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business insurance

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Agribusiness firm taps Ideal Mutual in reinsurance deal

By SUSAN ALT

DECATUR, ILL.—Archer Daniels Midland Co., after being cancelled by its liability insurer of 40 years, has placed its entire general liability insurance program with Ideal Mutual Insurance Co., *Business Insurance* learned.

Ideal Mutual is an insurance subsidiary of Kraftco Corp., the huge Illinois food conglomerate.

Ideal has underwritten $1 million of coverage, including product liability exposures, on a guaranteed cost basis and has agreed to reinsure a substantial portion of the risk with ADM's own captive insurance company, Agrinational Ltd. in the Cayman Islands.

This is only the second time Ideal Mutual, itself originally a captive insurer for Kraftco risks but now in the general insurance business, has underwritten a large corporate liability insurance policy and reinsured it with the policyholder's own captive. It is the first time American Risk Management's ARM International division in Bermuda has acted as reinsurance intermediary in such an arrangement, earning commissions on the business being ceded by Ideal Mutual to Agrinational. ADM, of course, is paying the reinsurance fee.

Marsh & McLennan formerly had the entire ADM liability account, which generates premiums of $1.5 million a year.

The liability program including auto liability, general liability including product liability, and workers' compensation coverage was previously underwritten by Continental Insurance Co. of New York, which had the business for 40 years. "So it hadn't been shopped around a lot," said Thomas A. Duffield, vp of insurance and risk management at Archer Daniels Midland.

Continental notified ADM, a large agribusiness company, last summer that the company's liability risks "were no longer acceptable" to the underwriter, said Mr. Duffield. The ADM relationship with Ideal Mutual and its president, Edward Lalley, originated at meetings which Mr. Duffield and Mr. Lalley attended on the problems in product liability insurance markets in general. Later, ARM International became involved.

"Any number of companies are willing to take your programs these days on a fronting basis, I am told by brokers," said Mr. Duffield. "But our deal with Ideal Mutual is that the firm is actually underwriting some risk. It is more than just a fronting arrangement. I didn't want companies taking our business on a no-risk basis. There really wasn't any significant reason to give them practically the same money we had been paying if they were doing nothing but fronting. There's a disproportionately high cost for fronting arrangements."

Mr. Duffield wouldn't disclose the actual percentage of the business that's being reinsured by Ideal back to the ADM captive, although he said it is a "substantial" portion of the risk.

"We've realized a savings in premium cost in that we had no other bid that was even closely competitive," said Mr. Duffield. "I'd say it was a significant saving of greater than 10%."

ADM simply substituted this fully insured program for the Continental policies, with virtually no changes in coverages or policy wording. "We still have our five layers of excess liability coverage above that and we didn't want to disturb those policies," said the ADM risk manager. Sometime in the future, however, policies may be restructured to eliminate some exclusions or provide broader coverage, he added.

ARM International is the manager of Agrinational Ltd. but didn't have any previous relationship with Ideal Mutual. According to John Quinn, the senior vp of Ideal Mutual in New York, the in-

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Pregnancy ruling faces new battle in Congress

By PAUL R. MERRION & GREG DAVID

WASHINGTON—Congressional staffs are already preparing legislation to get around the Supreme Court decision that excluding pregnancy from disability insurance is not discriminatory, *Business Insurance* learned.

A decision in favor of employers had been anticipated in the hard-fought, nearly four-year legal battle affecting over 100,000 former and current female employes of General Electric Co., according to Professor Charles Abernathy of the Georgetown Law Center here. Staffs of several congressional committees have started preparing position papers on legislation that would circumvent the high court's ruling.

"The result (of the Supreme Court's ruling) could very easily be changed by Congress," said Prof. Abernathy. "Congress could redefine sex discrimination to include discrimination against pregnancy." The House and Senate Judiciary Committees are two likely sources of action, he said, adding, "It would be easy enough to do by next summer."

However, Laurence Gold, an attorney for the AFL-CIO, said it would be very difficult to enact legislation. "My instinct is to believe changes in Title VII (of the discrimination law) are as difficult to enact as changes in the National Labor Relations Act and therefore it would be very difficult to predict what's going to happen," he said.

The attitude of the new Carter administration, Mr. Gold said, could be crucial.

Reaction from corporate interests, which GE said would face a nationwide increase of $1.3 billion in disability costs if the court's decision had gone the other way, was predictably favorable.

General Electric's only comment was that the company was "pleased with the decision."

Richard D. Godown, counsel for the National Assn. of Manufacturers, said, "Our reaction is one of elation with the decision." The NAM had filed a friend of the court brief supporting GE.

"We feel the practical ramifications of the opposite decision were so horrendous since the high cost of disability insurance for pregnant women would have diminished overall employe benefits," he said. "Everybody gains equally from the decision."

Mr. Godown said he expected unions and women's rights groups to use the publicity from the decision to get legislation to change the decision introduced in Congress.

"But it remains to be seen

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Single filing date pledged for 5500s

By PAUL R. MERRION

WASHINGTON—A single filing date for Form 5500 has been promised by the Internal Revenue Service to eliminate confusion between Labor Department and IRS due dates for the jointly-required report.

The announcement came at a Dec. 3 meeting of the Commission on Federal Paperwork during which the IRS agreed to implement immediately all of the commission's recommendations affecting the agency's administration of ERISA.

Plan administrators will have the option of filing the annual report form for employe benefit plans at the end of the tax year, as previously required by the IRS, or at the end of the plan year, which is the Labor Department's due date.

"The IRS has given its blessing to all our recommendations," said a spokesman for the commission, which is a bipartisan, 14-member group including members of Congress, the executive branch and the private sector. It is studying ways of reducing red tape throughout the federal government.

After hearings Nov. 18 and 19 in Miami, the commission prepared 14 tentative recommendations to "eliminate confusion, delay and excessive costs created by the paperwork requirements of the 1974 Employe Retirement Income Security Act," according to the commission.

All 14 proposals were formally approved at the Dec. 3 meeting.

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ERISA exemption planned

Benefit captives to be OK'd

By MARGARET LeROUX

WASHINGTON—The Department of Labor is expected to issue an exemption for employers that insure employe benefits through an insurance subsidiary or captive.

The exemption, government sources say, will be issued after the first of the year. It will refer to section 408(b)(5) of the Employe Retirement Income Security Act of 1974 (ERISA) which states that a subsidiary insurance company's premium volume from insuring the parent company's employe benefits can't exceed 5% of the subsidiary's total premium volume.

This limitation, effective Jan. 1, 1975, has been considered a major stumbling block to self-insurance of employe benefits.

The Department of Labor has received more than 500 applications for exemptions from various ERISA requirements. However, a majority of the applications concern the "5% rule" and the "wholly owned provision" which requires that the insurance subsidiary be wholly owned by the employer maintaining the plan, a source in the government said.

"The applications that have been filed suggest a need for retroactive relief dating back to Jan. 1, 1975," the source said.

Crucial to any exemption issued by the Department of Labor will be the conditions it requires.

Among conditions most likely to be contained in the exemption, the source said, is a requirement that there be an arm's length relationship maintained between the parent company and insurance subsidiary. "The premiums paid to

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Lloyd's covers bank robbery—page 72

Employe Benefits

Product reformers are gloomy about Carter

By PAUL R. MERRION

WASHINGTON—Leaders of the effort to reform product liability laws are upset at the defeat of President Ford and pessimistic about the prospect of receiving help from President-elect Carter.

Several of the reform leaders were counting on the pro-business attitude of the Ford White House to aid their campaign for the next four years.

"It's a whole new ball game," said Charles Derr, senior vp of the Machinery & Allied Products Institute in Washington. "We're back at square one."

Mr. Derr said he was "upset" by Mr. Carter's highly publicized alliance with Ralph Nader during the campaign. "Carter all but embraced Mr. Nader," Mr. Derr said.

"Whatever their feelings (about product liability), it's going to be way down on their priority line," he said. "Months will lapse before the new administration is installed."

A spokesman for the Multi-Association Action Committee (MAAC), a product liability reform clearinghouse sponsored by the Sporting Goods Manufacturing Assn., said his group's strategy following the election is to push hardest at the state level, hopefully forcing the federal government to take action."

"There are more action-oriented people at the state level," the MAAC spokesman said, "although it's not really a state problem. It's more of an interstate commerce problem.

"If the states start taking action, then we can say, 'Wouldn't it be better if we had federal standards.' "

"We're not giving up at the federal level," he added. "We will contact (the Carter people) as soon as they take office," he added.

And in the solid Ford territory of Kansas, Alvin D. Herrington, attorney for Cessna Aircraft Corp., said, "The feeling I gather is that it will make it more difficult with Carter at the helm—Ford was more business-oriented."

Mr. Herrington also said that a power shift in the Kansas state legislature, which gave Democrats a five-seat edge in the House where the Republicans had previously had an eight-seat advantage, "makes our job very difficult." Mr. Herrington is a major supporter of a Kansas bill that would adopt various product liability reforms.

"So it's bad on two fronts," he said. "It will be practically impossible unless we convince labor that (product liability reform) is in their best interest.

"I'm not as optimistic as I was before the election," Mr. Herrington said.

Nevertheless, President-elect Carter will undoubtedly be bombarded by those who predict disaster in product liability insurance, just as he will be bombarded by other special interest groups in the country during his first few months in office.

Referring to the report of the Interagency Task Force on Product Liability, a task force spokesman said, "How much attention this gets depends on who gets their ear the quickest."

Representatives of the Woodworking Machinery Manufacturers of America and the National Machine Tool Builders Assn. told this magazine that they also intend to contact the Carter White House soon after inauguration. Other groups can be expected to send emissaries as well.

What matters is the reception they will get. Late last year the Ford administration got involved in the product liability problem because L. William Seidman, the President's assistant for economic affairs, received a letter from Ralph Baldwin, president of Oliver Machinery Co. in Grand Rapids, Mich. Mr. Seidman and Dr. Baldwin were previous acquaintances from the days when Mr. Seidman had an accounting firm in the President's hometown.

That 10-page letter kicked off a 30-day crash research effort by the Commerce Department, which ultimately recommended further research and the formation of the Interagency Task Force.

The unanswerable question about the incoming Carter administration is how seriously the new appointees will consider the product liability problem.

Interesting comments on the incoming President's personality and attitudes toward business were offered by a fellow Georgian, William M. Brooks, of Brooks Burke Surgical Supply Co. of Atlanta.

Mr. Brooks, who is a member of the advisory committee to the product liability task force, said he has met Jimmy Carter but does not know him personally.

Mr. Brooks said he thought Jimmy Carter is "enough of a businessman to realize the product liability problem. Jimmy Carter isn't dumb." ■

Pick Ideal Mutual . . .

Continued from page 1

surer hopes "we'll be doing more business with ARM in the future." Ideal Mutual has also been working "with several other large brokers" on similar programs.

Mr. Quinn said Ideal Mutual has been "in the casualty business" since early in 1976. "We are working with other captives," said Mr. Quinn, although only one corporate liability program has actually been underwritten by Ideal Mutual and reinsured into a captive at this point. Other similar arrangements are pending, he said.

Ideal Mutual isn't specializing, however, in product liability risks, Mr. Quinn stated. The insurer is looking for a broad range of casualty risks.

ADM had serious losses in the last few years under the policy with Continental, particularly in the workers' compensation field. But Mr. Duffield said there was "no particular pattern of losses or significant changes in our operations that we felt would give rise to our being suddenly an unacceptably hazardous risk."

Overall the ADM loss picture was not unusually adverse or heavy, he added. ■

GUIDE TO FEATURES

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Vision care, dental additions key Harvester pact

INTERNATIONAL HARVESTER Co. in Chicago agreed to a vision care program, improvements in dental insurance and the addition of retirees to the dental program in the company's new three-year contract with the United Auto Workers. Under the vision program for the company's 40,000 workers, effective March 1, one eye exam and pair of lenses will be provided every 24 months. The plan will pay according to a schedule of benefits that provides $25 for an exam by a physician, $20 for an exam by an optometrist, $20 for lenses, $30 for bifocals and contacts and $14 for lenses. The company will set up a network of providers who agree to limit fees to the schedule in areas with a concentration of employes. The improved dental plan will cover 100% (up from 90%) for restorations and the lifetime orthodontic limit has been raised to $500 from $150. The contract also calls for six additional days off during the lifetime of the contract and an addition 1 to 1½ weeks of vacation time. There are also improvements in the company's life and disability insurance benefits.

GENERAL MOTORS Corp. has selected Delta Dental Plans of Michigan to administer the prepaid dental benefits program covered under its contract with the United Auto Workers. The program, covering 700,000 subscribers and dependents, was formerly underwritten by Delta Dental Plans and administered jointly by Delta and by Blue Cross Blue Shield of Michigan. A spokesman for Delta said the premiums had not yet been set. Delta Dental Plans says it now covers 14 million people, 41% of those enrolled in dental insurance programs.

KIMBERLY-CLARK Corp's educational program, now in its third year, has proved exceptionally popular with more than half of the 7,300 eligible employes adding their own money to the educational account. Under the plan, the Neenah, Wis., company contributes 25% of an employe's allotment (a typical allotment is $480) to the account. The employe may then add up to $200 a year and the company will add 20% of the workers' contribution. The program cost Kimberly-Clark $700,000 the first year and $800,000 in the second. More than 35% of the eligible employes are participating compared to the 1%-5% figure at most other companies. A spokesman for Kimberly-Clark said they had received over 400 inquiries about the plan from other companies.

LASALLE NATIONAL BANK, Chicago, didn't believe in limiting the number of bidders on its group benefit programs to four of five firms. The bank drew 14 to 16 bids for group plans covering 700 to 750 employes. The broker was Corroon & Black, but C&B didn't have an exclusive, so Marsh & McLennan was in there pitching, too, said Art Rayunec, senior vp. In the end, Prudential lost the account and Confederation Life of Canada won it. The premiums are under $1 million but a nice piece of business, in any case. Improvements in the benefit package included 120 day hospitalization coverage, 100% major medical coverage after the first $5,000 of expenses, medical maximum raised to $250,000 from $100,000, increased life insurance of two times salary from 1½ times salary, and a new long term disability insurance plan. As part of the benefit review, LaSalle National also considered establishing a 501(c)(9) trust for its group benefits, but figured it wasn't in the insurance business and didn't want to go that route.

THE SINGLE BIGGEST source of business for Peat Marwick & Mitchell's Chicago benefit consulting operation is smaller companies —with up to 150 employes—seeking advice on how to hold down the premium costs of insured pension plans in the wake of ERISA. The problem stems from the law's changes in elegibility requirements. Peat Marwick's Thomas R. McCall is pushing what he calls group funding, which involves what risk managers would call self-insurance. Take for example, the insured pension plan of Evanston Federal Savings & Loan Assn., Evanston, Ill. Before the federal pension law, only eight Evanston Federal employes were eligible to participate, so that annual premiums to the insurer were $60,000. Not cheap, but manageable. Post-ERISA, 38 employes of the S&L were suddenly eligible, and the premium cost soared to $120,000. Peat Marwick's advice was to change to a deposit administration contract, use this concept of "group funding," and lower costs to $50,000 a year. In this case, Evanston Federal even stayed with the same insurer—Ohio National Insurance Co.—although Mr. McCall says it's often necessary to drop the insurer altogether to keep costs down. ■

Utility suffers $8 mill. loss

CHICAGO—Commonwealth Edison Co. will have to cover $1 million of its loss, estimated at between $8 million and $10 million, from a fire at a generating plant here Nov. 14.

The fire began in a coal conveyor in the plant on the south side of the city. A fireman fighting the blaze was killed when he was trapped under part of the conveyor. The plant was shut down for about 24 hours.

A Commonwealth Edison spokesman said the company has a manuscript type fire and extended coverage policy to cover the loss with a $1 million per occurrence self-retention. The policy's limit is $150 million.

The company declined to name the insurance companies involved, although it did say the policy is in one layer involving 11 underwriters.

All the property involved in the fire was owned by the utility. The exact cause has not been determined yet.

The company said it would have no comment on whether the loss would result in any changes in the cost of its coverage. It also said it planned no changes in coverage as a result of the fire. ■

Philly hotel closing not expected to affect hotel liability insurance

By MARIE KRAKOWIECKI

PHILADELPHIA—The stately old Bellevue-Stratford Hotel was forced to close in November, the 30th victim of the mysterious "Legionnaire's Disease" which killed 29 persons last summer.

Philadelphia lost a landmark. But hotel insurers said the unusual circumstances surrounding the demise of the 72-year-old inn would not have any overall impact on hotel liability insurance.

The Bellevue-Stratford was uninsured for financial losses reported to have averaged $10,000 a day because its stream of paying guests slowed to a trickle following adverse worldwide publicity linking the hotel to the unexplained deaths.

During the final three months it remained open, occupancy dropped to as low as 3% or 4% at the 750-room hotel, which was once the site of fashionable balls and lodging for U.S. presidents and foreign dignitaries.

Travelers Insurance Cos., which was a liability insurer of the Bellevue-Stratford, confirmed that the hotel was unprotected by business interruption coverage for its lack of paying guests.

For such an occurrence, business interruption insurance is extremely rare if it exists at all in hotel liability insurance policies, industry sources explained.

Nor is innkeepers' liability expected to be an area which will be affected by the Bellevue-Stratford's forced closing. Innkeepers' liability was not involved at all in the Philadelphia hotel's circumstance, according to Francis Wolf, the former general controller for the Bellevue-Stratford.

Innkeepers liability covers losses or damage to items in the possession of a hotel but not owned by it. That would include things such as the personal property of paying guests.

The Bellevue-Stratford's majority owner, Bankers Securities Corp., commissioned Albert M. Greenfield & Co. to sell the hotel last month. Mr. Wolf identified a firm of the same name as the hotel's insurance broker. However, the person there in charge of the hotel's coverage refused to comment on any aspect of the insurance or what the Bellevue's closing would mean to other hotels' coverages.

Ironically, the same day the closing of the Bellevue-Stratford was announced, another hotel owned by Bankers Securities Corp. suffered a severe fire which required the evacuation at night of about 900 persons.

No information on insured losses was available on the fire, which hit Philadelphia's biggest hotel, the Benjamin Franklin. However, hotel insurance sources told *Business Insurance* that, unlike the lost business the Bellevue-Stratford suffered because its paying guests dwindled, lost revenues due to fire or smoke damage are generally reimbursed by hotel insurance policies.

Travelers said no claims had been filed against the Bellevue-Stratford regarding the deaths of the 29 victims in July, or the 150 others who were stricken but not killed by the puzzling Legionnaire's Disease.

That may be because scientists have not decided if the Bellevue-Stratford or anyone else was in any way to blame for the baffling illness or its consequences. All that is known is that the 27 victims who attended an American Legion convention and two who were at a Eucharistic Congress all spent some time at the hotel.

Adverse publicity linking the dread disease was what killed the Bellevue-Stratford, not any liability based on fact, hotel and insurance industry sources insisted.

The closing, effective Nov. 18, put 350 employes out of work, including some who labored at the Bellevue-Stratford for nearly half a century.

Three unions representing workers at the hotel filed an unsuccessful suit in federal district court to keep the hotel open, charging that the decision had been made unilaterally by the management, violating the terms of the unions' contracts.

James Clark, president of Local 234 of the Hotel and Restaurant Workers Union, said the closing would terminate all health and welfare benefits for the workers, an action he said was unfair.

It is said many of the Bellevue-Stratford employes were tipped off about the impending announcement of the hotel's closing when the outside security guard force employed by the hotel was increased just before the press conference. The employes guessed that the strengthened security force was there to guard against souvenir hunters who would try to walk away with "relies."

Although the circumstances surrounding the Bellevue-Stratford's forced shutdown were dramatically unusual, hotel insurance sources said the extent of risk and exposure involved was commonplace, even if its origin was bizarre.

"I hate to sound cold about this," one insurance spokesman said, "but most hotels face bigger liability risks every day from things like chandeliers falling on the heads of people at a banquet."

While the Bellevue-Stratford's case was tragic, he explained, on an actuarial basis the number of lives lost would not affect the overall insurance outlook for hotels.

After the fatal outbreak of Legionnaire's Disease, the last American head of state to visit the Bellevue Stratford was President Gerald Ford. He attended a reception there after his debate with Jimmy Carter at the Walnut Street Theatre a few blocks away ■

Action urged on asbestos

TORONTO—Throat cancer in workers exposed to asbestos dust should be considered an industrial disease and covered by workers' compensation programs, according to a leading cancer expert.

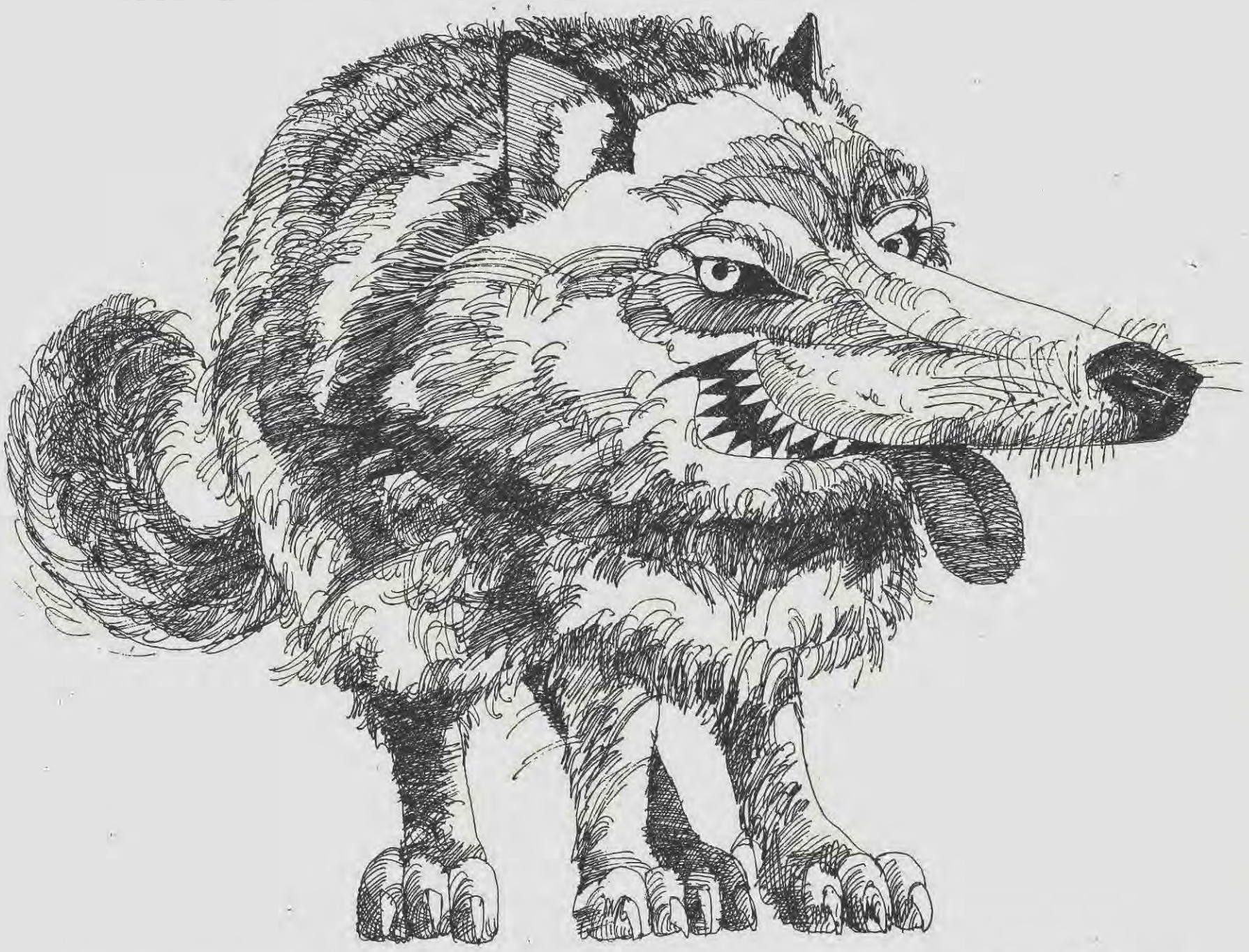
Dr. Irving Selikoff of Mt. Sinai Hospital in New York urged the Ontario Workmen's Compensation Board to bring asbestos throat cancer under its program. The WCB, citing insufficient evidence, has refused to consider it an industrial disease.

The evidence that asbestos dust causes throat cancer is "no longer vague," Dr. Selikoff said.

"The studies carried out in Great Britain and here in Toronto are reliable. We will be publishing research in about three months that suggests those scientists were correct in their findings," he said.

Dr. Selikoff addressed a labor-management conference held by the Ontario Construction Assn. ■

The product liability menace.



Too late to cry wolf. He's already in your boardroom.

Product liability has turned out to be an undisguised wolf who has invaded company headquarters, everywhere. And his presence has a lot of business people and their insurance companies scrambling up the same tree.

While preoccupation with medical malpractice insurance and OSHA compliance usurped attention from product liability, the problem kept growing.

The American public seems intent on going to court. "Sue the bastards" used to be a joke. Now it's a battle cry. With the help of eager attorneys, plaintiffs are not only quick to demand justice, but "extra" justice, because their chances of success are great. Courts have ruled that it's not necessary to prove negligence on the part of the manufacturer to collect damages.

There has been a frightening increase in the number of product liability claims—and in their dollar volume. Latest available figures show that for every dollar in product liability premiums, insurance companies have been paying out $1.35 in losses and expenses of handling claims.

So insurance rates are bound to go up even more. Perhaps to a point where many manufacturers may not be able to afford the coverage. And *no* one can afford *that*. Not producers. Not the insurance industry. Not the people who need the products. But on the other hand, consumers have a right to expect more than a "Use at Your Own Risk" label on the goods they buy.

Major changes in the tort laws must be made at the state level—and quickly—to correct a disastrous trend. Employers Insurance of Wausau recommends starting with these four modifications.

1. Prohibit the retroactive application of current manufacturing standards to older products. Product safety should be judged according to standards at the time of manufacture.

2. Exempt from liability a maker or seller of a product that was subsequently modified or misused.

3. Establish a statute of limitations on claims based on the time the product left the manufacturer's or seller's control.

4. Eliminate punitive damages which only inflate awards above and beyond full compensation for economic damages and pain and suffering.

We think these changes are reasonable and necessary. We also believe that until there are meaningful reforms in the state tort systems, *loss prevention* remains your best way to cope with the basic problem. And that requires a *partnership effort* on the part of every policyholder. In the long run it's the only way to control insurance *costs*. And to keep certain forms of insurance attainable.

Meanwhile there are other positive things to be done. If you run a small business, join with your trade association in spurring your state legislators to tort reform action. If you're in a large corporation, you have the expertise and specialists within your own company to do some shaking and moving.

We all have to talk up. Because if we don't, nothing will happen. And that's the worst thing that can happen.

Come to the source

Employers Insurance of Wausau

Wausau, Wisconsin

Transamerica to pay part of highrise fire loss

LOS ANGELES—Transamerica Corp. will pay a large part of the loss in its Nov. 20 highrise fire out of its own pocket, under a $250,000 self-insured retention which it must cover before submitting a property claim to its insurers.

A blaze occurred here in the 32-story Occidental Tower in the early morning hours, burning contents of the 20th and 21st floors and causing smoke damage on the 22nd floor. Estimates have put the loss at $2 million, although it's understood company officials expect the loss to be substantially less.

The floors were occuped by Transamerica Insurance Group and Transamerica Financing Corp., both subsidiaries of Transamerica Corp., owner of the building.

The company is known to have plenty of insurance to cover the contents loss, with a layered insurance program over the $250,000 deductible. The damage to contents alone is expected to exceed the retention.

Employers of Wausau is Transamerica's fronting insurance company for a program using Lloyd's as the lead underwriter. "A claim will be filed, but it won't be a very big one," said a source close to the company. Transamerica's property insurance program also covers business interruption losses, under a three-year program now in its second year.

Transamerica is confident it won't have any business interruption loss following the fire because employes hurriedly established standby offices.

The Occidental Tower has a smoke detection system throughout the building, although it is mostly without sprinklers. Transamerica's headquarters building in San Francisco, however, is fully sprinklered.

The blaze erupted on the 20th floor of the building at 3 a.m. About 300 firemen and 58 fire companies battled the fire for over two hours before it was brought under control. Investigators believed the fire was caused by an arsonist; some flammable fluids had been found in the area.

Eleven hours after the Transamerica fire was discovered, another fire was found in a sub-basement of another building in the same complex.

Two firemen were injured fighting the flames.

The fire knocked out electrical power and with elevators inoperable, firemen had to carry hoses 20 floors. Exploding windows on the high floors sent glass flying for blocks.

The fire occurred just as the insurance industry was preparing substantial rate increases for commercial fire insurance in California's three largest cities, Los Angeles included.

Los Angeles fire insurance rates for buildings such as the Occidental office headquarters were increased 20% earlier this year. San Diego rates went up 5% but San Francisco premiums were not increased.

Rates for those three cities are expected to increase again in 1977, according to the Insurance Services Office in San Francisco, because of the recent nationwide change in the methods used to establish appropriate risk premiums.

Previously the single factor used in rating cities was an inspection, conducted once every 10 years, of a city's fire department, hydrants, water supply and obstacles such as narrow streets and overhead wires.

The ratio established by the inspection was applied to a state's entire fire loss experience. The new method, much simplified but more costly, bases a year's fire insurance premium on the fire loss claims paid in the prior year.

The new method, according to the ISO, would have required a rate increase of more than 50% for Los Angeles alone. Instead, the 1976 boost was held to 20%, with another increase of as much as 30% projected for 1977.

San Francisco Fire Chief Andrew Casper says, "The city will be fortunate if we avoid a huge commercial fire insurance rate jump in 1977."

Economies following a strike early in 1976 by firemen as well as policemen have been blamed by Chief Casper for "a shortage of fire fighting manpower in the commercial industrial areas.

"Lack of manpower," he insists, "will make it difficult to hold down huge losses in big fires in commercial and industrial buildings. Most such fires start at night when the buildings are untended and they often are raging in full before our men are even notified."

In one month this year, at a time when the fire department lacked funds to pay overtime, San Francisco had 23 major fires. San Francisco is now averaging about five major fires a month.

The new rate determination method, according to Mr. Casper and the ISO, would justify a 2.2% commercial fire insurance cost increase in San Francisco and as much as 17% more for San Diego.

California's counties and smaller cities, using the new method, have a risk ratio which the ISO contends justifies an 11.5% reduction in fire insurance rates.

Nicholas J. Pandullo, chief of the rate regulation division of California's Insurance Department, has approved the new rate determination system.

"California's insurance laws," Mr. Pandullo points out, "permit insurance carriers to compete without regulation of their premium charges, so long as such charges are not considered excessive or so low that the companies might be unable to pay claims." ■

RVIA eyes a captive

CHANTILLY, VA.—The Recreation Vehicle Industry Assn. (RVIA), troubled by skyrocketing product liability insurance premium hikes, is considering establishing an insurance captive.

Benefits of the captive include "better initial insurance rates and the establishment of a loss control program," Bill Garpow, national legislative director told *Business Insurance*.

Pointing out that the concept is presently in "very early stages of development," Mr. Garpow said the next move will be to approach the association's board of directors with a proposal for an in-depth, third party feasibility study on the captive concept. He said the board of directors will meet next in February.

Both domestic and offshore captives will be studied, Mr. Garpow said.

He estimated the product liability premium potential of the association at about $15 million. ■

Take Advantage of Us. Our Engineers Will Love It.

Engineering services abroad is a lot more than having an engineer on staff who is on the run all the time. It takes back-up, plenty of experience, and an organization that knows the local markets in depth to provide a multi-national company with the kind of engineering services it should have.

Fire protection and loss prevention techniques demand an intimate knowledge of not only what can be done but what should be done. Uniform worldwide codes and standards are decades away and those that do exist are more often far below the standards that are taken for granted in the United States.

AFIA, the largest U.S. underwriter of foreign insurance with more branches overseas than any other, knows what the differences can mean. It has been the leader in fire protection and loss prevention services abroad and pioneered the HPR concept in Europe.

Like we said, it takes a lot more than an engineer to provide engineering services. AFIA, has over 4,OOO employees abroad and with almost 6O years of on-the-spot experience, we know the markets, the codes, the ins-and-outs like it was our own backyard.

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Acquisition has moved A&A into second place

NEW YORK—Bleichroeder, Bing & Co. Inc., a leading New York insurance brokerage firm, merged with Alexander & Alexander.

This acquisition puts Alexander & Alexander in a neck-in-neck race with privately-held Johnson & Higgins for the position as second largest insurance broker in North America. J&H was estimated to have had total gross revenues in 1975 of $149 million, compared to A&A's reported $124.31 million.

According to the *Business Insurance* Agent/Broker Profiles published Aug. 9, 1976, Bleichroeder, Bing had premium volume in 1975 of $25.5 million. The firm's gross revenues were $2,950,000, including commissions and fees. Bleichroeder, Bing said it had 100 employes at yearend 1975 and 90% of its business was commercial.

The combined gross revenues of the two firms now becomes more than $150 million, based on reported revenues of both firms. Bleichroeder, Bing is approximately one-fifth the size of Alexander & Alexander. It was one of the largest privately held insurance brokerage firms left in the U.S.

Bleichroeder Bing began in 1859, when Moses Bleichroeder, great-grandfather of the present board chairman, Thomas B. Herzfeld, founded the firm in Hamburg, Germany. The company was incorporated in New York in 1937. From its initial concentration in ocean marine insurance, the firm has expanded into all areas of insurance and risk management services.

Mr. Herzfeld, John W. Bing, president, and Andrew E. Rossmere, executive vice president, become vice presidents of Alexander & Alexander's New York office; other personnel join the A&A office in Chicago, where Bleichroeder, Bing had maintained a satellite facility. In all, 85 Bleichroeder, Bing employes are to be incorporated into various departments of A&A. ■

CPCU taps Finan

Robert M. Finan, 48, has been appointed director of continuing education by the Society of Chartered Property and Casualty Underwriters. He previously was director of education for the Independent Insurance Agents of Ohio. Mr. Finan said he plans to increase meetings with other professions.

RIMS conference set to open on April 24

NEW YORK—Employe benefit sessions divided by industry groups will be offered for the first time at the annual Risk & Insurance Management Society's annual conference April 24-29 in New York City.

Speakers at "Conference 77" include F. Lee Bailey, trial lawyer and author of several books, and Pauline Frederick, international affairs analyst for the United Nations. Conference sessions will be held at the Americana and New York Hilton hotels.

The employe benefits sessions will cover ERISA prohibitions, negotiations and trends for the coming year and pension liabilities in sales and acquisitions. Workshops will offer such topics as investment policies for benefit funds, executive perquisites, measurement of benefit plans and means of benefits communication. *Business Insurance* magazine will present its annual employe benefits communications awards April 26.

Industry sessions held April 25 and 26 will exchange ideas and problems found in a particular industry such as food chains, utilities, retailers and others. The employe benefits industry sessions will be held the morning of April 27.

Mini-seminars in the property/casualty area will include risk management accounting, self-insurance and systems safety approach to product liability. Seminars open to all participants include risks and techniques of contractual transfer, an overview of product liability and of workers' compensation, formation of a captive insurance company. Also group insurance funding alternatives, cash flow concepts, reserves and self insurance will be the subject of one of the seminars.

Cost of the conference is $300 for RIMS members before March 24; $325 after March 24. The full week cost for nonmembers is $375 before March 24 and $400 after.

Rates for partial week are available. ■

U.S., state regulation trade seen

NEW YORK—The insurance industry may face a "golden opportunity" to escape state regulation in return for giving up its antitrust exemption, according to a study by the Research Institute of the College of Insurance.

H. Clay Johnson, in a study financed by private insurance companies, said efforts to amend the McCarran-Ferguson Act come at a time when state regulation of insurance is at a crossroads.

