Week of February 7, 1977

business insurance

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

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Trim benefit plans to counter federal actions: Consultant

By MARIE KRAKOWIECKI

NEW YORK—A member of one of the nation's leading consulting firms suggests employers cut back on their employe benefits programs as one strategy to deal with increased government intervention.

Addressing the implications of government policy on employe benefits, Susan Koralik of Hewitt Associates told a Conference Board meeting here to consider reducing unnecessary private benefits as government benefits continue to expand.

Since the corporate trend over the past decade has been toward increasingly liberal benefits programs, Ms. Koralik's suggestion raised a few eyebrows as well as possibilities among the group, which was largely composed of employe benefit managers.

Commenting that total benefits from private and public sources seem "excessive" to many companies, Ms. Koralik suggested:

"One approach is to carve out a portion of these benefits—reducing the costs for these plans—and offer employes the opportunity to spend the cost savings on new optional benefits. Programs of this type increase the employe's knowledge of available benefits and increase the perceived value of the program by allowing employes to tailor their benefit package to meet their individual needs."

Ms. Koralik, when asked how an employer might "carve out" benefits which have been established through collective bargaining, explained that a more logical place to begin would be with salaried employes rather than a union.

One Hewitt client—a Fortune 100 company—had been spending up to 49% of payroll on employe benefits, Ms. Koralik said. The firm recently began restructuring its approach by reducing benefits in its pension plan and death and medical insurance programs for salaried employes. Instead, it will offer the salaried employes a flexible benefit plan which permits the individual employe to select a set of benefits tailored to his or her own needs, but which is limited to 8% or 9% of payroll. This gives the employes a definite idea of the worth of their benefits, allows for individual selection, yet controls the company's over-all program costs, she explained.

However, the Hewitt consultant said she did not know of any cases yet where a company has been able to work out an agreement to cut specific benefits for unionized employes in favor of of-

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Susan Koralik says many companies find total benefits to be 'excessive.'

Medium sized firms find prices up, market tight

By KATHRYN McINTYRE ROBERTS

CHICAGO—A Massachusetts medical instruments manufacturer with $3 million in sales last year paid $20,000 for $1 million of general liability insurance. This year the same policy was priced at $150,000.

A West Coast company with $300 million in sales last year paid $18,000 for an excess policy covering losses between $500,000 and $15 million. This year the insurance company is quoting a $200,000 premium and reducing coverage so the policy only picks up losses over $1 million. Thus, a new $500,000 primary policy is costing another $60,000.

Three large eastern companies each carrying less than $5 million of general liability insurance were cancelled by their insurers. They included a newspaper and magazine distributor, a chain of toy stores and a New York supermarket chain.

Those experiences are typical in the current insurance market for medium sized and smaller companies, according to risk management consultants. *Business Insurance* interviewed 16 consultants on the insurance problems of companies with annual sales from $500,000 to $300 million.

The consultants didn't always agree. But the majority pointed to several recurring frustrations:

• General liability premiums for these companies are continuing to skyrocket. Quoted increases ranged from a conservative 25% to an extreme 1,200%.

"The increases are astronomical. Where there's any obvious risk for the insurer, the advantage they take is unconscionable," said Leonard J. Silver, president of First Insurance Management Co. in Wyncote, Pa.

For most companies, product liability is included in the general liability policy. The biggest increases reflect product exposure, the consultants said. The new premiums are seldom less than double their previous cost where there is a product exposure, they generally agreed.

"Firms with no product liability have little problem," said Herbert C. Cox, president of Aldrich & Cox Inc. in Buffalo, N.Y. "But it's more expensive than they are used to—about 25% more."

Professional liability—including errors and omissions insurance for architects and agents in addition to the well-publicized medical malpractice problem—is difficult to obtain and is expensive, the consultants said.

• Umbrella policy premiums are jumping three, five and ten times.

"We'll get a call from a client who was paying $8,000 a year for an umbrella. On renewal the insurance company wants $65,000. We have to say 'that's a pretty good deal' because the last one we heard of was up to $100,000," said Harry C. Anderson, chairman of Corporate Policyholders Counsel Inc. in Chicago.

"I really think what we're facing is that umbrella policies for these companies will be too expensive. Ten years ago only the big operators carried umbrellas. They were the only ones who could afford it. I think it's going to be that way again," said Stanley Brock, president of The Lukes-Brock Co. in Milwaukee, Wis.

• Excess insurers are tightening their policy limits. That's forcing the insureds to buy buffer layers to fill in the gap between their primary and umbrella policies. The demand is driving policy prices up four and five times.

"Umbrella carriers are now requiring at least $500,000 or maybe $1 million for underlying limits. So the companies have to buy buffer layers and they come at enormous prices," said Robert N. Hughes, executive vp of RIMCO Inc. in Dallas, Tex.

He said a company last year paid $30,000 for a maritime liability policy covering losses to $150,000 in excess of $100,000. This year the premium was $198,000.

• Property and crime insurance

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The inside story

Pension law costly

The federal pension law is costing corporations a bundle, says our Employe Benefit Board. But despite dire predictions, terminations are hard to find. **Page 3.**

Product liability

Two bills have been introduced in the Senate calling for a federal reinsurance pool to reduce the soaring product liability costs. **Page 6.**

Elsewhere:

• THE TRAVELERS has won 2 AT&T health insurance contracts. Benefit Beat, **Page 3.**

• A CALIFORNIA legislator proposes an extension of medical damage limits to other areas. **Page 4.**

• SAFETY GRADUATES from a new Arizona program have found a fantastic job market. **Page 12.**

• AN EX-BROKER'S multi-employer job may open up new careers for others. riskWatch, **Page 26.**

• THE INSURANCE industry should keep unsafe tankers in port. Editorial, **Page 18.**

• DATA PROCESSING can help control employe benefits costs. Perspective, **Page 36.**

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American Home excess policies

Punitive damages excluded

By KATHRYN McINTYRE ROBERTS

CHICAGO — American Home Assurance Co. is excluding punitive damages when renewing some excess liability policies, *Business Insurance* learned.

An insurance consultant said the move indicates "we can expect to find exclusions for punitive damages in general liability policies in the future."

"It's pretty significant," said a broker with one of the largest national firms who had just recently encountered the exclusion. He said his firm will attempt to negotiate an alteration of the exclusion.

Dennis Busti, vp for commercial casualty at American Home, confirmed the move. "We are considering a punitive damages attachment and to some extent have done it." He declined to say how many policies had been changed, claiming, "We haven't come up with an over-all policy yet. It's under a lot of consideration from a corporate standpoint."

He noted that the exclusions pertain only to excess policies because the Insurance Services Office (ISO) rates and filings do not include the exclusion for primary policies. However, he said, "We expect the ISO to push for it in 1977, and to see all companies following."

Richard Savage, vp of ISO in New York, said, "We are examining it. It's still before committees so it would be premature to say what will be the outcome. We hope in the next few months to come to a conclusion."

But an executive with an insurance company influential in ISO told *BI* that there is general agreement in the ISO to exclude punitive damages in general liability, commercial auto and commercial package insurance. "Most have agreed it will take place. They are drafting the wording of it," he said.

He pointed out that the ISO reflects its member companies' opinions. The insurance companies want the exclusion particularly because of "the increased number of awards that have included punitive damages."

American Home supports the move to exclude punitive damages in general liability policies. Said Mr. Busti, "Our hope is that it does become excluded. We always felt policies shouldn't include punitive damages. It defeats the purpose of punitive action."

Other companies apparently have the same opinion. The Insurance Company of North America (INA), for instance, isn't yet writing exclusions for punitive damages. But its assistant secretary Robert Briggman said, "We would be as quick as anybody to adopt it when it's promulgated by the ISO."

At Aetna Life & Casualty, "the question is under study." ■

Changes urged in secondary health benefits

By SUSAN ALT

HILTON HEAD ISLAND, S.C. —Workers anticipating national health insurance won't perceive improvements in employe benefit plans to be worthwhile unless employers make changes in areas not likely to be altered by a national plan, says a leading benefit consultant.

"It can be anticipated that NHI is likely to give priority to basic coverages," said John van Steenwyk, vp of Martin E. Segal Co. "Thus, any improvements... should be in areas not likely to be affected by it—like dental care, vision care and direct-service health care arrangements."

This is one of the trends in health care plans Mr. van Steenwyk outlined at the Blue Cross Assn. conference here in mid-January. He also said:

- The emphasis is now on the "separable" benefits such as dental, optical and first-dollar drug coverages because these lend themselves to close definition of covered services and expenses.

van Steenwyk

- One anticipated effect of national health insurance will be the shift in emphasis toward direct - service health care arrangements (i.e. outpatient clinics), and toward guidance and counselling along with other forms of direct help.
- Health insurance modifications such as pre-admission testing provisions, use of extended care facilities and home care could make an appreciable difference in the extent of hospitalization.
- HMOs have proved their worth in terms of cost control and are now beginning to show price advantage over comprehensive Blue Cross/Blue Shield or insurance company coverage.
- Stopping short of near-universal enrollment in HMOs, the effects of cost control efforts by employers are marginal because "they simply chip away at the edges of the problem."
- While purse string tightening can have limited worthwhile results, the ultimate benefit cost control is the long term reduction in demand for physician services and hospital treatment.

Mr. van Steenwyk indentified three stages of employe benefit plan development. In the first "benefit building" stage, companies initiate and improve benefit plans. The second "cost control" stage involves an attempt by companies to "keep their financial obligations within bounds." A final stage, just beginning to emerge, involves a radical restructuring of the health care delivery system to limit demand for services.

The third stage "is not only a response to the cost problem, it is a logical adaption to the changing nature of medical care and the changing focus of disease problems," he said.

The cost control stage is a direct result of the enormous growth in health programs. Employer-provided health insurance covers 70% of all wage and salary workers. Nearly all plans provide primary coverage for hospitalization and surgical care, as well as providing in-hospital medical benefits, Mr. van Steenwyk noted. About half have major medical coverage, about one-fourth have prescription drug coverage and about one-fourth have dental coverage.

Prepayment or insurance covered 14.4% of private sector personal health expenditures in 1950; 38.7% in 1970; 43.2% in 1974. He cited impressive figures showing that 82% of hospital costs for those not covered by government programs were paid by third parties in 1975. Fifty-three percent of all physicians' fees and 10% of dentists' charges were also reimbursed by third party payers.

One currently popular change in benefit plans, he noted, is providing extra days of hospitalization coverage—for example, an increase to 365 days from 120 days —which he categorized among the improvements "which are more impressive-sounding than costly."

Among the coverages with effective cost control drawing growing attention is post-hospital visiting nurse service, which was available on a prepaid basis to 137 million people in 1974, up from only 60 million people in 1965. In addition, nursing home care rose seven-fold in the same period, to 70 million from seven million, while out-of-hospital X-ray and lab exams were prepaid for 153 million persons in 1974, up from only 79 million covered in 1965, Mr. van Steenwyk pointed out.

Because dental care is a new benefit which can be tightly defined and "inaugurated in bite-size stages," it has shown a dramatic increase to 35 million persons covered in 1975, up from 12 million in 1970 and three million in 1965, he added.

The influence of national health insurance (NHI) when enacted, will be to free money "so that the functions of employe benefit plans can be expressed in other ways—more life insurance, expanded drug and dental benefits; group legal insurance; group auto insurance," Mr. van Steenwyk predicted.

On the other hand, he went on to say that "there is growing doubt that NHI will remove the burden" of rising costs of health care, as borne by employers. One evidence of the growing cost burden, he noted, is the 10% hike in the cost of health care last year.

But to effectively control costs, Mr. Steenwyk recommended a radical restructuring of the health care delivery system to treat chronic long term disease.

"Of all the cost control devices possible, none are especially powerful," he said, "especially when used singly by an employer or welfare fund."

"One visualizes," he continued, "an army of pygmies with peashooters energetically attacking an elephant."

He pointed to the leading causes of hospitalization, disability and major expense as including non-infectious and non-accident-caused illnesses as heart disease, cancer, stroke, gall bladder disorders, ulcers, arthritis, diabetes, and hypertension.

Response to degenerative diseases should be geared to slow, gradual onset, potential arrest or management of the disease after early detection; reduced suffering and expense as a result of early attention; and behavior modification as a result of the individual's understanding and self-management, he believes. ■

Shirt-Sleeve Forum

Who's a New General Partner And Also Likes To Ski?

By Dinner Levison

(Asked in the financial district)

Gary Goddard, Insurance Broker 220 Bush Street, San Francisco:

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Feb. 28 deadline nears for BI benefit contest

NEW YORK—The deadline for entries in the fifth annual *Business Insurance* Employe Benefits Communication Award contest is Feb. 28.

Entry forms, contest rules and further information may be obtained from Ronnie Drachman, Award Coordinator, *Business Insurance*, 708 Third Ave., New York, N.Y. 10017. Ms. Drachman may be reached at (212) 986-5050.

More than 400 requests for entry forms have been received. The awards will be presented April 26 during the Risk & Insurance Management Society conference in New York. Categories to be judged include booklets, personalized correspondence, audio-visual presentations and total communications programs. A panel of six judges will be chosen in December.

Last year's winners for total communications programs included Owens-Corning Fiberglas Corp., Toledo, Ohio, first place; Continental Can Co. Inc., New York, second place; and Chemetron Corp., Chicago, third place.

Chemetron Corp. won top honors in the booklets category last year. The second place award went to Continental Can Co., New York. Birmingham News, a division of the Newhouse Group, which worked with Employe Communications Services Co. in Birmingham as a consultant, won third place. ■

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Pension law costing corporations a bundle

By SUSAN ALT

CHICAGO—The federal pension law has clearly cost America's corporations a bundle of money to upgrade benefit plans and in increased administrative costs. But notwithstanding the din of predictions that the law would doom the nation's pension plans, terminations are difficult to find among larger companies.

That's the picture that emerged from 66 benefit managers who responded to written questionnaires in the first *Business Insurance* Employe Benefit Board survey of 1977.

The results are similar to those in a recent *BI* story surveying consultants on the impact of the Employe Retirement Income Security Act (Jan. 10).

The survey also indicated that employe benefit managers are very concerned about rising costs of health insurance, hospitalization and doctors. Half the Benefit Board members said they were studying cost control measures and hope to implement tougher controls this year. Thirty-three different techniques were listed, with the most popular being tighter administration and claims review, HMOs and employe education programs.

In the pension area, benefit managers said forecasts of widespread terminations of defined benefit pension plans just aren't materializing. Only one of the 66 responding panelists said he has terminated such a pension plan in the wake of ERISA.

This single service-oriented company has already ended three pension plans, said the benefit manager, who is "reviewing each such plan with the intent to discontinue wherever practical."

A manufacturing firm hasn't killed any pension plans yet, but plans to "wherever we can, through consolidations."

A third firm has adopted a policy of not starting up any new defined benefit pension plans because of ERISA, but will continue what it already has. When the need arises for new plans, defined

employe benefit board survey

contribution programs will be introduced.

