

Hospital Assn. to use captive for malpractice

WASHINGTON—The American Hospital Assn. (AHA) is expected to establish a captive insurance company to reinsure 100% of the necessary malpractice cover for its member hospitals.

The annual premium generated by those hospitals amounts to about \$700 million a year, according to James Groves, risk manager for the AHA.

The reinsurance captive would probably reinsure the bulk of its book of business, Mr. Groves said, but was still expected to retain something in excess of \$1 million per loss.

AHA is looking at Illinois as the state

to domicile the company, but no firm decisions have been made on that question.

The captive insurance proposal went up for approval last week at AHA's annual meeting in Washington.

See related stories on pages 3 and 4.

Concurrence by the AHA House of Delegates was needed because the plan involves a one time increase in AHA member dues of \$4 per hospital bed.

That money would provide an initial \$2.5 million in capital to start the company and initial funds to seek a national solu-

tion to the malpractice crisis through legislative means.

Mr. Groves said AHA was considering four domestic insurance companies as the direct underwriter of the coverage, although these firms would not retain any of the risk.

AHA is considering the reinsurance facility because of the pressing need to make coverage obtainable for hospitals. AHA believes there isn't time to set up its own direct underwriting company and get it approved by state insurance officials across the country.

"It's panicsville right now," Mr. Groves

said, referring to the malpractice market.

He said many hospitals faced the possibility of being without coverage as of April 1.

Rep. James F. Hastings announced last week that a national conference on medical practice insurance has been scheduled for March 20-21 in Arlington, Va., in cooperation with the American Group Practice Association, which represents physicians in group practice.

The participants are to include Sen. Edward M. Kennedy (D-Ma.), chairman of the Senate health subcommittee, and Rep.

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business insurance

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Owner hit for \$12 million apartment-murder award

By RICHARD L. GORDON

ROCKVILLE, MD.—A New York-based real estate conglomerate already in federal bankruptcy proceedings has been hit with a \$12.1 million liability award by a Montgomery County, Maryland, circuit court jury.

The company, Investors Funding Corp. (IFC), has \$7.1 million in insurance coverage.

The award, considered by some the largest personal liability award in history, stems from the brutal rape and murder of a 30-year old

mother of two in her apartment in the IFC-owned El Dorado Towers apartment complex in White Oak, Md., on Sept. 17, 1971.

The killer, now serving a life prison term, was employed at the time by the other defendant in the liability case, National Service Industries Inc., an Atlanta-based conglomerate.

THE COMBINED award against both firms totaled \$13,355,000. IFC and National Service will split a \$2,355,000 compensatory damage award, but IFC was additionally

hit with \$11 million in punitive damages for "lulling the tenants (of the building) into a false sense of security" about the safety of the buildings.

Attorneys for both firms have asked that the reward be reduced and said they will appeal the case.

IFC officials said their coverage is with three domestic underwriters, whom they declined to name, with each taking a layer of the coverage.

National Service has insurance coverage for its part of the settlement, but Walter Buce, the com-

pany's insurance manager, declined to name underwriters or coverage amounts pending a more thorough investigation of the impact of the claim. The company's insurance broker is Alexander & Alexander.

OFFICIALS AT the John F. Curry Agency, New York, broker for IFC, declined to comment on the case.

IFC officials said they planned to release a statement later this month, presumably detailing for worried creditors how the award, if upheld, would affect the company's already troubled financial status.

The company, however, has already admitted that there is some question whether its insurers will cover even the \$7.1 million portion of the loss.

In its 1973 10-K (annual report) filed with the Securities and Exchange Commission last year, IFC noted, "The insurers disclaim coverage for punitive damages as being contrary to Maryland's public policy."

That was disclosed sometime after Benjamin Blum, husband of the murder victim, had filed his suit, which initially sought puni-

tive damages of \$16 million and compensatory damages of \$6 million.

In its SEC filing, however, the company noted that "In the opinion of (IFC's) local counsel, their policies contain no such exclusion, nor is there any statute or reported decision in Maryland on the subject; the general rule in the few non-Maryland jurisdictions that have considered the issue holds the insurer responsible."

IFC's general counsel also said that it believed any eventual set-

Continued on page 35

Lloyd's experts view of fiduciary liability risk supports high premium

By SUSAN ALT

LONDON—"The liability arising from the pension reform act is producing a class of business which will, in three years, make medical malpractice look profitable."

This view of potential losses under the Employee Retirement Income Security Act of 1974 came from Leslie Robert Dew, vice chairman of Lloyd's of London and chairman of the Merrett Group, Lloyd's largest underwriter of non-marine risks.

Mr. Dew's syndicate leads on nearly every important directors' and officers' liability insurance policy written at Lloyd's. Its members argue that it will not cover any future fiduciary liability claims involving corporate managers included under D&O insurance policies. Lloyd's underwriters maintain that coverage for risks posed by the new law must be purchased separately and is not included under policies presently in effect.

AND, SAYS ONE U.S. broker, "How can you argue with Mr. Dew? He owns the football."

Mr. Dew's view of possible losses under the pension law helps to explain the high rates and premiums being paid by corporations for fiduciary liability coverage. And to hear Mr. Dew tell it, rates should be even higher—a lot higher. "Domestic (U.S.) insurers have rushed into a field, which is in effect compulsory insurance,

basing their judgments (of necessary rate levels) on the entirely irrational domestic company which led the field," said Mr. Dew in an interview with *Business Insurance*.

"For 12 months, no losses will be recorded, but unless there is a complete revival of the stock market from its current state of depression, there will be a spate

of (fiduciary liability) losses in the next two, three or four years, because at the present time, there are uninsured pension funds which are technically insolvent," Mr. Dew said.

Mr. Dew is not the only Lloyd's underwriter to take this dim view of future fiduciary liability claims.

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Executive life insurance with group plan to cover suicide

NEW YORK—Eli M. Black, the chairman of United Brands Co., who plunged from the window of his 44th floor office in the Pan Am Building here last week in an apparent suicide, did not have key man life insurance, according to a company official.

The 53-year-old executive was insured under the company's group life insurance policy for all employes, however. The policy is underwritten by the Travelers Insurance Cos. Marsh & McLennan, Boston, is the broker.

BENEFITS UNDER the policy are tied to a multiple of salary. In 1973, the most recent year for which figures are available, Mr. Black's total remuneration from the company was \$200,000. A company official said there is no exclusion of benefits in the policy even though the death was classified a suicide by police.

The company chairman was reportedly under strain and depressed about heavy losses United Brands sustained on its banana plantations in Honduras last September when Hurricane Fifi hit. The losses were uninsured (*Business Insurance*, Sept. 30). Heavy losses from the company's meat-packing operations because of soaring cattle feed prices were also said to have made the executive despondent.

Tangled liability spurs \$30 million suit

Ship crash means millions in losses

By MARIE KRAKOWIECKI

MARCUS HOOK, PA.—A \$30 million lawsuit has been filed following the Jan. 31 collision of two ships here which caused a massive explosion and fire and a destructive oil slick extending over 45 miles.

The Corinthos, a Liberian-flagged tanker, carrying 17 million gallons of Algerian crude oil, exploded and sank after it was rammed by the American ship, Edgar M. Queeny, killing 3 and leaving some 21 others missing. It is thought that the collision may have been at least partially caused by an effort of one of the ships to get out of the way of a U.S. Navy vessel.

Last week, Zaillaneuva Compania Naviera, owners of the Corinthos, filed suit against



The burning Corinthos seen through a shattered warehouse window.

Monsanto Co., charter operators of the Queeny; Bankers Trust Co. of New York, owner of the Queeny; and Keystone Shipping Co. of Philadelphia, the shipping

agent for the American ship.

The accident left a long string of officials in Bermuda, London, Washington and New York scrambling.

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Oil tanker collision...

Continued from page 1
 bling to sort out respective roles and potential liabilities.

The Philadelphia Coast Guard said the resulting oil pollution extended in patches along Delaware River shorelines for 45 miles through three states, primarily New Jersey.

Marine sources in New York, some groggy from working on the case since one a.m. when they were awakened with the news of the holocaust, pegged protection and indemnity coverage in the area of \$30 million. Hull values for each vessel were estimated at over \$10 million apiece.

The Corinthos is insured for oil pollution up to \$25 million by the International Tankers Indemnity Assn. in Hamilton, Bermuda.

THE EDGAR M. QUEENY is insured for oil pollution up to \$25 million also by the International Tankers Indemnity Assn. in Hamilton.

Both vessels were entered in TOVALOP against pollution liabilities, *Business Insurance* learned. TOVALOP is the acro-

nym for the Tanker Owners' Voluntary Agreement on Liability for Oil Pollution, which was formed as a mutual insurance pool in 1969 after Aristotle Onassis lent his support (*Business Insurance*, Oct. 13, 1969.)

Leonard Bibby, insurance manager for Keystone Shipping Co., declined comment on hull, liability, and pollution coverage for the vessel.

However, in addition to the oil spill information provided by Washington, New York sources pieced together the following account: The American Steamship Mutual Protection & Indemnity Assn. Inc., New York, wrote approximately \$5 million of the first layer of liability for the Queeny. Total liability is estimated at \$30 million. The Home Insurance Co. and Mutual Marine Office, New York, underwrote excess liability coverage on the Queeny.

Robert Tellus, president of Home, confirmed that the company wrote excess coverage that would pick up after the first \$20 million. He added he thought it doubtful that the Home would be involved, since the primary layer was so high.

Mutual Marine Office was involved in an umbrella excess policy spun off from The Home Insurance Co., it was learned.

THE AMERICAN HULL Insurance Syndicate wrote 60% of the \$20 million hull coverage for the Queeny. A spokesman for AHIS indicated that additional hull coverage was underwritten in domestic rather than London markets.

AHIS also had a portion of the hull coverage for the Corinthos.

Lamorte, Burns & Co. Inc., a marine adjusting firm, is handling claims for one unidentified London protection and indemnity group which underwrote liability insurance for the Corinthos.

A SPOKESMAN FOR the General Adjustment Bureau reached shortly after the explosion said GAB was trying to determine how much damage was done to the dock where the Corinthos was moored. It is working out damage details for the British Petroleum Co., owners of the dock.

Preliminary unconfirmed reports of the cause of the crash indicated that a U.S. Navy vessel unwittingly forced the Queeny off course, resulting in the ramming of the Corinthos and the ensuing conflagration.

The office of water pollution responsibility in Washington, part of the federal maritime commission, said the U.S. government requires all tankers over 300 gross tons which sail in U.S. waters to be insured in the amount of \$100 per gross ton to reimburse the government for possible clean-up costs in oil spills.

THE OFFICE will not certify tankers unless they meet the minimum \$100 insurance per gross ton requirement, a spokesman said. He confirmed that both vessels were fully certified.

The Corinthos weighed 30,705 gross tons, making its minimum insurance coverage for oil pollution more than \$3 million. The Queeny, a 19,046 gross ton tanker, was required to have a minimum of \$1.9 million coverage, a requirement more than surpassed with the \$25 million cover from International Tankers Indemnity Assn.

The office of water pollution responsibility is the repository under the Federal Water Pollution Act. It administers the financial responsibility of tankers under section 311 of the act, including the insurance coverage necessary for each vessel.

RR property, liability risks to be studied

NEW YORK—The Assn. of American Railroads has commissioned a study to determine how railroad property/liability risks should be handled, *Business Insurance* learned.

Railroads have faced a tightening market for property/liability insurance to cover their risks, because of frequent serious losses over the past several years. (*Business Insurance*, Dec. 9, 1974.)

"We're considering a number of possibilities, including possibly the use of a captive," an official of the AAR disclosed. "Or maybe we'll set up a new captive. No decisions have been made yet," the official added.

RISK PLANNING Group Inc. has been commissioned to do the study in cooperation with an AAR internal committee.

The AAR is the parent company of Imperial Insurance Co. Ltd. a mutual captive set up in the 1950s in the Cayman Islands. The captive is managed by Hogg-Robinson, the British brokerage firm, and insures all AAR members. Imperial Insurance underwriters services interruption coverage for all AAR members.

The association counts among its members the 70 class I railroads in the nation.

The official said completion of the study is expected in July, "though I'm not hopeful we'll meet our deadline."

Heavy losses resulting from Darwin cyclone

NEW YORK—"The final impact of the cyclone losses in Darwin, Australia, could make it worse than Hurricane Betsy," predicted Edgar S. Clark, consultant with Risk Planning Group in San Francisco.

This view is supported by John Lancaster, managing director of AIU (London) Ltd., who told *Business Insurance* insured losses could total \$400 million following the Darwin cyclone. "A lot of claims have come trickling in during the last week," he said late last month.

WHAT WAS at first seen as a minor event to be recorded in the 1974 insurance books is, indeed, turning out to be the source of heavy losses pounding the London markets and other international insurers. Lloyd's underwriters were still clinging to the \$100 million gross loss figure near the end of last month, although several Lloyd's sources said when primary insurance and reinsurance losses are tallied, the total drain on the Lloyd's markets could reach \$150 million.

Marsh & McLennan's international department estimated total insured losses of \$250 million from the cyclone, which hit Australia's northernmost port city early Christmas morning.

Darwin was almost completely destroyed by the disaster. Most insured losses were initially thought to be in individual lines such as home and auto, and in domestic Australian markets. But Lloyd's underwriters last month

expressed growing concern over reinsured Australian business, and the rising number of unexpected commercial losses flowing into London.

In addition to the recent cyclone, Australia suffered heavy losses from floods and storms in the last year. Insurance rates across the continent are expected to jump substantially as a result of the experience. "Rates that had applied are certainly inadequate now," said an Insurance Co. of North America (INA) official.

Hurricane Betsy, which occurred in 1965, is frequently cited as one of history's worst disasters for the world insurance community. Betsy resulted in insured losses of a whopping \$715 million. Tornado damage in 1974 totaled \$420 million.

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No-fault policies for specific medical procedures

CHAMPAIGN, IL.—“The only way to solve the medical malpractice crisis is for doctors and hospitals to buy policies for specific types of operations which would list the risks of resulting injury and promptly pay any out-of-pocket expenses and wage loss for the patient,” according to Jeffrey O’Connell, University of Illinois law professor and outspoken proponent of no-fault auto insurance.

“The real problem is the difficulty involved in proving liability for alleged malpractice,” he said, adding that the bulk of the court-awarded settlements is “for the patient’s pain and suffering rather than for actual expenses incurred by the accident.”

“Changing the contingency fee system for lawyers or setting up government-regulated insurance pools won’t solve the problem facing the malpractice insurance market,” he continued, elaborating on a speech he prepared for the Nassau (NY) Physicians Guild annual meeting.

PROF. O’CONNELL envisions a voluntary contractual agreement in which the doctor or hospital would tell a prospective patient that the advised operation involved certain risks and that adverse results were covered by insurance, provided the patient would agree to waive any future suit over the liability.

The patient, he claims, would benefit from immediate monthly payments to cover medical costs and wage loss (which were not provided through other medical insurance). He added that another attractive feature is that patients

Pfizer’s new dental plan covers 12,000

NEW YORK—Pfizer Inc. put into effect a new group dental insurance plan for its 12,000 employees.

Underwritten by the Equitable Life Assurance Society of the U.S., the plan pays for 100% of “reasonable and customary” charges for diagnostic and preventive care including oral examinations, cleaning, scaling, polishing and x-rays.

Up to 50% of services charged for repair and replacement of natural teeth (including fillings, extractions, inlays, onlays, crowns, root canal therapy, bridgework, periodontal treatment and dentures) is also included in the Pfizer plan, according to Richard A. Harvey, manager, employee benefits planning.

MAXIMUM BENEFITS are \$1,000 per year for each employee and dependents, Mr. Harvey explained, with a \$5,000 maximum lifetime benefit.

The plan also pays 50% of “reasonable and customary” orthodontia charges up to \$1,000 per person covered per lifetime. The orthodontia coverage is in addition to other dental services and payments for orthodontia expenses are not charged against an individual’s calendar year maximum, Mr. Harvey noted.

“This is the first plan I know of that doesn’t charge orthodontia expenses against the maximum dental services provided,” he added.

Pfizer is paying the entire cost of the plan, which went into effect Jan. 1. There is no deductible included in coverage for dental services. ■

would not need a lawyer to secure payment of the benefits.

The advantage to a doctor or hospital, Prof. O’Connell explained, is reduced costs by avoiding litigation. Also, payments from other sources would be deducted from the payment to the patient.

“**OF GREAT** importance for doctors, the stigma of liability would be substantially—and often totally—removed,” he said.

“No longer would the enterpriser be paying because . . . he malpracticed, but rather on the morally neutral ground that the accident was just that—an accident,” Prof. O’Connell continued.

He acknowledged that “a patient might return to the tort system and sue the doctor if the injury in question was not clearly the result of the insured medical pro-

cedure.”

Still, he maintains, doctors and hospitals would be in a “better position because they’re not defending themselves by virtue of purchasing insurance for high-risk procedures specifying the adverse results that could occur.”

Prof. O’Connell also conceded the stress element of a patient agreeing to accept the doctor’s no-fault contract because he is emotionally distraught at the time but then later wanting to seek redress in court. “If the contract is fair, then it shouldn’t be in jeopardy just because the doctor is more knowledgeable about the risks.”

One strength of no-fault insurance, he believes, would be to offer it on a voluntary, contractual basis. “It’s a new step. It’s different. If it turns out to be unattractive, then it will die out. If

a statute is passed, however, you’re stuck with it,” Prof. O’Connell said.

He noted that “lacking a statute on no-fault medical malpractice, treatment by the doctor or admission to the hospital should not be refused if the patient declines the agreement, nor should it be used for emergency treatment.” He added that he could see these risks resulting in litigation but said he believes the number of law suits would be substantially lower than at present.

PROF. O’CONNELL disputed the view that contingent fees are largely responsible for large court settlements for medical malpractice. “Three out of four cases are being awarded by juries to doctors—not to plaintiffs,” he said, adding that the cases are difficult to liti-

gate and many lawyers aren’t interested in working on a contingency fee basis.

The tort system itself is at the root of the malpractice settlement problem, Prof. O’Connell believes. Industrial problems were eased at the turn of the century, he said, when no-fault insurance was established for workers’ compensation. He thinks no-fault can be applied effectively to medical malpractice and product liability insurance as well as to auto insurance.

“The concept of fault—that is, that a person who causes damage to another must pay the cost—is relatively new in American law,” he said. “The concept of negligence began with a case in 1840 and by the end of the 19th century, it was abandoned—at least for industrial injuries.” ■

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The Knowledge Broker

St. Paul Fire & Marine introduces 'pay as you go' malpractice coverage

By ROBIN SUHRBIER

MINNEAPOLIS—In a move to solve part of the problem involved in pricing future malpractice risks, St. Paul Fire & Marine Insurance Co. said it will discontinue writing malpractice insurance on an occurrence basis and will switch to insurance coverage written only on a claims-made basis.

St. Paul, which insures some 48,000 doctors, said no new or renewal business will be written after June 30 except on a claims-made policy. The claims-made policy will replace the old occurrence policy forms as soon as it is approved by the state insurance commissioners.

The present "occurrence" con-

tract has become very difficult to price since the initial rate charged must cover the claims expected to arise for five or more years from this year's business. Under a claims made plan, the policy covers claims reported during the year the policy is in force. It is a "pay as you go" policy since the doctor pays a rate calculated to cover that year's liability risk only.

THOMAS L. UEHLIN, professional liability risk management officer, contends that the policy holds real promise for the medical profession because it takes much of the uncertainty out of ratemaking.

Marked increases in medical malpractice claims coupled with

substantially higher settlements forced premium rates up more than 50% last year.

In the first nine months of 1974, St. Paul said one in 10 of its insured doctors had a pending claim, up from one in 23 in 1969. St. Paul insures 48,000 doctors and 1,600 hospitals.

The major problem, says St. Paul, is that losses can arise out of 1974 premium businesses for the next decade. The company attempts, based on past experience, to project today what the loss record will be. The way most policies are written today, the company has perpetual liability on policies sold in 1974. Years from now, an insurer may have to defend a doctor and pay a

malpractice judgement even though the company may not have insured the doctor for years. This makes pricing the risk very difficult in a time of inflation and changing negligence laws, according to St. Paul.

"In the past eight years the dollars paid out in losses by St. Paul have been substantially more than premium dollars collected," said Mr. Uehlin.

RAISING PREMIUM rates is only one answer and a short term one. St. Paul has obtained rate increases in most states with the average 1974 increase about 50%. Rate increases of over 75% have been necessary in some states however. Maryland denied the insurer a 48% rate increase so St. Paul withdrew coverage, leaving the Maryland Medical Assn. without a carrier.

"It's difficult to say how much each contributes to a rate increase," Mr. Uehlin said of the

inflation and claims frequency problems.

"In medical malpractice," Mr. Uehlin said, "the inflationary factor is reflected in the judicial system—the amount of damages sought or the amount of a jury award."

What do the increases mean in terms of dollars to the doctors? In Florida, for example, for the standard coverage of \$100,000-\$300,000, premium rates range from \$1,217 for class one doctors—general practitioners or specialists who do not perform obstetrical procedures or surgery—to \$7,702 for class five doctors—obstetric gynecologists, anesthesiologists, orthopedic surgery, neurosurgeons, plastic surgeons and nose and throat physicians with plastic surgery. This makes Florida the second highest in the country.

Minnesota, which ranks 31st, had a 66% increase, with rates now ranging from \$347 to \$2,196.

In some areas of the country coverage at any price may not be available. In Detroit, for instance, many class five doctors have turned to Lloyd's to get coverage and are paying \$20,000 to \$25,000 a year, the company confirmed.

Detroit doctors, Mr. Uehlin said, have set up a crisis committee to obtain legislative relief. Legislation has been requested to amend the state's Medical Practices Act, revise the criminal code as it relates to solicitation of cases, require reporting of malpractice cases and amend the arbitration statute, he added.

IN THE INTERIM, some doctors are moving out of Detroit; it's just not feasible for them to practice under such circumstances, he said.

Substituting a binding arbitration system to hear malpractice cases instead of the jury system is another possible solution, Mr. Uehlin said. He contends that an arbitration setting reduces both the time involved, the costs incurred and eliminates much of the emotional appeal that comes with a jury trial.