"The underwriting results are currently so poor as to threaten seriously the continued solvency of some companies. While resistance by state authorities to needed rate increases is not alone responsible, it does exacerbate the effect of economic and social inflation which is mainly responsible," Mr. Johnson said.

"The McCarran Act has often been described as having put a cloak of immunity over the shoulders of the insurance industry. The irony is that the cloak has been hanging virtually unused in the attic closet for many years and yet it remains an object of criticism . . . Worse than no privilege at all is one which is maligned but of little value. This may be the time for the inurance industry to surrender the cloak and face the elements ungarbed because only then can it compete equally with other segments of interstate commerce," he said.

The recommendations of the Ford Administration's antitrust task force to amend the McCarran act "may provide a golden opportunity for the insurance business to negotiate a broadened amendment which would liberate it from the unreasonable burdens of state regulation," Mr. Johnson said. "It would seem such an opportunity should not be ignored." ■

Clearing the canal

Pictured below are just two of the dozens of sunken ships which for nearly 8 years blockaded the Suez Canal during the Arab-Israeli conflict.

Removing these vessels was a massive undertaking—one which demanded both a skilled salvage company to head the project and a knowledgeable insurance broker to design a protection program against the unique and catastrophic hazards involved.

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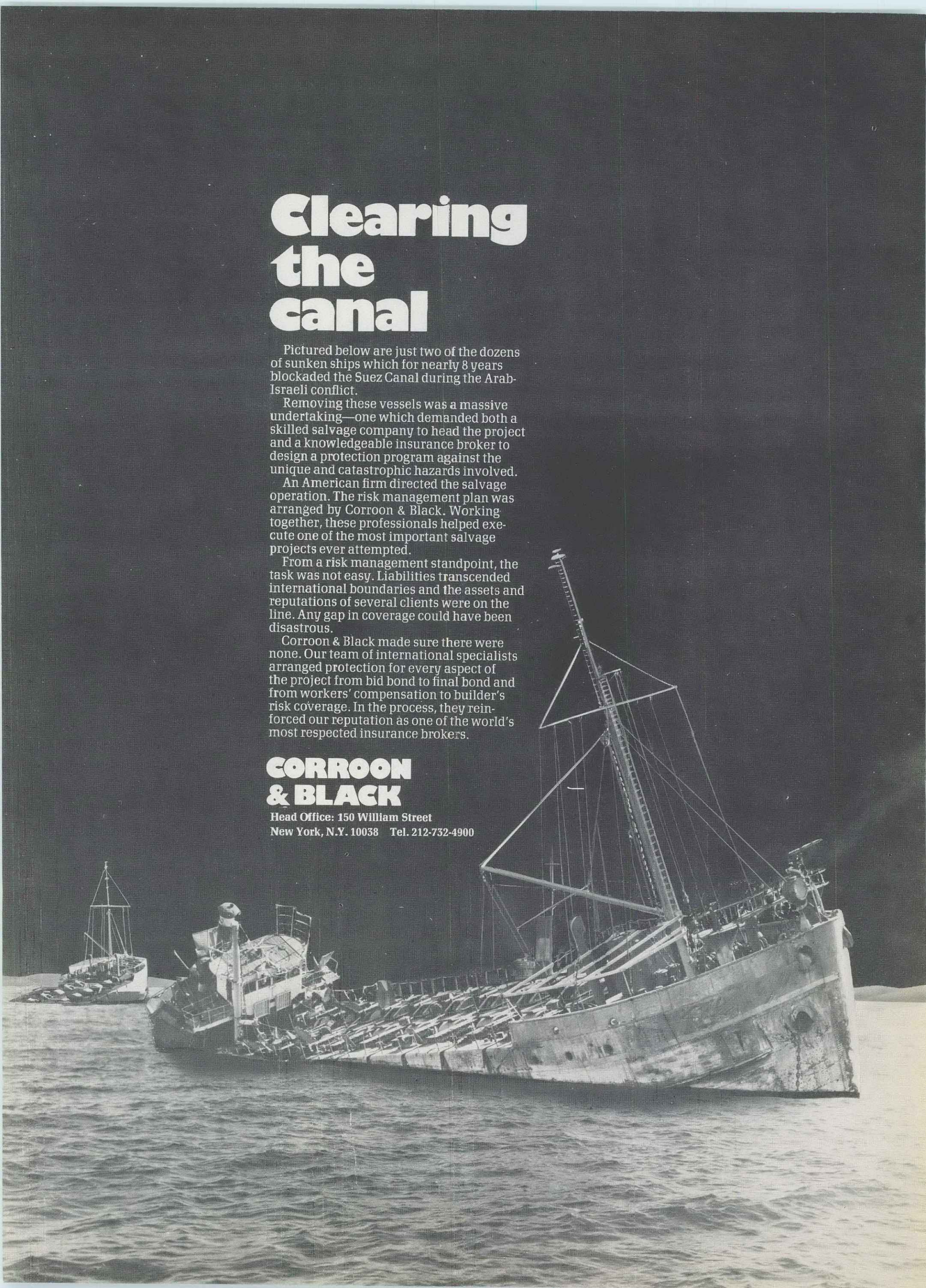

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Employe Benefits

Commercial insurers renew drive to end Blue's discount

By GREG DAVID

CHICAGO—In a move with important implications for the price and availability of hospitalization insurance, commercial insurance companies have renewed their efforts to eliminate the difference between charges to their insureds and those covered by Blue Cross.

The Blue Cross discount nationwide has been estimated at between 4% and 8%. But in the areas where the problem is most acute—New Jersey, New York, Pennsylvania, Michigan and parts of New England—patients covered by other insurance carriers pay 10% to 30% more than Blue Cross patients.

"We feel, regardless of who the third party payer is, charges should be the same and then the various carriers can compete on the basis of their efficiency," said Richard J. Mellman, a vp and actuary with Prudential Insurance Co. of America and a leading spokesman for the industry on the issue.

But W. Jefferson Lyon, vp with Blue Cross of New Jersey, contends the "civic burden" Blue Cross is required to carry justifies the discount. Without the discount, he said, "the competition will wipe us out."

Commercial insurance companies also argue that the discount has allowed hospitals a loophole to escape efforts at controlling their costs. In that view they are joined by many insurance regulators concerned with rising health care costs.

Legislation to deal with the discount has been introduced in New York and New Jersey. In addition, new laws designed to deal with rising hospital costs in several states—Maryland, Connecticut and most recently Massachusetts—often provide mechanisms for eliminating the discount.

The discount is largest where the Blue Cross plans originally were strongest—in the East and industrialized states in the Midwest, said James Purdy, second vp with The Travelers Insurance Co. in Hartford. The stronger the Blue Cross plan, the more economic leverage and the wider the discount, he explained. The wider the discount, the more attractive Blue Cross is to the company placing a large group insurance plan.

Experts agree the basis for the discount is that Blue Cross pays an audited cost under contracts with hospitals, while other insurance companies reimburse full hospital charges. Blue Cross refuses in most states to pay bad debts incurred by hospitals and occasionally won't cover some depreciation costs or costs of construction or operating research facilities. Hospitals then shift these costs to patients covered by other commercial insurance plans, creating a wide gap in claims for Blue Cross versus claims for other insurers.

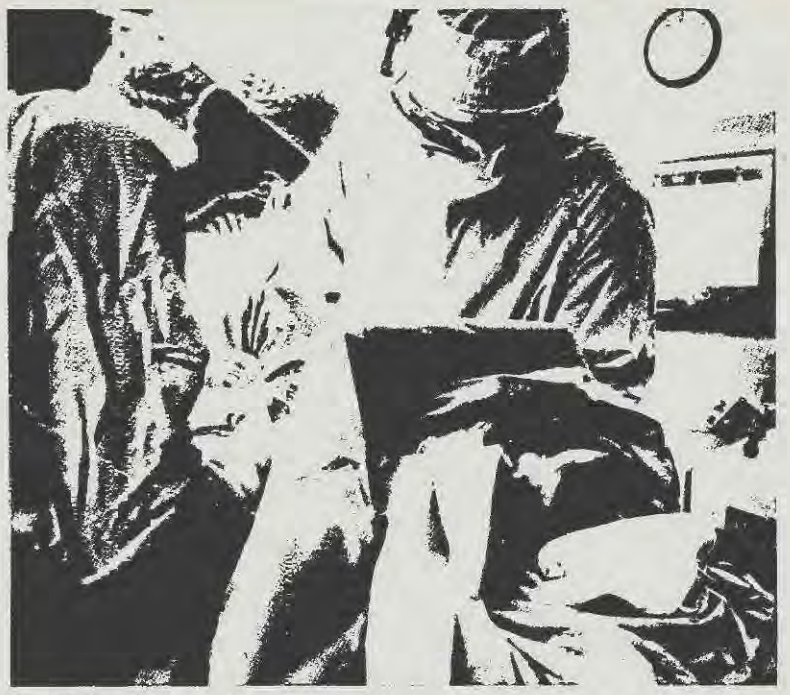
Complicating the problem still further are "prospective budget review" laws in many states. Under this legislation a state regulatory body approves hospital operating budgets and the charges to Blue Cross, Medicare or Medicaid patients. But in most states these same bodies do not have the authority to control charges to patients covered by insurance underwritten by carriers other than the Blues. Hospitals can move costs disallowed by the regulations to the non-Blues patients.

The discount has received the greatest attention in New Jersey. Blue Cross admits to a 20% discount in the state, a figure confirmed by the Department of Insurance. But Prudential and other commercial insurance company experts contend their insureds are charged 30% more than Blue Cross insureds.

Under New Jersey's prospective rate review law, hospital operating budgets and costs to Blue Cross, Medicare and Medicaid are regulated by the state Department of Health. Charges to private insurance patients, and the costs included in setting those rates, are not.

Like other Blue Cross plans, New Jersey Blue Cross excludes from its contracts bad debts at the hospitals and some depreciation charges. A hypothetical example of the discount at work comes from Mr. Mellman with Prudential:

A hospital spends $20 million for 100,000 days of patient care resulting in a cost per patient day of $200. Blue Cross, Medicare and Medicaid pay the hospital $200 per day for the 75,000 patient days incurred by patients they cover.



Hospital patients in New Jersey with insurance from a commercial company may be charged 30% more than a patient covered by Blue Cross.

The hospital's net income is $15 million.

Thus the hospital must raise $5 million from the remaining 25,000 patient days. But if 5,000 patient days are not paid, the hospital must charge $250 a day for the remaining 20,000 patient days.

According to one report, a Blue Cross patient in a hospital in northern New Jersey was charged $4,300 for a lengthy stay. If the patient had been covered by a different group insurer the cost would have been $16,984.

In New Jersey, according to Mr. Mellman, private insurance companies account for 17% of patient days while Blue Cross, Medicare and Medicaid patients account for 83% of patient days.

One insurance company official working in the group coverage area said the issue is one of "equality, fairness and justice." Tom O'Hare, a cost specialist with the Health Insurance Assn. in Chicago, said, "It's hard to see why the cost of third party payers should influence hospital coverage."

One industry official said, "The problem is reaching comic proportions—and I don't mean comic as in the comics but comic as in comic opera."

But in addition to the question of fairness, insurance company officials argue the present system allows hospitals to escape cost control efforts.

If a hospital does not get approval for the budget it wants, said William White, an actuary with the New Jersey Department of Insurance, it merely adds those costs to the charges for non-Blues insurance patients.

Mr. Mellman argued the present system is like establishing a budget for groceries but not controlling expenditures in other areas."

A bill to allow the state Department of Health to set rates for all hospital patients has been introduced in the New Jersey legislature with the support of the state

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BI Benefit Board expects higher health premiums

CHICAGO—Employe benefit managers, lamenting hefty premium increases for group health and medical insurance during 1976, are forecasting still more price hikes in group lines next year.

As a result, they are overwhelmingly considering establishing internal funding programs for their group benefits, either tax-sheltered trusts or other self-insurance plans. While many corporations don't yet use these alternatives to group insurance, the second *Business Insurance* survey of its Employe Benefit Board members indicates 1977 is going to see a spurt in self-funding of group benefits.

According to the 78 companies responding to the survey, long term disability is the leading candidate for self-insurance. Following closely behind are even larger benefit dollars, including health and medical benefit plans and prepaid dental care.

One of the benefit areas already heavily self-insured, if that is that correct term, is retirement programs—pensions and profit sharing. Twenty-seven companies have insured plans, 23 said they have trusteed plans and 28 said the question was not applicable to them. We believe that means 51 companies self-fund their retirement plans, perhaps using outside money managers.

During the past year, premiums on group insurance rose for 68 of the 78 benefit managers. Nearly all of these benefit managers have had hikes in their health and major medical insurance costs—67 of them—while only scattered increases were reported in other group lines. Four benefit managers said their long term disability insurance costs rose; two pointed to increases in sickness and accident coverage; five said dental insurance was more costly, and one said group life premiums have risen.

Offsetting these responses, however, were two benefit managers who noted their dental insurance premiums have fallen in the last 12 months by 5% and 10% respectively.

The average of hospitalization

Continued on page 12

INSURANCE COMPANIES WHICH UNDERWRITE CORPORATE BENEFIT PLANS

Group Life	Total
Prudential	25
Metropolitan	17
Travelers	12
Aetna	10
John Hancock	7
Equitable	6
Conn. General	5
Provident Life	4
General Amer.	4
Lincoln Natl.	2

One response each: Pacific Mutual; Sierra General Life; Mass. Mutual and Philadelphia Life.

Group Health/ Medical	Total
Blues	26
Prudential	24
Metropolitan	12
Travelers	10
Aetna	10
Provident Life	6
Equitable	6
Conn. General	5
John Hancock	4
General Amer.	2
Pilot Life	2

One response each: Lincoln National; Philadelphia Life; Tahoe Insurance Co. and Kaiser Health Plan.

Long Term Disability	Total
Prudential	14
Union Mutual	7
Metropolitan	6
INA	6
Continental (NY)	5
Conn. General	4
CNA	4
Aetna	4
Equitable	3
Provident Life	3
Travelers	2
Mutual/Omaha	2
General Amer.	2

One response each: Tahoe Insurance Co.; Reliance; Hartford Life; American Mutual and Lincoln National.

Travel Accident	Total
INA	23
Amer. Home	12
CNA	9
Travelers	5
Hartford	4
The Home	3
Foremost	2
Metropolitan	2
Mutual/Omaho	2
Reliance	2
Kemper	2
State Mutual	2

One response each: Lloyd's; Bankers Multiple Line; Equitable; Continental (NY); Bankers Life; Prudential and International Accident Facilities.

Group Dental	Total
Prudential	9
Equitable	7
Aetna	7
Metropolitan	6
Conn. General	5
Travelers	4
Delta Dental	4
Blues	4

One response each: Hospital Service; Provident Life; Sybron; Lincoln National and Tahoe Insurance Co.

Pension/ Profit Sharing	Total
Equitable	9
Prudential	7
Travelers	6
Metropolitan	6
John Hancock	5
Aetna	4
Bankers Life	2

One response each: Penn Mutual; Conn. General; New England Life; Mass. Mutual; Sun Life of Canada; Manufacturers Insurance; Pacific Mutual; Provident Life and Northeastern Life.

Board . . .

Continued from page 11

insurance increases was 19.5%. While the biggest group of answers (16) were at the 20% point, another large group of 13 benefit managers said their hospitalization insurance costs had gone up 25%. Eight managers said their premiums have risen 30% to 35%.

Over half of the benefit managers on the advisory board (42) anticipate group insurance premiums will continue to ride the UP escalator in 1977. A significant minority disagree, however, since 32 of the benefit managers said they expect group insurance premiums to hold steady next year. Four board members were undecided about what prices would do.

Hospitalization insurance again is expected to be the villain of rising benefit costs in 1977. Of the 35 Benefit Board members who forecast premium jumps in this line of coverage again next year, 17 look for increases to be in the range of 10% to 20%. Fourteen others wouldn't hazard a guess on what the increases will be. Four expect hospitalization insurance costs to rise between 20% and 35%.

Dental insurance is also one the list of potentially more expensive group lines for next year. Eleven managers said they anticipate cost hikes for dental benefits; five of those didn't estimate the amount of the hikes but the other six gave estimates ranging all the way from 5% to 60%. The average of expected increases was 15%.

A very few Benefit Board members are also looking for the costs of group life insurance, sickness and accident insurance and long term disability insurance to rise.

The trend toward self-insurance in the *BI* survey of employe benefit plans reinforces the findings of surveys done by several other organizations in the last several years. Coupled with the predictions of recurring premium and cost hikes for group insurance, it seems benefit managers represented on the *Business Insurance* Benefit Board view self-insurance as a necessity in a time of steep inflation.

Fifty-seven Benefit Board members said they now use some self-insurance in their group benefit programs, at least for deductible portions of insured plans if not for totally self-funded plans. Twenty-one (27%) of our participants in this survey said they don't self-insure at all.

Half of our group of 78 benefit managers said they plan to do more self-insuring of employe benefit programs in the future. Another 10—or 13%—are unsure whether they'll self-insure more benefits in future years. That left 29 (37%) who said they don't plan to self-insure more of their benefits in the future.

Pension and profit sharing plans are most frequently self-insured. Medical and hospitalization benefits are at least partially self-insured in 26 instances, followed by short term disability benefits which are self-insured at least partially by 22 companies. Long term disability benefits are partly or wholly self-insured by 14 firms, and sickness/accident benefits were mentioned by another seven benefit managers as being self-insured. Dental benefits were said to be self-insured by six companies.

Among the other programs mentioned once or twice as being self-insured were maternity benefits. survivor income benefits, executive sick leave, prescription drugs, foreign benefits, medium term disability, savings/thrift plan, profit sharing plan, severance pay plan, employe stock ownership plan, retiree medical benefits, and retiree life insurance.

Among the companies planning to use more self-insurance of benefit programs in the future, the most consideration is being given to self-funding of long term disability benefits (16 responses) and health/major medical benefits (12 responses). Two benefit managers said they plan to self-insure retiree life insurance benefits. Two others plan to self-fund dental benefits.

Benefit managers showed great interest of tax sheltered trusts for benefit plans. A whopping 77% of our benefit manager participants said they've actively studied the possibility of establishing a 502(c)-(9) trust for one or more benefit programs. Only one out of every five of the Benefit Board managers now uses a 501(c)(9) trust for any benefits, but nearly half of our participants said they plan to establish such an internal trust in the future for one or more benefit plans.

Those companies already having 501(c)(9) trusts said they are used for long term disability benefit plans (10 responses), dental or medical benefits (5 responses each), and retiree life benefits (3 responses).

Benefit managers mentioned long term disability benefits as the plan most likely to be put into the tax sheltered trusts (15 responses), although medical benefits, dental benefits, retiree life, short term disability, and survivor income benefits were also mentioned as candidates for trust funds.

As part of our second employe benefit survey, we asked benefit managers what insurance companies they use for various group coverages. We broke our question down into six parts, and asked for insurers used for group life, group health/major medical, long term disability, travel accident, dental and pension/profit sharing programs.

Prudential Insurance Company was first or second in every category except travel accident insurance. Prudential is first in group life (25), long term disability (14) and dental benefits (9). It is second in group health (24) to Blue Cross-Blue Shield and in pension/profit-sharing plans (7) to Equitable.

A total of 96 companies were named as insurers for group life programs. The top five companies, in order, were Prudential, Metropolitan Life, Travelers, Aetna Life & Casualty, and John Hancock.

Leading the 111 companies named as carriers for group health and medical benefit plans were

Continued on page 15

SELF-INSURANCE

Do you self-insure any employe benefits?

Yes:	57
No:	21

Do you plan to use any (more) self-insurance for group plans in the future?

Yes:	39
No:	29
Uncerta n:	10

501(c)(9) TRUST

Have you considered setting up a 501(c)(9) trust for any group benefits?

Yes:	60
No:	18

Do you anticipate using a 501(c)(9) trust for any benefits in the future?

Yes:	35
No:	31
Undecided:	10

Survey . . .

Continued from page 12

Blue Cross/Blue Shield, Prudential, Metropolitan Life, Travelers and Aetna Life & Casualty, in order. Seven benefit managers said they self-insure health and medical benefits, while three others said they use their insurer only for administrative services.

Long term disability insurers mentioned most frequently, out of 71 companies named, were Prudential, Union Mutual, Metropolitan Life, INA and Continental Insurance Co. of New York. Four benefit managers said they use the insurer for administrative services only. Eleven others said they self-insure their LTD programs fully. (Some use more than one insurer.)

Travel accident insurance is provided by 71 of the 78 companies responding to our survey. One company self-insures travel accident benefits. The 70 remaining benefit managers named 75 companies used to insure travel accident benefits, with the leading five firms being INA, American Home Assurance, Continental Casualty, Travelers and Hartford Fire Insurance Co.

Two benefit managers said their companies self-insure dental benefit programs, while another 35 said they don't offer dental plans to their employes. Of the 41 companies insuring their dental benefits, a total of 86 insurers were named, the leading ones being Prudential, Equitable, Aetna Life & Casualty, Metropolitan Life and Connecticut General.

The 27 companies using insurers for pension or profit sharing plans gave 48 votes to insurers. Most frequently used were Equitable, Prudential, Travelers, Metropolitan Life and John Hancock. Nine benefit managers specifically noted they've gone to guaranteed return contracts using insurers for these pension plans.

The story is based on the responses to a written questionnaire sent to 250 employe benefits managers at a cross-section of medium and large corporations, governmental bodies and institutions. ■

PREMIUM RATE INCREASES

Has your company experienced premium rate increases in group lines in the past year?

Yes: 68
No: 10

What lines, amount of increase?

Health/Medical: 67 responses

No amount given:	17	20-24%	16
5-9%	2	25-29%	13
10-14%	6	30-35%	8
15-19%	6	Average increase:	19.5%

LTD: 4 responses
Sickness/Accident: 2 responses
Group Life: 1 response
Dental: 5 responses

Do you anticipate further increases within the next six months?

Yes: 42
No: 32
Undecided: 4

What lines, amount of expected increase?

No estimate:	14	25-29%	2
10-14%	8	30-35%	1
15-19%	9	Average increase:	5.8%
20-24%	1		

Dental: 11 responses
Group Life: 3 responses
Sickness/Accident: 2 reponses
LTD: 1 response

Federal health outlook dim, congressmen say

CHICAGO—Congress will not enact a national health insurance program next year because of the high cost, two congressmen told the National Assn. of Independent Insurers at their annual meeting here.

Both Sen. Sam Nunn, D-Ga., and Rep. Bob Kreuger, D-Tex., said the cost would prevent enactment of a plan in 1977.

In addition to the high cost, Sen. Nunn said the potential for fraud and present abuses in federal insurance programs would deter the Congress.

"I happen to believe that we cannot afford to pass a massive, new health insurance program until we get our present program in order, and we have a long, long way to go in that regard," he said.

"If we did (pass a new program) we would be literally building a national health insurance program on quicksand, because we have tremendous fraud, tremendous abuse, in our present programs."

Rep. Kreuger said he expected President-elect Carter to delay a national health insurance "simply because I think the cost will be monumental."

The Texas Democrat said President-elect Carter had supported a "comprehensive health care plan" during the campaign but that did not mean he was committed to a national health insurance plan.

"He may be thinking of different kinds of plans without necessarily meaning national health insurance," Rep. Krueger said.

Rep. Krueger, who serves on the House committee that acts on no-fault legislation, said he opposed federal no-fault insurance because it would increase the cost for his constituents in Texas.

He cited a study by the University of Texas that contended federal no-fault would lower insurance costs for New York City drivers while raising them for West Texas drivers. "The people in West Texas would in effect be subsidizing people in other parts of the country," he said. ■

Fire rates lowered

Fire insurance premiums for industrial and commercial buildings throughout Oregon will be reduced an average of 9.5% and an average of 18.5% on extended coverage including windstorm and hail perils. The rate changes, recommended by the Insurance Services Office, are applicable to all new and renewal business.

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Traditional stock plans gain slowly while tax-related ESOPs blast off

By MARIE KRAKOWIECKI

NEW YORK—When introduced with a flourish as the modern way to make every worker a capitalist, employe stock ownership plans were expected to take the fringe benefit field by storm.

But traditional ESOPs are not picking up nearly as much momentum as their backers predicted or hoped. Large companies are still ignoring ESOPs on the theory that they are "uncompetitive" benefits since few workers understand how they operate or even know what they are.

The companies also say the tax incentives for establishing an ESOP aren't substantial enough. The nation's largest employe benefit consulting firm, William M. Mercer Inc., does not promote ESOPs and says only a handful of its clients have taken any action to install them.

And if that weren't enough, last month the AFL-CIO urged unions to be critical of management proposals to start ESOPs. The unions fear the plans could divert attention from other wage and benefit improvements their members need.

Employe Benefits

Nevertheless, while the traditional ESOPs are gaining ground slowly in the nation's larger firms, because of recent tax laws there is one form of the plan which seems to be taking off like a rocket. That is the Tax Reduction Act ESOP, which the Internal Revenue Service and some employers call a TRESOP.

Thirteen of the 15 major oil companies in the United States have all either established a TRESOP or are in the process of putting one in, according to a leading ESOP consultant.

Only Standard Oil of Ohio (Sohio) and Gulf Oil Corp., among the 15 major oil companies, have not established a TRESOP yet. Exxon Corp., Mobil Corp., Getty Oil Co., Shell Oil Co., Atlantic Richfield, Union Oil, Standard Oil of Indiana, Standard Oil of California and others have all either established a TRESOP or are in the process.

The reason oil companies seem to be the leaders when it comes to TRESOPS is that they are capital rich and spend the most money each year on investments related to their operations. The way the plans are structured, the more capital-intensive an industry is, the higher benefits it can expect to reap from starting a TRESOP.

Other capital-intensive industries such as utilities and paper vroduct companies are also joining the TRESOP trend. Consolidated Edison Co. of New York, Long Island Lighting Co., International Paper Co., Westvaco, Weyerhaeuser Co. and Union Camp Corp., are all examples of firms in these industries which have gone into TRESOPS. (See Weyerhaeuser story, page 46.)

A provision of the Tax Reduction Act of 1975, sponsored by Senate Finance Committee chairman Russell B. Long, allows companies to claim a tax credit of 1% of its qualified investments if the savings are put into an employe stock plan.

The 1% tax break provision was originally due to expire this year. However, the Tax Reform Act of 1976 extended the credit through 1980, motivating more firms to initiate Tax Reduction Act ESOPs.

Louis Kelso, a California lawyer, is generally considered the father of ESOPS. He developed the idea about 20 years ago as a cheap way for a company to finance its growth by setting up a tax-exempt trust fund of its own stock for employes. At the same time, the ESOP would insure that wage earners would own a piece of the outfit that they work for.

It wasn't until the early 1970s that Mr. Kelso's ideas seemed to grab the imagination of American companies. And at the start, many of the plans were for small, closely-held of family-run companies that used the ESOP primarily to get tax breaks on bank loans.

For many of them, the benefit to employes seemed to be a secondary consideration. Despite the fact that all the employes' potential benefits were tied up in stock from one company, which may have been questionably valued, a small firm's ESOP frequently would provide the only retirement benefit its employes could expect.

There are still some plans like that around today, and they give shudders to the more reputable consulting firms in the business. John E. Balkcom of Hewitt Associates, a Deerfield, Ill., consulting firm, said it is "alarming" that many firms still use "device-oriented thinking," when setting up an ESOP in their benefit package.

"Instead of evaluating their benefit needs, and then perhaps arriving at the conclusion that an ESOP might be a good thing, many companies are seizing the ESOP and saying, 'How can we make this fit into our program?' " Mr. Balkcom said in an interview.

He stressed that in no way should an ESOP be considered to be a substitution for a pension or profit-sharing plan. Instead, it should be a supplement to an employe benefit program.

This view has been articulated more frequently since ESOPs have become the topic of seminars, conferences and management powwows, as well as a lucrative line of business for some firms which seemed to have appeared overnight to help companies establish ESOPs.

One such firm, Specialized Corporate Services, Los Angeles, was charging upwards of $15,000 in 1973 to the small firms for which it designed and installed the tax-saving stock bonus plans. Some firms reportedly have paid as much as $75,000 to have an ESOP installed.

In any event, when the big-dollar aspects of the ESOPs became more publicized, particularly through such books as Robert Frisch's "The Magic of ESOT," companies started getting more sophisticated in their approach to the benefit. (ESOPs are also referred to as ESOTs, for employe stock ownership trusts.)

Fewer firms sought to intiate the ESOP as the sole retirement benefit vehicle for employes. Many began to regard the ESOP as a sensible alternative to an existing profit-sharing plan, because it would essentially fill the same purpose for the employe while allowing the employer to pick up some tax breaks.

The ESOP probably got its most respectable image when Hallmark Cards in Kansas City, Mo., decided to set one up in 1975 to replace its existing profit-sharing plan which had been clobbered by

Continued on page 20

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Stock ownership . . .

Continued from page 18
stock market losses in 1973 and 1974.

Ironically, Hallmark established an ESOP because it felt its own stock was much more stable than the securities market in general. The company reasoned that its own stock would give employes a safer benefit than the mixed investment portfolio of existing profit-sharing plans.

Few other companies that toyed with ESOPs at the time could say anything similarly flattering about the value of their own stocks. Indeed, one of the biggest bugaboos in the early days of the ESOPs was in figuring out how to arrive at a reasonable valuation for the stock of a small, privately-held firm.

By contrast, Hallmark's stock was valued every year by auditors and was consistent in its worth. When Hallmark first initiated its ESOP in 1975, it pumped $8.3 million into the trust to create the plan, and made arrangements for its profit sharing plan portfolio to be gradually but steadily converted to all Hallmark stock in the ESOP.

The Hallmark ESOP is spotlighted as a true employe benefit aimed more at giving the company's workers a better investment than at giving Hallmark a tax break of any sort. At the third quarter this year, the Hallmark ESOP was worth $54 million, with almost $38 million of the amount represented by Hallmark stock. As of 1975 yearend, each share was valued at $22.88.

All Hallmark employes with 18 months of service are eligible to participate in the ESOP, and about 85% of its 10,000 total workforce are in the plan, a company spokesman said.

A number of insurance brokers have become involved in the ESOP field, particularly in offering advice on installing the plans. Broker R. B. Jones set up an ESOP for its own employes as part of an unusual but unsuccessful attempt to switch from being a public firm to a private one. The national benefits division of Frank B. Hall has been active in offering tax advice and other assistance to clients wanting to set up a TRESOP. One informed source told *Business Insurance* that Hall helped the Long Island Lighting Co. establish its TRESOP recently.

However, there has been no discernable action by any major benefit insurance company to offer any co-ordination of ESOP administration with any other aspect of an insured benefit program.

Options which were permitted under profit-sharing plans don't work with ESOPs because of different tax liability considerations for the employers, so the insurance companies have had little to do.

For example, under the old profit-sharing plan at Hallmark, it was possible for an employe at age 55 to elect to transfer his share of dollars in the trust into an assured investment contract annuity with Connecticut General Life Insurance Co.

But when Hallmark switched from the profit-sharing plan to its ESOP, that option had to be dropped, or the firm would have incurred a tax liability, sources explained.

Somewhere between the capital-intensive oil companies and utilities which are setting up TRESOPS to reap a good tax break, and the companies like Hallmark which are setting up ESOPs solely for their employes' stock ownership, are companies such like Fuqua Industries Inc. in Atlanta.

Fuqua set up an ESOP which was designed to give itself tax breaks under the Tax Reduction Act of 1975. But it was determined to keep the ESOP in force even if the IRS denied it final approval for tax credit.

Technically, the Fuqua ESOP is a TRESOP, but Robert S. Spencer, the company's vp of insurance who was involved in developing the project just thinks of it as an employe stock ownership plan.

The initiative for establishing it came from chairman and chief executive J. B. Fuqua himself, and the plan was going to stay in effect even if favorable tax breaks were passed, the company said.

But the firm "sure was happy," Mr. Spencer said, when it discovered that the 1976 tax reform law would extend the tax break deduction for ESOPs until 1980.

Fuqua's plan is going along according to schedule, and if TRESOP consultants are on the mark, so will similar plans for companies across the nation which are looking for a benefit that gives them a break. ■

Expert asks efforts for alcohol plans

NEW ORLEANS—Insurance companies should use their "unusual" power to move companies toward treatment of alcoholism, an expert in the field told the annual meeting of the Home Office Underwriters.

"Considering the risk and potential loss that insurance companies are asked to underwrite, it would seem appropriate and just plain good business sense for the business to be leaders in alcoholism research and education," said Frances M. Messinger, director of the Sanivita Foundation in Los Angeles.

Ms. Messinger suggested insurance companies provide payment for early, out-patient treatment, demand better results from alcohol treatment centers, provide life, health and disability insurance discounts for non-drinkers and provide in-house alcohol treatment centers for their own employes.

"Today's token response, which is often politically motivated, simply will not cut the mustard and only buries further the problem," she said. ■

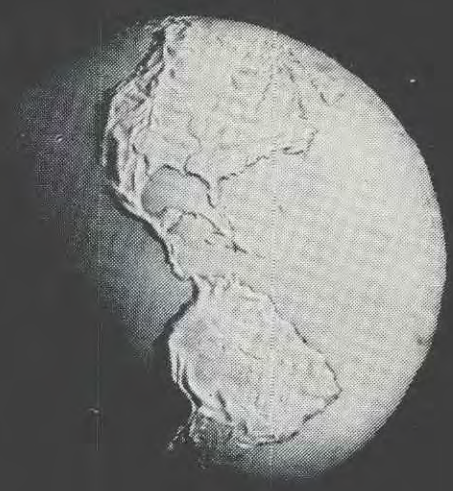
Doctor says contacts safe

ST. LOUIS—A contact lense specialist says companies prohibiting their employes from wearing contact lenses are carrying eye safety to unnecessary extremes.

Dr. Robert Koetting said reports of welding arcs melting contact lenses in a workers eye are unfounded. "This story has been told for years," he said. "Anyone should realize that the contact lense material is tougher than a human eye and could not be damaged by temperature or atmospheric conditions unless things were so bad that the eye itself would be injured anyway."

Dr. Koetting, chairman of the American Optometric Assn.'s committee on contact lenses, spoke at the annual meeting of the National Eye Research Foundation in Las Vegas.

"Contact lenses are not a substitute for safety eyewear," he said. "On the other hand, they are certainly not hazardous if worn with proper eye protection devices." ■



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Blue Cross discount . . .

Continued from page 11

regulatory agencies. Known sometimes as the "Prudential bill", it has been stalled in committee. Another bill, known as "Blue Cross's revenge," has been introduced in response. It would require all insurance companies to provide the same services if rates were equalized. A third bill has been introduced to set up a commission to study the matter.

The fallacy in equal rates, says Mr. Lyon of Blue Cross of New Jersey, is that Blue Cross has "civic burdens" that other insurance companies don't have to carry. Among those "burdens" are open enrollment periods the state mandates in order to increase the availability of insurance and special coverages such as those for cancer patients. Mr. Lyon estimates the special burdens add 14% to the cost of the group insurance business for Blue Cross.

If the discount is eliminated and Blue Cross is required to continue carrying these special burdens, he said, "The major group plans will say bye bye to Blue Cross and the competition will wipe us out."

The department of insurance's actuary, Mr. White, agrees that Blue Cross "makes a significant contribution to the people of New Jersey." His department supports the equalization bill, he said, because it will provide for continuation of a small discount.

Indeed, the U.S. Supreme Court in 1963 ruled the discount was constitutional in a suit brought by The Travelers Insurance Co. in Pittsburgh. "Blue Cross owes its success to the completeness of its coverage," the court said in its opinion. "In the past private insurance companies have provided indemnity up to a ceiling. Blue Cross has shouldered a considerably greater risk."

Despite one industry official's comment that the civic burdens argument was "hogwash", others believe that Blue Cross is entitled to some discount. Prudential's Mr. Mellman suggested a small discount of 3% would be fair. Another industry official said, "Perhaps you could justify a 3% or 4% discount if the Blues do all the things they say they do."

