLIS SIMON

Employe Benefits

NEW YORK—The notion that corporate executives serving on hospital boards and as trustees of Blue Cross and Blue Shield plans can bring cost effectiveness to health care delivery isn't as simple as it sounds.

"It's not a question of board members not doing their jobs, but what they define their jobs to be," explained John English, a staff assistant with the Philadelphia Health Services Council.

As Mr. English sees it, hospital administration and medical technology have become increasingly sophisticated, diminishing the effectiveness of the outside director. The outside director is often in the position of receiving insufficient or incomprehensible information and not having enough time to carefully consider the decisions to be made, Mr. English explained.

In addition, in many hospitals the chief administrator carries enough clout to veto the selection of most trustees, according to one knowledgeable source. Knowing this, it isn't surprising that until now executives serving on hospital boards have not had a great impact in keeping a lid on hospital costs.

However, several major corporations, including General Motors, Chrysler and Alcoa, have established programs to educate employes serving on hospital and Blue Cross/Blue Shield boards to become better participants and stronger voices for cost containment.

Mr. English's organization is seeking out Pennsylvania corporate officials who serve on hospital and Blue Cross/Blue Shield boards in hopes of establishing a similar kind of effort.

"Most business trustees just don't have presented to them enough information and the pros and cons of operating budgets, capital programs, etc. to make well-informed decisions," said Gerald Gleeson, executive director of the Philadelphia Joint Health Cost Containment Program, which includes the Health Services Council.

"They don't demand from (hospital) administrations the same kind of information and analysis they demand in their businesses. They don't have the time to go digging into things on their own," the director added.

Joseph Leyden, assistant to the president of General Tire & Rubber Co., who serves on the board of Akron City Hospital, compared the situation to that of a pilot of the corporate jet who tells him modifications are needed. "When the pilot tells me there's something that needs to be done, it has to be done. When the medical secretary (of the hospital) comes in with recommendations tied to the quality of care, you don't have too many options. You have to do it and you can't do it the cheap way."

Of approximately 27 employes who've completed Alcoa's hospital trustee training program, only about four had received any prior formal training from their respective institutions, according to Richard E. Wardrop, manager of employe benefits. Alcoa chose to develop its own trustee training program rather than rely on one developed by the American Hospital Assn.

Programs at Alcoa, GM and Chrysler stress the importance of having employe/trustees think and act like businessmen in their roles on their respective boards. "Good business sense is synonymous with cost containment," said G. Douglas Eavenson, assistant director of employe benefits at GM.

"We're not trying to prescribe what people should do, but we're saying 'If you're interested because of the impact upon the community and GM, we'll encourage you, but we don't want you to be a figurehead.'"

Adds Mr. Wardrop of Alcoa: "We've talked with some hospital associations and they don't object to what we're doing. We're not teaching them to vote 'No' on all money issues. We're teaching them to think like businessmen."

"Many executives thought that if a hospital could be run like a business things would be fine. But once you bring the executives in and they understand the regulatory complications involved, that attitude dissipates," said David Beers, president of Syracuse's Crouse-Irving Memorial Hospital.

Although trustees retain an interest in cost-effective operations, the only way savings can be achieved is to bring in efficiency experts and that costs money, Mr. Beers said. Trustees' attitudes sway from being concerned with wastefulness to beefing up public relations, he added.

Trustees at Crouse-Irving tend to complain that they are "overinformed," which, Mr. Beers said, is uncommon for hospitals. In addition to briefings at the regular board meetings, trustees receive numerous memos each month on various subjects.

However, Warner Co. president Robert Fox, who serves on the board of Philadelphia's Albert Einstein Medical Center, is more optimistic about the ability of informed trustees to influence costs. At Einstein a program has been developed to look not only at controlling non-reimburseable expenses, but also reimburseable costs, he noted.

Although direction for cost control at Einstein comes from the professional management, the directors must do their jobs placing emphasis on what they believe will be beneficial, Mr. Fox said.

Efforts by corporations to get their people on hospital boards raise questions of potential conflicts of interest. The possibility of businesses joining together to use their leverage against hospital as health care providers smacks of restraint of trade, cautions James Brennan, vp at Towers, Perrin Forster & Crosby, benefit consultants.

While Chrysler expects persons who have attended its trustee training program to use the information provided on health care cost containment, "we don't ask for an accounting," said J. William Reed, manager of group insurance and medical benefits.

Corporate officials serving on hospital boards apparently don't always feel they should tow the company line outside of the office. "I wear my hat as a board member of the hospital, not on the basis of other interests," said Mr. Leyden of General Tire. "I can't forget other things, but what effect it might have on the hospital costs of our company is not the deciding factor for me. What I'm concerned with is what people pay generally." ■

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A REGULAR EDITORIAL SECTION EXCLUSIVELY FOR AGENTS AND BROKERS

Ads: Breaking media silence

By LEN STRAZEWSKI

CHICAGO—Small agents and brokers are beginning to pull at the giant brokers' legs with an innovative use of media that contrasts markedly with the traditional campaigns of the big boys.

A nationwide sweep of agents and brokers, from the jumbo to the tiny, reveals that the key to advertising in this industry is to do what finds the market and fits the budget.

Goals vary. Some agents and brokers advertise to change their image before a select audience. Others want to keep their names visible in front of audiences who already know them. Still others believe they should advertise because they can afford it. More than a few don't bother at all.

With smaller markets to aim for, smaller agents have less difficulty valuating their efforts, while big brokers apparently feel compelled to go with the tried and true.

"It's hard to measure the effectiveness of advertising in this field," remarked Seth Faison, Johnson & Higgins vp and chairman of the advertising committee. After all, there's usually no coupon to send in that you can count up."

Johnson & Higgins has one of the few advertising campaigns that, according to management, follows a long term progression.

"J&H is a very old firm and everyone thought about us according to his own relationship," said Mr. Faison. "We had to ask ourselves how we could identify ourselves as different in thinking from Alexander & Alexander and Marsh & McLennan."

To play up J&H as one of the few large, privately held brokers, the firm began by identifying its staff with "personality ads," accompanied by its "We answer only to you," slogan.

The campaign progressed to the present plan, begun in September 1976, centering on the broker's expertise in certain areas. The ad copy talks about insurance problems and how J&H solves them.

Beginning soon, an addition to the campaign will focus on specific problems facing risk managers and what New York-based brokers can do.

Restricted to the business-oriented print media, the J&H campaign no longer appears in the national newsweeklies. But J&H has added Dun's Review to the media package, which, as for most of the major national brokers, includes stand-bys *Business Insurance*, New York Journal of Commerce, Wall Street Journal and Risk Management magazine.

J&H is pursuing large and medium size companies near large business centers with an overall budget, including public relations, of about $750,000. David Oksner & Mitchneck handles the account.

The Alexander & Alexander national campaign is much like the J&H campaign of a few years ago, featuring company management talking about what the firm can do.

This year's new campaign is exclusive to the print media on the national level, with a little radio and television advertising aired by the local offices.

"We were rather heavy into radio and television a couple of years ago," noted assistant vp of advertising and sales promotion David Vrieze. "But now we've tried to confine ourselves to media suited specifically to our targets."

A&A has targeted several geographic areas and industry classifications for heavy advertising, but would not disclose details.

"Much of our advertising is done at the local office level in local business news publications and weekly business pages," said Mr. Vrieze. "Our national advertising is designed to translate to the local office efforts."

The national chunk of the campaign, handled by NW Ayer & Co., is budgeted at $600,000 for print media, with additional funds spent by local offices using local publications including sports-football programs and regional editions of the national newsweeklies. Local offices are using less radio and television spots.

"That's been working very well with us," observed Mr. Vrieze. "We just pulled our field people in for a meeting and the response to advertising was very positive. For many this is a departure from electronic media to print, but it allows our local offices to advertise more frequently."

A&A had dabbled with airline magazines on a regional level, a new wrinkle for the large brokers with the exception of Marsh & McLennan, which has made heavy use of in-flight publications.

The airline magazines, primarily East/West Network publications, provide "very upscale demographics," according to M&M director of corporate communications Jeannette Paladino.

"We're reaching a lot of chief executive officers, because the business community is primarily a traveling community," she noted. Effectiveness is easier to measure because the M&M ad spreads contain an information offer which recommends writing for a descriptive booklet.

"We're doing very well with selected airline publications," noted

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INSIDE

Agents talk, insurers listen
In the northeast market area William G. Bailey is getting together agents and insurers to talk and listen. **Page 62E.**

Broker taps deferred comp
A Financial Guardian subsidiary is taking in $20 million in deposits with a unique deferred compensation plan. **Page 62D.**

Agents fight Safeco quota
Higher minimums in order to qualify for contingency commissions spark agent protests. **Page 62F.**

8 failures spur E&O claims
Agent researchers explain the eight most common ways agents and brokers cause E&O claims. **Page 62H.**

William G. Bailey

What's ahead for brokers?

Revenue growth will level into 1980: Observer

CHICAGO—Recognizing a current revenue growth slowdown in the brokerage industry, security analyst Harvey Bundy III still paints an optimistic picture of continued long term growth in the industry.

His general conclusions, taken from an industry report, include:

- Revenue growth will continue to slow through 1979 and perhaps into 1980. Overall insurance premiums, on which broker revenues are based, should increase by 13% in 1978 and 9% in 1979.
- The market share growth of the major brokers, which have contributed significantly to the record revenues of recent years, may moderate or disappear, bringing 1979 commission and fee revenue growth for the brokers down toward 9% premium growth.
- Insurance brokers with more casualty, excess and surplus lines or reinsurance business could suffer below-average revenue gains. A heavy mix of smaller accounts could also result in slower revenue growth.
- Controlling expenses may be a problem in the hypothesized environment.

Though commission rates have been declining at a rate of about 2% a year, according to Mr. Bundy, "most of this decline has, by our estimate, occurred in personal lines business. Since major insurance brokers receive only a small percentage of revenues from personal lines business, the relative percentage decline for these firms has probably been less.

"Therefore, we estimate that declining commission rates reduced the growth in commissions and fees paid to insurance brokers by approximately one percentage point per annum," he said.

Security analyst Harvey Bundy of William Blair Co. believes controlling expenses will be a problem in the future.

Though Mr. Bundy predicts that the insurance brokerage industry should grow about one percentage point faster than the gross national product, that growth will be cyclical, affected by the underwriting cycle (particularly as it affects premium rates) and the market share cycle for the insurance brokers, both on the downside currently.

"We are not trying to paint a picture of doom and gloom for the insurance brokers, but are merely raising a cautionary note concerning revenue gains over the next several years. It will clearly not be the easy exuberant atmosphere of the last several years and in fact insurance brokers could be showing revenue gains somewhat less than long term trends might indicate," he said.

Evaluating individual companies, Mr. Bundy said Marsh & McLennan's heavy reinsurance business and supply of large commercial accounts make its income stream "less sensitive to the insurance rate cycle than its principal competitors."

Mr. Bundy also notes that in earlier periods of declining revenue, M&M "has been hurt by an inability to control operating and compensation expenses. This was particularly true in 1972 and 1973 when Marsh & McLennan's budgeting and control procedures were somewhat lacking," he said. "But since 1973 the company made major strides in internal planning and control," he added.

Alexander & Alexander, however, may be "more prone to shift markets in a period of price volatility" because of the company's emphasis on smaller commercial accounts.

In general, Mr. Bundy reports that "1979 may be a difficult year for Alexander & Alexander. If all goes well, the company could show a 10% earnings gain, but there is a possibility that the earnings gain might be less than this. Both operating expenses and salary and employe benefits must be kept under tight control if the company is to perform well."

Corroon & Black Corp., he notes, has developed "a much more aggressive management style and new account activity," since acquiring Tennessee-based Synercon Corp. Also influencing the book of business is a large mass merchandising business, placing group programs for trade associations.

"Looking at the current period, we believe that Corroon & Black also may be somewhat more vulnerable to revenue slowing. This is due to the increased importance of casualty insurance and excess and surplus brokerage activities," said Mr. Bundy.

At Frank B. Hall & Co., revenue and earnings gains for 1977 and early 1978 "have lagged behind the other insurance brokers," Mr. Bundy said. "This is particularly due to the company's book of business, but it also may indicate a carryover of some management problems which existed within the organization."

Changes in the Hall book of business, however, indicate that 1979 revenue and earnings may be somewhat better than those recorded by most insurance brokers, according to Mr. Bundy.

"However, we are concerned about the Leslie & Godwin acquisition and possible morale problems," he said in the report.

The Fred S. James & Co.'s aggressive acquisition program "may have stretched management beyond its capabilities," observes Mr. Bundy.

Reflecting on the predominance of medium-sized casualty business in the James book, Mr. Bundy expects the company to have revenue gains modestly lower than the industry average for the next two years.

Rollins Burdick Hunter is expected to report revenues approximately equal to the average of the group, Mr. Bundy believes.

"The extraordinary performance by Rollins Burdick Hunter adding new property insurance in the last several years makes 1979 estimates somewhat more difficult than for other brokers," he said.

"However, should the company continue to add new business at the rate of the last several years, the relative performance could be much better," he concluded. ■

Outlook remains bright

In spite of a predicted softening in commercial premium rates and an overall slowdown in revenue growth, the outlook for the brokerage industry both as a business and as an investment is still good.

This is the consensus of security analysts Len Wilson of Drexel Burnham Lambert and Harvey Bundy III of William Blair & Co., who constantly monitor the brokerage industry for their investment firms.

Their specific observations about the industry and the top publicly held brokers follow in separate stories.

Mr. Wilson's comments are taken from his third quarter reviewed research abstracts and Mr. Bundy's evaluations are taken from the basic report "Insurance Brokers: Industry Outlook and Individual Company Perspectives." —lfs

Benefits save bust in slowup: Analyst

NEW YORK—Competitive premium rates on commercial lines and the resulting slowdown in the growth of the brokerage industry are the main factors influencing Len Wilson's third quarter evaluation of Marsh & McLennan, Alexander & Alexander and Fred S. James & Co.

What keeps the outlook from being pessimistic is a predicted increase in income derived from other areas of the brokerage business, especially employe benefits, excess/surplus lines and reinsurance.

"Marsh & McLennan," said Mr. Wilson, "has beaten down the general market and now seems reasonably valued against historical yardsticks . . . We are maintaining a neutral rating, however, because of the slowdown in the growth of the insurance brokerage that can be expected to carry at least through 1979, and possibly well into 1980."

Part of the neutral judgment about M&M is based on the almost negligible growth in property and casualty business with third quarter property gains placed at 1% or less and casualty gains at only 5% to 6%.

"The feeble performance of property and casualty has not been duplicated since the bad days of 1972 and 1973 when carriers were throwing caution to the winds," noted Mr. Wilson.

"Based on our contacts, premium rate competition seems to have grown more intense recently," a perception apparently corroborated by the company's property and casualty revenues," he said.

Meanwhile, M&M's expense were held down, according to Mr. Wilson. "Despite a probable 10% increase in head count over the trailing 12 months, expenses rose only 11% to 12%, we estimate. Management seems to be putting on the brakes in anticipation of continued modest revenue growth."

Alexander & Alexander, on the other hand, produced a more optimistic picture, with the general slowdown balanced by a flood of new property and casualty business and increasing profit margins maintained by holding down expenses, according to Mr. Wilson.

"We also believe that casualty rates have softened noticeably in recent weeks, so that the full brunt of rate competition has not yet been felt in operating comparisons," he continued. "A&A should do better in employe benefits."

Fred S. James & Co. faces the same problems according to Mr. Wilson. "The negative effect of rates stands out and is worse than we would have predicted a few quarters ago."

Yet James comes out smelling like a rose in the third quarter review, posting significant gains in employe benefits, marine, bonds and interest income. James, according to Mr. Wilson, continues to do well in reinsurance and excess lines.

"James has put more stress on employe benefits of late," he noted, "but has the potential for higher penetration in this field." The acquisition of the California employe benefits firm Olanie Hurst & Hemrich signals a program to broaden capabilities and growth in employe benefits and is also evidence of James's increasing aggressiveness," Mr. Wilson concluded. ■

Revenue, margins, people tell the tale

CHICAGO—Though security analysts Len Wilson and Harvey Bundy III occasionally disagree when evaluating the brokerage industry, they agree almost exactly on what to look for in a brokerage business.

Both Mr. Wilson of Drexel Burnham Lambert Inc. and Mr. Bundy of William Blair & Co. agree that revenue growth and changes in profit margins are the most important figures in evaluating a brokerage.

"The main thing to watch is the year-to-year revenue growth and the new business being generated over a period of years," remarked Mr. Wilson.

In examining how a broker is doing in his field of competition, Mr. Wilson gives attention to a "rate comparison as a result of competition.

"How a broker is doing in specialities or in his excess/surplus may also be important as different components of the whole picture," he said.

"It is important to know how well a broker did in the past," said Mr. Bundy, "so I have to look at the revenue growth and margins over at least the last six years.

"But also it is useful to note how a broker did in different kinds of marketing conditions. For example, it is more interesting to me to see how a broker did in the unusual market of 1973-74 than recently."

Mr. Bundy also noted that he is "more inclined to ignore" the excess/surplus or reinsurance branches as a distraction from the heart of the brokerage action.

"You also have to keep your ears open for an scuttlebutt that could affect revenue gain," he noted.

Both Mr. Wilson and Mr. Bundy include personal interviews of brokerage management as part of their evaluations.

Mr. Wilson likes interviews to "round out my general assessment of the company and its prospects," but Mr. Bundy places a higher priority on people.

"The insurance industry is basically a people business. There's no product like soap or soft drink to point at and say, 'There it is, there's the business,' " said Mr. Bundy.

"I like to meet and talk to as many people as I can within a given brokerage. In a sense you are only as good as your people."

Mr. Bundy admits that while his major evaluation is the result of facts and figures, his overall opinion is often influenced by his impression of the competence and style of the people he meets.

Mr. Bundy and Mr. Wilson are the only two security analysts who consistently watch the insurance brokerage business. ■

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American Hospital Assn. plan

Broker turns deferred comp profits

HINSDALE, Ill.—Financial Compensation Consultants, a wholly-owned subsidiary of Financial Guardian Insurance Agency Ind. here, is handling over $20 million in premiums and deposits in a deferred compensation program.

Deferred compensation? Yes, it's the kind of program that usually makes up only a tiny amount of an agent's or broker's business and is often handled solely as a favor to a client.

But FCC was established by Financial Guardian in 1974 to handle this lucrative program designed specifically for the American Hospital Assn. for hospitals making use of a tax shelter loophole. That loophole allows employes of tax-exempt institutions to defer up to 100% of their income derived from the hospital, according to FCC president Wayne Pearson.

The program is also open to persons who perform contract services for hospitals. They can defer up to 100% of their income derived from their service contract with a hospital.

Let's say, for example, that a private laundry performs $30,000 worth of services for a hospital, incurring $10,000 worth of expenses in the process. The hospital pays $30,000 to the laundry, 100% of which could be deferred, although expenses usually have to be covered. Thus, the laundry takes the $20,000 profit as deferrable income, sheltering it in the name of the laundry owner or an employe until that person is in a lower tax bracket.

This kind of program is theoretically available to any not-for-profit institutions, but most eligible associations have neglected to include the contract service businesses and have restricted the program only to institutional employes.

This ignores one major advantage of the FCC plan for the AHA—bargaining power.

"Many of the hospitals involved have realized the value this plan has in their contracting," remarked Mr. Pearson. "If some company offers to perform services for, say, $10,000, the hospital can come back and say 'Make it $9,000 and we'll let you defer the income in our plan.' "

That's one reason why the program has accrued over $20 million in deferred income from the 455 hospitals presently enrolled. According to Mr. Pearson, the program is growing at a rate of $300,000 to $500,000 a month.

"The program began in 1974 after two years of research and development and it has been growing effectively ever since," said Mr. Pearson, "though we do expect it to top out in another year-and-a-half or so."

Aetna insures the AHA program. According to Mr. Pearson, any agent licensed by the Securities & Exchange Commission could handle the program in his area and FCC is looking to expand.

"Actually our biggest stumbling blocks have been the IRS and the SEC, but we have worked this out carefully and have won all our court battles," said Mr. Pearson.

FCC has a private letter ruling from the IRS that approves their contract form as it relates to the employes of the American Hospital Assn.

The AHA program is highly unusual, both in its approved contract and the volume of dollars involved.

The National Council of Community Health Centers has a deferred compensation plan managed by Professional Insurance Management Inc. and insured by Safeco. It is limited to employes and has "nowhere near" the amount of money as is involved in the AHA tax-sheltered annuity program.

FCC is also developing a similar plan for the National Assn. of Club Managers, but it isn't expected to generate the AHA's level of deposits.

"How many employes of private clubs can there be?" mused Mr. Pearson.

In general, the low volume of money has been largely responsible for the lack of agent and broker interest in deferred compensation plans. Even the more traditional programs for individuals not qualified under a pension or profit sharing plan haven't generated interest.

Cook, Treadwell & Harry Inc. handles some of the more traditional individual programs, and "additions to our staff point more in that direction," according to vp John Barger. "But marketing the programs takes lots of calls and lots of 'No's.'

"When you do get a yes, however, you make out like a bandit," he said. "Mostly we do it for clients as opposed to new prospects."

Agents and brokers agree deferred compensation offers potential, but the spade work is slow and expensive, requiring trained personnel working exclusively on those accounts.

Emett & Chandler in Los Angeles sold its deferred compensation business to benefit consultant A.S. Hansen & Co. because they didn't have enough business to cover expenses.

Deferred compensation has become primarily the product of consultants rather than of agents, but selling the programs requires solid work making many cold calls and following up on referrals.

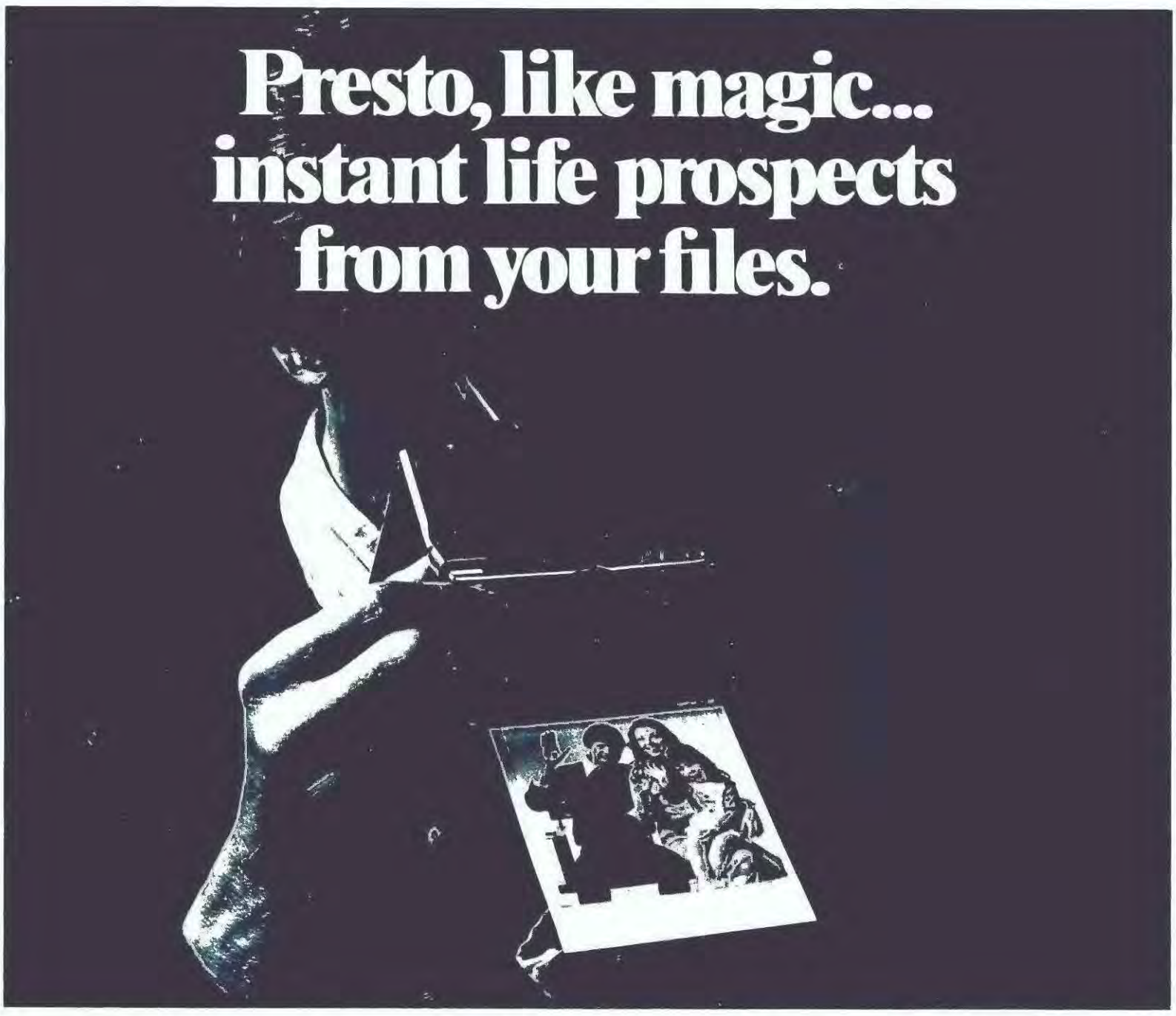
"In addition, we examine company proxy statements to see which companies have employes vulnerable to headhunters," said David Bardes, president of Clark-Bardes Group, a consultant with a working list of over 60 companies and clients among the Fortune 100.

"This is a specialty business and it takes from one to three years to develop it," remarked Mr. Bardes of the Cincinnati firm, who cites "a large market among companies who are looking to attract and hold administrators."

Clark-Bardes specializes in deferred comp for executives, a program used by some companies as a fringe benefit for top management.

"Young executives have no company loyalty whatsoever and now that pension plans, etcetera, must be paid up benefits, there is nothing to hold them," said Mr. Barger of Cook, Treadwell & Harry.

Clark-Bardes receives the equivalent of a broker's commission for its accounts. —lfs ■



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Northeast agent talks area coalition into action

DRYDEN, N.Y.—Strange things are happening between insurers and agents in the northeast market. Stranger things are happening between competing agent associations.

They are all talking to each other and working out ways to cooperate on service, agent/insurer relations and legislative matters.

If you look for a reason, you find William G. Bailey, president of George B. Bailey Inc. agency and immediate past president of Professional Insurance Agents—New York (PIA-NY).

"I just had the feeling that when people sit down and talk together they are going to get something useful done," said Mr. Bailey. "We've already had some really good meetings that many people said couldn't happen."

What "couldn't" have happened, but already has includes:

- An unprecedented meeting between PIA-NY and the Independent Insurance Agents Assn. of New York (IIAANY) resulting in a cooperation agreement between the usually competitive groups. The two groups have invited each other to meetings with insurers and are planning joint committee meetings to map out local legislative strategy.
- Agents from 11 northeast states joined under the banner of the Northeast Coalition of Insurance Agents to meet with officers of 22 major insurers to assess company-agency relations and the unusual market conditions of the area. They are meeting again this month to discuss the service problems of companies, marketing plans of insurers and the legislative issues of the area.

In both arrangements, Mr. Bailey was the prime mover, leading a small group of others who see unity as the only way to long range survival and success.

"We are concerned about the northeast area," said Mr. Bailey. "If we don't talk and work out our problems the direct writers will take our business away."

Political problems in the area are also of growing interest, as they are around the country, with increasing state regulation and the possibility of federal insurance regulation leading the issues.

Company-agent relations is an eternal issue, linked to governmental regulations.

"We have lots of problems with companies that need working out," said Mr. Bailey. "We have trouble quoting business promptly. We get very slow turnaround and service is a terrible problem."

Agents in his area report horror stories of waiting months past renewal dates for new policies in commercial and personal lines. The local rating systems, especially for urban auto coverage, makes quoting slow and rates high, according to Mr. Bailey.

Direct writers, with speedy quotations, are cutting deep into the business and are a problem for both companies and agents.

"It's a common problem. Companies need the agents; we are the marketing force. On the other hand it would be hard for Bill Bailey to write business by himself," he said.

As chairman of long range planning for PIA-NY, Mr. Bailey has also been working in his home state to smooth out the company-agent problems there. PIA-NY met with two groups of insurers last year to discuss the continuing difficulties and agreed to work together on developing less binding regulation on the state level.

"Now that I'm not president of PIA-NY, I can speak out more just as Bill Bailey," he said. "And there are a lot of things we need to speak out about.

"We need a more efficient system of handling day to day changes in the system, the kind of adjustments that we must make all the time that take so long now," he noted.

"We need a terminal system for each agent that can interface with all the major companies. And we need a new rate make-up so we can charge our insureds a fair and equitable rate. But most of all we need fairness between companies and agents," he continued.

Now that Mr. Bailey has taken on the problems of the industry as a personal quest rabble-rousing quietly among acquaintances during informal conversations and at industry meetings, he is finding more problems that need attention.

"I like people in the insurance industry to be well educated in their field and willing to work hard for their clients and their companies, but that isn't always the case," he said. "We have some people who aren't well educated, don't work for their customers and skin their companies. They don't belong."

But being a visionary isn't smooth sailing, Mr. Bailey has found. "One major insurer sent a letter to their branch office who passed it along to their field manager. The instructions were to ask around about Bill Bailey and find out what he's about.

"I think I am finally getting to this guy. His company needs to make some changes and we've been after him for a while," Mr. Bailey said. ■

'We have problems with companies that need working out. We get very slow turn-around and service is a terrible problem. We have trouble quoting business promptly.'

—William G. Bailey

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Agents fight Safeco contingency quota

SAN CARLOS, Calif.—Safeco's new contingency contract is burning small agencies, according to Paula Hammack, county chapter president of the Professional Insurance Agents Assn. (PIA) here.

The new contingency contract addendum changes contingency requirements to a breakdown between personal and commercial lines. An agent must produce premium business of at least $75,000 in each category for at least a $150,000 total in order to qualify for contingent commissions.

"Many of our 3,400 members in PIA California and Nevada are in the overall $500,000 class, and giving $150,000 of business to one company is just unreasonable and often impossible," said Ms. Hammack.

"Profit sharing checks are traditionally expected by small agents and many small agents count on the checks just to pay expenses," she said. "The new contract will eliminate many agents from the contingency program."

What really distresses the state association is Safeco's lack of consultation with local agencies before implementing the new contract.

> 'The new contract will eliminate many agents from the contingency program. Many agents count on the checks just to pay expenses.'
>
> —Paula Hammack

"We realize that it is not economically feasible for Safeco, or any other company, to negotiate a separate contract with each and every agency, but it is not only unfair, but unethical for a company to be unwilling even to allow agents the right to protest or suggest alternatives prior to effecting broad contract changes," charged Ms. Hammack.

Ms. Hammack's official letter of protest on behalf of local agents sparked Safeco's senior vp of marketing Richard S. Stevick to focus on Ms. Hammack's own agency, Professional Insurance Associates Inc. and its "mutually profitable relationship" with Safeco.

"I note that you qualified for a personal lines bonus commission in both 1973 and 1977," he said in a letter to Ms. Hammack. "So far in 1978, your personal lines loss ratio seems to be running higher than in the previous two years. However, it is probably too early to tell just how you will fare, insofar as a 1978 bonus is concerned.

"We appreciate the business with which you are favoring us and regret having to do anything to upset what appears to be a good relationship," he continued. "However, we too are being impacted by inflationary pressures and therefore, must make adjustments to keep our bonus commission program viable for both agent and company.

"We have not adjusted our minimums since the current bonus commission program was launched in 1972. We, therefore, feel the increase in premium levels in the past six years justifies an upward adjustment in our bonus minimums."

Mr. Stevick also noted that Safeco did hear the agents' point of view at Safeco's division agent's sales seminar.

About agencies other than Ms. Hammack's, Mr. Stevick said, "If our relationship hangs on so slender a reed as bonus formulas, giving rise to umbrage caused by our failure to carry on impractical and expensive negotiations, then perhaps some would be better served to select another of their agency companies whose main attraction lies in those areas, and favor them with the business.

"As an independent agent, Ms. Hammack," he continued, "you have the right to decide where and with whom you are going to do business. We, at Safeco, respect that independence and are working hard to furnish you with such a good array of products and services that there will be no question about our fitness for the business coming our way. Isn't that the true meaning of 'independence'?"

Ms. Hammack noted she never doubted her agency would meet the Safeco minimums.

"This isn't get Safeco week," she remarked. "Safeco is a tremendous company and we do a lot of business with them. I don't decry the company, but I do decry what the company thinks," she said.

The new Safeco contract also features a graduated step-up that would increase minimums again by 1980, according to Ms. Hammack.

"This isn't just Safeco, but is a general problem with the insurance companies that we do business with," she remarked. "My own agency is refusing to sign the Safeco contract on principal."

PIA California and Nevada is publically asking members not to sign contracts like the Safeco step-up without consulting with the association first. **lfs** ■

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To check their opinions, Z-A commissioned an independent research firm to survey property claimants who had suffered losses of at least $5,000 during the past two years. These opinions make up Z-A's "Insurance Industry Report Card" on Property Claims.

Here are some of the interesting results: 80 percent of the respondents rated the insurance agent as either very or extremely helpful in resolving the claim; 69 percent indicated satisfaction in availability of the carrier's claim representative, and better than four out of five respondents were satisfied with the speed of claim processing.

Those are pretty good marks. But the industry shouldn't rest on its laurels either. We don't at Zurich-American. We are continually striving to provide insureds with better products and service.