The pension law appears, however, to have put a damper on improvements in pension and welfare plans. Twenty Benefit Board members said their companies won't be making any improvements at all, and many of the 46 that do plan to improve the benefits in their plans will move cautiously.

Benefit managers with companies having union employes foresee continued improvements as a result of negotiations.

"We expect to continue to make improvements as required by union talks and competitive practices," said the manager for an electronics manufacturer.

"Improvements will be made as necessary. The passage of ERISA, although a factor in any decision, will not be the determining factor," said the manager at a firm in the foods industry.

"Plan design is determined by employe needs and competition in industry," said another, "and we will continue this philosophy."

By and large, corporations represented by our Benefit Board members haven't shifted their sights to other forms of retirement benefits from the defined benefit plans they had prior to the pension law. We asked contributors if their companies had decided to shift to such programs as defined contribution plans (profit sharing plans, thrift or other money-purchase plans) in ERISA's wake. Fifty-seven panel members said no; nine said they have made these changes.

A large electronics firm has had "some movement to defined contribution plans, but not just because of ERISA," pointed out its benefit manager.

A firm in the energy resources field has "introduced defined contribution plans in two new subsidiary companies" in lieu of sticking with defined benefit retirement programs, said the benefit manager.

For the nine firms which altered their benefit plans because of ERISA, the reduced costs of such shifts were substantial. Three firms estimated a difference in cost from the old plans of over $1 million a year, while three other large companies said the difference was between $100,000 a year and $300,000 a year.

The benefit manager for a petroleum supplier noted that the "defined contribution plan was introduced more to provide predictable annual costs and thus help budgeting, rather than to generate cost savings."

That estimated cost difference from the altered plans, however, is not nearly as significant as the data about the added cost of maintaining pension and profit sharing plans following ERISA.

A large group of benefit managers (18) said they know their costs are higher now, but they're too busy with paperwork to stop and figure out exactly how much. Another six gave no answer, while only four said the impact of ERISA has been minimal.

The remaining 33 Benefit Board members listed added costs between $10,000 a year and over $5 million a year because of ERISA, with the largest group (9) falling in the $50,000 to $100,000 added cost range.

Four said their additional outlays to maintain benefit plans are under $50,000 a year. One said the added cost to his company is between $100,000 and $200,000 a year.

Seven Benefit Board members pointed to added costs of $200,000 to $500,000 a year, four panelists said their costs have risen $500,000 to $1 million, seven said their costs are up more than $1 million a year and one said costs have gone up more than $5 million.

Some of the figures submitted didn't even include the cost of added actuarial work and legal fees. One manager who said his costs are up $5,000 to $10,000 a year said, "This is an ongoing cost and does not represent the cost of personnel people at locations. It also does not include increased actuarial and legal fees to bring the plan into conformance with the law."

At the other end of the spectrum was the benefit manager who bemoaned the $1 million added expense to his forest products company of the pension law, then added this figure doesn't include legal, actuarial or administrative costs which are as yet undetermined.

In between those two is a typical firm that foresees an added cost of about $275,000 for 1977, which is expected to go down to about $50,000 annually in added expenditures thereafter.

The second section of the survey dealt with health and medical insurance cost controls. Panel members have suggested that *Business Insurance* attempt to determine a full range of control techniques being used by benefit managers to hold down claims and expenses in the health field. They also expressed interest in knowing the extent of participation in cost control programs.

What we found out is that nearly everyone is seriously studying

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the benefit beat

Travelers wins 2 AT&T plans worth $46 million

TWO AT&T divisions have awarded the Travelers Insurance Co. their health insurance programs involving 195,000 active and retired employes and a reported $46 million a year in premiums. AT&T said the move is to simplify claims handling as well as hold down costs. Travelers will provide medical, surgical and major medical coverage for the 42,000 employes of the Long Lines division and the 113,000 employes of New York Telephone Co. Hospital coverage remains with Blue Cross. The company attributed that decision to Blue Cross service ("as good as any available") and the discount (which results in lower hospital charges to Blue Cross insureds than to patients with commercial insurance). Blue Shield had provided the medical coverage and Blue Cross the hospitalization for both divisions. New York Life Insurance Co. had major medical for Long Lines and Metropolitan handled that coverage for N.Y. Telephone. The conventional, experience-rated contract is for one year, although one person involved said the policy was "open-ended." The seven largest insurance companies competed in the competitive bidding; Johnson & Higgins served as a consultant for AT&T. The company maintains a uniform benefit package for all its subsidiaries.

FMC CORP. established a TRESOP (tax reform employe stock ownership plan) to take advantage of the new tax credit and to provide employes with a no-cost benefit. The Chicago-based manufacturer placed more than $2 million in the trust and expects each employe with one year of service and more than $5,000 earnings in 1975 to receive four shares of stock. Vesting is immediate and shares will be distributed in the event of disability, retirement, death or termination. Officers are excluded and the company expects to review the TRESOP each year in light of tax changes. The program is in addition to the company's defined benefit pension plan (with 10-year vesting) and a thrift plan. Under the thrift plan, employes may save in either an equity fund or a bond fund, with company contributions pegged to profits.

MUTUAL OF OMAHA won the CHAMPUS contract to handle medical and hospital claims for military retirees and dependents in Nebraska and Colorado. The company expects to process 60,000 claims a year at a cost of $5.67 a claim. Blue Shield/Blue Cross formerly handled the Colorado program while Mutual has administered the Nebraska program for over 20 years. In addition, CHAMPUS asked Mutual to resume handling claims in Texas after Health Application Systems failed to provide adequate service. Mutual administers CHAMPUS programs in 20 states.

EMPLOYES AT Operations Research Inc. (ORI) have bought their company from their parent conglomerate by using an ESOP (employe stock ownership plan). Reliance Group Inc. acquired the suburban Washington consulting firm in 1968, but is now selling subsidiaries that are not involved in the insurance industry. ORI employes used money placed in a profit sharing trust before the 1968 acquisition as an equity base, secured a term loan from a Washington bank and gave Reliance a note for the rest of the $3 million purchase price. The company is now completely owned by the ESOP, although the trust is heavily mortgaged, said ORI president Harvey D. Kushner. Shares will be distributed in relation to salary. A seven-year vesting schedule has been established and the trust will buy back shares from employes leaving the company in relation to the amount of money in the ESOP that is no longer mortgaged. ORI hopes to pay off the debts in seven or eight years since "everyone has an incentive to get the ESOP out of debt." The company also has a defined benefit pension plan with 10-year vesting for its 270 employes.

LARGER EMPLOYERS can be expected to move quickly to self-insure their health benefit plans in the event of a federal catastrophic health insurance program. Harry E. Hineman, vp for Blue Cross/Blue Shield of Indiana, made that prediction at a Blue Cross Assn. conference in Hilton Head, S.C. A catastrophic health insurance plan would simply "remove the self-insurance risk for large employers." Mr. Hineman said the result would be the evolution of Blue Cross and commercial insurance companies from risk mechanisms to service organizations.

RHODE ISLAND CARPENTERS have moved their dental insurance plan from Equitable to the Delta Dental Plan administered by Rhode Island Blue Cross. The new plan for the 1,100 carpenters is paid from the union's health fund, financed by employer contributions. The plan's first level covers 100% of the cost of x-rays, cleaning, fillings, extractions and biopsies up to $500 per year per individual. A second level adds 100% coverage for oral surgery, periodontics, endodontics, inlays and other services with a combined annual maximum for both levels of $750. Periodontics are covered at 50% up to $300 a year. The program was awarded as a result of competitive bids, although the union would not disclose premium costs or other bidders. The union chose the plan because there was no deductible and the members did not have to bother with claim forms. Over 90% of the state's dentists participate in the plan.

THE STATE OF NEW JERSEY is about to put its prescription drug benefit out for bids. Presently insured by Blue Cross of New Jersey, the benefit covers 60,000 state employes at a cost of $3.2 million a year. The benefit was previously administered by the department of treasury with a 12-month contract beginning in December. Administration has been shifted to the division of pensions and plans are underway for a 12-month contract to begin in July, the same as the state's fiscal year. "I wouldn't be at all surprised if Blue Cross got the contract again," according to a source in the division of pensions. The benefit was first introduced in late 1974 as a result of collective bargaining agreements. Managerial and other employes not covered by collective bargaining were included in 1976; legislation extended the program to Rutgers University employes. Employes pay the first $1.25 of each prescription with pharmacists billing Blue Cross directly for the balance. More than 90% of the state's pharmacists participate.

BLUE CROSS OF FLORIDA is revising its method of reviewing hospital charges. A profile of charges for the 200 to 250 most frequently provided services will be the basis a comparison of individual bills against the profiles. Bills with a large number of charges not on the profile or a frequency in excess of the norm will be investigated. The profile covers more than 85% of the total hospital revenues and charges to patients. Hospitals revising their charges submit a new profile with a statement on the impact of the changes.

Benefit Beat is designed to keep employe benefit managers and others in the insurance field informed on trends in other companies. We'd like to know if you've made any important changes in your employe benefit programs or know of any significant developments. Write Benefit Beat, Business Insurance, *740 N. Rush St., Chicago, Ill. 60611 or call (312) 649-5279.*

Legislator threatens an extension of malpractice limits to other areas

OAKLAND—Provisions of California's Keene bill, which restrict the amount of damages in medical malpractice lawsuits, may be applied to other types of liability lawsuits if the state supreme court decides that the bill is unconstitutional, state assemblyman Alister McAlister said at the annual meeting of the Public Agency Risk Managers Assn.

Trial lawyers will probably challenge the Keene bill as "special legislation" that discriminates in favor of the medical profession. Such a ruling from the supreme court, however, would result in a pyrrhic victory if the same provisions are applied to product liability, municipal governmental liability and auto liability, said Mr. McAlister, chairman of the state assembly's insurance committee.

The medical malpractice reform act, sponsored by assemblyman Barry Keene and passed by the last session of the California legislature, restricts the non-economic recovery for pain and suffering to $250,000, limits the amount of recovery from collateral sources, establishes a fixed schedule for lawyers' contingency fees and defines a statute of limitations for malpractice claims.

The Keene bill limits the defendant's right to double recovery from collateral sources such as Social Security benefits, state disability, workers' compensation, or accident, health, sickness or disability benefits the claimant may have through his group policy. Contingency fees for attorneys are limited to 40% of the first $50,000 awarded and 10% for everything awarded over $200,000.

Mr. McAlister sponsored the resolution that created a joint legislative committee on tort liability. The committee, which is composed of five state senators and five assemblymen, will explore the possibility of applying provisions of the Keene bill to other fields of liability litigation, he said.

Physicians and other professionals, hospitals, cities, public entities and local governments, as well as manufacturers and distributors, are experiencing great difficulties in obtaining liability insurance because of the strains that court decisions have placed on liability law, Mr. McAlister said.

"Major reform of tort law is needed so that business, professionals, and public agencies can function without undue uncertainties and undue liability, but not wholly removed from liability for wrong-doing," the assemblyman said. ■

N.Y. official named

Louis A. Brown, 59, was promoted to director of claims for the New York State Workmen's Compensation Board, replacing Jacob Schutzbank who retired after 33 years of service. In his new position, Mr. Brown, who was assistant director of claims for the past four years, will head a department of 300 employes who process claims under both the workers' compensation law and the volunteer firemen's benefits law.

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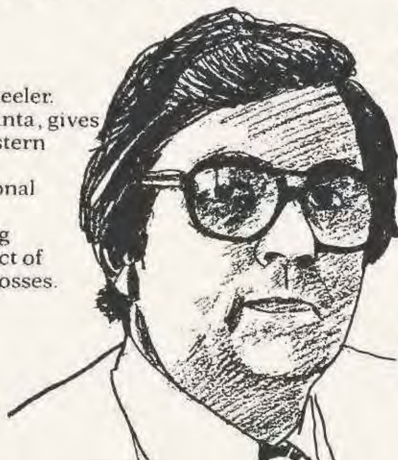

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RISK AND INSURANCE MANAGEMENT SERVICES; EMPLOYEE BENEFIT AND ACTUARIAL CONSULTING THROUGHOUT THE WORLD

Cities unveil proposals on soaring costs

OAKLAND—The League of California Cities has developed recommendations for state legislation to offset the prohibitive cost of liability insurance for public entities, Richard L. Knickerbocker said at the annual meeting of the Public Agency Risk Managers Assn.

The recommendations include extending payments over a 10-year period, eliminating or modifying the collateral source rule, mandatory arbitration, and a 120-day notice requirement for cancellation, said Mr. Knickerbocker, city attorney of Santa Monica.

Extending payment over a 10-year period would provide a public entity with a means to plan its losses and to pay on self-insured retentions. It would also prevent a situation where a claimant's illness disappears as soon as the money is paid out. The payments could be stopped if fraud is discovered during the 10-year period.

The collateral source recommendation would allow the jury to be told of all money received as a result of an accident from other sources as well as any liens against those payments in the event of a jury award.

The recommendations also urge that every claim be sent to arbitration. The losing side could appeal the abitration verdict in a jury trial, but that party would have to pay all legal and court costs if the jury verdict was not greater than the arbitration award.

The league suggested that a 120-day notice be required for cancellation or an increase of more than 25% over the previous year's premiums. ■

errors & omissions

• Holy Family Hospital, Des Plaines, Ill., bought its medical malpractice insurance from Continental Insurance Co. of New York before it went to Argonaut Insurance Co. in the fall of 1976. The hospital was incorrectly identified in a story in the Nov. 15 issue as having previously bought its insurance from CNA.

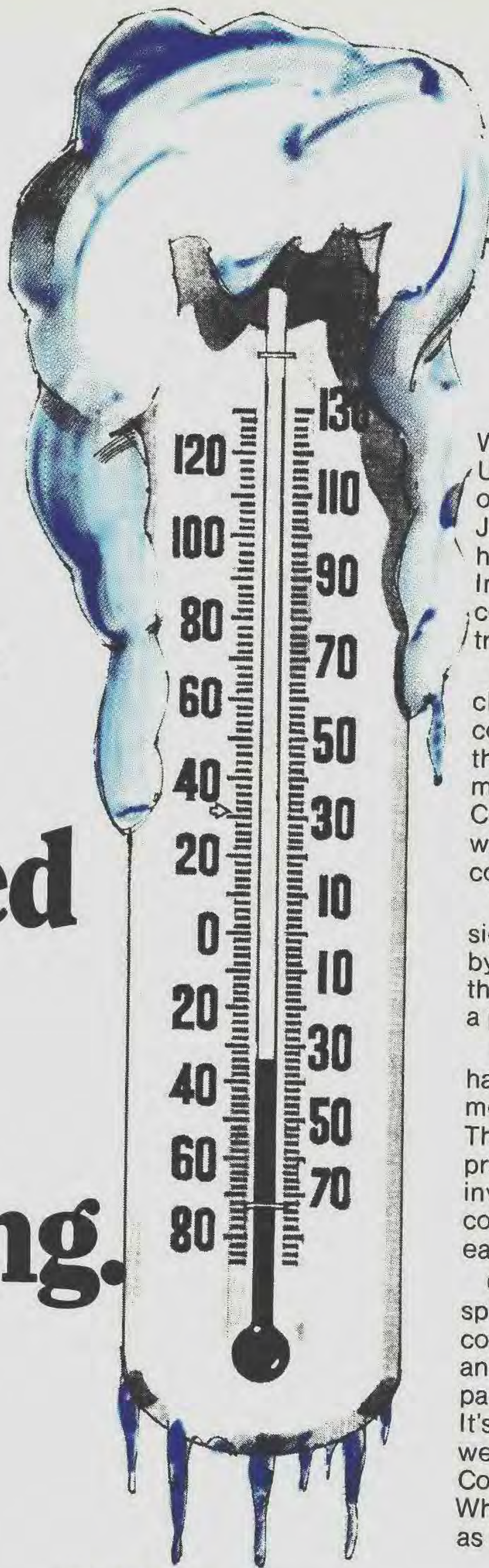
Alberto Heller, vp of finance for Holy Family Hospital, also corrected a statement he was quoted as making that he had dealt directly with the president of Argonaut concerning the hospital's risks during negotiations to obtain coverage from Argonaut. Mr. Heller now says he never dealt directly with the executive at Argonaut and would not have made such a statement.