David Wagner, an official with the New Jersey Department of Health, said he believed a 6%-10% Blue Cross discount would be fair.

A judicial attack on the discount in New Jersey has been launched by Harold Krieger, an attorney representing the Amalgamated Clothing Workers Welfare Fund and the Amalgamated Meat Cutters. In a suit now before the N.J. Supreme Court, Mr. Krieger argues patients covered by his clients' welfare funds are subsidizing Blue Cross patients, an unconstitutional confiscation of their property. A lower court has ruled against his arguments.

Employe Benefits

The movement to slow hospital cost increases by imposing rate review has provided a mechanism in some states to attack the discount. A law signed Oct. 15 in Massachusetts sets up a rate review board to set hospital charges for all patients. But the law also mandates a review of the standards under which those rates are calculated, setting the stage for an effort to limit the discount.

In Connecticut, rate review has had an interesting effect, according to Tom O'Hare of the Health Insurance Assn. Before the law only two out of 36 hospitals were paid by Blue Cross on a "charges" basis rather than audited costs. Now half of the hospitals are being reimbursed for their charges.

What will happen if the discount is eliminated?

"Elimination of the discount could ruin us," said Anthony Martin, a hospital costs expert with Blue Cross in Connecticut.

Mr. Lyon in New Jersey said elimination would lead to a "horrible situation" and that Blue Cross would have to raise its rates by 20%.

Not surprisingly, insurance company officials see the situation differently. Taking a 20% figure for the discount and the figure that private insurance covers 17% of patient days, Mr. Mellman suggests spreading the discount will result in a 3.5% increase for Blue Cross, Medicare and Medicaid and a 16.5% decrease for commercial plans.

The elimination of the discount, Mr. Mellman argued, would force Blue Cross to be more efficient in administration and claims handling. "With a 20% lead, it's like a horse race. There just isn't much incentive for Blue Cross."

Mr. White, the actuary with the New Jersey Department of Insurance, supports the bill that would lower the discount. The issue of fairness is important, he said, but closing the loophole for control of hospital costs is more important.

But. Mr. White is skeptical of the argument that eliminating the discount will force Blue Cross to be more efficient. The New Jersey Blue Cross plan is among the most efficient in the nation, retaining only 4% of premiums for administrative expenses, he said.

"Hospitals would rather recover the full cost from each payer. It's easier and would be more equitable," said Don Gulvinson with the Chicago Hospital Assn.

Peter Sparber, a spokesman for the New Jersey Hospital Assn., said, "It's terribly unfair but hospitals have no control over the situation." New Jersey hospitals want the state to take over payment of indigent patients, usually those not poor enough to qualify for medicaid but unable to afford private insurance.

The association may argue in court that hospital care is a right that should not be linked to an area's wealth.

"Hospitals generally support equalization of coverage," said Mr. White, "but on their own terms." Those terms would involve no control over their expenditures, he said, resulting in escalating hospital costs. ■

Blues with 'discount' gain, study contends

CHICAGO—An employe benefits manager with a Fortune 500 company located in New Jersey was asked what effect the Blue Cross discount had on his hospitalization insurance.

The official, whose program was with a large commercial insurance company, said, "We're looking into the discount to see if we should move to Blue Cross."

Richard J. Mellman, vp and actuary with the Prudential Insurance Co., said his company had lost two major groups, one with 12,000 members and the other with 6,000 employes, in recent months.

"I don't want to be an alarmist, but the trend in recent years has been away from insurance companies to Blue Cross to escape the burden of the differential," he said.

But Blue Cross of New Jersey is also singing the "blues." W. Jefferson Lyon, vp, said the civic burdens forced on Blue Cross have resulted in a trend toward private insurance.

"As long as our plan is being used as a social mechanism, taxing the heartland business groups, we're being pushed to a noncompetitive situation," he said.

Who is really losing business?

A confidential study circulating among private insurance companies and obtained by *Business Insurance* reports major increases in the market share of Blue Cross-Blue Shield plans over the last five years.

The study lists a 9% increase in Blue Cross's market share in New Jersey to a total of 51% of the market. The Blue Cross discount in New Jersey is given as 15% to 30%.

Some other increases in market share and the discount, according to the study, are:

- New York, discount 15-30%, market share up 13% to 59%.
- Pennsylvania, discount 15-30%, market share up 17% to 56%.
- Michigan, discount 10%, market share up 18% to 60%.
- Minnesota, discount 10%, market share up 14% to 32%.
- Alabama, discount 15-20%, market share up 18% to 41%.
- Delaware, discount 10%, market share up 9% to 60%.

Blue Cross also achieved major increases in market share in a number of other states where there are only small discounts. However, in none of those states was the Blue Cross share of the market greater than 50%.

The only states where the study showed a decrease or no change in Blue Cross-Blue Shield market share were the District of Columbia, no change; Mississippi, down 3% to 29%; Arizona, no change; Colorado, down 8% to 40%; Wyoming, no change, and Alaska, down 50% to 11%.

William White, actuary with the New Jersey Department of Insurance, said commercial firms compete in New Jersey by offering "incomplete coverage."

Mr. Mellman said 85% of Prudential's business in the state involves companies that purchase basic hospitalization coverage from Blue Cross and wraparound coverage from Prudential.

Isn't the 20% Blue Cross discount in New Jersey unfair to the patient whose employer purchased insurance from a commercial company—possibly with a 20% co-payment?

"The employer is at fault, not the system," said Mr. White. "I don't think the greed of the employer in purchasing incomplete coverage (instead of the 100% coverage in most Blue Cross plans in the state) by itself is justification in bringing the payments in line." ■

Bad Debts

ONE OF THE major factors behind the Blue Cross discount is the failure in many states of Blue Cross to pay a share of bads debt costs of hospitals.

"Hospitals don't incur bad debts from our patients," said a spokesman for Blue Cross of Western Pennsylvania in Pittsburgh.

"Well, our people don't have bad debts either," replied James Purdy, second vp with Travelers Insurance Co. in Hartford, Conn.

Survey says exposures prime threat

CHICAGO—Mushrooming exposures is the most important threat to the property liability industry, according to a survey of 141 companies by the National Assn. of Independent Insurers.

Almost all the companies listed the increased exposures from unlimited no-fault benefits, higher liability awards, new punitive damage concepts, class actions and expanded workers' compensation as the most important problem facing the industry.

Inflation was listed as the second most important threat, especially skyrocketing costs of auto repair and medical expenses. Other concerns, listed in order of their ranking in the survey, were: market availability, lack of capacity, possible bankruptcies, increases in state government controls and burdens, threat of government preemption of insurance functions, increases in federal control and burdens and the danger auto insurance will be absorbed or supplanted by health and accident insurance.

The survey was conducted by giving insurance company executives an opportunity to rank choices on a questionaire. ■

SEE OUR AD ON PAGE 3

editorial opinions

Employers subsidizing the Blues

NOBODY'S HEARD MUCH about the problem of the substantial hospital price discounts available to the Blues in certain states. As group insurers admit, they've been pretty tight-lipped about the matter, because they didn't want to advertise to the world that the guy down the block had a better deal to offer.

As a story in this special employe benefits issue makes all too clear, the problem of the Blue Cross/Blue Shield discount is not a new one. But it's steadily worsening. In the 10 states where hospital charges are between 10% and 30% less for the Blues than when other insurers are paying the bills, there is a shrinking competition in group insurance lines.

The Blues have picked up a significant share of the market in nearly every one of these 10 states in which the discounts are greatest. The Blues, to be sure, have also chalked up gains in their market shares in states where the discounts aren't so substantial. But the point is, in those states where there's a smaller or nonexistent differential in hospital charges, at least the Blues are forced to compete on fairer grounds.

In the interest of competition and as an incentive to the Blues to be efficient in their own operations, the discounts should be drastically restricted from present levels, if not eliminated altogether.

In addition to the question of fairness to the insurers trying to compete with the Blues, there's the question of fairness to individuals being treated in hospitals and to employers who are being forced to subsidize the Blues if they're insured with carriers other than Blue Cross or Blue Shield.

What happens is this. In negotiating their contracts with hospitals the Blues refuse to pay for certain kinds of depreciation or bad debts, for example, reimbursing the hospitals only for what are called "audited costs." Thus, the hospital charges one rate for patients insured with the Blues, then spreads its total remaining costs—including those not paid by the Blues—over all the other patients. Employers and employes not covered by the Blues are socked with much higher charges as a result of this practice.

Blue Cross/Blue Shield contends it's entitled to the discount because of heavy civic burdens it must carry, such as open enrollment provisions and the obligation to cover cancer victims. The Blues also say they are forcing greater hospital efficiency by closely monitoring the reimbursable costs.

We see little need, however, to create a government-condoned monopoly in the health insurance field because Blue Cross is trying to pass itself off as a public utility, which it's not. If there's any difference in hospital charges for different patients—and thereby for different insurers—it should be limited to less than 5% at most, if indeed the Blues should be favored at all for being such good public servants.

Hospital rate setting bodies aren't the answer, either, though. Right now, rate setting organizations in several states only control the charges made to Blue Cross by hospitals. Health care institutions are still allowed to unfairly penalize patients and employers using other insurers by charging higher prices of those customers.

Sounds to us as if employers and insurers alike had better get busy applying heavy pressure on hospitals to shape up in their accounting practices. Unwitting third party payers shouldn't reimburse any costs that the Blues won't accept. This kind of claims control is now a necessity.

Learning to fulfill the promises made

A MAJOR DETERRENT, if not the biggest one, to starting up or continuing a pension plan right now is the heavy responsibility placed squarely on the shoulders of those individuals who are the benefit plan fiduciaries and administrators.

Under the federal pension reform law they stand to be held personally liable for benefits promised to employes under the so-called defined benefit retirement plans established years before the law was passed.

The current rate of plan terminations reflects the fear that has gripped employers who choose to run away from their promises rather than live with them. Because administrative and reporting burdens increased substantially under the federal pension law, these factors also account for many of the terminations.

Benefit consultants fully expect the trend of about 1,000 to 1,500 pension and profit sharing plan terminations per month to continue through 1976 and on into 1977.

Should Congress choose in its 95th session to pass some sort of law redefining the scope of the potential personal liabilities of those managing and guiding benefit plans, it would go a long way toward assuring that the private pension system will continue to exist in this country, some say.

We're assuming that what everybody's talking about when they euphemistically refer to "redefining the liabilities" of employers and their agents is that they think liabilities of anybody dealing with retirement plans should be narrowed.

We don't want to see that happen. While it's agreed, and sadly so, that pension reform imposed a heavy administrative burden on corporations in this country, we said before the law was passed and we say again that beneficiaries deserve to be paid what they've been promised. That's just good business.

ERISA didn't impose any new liabilities on fiduciaries or employers that weren't there before under common law.

Now we would, indeed, like to see more retirement plans started up, instead of continuing terminations. The pension reform law was never intended to be the death of the private retirement benefit system in this country.

Perhaps some legislative clarification of the fiduciary liability rules is appropriate so that employers understand more clearly the scope of their responsibilities. Be we don't want to see those responsibilities lessened.

Employers who make promises to employes should have to stand by them. It's a contract, like any other to be honored.

letters

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

Pollution coverage

To the Editor: This refers to the page 6 article concerning Allied Chemical in your Nov. 1 issue. The statement in the second column of the likelihood that Travelers "will be fielding some of the . . . civil damage suits" prompts these questions.

Does the now-standard pollution damage exclusion apply to Allied Chemical's liability coverage? If so, why would the insurer offer any defense?

Adding to my curiosity is the portion in the last column of the story concerning the insurance manager's expectation of changes in the coverage. It is likely he means a restriction of coverage. If so, perhaps the pollution coverage does exist and is expected to be withdrawn. I find this unlikely and contrary to practice.

I will appreciate your reply. Having no connection with Allied Chemical, Travelers, or anyone connected with the suit even remotely, my interest in this matter is strictly academic.

Seeman Waranch
Insurance Agency of Norfolk Inc., Virginia Beach, Va.

Editor's note: Travelers says it is participating in Allied Chemical Corp.'s defense because pollution is just one of many problems involved in the civil damage suits against the company. The insurance covering Allied Chemical did contain some pollution coverage, but since the policy was tailor-made for Allied Chemical, the pollution coverage was not under the standard endorsement you refer to in your letter.

Hospital risk problems

To the Editor: Hurrah for your editorial concerning hospital risk management—"Cashing in on Hospital Risk Management," in the Oct. 18 issue. As you say, "So-called risk management consulting firms are springing up everywhere to cash in on this lucrative opportunity." And few, if any, are able to describe just exactly what it is they advocate, other than their fee engagement to "solve" the hospital's risk management problems.

Unfortunately, like many facts of life, it's not that simple. And traditional wisdom, combined with the lack of impartiality of the insurance carriers, agent, and brokers, makes it that much more complicated. Each hospital has its own matrix of risk problems and exposures, which have developed out of specific prac-

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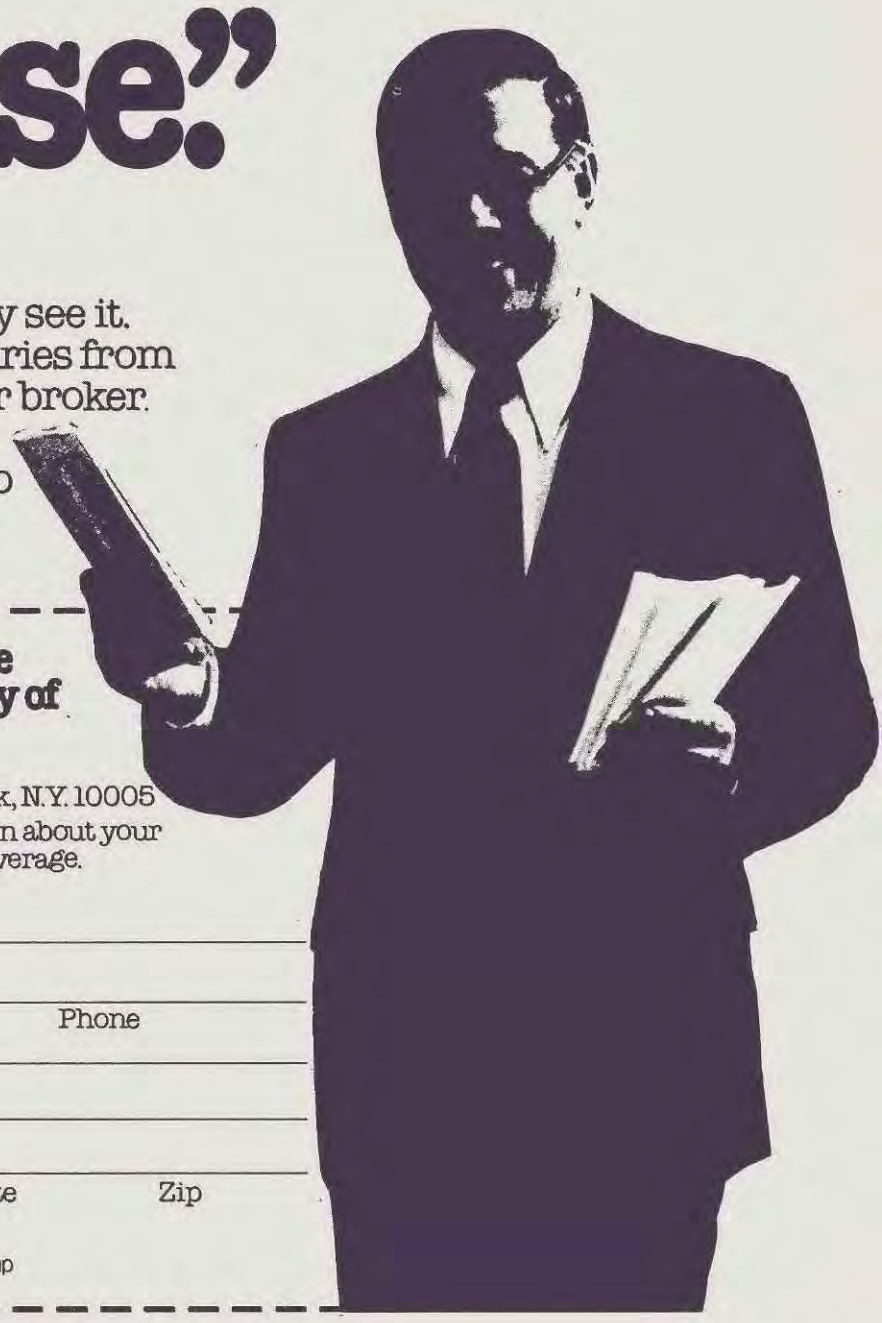

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Tax change sparks prepaid legal plan resurgence

By LINDA MOSKOWITZ

NEW YORK—Group prepaid legal plans received a major boost from Congress with the passage of an amendment to the Tax Reform Act of 1976.

Under the law, employer contributions to a legal service plan and employe benefits received from the plans will be tax-exempt for the next five years.

Tax-exempt status for the legal plan trust funds is still a controversial area.

Despite some remaining problems, many observers of the benefits scene think legal plans are back on the way to becoming a 'hot' topic for collective bargaining.

"The tax bill is really a major hurdle that's been overcome," said Wes Graham, vp and general counsel of Midwest Mutual Insurance Co., in Des Moines, Iowa. "Unions in particular have become dramatically interested in legal plans," Mr. Graham said.

The improving economy has also contributed to the renewed popularity of legal service plans, according to Lynn Ohman, program analyst and economist at the Resource Center for Consumers of

Employe Benefits

Legal Services in Washington, D.C.

"There are definitely more plans now than there were two years ago," she said. Unions are also more often negotiating for legal plans.

Among the union groups which have recently set up plans are Districts 33 and 37 in Philadelphia of the American Federation of County and Municipal Employes (AFCME).

The Municipal Employes Legal Service (MELS) program, run as an 18-month pilot program for a group of New York City AFCME members, is about to become a permanent fringe benefit for union members (*Business Insurance*, Dec. 9, 1974). This plan will cover 125,000 people.

In Massachusetts, construction laborers recently bargained for a statewide multi-employer legal plan.

Teachers in Michigan's Wayne-Westland school district have also just won a legal plan through negotiations. This open panel program will be run in conjunction with the state bar association.

Student legal plans are becoming popular on college campuses across the country. Most of these plans are sponsored through student government associations. Approximately 150 of these plans are now operative.

The University of Minnesota in Minneapolis, for example, with over 45,000 students, will soon have a working legal service plan, sponsored by the student government and funded by mandatory student fees. The first-year budget is expected to be $130,000.

A predetermined list of legal services will be available to students. "The very least a person will get is advice and a way to find an affordable attorney," said Bob Barnett, director of planning for the Student Legal Service Program.

The Minnesota student program will also acquaint students with their legal rights through seminars and workshops, and provide a legal information service.

Most of the existing legal plans are sponsored by unions, professional and trade associations, or other consumer groups. These organizations largely favor the closed panel approach to legal plans.

Closed panels are run by hiring a staff of attorneys for a specific group or by contracting the services of selected attorneys for a predetermined length of time and type of service.

Bar associations, however, prefer the open panel method, where consumers can hire a lawyer of their choice.

The trend toward closed panels, coupled with ambiguous and antiquated insurance codes in many states regarding legal services, has frustrated efforts by insurance companies to establish profitable operations.

The insurers offering legal service packages usually allow the policyholder "the freedom to retain any attorney of his own choosing provided the attorney is admitted to practice law in the jurisdiction where his services will be provided," as in an INA Corp. group policy.

This type of arrangement means, of course, the open panel approach.

"People, by and large, see an advantage in having an outsider administer the legal plans," said Ms. Ohman. However, "you end up paying for it."

The extra cost of providing legal services through an insurance company is one reason consumer groups use closed panel plans. The closed panel also "appeals to unions, because they have more control" of the plan, according to Mr. Graham.

Insured plans can offer advantages, Mr. Graham said, such as "financial guarantees, expertise in handling the benefit program and in administrative abilities," plus "supervision by the state insurance department."

Despite these advantages, there are a substantial number of insurance companies, including INA, Employers of Wausau, Stuyvesant, and St. Paul Fire & Marine, which offer group legal insurance, but have not sold any policies.

A major reason is that legal service plans are "not even insurance in over half the states," according to Charles Terrell, chairman of Unimark Cos. in Dallas.

This firm, with its affiliate, Unimark-Caldwell, is a broker, administrator and general agent for both life and casualty insurance. Unimark, which is very active in the employe benefits field, has been designing legal service programs for several years.

Mr. Terrell explained that in 22 states, only casualty companies are permitted to underwrite legal insurance. "But, not many casualty companies underwrite employe benefits," he said.

In Texas, an amendment was recently passed, allowing both life and casualty insurance companies to offer legal insurance.

New York State, however, still hasn't passed a bill permitting the sale of group prepaid legal insurance, even though such a measure has been proposed three times. Unions have formed a major bloc against such a bill here, because of the closed vs. open panel issue.

Only a few insurance companies have had notable success in this field, such as Midwest Mutual, which has worked out a joint venture relationship with several state bar associations in order to under-

Continued on page 29

Prepaid legal plan . . .

Continued from page 26

write programs.

Unimark has revised its entire legal service program and is now "gearing up to make an extensive national push" of its latest product. The new item is a trust arrangement, which Mr. Terrell describes as a reinsurance ERISA trust that will provide legal service to group members on a contractual basis.

Since the product is not insurance, Unimark will not have to contend with the complexities of the varied state insurance laws.

"We are totally committed to the closed panel approach," said Mr. Terrell. Unimark doesn't believe that "organized labor is going to accept open panels or state bar panels. Why should they accept lawyers that aren't their friends?" Mr. Terrell asks.

The primary market for the trust will be unions. Private companies and corporations could also use the plan, but Unimark doesn't anticipate many sales among that group.

Open panels can be adopted to the trust, if a client wishes.

The trust makes use of "a cafeteria approach" to legal services. A computer system is sold with the program, which "eases problems of billing, reporting claims," and other administrative tasks necessary to the program.

Among the benefits a trust member can choose are:

- Six yearly visits to an attorney for advice and consultation.
- Up to two adoptions per year.
- Up to two real estate transactions per year.
- Up to two wills per year.
- An estate closing in the course of a year.
- Debt collection defense.
- Consumer transactions.
- Divorce proceedings, including coverage for the insured member and the spouse, which has no dollar limit with a closed panel and a specified dollar limit with an open panel.
- Non-business bankruptcy.
- Criminal defense, including felonies, for up to $5,000.

The monthly cost for the entire package would be $7.60 per person. A beneficiary survivor benefit can also be purchased by itself or in combination with other benefits for $1.25 a month.

Unimark has also developed a program "to put insurance carriers in this business." Services available include actuarial, administrative, filing, and marketing consultation, and software computer equipment. This program has had three buyers so far. ■

Consultants begin survey of ESOPs

DEERFIELD, ILL.—A consulting firm here is working on a major survey of the characteristics of employe stock ownership plans (ESOPs) which have been started by Fortune 500 companies and some major utilities.

Hewitt Associates said in late November it was about to mail questionnaires on ESOP practices to these firms and that it expected results some time in January.

The survey will examine Tax Reduction Act ESOPs, also known as TRESOPs, which became popular with the passage of the Tax Reduction Act of 1975, and which also received favorable treatment under the 1976 Tax Reform Act.

Hewitt said the study will investigate the restrictions companies are introducing into their ESOPs in order to increase benefit levels to participants.

In general, there are two ways ESOPs can be restricted. Companies can limit participation to select employe groups rather than making the ESOP available to their total work force, or they can lower the maximum amount of annual compensation to which stock allocations are tied.

Under the 1975 tax law, employer contributions must be allocated to participants in proportion to employe compensation up to a maximum of $100,000 a year. But this ceiling can be lowered, Hewitt said last month.

The firm said it was conducting the survey partially because there is no one readily accessible data base about ESOP practices. ■

Employe Benefits Communications Awards Competition

Mail to: Benefits Communications Awards
Business Insurance
708 Third Avenue
New York, N.Y. 10017

Yes, I am interested in entering your communications program(s). Please send me _____ entry blank(s) and the competition rules.

Name, title_____

Company_____

Address_____

City_____State_____Zip_____

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BI benefit communications contest judges picked; deadline Feb. 28

NEW YORK—A panel of 12 judges has been selected for the fifth annual *Business Insurance* Employe Benefits Communications Awards Competition.

Members of the panel include corporate benefits managers and several corporate communication experts.

The judges will evaluate entries in the four categories of booklets, personalized correspondence, audio-visual presentation and total communications programs.

Awards will be presented at the annual Risk & Insurance Management Society (RIMS) conference to be held in New York at the Americana Hotel April 26.

Among the judges are: Nathan Smith, assistant vp and director of employe benefits of American Home Products in New York; Maryanne Sherman, manager, corporate communications at American International Group, New York; Herbert Hadley, director, pension and group insurance department of American Standard Inc., New York.

Also included on the panel are Therese Pick, administrator, employe benefits, AT&T, New York; Walt Klint, director, employe benefits program, Continental Can Co., New York; Joan Myers, assistant manager, employe benefits, Diamond International Corp., New York; Richard Doyle, vp, public relations and advertising, Home Insurance Co., New York.

Also, John Lamantia, employe benefits administrator, Lever Brothers Co., New York; R. B. Peters, manager, benefits, Mobil Oil Corp., New York; Mathew F. Morgan, director, employe benefits, Otis Elevator Co., New York; Edward P. Callahan, corporate manager, compensation and benefits, Philip Morris Inc., New York; and Joseph W. Dava, director, employe benefits and compensation, SCM Corp., New York.

Mr. Smith now serves as the chairman of the Health Insurance Committee of the Commerce and Industry Association of New York and was recently appointed to the Mayor's Task Force studying the Employe Group Insurance programs in New York City.

Mr. Callahan holds a Doctor of Law degree from Fordham University and is a member of the New York Bar.

Another panel member, Ms. Sherman, is a member of Advertising Women of New York. She is also a member of the Insurance Advertisers' Conference, where she works as a reporter for the organization's newsletter.

Many of the judges are responsible for benefits programs in a number of locations. Mr. Duva is responsible for planning and directing SCM's Employe Benefit and Compensation program on a worldwide basis.

Ms. Myers travels extensively to various company locations of Diamond International to communicate benefit programs to employes.

Entry forms, contest rules and further information can be obtained by contacting Ms. Ronnie Drachman, Award Coordinator, Business Insurance, 708 Third Ave., New York, N.Y. 10017; or call her at 212-986-5050.

Entries for the awards competition will be accepted between Jan. 1 and Feb. 28. ■

Arbitration in benefits

BROOKFIELD, WIS.—Arbitration rules specifically designed to settle employe benefit disputes have been developed jointly by the American Arbitration Assn. and the International Foundation of Employe Benefit Plans.

The project is aimed at providing a structure for prompt and inexpensive adjudication of claims disputes that cannot be resolved through direct negotiations between the employers and their employes.

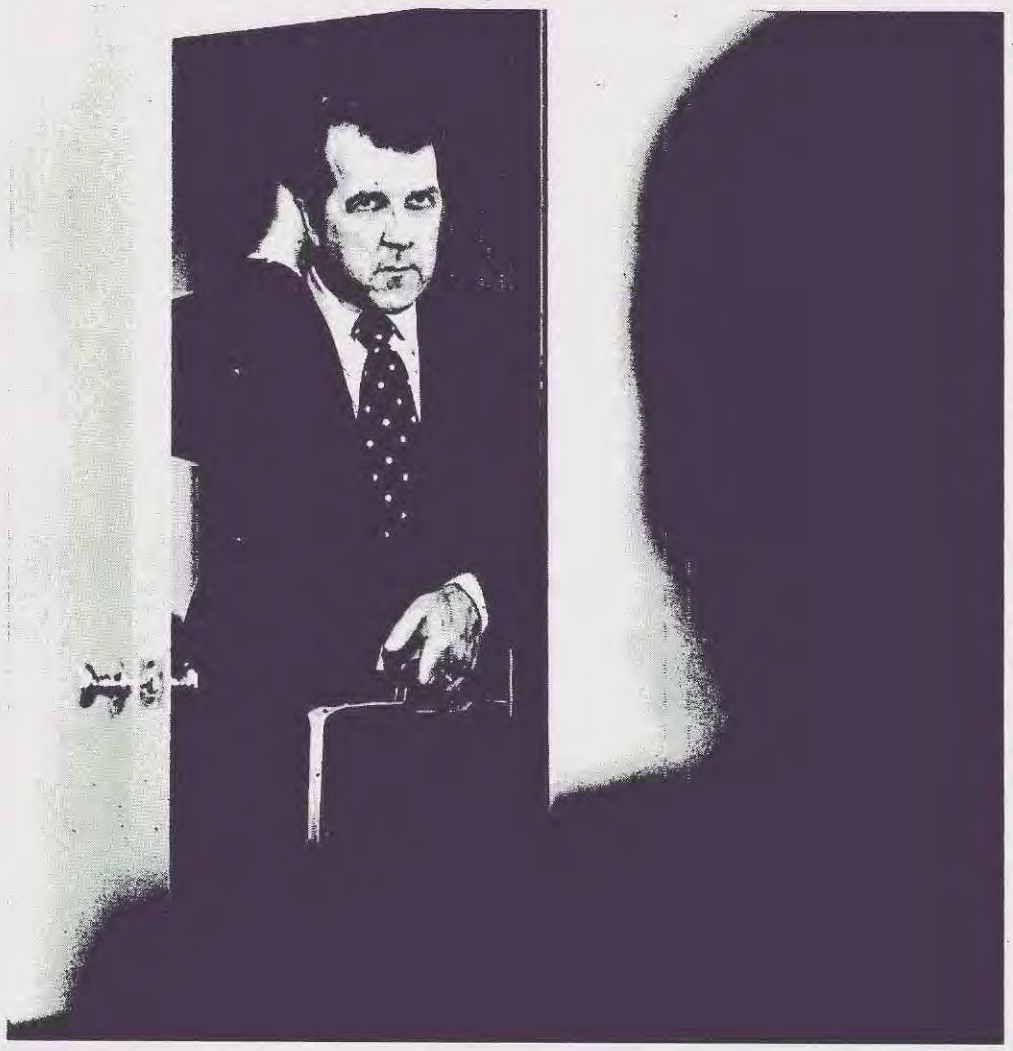
The two groups said the cost of arbitration has been shown to be significantly less than the cost of litigation.

The rules, to be administered by the American Arbitration Assn., have been published in booklet form. A list of arbitrators is also being prepared. Further information is available from American Arbitration Assn., 140 W. 51st St., New York, N.Y., 10020. ■

Surplus assn. meets

The Surplus Lines Claims Assn. elected David P. Bohen of Employers Reinsurance Corp. president for 1977 at the group's annual meeting in Bermuda. Other officers are Nicholas Briante, Prudential Property & Casualty Insurance Co., vp; Nino D. Crisafulli, Habor Insurance Co., secretary, and Roger H. Berenschot, Hallmark Insurance Co., treasurer.

Sometimes Arkwright-Boston people wish they weren't.



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A most unusual company

Campaign underway to boost employer use of minority-owned insurers

By GREG DAVID

CHICAGO—The Commerce Department and the National Insurance Assn. have launched a major campaign to increase the group life insurance placed with the nation's 42 black insurance companies.

Secretary of Commerce Elliot Richardson has written the chief executive officers of the Forutne 1,000 companies asking that they participate. Representatives of the National Insurance Assn. (NIA), the trade group for the black companies, followed with personal visits.

Charles Davis, NIA executive secretary, said the program's goal is to increase the amount of group life insurance with the black companies by $5 billion by the end of 1977. That would increase the

Employe Benefits

amount in force to $13 billion from $8.5 billion.

Companies are asked to either place a portion of their coverage directly with a black insurer or request that their primary carrier reinsure a portion of the business with a black company.

The large black insurance companies for the first time will then reinsure part of the business they receive with the smaller companies. "Unless we keep the small companies in business, we soon won't have any companies," said Mayfield Sloan, chairman of the campaign and an executive vp with North Carolina Mutual Insurance Co.

The program is relatively simple, according to Jim Marks, director of capital for the Commerce Department's Office of Minority Business Enterprises. The department undertook a similiar program in 1970 to increase deposits in black banks.

"This is a continuation of that effort," he said. "This is another area with a very sound situation. Each company is regulated. Each has the know how."

"This is a specific program to bring minority companies into the mainstream with a share of the group insurance business from major companies," Mr. Davis said.

Mr. Marks suggested $5 billion is a very small percentage of the total group life insurance market. According to the Life Insurance Institute, group life insurance is growing at the rate of $100 billion a year with more than $1.4 trillion in force. Five billion dollars represents only 0.5% of the total, he said.

Half of the companies contacted have responded favorably, Mr. Davis said. Another 25% have asked for more information and the other 25% have said they feel they are doing enough to encourage minority businesses.

Commitments for $400 million have already been received, Mr. Marks said. Most of the business is expected to be in the form of reinsurance.

The cost of reinsurance was estimated at $1,000 to 2,500 a year.

Lockheed Aircraft Corp. in Burbank has asked its group life insurance carrier to reinsure $87 million of its policy with Golden State Mutual Life Insurance Co. in Los Angeles. Richard Martin said the company considered the cost "minimal."

American Can Co. has been reinsuring a portion of its group life policy with Golden State Mutual since 1972, according to spokesman Gene Ecker. In response to the program the company will ask its primary insurer, Metropolitan Life Insurance Co., to reinsure another substantial amount with North Carolina Mutual Life Insurance Co. in Durham. American Can also considers the cost minor.

Pfizer Inc. had reinsured a portion of its coverage with a black company three years ago and had already planned to increase the dollar amount, according to Richard Harvey, benefits manager. Pfizer's plans coincided with the new campaign.

"We did it because we thought it's the right thing to do," he said. Mr. Harvey also believes the cost is not a significant percentage of the total cost of the program.

The Travelers Insurance Co. said it had received numerous requests from its clients to reinsure portions of their coverage and was cooperating in the program.

But John Kittredge, director of group insurance at the Prudential Insurance Co., was less enthusiastic. Prudential will follow the wishes of its policyholders, he said, but it is concerned that the small black insurance companies do not fully understand the large risks involved.

He argued the group life insurance business is very competitive and not always profitable. In addition, Mr. Kittredge said the cost of reinsurance should not be compared to total premiums but to the amount retained by the insurer for administrative costs. The $1,000 to $2,500 cost is a then much higher percentage that must be borne by the policyholder.

The NIA's Mr. Davis replied that "every company that will participate is doing so on an actuarial basis. There is no reason to believe they don't understand the risk."

Mr. Marks said the black companies had been asked to determine the amount of additional business they could handle and that the total was well in excess of the $5 billion goal.

"Many of the companies have said they are happy to pick up the extra costs," he said.

The six large black insurance companies leading the program are N.C. Mutual in Durham, Golden State in Los Angeles, Supreme Life Insurance Co. in Chicago, Chicago Metropolitan Mutual Life Assurance Co., Universal Life Insurance Co. and Atlanta Life Insurance Co.

N.C. Mutual had been seeking reinsurance business since 1969, Mr. Sloan said. But this will be the first time it would then reinsure part of the business it receives with smaller companies.

Supreme Life Insurance Co. had also been soliciting business from the nation's largest corporations for several years, according to company president Ray Irby. Supreme has more than $2 billion in force and hopes to increase its business on its own by $1 billion in 1977.

Mr. Irby said his company had never reinsured any of its business with smaller companies. "All the bugs haven't been worked out" and he said he is not convinced the amount of business would justify reinsurance. ■

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The Bettmann Archive

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Factory Mutual System

Labor looks to low cost benefits for future talks

By GREG DAVID

CHICAGO—Vision care—$4 a month per employe.

Hearing aids—$1.60 a month.

Dental insurance—$20 a month.

Compared with the present cost of major medical and hospitalization insurance—$100 a month in the United Rubber Workers Contract and $75 a month in the Brotherhood of Railroad and Airline Clerks contracts—the cost of adding these benefits is relatively small.