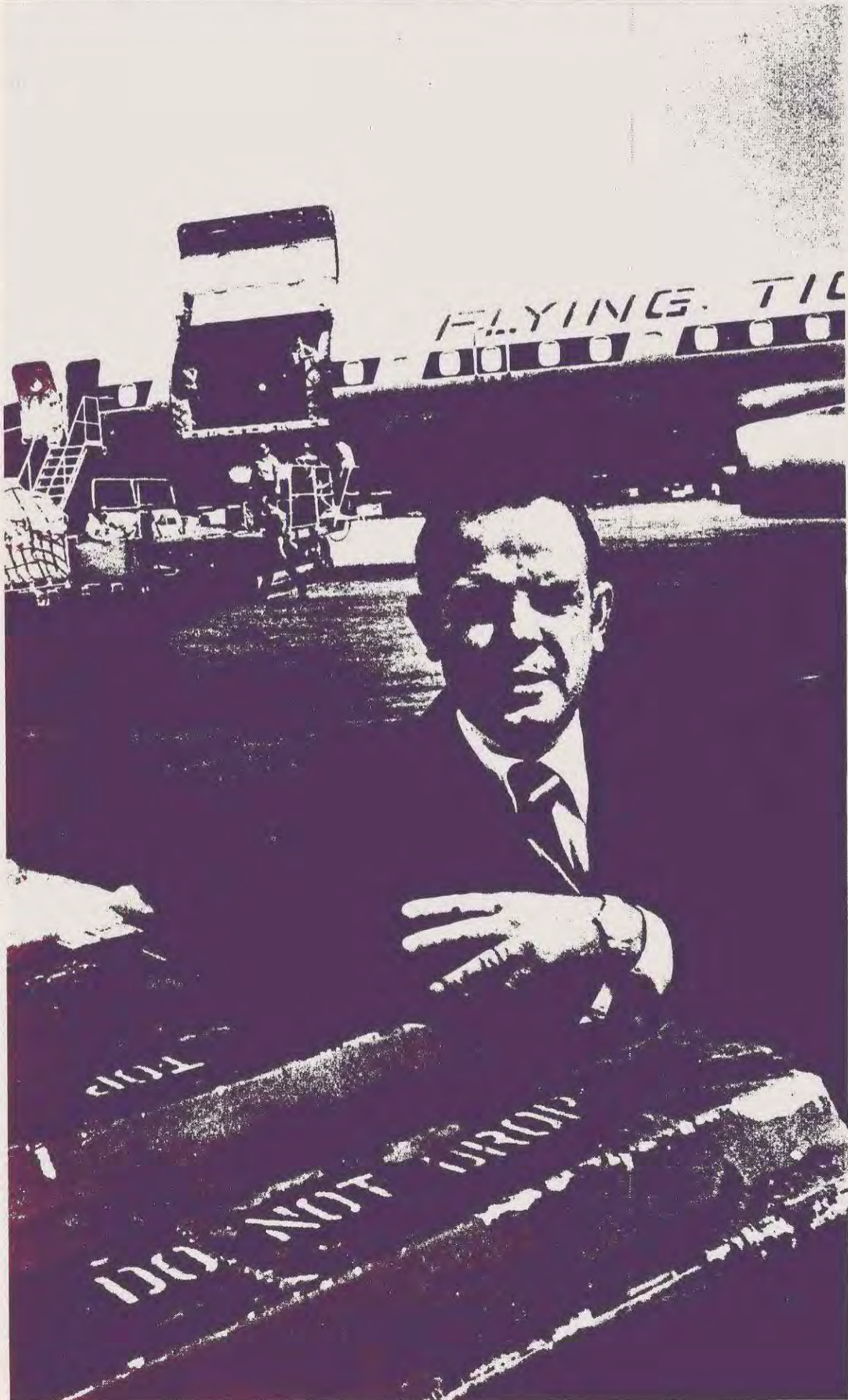
It has been suggested that arbitration can reduce the time involved from several years for a jury trial to 60 or 90 days. With arbitration, a doctor, preferably a specialist, able to comprehend the complicated medical procedures would usually be appointed to the tribunal of arbitrators. This, Mr. Uehlin added, makes possible a fairer and more equitable decision for both parties without the emotion of a jury trial.

St. Paul has successfully implemented binding arbitration in several areas of the country on a limited basis. In Massachusetts, for instance, the insurer drew up plans for an arbitration system and "we took it to the lawyers ourselves. They were agreeable to the concept of arbitration," Mr. Uehlin said and added that the first case is scheduled to be heard soon.

"We would like to see the plan used in more states but our one big hurdle to overcome is the plaintiff's attorney," he added. Mr. Uehlin is hopeful that arbitration will keep settlements more in line, and not allow for the costly appeals process.

St. Paul also stepped up its communications to doctors in an effort to make them fully aware of what the problems are. Increasing premium rates is not the real answer to any problems, but the increases have jolted the medical profession into recognizing that something has to be done to reduce losses. As a group, doctors have become much more receptive to listening to suggestions, Mr. Uehlin said.

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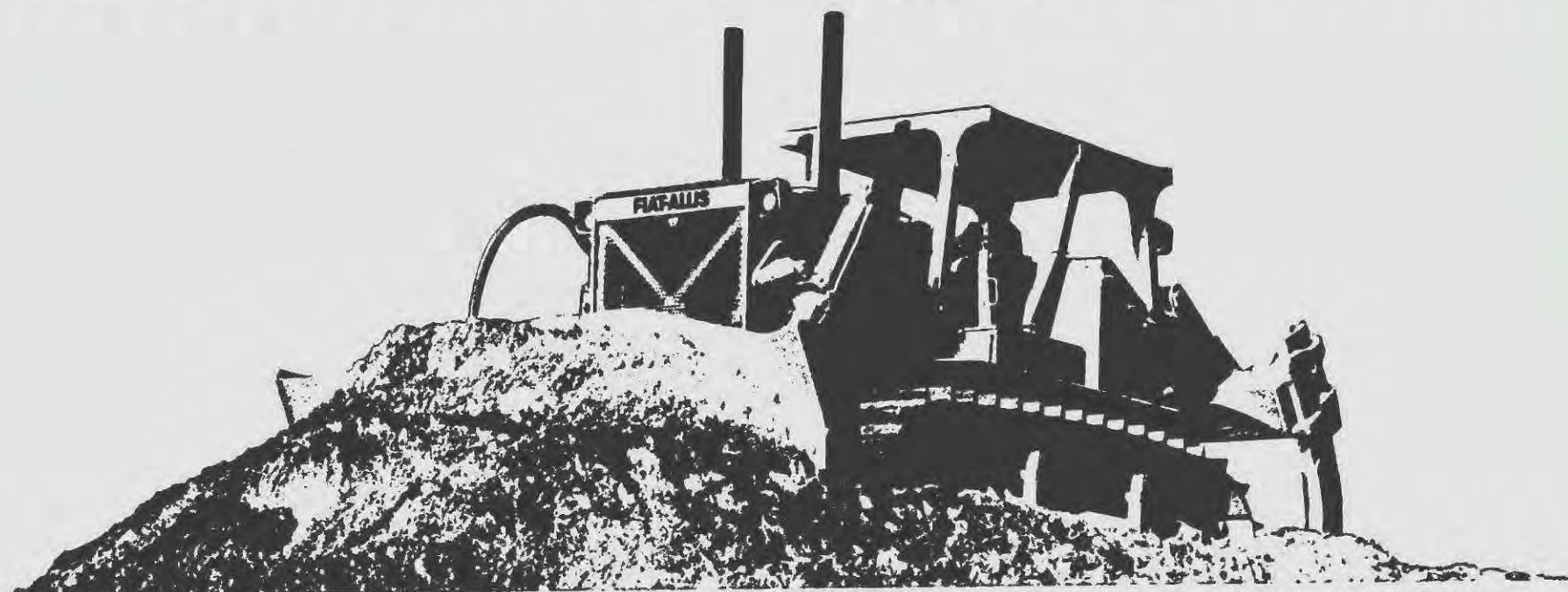


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Malpractice cover...

Continued from page 4

St. Paul also supplies the medical associations with claims analysis reports in those states where it is the sponsored carrier. The report, the first of its kind in the industry, codes in every physician and surgeon claim by state and county, nature of the claim, date of loss, amount of loss, and how much was reserved to pay that loss.

"We need," Mr. Uehlin said, "to return to a more personal doctor-patient relationship. From the claims files, St. Paul determined that often there is a communication breakdown between patient and doctor.

"We are alerting doctors to this problem," he added, "in a hope that they will begin to take more time with their patients."

Mr. Uehlin also called on physicians as a group to work together

to introduce remedial legislation at the state level. Generally, the key needs are: retention of the locality rule, restriction on the statute of limitations, confidentiality of peer review mechanisms and establishment of standards for informed consent, he believes.

THE BASIC difference between occurrence and claims-made policies is that the former covers claims reported any time in the future resulting from professional services rendered while the policy was in force, St. Paul said. The claims-made policy covers claims or independents reported while the policy is in force, resulting from professional services rendered either during the policy period or any past claims-made policy period, if the policy was written by St. Paul.

Occurrence policies in force before this changeover will continue to take care of claims yet to be reported from those previous policy years, St. Paul plans. The first day of claims-made coverage under a St. Paul policy will be known as the "retroactive date." As long as the doctor is carrying a claims-made policy from St. Paul, any claim reported which arises from a professional act performed on or after the retroactive date will be covered.

St. Paul said it will sell additional coverage in the form of a reporting endorsement to insured doctors who retire or otherwise change insurers, and this coverage will be available when the doctor needs it at rates reflecting the claims experience at that time. The endorsement, which would extend the period in which covered claims could be reported, will be sold in three installments, with the third taking care of all remaining exposure to claims arising from acts performed while claims-made policies were in force.

ST. PAUL guarantees that it will sell these endorsements even if it cancels policies or withdraws from underwriting malpractice insurance in a state.

Hospitals and dentists are being allowed to continue under St. Paul's occurrence-based policy "for the time being," according to the company. But hospital staffs, residents and interns, as well as students and others in teaching institutions will be covered only under claims-made, St. Paul said.

"We are studying the hospital liability situation to determine if claims-made should also be applied," the insurer declared.

St. Paul will continue to sell \$100,000/\$300,000 liability limits for malpractice. The insurer also disclosed that "if an unusual incident occurs during or following surgery, treatment or hospitalization which the doctor believes may later give rise to a claim, and he reports this incident to the company, that notice shall be considered to be a claim covered" by the new claims-made policy.

St. Paul said it will not honor a claim under a claims-made policy for damages arising out of acts performed while another company's policy was in force. Lloyd's has used claims-made for malpractice policies since 1867. ■

Budget request

A one year budget of \$1.85 million was requested by the Senate Labor and Public Welfare Committee, which oversees the activities of the Occupational Safety and Health Administration and the implementation of the private pension reform law. The budget would cover the period March 1, 1975, to Feb. 29, 1976.

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Lloyd's chairman predicts a return to London market

LONDON—Business which has been moving away from the London market in the past two years due to severe competition is now returning to Lloyd's, its new chairman, Havelock Hudson, forecast in a review of 1975 prospects.

So greater capacity to meet the expected calls on its services is now being planned, based on the changes for the "show of means" tests reported in *Business Insurance* Dec. 9.

U.K. names will be permitted a special facility, in order to encourage investment in Lloyd's, to put up as little as \$90,000 in 1976 if they wish to write comparatively small amounts of business.

THERE ARE also hopes that U.S. and other overseas businessmen will put money into Lloyd's, even though they are required to have a \$240,000 show of wealth, so as to hike its capacity in the coming

months.

Mr. Hudson told the London Daily Telegraph: "I've a feeling that the outlook for 1975 is really not too bad and that business is coming back on the right terms."

He thinks heavy underwriting losses in some sections, and the fall in many stock exchange prices, has affected the idea of generating premium income purely for investment purposes.

In the next year or two Lloyd's may have to review its system by which traditional markets handle different classes of business, but there will be several problems to face if this issue ever becomes crucial to its members. ■



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• *Pensions & Investments*, BI's sister publication, has compiled a handy, desk-top booklet of the more than 250 **Investment Adviser Profiles** as they appeared in the Dec. 2, 1974, issue. Prices are: \$5 each for up to 10 copies; \$4.50 each for 11 or more copies. To order, send your check, money order or cash to Investment Adviser Profiles, *Pensions & Investments*, 740 N. Rush St., Chicago, Ill. 60611.

• The series of articles that have elaborated the cost aspects, vesting provisions, fiduciary standards, funding requirements, reporting and disclosure aspects and termination insurance provisions of the pension reform law is now available in print form to *Business Insurance* readers. Copies of single articles are \$1 each; the entire series of six articles is \$4. Checks, money orders or cash must accompany order, made payable to *Business Insurance*, 708 Third Ave., New York, N.Y. 10017.

• **Highlights of the Profit Sharing Research Foundation's study** on the largest profit-sharing trusts in the U.S. is now available. This study of companies with assets of \$50 million or more shows that profit sharing is not a "small company phenomenon." Single copies are free; write the PSRF at 1718 Sherman Ave., Evanston, Ill. 60201.

• **The Captive Insurance Company**, a book by Harry New, president of Atlas Management Ltd., is now available. Copies are \$10 each; write the firm at P.O. Box 279, Hamilton 5, Bermuda.

• Important changes in the Medicare law are explained in **Medicare Booklet**, available from the Chicago-based Blue Cross and Blue Shield plans. The financial obligations of patients after Jan. 1, 1975, are highlighted. Free copies of the booklet may be obtained by writing Jim Strong, Blue Cross and Blue Shield, 233 N. Michigan Ave., Chicago, Ill. 60601.

• **LOCUS**, a loss control and underwriting system designed specifically for the construction of power plants, is available from the Synercon Corp. For a free descriptive brochure, write William A. Scanlan, vp, Synercon Corp., P.O. Box 1060, Nashville, Tn. 37202.

• **PAYPLUS**, developed by Pension Planning Co. Inc., is a computerized system to give employees a summary of the value of their fringe benefits. For a free descriptive brochure, write the firm at 355 Lexington Ave., New York, N.Y. 10017.

• **A Practical Approach to Inland Marine Insurance**, a book by James D. Youd, CPCU, is now available through the National Assn. of Mutual Insurance Cos. The author is a teacher and lecturer on inland marine insurance, a member of the Inland Marine Underwriting Committee of the Transportation Insurance Rating Bureau, and the president of Attleboro Mutual Fire Insurance Co. For information on cost and ordering write Dale R. Cummings, di-

rector of education, NAMIC, 2511 E. 46th St., Suite H, Indianapolis, In. 46205.

• Underwriters Laboratories has published a new **Catalog of Standards for Safety**. It is designed to be a handy reference tool when ordering any of UL's more than 300 "Standards for Safety." To receive a copy, write Underwriters Laboratories Inc., 333 Pfingsten Rd., Northbrook, Ill. 60062, attn: National Standards Stock.

• **Questions and Answers on Explosion-Proof Refrigerators** is being offered by Kelmore Inc. The four-page booklet explains why this kind of refrigerator is essential in class one hazardous locations. For a free copy write the Explosion-Proof Refrigeration Div. of Kelmore Inc., 599 Springfield Ave., Newark, N.J. 07103.

• The Health Insurance Institute has published the 1974-1975 **Source Book on Health Insurance Data**. It reports the number of persons in the U.S. with private health insurance protection, amount of health insurance premiums received and benefits paid. Single copies are available free by writing to the Institute at 277 Park Ave., New York, N.Y. 10017.

• A special report on **Working With the New, Tougher Funding Requirements of the Pension Reform Law** is available from Kwasha Lipton Inc. For a free copy write Henry F. Magnusen, Kwasha Lipton Inc., 429 Sylvan Ave., Greenwood Cliffs, N.J. 07632.

• The Research Institute of America has prepared a special comprehensive study of **The New Pension Law**, which provides a discussion, in clear business language, of the law. It is designed to give the executive an overall working knowledge of the requirements so that he can reevaluate his company's plan. Copies of the 56-page management guide are \$15; write Dept. 111, Research Institute of America Inc., Mount Kisco, New York, 10549.

• A pamphlet is available which explains OSHA's new legislation requiring audiometric testing in industry. The pamphlet is available free by writing Industrial Noise Services Inc., Dept. A, 543 Bryant St., Palo Alto, Ca. 94301.

• **Reporting and Disclosure Requirements for Plan Administrators** under the new pension law, a special summary report, has been prepared by Hay Assoc. and Huggins & Co. Inc. Write for free copies to Hay Assoc., 1845 Walnut St., Philadelphia, Pa. 19102.

• More than 100 publications that examine various aspects of property and liability insurance are included in the newly published edition of **Books in Insurance**. The list of books is compiled by the Insurance Society of New York and published in pamphlet form by the Insurance Information Institute. Single copies may be obtained free from the Institute at 100 Williams St., New York, N.Y. 10038.

Uphold ruling: Insurer must pay airline for D. B. Cooper hijacking

MINNEAPOLIS—Globe Indemnity Co. hasn't decided whether or not to appeal the recent Minnesota supreme court ruling ordering the insurer to pay Northwest Airlines \$180,000 of the \$200,000 loss sustained in a 1971 hijacking (*Business Insurance*, Dec. 6, 1971). But Globe did acknowledge that the implications of the ruling could be far-reaching.

"I hate to comment on the implications of the ruling until a decision has been made on whether or not to appeal," said John Szczepek, claims and loss manager for the Minneapolis branch of New York-based Royal Globe Insurance Cos., "but it probably will have a profound impact on existing insurance contracts if it stands."

"We don't know where our next remedy lies," Mr. Szczepek added, hinting that the company may appeal the decision to the U.S. Supreme Court.

The nine-member state supreme court upheld a lower court's ruling that extortion is covered by the broad language of the airline's crime policy. Northwest Airlines' \$200,000 policy carried a \$20,000 deductible.

"AN INSURER must indemnify the insured for payment made by the insured to a hijacker where the policy was a blanket crime policy, as opposed to one insuring for specific risks only," the court opinion, written by justice Lawrence R. Yetka, stated.

"In the event of ambiguity in a policy, the policy language will be strictly construed," the court opinion stated. This would tend to favor the insured party.

Northwest Airlines no longer is covered for crime insurance with Globe, according to an airline employee who did not wish to be identified. The coverage with

Cargill Grain appeal ruling shares costs

MONTREAL—The Quebec court of appeal ruled that half of a \$1,537,017 superior court damage award should be paid to a Winnipeg grain company for the collapse of a grain elevator on the Quebec north shore 14 years ago.

A three judge panel split two to one in favor of reducing the award to Cargill Grain Co. Ltd., upholding the appeal of Foundation Co. of Canada Ltd. and Davis Shipbuilding Ltd. that Cargill share the damages equally.

Cargill's claim, originally for \$2.6 million, was based on the collapse in August, 1960, of an 11-million-bushel grain elevator built by Foundation and Davis at Baie Comeau, 350 miles northeast of Montreal.

Cargill, a wholly-owned subsidiary of a U.S. corporation, launched three appeals against the superior court findings, naming three other defendants besides Foundation and Davis. All three were rejected by appeal court judges.

In its hearing, one judge said evidence established the elevator's collapse was due largely to errors in plans provided by a Cargill employee.

Globe was discontinued about two years ago, the source added.

The celebrated hijacking involved a passenger who purchased a ticket under the name D. B. Cooper. Once airborne, he ordered the airline to pay him \$200,000 ransom and provide him with parachutes.

He took the money and parachuted out of the plane over the Pacific Northwest. The ransom was never recovered and no trace of the mysterious hijacker was ever found including verification that he survived the jump into the heavily wooded territory.

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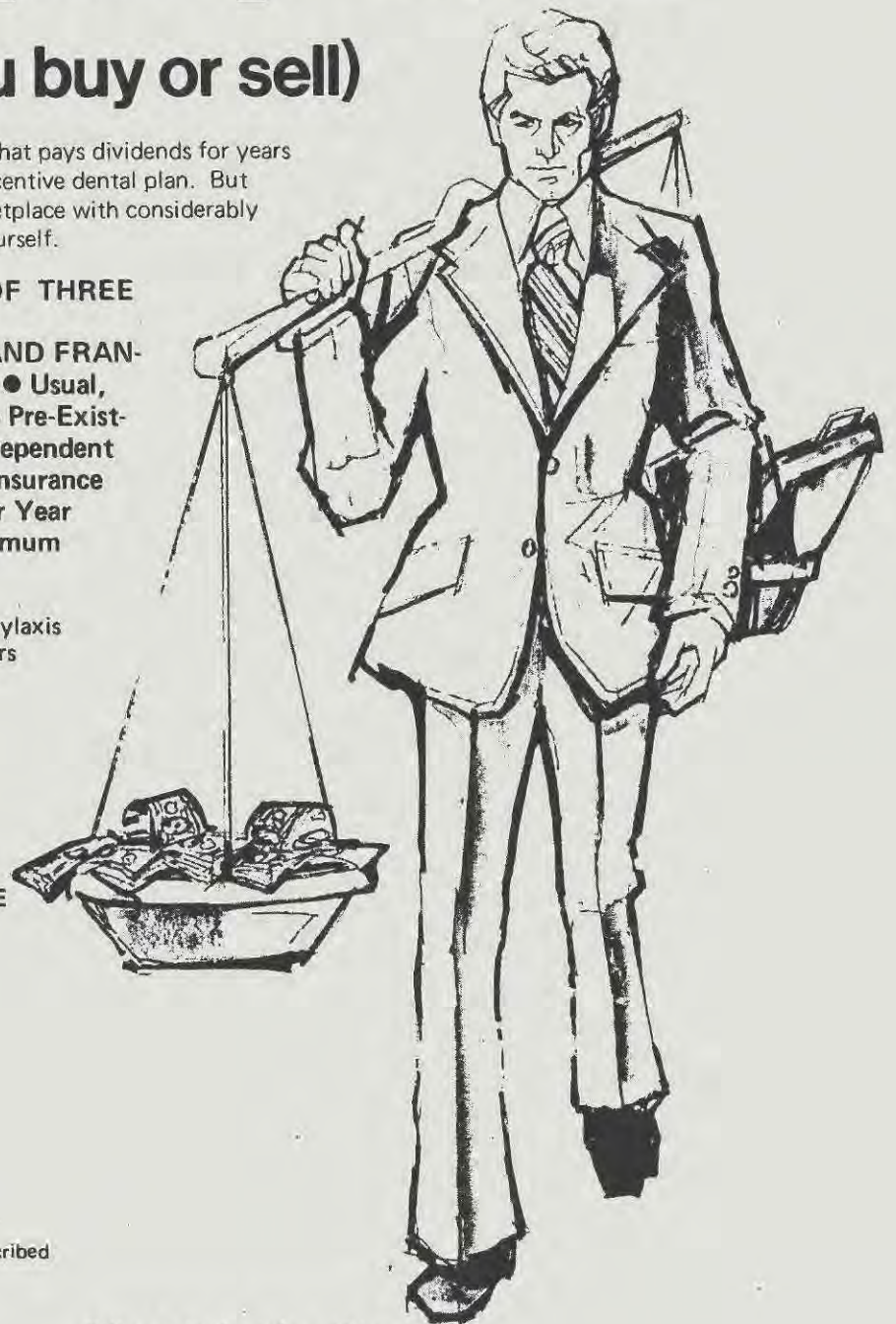
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Authority sees worsening results for insurers in first quarter of '75

NEW YORK—The first quarter of 1975 will be even worse for the insurance industry than were the results of underwriting for 1974, inevitably forcing premiums up.