He also said some hospitals in the suburban Chicago group which had investigated establishing a captive insurer didn't have any loss experience to speak of. Mr. Heller said, however, in a subsequent letter to *Business Insurance* that this statement is "patently not sensible," denying that he said or inferred this to anyone.

Business Insurance believes it accurately quoted Mr. Heller in both instances but is happy to clarify his position.

• Peter H. Wood was elected vice chairman of the Assn. of Lloyd's Brokers. He is a broker with Alexander & Alexander. His name and position in the association were inaccurate as reported in the Jan. 10 issue.

How a warm partnership developed from a frigid beginning.



Warroad, Minnesota, is located on the U.S./Canadian border on the west shore of the Lake of the Woods. And in early January, it's an icebox. (You've often heard its neighbor to the east, International Falls, mentioned as the coldest spot in the nation.) So wintertime travel can be tough sledding.

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Regardless, six of our intrepid claims-handling and service people flew in to meet the intrepid folks at Marvin. They spent the day establishing the best procedures for claim reporting, investigation, follow-up and unit report conferences. And everyone got to know each other personally. It's paid off.

Communications have been smooth in spite of the distance or weather conditions. Questions from either end are answered accurately and promptly, and paperwork snarls are nonexistent. It's typical of the kind of partnership we—and our policyholders—enjoy. Cooperative, productive... *warm*. Which is as welcome in Wausau as it is in Warroad.

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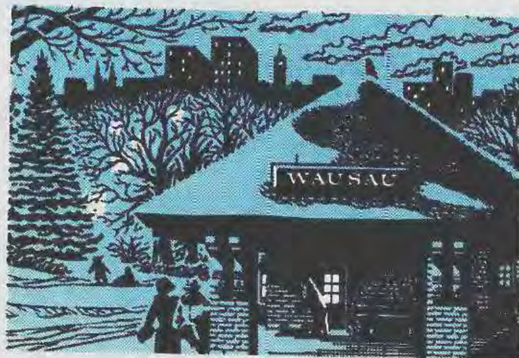


EMPLOYERS INSURANCE OF WAUSAU Wausau, Wisconsin

2 bills urge U.S. product liability reinsurance

By JERRY GEISEL

WASHINGTON—Two bills have been introduced in the Senate calling for the federal government to provide a reinsurance pool in an effort to reduce the soaring cost of product liability coverage.

The first proposal—introduced by Sen. Gaylord Nelson (D-Wis.), chairman of the Senate Select Committee on Small Business, and Sen. John C. Culver (D-Iowa)—would have the Small Business Administration provide reinsurance to companies insuring small businesses.

Sen. Culver said the bill is only an interim measure designed to buy time for small businesses while a long term solution is sought to the product liability problem.

The measure would limit federal reinsurance to three years. During that time the insurance industry could collect better statistics on the number and nature of product liability claims to improve the information used in determining product liability rates, Sen. Nelson said.

In the meantime, the bills offer relief for small businesses caught in the product liability crisis by allowing them to obtain coverage where premiums previously were prohibitive.

The second bill, introduced by Sen. James B. Pearson (R-Kan), asks for the establishment of a federally funded independent agency to administer and provide product liability reinsurance.

To qualify for reinsurance, an insurer first would have to arrange for a reinsurance contract with the National Product Liability Insurance Administration (NPLIA).

The NPLIA also would be authorized to offer reinsurance to a captive insurance company unable to obtain product liability coverage for the parent or which finds that the coverage "is only available at excessive rates or with unreasonable deductibles."

A captive could obtain reinsurance under the program only if the total insurance coverage needed to insure all liabilities of the parent develop $500,000 in total gross annual premiums.

In setting premiums an insurer would have to pay into the NPLIA pool, the agency would consider a manufacturer's product liability claim record as well as its quality control procedures.

The pool would be funded initially by $30 million in federal funds.

Another key provision of the Pearson bill, is the establishment of product liability arbitration panels in each U.S. judicial district. Members of a three-man panel would be appointed by the chief judge of the district.

The panel would arbitrate in cases where the party bringing suit failed to ask for a trial by jury.

Under the Pearson bill, states could set up their own product liability arbitration programs. To obtain federal support, the states' arbitration programs would have to:

- Establish a 10-year statute of limitation on product liability cases.
- Eliminate liability when a product is altered or modified.
- Recognize compliance with government standards as a defense where the government regulates the design and manufacture of a product.
- Recognize the "state of the art, defense in which a manufacturer is not liable if his product was made in conformity with recognized safety principles in effect at the time.
- Allow for installment payments for awards.

In introducing the bill, Sen. Pearson noted that cumulative increases in premium rates over the last seven years have averaged 5,000% in some industries. The average loss per claim has jumped from $11,644 in 1965 to $79,940 in 1973—an increase of 686%.

The Nelson-Culver bill now goes to the Senate Select Committee on Small Business. That committee has already held extensive hearings on product liability; hearings on this bill are planned for the end of February.

Sen. Pearson's bill heads for the Senate Commerce Committee. Hearings on the measure will be in the spring. ■

Oregon OKs legal plans

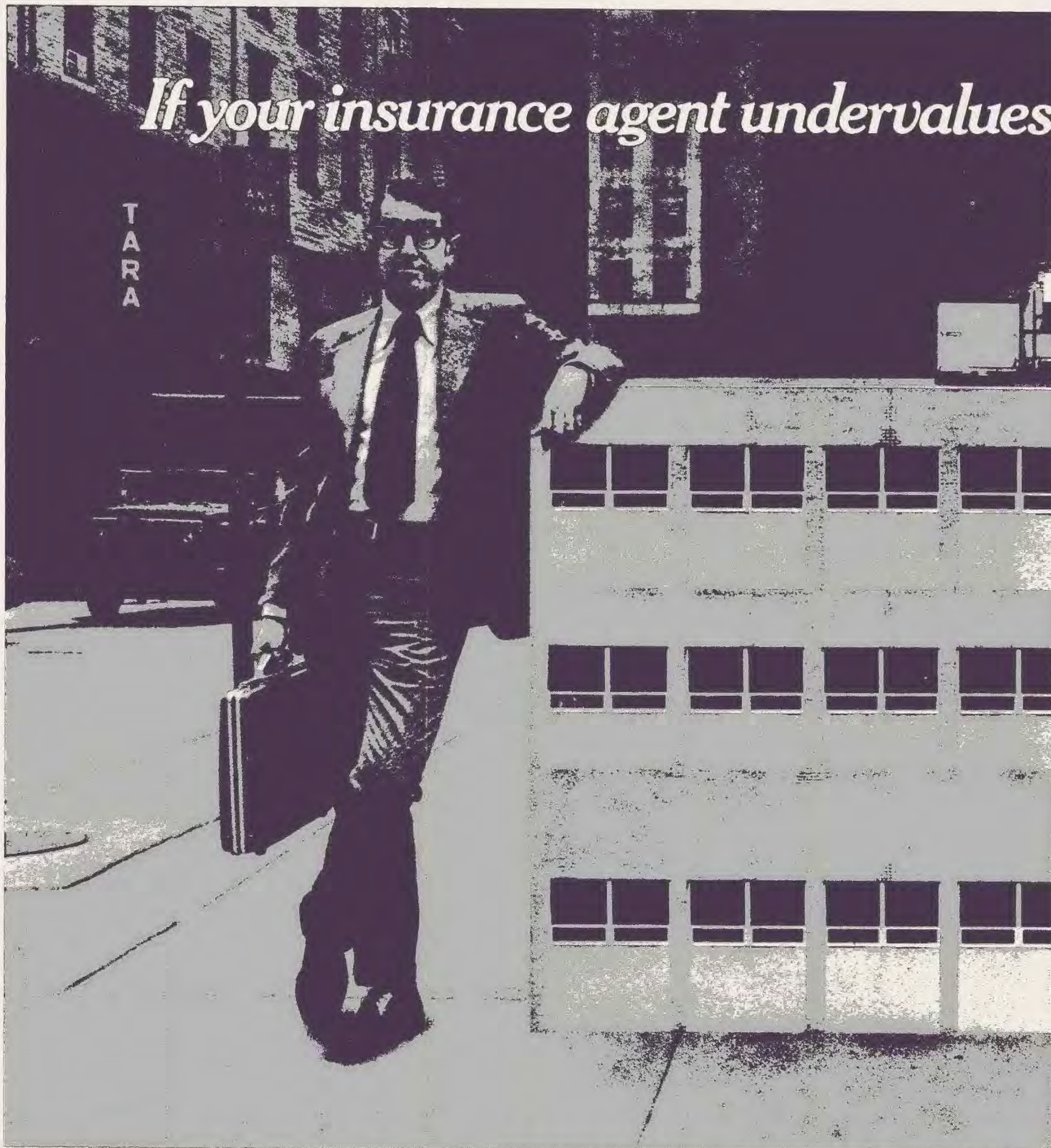
SALEM, ORE.—The state Insurance Commission has issued an order permitting life and health insurance agents to sell prepaid legal insurance policies.

Richard McGavock, deputy insurance commissioner, described the order as "an effort to provide an insurance service vitally needed by ordinary people who might otherwise have no access to legal services."

Seven insurance companies have been authorized to write legal insurance in Oregon. But only the Oregon Prepaid Legal Insurance Co. has issued policies. Covered are the staff of the Oregon State Bar Assn. and almost all the employes of Durametal Corp., a foundry.

Oregon Prepaid Legal Insurance is a non-profit corporation which was established by the bar association. Its policies only cover suits brought against its policyholders in an effort "to keep people from initiating lawsuits against each other."

Cost of the insurance is $6.92 for individuals and $9.23 for families. The state bar pays the entire cost for its employes while Durametal pays 50% of the premiums. ■



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Supreme Court to decide local immunity case

By JERRY GEISEL

WASHINGTON—The Supreme Court has agreed to decide whether local governments can be sued for violating federal grant agreements.

At issue is whether grant agreements between the Federal Aviation Administration (FAA) and a county-run airport gives an injured party the right to sue when the conditions of federal grants are violated.

The case involves the crash of a business jet on Feb. 26, 1973, at DeKalb-Peachtree Airport, a general aviation facility in Atlanta. Seven persons died when the plane crashed on take off after its engines sucked in a flock of birds.

Three families of the crash victims are suing DeKalb County, which has administrative responsibility over the airport, for $10 million. Fireman's Fund Insurance Co., San Francisco, also is suing to recover the $550,000 it paid as insurer for Machinery Buyers Corp., an Atlanta construction firm that owned and operated the Lear jet.

DeKalb County reportedly has a $1 million aggregate liability policy with American Home Assurance Co. of New York.

The county is charged with negligence because it maintained a garbage dump adjoining the airport which attracted thousands of grackles and starlings. The FAA said the dump was creating a hazard and asked the county to close it. DeKalb County authorities, however, refused to close the dump.

By failing to close the dump, DeKalb County violated an earlier agreement with the federal government to ensure safe flight operations in exchange for federal monies to improve airport facilities, lawyers for the plaintiffs said.

The injured parties are trying to collect damages from the county as third party beneficiaries of a breach of contract between the county and federal government, said Gilbert Johnston, an attorney representing the family of one crash victim.

The Fifth Circuit Court of Appeals, however, ruled earlier that the contract between the FAA and the airport did not specify an intent to compensate injured parties if the contract was breached.

The Supreme Court is being asked to overturn the lower court's decision since under state and federal law third parties have the right to sue for negligence associated with federal grant agreements, Mr. Johnston said.

Attorneys for DeKalb County maintain that Georgia's sovereign immunity laws protect the county from negligence lawsuits.

Under the immunity law, whose origin dates back to colonial days, a governmental body cannot be sued for an accident that occurs in the course of its normal operations. Immunity laws, however, have been struck down by the courts in many states.

In this case, the FAA repeatedly asked the county to close the garbage dump adjoining DeKalb-Peachtree Airport. While the county did hire a company to spread bird repellent around the airport area, it backed off from closing or covering the dump, citing a shortage of space for refuse.

A National Safety Transportation Board team concluded officially that the birds caused the accident. ■

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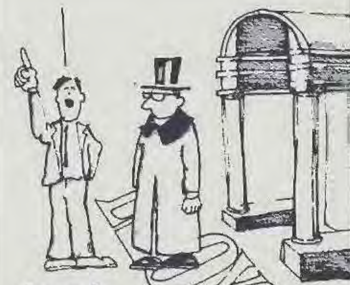

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Financial disclosure may be required

Self-insuring? Excess markets may be crucial

By MARIE KRAKOWIECKI

TAMPA, FLA.—Any company considering a self-insured program needs to pay careful attention to the way it handles the excess and surplus lines insurance market.

Even without a specific session on the topic, excess and surplus insurance was mentioned so frequently at a self-insurance seminar here that the message was obvious: Excess and surplus underwriters and brokers have a significant impact on the way an employer puts together a self-insurance program backed by excess or stop-loss insurance.

The two-day seminar last month was sponsored by the Society of Chartered Property & Casualty Underwriters.

Bernard J. Daenzer, president of Howden-Swann Ltd. and the author of a text on excess and surplus lines, gave a clear picture of how influential that market is.

Excess underwriters demand financial disclosures from a would-be self-insurer, he said, because "no one wants to write an excess over a financially questionable insured." Excess insurers can and do demand Dun & Bradstreet reports, financial statements, an analysis of assets and liquidity, an assessment of the stability of a firm's cash flow and even letters of credit before agreeing to provide excess coverage.

There are also some ticklish matters concerning terminology which the self-insurer must confront when using excess insurance, Mr. Daenzer said. He emphasized the importance of learning correct, precise policy language to get the best deal. "Beware of doing business with an underwriter or excess carrier who suggests 'we won't define it now,' " he warned.