That may be why a *Business Insurance* survey of a number of major unions, where employe benefits are often first introduced into the economy, failed to turn up any major push in new directions.

In fact, that's the view of John Zalusky, an economist with the AFL-CIO in Washington. "We are in a restrained situation in bargaining," he said. Employers can add these benefits at a relatively low cost and union workers are more likely to approve contracts with some additional or improved benefits.

"We have to be concerned about the basics in today's difficult economic situation," echoed William Burns, assistant research director for the Amalgamated Meatcutters and Butchers Union in Chicago. "We find that most unions with any sense are filling in the holes (in the coverage). People need the basics."

But other union officials said the reason for the movement into inexpensive areas such as vision, hearing aids and dental was simply a result of the comprehensive coverage unions have won in previous years.

"For years we've had coverage from the cradle to the grave," said George Marinick, director of pensions and insurance for the United Rubber Workers. "We've got as comprehensive a major medical-drug-hospital package as you can find. Now we're moving into other areas."

An official with the United Steelworkers Union in Pittsburgh agreed: "Our basic program is in place. We are limited by the availability of additional benefits."

"The economic situation has its effects," said a Railroad and Airline Clerks official, "but I don't think its insurmountable."

As is often the case, the contract won by the United Auto Workers has set the agenda for union demands over the next few years. Almost of the unions contacted said they were looking at the establishment of a vision care program.

Employe Benefits

The Steelworkers, whose contract comes up for negotiation next year, are considering asking for a vision care program, according to a union official. Other benefits under consideration are expanding the retirees' insurance program since those members have been particularly hard hit by inflation, prescription care under a separate program and increasing dental insurance coverage to 100% of the cost.

The Railroad and Airline Clerks are also in the process of reviewing their benefits for negotiations next year, a union official said. Improvements in dental programs, implementation of a vision care package and vacation and holiday additions are high on that union's list.

The machinists are planning a strong effort to win prepaid legal insurance, according to research director Mr. Reginald Newell. The new tax law allowing deductions has made this attractive, he said, "and there is a great need for it."

The machinists have dental insurance in 25% of their contracts covering 33% of their workers, he said. Since the union has so many

contracts with small companies, it takes the machinists several years to extend new benefits to all its members. The union has its own dental insurance program an employer can join for $15.58 a month, he said, much less than the $25 a month a similar plan would cost in California.

A spokesman for the Amalgamated Clothing and Textile Workers Union said the union is presently preparing an agenda for next year's negotiations. "We are always seeking to make improvements for our members" is all he would reply in answer to questions about specific benefits.

But the clothing workers union has been a pioneer in winning day care benefits. The union has more members placing their children in centers than any other organization, he said. The funds come from the union's health and welfare plans, with members paying a nominal fee.

The clothing workers receive inquiries from other unions "all the time" about the program. Other union officials said they expected day care to spread in unions with a large number of women workers.

Another major area for the ACTWU is health maintenance organizations (HMOs). The union is proceeding slowly because of the difficulties involved, he said, but expects to be able to provide better care for its members. The lesser cost is an important but secondary consideration, he said.

Vision care is one area under consideration by the Communication Workers of America said spokesman Lee White.

His union has found it necessary "to talk about a benefit for a few years to get the other side to believe you are serious. Much more than strike action, the way to get managers to believe you is to develop the case for a new benefit using experts and statistics," he said.

A retirement system based strictly on years of service is a major goal of the rubber workers, according to Mr. Marinick. That plan was on the table last time, he said, but was not agreed to.

Under the Rubber Workers recent contract, dental insurance programs can be established by each industry group to be paid out of cost of living increases. He said he expects the unions, led by workers at Firestone, to have dental coverage by July.

A special problem is faced by the American Federation of Government Employes who are unable to bargain collectively with the government, said John W. Mulholland, director of contract negotiations for the union. For that reason that union's main goal is passage of a collective bargaining law in the next Congress, he said, "so we can work like everybody else."

On the benefits side, the union would like to have its health insurance coverage increased to 100% from the present 60% and would also like the government to pay part of the dental insurance premiums. The union also wants federal work laws expanded to federal employes. At present each department can set the safety standards for its own workers.

Willing to look further into the future was the machinists' research director. Mr. Newell looks for more cafeteria-style benefit plans, with workers able to choose different plans having a dollar ceiling. Group legal and group auto insurance are possibilities, despite some unions' difficult experiences with group auto. More self-funding of insurance is another major trend as more and more employers are turning to multiple-employer trusts to deal with the funding requirements of the federal pension reform law. ■

NAII forms political fund

CHICAGO—The National Assn. of Independent Insurers says it has formed a political action committee to help counter the clout of labor and other anti-business groups.

The National Assn. of Independent Insurers Political Action Committee was registered with the Federal Election Commission in September. Requests for contributions from stockholders or executives of firms belonging to the association are expected to begin shortly.

A seven-member committee will select candidates to be given campaign contributions. ■

Called the 'cost benefit' test

Too many blood tests already? Here's another

NEW YORK—Now there is another type of blood test. In addition to the blood type, rh factor and high blood pressure tests, we have the cost benefit test.

And the findings of a Cornell University program of occupational-based hypertension screening and treatment show there is a favorable reaction to costs, hospital stays and treatment—in time.

The Cornell program results show that after two years of screening and treatment, 92% of the original 1,066 employes remained in the prevention program. The cost of the program for 1,000 workers

Employe Benefits

(assuming 100 employes are treated for hypertension) is $12,500 the first year and $10,000 a year thereafter.

"If days of disability are calculated at $43.28 per day and hospitalization at $200 per day," the report says, "the sum of program expenditure plus disability and hospital payments compared to the costs in the year before the program began shows a net additional cost to the health and security plan of $1,246 the first year and $1,665 the second year, or from $1.25 to $1.67 per employe per year."

Included in the Cornell program were employes of Gimbels, Bloomingdales, City of New York municipal workers, Rockefeller Center and New York University Building Service employes as well as members of the United Storeworkers Union, a municipal employes union and Building Service Workers unions. Over 8,467 employes were screened. Of 1,400 members found to be hypertensive, 1,066 volunteered to enter the program.

Dr. Michael H. Alderman, head of the program, said he felt costs would level off after the first two years of operation as decreased hospitalization and disability became more apparent.

So far, the hypertension program appears to be working. The United Storeworkers Union, which participated in the study, reported days of disability per 100 employes in 1972-73, before treatment, for the hypertensive group was 760 days of disability and the control group 772. In 1974-75, after two years of treatment, the treated group had 566 days and the control, or untreated group, had 691 days.

Another part of the study showed that for 320 hypertensive employes in the program, days of disability and hospitalization due to cardiovascular involvement decreased from 2,449 in 1972 to 1,999 in 1974-75, after treatment.

Total hospitalization due to cardiovascular involvement increased, however, from 76 to 94. Total hospitalization in general decreased from 219 days in 1972 to 183 days in 1974.

In the case of the patients, "satisfactory blood pressure control was achieved in four months." After one and two years of treatment, more than 80% had either maintained a blood pressure reading of less than 160/95 or had a 10% reduction in pressure.

Blood pressure treatment programs that have achieved good results usually use a systematic approach, have cooperative medical personnel and have made access to care easy, the program report points out.

The Cornell program used three screenings to determine if a person had blood pressure above normal, required one-page patient histories and gave the tests in employe cafeterias, lounges or meeting rooms. Hypertensive patients were advised to initiate treatment and were given the option of on-site care or going to their regular medical doctors. Personal physicians' approval was sought in all cases.

Only those patients with uncomplicated hypertension were accepted for treatment. Care was scheduled during work breaks, lunch periods, or before or after work so no time would be lost. The program also administered drugs. Program participants averaged 11 clinic visits during the first year and seven the second year.

The breakdown of costs involved in the hypertension control program are for every 100 patients, $2,700 was spent for nurses and paraprofessionals; $2,200 for a physician; $1,200 for administrator's time; $1,800 for laboratory fees and $2,150 for drugs based on wholesale drug prices. ■

Hartford's new annuity

HARTFORD—The Hartford Insurance Group introduced an endowment contract with a flexible annuity rider—called "Endowment Plus"—for corporate pension and profit sharing plans.

The endowment provides pre-retirement death benefits, guaranteed cash values for lifetime income or a lump sum payment at retirement. The payment rider provides either higher guaranteed cash values, higher monthly retirement income or an increase in the pre-retirement death benefits.

The amount contributed to the endowment becomes a fixed level payment. The payment to the annuity rider may be increased, decreased or suspended in response to changing conditions. It is also used for IRA and Keough plans. ■

Before you sign for a new group dental insurance program for your employees, read these results of a recent independent survey* of dentists first:

INSURANCE CARRIERS	GOOD(2)	FAIR(3)	POOR(4)
Connecticut General Life Insurance Co.	83.0	15.9	1.1
Metropolitan Life Insurance Co.	69.2	26.0	4.8
Ohio Medical Indemnity Plan	65.5	29.4	5.0
John Hancock Mutual Life Insurance Co.	53.0	36.4	10.6
Blue Cross/Blue Shield of Michigan	50.9	38.3	10.8
Delta Dental Plan of Michigan	30.9	44.0	25.1
Aetna Life and Casualty	23.3	47.5	29.2

*Source: American Dental Association, 1976.

(1) 44.4% of this total replied.

(2) Good—Usually prompt, courteous, problem-free.

(3) Fair—Some problems but not chronic.

(4) Poor—Frequent problems.

Before putting pen to paper, there are some very important papers you should look over first. They're the recent findings of a survey of dentists by an independent association.

One of the things the association wanted to know was how well a number of group dental insurance companies were performing.

So, they surveyed almost 2,000(1) dentists serving a major industry dental program in four Midwestern states: Michigan, Indiana, Missouri and Ohio.

This is what the survey asked:

"Please evaluate the general performance of the (insurance) carriers you deal with..."

These are the results:

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Connecticut General Life Insurance Company

Inflation slows early retirement trend, despite successful plans

By JOANNE GAMLIN

LOS ANGELES—There are signs that the trend toward early retirement, hailed as a promising movement just five years ago, may be heading into a clouded future, *Business Insurance* found. But some companies that have created inducements to make retirement prior to age 65 more attractive have been satisfied with the results.

Nevertheless, the roller coaster movement of the U.S. economy in the 1970s from disastrous inflation to ruinous recession has eroded enthusiasm for the concept of early retirement from what it would have been in a more stable economy, a number of employe benefit managers maintain.

"Only if inflation would stabilize would we be in a position to judge the acceptance of early retirement as a concept," says Bernard Brody, manager of employe plans for Armour Foods, Phoenix.

Armour & Co., the parent company, is one of many corporations that has adopted one of two major methods of making early retirement more attractive to its employes. Last January, it cut drastically the actuarial reductions which have to be taken by employes wishing to retire before age 65.

"It was a substantial change," Mr. Brody recounts. Under the old plan, a worker retiring at age 64 would have received 91.4% of accrued benefits while the same employe today will get 97% of accrued benefits. At age 62, an Armour employe would have gotten 76.44% of accrued benefits, a 25% reduction, under the former plan. With the new plan, he is entitled to 91% of accrued benefits, a handsome incentive to bow out at an age when he can also begin to collect Social Security benefits.

The new schedule encompasses retirement benefits down to age 55, where a worker now gets 56% of accrued benefits compared with 44% under the former plan.

All Armour & Co. employes who retire early, to be sure, must expect to receive somewhat lower benefits than they would have received had they worked to age 65. They reduce their years of service.

The majority of Armour workers still retire between the ages of 62 and 65, which is the mandatory retirement age. Mr. Brody says, however, that the new schedule appears to have produced an upsurge in the number of people choosing the leisured life before age 65.

"But I don't know," he goes on. "The pick-up may amount to the kind of initial leap that occurs when dental insurance plans are enacted- and everyone who ever suffered a toothache rushes to see a dentist."

The accelerated early retirement activity at Armour may also be fueled by the slowing of inflation this year to a 5% annual rate, he adds.

Seattle-based Boeing Co., too, has discerned a rise in the number of employes electing early retirement. This has occurred since 1969 when Boeing wiped out actuarial reductions for those retiring at or after age 62, according to Ray L. Casey who manages employe benefits. Boeing's actuarial computations now assume that retirements occur one year earlier than they did five years ago. Previously, the assumed retirement age was 64; it is now 63.

The other major method of making early retirement more appealing was adopted by a West Coast paper company three years ago when it dumped its actuarial reduction schedule and replaced it with a formula of flat percentage reductions.

Employe Benefits

"We regard the percentage reductions as giving the potential retiree a higher benefit than he or she would have obtained with the actuarial reduction," explained a spokesman for the company. The spokesman insisted that neither he nor the company be identified.

However, unlike Boeing and Armour, this corporation has noticed no spurt in the number of persons taking early retirement.

"My feeling is that inflation fears have dampened putative interest," says the spokesman, echoing the puzzlement of R. A. Dietmeyer, corporate benefits administrator at Abbott Laboratories, Chicago, who noted early retirements at his firm seem to have hit a plateau. This is a change from just two years ago when demand for early retirement was rising, he says. Nonetheless, three out of four Abbott employes retire before age 65.

International Business Machines Corp., Armonk, N.Y., is one of several large corporations that have periodically created special inducements to encourage early retirement in order to, among other things, correct work load imbalances. One such program was enacted Nov. 1, according to an IBM spokesman, who described it as a full employment incentive for workers with 25 years of service.

Under this program, created for a single geographical area, IBM employes with 25 years of service are eligible to receive two years of salary over a four year period.

"If, for example, a 46-year-old woman who began employment at IBM at age 21 wishes to stop working, she is more likely to do so if she can receive an income which will act as a bridge till she is age 55 and eligible for early retirement," explains the spokesman.

IBM has offered this particular incentive three times since 1971, twice on an across-the-board basis. The plan is especially appropriate to veteran employes too young to qualify for early retirement.

In addition, the giant computer company on Nov. 1 introduced the IBM Retirement Educational Assistance Plan. According to this program, IBM promises to pay up to $500 a year, up to a lifetime maximum of $2,500, for retired employes wishing to take courses at state accredited secondary schools and universities.

"Our purpose is to help employes formulate rewarding retirement lives," the spokesman says. He notes retirees are eligible for $1,000 toward further education. Also boosted was family lifetime maximum, for education, to $250,000 from $100,000.

Yet outside of these program, IBM is experiencing no new pressure for early retirement, the spokesman states.

American Airlines in New York

abolished its actuarial reductions in 1972 for persons retiring between ages 62 and 64, and was nearly swamped with demands for early retirement. Donald Scotland, director of benefits, can rattle off the impressive statistics: In 1969, only 27% of ground/flight employes who retired opted for early retirement. But by 1970, the figure was 40.3%; by 1971, 46.5%; by 1972, 58.6%; by 1973, 57%; by 1974, 66%; by 1975, 69%, a level that has continued this year. He believes the slight decrease in early retirement in 1973 can be explained by the fact that the 63- and 64-year-olds who were contemplating taking that action moved to depart in 1972, the year the actuarial reductions were scrapped for the most popular retirement ages.

A second reason for the pronounced early retirement trend at American might be the airline's level of pension benefits, which are higher than the industry average. Mr. Scotland notes the airline boasts a minimum benefit formula of $19.25 a month per year of service, which he says compares favorably with other industry averages.

As a result, an unskilled worker at American with 25 years of service can expect to receive $481 a month; similarly, an employe with 40 years of service can look forward to $770 a month in addition to Social Security.

Still, American Airlines was the only company contacted by *Business Insurance* to report a huge surge in demand for early retirement. "Perhaps, we just wear out faster in the airline industry," suggests Mr. Scotland.

At most other companies, the pressure for release from work before age 65, although still a demand by organized labor, seems to be becoming more muted. In addition to inflation, the faltering Social Security system seems to be inhibiting the trend, although it is not a conscious worry in the minds of most workers. Due to an anticipated deficit by 1982, prompted by an increase in the proportion of older, retired people in the population versus younger, working people, it has been proposed that the mandatory retirement age be moved up to 68 and 70.

Indeed, the arbitrary retirement age of 65 may soon have to be jettisoned in favor of a flexible retirement setup, Dr. Peter Drucker predicted during a recent conference of the Assn. of Private Pension & Welfare Plans (APPWP) in Los Angeles.

Underscoring the burgeoning pressure in this country for retired persons to return to work, Dr. Drucker urged that a more flexible concept of retirement be explored. Persons could be allowed to return to work with no seniority, he said, pointing to a Japanese system where a worker, retired at age 55, can continue to work as a parttime employe with no seniority.

Retired people are calling for changes in the mandatory retirement age, which Dr. Drucker says was affixed at 65 in the 1920s because, at that time, few people survived to that age. Organizations of retired persons, for instance, are proposing the upper age limit be stricken from the Age Discrimination in Employment Act of 1967.

Compounding the confused outlook for early retirement is the recent decision in the U.S. Circuit Court of Appeals in Richmond, Va. It ruled that a United Airlines flight pension plan, requiring retirement at age 60, is illegal under that act. (*Business Insurance,* Nov. 1) Earl Dolan, attorney for United, said the lawsuit was brought by a technical specialist and ground employe who took the action after he was required to retire at age 60 in line with the plan.

United intends to appeal the case to the Supreme Court, Mr. Dolan says. He adds that the provision for mandatory retirement at age 60 was put into the plan for the benefit of flight employes, mostly pilots, and was not meant to discriminate against older workers.

A far more exotic imponderable overshadowing the future of the early retirement concept—or retirement at any age accepted today—is the advances being made in biological research to curb the human aging process. Under some theories, human aging is regarded as a curable disease. One man who believes that a breakthrough is at hand is the author of a new book, Prolongevity, which predicts that babies born in 25 years will live in states of well-being until ages 125 to 150.

In any case, organized labor has vociferously championed earlier and earlier retirement—as, for example, the "30 and out" concept of the United Auto Workers (UAW). At Chrysler Corp., the "30 and out" concept, in effect for two years, has resulted in early retirements by about 50% of UAW members eligible for the procedure, according to a spokesman. The idea can also be used by non-union employes, he says, although Chrysler has no figures for these people.

Despite this activity, the Chrysler spokesman says they haven't experienced a noticeable step-up in demand for early retirement.

By contrast, numerous companies, including Litton Industries, Boeing and the Hearst Corp., have permitted employes who are able and who are wanted by their employers to work beyond age 65. None of these firms could offer any details on how these programs work, however.

Perhaps a typical example is the Ingalls Shipbuilding division of Litton Industries, the largest unit of the diversified manufacturer. It has a policy stating that employes can work beyond age 65 if they want to and if Ingalls wants them. The two criteria, says a spokesman, are health and the job held by the employe.

Many obstacles lie in the path of picking and choosing employes to work beyond age 65 in the opinion of employe benefit managers interviewed for this article. While he has sympathy for the notion of abolishing the mandatory retirement age, one benefits manager says "the problem is that people really do differ in ability." ■

SEE OUR AD ON PAGE 3

Business

Whenever an employee steps into a non-commercial aircraft—whether rented, chartered or company owned—his firm is exposed to major liabilities. For some of them, needed insurance coverage may be overlooked.

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

Business flying—flying for business purposes by means other than the scheduled airlines—has become a way of life in corporate circles.

In the past five years alone, business aircraft flight mileage is estimated to have increased by about 33%, with about 1.5 billion miles logged in 1975, according to the National Business Aircraft Association. At the same time, the number of cities served by commercial airlines has continued to decline (the total is down 30% since 1960), making non-commercial business flying a necessity for more and more firms as well as a convenience for all of them.

How safe is flying on business aircraft? The National Transportation Safety Board says that the accident rate for business flying is well below that for general aviation, which takes in all non-airline operations. For the professionally piloted corporate/executive segment, the accident rate is lower still—in fact, it is comparable to that for scheduled airlines in terms of aircraft-hours flown. The long-term trend toward fewer accidents is reflected in aviation insurance rates, which have decreased steadily as a percentage of total operating costs over the past decade.

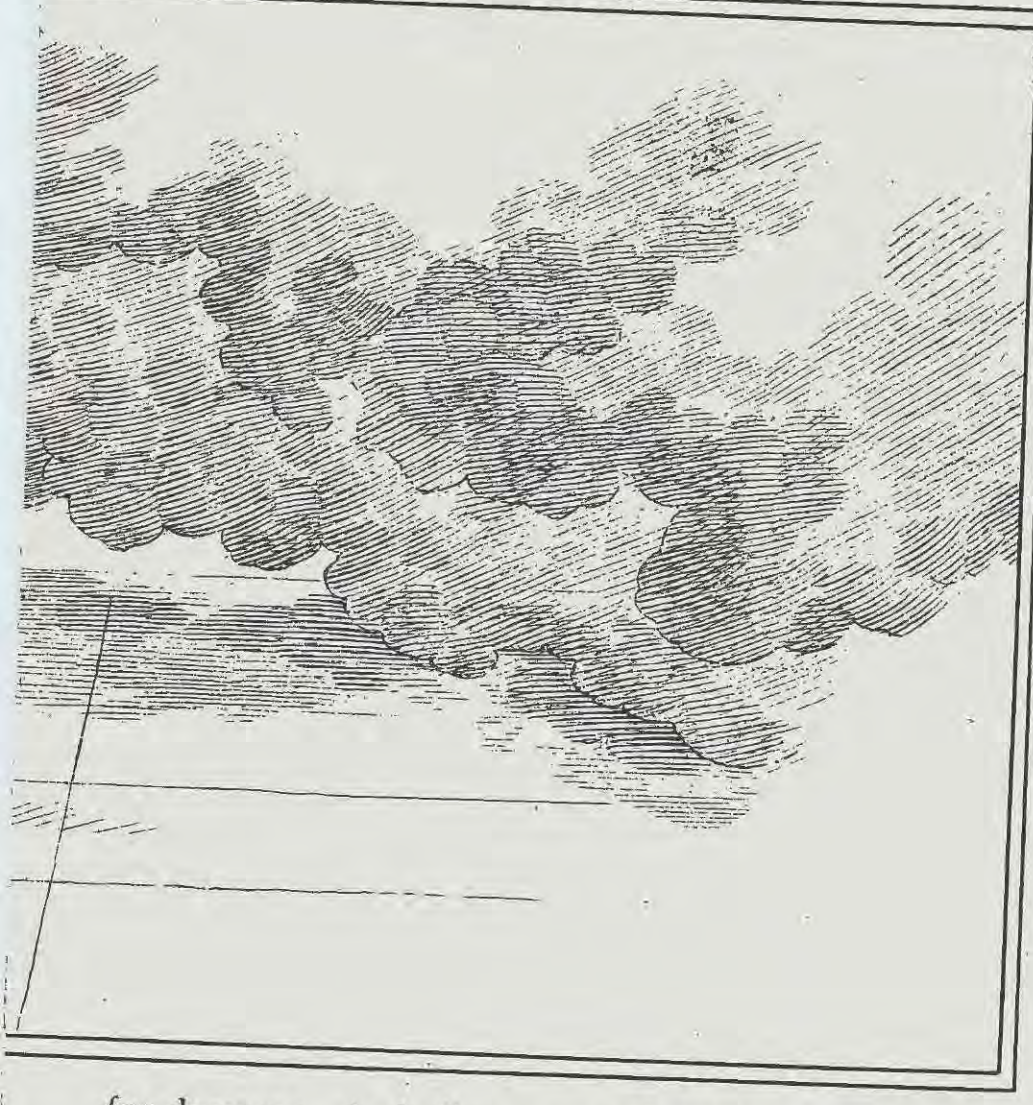
The conditions that make for safe business flying can be succinctly stated: an alert, well-trained and experienced professional pilot with final authority for aircraft operations decisions, flying a modern and meticulously maintained airplane. Despite sophisticated navigational aids and fail-safe devices the principal safety factors continue to be the pilot's skill, judgment and familiarity with the specific make and model of the aircraft he is flying.

When an accident does occur, however, it can have widespread legal ramifications—many of which come as a surprise to executives who assumed their firm was well protected against all eventualities.

Who pilots the pilot?

Suppose, for example, that a company salesman charters a plane in order to keep an important appointment with a customer. Even though his firm may have rules forbidding charter flights for business purposes, if an accident takes place the firm could be held liable

Flying



for damages—including any suffered by the crew and passengers and any damage to the plane itself. The presumption is that in directing the pilot where to take him, the passenger is exercising control over the pilot and may therefore have to share responsibility for what takes place.

If the salesman is himself a pilot and rents a plane for a business trip, he may not be covered as a pilot under the owner's liability policy, or the coverage may be insufficient for the extensive damages usually involved. The same principle applies if he flies his own plane or that of a friend. An aircraft non-ownership policy can provide large amounts of liability coverage at relatively little cost—coverage seldom furnished by regular business insurance.

Federal regulations do not require insurance for company-owned planes used in the furtherance of business pursuits unless those planes are hired or chartered by others for interstate carriage of passengers or cargo. ...ice, of course, liability insurance against ...perty damage, as well as damage to the aircraft itself, is a necessity—particularly in this day of high jury awards.

If a company-owned plane is flown to another country, it is advisable to determine in advance whether the insurance coverage provided by a U.S. carrier is legally recognized in that country. If not, acceptable coverage should be arranged before arrival. Otherwise, in the event of an accident, the plane could be seized and its occupants held to face criminal charges.

Admitted liability

All-purpose corporate aviation insurance, including both owned and non-owned aircraft coverages, can be obtained in a single broad contract with protection adjusted to company needs.

Such insurance may include the feature known as "admitted liability," which pays specified benefits for injury or death of passengers and crew whether or not the company is legally liable. In the aftermath of an accident, this provision can help a firm retain good will and avoid litigation.

As a fuller discussion of business aviation insurance from an objective standpoint, INA has prepared a booklet entitled, "Business Flying: Some Professional Considerations." Copies may be requested by writing INA Corporation, 1600 Arch Street, Philadelphia, Pa. 19101.

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The Insurance Company of North America was founded in Independence Hall, Philadelphia, in 1792. Today INA and its affiliated companies operate around the world with major interests in property and casualty insurance, marine and aviation insurance, life and group insurance, reinsurance and risk management services.

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Insurance Professionals

5-year vesting rule is coming, says expert

FREEPORT, Bahamas—Within the next 10 years there will be an amendment to the Employe Retirement Income Security Act requiring five-year vesting, Dr. Dan McGill of the University of Pennsylvania, predicted at the Southern Pension Conference here.

Dr. McGill, chairman of the Insurance Department at the Wharton School and chairman of the advisory committee of the Pension Benefit Guaranty Corp., said most employers seemed to be adopting the 10-year full vesting option from among the three provided by the pension reform act.

In no other country, Dr. McGill said, do they defer vesting for more than five years. In Scandinavia the concept of vesting is unknown because workers are immediately entitled to their pensions.

The U.S. pension system could go to five-year full vesting without much additional cost, he claimed.

Dr. McGill said a move to introduce full immediate vesting in the United States, would be a mistake.

Commenting on other directions in private pension systems, Dr. McGill said it was uncertain if the defined benefit or the defined contribution approach will prevail.

ERISA had revived interest in the money purchase approach because it avoids the funding requirements of the law, avoids contingent liability and would minimize the reporting requirements, he said.

Dr. McGill said inflation would be a major problem for pension funds in the future.

He told the conference that for every 1% increase in inflation, or 1% adjustment in retirement benefits, the long-run cost of the pension plan increased 10%.

"If you have 5% inflation and you adjust benefits, then you will add 50% to the cost of your plans," he said. "If employes will accept a later retirement age there will be cost savings which will pay for cost-of-living adjustments."

Dr. McGill predicted the mandatory retirement age would be increased in the future, partly because by the year 2000 there will be a shortage of workers and an increase in the number of retirees.

On the investment front, Dr. McGill said ERISA has brought a sharp shift from equity investments and to insurance companies. ■

info for buyers

To receive literature listed in Info for Buyers write directly to the name and address accompanying each item, mentioning that you saw the offering in *Business Insurance*. Readers are welcome to submit items for possible inclusion in the column. All items that are free and have informational value to readers are eligible. The column will also consider items for which there is a modest handling change. A sample of your literature should be sent to Info for Buyers, *Business Insurance*, 740 Rush St., Chicago, Il. 60611.

• How to administer an **On-Line Computerized Claims Administration System** for medical, dental, drug and vision claims. In-house or on-site claims, accounting, eligibility, pension, and administrative capabilities are offered by Automation Business Equipment. For a free brochure write Herbert Schaffer, Automation Business Equipment, 221 E. Walnut Avenue, Suite 271, Pasadena, Calif. 91101.

• Some professional considerations concerning **Risk Management** are now offered in a free pamphlet from INA. The brief explanatory booklet is designed for business executives. For a copy write INA Corp., 1600 Arch St., Philadelphia, Pa. 19101.

• The National Fire Protection Assn. **Standard for the Installation of Air Conditioning and Ventilating Systems** has been issued. Restricting spread of smoke, heat and fire through duct systems; minimizing ignition sources, and permitting use of the air duct system for emergency smoke control are discussed. Copies of the 44-page book (NFPA 90A) are available for $3 from the NFPA Publication Sales Department, 470 Atlantic Ave., Boston, Mass. 02210.

• **SEC Liability Insurance for Private Placements** is a promotional brochure offered free from the National Union Fire Insurance Co. of Pittsburgh, Pa., a member of the American International Group. Write National Union Fire Insurance Co. Of Pittsburgh, Pa., 102 Maiden Lane, New York, N.Y. 10005.

• The **HMO & Dentistry,** written by Gordon Ledingham, DDS, is available for $2.40 to Business Insurance subscribers, $3.00 to others. Write Protech Publishing Company Inc., 2182 DuPont Drive, Irvine, Calif. 92664.

• **Employe Communication and the Law** describes the influx of federal regulations in the employe benefits field, including ERISA. The gap between employes and employers in communications, some court cases and the future of employe communications regulations are discussed in this Kwasha Lipton newsletter. For a free copy write Department M, Kwasha Lipton Inc., 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

• **Group Pension Portfolio** contains a brief description of four group pension products available from Crown Life Insurance Co. The colorful display concentrates on funding and investment options provided. For a free copy, write to Mr. M. P. Buriak, manager, group marketing dept., Crown Life Ins. Co., 120 Bloor St. E., Toronto, Ontario, Canada.

• **Handbook & Standard for Manufacturing Safer Consumer Products,** published by the Consumer Product Safety Commission, outlines a step-by-step method to implement a product safety policy and procedures. Technical recommendations focus on design review, identification and evaluation of potential hazards, documentation of any changes in design, materials or production that could affect safety, safe production practices, maintenance of records and product safety audits. Single copies are available at no cost from the Commission in Washington, D.C. 20207.

• **Ansul Halon 1301 Fire Control Systems** explains The Ansul Co.'s extinguishing agent. It outlines, with photographs and flow charts, how the system operates, where it is to be used and how it is designed. For a free copy of the brochure, write to R. D. Evenson, Manager Marketing Communications, The Ansul Co., Fire Protection Group, One Stanton St., Marinette, Wis. 54143.

• **Everything You Always Wanted to Know About Broker Services . . . Internationally,** a reprint from Risk Management, provides a question and answer approach with five major insurance brokers. The brochure explains how brokerage firms service clients with risks outside the U.S. and Canada. The cost is $1.00. Write to: Dept. BSI, Risk and Insurance Management Society (RIMS), 205 E. 42nd St., New York, N.Y. 10017.

• A reprint of a three-part series of articles describes the possible broadened features of **CGL Extensions** available through the excess and surplus lines market. The series was written by Bernard J. Daenzer, CPCU, president of the Howden Swann Group of Companies. Free copies are available by writing to Anthony C. Bova, senior vp-marketing, Wohlreich & Anderson, 55 John Street, New York, N.Y. 10038.

• **Investment Tax Credit, an Opportunity for Increased Cash Flow** is a brochure published by Valuation Research Corp. describing some ways to achieve tax relief and reduce costs for new capital facilities, by recognizing that certain operating features of plants, warehouses and commercial buildings which are part of a basic construction contract will qualify for tax credits. For a free copy, write to: Michael Colhoun, Valuation Research Corp., 250 Wisconsin Ave., Milwaukee, Wis. 53202.

• Dental insurance not only meets the needs of the employe but can now fit the pocketbook of the employer. **PruDental,** a brochure prepared by the Prudential Insurance Co. of America, shows you how this can be done. For a free copy, write Director of Group Insurance, Prudential Insurance Co. of America, 3 Plaza, Newark, N.J. 07101.

• Northwestern National Life Insurance Co. publishes a digest of information on HMOs for corporate benefits administrators, entitled **A Guide To Health Maintenance Organizations.** The 12-page booklet defines HMOs, points out their advantages and disadvantages, and discusses [illegible] aspects of HMO[illegible] available [illegible]

B. Benson, Northwestern National Life, 20 Washington Ave South, Minneapolis, Minn. 55440.

• **Health & Safety at Work: An Appraisal for Management** by David Farmer deals with the historical background of the legislation and the resulting general responsibilities of the employer and employe, the enforcement system, the research and design functions of industry and the role of the Health and Safety Commission. Copies are $5 each sent to the U.S. or Canada. Write to Jan Wisotzkey, publications officer, Keith Shipton Developments Ltd., Adelaide House, London Bridge, London EC4R 9DS.

• **Report N. 4: New Doorways to Mid-America via Lash & Seabee Systems,** provided by International Adjusters Ltd. for $5 a copy, reports on inland waterway freight transportation available from Lash & Seabee. Its barges pick up cargo at a inland points in Europe, Asia or America and transport the cargo on waterways to a port of loading where it is lifted aboard a ship for ocean crossing. For a copy of the study, write to Mr. E. Raymond Keyes, president of International Adjusters Ltd., 16 John St., New York, N.Y. 10038.

• The International Safety Academy's **Catalog of Safety and Training Films** is available. It includes films for general industry, hospital safety, chemical and construction industries, first aid training, motor transportation and other topics. For a free copy, write to the Film Library, International Safety Academy, P.O. Box 76146, Los Angeles, Calif. 90076.

• The trend towards steadily increasing health insurance benefits is just one of the findings in the Health Insurance Institute's survey of 1975 trends in **New Group Health Insurance.** Hospital expenses and the five-year trend from 1970-75 are examined. Write the Health Insurance Institute, 277 Park Avenue, New York, N.Y. 10017.

• Ebasco Services Inc. discusses the need for proper planning and evaluation of an organization's compensation program to produce an effective employe benefit and reward system, in its 40-page **Total Compensation Planning** booklet. The illustrated book outlines typical benefit options, competitive provisions and trends, and benefit components from base compensation to executive perquisites. For a free copy, write to John J. Flood, Manager of Services, Ebasco Services Inc., 100 Church St., New York, N.Y. 10007.

• Equitable Life Assurance Society has published a new and extensive survey called **1975 Hospital Room and Boad Charges.** The survey, updated from the 1973 edition, is based on data from 2,593 short-term general hospitals, providing weighted average charges for private, semi-private and intensive care accomodations in 1,420 cities. State and national averages are also included. For a free copy write to: John H. Goddard, vp, Equitable Life Assurance Society, 1285 Ave. of the Americas, New York, N.Y. 10019.

• Metropolitan Life's annuity and endowment programs are explained in a 14-page booklet, **Individual Retirement Annuity: Questions and Answers.** It reviews the disability provision, death benefits, non-forfeiture provision and the retirement income arrangements and summarizes the qualification requirements in terms of plan design and funding. For a free copy, write to Info for Buyers, Donald G. Shapiro, Metropolitan Life Ins. Co., 90 Park Avenue, New York, N.Y. 10016.

• **Total Line Security** describes Mosler's electronic security systems—Hi-line security, coded line security, and internal line security —in a colorful, illustrated brochure. For a free copy, write to Ken Bird, Marketing Communic., Mosler, 1561 Grand Blvd., Hamilton, Ohio 45012.