This was part of an overview of the insurance climate as outlined by Robert J. Schraeder, vp of the A.M. Best Co., in a speech at the Insurance Information Institute's 15th annual meeting at the St. Regis Hotel last month.

A. M. Best has a 75-year relationship with the insurance industry and publishes statistics on the economic health of the companies. Mr. Schraeder said of the firm's most recent findings:

"Since making our estimates of 1974 results of the insurance in-

dustry—results which were the worst since 1932 in terms of the combined loss and expense ratio and the worst in history in terms of money lost in underwriting—since those estimates were published, we have reason to believe our figures are conservative.

"**DECEMBER APPEARS** to have been a bad month; unhappily, it probably is the precursor of an even worse experience in the immediate future. Indications are that the first quarter of 1975 will bring in results that may even make believers out of heretofore doubting regulators who have been slow and niggardly when it comes to rate increases.

"This downtrend in underwrit-

ing affects the whole industry, and there is only one remedy that will do any substantial good—an adequate rate level, with full recognition of inflationary factors," he said.

Mr. Schraeder pointed out that the insurance business is operating today at an expense ratio of about 26% on a premium volume of nearly \$45 billion, as opposed to the situation in the mid-1950s when it was at the level of 34% to 35% with premiums around \$10 billion.

"If the present marketing system is to be maintained, not much more can be whittled from expenses as a means of improving the underwriting account," he cautioned.

The Best vp criticized some state regulators for trying to lower insurance rates in attempts to become instant consumer advocates, but without looking to the long-range effects on insurance company solidity.

"If the regulator will not act responsibly, that is, for example, if he refuses to grant needed increases for political reasons, or worse yet, insists on decreases as happened in Arkansas and Oklahoma—the companies should not hesitate to take their case to court. The insurance industry cannot afford to be the subject of political gamemanship," he said.

MR. SCHRAEDER urged that adequate rate levels be instituted at insurance companies to deal with the worsening underwriting situation, since neither lower expenses, surplus nor investment income nor fresh capital is available to deal with the problem.

In the interests of the policy-

holders, he urged insurance companies not to have underwriting exposure and an investment exposure both relying on the equities market.

"To relate capacity to the vicissitudes of the stock market puts the interests of policyholders too close to the foot of the table," he said.

"The equities—surplus relationship is a problem which we believe demands prompt resolution, and we hope the initiative and the answer will come from within the industry."

He urged the insurance companies to approach their problems responsibly and not communicate them differently to different audiences:

"Companies running combined ratios of 104 or higher are undergoing strain: to discuss it one way with agents, another way with regulators, and still another way with stockholders indicates either that management doesn't understand the situation or that it is playing games rather than dealing with realities," Mr. Schraeder told the industry gathering. ■

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Malpractice study to focus on arbitration

NEW YORK, N.Y.—A \$60,000 grant to study medical malpractice dispute settlement systems now in use and to recommend alternative systems has been awarded to the American Arbitration Assn.'s (AAA) Research Institute here.

The Henry J. Kaiser Foundation and the Commonwealth Fund share in supporting the two-year project.

Dr. Irving Ladimer, director for the project's professional team, said the survey will determine how patients' complaints about medical service and claims of alleged injury are now being handled. Based on the findings, the AAA will recommend methods of better communication and settlement through mediation and arbitration.

"Health plans must have workable systems for handling complaints about medical service and care," Dr. Ladimer said. "Consumer education and participation and the use of arbitration to settle disagreements and appeals are considered by experts to be more effective ways to remove obstacles to a good health service, he added.

NEW GROUP practices and health maintenance organizations (HMOs) are particularly interested in alternatives to malpractice litigation, according to Richard E. Lerner, AAA associate legal counsel who will supervise the analysis of the legal aspects faced by health agencies.

The AAA will issue a manual and explanation for health agencies, doctors and consumers describing existing arbitration methods and recommending how others may benefit from successful practice. The project aims to identify the problems in installing and using a binding or final arbitration system and will develop the best ways of explaining how it works.

The survey will run concurrently with a project supported by the Robert Wood Johnson Foundation to install systems for the prevention and resolution of conflict in health care agencies.

The intention is to show how early introduction of democratic processes such as consumer communications, grievance adjustment, elections, representative management, methods for settling contract and professional disagreements can improve the quality and delivery of service. ■

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View fiduciary liability risk . . .

Continued from page 1

Another leading non-marine insurer at Lloyd's offered: "Because of very large corporate unfunded liabilities and because in many cases pension funds have been used to boost the price of a company's own stock, beneficiaries will increasingly level charges of mismanagement at the fiduciaries."

M. John Manning, managing director of H. Clarkson Ltd., predicted a court test of the new pension law's fiduciary liability provisions within the next 12 to 18 months. In agreement with this opinion is Adrian Dodd-Noble of the Langton Syndicate at Lloyd's, leading underwriter of the fiduciary liability insurance policy being marketed through Mr. Manning and through Professional Indemnity and Great Lakes Agencies in the U.S. Clarkson is a large

Lloyd's broker.

Mr. Manning and Mr. Dodd-Noble also think the law will force benefit fund fiduciaries and investment managers to base their decisions on "prudent expert" standards, rather than continue to follow the "prudent man" rule.

"I think the net effect of the law will be higher professional standards on the part of professional money managers, accountants, actuaries and everyone involved with benefit plans as they are now fiduciaries of the plan assets under the act. They may have to review their own standards," Mr. Manning declared.

"THE ADVICE that (money managers and investment advisers) give to their clients will have to comply with the law, particularly as to the diversifica-

tion of fund assets, so that any possible loss of assets to the company is minimized," Mr. Manning continued.

He said he could not name any specific investment standards that may need revision.

Mr. Dodd-Noble, underwriter handling fiduciary liability policies for his Lloyd's syndicate, believes the pension law "clearly puts it on the line" about an expansion of liabilities which will be interpreted by the courts in terms of a "prudent expert" rule. "A pension or benefit fund can't just go out and get a man off the street to manage the funds. The chosen manager has to be a real expert," he asserted.

"The manager who makes a prudent expert judgment on investments" will have a solid defense against claims of breach

of fiduciary responsibilities, Mr. Dodd-Noble asserted.

"We expect the law to be tested in court," he added. "The first big case will come in about 18 months in my underwriting judgment."

Mr. Manning noted that there will be a lapse of time until the test comes because of the time it will take for the Treasury and Labor Departments to gear up to scrutinize pension plans closely.

ASKED WHETHER this prudent expert guideline, supplanting the previous prudent man rule, would affect the choice of investment advisers, Mr. Dodd-Noble said that "If a pension fund goes to the top bank, to the top investment advisers, instead of the guy around the corner, it's going to be okay."

"The onus will be on a fiduciary to choose people of high repute," asserted Mr. Manning.

Fiduciary liability insurance has been written since 1969 by Lloyd's through Professional Indemnity

Agency, and through Clarkson as the Lloyd's broker, Mr. Manning said. This policy covers only the trustees of the funds themselves, he noted, and not banks as trustees/fiduciaries. "They are in a completely different area," he maintains.

Minimum annual premiums for this Lloyd's policy are \$1,375 for coverage up to \$250,000 annual aggregate limit, \$1,950 for \$500,000, and \$2,500 up to \$1 million. There is a \$1,000 deductible per claim on each of these coverages. The Lloyd's policy covers defense costs in addition to the limit of liability, unlike most policies sold by U.S. insurers whose limits include defense costs.

A policy with a limit including defense costs, said Mr. Manning, has a drawback in that it leaves little, if any, room for damage payments. "In some cases, the defense costs exceed the limit of the policy," he cited as a reason the Lloyd's policy was drawn up to cover defense costs outside the policy limit. ■

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Hospital . . .

Continued from page 1

Paul G. Rogers (D-Fl.), chairman of the House subcommittee on health and the environment.

Public officials, doctors, attorneys, consumers, and insurance companies are expected to be represented at the meeting.

REP. HASTINGS said he expected the companies would be asked to provide some hard data on their costs in offering the coverage.

Sen. Kennedy has postponed from March until April 8 his subcommittee's planned hearings on legislative solutions for the malpractice problem.

The Senator has also submitted a second bill of his own in the malpractice area, which offers an arbitration approach to solving malpractice claims. An earlier bill offered a no-fault approach.

St. Paul Fire and Marine Insurance Co. announced last month that it would not write any new or renewal policies except on a "claims-made" basis beginning June 30.

The claims-made form would replace the present "occurrence" form which pays claims arising out of incidents that occur while the policy is in force, no matter when the claim was made.

BECAUSE OF the long time it often takes for claims to be reported, St. Paul said its actuaries are unable to price the risk on the occurrence form.

The claims-made policy would cover claims reported during the year the policy is in force.

St. Paul said it would guarantee to sell doctors coverage for claims not yet "reported when the doctor retires or otherwise ceases to be insured by the company." The company said this offered the doctors the same degree of financial protection as the occurrence policy.

A St. Paul official has been invited to speak at the March 20-27 meeting and the company's proposal is expected to receive close attention. ■

Transport task force set

The Transportation Department formed a task force to review the hazardous materials carried on aircraft to determine which materials could as reasonably be carried by surface transportation and have no justification for carriage by air. The task force will be headed by William J. Burns, director of the department's office of hazardous materials. It has been ordered to report the findings of its studies within 60 days.

Bechtel initiates worldwide benefit plan for its third country nationals

By ELISABETH M. WECHSLER

SAN FRANCISCO—Enrollment began this month for Bechtel Corp.'s new international insured benefit plan, designed specifically for nonmanual, third country nationals and local nationals assigned to a permanent overseas office.

The program includes major medical, life insurance, voluntary personal accident insurance and business travel insurance, said William A. Weiler, international employe benefits manager.

The contributory plan is aimed at easing one side effect of a highly mobile workforce common to the engineering and construction industry overseas: Lack of continuity in benefits. The plan would cover, for example, a German engineer working for Bechtel in Indonesia.

"Unlike manufacturing corporations overseas," Mr. Weiler explained, "we don't staff permanent facilities except for offices. Most of our staff move every few years and it's too difficult to set up individual programs in each country," he said, adding that U.S. and Canadian personnel take their plans with them as expatriates.

MR. WEILER admitted that the costs of setting up the plan—which does not cover U.S. or Canadian personnel—are "on the high side."

The rates which American International Underwriters (AIU), a division of American International Group, quoted Bechtel "had to be conservative because no actual employe census or demographic information was available," Mr. Weiler explained.

"The cost of the international plan to employes and Bechtel is about 3.0% to 3.5% of average base pay. This is comparable to the cost of our domestic plan," Mr. Weiler said. He declined to be more specific about the interim costs of the plan but indicated that the final rate, based on actual experience, will be "substantially lower."

"Fifteen months from now we will establish a rate based on our true experience," Mr. Weiler said.

Highlights of the coverage are:

- life insurance—up to two times annual base salary, with a maximum of \$100,000 per employe;
- voluntary personal accident insurance—\$50,000 or \$100,000 coverage at the employe's option for accidental death or dismemberment, with lesser amounts available for dependents' coverage;
- business travel insurance—

two times annual base salary coverage with a maximum of \$70,000 per employe and \$350,000 for all employes involved in a common accident;

• major medical insurance—after a \$50 annual deductible, 80% of reasonable and customary charges—paid up to a lifetime maximum of \$50,000 per individual. Maternity benefits are paid at specified flat rates for the more common delivery procedures, but complications of pregnancy are covered at 80%.

"BENEFITS PAYABLE from a government health plan, Social Security or social insurance system, workers' compensation or other mandatory plan for which a Bechtel employe or dependent is eligible are not covered by the company plan," according to the descriptive brochure.

Mr. Weiler explained that in cases where a \$50 deductible is "too high for the locale, Bechtel self-insures a portion of the deductible depending on local customs or requirements or Bechtel commitments."

Bechtel prefers centralized control for premium payment and claims processing, Mr. Weiler said. "This prevents duplication of efforts and costs."

"We report each employe by name indicating the coverage he has on a continuous reporting form," Mr. Weiler explained. "Bechtel initiates the premium statements. Based on enrollment forms, we prepare a monthly premium statement for each operating or service division. That stays in San Francisco. A check payable to the insurance company is made out by the central finance and accounting department. It, in turn, gets reimbursed through accounting for each overseas program," he continued.

Bechtel's insured plan is a U.S. dollar account, Mr. Weiler pointed out, which solves the problem of currency conversion.

"Claims come directly to the international benefits department where they are screened for supporting bills, diagnosis and claims forms," Mr. Weiler said. "Payments are now being made by AIU out of New York but we hope to move the operation here soon."

He explained that a check for a claim is made out to the company for the account of John Doe by AIU because of "the expected lag in payment to some areas of the world." This way, he said, the employe can be reimbursed immediately by an advance payment from the local job site.

THERE ARE SOME problems with non-admitted insurance company laws in some countries, Mr. Weiler said. "In those cases, we work with AIU affiliates and claims are processed locally. The premium is billed in the local currency—for example, such as in Brazil," he added.

He observed that "open and unreported claims in those developing countries where Bechtel is operating reserves are less for international plans than for domestic plans but their retention is generally higher."

Next on Bechtel's list of benefit priorities, according to Mr. Weiler, is a worldwide retirement plan, which may come along in a year or so.

Bechtel Corp. is one of three closely interwoven companies in the Bechtel group. Together, the privately-held companies employ

about 10,000 engineers out of 25,000 full-time employes. About 35,000 temporary personnel work at various construction sites.

Bechtel will not disclose any financial details, but a recent story in Fortune magazine estimated the company has annual profits of \$40 million and gross revenues of \$2 billion a year.

PRIMARILY AN engineering and management company, the Bechtel group reportedly does construction work on only about half its jobs.

The company is operating in two dozen countries and is currently at work on 119 projects worth at least \$25 million each.

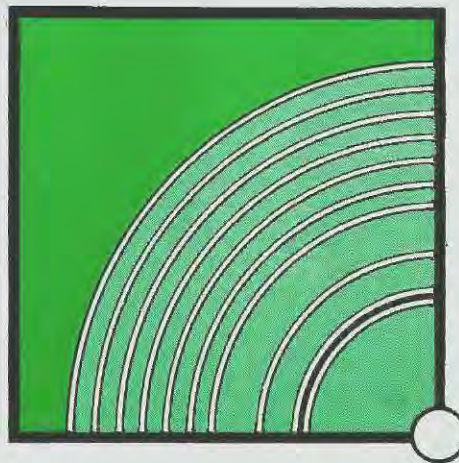
Bechtel Corp.'s principal proj-



Bechtel employes laying pipeline in Indonesia.

ects outside the U.S. and Mexico are in Brazil, Mexico, Spain, Ireland, England (including the North Sea), France, Lebanon, Saudi Arabia, Egypt, United Arab Emirates, Japan, Indonesia and Australia, according to Mr. Weiler.

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Idaho looking

The state of Idaho is looking for a chief of risk management who will be "expected to improve the already existing keen attitude towards reducing the total cost of risk for the state," according to D. E. Chilberg, state director of administration. Job responsibilities "are geared to a total perspective of the risk management process including the familiar risk identification, evaluation, loss abatement, risk transfer and risk retention functions." The successful candidate will work with state employes currently responsible for portions of the risk management activities. For more information, write to Mr. Chilberg, director of administration, Statehouse, Boise, Id. 83720.

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Bermuda preferred site for captive 'no advantage' in Colorado: Report

CHICAGO—Bermuda continues to be the "preferred location" for captive insurance companies, despite legislation in Colorado and efforts by some people to attract captives to that state, according to the latest issue of Risk Management Reports.

The focus of the January RMR is captives, and the report provides information on the latest activities of companies operating captives, along with an up-to-date list of 159 companies with active insurance subsidiaries. The report also includes a bibliography of articles and information sources on captives.

According to H. Felix Kloman, author of RMR, and president of Risk Planning Group, consultants,

Colorado captives are subject to investment regulations in the state, come under the scrutiny of the insurance department and may only write risks of the parent company. "We see no advantages, and in fact see disadvantages in choosing Colorado as the location for a captive," stated Mr. Kloman, noting that some of these disadvantages are less favorable tax treatment for taxes on reserves, and the fact that profits cannot be deferred.

THE REPORT, which is published by *Business Insurance* but not editorially connected with the magazine, suggested that captives do not necessarily require such a conservative retention rule as con-

ventional insurance underwriters: "a capital/surplus-net retention ratio of four to one or two and one half to one would probably be reasonably acceptable," the report noted.

The report named three law firms in New York which are handling the bulk of cases involving negotiations between captives and the Internal Revenue Service. Legal experts, the report said, "feel that there is not only a lack of relevant IRS rulings and court cases, but an ambiguity in the wording of certain sections" of the tax code concerning deductibility of premiums paid into captives.

The latest international tax angle for captives is the creation of the subsidiary on one of the Channel Islands, but managed in Bermuda, thus maintaining all funds within the pound-sterling area, the report noted.

"**MANY CAPTIVES** have been formed by industry associations to insure members," the 40-page study continued. "The Factory Mutual System and Liberty Mutual are perhaps the best examples along with the various marine pools in the United States and England. However, there have been some very interesting recent developments in the formation of jointly-owned captives," Mr. Kloman wrote.

Among the alternatives to captives, Mr. Kloman noted that "the use of retrospective rating plans in the casualty field has been, we believe, the prime reason why many casualty insurance captive companies were abandoned." ■

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135 million people have catastrophic illness cover

NEW YORK—The Health Insurance Assn. of America (HIAA) reported that nearly three of every four Americans under age 65 are insured against the expenses of catastrophic illness.

Of the 135 million people found to be insured, some 81 million are covered under company major medical plans. An estimated 11 million are covered under "high limit policies."

An example cited by the HIAA is the 1.5 million member United Auto Workers' medical plan which provides 365 days of semi-private hospital care and 730 days of convalescent care.

ANOTHER FINDING by the HIAA survey notes that 32 million people have major medical protection under Blue Cross-Blue Shield plans and 11 million under plans like Kaiser-Permanente and Health Insurance Plan of New York (HIP).

"Along with the rise in the number of persons covered for catastrophic health care costs, there has been a significant increase in the breadth of coverage they hold," HIAA president, Leslie P. Henry said.

Surveys conducted earlier, in 1966 and 1973 "demonstrate clearly that maximum benefits have risen dramatically while there has been a reduction in coinsurance—the percentage of covered expenses which insured persons have to pay out of pocket," he added. ■

Beware of the back burner

Every risk manager wants to believe his company's insurance program receives the finest services his broker can provide.

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editorial opinions

A tactless move

THE WHITE HOUSE announcement that the Ford administration will not submit a national health insurance proposal to Congress in 1975 and that President Ford is "almost certain" to veto any national health insurance measure passed by Congress this year is a shortsighted move by the Executive branch of government.

That health care and its accessibility for every American is one of the nation's most pressing domestic issues is a well established fact. That the President should push it to the rear of the priority line distresses us.

The President has said that the decision was based on the state of the economy and his announced intention that there will be a one-year moratorium on all new federal spending programs.

We can't really argue with that. The state of the economy may indeed be more pressing than the state of the nation's health care system.

What we do argue with is the President's tact on the matter. True, the White House has said that the Health, Education and Welfare Department would continue its work in the national health insurance area. However, some of the enthusiasm and momentum must be gone at HEW now that Mr. Ford has brushed the matter aside indefinitely.

The President's action shows a lack of real concern on this pressing domestic issue. How much better it would have been had he said nothing or had he said that this Administration would charge ahead on the subject of national health insurance.

We only hope that responsible members of Congress do not lose their enthusiasm or momentum. The health of the economy will surely improve, and when it does we should be ready to get down to business on national health insurance.

Inflation fighter

ASSISTANT SECRETARY of Labor John H. Stender threw an interesting inflation fighting idea the other day. True it's not a new one, but it is one that's too easily overlooked by top management.

"We can help put the lid on inflation by holding down costs that accompany an unsafe or unhealthy work situation," Mr. Stender told an employe relations conference sponsored by the American Paper Institute.

Mr. Stender, head of the Occupational Safety and Health Administration (OSHA), noted that a study by the National Safety Council recently pointed out that the inflation rate could be reduced about one-sixth by eliminating accidents.

Accidents, according to the council, represent a \$24.4 billion productivity loss in the U.S. Compared with this country's \$1-trillion gross national product, this represents about two percent of the nation's productivity.

"Elimination of accidents would increase productivity significantly while reducing operating costs for business and industry," the Labor department official said. "And since the consumer ultimately pays all costs, increased productivity

and decreased operating costs are two essential ingredients in any fight against inflation."

Mr. Stender said that in a workplace environment free from health and safety hazards, everyone gains: the workers because they can earn a living without sacrificing their health and the employer because of increased production and profits along with the elimination of injury claims.

Pretty basic, you say? Nothing new there. True. But it's too often overlooked by top management. This is no time to scrimp on safety and health measures.

Wise decision

ON THIS PAGE an issue ago (Jan. 27) we wrote of our concern at the reluctance of insurance regulators to disclose the names of insurers whose financial conditions are being monitored closely by their departments.

The words were hardly out of the typewriter when insurance commissioner Stanley DuRose of Wisconsin released the names of 14 companies that have been served with compulsory surplus orders by his department. Mr. DuRose's office also reported that 91 other companies have been ordered to report financial data to the Wisconsin department on a quarterly basis.

At the same time, Mr. DuRose made it abundantly clear that in no instance does he possess data that any of the companies named or ordered to report quarterly is insolvent.

Stanley DuRose has made a wise and prudent decision as a regulator. By putting some information before the consumer he has served what should be his real constituency.

Companies that find their financial strength weakened should not expect anything less than disclosure of the facts; especially in a business as "public" as insurance. By the same token, companies that have not found their way onto an insurance regulator's "watch" list do not deserve anything less than disclosure either—disclosure that they are not on any such lists. In an economic climate such as we have, cheap opportunism thrives on rumors. Disclosure puts the damper on it.

New perspective

DONALD W. BROWN, former risk manager of the State of West Virginia, has been named insurance commissioner in that state. Mr. Brown is the first risk manager to get the top regulatory post in a state, and it should augur well for the profession which in times past has had difficulty even getting the ear of the nation's insurance regulators.

Mr. Brown seems well-equipped for the job. He joined the West Virginia department in 1969. Later he served as acting fire marshall and as an administrative assistant to the commissioner before being named risk manager for the state.

The latter position undoubtedly gives Mr. Brown a perspective on the nature of risk management as a large commercial consumer of insurance. It will be interesting to see how he applies this perspective to the regulatory process, and we wish him well.

letters

This column is a reader's forum. Letters are welcome. Address letters to the Editor of Business Insurance, 708 Third Ave., New York, N.Y. 10017.