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Conventioners earn credit

NEW ORLEANS—Oregon's delegates to the 47th annual convention of the National Assn. of Professional Insurance Agents (PIA) had an unexpected benefit from their trip—education requirement credits.

The Oregon Insurance Department, after reviewing the convention program content, granted credits to attending Oregon agents which can be applied toward the state's new mandatory continuing education requirements.

Five convention workshops were approved for credit: E&O claims prevention, agency perpetuation, agency evaluation, directors and officers liability and inland marine insurance as was a three-hour panel discussion on efforts to amend or eliminate the McCarran-Ferguson Act. ■

C&B of Ill. hires ad firm

CHICAGO—Corroon & Black of Illinois has appointed Source/Inc. as its marketing communication agency.

Source/Inc. will initially be concerned with developing a statewide advertising campaign and back-up material consistent with the national campaign being prepared by C&B Corp. ■

Agents lobby to defend McCarran-Ferguson

WASHINGTON, D.C.—Agent associations around the country are gearing their state and federal legislative efforts toward defending the McCarran-Ferguson Act and state regulation of the insurance industry.

Though industry watchers do not expect any changes in 1979, they expect the upcoming 96th Congress will show heavy interest in the insurance industry. Predictions are that either the House or Senate Judiciary committee will hold hearings.

Sparking the interest of the federal government are a series of proposals summarized for review by the National Commission for the Review of Antitrust Laws and Procedures. The 69-page "Staff Paper on Insurance" reveals the interest of the House, Senate and the Department of Justice during 1978, an interest expected to continue in a more directed manner during 1979.

The paper notes:

- **The Brooke bill** (S. 1710), proposed by departing Sen. Edward W. Brooke (R-Mass.), prompted hearings before the Banking, Housing and Urban Affairs Committee of the Senate. The bill, titled the Federal Insurance Act of 1977, envisions a dual system of Federal-State regulation held together by an independent agency, the Federal Insurance Commission, which would administer the federal insurance guaranty program proposed by the bill.

Section 109 of the bill allowed for keeping the antitrust immunities provided by the McCarran-Ferguson Act, but would have removed those immunities from federally chartered insurers engaged in activities exempt from state law under another section. Title II of the bill stated procedures for establishment and regulation of federally-chartered insurance companies.

- **The LaFalce proposals,** a series of four bills, were proposed by Congressman John LaFalce (D-N.Y.) following hearings on product liability. The bills were designed to repeal or amend the McCarran-Ferguson Act.
- **The American Insurance Assn.** has proposed several changes to the present regulatory scheme for insurance, including a federal insurance guaranty law to protect against insurance company insolvencies. The proposal, however, does not support the repeal of the McCarran-Ferguson Act, arguing that the act should be amended to eliminate state prior-approval laws and to prohibit agreements among insurers to adhere to certain rates. The AIA would make the antitrust laws applicable to such agreements. States, however, would retain the right to disapprove rates that were excessive, inadequate or unfairly discriminatory.
- **The Department of Justice,** like Sen. Brooke, has proposed a system of insurance regulation comparable to other federally chartered financial institutions. By far the most comprehensive proposal, the Justice Department plan would allow insurance companies either a federal charter and no antitrust protection of McCarran-Ferguson or that protection under a state charter.

Companies under the federal charter would be exempt from state rate regulation, state restrictions on collective merchandising and direct writing, state guaranty funds and state solvency regulations.

The federally chartered companies would still be subject to state regulations on the insurance contract and local taxes could still be imposed on companies doing business in a certain state.

Under the Justice proposal, a federal agency, such as the Federal Insurance Administration, would develop a uniform system of solvency regulation and a guaranty fund like the FDIC in which federally chartered companies must participate.

Traditionally attempts to amend or repeal McCarran-Ferguson have died deaths of loneliness, a simple case of widespread opposition and virtually no support. But the increase in such proposals indicates change of some sort is coming, though not immediately, industry observers say. ■

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People column . . .

Continued from preceding page

work in the field of corporate fringe benefits. Membership includes independent agents and consultants, insurance company group representatives and corporate benefit managers.

Lawrence LaBissoniere has joined the Los Angeles division of Bayly, Martin & Fay insurance brokers as an account executive. He entered the insurance field in 1949 with Sayre & Toso Inc. and since then has served in underwriting, production and management capacities with excess and surplus lines general agencies. The New York office of that firm has named **Peter Malito** vp of business development, **Mark Bender** major account coordinator and account executive and **Alan Rovin** vp and coordinating account executive. **Tom Axon** has been named account executive and loss funding analyst.

LaBissoniere

Jones

* * *

Theodore D. Olmsted has been appointed director of agency development for the Independent Insurance Agents of Connecticut. He had formerly been associated with Goodwin, Loomis & Britton, an independent insurance agency in Hartford, where he had been vp and corporate secretary.

* * *

The Seattle office of Marsh & McLennan has named **Henry K. Sander** vp and **Stephen L. Hullin** and **David C. Storey** assistant vps.

* * *

Jack W. Jones has been named a director of Rollins Burdick Hunter Co., succeeding **Norman E. Roop** who retires Dec. 31 as director and chairman of Booth, Potter, Seal & Co. Inc., an RBH subsidiary. Mr. Jones is president of Rollins Burdick Hunter of Northern California, Inc. and the firm's California division coordinator.

* * *

R.E. "Buffy" Mayerstein Jr. was installed as president-elect of the Independent Insurance Agents of Indiana during the association's recent 80th annual convention. Mr. Mayerstein is secretary of Mayerstein-Burnell Co. agency in Lafayette, Ind.

* * *

Donald R. Johansson was promoted to senior vp of brokerage Kindler & Laucci in Newport Beach, Calif. Mr. Johansson is directing the firm's new Orange County office. He is a graduate of UCLA and holds a master's degree from University of Southern California.

* * *

Dennis E. Jelen has joined Kelly & Associates as an account representative. He will assist in the management of the firm's Chicago office which provides administrative services to employe benefit plans. Mr. Jelen was formerly with Union Labor Life Insurance and Combined Insurance Co.

* * *

The Independent Insurance Agents of America Inc. has appointed **David G. Colman** as staff member of the legal department assisting general counsel **Jeffrey M. Yates** and counsel **Susan Burns Orsher.** Mr. Colman was previously assistant district attorney in New York County, N.Y.

* * *

James D. Wallace, executive manager of the Independent Insurance Agents of Kansas, received the Award of Merit for 1978 from the Kansas Insurance Assn. He has more than 25 years experience in multi-line underwriting, claims and management. He also holds professional designations in property and casualty insurance, risk management and life insurance.

* * *

Larry Gosewehr of Frankfort, Ind., 1978 National Champion of the Insurance Youth Golf Classic, received a commemorative album from former president **Gerald R. Ford** during the Independent Insurance Agents of Indiana Inc. convention.

* * *

Gene J. Vignone has joined the Los Angeles division of Bayly, Martin & Fay as an account executive. Mr. Vignone has worked in the insurance field since 1961 when he operated a State Farm agency. He joined S. Cruz & Associates of San Juan, Puerto Rico as vp-operations in 1977.

* * *

Albert P. Sorrentino has been named assistant vp for claims of American Internation Aviation Agency Inc. He has served as a claims and aviation underwriter at Home Insurance Co. and Royal Globe Insurance Group.

•

We'd like to report on staff changes. Just drop a note to Len Strazewski, Business Insurance, *740 N. Rush St., Chicago, Ill. 60611 or call 312-649-5393. We'd also like to receive pictures of those involved.*

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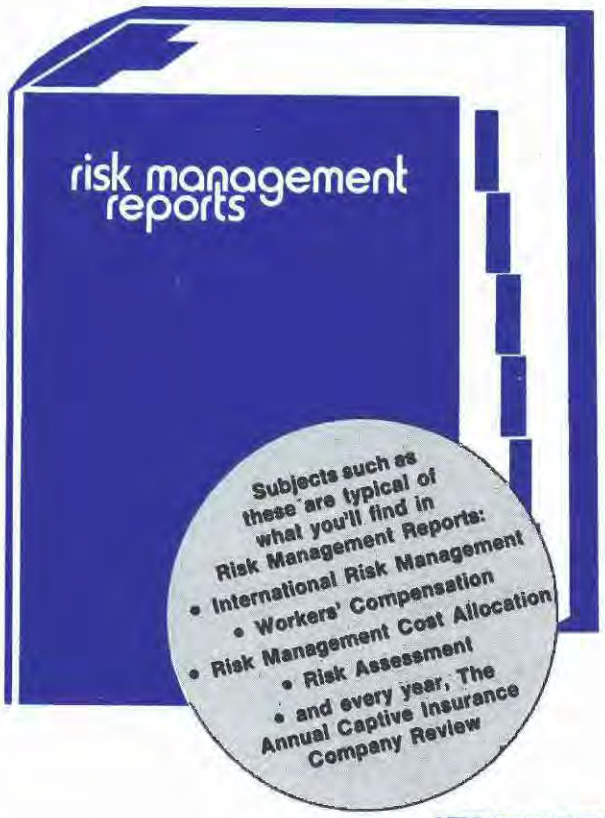

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Don't dock us for no life sales: IIAA

SYRACUSE, N.Y.—Under pressure from members, the Independent Insurance Agents Assn. of New York Inc. (IIAANY) has resolved to oppose "efforts of insurance companies to coerce agent representatives into life production by penalizing in any way the casualty book of business."

Although worded in general terms, the resolution is aimed at Aetna Casualty & Surety Insurance Co., according to Alan L. Hagerman, vp of Richardson, Hagerman Inc. agency in Clifton Springs, N.Y.

"The Aetna basic profit sharing agreement says that agents licensed for life production should support the Aetna life program," said Mr. Hagerman, who recommended the resolution to the association.

"Though they have never enforced that requirement, Aetna has recently alluded to the possibility of penalizing us for no life production," he continued. "I suggested we make a stand on this to prevent companies from getting away with this."

Unlike a similar protest from West Coast agents involving the Safeco Insurance Co. profit sharing program, no minimum life and property and casualty amounts have been set by Aetna.

Profit sharing requirements demanding life production with property and casualty production is "not exactly rampant," but does involve a few companies, according to John D. LaValle, assistant executive vp of IIAANY.

"Companies usually test their requirements on a certain area to see if they can get away with it," he said. ■

Study shows agents lose to direct writers

TALLAHASSEE, Fla.—Agents are losing their battles with direct writers when they compete for commercial accounts, according to preliminary research conducted by the Florida Assn. of Insurance Agents.

In the first week of the association's "competition alert," the organization received 90 reports from the 275 agencies who have agreed to cooperate. Agents are losing 78 to 12. Reports are submitted by agents who are in competition with direct writers.

State Farm surfaced as the leading competitor, named in half of the reports, competing especially for condominium, mercantile and office accounts.

State Farm's average rate was 63.2% of the competing agent's rate. Other major competition for independent agents include the Florida Farm Bureau and Liberty Mutual.

"We've been hearing horror stories like this for years," remarked Tom C. Johnson, association executive vp, "but our research is indicating, as we expected, that these cases are not isolated at all."

One agent member, according to the association's newsletter, reported that Northwest Florida is "engaged in the most cut-throat pricing competition" in years. The independent agent is discounting 40% to 60%, even against other agencies.

Mr. Johnson, whose often-discussed "Fourth and Last Manifesto" singled out direct writers as the agent's bane, said the competition problem isn't just in Florida but is also nationwide.

"Select any city in Florida and you'll find the same situation. Select any city in the country and you'll find the same thing," he said. ■

What to ask on buying a computer

CHICAGO—If you are looking for a computer and need a place to start, a new booklet published by computer designer Improved Insurance Systems Inc. may help.

Though the booklet, offered free of charge, does promote the firm's "Agency Management Organized Record System," it contains advice applicable to researching any system for the insurance industry.

The booklet includes a complete practical glossary as well as answers to basic questions. Most useful, however, are the questions to ask computer system sales people. They include:

- How many display terminals can I add before requiring more machine connections and how much will it cost?
- What condition requires core memory capacity to be added to the computer and how much?
- Can I print a report and at the same time perform data entry and inquiry at different stations?

If those questions sound technical, you are right. But the booklet answers and explains them as well as their importance to agencies. ■

"Helping You Select The Proper Computer," is available by writing: Marketing Dept., Improved Insurance Systems, 300 West Adams Street, Chicago, Illinois 60606.

Calif demands agent fingerprints

SACRAMENTO, Calif.—How careful can you get?

Applicants for new insurance licenses here are now fingerprinted.

The new procedure, started last month, helps regulators obtain "necessary background information and check the identity of applicants" in accordance with two sections of the California insurance code, said insurance commissioner Wesley J. Kinder.

Fingerprints are included with the notification of date and place of the insurance examination and applicants must be fingerprinted before taking the test.

Also required is a fee of $6.15 to cover processing costs. ■

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Oh, the turmoil of fingerprinting agents . . .

By
LEN STRAZEWSKI

LOOK J.B., it's only fingerprints! They don't want you to pose naked for Playgirl."

The CEO did not look happy, seated behind his oak desk with an alphabet logo impressively placed behind and above him, the way a political candidate uses a backdrop of the Stars and Stripes.

"Well I don't like it, even if it is state law. They have no right to put ink all over my fingers and smear them on paper like I was a common criminal," he said with a most uncommon scowl.

"Come on J.B., it will only take a minute and you have to get it done to get your license," returned the executive vp. "If you want my advice you'll just get it over with, renew your license in this state and no one will ever charge you're out of touch with production."

"Advice! The last time I took your advice we hired that motivational consultant who told me to wear a Big Bird costume for presentations—$15,000 for someone to tell me to dress like a chicken!"

"We got the account, didn't we—all the risks of that new African nation."

"Yeah, sure, but not because we were so perfectly motivated. The chief thought I was wearing their ceremonial dress for the bountiful harvest festival."

"Good thing you weren't dressed for the fertility festival."

"Shut up! It was hot under all those feathers. When the zipper stuck I thought my goose was cooked." The CEO stood and shook his head ruefully. He had taken to doing that a lot lately. The exec suspected it was the softening of commission rates and revenues that caused it, but actually it was a habit picked up from the weeks of shaking out feathers.

"J.B. it must be done. If you don't get your fingerprints taken the stories will go around again—about how the Old Man hasn't made a call or put together a deal in 20 years. How the Old Man doesn't know what it is like to be out in the field. How the Old Man . . ."

"Enough. I'll do it, but get the public relations staff ready. If the state finds out anything from this I'll have heads rolling. I'll reassign the lot of them to our new Nairobi office.

The exec ran his fingers through his styled hair. Nairobi was very warm in the summer and the new branch office was not yet air-conditioned.

"Okay J.B. I'll set up the appointment with the fingerprint service. Don't worry, what can they discover that they don't already know?"

The CEO moved from around his desk. It took a while. Then he put his arm around the shoulder of the exec affectionately, the way a salesman does to a new client.

"Junior, there's something I never told you or your mother. Back before grandpop started the little excess/surplus lines office in Iowa he changed the family name."

They walked slowly toward the picture window.

"J.B. you can't mean . . ."

"Yes son, we are really Polish. I lied to you all these years."

Silence was heavy. Then the exec spoke up.

"But J.B., it's chic to be Polish now. The Pope's Polish!"

"By George you're right. The Pope. It's all okay now."

He took his arm from around the exec.

"Make that appointment," he said. "And while you're at it, see who writes the Vatican's business." ■

"Mr. Babcock, you'll be surprised to learn the premium audit has finally arrived."

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Get political for state laws: IIAA exec

LOUISVILLE—Agents must begin to function as both consumer advocates and political activists in their relations with the federal government and insurers, according to Lee R. Meyer, Independent Insurance Agents of America, Inc. president.

As political activists agents "must do everything in their power" to stop the move toward more federal regulation of the insurance industry, he told the Independent Insurance Agents of Kentucky convention here.

Mr. Meyer noted that there are "two groups outside the insurance business with which agents may have a chance. They are the politicians—the elected officials in Congress and in the state legislature—and the consumers.

"Elected officials realize in many, many areas of this country agents are in almost every place they must get their votes from. They also realize that agents have influence in their districts."

Mr. Meyer suggested that all agents and their associations become more active in political activities to protect the interests of the industry against the growth of bank holding companies in the field.

Mr. Meyer also suggested agents "take the lead as consumer advocates in the property and casualty field" and protect the consumer's interest in dealing with insurers. ■

London stockbroker charts world's top 12 broker firms

LONDON—With increased interest by U.S. brokers in forging links to this insurance center, a firm of stockbrokers here compiled a list of the 12 largest publicly held insurance brokers in the world whose stocks are traded on major exchanges.

Kitcat & Aitken insurance specialist Alan Clifton ranked Marsh & McLennan as the largest publicly held broker in the world with $288 million in 1977 commissions and fees from brokerage activities.

Alexander & Alexander ranked second with $140 million and Frank B. Hall held down the third spot at $161.4 million.

Mr. Clifton notes that Johnson & Higgins would be third if privately held firms were included and Bland Payne would rank 10th.

"While Marsh & McLennan is the clear leader," Mr. Clifton observes, "it is worth noting that the top three companies, all U.S. based, generate almost as much commission and fee income as the other nine companies combined."

Reed Stenhouse is the first non-U.S. firm to make the list, at fourth with $131 million, followed by Fred S. James in fifth at $107 million.

Sedgwick Forbes is the leader among the U.K. firms with $101 million followed by U.K. rival C.T. Bowring at $91 million. New York-based Corroon & Black is eighth at $82 million.

Three London firms hold spots nine through 11. Matthews Wrightson is ninth with $66 million from insurance brokerage activities, Willis Faber is 10th with $56 million and Alexander Howden is 11th at $55 million.

The last place on the stockbrokers' list is J.H. Minet with $48 million in commissions and fees.

These figures do not correspond exactly to the figures published in *Business Insurance's* Agent/Broker Profiles issue (Aug. 7) because they represent only the brokerage business commissions and fees, excluding revenues from non-brokerage operations. Figures published by *Business Insurance* included revenues from the sales of group insurance, benefit consulting fees, investment service fees and other related income.

Kitcat & Aitken's figures are also translated from pounds sterling into dollar equivalents using an exchange rate of $1.82, applicable at the time Mr. Clifton's report was published. ■

Top 12 Worldwide Firms

Group broking commissions & fees

Marsh & McLennan	$288.47
Alexander & Alexander	190.37
Frank B. Hall	141.96
Reed Stenhouse	131.22
Fred S. James	107.38
Sedgwick Forbes	101.01
C.T. Bowring	91.00
Corroon & Black	82.26
Matthews Wrightson	66.25
Willis Faber	56.42
Alexander Howden	54.60
Minet	48.41

All figures are expressed in millions of dollars.

Small agents oppose N.Y. free zone fees

CHICAGO—Small agents and brokers may find the financial commitment required for maintaining a New York office and an estimated $1,000 fee for associate membership, both N.Y. insurance exchange requirements, just too much to handle.

Chicago-area brokers and agents cited these complaints during a CPCU seminar here on the proposed New York free zone/insurance exchange.

The seminar turned into a question and answer free-for-all with sides quickly forming into major brokers who supported the proposed "American Lloyd's" and small brokers and independent agents who opposed it.

Excess/surplus lines brokers were particularly vocal, following the lead of Alexander E. Fox, National Assn. of Professional Surplus Lines offices liaison director, who explained the association's objections to the proposal.

Mr. Fox, formerly deputy insurance superintendent in New York, called the New York state plan for a free zone and insurance exchange "just a way to circumvent the regulations and taxes of states other than New York."

The plan, he noted, may also take business away from local excess/surplus lines brokers. ■

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For more facts circle 168 on reply card

PERSPECTIVE

Know your needs, then target local ad attack

By Maryanne Sherman

As a professional insurance agent, people turn to you for advice, knowing that your experience and expertise will save them from financial worry if a catastrophe should occur. They depend on your professionalism. You, too, should depend on a professional to help you to solve your advertising problems.

Most agents use some form of advertising, whether it's a "facilities" brochure, direct mail, radio, television or print advertising. Determining what you need depends on your goals and your local situation.

Perhaps building a public image for your agency would be handled best through a special newspaper campaign—"The Insurance Corner" type of idea where you could give weekly insurance advice to people in your area. Or, sponsoring the local little league may be all you need.

Advertising can provide tremendous benefits for your agency, but for it to do an effective job, it must be tailored to your individual needs. A professional, whether a small advertising agency or a free-lance specialist, can determine what you should be advertising and what media fits your needs and budget.

There are hundreds of small-to-medium sized advertising agencies scattered around the country that would find your business exciting, and you would find affordable. Talk to local businessmen whose advertising you like. Ask who does it for them. Or look in the Yellow Pages. Most local advertising agencies will work on a fee basis. If you prosper, your advertising agency should also prosper. Negotiate the fee.

Once you've selected an advertising agency, treat the relationship as a business partnership. Discuss your goals, your strengths and your problems. Take the principal along on sales calls. The only way you can come up with an advertising program that truly reflects you is to bring the advertising agency into your confidence. They should be your alter-ego.

Ask yourself what you want your advertising to reflect about you and your agency. Who do you want to reach?

Develop a consistent, overall slogan, theme or image which can be used on all agency communications with your customers—print advertising, radio, letterhead, even billing correspondence.

Explore the media available in your area. In larger metropolitan areas, newspapers and radio tend to reach too wide an audience and are extremely expensive. A solution might be direct mail advertising which could be targeted to your audience. In smaller communities radio spots are both affordable and available and might prove more effective than direct mail or print advertising. Again, the local situation determines the media.

Frequency is another one of those questions that can't be generalized. My only suggestion is that you be consistent. Select and concentrate. You may not be able to do everything. Choose the appropriate medium and use it as frequently as your budget will allow.

What if there isn't a professional advertising agency or free lance specialist in your area and you want to advertise? You still have several choices. First, local, state and national agents' associations will provide advertising tie-in with their promotions. Send for their advertising kits. And when you attend their conventions or meetings, talk to other agents about advertising. You have similar problems and experiences and can benefit from each other. Consider forming a cooperative or agents' advertising association.

The IIAA (Independent Insurance Agents of America) has a special agent tie-in advertising kit that will let you identify with the "Big I" campaign. If this fits with your agency goals, use the materials they've produced. They're professionally done.

Most insurance companies supply advertising help to their agents in the form of tie-in advertising, ad mats on special product lines and even co-op advertising in some cases.

Tying in with insurance company advertising campaigns can be extremely beneficial. Pick a company whose image you can identify with.

INA, for example, offers agents and brokers advertising kits.

You can individualize company promo books simply by imprinting your agency's name and address on the back cover. They can then be used in a direct mail campaign to existing and prospective clients, or can be behind at sales calls.

Whether you tie-in with an association's or insurance company's advertising campaign or develop your own successful advertising isn't easy. It requires a lot of work, but more important it requires a commitment on your part to make it work. Hire a professional advertising agency, if possible. Use all available materials; there's an absolute wealth of it out there. You'll get your money's worth. ■

Maryanne Sherman is corporate director of advertising in INA Corp. in Philadelphia.

"YOURS IS AN EXCELLENT PUBLICATION AND ONE WHICH SHOULD BE READ BY SELLERS AS WELL AS BUYERS OF INSURANCE."

Insurance Agency Executive*

They Do, Mr. Agent, that's why so many insurance companies and services use Business Insurance ...to reach both, buyer and agent/broker.

Business Insurance is read by over 59,000 commercial insurance/benefits buyers and over 29,000 insurance agents and brokers. Details upon request.

*One of 887 who replied to a special Business Insurance research study among agent and broker readers.

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Los Angeles: 6404 Wilshire Blvd., CA 90048, 213/651-3710

Newsletter promotion warms cold sales calls

SANTA MONICA, Calif.—One alternative to an advertising program used with some success by smaller commercial agents and brokers is the "friendly" newsletter sent to clients and prospectives.

A series of such newsletters, including editions on insurance and risk management, OSHA/business security, construction, trucking and personal protection, are franchised by Insurance Marketing Services Inc. here.

The four page newsletters contain tips, regulation updates and news tidbits of value to clients and are published on the letterhead of the purchasing agent/broker. For all appearances it is the work of the local agent.

"It's not as good as a visit," remarked Peter L. Woodsmall of Woodsmall, Frick & Innis in Kansas City, Mo., "but it is great for following up a referral.

"We may come in to see a prospective client once and then put them on the mailing list. I admit that we don't get a flood of telephone calls after the newsletters go out, but at least when we go in again they recognize us and say 'Yeah, I get your newsletter,' " he said.

The Lasher-Cowie Agency in Phoenix, Ariz., has been sending out the franchised newsletters for two years and finds it has warmed up prospects, if not actually attracting them.

"We don't actually get an overwhelming response from prospectives based exactly on the newsletter, but when we do get a return card we usually wind up writing the business," said president Robert Cowie.

Lasher-Cowie sends the newsletters to all clients and to selected prospects "that we want to know our name," according to Mr. Cowie.

"It's a non-cost item for us, easily paying for itself and maybe showing a good profit if some of the prospects we are working on now turn out," he said.

Mr. Cowie reports that a few $20,000 range accounts can be directly attributed to the newsletter and a $150,000 account currently being negotiated came from that connection.

In general, however, success depends on the follow-up and work of the producer rather than on the newsletter itself.

"The commercial lines newsletter also has a certain value for errors and omissions, letting clients know about regulation and coverage changes that agents and brokers are held responsible for informing them about," he said.

"We use the personal lines newsletter, too, just beause we do so little for our few personal lines clients. It settles my conscience." said Mr. Cowie.

Prices vary according to quantity and type of newsletter, but for 500 copies of the insurance and risk management publication, designed for commercial insurance clients, costs are $150 and the agent's own mailing expense.

Insurance Marketing Services reports that about 800 agents currently use the commercial lines newsletter with many of those subscribing to two or three of the area-controlled publications. They are published every other month.

"One advantage to this system over advertising is the newsletters go only to the people we want it to," said E.R. Ledbetter Jr. of Ledbetter Insurance and Risk Management Inc. of Oklahoma City, Okla.

Ledbetter aggressively advertises, but also sends the newsletter to prospects spotted on the Dun & Bradstreet listing.

"Potential clients get a couple of newsletters and then we follow-up with a call. Usually they don't call us, though we just picked up an $80,000 account because they were having product liability problems and called us, stimulated by the newsletter," said Mr. Ledbetter.

The newsletters are part of a complete marketing package produced by Insurance Marketing Services. President George Nordhaus says that the newsletter alone is not the key and recommends the complete package. ■

Agency ready to dive into ad campaign

KANSAS CITY, Mo.—Woodsmall, Frick & Innis Inc. is almost ready to take a plunge into advertising.

The firm's advertising campaign, planned to break in three months, is a major shift in promotional thinking and is the result of no small decision, according to president Peter L. Woodsmall.

"We've decided that we have a lot of good young producers on the street and we need advertising to support those people who are calling on accounts," he said.

Woodsmall's enthusiasm for advertising is brand new, sparked by the response to a radio spot they shared with a local bank. The firm previously had not advertised in major print media or on radio and television.

Now they are planning local radio spots and advertising in Kansas City newspapers on a budget of $10,000 to $15,000, "though if we find it costs more we may go up," said Mr. Woodsmall.

"We have also looked at the Time magazine regional editions," he said. "The cost ($830 for one page run once) is not as high as you might think."

Though the guaranteed Time 30,000 circulation for a Kansas City regional edition is "not all that high," according to Mr. Woodsmall, "Time adds a certain prestige that we want.

The goal of the campaign is to give credibility to local producers and boost name recognition "so prospective clients can say 'Oh yeah' when you tell them who you are with," said Mr. Woodsmall.

Evaluation of the advertising is expected to be a problem and "that's one reason we want to find an (advertising) agency," he said. "We know the kinds of things we want. We want a new agency brochure, radio spots and print ads with a lot of repetition, not just an occasional full-pager."

The firm in the past has relied on cold calls, direct mail marketing, including a newsletter purchased for the purpose, and some local sponsorships.

"There's not a lot of advertising going on in this area," remarked Mr. Woodsmall. "We would be one of the first." ■

PLAY YOUR PART IN CRIME PREVENTION

Bring CU's new teaching kit to local schools.

Create some meaningful drama and excitement in your neighborhood schools... and put *your agency* in the spotlight, too.

Introduce teachers and students of grades five, six and junior high to CU's "Play a Part in Crime Prevention" kit.

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So take a cue from Independent Agent, Joe Cook. Send for your *free* kit today.

Help unlock America...take action against crime.

123

CU Commercial Union Assurance Companies

Box 417, Cathedral Station
Boston, Massachusetts, 02118

Please send me your *free* "Play a Part in Crime Prevention" kit.

Agency Name

Address

City State Zip

Broker ad plans . . .

Continued from page 62A

Ms. Paladino," and very well on reader-inquiries in general."

M&M has by far the biggest campaign with over $1.5 million budgeted for measured media. The official goal of the campaign is simply to "keep awareness up."

J. Walter Thompson Co. in New York handles the M&M account and places ads in a spectrum of the general business press, including Harvard Business Review, Fortune, Forbes, New York Journal of Commerce and *Business Insurance*, along with other general business magazines.

Advertising is very serious business among jumbo brokers, some of whom feel their advertising information is highly proprietary. A spokesman for Frank B. Hall refused to be interviewed on the subject because "it would be like giving away secrets to the enemy."

Emett & Chandler in Los Angeles hardly advertises at all, but badly wants to. It has been trying to get a budget from the parent company, Pinehurst Corp., for a long time without success.

'Crafty mix'

In general, national advertising by major agent/brokers presents a conservative image—full of pictures of people in suits and ties, with an occasional hard hat or bulldozer in the picture.

More innovative advertising appears on the local scene, with expanded use of radio and even television by small and medium size agencies, who also like local sponsorship of social events and public relations projects.

Nahm, Turner, Vaughan & Landrum (NTVL) in Louisville. Ky., says it advertises sometimes "just to be outrageous," with a catchy jingle in radio and television spots, including a TV spot that shows a model of Louisville burning.

But actually the firm's big campaign is a very crafty mix of conservative print ads in the Louisville papers and the Kentucky Business Ledger, serious and jolly electronic spots and very serious sponsorship of a seminar for local clients and prospects.

The NTVL budget is 1.5% of revenues and the company relies heavily on the advice of local ad agency Louis Schneider Inc., whose principal is "a genius with words," according to NTVL president Baylor Landrum Jr.

Woodsmall, Frick & Innis Inc. of Kansas City, Mo., was so impressed by the response to a radio spot it shared with a local bank that the firm is planning more use of that medium soon (see related story).

In Oklahoma City, Ledbetter Insurance & Risk Management Inc. goes all out with its advertising, piling a budget of 3% of estimated commissions into two billboards, radio spots on adult radio stations and newspaper ads rotating through business, sports and general news sections of the daily newspapers.

"We also use regional buys of Time and Newsweek," remarked president Bud Ledbetter, "with Aetna C&S, our main carrier, helping us out a lot with copy and concept development. In a lot of ways they do what an ad agency usually would do."

Budgets vary

Mr. Ledbetter said Aetna charges his company about 25% of what he estimates an ad agency would charge for creative and printing work.

"The major advantage is that Aetna knows the insurance business and this cuts down the amount of time we have to spend on advertising way down," he said.

All the Ledbetter ads stress business insurance and are aimed at supporting the marketing program with company identification.

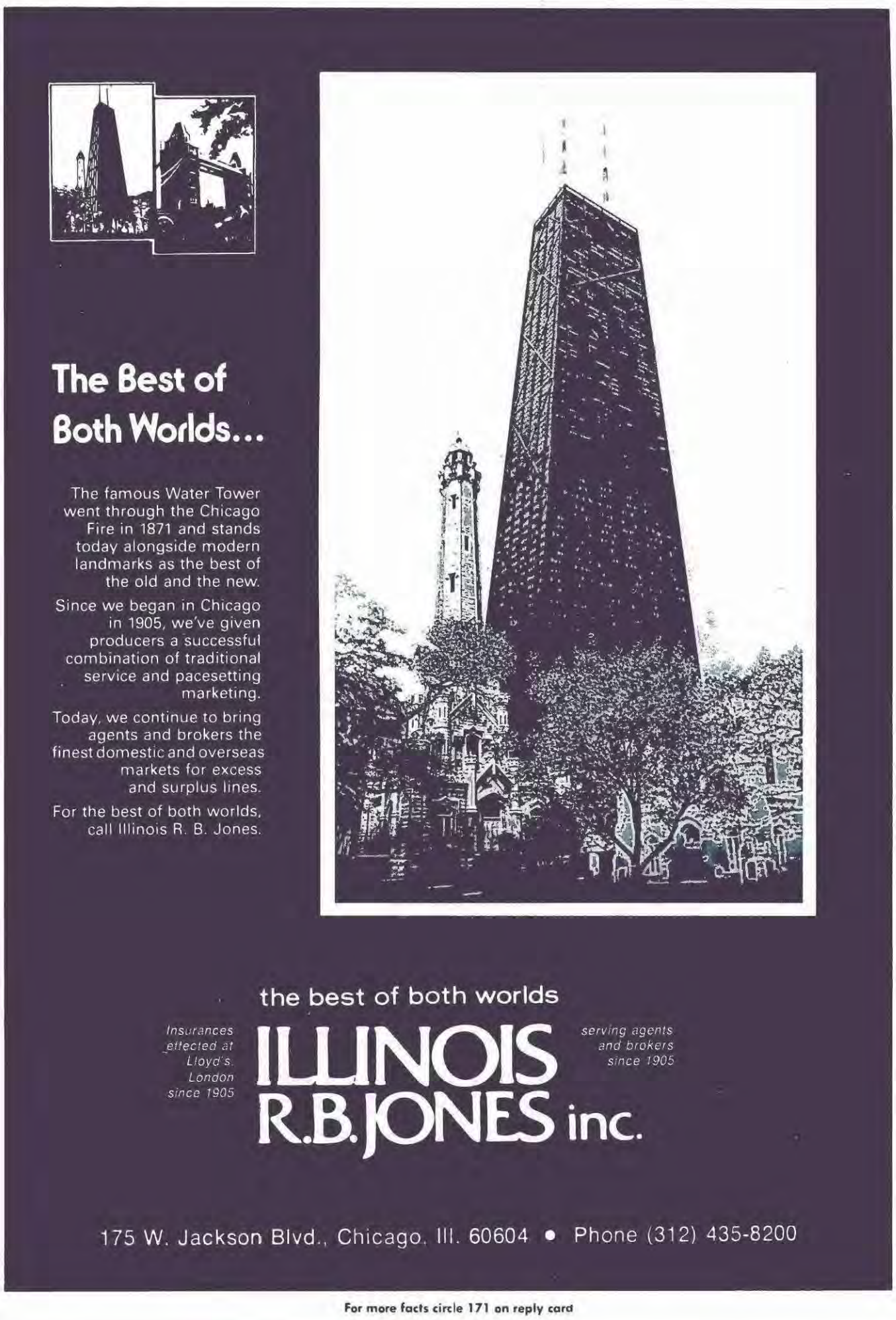
Bliss Insurance Co., a small downstate Illinois specialist in excess/surplus lines and municipal accounts, has an armlock on its audience with careful use of trade magazines like "County and Township Magazine" and institutional publications.