• The **LRS Bibliography List** provides a record of literature on ambulatory health care administration, including available materials on health insurance costs, medical care costs, HMO costs, and health medical recordkeeping. For a free copy of the list from Medical Group Management Assn., write to: Carolyn Crawford Korkmas, Director of Reference Service, Medical Group Management Assn., 4101 East Louisiana, Denver, Colo. 80222.

Even Mercedes finds the savings from self-funded trusts welcome

By MARGARET LeROUX

MONTVALE, N.J.—A 501(c)-(9) trust established at the beginning of the year has saved Mercedes-Benz of North America Inc. 15% of the cost of claims for employe medical and dental benefits.

In addition, the trust allows the company "down-to-the-penny control over costs," Norber Brandon, director of personnel, said in an interview.

When the benefits were insured —Mr. Brandon declined to name the insurance company—"we found our costs were increasing at a tremendous rate."

During its first year with the trust, Mercedes-Benz has been able to keep a handle on medical cost increases, the personnel director noted. U.S. government statistics for the first six months of 1976 show medical costs 16% higher than 1975 costs. "Our costs are appreciably lower than the average figure," Mr. Brandon said.

Employe Benefits

Before self-insuring, it was difficult to pinpoint where the premium dollar was being spent, he continued. Computer printouts on claims made and benefits paid by the insurance company were difficult to compare with statistics kept by the benefit department, the personnel director said.

Now that medical and dental benefits are self-insured, "our figures are incomparably more informative," Nita Ballard, manager, employe benefits said.

"We can tell to the penny how much we've spent on any given employe for any period of time," she said. Such control is invaluable for benefits planning. "We can tell where to put the corporate benefit dollar in the future," Mr. Brandon said.

The primary considerations in deciding to use the trust for self-insurance were tax savings, Mrs. Ballard said. Use of the trust also cushions the fluctuations in the cost of claims. "With a trust we pay the same amount each month, which helps the cash flow," she said.

Both Mrs. Ballard and Mr. Brandon did considerable research on self-insuring employe benefits. They studied each benefit separately, noting the premiums paid, surcharges and amount the insurance company reserved for claims over a five-year period.

"Then we noted how much we would have saved if we had the reserves from the insurance company," Mrs. Ballard said.

The figures for medical and dental benefits were the most dramatic, which led top management to approve them for self-insurance through the trust.

"We hope to self-insure other benefits in the future," Mrs. Ballard said.

Claims administration for the self-insured benefits is handled by three members of the benefits department. The staff is also involved in administrating all other employe benfits.

"We've been able to improve the turnaround time in claims handling," Mrs. Ballard said. "It now takes on an average only three days from the time a claim is processed until the check is received" from the trustee for insurance to an employe.

Each of Mercedes-Benz's 1,300 employes is assigned a benefit staffer to contact on claims. Dealing with the same person each time you file a claim makes for better rapport, she noted. "The staff has a much better feeling of achievement with the self-administration of the benefits. Everyone likes to feel they're instrumental."

Another benefit of self-administering claims is consistency, Mr. Brandon said. "We have a consistency of claims settlement that would be difficult for an insurance company to match."

There is a tendency for insurance companies to settle questionable claims, he explained. "But our benefits staff knows our people and our program."

Before the trust went into effect, Mercedes-Benz employes were sent a memo explaining it and the reason why medical and dental benefits were being self-insured. In addition, the employe benefits handbook was revised. "It is very specific as to what is covered and what is not," Mr. Brandon said.

That Mercedes-Benz's medical and dental plans can be administered manually without the expense of a computer is another cost-saving factor stressed by both Mrs. Ballard and Mr. Brandon.

Not only are the startup costs lower without a computer, but claims information is available at any time, they said.

Though enthusiastic about the benefits Mercedes-Benz has realized in the first year with a 501-(c)(9) trust, both the personnel director and benefits manager suggested that other companies considering such a move to study the situation carefully.

They urged other benefits managers to make a thorough evaluation of premium and claims experience for at least the past five years. "During that period you'll most likely have both the extreme favorable and unfavorable conditions to compare."

In addition, "plan for the administration of self-insurance—consider it a cost factor," Mr. Brandon said.

"Up to this point, our experience with self-insurance through a 501(c)(9) trust has been favorable," he concluded. "It was worth the research and statistic gathering to set up a program that works well." ■

SEE OUR AD ON PAGE 3

N.Y.C. bank markets 501(c)(9) programs

NEW YORK—The 501 (c) (9) trust, currently a popular method of self-insuring some forms of employe benefits is being marketed by Manufacturers Hanover Trust Co. as an investment vehicle.

Manufacturers Hanover began the effort this summer and got an "enthusiastic response from a number of major corporations," a spokesman for the bank said.

As a trustee, the bank provides investment management of 501 (c) (9) trusts on a fee basis of one-half of 1% for the first $1 million, one-fifth of 1% for the next $4 million. The funds are invested in conservative, short-term, fixed income securities, the spokesman said, "not in a portfolio of equities."

Within this framework, the objectives are to maximize the yields and assure liquidity, he continued.

The bank works with a corporation's actuary to determine premiums paid to an insurance company for coverage such as long term disability, he said. "If the amount paid in premiums is greater than the amount paid out in benefits, then a 501 (c) (9) trust would be a savings."

Another savings realized by a 501 (c) (9) trust is state premium taxes. "If a corporation pays a sizeable amount in premiums—say $.5 million—this means $30,000 in sales tax," the Manufacturers Hanover spokesman said. 501 (c) (9) trusts are exempt from this tax in most states.

Although the investment role is new for 501 (c) (9) trusts, employe benefits managers are actuarial consultants have been enthusiastically studying the trust since the passage of the Employe Retirement Income Security Act (ERISA)

Under ERISA, a welfare plan that is structured to accumulate assets and is not completely insured must be implemented through a trust fund.

"There's been a virtual explosion of interest in 501 (c) (9) trusts," a member of a leading employe benefits consulting firm said.

"We've done more business in 501 (c) (9) trusts this year than ever before," one of his competitors noted.

Among Fortune 500 companies that have established a 501 (c) (9) trust recently are Mercedes-Benz of North America Inc. (see story page 44) and CPC International.

The trust was also set up by several other companies who declined to be identified, including a food manufacturing corporation located in the Chicago area and two New York city banks.

CPC established a $1.75 million 501 (c) (9) trust for its health and long term disability (LTD) benefits, Carlton Craigwell, senior employe benefits analyst said.

These benefits had been insured with Aetna Life Insurance Co. which now provides claims administrative services on an administrative services only (ASO) basis.

Mercedes-Benz has self-insured major medical and dental benefits in a 501 (c) (9) trust as of Jan. 1. The company plans to incorporate short and long term disability benefits in the trust in the future.

Since establishment of the trust, there has been a decrease in the cost of major medical claims, a spokesman said. "For the first six months of 1975, we had a 30%-35% increase in cost of claims over the previous year. For the first six months of 1976, with the trust, we had only a 2% increase in cost of claims." ■

E&O policy halt called

SAN FRANCISCO—Fireman's Fund Insurance Co. will not accept any new errors and omissions policies in California, Oregon or Washington because it is revising its E&O policy.

The company will continue to renew old policies, a spokesman said. At least 1,200 policies are due for renewal after Jan. 1.

Fireman's Fund reported more than 70 claims in California alone during the first nine months of the year. The company's loss ratio was 116%, higher than the national average.

Fireman's is considering substantial rate increases and upping deductibles to $2,500. It also wants to establish an improved loss control program.

The company said the increase in claims was a result of court decisions holding agents and brokers liable for mistakes in placing insurance. ■

Two companies consider ESOPs, but find their bottom lines differ

By MARIE KRAKOWIECKI

NEW YORK—The Pillsbury Co. in Minneapolis considered installing an employe stock ownership plan for its 38,000 employes, but rejected the idea in September.

That same month, Weyerhaeuser Co. in Tacoma, Wash. made its first allocation of common stock for the ESOP it established for the salaried portion of its 47,000 person workforce.

The contrasting decisions of the foodstuffs company and the forest products concern mirror the very different advantages which corporations believe they can derive from the controversial benefit.

Under the Tax Reduction Act of 1975, firms can claim a credit of as much as 1% of total investments for contributions transferred into an ESOP. This makes the plan particularly attractive to highly capital intensive companies, because it gives them a way to contribute money or stock to their own employes instead of paying the same amount in government taxes.

Weyerhaeuser, as a paper and forestry firm, is in a capital intensive industry. Back in November 1975, it wanted to take advantage of the new law and install an ESOP for all of its workers.

But as a practical matter, it found that a program covering everyone would provide a benefit that was not very meaningful on an individual basis. It needed to select a smaller universe of employes able to participate in the ESOP, so it narrowed eligibility to the 8,000 salaried workers who had one year of service with the company.

Richard B. Spitznass, Weyerhaeuser's manager of employe benefits, explained that the mechanics of the program are such that you don't know exactly what each year's investment tax credit will be until about August of the year following the calendar year in which the shares of stock are allocated to the ESOP.

In other words, although the Weyerhaeuser ESOP had an effective date of January 1975, the company didn't know until August 1976 what its investment tax credit was equal to, and therefore it did not allocate shares of stock into the trust until September 1976 for the previous calendar year.

Weyerhaeuser, a forest products company, decided to establish an ESOP.

In September, it bought shares of stock equal to 1.4% of the gross 1975 salary for each eligible employe. That was the ratio Weyerhaeuser worked out by dividing its 1% investment tax credit by eligible gross wages for 1975. The allocations were based on a 1975 stock price of $45 per share.

The new benefit was communicated to eligible employes by a letter sent to each person by company president George H. Weyerhaeuser, along with an announcement of two new voluntary life insurance programs.

Mr. Weyerhaeuser's letter outlined three important features of the new ESOP, including a seven-year holding period for each year's allocation of stock, 100% vesting and distribution within 60 days for any employe who leaves the company, retires or becomes disabled, and reinvestment of dividends by the trustee—Bankers Trust Co.—to purchase additional shares of stock to be added to the account.

The allocations of Weyerhaeuser stock cost the employes nothing. It is part of the company's total compensation program for salaried employes.

According to Mr. Spitznass, the Weyerhaeuser ESOP has no connection or overlap with retirement benefits provided by the company's pension plan, which last year was estimated to be worth $130 million. The company also has a stock savings plan for employes which provides benefits separately from the ESOP.

Weyerhaeuser has a reputation for offering generous employe benefits; it was named by Money magazine as one of the 10 best companies to work for in the United States. In keeping with this image, the company says the key advantage of its new ESOP is that

SEE OUR AD ON PAGE 3

it makes the employes shareholders in the company.

The "only problem" with the plan is the mechanical process involved in figuring out the tax investment credit and working out the proper allocation of stock to be put into the trust.

On the other side of the fence is Minneapolis-based Pillsbury Co., which rejected the concept of an ESOP at the same time Weyerhaeuser was allocating stock for one.

Since Pillsbury's operations are not as highly capital intensive as a paper products firm or an oil company's might be, its refusal of an ESOP would not be particularly noteworthy except for one thing: As a state senator, one of the most prominent supporters of ESOPs in Minnesota is company board member George S. Pillsbury. A law he co-sponsored in 1975 made Minnesota the first state to officially encourage the use of ESOPs through tax benefits, and he has been urging that the concept be applied at the company which bears his name, but with no luck.

"The only pressure for an ESOP at Pillsbury is coming from George," said one member of the committee which first studied, then rejected, the latest ESOP proposal.

Business Insurance talked to Pillsbury's director of compensation and benefits Michael Holt to find out what the case against an ESOP is from a benefits point of view. "We already have both a pension plan and a savings plan. If we put in an ESOP as a benefit, we'd probably have to cut back on some other benefit area," he said.

"We haven't considered it a dead issue because we could make it part of our existing savings plan. But at Pillsbury, we're going to be competitive with other large employers, and not many companies have ESOPs yet.

"If we clearly see a trend where more and more larger companies start to establish ESOPs, we might start one up to be competitive."

Pillsbury did not dismiss the idea of an ESOP lightly. Before turning thumbs down on the plan in September, the company's entire in-house employe benefits committee, a tax expert, a legal expert and senior line managers all conferred on George Pillsbury's proposal. They also worked with an outside law firm and a private consultant to examine the benefit from every angle.

Like Weyerhaeuser, Pillsbury discovered that if it included all its employes in a trust fund for an ESOP, the benefits accruing to each individual would be quite low, perhaps equal to a tax deduction of about $35 per employe per year.

But unlike Weyerhaeuser, Pillsbury was not willing to restrict the employe base for an ESOP to its salaried employes. "We prefer to treat all our non-union employes the same," Mr. Holt explained, after noting that unions negotiate benefit levels for their members.

George Pillsbury is understood to prefer that an ESOP's benefits be extended to all employes so they have an equal chance to share in the ownership of the company. He was expected to meet with the Pillsbury benefits committee in early December to again discuss implementation of an ESOP.

But at this writing, there is no indication that Pillsbury Co. considers ESOPs competitive enough as corporate employe benefits to install such a plan before the practice becomes widespread.

As Mr. Holt put it, "For now, we like to be able to tell employes they have a nice clean benefit like a dental plan. If you tap them and say, 'Hey, you've got an ESOP now,' they'll probably just look at you and say, 'Fine. What's an ESOP?' " ■

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PERSPECTIVE

Self-funded health trusts: The Pros and Cons

Benefits outweigh disadvantages, which can be reduced by insurance

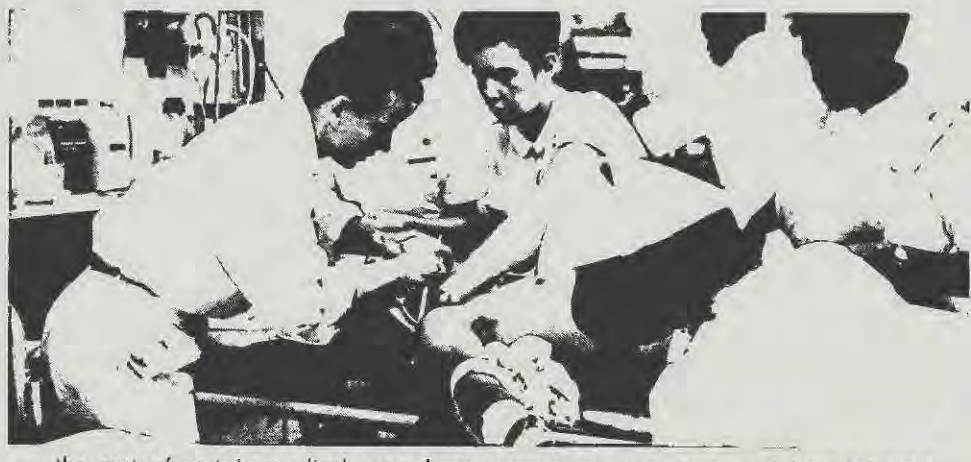
By John H. Fabretti
Health Application Systems
Burlingame, Calif.

IF AN ORGANIZATION knows that it can expect fairly predictable losses of certain kinds year after year, it can choose to pay all or part of those losses itself, rather than cover them with commercial insurance. This is the essence of "self-insurance," "self-funding," or risk retention, a procedure being employed by a variety of organizations today.

Although not a new concept, self-funding is getting ever increasing attention and consideration as a funding mechanism for health care benefit programs. In almost every instance, the major reason for self-insuring is to save money.

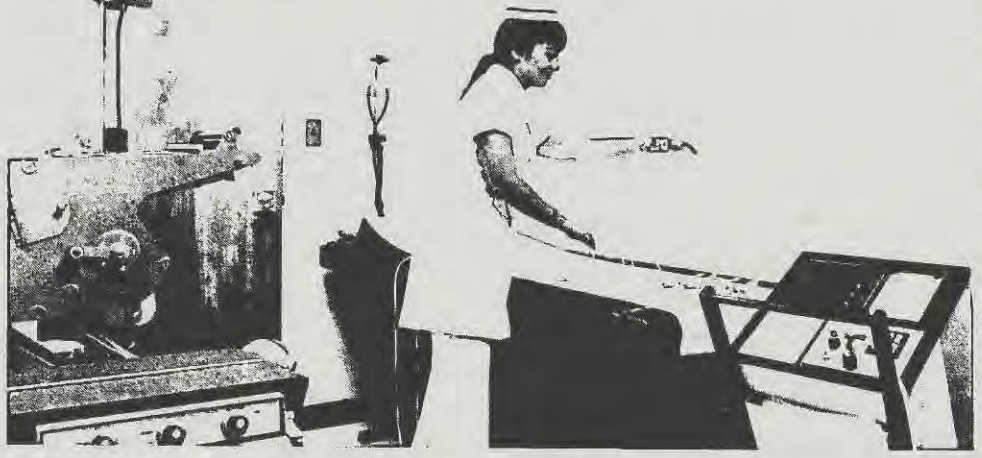
The original interest in self-funded programs came from the very large employers for whom the premium tax aspects and capital requirement could have a major financial implication. The continuation of explosive inflation in health care costs has resulted in rapid growth of current premium outlays for even moderate sized employers In this inflationary environment, routine rate increases of 20% to 40% a year on moderate sized groups are the rule rather than the exception. This has led to the reasonable question: Isn't there an alternative?

A self-funded health care program is one in which the employer agrees to reimburse employes for certain medical expenses incurred by them or their dependents. The plan may be paid either partially or entirely by the employer. State laws vary and thus should be consulted to determine whether the employer must agree to pay at least a given portion of the medical cost.



. . . the cost of certain medical procedures, emergency treatment, and hospitalization

Under self-funded health plans, the employer pays out of the company pocket . . .



Claims are typically administered by either the employer or a third-party professional administrator.

The major aspects of a self-funded plan include:

A. 501(c)(9) Trust

Self-funding of group health benefits may involve the use of a 501(c)(9) trust. The trust is useful if the plan requires employe contributions; it avoids having the employer being accused of doing business as an insurance company.

The trust is also used by employers as the vehicle to accumulate reserves. Investment income of the trust is not taxable, as it may be if reserves are maintained by an employer or a commercial insurer. Certain types of investments yield tax-exempt income, but typically the return is lower to reflect this favorable treatment. The 501(c)(9) trust is free to invest in most any type of investment without concern over the taxability of the income.

A number of employers desire to level out their cash flow, and do this by establishing a nearly level contribution to the trust without regard to the current level of payments. Direct payment of claims out of current cash flow could create some severe difficulties during the months of the year when claims are usually high. Monthly claim payments may fluctuate as much as 25% above the average for the entire year. Direct payment of claims may have an adverse compounding affect on an employer's cash flow.

B. Administrative Services

Claims administration may be performed directly by the employer, or he may contract with a third-party to provide these services. Consultants have provided this type of service in the past, generally for Taft-Hartley Health and Welfare Funds. Recently, however, a number of insurers and professional claims administrators have made their services available through an arrangement known as an administrative services only (ASO) contract.

Additional services may be contracted for on an as-needed basis, with the employer relying heavily upon his own staff to provide the expertise needed for the normal operation of the plan.

C. Stop Loss Insurance

Unless a plan is large, it may not be appropriate to establish a self-funded program without some assurance that the employer's claim liability will not exceed a certain affordable level.

Typically, this is accomplished through the purchase of stop loss or excess coverage insurance. The stop loss premium is relatively low, perhaps under 1% of the projected claims if the stop loss level is set at 150% of expected claims. Break points can range from 125% to 200% of estimated claims.

D. Legal Situation

During the past 10 years, many of the different approaches discussed above have been involved in the expensive litigation or at least negotiations between carriers and insurance departments. At the present time, most legal questions about self-funding now seem to be resolved for the following reasons:

a) The "Monsanto Case": In 1964, Monsanto Co. developed a minimum premium arrangement with Metropolitan Life similar to a self-funded plan because the excess risk limit was never reached. The state insurance commissioner of Missouri sued to enjoin Monsanto from engaging in the business of insurance and assessed substantial penalties. The circuit court agreed with the insurance department's position and assessed fines and penalties arising from operation of the self-funded plan.

In December 1974, the Supreme Court of Missouri reversed the lower court's decision and cited a number of cases in other parts of the United States where it was held that providing benefits does not constitute the transaction of insurance business. This reversal has cleared the air through resolving a very visable and potentially dangerous problem for an employer.

b) Section 514(b)(2) of ERISA preempts states from regulating self-funded plans under insurance, banking, and investment laws. This apparently removes any legal barriers to full self-funding. It is generally assumed that the preemption does not apply to minimum premium type plans.

Continued on following page

Consultants explain changes

Latest tax act alters TRASOPs

By Hewitt Associates,
Consultants, Deerfield, Ill.

TAX REDUCTION ACT type ESOPs were originally defined by the Tax Reduction Act of 1975. Such ESOPs are commonly referred to as TRASOPs. This article discusses the current status of TRASOPs following the recent passing of the Tax Reform Act of 1976, which provides continued encouragement for such plans.

Both Tax Reduction Act ESOPs and the more traditional type of ESOP defined by the Employe Retirement Income Security Act of 1974 (ERISA) were discussed in previous briefs done for clients which covered employe stock ownership plans (ESOPs). That prior material was intended to help employers analyze the applicability of both types of ESOPs for their companies. This article is intended to supplement that discussion by focusing on the modifications applying to TRASOPs as a result of the Tax Reform Act of 1976. Additionally, to provide a more complete summary, a plan characteristics profile is also included.

Under the original Tax Reduction Act of 1975, a company could receive an additional 1% tax credit for eligible capital expenditures placed in service during 1975 and 1976 by contributing a corresponding amount to a TRASOP to invest in employer stock. The new Tax Reform Act of 1976 extends the period in which companies may obtain the additional 1% tax credit through 1980.

Further, under the Tax Reform Act of 1976, companies with TRASOPs will be eligible for up to an additional ½% tax credit for taxable years beginning after Dec. 31, 1976 (through 1980). The exact amount of the additional tax credit is dependent on voluntary employe contributions made by plan participants. A company will be allowed an additional tax credit equal to total voluntary employe contributions up to an amount equal to ½% of the employer's qualifying capital expenditures, including:

- The employer may not make participation in the plan a condition of employment and the plan may not require matching employe contributions as a condition of participation in the plan.
- Each employe who participates in the plan must be entitled to make such matching contributions.
- Employe contributions under the plan must meet the requirements of section 401(a) (4) of the Internal Revenué Code relating to nondiscriminatory contribution levels.
- Employe contributions can be taken into account for the additional credit if they are contributed to the plan before the end of the year in which the credit is allowed, or if the contributions are pledged by the employes to be paid within two years after the close of that year and the pledge is made before the company's tax return is filed.

Employe contributions made under the matching rules must be invested in employer securities. Similarly, such contributions are subject to the same restrictions on distribution as employer contributions. Generally, no withdrawal is permitted for seven years.

In addition to extending and expanding the tax credit available to companies with TRASOPs, the Tax Reform Act of 1976 also contains other TRASOP provisions that will make these plans more attractive to companies.

TRASOPs may be considered permanent plans even though contributions are contingent upon the availability of the additional investment credit. This would appear to allow TRASOPs to also be qualified under section 401(a) of the IRC without committing the employer to future contributions if the tax credit is no longer available.

A limited amount of "start up" expenses (generally, 10% of first $100,000 of required employer contribution and 5% of excess) and administrative expenses (generally, 10% of first $100,000 of the income from dividends paid to the plan with respect to stock of the employer during the plan year ending with or within the employer's taxable year, plus 5% of the excess, subject to a $100,000 overall maximum) can be charged against the additional investment credit contributed to a TRASOP.

Continued on following page

Latest tax act changes . . .

Continued from preceding page

Future contributions under the investment credit rules may be reduced if investment credits which have been contributed to a TRASOP are recaptured or disallowed. Further, upon recapture, the alternatives of a deduction for the employer or recovery of the recaptured contribution from the TRASOP are available. To use the option of recapture from a TRASOP for any year's contribution, the plan must establish separate accounts for that year's contribution.

The additional investment credit for contributions to a TRASOP will not be allowed a public utility company if it is required to flow through any part of the additional investment credit to consumers. The Committee Report appears to indicate that the purpose of this provision is to prevent such flow through of investment credit, since such flow through would nullify the tax credit advantage to the company.

Employer securities may be contributed to a TRASOP as the credit is allowed rather than when it is claimed, in cases where part or all of the claimed credit exceeds the limitations of a section 46(a) of the IRC and must be carried over to a later year.

Employer stock held by a TRASOP can be excluded for purposes of determining whether corporations are sufficiently affiliated to permit the filing of consolidated returns.

The dollar amount of the overall limitation of annual additions to an employe's account permitted under section 415(c) of the IRC (presently $26,825) made to a TRASOP may be doubled. However, since such additional amount appears to apply to the numerator but not the denominator of the defined contribution plan fraction defined in seciton 415(c) (3) of the IRC, it is unclear how this change will effect the maximum fraction rules applying to defined contribution plans and defined benefit plans.

The stock of "brother-sister" corporations, "second-tier" subsidiaries and corporations which would be affiliates except for nonvoting preferred stock may be contributed to a TRASOP under the investment credit rules.

The following profile of TRASOP characteristics includes modifications resulting from the Tax Reform Act of 1976.

Form of Plan

A defined contribution plan which is a stock bonus plan, a stock bonus and a money purchase pension plan, or a profit sharing plan, which is designed to invest primarily in employer securities. May be combined with an existing plan, but amounts allocated under the TRASOP portion of such combination would have to be accounted for separately.

Participation

Must comply with the nondiscriminatory participation rules of section 410 of the Internal Revenue Code. However, it cannot be a plan integrated with Social Security. If qualified under section 401(a) of the IRC, plan must meet all requirements for such qualified plans.

Investment in Employer Securities

Must invest primarily in employer securities. In particular, the plan must invest all contributions made for purposes of receiving a tax credit in employer securities.

Qualifying Employer Securities

Common or convertible preferred stock of the employer or an affiliate. The stock of "brother-sister" corporations, "second-tier" subsidiaries and corporations which would be affiliates except for nonvoting preferred stock may also be contributed.

Employer Contributions

Companies may claim an additional tax credit in an amount equal to 1% of the corporation's qualified investment (with respect to property acquired and placed in service after Jan. 21, 1975 and before Jan. 1, 1981) if such an amount is transferred to a TRASOP. Further, beginning in 1977, companies may contribute and receive a tax credit for an additional amount up to another 0.5% of the corporation's qualified investment if employes agree to contribute a matching amount. Contributions to a plan in excess of the 1% (or 0.5%) tax credit may be tax deductible if the plan is also qualified under section 401(a) of the IRC.

The Hewitt team that put together the TRASOP study, from left to right, John Miller, Fred Sher, Janet Shepherd and John Balkcom.

Employe Contributions

May not require employe contributions or reductions of other employe benefits. Beginning in 1977, employes may receive a matching employer contribution for their contributions up to an amount equal to 0.5% of the company's qualified capital investment. Employe contributions must meet the nondiscriminatory requirements of section 401(a) (4) of the Code.

Allocations

Employer contributions for initial 1% tax credit are to be allocated to participants in proportion to pay. Annual pay in excess of $100,000 is to be disregarded The Tax Reform Act of 1976 provides that employer contributions for the additional 0.5% tax credit must be allocated to each participant in an amount equal to his matching employe contributions for the year; it is unclear how amounts individual employes contribute to total the 0.5% tax credit would be determined in practice.

Voting of Stock

Participants must have right to vote stock allocated to them. Voting rights must be no less favorable than the voting rights of other common stock issued by the employer.

Dividends

Dividend rights must be no less favorable than the dividend rights of other common stock issued by the employer.

Vesting

Amounts allocated to participants must be immediately 100% vested.

Distributions

Distributions of stock to a participant (except in case of death, disability or separation from service) may not occur until the end of the 84th month beginning with the month in which the stock is allocated to the participant's account. ■

Self-funded health trusts . . .

Continued from preceding page

In California, the insurance code relating to self-funding is clearer than in most states since in many states the insurance code makes little or no reference to self-funding. According to Section 10, 494.5 of the California law, an employer may establish a self-funded program for his employes provided that (a) only non-industrial and non-occupational injuries or sickness are covered and (b) he agrees to pay at least 50% of the cost of these benefits.

The major potential advantages of a self-funded medical reimbursement plan are frequently listed as:

1. Coordination of Benefits: Any group insurance policy must be considered the primary insurer with respect to claims on persons employed by the policyholder. The term "primary insurer" is used to define that insurance company which has the primary liability in situations where there is more than one group insurance policy and where both policies have a coordination of benefits provision which prevents a duplication of benefit payments. Thus, the primary insurer would cover all claims up to its liability limits for all covered employes whether or not they are covered by another policy.

A medical reimbursement plan is not subject to regulation under the state insurance laws, and thus, can take a position that its benefits are secondary to all other group insurance policies. The exclusion of medical reimbursement plans from being subject to the state insurance laws discriminates in favor of organizations with a high percentage of second wage earners.

Another example of duplicated insurance programs is the typical automobile accident policy. To the extent that the limits of these policies are not exceeded and that benefits are not coordinated, there is usually some duplication of coverage.

In all of these situations, under a medical reimbursement plan, employe claims could first be assumed by other group policies. An employer's medical reimbursement plan liability would commence only after the other plan reached its liability limits. The claims assumed by other policies which would have been paid by the insurance company represent a direct savings to the employers in the form of reduced benefit cost.

It should be realized that this approach to coordinating health benefits only redefines which funding agency will pay certain claims and as such, results in absolutely no change in the level of benefits to the employe or his dependents.

2. Claims Control Procdure: A very important factor in keeping the cost of an employe medical program down is the system which the professional claims administrator has designed to detect fraudulent and excessive claims. Advanced systems involve substantial use of the computer by well-trained personnel. There is wide variation in the level of expertise provided in this area by both the insurers and the claims administrators.

3. Investment Income: Because the employer is the party who is obligated to pay claims which have been incurred but not yet paid, he is the one who must hold the reserves under the plan. The employer can often realize a greater return on the invested reserves than the insurance company is prepared to credit on the reserves which it holds. Furthermore, the fact that the employer controls the assets of the plan can greatly facilitate the company's cash flow planning.

4. Flexibility of Plan Design: Patterns of health care are constantly changing to keep abreast of advances in medical technology and employe requests for additional coverages. Professional claims administrators are often more flexible in the type of benefits they are prepared to administer than are insurance companies. For this reason, it is usually easier for employers to adapt to employe requests for new coverages with self-funded plans than with fully insured plans.

5. Decreased Costs for Large Groups: Larger groups can realize a reduction in the expected cost of their employe medical program with some form of self-funding. The major areas of saving are: elimination of the state premium tax; elimination of insurance company profit margin and/or contribution to surplus and reduced claims cost through more efficient claims administration.

The major disadvantages of a small self-funded medical reimbursement plan may be described as being:

1. Risk: The significant difference between an insured plan and a medical reimbursement program is that, under the latter, the organization assumes the risk inherent in claims fluctuations from one year to the next. Because most employe groups are not large enough to permit total self-funding, the majority of medical reimbursement programs limit their benefits to a fixed dollar amount per disability. Amounts in excess of this level would be covered under an insurance policy designed specifically to protect against adverse fluctuations.

In addition to limiting the claim liability on an individual claim basis it is possible to insure against aggregate claims exceeding a predetermined percentage of expected claims, probably within the range of 125-200% in any single year.

2. Employe Relations: One of the disadvantages of a medical reimbursement plan is the possibility of more effective claims administration. This implies a tighter control on allowed charges and, in turn, the possibility of employe concern about non-covered costs. These concerns can be minimized by effective employe education at the inception of a medical reimbursement plan and open communications after the plan has been implemented. Employers and claims administrators must emphasize and show by their actions that legitimate claims will be allowed and settled rapidly.

Because the firm or organization becomes the party having the interest in controlling claims under a self-funded medical reimbursement plan, they replace the insurance company as the one who must say "No" to employes. For this reason, those who establish self-funded programs must be prepared to take a firm position on the claims administration and risk occasionally upsetting employer/employe relations.

In summary, self-funding of a medical care benefit plan has several possible advantages. The reduction or elimination of premium payments can mean an obvious cost savings to the degree that retained losses plus expenses are lower than the premiums would have been. Perhaps even more important, self-insurance can permit a firm to retain cash over a longer period, improving cash flow and profitability to a marked degree.

A further benefit may be greater motivation for preventing losses or minimizing them, since the organization itself must pay such losses with funds it could otherwise retain. The organization may well have much more flexibility in dealing with the claims of its employes or members. The introduction of claim control factors such as "second opinion surgery," for example, would appear much more feasible.

Among the drawbacks to self-insurance, the possibility that unexpectedly large or frequent losses can cut into profits is the most serious. Even if such losses do not materialize, the uncertainty involved can be a psychological burden on management. And, it may be difficult to find personnel able to administer self-insurance with its societies demanding program and claims requirements.

Most of the disadvantages can be minimized, however. The impact of unexpectedly large or frequent losses can be reduced by determining the firm's capacity to absorb such losses. Once this aggregate limit has been established, insurance for losses exceeding it can be purchased—as can such self-insurance services as administration, loss prevention and claims handling. ■

JOHN H. FABRETTI is group product manager for commercial health, drug, and HMO products at HAS. Mr. Fabretti's experience includes 20 years service with a major insurance carrier, where, as a senior officer, he had operational responsibility for life and health insurance activities. Mr. Fabretti also served as chief executive officer of a firm providing consulting services to the insurance industry.

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FEARS OVERBLOWN:

Here's a step-by-step blueprint for solving Social Security ills

By Bernard Clyman,
Assistant vp
Office of Social Security Affairs
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A PENSION SYSTEM takes about 40 years to mature and come of age. Our nation's Social Security system has just completed its 40th year. It has come a long way. Its coverage is almost universal and it pays out inflation-proof, cash benefits topping $68 billion a year. Yet some critics are saying that the system is a fraud and are predicting that it soon will be bankrupt. To me such criticism is exaggerated and overdone. Social Security is not a fraud and it will not be permitted to go bankrupt.

That is not to say, however, that Social Security does not have any problems, especially financial problems. It does, but these are more serious in the long-run than in the short-run. The short-run financing problem is easily manageable and so is a good portion of the long-run problem as well; and we do have time to work out the rest of the long-run financing problem—but we are going to have to face up to it and make some hard decisions.

The short-run financing problem is largely a matter of economics. Benefits, continously expanding and increasing in in scope, are now boosted further by the automatic adjustment to offset inflation. At the same time, Social Security revenues are falling short because of high unemployment during the recent recession and expected slow reemployment in the years immediately ahead.

Benefits are now exceeding payroll contributions and the Old Age Survivors and Disability Insurance Trust Funds (OASDI) are running down. The funds, which serve as a reserve to cushion adverse short-term, outflows, have been kept in recent years at about 75% to 125% of the expected annual benefit payout plus administrative expenses. Today, the reserves are at 57% and the trustees of the funds expect the OASI Fund to be depleted in five to eight years and the DI fund by mid-1979.

To stem the decline in the funds' reserves and to hold reserves at about one-third of a year's payout over the next five years, the administration has proposed a 0.3% rise in the Social Security tax rate on employers and employes alike to 6.15% on a $16,500 earnings base effective Jan. 1, 1977. Others would hold off on taking immediate steps to finance the short-fall in revenues preferring instead to let the funds' reserves run down a bit more.

My position, however, would be to build up the reserves a bit to be able to meet all expected, adverse, temporary outflows due to seasonal and cyclical fluctuations in the economy. Accordingly, I believe in increasing contributions to the funds now.

Before discussing how to do this, let me remind all buyers of other people's views that no one's recommendations on this score (including mine) should be taken at face value. Each person's views must be weighed against that individual's philosophy with regard to Social Security's purpose within the nation's overall income maintenance system. So let me state mine before proceeding further.

Our country has a three-tiered income maintenance system: a broad-based basic tier (social security), a tier for additional, supplemental protection through private initiatives (such as private savings, pensions and insurance), and a third tier for those in need (public assistance). Each tier has an appropriate role in the system; and a fundamental tenet throughout the history of the system is that the central Social Security tier should not encroach unduly upon either of the other two tiers.