Survey booklet

To the Editor: I am inquiring about the article entitled "Top execs: Risk manager's influence climbing," *Business Insurance*, Nov. 25. Is this article available in booklet form?

Russ Brown

Harrison Insurance Center Inc.,
Wichita, Ka.

Editor's note: The article Mr. Brown is referring to detailed the results of our risk management survey of top corporations in the U.S. The article may be made available in booklet form if enough readers are interested, please let us know.

Pension law series

To the Editor: My personal opinion is that the series of articles in *Business Insurance* is the best explanation of the pension law of all the articles I've seen on the subject.

Stanley S. Pearson

Controller, Woolf Brothers,
Kansas City, Mo.

Editor's note: Who can argue with an opinion like that. We appreciate your interest.

Enjoyed series

To the Editor: I have greatly enjoyed the series of articles on Employee Retirement Income Security Act of 1974.

They are the best source of information on the new law that I have come across.

Humphrey D. Ridgely Jr.

VP, Neave-Ridgely Insurance
Center Inc., Waldorf, Md.

Misquoted

To the Editor: In the December 1974 issue of *Business Insurance* which purported to review my talk at the Advanced Management Research Conference on "Liabilities of Directors and Officers and Their Advisors", I was unfortunately substantively misquoted. My subject is so technical, it would have been helpful to have let me check the copy.

The first quote, "Where are you going to get the money if you have a \$5,000,000 judgment against you?" is incomplete, since it is in the context of a derivative action where settlements and judgments (having been paid to the company net of legal expense) simply cannot be reimbursed under any circumstances, something still not understood by too many. The second item covers availability of

Continued on page 20

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'75 RIMS conference in Dallas, April 20-25

NEW YORK—The Risk and Insurance Management Society (RIMS), formerly the American Society of Insurance Management (ASIM), will hold its 13th annual risk management conference during the week of April 20-25 in Dallas, Tx.

The conference theme, "Out of the Past . . . Comes the Future," will mark the society's 25th year as a national organization.

Ronald Reagan, former California governor—turned radio personality, and Leslie Robert Drew, deputy chairman of Lloyd's of London, are both on the program. The society said in New York Mr. Reagan had not yet confirmed what his topic will be.

A preliminary program releas-

ed by RIMS includes special panels on the future of risk management; the impact of the 1974 Employee Retirement Income Security Act on employee benefits; and political risk insurance.

The week-long conference will feature a silver anniversary panel which will look into the future of risk management, a session on Canadian risk management and other sessions on political risk insurance, large property losses, international risk management, captives and risk management for financial institutions.

MINI-SEMINARS in property/casualty include: products liability, kidnap and extortion insurance, property values and inflation, the

NASI system analysis techniques for loss control, large deductibles, self-assumption, workers' compensation and risk measurement.

Employe benefits workshops will include HMOs, labor negotiations, national health insurance, group dental plans, Canadian and international benefits.

Also featured will be a panel about the adoption of new accounting rules proposed by the Financial Accounting Standards Board, which threaten loss reserves set up by companies that self-insure risks. The FASB has urged the elimination of the practice of accruing for potential losses.

The various conference programs are scheduled to take place at three different hotels in Dallas. Industry sessions and employe benefits will be discussed at the Sheraton-Dallas Hotel April 21 through April 23; property-casualty exposures will be handled at the Fairmont Hotel

April 23 through April 25. Additional sessions will be held at the Statler Hilton.

B.P. RUSSELL, chairman of the board of Crum & Forster, will be panelist on the future of risk management. Others on the panel include Joe Christie, Texas insurance commissioner, and E. William Alstaetter, Rockwell International's director of risk management and current RIMS president.

This year's conference, a RIMS spokesman said, will also include a session based on a survey of how executives view their employe benefits.

In all, more than 125 sessions, including 50 mini-seminars, 25 workshops, and 25 industry sessions, are on the agenda for the conference.

For additional information, including programs and registration forms, write RIMS, 205 East 42nd St., New York, N.Y. 10017. ■

letters

Continued from page 18

D & O. I did not say it was "Readily available"; it is *more* readily available, a distinction with a difference. Some companies would love to buy it but cannot. I didn't "warn" of certain insurers. I said only a few were underwriting it independently. All companies with the same reinsurance in London will probably not be too competitive with the other. How could they be? I did suggest a competent, knowledgeable broker who understands the subject and the marketplace (this was not quoted). As to deductibles, I did not say the usual deductible is \$20,000. What I said was, "Originally there was a standard deductible of \$20,000 per occurrence." I said now there are many variations including triple deductibles, i.e., one per person, one where more than one person is involved, and a third for the reimbursement section. I went on to say the insured should understand that in the application of split deductibles, the reimbursement deductible may be the one used where claims come under both sections. Suits against the corporation are never covered. This is a people policy; the corporation is involved only when it can obtain reimbursement from the insurer for having indemnified its own people. As to the Employee Retirement Income Security Act, I did not say, "No D & O policy will take care of litigation brought against pension plan trustees". Actually, I said I have personally arranged such coverage under a D & O policy. What I said was there was controversy among lawyers as to whether the standard unamended policy would or would not cover.

Stanley L. Wallace

vp, Johnson & Higgins, New York, N.Y.

Banking thesis

To the Editor: The December 23rd 1974 issue of *Business Insurance* contained an article by Paul R. Merrion on Mr. John R. James thesis "Risk Management in Banking" submitted to the Stonier Graduate School of Banking at Rutgers University. I would very much appreciate if you could advise me where I might get a copy of Mr. James thesis as it would be of interest to me relative to a project presently being undertaken on this bank's insurances.

I would also be interested in obtaining a copy of the article "Top executives: Risk Manager's influence climbing" mentioned in your letters column.

G. P. Long

Purchasing Officer, Bank of Ireland, Dublin

Editor's note: The American Bankers Assn. published Mr. James's thesis from Stonier. The ABA can be reached at 1120 Connecticut Ave. N.W., Washington, D.C. 20036. There is a charge of \$7.50 per copy. We've sent a copy of the risk management article.

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An invitation

Readers are invited to respond to stories in *Business Insurance* and to events having an impact on insurance and risk management. The letters to the editor column, at its best, can provide a valuable forum for readers' views on trends as well as matters affecting management and funding of risks. Address letters to the Editor, 740 N. Rush St., Chicago, Il. 60611.

Nationwide, job-related fatalities drop 7% in '73

WASHINGTON—Job-related fatalities dropped 7% in 1973, to 5,100 from 5,500 in 1972, the Bureau of Labor Statistics (BLS) reported in its first nationwide comparison of overall job-related injury and illness rates.

The Labor Department said the entire package of results in the survey represented "positive evidence that efforts to reduce the toll of job deaths, injuries, and illnesses are succeeding."

All five industries targeted for special emphasis by the Occupational Safety and Health Administration (OSHA) because of high injury rates showed across-the-board reductions in incidence rates (the number of recordable deaths, injuries and illnesses per 100 full-time workers).

Assistant Labor Secretary John H. Stender, head of OSHA, said these reductions show beyond any doubt that concentrated attention to job hazards by a labor-management-government team can reduce work place risks.

THE INJURY and illness incidence rate for all industries combined, however, only declined to 10.9 in 1973 from 11.0 in 1972. OSHA officials noted, however, there was an increase of 270,000 recordable cases in 1973, largely due to an increase in employment during 1973 of nearly three million.

Mr. Stender said he believes the 1973 rate does reflect an increase in reporting accuracy, but also an overall drop in the frequency of recordable cases. That offset the increase in reporting and resulted in virtually no change between the two years, he said.

"This is heartening," he said, "because it means that when the survey results for 1974 are tabulated, we should see significant drops in all areas."

The mandatory survey involved a national sample of about 200,000 private employers. Another 450,000 employers were included in the survey so states could produce similar estimates. Reported occupational injury and illness data were based on records employers maintain under the Occupational Safety and Health Act.

The survey also found about 5.9 million work-related injuries and illnesses occurred in 1973, up from an estimated 5.7 million in 1972.

LOST WORKDAYS in 1973 due to injury or illness amounted to about 28 million, BLS said, compared with about 24.7 million in 1972.

On the average, about one in every 10 workers suffered a job-related injury or illness in 1973, the same approximate ratio as in 1972.

The five OSHA targeted industries were roofing and sheet metal work, meat products, lumber and wood products, miscellaneous transportation equipment, and water transportation services.

Despite the 1973 decreases, injury and illness incidence rates remained substantially higher in these industries than the national average of 10.9.

Roofing and sheet metal dropped 4.2% to a rate of 27.7 in 1973 from 28.9 in 1972; meat products dropped 3.5% to 27.2 from 28.2; lumber and wood products dropped 5.1% to 24.1 from 25.4; miscellaneous transportation equipment dropped 2.7% to 35.5 from 36.5; and water transportation services dropped 2.6% to 26.2 from 26.9.

OSHA said that because of improvements special emphasis programs will continue but on a

decentralized basis.

Mr. Stender said, "We are testing now, and will put into full effect July 1, 1975, a program where each of OSHA's regions will select its own target industries for special inspection emphasis."

IN THE JOB fatality area, the largest decrease in the number of deaths in 1973 occurred in the contract construction area, which fell to 1,000 from 1,500 in 1972.

Trenching and excavation activities in construction, which have had relatively high fatality experience, were among the targets of special OSHA attention, BLS said.

Despite the decrease in deaths, BLS said the contract construction industry still reported a "significant" 4.2% rise in overall injury

and illness rates in 1973, compared to 1972.

In almost every industry division, the very large (2,500 employees and over) and the very small (one to 19 employees) reporting units showed decreases in overall incidence rates between 1972 and 1973.

In both 1972 and 1973, about three in every 10 injuries and illnesses resulted in absences. The average number of days lost per case rose from 14 in 1972 to 15 in 1973. The incidence rate of lost workdays (number of lost workdays per 100 full time workers), another measure of severity, increased from 47.9 in 1972 to 52.0 in 1973.

In what has become the increasingly sensitive area of occupational illnesses, BLS reported a decline of over 15,000 illnesses,

or about 7%, between 1973 and 1972. The 1973 total was 195,000 cases, down from 210,000 in 1972.

BLS SAID THAT contract construction accounted for about 626,500 recordable injuries and illnesses, slightly over 10% of the 5.9 million total, while the industry represented about six percent of the total employment.

Manufacturing, which accounted for nearly one-third of employment, had almost half the number of recordable cases. Among 20 major groups within the manufacturing division, 10 had incidence rates above the 15.3 all-manufacturing average.

In manufacturing, the highest rates were generally concentrated in reporting units of 100 to 249 employees, with reporting units of more than 1,000 employees or less

than 50 faring better.

Based on preliminary figures compiled by the Mining Enforcement and Safety Administration (MESA), BLS reported that mining, with an incidence rate of 12.5, exceeded the all industry rate of 10.9 in 1973.

Coal mining, with an incidence rate of 19.1, was much higher than the other two major groups in the mining industry—oil and gas extraction (12.8) and metal and non-metal mining (7.8).

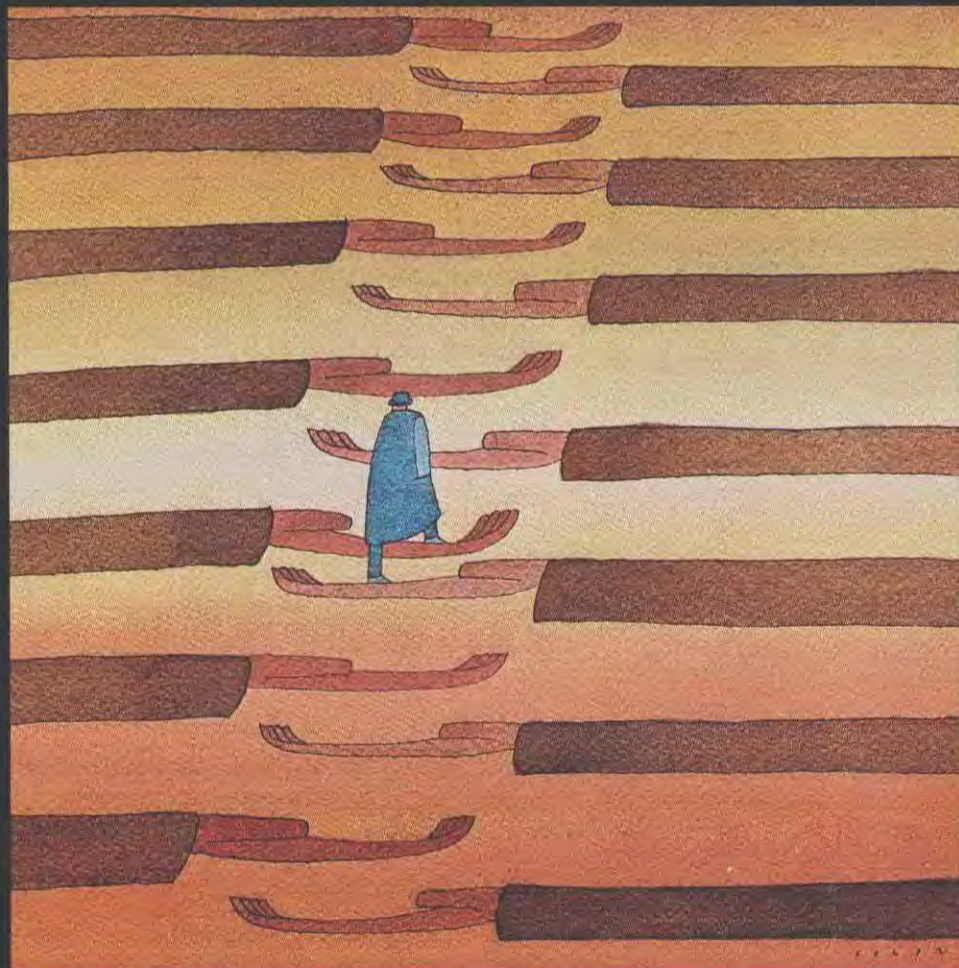
Injuries and illnesses in the mining industry were also much more likely to result in lost worktime, BLS said. Of the nearly 76,000 recordable cases in mining, 35,000 or 46%, involved lost worktime. There were 300 fatalities reported in coal, and metal and nonmetal mining activities during 1973. ■

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Payne favors no-fault as malpractice solution

LOS ANGELES—Describing the medical malpractice insurance situation in California as "an emergency," outgoing state insurance commissioner Gleeson L. Payne told *Business Insurance* he proposed the creation of a state-supported no-fault system of medical malpractice coverage.

"The problem," he said, "stems from the fact that, according to my figures, no carrier in California has made money in medical malpractice and many have lost money, in fact, millions of dollars."

He said the emerging malpractice insurance crisis is compounded by the dramatic decline in the number of underwriters serving California physicians. Today, he said, there are only four: Travelers Insurance Co., C&A Insurance Co., Argonaut Insurance Co. and the Signal-Imperial Insur-

ance Co. By contrast, as recently as early 1974 there were 10 underwriters issuing malpractice policies in the state, he said. Prior to that, there were as many as 40 or 50 malpractice underwriters in the state.

Taken as a whole, California doctors annually pay between \$80 million and \$100 million for malpractice coverage, according to Commissioner Payne, who left his appointive office Feb. 1. He said that the average doctor in the state pays about \$4,000 a year in malpractice premiums—although certain specialists pay as much as \$40,000 annually.

"WHEN PACIFIC Indemnity bowed out, about 1,000 physicians were left without malpractice coverage," he related. That situation could grow far worse, he

said, if Argonaut Insurance which covers doctors in San Francisco, Marin, Alameda and Contra Costa counties, decides next May 1 to tell its doctor policy holders that they will have to look elsewhere for coverage.

"If Argonaut decides not to renew the approximate 4,000 physicians it covers in North California, I see no one on the horizon who will take these physicians," Commissioner Payne declared.

However, if Argonaut decides to renew the 4,000 policies, he predicted it will demand a "whale of a premium increase."

To head off an immediate crisis in medical malpractice in California, Commissioner Payne said he has developed a three-step plan. As a first move, he said he has asked 10 carriers, including the four now writing malpractice in

the state, to volunteer to offer coverage for the next 90 days to six months.

To create a less inflationary, more effective, permanent malpractice system, he disclosed that he has suggested legislation that would mandate property/casualty insurers in the state to create an insurance pool to handle the policies of the physicians left without coverage.

"UNDER MY PLAN, all property/casualty underwriters doing business in California would have to assume malpractice business in direct proportion to the percentage of p/c business they write in California," he elaborated. For example, if a company writes 1% of the property/casualty coverage in the state, then it would have to assume 1% of

the malpractice business.

At the same time, he acknowledged that his actuaries have informed him that premiums will have to rise, probably from the average of \$4,000 a year to \$6,000.

To place a permanent lid on premium cost hikes, he recommended that the state establish a no-fault system of handling malpractice claims, with a set schedule of benefits, similar to that of workers' compensation.

"We figure that between \$40 million and \$50 million a year in California goes to attorneys involved in malpractice cases," he pointed out. He said that for a no-fault malpractice insurance system to be established in California, state laws must be altered.

The state legislature is currently preparing bills based on his proposals, he said, adding:

"I've given the (Gov. Edmund G.) Brown administration my position paper and administration spokesmen have expressed concern."

"I'm not too encouraged about the chances of the legislation's being enacted," he admitted, noting there will be certain opposition from lawyers.

The public, too, might resist accepting a set schedule of malpractice benefits, Commissioner Payne added. This is why he favors a thorough public airing of the effect of malpractice costs on overall medical expenses. ■

Exemption proposed for pension law

WASHINGTON—The Labor Department proposed a regulation that would exempt unfunded welfare benefit plans from a requirement in the pension reform law that the plans be operated as a trust.

The trust requirements are considered unnecessary for such unfunded plans, the department said, because these plans have no assets which could be commingled with assets of persons managing such trusts.

The regulation defines an unfunded welfare benefit plan as paying benefits only from general assets of the party establishing such a plan. However, employees cannot make contributions to the plan, and the plan cannot maintain a separate bank account if it is to be considered unfunded.

Despite this specific exemption, persons who manage unfunded welfare benefit plans are still subject to all the other fiduciary responsibilities and reporting and disclosure requirements of the law, except those specifically exempted. ■

Special Risks Assn.

A new accident/health special risks association was formed in New York. The American Special Risks Assn. (ASRA) lists as its goals: "To achieve professional recognition for its members within the insurance community and to provide an organized social program for the benefit of ASRA participants." The association is comprised of brokers and underwriters. Recently-elected officers include Peter Franco, president, from Johnson & Higgins; James Amadei, American Home elected vp; treasurer, Al Grippo, Frank B. Hall; secretary, Penny Zupicich, Alexander & Alexander.

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Most small groups covered for basic benefits, eyeing more sophisticated

By LINDA MOSKOWITZ

NEW YORK—If small business employers are willing to cope with higher rates and less flexibility in their employe benefit packages, the consensus among insurers and brokers is that these business owners are able to buy coverage at costs equalling that of large corporations.

In fact, one broker feels that small groups are the best targets for innovative policy sales, as these groups have a smaller loss impact to consider when purchasing new benefits.

Dental benefits are one form of coverage John Buchanan, of Marsh & McLennan's Riepe, Buchanan & Piper division, sees as a "hot item" in the small group market.

Legal insurance, preventive health care, and vision care are other areas which he believes "can be much more quickly implemented in small groups," than in large corporations.

Yet, despite Mr. Buchanan's optimism, many insurers remain cautious toward benefits which have not yet become part of the standard package.

DENTAL INSURANCE, currently the most popular of the new small-group options, if offered, is usually for groups of 10 or more.

No dental insurance for small groups is offered by the Hartford Group, where Lawrence Rupp, vp, claims "there is not much demand for it in these small companies."

Insurance Co. of North America (INA) also does not offer dental coverage for small groups. "We don't see a big market for it," said John Stozenski, assistant vp in the group department, putting this coverage on a par with legal or group auto insurance.

"We think it's purely swapping dollars," Mr. Stozenski continued. "It's pretty tough to insure against normal body deterioration."

While dental care is slow to catch on in most small-group insurance packages, comprehensive medical plans, with maximum benefits as high as \$1 million, can be more easily found.

Mutual Life Insurance Co. (MONY) offers dental coverage, as well as a \$1 million limit on major medical, to small groups.

MAJOR MEDICAL policies are fairly common for small groups under 10, especially in New York state, where they are offered mostly as supplements to Blue Cross/Blue Shield basic health care coverage, and are known as wrap-around policies.

Life insurance is also a standard coverage in small-group plans, but insurers will frequently require medical proof of insurability for each member in groups under 10. If such proof cannot be provided for just one or two members, the group may be ineligible for group life coverage.

A further restriction on small groups is a compulsory minimum amount of life insurance to be purchased.

The average minimum is \$5,000, claims Jennifer Enanti, benefits coordinator of Frank B. Hall. With groups over 10, this minimum is often lower or nonexistent, Ms. Enanti commented.

Costs in general for the small group are higher than for groups over 100; often as much as 15% to 20% higher, according to Mr. Rupp. But a discount, especially in the life insurance area can be

obtained by membership in a multiple employer trust (MET).

METS ARE sponsored by insurance companies, consulting firms or professional and state trade associations, and form one large group from many small groups to provide lower insurance rates.

Regulations for METs vary from state to state, often requiring these groups to be formed by industry, or sometimes allowing membership to remain open-ended.

Such measures allow the small company employe to enjoy "more sophisticated coverage on better contractual terms," according to Mr. Buchanan.

"Prices are much more favorable," he continued, citing a 20% to 30% premium savings with METs, compared to individual small group policies, in a conservative estimate.

State-wide professional groups are often more effective than the national groups, Mr. Buchanan believes, due to the homogeneity of a regional group which allows for clearer understanding of the group's insurance needs.

Riepe, Buchanan & Piper of Iowa acts as broker for professional organizations in the Midwest, including the Iowa Independent Telephone Assn. (IITA), made up of 168 telephone companies, including several large companies and many more small, non-

unionized, rural operations.

It is the smaller firms, where automation has had a "shrinking effect" on their staffs, that Mr. Buchanan explains "can hardly buy anything on their own," and benefit most from professional or trade association trusts.

THE IITA now offers members group life, comprehensive health with major medical and a \$250,000 per cause maximum limit, long-term disability, and a pension plan.

No dental coverage is provided, although this has been briefly discussed, according to Kent Jerome, executive secretary of the association.

All benefits offered by Riepe, Buchanan & Piper are provided on the cafeteria style, which means no pre-packaged plans and employers choose options as they need them.

One new package on the market, just under a year old, is All-

state's "Business Owner's Deluxe Policy," which provides liability, property, casualty, and crime protection insurance.

Although rates could not be quoted for this policy, they were termed "competitive" by a spokeswoman, who termed sales "smashing."