Why advertise

The firm does not use an ad agency, but prepares camera-ready ads themselves, keeping the ad budget at less than $13,000 for all branches of the business, said president James Bliss.

Many, many small agencies do not advertise at all, relying on insurer advertising to give them a boost when they make a sales call. Public relations-minded firms sponsor local events or help with sponsorship—everything from picnics to World Cup Tennis.

Direct mail and "friendly newsletters" are common techniques used by Brain & Fritson Inc. in Kansas City, Mo., Livermore & Associates Inc. in Pompano, Calif., and many others for the same reasons all brokers advertise: To keep a name in front of a potential client and warm up the reception during a cold call. ■



For more facts circle 171 on reply card

NTVL jingle

Below are the lyrics to the NTVL company song.

Sometimes people think insurance
is a test of their endurance
until they deal with NTVL people.
NTVL means protection
through insurance with direction
a speciality with NTVL people.
If there's a better way to cover
business risks they might discover
they'll help you find the answer.
NTVL has solutions
they know how and where and why
they can help you reach conclusions
help with your insurance buy!
Is my business well-protected?
Are there risks to be corrected?
The answers are with NTVL people.
Has our firm increased in value?
NTVL folks will tell you
they'll help you find the answer.
When you've got insurance questions
NTVL has directions
NTVL people have the answers!

Women honor industry educator

DENVILLE, N.J.—The New Jersey Insurance Women's Assn., an affiliate of the National Assn. of Insurance Women, named Patricia Hric 1978 Woman of the Year.

Ms. Hric, vice president of Castellini & Hric Insurance Services here, an educational and consulting firm and a general insurance agency, is also assistant director of the ARC school of insurance. ■

M&M buys out firm

NEW YORK—Marsh & McLennan International Inc. has purchased full ownership in Kabban-Marsh & McLennan Middle East Corp. and its affiliates.

M&M had previously had a 49% interest in the Middle East firm with offices in Athens, Beirut and London. No changes are planned in the Kabban-M&M staffing. M&M first purchased interest in the company in 1958 and formed the joint venture in 1969. ■

people

Ryan promoted; Huff new RBH division president

Donald S. Huff has been named president and chief executive officer of Rollins Burdick Hunter of Southern California Inc. succeeding **Charles F.S. Ryan** who has been promoted to chairman of the board. **Donald D. Herington** has been named executive vp and chief operating officer, the post formerly held by Mr. Huff.

* * *

W. Arthur Boynton joined the corporate risk department of Bellefonte Insurance Co. in Dallas, reporting to the assistant vp of that department. He has a B.A. degree from Wayland College. **Eric Parris** joined the firm as assistant statistical analyst. He has a B.S. degree from the University of South Carolina.

Also **Veronica A. Roth** was named supervisor of records and **Victoria Taylor** has been appointed supervisor of correspondence. Both are transferring from the firm's Middletown, Ohio office.

* * *

The National Assn. of Professional Insurance Agents (PIA) announced several staff changes. In the communication division, **Miriam R. Taylor** was appointed director of marketing, a new position. She is the former manager of communications for the National Tool, Die and Precision Machinery

Roth

Taylor

Assn. where she handled national meetings, public relations and produced a newsletter. Her duties include directing the overall operations of PIA's benefits and services program, membership promotion, convention and trade fair planning and advertising sales of The Professional Agent magazine.

Also in communications, **Gail A. Krone** has been named manager of consumer relations. She has formerly served as an underwriter for several independent agencies in the Washington, D.C. area. Ms. Krone replaces **Particia A. Borowski** who was promoted to the government and industry affairs division as director of state government affairs. Ms. Borowski will be working with PIA's state and regional affiliates. She is a former independent agent of Dayton, Ohio.

PIA also announced the appointment of **Robert Tabares Jr.** to the post of director of industry affairs and **Richard M. Charlton** to director of federal legislation.

* * *

James Adams has been named manager of a new branch service office of Crump London Underwriters, Inc. in Springfield, Mo. Mr. Adams was formerly Southwest Missouri regional sales manager of Silvey Insurance Group. He also spent seven years with Sentry Mutual Co. in sales and sales management.

* * *

Marvin J. Paul has joined Dan McGinn & Associates of Los Angeles as an actuary specializing in corporate pension and profit-sharing plans. Mr. Paul was formerly manager of insurance actuarial consulting and auditing services with the western office of Peat, Marwick, Mitchell & Co. He is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

* * *

John Robert O'Connor has joined Marsh & McLennan Inc. in New York as vp in charge of major commercial accounts. Mr. O'Connor was previously an account executive with Emett & Chandler in New York. Before that he spent 17 years with Liberty Mutual Insurance Cos.

* * *

Lynda Katsakos has been appointed assistant controller of S&H Insurance Cos. She entered the insurance field in 1974 as assistant manager of actuarial services for AVCO Financial Insurance Group. Ms. Katsakos is a graduate of State University College, Potsdam, N.Y.

* * *

Kenneth Bergquist and **Larry Zimmer** have been named assistant vps of Dependable Insurance Associates Inc., a surplus lines broker. Mr. Bergquist joined the firm in 1977 with an underwriting and brokerage background in commercial excess and specialty lines. Mr. Zimmer joined the company in 1976 and is a graduate of Illinois Wesleyan University.

* * *

Paul V. Colony has been named managing vp of the Los Angeles office of Alexander & Alexander of California Inc. Mr. Colony joined the company in 1962 as an account executive and was most recently head of the account executive group. He began his insurance career in 1960 with Prudential Insurance Co.

* * *

Angie V. Mauricio has been named vp/bond manager of Robert F. Driver Co. Inc., a California independent insurance agent. Formerly assistant manager of the surety bond department, Ms. Mauricio has 28 years experience in the surety bond and insurance field. She joined Robert F. Driver in 1958.

* * *

Margee Harris of Bayly, Martin & Fay has been elected president of the Employe Benefit Planning Assn. of Southern California. Other officers are **Thomas R. Billings,** Clifton and Co. and **Mark A. Straus,** Alexander & Alexander, Inc. The Employe Benefit Planning Assn. is an organization of 500 professional men and women who

Continued on following page

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THE TRAVELERS

For more facts circle 175 on reply card

8 agent failures spark E&O claims

AUSTIN, Tex.—The Independent Insurance Agents of Texas Assn. is preparing a set of cassette tapes to advise agents on preventing errors and omissions losses.

Based on solicited claim reports and the files of several E&O carriers, the tapes take a positive approach to loss prevention, according to association director of legal affairs John Cones.

Mr. Cones, one of two anchormen for the tapes, noted the goal is "to make agents aware of their overall liability and give them practical advice based on specific cases on how to prevent claims and losses."

Legalese and formal legal defenses have been minimized, according to anchorman Tom Loughrey, association director of education.

Preventing errors and omissions claims requires an agent's time and effort, maybe even time off from making calls on prospective clients, counsel experts John Cones, left, and Tom Loughrey, right.

Mr. Cones and Mr. Loughrey discuss 75 specific cases, dividing the most common problems into eight groups according to when they happen:

- Failure to provide coverage after agreeing to.
- Failure to fully disclose the nature of a risk or to supply information about the risk to the insurance company.
- Failure to advise the client of rejection or lack of coverage.
- Failure to give proper advice and giving unauthorized instructions or interpretations to the insured.
- Failure to place insurance at best obtainable terms.
- Failure to place insurance with authorized or solvent carriers.
- Failure to renew service policies.
- Failure to cancel a policy upon request of an insurance company or notify an insured of cancellation.

"What we try to make clear as we advise agents about the specific cases is that, at least according to the courts, insurance agents and doctors are no different. They both have some professional duties that they are responsible," said Mr. Cones.

Just as doctors now carefully document procedures in each case, so must agents take care to document their interactions with insureds, according to the researchers.

"Keep a file and be consistent. If a claim develops, that file will become important, counseled Mr. Loughrey. "The new account-selling technique by which an agent promises to handle all a client's insurance needs has created more problems. To be safe an agent must have a written record of what has been accepted or rejected by a client."

The most frequent E&O problems arise when an agent has bound an insurer to a risk and has told the customer coverage is being provided, Mr. Cones found when reviewing the 75 cases.

"We suggest the agent ask himself questions like 'Do you have binding authority? Is the binder immediately sent to the company? Is a letter sent to the risk? And is there a binder folder with someone in charge to keep it always up to date?' " the tapes advise.

Failure to cancel and failure to service and renew rank second and third among the most common problems, according to the team. Procrastination is often the culprit.

"At the end of the tapes we try to develop check lists for the agent so that he can be sure that everything is done," said Mr. Cones. "But we also emphasize that loss prevention takes time and it's going to require time and effort, maybe even take time off from making calls on prospective clients."

In general, the team suggests agents and their office staff continually improve their knowledge of their insurers, keeping and reading the current manuals and addendum.

"This business has a terrific turnover and it is important to keep up technically," remarked Mr. Loughrey. "Agents and staff should continually be involved with self-improvement courses.

"We are also recommending that agents have a set program for loss prevention, meeting once a week, once a day, or whatever it takes to keep themselves aware and minimize mistakes," he said.

•

The cassette taped seminar will be available after January 1. For information, write Independent Insurance Agents of Texas, P.O. Box 1663, Austin, Tex. 78767.

Agents rate 4th in E&O claims

CHICAGO—Recent studies show insurance agents rank fourth in errors and omissions claim frequency, behind doctors, accountants and lawyers.

The Professional Insurance Agents of California and Nevada report the leading causes of E&O claims against agents are failure to place proper coverage and failure to place coverage at all. ■

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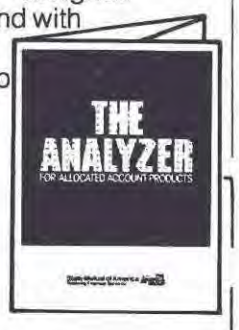

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Crain's Chicago Business
THE WEEKLY NEWSPAPER FOR MID-AMERICA

*Leo J. Shapiro & Associates, July 1978

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TELEX 28-3505

Insured trusts . . .

Continued from page 11

trusts, group life insurance is an option, not part of the basic package, as is dental and long term disability insurance.

The trust now receives $60 million a year in premiums, pays more than $3 million a month in medical claims and sends out commissions to 8,000 agents and brokers each month. Most of its employers have between two and 14 employes.

The trust is insured by Pacific Mutual, which gives that company two separate and possibly competitive multiple employer trusts. But vp Tom Tennant says that with a market of two million employers, a company needs a huge force of agents just to reach 8% of the potential customers.

"It's like having different models of automobiles," he observed.

The Pacific Mutual trust is six years old and is keyed to a health maintenance concept with little out-of-pocket expense for outpatient treatment and coverage for pap smears and physicals.

In Los Angeles, the cost for family coverage with no deductible on outpatient care and a $100 deductible on inpatient care would be $102 a month. Pacific Mutual concentrates on two to 14 employe groups.

State Mutual of Worcester concentrates its efforts on small firms with three to nine employes.

John Hancock, which declined to discuss its program, is writing its small employer business through its individual insurance section, according to sources close to the business.

"Every good life insurance agent has a number of small business clients who need health insurance," observed Pacific Mutual's Mr. Tennant to explain the entry of the giant insurers into the multiple employer trust area.

The competition from Prudential, Aetna, John Hancock and other large life insurers is having an impact. Mr. Biles attributes much of the difficulty in rebuilding the National Employers Security Trust to new competition from Aetna and State Mutual.

Mr. Lawrenz, however, warns small employers who sign up with the trusts marketed directly from the big group insurers, "the home office companies can be autocratic about rates and business. A third-party administrator can always move to another company if the insurer becomes autocratic."

The rapid movement of independent administrators between insurance companies and the inability to set profitable rates is often cited by the insurers for their reluctance to insure the third-party operations. Old Republic's disasterous experience, as well as the near bankruptcy last year of Loyal Protective Insurance Co. of Boston when its trust grew too quickly and piled up substantial losses, have scared many smaller insurers.

"Often the small life companies insuring multiple employer trusts didn't realize they were going bankrupt until it was too late," observed Mr. Lawrenz of BEST.

Phillip R. Hindenberger, an attorney with the California department of insurance, notes many insurance companies reacted to losses and tighter market conditions by cutting off the administrators and canvassing the employers directly for new coverage.

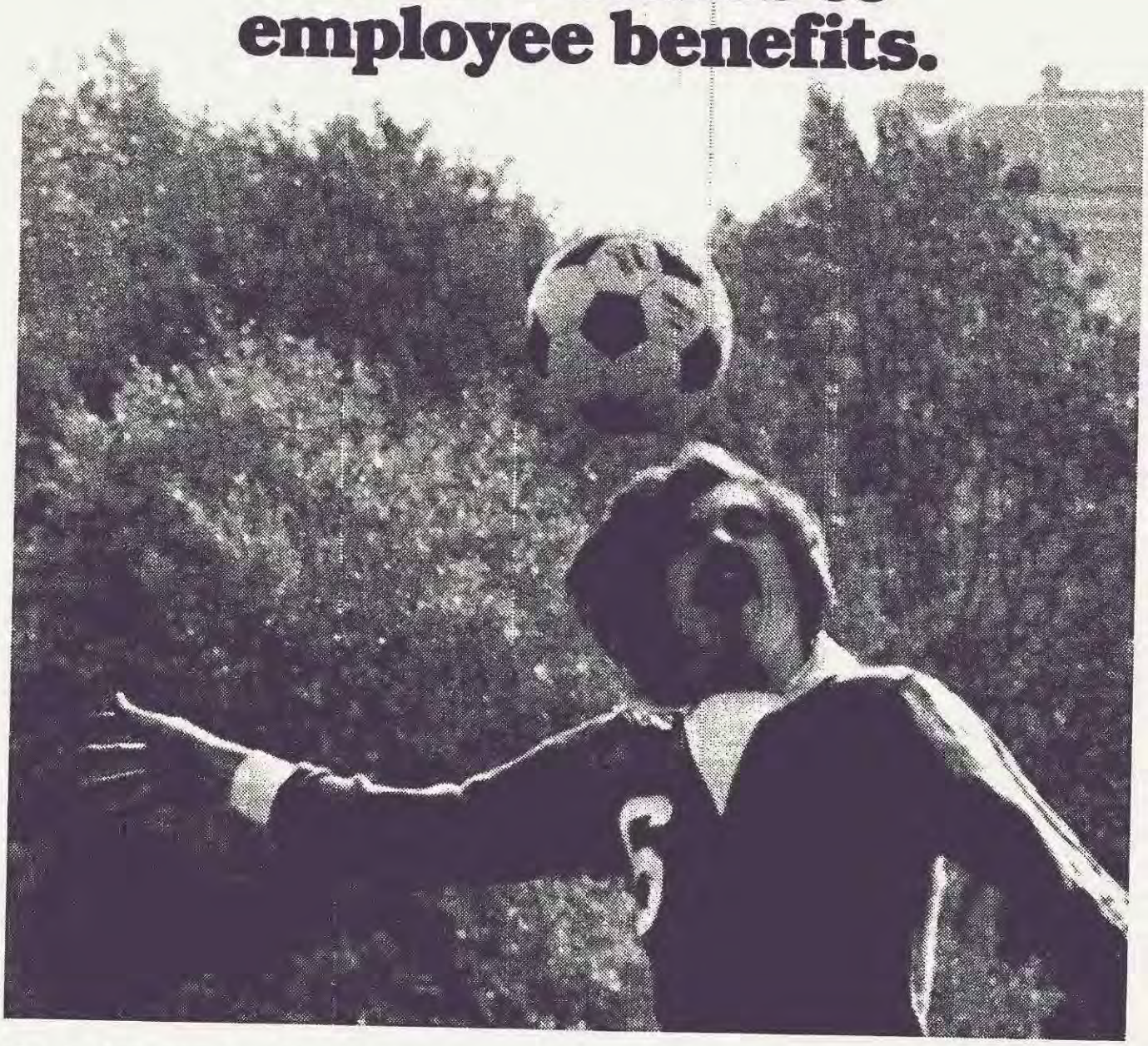
"Insurance companies always want to do as much of the administration and claims handling as they can," says Los Angeles attorney Claude J. Dorais, a close observer of multiple employer trusts.

California insurance regulators pay careful attention to group insurance loss ratios for companies insuring multiple employer trusts, said Mr. Hindenberger. Small California insurance companies have landed in trouble on trust business, he recalled, but state examiners found the problem in time to force the company to sell the business or take other action.

Turnover is a major problem for the trusts. "Small employers are often undercapitalized and this results in delinquencies and terminations," said Pacific Mutual's Mr. Tennant. Less than 10% of the terminations at BEST are the result of dissatisfaction, adds Mr. Lawrenz.

"The high cost of a 15 to 20 person group to obtain a single master group policy makes a good trust the most practical approach," concludes third-party administrator Mr. Biles. ■

Use your head when it comes to employee benefits.



But don't use your head like a battering ram—forcing an issue with your insurance carrier, actuary or bank trustee without the knowledge and expertise which an EBASCO Total Cost Effective (TCE) analysis can provide.

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For more facts circle 118 on reply card

Officials defuse explosion of self-funded METs

CHICAGO—The nationwide controversy over self-funded multiple employer trusts, often suspect vehicles for providing medical coverage to small employers under the pension reform law, is waning.

Although a number of trusts continue to operate in some states, insurance executives, trust attorneys and state insurance regulators say the explosive growth of self-funded trusts is over.

David Brummond, an attorney with the National Assn. of Insurance Commissioners who coordinated much of the legal action last year against the trusts, said that the issue is fading. "However, the situation is spotty," he continued. "Florida, where there was a major self-insured trust effort, says that nothing is going on, but Michigan and South Carolina and to some extent California say there are still problems."

Modeled after multiple employer trusts underwritten by insurance companies, the self-insured variety boomed in 1976 and 1977 as insurers became reluctant to work with the administrators who historically created and marketed the trusts. The trusts claimed to be employe benefit plans under the pension reform law and argued that ERISA's preemption clause exempted them from state insurance laws.

Early in 1977 two large self-funded trusts in California—the National Multiple Employers Trust and the Hospital Welfare Assn.—filed for bankruptcy leaving more than 40,000 persons with no medical coverage and unpaid claims that totaled more than $5 million.

Prompted by the bankruptcies and reports that other trusts were flooding the scene with high-commission, high-benefit but low-cost programs, state insurance departments in Arizona, Kansas and California sued the trusts, claiming they were merely unlicensed insurance companies.

The U.S. Labor Department, which the trusts argued was the sole regulator of their activities, issued several opinion letters that the trusts did not qualify as benefit plans under ERISA.

Finally, federal district courts in Arizona, Kansas and Oregon and a federal appeals court in Chicago agreed with the state insurance departments that the trusts were merely unlicensed insurers subject to state laws.

"We are four years down the road," observed Claude Dorais, a Los Angeles attorney who at one time was a leading spokesman for the self-insured trusts, "and the Labor Department has failed to come forward to regulate an area I think is clearly within their purview."

The combination of aggressive action by state insurance departments and a loose market which allowed some trust administrators to find insurance companies to underwrite their groups has had "a chilling affect on trust organizers and producers," added Mr. Dorais.

About 50 trusts are still operating to some degree in California, said Philip R. Hindenberger, an attorney with the California insurance department. California is suing to assert its jurisdiction in six trusts actions, but the cases take more than a year to complete.

Employe Benefits

The failure of the U.S. Labor Department, the interpreters of the pension reform law, to issue guidelines on what trusts qualify as employe benefit plans under ERISA and what operations are merely sham insurance companies continues to hamper efforts to control abuses, Mr. Hindenberger explained.

Although no accurate figures on the number of self-insured trusts were ever compiled, a consultant to the self-insured trusts estimated in 1977 that 1.6 million persons were covered under the programs. That figure would appear to be much smaller today.

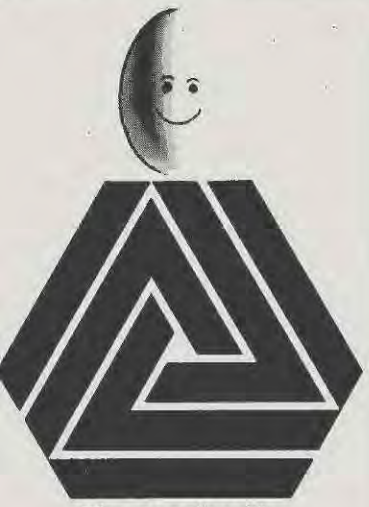
"I haven't heard much complaining lately from insurance companies about competition from self-funded multiple employer trusts," said John Meyerholz, counsel with the American Council of Life Insurance. "I think I would have if there were continuing problems."

One self-insured trust in continuing difficulty is United Chambers Trust. It began as an insured operation offering medical coverage to employers who were members of local Chambers of Commerce. The trust used the chambers to give it credibility and the chambers used the trust as a recruiting device. The trust opted for self-insurance in 1977 and at one point provided coverage for more than 33,000 individuals, taking in $11 million in premiums during a six-month period.

The trust came under scrutiny of state insurance regulators early this year. Vermont has received a promise from the trust that it will seek an insurer and United Chambers has posted a $300,000 deposit with the insurance department to cover outstanding claims. Georgia issued a cease-and-desist order against United Chambers' operations and said there may not be sufficient funds to cover outstanding medical claims. Illinois, where the trust is based, and California authorities are also investigating United Chambers.

Despite the end of the skyrocketing growth of self-insured multiple employer trusts, the issue may not be decided forever.

"Still, there is no definitive decision on the issue," complains Mr. Dorais. "The issue is ripe to come up again if there is a major disruption in insurance markets." ■



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First of its kind

Benefit execs unite to sway regulators

By KATHRYN J. McINTYRE

WASHINGTON—Employe benefit managers are flexing the muscles they developed heaving tons of ERISA-related paper work and for the first time are organizing as a clearly defined group to lobby for what they consider reasonable regulation of benefit plans.

At the National Employe Benefits Institute (NEBI) here, benefit managers from 25 U.S. corporations are defining the issues they grapple with every day and are pressing Washington legislators and regulators to adopt a corporate viewpoint into their deliberations.

"We're concerned about laws and regulations placing limitations on companies to tailor their benefit programs to meet the needs of their own employes," said William Zeigler, chairman of NEBI's policy board and employe services manager for Wilson Foods Corp.

"We formed NEBI because there was no organization in Washington that spoke for the benefits professional and only about benefits issues," he added.

Just one year old and only a sixth of the size it hopes to be, NEBI has already tackled formidable issues such as amendments to the pension reform law and the Department of Labor interpretive bulletin on complying with the 1978 amendments to the Age Discrimination in Employment Act.

NEBI members such as Dart Industries, General Foods and Pepsico depend upon the Washington staff of Schanes Associates to monitor developments in benefits regulations, to alert them and to act on recommendations of the policy board. Members also call on Schanes Associates staff to put them in touch with regulators for private discussions of issues.

Employe Benefits

Contracting with Schanes Associates for lobbying services lends the fledgling group credibility and experience. Steven E. Schanes, who with attorney Richard A. Van Durean, brought the benefit managers together under the NEBI banner, is well known in Washington. Years of government service culminating in duty as the first executive director of the Pension Benefit Guaranty Corp. give Mr. Schanes the knowledge and "name identification" to open the right doors in Washington.

But NEBI doesn't burst into the chambers of Washington power, choosing instead the tact of "quiet lobbying" as Mr. Schanes calls it.

"It's catching an administrator like Ian Lanoff (of Labor) or Matt Lynd (of PBGC) at a meeting and sitting down to explain a problem," Mr. Schanes said. Regulatory and congressional staffers, who develop and implement employe benefits related laws, are also targets of NEBI's quiet lobbying.

Steven Schanes' name opens doors in Washington for NEBI, which he organized.

Last year, for example, Mr. Schanes escorted Peter H. Turza, special counsel to the Senate Human Resources Committee, to Sybron Corp. in Rochester for a meeting with pension trust administrator Andrew R. Graham.

A conglomerate of smaller companies, Sybron issues annually 60,000 summary annual reports on benefit plans to comply with ERISA regulations. "We showed him the thousands of notices," Mr. Schanes recalled. "And they had just two responses from retired workers asking, 'What are you doing to our benefits?' "

The amendments to ERISA introduced in the last session of Congress by Senators Jacob Javits (R-N.Y.) and Harrison Williams (D-N.J.) eliminated the summary annual report requirement.

Mr. Schanes declines to give NEBI all the credit for this change, expected to be made in the new session of Congress, noting "they've been under a lot of pressure" to tone down the communication requirements.

"But we are bringing the staff people to the benefit administrators. We're trying to break down that awful wall that exists between Washington and the people who live with these laws," Mr. Schanes explained.

"There's little point in breast beating before hearing," he maintains. "We have to work with Congressional staffers on matters that can be changed. It's slow and steady education on the technical level."

NEBI presented written opinions on the proposed ERISA amendments and the regulations governing benefit plans for workers over 65, for example, to guide the regulatory process.

Regarding the pension reform law, NEBI asked for "any amendments which lighten the burden or

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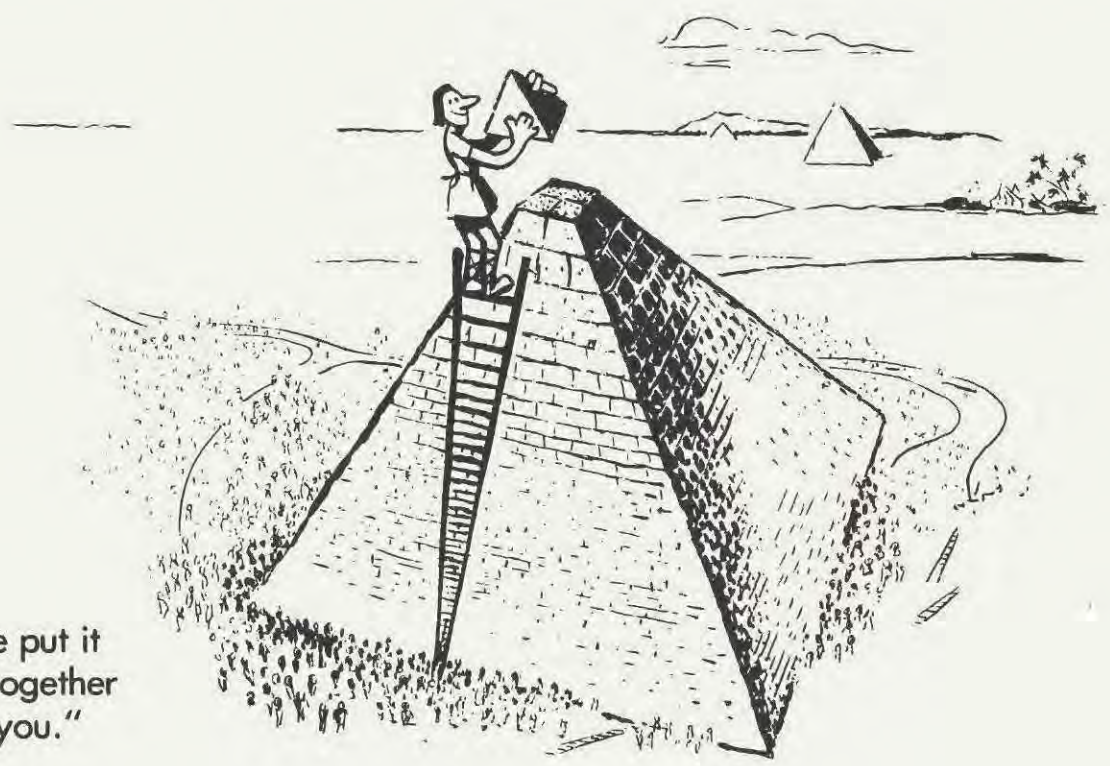

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reduce the complexity employers must face, while still maintaining proper and sufficient protection of the rights of participants and beneficiaries."

Specifically, the benefit managers asked the Senate Human Resources Committee to address the ERISA-related problems of multiple-jurisdiction by federal agencies implementing the law, preemption of state benefit laws by the federal law, reporting and disclosure requirements and the definition of seasonal industries.

NEBI is now waiting to see the results of the Administration's reorganization of ERISA enforcement, but it's still asking for a strengthening of ERISA's preemption of state benefit laws to free multi-state employers from complying with myriad state benefit requirements.

Decrying "much of the reporting to participants required by the law (as) counterproductive," particularly the summary annual reports, NEBI told the committee "a personalized statement of benefits is much more important to the individual participant."

The definition of a "seasonal industry" for benefit consideration under ERISA is a major concern to some NEBI members. "The real objective should be to find a way to provide benefits to regular part-time employes," the benefit lobbying group suggested.

Responding to the Labor department's proposed regulations governing benefits for workers older than 65, NEBI complained the interpretive bulletin focuses too much on isolated benefits instead of considering the employer's overall benefit package and too much on cost instead of the value of a benefit to an employe.

NEBI's comments on the proposed Labor department regulations were written after the group had met with James B. Leonard of the department at a seminar sponsored by NEBI and attended by 40 member and non-member benefit managers.

Continued on following page

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Benefit execs . . .

Continued from preceding page

Mr. Leonard described the meeting as a "useful format to exchange views with people, which focused my thinking and made me more aware of where issues generated the most interest." He denied, however, that the benefit managers had "convinced me of anything."

NEBI's efforts to influence the type of ERISA amendments passed and ADEA regulations adopted are just the beginning of what it intends to accomplish.

"We want a chance to comment on proposed legislation and regulations before they occur and we can't change them," said policy board member Hal Sabastian, manager of benefits for Standard Oil Co. (Ohio).

While Sohio maintains its own lobbying office in Washington, Mr. Sebastian convinced management to spend the $2,500 a year to belong to NEBI as the only Washington organization solely representing the corporate employe benefits buyers' viewpoint. (Sohio spends $100 million a year on benefits for its 23,000 employes.)

Other employe benefit-related organizations don't fit the bill, NEBI members maintain. The prestigious Council on Employe Benefits, for example, is more education and position oriented. The influential Washington Business Group on Health is concerned with only health issues and the ERISA Industry Committee primarily addresses ERISA issues with a legal emphasis.

These organizations also represent the sellers of employe benefit services and products, but NEBI is only representing the corporate buyer and provider of employe benefits, NEBI members stress.

"We're not going to try to do things others are," emphasized Mr. Zeigler of Wilson Foods, a subsidiary of LTV Corp. which he represents as a member of NEBI. "Where others are doing a proper job, we'll be supportive. But where no one is doing anything, we'll try to fill the void so industry, as the provider of benefits, will have its point of view known."

While many special interest groups are lobbying for and against a national health insurance plan, for example, NEBI is asking that whatever is resolved, employers be "permitted to provide coverage under any mechanism, such as self-insurance," Mr. Schanes noted. "There are rumors around that approved consortia of insurance companies would be allowed for providing the benefits while doing away with self-funding," he grimmaced.

Although trying to affect the future course of government regulation of benefit plans, NEBI isn't going to chase paper tigers, Mr. Schanes promises.

When he heard that PBGC is considering restructuring the U.S. private pension funding system to allow employers to book reserve for pension promises instead of funding, "we had lunch with Rep. John N. Erlenborn," Mr. Schanes said. "We found out he's against it. It won't go anywhere, so there's no point in pursuing this."

"The objective of NEBI," said Mr. Zeigler, "is to have a professional Washington staff on the scene for constant dialogue with staffers, to react quickly." The "relatively high" $2,500 annual dues, he continued, "is not to exclude anyone, but to support the qualified staff and attract only the really interested."

The organization is "the kind of vehicle private U.S. industry should appreciate and take advantage of," Mr. Zeigler asserts. "If they do not, it may be to their detriment in the short as well as long term."

Mr. Schanes believes "everyone understands government is an active participant in employe benefit structure. Private industry has to organize to deal with it."

Suffering the birth pains of a young organization, including convincing more corporations to join and building up an operating budget, NEBI is hopeful membership will surge this year. ■

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The new policy "written in conjuction with, not attached to the basic D&O policy" won't affect limits in the corporate policy, said Joseph P. DeAlessandro, National Union president.