With that as background, I take the position that Social Security has an important and necessary function to perform in the overall income maintenance design, but that it cannot and should not be responsible for the whole job of income maintenance. Social Security was designed to provide benefits as a replacement, in part, for lost earnings due to death, retirement or disability, but it was not intended to cover earnings of higher paid people in full and pay correspondingly higher benefits. That was to be a function of private initiatives.

I believe that the benefits paid reflect an appropriate combination of social adequacy and individual equity. They reflect individual equity in that benefits are earnings and contributions related, though not proportionately so. They reflect social adequacy in that the benefits provide a minimum floor-of-protection (regardless of contributions) and in that there exists a social adequacy tilt in benefits as a percentage of previous earnings (i.e. the lower income earners receive proportionately more benefits with respect to their previous earnings than do the higher income earners).

I also believe—if the system is to work well and equitably—that there should be universal coverage, that all covered workers should contribute to OASDI, that all contributions should be made via payroll taxes shared equally by employers and employes alike, and that any change in benefits or any emerging deficit should be financed by increased contributions.

Accordingly, I believe the short-term deficit should be met by a rise in the payroll tax rate at least as large as that recommended by the administration (a somewhat larger correction will be necessary, the longer legislative action is delayed). I believe a tax rate increase is the only way to make all the people aware of the true cost of the program, that it is the best way to foster a sense of responsibility among all workers wih regard to the extent and scope of benefits under the program, and that it is the only way to maintain the widespread public acceptance of the program.

Even though the program really involves an intergenerational transfer of funds, workers look upon their future benefits as an earned right from their own contributions; and widespread public acceptance of the program depends on maintaining the psychology of this benefit-contributions relationship.

Any resort to general revenue financing or any quantum jump in the maximum taxable earnings base beyond that developing under the automatic provisions now in effect should be avoided. Resort to general revenue financing would break the earned-right-to-benefits by virtue-of-contributions relationships that gives the program public acceptance and would tend undesirably to change the Social Security program into more of a welfare instrument. Furthermore, it would remove any important restraint on unreasonable expansion of benefits in the future. It would also conceal the true cost of closing the deficit gap.

I oppose a quantum jump in the maximum taxable earnings base above that produced by the automatic adjustment provisions because it would have a cost impact on only a small segment of employed workers (about 15%) and because it would hide the true cost from the other 85% who would not be affected. This small group of higher income earners are an important group of savers, who would save less and thus lower the amount of savings that would be available for capital formation and the economic growth of the nation.

Furthermore, a quantum jump in the earnings base is an inefficient way to raise additional funds. A jump in the base means considerably higher, tax-free, inflation adjusted, retirement, survivor and disability income benefits for those who can best provide these benefits for themselves—which is a violation of the fundamental principle that Social Security should not encroach unduly on the other two tiers of our income maintenance system.

I would remind those who advocate a rise in the earnings base to lessen the regressivity of the tax schedule, that the system, as a whole (i.e. inclusive of benefits) is not regressive at all. In fact, it is just the opposite. The disproportionate weighting of benefits toward previous low earners more than offsets the relatively higher payroll taxes collected from these earners.

Continued on following page

SPEAKING OUT

Illiteracy: An insurance plague

By Peter Downes
Manager of Insurance
American Trading & Production Corp.
Baltimore, Md.

A FEW YEARS AGO it was agreed by many that it would not be the meek who would inherit the earth, but American managers. Books such as "The New Industrial State" by J. K. Galbraith and "Le Défi Americain" by J. J. Servan-Schreiber were held in great repute and became required reading for students of management. Nowadays they seem naive but at the time the gospel they proclaimed was cited with approval in flourishing management schools and at crowded seminars sponsored by the American Management Assn. and others. All gave testimony that the future was set fair for American management.

And then what happened? Why, the demise of the Penn Central Railroad, that's what. Then we saw Lockheed in trouble and its bailing out by a sympathetic government. We also saw other monuments of American management such as the conglomerates who were to reshape American industry. They are still around but we do not hear too much from them nowadays. And who can look at the results of some insurance companies over the past 10 years and not laugh out loud?

All this certainly proclaims management which was mediocre when it was not downright lousy. But it should not be inferred that American management is wholly poor because here and there one does come across somebody who knows how to do his job and does it well. However, can it be that there is some common factor which governs the ability of a manager to do his job?

I think there is and I think it begins in grade one. Simply put, I think it may be posited that the indifferent performance of so much of American management results directly from an inability to read and write of many of its practitioners. Moreover, nowhere is this more apparent than in the insurance industry.

A statement of this kind seems rather extreme even for an iconoclast like myself. Surely it may be said that while the average American manager is no John Galbraith he does succeed in communicating his wishes and orders and things get done. Indeed he does. And the results are sometimes frightening when they are not disastrous.

Many years ago some insurance companies employed people with talent. One is reminded of Wallace Stevens who became a well regarded poet as well as a vice president of his company. Less well known was Benjamin Whorf who was seen as a first class engineer by his colleagues at the Hartford Fire Insurance Co. but whose avocation was linguistics. As a result of his studies he propounded the theory that a person's perception of reality is governed by the language he speaks.

This was a profound statement. Indeed, if there is any truth in it at all then it may be deduced that any manager's performance will vary directly with his ability to read and write. If such a manager is unable to

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Illiterate . . .

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express himself clearly, finds difficulty in comprehending the materials his subordinates supply him and has a limited vocabulary, then his managerial performance will tend to be as poverty stricken as his linguistic abilities. And we all know such managers, do we not?

Perhaps the population at large is beginning to think about the subject of literacy to some purpose since during the past year syndicated columnists have written about it at length. And merely scanning news columns for comments on educational matters will demonstrate that there is a real and growing concern about the matter.

For years we heard complaints about Dick and Jane and that confounded dog. The latest manifestations of this saga are the regulations introduced by California and Maryland and probably other states which prescribe that each child shall pass a test of functional literacy before receiving a high school graduation diploma. This means that they must demonstrate that they can count change and be able to read the label on a ketchup bottle so that they will know what is inside it After graduation some will enter college and there they will find that they must attend compulsory rhetoric classes.

The purpose of these classes is to insure that the student can read and write, but the classes are often so crowded that it may take until his junior year before he can find room in one. After graduation he may decide to take his master's degree. Perhaps his professor will be among the many that tell us each year that few graduate students are able to read and write well enough to compose a thesis.

But as the most recent literature on the subject shows all this is being rationalized. Some educational specialists are telling us that literacy is unnecessary since modern modes of communication eliminate the need for it. Indeed, they say, if the student needs to learn a language at all he should learn one of the computer languages for which there is a practical need. Can you imagine voicing sweet nothings to your paramour in cobol? There is no need to be funny, said such an educational specialist just a few months ago, there are far too many things for children to learn for them to waste their time reading books.

Perhaps the results of our complacency can be measured against the numerous surveys on management practice and habits which have been published over the years. Many such surveys included a question on the reading habits of managers from which we learned that they skimmed through the Wall Street Journal and trade magazines and some even owned to reading perhaps one book a year. The answers to this question, and others contained in such surveys, gave the distinct impression that the ability to think and communicate those thoughts had been arrested a long time before.

This illiterate state of affairs is only too apparent in the insurance world of today. To take but a single example, many insurance policies are no more than verbal garbage with redundancy piled on redundancy in language so obscure that it could only have been composed by a mad man. If anyone does have the tremerity to suggest that the wording be changed to cope with a particular situation, we learn that this deathless prose is akin to the laws of the Medes and Persians and may not be changed. Some companies, of course, have recognized that such policies are nonsensical and have drafted documents which can be plainly read by most members of the public to which they are being sold.

In terms of insurance management there is probably not too much which can be done about this state of affairs except to make sure that the assistants we hire can indeed read and write. The sad fact about the whole affair is that those who are most afflicted are quite unable to recognize their deficiency, In fact, one can almost hear an imaginary conversation on the topic . . .

INSURANCE MANAGER: Did you get a chance to read the article I sent you?

V.P.: Well, yeah, I did, but it di'nt do nothing for me. What was it all about?

INSURANCE MANAGER: The author said that some managers cannot really read and write, but only think they can.

V.P.: That's stoopid. Nobody could'nt get to be a manager unless he could. Anyway, if that's what he said, why'nt he tell it like it is instead of usin' that fancy language?

INSURANCE MANAGER: I think he did try.

V.P.: Well, he should've wrote so's we could unnderstan' what he said. Language-wise he's a bust.

INSURANCE MANAGER: Very likely.

V.P.: Still an' all, somethin' I wanna know. Whatsa eye-ko-no-clasp? ■

Benefit trusts have long term advantages

By Francis X. Cody, FSA

ARE THERE ANY real long term benefits to be gained by adopting a 501(c)(9) trust? Or are the advantages temporary or one-shot in nature and hence probably not worth the trouble? The answer depends on what kind of employe benefit program is being provided by the trust.

Some applications of the 501(c)(9) trust undoubtedly do produce financial rewards which are principally short term. A good example of this is the adoption of a self-insured health benefit program to replace an insured contract.

Immediately following the change, IBNR reserves held by the insurer run down as they are used to pay benefits. Since there is no need to maintain reserves of this magnitude under the self-insured program, there is a considerable short term gain to the employer, perhaps as much as 25% or 30% of annual health insurance premiums.

The short term gain in this example will occur regardless of which type of self-insurance arrangement is followed, such as:

- Administrative services only (A.S.O.) with an insurer;
- Using a health benefit administrative organization (not an insurer);
- Going it alone with no outside help.

Incidentally, the presence or absence of a 501(c)(9) trust will not affect the short term financial gain in this example.

Gains of an ongoing nature may also be realized, such as a reduction in premium taxes and/or administrative charges.

Other applications of the 501(c)(9) trust will being long term financial benefits to the employer. Certainly the optimum use of a 501(c)(9) trust occurs when the employe benefit program is of such a type as to require the accumulation of excess funds in the trust in order to pay future benefits. When this occurs with a qualified 501(c)(9) trust, not only are contributions to the trust tax deductible but investment earnings on accumualted funds are also exempt from tax.

Two applications of the 501(c)(9) trust which provide long term financial benefits to the employer are the self-insuring of long term disability benefits and the pre-funding of post-retirement death benefits.

It is generally agreed, I believe, that the life insurance industry finds it difficult to insure long term disability benefits for private employers in a satisfactory manner. The problem is that the insurers, in order to protect themselves against early termination by the employer, will set up redundant reserves on claims whenever they occur. As soon as two or more consecutive years of heavy claims are encountered, a deteriorating process may be triggered by a rate increase which results in diminished participation on the part of employes (assuming the plan is contributory).

Since the poorer risks tend to remain, still higher premium rates are imposed in the next year, leading to still lower participation and so on, until, finally, the employer is forced to take a drastic action. Either he self-insures the plan, discontinues it, or pays an increasing share of the cost himself.

If self-insurance is adopted, the employer can manage his own claim reserves and, providing he acts rationally and in sound actuarial fashion, can set up a realistic program under which funds are accumulated as needed to pay future benefits. A qualified 501(c)(9) trust is admirably suited to serve as the funding mechanism since it ensures that the employer's contributions will be tax deductible and that the earnings on excess funds built up in the early years of the program will be exempt from tax. This is a long range program and, providing the trust is well managed, the benefits to the employer are definitely long term.

Another application of the 501(c)(9) trust providing long term benefits is the pre-funding of the costs of post-retirement death benefits. Many corporations still offer post-retirement death benefits and usually the cost is buried in the overall cost of group life insurance on active employes.

However, although the cost may be hidden, it normally increases rapidly as the insured population ages and eventually it will become too large to ignore. Pre-funding is certainly one possible solution to the problem.

Pre-funding is not for every employer. The pros and cons of pre-funding per se should be debated thoroughly before any decision is made. On the other hand, there may be compelling reasons for pre-funding, such as a desire to account properly for employe benefit costs as they are incurred, particularly in connection with cost-plus contracts involving the government.

In any case, once a decision to pre-fund had been made, then the employer may set up a 501(c)(9) trust into which contributions are made over a period of years. In this application self-insurance is not really involved. The employer makes annual contributions into the fund, on an actuarially determined basis and assuming once again that the trust has been properly qualified, the contributions are tax deductible, and investment earnings on accumulated funds are tax-exempt. There will be annual withdrawals from the trust in order to pay one year term group insurance costs to the insurance company on behalf of the retired lives.

It is these annual term insurance costs on retirees which are being pre-funded and, in the typical case, these payments to the insurer will increase steadily.

Certainly this type of arrangment, given the desire for pre-funding on the part of the employer, will provide tangible, long-term financial benefits to the employer. Although some applications may only give short term benefits, important long-term financial benefits can also be realized from well conceived applications of the 501(c)(9) trust. ■

Mr. Cody heads his own independent consulting actuarial firm. He has served as sales executive in the re-insurance industry and also as chief operating officer of a captive life insurance company. Recently he has been associated with Risk Planning Group.

Social Security won't go bankrupt . . .

Continued from preceding page

For those concerned with the tax burden on the poor, I would suggest that offsetting changes—if needed—can be made in the federal income tax system. I would strongly prefer that, to tinkering with the Social Security tax. I think it most important to preserve the principle that the program should be financed by contributions from earnings of all covered workers in order to maintain its widespread public acceptance.

The 1976 trustees report placed the long-run deficit at an annual average 8% of taxable payroll over the next 75 years (up from 5.3% in the 1975 trustees report), with the bulk of the deficit materializing after the turn of the century. The deficit results from current and projected low fertility rates and also from a rise in the ratio of beneficiaries to workers as the World War II "baby boom" population begins to retire in the year 2005 and thereafter. That ratio is now 30 beneficiaries per 100 workers; by the year 2030, it will be 50 per 100.

To put it another way, today there are three workers to support every social security beneficiary; by the year 2030, there will only be two. Further aggravating the situation is a projected high inflation rate, with assumed limited growth in real wages.

But one should note here that long-range population and economic assumptions are notoriously subject to error (especially over 75 years). The trustees recognize this in making their 8% deficit an intermediate projection. The trustees cite as alternative possibilities a 3% deficit (using pessimistic assumptions) and a 15% deficit (using optimistic assumptions). Since the problem really arises after the turn of the century (for the next 25 years, the deficit is a more manageable 1.9% of payroll), we do have some time to wait and see if the projections look reasonable.

Fortunately, a large part of the deficit can be removed—if we correct an inadvertently created, technical flaw which was introduced into the benefit formula when the automatic-adjustment provisions were added in 1972. The flaw occurs because the automatic price adjustments for future benefits are coupled with the automatic price adjustments for current benefits in such a way that benefits for future retirees are adjusted twice for the rise in prices.

As a result of this flaw, initial benefits as a percent of pre-retirement earnings can fluctuate widely either up or down, depending on future movements of wages and prices (over which Social Security has no control). Under the economic assumptions used by the Trustees in their 1976 Report, benefits to many future retirees would be in excess of their pre-retirement earnings (which just doesn't make any sense).

The administration has proposed to "decouple" the benefit formula so as to eliminate the double adjustment of future benefits of current workers for the change in prices; and it proposes to do this in such a way as to stabilize these benefits as a percent of pre-retirement earnings at approximately their current levels, while still maintaining the adjustment for inflation in benefits paid to current beneficiaries.

I would support "decoupling" in principle because it would bring the system under control again, and because it would reduce considerably the long-term deficit—under present economic assumptions—by anywhere from about one-half to four-fifths, depending on the technique and benefit formula recommended. My own preference is to use the "decoupling" revision to eliminate more, rather than less, of the deficit in this fashion.

There are many other issues in Social Security that need to be discussed and resolved, but financing is the most fundamental. As such, it deserves and requires our careful attention and study. The financial problems are not insoluble, but their solution should not be obtained apart from a discussion of the purpose and philosophy of Social Security. Such an open discussion is needed if we are to formulate a constructive evolution of Social Security's role in the nation's tripartite income maintenance system. ■

Mr. Clyman, who joined Equitable in 1958 as an economist, has his BA from Temple University and his PhD in economics from the University of Pennsylvania. He became head of Equitable's office of social security affairs in late 1975.

GM agrees to costlier vision plan; 3 insurers split industry coverage

DETROIT—General Motors Corp. has agreed to a vision care program with substantially more benefits than the plans won by the United Auto Workers at Ford Motor Co. and Chrysler.

In return, the UAW for the first time agreed to a single, nationwide insurance company for a health insurance program, according to Bob Lennox, in charge of the program at GM.

One source said GM agreed to the expanded program only after the UAW accepted Metropolican Life Insurance Co. instead of Blue Cross-Blue Shield. The improved program is identical to one that has been in effect for two years for 24,000 GM employes represented by the International Union of Electrical Workers in Ohio, Upper New York State and New Jersey.

The GM program is expected to cost 20% more than the $45 to $50 a year per employe expected by company and insurance officials for the Ford-Chrysler plan.

In the meantime, Ford has divided its vision care program between Blue Cross-Blue Shield of Michigan for employes within the state and John Hancock Life Insurance Co. for employes outside of Michigan. Health Application Systems (HAS) of Burlingame, Calif., will administer the progtram for Ford.

Chrysler has placed its entire program with the Blue Cross-Blue Shield system, with Blue Cross-Blue Shield of Michigan serving as the "control" plan, according to Colin Wilkinson, vp in charge of the automotive section at Michigan Blue Cross.

The Ford-Chrysler plan goes into effect Oct. 1, 1977, for employes with at least one year of service. (Retirees are not included.) Both plans will require the establishment of a national network of opticians, optometrists and ophthalmologists who agree to provide services under the terms of the contract.

The Ford-Chrysler plan will cover, once every 24 months, 80% of the reasonable and customery charges for:

- A vision exam.
- Acquisition of lenses. Acquisition cost is defined as the cost to the provider.
- Contact lenses when vision in the better eye cannot be corrected to at least 20/70 by regular lenses.
- Contact lenses in other cases up to a maximum of $35.
- Frames up to a maximum of $12.50.
- The dispensing fee of the provider for lenses, contact lenses and frames.

Payments to non-participating providers will be substantially less.

The GM program will allow examinations and new lenses every 12 months instead of every 24 months. It also provides for a flat co-payment of $5 for an exam and $7.50 for lenses and frames. It requires use of participating providers only for the purchase of frames.

Burt Armstrong, vp in charge of the General Motors account for Metropolitan, said he expects the cost of the GM and Ford-Chrysler programs to be the same in the first year. After that, as inflation increases the cost, the flat co-payment and additional exams will result in a higher cost in the GM program, though he could not say how much higher.

Ford Motor Co. is particularly concerned about the possibility of rising costs, according to Ernie Savoy, the man in charge of the program at Ford.

"You will find this program has been set up more on a cost control basis than other programs," he said, citing the time limits, relatively high co-payments, and evaluation programs.

Ford also split the program between Michigan Blue Cross and John Hancock "because we wanted an opportunity to see who the hell would do a better job." In the past, Mr. Savoy said, Ford did not always get the cost control it wanted when a single carrier was given a section of coverage the Blues couldn't handle.

With implementation of the program less than a year away, both Michigan Blue Cross and HAS are working to set up the program. Michigan Blue Cross was working on a vision program even before the negotiations began, Mr. Wilkinson said, and is continuing to contact providers in the state and consultants across the nation to discuss setting up a national network of providers.

That national network is the biggest problem facing Dave Ferguson at Health Application Systems. His most important decision will be whether to use any of the panels of providers now in existence or establish a new one. The new panel would require a great deal more effort, he said, although there would have to be some negotiations even if HAS decides to use an existing network.

Mr. Ferguson hopes there would be one national network of providers, but there had been no contact between HAS and Michigan Blue Cross by the end of November. The groups are required by the UAW-Ford contract, however, to establish one administrative manual for the plan.

Mr. Armstrong said Metropolitan expects a much easier time setting up a national system of providers since participation is only required for frames.

Both HAS and Michigan Blue Cross have begun internal planning on claim forms and computer capacity. Mr. Wilkinson doubts there would be any coordination on those matters between the two groups because they are independent competing organizations. ■

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benefit tax slants

Changes require new evaluation of executive benefit programs

By JOSEPH S. ROBINSON
Attorney-at-Law

SWITCHES IN pay plan patterns will be more pronounced in the near future than has been the case for the past several years. New tax rules and revisions of some old rules call for fresh calculations and re-evaluation of existing plans. Such areas as group insurance, qualified retirement plans, deferred compensation and stock options stand out as clear candidates for review.

The following may serve as pointers to be considered in meeting executive financial security needs and goals under the current tax climate.

Group Life Insurance: This old standby is basic with many firms since it is one of the least expensive fringes a company can offer its employes. The premiums are deductible by the employer and tax free to the employe up to $50,000 of protection. Above that sum, the employe has added income equal to the extra amount paid by the company. However, this is far less than the premiums the employe would pay if he were to buy similar coverage himself.

Executives who have built up sizeable personal estates often seek ways and means for removing the death proceeds from their estate. They should be reminded that the estate tax consequences of such insurance supplied by their company depends on whether the employe had retained any rights in the insurance policy. If the employe could change the beneficiary, get the cash surrender value (if any), or if he in fact transferred the policy within a three year period before his death, the tax collector almost certainly will try to nail the estate for the full insurance proceeds. However in a recent ruling, the IRS put its stamp of approval on a method for sidestepping the estate tax.

X company entered into an agreement with an insurance company providing for an optional contributory group insurance policy insuring the lives of its salaried employes. An employe could enroll for the insurance coverage. If he didn't, "an applicant owner" (certain specified adult relatives of the employe) including his wife could pick up the coverage and pay the policy premiums. The "applicant owner" (i.e., wife) then becomes the owner of the policy with all rights of ownership.

Smith, an employe, had his wife enroll for the insurance on his life and she paid the premium for the optional group life insurance out of her own separate funds. Several months thereafter, Smith died and his wife collected the proceeds. The IRS ruled the proceeds are exempt from estate tax because neither Smith nor his estate had any ownership rights in the policy. (*Rev.Rul.76-421*).

The IRS raised no contemplation of death issue, presumably because there was no transfer by the employe under this procedure. Therefore, employers with similar optional group life insurance may want to check whether this approved method of avoiding estate tax is allowed under their contracts.

Qualified Retirement Plans: Pensions are another important area for fringe benefits providing a steady flow of income after the working years. Profit-sharing also helps build financial security through the accumulation of a nest egg. These plans offer three tax breaks: Deductible pay-ins, tax-free accumulation of income and delayed low-tax payouts.

Most pension payouts are turned over to executives upon retirement in the form of an income for the duration of his life and that of his spouse. Any balance of principal disappears when the executive and his spouse die. This latter financial fact causes concern to many executives who find themselves with little to leave their heirs—despite substantial compensation during working years.

Here's how D. F. Stout, president of Bliley Electric Co. of Erie, Pa., solved the problem. The company added an option that permits a retiring executive to arrange his pension so that a lump sum probably will remain after death for the heirs. Take this example: An executive with a salary of $50,000 a year could expect a pension of about $28,000 based on years of service. Instead of taking this pension, he exercises the option and takes a lower amount each year—$21,000 for example.

Meanwhile, the actuarial equivalent of the total the company must set aside for the executive's basic pension remains in trust. If the trust earns enough to cover the $21,000 each year, fine. The total amount, (estimated at $265,000) remains intact for his heirs, but if the trust earns less than enough, the principal will be invaded.

The potential benefits to the employes in such brackets who have families to consider are so important that the plan is worth considering even if it might cost the company a little money. But when a company has a lump-sum benefit option anyway, the new plan does not cost the firm anything extra.

REMEMBER THIS! Under ERISA, if a pension includes a life annuity for a participant among its payout provisions, it must provide that the annuity option be a joint and survivor annuity. A survivor annuity guarantees a surviving spouse a lifetime income based on the value of the decedent's retirement account (and these payments cannot be terminated because of remarriage). Since the participant must usually pay the price of reduced benefit payments at retirement, he has election rights where an annuity payment is involved.

The plan must give the participant the opportunity to elect in writing not to take a joint and survivor annuity (*I.R.C. 401 (a)-(11)(E)*).

Suppose a lump-sum payout election is written into the plan. The Tax Reform Act permits a taxpayer to irrevocably elect to treat all of such distribution as if it were earned after 1973 so that it its taxed as ordinary income and can qualify for 10-year averaging. The election applies to distributions made in taxable years beginning in 1976.

Keep in mind that employes

will have to weigh lump-sum versus annuity payments to their beneficiaries in the light of changes in the tax law. Under the new rules single payment distributions no longer are exempt from a deceased employe's estate. Installment payments (at least 36 months) continue to receive estate tax clearance. Comparative dollars and cents calculations may have to be made.

Deferred Compensation: We can look for an upsurge of activity in deferred pay agreements as a compensation tool for key people. Thus, executives can be kept on board by permitting them to delay part of their pay hikes until retirement when presumably they'll be in a lower income tax bracket. The reason for the anticipated return to these plans is the tax revision which now makes deferred compensation eligible for the "maxi-tax"—the 50% ceiling on personal service income. And as long as the agreement is unfunded the employe is not taxed until paid.

Nevertheless, because of the estate tax consequences of a typical deferred pay plan, for a good many executives, a straight-out agreement to pay his widow an annuity or stipulated amount in periodic installments after his death (eliminating the deferred compensation aspect) may well suffice.

For instance, a $1,000,000 life insurance policy was taken out by a company on the life of its chief officer. The policy was payable to the company and it, in turn, agreed to pay the officer's beneficiary $100,000 a year over a ten-year span, if he died while so employed. The company stated that proceeds were tax free to the corporation in a lump-sum, and its liability for death benefits would be spread out over a ten-year period . . . a substantial economic gain to the corporation.

The spread-out of payments over 10 years simply meant that the corporation had the chance to earn interest over that period on the reducing amount of $1 million. At a net after-tax rate of 3%, this produced a yield in excess of $150,000 in compound interest.

But the story doesn't end here. The gain from the tax leverage is $480,000 (48% corporate tax bracket). Since the corporation pays out $1 million in deductible payments, its payout cost is only $520,000 . . . it has a $480,000 profit minus its total premium cost.

Here's the estate tax picture:

Where a corporation sets up a typical deferred compensation arrangement (combining retirement and death benefits) there is an estate tax impact by absent deferred compensation tied to a straight death benefit, we can avoid inclusion of benefits in the estate of the executive. No annuity or other payment is payable to the employe . . . a condition required under the tax rules.

Qualified Stock Options: The new law repeals the present tax treatment of qualified stock options, thus subjecting qualified stock options to the same rules as presently apply to non-qualified options. In general, the new rules apply to options granted after May 20, 1976. The new rules do not apply to options granted on or before that date, even though the option is exercised in the future (provided it satisfied the present requirements for qualified options). Options covered under the transition rules must be exercised before May 21, 1981, in order to receive the federal tax treatment that is presently accorded qualified stock options.

Since qualified stock options for executives have lost their tax appeal, other rewards will have to be substituted such as nonqualified options, phantom stock or performance shares.

Under the typical performance share plan, awards of company stock are made to executives at the beginning of a period that extends for several years (usually from four to six years), to be earned out over that period if a predetermined company performance objective is attained and if the executive has remained with the company.

Miscellaneous Fringes: Group permanent insurance is one of the hottest items on the fringe benefit drawing board. It costs the company more than group term coverage, but offers more to employes. It builds cash values that the latter can carry with them when they leave, merely by taking over the company's premium payments.

Split-dollar insurance is another valuable way of offering low-tax pay to key people. It costs the firm nothing other than the loss of the use of its money which it eventually recovers. ■

Judge acts to protect supervisors

ST. LOUIS—A former employe of Trumball Asphalt Co. was awarded two years in back pay by a federal district court judge who ruled the employe was fired for filing a job safety complaint.

The U.S. Labor Department, which filed the suit on behalf of Jerold Lee Miller, said it was the first time a court had extended the protection of the Occupational Health and Safety Act to a supervisory employe.

Mr. Miller, general foreman of a Trumball plant in Hazelwood, Mo., and several other employes were fired after filing a safety and health complaint. OSHA prohibits the firing of any employe who files a complaint. The National Labor Relations Board ordered the employes, with the exception of Miller, reinstated. The board said its rules did not include supervisors.

District Court Judge H. Kenneth Wangelin did not reinstate Miller because he said the supervisor did not act in good faith after his discharge. Back pay will cover the period from Oct. 16, 1974, to Nov. 2, 1976. No amount has been set. ■

Cost of multiple health tests vary widely: Study

CHICAGO—The total cost per employe of conducting regular multiphasic health tests in the workplace is usually $25 to $100, although the cost often runs over $100 and sometimes hits $200 levels.

This was one of the key findings of a survey conducted by the Washington Business Group on Health, working with Arthur D. Little Inc.

In testimony recently presented to the Council on Wage and Price Stability, Willis B. Goldbeck, director of the Washington Business Group, said the object of the study was to ascertain employer involvement in health testing programs.

The survey of 169 employers elicited 101 responses. Of the 101, 48 companies said they have multiphasic health testing programs.

Some 98% of the firms having health testing plans pay for the screening for employes. Only 2% said employes have to pay for their own tests, through their unions. Surprisingly, not a single company uses insurance to pay for health screening.

Employe Benefits

"There is a very wide range of costs because there is no commonly accepted MHT program against which to measure costs," said Mr. Goldbeck.

Pre-employment health screening is generally less costly than screening of regular employes, the study found. And the most expensive tests are the comprehensive health testing done on company executives, it was revealed.

Some of the 48 companies already having multiphasic health testing programs haven't separated their costs of these programs from the total costs of all medical examinations, so that MHT costs are not available in all cases.

Almost no company has long term cost data, Mr. Goldbeck said.

The confidentiality of health testing results is an issue for both employes and firms considering the programs, although not an insurmountable one, Mr. Goldbeck believes. In fact, one company assures complete confidentiality and also increases employe awareness of health care costs by having the health testing bill sent directly to the employe who is then reimbursed by the company.

Of the 48 major corporations having health screening programs, tests are done 39% of the time by company personnel, 32% of the time by an outside contractor, and 30% of the time by both. Both the location of test facilities and the use of a contractor depends on in-house capacity, the desire to divorce test results from the sponsoring company, and whether the tests are mandatory or voluntary," Mr. Goldbeck noted.

"And in the vast majority of cases, MHT is not done in cooperation with other companies or unions," he added.

Multiphasic health testing is most frequently used for entry physicals and after exposure to health hazards, the study found. Sixty-six percent of the firms having MHT programs do entry physicals on all employes, plus another 20% which test at entry for health hazard groups, susceptibles, symptomatics and managers.

MHT is done by 41% of the firms on all employes after exposure to health hazards. Periodic physicals for all employes are provided through MHT by 27% of the firms having programs, while 57% of these companies have their managers go through MHT periodic physicals. Over three-fourths of the firms have health hazard groups, susceptibles and symptomatics undergo periodic MHT physicals.

Other common uses of MHT included tests administered after an employe returns to work from an illness of a given duration, and when reassigning an employe to work which may affect the employe's health.

A small percentage also test an employe's health at the time of termination or layoff, the study revealed.

Forty percent of the employers having MHT programs said they plan to expand their MHT systems to cover more employes during the next two years, while 42% don't plan to expand the programs. Another 18% were uncertain what they'd do. Some of those in the negative 42%, of course, already cover 100% of their employes, which amounted to fully 23% of the positive responses from companies having multiphasic health testing programs.

Major positive results of MHT programs were shown as employe good will (63% of the companies having such programs), improved employe health (52% of the MHT group), reduction of disability (32% of the MHT group), reduction in absenteeism (20%), and reduction of health insurance costs (14% of the multiphasic health test users).

Some of these results pointed to the fact that employers had accomplished exactly what they intended when setting the programs up. The most important factor influencing companies to establish MHT programs was reducing employe disability, cited by 57% of the group having these testing systems. In other instances, employers wanted to boost employe morale (36%), comply with regulatory requirements (34%), and pinpoint causes and symptoms of job-related ill-health (30%).

Computers were used in nearly 60% of the MHT programs disclosed in the study. EDP systems were found to be used most frequently for data analysis, patient medical results files, epidemiology base, and on-line computer data capture.

The Washington Business Group on Health found that among those companies not having health screening programs, the primary reasons for shunning such involvement included costs—in both dollars and employes' time—and employe populations too small to be cost effective. Some companies also said they preferred alternative health maintenance programs to health testing.

Only two companies cited union-employe relations as a reason not to establish MHT programs, the study found. In addition, savings are often viewed as long term, which makes MHT less attractive for high turnover employe groups, said Mr. Goldbeck.

Most frequently included in multiphasic health tests when they are performed are standard health history profile, blood pressure, temperature and pulse, visual acuity, color perception, audiometry, chest x-rays and urinalysis. For managers, the following tests are frequently added: electrocardiogram, blood chemistries, hematology and interocular pressure. ■

N.J. meat cutters win 1st legal plan in state

EAST ORANGE, N.J.—The first prepaid legal services benefit plan in the state of New Jersey has been established by collective bargaining between a large meat cutters' union here and 148 food stores.

Local 464 of the Amalgamated Meat Cutters and Butcher Workmen of North America, which represents workers in New Jersey and New York, said the law offices of the plan began serving members Nov. 15.

The plan provides covered employes with benefits including office consultations; wills; real estate closings, variances and foreclosures; landlord and tenant disputes; consumer matters; name changes; adoptions; domestic relations, and certain criminal defense proceedings.

Only the services of an attorney are provided. All other court costs such as filing fees, witness attendance fees, deposition costs, transcripts or any fines, penalties or judgments assessed are not included.

Initially, most benefits will be confined to the covered employes only and not their eligible dependents. However, the legal services fund board of trustees said the union wants to expand benefits and eligibility as soon as it can.

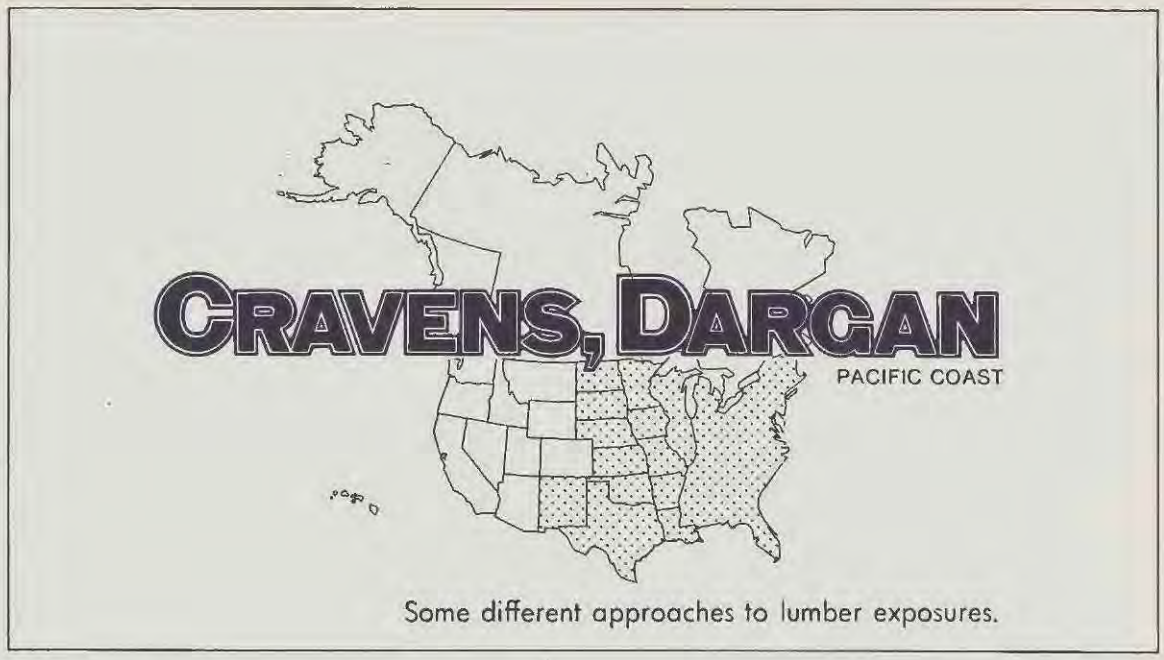
The legal benefits will be completely employer-paid. The union negotiated employer contributions of $1.00 per week on a monthly basis for each full-time employe. Among the 148 employers signing the agreement were stores such as Acme, Food Fair, Grand Union, Pathmark, Shop Rite, and Stop and Shop.