"We think this is a big market," said the Allstate spokeswoman, referring to small business employers, claiming that "there are many more small businesses than large corporations in the country," and adding that the small group market has been "largely untapped."

Benefit plans for groups of three to 25 are also offered by Allstate including life, disability income, accidental death, basic health and hospital coverage, unlimited major medical, and maternity benefits.

In addition, Allstate currently administers seven METs, in as many different industries. ■



How good is Michigan Mutual Service? (Some clients send bouquets our way!)

Angela Massa, a Michigan Mutual Service Representative, did, indeed, receive flowers from a lady for whom she handled an automobile claim. Of course, the bouquets don't happen every day. We really don't expect or encourage them. As a leading insurance writer for over 60 years, we've always been committed to providing day-in, day-out, prompt, personal service. We try to put ourselves in your shoes when you need assistance. Our special policy has always been to provide the best in property and casualty insurance. **NOW LIFE, TOO!**

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Health plan includes dental, vision, hearing

HARTFORD, CT.—Travelers Insurance Co. is marketing a new group health care package which includes dental, vision, and hearing benefits as well as routine annual medical check-ups.

Called the Care-Pak plan, the package is being offered to employee groups of 25 or more persons, according to Christian Paul, vp-underwriting.

The plan pays 100% of preventative dental services including oral examinations, teeth cleaning, fluoride applications, and emergency office visits; 85% of general services such as x-rays, fillings, extractions and oral surgery and 50% of prosthetic services. The maximum benefit the plan pays for each insured family member is

\$1,000 per year.

Care-Pak vision benefits include eye examinations every 12 months, a pair of prescription lenses every 12 months and a set of frames every 24 months.

HEARING BENEFITS include 80% of the cost of the following: tests to evaluate the extent of hearing loss, preparation and fitting of an ear mold and the hearing aid itself. Maximum amount payable for each insured family member is \$300 in a three year period.

Medical benefits, which are optional, include physician's charges for a physical exam, all x-rays and laboratory tests, including a pap smear and multi-phasic

screening. The maximum benefit payment is \$50 in any calendar year for each insured family member.

The Care-Pak plan can be written either with or without deductibles, Mr. Paul explained. Average cost of the plan, with no deductible for the dental benefits, is \$20-\$25 per month per employee; if a deductible is included for the dental benefits, the cost will average \$11-\$12 per employee, per month.

However, the cost will vary according to geographic location and characteristics of the group, Mr. Paul added.

"This is the first time I know of that this combination of benefits has been marketed to groups other than large-scale ones," Mr. Paul stated.

Since Care-Pak's appearance in the market in late December, "a number of proposals are under consideration," the underwriter added. ■

Safety engineer calls noise standards 'inept'

HARTFORD—The safety engineering manager of United Aircraft Corp., largest industrial employer in Connecticut, has labeled proposed federal safety standards for noise "inept" and, if made law, a needlessly expensive burden for employers.

Jimmie A. Martin, who is also a member of the Connecticut state committee on occupational safety and health, charged that the proposed standards, detailed recently in the Federal Register, set excessively low noise levels for work places in which employees wear ear plugs.

The proposals, he continued, also tell how to measure a factory's hearing, but without noting that

people, in the main, naturally lose some of their hearing with age.

Mr. Martin remarked that the proposals also include formulas that set a lower noise ceiling for workers moving from one area to another during the day than for those staying in one place.

IN THESE respects, he told fellow committee members, the proposed standards differ markedly from the recommendations of both the National Institute for Occupational Safety and Health (NIOSH) and the department's own advisory committee.

The department staff members, he said, did not make the changes deliberately, but, rather, came up with a careless "cut and paste" job adapting recommendations.

At Mr. Martin's urging, the committee voted to request that state labor commissioner Jack A. Fusari seek a delay in the process by which the proposed standards become law.

Significantly, a spokesman for the Occupational Safety and Health Administration (OSHA) of the U.S. Labor Department has denied that the proposed noise standards differ in any striking way from those recommended by NIOSH and the advisory committee.

The spokesman added that any differences could be called simply "cosmetic."

He said, moreover, that projected cutoff date for public comment on the standards was not rigid, with proposals to be accepted through the end of January, at which time the federal agency will hold public hearings in Washington.

And the proposals, he said, would not become law until at least two weeks after the hearings. ■

Rates up for Pennsylvania Blue Shield

HARRISBURG, PA.—About 2.8 million of Pennsylvania Blue Shield's 6.2 million subscribers will experience increases amounting to \$23.9 million a year in their monthly rates beginning in February, according to the state insurance commissioner, William J. Sheppard.

The main reason for the increases ranging from \$1.12 to \$2.63 a month is to offset a \$16 million loss in 1974, Mr. Sheppard explained. He added that Blue Shield had operated at a substantial loss for several years.

"I believe that any further decline in Blue Shield's reserves would seriously threaten the financial stability of the plan," he added.

Because the increase does not become effective until Feb. 1, the increase for 1975 will amount to \$18.5 million.

A public hearing was held Oct. 15 on Blue Shield's rate request. ■

Another Poe merger

Poe & Assoc. Inc., a Florida-based independent insurance agency, announced completion of its merger with the William P. Toole Agency Inc., also located in that state. The Toole Agency, whose entire stock was acquired by Poe, will operate as a division of Poe, it was learned.



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Require fidelity bonds for pension fund officials

By MARIE KRAKOWIECKI

NEW YORK—A Labor Department official here said the final bonding regulation under the Employee Retirement Income Security Act of 1974 will require pension plan officials to buy fidelity bond coverage for themselves even if the plans they administer are fully insured.

The bonding requirement was supposed to have gone into effect the first of this year. But late last month, the Labor Department was still advising plan officials to follow directives laid out in the older Welfare and Pension Plans Disclosure Act.

Despite wording in the preliminary form of the new pension reform bill, section 412, which reads that a fiduciary of a benefit plan need not be bonded if it "is authorized under such laws (of the United States of any state) to exercise trust powers or to conduct an insurance business." The department official told *Business Insurance* that the final form of the regulation will require even insured retirement plans to have their plan officials bonded.

THIS REQUIREMENT promises not only to produce a surge of business in the fidelity bonding departments of insurance companies, but may soon prove to be the most violated section of the new pension reform bill, according to one life insurance actuary.

Howard Hennington, vp and chief actuary of the National Health & Welfare Retirement Assn., which functions largely as an underwriter for retirement plans of non-profit organizations in the health and welfare fields, voiced concern last month that many of the association's participants might not realize their obligations to get fidelity coverage.

Mr. Hennington pointed out the possibility exists that the new law might require fidelity bonds for plan officials even if they have as

little to do with the plan as writing out premium payment checks to their insurance companies.

"It hasn't been settled yet that this will be the case," the actuary said, "but if they do make it mandatory to bond even premium check-writers, the bonding requirement of the new pension law will probably be the most violated provision of the bill."

Many of the non-profit organizations that buy coverage through the National Health & Welfare Retirement Assn. are small operations with as few as 10 plan participants, Mr. Hennington noted.

UNDER PROVISIONS of the Welfare and Pension Plan Disclosure Act, organizations with fewer than 26 participants were not obligated to bond officials.

"Not any more," the Labor De-

partment said last month, confirming there will be no exemptions from the bonding requirement even for the smallest retirement plans.

The Labor Department said it has no idea what the new requirement will mean to bonding departments of insurance companies. But one official reached at the fidelity bonding division of Aetna Life & Casualty said there has been a great amount of activity.

"A lot of people who should have bonds even under the old law, but ignored doing so have been buying fidelity bonds. There have also been a lot of smaller operations buying fidelity bonds for the first time," he commented.

"I'd say about 60% of new fidelity bonding coverage here is written for the smaller plans. We have done some more bonding for me-

dium-size companies, but usually your larger companies already have bonding coverage added in their corporate insurance package."

PRELIMINARY requirements by the Labor Department on the bonding issue outlined that plan officials must have minimum \$1,000 bonds and the limit would extend up to \$500,000 bonds. For larger companies, bonds could be higher than \$500,000, but that would be decided on an individual basis.

The Aetna bonding source said his department hadn't been writing fidelity bonds with as little as \$1,000 in coverage, indicating that even the smallest plans were going for more protection than the minimum required under the new legislation.

"The average size bond we write

in a case like this is usually \$5,000 to \$10,000. The premium depends on the number of trustees covered, of course. But you can get \$5,000 in coverage for a \$133 premium for three years. \$500,000 in fidelity bond coverage costs \$750 for the same amount of time. Both types cover up to five trustees. Ninety-nine percent of your plans have two, three, or four trustees," the bonding source said.

Despite the Labor Department's statement that fully-insured plans will need to have administrators bonded, insurance industry officials are confused about whether the law will apply to insured plans.

"As far as we know," one fidelity bond writer said, "plans with insurance company trustees are exempt, and that's how we've been advising clients." ■

Provide new insurance for fiduciaries

HARTFORD—Fiduciaries seeking liability protection from losses resulting from breaches of their responsibilities as defined by the Employee Retirement Income Security Act of 1974, can purchase a new policy meeting their needs from Aetna Life & Casualty.

A minimum annual premium of \$450 will provide \$250,000 worth of coverage. There is a \$1,000 deductible that is not applicable to legal expenses.

Policy limits apply to all claims made within the policy period of one year. Rates are based on total assets of the fund and the number of participants.

Aetna reports "a lot of sales" so far. The new law becomes effective January 1, and will hold fiduciaries personally liable for the full extent of losses attributed to violations of the Act. ■

Insures Panda pairs

Two pairs of Pandas from China, scheduled for a permanent home at the Columbus zoo, are insured for thirty days in their new habitat by the Rhulen Agency, a Monticello, N.Y.-based firm. It is assumed that after 30 days "the Pandas will have acclimated to their environment," according to a Rhulen spokesman. The agency specializes in insuring exotic animals

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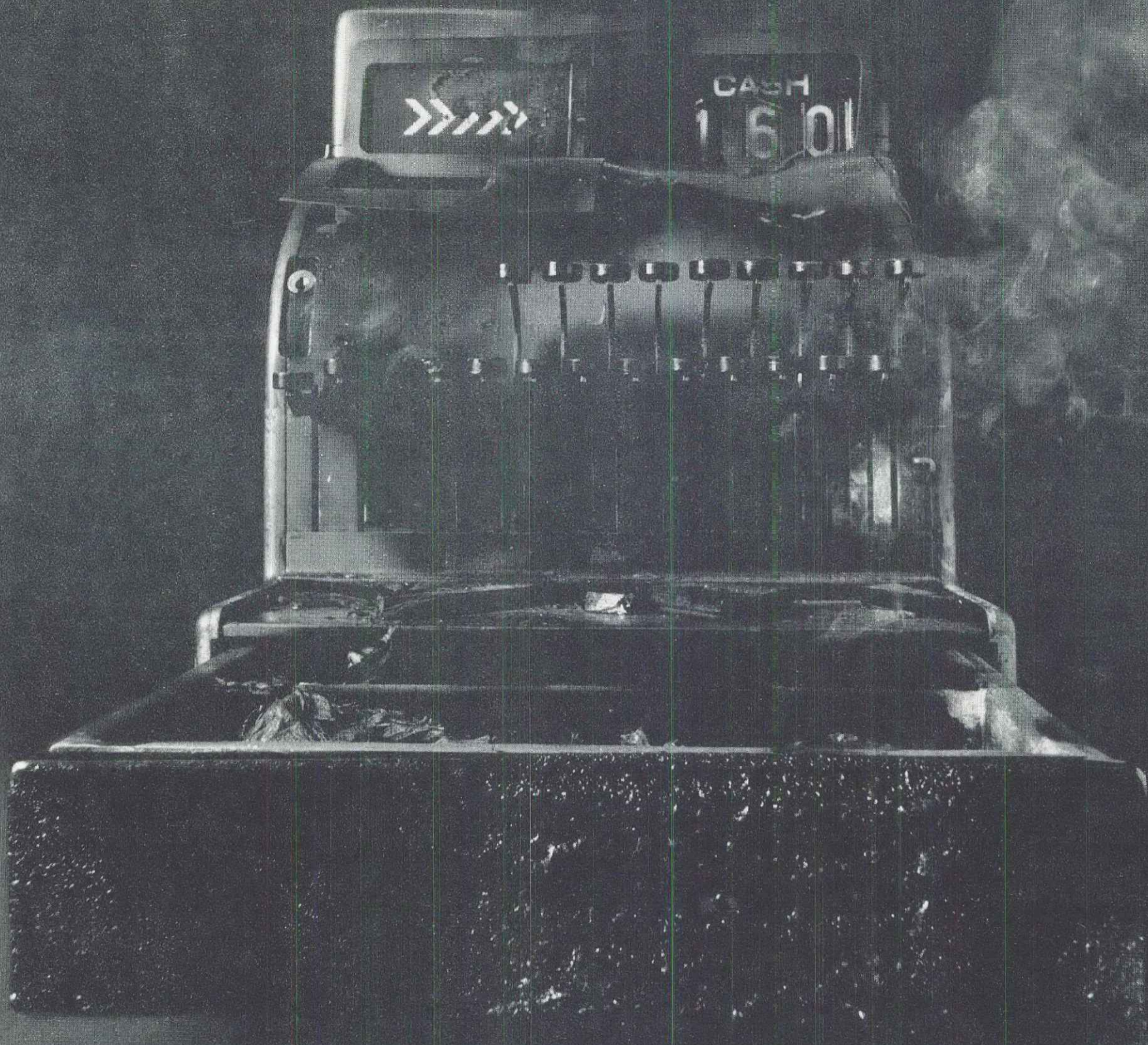


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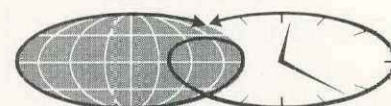
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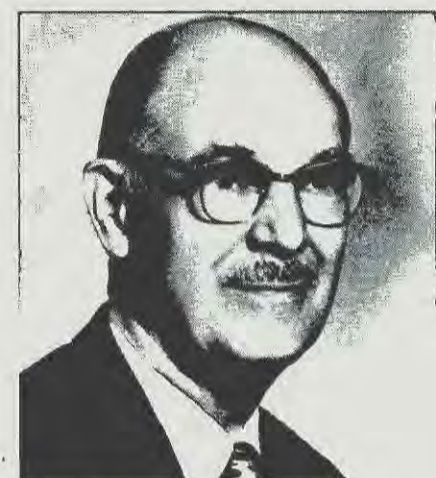
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PERSPECTIVE

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By WILLIAM H. RODDA

Pres., Marine Insurance Handbook, Inc.
Chicago, Illinois

INSURANCE TO COVER the replacement cost new of damaged or destroyed property sounds like a very good idea. It is a good idea where it fits the needs of the property owner, but it creates some problems, and it may be expensive.

Replacement of "new for old" is almost as ancient as insurance itself. Many years ago ocean marine underwriters established a

practice known as "thirds off." An underwriter would deduct one third from a loss payment whenever a ship's hull was repaired using new material to replace old material. However, it developed that this practice encouraged the use of old material in making repairs, and this could constitute a safety hazard.

Underwriters began to waive any right to take "thirds off." New material was used to replace old and worn material without any deduction for the depreciation. This "new for old" replacement also became standard in the aircraft insurance business. It is unthinkable that a used or worn part would be used in making an airplane repair because of the possible safety hazard.

RATES FOR OCEAN marine hull insurance and for aircraft hull insurance take into account the fact that there will be no deduction for depreciation in adjusting a repair claim. There may not be any identifiable factor in the rates for the new-for-old adjustment but the charge is there.

There are many other circumstances where insurance coverage is actually on a replacement cost basis even though it is not so stated. Insurance policies usually cover for the "actual cash value" of the property. (We discussed the meaning of "actual cash value" in our *Business Insurance Perspective* article in the May 10, 1971 issue). There are many situations where the actual

cash value of property is the replacement cost new. This is the case if the property is new merchandise which the insured has bought and is holding for sale.

INSURANCE POLICIES frequently contain valuation clauses that establish insurable values which are essentially replacement cost. Transit policies, for example, may set the value at "invoice price" or "invoice cost." Other terms appearing in cargo policies of various kinds are "cash market value" and "cost to repair or replace." These valuation clauses are used in the insuring of commercial property where the replacement cost to the insured would be his actual loss.

Replacement cost insurance in this sense has been in use for a long time. Such an insurance policy would be written in an amount equivalent to the insured's cost. But some new insurance policies provide for replacement cost coverage on property that may be old and subject to depreciation or obsolescence. It looks attractive to have an insurance that would replace new for old but there usually are additional premium costs and there may be other problems.

This availability of replacement cost insurance for old property is principally for buildings, furniture, fixtures, equipment and machinery. Physicians and surgeons have been able to buy replacement cost insurance for their equipment for several

years. This is available in the special multi-peril policy program and also in the inland marine policies. The special multi-peril policies (SMP program) also have provision for replacement cost coverage on buildings and business personal property, including furniture, fixtures and equipment. Some of these policies exclude from this coverage the kinds of property that obviously wear out rapidly, such as carpets, awnings, air conditioners, tapestries, and similar decorative items. Replacement cost insurance is optional. The insured has a choice whether he buys insurance on a replacement cost basis or for actual cash value. When should he buy replacement cost insurance?

Before buying replacement cost insurance the property owner should determine to a reasonable degree whether he would replace the property in essentially its present form if it were destroyed. Insurance companies usually will not pay the replacement cost unless the property is actually replaced. It is considered that payment of replacement cost where the property is not to be replaced would create a temptation to arson and would thus bring about a moral hazard. A typical policy restriction in this respect is:

- The company shall not be liable under this endorsement for any loss unless and until the damage or the destroyed property is actually replaced or repaired by the insured with due diligence and dispatch.

Another provision limits the amount of any loss payment to:

- The replacement cost of the property or any part thereof identical with such property on the same premises and intended for the same occupancy and use.

THE INTERPRETATION of the word "identical" in a loss adjustment might cause some problems. The intent is that the property be replaced with new property for the purpose of conducting the same business in the same way and at the same location. A move to another location is intended to set aside the replacement cost provisions.

It is not so clear whether an insurance company would pay for the construction of a one story building, for example, in place of a two story structure if the materials and facilities were substantially the same. It does appear that an insurance company would be within its rights if it refused to pay replacement cost if the new building

Continued on following page

Cafeteria plans adapted to executive choices

"Because of its synergistic effects on an executive's personal finances, supplemental life insurance is becoming an important element in improving the utility of cafeteria compensation."

By JOHN O. TODD, CLU
Founder and Senior Partner
John O. Todd Organization
Evanston, Ill.

THERE HAS BEEN a rash of discussion recently about cafeteria compensation. A casual reader might get the impression that this was a brand new concept—or at least the resurrection of an approach that had never been widely used. In reality, cafeteria compensation is just another name for the executive compensation plans employed by a number of U. S. corporations—and life insurance is a key element of most of these plans.

To gain a full understanding of this, let us first redefine exactly what we mean by cafeteria compensation. Reduced to its essentials, it is simply a plan which permits selected employees to spend their fringe benefit and/or bonus dollars by selecting from a shopping list of incentive programs. Thus, each executive can tailor his compensation program to his own personal and tax situation by integrating salary, life insurance, pension, and a number of other

prerequisites into one overall compensation program.

Now, in the keen competition for top-flight executives, corporations commonly tailor compensation programs to the individual needs or wants of executives they want to recruit—or hold. Almost invariably, the key to the design of these programs have been legitimate tax deferrals. Companies which offer cafeteria compensation programs to their executives as an inducement generally offer alternatives which allow their key men to build estates with a minimum tax impact.

WITH EXECUTIVE compensation rising so dramatically, it only makes good sense to try to arrange things so that as many of those dollars as possible go to the executive rather than the IRS.

This policy has become particularly important with the trend among major U.S. companies to relate the compensation of their executives to their individual performances. Whether these performance incentives are in the form of bonuses, phantom stock plans, or other such vehicles, today they frequently amount to a figure ap-



Supplemental life insurance is coming into widespread use by major corporations.

proaching the executive's base salary.

While the trend toward meaningful performance incentives is an encouraging development, these hard-earned rewards often times mean more to the federal and state governments than they do to the executive involved.

Cash bonuses invariably result in tax burdens that sharply reduce their value

to the executives and hence their incentive value to the company. Since a company's executives are so key to its success, surely it behooves a company to maximize the yield of the bonuses its executives earn.

Cafeteria compensation, then, is just a flexible incentive program that enables different executives with very different per-

Continued on following page

business insurance

PERSPECTIVE

Replacement cost insurance for commercial property . . .

Continued from preceding page
were entirely different from the old—a fire resistive structure, for example, in place of a wooden building.

However, these questions would be subject to agreement with the insurance company. They could complicate an adjustment of a loss. It would be best for the insured to discuss rebuilding plans with the insurance company before paying the additional cost of replacement cost insurance. An agreement might be reached in advance regarding the amount of variation in construction that would be acceptable to the insurance company.

THE AMOUNT OF insurance must be determined with care. The coinsurance provisions of these replacement cost policies require that insurance be maintained in proportion to the replacement cost rather than to the current value. Replacement of a fifty year old building with its fancy decorations might cost many times the price of a new but simpler structure. The amount of insurance required for replacement cost insurance would be the amount required to duplicate the old building with all of its fancywork. The premium would be computed on the basis of the dollars needed to rebuild the old structure. This could be very expensive where the replacement cost of the existing building would be out of line with the needs in a modern facility.

The application of replacement cost insurance to commercial personal property

(as distinct from real property) is principally in connection with furniture, fixtures and equipment. (It has already been explained that merchandise normally would be covered for its replacement cost because the replacement cost and the actual cash value usually would be the same). The insured must ask himself whether he would replace his present equipment, or is it so out-dated that he would buy new types of equipment. An insurance company might

“An insurance company might allow some latitude in the replacement of equipment . . . but a technically minded adjuster might apply the conditions of the policy literally and insist upon identical replacement.”

allow some latitude in the replacement of equipment—perhaps if certain kinds of equipment are no longer available, but a technically minded adjuster might apply the conditions of the policy literally and insist upon identical replacement. Would the extra cost of insurance on a replacement cost basis be justified? What would be the effect of the coinsurance clause as related to replacement cost? Agreement, or at least an understanding, between the insured and the insurance company regarding the interpretation of the word “identical” would help to avoid a dispute after a loss had occurred.

Another complicating factor is the existence of laws or ordinances restricting the reconstruction or occupancy of a building. It may be impossible to rebuild or to continue an occupancy that was permitted to exist under a grandfather clause. The extra cost of complying with such requirements is not covered under replacement insurance without special provisions.

A FORM OF INSURANCE known as “increased cost of construction” coverage might be included with the replacement cost coverage. This is usually written with actual cash value policies, but it could be included with the replacement cost insurance. It covers the additional cost of complying with building laws and similar ordinances. Substantial additional charges are made for adding this coverage to insurance where it appears that compliance

tional cost would be large. The additional charge for this kind of insurance may be something like ten percent more than for identical replacement. This kind of replacement cost insurance usually is a good buy for the insured.