The policy was developed in response to numerous requests from the banking industry for blanket outside director coverage, Mr. DeAlessandro said.

"I don't believe many corporate officers understand how their liability would be extended this way," he said. "It's conceivable should one of their directors or officers be involved in a sticky situation while they're serving on the board of another corporation, the limits on the basic corporate D&O policy could be eroded.

"Buying a separate coverage that doesn't detract from the limits on the basic policy is a solution," he added.

The separate D&O policy will protect the named insureds against any loss suffered by them over and above any protection offered by the basic corporate D&O policy.

The new policy will be "tightly underwritten," Mr. DeAlessandro said, and will be written only in conjunction with the basic D&O contract offered by National Union. ■

info for buyers

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• The 1978 edition of the **Life Insurance Fact Book** is now available from the American Council of Life Insurance. The book provides statistical information on the average amount of life insurance coverage for each insured family in the U.S., payments to beneficiaries, policyholders and annuities over the past year, assets of life insurance companies and the number of people covered by pension plans administered by life insurance companies. For a free copy of this book circle 232 on the reader service card.

• **Insurance Facts** is an 80-page booklet annually published by the Insurance Information Institute containing statistics and information about the property and liability insurance business. This yearbook reviews the factors contributing to underwriting losses in 1977, including the increased cost of goods and services for which insurance must pay and the increased number of lawsuits resulting in larger jury awards. A new section on industry operating results has been added that compares the fluctuation of profits and losses of property/casualty insurance companies to other industries such as banks, utility and industrial companies. For a free copy of this booklet circle 233 on the reader service card.

• **In Your Racquet, You Need Protection** is the title of a promotional brochure which highlights the racquet club proprietor insurance program now being offered by the Commerce and Industry Insurance Co. For a free copy of the brochure circle 234 on the reader service card.

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• **A Comparison of Pension Plans** is a four-page brochure from David Langer Co. Inc. that contrasts a prior plan and an amended plan. Factors considered are number of covered employes, total salary, annual pension benefits, insurance volume, pension contributions and insurance premiums. For a free copy circle 236 on the reader service card.

• Surveys indicate that most people do not shop around for insurance. The Missouri consumer information center is now offering **a guide for buyers of health insurance** to encourage shopping for insurance. Some advice, caution and guidelines are given in the 15-page booklet so that consumers, armed with a better understanding of health insurance, will shop for the policy and rates that best suit their needs and lifestyle. For a free copy of this booklet circle 237 on the reader service card.

• Are your employes over 65 confused about how they can supplement their Medicare coverage? If so, the private health insurance industry has compiled a "plain language" booklet describing the kinds of health insurance policies available from commercial companies, Blue Cross/Blue Shield plans and retirement organizations. The booklet titled **Retirement Health Insurance Booklet** also describes how to use the Medicare program effectively, where the gaps in coverage exist and how different policies fill these gaps. For a free copy of this booklet circle 238 on the reader service card.

• Do you know how the **new mandatory retirement act** will affect your company's benefit program? If not, then read a newsletter prepared by the Pension Planning Co. Inc. that reviews the basic provisions of this new law and the possi-

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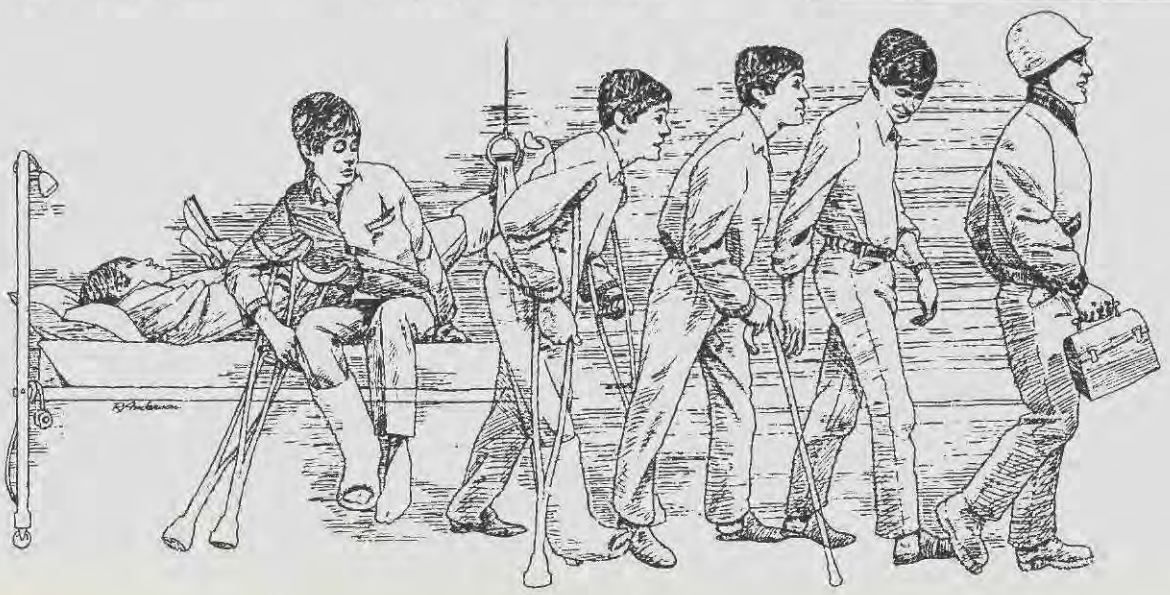

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• The International Foundation of **Employe Benefit Plans** has compiled a **bibliography** of source materials from its publications and cassette tape subscription service. Listings date from the passage of ERISA in 1974 and are divided into 33 subject sections. For a free copy of this extensive bibliography on employe benefit developments since ERISA circle 242 on the reader service card.

• Kwasha Lipton has just published a new newsletter—The "Other" **Post-Retirement Benefits:** When Should The Cost Be Accrued? Should They Be Funded? For a free copy circle 243 on the reader service card.

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• The seventh edition to the **Guide to Pensions in Western Europe** is now available from Lowndes Lambert Group. Though the company readily admits that due to the rapidly changing subject the booklet is out of date almost as soon as it is published, its real value lies in the essential but brief background information provided. The booklet details the pension programs of nine countries and also the multilateral agreement on social security for migrant workers. For a free copy of this booklet circle 245 on the reader service card.

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• **Federal Taxation & Regulation of Health Insurance Plans** is a guide with charts from Unionmutual. The 44-page publication presents general information based on rulings and regulations in effect as of Jan. 1, 1977. Discussions center on buy-sell plans, chances of recovery, corporations, ERISA, individual plans, medical reimbursement plans, partnership, probability of death and disability, sole proprietorship and wage continuation plans. For a free copy circle 248 on the reader service card.

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• The U.S. Department of Labor is offering to tell you **What You Should Know About the Pension and Welfare Law.** For a free copy of this guide to the Employe Retirement Income Security Act of 1974 circle 254 on the reader service card.

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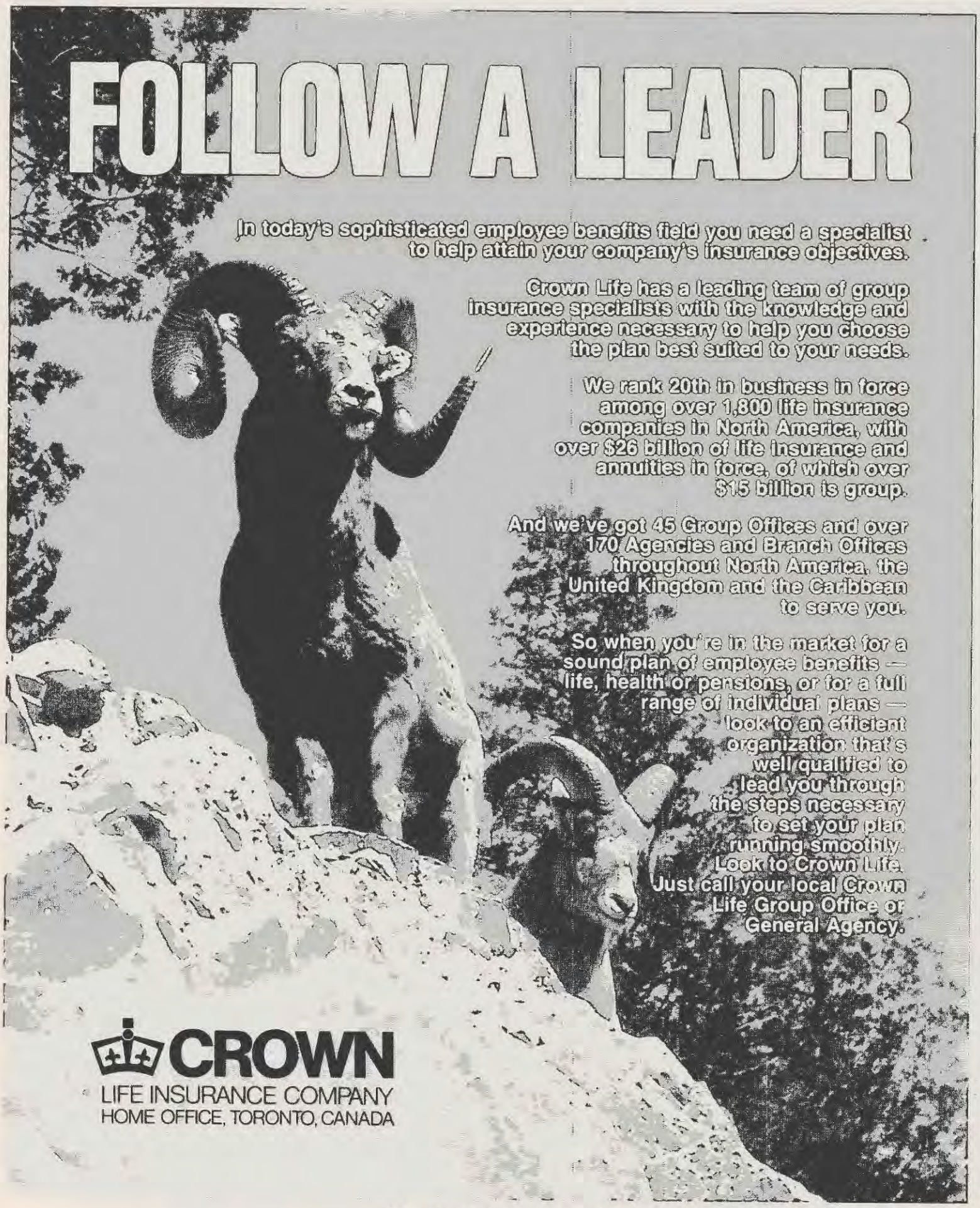

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development of health maintenance organizations published by Personnel Research Associates. The report deals with the 190 most frequently asked questions about HMOs. For a free copy of this report circle 255 on the reader service card.

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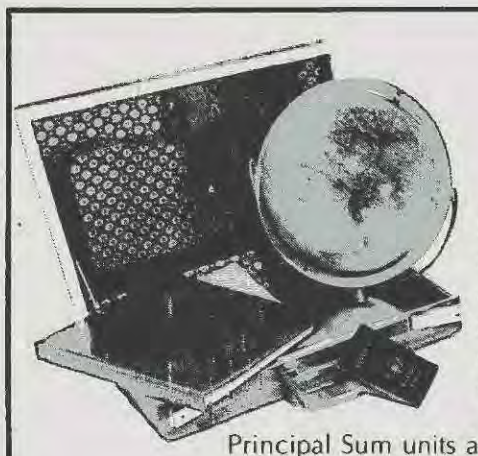
• If you ever tried to locate a **UAC** adjuster in the case of fire, auto accident, catastrophe or other losses, you may find the Underwriters Adjusting Co. **revised 1978 directory** just what you need. For a free copy circle 262 on the reader service card.

• The International Foundation of Employe Benefit Plans has published the **proceedings** of its **1977 Public Employe Conference.** The 141-page book contains the edited presentations by 12 speakers. Cost for foundation members is $4.50 per copy for orders under five and $4 per copy for orders over five copies. Cost for non-members is $7.50 per copy for orders under five and $7 per copy for orders over five copies. Write International Foundation of Employe Benefit Plans, P.O. Box 69, Brookfield, Wis. 53005.



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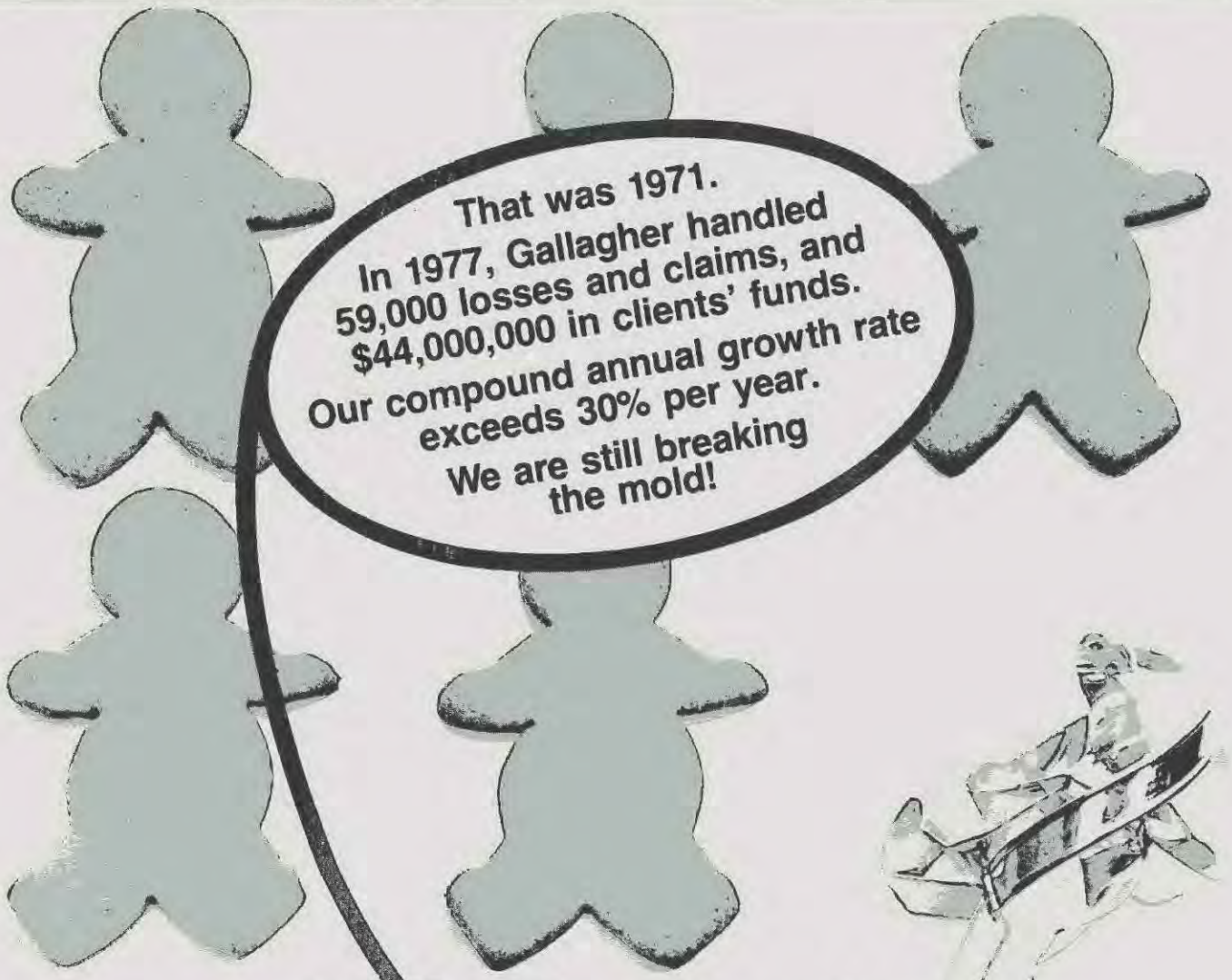

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dates for buyers

JAN. 8-10. Self-Insurance, Risk Retention is the title of a program sponsored by the center for management development of the American Management Assns. to be held at the Sheraton Inn International Airport in New Orleans. The program will be repeated **Feb. 5-7** at the Dunfey Atlanta Hotel in Atlanta, Ga. Contact division manager, Insurance & Employe Benefits Division, AMA, 135 W. 50th St., New York, N.Y. 10020; phone 212-586-8100.

JAN. 16-17. RCI Communications Inc. will present an advanced seminar in San Francisco on the **reduction of construction insurance costs.** Workshops will cover new material such as preparations for premium audits, rating plans for competitive proposals, management for professional liability, captives and self-insurance funding, determining insurance costs for construction bids, the London market and workers compensation guaranteed cost plans. Cost: $395, team fees available. Contact RCI Communications Inc., Suite 350, Building V, 10300 North Central Expressway, Dallas, Tex. 75231; phone 214-363-9656.

JAN. 17-18. How to profit from the London market by improving coverage and lowering costs is the title of a RIMCO seminar to be held in San Francisco. The program will cover an introduction to Lloyd's, the other London companies, security, role of the Lloyd's broker, role of the surplus lines broker, collecting a loss, role of a Lloyd's agent and how to present a risk for a London placement. Cost: $395, team fees available. Contact RCI Communications Inc., Suite 350, Building V, 10300 North Central Expressway, Dallas, Tex. 75231; phone 214-363-9656.

JAN-22-25. Executive Protection is a workshop and exhibition sponsored by Indiana University to be held in Phoenix, Ariz. This is just one of many programs planned this year by the university's center for public safety training. The workshop will be repeated **April 30-May 2** in Indianapolis. Cost of the workshop is $200. Contact Indiana University, Center for Public Safety Training, ISTA Building, Suite 400, 150 W. Market St., Indianapolis, Indiana 46204; phone 317-264-8085.

JAN. 22-28. The Cardio-Metrics Institute and the Human Performance Laboratory are the sponsors of a symposium on health and preventive medicine in the corporate setting to be held in Hollywood, Fla. The symposium will cover the role of industry in the control of preventable disease and health abuse with particular emphasis on the areas of stress, nutrition, physical activity, heart disease and alcoholism. Current research findings will be presented and discussed by medical authorities and selected corporate health programs will be reviewed. Cost: $475. Contact Cardio-Metrics Institute, 295 Madison Ave., New York, N.Y. 10017.

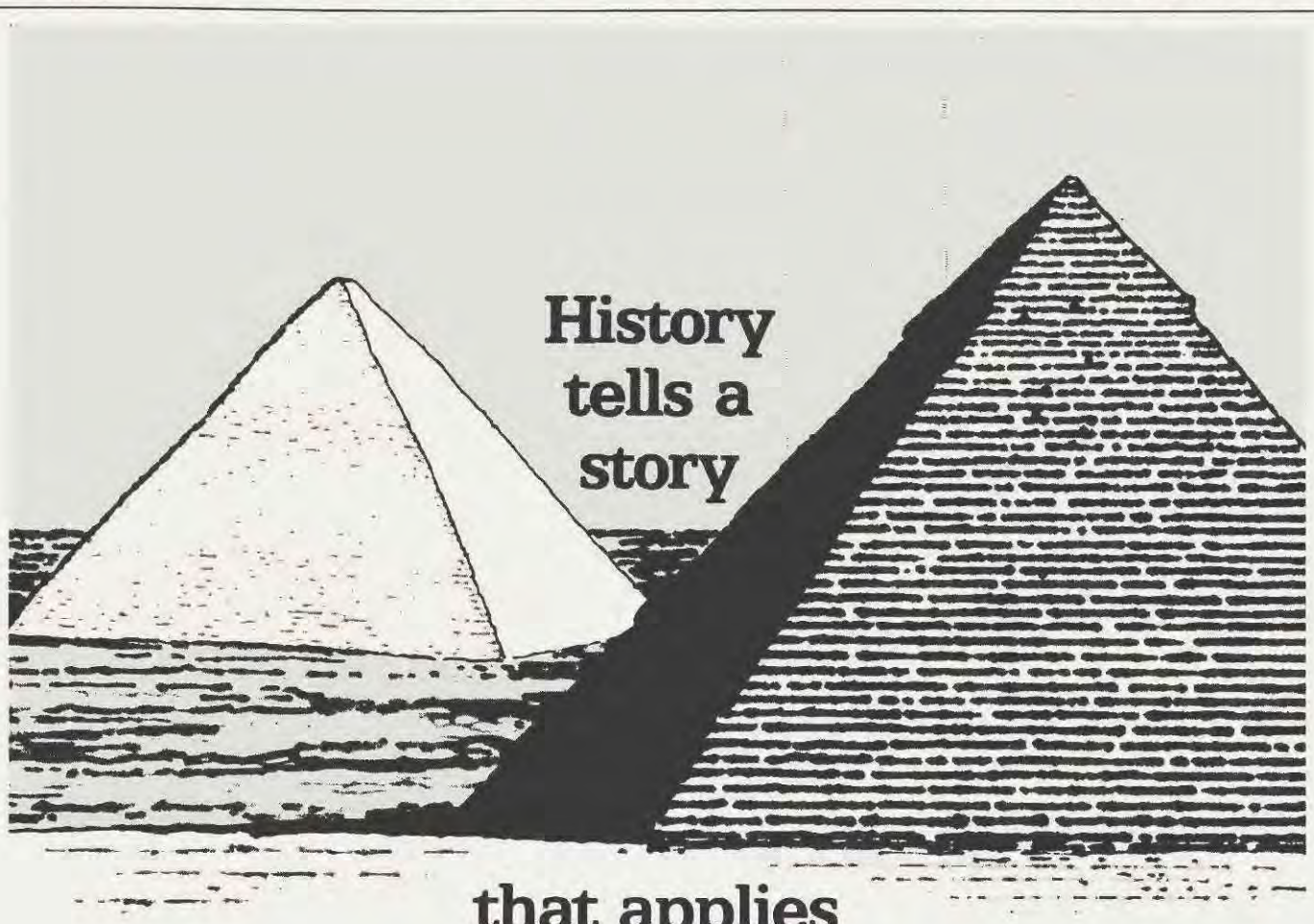
JAN. 25-26. Self-Funding Your Employe Benefits is the title of a program sponsored by the American Management Assns. to be held at the AMA headquarters in New York. Contact Division Manager, Insurance & Employe Benefits Division, AMA, 135 W. 50th St., New York, N.Y. 10020; phone 212-586-8100.

JAN. 28-31. The insurance and protection division of the American Bankers Assn. is sponsoring a **risk and insurance management in banking** seminar at the Hilton Palacio Del Rio in San Antonio, Tex. The seminar is designed to provide executives responsible for a bank's insurance program with knowledge of risk and insurance management techniques with special emphasis on loss control methods, minimizing insurance broker and company service and the bankers blanket bond. Other topics include properly insuring against losses arising from directors and officers liability, ERISA and other fiduciary liabilities and electronic funds transfer system participation. Cost is $255. Contact Nancy Krakover, registrar, insurance and protection division, American Bankers Assn., 1120 Connecticut Ave. N.W., Washington, D.C. 20036; phone 202-467-4049.

JAN. 29-FEB. 1. Financial Costing in Risk Management is an advanced seminar to be offered by The University of Dallas. The seminar will examine the impact and timing of risk management accounting decisions with an emphasis on the identification of accounting decisions in self-insurance and captive operations, the allocation of risk management costs to various divisions and the building of a risk management operating budget. Cost is $345 for RIMS deputy members and $375 for others. Contact Professor Bruce Evans, The University of Dallas, Management Laboratories of America Inc., Irving, Tex. 75061; phone 214-438-1123 ext. 360 or 214-438-5765.

FEB. 5-7. Reporting and Disclosure Compliance under ERISA is the title of a program of the American Management Assns. in New York. Contact division manager, insurance and employe benefits division, AMA, 135 W. 50th St., New York, N.Y. 10020; phone 212-586-8100.

FEB. 15-17. Union Planters National Bank is holding a second **fidelity bond claim seminar** which will be held at the Tamarron in Durango, Colo. It will examine executive fidelity, bond claims and related matters. Seminar participants will be shown how to file and pursue a claim, possible consequences of the claim, the insurer's part in the claim, legal strategies if a claim is not paid and steps to reduce fidelity bond claims. Cost is $495. Contact Union Planters National Bank of Memphis, James A. Cook Jr., special assistant for financial affairs, 67 Madison Ave., Memphis, Tenn. 38174; phone 901-683-1985.



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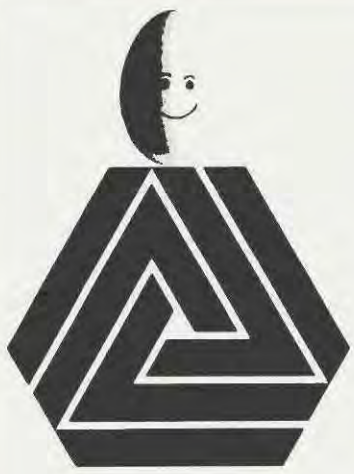

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Reject group plan

Texas teachers protest insurer's shenanigans

AUSTIN—A teacher's association here protested to regulators when its disability insurer began charging lower premiums of policyholders in some parts of the state. The insurer also switched the teachers' individual policies under the association program to group policies without obtaining their approval.

These actions cost Washington National of Evanston $7,500 in fines and the loss of $3.2 million in premiums from members of the Texas Classroom Teacher's Assn.

E.J. Voorhis, Texas insurance commissioner, ordered the Evanston company to stop doing business in the state or pay the fine when a five-month investigation into the insurance company's handling of the association's business revealed violations of the state's insurance code.

"Association members in El Paso were paying less than members in Odessa and Midland," Thomas Duck, spokesman for the teacher's group explained. "This is blatantly discriminatory especially when the same class of people are being charged different premiums for the same policy and the same benefit levels."

Charges that the insurer switched from individual disability policies to group policies under the local school district name without the consent of the teachers or notice of the action were also made by the group.

"What people thought they had, they did not actually have," Mr. Duck added. "Our members still had the individual policy in their hands."

Members of the association had opted for individual policies over group policies for a reason. "They felt that the provision of an individual policy afforded them more security," Mr. Duck said.

Teachers under the individual policies would carry their policies with them when transferred from district to district—a common occurrence in Texas. This eliminates an awkward transition period as a teacher switches from a group policy in one local school district to one in another school district, he added.

Individual policies also require that an insurance carrier give a policyholder 90 days notice of cancellation as opposed to 30 days cancellation notice under a group policy.

"This kind of security was of foremost importance to these teachers and Washington National should have at least allowed the teachers to make a choice about their own policies," the association spokesman said.

Mr. Duck termed the insurer's action "underhanded and highly unprofessional."

Washington National provided disability benefits for association members for 10 years, Mr. Duck said, and ruined a working relationship that the association had developed with the insurer over that period of time.

In response to this finding, the Texas teacher's group placed their business of 23,000 members in 180 local school districts with another carrier—Republic National of Dallas, Tex.

Meanwhile, Washington National paid the fine but denied any unethical or illegal procedures taken in connection with the Texas Teacher's Classroom Assn. policies. The fine was paid, the insurer says, to allow the company to do more business in Texas. ■

Marine panel chief

William A. Bennett, senior vp and director of Frank B. Hall & Co. of New York, is the new chairman of the marine committee of the National Assn. of Insurance Brokers to fill the unexpired term of the late Andrew E. Rossmere. Mr. Rossmere resigned shortly before his death. Executive vp and director William Bumsted and vp Emil Kratovil of Johnson & Higgins have also retired from the committee with J&H vps David Welles and Gilbert Dunham replacing them.

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benefit tax slants

Pre-fund pensions to shelter earnings

By JOSEPH S. ROBINSON
Attorney-at-Law

THERE'S A NEW wrinkle in connection with funding pension plans. Sponsors are no longer automatically making the minimum required contributions. Many companies that can afford it are prepaying partial future commitments and for very good reasons. It's a tax shelter for invested capital. In other words, it gives the company the chance to pick up tax exempt income. **Reason:** The earnings on pension investments are not subject to income tax. It's just that simple.

So if a company elects to deposit $1 million in addition to regularly scheduled contributions and invests it in 9% bonds of another company, it would take a pre-tax return of roughly 17% (even under the new lower rate structure of the Revenue Act of 1978) to match this yield. Most companies would gladly settle for that kind of profit in the operation of their business. Some firms go a step further by financing the above-minimum contributions through loans. But to come out ahead, they would have to arrange the borrowing at an equivalent interest rate to match the investment yield.

Result: The fund earns tax-free interest while the company pays the same amount of interest but gets a tax deduction to boot.

In addition to the tax break, there are other advantages to advance funding of pensions under current ERISA rules. Of paramount concern to stockholders is that they personally risk at least 30% of their net worth in the event the company goes out of business or ends the plan. In addition, the corporation remains liable for vested benefits of up to about $12,000 annually per participant even if the plan is terminated.

For these reasons and more—such as the possibility of poor performance of pension investments—a growing number of pension sponsors are taking a new look at their funding policy and whenever possible are depositing more money into the pot than legally demanded.

Lump sum distributions

The Revenue Act of 1978 did not disturb the tax aspects of pension or profit sharing payouts. Thus, if you have been a participant in a plan for at least five years, you still have some choices. You may put the money into an individual retirement account within 60 days of distribution and thus postpone the payment of taxes until you retire, when you may be in a lower tax bracket. If you decide to take your tax lumps now, you can pay capital gains on a portion of whatever accumulated before 1974 and pay ordinary income tax on the balance, on which you can use 10-year income averaging. In certain circumstances where taxes would work out lower, you can elect to take the whole amount as ordinary income and use 10-year income averaging.

Working for government

The average employe worked until May 6 just to take care of the tab for federal, state and local taxes. Put in terms of an eight-hour day, calculates the Tax Foundation, the bite for taxes is 2¾ hours—way more than any other item in the family budget, including housing and household operations (a little under 1½ hours) and food and beverages (a little over one hour).

Consulting agreement

With the change in mandatory retirement age, effective Jan. 1, many executives will be weighing the pros and cons of retirement at 65. If they nail down a consulting arrangement that does not involve loss of Social Security benefits, both employer and employe can work out a mutually advantageous contract. If the agreement can be interpreted adversely to the employe, he can lose a valuable tax break when he retires. Here's a recent case in point.

A bank agreed to pay $1,000 monthly to Mr. Barnett, a retired executive, for his consulting services as an independent contractor, provided he did not perform similar services for any business that competes with the bank in its local area. While Mr. Barnett actually performed services only for the bank, there was a clear understanding that he expected to be available to perform similar services beyond the local area.

Thus, Mr. Barnett was held liable for self-employment taxes, even though there was no evidence that he did actually hold himself out to other businesses as engaged in selling his services. *(Barnett, 69 TC No. 48).* ■

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Stewardesses win N.Y. case

WASHINGTON—The Supreme Court last month upheld a lower court ruling barring United Airlines from imposing mandatory maternity leaves on pregnant stewardesses based in New York State.

The court declined to review a New York state court decision that United violated New York's sex-discrimination law by requiring its stewardesses to go on leave once they learn they are pregnant.

United contended that the state court ruling clashed with a federal appeals court decision that the airline's forced leave policy was justified since pregnancy "could incapacitate a stewardess in ways that might threaten the safe operation of aircraft."

But the New York State division of human rights, whose position was upheld by the state court, maintained that the federal appeals court hadn't decided that all pregnant flight attendants presented a risk to flight safety.

The state contended that United would not be required to retain for flight duty any stewardess "whose pregnancy has been medically certified to be disabling or to constitute a risk to safety."

The New York decision requires United to permit a pregnant stewardess flying in and out of New York to work until the 20th week of pregnancy if her physician certifies that her working would not be a hazard to health or safety. ■

around the states

Pa. doctors must buy insurance from approved firm

HARRISBURG—Medical malpractice insurance must be purchased from a Pennsylvania licensed or approved insurer in order for the health care provider to comply with the state's cumpulsory insurance requirement, a bill passed by the state's legislature says.

The Pennsylvania insurance department had been concerned some health care providers were doing business with substandard insurers which, not approved by the state, could be underreserved or poorly run, the department said.

In the same legislation, the state's joint underwriting authority (JUA) was authorized to extend medical malpractice insurance to protect the assets of professional associations, corporations and partnerships in addition to the personal assets of individual doctors.

Meanwhile, the state's medical malpractice law establishing arbitration panels to hear professional liability claims was upheld by the state supreme court.

Cities study options

ST. PAUL—The League of Minnesota Cities is studying the feasibility of self-assuming property, liability and workers compensation risks.

The St. Paul consulting firm of William Peet Co. is investigating alternatives for the league, including self-insurance, creation of a municipal owned insurance company or a combination of these and other approaches.

Most Minnesota cities now purchase insurance in the commercial markets, the consulting firm said.

Surcharge eliminated

TOPEKA—The 8% surcharge on workers compensation insurance underwritten by the Kansas assigned risk plan was eliminated this month, providing the 2,600 employers in the pool with a $320,000 savings.

The surcharge was applied "to prevent unnecessary growth of the plan," insurance commissioner Fletcher Bell said. "Since this was no longer being accomplished, there was no reason to continue its existence and I therefore requested its elimination," he explained.

The assigned risk plan, which provides employers who can't find a commercial insurer with workers compensation insurance, earned $4 million in premiums in 1977.

Printers don't libel

PORT WASHINGTON—Printers can't be held liable for editing their clients' copy, a Wisconsin circuit court judge ruled in dismissing a $75,000 libel suit against the printer of a controversial magazine here.

Port Publications Inc. had "no legal duty to scrutinize the contents of TakeOver (magazine) before printing it," the judge said. "Imposition of such a duty could lead to the questionable result that contract printers would become censors of our information," he reasoned.