The employer contributions to pay for the plan are going into a special trust fund set up according to Taft-Hartley Act regulations. The fund will be managed by a board of trustees made up of three members from the contributing employer groups and three members from Local 464. Director of legal services is Steven S. Kaplan. John Niccollai, secretary-treasurer of the board of trustees, is the designated agent to receive all legal process on behalf of the fund.

In most cases the union plan will provide the lawyer to represent a covered employe. However, if a conflict of interest should arise between two or more employes in proceedings like divorce, nullity, separate maintenance, custody, child support or disputed property rights, the fund will represent the covered employe having the greater period of seniority.

If that happens, the remaining covered employe can hire outside counsel of his or her choice and the plan will reimburse those costs subject to a maximum fixed schedule. For instance, the plan will reimburse costs for a contested divorce at a rate of $250 with the same hourly fee.

The plan excludes about 20 areas of legal defense such as proceedings directed against any covered employer or other employer or labor organization in matters covered by the National Labor Relations Act. ■



Some different approaches to lumber exposures.

New alcoholism program aims at early diagnosis

NEW YORK—A new treatment service for employes afflicted with alcoholism and other behavioral or medical problems was introduced by the Beekman Downtown Hospital in lower Manhattan.

Called Personal Consultation Services, the program is aimed at helping companies identify a troubled employe and then providing comprehensive treatment on an inpatient or outpatient basis. It was set up by a grant from American International Group Inc. and USLIFE Corp.

John J. Dolan, program director, told *Business Insurance* that PCS can be integrated with a corporate employe benefit program if companies contract with Beekman Downtown Hospital for rehabilitative services.

So far, AIG and USLIFE are the only two companies which have contracted with PCS for treatment programs for their employes. But Mr. Dolan said the goal of PCS is to extend its services for early detection and treatment of alcoholism and other emotional or mental disorders to any firm seeking to help its employes.

Part of the problem in coordinating the PCS program with an insured benefits plan apparently is that few insurance companies will provide coverage for alcoholism treatment on an outpatient basis.

Mr. Dolan said Kemper Insurance Cos. will provide coverage on an outpatient basis, and that the AIG program for its own employes included oupatient care, but that the concept is still new.

PCS will be available to a potential working population of 300,000 to 500,000 persons in the downtown Manhattan area. Statistics released by Beekman Downtown Hospital indicate 10% of that population will be affected by alcoholism or other problems at an estimated cost to employers of more than $125 million annually.

The principal benefit of PCS lies in early identification and diagnosis of employe problems, the hospital said. It noted that alcoholism ranks third as the nation's most serious health problem. The program will specialize in treating alcoholism, drug abuse and emotional disorders and stress caused by marital, financial or family problems.

It features not only rehabilitative services and treatment but also a thorough program of follow-up sessions and consultations so that the employe is not thrust back into his or her old environment without support.

The treatment resources can be used in two ways. Companies can contact PCS and contract for employe assistance programs, or individual employes can go directly to PCS for personal help. For the best results, the hospital recommends that a company set up an assistance program for its employes and communicate the benefit to them.

PCS is in the department of ambulatory care of Beekman Downtown Hospital at 70 Pine St., Suite 1415, New York, N.Y. 10005. ■

Ill. receives big refund

SPRINGFIELD, ILL.—The state has received a $3 million refund on its Blue Cross/Blue Shield group health insurance premiums under a new provision calling for interim refunds.

Previously the state was refunded excess premiums only after all claims were satisfied. Now Blue Cross provides an interim refund subject to change.

Last year was the first year in which premiums exceeded claims. In the two previous years, Blue Cross lost almost $11 million on the program. The Blues must absorb these laws, the state said.

Blue Cross is allowed to retain 5.5% of premiums for administrative expenses. Under the plan it kept $3.7 million in fiscal 1976. ■

Blood pressures drop, companies cut costs, with screening program

By JANE WINEBRENNER

CHICAGO—Hypertension may be aggravating the high blood pressure of insurance managers. The deceptively innocent complaint costs employers millions of dollars in money and man-hours.

However, once a hypertension screening and treatment program is set up in the workplace the program costs are offset in several years by the savings.

Employers, the Department of Health, Education and Welfare, unions and insurance companies are becoming increasingly aware that hypertension screening and control programs are not just a benefit to employes, but to employers as well.

Because it is a silent killer, inflicting no pain on its victim, hypertension has been minimized in terms of absenteeism, increased costs in workers' compensation, and long term and short term disability insurance. The total cost of cardio-vascular disease is estimated at $20 billion.

Dr. Michael H. Alderman said his Cornell University studies show that while the cost of setting up a program in the first two years equals the savings, in time, the savings surpass the cost on an incremental basis. This means with each year there is more savings because of the increasing age of patients/employes and the higher risk of heart attack, stroke or other coronary disease. And while the age of the employes he studied increased, the odds of their having a hypertension-related disease did not.

He said absenteeism was reduced 29% in the study. Absenteeism and low wages cost $8.6 billion in 1975 the American Heart Assn. said.

To help employers who want to start up hypertension testing and control programs, a consulting firm was set up earlier this year called National Health Watch Inc. in Cleveland, Ohio. Its president, Whitney Evans, said the group uses its own nurses or can work with a company's nurses to operate the blood pressure screening tests for employes.

The small consulting firm also provides educational materials and can instruct employes. Health Watch also offers quality control to keep track of the employes who have hypertension. The company is given a computerized report of those persons using the program.

Other employers such as Mobil Oil Corp. and Boeing Corp., have used in-house testing and control of hypertension. Dr. Richard B. Singer, second vp of New England Mutual Life Insurance Co., said he favors use of in-house facilities because of the convenience to the patient.

"Experience in hypertension clinics shows unless you make things as easy as possible, patients do not want to return for the frequent tests required," Dr. Singer said.

Small companies without in-house medical services or nurses on hand might find it advantageous to use the National Health Watch firm. Screening for all employes each year is free and the cost for the control program is $195 per employe the first year and $145 for the second and successive years. Mr. Evans estimates that 10-15% of the employes screened would use the control program.

The control program keeps track of hypertension patients and establishes records for both consultant and employer. Nurses regularly go to the work site and administer the patient/employe's medication to keep the hypertension victims under treatment. The $145 cost includes the medication.

One of National Health Watch's clients, Lake County National Bank in Painesville, Ohio, screened

Employe Benefits

400 employes. Of the 17 hypertension victims identified, 13 decided to use the program. The Bank picked up the tab of the medication but they are hoping their Blue Cross-Blue Shield plan will pay for part of the cost, according to David Seigel, vp of personnel.

Why the burgeoning interest in hypertension in the workplace?

"We had enough convincing data to indicate we had a potential problem. Though the bank had no figures tracing absenteeism or illness to hypertension, it wanted to know how many cases it had and where any problems might be," Mr. Seigel said.

Any way to decrease rising health costs has become fair game for employers, according to Willis B. Goldbeck, staff director of the Washington Group on Health. He said there is also a society-wide basis for hypertension testing and treatment.

"An employer has responsibilities larger than that to just the employe. If an employe that tests out (has high blood pressure) so that he can't perform functions adequately, he is putting other workers and society in danger," Mr. Goldbeck said.

He also said there is a caretaking component implicit in hypertension treatment. The worker should be assured that he is not going to be fired. He is "disabled just as much as if he came in with a broken back," which means he can be retrained if the present job is too stressful or dangerous.

The scope of hypertension testing among corporations still is unknown. The Washington Group on Health survey of 101 companies, found 48 performing multiphasic testing, which includes not only blood pressure tests, but also urinalyses, hematology, and other chemical tests. A survey of large corporations doing high blood pressure testing and treatment is forthcoming according to Mr. Goldbeck.

But, as Cornell's Dr. Alderman bluntly said, "It's more than testing, it's treatment. You either got high blood pressure or you don't. The trick is to make it better."

Dr. Alderman is currently providing hypertension treatment for various employers and unions totalling 1066 persons. Participating in his test program, conducted by Cornell University, are employes from Gimbels Department store, Bloomingdale's, employes of the city of New York, New York University, Rockefeller Center and construction union members.

The study is completing its third year. Dr. Alderman said the health data is fairly conclusive but more time is needed for economic input data.

Meanwhile at Mobil Oil Corp., employes have been screened for hypertension since the 1940s but it is only in the last five years that Mobil's doctors have begun treating the disease.

Mobil's assistant medical director, Dr. Benjamin Kightlinger said

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letters

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tices, human, physical and financial resources, patient populations, the hospital/doctor/patient/attorney interface, and the socio-legal environment within which the hospital and its clientele operate. There are no patent solutions we know of, which would apply to any and all hospitals. Only a quantitative, integrated approach to problem solving.

Unfortunately too, there are almost no consulting actuaries with the level of experience sophistication and professional credentials which are required to address this complex and costly area. The roster of Fellows and Associates of the Casualty Actuarial Society shows that, of the 610 credentialed casualty actuaries, only 48 are consultants not "captive" of the insurance industry. Many of these may work for brokers, or other insurance based organizations, so their impartiality is also suspect.

The American Academy of Actuaries lists 3,505 qualified, crecentialed members, but only 977 (including, presumably, the 48 casualty actuarial consultants) who are engaged in consulting actuarial work. Clearly, many of these are "captive" of brokers, which call into question their impartiality, if not their experience or credentials.

Perhaps the approach which needs to be considered is for the federal Department of Health, Education and Welfare, together with the Social Security Administration, to require actuarial analysis and certification by a new class of "Enrolled Actuary." In the absence of such new federal credential, the following should be required of any consultant or actuary retained by the hospital:

1. *Credentials*: certification by the Department of Labor or the Department of Treasury as an Enrolled Actuary.

2. *Education*: credit for the examinations prescribed by the American Academy of Actuaries or other recognized actuarial body.

3. *Experience*: at least five (5) years of responsible actuarial experience in the area in which the consultant or actuary proposes to work.

4. *Impartiality*: full and timely disclosure of all relationships and compensation, both direct and indirect, which the consultant or his firm may have with insurance carriers, agents, or brokers, in relation to the assignment which he proposes to undertake for the hospital.

5. *Independence*: in any situation in which there is or may reasonably be expected to be a conflict of interest between the hospital, as principal, and the employer of the consultant or actuary, the hospital should seek a second opinion from an independent actuary.

Clearly, the cost of medical care, and its control, is too important an issue to be left to the uncredentialed fire and allied perils "insurance expert," as well intentioned as he may be.

Charles E. Hiatt

Managing Partner, The Hiatt Co., Malibu, Calif.

In the public interest?

To the Editor: There is an incestuousness to the civil law in America where lawyers in their roles as legislators, judges, and educators determine the rules of the legal games in personal injury litigation.

Members of the Bar disguise self-interest even from themselves through the rhetoric of "individual rights" and "common law traditions." Instead of coming to terms with the real issues confronting us, jurists have been content to leave aside the problem of adequate compensation and improved safety while they profited from the "system" and congratulated themselves on their skills in social engineering.

Meanwhile, American suppliers, innovators, risk-takers, and entrepreneurs are being destroyed and are still expected to provide the assets with which to maintain our society and from which to distribute our wealth.

How would you feel if you knew that the dollars involved in the litigation process were not being distributed to the "poor man" for whom attorneys declare that "the tort system is the key to the court house?" How would you feel if you knew that the "key to the court house" had produced what Kevin Phillips refers to as the GLP—Gross Legal Product—in billions and billions of dollars? How would you feel if you knew

Testing . . .

Continued from page 61

it is only recently that hypertension is "recognized as big a problem as it is." Before that, Mobil used to refer their employes with hypertension to private physicians. But the tendency for patients is to get medicine, use it for a while, and then discount treatment Dr. Kightlinger said.

To make sure that Mobil employes continue their medication, which they pay for themselves, the medical department is starting a program to contact those people that drop out and computerize medical diagnoses for easier detection. Mobil pays for the doctor's supervision; he prescribes things as when to take medicine, how often, what kinds, and how much.

Previously, it was thought that hypertension was an affliction of old employes or senior executives under stress and strain. Now, Dr. Kightlinger said, it is believed stress and strain merely aggravate an existing condition.

The cause of hypertension is not known even though it affects 18% of all adults in the United States. There are no specific job classifications that have a higher incidence of hypertension; blacks do have a higher rate of hypertension and it is more dangerous and more accelerated, the Mobil doctor said.

At Boeing Corp. in Seattle, 120 blue and white collar workers participate in a program to examine employes and prescribe exercises before heart diseases begin, its chief of preventive medicine, Dr. Manuel Cooper, said at an October Blue Shield conference.

Despite an increase in the average age of Boeing workers to 47 years and an increase in stress, Boeing's mortality rate has decreased from 376 per 100,000 in 1967 to 241 per 100,000 in 1975.

Most, if not all, programs for hypertension testing and treatment are voluntary and confidential. At Mobil, the tests are protected under a doctor-patient relationship and a worker must give his written permission before the information can be released.

Unions such as the United Storeworkers Union have been using the screening and treatment. Mr. Goldbeck of the Washington Group said the issue is not one of labor-management conflict, as long as management pays for the tests.

Confidentiality of test results and union's fear of recriminations are a "sham" issue according to Mr. Goldbeck. "The last thing employers want to do is muck around with data." ■

that "the tort system combined with strict liability" played no essential part in the delivering of adequate compensation to those who are injured in the use or misuse of products? How would you feel if you knew that "it was so open-ended as to be actuarially incalculable" and that any benefits derived from its application were clearly outweighed by the public interest in a wise use of our national wealth and a continuing respect for law?

E. H. Rosenberg
President, RETORT Inc.,
Franklin, Mass.

What ASSE is doing

To the Editor: I see the Professor of Insurance and Risk at Temple University gently chiding that the American Society of Safety Engineers should take responsibility for product liability.

Frankly I do not understand him because for the last 15 years since we have been interested in the subject, I have from time to time been in touch with the ASSE myself and well remember sessions by Harry Philo and Vance.

Could it possibly be that the Professor of Insurance does not know what the ASSE is doing?

James Tye
Director General, British Safety Council, London

Tell diabetes story

To the Editor: Recently I received a letter that stated "I am looking forward to seeing a healthier and thinner Cal Rosenbaum in the future. How are you doing it?" Enough of my friends have asked me how, why, and where, that I realized the story of the Diabetes Research & Education Hospital in Birmingham, Alabama, had not yet been told.

Cal Rosenbaum was one of the lucky ones to discover the fact the Diabetes Hospital did exist. It specializes in diabetes and is under the division of Endocrinology and Metabolism of the University of Alabama Hospitals and Clinics, perhaps the South's largest Medical Center. After recognizing how the hospital, Dr. Boshell and the Trust Fund changed my life, it was necessary for me to communicate to my friends just what it was all about, with the hope that any of my friends, associates, employes or relatives that have diabetes, hypoglycemia or other endocrine problems, then they too should have the story of the Diabetes Research & Education Hospital told to them.

It has been said that if a cure for diabetes has not been discovered by the year 2000, close to 100% of our population will be diabetics or carriers.

Those of us that have had our lives touched by the hospital, the staff, the Trust Fund, and Dr. Buris R. Boshell are the press agents, public relations staff and communications network, otherwise known as good friends. I am personally intersted, as I hope you would be, in having the story told in as many places as possible. Now that the United States has a facility such as the Diabetes Research & Education Hospital, the story must be told! The only favor that I ask of my friends is that they assist me in telling the story.

Arrangements have been made whereby Dr. Boshell, himself, will attempt to schedule as many speaking engagements across the nation to educational conferences, seminars, and consumer groups as time and economics may permit.

To the end of communicating the Diabetes Research & Education Hospital story, I am committed, and I ask you to help in communicating this story so that those in need may avail themselves of a more normal life expectancy. Without detection, evaluation, treatment, and education, the diabetic's natural and eocnomic life expectancy is materially shortened.

To employers and insurance companies, a controlled diabetic is in fact a more efficient and productive employe. We all benefit economically.

Cal B. Rosenbaum
vp, Wometco Enterprises, Inc. and Friend of the Diabetes Research & Education Hospital, Birmingham, Ala.

Belated mention

To the Editor: The Nov. 1 issue of *Business Insurance* featured an article entitled, "Efforts Intensify Nationally In Push for Liability Reform". Although it was a very comprehensive piece, I was amaxed there was no mention of RETORT INC.

Unless I am mistaken, RETORT was the first organization founded to work exclusively for reforms in the areas of product liability litigation and the resulting unavailability of insurance coverage at an affordable price. Officially incorporated in March of this year, RETORT now has members in 18 states.

Patricia B. Maxwell
vp, RETORT Inc., Franklin, Mass.

R.J. Reynolds plane crash fully insured

WINSTON SALEM, N.C.—R. J. Reynolds Tobacco Co. was fully insured with Associated Aviation Underwriters for the $2,650,000 loss of one of its corporate aircraft Nov. 12 when the plane crashed on takeoff from Naples, Fla.

All 11 passengers of the plane were hospitalized. Although one passenger remained hospitalized until nearly Thanksgiving, no one was seriously injured. The two crew members and nine passengers were all Reynolds' employes.

A spokesman for the cigarette producer said Reynolds isn't sure yet what the total medical costs are; the twin-engine jet was a loss.

Among the passengers was the president of a Reynolds subsidiary. Had there been any deaths or seriously disabling injuries, Reynolds would have used its standard business travel accident coverage, purchased as an endorsement to another corporate insurance policy. The policy pays double indemnity for travel accident deaths. ■

SEE OUR AD ON PAGE 3

london line

Lloyd's increases members by 25% but inflation cuts growth in capacity

LONDON—Increases in capacity are now certain for Lloyd's worldwide operations in 1977 as a result of a 25% hike in membership effective in January.

More than 2,400 new names will be joining Lloyd's syndicates to provide for the expected growth in business. Underwriting activities will expand in various directions.

This means that there will be more than 10,000 members in all, which is regarded as a very encouraging trend.

But it was pointed out by leading Lloyd's sources that while this is a significant increase, much of the extra capacity will be absorbed by inflation. The volume of new business which Lloyd's can effectively take on will be substantially less than the formal increase.

Estimates from sources concerned with the U.S. market are that the gain in real terms will be between 12% and 15% to its existing capacity.

Much of this, in turn, will have to be available to maintain those lines of business where premium demands are soaring along with the rising cost of modern industrial risks in the technological field, or in sectors where liability problems are paramount.

With world demands for insurance capacity still unsatisfied, the main benefit of the influx of new members to Lloyd's will be to strengthen its position without giving too much scope for unrealistic competition in handling premium rates.

The growth in membership was announced by Havelock H. T. Hudson, who has been elected chairman of Lloyd's for the third year.

He will be assisted in his work in 1977 by Leslie R. Dew, who is returning to the post of deputy chairman for a third time, and by Ian H. F. Findlay, insurance broker with the Sedgwick Forbes group, as joint deputy chairman.

Mr. Dew, who recently outlined capacity needs in the U.S. (*Business Insurance*, Nov. 15), has now completed a 50-page report on the problems of Lloyd's capacity, which is being studied by leading members.

Some of its recommendations are being examined by working parties set up under the Committee of Lloyd's, and others have been implemented within the Lloyd's market, although their details are being kept confidential.

Underwriting operations at Lloyd's are restricted in premium volume by arrangement with the U.K. government's supervisory office in the Trade and Industry Department. The figure ensures a clear margin for solvency.

This is directly related to the amount of money which members are able to deposit for their various underwriting activities. It has, naturally, been examined to see if any increase in the permitted margin is justifiable.

Traditionally the Lloyd's market has always operated well within these terms. Because of demands on its services, the margin has been reduced considerably over the last five or six years. But there is no intention at Lloyd's of diluting its solvency requirements to maintain its reputation for meeting any claim upon its funds.

Schemes to raise capacity by an average growth of 15% every year are in the mainstream of Lloyd's market thinking. So it is hoped that many members will increase their actual cash deposits so that their syndicates can in turn write more business.

Membership requirements were last re-graded in April 1975 to keep pace with inflation. The present required "show of wealth" is fixed in sterling, at 100,000 pounds (currently around $160,000 to $165,000) for U.S. and other non-U.K. nationals, and at 75,000 pounds for purely British names. This enables them to write up to about $240,000 to $250,000 worth of business in sterling. There is a sliding scale for those wanting to write more business, ranging up to 235,000 pounds ($370,000 to $390,000) as a "show of wealth" for a maximum yearly premium operation of $560,000 to $580,000. Proof of possessing this wealth is all that is initially required for membership in Lloyd's. But members then have to provide varying amounts of deposits to their syndicates before their operations can begin, related to an agreed proportion to the amount of premium business they hope to write in any one year.

Mr. Hudson in announcing the 25% membership hike, said: "The large increase in membership is welcomed particularly because the capacity of the market has been reduced by the continuing decline in the value of sterling which has affected the base from which we work.

"The decline in the value of sterling has increased concern at the mounting sterling cost of meeting liabilities expressed in other currencies.

"Liabilities in respect of U.S. and Canadian dollar policies are covered, of course, in the ordinary course of events by the U.S. and Canadian Trust Funds. Improvements in the terms of the currency investment scheme which applies to sterling trust funds have been negotiated with the Bank of England."

Lloyd's now plans to expand the space available for future business by re-opening its old underwriting room, which has not been in use for some years, to supplement the main room where most business is now written.

* * *

Marine insurers are trying to assess their losses in a $150 million fire which destroyed an international transit complex at Julfa, on the Soviet-Iran border, four months ago.

Goods stored in the complex were on their way from business centers in Western Europe and came under marine cargo policies in the traditional way.

There is also believed to be substantial reinsurance for fire cover in the blaze, which started near a customs post under Iranian control and spread to the network of storage warehouses in its vicinity.

The effects of the fire are being felt by underwriters at Lloyd's, in the U.K. company market, and by reinsurers in Germany, Switzerland, and Italy.

U.S. insurers may also be involved as efforts were being made to place some of the reinsurance there.

Thousands of separate consignments were destroyed in the blaze, including supplies for Iran's auto industry from Chrysler (U.K.), Mercedes and Chevrolet (West Germany), and from the Fiat production line in Poland. There were probably goods from the U.S. as well.

Salvage Assn. officials from London have been trying to piece together the extent of the losses but admit they are baffled by their complexity and the difficulty of ascertaining just how much was damaged.

It is described as a "problem area" because of the many different countries from which the destroyed goods originated, as it is on the main overland truck and rail route from western Europe to Iran.

The main liability will fall on Bimeh Iran, the state-run insurance organization, because it takes over responsibility for the goods if they have not been cleared through customs after 45 days. Sixty percent of the destroyed goods are thought to come under this category, with the rest still covered by marine "cargo in transit" insurance.

Bimeh Iran is believed to have placed substantial reinsurance with Munich Reinsurance group, and further heavy reinsurance in Italy, but was itself still heavily exposed. Negotiations to renew some of its coverage were still underway when the fire broke out. It also had a portion of its coverage with its own state-owned reinsurance group, Bimeh Markazi.

Cargo losses are expected to reach $120 million, and fire damage to buildings $30 million. Assessments of the losses are still being undertaken.

The blaze follows a fire at the Iranian port of Khorramshahr last year which was put at $35 million and was later settled for about $20 million. Effects of the Julfa blaze are spread so widely over the market that, although it is the biggest fire damage claim ever to originate from the Middle East, there are not thought to be any major individual losses in the U.K.

* * *

Reinsurance claims are expected at Lloyd's after a jet crash involving three executives of the U.S. firm Johnson & Johnson occurred on a flight between Trenton, N.J., and Hot Springs, Va., some weeks ago.

But the main extent of any losses for liability over the deaths of the three businessmen are believed likely to affect the U.S. market.

Sources in the London aviation market have noted reports in the British press that the businessmen were heavily insured, but discount suggestions that this might result in claims running as high as $20 million. There is no guideline so far from the U.S. on the amounts likely to be involved. It is felt that any figures so far are purely speculative. ■

M&M taps Italian

Alessandro di Montezemolo, 57, has been elected president of Marsh & McLennan International Inc. at the company's annual board meeting in New York. Mr. Montezemlo succeeds William V. Platt, 60, who remains a consultant to the brokerage firm, a subsidiary of Marsh & McLennan Cos. located in New York.

Pregnancy . . .

Continued from page 1

whether the next Congress is going to be irresponsible enough to do what the court would not do," Mr. Godown said.

Fierce pressure is expected from interest groups that had sought an affirmation of the Equal Employment Opportunity Commission's 1972 ruling that excluding pregnancy from a benefits program amounts to sex discrimination. The Court's six to three decision, with Justices William Brennan, Thurgood Marshall and John Paul Stevens dissenting, struck down the ruling and reversed the decisions of six courts of appeals.

The president of the International Union of Electrical Workers, which brought the class action suit on behalf of its GE female employes, said: "The IUE will immediately move to get Congress to enact legislation making discrimination because of pregnancy equally as illegal as other discrimination because of sex, race, nationality or religion.

"We expect favorable action by the new Congress on legislation to amend the law to prohibit such discrimination," said IUE president David J. Fitzmaurice.

Another official with the union said, "Maybe we should have been in the Congress in the first place."

Susan Ross, a lawyer with the women's rights project of the American Civil Liberties Union in New York, said, "I think this decision is very harmful for millions of pregnant women. It will be disasterous in terms of employers being able to fire women when they get pregnant."

Ms. Ross also said the women's movement would launch a strong effort to reverse the decision in the next Congress.

In the majority decison wrtten by Justice William H. Rehnquist, the Court relies on a 1974 decision in the case of Geduldig versus Aiello. In that case the court ruled that the State of California does not have to include pregnancy in a state-run disability insurance program because "there is no evidence in the record that selection of the risks insured by the program worked to discriminate against any definable group or class in terms of the aggregate risk protection derived by that group or class from the program.

Put more simply "there is no risk from which men are protected and women are not. Likewise, there is no risk from which women are protected and men are not," the Court said in its Geduldig decision.

Some observers thought the Court might rule differently in the GE case because Geduldig was based on the equal protection clause of the 14th Amendment, while the GE suit was brought under Title VII of the 1964 Civil Rights Act. The Supreme Court usually applies a specific statute more broadly than interpretations of the Constitution, according to Dr. Abernathy.

The Court held that "gender-based discrimination does not result simply because an employer's disability benefits plan is less than all inclusive."

The GE plan "is nothing more than an insurance program which covers some risks but excludes others."

In its action, the court said the 1972 EEOC guidelines go beyond the intent of the 1964 Civil Rights Law. Thus it appeared Congressional action to include pregnancy disability under the law would survive a future court test.

In his dissenting opinion, however, Justice William Brennan argued that "in fostering the impression that it is faced with a mere inclusive assignment of risks in a gender-neutral fashion—that is, all other disabilities are insured irrespective of gender—the Court's analysis proves to be simplistic and misleading," noting further that the GE plan covers such exclusively male risks as "prostatectomies, vasectomies, and circumcisions."

The majority ignored "a history of General Electric practices that have served to undercut the employment opportunities of women who became pregnant while employed," Justice Brennan added.

The day before the decision, the Supreme Court had refused to review a lower court ruling that a Liberty Mutual Insurance Co. disability plan was discriminatory because it excluded pregnancy. ■

Single filing date . . .

Continued from page 1

The commission has no legislative or administrative authority, and its strength lies in its ability to jawbone for changes. Also, when oversight hearings are held next spring on ERISA, its recommendations are certain to be used as a stepping off point for discussion on changing the law and the practices of the agencies that administer it.

Savings to business from the 14 recommendations were estimated to reach more than $100 million if they are all implemented. However, even among the business groups that helped to steer the commission's thinking, there wasn't solid agreement on improvements to be suggested.

One of the more important recommendations is that summary plan descriptions be eliminated. They're required to be filed with the Labor Department every five years.

Elimination of the summary plan description requirement would not only save businesses $7.2 million every five years, the commission estimated, it would also save the Labor Department about $1 million in storage costs over that period.

The reasoning behind the proposal is that the department also requires companies to file the complete plan description, and "discussions with the Department of Labor indicate they wouldn't use the (additional) information," a commission spokesman said.

However, at the Miami hearings a representative of the American Bankers Assn. urged that the summary plan description requirement should not be dropped.

"The summary plan description, advising participants of their rights and responsibilities under the plan, is a major portion of what ERISA is all about," said Charles W. Bisset, vp of First National Citibank in New York. "We feel they should be a matter of public record."

Another recommendation—estimated to save business about $12 million annually—would allow notices of amendments to a plan to be filed with the annual report, rather than 60 days after the change, as now required by the law. "The same result can be accomplished by putting a notice of amendment with the annual report—employes still have to be notified, and it doesn't affect notification of the IRS," a spokesman said.

Another recommendation to streamline ERISA's disclosure provisions would allow employers to give their workers a simple statement of accrued benefits and vesting rather than a complicated financial statement.

Proposals four through six would eliminate five forms required by the IRS, a commission spokesman said. "The IRS says it doesn't have the resources to perform audits at this time," he said.

Among the forms that may be eliminated are: Form 5498, filed by the institutional administrator and holder of an account for verification of the account, and Form 5499, a transmittal form for Form 5498 (estimated to save $2 million); Form 5504, which is a statement of support for the employer's contribution deduction—used to select plans for audit although a commission spokesman said it "doesn't provide the information needed for an audit"; and Forms 5501 and 5505.

Elimination of Forms 5504, 5501 and 5505 would result in an estimated savings for business of $9 million.

Another recommendation affecting the IRS endorses the service's efforts to develop a checklist for determining criteria needed to qualify a plan for tax-exempt status, a spokesman said. "It should eliminate discrepancies between district offices," he said.

Recommendation eight urges the Labor Department and IRS to eliminate duplicate questions on the EBS-1 Form and the IRS Form 5301 or 5300. "They should agree to have one agency collect the information and pass it to the other on a reimbursable basis," the spokesman said. Estimated savings to businesses are about $12 million.

Another recommendation asks the two agencies to jointly examine all the pension plan information they require and institute changes so that as much information as possible is filed on a single date.

With the eleventh recommendation the Labor Department and the IRS would take a giant leap into the computer age with a proposal that the two agencies should allow companies to submit information about their plans on magnetic tape, in lieu of filing Form 5500.

This proposal would produce the biggest single savings for business —estimated at $80 million—in addition to making access easier for plan participants and the public, the spokesman for the paperwork commission said.

The twelfth recommendation tackles part of the dual jurisdiction problem: conflicting instructions to plan administrators arising out of differing interpretations of ERISA. The commission has already suggested that the two agencies set up a joint office to provide help in filling out the annual report, a spokesman said. The commission also endorses an agreement of understanding reached recently by the IRS and Labor. "Our understanding is that the two agencies have reached agreement to encourage field officers to work together," the commission spokesman said.

Recommendation number 13 deals with section 103(e) of ERISA, which requires that insurance commissions and fees paid by the plan be reported.

On August 3, temporary exemption was granted for reporting this information for plans with less than 100 participants. However, the commission is seeking to make this requirement less burdensome for all plans. "An alternative method would require insurance companies to furnish rate schedules and allow administrators to compute fees and commissions," a commission spokesman said.

The last recommendation concerns the 3% transactions rule, which requires that any transaction involving more than 3% of the plan's assets has to reported on the 5505 Form. Problems have developed when a plan is made a part of a trust, such as a commingled fund, where transactions can't be traced to individual plans. Also, for small plans, the 3% reporting rule could apply to payments made for supplies or accounting fees or other ordinary expenses. ■

Captive . . .

Continued from page 1

the subsidiary would have to be comparable to those paid to a third party insurer," the source said.

The department will probably insist the insurance subsidiary be licensed in the U.S., "I tend to look at offshore captives with a jaundiced eye . . . I'd have problems with them," the Labor Department insider said.

The amount of the employer's contribution to employe benefit plans will also be a consideration in granting an exemption. "A company would have a far better chance at an exemption if the employer's contribution is 100%," the source noted.

Among companies that have applied for exemptions under section 408(b)(5) are: U.S. Industries Inc., John Deere & Co., Gamble-Skogmo Inc., H. F. Ahmanson & Co., Food Fair Stores Inc., Field Enterprises Inc., Springs Mills Inc., Mid-Florida Freezer Warehouses Ltd. and Agway Inc.

Included among insurance companies that have applied for exemptions are: Fireman's Fund Insurance Co., Connecticut General Life Insurance Co., California Casualty & Life Insurance Co., Mutual of Omaha Insurance Co. and Nationwide Life Insurance Co.

The exemption will be issued either by the Labor Department alone or jointly with the Internal Revenue Service. ■

Liability problem stalls cabs in 6 Calif. cities

By JOANNE GAMLIN

LOS ANGELES—Yellow Cab companies in six California cities, including Los Angeles, San Francisco and San Diego, were shut down Dec. 1, after the Westgate California Corp., which owns them, failed in a desperate effort to obtain required public liability insurance coverage.

Six days later, the California Yellow Cabs remained idle amid reports that efforts were being made by trustees of the bankrupt Westgate California Corp. to sell the taxi companies. Along with the cab operations, Westgate California owns the airport transit bus lines in Los Angeles and San Francisco. In Los Angeles, the publicly-owned Rapid Transit District (RTA) put on special buses to service the airport; in San Francisco the airport transit bus line was sold by Westgate California and the new owners, the Airport Transit Company, put the buses back into operation.

In Los Angeles an application to form a cab cooperative, to be called the Brown & White Cab & Limousine Co., was filed Dec. 6. Bill Griswold, who heads the Griswold Group, Ltd., Los Angeles, and who is acting as an adviser to the new cooperative, told *Business Insurance* the group will be owned by individual cab driver members.

"It will be similar to a farm cooperative," he said, noting that he is working with Marsh & McLennan on securing public liability insurance for the group. He disclosed the broker estimates the total premium will be $600,000 a year based on an estimate of $2,000 a year for 300 taxis.

Yellow Cab, Los Angeles, had about 547 cabs on the streets, "but most of them are junk, five to six years old," Mr. Griswold said.

He described his business as "insurance, pension, investment management and lobbyists."

Westgate California, San Diego, had been negotiating with its two public liability carriers, Alliance Insurance Co. and Midland Insurance Co. for renewal coverage for some time. Originally, the public liability coverage was to have lapsed Nov. 10, but Westgate California averted a crisis by obtaining an extension until Nov. 30.

In addition to the six California cities, Westgate California owns the Yellow Cab operation in Phoenix, Ariz. But Angus McDonald, director of administration for Westgate California, told *Business Insurance* that the cab company in Phoenix had not been shut down because the cab operation had been placed in the assigned risk pool of the Arizona state fund.

"But this is all that I shall say on the matter," he said.

Mr. McDonald had earlier refused to detail his company's search for renewed or new public liability coverage.

At that time, though, he did predict that he would be able to meet the Nov. 30 deadline for Phoenix, San Diego, Oceanside and San Jose. As things turned out, he was successful in obtaining coverage only for Phoenix.

The broker on the Yellow Cab account is Gil Hayward of Marsh & McLennan, Los Angeles. He could not be reached for comment, however.

Although Mr. McDonald declined to disclose information about the public liability coverage for the cab and airport bus system, an informed California insurance source said that for years the coverage has come in the form of an unusual fronting policy. It stipulated that the cab companies assume the first $50,000 of each loss, he said. In recent years, losses under this policy were totalling between $2.5 million and $3 million, which would not have been serious if the financial condition of the cab companies was stronger, according to the source.