When should replacement cost insurance be bought, and when is it better to buy “actual cash value” insurance?

- Replacement cost insurance for a building may be justified if the building is relatively new and is suitable for continued use in the insured's business.

- Replacement cost insurance for furniture, fixtures and equipment may be justified if this property is new or is efficient in its present form for the insured's operations.

- Premium cost and coinsurance must be considered. Coinsurance for replacement cost insurance requires an amount of insurance in proportion to the replacement cost new of the subject property. The additional cost of such insurance may not be justified.

- Replacement cost insurance may not be advisable if the property is old or obsolete, or if ordinances would prohibit replacement.

The businessman should plan ahead as to how he would continue in operation if his present facilities were destroyed. Replacement cost insurance may be the answer if he has a modern facility and a good location. However, the extra cost of such insurance might be used more effectively in setting up reserves if the building or equipment is old or obsolete. Replacement cost insurance can be a useful tool—it is not a panacea. ■

William H. Rodda, a CPCU and a member of Phi Beta Kappa, graduated with honors from Rutgers University. He is the president of Marine Insurance Handbook Inc., which publishes the standard inland marine insurance rate book for agents, and he is a consultant to numerous companies in the multiple line field.

Cafeteria compensation . . .

Continued from preceding page
sonal and economic situations to maximize their yields. To this end, a number of innovative programs have been developed. One of the most interesting is supplemental life insurance. The advantage of supplemental life insurance is that it simultaneously enables an executive to obtain protection for his family, safely build his estate, and reduce his tax burden. To derive these incentive values, the company pays part or all of the premiums. While this involves a substantial outlay for the company over the years, it is guaranteed to recover this outlay at the executive's retirement—plus a factor for the cost of money if it so desires.

In a sense, such a program does not even represent a cash drain for the company if it customarily provides incentives for its executives through bonuses or integrates supplemental life insurance into a fixed ceiling compensation program. The cash that would have been spent on bonuses is instead used to pay premiums.

MANY VARIATIONS of the premiums division between employer and employee are possible, so the tax impact can be placed wherever it is to the best advantage. The executive only pays taxes on the imputed benefit to him, which the IRS defines as the cost of term insurance at his attained age. If the executive pays some part of the premium costs, this contribution is a credit against such imputed taxable income.

Such an arrangement is clearly a strong inducement for executives, and companies are taking full advantage of it for recruiting and for holding key executives. Moreover, such a program can be adopted without any adverse effects on operating ratios. Premiums paid by the company are not deductible as expense nor chargeable against P&L.

Although supplemental life insurance is coming into increasingly widespread

use by major corporations such as General Electric, the Hanna Mining Co., Chase Manhattan Bank, Prentice Hall, and Cargill, to mention a few, it is just one of the elements of today's executive compensation package. Because of its synergistic effects on an executive's personal finances, supplemental life insurance is becoming an important element in improving the utility of cafeteria compensation.

would be expensive.

A simple example of this situation affects glass insurance. A form of shatterproof glass is now required in portions of buildings where people could be injured by glass breakage. Glass insurance usually is sold on a replacement basis, but this intends identical replacement. The additional cost of the shatterproof glass is not covered. An insurance company may waive the right to charge the additional cost to the insured where the difference is small.

However, insurance can be written to cover the total cost of the new glass if the amount of glass is extensive and the addi-

That's the only really new development in cafeteria compensation—improving its utility. The pressures are perhaps greater today, but forward-looking companies have always sought ways to maximize the benefits of each compensation dollar. In the modern tax environment, that means some degree of individual choice as to the form in which an executive receives his pay. Call it cafeteria compensation, flexible compensation, or any of the other buzz words so popular today; the basic approach is to provide greater satisfaction for the executives by getting more net dollars to him for a given level of corporate cost. That's not a

radical new idea; that's just good business. ■

Mr. Todd is one of the life insurance industry's distinguished underwriters and has served as president of many organizations, among them the Million Dollar Round Table and The Assn. of Advanced Life Underwriters. Long associated with the Northwestern Mutual Life Insurance Co. of Milwaukee, he is also now senior partner in the John O. Todd Organization, which specializes in business insurance with emphasis on executive compensation programs.

RISK MANAGEMENT NOTES

Valued U&O form reinterpreted

By WARREN, McVEIGH, GRIFFIN & HUNTINGTON
risk management consultants
San Francisco—Newport Beach

IT HAS OFTEN BEEN stated that one advantage of a valued form of business interruption (one that pays a stated amount per day of shutdown) over an actual-loss-sustained form is that recoveries are treated as capital gains rather than ordinary income. This assertion can no longer be made. Revenue Ruling 74-444 states:

“Taxpayer entered into a valued use and occupancy contract with an insurance company . . . The taxpayer's production facilities qualify as Section 1231 property. However, the proceeds received under the use and occupancy policy were not for the production facilities themselves, but for the right to use them. Proceeds received for the use of property are in the nature of rent because they provide compensation for the deprivation of use of the property for a period of time. Accordingly, since the proceeds received under the use and occupan-

cy policy were not to compensate for the loss of the facilities, themselves, but for deprivation of the use of the facility, such proceeds will not qualify for capital gain treatment under Section 1231 of the Code even though the facilities are Section 1231 property.”

ACCOUNTING FOR LOSSES

In the back of most risk managers' minds, as they deal with their retained risks, is the fact that if a loss should occur, it would be tax deductible. This, however, may not always be so, since a deduction cannot exceed the asset's book value. Therefore, on old equipment which has been thoroughly depreciated or for property carried on the books at artificially low figures, there may be little or no tax deductibility following a loss.

Where this situation prevails, it may be possible to attain tax deductibility through a special arrangement with your property policy. Include this coverage with a rating plan so that only a token premium is paid until a loss occurs. After a loss,

the insurer will be completely reimbursed by a surcharge on subsequent premiums. This will develop complete deductibility as an insurance premium. If no loss occurs, the premium should be insignificant.

If a loss occurs, the insurance recovery excess of book value will then be treated as an involuntary conversion of property and taxed at capital gains rates.

To illustrate: Property worth \$1 million is on the books at \$100,000. If total loss is uninsured, net loss is \$1 million less \$48,000 (tax credit on \$100,000 deduction), or \$952,000.

If loss is insured as described, net loss is \$1 million less \$480,000 (tax credit on additional premium) plus \$315,000 (capital gains tax on \$900,000 involuntary conversion), or \$835,000. This is an advantage of \$117,000 for the insured approach (about 12% of the principal amount) and may well be worth the small annual service fee (premium) for the insurer to add this to the policy. (All this assumes profits taxed at 48% and capital gains at 45%.) ■

Insurers operating in NY told to regularly report profits on p/c lines

NEW YORK—The New York insurance department issued a new regulation requiring insurance companies to publicly report their profits in this state on 19 lines of property and liability insurance.

A spokesman for the department told *Business Insurance* the measure could provide corporate buyers of insurance with more evidence to help them determine to what extent, if any, their premiums were boosted due to investment losses in the industry.

One of the most innovative aspects of the measure is that it will force insurers to report not only premium income, but all realized gains and losses, including investment results.

The regulation, which applies to 1974 earnings, is the first state-adopted measure of its kind, according to the New York department.

The new profit measurement methodology provides for the computation of New York profits on two bases: the company's own investment income (including underwriting income) and net worth and assets; and secondly, a combination of the company's own underwriting income with industrywide average investment earnings, net worth and assets.

Some industry estimates for 1974 placed stock market losses by insurers as high as \$6 billion. Accusations by some corporate insur-

ance buyers to the effect that the companies raised their prices to make up for investment losses followed these estimates, and have been a source of contention between buyers and sellers of commercial policies.

EARLY THIS month, an insurance department spokesman said that while the new regulation could not provide conclusive data correlating premium increases to

stock market losses of insurers, it might provide risk managers and corporate insurance buyers with a valuable set of records to help them make judgments in that area.

He cautioned against reviewing figures for only one year, however. "One has to review investment results over a long period of time," the spokesman warned.

The new regulation is part 165 title 2, of the official compilation of codes rules and regulations

(regulation 70) of the insurance department. At a public hearing on June 19, 1974, representatives of the insurance business objected to the proposed inclusion in profit computations of unrealized capital gains and losses, and to the measurement of profits on the basis of net worth.

THE INSURANCE department decided to retain those features.

The regulation builds upon profit measurement studies conducted by both the New York insurance department and the National Association of Insurance Commissioners. Its inclusion of investment income in the profit measurement and use of net worth in the compu-

tations, however, goes beyond the NAIC approach.

Insurers will have until April 15 of this year to file profit reports with the New York insurance department on their 1974 income. The profit measurement and reporting regulation will form the basis for, and will be followed by, a second regulation defining "excess" or "windfall" profits by insurers, the department said.

New York's no-fault automobile insurance law and the energy crisis insurance consumer protection law require insurance companies to refund to policyholders any excess profits earned in the three-year period from 1974 through 1976. ■

State issues industrial safety forms

OLYMPIA—The Washington State safety regulations requiring all state employers to keep certain occupational injury and illness records will become effective July 1, 1975, said William C. Jacobs, director of the Department of Labor & Industries.

He said safety record forms which will meet the requirements of the Washington Industrial Safety and Health Act (WISHA) are available from any the department's service offices throughout the state.

The new WISHA record-keeping requirements apply to virtually all public and private employers regardless of the number of their employees.

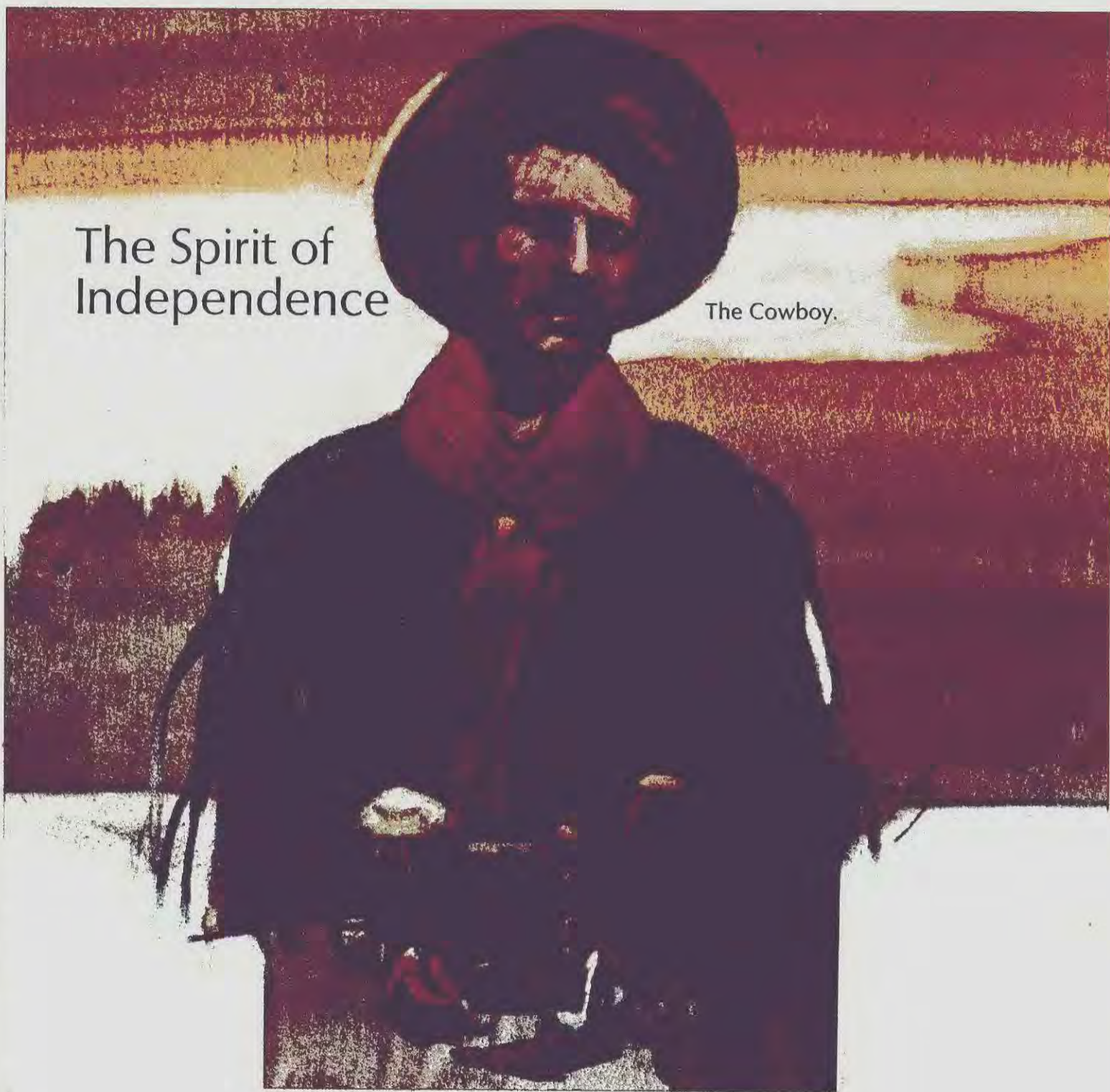
Starting January 1, employers who keep WISHA records will be exempted from the record-keeping regulations of the U.S. Department of Labor's Occupational Safety & Health Administration.

"Information recorded by employers will assist the department in improving its safety services," the director said. "It will also help employers identify any continuing safety problems in their own work places."

The WISHA record-keeping requirements ask employers to record each work-related injury or illness and to inform employees of these incidents following each calendar year.

Employers will keep their records at their work place for five years unless a variance to do otherwise has been granted by the department. Records will not be mailed to the department.

Department inspectors will review the employers' records during regular workplace inspections, Mr. Jacobs noted. A mandatory penalty of up to \$200 will be charged against employers who fail to keep accurate records. ■



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Must build cost control into prepaid legal plans

NEW YORK—"Some cost control (for prepaid legal insurance) must be built in from the start," said Howland G. Keller, director of group legal services for INA Corp. "Just how to go about it is one of the controversial issues of the day."

"The trick is to take the improved delivery resulting and yet avoid the cost spiral (such as the) consequent threat of national health which now worries doctors," he told the Practising Law Institute here.

Regulation is important, he continued, because "the potential for abuse and resulting injury to the public requires some sort of watchdog. A few dishonest promoters with their activities well-publi-

cized could severely hamper development of prepaid legal service programs and damage the image of the legal profession," Mr. Keller said.

BUT REGULATION by lawyers themselves is not enough, according to Mr. Keller. "Current regulation . . . is aimed at the quality of services. There is very little attention paid to financial stability," he added, referring to the need for adequate reserves.

In Mr. Keller's opinion the California Legal Insurance Bill is notable because it allows experience rating on an account basis. "This means that different going-in rates can be charged to different groups based on identifiable char-

acteristics of the group. Without this provision the insurer must charge the same rate to all groups, then wait for the account to develop its own experience before revising rates," he said.

Because of marketing and administrative experience, Mr. Keller believes insurance companies are ideally suited to act as intermediary between lawyer and client.

Insurers see advantages to the pooling approach such as modification of adverse selection, simplified administration and streamlined premium reporting and claims verification, according to Mr. Keller.

"When prepayment is used to improve delivery of a service, certain functions must be performed . . . Someone must do them," he said.

"**RECORDING** accuracy is particularly important where the rate is adjusted depending on account experience, Mr. Keller said. "Insurance carriers have developed the necessary forms and computer software to handle legal insurance program enrollments and claims payments."

"Viewed in a marketing sense, delivery of legal services represents a classic textbook situation in which the seller (lawyer) and buyer (client) are not getting together."

"Fear of cost, inaccessibility of attorneys, inability to recognize a legal problem and unwillingness to enter an unfamiliar relationship—are the reasons why middle income earners don't make adequate use of lawyers," Mr. Keller said. He also blamed the restrictions placed on lawyers by the Canons of Ethics.

RIMS election

The New Jersey Chapter of the Risk & Insurance Management Society (formerly American Society of Insurance Management) recently elected officers for 1975: President—David P. Gray of Beeton, Dickinson & Co.; vp—Fred B. Molineux of Foster Wheeler Corp.; secretary—Leonard Zawodniak of J. B. Williams Co. Inc., and treasurer—Wilson King of the Boy Scouts of America. Two new directors were elected to the board of directors: Diana Sinkey of Thomas J. Lipton Inc., and Spencer Rankin of C. R. Bard Inc.



Geoffrey J. Burns, who is retiring this month as second vp for insurance administration from the Continental Illinois Bank, is congratulated by William Altstetter, national president of Risk and Insurance Management Society (RIMS) at the January dinner meeting of the Chicago chapter. Mr. Burns, who has served as treasurer of the chapter for several years and was one of its early members, was made an honorary member. James A. Crawford formerly insurance officer under Mr. Burns at the bank, will be taking over his responsibilities as Mr. Burns leaves for an extended vacation in Texas and Florida. Cliff Manning photo

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Settlement . . .

Continued from page 1
tlement of more than \$7.1 million "would be set aside as excessive."

THEY ALSO said that there was "no appellate authority in Maryland to sustain the verdict in a case such as this."

Whatever the outcome, the case has caused concern about liability exposures among apartment and office building operators in the Washington, D.C., area.

The killer was inside the apartment building as part of a furniture moving crew employed by Certified Furniture Leasing, of Capitol Heights, Md., a National Service subsidiary.

The men had been brought by a building employe to an unoccupied apartment where leased furniture was to be removed. The building employe opened the apartment for the movers and then left the scene.

The crew returned after lunch, when the killer, Robert E. Watson, had been reported drinking. Mr. Watson strayed from the worksite, forced his way into Mrs. Barbara Blum's nearby apartment, and then raped, stabbed, and strangled her while her two small children were present.

The body was discovered when Mr. Blum returned from work that evening.

THE JURY found National Service guilty of "negligent hiring" for failure to learn that Watson had a previous felony conviction. The company since has begun screening all prospective employes for criminal backgrounds.

IFC, as building operator, was found negligent because the building employes had failed to eject the movers from the building even though they had been drinking.

They were also found guilty of "reckless indifference to others" for falsely leading tenants to assume the building was secure.

A spokesman for the Apartment and Office Building Assn. of Metropolitan Washington said the El Dorado Towers had, "by all standards I'm aware of, a typical security system, somewhat better than most."

That included a guard on duty in the lobby from 3 p.m. to 11 p.m.; a foot patrol of the grounds from 6 p.m. to 2 a.m.; and a motor patrol of the grounds from 11 p.m. to 7 a.m.

Doors to the building were locked from 11 p.m. to 7 a.m.

One damaging aspect of the

White House pension meet set for May

WASHINGTON—Employ benefits officials are expected to be among a 20-member delegation from the pension industry that will meet with White House officials for an afternoon conference tentatively set for May 7.

White House officials for several months have been meeting informally with representatives from various industries, but this is a first for representatives of the pension field.

The delegation is being formed by the sponsoring organization for the May session, the Washington-based Assn. of Private Pension and Welfare Plans.

Also expected to be in the group are investment professionals, actuaries, and benefits consulting men.

The association is expected to finalize its delegation list sometime this month. ■

case was that the building complex had had several incidents of sexual assault in the 18 months or so previous to the murder, however.

"Every one feels very confident that the reward will be reduced substantially, but I don't feel personally that that's any salve to my fears for the future," the spokesman said. "Absolute security is impossible."

"I BELIEVE our premiums, if this kind of case holds up, are going up substantially," he said. "I don't think anyone will ever again advertise security as a benefit."

A spokesman for one liability underwriter, not involved in this case, said he did not expect the huge award to reflect on the package liability in excess liability markets.

He said his firm had established no new criteria recently for the apartment house security of its insured. ■

Self-insureds must pay price for excess lines

NEW YORK—Excess lines of coverage for self-insureds is becoming increasingly more difficult and expensive to obtain, William D. Hare, senior vp-Fred. S. James and Co., insurance brokers told a meeting of the New York chapter of the Society of Chartered Property and Casualty Underwriters.

Speaking on a panel discussion on the various aspects of self-insured retention plans, Mr. Hare said "The capacity is there, but the client must be willing to pay the price," in an era of double-digit inflation, a declining stock market and severe underwriting losses experienced by many firms.

Mr. Hare advised pooling of resources as a defense against a

deteriorating market in order to gain coverage.

Michael F. White Jr., vp-S.W.S. Risk Management Services, another panel member, noted the information required by excess carriers in order to quote a cost for excess coverage.

PREMIUM history and loss history by line for the last three years, estimated premium for the ensuing year by line, exposure to special hazards, risk locations, details on all claims in the past five years and the coverage desired are the basic factors taken into consideration when quoting a premium, Mr. White said.

Describing the services available to self-insureds by a services com-

pany, Mr. White noted that computer generated loss reports are an extremely important function.