Work comp rates

RALEIGH—The North Carolina Rate Bureau has filed for a 19.8% increase in the overall rates for workers compensation insurance to take effect March 1.

A 28.4% rate increase effective Feb. 1 was the first increase in rates since 1972. The most recent rate increase request is based on underwriting losses totaling $47 million in 1976 and 1977, the rate bureau said. The increasing cost of medical care, disability benefits and death benefits demand the rate increases, the bureau added.

Malpractice reforms

SACRAMENTO—The California legislature's joint committee on tort liability is considering a proposal to create an assigned risk plan for physicians unable to obtain malpractice insurance.

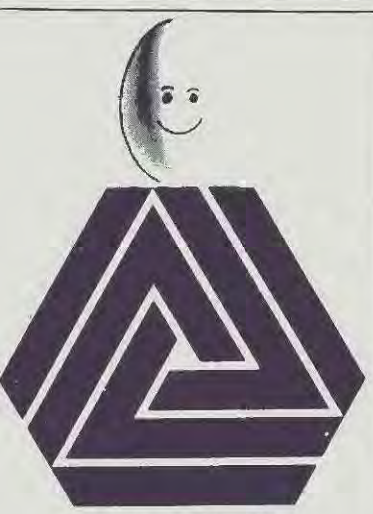
The committee is also considering staff proposals including: requiring tort suits be tried in two parts, the first on liability and the second to determine damages; requiring arbitration awards, settlements or judgments exceeding $30,000 instead of $3,000 be reported to the state to promote settlements, and mandating that medical malpractice insurance policies expressly state whether coverage extends to punitive damages.

Product liability

HARTFORD—The number of product liability cases filed in federal court in Connecticut in fiscal year 1978 leaped 40% over the previous fiscal year.

In fiscal year 1978, which ended June 30, 87 product liability cases were filed in the state, according to a report issued by the administrative office of the U.S. Courts; in fiscal year 1977, only 62 product liability cases were filed.

The 40% increase in number of cases filed in Connecticut was the biggest percentage increase for any major Eastern state. ■



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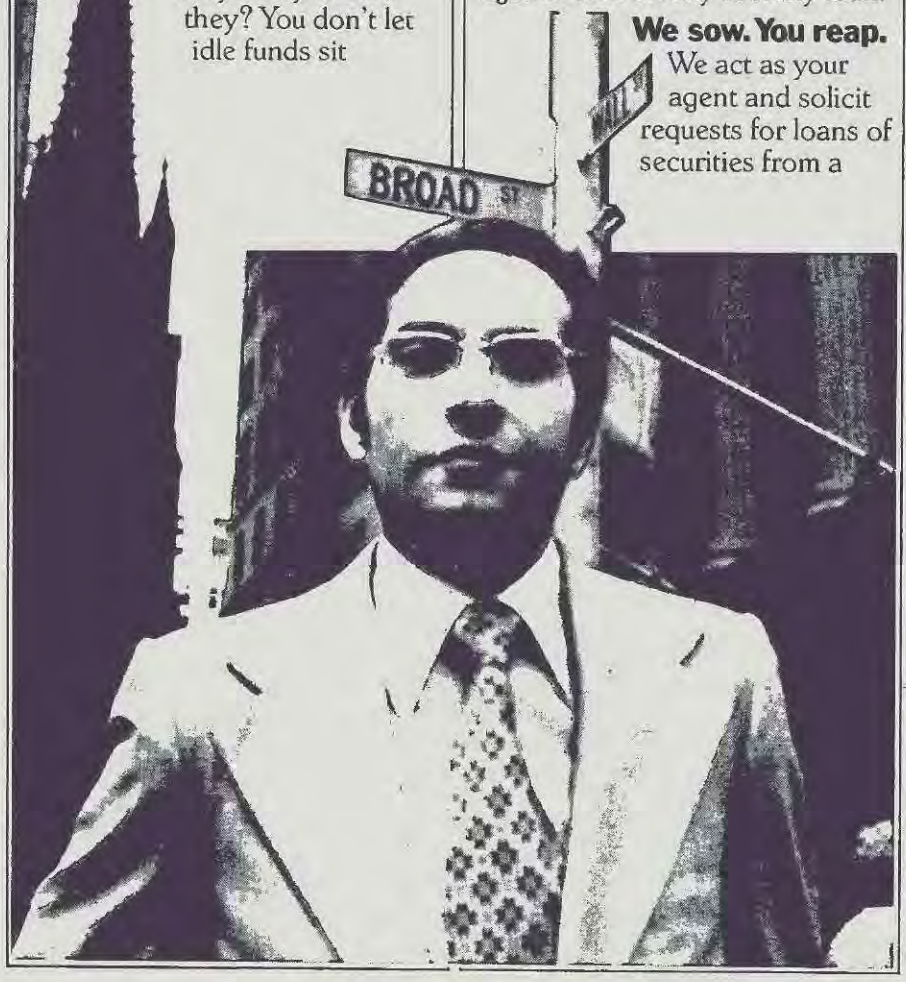

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Lloyd's official opposes price cutting

By JOHN H. MILLER

LONDON—Non-marine underwriters at Lloyd's have been warned against price cutting during the next 12 months particularly if their likely rise in capacity is not matched by adequate growth in premium volume.

But insurance buyers are assured by Murray Lawrence, chairman of Lloyd's Non-Marine Assn., that their own business relations with the U.K. market will be unaffected.

"The security of policies is inviolate," he emphasized to *Business Insurance* after confirming that he had spoken frankly to underwriters at their annual meeting attended by 80 to 90 non-marine risk placers. "So there is no likelihood that any particular market problems will impinge on buyers of insurance as far as Lloyd's is concerned. But the market needs reminding in its own right, both as it affects brokers and also underwriters, of the need to maintain its own standards of good faith among themselves so that everything goes well," he said.

Incidents in recent months have drawn increasing attention to the Lloyd's market. Mr. Lawrence felt it prudent to tell the Lloyd's Non-Marine Assn., "The temptation to cut corners is very likely to increase with the continuing growth in capacity. I believe that most of the problems that have arisen in the last 12 months have little to do with any shortcomings in our set-up or in the way in which we are organized.

"But they have a lot to do with failure to conduct our business to the highest standards of utmost good faith on which we have prided ourselves over the years. It needs the utmost vigilance on the part of the whole market so that any attempt to lower our standards is contained and isolated.

"If those involved are not prepared to discipline themselves properly, they can only blame themselves if there are moves to impose a code from outside," he warned.

Capacity in the non-marine market will outstrip demand for the time being, Mr. Lawrence believes. Inevitably more people will be trying to "have a slice of the cake" and this is where problems of good discipline can arise, he said.

Improved U.S. results

LONDON—Leading U.K. insurance companies are reporting much better results from their U.S. operations this year, particularly in property lines.

Commercial Union cut its operating ratio for the first nine months to 99.4% compared with 101.2% for the similar period last year and turned a $2.8 million underwriting profit so far on its U.S. account against a near-$10 million loss at the same time last year. Property lines are showing particularly helpful results, according to its reports, which indicate improved business for the group both in Britain and many other world markets.

Royal Insurance reports "all major lines showing improvement" in the U.S., again with higher profits in property classes, while losses were reduced in auto, liability and workers compensation in the U.S.

General Accident faced a third quarter ratio of 95.5%, with all lines except workers compensation showing improved results.

Dutch "bourses"

AMSTERDAM—Moves to set up the New York Insurance Exchange are welcomed in Holland, where two domestic "bourses" or insurance exchanges have operated for nearly 400 years.

The influence of the exchanges, located in Amsterdam and Rotterdam, has declined over the centuries as they tended to become convenient markets for ordinary company business. Lloyd's of London, although begun later kept its individual structure.

Now there are hopes that the Dutch centers may attract increased capacity, especially if they are able to merge, and in turn play a greater role in both the domestic and international markets.

The NRG quarterly review, produced by the Nederlandse Reassurantie Group of Amsterdam, comments, "The fact that a brand new insurance exchange is being started in New York may herald similar initiatives elsewhere and could lead to a general revival of this way of transacting some kinds of insurance business."

Premium volume passing through the two Dutch insurance exchanges is between $600 million and $750 million a year, with British and other foreign companies writing two-thirds of the business and the rest domestic companies.

Mergers of insurance corporations in recent years have decreased the number of underwriting authorities working at the bourses to about 120, representing 50 brokers, 50 agency firms, and 20 direct operating insurers.

Nederlandse Reassurantie, one of the largest Dutch insurers, reflects the view of many that the erosion of the bourses will continue unless counter-measures are taken.

Largest towing risk

LONDON—Insurance cover taken out with Lloyd's and other insurers on a $240 million marine risk by the U.S. industrial group Universe Tankships Inc. will end early-1979 when a pulp plant built by a Japanese shipyard is formally handed over in the River Amazon.

It is the biggest towing risk of its kind, involving a 13,000-mile trip across the world to Brazil.

The tow itself was completed earlier this year, but marine insurers are responsible for the structures until they are finally accepted on the site which they will ultimately occupy.

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legal briefs

Child born out of wedlock wins work comp award

AN INDIANA APPELLATE COURT has held that the workers compensation statute, insofar as it denied benefits to an illegitimate posthumous child because a requirement of the father's acknowledgment was not met, was unconstitutional as denying equal protection.

The state industrial board had determined that the decedent was the father of a child born eight months after his death resulting from a compensable accident. The decedent and the child's mother were not living together. However, they had known each other for about four months prior to his death and were planning to marry and to get their marriage license on the Saturday of the week he was killed.

Furthermore, it was established that the decedent and the child's mother had had sexual relations and she had not been dating anyone else. At the time of his death, the decedent was unaware that his fiance might be pregnant. The mother's claim for compensation on behalf of the child was denied because under Indiana law the father was required to acknowledge the child as his to qualify as a dependent.

The appellate court concluded that the requirement of acknowledgment violated the equal protection clause of the 14th Amendment. According to the court, the law classified children for purposes of presumptive dependency under workers compensation as unacknowledged illegitimates on the one hand (therefore not presumed dependent) and legitimates or acknowledged illegitimates on the other hand (therefore conclusively presumed dependents) which was constitutionally unreasonable. *Anonymous Child* v. *Deceased Father's Emp.*, Court of Appeals of Indiana, June 20, 1978 (BI/01/J.-$4).

Accident insurance

A principal issue in this case before a federal court was whether the operation of a hang kite constituted piloting an aircraft within the meaning of an exclusion clause in a group accident and dismemberment policy. The court ruled that the exclusion applied.

Patricia Wilson sought to recover benefits under a group policy that Insurance Company of North America (INA) issued to her as an employe of Fairchild Camera. She was the named beneficiary in the policy in the event that her husband should die as the result of an accidental death. Although Mrs. Wilson never received a certificate of insurance or a copy of the policy, she had received the informational brochure. The policy excluded "travel or flight in any vehicle or device for aerial navigation." The informational brochure said that benefits were not payable for losses when piloting an aircraft.

Mrs. Wilson's husband was killed when his hang kite failed to break his fall from a high cliff. The kite he operated was patterned on a parachute in contrast to hang gliders designed like a wing. INA denied coverage asserting that the activity Mr. Wilson was engaged in at the time of his death came within the aerial navigation exclusion.

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

The court noted that generally an insurer cannot claim a defense of an exclusion when the employe never received a copy of the policy and the coverage is more limited than that afforded by the certificate or by the brochure. However, in reviewing the language of the policy and the brochure, the court believed that difference in language here was merely one of semantics. "That the terminology of the policy exclusion," the court said, "may be broader than that of the brochure exclusion does not necessarily mean that the coverage afforded by the policy is more limited than that afforded by the brochure." The court was satisfied that Mr. Wilson's activity at the time of his death was not covered by the policy. *Wilson* v. *Insurance Co. of North America*, United States District Court for the Northern District of California, June 6, 1978 (BI/02/J.-$4).

"Fortuitous" defined

This case involved judgments exceeding $1.6 million in favor of two insureds against the Kansas City Fire and Marine Insurance Company (insurer) under an all risks policy after the collapse of an underground storage facility under construction.

A federal appellate court ruled that when past experience indicated that the particular design for the facility would be satisfactory, and it was not for some reason which was uncertain, a fortuitous event occurred within the loss provision of the contract not excluded

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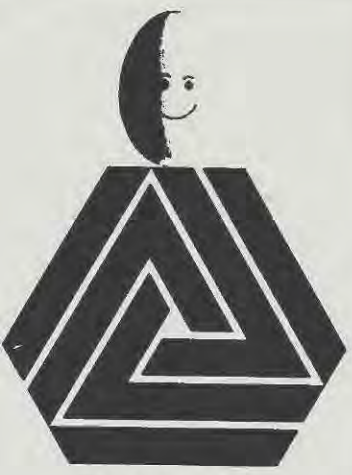

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Legal briefs . . .

Continued from preceding page
by a "deficiency in design" clause.

The contractor and owner of the facility acquired an all risks insurance policy from the insurer. The policy excluded as a peril not insured loss resulting from "error, omission, or deficiency in design . . ." The cavern collapsed during the night and there was no obvious earthquake, explosive sound or other unusual phenomenon.

The contractor, a pioneer in the construction of underground storage caverns, had built 70 of them throughout the world. The design here, and the shale condition encountered, was similar to 31 other installations the contractor had made. The insurance company refused to pay a claim for damages asserting that the loss resulted from a peril not insured. A jury awarded recovery to the construction company and owner.

The appellate court said that under an all risks policy the insured must prove that a loss occurred and that it was due to some fortuitous event. According to the court, a fortuitous event is one which, so far as the parties to the contract are aware, is dependent on chance. The insurance company had argued that the evidence only supported a conclusion of a deficiency in design and that no "external" cause of collapse was established. In the context of this case, the court said that it was difficult to see what risks the insurance company was insuring against if its position was upheld.

Texas Eastern Transmission Corp. v. *Kansas City F. & M. Ins. Co.*, United States Court of Appeals for the Tenth Circuit, June 23, 1978 (BI/03/J.-$4).

Death ends disability

The Court of Appeals of Kentucky has ruled that state law did not authorize the continuation of permanent disability benefits to dependents of a claimant following his death from causes unrelated to his work.

In November 1974 Raymond Silvers filed a workers compensation claim for injuries sustained while in the employ of the Marley Co. Before this was decided, Mr. Silvers died and his widow was substituted as a claimant on behalf of herself and three minor children.

Subsequently, the compensation board determined that Mr. Silvers was 100% occupationally disabled from his injuries but declined to award income benefits because his death was found not to be work-related. However, the board ordered benefits to be paid for a period during widowhood not to exceed the life expectancy of Mr. Silvers. The trial court reversed and denied any award.

The appellate court recognized that under Kentucky law where an employe has sustained disability compensable under the law, benefits will continue to certain named dependents in case of death from other causes for the period specified in the law. The wife argued this should be interpreted as meaning for a period of life expectancy of a deceased workman.

However, the court said that the key to the determination was that a period of disability lasts only so long as the results of the injury "and they certainly terminate upon death. To hold otherwise," the court said, "would convert any workers compensation benefits subsequent to the non-work-connected death of life insurance benefits." According to the court, the law did no more than provide a mechanism whereby the death of one disabled does not prevent the collection of the benefits for disability sustained until the time of such death. *Silvers* v. *Marley Co.*, Court of Appeals of Kentucky, January 13, 1978, *rehearing denied* April 7, 1978, *discretionary review* denied June 27, 1978 (BI/04/J.-$4).

Professional liability

This was a case of first impression in Iowa raising the question of whether there is a duty to defend, under a professional liability insurance policy, against a claim of a fraudulent or dishonest act when the policy excludes liability coverage for such acts. The Supreme Court of Iowa concluded that under these circumstances an insurer has no duty to defend.

John L. Chipokas, an attorney, was covered under a professional liability policy issued by The Travelers Indemnity Company (Travelers). The policy required Travelers to defend any suit based on acts or omissions of Mr. Chipokas even if such suits were groundless, false or fraudulent. An exclusionary clause stated, however, that the policy did not apply to any "dishonest, fraudulent, criminal or malicious act or omission . . ."

While the policy was in force, Mr. Chipokas was named as a defendant in a lawsuit brought by the heirs of a deceased client. That suit claimed that Mr. Chipokas fraudulently conspired to force the signature of the deceased client to a will. Travelers refused when Mr. Chipokas requested that they defend him. Mr. Chipokas retained counsel to represent him, won the suit and sued Travelers to recover the fees and costs expended in that defense. The trial court ruled for Travelers.

On appeal, Mr. Chipokas based his argument on the contract language which obligated Travelers to defend groundless, false or fraudulent claims. Travelers contended that its duty to defend was only as broad as the liability protection of the policy. The appellate court, noting that the question had not previously been addressed in Iowa, reviewed the authorities from other jurisdictions. The court concluded that it agreed with the majority of jurisdictions which do hold there is no duty to defend against a claim wholly outside the liability coverage. *Chipokas* v. *Travelers Indem. Co.*, Supreme Court of Iowa, June 28, 1978 (BI/05/J.-$4).

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(Copies of the entire decision may be obtained by sending a check for $4 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.)

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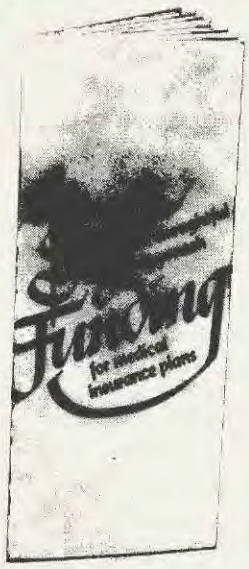

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Retired workers can earn more

A worker retiring at age 65 this year will be allowed to earn $4,000 by working and still receive full Social Security pension benefits, reports the American Council of Life Insurance.

In 1977, a retiring worker could only earn an additional $3,000, says the Council, but Congress amended the Social Security laws to permit retired workers to better themselves financially after retirement. By 1982, Social Security beneficiaries will be permitted to earn up to $6,000 in addition to their other benefits.

Meanwhile, people who retire early at age 62 can earn $3,240, notes the Council, and this amount will be increased each year, though at a slower rate than for workers who retire at age 65. ■

INA joins Danes

INA Corp. has formed a new Danish property/casualty insurance subsidiary, INA Forsikrings Aktieselskab, headquartered in Copenhagen, as part of its expansion of international facilities.

Only 4 states increase work comp benefits in 1978

WASHINGTON—Workers compensation benefit maximums were increased in only four states this year—Connecticut, Georgia, Missouri and Nebraska—reports UBA Inc., a research and education organization specializing in workers compensation and unemployment compensation.

However, 42 states now use "escalator" provisions to automatically adjust benefit maximums according to changes in the state average weekly wage, UBA notes.

In its fall up-date of changes in state workers compensation laws, UBA also says five states increased or expanded their allowance for medical expenses and "occupational disease provisions were liberalized in a couple states."

At least 27 states made no changes in their workers compensation laws.

Attention is now focused on Florida, which repealed its workers compensation act effective July 1, 1979 to force a complete review and redrafting of the law by next July. Ohio lawmakers are also still considering amendments to that state's workers compensation law.

A state-by-state summary of major legislative changes in state workers compensation laws, prepared by UBA from information available November 9, follows:

ALABAMA Adjourned. No changes.

ALASKA Adjourned. No changes.

ARIZONA Adjourned. No major changes.

CALIFORNIA No major changes expected.

COLORADO Adjourned. No major changes.

CONNECTICUT Adjourned. Maximum weekly benefit payable in death and disability cases was increased to 85% of the state's average weekly production wage from 66⅔% (effective 1/1/79). The off-set against death benefits for disability benefits paid when death occurs more than two years after injury was eliminated. Amended law provides that an employe injured due to a failure on the part of the employer to correct a cited OSHA violation within the prescribed time may receive compensation equal to 75% of his average weekly earnings at the time of the injury (effective 10/1/78).

D.C. No major changes expected.

FLORIDA Adjourned. Amended law changed the mandatory coverage from employers with one or more employes to employers with three or more employes. Amended law changed the number of weeks on which permanent partial benefits are calculated for "other cases" (body as a whole) as follows: (1) 1% through 10%—equivalent percentage of 175 weeks; (2) 11% through 50%—equivalent of 525 weeks. The legislature provided for a joint committee to study specific phases of the workers compensation law. The committee is to report to the legislature on March 1,1979 and make recommendations for changes. To be sure this is accomplished, the legislature repealed the workers compensation act in its entirety effective 7/1/79.

GEORGIA Adjourned. Total disability benefit maximums were raised to $110 from $95 and partial disability benefit maximums were increased to $80 from $70. Amended law provides for rating disability according to the "body as a whole." The overall limitation of $24,500 for temporary partial disability payments was eliminated. The time in which claims may be filed was expanded from one year from date of accident to one year from either the injury or of employer-furnished remedial treatment, or within two years of the last payment of benefits. A requirement that an employer maintain a list of three physicians from which employes are to select was added. Amended law provides for the assessment of attorney's fees against an employer who fails to comply with the new requirements for the timely payment of benefits for uncontroverted claims.

HAWAII Adjourned. No major changes.

IDAHO Adjourned. The rehabilitation program under the Industrial Commission was reinstated. The system of computing permanent partial benefit levels was replaced with one providing for a set number of weeks of benefits for enumerated injuries. Limitation for replacement of prostheses that restricted replacements to no more frequently than once every five years was eliminated. Amended law provides that all providers of medical service must assist with rehabilitation and inform the Commission if the employe is unable to return to his former job. The burial allowance was increased to $1,500 from $750.

ILLINOIS No major changes expected.

INDIANA Adjourned. No changes.

IOWA Adjourned. No major changes.

KANSAS Adjourned. No changes.

KENTUCKY Adjourned. No major changes.

LOUISIANA Adjourned. No major changes.

MAINE Adjourned. No major changes.

MARYLAND Adjourned. No major changes.

MASSACHUSETTS Adjourned. Death benefits were increased to a maximum of $110 per week plus dependency allowances from the present $55 per week plus six dollars per dependent child. The maximum payment for death benefits, except when the surviving spouse is not fully self-supporting, was raised to $32,000 from the present $16,000.

MICHIGAN Adjourned. No changes.

MINNESOTA Adjourned. No

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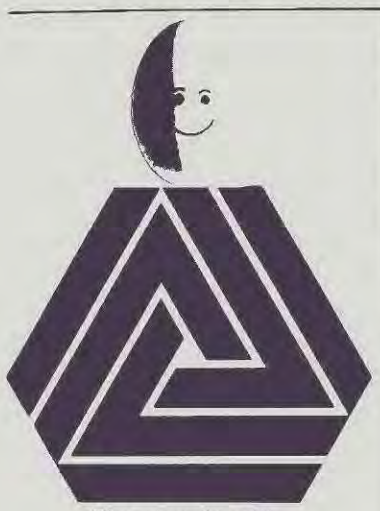

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Workers comp . . .

Continued from preceding page
major changes.

MISSISSIPPI Adjourned. No major changes.

MISSOURI Adjourned. Maximum weekly benefit payable in death, permanent and temporary total and temporary partial disability cases was increased to $115 from $95 and permanent partial maximum benefits were raised to $90 per week from $80. Amount limits payable were increased accordingly.

NEBRASKA Adjourned. Maximum weekly benefits payable in death and all disability cases were raised to $155 per week from $140. Law was also amended to provide for dental appliances, hearing aids, and eyeglasses if personal injury accident occurs and for the replacement of artificial members destroyed in work accidents and for plastic surgery (but not cosmetic surgery per se).

NEW JERSEY No major changes expected this year.

NEW MEXICO Adjourned. No major changes.

NEW YORK Amended law provides for the payment of survivors' benefits to a fulltime student to age 23 and the burial allowance was raised to $1,250 from $750.

NORTH CAROLINA Adjourned. Short 30-day session with no changes.

OHIO More than even chance that law will be amended as follows: Temporary total disability will be paid at the rate of 72% of employe's average wage for first 12 weeks of disability then revert to the present 66⅔% after 12 weeks; temporary partial cumulative maximum will increase to $17,500 from $12,500—benefit rate would continue at 66⅔% of impairment of employe's earning capacity; permanent partial weekly maximum will be escalated, based on 33⅓% of the statewide average weekly wage ($72 a week based on present SAWW) instead of existing flat $56 maximum; compensation will be paid for first week of temporary total disability when employe is totally disabled for at two weeks instead of present three week qualifier; eliminate the present requirement that eyeglasses, artificial teeth, and hearing aids damaged during employe's accident be in place in order to qualify for repair or replacement permit appeals to court in cases involving occupational disease claims; require that employe be given reimbursement of expenses for lost time and any wage loss when employer requests medical exam; some statute of limitations provisions be expanded and state fund employers could get a reduction in premiums for early payments.

OKLAHOMA Adjourned. No major changes.

PENNSYLVANIA No major changes expected.

PUERTO RICO Adjourned. No major changes.

RHODE ISLAND Adjourned. Adopted a cost of living "escalator" for second injury fund benefits.

SOUTH CAROLINA Adjourned. The $40,000 amount limit payable in death and disability cases was deleted, but 500 week limitation was retained.

SOUTH DAKOTA Adjourned. The "Subsequent Injury Fund" was amended to allow employer reimbursement for second injuries resulting in either permanent partial disability, permanent total disability or death. The compensation payable for permanent disfigurement was revised to provide for a formula based on the relationship of the disfigured portion of the body to the body as a whole. The time period for which an employe must make a claim was extended to two years from last payment of compensation or medical expenses from two years from date of injury or death.

TENNESSEE Adjourned. Burial allowance was raised to $1,250 from $750.

UTAH Adjourned. No changes.

VERMONT Adjourned. Hearing aids were added to the employe's entitlement to medical attention. The distinction between widows and widowers who are the surviving spouse was deleted. The limitation on a spouse's right to compensation in the event of re-marriage was eliminated. The 330 week limitation in cases of permanent partial disability was eliminated. The burial allowance was increased to $1,000 from $500.

VIRGINIA Adjourned. No major changes.

WEST VIRGINIA Adjourned. Amended law provides for benefits based on 70% of worker's former earnings (formerly 66⅔%), first three days of lost time will be payable if disability lasts eight days (formerly 15 days); benefit will be paid to surviving students to age 25 (formerly 23); scheduled hearing loss awards were increased; and amended law provides for a 5% permanent partial disability award for occupational pneumoconoisis without impairment.

WISCONSIN Adjourned. No major changes in 1978. Major amendments were adopted in late 1977.

WYOMING Adjourned. Short session with no changes. ■

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Midwest firm shows a film to sell risks

CLEVELAND—Diamond Shamrock Corp. thinks it's a good idea to show a film about the company to its excess liability underwriters.

The company's insurance department regards the two-year-old film, made by the public relations department for many uses, as a risk selling tool, according to insurance manager D. M. Purdy.

Although he has no figures to prove that the 45-minute, color film has actually moderated rate increases for excess liability coverage, Mr. Purdy believes the movie is an effective way to tell underwriters that Diamond Shamrock doesn't deserve the highest insurance rates.

The movie gives a thorough description of each of Diamond Shamrock's units, detailing their operations and products, Mr. Purdy said.

Normally, the insurance department uses the film when its excess liability coverage is up for renewal. Mr. Purdy noted the movie was shown to a Lloyd's broker when he was in town and it has been shown to various domestic primary insurers.

"In fact, we show it whenever we can," he said.

In addition to the film, pictures of plan properties and details about each unit are presented to the underwriters. Together, the insurance manager believes, they convey a sharp picture of what Diamond Shamrock is all about. Underwriters do learn from the film, because they ask questions when it ends, he said.

"I think they really appreciate this type of presentation," he asserted. "It enables them to see something and breaks the normal pattern when all they do is listen to a broker talk."

Because he is so certain that the film is making a positive contribution to his company's excess liability coverage, Mr. Purdy regards it as a permanent part of his inance department. ■

Employer nudge sways Labor Dept. on benefit rules

By JERRY GEISEL

WASHINGTON—The Labor Department is considering a phase-in period for employer compliance with final regulations on how much companies can reduce benefits for workers over 65, *Business Insurance* learned.

At the same time, the Labor Department is considering a series of revisions to its rules governing proposed benefit cutbacks based on the hundreds of comments it received from employers, insurers, brokers and consultants.

The final regulations, expected by the end of the month, also will provide a clear answer on whether employers have to give credit in pension plans for pay increases earned after age 65. Earlier proposed guidelines failed to provide a clear-cut answer, causing considerable anxiety in the benefit community.

Employers say a phase-in period is crucial because time is needed to amend their benefit plans to comply with the final regulations.

The earlier proposed guidelines, published in September, touched off howls of protests from business groups (*BI*, Oct. 2).

"Adoption of the proposed interpretations would create an administrative nightmare and is likely to lead to considerable litigation," warned B.J. Freeman, vp-personnel at Days Inns of America. "The vast majority of existing employe benefit plans will need to be revised to conform to these regulations," he said in written comments to the Labor Department.

Guidelines to implement the law raising the mandatory retirement age to 70 limit cutbacks in life insurance, medical benefits and long term disability coverage for workers staying on the job past 65. Most benefit managers planned to slash benefits.

Employers objected most in their written comments to the Labor Department's twin proposals concerning long term disability benefits.

The first alternative would not permit cutoff of any long term disability benefits before age 70. Under the second alternative, companies could stop benefits at age 65 for an employe who became disabled before reaching 60.

For workers who become disabled after 60, disability benefits could continue for up to five years or until the employe reaches age 70, whichever occurs first.

Some employers warned that if either alternative is adopted, serious abuses could result. "We could expect a great number of alleged disabilities running past age 65 to age 70," said Consolidated Aluminum of St. Louis, Mo.

Older workers might allege that they are unable to work so they can collect disability benefits equaling two-thirds of salary, as well as Social Security benefits, he believes.

Unless the Labor Department's long term disability benefit proposals are revised, older workers could make more money by not working than working, Consolidated Aluminum predicted.

It isn't necessary to provide payments for total disability to workers over 65 because of the availability of pension plan benefits and Social Security, said Miles Laboratories Inc. manager of insurance and employe benefits F.C. Ahlborn.

Miles Laboratories plans to continue short term disability benefits (up to six months) for all employes, regardless of age, but older workers who couldn't return to the job at the end of the six-month period would be required to retire. Mr. Ahlborn urged the Labor Department to allow employers to terminate long term disability benefits as soon as an older worker is entitled to unreduced benefits from a corporate pension plan.

It's illogical to provide disability benefits beyond the date when an employe has passed into retirement status and is eligible for unreduced pension and Social Security benefits, said David Haskin, vp-personnel at Dayton Hudson Corp. in Minneapolis. He suggested a 12-month maximum on disability payments for older workers.

It is crucial to place some kind of limitation on disability benefits for older workers, he added, since mandatory retirement probably will be abolished one day. "It is im-

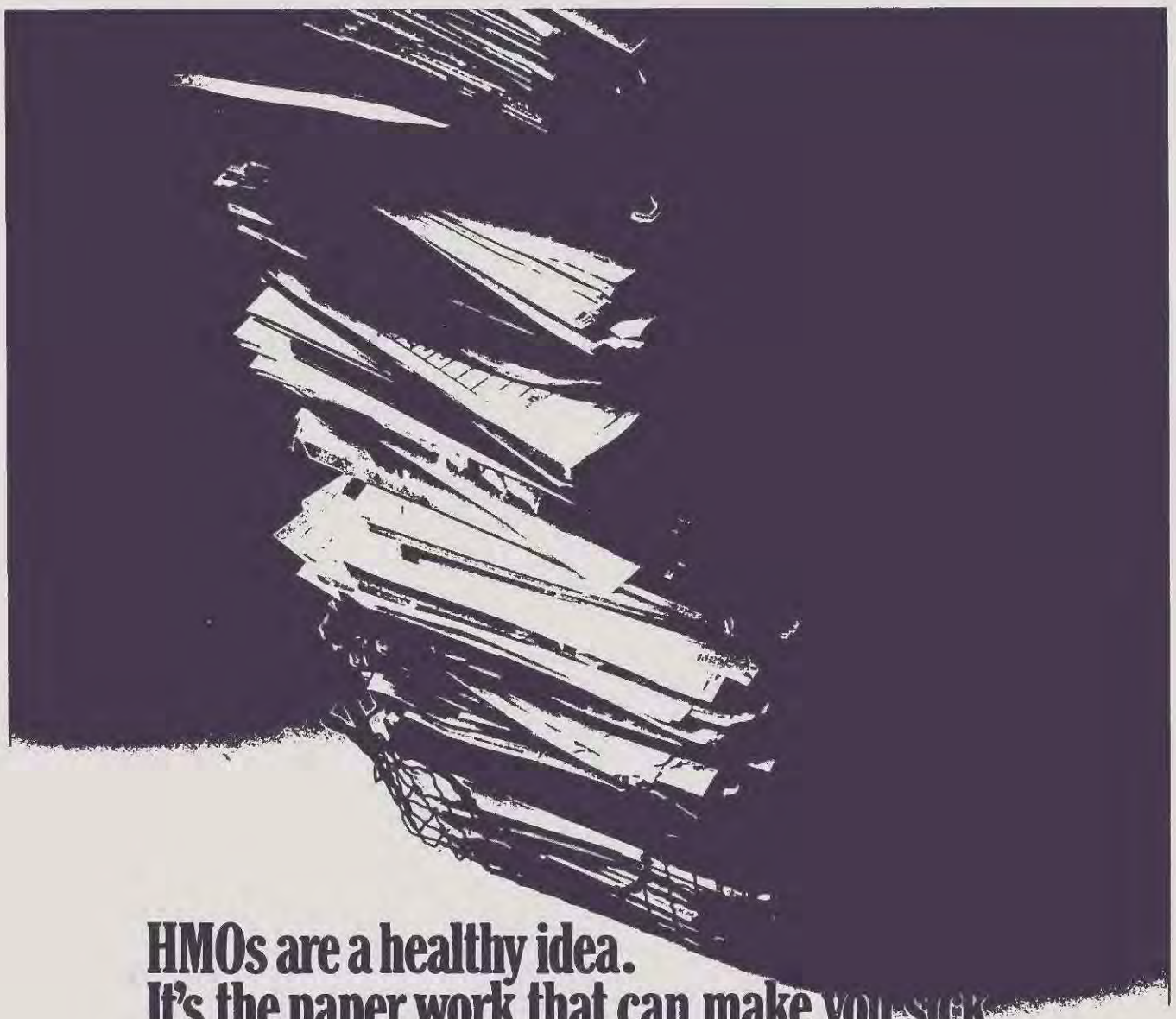
Continued on following page

Firms doubt law's impact

NEW YORK—Some employers believe the higher mandatory retirement age law will have little impact on their employe benefit plans.