"However, the losses represented a fair undertaking for an insurer which was serving as a guarantor," he asserted, explaniing that this is the crux of the difficulties plaguing Westgate California in its efforts to find public liability coverage for the Yellow Cab and bus line operations.

The source said an attempt to place the taxi companies under the California Assigned Risk Plan failed when it was found that no provision for experience rating existed and that the cab companies would have to accept manual ratings.

In a public statement, Don Bientara, president of Yellow Cab, Los Angeles, said that his firm's insurance woes are related to the "problems being experienced by the property and casualty insurance industry in general and the weak financial condition of Yellow Cab Co., which precludes the company from satisfying the insurance company's demand for substantial and extraordinary initial deposits."

Yellow Cab Co. is the largest tax franchise in the greater Los Angeles area, carrying approximately 75% of cab riders in the city of Los Angeles alone. About 500 cabs and 1,000 drivers making 8,000 trips a day were affected.

"It would be a catastrophe for Yellow Cab to be out of business at San Francisco International airport," said Henry Bostwick, Jr., executive vp and general manager, San Mateo County Development Assn. The city's convention business is running at a peak during winter months, he said.

One Los Angeles resident may have summed it up for the thousands of people arriving at both airports, when he said upon being told that there may be no bus or taxi service to Los Angeles International Airport in the future, "Oh, shit!" ■

Lind takes over at PBGC, lists his priorities

WASHINGTON—Matthew M. Lind, 34, has been named acting director of the Pension Benefit Guarantee Corp. (PBGC). His appointment followed the Nov. 30 resignation of PBGC executive director Kenneth L. Houck.

The appointment was made by the agency's board of directors consisting of the secretaries of Labor, Treasury and Commerce.

Mr. Houck, 66, became executive director on Feb. 15, 1976, after the unexpected resignation of Steve Schanes, PBGC's first director. observers said Mr. Houck's move was not surprising since he had been expected to serve only on an interm basis.

"It was understood when he went in he'd only serve an interim appointment," said one well-connected source.

The reason given was a desire to retire from all full-time employment. Mr. Houck, who was a member of PBGC's advisory committee at the time of his appointment, had retired in 1974 from a position as assistant corporate counsel for Bethlehem Steel Corp., where he coordinated pension activities.

Mr. Lind was on the original task force that set up the PBGC when it was created by the pension reform law in September 1974 to insure the basic pension benefits of workers in the event that a plan is terminated.

Since the PBGC's inception, Mr. Lind has served as director of the Office of Program and Policy Development, an influential post where he was responsible for overseeing many crucial PBGC functions, including development of the contingent employer liability insurance program, interagency liaison activities, program evaluation and policy development, research and actuarial services.

In an interview with *Business Insurance*, Mr. Lind outlined his regulatory and organizational priorities for the PBGC over the coming year, adding that regardless of the Presidential transition, "I'm viewing (the appointment) as a long-term challenge."

Mr. Lind said he believes he has "across the board" support from the various political groups interested in pension issues, which should make it possible for him to remain in his position.

At any rate, Mr. Lind said he is hoping to accomplish many of his priorities quickly, before the transition reaches the relatively obscure PBGC.

On top of his list is a set of guidelines—not regulations—that would spell out voluntary termination procedures, with an emphasis on finding appropriate alternatives to termination.

"I want to make administrators aware of alternatives (to terminating plans)," said Mr. Lind. For instance, when a plant shuts down, the plan doesn't have to terminate if funding continues, he said. "Many will find an incentive for the parent company to assume the obligations."

Other priorities include developing final regulations on valuation of insurance contracts and determination of net worth, which are needed to process many terminating plans; final rules on defining what reportable events must be called to the PBGC's attention; and finishing rules for mergers. Mr. Lind added that the PBGC has already worked out a "broad agreement" with the Internal Revenue Service on the merger rules.

There were several major problems in development of a contingent employer liability insurance program, Mr. Lind said. But the PBGC staff has developed broad options for review by the PBGC advisory committee, including such variables as mandatory versus voluntary coverage and full versus partial coverage.

However, he said there is "not much interest" from the private insurance industry in participating in such a program. "Participation by the private sector will be difficult," he said.

In addition, he said, the absence of insurance may be a worthwhile option. "Employer liability is a deterrent" against terminations, he said. "It's good for us, good for the participant, and good for the employer" if only because it makes the company's cash flow more predictable, according to the new acting director.

Mr. Lind said another priority is the organization of PBGC. "I think we've reached the point to strengthen our operating capabilities," he said. Increased training of inhouse talent and integration of disciplines such as legal and actuarial personnel will be emphasized, he said.

"Merely adding people wouldn't solve the problem. We need better utilization of personnel."

"We're going to have tougher cases coming in," he said. "We've had a free ride" because most of the termination so far have involved pre-ERISA plans, he added. ■

Hike premium for contractors

SACRAMENTO, CALIF.—Sentry Insurance Co. will increase premiums 15% on Jan. 1 for the health care portion of the insurance package covering the state's plumbing, heating and air conditioning contractors.

Sentry will increase the amount of life insurance available to $75,000. Premiums vary for each local group.

Maximum benefits under the program will increase to $1 million. An extended security benefit will be added to provide health insurance for survivors of a contractor who dies while covered by the package. ■

$5.1 million disability award halved but Mutual of Omaha to appeal

LOS ANGELES—A California court has cut in half a $5.1 million punitive damage award against Mutual of Omaha Insurance Co. in connection with the ending of benefits under a long term disability policy.

Acting on an appeal by the insurance company, the state Court of Appeals reduced to $2.6 million the award to Michael Egan, now 61, a Pomona roofer.

The award had been among the largest ever awarded in a bad faith suit under a disability policy. Last summer a Newport Beach, Calif., attorney won $5.4 million in connection with the failure of Washington National Insurance Co. to pay benefits under the attorney's long term disability policy.

Frank. J. Barrett, executive vp and chief counsel of Mutual, said the company would appeal the case to the state Supreme Court.

The plaintiff fell from a ladder, injuring his back in 1970. He applied for disability benefits under a policy from Mutual of Omaha which stated that he was entitled to $200 a month in lifetime benefits for disability resulting from an accident, but to only three months of benefits from a sickness disability. After undergoing surgery in 1972, Mr. Egan found that the insurance company had reclassified his disability to a sickness, thus ending his benefits.

During a 12-day jury trial in November 1974, his attorney, William Shernoff, argued that Mutual of Omaha reclassified Mr. Egan's disability to sickness in order to renege on paying the $200 a month lifetime benefit.

The jury agreed, finding the insurance company and two employes, John M. Segal and Andrew T. McEachen, an adjuster and claims supervisor, respectively, acted with malice, fraud and oppression in ending the plaintiff's lifetime benefits.

It awarded Mr. Egan $5 million in punitive damages, $45,600 in compensatory damages due under his policy and $78,000 for mental distress. Under the verdict, Mutual of Omaha was required to pay almost all of the judgment with Mr. McEachen paying $500 for punitive damages and $500 for mental distress and Mr. Segal, $500 for mental distress and $400 for punitive damages.

The appellate court, in an opinion written by Justice Bernard S. Jefferson, said that the jury was correct in finding that the intent of the defendants was to "vex, injure and annoy" Mr. Egan.

"That such conduct constituted fraud, malice, oppression and a complete disregard of plaintiff Egan's rights is simply not open to question," he said.

However, Justice Jefferson said the amount of the punitive damages "was excessive and was the result of passion and prejudice on the part of the jury." He called the punitive damages "grossly disproportionate" to the actual damages awarded. Yet he said the reduced figure of $2.6 million is "reasonable and does not bear an unreasonable relationship to the award of actual damages."

The appellate court also reversed the awards against Messrs. Segal and McEachen, ruling that under California court decisions employes of an insurer may not be held liable under such circumstances.

Mr. Barrett said, "This Egan case was most ironic from the beginning as Mutual has paid nearly $21,000 in disability income benefits to Mr. and Mrs. Egan (she is also disabled), both insured by Mutual of Omaha."

The law firm of Pettit, Evers & Martin, San Francisco, which represents the insurance company, said the Court of Appeals opinion does not "bring out that the reclassification (of Mr. Egan) was based on a policy provision defining 'injuries' as 'accidental bodily injuries received while this policy is in force and resulting in loss independently of sickness and other causes.' " The paper says that the reclassification was based on medical evidence that included the records of a Dr. Carpenter, the plaintiff's surgeon, stating that (Mr. Egan's) condition was 'discogenic disease," as well as other physician reports relating the plaintiff's condition to pre-existing causes. ■

Tort reform only remedy: Rottman

CHICAGO—Tort reform is the only remedy for the problems plaguing the insurance industry, according to the president of the National Assn. of Insurance Commissioners.

Dick L. Rottman, Nevada insurance commissioner, urged insurers to work closely with state regulators to develop meaningful reforms. He spoke at the annual meeting of the National Assn. of Independent Insurers here.

Trial lawyers have contributed greatly to the underwriting losses of the last year, Mr. Rottman said. To meet the problem, he urged insurance companies to "infiltrate the ranks" of the lawyers to discover what new areas they are considering for future litigation.

"Lawyers have a way of picking up an issue and going full bore. And by the time insurance companies find out about it, they've already lost millions of dollars," he said.

The growing philosophy of entitlement which results in consumers demanding better products and services without price increases will also have a severe effect on insurance company profits, Mr. Rottman told the meeting.

"I am convinced that we need some broad tort reform, and we need it soon. We should enthusiastically take the lead in bringing about these reforms whenever it will do the most good for the consuming public," he said.

Mr. Rottman also said he detected a change in the attitude of insurance commissioners toward the industry they regulate. In light of the recent underwriting losses, he said, insurance commissioners have recognized "we're here to make sure insurance services are provided to the public."

Insurance commissioners are adopting "a more liberal, lenient attitude in regulation, an attitude more in line with the public interest," Mr. Rottman said. ■

Fire damage up

Fires in September caused an estimated loss of $316 million, up $40 million from the same month last year, according to the Insurance Services Office.

Health care inflation checked, says educator

CHICAGO—The runaway inflation in health care costs has been checked and costs are now rising only slightly faster than other goods in American society, according to the dean of the University of Chicago's Pritzker School of Medicine.

Parting company with most nonmedical experts in the health field, Dr. Daniel Tosteson said price increases are still too large but have improved dramatically since 1974.

Nevertheless, Dr. Tosteson recommended some prospective pricing systems for basic medical services.

Rising medical costs must be expected as medical care improves and costs rise in other sectors of the economy, he said.

The increases in health care costs can be attributed to the increased defensive medicine as doctors fear malpractice suits; the expansion of third party coverage that has diffused responsibility for restraints, and increased access by Americans to medical care that has increased demand for health care.

After price controls were lifted in 1974, health care costs rose by 16.6% in the third quarter of that year and hospital services rose 20%.

"However, economic indicators for calendar 1976 show signs that the health care sector is beginning to cool off. For the first six months of 1976, medical services prices rose at an annual rate of 8%, and hospital service charges, 7.2% compared to a general inflation rate of 5% on an annual basis," Dr. Tosteson said. "These health cost increases are still too great, but they suggest that after several years of runaway inflation, health care prices are beginning to respond to broader economic conditions."

While Medicare and Medicaid increase the health care costs, Dr. Tosteson disapproved of "rigid ceilings on cost increases, or rate freezes such as here in Illinois, (which) will undeniably damage the health of the poor by reducing their access to care."

He did approve, however, of a form of predetermined rates for a basic package of health care services: "The price for each unit of service should be agreed upon before the service is rendered. Providers and consumers as well as the government third party payers should participate in the process of rate setting. Utilization of this package should be prudently restrained by an appropriate level of direct financial responsibility for patients in the form of co-insurance or deductibles."

To ensure the quality of services under such a program, a peer review group would be installed and would include incentives for the cost effective use of new medical technologies and good financial and business management.

"Providers which use, whenever possible, ambulatory rather than hospital based services, which develop efficient modern systems of budget control, information processing and risk management should be rewarded, not punished.

"Most important, this basic package of health care services should not be administered under rigid regulations imposed by the federal government in the same form for all communities," he said.

The medical school dean also advised that more expensive health care services be continued for those patients who can afford them. "If some persons are willing and able to buy lobster rather than hamburger for their hospital food tray, they should be able to do so. Any other stance would be inconsistent with our American traditions," Dr. Tosteson said. ■

Collier adds Midwest

The Collier Cobb & Associates insurance agency based in Chapel Hill, N. C., has opened a Midwest office under the name Collier Cobb & Associates Midwest Inc. The office is in Southfield, Mich.

Lloyd's payouts large in $15 million robbery

LONDON—Substantial payments have been made by Lloyd's of London under insurance policies held by the Bank of America following a $15 million raid on its prestigious Mayfair branch in London 18 months ago.

The payouts cover losses from Bank of America's safe deposit vaults where clients had stored jewelry and other valuable articles.

But there will be lawsuits filed in California courts to determine the rest of the coverage, in which 15 U.S. insurance companies are involved, *Business Insurance* learned.

Detectives from Scotland Yard have arrested the gang which planned the robbery resulting in the world's biggest bank crime.

Lloyd's interest is confined to a policy containing limits of $5 million for clients of the bank who lost their property when the vaults were entered. The amount paid out so far has not been disclosed.

This was a special policy arranged through John Twitchett, of the Roy Merrett syndicate, to cover any losses sustained in the U.K.

The bank's primary coverage was a banker's blanket bond policy taken out in the U.S. which protects the Bank of America against any losses suffered through the dishonesty of its employes.

The ingenuity used in the robbery has established it as a classic story in the annals of crime. The take exceeded even the hefty $12 million raided by a "sewer gang" in Nice in July. There are sure to be interesting interpretations of insurance law before this case is finished, sources say.

The Mayfair gang used an "electronics genius" with a criminal record to gain access to the bank under cover of nightfall. No one suspected that he had been working inside the bank until it was too late.

Payments made so far by Lloyd's are on a "goodwill basis" as part of the claims they may ultimately have to meet.

Sources in London pointed out that there may eventually be legal clashes in U.S. courts over whether the robber was an employe of the bank or not. One police theory is that he was an independent electrical contractor who tricked the bank into employing him for maintenance work even though he had just come out of a penitentiary five months earlier for handling stolen goods.

Alternatively, he may be regarded as an employe of the bank during the time he worked there, in which case the U.S. insurance companies may have to bear the entire loss.

The Lloyd's syndicate which covered potential losses in the U.K. has advanced money in settlement of claims pending the final outcome of lawsuits which will determine whether the burden will be taken over by the banker's blanket bond carriers, in the event employe dishonesty is proved.

In any case, arguments in the U.S. courts will also determine whether the bank was negligent in employing a criminal to repair its electrical installations even though there may have been no easy way to check his background.

Joseph R. Webb, an assistant vp of Bank of America in London, refused to answer questions about the affair. But in the trial hearing at London's central criminal court it was revealed that the inside man, Stuart Buckley, 26, had worked at the bank for several months before meeting the robbers at a secret rendezvous.

Attorney Michael Worsley told the court, "It seems he could come and go as he pleased at any branch of the bank, and had access to its keys so that he could get his work done on weekends."

He helped the robbers to get the number-code to combination locks by watching clerks at work through a "spy hole", and passed on secrets of its theft-alarm system so that they could enter undisturbed.

Consequently they were able to enter nearly 100 safe deposit boxes rented by wealthy customers.

Detectives who had been tipped off that there might be a major bank raid in London were soon in possession of vital clues which led to the capture of most of the robbers shortly after they had split their haul.

By then, however, most of the cash and jewelry had vanished, so that less than $1 million of the stolen property was recovered. ■

Bank group has booklet

WASHINGTON—The American Bankers Assn. has developed a risk and insurance management guide to help bankers implement effective programs.

The guide, entitled "Risk and Insurance Management Guide for Financial Institutions," has been tested at Rutgers University graduate school of banking. It was written by Felix Kloman and Tom Briggen of Risk Planning Group.

Copies may be obtained from the American Bankers Assn., Order Processing, 1120 Connecticut Ave., N.W., Washington, D.C. 20036. Cost is $17.50 for members and $22 for non-members. ■

Inflation affects excess coverage the most, insurance seminar told

By MARIE KRAKOWIECKI

NEW YORK—Because of a "spillover effect" due solely to inflation, excess portions of loss are much more seriously affected than basic portions of an insurance policy during the same period, a seminar here was told.

For example, experience on a health benefit policy with a basic limit of $25,000 and a $5,000 excess layer, measured since 1973, shows that losses under the basic portion would rise 9% compared to a dramatic 196% rise for the excess portion. This is based on a 20% annual rate of inflation in health care costs.

Liberty Mutual Insurance Co. ran a session on weathering loss inflation, using examples like these to explain to about 150 of its corporate policyholders why their insurance costs are steadily rising.

The New York gathering, held Nov. 9, was the windup of a virtual road show the mutual insurance company staged in nine different cities across the country to tell risk managers why their costs are high, and what they can do to help keep them down. The company said the sessions were offered at no charge, as part of its service to policyholders.

The message that came across was that excess and surplus lines of coverage are the ones most severely impacted by inflation. And within the excess and surplus fields, the three biggest problem areas are product liability, automobile liability and workers' compensation.

Trending factors based on figures from the Insurance Services Office for both basic and total limits were explained by George E. Anderer, vp and manager of special risks.

Mr. Anderer showed how an inflation rate of 20% could impact the excess portions of a health insurance policy. He cited a broken arm case which in 1973 represented a claim of $10,000. With a 20% inflation factor, the $10,000 claim actually cost $12,000 to settle.

By 1975, however, the same broken arm claim would cost $28,000 to settle. So the excess portions of the policy would have to be tapped for $3,800, since the basic limit of $25,000 remained the same and was insufficient to cover the inflated settlement cost. Since no part of the $5,000 excess coverage was touched in 1973 or 1974, the $3,800 drawn in 1975 represents a 196% increase for the policy's excess portions of loss.

Mr. Anderer explained how such loss experience would affect premium costs, based on the ISO trending factors: "The annual trend factor for the basic portions is 17.1, but the annual trend factor overall for the basic and excess portions is 27.7 times four years, or 266%."

He explained that if the premium for the broken arm coverage in 1973 had been $1,000, the trending factors and loss experience over four years as described above would force the premiums to be 266% of what they were before, or $2,660.

"The impact of inflation is always greater on the excess portion of loss than on the basic portion," Mr. Anderer emphasized. He suggested that the Liberty Mutual policyholders try to negotiate the highest loss limit possible on their basic coverage which is consistent with their risk management objectives.

Richard J. Finegan, vp in Liberty Mutual's loss prevention department, addressed the group on another factor which affects their premium costs: loss development.

If all cases for prior years were paid and if there was a guarantee that no other case would be reported later and changed to that year, then loss development would not be necessary, he said.

But because some cases are not closed, the most recent years used for ratemaking are not entirely accurate. Changes in case reserves, therefore, can be substantiated only as each loss matures. And because of circumstances beyond the policyholder's control, a number of cases will be reported late.

"The purpose of the loss development factor is to adjust incurred values to reflect both subsequent development of known cases and to afford a provision for incurred but not reported claims," Mr. Finegan said.

The only immediate way to keep insurance premiums down would be to control claims costs through a total, coordianted risk management program of loss prevention, he stated.

He cautioned tractor trailer fleet owners that although trailers represent only 2% of highway loss, they are involved in 20% of cases involving excess loss.

He recommended that fleet owners run a tight risk management program involving careful selection of sober, mature drivers, and a vehicle safety program featuring driver training.

Since 30% of all fatalities occur on highways, Mr. Finegan also suggested companies with fleets of trailers have a potentially serious workers' compensation exposure.

Mr. Finegan pointed to workers' compensation as one of two factors likely to boost occupational disease losses into the excess range of insurance coverage. He blamed government regulation of insurance as the other factor.

Paul W. Fagar, vp and counsel for Liberty Mutual, spoke to the group on how to contain the costs of legal services and how to improve defense costs. In the product liability area, he suggested a number of legal reforms which could help, including the insurance industry proposal that a descending order should be enacted for the number of years a product has been on the market in order to limit the liability of a manufacturer.

He also called for a statute of limitations in strict liability areas from the time a product's first purchaser puts it to use, and a presumption that a product is not defective if it has been in use for a number of years.

Mr. Fagar also called for lawyers' contingent fees to be reduced, for contributory negligence to be allowed as a defense, and for groundless suits to be discouraged.

One bright spot Mr. Fagar mentioned concerning liability was that for commercial losses, liability is limited to the terms of the sales agreement contract. The seller of a product, he pointed out, is legally able to limit his own liability through warranties and indemnity agreements.

Reflecting some of the high-figure losses it was warning its policyholders about, Liberty Mutal revealed that its medical bill for 1975 totaled $195 million. ■

Defense groups unveil product liability plan

MILWAUKEE—Four national associations of defense attorneys have developed a legislative proposal to deal with the product liability problems they say have been created by "judicial excess."

The proposal has been given to the Interagency Task Force on Product Liability and 60 local defense attorney groups. The four sponsors are the Defense Research Institute based in Milwaukee, the International Assn. of Insurance Counsel, the Federation of Insurance Counsel and the Assn. of Insurance Attorneys.

Donald Hirsch, associate research director of the Defense Research Institute, said, "The main feature is not to take a Band-Aid approach but to try and take a methodical approach."

The draft has been in preparation during most of 1976, he said.

The groups urge product liability reform on a state-by-state basis. They also would restrict strict liability to those actually engaged in the sale of products and prohibit the application of the concept entirely to hazardous products.

Other proposals would:

- Establish a comparative responsibility system under which awards will be reduced in proportion to the plantiff's responsibility for an accident.
- Reduce awards against manufacturers by the amount of responsibility borne by an employer. Subrogation liens would be prohibited and workers would be unable to collect for medical expenses and wages paid by workers' compensation.
- Enact a statue of limitations from the date of manufacturer or the date of the accident.
- Prohibit suits against a manufacturer when the cause of an accident was an alternation in the product.
- Eliminate a manufacturer's duty to warn when a hazard is "open and obvious."
- Not allow a product to be considered defective when it met the "state of the art" at the time of manufacturer. Evidence of later improvements would not be admitted into evidence at a trial.
- Establish compliance with state or federal safety standards as a defense in a product liability suit.
- Allow the defendants to adjust contributions to an award even if they were found liable under differing product liability theories.
- Allow installment payments.
- Eliminate punitive damages. ■

Consulting firm

An actuarial and benefit planning consulting firm has been established in Baltimore to provide professional services only on a fee basis. Yaffe & Offutt Associates Inc.'s two principal officers are Rian M. Yaffe and Charles E. Offutt, former officers of S. M. Hyman Co.

End malpractice deal, Glacier asks U.S. court

MISSOULA, MONT.—Glacier General Assurance's request that a 1974 trust agreement it signed with Casualty Indemnity Exchange (CIE) of Jefferson, Mo., be rescinded, goes to trial in federal court here Dec. 20.

The trust agreement, which had assets of about $12 million at that time, ceded CIE's outstanding medical malpractice claims to Glacier General. All the claims were written for physicians, 75% to 80% of whom resided in California.

John Mayden, Glacier president, told *Business Insurance* that Glacier wants the trust agreement repeated because "CIE supplied us with incorrect information." It will be Glacier's position at the trial, he said, that "if we had known the correct facts we would have either asked for more money (more than $12 million) or we would not have entered into the contract at all."

He said the $12 million was raised by contributions from reinsurers of CIE which was, at that time, in trouble, and from Pritchard & Baird, the New Jersey reinsurance broker which is now under investigation.

CIE president, Art Firley, said that it will be his company's position that "all the information we gave Glacier was substantially correct." He went on to point out that Mr. Hayden had "personally" reviewed the medical malpractice claims and that he appeared at a hearing of three state insurance commissioners in October 1974, when he testified that he was satisfied with the information supplied to him by CIE. The three state commissioners, representing California, Montana and Missouri, subsequently approved the agreement.

This fall, however, the Montana insurance department issued an order directing Glacier General to discontinue the payment of further claims on the ceded malpractice policies pending the outcome of the trial.

Not long after that the California insurance department issued a cease and desist order blocking Glacier from writing any new or renewal malpractice business in the Golden State. A hearing on the order is scheduled for January 4.

In 1974, CIE was insuring California doctors and found itself with problems. It was placed under a conservatorship in June 1974, although it was later released during the following October.

Mr. Bertram asserted that it is the department's position that Glacier's liabilities under the trust agreement go to the "payment of all malpractice claims of CIE and that it (Glacier) is the only reinsurer of the policies."

Noting that one problem with the agreement is that it is ambiguous, Mr. Bertram said that his department has been hit with a plethora of complaints from physicians whose claims have not been honored by Glacier since it received the order from the Montana insurance department to cease

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Hospital chief says controls not answer

By JANE WINEBRENNER

CHICAGO—The American Hospital Assn.'s (AHA) chairman-elect said predetermined hospital rates and controls limiting third party insurers' payments are not the answer to rising health care costs.

In remarks made before a Blue Cross/Blue Shield symposium on escalating health care costs last month, John M. Stegl said the flaw of expenditure controls was they "don't tie such limits to restrictions to promised benefits or care." Expenditure controls are ceilings on payment rates and limits on what third parties can pay for the levels of care they have promised their beneficiaries and which hospitals are required to provide.

Instead, Mr. Stegl recommended that third parties should promise no more than they are "willing and able to pay for" and pay "adequately and equitably for those promised services."

Employers can reduce their benefit packages, make employes pay a greater share of the premiums or they can take money away from another fringe benefit in favor of health insurance he said. The best long-range solution is to solve the underlying problem of employe benefit utilization using health incentive programs and alternative methods.

Prospective reimbursement is an unsatisfactory way to control costs, according to Mr. Stegl, because it is "subject to the political considerations of the moment and not to the objective evaluation of society's needs." Prospective reimbursement requires that payment rates be predetermined and paid to the hospital regardless of the costs the hospital incurs.

The idea behind prospective reimbursements is to create an incentive for hospitals to be efficient without sacrificing quality.

In breaking down the reason for higher health care costs, Mr. Stegl said in 1975, 29% of the increase in hospital costs per day went to pay wages and salaries. Prices for raw materials, services, equipment, food, energy and malpractice insurance accounted for another 45% of the average increase. Other factors adding to the cost are government regulation, research, technology and clinical tests. Mr. Stegl said he was against expenditure controls and predetermined rates because they were ineffective in controlling rising costs.

"As a result (of restrictions), a hospital must provide certain mandated care, as under Medicare and Medicaid, knowing they will not be reimbursed for their full costs. In order to accomplish this, the hospital must shift those unmet costs on to someone else.

"Today there are some very real issues involved where an institution that holds itself out as the image of community service by its care of the indigent, does so by simply overcharging its paying patient. I doubt that anyone who gets a higher bill as a result of this would agree that it's an effective way to control rising costs or provide community service," he said. ■

Glacier . . .

Continued from page 74

paying claims until the resolution of the lawsuit.

Mr. Hayden of Glacier, asserted that under the agreement his company acts solely as a claims administrator, not a reinsurer.

"The trust agreement is not a reinsurance policy," he said.

He further noted that Glacier's financial condition is sound, with a Sept. 30 surplus of $8.9 million.

Mr. Bertram went on to contend that Glacier brought the lawsuit against CIE because "there is no money in the trust agreement at present and so Glacier has to turn to its own money." He said Glacier put $6 million in reserves for future claims on the CIE business, over and above the $12 million it received in the agreement.

Countering that, Mr. Hayden said that the lawsuit was filed in January 1975, and there were no money problems at that time.

Yet since that date, the $12 million in the agreement has been exhausted, he agreed. ■

people

Motorola picks Dalton in insurance shakeup

Thomas Dalton will take over Dec. 16 as manager-corporate insurance at Motorola Inc., Chicago, replacing **Don Schieck,** director of insurance and risk management, who left the company in mid-November because of policy differences. Mr. Dalton, 38, has been assistant insurance manager for Sears, Roebuck & Co., Chicago for five years. He has an MBA from Loyola University. He will report directly to Ed Harty, vp and comptroller. His replacement hasn't been named.

Mr. Schieck joined Alexander & Alexander as an account executive in its Indianapolis office. He had been with Motorola since April of this year. Following a major change in Motorola's property insurance program, in which Factory Mutual was selected as insurer after 30 years of doing business with Factory Insurance Assn. through Rollins Burdick Hunter, Mr. Schieck is understood to have been told to leave Motorola. It is not known what factors prompted Motorola's decision.

* * *

Arnold F. Berg, 49, director of risk management at Borg-Warner Corp. in Chicago, died Dec. 1 of a heart attack in Toronto. He was also vp of Centaur & Creon Insurance Co., the captive insurance subsidiary of Borg-Warner. Mr. Berg joined Borg-Warner in 1945 as a clerk in the accounting department. He transferred to the insurance department in 1954 and was named director of risk management in 1961. He was a graduate of Northwestern University.

* * *

Gary Bausom, 28, is leaving Transamerica Corp., San Francisco, where he has been risk manager for two years, to take over Jan. 1 as vp-risk manager for Budget Rent-A-Car, Chicago, a Transamerica subsidiary. In his new position, Mr. Bausom will report directly to the president of Budget, and also to the financial executives at Transamerica. At Budget, Mr. Bausom takes over part of the myriad responsibilities which have been handled by Ronald D. O'Nan, vp of administration, who was responsible for personnel, purchasing, office services, employe benefits and property/casualty insurance. The change resulted from an integration over the past two years of Budget's corporate risk management and insurance programs into the parent company's programs. Mr. Bausom has not yet been replaced at Transamerica Corp.

* * *

Richard Farrell, former director, compensation and benefits at GAF Corp. joined NL Industries Inc., as director of employe benefits. At GAF, his responsibilities have been divided between **Edith H. Gazda,** director of compensation and **George Doukas,** director of corporate benefits. Miss Gazda had been manager of exempt salary administration and Mr. Doukas had been manager of employe benefits. In his new position Mr. Doukas is responsible for employe benefits and services such as relocation, suggestion awards and tuition reimbursement. He reports to the vp, personnel relations.

* * *

Raymond C. Regan, 29, joined American Hoechst Corp., Somerville, N.J., as manager of employe benefits, a new position in the company. Mr. Regan, formerly a pension consultant for Prudential Insurance Co., now has responsibility for administration of pension, health and life insurance plans. He reports to the director of personnel.

* * *

Lynn Aho, 27, was named benefits planning assistant at ICI United States Inc., Wilmington, Del. The initial emphasis for the newly created position is on communication involving ERISA requirements, Ms. Aho said. Additional responsibilities include developing and executing plan installation programs Formerly a consultant with Huggins & Co., consulting actuaries in Philadelphia, she now reports to the director of employe benefits.

* * *

Sue Gahagan, 35, left Booz, Allen & Hamilton, Chicago, where she was risk manager and assistant tax manager to join Alexander & Alexander's international department in Chicago. Booz, Allen & Hamilton's decision to move its corporate financial management functions to Florham Park, N.J., was the reason Ms. Gahagan left the international management consulting firm. Her responsibilities were taken over by two people. **Jerry Cutter,** director of insurance and taxes and formerly Ms. Gahagan's superior, resumed direct involvement in management of property and casualty programs. **Raye Pappas** was promoted to insurance coordinator from her former position as an administrator in the employe benefits department of Booz, Allen's Chicago operation. She is responsible for day to day administration of property and casualty programs.

* * *

Larry R. Geller, 30, was named benefits manager for North American Car Corp. in Chicago. He is responsible for the administration and improvement of the company's employe benefits program and will report to Robert J. Sera, senior director-personnel. Mr. Geller previously was benefits manager for Cook Electric Co.

* * *

Michael D. Bailey, 29, joined Fluor Engineers & Contractors Inc., Los Angeles, a wholly-owned subsidiary of Fluor Corp., as an insurance department representative. He reports to Richard J. Wist, insurance administrator in his new post. Mr. Bailey, who has a B.A. degree from Loma Linda University, Riverside, Ca., was formerly a risk manager and consultant for the Seventh Day Adventist Church. No one has been named to replace him at the Church.

* * *

John J. Prendergast, 52, died of a heart attack suffered while jogging Nov. 23 near his home in Sunnyvale, Calif. Mr. Prendergast was corporate insurance manager for Hewlett-Packard Co. of Palo Alto, a position he held since 1962. A native of County Tipperary, Ireland, Mr. Prendergast had worked for H-P since 1958 in various financial and accounting posts. He had a BA from Menlo College, was a past president of the Northern California chapter of RIMS and served on the Machinery & Allied Products Institute insurance council.

dates for buyers

Jan. 10, 11, 12: Assn. of Private Pension and Welfare Plans—Employe benefit managers will hear pension expectations and highlights for 1977, national health insurance outlook and congressional issues. The one-day meetings will be held Jan. 10 at the Roosevelt Hotel in New York City, Jan. 11 at the Hyatt Regency O'Hare in Chicago and Jan. 12 at the Hyatt Regency Atlanta. Cost is $90 for APPWP members, $125 for nonmembers and $100 for regional pension plan association members. Contact Assn. of Private Pension and Welfare Plans Inc., Suite 909, 1028 Connecticut Ave., N.W., Washington D.C. 20036.

Jan. 11-12: Safety Council of Greater Baton Rouge—An industrial hygiene workshop for safety personnel and professionals will cover welding and flame cutting, abrasive blasting, potential health problems from chemicals and industrial health monitoring including air and biological sampling and medical surveillance programs. Cost is $75 for nonmembers and $60 for member of the National Safety Council or Baton Rouge safety council. Persons must be enrolled in advance. For more information contact Joseph Andre, managing director, Safety Council of Greater Baton Rouge, 1536 N. Foster Drive, Baton Rouge, La. 70806 Phone: (504) 926-6650.

Jan. 24-28: International Safety Academy—A course in total loss control management teaches new concepts and practices in advanced safety management. Such concepts as management involvement in loss control, hazard classification, product loss control and environmental health updatigs covered. The course is also taught Feb. 28-March 4. Cost is $400. Contact the International Safety Academy, P.O. Box 19600, 10575 Katy Freeway, Houston, Tex. 77024.

Feb. 1-3: University of Dallas—Financial costing in risk management, risk reduction transfers and budgeting, FASB #5 and SEC requirements for replacement cost disclosures will be discussed. Accounting decisions in self-insuring, and cost allocations also will be topics. Among the session instructors are corporate risk managers and accountants. Tuition is $325; cost for RIMS deputy members is $290. Contact the University of Dallas, Management Laboratories of America Inc., Irving, Tex. 75061. Attn: Bruce Evans, executive director, the Risk Management Institute. (214) 438-1123, ext. 360.

Feb. 3-5: Defense Research Institute—A professional liability institute will be held at the Marriott Hotel in New Orleans to discuss defense aspects of professional liability litigation. Practical trial problems of attorneys, insurance agents and brokers, officers and directors, architects and engineers, and accountants will be featured. Also discussed are federal rules of evidence, extent of liability, and the effect of statutes of limitations and contractual limitations. The sessions are open to the public; cost is $125. Contact the Institute, Anthony Karpowitz, 1100 W. Wells St., Suite 702, Milwaukee, Wis. 53233.

Feb. 6-9: American Bankers Assn.—Experts in bank insurance and risk management will conduct a seminar on banker's blankt bond insurance, D&O insurance, fiduciary, errors and ommissions and safe deposit liability insurance. The seminar will be held at the Double Tree Inn in Tucson, Az. Contact Edgar Armstrong, associate director, insurance and protection division, American Bankers Assn., 1120 Connecticut Ave., N.W., Washington, D.C., 20036.

Mar. 16-18: New Jersey Institute of Technology—The seventh annual international product liability prevention meeting, will be held at the Cabana Hyatt House, Palo Alto, Calif. Twenty-three prefessional organizations are cosponsoring the workshops, including the American Society of Safety Engineers, Assn. of Trial Lawyers of Amtrica, National Safety Council, American National Standards Institute and the American Insurance Assn. Cost is $350 with a $25 discount for registration before March 2; members of sponsoring organizations pay $325.

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