As one example, he explained the two most popular forms for property coverage in a self-insured program are called EEL/EELs and EEL/EEL BAOLs. The first stands for "each and every loss at each and every location"; the second is identical, adding, "blanket any one location." Mr. Daenzer explained that the more locations which can be included under an EEL/EEL or EEL/EEL/BAOL, the more risk a self-insurer can retain and the lower the cost of excess insurance.

But it apparently doesn't pay to become too exacting on excess policy language for a self-insured program, particularly on property coverage. For example, if a buyer tries to get split deductibles on properties within a single coverage, "the excess writer thinks you're trying to outguess him and is going to be harder to deal with," Mr. Daenzer warned.

Similarly, he called franchise deductibles and disappearing deductibles "kid stuff" and said excess underwriters don't like them because they confuse the underwriter about the insured goals.

A self-insurer may also inadvertently distort the thinking of an excess underwriter and may end up with higher prices as a result, Mr. Daenzer warned, if the firm seeking coverage insists on purchasing excess coverage on an AAOPY basis (aggregate any one policy year). Howden-Swann's president recommended avoiding the cost of aggregate production unless the self-insured risk has some special problem.

If an aggregate policy is selected, it should have a time factor or the underwriter might cancel prematurely to avoid aggregation. A self-insurer should always obtain a non-cancellation clause with an aggregate program, he advised.

Excess underwriters will want an audit and complete information on the buyer if the firm's self-insurance program for product liability risks includes in-house or outside supervision costs plus allocated costs and claims handling.

This story and the article on page 9 are from the self-insurance seminar sponsored by the Society of Chartered Property & Casualty Underwriters in Tampa, Fla.

Edward W. Siver, an insurance consultant from St. Petersburg, said the principal interest in self-insurance in Florida is generated by product liability and medical malpractice risks. The excess and surplus lines market definitely determines the retention level for self-insured programs in these areas, he added.

During a question and answer period, one person said his experience has been that excess underwriters don't want to accept bank letters of credit as security for a self-retention liability program because a time limit set by the Federal Deposit Insurance Corp. limits the period for which banks can commit an obligation.

If the letter of credit is not going to be renewed, the bank has to give a certain period of notice, and during that time, a company can draw down on the letter of credit, and the excess underwriter will lose its security, he said.

A broker responded that a letter of credit may be converted to a certificate of deposit, so that the insured party would pay only the net difference in interest rates of about 3% between the letter of credit and the CD.

Grumbling in the audience indicated not everyone was in agreement over the wisdom of such a move by the self-insurer just to keep the excess market happy. "Three percent, hah!" said one opponent to the idea. "It would be more like 6%", a cost difference which he seemed to find unacceptable.

Frederick B. Gillette, a consultant from the risk management services division of the Wyatt Co.'s Dallas office, said setting objectives and limitations are vital to a self-insurance program.

One of the biggest problems consultants have in helping set up a self-insurance program is that many clients have no idea what their past losses have been, Mr. Gillette said. A management information system is vital, he urged.

And the first element of a good management information system is having accurate, reliable data on claims and losses that will allow the self-insurer to negotiate favorable renewals with the excess and surplus lines underwriters, he added.

Continued on page 9

A SELF-INSURED $93,000 LOSS

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Cost control called a vital component of any firm's self-insurance plan

TAMPA, FLA.—Just one claim improperly handled can offset all the cost savings a company may have realized from buying a less expensive service operation for a self-insurance program, a seminar here was told.

Donald Krutek, speaking at a two-day self-insurance seminar sponsored by the Society of Chartered Property & Casualty Underwriters last month presented a cost control program for self-insurers. A major feature in the program outlined by Mr. Krutek is assuring that the people who service a self-insurance program are capable.

Mr. Krutek, unit manager of the self-insurance division of Arthur J. Gallagher & Co., Rolling Meadows, Ill., noted two major areas of cost to be controlled: Fixed costs for service such as excess insurance, bonds and taxes, and loss costs. Controlling losses, the key to self-insurance success, is directly related to who is administering the claims, Mr. Krutek said.

He outlined several options for claims administration, including in-house servicing, services purchased from an insurance company or services purchased from an independent operation.

"To decide, don't look just at the service fees quoted," Mr. Krutek advised. "Your ultimate costs will be determined by the capability of the people providing the service," he said.

Self-insurers shopping for a good servicing arrangement should:

- Determine the experience and background of the key personnel who will be handling your account. Don't assume that servicing something like a workers' compensation program in-house is a clerical function only; that could lead to trouble.
- Not be afraid to ask the insurance carrier who is handling your account what his background is and how much he knows about your account. It's valid to ask whether he has performed this kind of service before.
- Consider the case load of the people handling your claims. Very simply, do they have enough time to devote to your claims? If they are overworked, claims handling will suffer.
- Look into the reserving practices of people handling your claims, keeping in mind the future potential liabilities of the self-insurance program. Mr. Krutek said he knew of one service organization which presented very low reserves because the person in charge wanted his boss to think the self-insurance program saved a lot of money. This approach should be avoided. Procedures to review and update reserves should be reviewed.
- Look closely at the capabilities of your service organization to provide subrogation services. Can it go after third parties to recoup losses?
- Examine the recordkeeping practices of the organization. Are the files available to you for review and tailored to your needs?

Only with planned safety and loss control programs can a self-insurer really keep costs down. If an outside service is used for these objectives, its capabilities should also come under close scrutiny, Mr. Krutek said.

"Don't be satisfied completely with plant inspections. They are useless if the sites are visited, reports are made, but then nothing is done," he pointed out. "Inspections are frequently nothing more than a way the insurance companies evaluate their own exposures."

Safety and loss control programs ideally should be problem oriented and should have some accountability built into them to reward good experience and penalize those causing losses, he also suggested. However, a self-insurer could run into some difficulty trying to use in-house services in this area, Mr. Krutek warned, because excess underwriters may balk at accepting an in-house service program. ■

AN INSURANCE COMPANY'S $68,000 LOSS

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Excess . . .

Continued from page 8

Donald Krutek of Arthur J. Gallagher & Co. pinpointed excess insurance as one of the fixed costs of any self-insurance program. Controlling the fixed costs and the losses must be the goal of every self-insurer or their programs will be extremely expensive to operate, he said.

Part of his cost-control presentation warned that a self-insurer's in-house capability for safety and loss control services could be thwarted by the excess and surplus lines market.

"Your excess underwriters may not accept the program" if you have in-house services, Mr. Krutek said, based on the experience of one of his own clients.

For the first year or two of a self-insurer program, until the buyer can figure out what his annual maximum cost will probably be, Mr. Krutek suggested buying layers of coverage including specific and aggregate excess insurance. (Aggregate coverage provides a ceiling on total losses over a contract period up to the limit of liability.)

After the first two years, however, a self-insurer should just need specific excess coverage (in which the insurer pays for amounts above the self-retention level of the insured on a per-loss basis up to the policy limits).

Mr. Krutek advised the CPCUs against bidding their insurance programs in the excess markets because the markets are so tight right now. Bidding on excess coverages could actually drive a self-insured's prices up, he warned, because "the marketplace realizes that nobody knows what's going on."

He did, however, recommend that a self-insurer obtain bids from an excess or surplus lines broker who would then go out to the marketplace for him. A broker is necessary, he emphasized, because many excess underwriters refuse to deal directly with buyers. A broker is also useful because some surplus lines markets are here-today-gone-tomorrow type, Mr. Krutek said. A good excess broker would know the difference and be of some help in placing risks with a reliable carrier.

Robert S. Spencer, vp, risk management for Fuqua Industries Inc., Atlanta also encouraged the group to take the excess markets in stride and make self-insurance a part of their companies' risk management game plan. Citing the success Fuqua has had with its Bermuda captive Mr. Spencer said:

"Any time your frequency is high and your severity is low, I think you should self-insure," he said. ■

info for buyers

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

• An **Investment Policy Guidebook** for benefit plan trustees is available from the International Foundation of Employe Benefit Plans. The 92-page book is a do-it-yourself guide to mapping policies and goals, working with an investment manager and setting up a system to review and revise investment programs. Cost is $5 a copy for foundation members and $8.50 for non-members. Write the foundation at P.O. Box 69, Brookfield, Wis. 53005.

• **An Employers' Guide** to California's workers' compensation system is available from the California Workers' Compensation Institute. The new eight-page pamphlet explains the principles and operations of the system and is intended to prevent unnecessary compensation insurance. Copies are available in lots of 100 at $9 from the institute at 201 Sansome St., San Francisco, Calif. 94104.

• Two manuals on **Using the Early Warning System,** one on life and health insurance companies and one on property and casualty companies, are available from the National Assn. of Insurance Commissioners (NAIC). Designed to help state insurance departments identify insurance companies most likely to experience financial difficulties, the manuals describe the early warning system, how to use it and include worksheets for computing the tests. Cost is $6 a copy. Write NAIC, Publications Dept., 633 West Wisconsin Ave., Suite 1015, Milwaukee, Wis. 53203.

• **Insurance and Reinsurance Lexicon** covers over 5,000 terms, expressions and abbreviations currently in use in the insurance business in France, Britain and the United States. All terms with a professional meaning are followed by examples of typical expressions. Cost is $7.50. Write Editions, Berger-Levrault, Cendex 11, 54017 Nancy Cedex, France.

• **Consulting Actuarial Services** is a brochure available from Alexander & Alexander Inc. describing pension plan design aspects of benefit planning, and discussing actuarial projection considerations. For a free copy write Scott Taylor, vp Communications, Alexander & Alexander Inc., 1185 Ave. of the Americas, New York, N.Y. 10036.

• To maximize reimbursement relating to property depreciation, an accurate record of all facilities should be maintained, says Valuation Research Corp. in its brochure on **Maximizing Cost Reimbursement for Hospitals Through Property Control and Depreciation.** For a free copy write Michael Colhoun, Valuation Research Corp., 250 Wisconsin Ave., Milwaukee, Wis. 53202.

• Underwriters Adjusting Co. is offering **Employers' Liability,** an examination of worker's compensation policy in regard to the actions of an insured employe. The liability of an employer to a defendant who has been sued by an injured employe is one of the most rapidly developing areas in the field of contribution and indemnification. For a free copy, write Underwriters Adjusting Co., Sylvia T. Jurkovich, Director of Communications, 224 S. Wacker Dr., Chicago, Ill. 60606.

• **The Role of the Risk Manager in Industry and Commerce,** written by John Parkinson, former chairman of the Assn. of Insurance & Risk Managers in Industry and Commerce, is now available. The Keith Shipton Developments Special Study explores such basic questions as the risk management process and where a risk manager fits into the company organization. Cost is $5.00 including airmail postage. Write Keith Shipton Developments Ltd., Adelaide House, London Bridge, London EC4R 9DS, England.

• The services, advantages and outlook of Schiff Terhune Inc. insurance brokers are discussed in their booklet **We have something you don't....** For free booklet write Schiff Terhune, 100 William St., New York, N.Y. 10038.

• **Governmental Risk Management,** a reprint from Risk Management magazine, is available for $1 a copy. The 16-page article focuses on the preservation of human and physical resources within government agencies. Write Dept. GRM, Risk and Insurance Management Society (RIMS), 205 E. 42nd St., New York, N.Y. 10017.

• The role of the **Outside Director of the Public Corporation,** prepared by the University of Pennsylvania Law School, is described in a 50-page book published by Korn/Ferry International, an executive search firm. The responsibilities of directors and their increasing exposure to liability are also covered, including indemnification, third party actions and government anti-trust suits. Copies of the book are $3.85 plus $1.00 postage; write P.O. Box 64608, Los Angeles, Ca. 90064.

• A brochure from the National Assn. of Insurance Agents tells **How to Avoid Costly Mistakes in Business Insurance.** A loss exposure checklist is included. For a free copy, write James M. Shea, Director of Advertising, National Assn. of Insurance Agents, 85 John St., New York, N.Y. 10038.

• A booklet to help management set up its own product safety and loss prevention program is available from the National Safety Council. **Company Product Safety and Product Loss Prevention Program: Guidelines for Management** is designed for medium and large manufacturers. Cost is $4.50 a copy. Write the National Safety Council, Membership Dept., 444 N. Michigan Ave., Chicago, Ill. 60611.

• **Wells Fargo Guard Service** is offering **Basic Planning for Pilferage Control,** a brochure which explains employe pilferage and suggests ways of controling it. For a free copy, write to George Mulqueen, Director of Marketing, Wells Fargo Guard Services, Randolph Park West, Rt. 10, Randolph, N.J. 07801.

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State fund to provide longshoreman's insurance

SACRAMENTO, CALIF.—The state legislature has authorized the State Compensation Insurance Fund to provide the liability insurance required by the federal Longshoreman's Act until July 1978.

The move was spurred by complaints by a number of California employers, particularly small businessmen, who were unable to afford or obtain the coverage from private insurers.

The state fund was formerly authorized to write longshoreman's and harbor workers' (L&H) coverage on an "incidental basis" to its regular workers' compensation insurance.

However, an informed source said the state fund underwrote "more primary L&H exposure in the past than it wishes to acknowledge."

The California bill is designed to help employers cope with the 1972 amendments to the federal Longshoreman's Act that increased benefits and broadened coverage.

Those amendments and benefits were denounced by some companies, mostly small, that are now buying L&H coverage from the state fund. While they said they can probably remain in business with the somewhat lower premiums they pay to the state fund, they argue that their businesses should never have been brought under the L&H act and that the very costly benefits mandated by the act may yet jeopardize their survival.

Typical is Roland Mounce who owns the Lodi Skindiving School in Lodi, Calif., who said he can live with the L&H premiums he must pay the state fund, although he must increase the price he charges his students.

Nevertheless, Mr. Mounce calls the L&H insurance situation for diving enterprises like his "the worst situation I've ever encountered."

He said that last year he attempted to obtain L&H coverage from Fireman's Fund, but he was told that the premium rate would be $48 per $100 of wages. Regarding that as "crazy," he noted, he then joined diving school groups to lobby in Sacramento for state help.

Today, Lodi Skindiving School pays $12 to $13 per $100 of wages for employes who go into the ocean and $4 per $100 of wages for workers who labor inside the school or the stores.

Mr. Mounce asserted that while he is not altogether content with the new bill, he is bitter about the fact that diving schools such as his were pulled into the L&H act in 1972.

"The only reason we are in is that we work on open water," he said.

Dave Tillery, who operates L.A. Marine Transport, an ocean transport firm, also expressed resentment that his tiny business was swept into the L&H orbit four years ago. By paying the rates demanded by the state fund, he also indicated that he can just barely survive.

"Premiums from our previous private carrier were leaping forward at an incredible rate," said a spokesman, noting that most of his larger competitors now self-insure their L&H coverage.

Although he does not yet know what his L&H annual premium rate will be, this spokesman said he is confident that it will be lower than the last figure quoted by his former insurer.

A spokesman for the state fund said that legislation has brought the agency a little less than $2 million in L&H business in seven months. He said the agency is writing both large and small risks.