So says The Conference Board, a business-research organization based here, following a recent survey of corporate personnel officers nationwide. Generally, these executives doubt the new law will disrupt their benefit plans.

The personnel officers' lack of concern is prompted by the tendency for workers to retire before age 65, a trend they feel is likely to continue despite the new law. In the companies the Conference Board surveyed, employes are frequently retiring well before 65, with 62 being the typical retirement age.



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SEE OUR AD ON PAGE 6

Benefits after 65 . . .

Continued from preceding page
portant that we control the mushrooming liability of escalating disabilities at advanced ages."

J.R. Storey, director of personnel at The Maytag Co., told the government older workers might be motivated to claim they are disabled rather than retire because long term disability benefits normally are larger than retirement benefits, continuing to accumulate years of service toward a pension though not actually working.

Labor Department guidelines would allow employers to reduce medical coverage as long as Medicare, which begins at 65, would compensate for the reduction in employer-paid benefits.

However, benefit experts have warned that employers would be expected to pay the individual's Part B Medicare premium since the proposal says older workers cannot be required to contribute more for benefits than their younger counterparts. Part B Medicare now costs $8.20 a month per employe. Towers, Perrin, Forster & Crosby, the national consulting firm, claims it could be against the public interest to require employers to pay the Medicare premium for their employers.

"The premium payments, are, in a sense, a tax designed to ensure that users of the program help to defray costs. It would be poor public policy (as well as a dangerous precedent) to require employers to undertake to pay employes' taxes," TPF&C said.

Attorney David Raish, representing the National Assn. of Independent Schools, implored the government to provide answers on two vital issues affecting defined benefit pension plans. Labor Department guidelines fail to establish applicable rules for cases when the terms of a defined benefit plan are amended after an employe has reached "normal retirement age."

For example, a plan providing a monthly pension of $2 per month for each year of service may be amended to pay $3 per month for each year of service. "Would this benefit increase have to be given to workers over 65?" Mr. Raish asked the Labor Department.

The legislative history of the higher mandatory retirement age clearly shows that employers should not have to extend increased benefits to employes who have reached normal retirement age at the time the benefits are increased, Mr. Raish asserted.

The government also must clarify whether employers have to give pension credit for pay increases earned after age 65, Mr. Raish urged. Credit for pay increases over 65 directly affects pension plans in which final benefits are based on the average highest salary over a certain number of years.

"We submit that the new legislation permits employers to freeze retirement benefits at age 65 notwithstanding subsequent pay increases," Mr. Raish said. The intent of legislation raising the mandatory retirement age bars credits for salary increases after age 65 in determining pension benefits, he believes.

The guidelines said employers could reduce life insurance coverage by 8% a year beginning at age 65 to cover the increased cost of this benefit for older workers. Most employers said the 8% annual reduction is too low and would like to be permitted to reduce life insurance coverages by 50% for workers over 65. This has been a common provision in corporate benefit plans.

The Labor Department said employers could reduce benefits for older workers by more than the guidelines allow if they could furnish economic proof that the cost of providing these benefits for the over-65 group is excessive compared to the cost of the same benefits for younger employes.

Beginning next July, this economic justification would have to be turned over to the Equal Employment Opportunity Commission which has jurisdiction over age discrimination cases.

Corporations should also be allowed to make age-based benefit reductions if there are legitimate economic or business reasons making reductions necessary, asserted Ford Motor Co.'s J.R. Jackson, general counsel for industrial relations. ■

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U.S. reinsurer premiums hit 28-year high

WASHINGTON—U.S. insurance companies received more than $820 million in net reinsurance premiums for coverage sold in foreign countries in 1977, the largest amount reported in 28 years, but still less than was paid out to foreign reinsurers by U.S. companies.

U.S. firms reinsuring foreign risks received net premiums of $822.5 million, paid out $633.4 million in losses and had net receipts of $189.1 million, said the Commerce Department in an annual report on international reinsurance transactions.

At the same time, U.S. insurance companies paid out more than $1.4 billion in net premiums (premiums minus commissions) to foreign reinsurers in 1977, which also was the largest amount in that category for the department's 28-year reporting period.

The lion's share of those payments, $703 million went to reinsurance companies in the United Kingdom, while reinsurers in six member countries of the European Economic Community received a total of $147 million in net premiums last year, the department said.

U.S. insurance companies recovered $633.4 million in losses on the $1.4 billion in net premiums they paid to the foreign reinsurers, resulting in net U.S. payments of $803.1 million for reinsurance of U.S. risks accepted abroad.

The Commerce Department cautioned that the reinsurance figures are meant to show the effect of reinsurance transactions on the nation's balance of payments, to indicate underwriting results of the reporting companies.

"This is especially true with the results for any single year because of the normal time lag between the payment of premiums and the settlement of claims," the department said.

Comparing the net U.S. receipts of $189.1 million with the net U.S. payments of $803.1 million, the effect of all 1977 international reinsurance transactions was a net outflow of $614 million to foreign reinsurers. In 1975, the net outflow was $271.7 million.

The insurance statistics indicate long-term trends in underwriting, with growth of U.S. reinsurance payments outstripping receipts. In 1950, the first year for which figures are available, foreign reinsurers received $129.7 million for reinsuring risks of U.S. companies. By contrast, the U.S. companies received only $17.5 million for reinsuring risks of foreign underwriters. Those figures compare with the $1.4 billion (payments) and $822.5 million (receipts) recorded. ■

First industrial state

Michigan tort reform passes; Ohio tastes defeat

By JERRY GEISEL

LANSING—The business community in Michigan scored a major victory late last month when the legislature gave final approval to a product liability reform bill.

If Gov. William Milliken signs the bill this month, as business leaders expect him to, it will mark the first time that a heavily industrialized, liberal state has enacted a product liability tort reform law.

Product liability reformers believe that with Michigan's passage of a reform bill, other industrial states might follow the precedent Michigan has set.

Product liability bills have been approved in 16 states since the current drive to change the tort law as it affects product liability began in 1977, but nearly all bills have been approved by sparsely populated relatively non-industrialized states.

While business groups were savoring their victory in Michigan, Ohio's business community was tasting the bitterness of defeat. The Ohio state senate's judiciary committee failed to take action on a tort reform measure, killing the bill there.

The key to success in Michigan was a united business community, said John Thodis, president of the Michigan Manufacturers Assn. here.

"We decided from the very beginning that we had to work together on one bill if we were to be successful," he said.

Mr. Thodis credited employers with doing their homework and furnishing legislators with hard economic facts showing the chilling effect product liability has had on corporations. He described the measure (Substitute H.B. 5689) as a "hell of a good beginning," noting, "The measure isn't perfect, but it is an important first step."

A major effort will be made next year to pass an even more comprehensive bill, Mr. Thodis said.

Under Michigan's measure, overwhelmingly approved by the senate and house, the burden of proving liability will shift to the plaintiff 10 years after the product was first put into use. In a product liability action, a defendant could introduce as evidence the fact that the product conforms with industry or government safety standards.

Defendants will also be allowed to introduce evidence that the cause of injury was a result of product alteration or modification. Under the law, a court could reduce an award to the extent that a plaintiff's own negligence contributed to an accident. Courts also could award costs and reasonable attorney's fees to the winning party if a claim or defense is found to be frivolous. The bill would bar evidence of product improvements since the accident during a trial.

The measure goes into effect as soon as it is signed by the governor.

Meanwhile in Ohio, business groups had been optimistic about the bill's (H.B. 319) chances after the house approved the measure by a whopping 86 to 7 margin in June 1977. But the tide turned in the senate when the measure was assigned to the judiciary committee, which is heavily dominated by plaintiff attorneys, instead of the more receptive insurance or small business committee. In addition, support for the bill ebbed when state labor organizations announced their opposition.

The Ohio Manufacturers Assn., a major backer of the measure, is rethinking its strategy in view of the setback. "But if we come out for another bill we'll be absolutely sure that we have the commitments we need ahead of time," a spokesman said. It won't be any easier the next time around trying to pass a bill "unless we settle for a gutted bill and we are not willing to do that," he added.

The defeated product liability bill included a 10-year limitation on product liability lawsuits. The measure also would have given manufacturers an affirmative defense against liability if an injury were the result of product alteration or modification. In addition, the burden of proving liability would have been shifted to the plaintiff if the product conformed to government safety standards.

If a new bill is introduced, it could come as early as next January when the next session of the Ohio legislature begins.

Since 1977, major product liability tort reform bills have become law in Arizona, Colorado, Florida, Georgia, Illinois, Indiana, Minnesota, Nebraska, New Hampshire, Oregon, Rhode Island, South Dakota, Tennessee and Utah. Connecticut passed a product liability bill earlier this year, but Gov. Ella Grasso vetoed the measure. ■

Feds boost insurance

The Federal Home Loan Board last month increased to $100,000 from $40,000 the maximum amount of insurance coverage for Individual Retirement Accounts and Keogh plans in institutions insured by the Federal Savings and Loan Insurance Corp. The change is the result of congressional legislation that President Carter signed boosting insurance coverage.

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SEE OUR AD ON PAGE 6

Texas firm settles jury awards for less

LUBBOCK, Tex.—Lubbock Manufacturing Co. here paid $5.74 million in settlements covered by insurance to victims of a 1975 disaster in which a gas propane tank truck overturned and exploded.

Sixteen persons were killed and dozens injured in the accident in Eagle Pass, Tex., a town of about 15,000 on the Mexican border.

Originally, 28 personal injury or wrongful death suits and four property damage suits were filed against Lubbock. Eleven of those suits were settled for $2,169,000 shortly before a Del Rio, Tex., jury awarded $50.1 million to the accident victims.

About a month after the jury verdict, Lubbock settled an additional seven suits, including the four property damage claims, for $3,575,000, according to the firm's defense attorney Damon Ball.

Insurance carriers for a second defendant, The Altamil Corp., which manufactured a fifth wheel linking the cab and the tank, settled out of court for about $5 million before the case began.

Lubbock, the manufacturer of the tank truck, is now appealing 14 suits for which a state court awarded a total of $2,672,000 and the company has not settled.

Insurance will cover all the settlements Lubbock made. Lubbock's comprehensive general liability policy with Employers Casualty Co. of Dallas, Tex., had a $300,000 limit. Above that is an excess umbrella policy underwritten by Affiliated FM of Johnston, R.I., with a $20 million limit.

The largest settlement was $1.5 million to a 16-year-old boy whose entire body was burned except for the soles of his feet and the top of his head. The jury originally awarded the injured youth $20 million.

"I think the settlements reached so far have been reasonably good," said plaintiff attorney Franklin Houser of San Antonio. But Mr. Houser said Lubbock could have saved millions of dollars in damages if it had settled the suits before the trial began last year.

Defense attorney Mr. Ball said Lubbock didn't settle because the big tank manufacturer didn't feel it was liable. Mr. Ball placed the blame for the accident on the driver of the truck who he said was speeding. The driver perished in the explosion.

The accident occurred April 29, 1975 when a tank truck loaded with a combination of propane and butane approached the outskirts of Eagle Pass.

Suddenly, the driver of tank truck veered sharply to the left on the two-lane highway, possibly to avoid a turning car in front of him. Then he cut sharply to the right to avoid the oncoming traffic.

The tanker tipped over, bounded 108 feet, struck the corner of a one-foot thick, steel reinforced, concrete headwall of a culvert and exploded, injuring and killing bystanders in the area.

The jury found that the tank was defectively designed with its center of gravity too high. As a result of this alleged design defect, the tank was "top heavy" causing it to tip over when subject to sharp turning maneuvers, plaintiffs attorneys said.

But defense attorney Mr. Ball said the design and manufacture of the tank met the regulations established by the Texas Railroad Commission, the state agency that regulates tanker design and operations.

At the trial, a team of experts from the National Highway Transportation Safety Administration testified that the tank design also was in accordance with Department of Transportation regulations, Mr. Ball said.

Attorneys for the plaintiffs said the design of the tank may have been in compliance with the regulations of the Texas Railroad Commission, but the state regulations are only minimal standards, they added. Higher standards should have been followed, they argued.

During the three-month trial that ended late last year, plaintiff attorney Mr. Houser introduced into evidence a tank design that lowers the center of gravity by 26 inches, enormously reducing the risk of the tank flipping over when sharp turns are made.

"If the particular design that we espoused was utilized in the circumstances of this accident, the tank would not have tipped over," Mr. Houser contended. ■

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Bell unit cleared in slander suit

SAN ANTONIO—Southwestern Bell Telephone Co. has been cleared by a Texas appeals court of a $3 million slander and wrongful death verdict awarded after a lower court trial in September 1977.

The company had been found guilty of slandering two former employes of Bell, James Ashley and the late T.O. Gravitt, with an improper investigation in 1974 of the two men's alleged promiscuity with subordinate employes and falsification of expense vouchers.

Southwestern fired Mr. Ashley from his executive post as a result of the investigation. Mr. Gravitt, who headed the San Antonio office, killed himself one week later although is name had only surfaced twice in the investigation. Mr. Gravitt's role was explored more thoroughly after his death.

The suit, brought by Mrs. Ashley and Mr. Gravitt's widow, sought $29 million. The lower court awarded $1.5 million in compensatory and punitive damages to each.

As reported, (*BI*, Oct. 3, 1977) Southwestern Bell, a unit of American Telephone & Telegraph Corp., is self-insured for $2 million with an excess liability policy underwritten by The Home Insurance Co.

The appelate court, in reversing the decision, said information received from Bell's investigation indicated that Mr. Ashley and Mr. Gravitt had been promiscuous with subordinate employes and that they had submitted false claims for reimbursement of purportedly business expenses.

In addition, the court said the company made inquiries only after it had received reports relating to serious wrongdoings. "Any reasonable employer would investigate such reports in order to reserve its own effectiveness," the opinion said. ■

Small cars risky

Small car drivers run twice the risk of being seriously injured or killed in crashes as drivers of larger cars. Research conducted by the University of North Carolina found that 25% of the drivers of the smallest cars are injured in auto crashes compared with 14% of drivers of the heaviest cars.

Maple Leaf's loss program cuts costs to the bone

By JERRY GEISEL

TORONTO—In risk management circles, it's understood that companies often budget insurance costs at around 2% of sales, a rule of thumb that doesn't apply at Maple Leaf Mills Ltd., the big Canadian grain, agricultural, vegetable oil and consumer food products concern.

Aggressive loss prevention techniques have paid off, holding property and casualty premiums, absorbed loss costs and the administrative expenses of running the department to an incredibly low ⅛ of 1% of annual sales.

"I'm very proud of that figure," Maple Leaf Mills risk manager Carol Caswell told *Business Insurance* during a recent interview in her 23rd floor office over looking Toronto.

Mrs. Caswell not only has been able to keep insurance-related costs down to a level that most corporations would give their eye teeth to equal, but also has been able to purchase higher coverages at lower costs.

For example, Maple Leaf Mills used to purchase a marine cargo loss policy with a $4 million limit to protect its agricultural products while being shipped.

The limit of the marine cargo policy, now underwritten by Lloyd's of London, was recently raised to $7.5 million. At the same time, Mrs. Caswell was able to win a premium reduction due to outstanding claims experience.

Purchasing more for less, when a company has $578 million in sales, 5,000 employes and lots of potential exposures, doesn't happen by itself. Maple Leaf's finely tuned risk management program reduces the possibility of losses to an absolute minimum.

Mrs. Caswell has been closely watching the product liability problems facing U.S. manufacturers. "Fortunately, product liability is not such a severe problem in Canada, but we're probably catching up," she says. Indeed, she's taken steps to meet product liability head-on before it gets out of control, by setting up product liability committees in Maple Leaf's agricultural and food divisions. Committees are now being organized in the grain and flour and vegetable oil divisions.

Members of each committee include the divisional vp, the production manager and the quality control manager along with Mrs. Caswell. The committees regularly review all operations and claims to suggest cause of problems and "remove the cause," says Mrs. Caswell.

In addition, Mrs. Caswell has reduced Maple Leaf's corporate exposure to product liability claims by increasing the limit of the firm's comprehensive general liability policy from $16 million per occurence from $6 million per occurrence. The Royal Insurance Co. supplies the first $1 million of coverage with the remaining $15 million in various excess umbrella layers.

Maple Leaf Mills has more than 160 locations across Canada and in the Caribbean. To protect its diverse facilities—flour mills, vegetable oil plants, grain elevators, poultry hatcheries and farm supply centers—Maple Leaf purchases property insurance from Northumberland Insurance Co. of Toronto. The property policy has a $40 million limit with a $25,000 per occurrence deductible and a $100,000 deductible applying to the first loss.

The Royal Insurance Co. underwrites Maple Leaf's boiler and machinery policy. This policy, currently under review, has a $2 million direct damage limit and a limit of $2 million for business interruption losses, with a $5,000 deductible.

The telephone is Carol Caswell's most valuable instrument. Almost daily, she is on the phone with Jack Vaughan, Reed Shaw's loss control engineer on the Maple Leaf account, checking the results of Mr. Vaughan's inspections. And almost from the time she arrives at her office at 7:30 a.m., she's on the phone with plant branch managers discussing safety reports received from the field to see if there are any problems carrying out safety recommendations.

The telephone is Carol Caswell's most valuable instrument in controlling losses. Almost daily she is on the phone with her broker's loss control engineer to check the results of inspections and every day she calls branch managers about safety reports.

Mrs. Caswell doesn't limit her interactions with plant managers just to phone calls. She spends about two months of the year out in the field, visiting all major locations at least once a year.

"I want to have a firm picture of the properties in my mind when I

Continued on following page

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Maple Leaf . . .

Continued from preceding page
am discussing coverages with our broker and the insurance company," she says.

Mrs. Caswell is critical of risk managers who have given themselves that title, but who either don't believe in risk management or who don't understand what the concept means. Many risk managers are still acting as insurance technicians and until they get over that problem and decide they are part of the management team, they will remain just technicians, she complained.

When Mrs. Caswell became risk manager in 1970 after working for an insurance agency in Detroit, the biggest problem she faced was corporate acceptance of the difference between the new risk management function and the difference between the new risk management function and the old insurance purchasing function. But this is no longer a problem. "In the beginning, people used to say, 'Why are you interested in this...this has nothing to do with insurance?'

"But now people within the company call and say, 'I don't know if you are interested, but just in case you are, we are thinking about doing something now and we wanted to know if there might be any risks involved," the risk manager said.

With risk-related costs already so astonishingly low, some risk managers might be content to rest on their laurels. Not Mrs. Caswell. She soon plans to hire a director of loss control to lend even more strength to the risk management department. ■

Incident reports prescribe hospital loss control plan

Crain News Service

NEW YORK—More hospitals are using incident reports for feedback in preventing risks, according to Erik Ploen, executive director of Affiliated Risk Control Administrators.

The only way to reduce future exposure is to monitor potential liability through incident reporting, Mr. Ploen said. His firm uses a computerized incident retrieval program to spot trends and problem areas in each hospital.

ARCA, a division of S.B. Ackerman and Associates in New York, serves as consultant to 30 New York hospitals with 1,100 beds.

About 75% of the claims against the hospitals using ARCA's system have shown up in verbal or written incident reports. ARCA tells hospital personnel that incident reporting can help make a hospital a safer place in which to stay and work. Incident statistics can reveal a hospital's problem areas and allow personnel to analyze them, he said.

Registered nurses with at least six years' experience are risk management coordinators. The RNs are trained by ARCA attorneys.

Proper report writing is stressed, Mr. Ploen said, because semantics can create problems later on. Nurses are trained to write a report based only on what was observed, without drawing conclusions. If a patient was found on the floor, the report should read "Patient was found on the floor" rather than "Patient fell out of bed," he said.

Missed diagnosis and incorrect treatment of an ailment top the list of most frequently occurring incidents, followed by slips and falls, Mr. Ploen said. Incidents of adverse drug effects, resulting from dispensing the wrong drug, abuse, or overdose, occur less than 3% of the time.

Most incidents come to a hospital's attention in four ways: a verbal notice by hospital personnel; a verbal complaint by the patient; a legal complaint by the patient, and a complaint filed through a hospital committee.

Written incident reports can be fed into a computer and organized into a more useful form. Data can be retrieved according to the time incidents occurred, shift, location in the hospital, or the type of patient.

In New York state, risk management and other patient care quality assurance committees are immune from legal discovery. This is important since a physician or nurse won't report a fellow staff member's problems or mistakes unless his or her own mistakes are protected from legal discovery, Mr. Ploen said. The purpose of such committees is to reduce or remove risks, not to penalize wayward staff members.

Lawyers are available on a 24-hour basis for consultation. Mr. Ploen stressed, however, that the attorneys' services are more directly related to potential specific claims than to risk management and therefore aren't considered part of the program. Attorneys are consulted when consent for treatment is either lacking or unclear. ■

Fatalities up 21% at work

WASHINGTON—Workplace fatalities shot up 21% last year, the first time in four years on-the-job injuries have increased.

The Bureau of Labor Statistics' annual survey found 4,760 work-related fatalities last year at workplaces with 11 or more employes. That compares with 3,940 deaths in 1976.

Previously, there had been a steady drop in occupational fatalities since the survey began in 1973. The first survey found 5,340 deaths.

The Occupational Safety Health Administration (OSHA), the government agency charged with enforcing workplace safety rules, had no explanation for the sharp rise in occupational fatalities.

But Rep. George Hansen (R-Idaho), who introduced legislation to abolish the safety agency, said the rise in deaths was the result of OSHA forcing employers to concentrate on complying with nonproductive rules "rather than in areas the business managers believe would produce the greatest benefits in protecting workers safety and lives."

The Bureau of Labor Statistics survey also revealed that the number of on-the-job injuries increased last year about 5.5% from 1976. In 1977, there were 5.3 million work-related injuries, compared with 5 million injuries the year before.

Injury rates declined slightly in the mining, transportation, and public utility industries. However, injury rates rose in construction, services, wholesale and retail trade and agricultural businesses. ■

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More hospitals nurse captives for insurance needs

Crain News Service

CHICAGO—Hospitals representing about 19% of the nation's nonfederal acute-care general hospital beds will insure their professional liability risks through state hospital association-sponsored insurance captives by the end of 1978, up from 12% a year earlier, a survey by Modern Healthcare Magazine found. The number of beds covered by captive companies, trusts or other hospital-association-affiliated carriers will rise to 21% by the end of 1979, the survey found.

Seventeen association carriers responding to the survey reported that in 1978 the number of beds covered by them will have increased 48% to 170,169 from 115,110 a year earlier. They project a 19% increase to 20,819 beds in 1979.

The number of hospitals covered by the captive carriers will have jumped 47% to 1,126 in 1978 from 767 a year earlier. The number of hospitals is expected to increase 22% to 1,368 in 1979.

This means state association-sponsored carriers in 1979 will insure 23% of the nation's nonfederal acute-care general hospitals, compared with 19% in 1978 and 13% in 1977.

Hospital councils serving major cities and proprietary and tax exempt multihospital systems also sponsor large hospital professional liability insurance captives.

Sixteen of the carriers indicated they had aggregate assets of $187.5 million. They reported combined loss reserves of $93.5 million in their last fiscal years.

Carriers responding to the survey included those sponsored by state hospital associations in Pennsylvania, New Jersey, New York, Ohio, Virginia, North Carolina, Missouri, Oklahoma, Wisconsin, Michigan, Washington, Texas, Alabama, Louisiana, Minnesota, Colorado and Kentucky.

North Carolina's trust is the oldest and was established in 1975. Seven carriers began operation in 1976. They include Pennsylvania, New Jersey, Missouri, Michigan, Texas, Alabama and Louisiana. Five carriers, including those in New York, Virginia, Oklahoma, Wisconsin and Washington, started in 1977. Association carriers were established in 1978 in Ohio, Minnesota, Colorado and Kentucky.

Six of the carriers are insurance trusts. They include: Alabama, Wisconsin, Kentucky, Louisiana, Colorado and North Carolina. Carriers in Minnesota, Michigan, Washington and New York are mutual insurance companies. Pennsylvania, Ohio and Oklahoma are stock companies. Carriers in Texas, New Jersey and Virginia are reciprocals. Missouri's captive is a combination of a reciprocal and mutual insurance company.

Wisconsin set up an optional segregated account with its insurance program fronted by Sentry Insurance.

Pennsylvania Hospital Insurance Co., in Camp Hill, Pa., remains the largest underwriter, expecting to insure 37,000 beds at 200 hospitals by the end of 1978, a 25% increase over 30,000 beds at 171 hospitals a year earlier. PHICO president Don Steffes estimated the stock company will increase its beds 4% to 39,000 at 210 hospitals by the end of 1979. Established in March 1976, PHICO has $67 million in assets, $48 million in loss reserves, and a $16 million surplus.

New Jersey's Health Care Insurance Exchange in Princeton, N.J., is the second largest mechanism in terms of beds with about 19,000 by the end of 1978. The reciprocal captive, however, will have the largest share of any state's non-federal acute-care general hospital bed market with 65% of the New Jersey market. Oklahoma Hospital Casualty Co. was second highest with 60%. Virginia, Pennsylvania and Washington companies reported insuring more than 50% of their state's non-federal acute-care general hospital beds in 1978.

All the mechanisms have risk management and loss prevention programs to go along with their insurance programs. Virginia's Hospital Underwriters Inc. requires each hospital to have a risk manager and gives a 10% discount on premiums to hospitals meeting upgraded standards. It also gives 10% premium discounts to hospitals with risk reducing programs in anesthesia administration, biomedical engineering and emergency room services.

The North Carolina Hospital Assn. Trust Fund conducts loss prevention seminars for hospitals and takes hospital administrators and trustees to seminars held by outside consultants.

New York's Hospital Underwriters Mutual Insurance Co. spends up to 27% of the captive's total expense on risk management programs, according to vp Robert Nugent.

HUMI has eight field investigators, each responsible for surveying 13 hospitals. Each month, they follow up on the risk management programs at those hospitals. HUMI also provides seminars on loss control and claims administration, Mr. Nugent said.

The Texas Hospital Insurance Exchange contracts for the services of engineers employed by the Texas Hospital Assn. to survey electrical safety hazards.

Establishing captives and trusts has had varying impacts on commercial insurers. Premiums in some states stayed the same or increased slightly while there have been substantial reductions in most states. North Star Hospital Mutual Assurance Ltd.'s president Allin Karls said commercial insurers reduced their rates by as much as 50% in Minnesota since the captive was established. ■

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Goshay study . . .

Continued from page 6

ing alternatives, with 13 respondents indicating "serious contemplation of, or current implementation of, plans to form a captive." Insurance costs were most frequently cited (half the time) as "making captive insurance company formation more feasible."

Only one company in the study group complained that FASB No. 5 had increased the cost of legal services. Instead, increased frequency of claims and general judicial/social trends were blamed for higher legal costs as were the companies general litigation and attention to legislation.

Loss prevention/loss protection budgets were increased mostly because of management choice, with no indication whatever that this was even an indirect result of losing reserves to pay losses, Mr. Goshay noted.

FASB not only denies corporations the right to accrue reserves for unknown future losses, but it also requires companies to disclose loss contingencies when there is a reasonable possibility that losses may have been incurred. Only six of the 159 responding companies said the disclosure requirement had altered risk and insurance management decisions.

About half of the corporations in each group said they had purchased insurance in the last few years for previously uninsured risks. The newly insured risks include those created by government legislation (ERISA), changed laws (workers compensation), increased litigation (directors and officers liability) and increased complexity of exposures.

Mr. Goshay noted that certain indirect effects of FASB No. 5 couldn't be directly tested: Interaction between risk managers and senior management, financial capacity of the insurance industry, effect of risk management costs on pricing decisions and the effect of statement No. 5 on insurance marketing.

In response, he offered from his experience personal observations that:

- Statement No. 5 disrupted, at least temporarily, the development of the art/science of risk and insurance management.
- The insurance industry is financially undercapitalized and is therefore not motivated to take advantage of any reduction in self-insurance induced by No. 5.
- Corporate risk managers and others may not completely understand the differences between financial reporting and other forms of accounting information.
- Although the insurance brokerage community attempted to devise insurance arrangements to smooth the income of self-insurers—such as income leveling insurance packages—there are no indications that corporate risk managers saw the need for such arrangements. These programs would have involved level annual premiums, similar to self-insurance reserving protection, Mr. Goshay said. "Corporate risk managers simply did not buy coverages for such purposes. The author does not know any insurers now underwriting this type of financing/insurance service," he added.

•

Copies of Mr. Goshay's study, Statement of Financial Accounting Standards No. 5: Impact on Corporate Risk and Insurance Management, cost $2.50 and can be ordered from the Publications Department, Financial Accounting Standards Board, High Ridge Park, Stamford, Conn. 06905.

Colorado trust enlists 30 hospitals in program

DENVER—The Colorado Hospital Assn. has formed a trust to help its participating members keep a lid on hospital costs and improve the risk management programs in hospitals.

When the association first presented the Colorado Hospital Assn. Trust (CHAT) concept to its members, 28 hospitals signed up to join the program. But interest is waning; only two hospitals have signed up in over three months since the initial enlistment.

Richard Grant of Warren & Sommer Management Co. and trust administrator contends the lack of interest is caused by insurance companies cutting malpractice insurance rates when news of the trust became public.

Mr. Grant, however, remains optimistic about future participation in the program. "Interest in the trust will pick up when hospitals realize that its advantages go beyond lower costs for professional liability protection," he added

The trust, which is set up to cover claims up to $1 million, offers additional services over an insurer, according to the trust's administrator.

One of these services, and according to Mr. Grant, CHAT's major asset, is the participation of Medical Liability Consultants in the self-funded program.

Medical Liability Consultants, a firm of physicians and lawyers, headed by one of Colorado's most prominent doctors, will give medical and legal advice to trust-participants.

"Malpractice coverage by an insurer falls short because they don't have ready access to medical expertise and knowledge of the law," Mr. Grant explained.

Medical Liability Consultants will conduct in-depth reviews of medical services in a hospital and will impose loss control measures to reduce the number of preventable accidents and injuries.

Hospitals joining the trust will contribute to the fund as they enter the program. "Typically what happens is a hospital will wait until the professional liability policy with the insurer expires and then enters the trust at that point." Mr. Grant explained. However, some hospitals in Colorado are cancelling policies to join the trust as soon as possible.

"Rumors about insurance companies entering another downward financial cycle worried the Colorado Hospital Assn." Mr. Grant said. "In the event these rumors are true, product liability and medical malpractice will be the first items axed by insurance companies.

"By setting up this trust, the Colorado Hospital Assn. has protected its hospitals from the irregular ebb and flow of the insurance marketplace," Mr. Grant concluded. ■

Consultant fears government role

HAMILTON, ONTARIO—The relationship of private pensions in Canada to government retirement benefits indicates the government will almost certainly play a bigger part in the total pension picture here, predicts a benefit consultant based in Vancouver.

Alan F. Pierce, managing director of William M. Mercer Ltd., said he is sure studies now underway will "put private pensions in an unattractive position relative to government plans because of (their) timing."

Private employers should strengthen their plans if they want to avert government intervention, Mr. Pierce said. Anti-inflation board restraints in Canada have resulted in a marked slowdown in the creation of new pension plans and upgrading existing ones. ■

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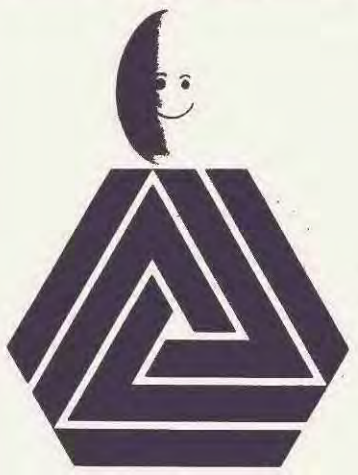

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London in turmoil as news of A&A link hits home

By JOHN MILLER

LONDON—The proposed link-up of Alexander & Alexander with merged London brokers Sedgwick Forbes and Bland Payne is the biggest surprise to hit the insurance industry here in two centuries.

Headlines reading "Broker in shock plan" that appeared in the U.K. market's own newspaper, the 245-year-old Lloyd's List, indicate the impact the planned link-up is having on both underwriters and brokers in London.

There is still an eerie silence over the real significance of the decision to merge by these two major U.K. broking groups, together worth more than $500 million.

Everyone speculated there would be further developments after Marsh & McLennan and C.T. Bowring had agreed to co-ordinate their insurance operations and Frank B. Hall & Co. had made a near $50 million bid for Leslie & Godwin.