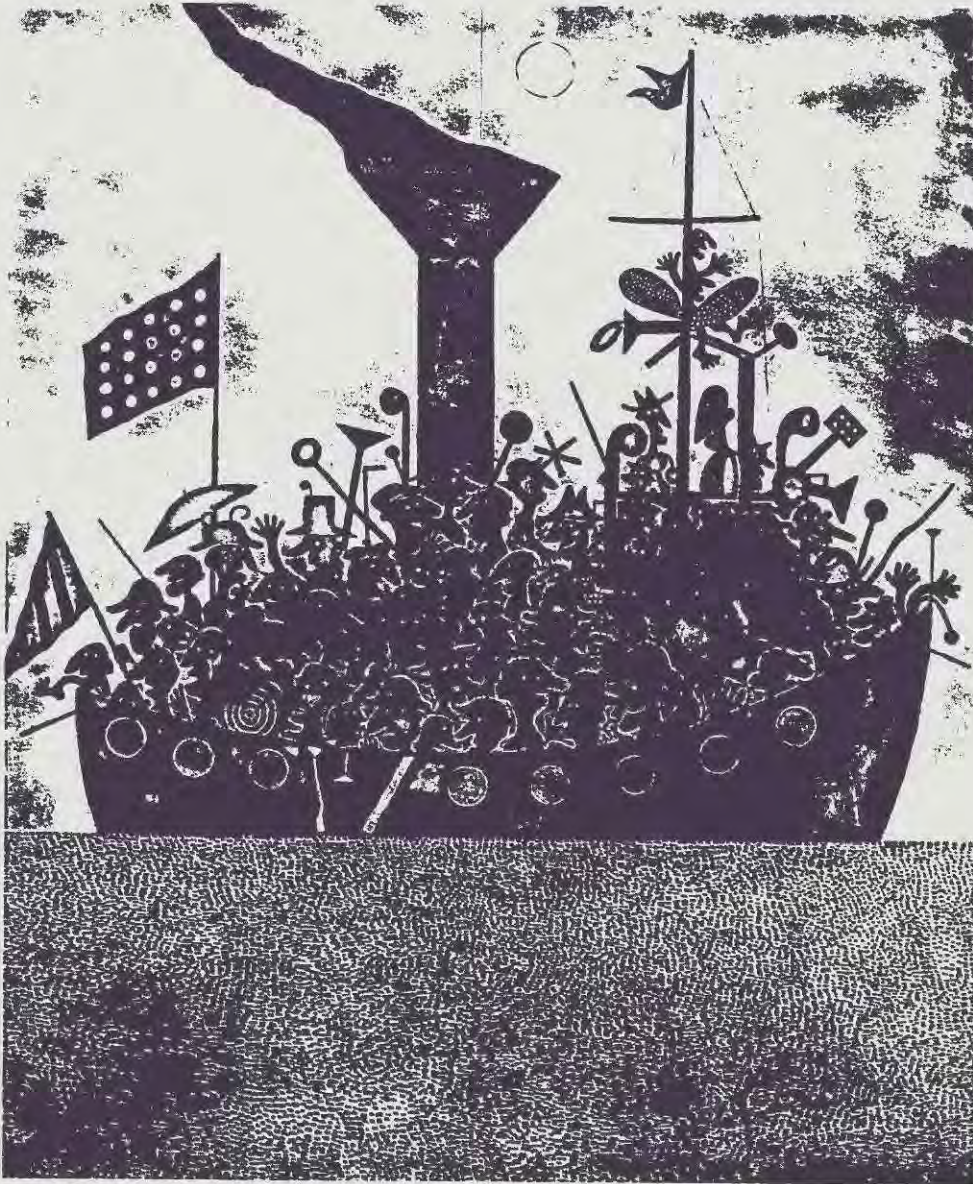
Claim reports tailor-made to meet the needs of each client are reported separately for each corporate unit and provide information for inter-unit comparisons while pinpointing trouble areas.

"Although insurance against catastrophes is a necessity for most businesses, it must be recognized that insurance is an expensive mechanism for covering risks a company can afford to assume," S. Peter Law, corporate director of insurance, U.S. Industries, the third panel member stated.

The risk manager must examine the individual situation line by line, Mr. Law pointed out, and analyze all areas of self-absorption including hidden absorptions involved.

A definite advantage of a self-insurance plan, Mr. Law added, is that it promotes loss prevention in the plant. ■

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Life, health underwriter put into conservatorship

LOS ANGELES—Union members who were insured by Coastal Insurance, a life and health underwriter which was placed into conservatorship by the state insurance commissioner's office Jan. 6 don't seem to be suffering any undue apprehension.

Coastal Insurance is a wholly owned subsidiary of HMO International, a company that administers prepaid health plans and is involved in a long-standing internal battle for control.

A spokesman for the state commissioner's office said that "the reason we took over Coastal Insurance is that its balance sheet showed it to be insolvent."

He said Coastal's loss ratios ran as high as 100% and even as high

as 140% to 150% for certain groups.

However, he noted that according to his office's analysis the company's liabilities exceeded its assets by about \$200,000.

THE SPOKESMAN said that his office has told Coastal that it will terminate materially unprofitable insurance and channel its assets into preserving profitable business. Under California statute, the conservatorship will be terminated if the company returns to profitability. If it fails to do this, it is liquidated.

About 40 groups of insureds, both large and small, were affected by the takeover, according to the spokesman for the state com-

missioner's office. He explained that workers insured by the HMO subsidiary had the option of being insured by Coastal or being insured by California Medical Group, a prepaid health plan operated by HMO International.

Members of three unions at Royal Industries, Pasadena, are insured by a combination of CMG and Coastal, according to Ken Pearson, vp of industrial relations.

He said that the three unions are: the Machinists, IAM, local 906, the United Auto Workers, local 509 and the Operating Engineers, local 6. Of the approximate 400 members in the three locals, he said about half were insured by Coastal, the other half by CMG.

"For the 200 people involved, we're now in the process of taking bids from new carriers," he said. He noted he has obtained a second time extension that allows him until Feb. 28 to locate a new underwriter.

Thus far, no union member has

expressed any great apprehension about the fact that their life/health carrier has been taken over by the state commissioner's office, he said. "And I don't foresee any problems, either," he added.

SIMILARLY, John Calvin, with the brokerage firm of Elwell Averbek, Pomona, said the eight or nine groups formerly insured by Coastal which he is representing have not been traumatized by the experience of losing their life/health carrier. "I don't think I'll have any problems in replacing them," he asserted.

HMO International, the parent company, meanwhile, reported losses for the fiscal second quarter and for the first half compared with profits for the same periods a year ago.

Dr. Donald K. Kelly resigned as president of the firm as part of an agreement with a dissident stockholder group. But the agreement was later dissolved. ■

\$10 million suit filed in Golden West Airline crash

LOS ANGELES—Golden West Airlines is thought to have more than adequate insurance to cover any outcome of a \$10 million damage suit filed here last month following the crash of a commuter transport plane which killed 14.

The suit was filed in Norwalk superior court seeking damages in the death of James H. Krieger, a prominent Riverside, Ca. attorney who was a passenger in the Golden West plane. The commuter flight collided in midair Jan. 9 with a single-engine private plane, spattering wreckage over a two-mile area of Whittier, Ca.

Ten of those who died were passengers in the commuter plane, and another two were crew members on the Twin-Otter prop jet. The flight instructor and a student aboard the Cessna 150 private plane were also killed.

The commuter flight was en route from Ontario to Los Angeles International Airport, while the Cessna 150 had come from Long Beach Municipal Airport.

LIABILITY insurance underwriter for Newport Beach-based Golden West Airlines reportedly is Southern Marine & Aviation Insurance Co., New Orleans. Insurance adjusters believed the airline has sufficient liability coverage to cover the collision and any lawsuits arising from it.

Ned Good, the attorney filing the lawsuit against Golden West and Cessnair Aviation for the death of Mr. Krieger, told *Business Insurance* he estimates Golden West's liability coverage to be in the neighborhood of \$50 million.

Golden West declined comment on the matter. Cessnair also declined to reveal its liability insurance coverage.

Both planes were said to have been operating under visual flight rules when the accident occurred in late afternoon in clear weather.

Lynn Hink, acting director of the Federal Aviation Administration western region, later reported that while the commuter plane was visible on the radar scopes at the control tower when the collision occurred, the Cessna private plane was never seen. ■

Board issues tank car rules

WASHINGTON—The Hazardous Materials Regulations Board has required shippers, effective immediately, to notify railroads when they use tank cars without head shields to transport flammable compressed gas.

The notification must be included on shipping papers, the board said.

The board in late last year required railroads to treat such shipments in unshielded cars as they would poisons or explosives in all switching operations. ■

L.A. agents merge

Berny Byrens & Assoc. Inc. recently merged with Abbott, Belmont & Lawrence Insurance Agents & Brokers Inc., both based in Los Angeles. Mr. Byrens will be appointed senior vp of Abbott, Belmont & Lawrence. Lawrence Rosenbloom, president of the firm, is a Los Angeles County construction commissioner.

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NY Blues request 22% average rate increase

NEW YORK—An average increase of 22.2% in the rates for present benefits, reaching approximately 3.4 million subscribers, was requested by Blue Shield and Blue Cross of Greater New York.

The Blues also seek permission to increase rates an additional 5.6% to provide improved benefits.

Applications for these changes will affect 45% of the plan's membership and have been submitted to the New York state insurance department.

Proposed improvements in benefits include:

- increasing by \$200 the maternity indemnity allowance;
- covering the cost of appropriate blood products used outside the hospital for treatment of hemophilic patients;
- providing 30 days of benefits each year for acute mental care not only in a general hospital (as at present) but also in a private psy-

chiatric hospital or the psychiatric division of a county or municipal hospital;

- extending full coverage in an approved premature nursery from the present 4.4 pounds to infants weighing up to 5.5 pounds;

- eliminating the present eleven-month waiting period for treatment of congenital anomalies in children covered under family contracts.

ADDITIONAL increases requested include rate hikes ranging from 56 cents to \$1.35 a month

for 657,000 subscribers enrolled in the various programs that supplement Medicare.

Approximately 3,000 contracts covering Queen and Nassau County residents enrolled in the plan's prepaid group practice program operated in cooperation with Long Island Jewish-Hillside Medical Center will be scheduled for two-stage increases, if the proposal is approved.

The projected increases for these members are an average of 17.4% for March 1, 1975 and 10.3% for January 1, 1976.

These adjustments, if approved, are anticipated to be effective until the spring of 1976, said president Edwin R. Werner.

THE LAST INCREASES in rates for hospital and Medicare supplementary coverages, averaging 7.4% and 5.8% respectively, went into effect on April 1, 1974.

While the plan has tried to implement various cost control measures in the past, such as trying to "limit cost increases in hospitals to the level of the inflation rate of the general economy," accord-

ing to Mr. Werner, other factors are cited for new increases.

These include rising hospital costs for food, fuel and other supplies, and higher collectively-bargained hospital wages, salaries and fringe benefits.

A recently enacted New York law requiring the plan to double its payments to hospitals as of 1975 to subsidize losses sustained as a result of rendering services to all patients using clinics and out-patient facilities, has also necessitated rate increases for this region. ■

State files suit against largest HMO

LOS ANGELES—The state attorney general's office filed a civil suit against National Prepaid Health Plan Inc., and its principal officers, charging them with violating several state laws and failing to pay more than \$2 million of its subscribers' medical bills.

A spokesman for the State Attorney General's office said that National Prepaid Health Plan Inc. (NPHP) was the largest prepaid health plan company in California—a state which one source said has about 80% of all HMOs in the nation—to have been served with a suit.

NPHP is currently in liquidation; it declared bankruptcy in January, 1974.

The suit seeks an injunction and penalties against the defendants. It also asks that they be forced to make restitution to all persons or companies who suffered financial losses because of the allegedly unlawful conduct.

FIVE PERSONS were named in the suit which was directed by deputy attorney general Sanford H. Feldman. They are: Joseph Hauser, a leading figure at NPHP and a successful labor union insurance specialist; Herbert Davis, a former deputy attorney general in charge of regulating state-chartered prepaid health plans; Sidney Bleifeld, secretary-treasurer to Equitable Health Corp. of America, the profit-making management firm that had a contract to run the non-profit prepaid health plan; Louise Rosenblum, the health plan's vice president; and Joseph Levey, NPHP secretary-treasurer.

Frank L. Kendall Inc., a Los Angeles-based insurance brokerage firm which acted as the health plan's sales agent, also was named in the suit.

At one time NPHP insured approximately 60,000 members of Southern California labor unions.

A source knowledgeable about the HMO scene in California said that there are 247 such health groups in the state. Another 85 are in some stage of development, he said, and "between 20% and 25% of these are suffering financial problems." Most of these are in Southern California.

Undercapitalization and lack of business expertise are two key reasons why HMOs are encountering hard times, he said. ■



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the legal brief

Mailing of report satisfies "filing" clause of monthly reporting policy

THE UNITED STATES Court of Appeals for the Fourth Circuit has ruled that the mailing of a monthly valuation report to an insurer satisfied the "filing" clause of a monthly reporting insurance policy.

In this case Jones Wholesale Co. (Jones) held a monthly reporting insurance policy issued by General Accident Fire and Life Assurance Co. (General). The policy covered inventories in Jones' warehouses. On Friday January 19, 1973, Jones

mailed to General's agent a valuation statement that increased its coverage. In the same envelope Jones requested General to increase its maximum policy limit

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

to protect its expanded inventory. With normal mail handling General's agent would have received the letter on Saturday. However, since the agent's office was closed

that day, the letter was not received until Monday, January 22nd. On Sunday, January 21st a fire burned Jones' warehouses causing damage to goods in inventory in excess of the policy's limits. Jones brought this action to recover the losses in excess of the original policy limits. The trial court ruled in favor of General.

On appeal, Jones contended that its request for an increase in the maximum liability should have been honored because General had

given retroactive approval to similar requests in the past. But General contended that it was not bound by the January valuation report because the "filing" required by the policy required the agent to actually receive the report before the loss.

The court of appeals agreed with the trial court's judgment that only General and not its agent had authority to approve liability increases beyond the stated maximum. Thus the court concluded that Jones' recovery, if any, had to be limited to the stated maximum. However, the court also ruled that the placing of the valuation report in the mail to General's agent was a "filing" under the policy occurring before the fire. The court noted that Jones' recovery for the January valuation was still subject to the original maximum policy coverage. *Jones Wholesale Company, Inc. v. General Accident Fire & Life Assurance Corporation, Ltd.,*

United States Court of Appeals for the Fourth Circuit, November 4, 1974, *per curiam*, (BI/01/M.-\$2)

Group credit life

In a suit brought under a group credit life policy, the Supreme Court of Oregon has ruled that an insurance company could not assert the defense that the insured was not in "sound health" at the time the policy was issued when the company issued the certificate of insurance without requiring a written application and did not advise the insured his physical condition was relevant to the issuance of the policy.

In March 1968 the Hayes Truck Lines Inc. (Hayes) executed a lease and option to purchase with Northwest Acceptance Corp. (NAC) covering commercial trucks purchased from Automotive Equipment Co. Since Hayes was undercapitalized, NAC required a guarantee agreement by the officers of Hayes and credit life insurance on each of the officers' lives. NAC obtained a master policy from Investors Insurance Corp. (Investors) and at NAC's request, Investors' agent issued a certificate of credit life insurance on the life of Sidney Hayes, showing NAC as the beneficiary.

Sidney Hayes, the principal shareholder and president of Hayes, died in November 1968 from an illness of which he was aware at the time he signed the lease-option and at the time the certificate of insurance was issued. Investors' agent knew nothing of Sidney Hayes' health condition. The agent neither inquired into Hayes' health nor asked Sidney Hayes to sign an application for insurance. After Sidney Hayes' death NAC filed its "Claimant's Proof of Death" requesting payment of \$8,016.64, the balance of the lease-option debt. Investors refused payment. NAC brought suit and was awarded the sum of \$8,016.64 by the trial court.

On appeal Investors contended that it did not issue any policy of credit life insurance on the life of Sidney Hayes because the certificate was not, in itself, a contract of insurance. Even if there were a master policy of insurance, Investors maintained that Sidney Hayes was not covered because he was not in sound health as required by the master policy.

The supreme court pointed out that there were two types of insurance issued by Investors—the master policy and the certificate of insurance. The certificate, the court observed, showed none of the conditions such as requiring the debtor to be of sound health.

Since Investors received a copy of the certificate, accepted the premium and made no inquiry as to whether Sidney Hayes was an "eligible debtor", the court ruled that it could not now deny coverage. As an additional reason for concluding that coverage existed, the court noted that both NAC and Sidney Hayes had relied on the issuance of the certificate of insurance and failed to seek credit life insurance from another insurer. *Hayes Truck Lines, Inc. v. Investors Insurance Corporation*, Supreme Court of Oregon, September 6, 1974, Bryson, J. 525 P. 2d 1289 (B/02/M.-\$2)

Group accident and health

This action was brought by the father of an eligible insured dependent child to recover benefits under a group accident and health policy. The Supreme Court of Oregon held that where the insured's eligible minor dependent was the only person who suffered actual physical injuries which required medical treatment and hospitalization, the son had to be

Continued on page 39

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Continued from page 38
the "insured person" referred to in both the policy and the third party agreement and, as such, was the only party entitled to bring an action to recover benefits under the policy. From the language of the policy it was clear to the court that it was the intent of the parties to provide coverage to either the father as an employee or his eligible dependents only if either or both had suffered actual physical injury thereby necessitating medical treatment and hospitalization.

Since the father instituted this action in his individual capacity as a parent and not as representative of his injured minor son, the court concluded that the father had no right to benefits under the policy. In reaching this conclusion the court was not persuaded by the father's principal contention that the child could not legally "incur" medical expenses or recover the same from a negligent third party, and therefore, the father must qualify as the "insured person" referred to in the third party agreement.

The court emphasized that the language of the policy "clearly indicates" that the parties intended that the "insured person" could only be the one who suffered actual physical injury, thereby necessitating medical treatment. The court pointed out that if the father had been injured the entire net recovery from the third party would have been credited to the defendant insurance company's obligation under its policy. "The fact that the (father's) eligible insured dependent was injured instead of the (father) does not alter the result and permit the (father) to avoid the express provisions of the policy and, in effect, obtain a double recovery" the court said.

The father contended that most of the recovery from the third party was received for his child's general damages but not for the hospital and medical expenses brought about by the child's injuries. But the court noted that there was no reason here for the defendant International Health and Life Insurance Co., to require the injured to recover anything but medical and hospital's expenses caused by the third party's negligence.

This being so, the court pointed out that if the father had instituted an action against the insurer as guardian of his injured child he would still be entitled to recover no more than the difference between the net amount recovered

Reinsurance Association extends talks

LONDON—The theme of the seminar which Britain's Reinsurance Offices Assn. is holding in April (*Business Insurance* Dec. 9) has been extended to cover all aspects of reinsurance in the current world economy.

Panels will be split up into six discussion groups, and insurance leaders from Lloyd's, brokers, reinsurers, and the company markets will express their views on the problems likely to be faced in 1975.

U.S. and other overseas delegates are expected to attend the seminar, which will be held at Sussex (England) University April 15-17. C. Alastair Ogilvy, Director of the R.O.A., told *Business Insurance*: "We've hit on a theme which ought to be of interest to all reinsurers and we hope there will be a good response from our friends in the U.S." ■

from the negligent third party and the coverage provided by the applicable provisions on the insured's policy. *Denton v. International Health & Life Insurance Co.*, Supreme Court of Oregon, November 21, 1974, McAllister, J. 528 P. 2d 546 (BI/05/M.-\$2)

Hospital liability insurer

Does the failure of a nurse to recognize a patient's condition and capability of returning safely from the nurses' station to his bed constitute an exercise of the nurse's expert professional ability? The Court of Appeals of Kentucky ruled that it did and thereby released a hospital's liability insurer from responsibility for a patient's injuries where the policy had a professional services exclusion.

In this case Foundation Hospital, Inc. (Foundation), owned by local physicians and specializing in psychiatry, had a general liability insurance policy issued by

Employers Liability Assurance Corp. (Employers). The policy contained a clause excluding from coverage "Malpractice and Professional Services."

On December 12, 1966, Fred Ratliff was a patient at Foundation being treated for alcoholism. He woke up in a nervous and anxious condition and walked to the nearest nurses' station where he asked for and received assistance from nurse Yocum to the restroom door and back to the nurses' station. Then nurse Yocum administered to Ratliff 4-CC of seconal orally, which was a rapid acting sleep inducing sedative. Ratliff then began to walk back to his room without assistance. Without remembering how it happened, Ratliff next recalled sitting on the floor of his room with a broken leg. Subsequently Ratliff obtained a judgment against Foundation for \$9,682.60 as damages for his personal injuries. Unable to collect from Founda-

tion, Ratliff sought to recover from Foundation's insurer, Employers. The trial court ruled in favor of Employers.

On appeal Employers contended that the accident in question was not covered under the general liability policy because the policy excluded malpractice and professional services. The principal issue, therefore, was whether nurse Yocum's decision to administer the seconal and to allow Ratliff to return to his room unaided was an exercise of "professional services" as contemplated in the policy exclusion.

After reviewing many cases involving hospital oriented injuries and accidents, the court concluded that in this case the negligent act of the nurse did involve professional training or experience. The court believed that in this case the nurses failed to recognize Ratliff's debilitated condition as a result of acute alcoholism. "Determining whether Ratliff was capable of re-

turning safely from the nurses' station to his bed," the court emphasized, "required the nurses to exercise their expert professional ability."

Failure to do so, according to the appeals court, constituted a failure on the part of the hospital to render professional care and fell within the exclusion provision of the insurance policy. *Ratliff v. Employers' Liability Assurance Corp. Ltd.*, Court of Appeals of Kentucky, October 25, 1974, *per curiam*, 515 S.W. 2d 225 (BI/03/M.-\$2) ■

(Copies of the entire decisions described in this column may be obtained by writing to Business Insurance, attn. Managing Editor, 740 N. Rush St., Chicago, Ill. 60511. Please enclose a check made out to Cases Unlimited Inc., for \$2.00 to cover the cost of each case you order, and specify the code number of the opinion, which is at the end of each brief.)



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This year, BUSINESS INSURANCE's special INTERNATIONAL INSURANCE issue, while also covering other geographic areas of the world, will focus primarily on insurance markets in the United Kingdom and London, in particular.

Coverage will be given to corporate ventures abroad and the methods of handling risks for these. Changes in the domestic insurance and reinsurance markets vs. the London markets will be reviewed along with topics such as:

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Encyclopaedia Britannica likes 1st dollar coverage

By ELISABETH M. WECHSLER

CHICAGO—Can a salt mine substitute for insurance coverage? For one of Encyclopaedia Britannica Inc.'s affiliates, it apparently can.

The 200-year-old company, which started as a society of gentlemen compiling a dictionary and now is held along with several subsidiaries and affiliates in a voting trust by the Benton Foundation, stores its original educational films in a Hutchison, Ka. salt mine.

Besides providing the right humidity level, the mine offers top notch protection against fire, theft and other potential losses. Hence, films which normally are insured for \$25,000 and more when they're outside the mine are covered for \$600 while stored below ground, according to Raymond C. Bevans, Britannica's assistant treasurer.

As the company's manager for insurance and group benefits as well as supervisor of the cash management department, Mr. Bevans is conscious of keeping

costs trimmed on the largely first-dollar-coverage insurance program.

"Our coverage hasn't changed in the last few years and I don't anticipate a change in the future," Mr. Bevans told *Business Insurance*.

Mr. Bevans, who joined Britannica in 1964 as assistant to the treasurer, says he allocates about half his time to corporate and group insurance with 12 employees reporting to him and the other half to the cash management department with 25 people to supervise in Chicago.

ASIDE FROM publishing the almost legendary Encyclopaedia Britannica, the company includes G&C Miriam Co., Praeger Publishers, Library Resources Inc., Britannica International and Encyclopaedia Britannica Educational Corp.

Although Mr. Bevans reviews each division's insurance with his boss, Britannica's treasurer, he is only directly responsible for buying insurance for the main company and Encyclopaedia Bri-



Raymond C. Bevans (right), Encyclopaedia Britannica Inc.'s assistant treasurer, is congratulated by company president, Charles E. Swanson, for receiving the Silver Beaver Award, the highest adult honor, from the Boy Scouts of America. Mr. Bevans has also been an active participant in the Metropolitan Crusade of Mercy.

tanica Educational Corp.

"I don't see any point in tearing up their method of (buying) insurance," Mr. Bevans said. "Nor do I see an advantage, per se, to consolidation."