The bill appropriates $2 million from the Harbors and Watercraft Revolving Fund as a five-year interest-bearing loan to the state fund to provide security for the coverage.

A knowledgeable brokerage source said he believes "the vast majority of small businesses were caught in a political trade-off between the big stevedoring firms and the unions."

He said a stevedore who was injured on a ship prior to 1972 was forced to sue the ship as a third party and the ship, in turn, subrogated against his employer. Stevedoring firms, in fact, were asked to defend the ships and to hold them harmless.

"Thus, in 1972, even though the entire shipping industry was against the proposed amendments to the L&H act, a trade-off occurred between the stevedores, who had their employes put under the L&H act, and the union which got a highly desired, huge boost in benefits," this source said.

Yet he added that the extension in coverage to businesses like marinas and diving are "murderous."

On the other hand, he said that diving enterprises can easily become loosers for both underwriters and brokers. All it takes, he said, is one death. ∎

Blue Cross discount is upheld

TRENTON, N.J.—The state supreme court has upheld the constitutionality of the Blue Cross discount which results in lower hospital charges to patients covered by Blue Cross than to those with insurance from commercial companies.

The decision was the latest in a series of court rulings in various states upholding the discount. The N.J. court said it was not "unreasonable" for the state to regulate some hospital rates while not determining others.

Under state law, hospital charges to patients whose bills are paid by the government or Blue Cross are regulated. But hospitals charge patients with other insurance costs or programs that are excluded from Blue Cross bills. These patients in the state pay 15% to 30% more than patients with Blue Cross.

Harold Krieger, attorney for the Amalgamated Meat Cutters local 464, argued the higher charges violated his clients' constitutional rights under the equal protection clause of the 14th Amendment.

Mr. Krieger said he is considering appealing the ruling to the U.S. Supreme Court.

The Blue Cross discount has become a prominent issue in the state with several bills pending to modify the discount. ∎

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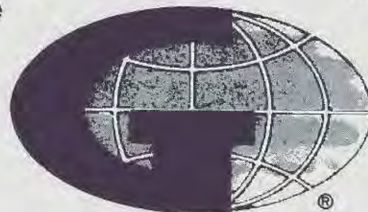

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Safety graduates find fantastic job market

By GREG DAVID

TUSCON, ARIZ.—The first graduates of a new and innovative master's program in safety management at the University of Arizona have found a "fantastic" job market.

"There are so many jobs it's unbelievable," said Larry Young, now a safety engineer with Sandia Laboratories in Albuquerque, N.M. Mr. Young was offered six jobs, with salaries from $15,000 to $16,800 a year, despite his lack of experience.

William Jenkins, now an assistant safety engineer at an Asarco Inc. mine south of Tuscon, said he received three job offers with salaries between $12,000 to $16,500.

Daniel Otremba, who had spent 10 years as a safety consultant in San Francisco before enrolling in the Arizona program, will manage the safety department of the Home Insurance Co. office in San Francisco. Mr. Otremba said his salary will be in the $20,000 range.

Carol Padera Ladue returned to the Hartford Insurance Group in Norwalk, Calif., as a loss control technical representative. She spent five years in safety at The Hartford before enrolling in the Arizona program. In addition to Hartford, Ms. Ladue said she was offered a consulting job, but that position involved more traveling and a certain lack of security.

Ms. Ladue said there is a particular demand for women, since there are so few in the field.

The Arizona program is financed by grants from the National Institute of Occupational Safety and Health. Students receive stipends up to $6,000 a year to cover tuition and expenses, according to program director Nestor R. Roos.

The program has put a particular stress on new approaches to safety, Mr. Roos explained. Students are taught a behavior approach to safety, as well as a different way to looking at statistics and a unique course in safety law.

"More than anything else, the program took safety out of the physical area and into the people area," said Ms. Ladue. "I used to think of safety in terms of fire extinguishers. Now I think in terms of supervisors and communication."

Students divide 36 hours among 12 courses. They are also required to do a detailed research report, which hopefully will expand the literature in the safety field. Professor Roos, who teaches insurance, draws on existing faculty for the courses.

Ms. Ladue said she felt the course had given her career a major boost, an assessment shared by Daniel Otremba. Mr. Otremba said he had been offered several field jobs at $17,500, while he thought the normal pay for that position was closer to $15,000.

Seven of the 15 members of the first class have received their degrees. The other eight have failed to complete their research reports. The current class of 11 students to expected to graduate in August and the school is recruiting additional students for a program to begin during the summer.

•

Further information is available from Dr. Nestor R. Roos, Safety Management Program, Economic Building, University of Arizona, Tucson, Ariz. 85721. ■

Malpractice law killed

SALEM, ORE.—The state supreme court has refused to rule on the constitutionality of a 1975 medical malpractice insurance law, thus leaving in effect a lower court decision that the law was unconstitutional.

A circuit court judge, acting on a challenge by the Oregon Medical Assn., ruled illegal a provision establishing a sliding scale of premiums for doctors in various risk categories.

The law had created an excess liability fund managed by the Oregon insurance commissioner. Premiums ranged from $150 for $100,000 of coverage to $750 for $750,000. ■

Earthquake fears help this business

By JOANNE GAMLIN

LOS ANGELES—Seismic Engineering Associates is in the business of reassuring nervous corporate risk managers, located mostly in the Midwest and the East, that their California property can be protected against earthquake damage.

The tiny company is riding a surge of business these days, advising corporations how to upgrade their California property to withstand quakes as devastating as the 1857 tumbler which registered plus 8 on the Richter scale.

A similar quake today near the now famous bulge on the San Andreas fault outside of Los Angeles would result in $25 to $50 billion in damages and several thousand dead as well as many more injured, calculates Jim Lord, a structural engineer who founded Seismic Engineering in April 1975, after operating a similar earthquake service for A. C. Martin, a Los Angeles architectural and engineering concern.

Such a quake would have a catastrophic effect on the entire Los Angeles basin or all of Los Angeles county as far south as Long Beach in the opinion of Mr. Lord.

While the bulge on the San Andreas fault has drawn a lot of attention to the quake perils enfolding Los Angeles, Mr. Lord told *Business Insurance* that a tumbler of like magnitude could as easily rock the San Francisco Bay area.

"We, that is the people in the two major cities, will have a big quake within a decade," he predicted.

Mr. Lord said his client list must be kept confidential because insurers could feel impelled to increase premiums if they learned of the earthquake risk analysis (ERA) of a company's California property.

However, he did note that 1976 was a good year for Seismic Engineering and it is not difficult to guess why. First, Caltech seismologist James Whitcomb predicted that a strong quake would rip the Los Angeles area before April 1977. Dr. Whitcomb has since withdrawn that forecast, the first formal scientific earthquake prediction ever made for Southern California.

Then NBC's John Chancellor and David Brinkley gave national publicity to Henry Minturn of Hawthorne, Calif., who believes he can predict quakes on the basis of Lunar positions and phases. Mr. Minturn issued three quake forecasts, one for Southern America, one for the area near the Solomon Islands and one for Dec. 20 to 22 for Southern California.

Mr. Minturn, who reportedly has held a variety of jobs ranging from aerospace engineer to security guard, said shortly before Dec. 20 that he would refrain from issuing further earthquake predictions.

Finally, Dr. Robert M. Hamilton, of the highly respected U.S. Geological Survey, said that an impending quake awaits Southern California because of the "tremendous strains" that have been amassing for more than 100 years in the San Andreas.

Seismic Engineering Associates feels it can assist a company in protecting its California property from quake devastation at a cost of "only a modest investment." Mr. Lord defines "a modest investment" as the cost of returning an existing building to the shape it was in before the earthquake.

"When we talk a percent loss, we are speaking of the cost of restoring a facility to its pre-earthquake condition (allowing for salvage and demolition) compared to the cost of replacing the entire facility on the same site," he explained.

He went on to define what he means by a percent loss. "A 20% loss means that the loss amounted to 20% of the cost of replacing the building as a whole. That is, a $1 million loss means that it would cost $5 million to rebuild the entire structure," he said. One reason for using percentages, he added, is that they can be employed in the future if the economy remains on a reasonably steady course. Also, they are the way the insurance industry chooses to refer to such losses.

Seismic Engineering's basic product is a report which gives a client the aggregate value at risk, the critical aggregate single event in terms of maximum foreseeable losses (MFL) and probable maximum losses (PML), plus the percentage probabilities of experiencing losses ranging from 2% to 100% of the aggregate value at risk for time periods of from 10 to 400 years.

Consulting during the conceptual stage of new building design is another service performed by Mr. Lord's firm. Basically, what a client has to do is to step forward and say: "I want a facility in the 5 to 10 PML range."

Seismic Engineering can devise criteria to hold PMLs down to any pre-determined limit, according to Mr. Lord. The starting point is a sound structural system. After that, plans can be laid to design a facility to withstand almost anything the earth can dish out, he believes. ■

1971 earthquake demolished expressways in the Los Angeles area.

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Yellow Cab problems continue in 3 cities

By JOANNE GAMLIN

LOS ANGELES—Yellow Cab operations, which were brought to a halt in six California cities by an inability to obtain liability or workers' compensation insurance, remain in limbo here and in San Francisco and Los Angeles.

The Yellow Cab operations in three other cities—San Diego, Oceanside and San Jose—have been sold by the financially strapped Yellow Cab Co. (YCC), which filed for bankruptcy in December. The airport bus lines, also owned by YCC, have also been sold.

YCC is a subsidiary of Westgate-California Corp. of San Diego, which is also in bankruptcy proceedings.

The fate of the Yellow Cab operations remained unresolved in late January. The Los Angeles city council put the company's downtown and three other franchises on the auction block when a committee considered whether to revoke the license due to Yellow Cab's failure to meet city insurance requirements.

However, the recommendation was delayed by a U.S. bankruptcy court in San Diego restraining order preventing cancellation of the license pending a hearing.

At the same time, it appeared that the efforts of Bill Griswold, head of the Griswold Group Ltd. of Los Angeles, to form a cab cooperative had fallen by the wayside. Mr. Griswold said the Teamsters union which represents Yellow Cab drivers vigorously opposed a co-op.

A spokesman for Red/White cab, Los Angeles, said he believes YCC will fail in its efforts to settle its liabilities and emerge from bankruptcy. As a result, he said that YCC's franchises in San Francisco, Oakland and Los Angeles will be moved to new owners, meaning that the largest cities in the state will be without taxicab companies that go by the name of Yellow Cab.

Meanwhile, the bulk of independent cab companies in the state, including the companies that bought the Yellow Cab operations in the three California cities and in Phoenix, Ariz., anxiously watched the efforts of L.F.C. Insurance Brokers of Beverly Hills to negotiate a new public liability and workers' compensation package with a new underwriter. The Eldorado Insurance Co., which had been writing this business, withdrew late last year.

Noting that his firm boasts about 72 cab company clients, Ronald Jackson, an account executive, said his firm is now negotiating with a new carrier and he hopes the coverage will be placed by March 1. Until that date, he said he could not reveal the name of the prospective underwriter.

The insurance situation for cab companies is so grim in California, he said, that most companies are restricted to going through L.F.C. or the state's assigned risk plan and its steep premiums.

Last December, the Los Angeles Times reported YCC went broke as a result of high insurance premiums paid to Westgate-California Insurance Co., a wholly owned subsidiary of the parent company, and high benefits paid to the Teamsters. Former YCC executives said that from 1972 to 1974 their company had to pay higher than necessary premiums to the insurance subsidiary, which failed in 1974.

However, a Westgate-California spokesman said that these officials were resentful because they valued the cash flow which their company had when it self insured its public liability and workers' compensation coverage.

"Westgate-California made a business decision in 1972 to have YCC buy its insurance coverage from the new insurance subsidiary," he said. YCC had to make the transistion to paying for full insurance "and they didn't like it."

He said the insurance subsidiary went broke in 1974 because C. Arnold Smith, who owned Westgate-California, forced it to invest in stocks and bonds from U.S. National Bank, San Diego, which later collasped. ■

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editorial opinions

Oil spills and you

IT'S ABOUT TIME the insurance industry—the risk management profession included—takes an active role in assuring that poorly maintained and unsafe vessels be kept from the world's oceans.

For all the hullabaloo about product liability, we see an issue of risk involving lost tankers, spilt oil and pollution liability which is at least as great as any risk in the product field.

Why, then, don't insurers put pressure on the world's ocean fleets to clean up their risks? We don't see premiums rising by 1,000% the way they're jumping in the product field. We don't see anyone requiring more ship inspections to assure safety. We don't see the world's insurers taking steps to prevent the kind of seagoing demolition derby which has taken place since early December, resulting in a half-dozen major ship disasters.

Lest our readers think we are being overly critical of the insurance industry—U.S. and foreign insurers alike—for what was a fluke in statistics, we would remind those who so question that in all of 1976, 19 tankers sank, exploded or went aground. This was more than double the 1975 toll. 1974 was also a bad year.

There's a failure of commitment on the part of those who would insure against such frequent and massive losses—a commitment to loss prevention and safety that any good risk manager recognizes as essential.

Product liability news

MANY OTHER PUBLICATIONS are taking up the banner of product liability, giving more news space to coverage of the problems businesses face with rising product insurance costs. They are also taking editorial positions on the need for some tort reform measures and reasonable limits on awards.

If nothing else, consumers—you and I and our neighbors—are getting an education in the process. Excellent. One of the major problems with the tort system as it's now constituted is that people use it too quickly, in the heat of anger and often feeling entitled to profit from bad experiences.

The more news stories that appear on this subject, the better the citizenry will understand the long term cost of such attitudes. And cost, they do.

National health—again

FOR THE FOURTH year in a row, Congress will deal with the prospect of national health insurance, wrestling with three major bills reintroduced within recent weeks.

A new Congress, a new administration, but the same old battle. The conflict, of course, will come when Ted Kennedy and his cohorts press for a system so comprehensive that the country might not even begin to be able to pay for it.

Although the goals of those who would revamp the health care delivery system are laudable, the methods are worrisome. As consumers of government services and as taxpayers, we are worried about the push for broad-based government health care.

The new secretary of HEW, Joseph Califano, has said that the Carter administration will move slowly—ever so slowly—on national health insurance, taking at least a year to study the many proposals and submit its own recommendations.

Good for Carter. He deserves to be applauded for resisting the temptation to rush headlong into cumbersome federal programs which are sure to substantially raise the cost of health benefits for business, as well as boosting the taxes you and I pay.

In fact, if there is anything we'd fault both the public and private sectors for, it's the failure to do enough studies scrutinizing just how much NHI will cost us over the next 10 to 20 years. The added cost at the onset of such a massive program is one thing, but the long term economic impact is a far more serious problem.

Two decisions we like

ACCEPTING AS WE DO that some—if not most—of the current abuse of the legal system, in the form of too much litigation, is the result of lawyers' successful efforts to make money, we offer the comment that we don't cry when we see some firms lose cases.

One such outfit is the law firm belonging to Herb Hafif of Orange County, Calif., who brags that his firm has won something like 13 of the 97 cases in which more than $1 million was awarded to the plaintiff(s).