Only a few people, however, have yet dared to comment on the future market impact of all these moves, which undoubtedly will be followed by other developments that may lead to the concentration of broking interests in ever-larger groups.

What will happen to the insurance buyer in all this rash of mergers and pooling of interests?

There are about 270 brokers and 270 syndicates at Lloyd's and many of the Big 12 broking groups manage important underwriting agencies with the full approval of the Lloyd's authorities.

Technically these two activities, broking and underwriting, are kept at arms length so as to maintain their independence. But can this relationship be fully preserved if the premium flow which is their lifeblood is coming through the same source?

It is perfectly possible to separate the two interests and competition from other insurance centers will at all times keep Lloyd's on its toes so as to give keen rates for all classes of business, market people insist.

But suppose there are further linkups in the future which could cut the number of large brokers down to five or six in the interest of so-called economy or expertise?

Many people accept this would be a rather frightening situation. But they contend it will never happen and that even if it did it would not deprive Lloyd's of its traditional independence as far as underwriting quotations are concerned.

As one prominent Lloyd's broker put it: "If Lloyd's ever ceased to be a market, with enough people in it to provide the keeness and independence which has been its lifestyle for more than 200 years, it would no longer have any purpose for the insurance community.

"So there's really no need to worry about its future activities, which will go on as effectively as ever in spite of mergers. There's so much competition from other world markets that it can't afford to lose its present traditions and I'm sure the larger broking groups don't want this to happen either."

But there are people who fear that the financial impact of huge international brokers, able to offer large flows of premium to capacity-conscious underwriters, can sway market rates.

It will not happen suddenly and may never occur if the normal balance of supply and demand is maintained at Lloyd's, where the committee is anxious to ensure that sensible risk-taking is still the hallmark of its operations.

"In light of the recent mergers in the insurance broking world, there is naturally concern that the existence of these giants in the market may cause some damage by reason of their very size," observes Francis Perkins, chairman of the British Insurance Brokers Assn. and one of the few Lloyd's observers willing to comment.

The chairman of the brokers association, which represents both domestic U.K. firms dealing only in personal lines and the big international groups, knows the importance representing all interests. "Insurance broking to be successful has in the past, and must in the future, base its skills on the personal approach to clients, whether individual or corporate," he said.

"The market must face realities. If through mergers it needs to become bigger, to enlarge special skills, so as to meet bigger competition from other markets elsewhere, then this must and should inevitably happen," the former Hogg Robinson chairman said.

"However, one hopes these mergers will avoid damaging the existing links between U.K. and U.S. insurance broking firms which have always provided a healthy and competitive market."

"One can foresee a number of relationships being sorted out. Doubtless many more changes will be forced on the market by the formation of other relationships brought about as a result of these mergers."

"On the other hand, you mustn't forget that, seen through the eyes of insurance brokers of lesser size, there should be an opportunity for them to acquire much of their own business in the event of any failure or inability of the 'giants' to recognize the personal element on which any successful relationship between insurance broker and client is based," he continued.

"The remaining large international U.K. brokers who have not been wooed by U.S. insurance brokers must now be considering their position. Are they going to be strong enough and big enough to stand up to the competition of the newly formed U.K.-U.S. giants? Can they survive in the newly created world of the super-international insurance broker? Must they consider mergers with U.S. insurance brokers to attract the big business which only the giants will be able to handle?

"We're bound to see great changes in the next five to 10 years, with more U.S. insurance brokers moving into London, as their banks have done, so as to get a more direct share of business," Mr. Perkins predicted.

"Certainly Lloyd's has had a unique and wonderfully secure position for many years. But it's inevitable this should be challenged. Now, however, some London brokers may try to reverse the trend by competing in the U.S.

"In fact, the amount of U.S. business reaching London may well be favorably affected, for their businessmen may want to back their own investments by channeling more risks into the U.K. market.

"There's going to be a tremendous sorting-out of cross-interests between U.S. and U.K. broking firms, but I welcome the statement reported from Jack Bogardus of Alexander & Alexander that links with other Lloyd's brokers with whom they have traditionally done business will be maintained," Mr. Perkins added. ■

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Supreme Court limits city's exposure to suits

WASHINGTON—The Supreme Court is apparently limiting cities' exposure to civil rights suits to those brought under the civil rights law, barring cases brought under the 14th Amendment to the Constitution.

It's an important limitation of a growing city exposure, says attorney Paul A. Scholder, interpreting recent Supreme Court actions.

On an appeal by the city of West Haven, Conn., the Supreme Court last month ordered the 2nd Circuit Court of Appeals to reconsider its June ruling that the city could be sued under the 14th Amendment for violating a citizen's civil rights.

West Haven had appealed the circuit court decision in light of a Supreme Court ruling handed down one day after the circuit court's in which the Supreme Court said New York City could be sued under the civil rights law (*BI*, June 26).

At the same time that the Supreme Court vacated the circuit court's decision to allow the 14th Amendment action against West Haven, it denied a plaintiff petition asking the court to rule that the city was liable for actions of an employe under the agency theory.

"It's narrowed the kind of cases that can be brought against municipalities, " said West Haven's attorney Mr. Scholder. "That's my interpretation," he added, "but there's no other explanation for the court's action. The only thing better would have been for the case to have been argued and a written decision handed down."

If cities are to be sued for violations of civil rights, it's better for the cities to be sued under the civil rights law than under the Constitution, Mr. Scholder stressed. "Under civil rights law, there's the defense of good faith. We don't know if we would have had that under the 14th Amendment," he explained.

In addition, "there's a body of case law on the civil rights law," he said, including a time bar on actions and definitions of direct responsibility. "It's a lot narrower than it ever would have been under the Constitution," the Connecticut lawyer said.

"There would have been no way to estimate liability under the 14th Amendment and therefore no way to insure against it," he added.

Insurers, however, maintain insurance doesn't cover awards in civil rights cases, regardless of the basis for the case, but some insurers have reportedly written endorsements extending coverage to discrimination liability.

The Supreme Court's refusal to hold a city liable for the actions of any employe, as requested by the plaintiff in the West Haven case, is also significant, Mr. Scholder said. "It means the city has to be directly responsible, through policy, direction or involvement by a high official," to be found liable.

The West Haven case is not an isolated one, Mr. Scholder emphasized. There is "plenty of this litigation." In Connecticut alone, 80 cases are pending against municipalities charging civil rights violations, he said.

Although confident he is correctly interpreting the Supreme Court's actions, Mr. Scholder is looking for confirmation in the court's decisions of three similar cases pending before it. "I want to see consistent action in the other three cases. Then it will be crystal clear the court won't sanction the 14th Amendment actions.

Now the case against West Haven goes back to the circuit court which has to decide if it's an appropriate case under the civil rights law. Commercial Union Insurance Co., the city's general liability insurer at the time of the incident, is defending the $200,000 suit against the city under a reservation-of-rights notice. That means the insurer has told the city it may decide not to pay a liability award.

The plaintiff is charging the city violated his civil rights in the handling of arrest incidents involving him.

Some time ago, Thomas Turpin won a false arrest case against a city police officer and recovered damages. He is now fighting a later arrest, claiming it was also improper. But in addition to suing the police, he is also suing the city for promoting the officer involved in the first incident. The promotion, he charges, caused other officers to believe they could wrongly arrest him without fear of discipline.

If West Haven doesn't win in court against Mr. Turpin, the city could be back in court against its insurer. Not only is insurance against judgments in civil rights cases at issue, but the insurers responsibility for judgments rendered against the police is also in question.

"There is a very limited endorsement on what the city is responsible for by a cop in the line of duty," Mr. Scholder said. Whether or not Commercial Union will find there is coverage for any award made in the case "depends on what the police are found to have done," said the attorney, who is based in New Haven. ■

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Northrop's young risk exec saves 6% in 6 months

By SUSAN ALT

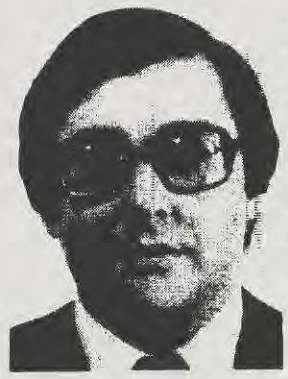
LOS ANGELES—When Gregory P. York was hired to be Northrop Corp.'s risk manager at the ripe old age of 29, he didn't even have a business suit. But he hustled out to find a new wardrobe and underwent a quick metamorphosis, emerging as the picture of a corporate executive, dressed in dark three-piece suits and white shirts.

Little more than six months later, his accomplishments as corporate director of risk management and assistant treasurer for one of the nation's largest aerospace manufacturers speak for themselves. The country boy from Maine, using his considerable talent for soft speech and understatement, saved Northrop almost $2.8 million, about 6% of the $50 million-plus spent annually for all kinds of insurance.

These savings grew primarily out of programs renegotiated and renewed in the months after he came to Northrop, with only three of seven programs significantly changed during renewals. Mr. York, moreover, was in the fortunate position of being able to implement some plans already well-laid by his predecessor, Alan Troop, initiating some of his own changes as he went. He also credits an exceptional team of brokers and insurers with whom Northrop works.

At the same time he was renewing Northrop's insurance programs, Mr. York was visiting the company facilities around the world, routinely putting in 15 hour days from the start. This was a major change from the more casual and relaxed atmosphere of Brevard County in Florida, where he had been in the risk management department for several years.

Just turned 30, Mr. York is the youngest department director at Northrop by eight years and is the youngest corporate officer by more than that. His predecessor had been risk manager for three years.



Gregory York saved Northrop almost $2.8 million on its $50 million insurance bill when renewing seven programs, three of which were changed significantly.

Since he joined Northrop in early February, Mr. York has renegotiated four major programs, including aircraft product liability/aviation liability, international workers compensation, international general liability/auto liability and domestic workers compensation. (The last of these represents about a $10 million premium, by itself.) These programs were renewed without significant changes, though significant savings were part of the outcome.

The two major programs that were altered, resulting in new coverage, new carriers and sometimes new brokers, included builders' risk and group dental.

A seventh, domestic general liability/auto liability, was renewed with Great American Insurance Co., leaving the primary layer of coverage unchanged, but with all new insurers on the excess umbrella layers up to $100 million. A much better price came out of the new package put together by Johnson & Higgins' Willis King, be-

Continued on following page

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In early films, the camera's need for authenticity led to some dramatic, if expensive, mock disasters. This building collapse was created full scale on the Mack Sennett lot. Today most such special effects are done with scale models. Illustration courtesy of Museum of Modern Art Film Stills Archive.

The plain-talk printout.

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Northrop's York . . .

Continued from preceding page
cause of price competition within the lower layers up to $10 million of coverage.

Northrop's three biggest insurance programs are international workers compensation, international general liability/ auto liability and aircraft product liability/ aviation. Better than two-thirds of the ultimate gross savings were from these three programs, said Mr. York.

Alexander & Alexander, J&H and Marsh & McLennan all have pieces of Northrop's business. Its insurers include AFIA, Industrial Indemnity, Lloyd's of London and California Dental Service, part of the nationwide Delta Dental Plan system.

Premiums for the builders' risk program were slashed 25% from the 1977 level, thanks to the efforts of A&A's Hugo Standing and Larry O'Donnell, who handle this account along with Northrop's entire domestic and international property programs, aviation and aircraft programs and marine cargo coverage.

Group dental became self-insured using a 501(c)(9) trust and California Dental for administrative services. Changing from an insured dental plan with Travelers resulted in "significant" savings for the program, which Mr. York describes as "a $2.5 million exercise." Dental benefits are provided for two-thirds of Northrop's 29,000 employes. Assisting in the changeover were the benefit department of J&H and Los Angeles-based consultants Olanie, Hurst & Hemrich. Don Conklin and Guy Chetelet at California Dental handle the ASO account.

This is Northrop's second foray into self-funded benefits, having gone self-insured in January for its $25 million health and medical benefit plan. Administrative services are provided by Prudential.

Competitive markets dictated aviation coverage be put out for bid, but the London markets "were able to hold onto that business, because they responded well" to some rugged competition from the U.S. domestic aviation underwriters, said Mr. York. He credits John M. T. Hewitt of the Lloyd's Ariel Syndicate with handling the successful underwriting, placed by Alexander & Alexander through Sedgwick Forbes.

J&H's Dickinson Ross and Mr. King manage Northrop's international and domestic casualty business, including general liability, auto and workers compensation. AFIA's Berry Wallace underwrites all of Northrop's international workers compensation risks as well as international auto and general liability. Industrial Indemnity's Bob Gowdy and Don Felt handle underwriting for domestic workers compensation. Marsh & McLennan's Don Buck and John Ireland handle Northrop's bonds and part of the employe benefit program.

Mr. York tends to talk in terms of liking long term relationships with brokers and insurers, but he doesn't think it's necessary to make solid commitments. He thinks it's healthy, though, for a policyholder and insurer to stay married for at least two or three years, if not longer. He cited Northrop's 37 year relationship with one insurer as an example of staying power, along with the 14 year relationship the Los Angeles firm has had with Industrial Indemnity.

He views insurance as similar to bank credit, and thinks buyers can deal with insurers much like they'd deal with their bankers. Over the long haul, he said, "we don't want anyone to lose money on Northrop's account. Eventually we pay for our own experience anyway."

Mr. York's risk management department at Northrop, unchanged since the days of Alan Troop, includes an assistant in charge of risk management and insurance administration, a staff accountant, an international specialist, an insurance analyst and a clerk. Mr. York reports to the senior vp of finance. ■

N.Y. starts new MAP plan

NEW YORK—The insurance industry in New York State has established a marketing assistance program to aide municipalities having problems purchasing general liability insurance or package policies including general liability insurance, state insurance superintendent Albert B. Lewis has announced.

Called "New York-MAP-Municipalities, the program is intended to a temporary method of providing market assistance for public entities within the state including counties, cities, townships, and school, water, sewer, fire and New York similar service districts.

According to the insurance department, New York-MAP-Municipalities will make available on request an advisory bulletin informing agents and brokers of the specific procedures to be followed in obtaining general liabilities coverage for any municipality under the program.

The program is being coordinated by the New York Metropolitan Insurance Brokers Assn., Council of Insurance Brokers of Greater New York Inc., Professional Insurance Agents, Independent Insurance Agents of America and Independent Insurance Agents of New York. ■

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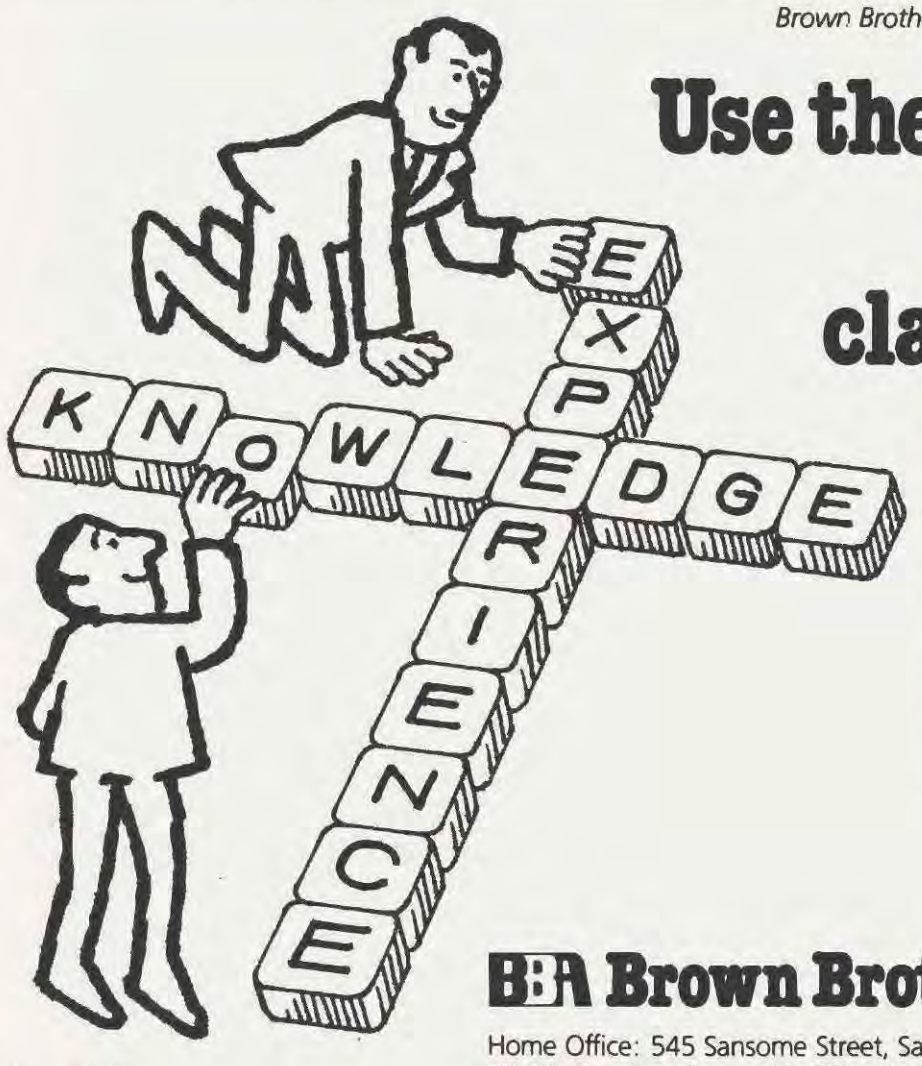

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Fortune 500 and insurers propel HMO growth

By JOANNE GAMLIN

SOUTH PASADENA, Calif.—Health maintenance organizations could be entering a new era of expansion, fueled by the involvement of Fortune 500 corporations and huge insurance companies.

Kaiser-Permanente and Prudential Insurance Co., for example, recently announced they will jointly launch an HMO for the Dallas-Fort Worth area, now lacking any HMO. Kaiser will provide the medical and planning management and Prudential will contribute to the medical, planning and financial management, said Prudential's Terry Burke, vp of alternative health programs.

The big three auto makers, plus Burlington Industries and John Deere & Co., are also placing considerable support behind the HMO concept.

These developments were cited by speakers at a day-long conference here on HMOs, chaired by former HEW secretary Robert H. Finch.

"Fifteen Fortune 500 companies have either started alternative health care facilities or are thinking about doing so," asserted Paul M. Ellwood Jr., M.D. and president of InterStudy, a Minneapolis think tank.

Conference speakers also pointed out that the three major automobile manufacturers together with the United Auto Workers (UAW) are cooperating on converting Detroit's Metro Care health plan and Henry Ford Hospital into a large HMO, one that may enroll as many as 150,000 to 200,000 persons.

Deere & Co. is embarking upon establishing an HMO as a means of correcting the "weaknesses" or lack of competition in the present health care system, said Anthony R. Masso of HEW.

"If they are to have an impact on the health care costs of this country, HMOs must become a part of the mainstream," stressed Mr. Masso.

R. J. Reynolds' HMO in Winston Salem, N.C., could stand as a model for corporations wanting to set up alternative health care facilities, said John Boardman, executive vp of Kaiser-Permanente Advisory Services in Los Angeles, a unit of Kaiser-Permanente offering consulting services on how to establish HMOs. The Reynolds HMO, created in 1976, enrolled 75% of the company's work force, he noted.

Although he lauded the success of the Reynolds HMO, Mr. Boardman also criticized it for not opening up its services to people who are not employes.

Twenty insurers are said to be involved, but the companies with the most serious interest in HMOs are John Hancock, Metropolitan Life, INA and Prudential, according to Larry Kugelman of Community Health Management Inc. of Oakland, Calif., a unit of INA which develops and manages HMOs and advises others on how to set them up. Insurance company involvement in the still-infant industry may turn out to be a make-them-or-break-them catalyst, he observed.

There are compelling reasons why insurance companies are expanding their involvement with alternative health care systems, according to Prudential's Mr. Burke. The insurer has had HMO involvement for six years because self-insured group health plans are growing at such a rate they threaten the role that insurers like Prudential have had in the group health plan market for years, he explained.

The company derives a large part of its cash flow from the provision of group health insurance to about 10 million employes and 25 million individuals. Beyond this, federal and state intervention in the health field has prompted concern at Prudential, he said.

Nevertheless, Mr. Burke frankly revealed that taking a stand on HMOs has not been without costs to Prudential. For one thing, those with vested interests within the insurance company have regarded HMOs as a threat to their livelihood. Also, when Prudential began its activity with HMOs, he said it encountered sizeable opposition from entrenched medical societies. However, there has been a dramatic improvement in that situation, he noted.

Economists who have thrown up their hands with the idea that health care costs can be reined in should look at the Twin Cities and Honolulu, said Paul Ellwood. In Honolulu, where Kaiser-Permanente competes with an insurer in a vigorous battle, hospital beds cost about one-third less than they do in most major American cities. Likewise, in the Twin Cities, where hot competition rages among seven HMOs and most local hospitals, the cost of hospital beds—the main ingredient in health care inflation—is declining, he indicated.

The market works in medical care in these two communities," Mr. Ellwood argued, noting that the most respected hospitals must join in if a truly competitive medical marketplace is to develop.

Mr. Burke of Prudential objected to the strong theme of marketplace competition sounded at the conference. Although a rivalry of efficiency may emerge between conventional and alternative health care systems, he said that two factors will prevent real price competition from materializing: The nation's aging population which continues to hold dreams of immortality, and the population's relentless demands for better health care.

Mr. Ellwood advised four actions he believes that corporate purchasers of HMOs must take if price-efficiency competition is to heat up:

- Make it a policy to make equal premium payments to all sources of health care coverage. That is, the least efficient source, be it insurer or prepaid health plan, should not receive the higher premium pay-
- Offer employes a multiple choice of health care coverage, not the standard two. The choice of a conventional insurer and an HMO is not adequate to foster the growth of alternative health care systems, he believes.
- Search for health insurers willing to compete on price and benefits. In this way, insurers will be forced to devise methods of offering lower cost health care coverage.
- If all else fails, establish alternative systems.

HMOs have been hurt by a dearth of marketing savvy, he said. Without an ability to sell their concept of health delivery of the public, he warned, they will never enter the mainstream and spawn the competition in price and in benefits that could ultimately lower costs. ■

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Hogg Robinson to buy 30% of surplus broker

RICHMOND—Hogg Robinson Group Ltd., a Lloyd's of London broker, has agreed to purchase for $2.5 million 30% of the common stock of Markel Service Inc., a specialty lines broker which also offers safety and claims handling services.

Steve Markel, vp-finance at Markel, said the sale of Markel stock to Hogg Robinson will benefit both brokers, though in different ways.

From Hogg Robinson's perspective, it will increase their access to the U.S. market," he said.

On the other hand, Markel hopes that the infusion of capital from the sale of stock will help it to accelerate its expansion program and to get into new lines of business.

Mr. Markel also said that he expects the sale to give Markel's safety and claims handling divisions better access to handling more claims for other Lloyd's accounts.

Currently, Markel specializes in transportation and other property/casualty lines. It has been placing the lion's share of its Lloyd's business with Hogg Robinson and will continue to do so.

Markel operates seven regional offices in the U.S. in Boston, Richmond, Atlanta, Tampa, Dallas, San Francisco and Chicago. It plans to open an office in New York next year.

The sale of the stock is expected to be completed in December. ■

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Russian rule easing: Fain

NEW YORK—The U.S.S.R.'s regulation that cargo insurance on foreign trade be placed with Russian insurers may be easing, according to Thomas A. Fain, president of the American Institute of Marine Underwriters (AIMU).

Mr. Fain noted that the U.S.S.R. as well as 30 other countries direct insurance premiums to their own countries, which AIMU contends injures all those engaged in international trade, including the foreign governments imposing the regulations. Ultimately, the requirement is reflected in increased shipping costs, he said.

Speaking at a luncheon meeting of the Propeller Club in New York, Mr. Fain said that AIMU has been pressing for six years for the U.S. government to intervene in the trade restrictions.

President Carter recently called the restrictions an "unreasonable burden on U.S. commerce," a statement welcomed by AIMU. ■

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Benefit value increases lag salary raises: Survey

PHILADELPHIA—For the first time in three years the value of employe benefits stopped rising faster than salaries, according to the results of the lastest Hay-Huggins study of executive benefits and compensation practices of 526 U.S. industrial, financial and service companies.

In all job levels for industrial companies, for example, salaries amounted to 1% more of total compensation while the percentage of benefit costs to total remuneration slipped 1%.

For financial companies, benefit costs in the lowest level jobs remained the same as last year. However, salaries in the other two job categories increased by 1% and the ratio of benefits to total compensation decreased by 1%.

Finally, in the lowest job level for a service organization, salaries rose by 2%, while the percentage cost of benefits slipped 2%. The salary in the middle job level and the percentage of benefit costs remained the same at 73% and 27%, but salary in the top executive job level increased 1% corresponding to the dip in the percentage of benefit costs.

Despite this slight shift away from employe benefits in the overall compensation picture, death benefits are still increasing with inflation, health care benefits are still rising and dental plans are becoming a popular addition to executive benefit packages.

Other highlights of the firm's ninth annual noncash compensation comparison study include:

- Employers are offering executives thrift plans in greater numbers this year than in the last three years. Under these plans the employer matches or partially matches an employe's own savings.
- Stock options and deferred compensation plans continue to grow in popularity as a means of rewarding executives.
- Perquisites are being offered by fewer employers this year, reflecting closer public scrutiny being given such "perks."

All employers surveyed offer some type of hospital and medical plan. Now 44% also offer dental coverage, almost double the percentage of employers offering dental coverage last year. Only 5% offer vision care coverage and 80% offer benefits to retirees.

The percentage of employers offering short and long term disability plans for workers hasn't changed much in the past three years, with 85% providing short term disability, 91% providing long term disability, 54% providing maternity disability benefits and 13% offering a combination or another formal or informal program. Only 2% of employers provide sickness and accident insurance. The only shift in this group has occurred in relation to maternity disability, which is down 20% from last year.

Basic group life was offered by 99.8% of participants, basic accidental death by 84%, business group life by 51%, dependents group life by 27% and additional accidental death by 25%.

Of all the options of an employe benefit package, thrift plans, according to the survey results, are growing the most in popularity among employers. Thrift plans are offered by 36% of the participating companies, almost double the survey figures in 1977.

Behind thrift plans in popularity are profit sharing plans with 22% of the employers surveyed offering this kind of capital accumulation plan. Thirteen percent offer stock purchase plans, 6% provide ESOPs and 7% provide TRASOPs.

Directors and officers liability coverage has almost doubled compared to last year's figures, with 67% of employers providing this kind of coverage for executives. Now 18% provide financial counseling, up from the 9% that offered it last year. Eleven percent offer key man insurance, 15% offer excess liability and only 7% offer split dollar insurance.

The Hay-Huggins study found that, depending on the salary level, employer-paid benefit values varied.

Industrial companies pay approximately 29% of an employe's annual $100,000 salary for noncash compensation. But an employe earning $10,000 annually gets benefits equal to 42% of annual earnings.

Financial company figures are not very different from the industrial companies surveyed. Finan-

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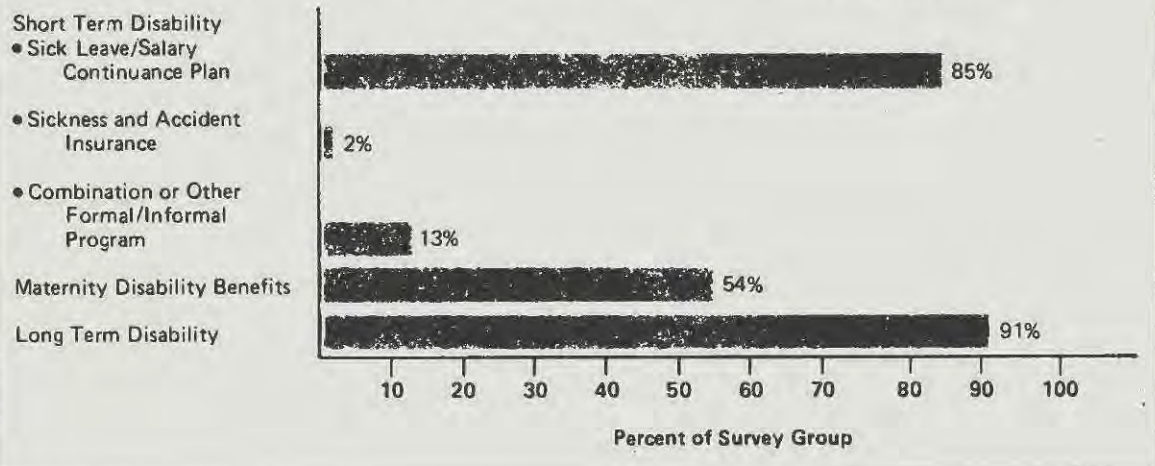
Prevalence of sickness and disability plans



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Continued from page 1
to payment or when the company actually sets aside sums to be paid in the future.

The guidelines as now written will almost surely shelve benefit improvements. Air Products & Chemicals Inc., for example, has already made the decision to do just that.

"If the guidelines are interpreted literally, we have a pretty severe problem on our hands," concludes Gene McGarrah, corporate benefit manager at Texas Instruments.

Of 16 corporations surveyed about how they'll handle the wage guidelines in light of benefit inflation, everybody's hoping—or praying—the Carter Administration will change the rules to take benefit maintainance costs out of the wage calculations not to exceed 7%.

If non-unionized companies are in a bind over the benefit squeeze, unionized firms are in a double-bind. Unions are denying they'll abide by the 7% wage limitations in their negotiation demands, indicating they want benefit improvements in their new contracts. But if unions win benefit improvements, employers worry they'll be faced with a terrific morale problem if they don't give those same improved benefits to professional and salaried non-union workers. It will all add up to packages worth more than 7% overall, employers fret.

At the very least, the increased costs of maintaining benefits at current levels would take up fully 1% to 2% of the 7% allowable wage hike, estimated benefit managers for a number of corporations.

Employes want raises

One midwestern employer who recently signed a new contract covering 250 non-union production workers allocated 1% of pay increases to the cost of maintaining benefit programs. That 1% was based on estimated benefit increases of 12% for 1979 without any benefit improvements. The company chose to increase the workers' pay by 7%, putting the package one percentage point over the target suggested by the Carter Administration.

A 7% wage increase was approved by that company because it was optimistic that benefit maintenance costs would be exempted from overall wage package calculations. In addition, employes were "expecting" a 7% wage boost, said a source, explaining he didn't think employes would understand that benefits were also expected to be included in the guidelines.

The cost of maintaining benefits will absorb less than half a percent of the 7% allowance, estimates William J. Englehart, director of employe benefits for Akron-based B.F. Goodrich Co. His estimate is substantially lower than those of other corporations. He derived the figure from projected benefit cost hikes of 10% for 1979, excluding any improvements. The company's first contract to fall under the guidelines comes Jan. 8, 1979, when it enters negotiations with the Oil, Chemical & Atomic Workers Union.

Compliance is certain

Hewitt Associates, a benefit consulting firm, pointed out that if average pay for a group of employes is $15,000 and the cost of the medical benefit program averages $800 per employe, an insurance rate increase of 20% would use 1% of the available 7% wage escalator.

Most corporations agree with Champion International's assessment that "no one with a company of our size can afford not to comply" with Carter's wage guidelines. This was generally the view expressed by General Motors Corp., Honeywell Inc., Armco Steel Corp., Monsanto Co. and Foremost McKesson Inc.

"We're looking at it," said Kenneth E. Olthoff, director of employe benefits at General Motors.

General Mills, like others, has "been looking at the guidelines," but is "hopeful that there will be some changes coming forth in the area of maintenance of benefits," said David F. McIntire, manager of employe benefits.

Likewise, Eastman Kodak Co. is optimistic about some modification of the guidelines.

Benefit managers whose contract negotiations with unions preceded the guidelines were grateful for their good fortune. At American Motors Corp., a two year contract was signed that raised costs more than 7%, some of which was attributable to benefit cost hikes, according to Joseph L. Fromm, director of employe benefits and risk management. The auto company's next contract comes up in July at a subsidiary, on the heels of larger contracts in the trucking industry, whose contracts expire April 1, and the oil industry, which begins negotiations in January.

To assure compliance, many corporations have set up task forces of personnel top managers and other executives, assigned the task of studying the guidelines and establishing methods of compliance. ■

Hewitt wants guidelines to reflect benefit costs

LINCOLNSHIRE, Ill.—Hewitt Associates believes there are several issues involving benefit costs that the Council on Wage and Price Stability must address.

The consultants protest that plan costs can increase total pay absent any improvement in benefits and urged the council to monitor benefit levels rather than costs to maintain current levels.

Substantial increases in the cost of profit sharing plans can result if the base period contribution was low due to a company's financial performance, said Hewitt, because higher contributions in subsequent periods boost total pay.

Under a savings and thrift plan, the company's contribution depends on the level of employe contributions, so that a change in active participants or the amount of participant savings can affect total pay, said Hewitt.

Pension plans are also subject to conditions that can affect their cost without any change in benefits, the consulting firm pointed out. Actuarial assumptions, funding methods, investment results and actuarial gains and losses all affect benefit costs.

The guidelines are unclear, Hewitt believes, about whether a TRASOP, a tax reduction stock option plan, is excluded from the guidelines.

Overtime can also indirectly increase the cost of employe benefits, because overtime increases company contributions to pension and profit sharing plans. Thus, in an indirect way, overtime would have to be included in determining compliance with the wage guidelines, Hewitt said.

Cost increases or decreases due to legislation on age discrimination and pregnancy disabilities will also directly affect the 7% guidelines, Hewitt said. ■

Discovery clause is crucial: Exec

SAN FRANCISCO—The discovery clause is the most important point to consider in a directors and officers (D&O) liability policy, Joseph DeAlessandro, president, National Union Insurance Co., believes.