Property coverage, handled primarily by Marsh & McLennan Co. Inc., is divided into three areas: in-process, film float and furniture/fixtures.

THE COMPANY leases rather than owns its buildings. R. R. Donnelly & Sons Inc. is contracted to do the firm's printing. These features seem to point to heavier potential risks in the materials Britannica produces.

Britannica's in-process coverage has a limit of \$17,310,000 and is set up to insure books and other "manuscript" items. The value is determined on a reporting basis for various locations to include all risks while the materials are being stored or shipped, Mr. Bevans explained.

There is no deductible for this policy, he said, "because they are all small items, easily damaged or lost." The main problem Britannica has encountered is salt water damage and containerized shipping has reduced that risk, he

said. Running a distant second, are warehouse thefts.

"Our coverage is for all risks," Mr. Bevans said. "This means that unless it's excluded specifically, it's covered. We have very few exclusions because we don't want to assume any risks."

Most of Britannica's shipping is by container and it is insured by J.S. Fire Insurance Co. Sam Cherman & Co. of New York is Britannica's broker for container shipping.

Chubb & Scr. Inc. insures Britannica's non-container shipping which is generally "odd lot," Mr. Bevans said. Marsh & McLennan brokers that coverage.

The film floater policy, also a type of manuscript coverage, protects Britannica's educational division up to limits of \$956,000 with no deductible—other than the salt mine—when film copies are being made. Rain damage is the only occurrence which rates a \$100 deductible, Mr. Bevans explained.

MR. BEVANS emphasized that first dollar coverage has not caused an increase in premium costs. "The loss experience has been good," he said.

Furniture and fixtures in U.S. locations are insured to a limit of \$7,833,000 with a \$500 deductible per occurrence, Mr. Bevans said.

For all the property coverage, several carriers with a 5% to 20% participation share the underwriting. "This spreads the risk around," Mr. Bevans said.

For casualty coverage, James S. Kemper Agency of Chicago is the primary broker, he said.

Britannica has an umbrella liability policy with a \$5 million limit and a \$25,000 deductible, he said. It's insured through the Kemper Insurance Co., he added.

Britannica is insured by Kemper Insurance for CGL up to a limit of \$300,000/\$300,000 with no deductible, he said. The umbrella policy goes into force if the claim is higher than \$300,000.

The company has no product liability coverage, Mr. Bevans said. But it is covered for advertisers liability up to \$150,000 in a separate policy. After that point, it becomes part of the umbrella policy, he said. Marsh & McLennan is Britannica's broker for this coverage.

A few years ago, computer personnel stole a mailing list which the company eventually recovered, Mr. Bevans said. The company's fidelity bond covers each Britannica employee for up to \$50,000 each and for \$250,000 per

Continued on page 41



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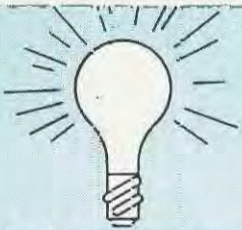
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Correspondents in All Other States

Britannica . . .

Continued from p. 40
occurrence, with a \$500 deductible.

Warehouse thefts are difficult to control, he said, adding that though they are not infrequent, the losses are not costly. Asked if any changes had been made in security as a result of the thefts, Mr. Bevans smiled and said no. "But even if we had done something, I wouldn't tell what it was," he added.

Britannica owns only 30 vehicles but it is the secondary insurer of its sales persons' cars. Courts have held that a sales person who uses a car on business is technically on business 24 hours a day, Mr. Bevans said.

Kemper Insurance covers Britannica for up to \$300,000/\$300,000 if sued directly or if the sales person is sued and the insurance does not cover the claim. There's no deductible but the individual's own auto insurance serves as primary coverage, Mr. Bevans explained. Under this policy no claim settlement has been over \$10,000, he said.

ASKED IF HE ever considered self-insuring Britannica's auto policy, Mr. Bevans said he had considered it but decided against it because "you never know when you could have a real juicer (accident)—like hitting a school bus. The premium is so low that the umbrella policy is like excess insurance," he said.

Workmen's compensation is covered by American Motorists (Kemper) except where state funds exist, Mr. Bevans said. The loss experience has been good for the 5,000 U.S. employees and 9,000 total employees worldwide. "It's mainly medical bills," Mr. Bevans said. "We have about two a year."

"There are only 23 people in

Court rules for insurer in disability case

PHOENIX—The Arizona supreme court said an injured worker's disability payments can be cut off while an insurance company seeks to have the amount of the worker's benefits reduced.

The high court ruled in a case involving Thurman Brown Jr., a partly-disabled Tucson construction worker whose benefits were halted in August 1973 by an insurance firm objecting to a permanent disability award of \$102.92 per month made to him by the state industrial commission.

Mr. Brown was injured in October, 1970 while employed by the M. M. Sundt Construction Co. He was granted workers' compensation benefits in December, 1970. They were paid by Employers Mutual Liability Co. of Wisconsin, the carrier for Sundt, until the industrial commission made the permanent liability award to him.

THE INSURANCE company sought to have the award decreased and terminated the benefits pending a hearing on the issue. Mr. Brown asked for higher benefits and requested continued payments pending his appeal.

The commission refused to order the continued payments, citing a state law that provides for benefits to continue only if an increase in a commission award is sought.

The high court said it was reluctantly affirming the commission's decision because of the state law. ■

the warehouse here. That's less than 1% of the workforce and most accidents would occur there. No one gets workmen's compensation claims from office personnel," he said.

BRITANNICA'S employe benefits are primarily group insurance plans including hospitalization plus major medical, life insurance and pension annuity, all underwritten by Equitable Life Assurance Co.

This month the major medical plan will increase its coverage limit to \$50,000 per employe or dependent.

One times the annual salary in life insurance is provided by Britannica free of cost. The employe has an option to purchase two times in addition to that up to \$150,000.

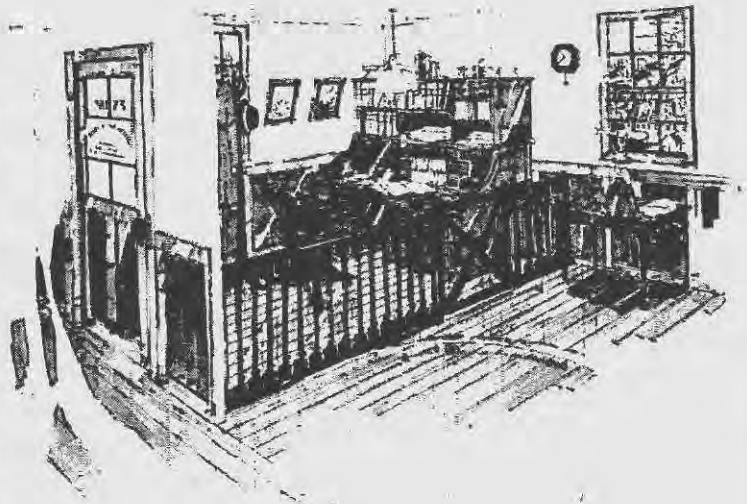
The company has two pension annuity plans: one for the sales force and the other for home office employes. ■

Underwriters office in the Smithsonian

A 19th century marine underwriters office, duplicating those found between 1840 and 1880 is being erected at the Hall of American Maritime Enterprise at the Smithsonian Institution in Washington, D.C.

The Hall is expected to open its doors in time for the 1976 Bicentennial celebration. A committee of the American Institute of Marine Underwriters is in the process of gathering pertinent pictures, documents, furniture and artifacts of the 19th century.

Companies, organizations or brokers who have material to donate are asked to contact C. B. Mitchell at the American Institute of Marine Underwriters, 99 John St., New York.



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Name companies on compulsory surplus orders

MADISON, WI.—Fourteen insurance companies have been served with compulsory surplus orders since August from state insurance commissioner Stanley C. DuRose, who announced a hearing Feb. 20 to discuss proposed amendments to the state administrative code covering regulation of insurance companies.

The companies which have received compulsory surplus orders are, according to Commissioner DuRose: All-Star Insurance Corp., American Mutual Insurance Co. of Boston, American Mutual Liability

Insurance Co., Central National Life Insurance Co., Commercial Standard Insurance Co., Fidelity Bankers Life Insurance Co., Foremost Insurance Co., Globe Life Insurance Co., Industrial Indemnity Co., Lone Star Life Insurance Co., Mammoth Life Insurance Co., National Home Life Assurance Co., Northeastern Life Insurance Co. of New York, and Classified Insurance Corp.

Commissioner DuRose emphasized the order does not indicate "that any of the companies listed are insolvent" but said rather that

the purpose is to alert insurers about "their deteriorating financial condition and the possibility of additional administrative action."

THE COMPULSORY surplus is in effect "a floor," Mr. DuRose continued. "If an insurance company's financial condition gets close to that level, we issue a compulsory surplus order. Unless the firm's condition gets worse than that level, the carrier should not automatically lose the confidence of the public," he said, adding that the company's year-end financial results are evaluated to determine whether sufficient improvement has been made to warrant removing its name from the list.

He said 59 fire and casualty companies and 32 life, accident and health insurance companies are currently on a quarterly financial reporting system. A number of factors and combinations of factors are used to determine which companies must participate, Commissioner DuRose said. One indicator is a surplus decrease of 25% to 30% or more.

Wisconsin statute allows the insurance commissioner to set compulsory surplus requirements for admitted carriers. According to Commissioner DuRose, factors considered in issuing the orders are: Premium volume; past operating results including underwriting and investment; lines and classes of business written; and present capital and surplus.

"Dramatic exposés are a lousy

way to regulate," the Commissioner said, adding that he is "concerned that the information about compulsory surpluses gets published with proper perspective."

Basically the compulsory surplus requirement is "an amount that provides reasonable security against contingencies affecting its financial position that are not fully covered by reserves or by reinsurance."

Insurer offers new policy for contractors' liability

HARTFORD—A new contractors' casualty insurance policy designed especially for large-scale building and construction contractors, is being offered by Hartford Insurance Group.

The policy includes a single general liability premium rate that can be applied to any job during a one year policy term. Rates are determined by the type of construction work usually done by the contractor and the anticipated workload for the year. Applying the premium rate to the contract cost will determine the premium estimate for each project.

IN ADDITION to basic bodily injury and property damage liability coverages, the new policy offers:

- personal injury and advertising injury liability protection in

the event of civil action for such offenses as libel, slander, false arrest, malicious prosecution or invasion of privacy;

- blanket contractual coverage for bodily injury and property damage liability assumed by written agreement;

- blanket explosion, collapse and underground hazards insurance, where exposure to such hazards exists in a construction project;

- coverage extending liability protection to employees when they are acting within the scope of their duties; and,

- broad-form property damage liability coverage to protect the contractors for damage to certain property of others in his care, custody or control in the course of construction, or damage which results from work completed on behalf of the contractor. ■



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Expansive benefit plan may offer long-run savings, says consultant

ENGLEWOOD CLIFFS, N.J.—A generous view of employee benefit planning may prove less expensive in the long run, according to Richard C. Sears, senior vp at Kwasha Lipton Inc., an actuarial consulting firm.

"Considering the administrative costs involved in heaving to a minimum requirements program, such as in the Employee Retirement Income Security Act (ERISA) of 1975, it comes down to a question of being penny-wise and pound-foolish," Mr. Sears said.

Aim to make CNA 'premier' insurer under new chief

CHICAGO—"We want to be more innovative in the future but we're not trying to set any sales records," said Edward J. Noha, CNA Financial Corp.'s newly appointed chairman and chief executive officer.

Although he hinted that some changes might be made in the future—"we'll be looking at pricing, organization and markets"—Mr. Noha seemed content to take charge by quietly rolling up his sleeves rather than by making big speeches.

"It would be presumptuous to know what changes would be made now," Mr. Noha said at his first CNA-Loews press conference since leaving Allstate Insurance Cos. where he was executive vp. "I've got to have time to get into the situation and look at it hard," he added.

"SOME UNPROFITABLE lines will be eliminated," he said, adding that on a nationwide basis medical malpractice and products liability are two lines that "should be examined very carefully."

Mr. Noha predicted that "commercial lines will continue to be a very important part of CNA's business in the future."

Lawrence Tisch, chairman and chief executive officer of Loews, indicated that whatever money is needed to bolster CNA in any future crisis will be "available." But he added that the money is not needed now. "The surplus situation will be no worse by yearend than at any other insurance company," Mr. Tisch predicted. "The reserve situation is excellent."

"We don't want our insurance people to take their eyes off the insurance," Mr. Tisch said in a reference to CNA's previous diversification efforts. "Ed (Noha) will be involved in making CNA a premier insurance company."

With a premium volume of \$1.5 billion, how can an executive get involved in small matters?" he added with a smile. ■

Merger talks ended

Merger discussions between United American Life Insurance Co. of Denver and American Commonwealth Financial Corp. of Dallas were terminated. Exploratory negotiations were announced in October and involved the purchase of authorized but unissued shares of United American stock by American Commonwealth. A class action suit, among other developments, was given as the reason for ending merger negotiations.

"If the plan is excessively restrictive in small ways, you run the risk of losing the credit you should be receiving for the positive benefits your program provides," he explained.

VESTING IS one area that could be "treated minimally under the new law," Mr. Sears told *Business Insurance*. An employer could incorporate all the legal exclusions regarding breaks in service and could choose a vesting standard merely because it is the least costly, he continued.

But these "tricky plan designs," as Mr. Sears calls them, may not be worth the time spent on them because of communication problems and extra administrative

workloads, he explained. "You'd have a plan that is hard to understand, hard to communicate, hard to administer and probably only marginally less expensive than a more straightforward plan would have been," he said.

"Your employees would probably disparage the entire program," Mr. Sears said. "If the plan is excessively restrictive in small ways, you run the risk of losing the credit you should be receiving for the positive benefits."

Other ways for employers to get "good mileage" out of their benefit program without major additional expense include adding surviving spouses' benefits to the pension plan, he said.

"It won't add much to the cost

if deaths after a certain age, such as 45 or 55, are already covered," Mr. Sears explained. "Younger employees who typically have young families will appreciate the added protection this gives them—especially if the death benefit is based on projected rather than accrued pension," he added.

ANOTHER SUGGESTION Mr. Sears has is to provide full service disability pensions at age 65 as a supplement to the long-term disability program, which usually ceases benefits at that age. "Because of high mortality rates among disabled persons, the cost of this benefit is low," he pointed out. "But having it in your plan shows your concern for the long-term needs of employees."

In spite of the liberalized vesting required by ERISA, Mr. Sears believes employers might want to liberalize their vesting provisions even further, since young employees "tend to discount the value

of a retirement plan."

"Benefits they can relate to—whether earlier vesting, immediate vesting or protection against disability—can turn your pension plan into a plus in their eyes," he said, adding that the increased cost to do this is low.

Mr. Sears advocates contributory thrift plans over non-contributory profit sharing plans—again, because an employer gets more "mileage" out of them. "An employer can bask in the magic of a savings plan for a relatively modest cost, say 2% of payroll," he said.

He contrasts two hypothetical reactions an employer might receive depending on whether he chose a thrift plan or a profit sharing plan.

• "You mean for every dollar I save my company kicks in 50¢? That's terrific." Or,

• "You mean all I have to show for my efforts this year is a lousy \$300? Some profit sharing." ■



Johnny Unitas

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Most passes attempted, 5,186.
Most passes completed, 2,830.
Most touchdown passes, 290.
Most yards gained passing, 40,239.
Most games, 300 or more
yards passing, 23.

Most consecutive games,
touchdown passes, 47.
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Perry named risk manager at Amfac Inc.

Ralph F. Perry, CPCU, was named corporate risk manager of Amfac Inc., San Francisco. He replaces Joseph E. Bridges, who left the company after five years service. He reports to Richard A. Hagberg, vp-finance. Mr. Perry, who is president of the northern California chapter of the Risk and Insurance Management Society, has been concerned lately with the company's headquarters move from Honolulu. The 48-year-old risk manager was formerly with Fairchild Camera and Instrument Corp. in Mountain View, Ca. The position he vacated there remains unfilled.

Anthony M. Black, 25, was promoted to insurance manager at Bunker Ramo Corp., Oak Brook, Ill., following a reorganization of administration in the insurance department. As insurance administrator, from May, 1972, until his promotion, Mr. Black assisted the director of insurance, Harold Lang. The director's position was abolished and the manager's position was created when Mr. Lang became the director of facilities, with responsibility for real estate, facilities engineering and insurance. Mr. Black, a native of England,

oversees the manufacturing concern's property and casualty program, financial aspects of group benefits and international insurance.

Allan A. Crystal was elected treasurer of Pitney Bowes Inc., after serving as director of corporate taxes and insurance since 1973. He will continue to direct the company's corporate taxes and insurance functions in addition to his new responsibilities for cash and securities administration and administration of the pension fund. He reports to George B. Harvey, vp-finance, who served as vp-finance and treasurer until the election of Mr. Crystal. Assisted by corporate insurance manager Irv Berger, Mr. Crystal's main concerns will be in the property and casualty area.

Al Hall, 31, was named risk manager at Investors Funding Corp. in New York. He was formerly with the Southwest Virginia Community Development Fund. Mr. Hall's responsibilities will include property and casualty programs for the company and its subsidiaries, as well as employee benefits. He reports to Warner D. Norton, vp. Mr. Hall replaced Bert Weber, who left the company.

William D. Hahn, formerly insurance manager for the Roman Catholic Archdiocese of Boston, joined the risk management consulting firm of Betterley Assoc. in Boston. Mr. Hahn was replaced at the archdiocese by Francis X. Walsh formerly with Kaler, Curney, Liffler & Co. Inc., a Boston brokerage firm. Mr. Hahn, 33, is a past director of the Massachusetts Risk and Insurance Management Society.

Safety and health consultations won't trigger OSHA inspections

WASHINGTON—The Labor Department assured small businesses that on-site safety and health consultations beginning soon will not trigger Occupational Safety and Health Administration inspections.

If there is a subsequent inspection, however, compliance officers could issue citations regardless of

earlier findings or recommendations of the consultant, the department said.

Congress allocated \$5 million last year for fiscal 1975, ending this June 30, to allow OSHA to establish on-site consultative services for small businessmen in states where OSHA runs the job safety and health program, rather than

Federal no-fault auto insurance likely as new, favorable Congress convenes

WASHINGTON—With only four states adopting no-fault auto insurance standards in 1974, the chances for passage of a federal no-fault law in 1975 look better than ever.

Georgia, Kentucky, Minnesota and Pennsylvania adopted some form of no-fault law during the year. These laws restrict the right to sue for pain and suffering and provide varying levels of benefits for medical and rehabilitation costs, lost income and other losses, regardless of who was at fault in the accident.

South Carolina passed a law that provides up to \$1,000 in no-fault benefits, but places no restrictions on lawsuits for pain and suffering.

At the end of 1974, there were 15 states with no-fault laws. In addition, eight others had so-called "add-on" laws that add no-fault benefits to the existing tort system without restricting lawsuits for pain and suffering.

FEDERAL NO-FAULT legislation, under consideration by the Senate since 1970, came close to passage when the Senate passed S.B. 354, a federal no-fault standard bill, on May 1, 1974.

But time ran out before any action could be taken on S.B. 354 and other no-fault bills under consideration by a House subcommittee in late 1974.

S.B. 354 would have required states to enact laws providing unlimited medical and rehabilitation benefits, plus substantial

benefits for lost income, replacement services and survivor's loss. It would allow recovery of damages for pain and suffering only after 90 days of continuous total disability or if the injury was serious or permanent. If a state failed to enact these no-fault standards, a more stringent set of standards would automatically take effect.

PASSAGE OF a federal no-fault law in 1975 is likely because of two developments: the Congressional elections appear to have increased the number of no-fault supporters and procedural

changes adopted by the Democratic caucus in the House should make it harder to bottle up legislation in committees.

The courts are also playing a major role in shaping the future of no-fault. Supreme courts in Florida and Kansas upheld the constitutionality of no-fault laws in their states in 1974. A circuit court in Detroit upheld most sections of Michigan's no-fault law, but the final outcome will be decided by the state supreme court.

No-fault laws are also being tested in the courts of Colorado, New York, Pennsylvania and Kentucky.

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dates for buyers

Feb. 19: Hay Assoc. is presenting an executive insurance planning institute in Chicago. Demonstrated will be ways to coordinate corporate and personal coverages in life, disability and medical insurance, and casualty and liability insurance for the individual. The attendance fee is \$150. For registration write the firm at 1845 Walnut St., Philadelphia, Pa. 19103.

Feb. 24-28: The American Society for Industrial Security is sponsoring a comprehensive asset security course in Atlanta. Included will be courses on security management and administration, security surveys and surveillance and communications. For more information contact ASIS, 2000 K Street, N.W., Washington, D.C. 20006.

Feb. 26: The New York chapter of the Society of Fire Protection Engineers will hold its fourth annual seminar in New York. This year's topic will be "Learning to Live With Plastics." For reservations, write Robert Powers, New York Board of Fire Underwriters, 85 John St., New York, N.Y. 10038.

Mar. 12-14: The American Management Assn. will hold a seminar on self-insurance and risk retention, in Chicago and Dallas. For more information, write the AMA, 135 W. 50th St., New York, N.Y. 10020.

Mar. 19: The second annual Capital I Day will explore a wide range of problems facing the insurance business. Sponsored by 11 insurance associations representing companies, agents, buyers and professional societies, the meeting will take place in Washington, D.C. Reservations can be made through the Metropolitan Washington Assn. of Independent Insurance Agents, 1750 Old Meadow Rd., McLean, Va. 22101.

Mar. 20-21: The Society of Actuaries will hold a meeting in Los Angeles. For more information, write James C. Harrison, North Carolina Mutual Life Insurance Co., Durham, N.C. 27701.

a state agency.

States operating their own programs under OSHA-approved plans are already authorized to provide such services.

THE NEW consulting services will also be provided by a state agency, but under contract with the Labor Department.

"As in a normal inspection," the department said, "each consultation will consist of an opening conference with the employer, a walk-through of the company facility, a closing conference, and a written summary of the findings."

No citations will be issued, but consultation agreements also will contain provisions for immediate abatement of imminent danger situations and for protecting the confidentiality of trade secrets.

During walkthrough inspections, consultants are to:

- Explain to the employer which OSHA standards and rules apply to his workplace.

- Explain the technical language and application of applicable standards.

- Point out to the employer where he is not complying with OSHA standards.

- And, where possible, suggest means by which identified hazards may be abated.

Because they already have state programs, the new OSHA consultations will not be available in the following states or territories: South Carolina, Oregon, Utah, Washington, New Jersey, North Carolina, California, New York, Minnesota, Maryland, Tennessee, Iowa, Kentucky, Alaska, Virgin Islands, Colorado, Michigan, Vermont, Illinois, Connecticut, Hawaii, Nevada, Indiana, Wisconsin, Wyoming, and Arizona.

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