But he recently lost a couple, if you can call reduced awards lost cases. An award against Washington National Life Insurance was thrown out altogether, a switch from the earlier jury award of over $5 million to a policyholder who had his insurance claims denied. The judge would have let stand a $250,000 award, but the plaintiff would not accept that figure.

Mr. Hafif's law firm also won a $5.1 million ruling against Mutual of Omaha in a similar case, although that award also has been reduced to a still-large $2.6 million.

"It's an encouraging letter from ABZ Insurance Brokers. Last year, they wouldn't touch us with a ten foot pole—this year it's down to eight."

letters

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

Grads with experience

To the Editor: Ms. Krakowiecki's riskWatch column on the problem of college graduates finding risk management jobs in your Jan. 10 issue was interesting in what it said, and more interesting in what it omitted.

Her article mentions that "after speaking with Mr. Judd, *BI* contacted leading business schools like the University of Pennsylvania's Wharton, Temple University and the universities of Georgia, Arizona and Wisconsin. . ." The interesting omission is that the two largest colleges of risk management and insurance—The College of Insurance in New York, and Georgia State in Atlanta—were not contacted.

I cannot speak for Georgia State, but I can speak for The College of Insurance.

The college's full-time degree program is on a work-study basis, providing internships whose absence she lamented. Students entering the program are sponsored by one of the over 200 organizations which support the college, and embark on a five-year period of alternating four-month periods of school and work. At the end of the five years they have a degree (Bachelor of Business Administration. with an insurance major, or Bachelor of Science, with an actuarial science major) and two and one half years of actual work experience. Sponsors using the program include insurance and reinsurance companies, agents, brokers, accounting firms, adjusting firms, rating bureaus, and consultants. Unfortunately, there are no industrial firms using the program at this point.

While the vast majority of graduates remain with their sponsors after graduation, not all do, and those who have wanted to go into the field of risk management have been placed with no problem, even though we do not have a regular placement office.

The article refers to the use of students by consultants. One of our graduates was hired by Peat, Marwick & Mitchell and another by Gilbert Management Consultants immediately upon graduation. Risk Planning Group, to which reference was made, employs one of our alumni as a vp, though admittedly he went there after completing graduate studies at Harvard and accumulating some experience.

Continued on page 20

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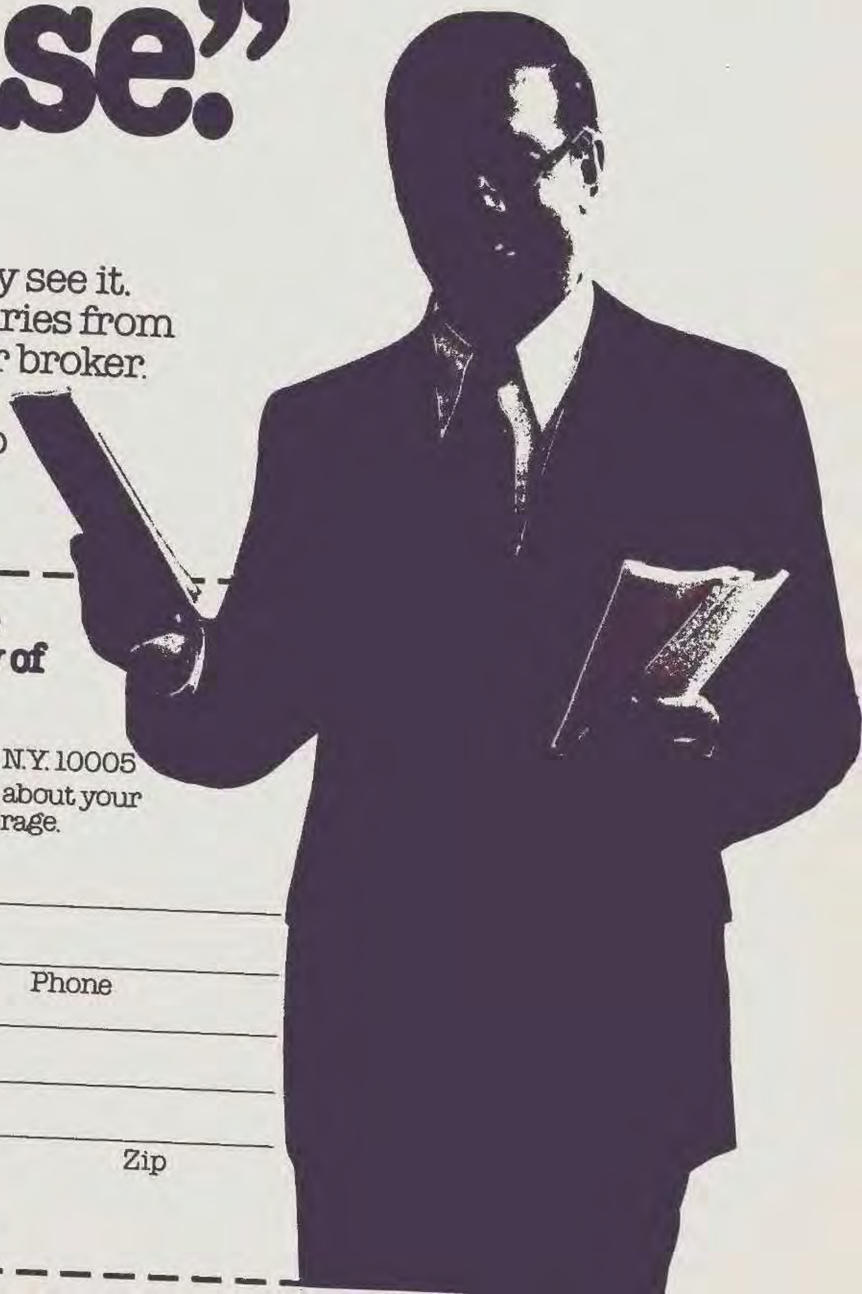

letters

Continued from page 18

Ms. Krakowiecki complains that "there are very few companies with enough guts or imagination to gamble on a risk manager who hasn't made a slow crawl up through an insurance company or a brokerage firm." While I agree that insurance company or brokerage background is not necessary for the job, I cannot fault any company for not hiring a risk manager with no experience. The student should recognize that is will be necessary to start in a "back-up" position to learn the practical application of the theories and principles which have been taught at school.

Since the discipline of risk management is still evolving from the discipline of insurance, it is only logical that insurance companies and brokerage houses would be looked upon as the source of personnel. We have seen a trend (in New York City, at least) for industrial firms to hire beginners who can be trained in risk management concepts from the beginning without the necessity of getting rid of the hang-ups somebody from an insurance background might have.

We do not really see the problems Drs. Leverett and Snider complain about. Maybe New York is different from Athens or Philadelphia, or maybe their aspiration levels are unrealistic.

Matthew Lenz, Jr.
Chairman, Property-Liability Insurance Division, The College of Insurance, N. Y.

Product liability crisis?

To the Editor: I must take strong exception to your editorial of Jan. 10 entitled "Product Liability: A Crisis or a Problem?" I am very much afraid that the editorial written in the vein you have followed would result in legislators at various levels putting off any action until the wheels of industry in this country grind to a halt because of the weight of product liability insurance or the inability to secure insurance at all.

If you were to dig more thoroughly into the problem, you would find that there are companies which have been forced out of business and companies or associations which have been forced to the extreme of a captive insurance setup because they were unable to secure projection through the normal channels. Also I must object to the way in which you blithely toss around increases in product liability insurance premiums of from .02% to 23.4% as though costs are of little impact.

I agree that we should not become hysterical and attempt to arrive at half-baked solutions but that does not mean that we should relegate the problem to the back burner which I am afraid the form which your editorial has taken would lead many people to do.

W. Brandschutz
President, The Manufacturers Brush Co., Cleveland, Ohio

. . . More on product

To the Editor: Your Jan. 10 "Editorial Opinions" deserve comment. The present product liability legal situation needs to be reformed, for the simple reason the application of the law is unjust. The public is entitled to be protected, as they should be against any wrong. I quite agree with your last sentence recommending "solutions methodically developed and systematically applied."

Unfortunately some of the problems are being compounded by insurance buyers ringing their hands and crying on the shoulders of underwriters who have their fingers stuck in their ears and their heads buried in the sand. People only engage insurance consultants or create risk manager staff positions because they have a problem. As I tell our clients, I don't have any problems, I only have projects.

Possibly some of the groups seeking reform should keep that in mind. It's surprising how many more solutions you can find if you only have projects.

Stanley C. Brock
The Lukes-Brock Co., Milwaukee, Wis.

* * *

To The Editor: You don't think there is a genuine product liability insurance crisis.

What then do you think the National Assn. of Insurance Commissioners is up to when it calls for the product liability insurance industry (PLII) to develop "on a voluntary self-supporting basis a residual market mechanism (e.g. syndicate pool) to provide full insurance availability for product liability coverage?"

Fortunately those companies who are in the process of being destroyed do not have to rely on your thoughts on the subject that you are not convinced that "there are very many companies that cannot obtain the necessary liability insurance at any price."

To justify your conclusion that there is no general crisis, you cite RETORT's survey results and expressly imply that our report is representative of the exception rather than the rule, thereby supporting your conclusion that there is not much evidence that "anybody's going out of business because they won't operate without insurance."

You glibly dismiss the critical concerns of the 12 companies which listed premium quotes yet complained they couldn't get product liability coverage. One is in default on a $9 million line of critically important bank credit which requires maintenance of $6 million total products coverage. Another cites 35 of 37 carriers refusing to quote. One states that he dropped coverage completely because of drastic increases in rates.

You go on to state that RETORT "has not done any tabulating of responses on its own" and then you proceed to declare that the upper range of our figures is a distortion. If there is any distortion, it is yours. Furthermore you left out some interesting areas which should be studied by a standing committee of Congress to see if our random responses are indicative of a national situation.

There are seven companies in our survey results which, although they never had a single claim, not to mention a judgment or even a settlement, have received increases in one year of 1,000%, 1,349%, 787%, 300%, 2,224%, 340%, 576%. There are five companies which have only one claim which received increases in one year of 352%, 600%, 923%, 1,333% and 2,437%.

It is amazing that your concern permits you to concern yourself with companies that are "very hesitant to introduce and sell new products" because, you say, of the threat of increased litigation and broader legal liability rules. It is a fact of the "system" that there wouldn't be any legal liability if there were not an insurance mechanism. New products are not being produced and marketed because of the refusal by the PLII to offer insurance coverage.

Of course it is the initiation of the litigation itself and the accompanying discovery costs which have triggered the "loss control" activities of the PLII. But until such time as the tort system itself is abandoned in personal injury litigation, then we

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do not see how you can fail to support consumer advocate Ralph Nader's urging that Congress set up a standby insurance program for small businesses and manufacturers hit by skyrocketing premiums for product liability insurance.

In our opinion every time a powerful group in this country takes advantage of its position to strip individuals of their rights and liberty and dignity, these organizations debase the country and themselves. Our government will be no better than our response to the abuse of powerful organizations. It seems that you have a uniquely important role to play in your editorial opinions.

E. H. Rosenberg

President, Retort Inc., Franklin, Mass.

Carcinogen dispute

To the Editor: The Nov. 1 issue of *Business Insurance* carried a piece ("Tanker Deductibles Up; Casualty Losses Down") in which Mr. Arthur McKenzie states that an analysis by Exxon Corp. scientists shows that between 250 and 500 tons of potentially cancer-causing compounds are spilled into the oceans each year.

Well before publication of these statements, Mr. McKenzie was notified that his statements are erroneous in the context offered. On Sept. 24, Mr. R. A. Brown, scientific adviser with Exxon Research and Engineering Co., and one of the authors of the report which Mr. McKenzie cites, wrote Mr. McKenzie the following statement:

"Your claim that 250-500 tons per year of these carcinogenic compounds are entering the oceans . . . is based upon including the three compounds: benzo(a)pyrene, benz(a)anthracene, and chrysene. Benzo(a)pyrene is recognized as a highly potent carcinogen. Chrysene, on the other hand, at worst is a weak carcinogen and indeed may not be carcinogenic at all. To place chrysene in the same category as benzo(a)pyrene is like mixing apples and oranges. Since most of the 250-500 tons per year of your claimed input is due to chrysene this statement is misleading. I would suggest that benzo(a)pyrene is the only legitimate yardstick that you can use. This yardstick has been accepted and is used by investigators in many disciplines including chemistry, biology, medical research, and environmental science."

Brown's letter also cited improved analytical methods used by investigators which clearly show that hydrocarbons present in the marine environment do not all originate from petroleum, and that even the highest concentrations of plycylic aromatics found in marine organisms such as clams, oysters, crabs and some fin fish are less or no more than levels observed in common foodstuffs.

W. O. Gray

Exxon Corp., New York

Mr. McKenzie replies:

I disagree with Exxon's letter that states, ". . . his statements are erroneous in the context offered." The data in the report concerning potentially cancer-causing compounds was obtained from two published reports. The fact that the amount of at least three of these compounds is considerably greater than previously suspected is something people should know about.

Seamen cleaning tanks come in close contact with oil. Beaches that are sometimes polluted with oil and tar lumps offer oil-contact to bathers and beach users. It is only prudent for people that may come in contact with oil to be aware of the new data that has come to light.

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HERE ARE 58 BENEFIT BOARD MEMBERS

Employe benefit managers serving on the Business Insurance Benefit Board approved disclosure of their employers' names, so our readers know our sources.

Of the 66 panelists, 58 gave permission to list their companies' names.

Abbott Laboratories
ACF Industries
Addressograph Multigraph Corp.
American Can Co.
Babcock & Wilcox
Bemis Co. Inc.
Borden Inc.
Brown & Williamson Tobacco Corp.
Campbell Soup Co.
CBS Inc.
Celanese Corp.
Cherry-Burrell (div. of AMCA International Corp.)
Container Corp. of America
Continental Group
Control Data Corp.
CPC International Inc.
Crain Communications Inc.
Cranston Print Works
Crown Zellerbach Corp.
Dart Industries
A. B. Dick Co.
FMC Corp.
General Dynamics Corp.
General Mills
Gulf Oil Corp.
Hercules Inc.
Honeywell Inc.
S. C. Johnson & Son Inc.
Lever Bros. Co.
Eli Lilly & Co.
Thos. J. Lipton Inc.
Lockheed Aircraft Corp.
Mead Corp.
Medtronic Inc.
Meredith Corp.
Mobil Oil Co.
Morton-Norwich Products Inc.
National Service Industries Inc.
Nordstan Corp.
Northwest Industries Inc.
Otis Elevator Co.
J. C. Penney Co. Inc.
Pfizer Inc.
Polaroid Corp.
Quaker Oats Co.
Ralston-Purina Co.
Republic Steel Corp.
Ryder System Inc.
Sherwin-Williams Co.
St. Regis Paper Co.
Sun Co.
Sybron Corp.
TRW Inc.
TRW-Defense & Space Systems
United Airlines
U.S. Industries
Weyerhaeuser Co.
Wickes Corp.