"If your corporate D&O policy is cancelled the discovery clause becomes most important, as it applies toward claims brought on actions prior to termination of the policy," Mr. DeAlessandro told a seminar at the Northern California Chapter of CPCU's All Industry Day.

During this extension, he continued, the policy is in effect, though cancelled for future claims.

"It's in your best interests to negotiate the longest possible discovery clause," the National Union executive told risk managers attending the seminar. "It's a long day when an underwriter cancels a D&O policy; you'll probably not be able to get other coverage."

The average discovery period for a one-year D&O policy is 90 days, according to Mr. DeAlessandro, and the longest on a three-year policy is one year. ■

Officers elected

The newly elected officers for 1979 of the Railroad Insurance Management Assn. are C.W. Colborg, insurance manager for Denver & Rio Grande Western Railroad Co., chairman; Lance Harrison, insurance supervisor for the Chicago & Northwestern Transportation Co., vice-chairman, and Roy E. Foultz Jr., insurance manager for the Norfolk & Western Railroad Co., secretary-treasurer.

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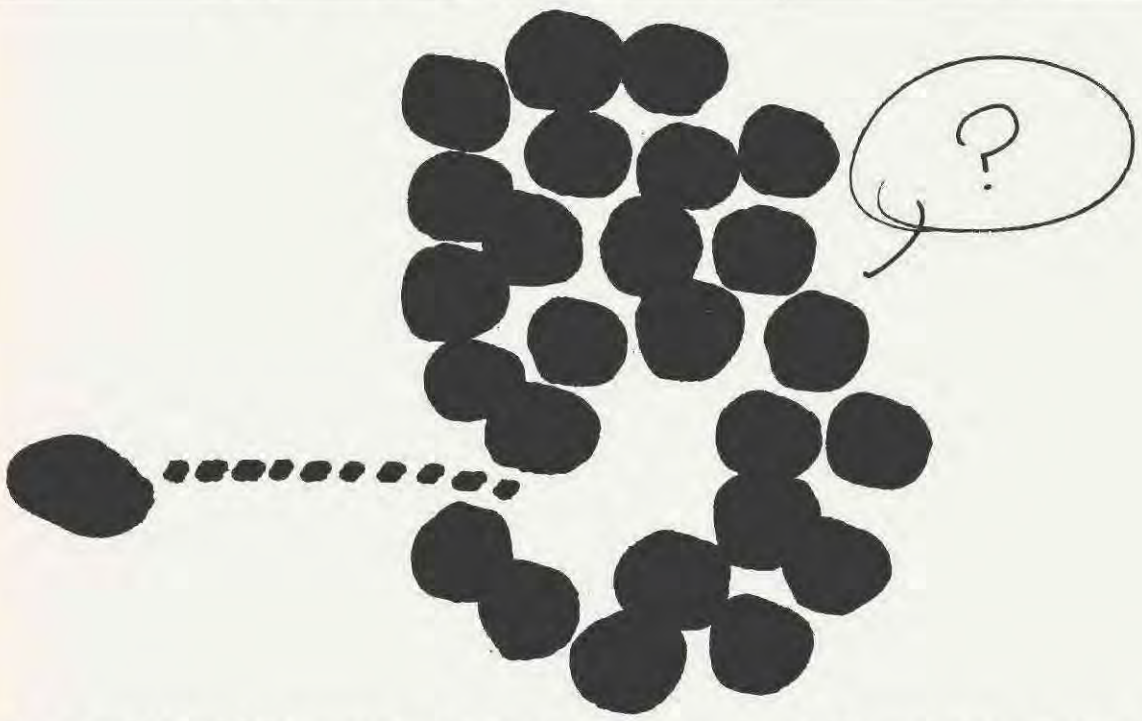

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Unions want more benefits despite wage guideline

CHICAGO—The Administration's anti-inflation wage guidelines, especially the inclusion of employe benefits in the 7% cap on wage increases, will be tested over and over in the coming year of heavy union contract negotiations culminating in the benefit trend setting United Auto Workers contract.

Labor unions at this point say they either hope to remove employe benefit cost increases from the guidelines or they intend to ignore the fact that benefits are supposed to be included in the 7% increase suggested for their contract settlements.

As the major unions are still drawing up their demands for the coming contract negotiations, they are hesitant to identify the specific benefit improvements they will seek. But a spokesman for the United Auto Workers summed it up with, "You can assume we'll want more."

The UAW says it is "looking to change" the inclusion of benefits in the 7% wage guideline, but it apparently doesn't consider this a pressing issue. "We have almost a year before our contracts expire," the UAW spokesman noted. "We will know before our negotiations start if the wage and price guidelines are working."

Mostly defiant about the guidelines, few unions will even address the question of how they would split the allowed increase between benefits and wages. The UAW, however, explained its own dilemma. "We try to satisfy all segments of our membership, but generally the younger workers want salary increases and the older workers want pension improvements."

This year, older UAW members are clamoring for cost of living increases in their pensions. The benefit, even the UAW admits, "is difficult, if not impossible, to fund under ERISA. If you fund those, there's nothing left for anything else."

The UAW is already eyeing a prepaid legal plan for its members, modeled on the legal plan for Chrysler workers put together with unused supplemental unemployment benefit money. "If it's working," in its first months of operation next year, "we'll ask Ford and GM for funding," said a UAW spokesman.

The contract goals for 672,000 UAW workers will be drawn up at an April convention.

Before then, the Teamsters will have been hammering out a contract for 500,000 truckers, which expires March 31. "Benefits have to be excluded from the 7%," demanded a Teamster spokesman. "Pension plan costs are increasing at a rate of 2% to 5% to meet ERISA and health insurance is going up. If you deduct for health and pension costs, that leaves 4% for wages."

The only way the Teamsters would consider negotiating only a 4% wage increase, the spokesman suggested, would be if inflation were held to 4%.

The United Rubber Workers have also said they don't believe they can comply with the 7% guideline on wage and employe benefit cost increases. On benefits, the union is especially interested in increased pension benefits and more outpatient coverage in its health insurance plans, *Business Insurance* learned. Its contracts for 60,000 workers are due to expire April 20.

The United Steel Workers, who don't negotiate contracts until 1980, drew up a list at its constitutional convention last fall of considerations for its bargaining committees based on concerns expressed by local unions. Among the benefit proposals listed are:

- Liberalize sickness and accident benefits with coverage extended after contract expiration date.
- Improve hospitalization, medical and surgical, dental and eye care programs and provide full payment of all expenses. Require the company to pay for all hospitalization, medical and insurance programs during strikes.
- Improve pension plans, such as pension benefits, special pension allowance resulting from shutdown of facilities, pension benefits to surviving spouses and bridging of breaks in service for pension benefits. Provide cost of living adjustments in pension benefits; early retirement after 25 years of service; a pension supplement for all early retirement payable until age 65 and eliminate all deductions from pensions.
- Eliminate reduction of life insurance coverage on retirement and extend full payment of hospitalization and medical bills, including drug bills, over and above Medicare payment for all pensioners.
- Have the company provide complete physical examinations on a yearly basis to employes in all operations which include toxic and cancer bearing substances.
- Negotiate an annual sick leave program with no loss of earnings for employes.

Meanwhile, the AFL-CIO is dismissing the Administration's entire anti-inflation program as an unfair set of rules and regulations that deny equity to workers while allowing companies and employers carte blanche to further profits. ■

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N.Y. Exchange . . .

Continued from page 1
tions that I had to it have been overcome."

Under the proposed setup, it's conceivable that eight seats could be in the control of brokers through their control of underwriting syndicates or in the control of underwriters through their ownership of member brokers, explained New York insurance superintendent Albert B. Lewis, chairman of the Committee of 13.

Whoever controls the board of governors in effect controls the operations of the exchange. The constitution calls for the board to "have all the powers necessary for the government of the exchange, the regulations of the business conducted through the exchange and the promotion of the welfare, objects and purposes of the exchange."

The board will be responsible for interpreting the rules and constitution of the exchange, examining accounts and receiving annual statements from exchange members, determining solvency of members and taking the necessary steps to correct insolvencies, including rehabilitation and liquidation.

Governors would be elected for three-year terms and would be allowed to serve two consecutive terms. They could serve for additional three-year terms after an interim three-year period.

Underwriter or broker vacancies on the board would be filled by the remaining underwriter or broker governors. Vacancies among public representatives would be filled by a two-thirds vote of all remaining governors. Governors elected to fill vacancies would serve their terms only until the next annual meeting of the exchange membership.

Votes are divided

Governors would be elected at the annual membership meeting to be held on the second Monday in April. Underwriter and broker nominating commitees would be selected at that time and they would propose candidates for election at the following year's annual meeting. The two nominating committees would separately recommend candidates for the underwriter and broker seats on the board and jointly for the public seats. Candidates could also be placed in nomination through a petition endorsed by not less than 5% of the appropriate memberships.

Each broker member will have one vote at the annual meeting while underwriting members will have a total number of votes equal to the brokers, but divided equally among the underwriting members. For example, if there are 40 broker members, each having one vote, and only 20 underwriters, the underwriter members will have two votes each.

The board is required to hold one annual meeting following the annual exchange members' meeting. At that time, the board's chairman and vice-chairman would be elected and they would serve until the next annual meeting.

Regular meetings of the board would be scheduled at its convenience and special meetings at the request of the chairman or of three governors. In addition, resolutions requiring approval by the board of governors could be adopted without meeting by unanimous written consent of the governors.

Public hearings on the proposed New York Insurance Exchange Constitution will be held Dec. 15 and 18 in Two World Trade Center and Dec. 19 in the Empire State Plaza, Albany.

A governor of the exchange could be removed from office by two-thirds vote of the exchange membership, for three unexcused absences from regular meetings of the board or for having lost the qualification necessary for him to hold that office.

The constitution proposes four membership classes: underwriting members, broker members, associate brokers and subscribers. Only the first two classes would have voting rights.

The underwriting member would be a syndicate authorized to insure or reinsure risks as a member of the exchange. The state law enabling formation of the exchange limits its classes to reinsurance, foreign risks and risks certified as rejected by free trade zone companies.

The free trade zone, which allows insurance companies to write certain hard-to-place and high premium lines without prior approval on rate and form, was created under the same act.

An underwriting member would be required to have initial paid in capital surplus of $3,550,000 and thereafter maintain a minimum policyholder surplus of $2.2 million in order to write property/casualty lines or life, health and accident lines. To write all kinds of insurance, the member would have to have initial surplus of $6,550,000 and maintain a minimum of $3.3 million afterwards.

Security fund set

Of the initial surplus required, $500,000 would be placed in the exchange's security fund. The balance would be invested in accordance with state insurance law. In addition underwriting members would contribute to meeting the exchange's operating expenses and pay a $10,000 initiation fee and annual dues set by the board of governors.

Broker members would be agents, brokers or reinsurance intermediaries licensed under state insurance law and having been in business no less than three years prior to applying for exchange membership. They would be permitted to transact only those lines of business for which the broker has a New York license and would be required to demonstrate financial responsibility by furnishing a bond in an amount determined by the board of governors or by providing the board with an acceptable financial statement.

In addition, broker members would have to maintain a principal office in New York and agree to pay part of the operating costs of the exchange.

The broker member would be able to place business on behalf of other brokers and have voting powers. The broker member would pay a $10,000 initiation fee and annual dues set by the board.

An associate broker would be subject to the same membership qualifications but would only pay $1,000 annual dues. Associate brokers would only be able to place business for their own accounts and would not have voting rights.

A subscriber would be any person, firm or organization approved by the board that pays initiation fees and annual dues determined by the board. Subscribers would not have voting powers or the right to transact business on the exchange, but would be permitted on the floor and enjoy other privileges determined by the board.

All business placed on the exchange will be required to be made through a broker member or associate broker. Only transactions between underwriting members and retrocessions off the exchange by underwriting members can be made without broker participation.

The constitution calls for establishment of a central processing facility that would collect and distribute all monies due underwriting members on insurance and reinsurance contracts. The central facility would provide recordkeeping, data collection and statistical compilations of all insurance and reinsurance transactions involving a member or associate broker.

The facility would hold collected funds in an interest-bearing premium trust account and the exchange's treasurer, who would manage the facility, would keep records of receipts and disbursement of funds and file monthly reports. Monies would be distributed to underwriting members following recording and processing by the treasurer, who would deduct surcharges for the security fund and premium taxes.

Startup process

All underwriting members would be member's of the exchange's security fund, to which they will be required to contribute $500,000 upon joining the exchange. A surcharge of up to 5% of premiums would be levied at the discretion of the board of governors to build up the security fund.

The security fund would meet the unpaid contractual obligations of insolvent underwriting members at the time of insolvency and up to 30 days after insolvency has been determined. At the discretion of the security fund's board of directors, an insolvent underwriting member's policies can be transferred to other underwriting members or insurers.

Under the draft constitution, the security fund will not make payment on a single risk exceeding 10% of a syndicate's surplus to policyholders, to a party owning 10% of an insolvent syndicate, in cases where the premium paid was "grossly disproportionate" to the benefits provided by a policy or where a transaction has been shown to have been made with intent to "hinder, delay or defraud either then existing or future claimants against the insolvent underwriting member or the security fund."

In the event of payment of claims by the security fund, monies will be paid first from the premium surcharge fund and secondly from the initial deposits of the underwriting members. Security fund liability would be limited to the aggregate amount within the two funds.

To start operations of the exchange, the constitution provides for a seven-member board of governors to serve without compensation for the purpose of receiving applications for membership, initiation fees and dues and to conduct the first membership meeting.

The meeting would be scheduled for 45 days after the interim board is appointed and the first regular board of governors and nominating committee would be chosen at that time. Nominees for the first board of governors would have to be submitted to the interim board 10 days prior to the first membership meeting to determine whether nominees meet qualifications to hold office.

Governors elected at the first membership meeting would serve terms of varied length.

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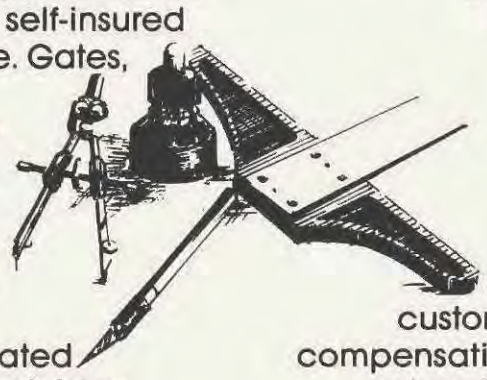

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Benefit execs expect higher salary, stature

NEW YORK—Salaries for corporate benefit managers appear to be headed upward over the next few years, considering the "very bright" outlook in the field.

This is the picture indicated by Martin E. Segal & Co.'s recent survey of 220 corporate benefit managers revealing an average salary near $22,000 a year.

Segal's Neil Burger, senior vp and manager of Segal Associates, says his analysis of the survey results "indicates that benefit managers are occupying an increasingly important role in the corporate structure."

Segal found 113 different titles used by managers responding to the survey, with employe benefits manager most frequently used (49%) by respondents. Only 7% of those surveyed, however, have the title of vp or assistant vp. Corporate benefit managers are youthful, averaging 41 years of age, with 47% of the group between 30 and 40 years old. Nearly three out of every four benefit managers is male and most have been at their present jobs one to five years. Only 9% have been there 10 or more years.

Benefit managers generally make between $20,000 and $30,000 a year (57%), though another 22% reported salaries of $30,000 to $40,000 a year. Only 4% make more than $40,000 a year, while 3% make less than $15,000 a year. That leaves 14% making between $15,000 and $20,000.

One-third of the group collects annual bonuses equaling 10% to 19% of salary, though another 24% collect less than 10% of salary in annual bonuses. A sizeable group (15%) collects between 20% and 29% of salary in bonuses, while 7% collects 30% to 49% of salary in bonuses. Only 1% gets bonuses over 50%.

Responsibilities include five basic areas in virtually all cases: Pension benefits (90%), group hospital and medical benefits (98%), group life insurance (97%), disability insurance benefits (98%) and employe benefit communications (97%). In only one area—profit sharing plans—was responsibility somewhat lower, at 70% of all responses.

Benefit managers said they're very optimistic about their careers in the benefits field, describing the future as "very bright" in a majority of cases (67%). Nobody said benefits are declining in importance.

Since enactment of the federal pension law, 97% of the benefit managers surveyed have had their workloads increased, while responsibilities have also increased in 76% of the cases. Professional personnel have been added to benefit departments for 38% of those responding, and 47% of the managers have added clerical staff.

The single biggest problem faced by benefit managers is ERISA compliance, with 100 managers citing this as their leading headache, followed up by such problems as wage and salary demands of employes, administrative coordination and employes' benefit demands.

Benefit managers surveyed work for companies ranging in size from a small firm with only 225 employes to one with 120,000 workers. The average was about 8,200 employes.

Before assuming their present positions, only 11% of the benefit chiefs had obtained any formal training in the benefit field through classes or seminars, although after they became involved in their present positions 68% attended outside courses related to the jobs. ■

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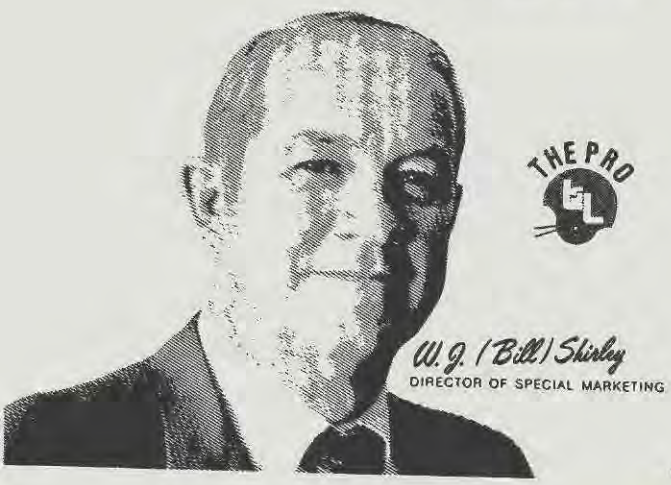

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30% penalty . . .

Continued from page 1

ance premiums paid to foreign insurers and reinsurers with the 30% tax, an IRS spokesman confirmed. Resolution of the issue could take weeks, years, or the 30% tax may never be imposed on insurance premiums, he added.

Mr. Clements said if insurance premiums were subject to the withholding tax, the cost of insurance for all consumers would rise. U.S. insurers would have to pay the withholding tax on the big chunk of business they reinsure overseas. And U.S. companies with offshore captives would have to pay the tax on insurance from their captives. Moreover, U.S. corporations purchasing insurance from Lloyd's would face bigger bills.

If the withholding tax is ever imposed for sponsors of captives "it would dictate the consideration of alternative risk management techniques," said Mr. Clements.

Another insurance industry source doubts the IRS would be the chosen instrument to effect such a massive change. "We would make it an area of congressional concern if the IRS ever produced such a ruling."

The premium redefinition issue is similar to the earlier New York fronting controversy, in which the New York insurance department proposed prohibiting fronting arrangements where the reinsurer is affiliated with the corporation whose risks are being insured, said one observer.

The fronting proposal touched off cries of outrage from the entire insurance community and the proposal was hastily withdrawn. "The premium redefinition is just like the situation in New York," said this source. "An idea may have some superficial appeal on paper, but could never survive in the real world."

George Betterley, managing director of Betterley Consulting Group of Boston, labeled the IRS proposal as "preposterous." If the IRS ever would implement this proposal it would show that they failed to understand a couple of fundamentals of insurance: The law of large numbers and the spread of risks, both of which demand a worldwide system of risk-sharing, Mr. Betterley said. ■

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Book review

Students of product liability will find prevention, defense guide invaluable

By SUSAN ALT

NEW YORK—The Practising Law Institute here has published a massive paperback volume on the prevention and defense of product liability claims for manufacturers. The 935-page book is a compilation of lectures and papers presented for distribution at two programs on the same subject, sponsored by the institute in September and November of this year.

The volume contains 17 major sections with contributions from about 20 authors who present their views on every conceivable subject concerning product liability and its related problems.

For those who need a relatively up-to-date compendium of what's happening in the field of casualty risk management and product liability loss control, this volume is a must. Although the lists of state statutes of limitations and key legislative issues around the country will rapidly become obsolete, there are practical sections that virtually explain step-by-step procedures for corporate executives to use in setting up workable product liability loss control programs.

Moreover, the annotated references to product liability case law are invaluable for those who'd like a single broad source of leading cases for legal research purposes.

Several speakers at the institute's two workshops, and therefore several sections of the book, deal with warnings and labels. Risk manager, Thomas Hallett's missive to Joy Manufacturing Co. managers is reprinted, illustrating the need to re-examine advertising copy, manuals, labels and warnings. One section contains a reprint of FMC Corp.'s manual on policies and procedures for limiting product liability exposures and for creating labels and posters warning of dangers. It is so detailed that even sizes, colors and artwork are specified.

Another section describes the need for corporate product liability committees, their organization, procedures, product recall involvement and advisory capacity in new product evaluations. Included in this section is a discussion of the corporate need for a product liability manager, along with a job description and policy statement for such a functionary.

Frequently, companies question what documents they should retain, fearful of legal discovery. An entire chapter of the Practising Law Institute's book deals with document creation, retention and protection and the need for a specified corporate program to handle this matter.

Another valuable service provided by the book, aside from its emphasis on pre-accident and post-accident liability loss prevention, is its reference sections containing the Consumer Product Safety Act and Consumer Product Safety Commission documents. In addition, the book contains the Interagency Task Force's final report on product liability loss prevention methods.

•

Prevention & Defense of Manufacturers' Product Liability, Course Handbook, $20, Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019.

BI announces ad staff changes

CHICAGO—Robert L. Niesse was named midwestern advertising sales manager for *Business Insurance*, a newly created position. Mr. Niesse has been a salesman for the publication for nine years. He will continue to manage all of his present accounts. Before joining *BI*, he was with the Chicago Tribune and IBM.

At the same time, Don Mahlmeister was hired as a midwest advertising salesman for *Business Insurance*. Mr. Mahlmeister was previously a sales rep for a firm representing other business publications. His position was vacant for several months. ■

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people

Stasch leaves Federal Mogul for A&A office

Ronald W. Stasch is leaving Federal Mogul Corp. in Detroit to join Alexander & Alexander's Detroit office. Mr. Stasch was corporate risk manager for Federal Mogul, reporting to Larry A. Edwards. The company is currently interviewing applicants to fill the position. At A&A, Mr. Stasch will be a regional vp in charge of the risk analysis and management group. The group was formed in 1976 to bring together A&A's risk analysis services for national accounts. Mr. Stasch will be servicing accounts in the Midwest region.

Sims Guyton

* * *

Joy A. Guyton, has been promoted to assistant vp from risk manager in an increased recognition of the function at Great American Management & Investment in Atlanta. She reports to executive vp **Delbert Reicherdt.** Ms. Guyton joined the company one year ago and has maintained the national insurance program on the trust's properties. Ms. Guyton said she anticipates an expansion of the department because of its growth in status. Prior to joining Great American., Ms. Guyton was an account administrator for five years with Oberdorfer Insurance Associates Agency in Atlanta. Previously, she was employed by Bankers Fire & Marine Insurance Co. in Birmingham as an underwriter. Ms. Guyton is a graduate of Georgia State University where she majored in insurance.

* * *

Althea Sims has joined the Santa Monica office of EBI Cos. to direct human resources for the branch of 70 employes. She reports to California division director of human resources **Stan Lopata.** Prior to joining EBI. Ms. Sims spent four years as employment administrator for Western Mortgage Corp. of Los Angeles.

* * *

The first manager of Planet Corp., a subsidiary of Maxco Inc. in Lansing, Mich. is **Jack Barron**, 33. Mr. Barron reports to Planet president and Maxco board member Gerald R. Houseman. Most recently, Mr. Barron was corporate insurance manager for the Michigan Farm Bureau, where his position hasn't been filled. His previous experience includes underwriting and claims adjusting for Michigan Millers Mutual Co.

* * *

B. Eric Cooper, 31, has joined Burndy Corp. in Norwalk, Conn. as manager of benefits, reporting to **Jack Akin,** director of personnel and industrial relations. Mr. Cooper replaces **Edward Skarren,** who became Burndy's manager of training. Previously, Mr. Cooper was administrator of employe benefits for four years at Kennecott Copper Corp. in New York. His replacement is **Ralph J. Cangelosi,** 28, who reports to **Walter Wilson,** insurance manager. Mr. Cangelosi worked for a year prior to joining Kennecott as a benefits and compensation analyst for Sunshine Biscuits in New York. **Thomas J. Pinto,** 28, replaces him, reporting to **Gerry Krako,** manager of benefits and compensation. Mr. Pinto previously was a group representative for Metropolitan Life Insurance Co.

* * *

Craig J. Mockler, 28, has been named manager of property and casualty insurance for Parker Hannifin Corp. in Cleveland. The position is newly created, reporting to **W.W. Creamer,** assistant treasurer. Mr. Creamer previously handled insurance as well as financial matters. Mr. Mockler was employed by Motorists Mutual Insurance Co. in Euclid, Ohio.

•

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to Rebecca A. Fannin, Business Insurance, *708 Third Ave., N.Y., N.Y. 10017 or call 212-986-5050.*

ANSWER:

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Letters column . . .

Continued from page 8

that the article quotes sources who accuse insurance companies of charging high premiums for low limits of liability and in the very same article it is cited that Baron's Mutual Insurance Co., the Virgin Islands captive, is offering the same limits at the same range.

Secondly, did the author contact either the California Department of Insurance or the Surplus Lines Assn. of California about the advisability of placement of insurance coverages in "offshore captives?"

Finally, where did the author mention the higher cost to park owners of "offshore" coverage because of the Internal Revenue Service ruling regarding the non-deductibility of premium payments as business expenses made to association captives? Although we are not aware of the exact structuring of the captives mentioned, another question is in order as to whether or not the individual members can be assessed for more premium should the loss experience warrant it. Also, it is my understanding that in some "captive" structures the financial liability of the individual association "captive" member could extend beyond involvement in the program i.e., the member may not even be in the business any longer.

Baird K. Smith
Manager, commercial underwriting department, Calgaro Insurance Services, San Diego, Calif.

In our experience, neither the departments of insurance nor the various industry associations have rendered opinions, supported by any sound data, on the financial strength of captive insurance companies. We've never heard of any single-parent or multiple-parent captives going under, although several companies have apparently voluntarily chosen to stop using their captives. Moreover, there's never been any question about the legitimacy of tax deductions for premiums paid into multiple-owner captives such as those formed to insure members of an association.

Uniform excellence

To the editor: This is to express my admiration and thanks for the uniform excellence of your newsmagazine.

The international news is done especially well, and I encourage you to expand this to have the best insurance publication in the world.

Peter Downes is worth the price of your subscription for his contributions of humor and art. His powers of observation and communication astound me. He is a scholar and I am sure an excellent risk manager. Could you get him to publish a short story of his life and his insurance background?

Please also explore and report on currency risk as related to insurance. Your legal and tax sections are great in explaining the problems of captives and keeping current the unusual complications of their development. There have been no currency problems reported, but some are brewing along with reinsurance difficulties. The cost of capital is rising sharply and efficient deployment is going to wipe out uneconomic units.

S. A. Chalk Jr.
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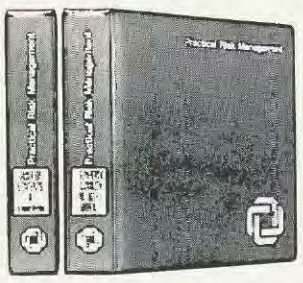

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The people with know-who in
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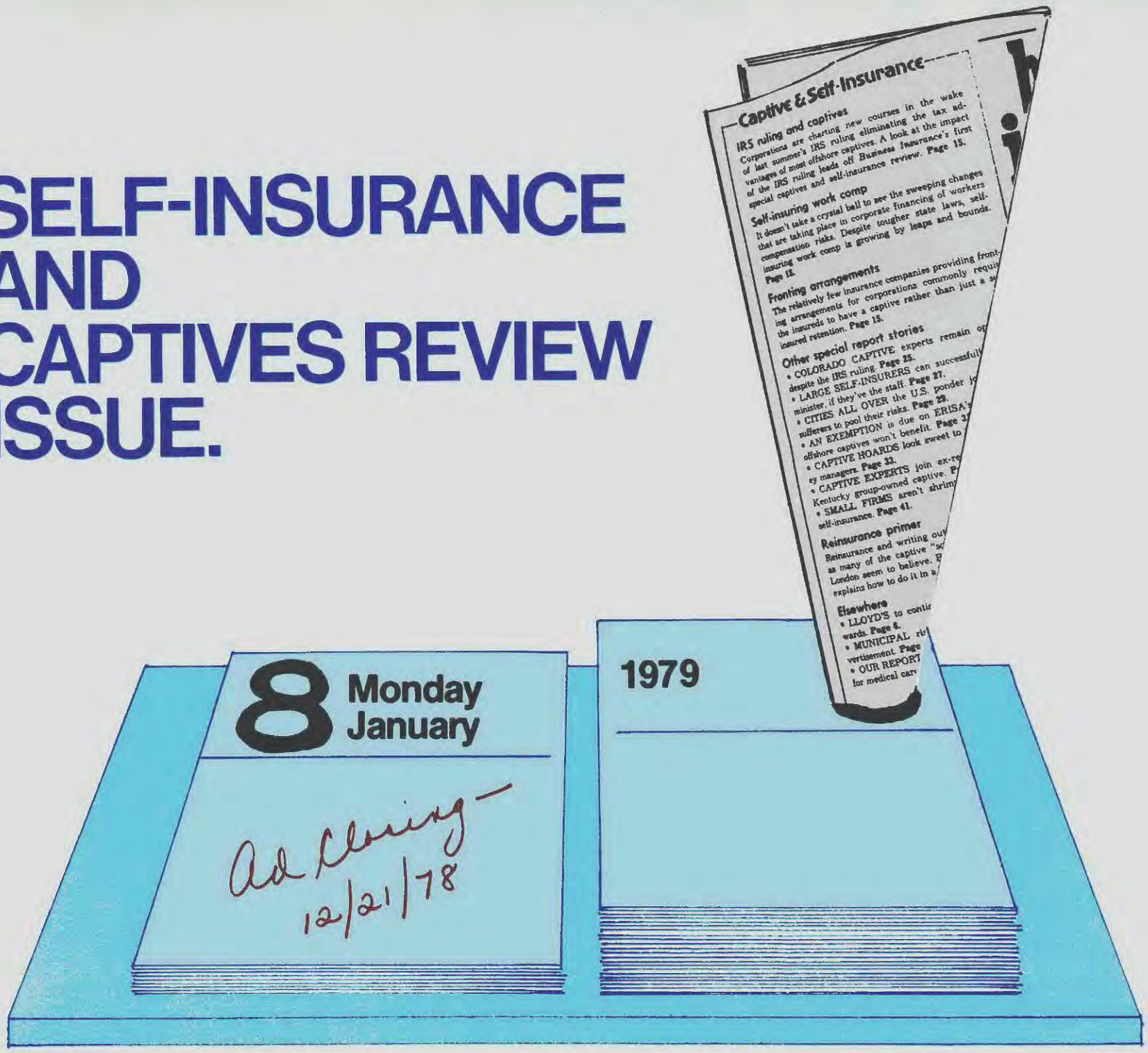
SEE OUR AD ON PAGE 6

SELF-INSURANCE AND CAPTIVES REVIEW ISSUE.



Last year's special report on Self-Insurance and Captives was an editorial blockbuster. For the first time alternative risk funding methods were thoroughly examined.

Since much has happened in past months to change the shape of things, the publishers of **BUSINESS INSURANCE** plan to kick off the new year with its second annual **SELF-INSURANCE AND CAPTIVES REVIEW ISSUE.**

On **JANUARY 8, 1979** the editors will report what has happened as well as what lies ahead with captives and self-funded programs. They'll look at the response by insurers to having policyholders get into the insurance business. And, they'll probe the mushrooming growth of domiciles for captives, both onshore and offshore.

This special report will deal with questions such as: What's the level of interest in new captives and self-insurance programs when there aren't any insurance crises to spur their growth? Who's using new and sophisticated banking or cash flow plans? What's the status of self-funding in the benefit business? What are small businesses to do when they need captives and self-insurance?

Nearly 100,000 Business Insurance readers—risk managers, financial and employe benefits executives, insurance agents and brokers as well as captive insurance company captains and their underwriters—will be reviewing and studying this special report with keen interest.

If your company has products or services geared to this influential audience, the January 8, 1979 issue is an outstanding opportunity to reach the decision-makers.

Mark your calendar now! **Advertising closing date is December 21, 1978.** For more information contact Don Walsh, Advertising Sales Director, at (212) 986-5050, or one of our sales offices listed below.

business insurance

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Peter Bleyler, vice president, tells how A&A works from a client's point of view:

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Working from a client's point of view is our way. In St. Louis, where Pete Bleyler, F.S.A., is a consulting actuary. And in over 110 cities here and overseas. That means working as allies, solving business problems together. Our Human Resource Management experts not only coordinate benefits planning to avoid costly overlapping, but they're on top of late-breaking governmental regulations.

We think our dedication to acting as an ally of the clients we represent is a big reason why A&A has become a worldwide leader in the insurance brokerage and financial services business. We have the facilities, expertise and strength to act as effective allies. We work from the client's point of view, whether the corporation is large or small.

Alexander & Alexander
The Allies

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