Benefit survey . . .

Continued from page 3

the problem and will most likely be instituting new or tougher controls on claims and costs in the next year or so. Only four benefit managers responding to the Benefit Board survey said they don't have any problem with rising costs and aren't worried about controlling outlays for health benefits.

Six panelists are worried about rising claims and costs in the health care field, but they don't know what to do about the problems within their own companies. Some comments from benefit managers indicate they feel almost powerless to control costs in the face of almost overwhelming utilization and inflation.

Take the comment from one manager when we asked what he was doing to control costs: "Not much. We have tried to squeeze all the 'water' out of the program by consolidating coverage under a master ASO contract, pushed deductibles and coinsurance, are looking into second opinion programs, but it's like bailing out the ocean with a spoon."

Similarly, another manager also admitted he's doing "very little" to control costs, mainly attributable to "plan design (which) has become so broad and comprehensive that our insurance plans tend to increase costs rather than to control costs. Responsibility for cost control has largely been delegated to carriers and to 'jawboning' with providers of hospital and medical care.' "

Many benefit managers have already instituted claims and other control mechanisms, listing 33 dif-

$5.4 million jury award overturned

By GREG DAVID

EVANSTON, ILL.—A California trial judge has overturned a $5.4 million award against Washington National Insurance Co. in connection with the insurer's failure to pay a long term disability claim.

The judge ordered a new trial only on the issue of the amount of damages. Washington National has appealed the ruling, asking for a new trial on the issue of liability as well.

An Orange County jury last summer awarded Julius Austero $100,000 in compensatory damages and $5.3 million in punitive damages. Mr. Austero, a lawyer who suffers from a rare brain disease, argued Washington National acted in "bad faith" when it refused to pay him disability benefits.

Washington National, the insurance carrier for the medical and disability coverage for California lawyers, argued the policy had lapsed for failure to pay premiums 12 months before a claim was filed.

Mr. Austero argued he was already disabled when the policy lapsed. But the insurer contended he had continued to work for nine months and that the policy required "total disability."

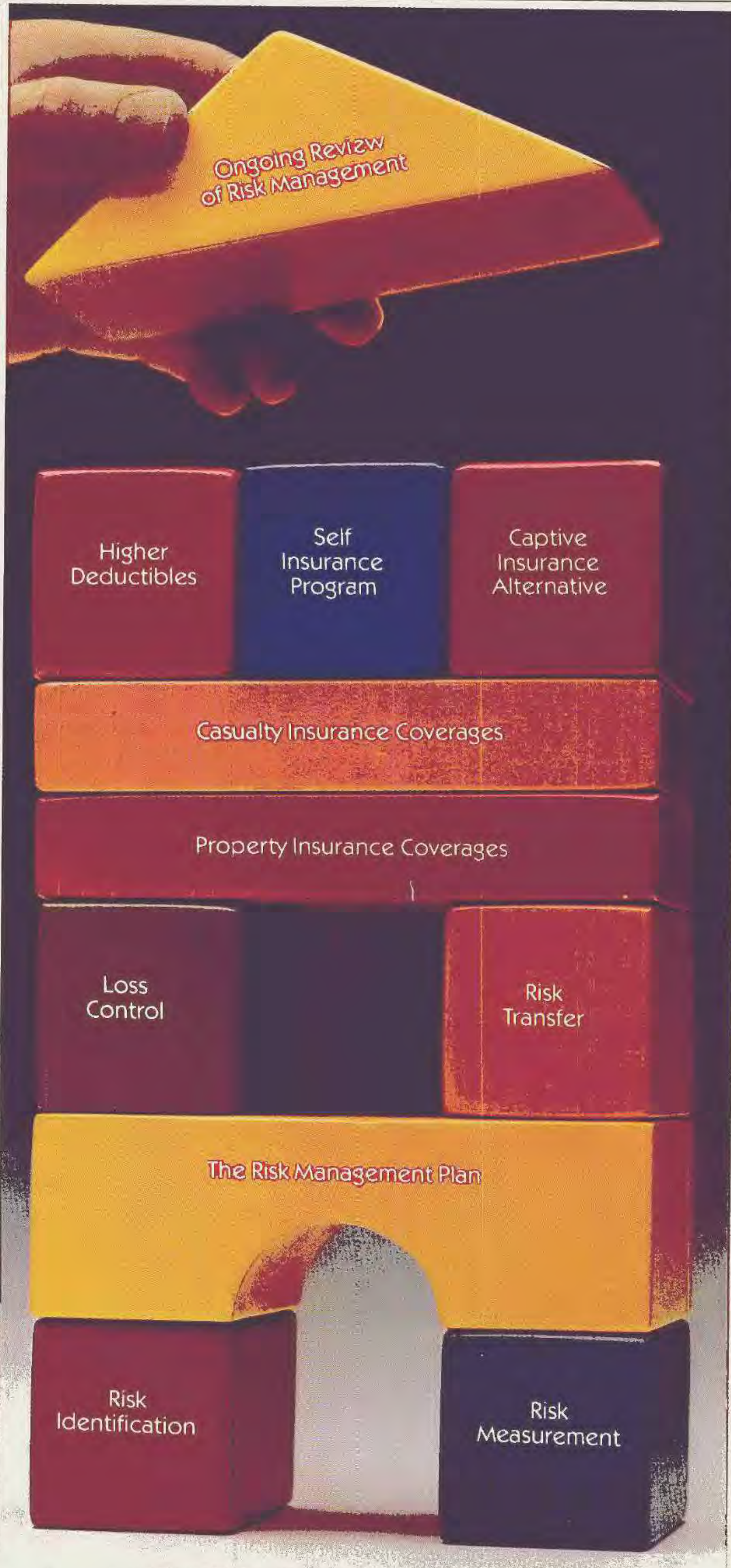
The judge ruled the jury's award was based on insufficient evidence and "passion and prejudice." The court offered to allow the verdict to stand if Mr. Austero would accept a $254,000 award—$54,000 in compensatory damages and $200,000 in punitive damages.

Mr. Austero's attorney, Herb Hafif, said he would also appeal the ruling, asking the higher court to reinstate the jury verdict. Mr. Hafif said he is tired of judges substituting their judgments for the decisions of the jury.

Vowing to take the case to the California Supreme Court, Mr. Hafif said he was "goddamn mad at this one" and that it was a case of institutionalized "corporate arrogance."

The award was believed to have been the largest in a breach of faith case. A California appeals court late last year reduced to $2.6 million from $5.1 million an award against Mutual of Omaha in another breach of faith case involving disability benefits.

Mr. Hafif's firm also handled the Mutual of Omaha case. The attorney said he felt the Austero case was stronger than the Mutual of Omaha suit. ■



MEMO FROM MARSH & McLENNAN

How your company may be able to obtain 'more insurance,' without necessarily buying more insurance.

What's insurance all about anyway? Just one thing: shielding your assets from unexpected losses. For this protection and peace of mind, you are willing to plan for and pay a specified sum that you consider a fair price for this removal of risk.

Errors are made when you lose sight of the fact that protection is the goal while insurance is merely one means to attain that goal. It follows then that "more insurance" is not necessarily the most advantageous way to achieve a higher level of protection.

The risk management concept

The idea is to start thinking in terms of managing the multitude of risk situations, search-

ferent techniques being used to cut costs or at least hold them steady.

Tighter claims administration programs, including tougher standards for claims review, are the most frequently used method (23 respondents) of holding down costs.

Four benefit managers specifically noted that they're strictly enforcing coordination-of-benefit (COB) provisions in their health policies.

Second in order of frequency of use is the adoption of health maintenance organizations (HMOs) as a tool of cost control, by 11 corporations. These companies are in the forefront of what appears to be a long term shift to preventive medicine and clinical practices.

Ten benefit managers said they've begun expanded programs of educating employes. These efforts usually include information sessions, booklets, and other methods to teach workers proper utilization of their health benefit plans, the advantages of good personal health habits coupled with preventive medicine and the actual cost of benefits provided by their employers.

These programs, along with greater use of HMOs, are closely linked to the change noted by eight additional benefit managers to "more preventive medicine, use of regular physical examinations and health screening programs."

Eight corporations have instituted second opinion programs for surgery and/or for any elective processes. Included in this group are the firms requiring pre-certification or predetermination of procedures involving dental surgery. Two other benefit managers also noted their companies "support professional standards review organizations (PSROs)" to control the quality and quantity of physician services provided in a community.

Along these same lines, one benefit manager hired an outside service provider to do a major study of hospital confinements paid for by the company.

Three other managers have arranged with their insurer for monthly statistical reports on all claims filed, reserved and paid so that they can track the charges.

Several of the cost control techniques fall into the category of reducing long term payouts for serious or chronic illnesses. These include rehabilitation for certain long term disability cases (2 panelists), treatment of drug abusers and alcoholics (2 panelists) and use of home health care and/or nursing home care whenever possible (3 panelists).

In the fight against expensive hospitalization claims, six companies have provided more benefit coverage for outpatient care, and encourage pre-admission diagnostic testing as well.

Internal funding and administration of health benefit plans are often seen as prospects for cost control. Seven contributors said they've gone to more self-insurance of health plans, and another panelist also said he'd "changed the funding method." Another 6 panel members said they're taking a harder line with their insurers, reducing the reserves held by carriers to pay future claims.

Eight companies have raised the coinsurance or deductible provisions of their policies.

Three said they controlled costs by switching to flat fee schedules for benefits, instead of covering more costly "reasonable and customary" charges.

Four managers said they're working to restrict the expansion of medical benefits.

Several panelists specifically noted that they've recently integrated their health plans with their corporate auto insurance programs, so that they routinely exclude health insurance claims related to vehicular accidents where other insurance is available.

Four companies whose benefit managers are on our panel now have representatives on hospital boards.

Several companies have initiated task force committees to develop cost control tools.

Two companies work with the Washington Business Group on Health to stay on top of health benefit costs and trends. ■

Insurance role curtailed for affiliates

WASHINGTON—A recent court decision sharply limits the types of insurance non-bank subsidiaries of bank holding companies may sell.

The U.S. Fifth Circuit Court of Appeals ruled that banks' non-banking subsidiaries, such as their mortgage and finance companies, no longer could sell insurance in connection with loans.

The court said in the Jan. 10 decision that bank holding companies now may sell insurance only through their banking operations.

The only exceptions would be credit disability and mortgage redemptive insurance which a non-banking subsidiary could still sell in connection with loans.

The decision represents a partial victory for insurance agents who have been pressing the courts to get banks out of insurance.

The Independent Insurance Agents of America (IIAA) maintains that Federal Reserve Board regulations permitting banks to market insurance in connection with loans give banks too much power and represents a potential for coercion.

The agents will appeal the ruling since it did not overturn earlier Fed regulations allowing banking subsidiaries of bank holding companies to market insurance in connection with loans, said John Neville, IIAA general counsel.

As a result of the decision, some bank holding companies might transfer the insurance related activities of their finance and mortgage companies to their banking subsidiaries.

But such a transfer would be extremely complicated and cause many procedural problems, according to several sources in banking circles.

Risk managers minimized the impact of the decision. They said it was unlikely that banks would attempt to capture a chunk of the insurance business that non-banking subsidiaries were forced to give up.

"The banks are already too big to handle more insurance business," said Jerry Lane, director of insurance for McDonald's Systems Inc. "They just aren't geared to handle this."

Despite the decision, banks still could coerce their customers into buying insurance from them, one insurance broker in central Wisconsin, fears.

"What if a corporation owes a bank a huge amount of money? The bank could then turn the screws on the company and threaten to call the loans in unless the company bought insurance that the bank was handling," he said.

Federal Reserve Board regulations, however, forbid banks from selling insurance as a precondition to approving a loan.

The U.S. Supreme Court is unlikely to act on the IIAA's appeal before its June recess. ■

ing always for the most efficient method of attaining the necessary protection. The concept of risk management in today's complex business and legal environment requires more than conventional insurance responses.

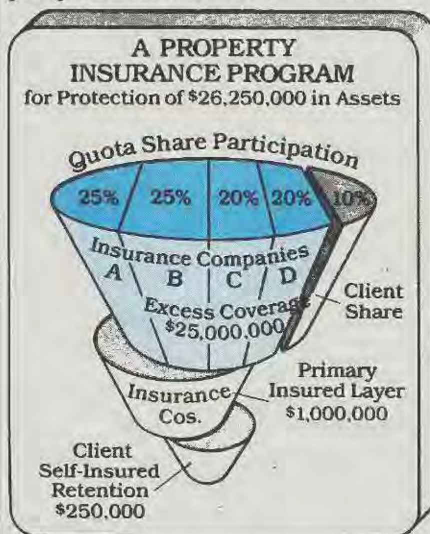
In simplest terms, risk management entails identifying risks, assigning value to them, anticipating losses and making objective decisions about what steps to take before losses occur, so that they have the least impact on the operation of your business.

Linked to this, of course, is the need to implement a meaningful loss control program which will help to prevent or reduce the incidence and severity of losses.

Two principal options are open

First of all, risks may be transferred in the conventional insurance manner. The important thing to remember here is that this decision is made only after a thorough review and examination when it is concluded that this is the correct response in the particular case under consideration. It should not be a reflex action.

Secondly, risks may be assumed by your company, either in whole or in part. A higher deductible is an obvious way for a company to assume a portion of the risk and thereby reduce the cost of purchased insurance—yet still retain adequate insurance protection against catastrophic loss. An established self-insurance program is another way for a company to assume its own risks,



while diverting the money earmarked for premiums into a separate fund to cover projected losses.

The optimum plan may very well contain elements of both(see chart) but only with expert analysis can one approach the optimum with confidence.

Which direction for you?

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The fact is, nobody in the industry is better equipped to counsel you on the best course to follow and to assist you, at every step along the way, toward a risk management plan which makes sense for your operations.

For a more complete examination of this and related subjects, simply send for your copy of: "The Risk Management Concept—Insurance Plus." Write to Dept. 100-BI, Marsh & McLennan, Incorporated, 1221 Avenue of the Americas, New York, N.Y. 10020

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benefit tax slants

Despite tax changes on sick pay, disability plans can reduce costs

By JOSEPH S. ROBINSON
Attorney-at-Law

THE FORMER RIGHT of an employe to exclude from income up to $100 a week in sick pay has been wiped out by the tax reform law. Thus, many sick pay plans will no longer provide the full benefit that they were intended to give.

However, despite the changes in the Tax Act, disability income plans still provide a way for employers to cut employment taxes. Here's why:

FICA taxes in 1977 go as high as $965.25 (5.85% on the first $16,500 of earnings) for both employers and employes alike, an increase of $70.20 over the maximum contribution for 1976. FUTA taxes for 1977 go to 3.4% on the first $4,200 of earnings for each employe, (compared to 3.2% for 1976), with the wage base going to $6000 for 1978.

Suppose you employ 100 persons who are paid $50 per day and average four sick days per year. The FICA savings is $1,170 ($20,000 x 5.85%) for you and for your employes alike.

In order to obtain the exemption, the employer must have a sick-pay plan that pays all or part of an employe's salary while he's sick or injured. The plan needn't be all inclusive. It can cover some or all of the employes. What's more, there can be different plans for different classes of employes.

* * *

The Employe Retirement Income Security Act (ERISA) provides that, under certain circumstances, interested parties can get a declaratory judgment from the Tax Court with respect to qualification of a retirement plan (*I.R.C. Sec. 7476*). This relief is aimed at giving parties who receive an unfavorable determination or no determination from IRS an avenue of appeal.

In three recent cases, however, the Tax Court has turned down three attempts at declaratory judgments by employers seeking relief.

First Case: Sheppard & Myers, Inc., received a favorable determination letter regarding the initial qualification of its pension plan. IRS later audited the plan and disqualified it for failing to meet the requirements in its operation. Sheppard & Myers disagreed and sought relief.

The Tax Court ruled that it lacked the power to hear the case. The Court found that Congress intended the Tax Court to have jurisdiction only when a new plan, a plan amendment, or a plan termination is involved, not when qualification is being revoked because of the operation of the plan (*Sheppard & Myers, Inc., 67 TC No. 3*).

Second Case: The Federal Land Bank Assn. adopted a retirement plan in 1973 and submitted application for determination letters before notification of interested parties became a requirement under ERISA. IRS sent unfavorable determination letters in February 1976, and the association turned to the Tax Court for declaratory relief. But it was to no avail. (*Federal Land Bank Assn., 67 TC No. 4*).

Third Case: On Sept. 26, 1975, the Prince Corporation filed a request with IRS for an initial determination that its ESOP qualified as a "retirement plan" for tax purposes. Despite telephone conversations, written correspondences, plan changes and a conference, the Prince Corporation and IRS remained at odds on some issues. On Aug. 10, 1976, the Prince Corporation filed a petition for declaratory judgment because of IRS's failure to issue a determination. On Aug. 17, IRS sent Prince a proposed adverse determination letter listing the unsettled issues as reasons for denying qualified status to the plan.

Tax law requires that administrative remedies be exhausted before the Tax Court can consider the issuance of a declaratory judgment. When IRS is being challenged for failing to make a determination, the rule says a party must wait 270 days after requesting the determination to seek relief from the Tax Court. But the mere passage of time does not entitle a corporation to a Tax Court hearing.

The Tax Court found nothing compelling in the passage of the 270-day period and chose to look at the actions of the parties throughout the period to see whether administrative remedies were exhausted. The court indicated that after working at an agreement for 270 days a taxpayer need only demonstrate that progress is severely hampered due to causes beyond its control without necessarily showing that it has met every single step that IRS sets out in its administrative rules. However, this failed to aid Prince because the court concluded that "the parties have not deviated sufficiently from a normal progression through channels to support a finding that there has been an exhaustion of administrative remedies." (*Prince Corp. 67 TC No. 25*).

It would appear from a reading of these three decisions that taxpayers will still have to continue the old practice of ironing out such qualification problems with IRS directly, despite the new provisions under ERISA. ■

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around the states

Teachers entitled to receive benefits even while on leave, says Pa. court

HARRISBURG—Pennsylvania's Commonwealth Court has ruled that public school teachers on sabbatical leave must continue to receive fringe benefits negotiated through collective bargaining. The court upheld an arbitrator's ruling that the Central Dauphin School District must reimburse a teacher for deductions from his paycheck for medical and dental insurance. These benefits are noncontributory for active professional employes.

•

LANSING—Gov. William Milliken has vetoed legislation designed to speed up worker's compensation claims in Michigan. The measure would have imposed a fee on insurance companies writing worker's compensation policies in Michigan. The resulting revenues would have been used to hire additional staff and ease the case backlog. Gov. Milliken said the bill would impose an additional $5 million a year burden on employers, who would pay the assessment through higher premiums, while failing to solve the basic problem.

•

TOPEKA—Legislation has been introduced in the Kansas General Assembly that would require the state and all local governments to provide paid legal counsel for their employes. The measure applies only to legal actions growing out of the employes' official duties.

•

DOVER—A special state commision has recommended that directors of the troubled Farmers Bank receive state-backed liability insurance because "their personal fortunes are in jeopardy." The Delaware commission urged passage of legislation that would provide the seven bank directors with either insurance or immunity from lawsuits. The bank suffered losses in 1975 that eventually reached $20.8 million, and it is now in the midst of a federal-state rescue plan that has resulted in the state owning 83.5% of the bank's stock.

•

TALLAHASSEE—A new law is on the books in Florida that requires increases of any government-supported retirement system to be fully funded by the legislature and the pension plan.

•

RALEIGH—North Carolina Insurance Commissioner John Ingram has signed an executive order outlawing discrimination on the basis of sex or marital status in the sale of insurance. The new regulation takes effect May 5. Insurers must provide the same life, health, disability and auto insurance for women as for men and apply the same eligibility standards for single, married and divorced women. The regulation does not apply to rates, and the department believes that "some of this coverage may be a little higher than it is for men."

•

HARRISBURG — Pennsylvania purchasing officials claim that the malpractice insurance program for state-employed physicians is saving taxpayers $768,000 a year. The state General Services Department said the state is paying $432,000 annually for full coverage of its 728 doctors, about one-third the cost of similar plans on the open market. The department said the savings were possible through the State Employes Self Insurance Fund, a two-year-old program that provides protection for all state employes and volunteers against liability claims. The department said that without the fund the malpractice coverage would have cost $1.2 million.

•

LINCOLN—A district court has ordered the Nebraska insurance director to implement the state's new medical malpractice law despite a pending appeal. The state attorney general had advised the insurance commissioner not to implement the law because of its "constitutionally suspect" $500,000 ceiling on malpractice claims, but he was overruled by the court.

•

MADISON—New Wisconsin laws requiring coverage of kidney disease, tuberculosis, nursing home care and newborn infants in hospital treatment policies have been challenged in court. The suit challenging the constitutionality of the laws was brought by Insurer's Action Council Inc., a nonprofit corporation made up of insurance companies authorized to write accident and health policies in Wisconsin.

•

RICHMOND—The State Employment Commission has asked the Virginia General Assembly to approve legislation extending unemployment insurance to local government employes. The commision said there are about 3,000 cities, towns and counties in Virginia that employ a total of 235,000 persons. The commission said the expansion would bring coverage to the last large pool of ineligible workers.

•

ANNAPOLIS — Maryland's Health Sevices Cost Review Commission has approved a hospital charity plan that provides free care for indigent patients and reduced rates for uninsured persons with unaffordable bills. The plan was adopted on an experimental basis for several Baltimore hospitals.

Around the States, a new column in Business Insurance, *is designed to keep our readers informed of insurance developments in state government.* ■

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Suit demands $850,000

PORTLAND, ORE.—A lawsuit seeking $825,000 in damages in connection with a 1974 accident involving a cabin cruiser and tugboat has been filed here by Arthur A. Wheeler, whose wife was killed in the collision on the Willamette River.

Named as defendants are Willamette-Western Corp.; Ward M. Bennin, pilot of the tugboat, and John Heffelfinger, owner and operator of the 26-foot cabin cruiser "Minaki."

The death of Geraldine Wheeler, 34, left her husband with four children to support.

Mr. Wheeler charged the defendants were careless and negligent in operation of the vessels involved. The corporation owns the tugboat which was pushing two large barges downstream when the collision occurred. ■

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legal brief

Court decides what is a 'direct loss'

THIS SUIT WAS brought by an insured against its insurance company to recover a claim under a fire, lightning and other hazards policy which included vandalism and malicious mischief.

Water damage to the insured's property had resulted from burglars uncoupling water pipes to remove bathroom fixtures on the third floor of a warehouse which allowed water to run down to reach goods stored on the first floor. A New York appellate court ruled that the insured was covered under the policy notwithstanding a policy exclusion for pilferage, theft, burglary or larceny.

Here the insured was a tenant on the ground floor of a warehouse where it stored buttons and button fixtures which it manufactured. In May 1973 someone broke into the unoccupied third floor of the warehouse, uncoupled pipes carrying water to the bathroom fixtures and carried away the fixtures. Water left running from the severed connections ultimately reached the ground floor, damaging the insured's stock.

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

Providence Washington Insurance Co. (Providence) had issued the tenant the insurance policy which included protection against "direct loss" from vandalism and malicious damage to the property covered. The policy also contained an exclusion for loss "by pilferage, theft, burglary or larceny. . ." Providence rejected the insured's claim, and the insured brought suit. The trial court also rejected the insured's claim.

The principal issue facing the appellate court was the interrelation of the "vandalism" coverage with the exclusion for burglary, particularly since the court recognized that there was no controlling law in this area. The court concluded that it was "undeniably clear" that there was an act of vandalism committed here since the severance of the pipes and fixtures *prior* to their removal constituted a completed act. Furthermore, the court believed that the meaning of valdalism includes destruction of property from "ill will toward its owner *or from mere wantonness.*"

Consequently, the court determined that there was a direct connection between the insured's damages and the act of the perpetrators in severing the fixtures. In addition, the court believed that the exclusionary language was ambiguous, thus rendering Providence liable. Accordingly, the court ordered that the insured should recover from Providence once its damages were assessed. *Cresthill Industries v. Providence Wash. Ins. Co.*, Supreme Court of New York, Appellate Division, Second Department, July 19, 1976, Shapiro, J., 385 N.Y.S.2d 797 (BI/03/D.-$3)

Fire insurance

Here suit was brought to recover on a fire insurance manufacturer's output policy issued by Fireman's Fund Insurance Co. Fireman's had issued two policies to Carpet Mills, a carpet manufacturing firm. One fire insurance policy covered Carpet Mills plant and also provided coverage for business interruption losses. The second policy covered personal property, including the inventory-output still owned by Carpet Mills, in the Carpet Mills plant.

Imperial Enterprises was a Georgia corporation whose sold assets consisted of Carpet Mills' stock and a note from that corporation. Carpet Mills and Imperial merged in November, 1971 pursuant to the Georgia Statutory merger scheme. Imperial was the surviving corporation, but business continued as before under the Carpet Mills trade name. The premiums for both fire insurance policies were paid with Carpet Mills' checks.

Upon finalization of the merger, Carpet Mills' assets, including the fire insurance policies, were transferred to Imperial by operation of law. Articles of merger were properly filed and reported but Carpet Mills did not take any action to assign the policies to Imperial. Fireman's was not notified concerning the transfer of the policies and did not consent to it.

In May, 1972 a fire occurred at an Imperial plant causing substantial damage to the plant and its contents. Shortly after the fire Imperial furnished Fireman's with a copy of its fiscal 1972 financial statements, which were in its name and contained a footnote concerning the merger. Checks signed by Carpet Mills continued to be accepted by Fireman's for premiums on the output policy, until its cancellation some seven or eight months after the fire.

Relying on a proof of loss statement by a party purporting to sign for Carpet Mills, Fireman's paid over $34,000 on the building policy in August, 1972. However, Fireman's denied liability under the output policy, stating that Carpet Mills had undervalued its inventory, thereby reducing its premiums on this policy. It asserted the alleged wrongful assignment without its consent as a basis for denying liability.

Since the transfer of the policy to Imperial occurred by operation of law rather than through a personal assignment by Carpet Mills, the United States Court of Appeals for the Fifth Circuit was unable to conclude that the policy's no-assignment provision unambiguously and unquestionably applied to this transfer. Accordingly, the court interpreted the policy in the insured's favor and so as to avoid a forfeiture, "since the statutory merger caused no increase in the risks or hazards incurred by Fireman's Fund."

Thus, it was the court's conclusion that the no-assignment clause should not be applied ritualistically and mechanically to forfeit coverage in these circumstances. *Imperial Enterprises, Inc. v. Fireman's Fund Ins.*, United States Court of Appeals for the Fifth Circuit, July 14, 1976, Gewin, J. (BI/05/D.-$3) ■

(Copies of the entire decision of cases described in this column may be obtained by sending a check for $3 made out to Cases Unlimited to Legal Briefs, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the code number for each opinion requested, which can be found at the end of the brief.)

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March 16: Horizons in Risk Management is the theme of the Massachusetts Risk and Insurance Management Society's eighth annual spring conference in Woburn, Mass. Liability insurance, workers' compensation and risk funding mechanisms will be discussed by panels in the afternoon. Dinner speaker is Paula W. Gold, assistant attorney general and Consumer Protection division chief in Massachusetts. Cost is $25. Contact: Lawrence J. Babbitt, Stop & Shop Cos. Inc., P.O. Box 369, Boston, Mass. 02101

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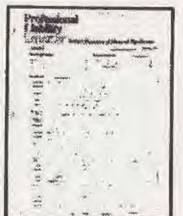

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PERSPECTIVE

Data processing: A tool to control benefit costs

By Grant H. Morris
Consultant, Morris Associates
New York, N.Y.

TWO IMPORTANT DEVELOPMENTS in the data processing field over the past few years lead me to believe that there is a way for many companies to stabilize their benefits administration costs while improving service to users of this information. They are: minicomputers and data base management. Together they have a direct bearing on the employe benefits recordkeeping systems of many companies.

Minicomputers have been around for many years, but are now coming into increasing use in a variety of commercial applications. For small companies they have become the general workhorse, doing all the accounting, bookkeeping, inventory, payroll, etc. For larger firms, they have been employed by many kinds of dedicated applications, particularly those that stand somewhere apart from the mainstream of large scale processing, or those that were not receiving adequate attention from the corporate data center.

The important point about minicomputers is that, in addition to the processing power of larger machines, which they have always had, they now have all the storage and input/output devices (direct access, tape, CRT's, printers, etc.) which were available only on the large scale computers a few years ago.

Data base software, which permits integration of files and elimination of redundancies, has also been around for several years. Until recently, this type of software has been associated with large-scale computers, because only machines of this size could afford the extra main memory required for these programs. At present, at least one major data base system has been adapted for use on minicomputers, and others will undoubtedly follow.

Both of these developments have direct application to typical employe benefit recordkeeping systems. In many respects, the peculiar organizational position of the employe benefits function makes it a very good place to use a minicomputer with data facility. The same general reasons which apply to other dedicated commercial applications certainly apply here:

1. Employe benefits records stand apart from the mainstream of any company's data processing, simply because they are not the main reason any firm installs large scale data processing.

2. Because this function stands apart, it frequently does not receive consistent or adequate attention from the corporate data center. Analysts, programmers, and other data processing people are usually assigned to work on projects directly related to the conduct of the business.

3. As to the value of the data base approach, employe recordkeeping is an area where the same information is copied over and over again from file to file, some of them manual, some of them machine sensible. If there were one central file of employe benefits data to which all the users in personnel, payroll, employe benefits, and other departments could refer (on a need-to-know basis), the potential savings in time, money and increased accuracy would be large.

The fundamental structure of any organization guarantees that the position employe benefits records will always be somewhat "peculiar." Think of the number of places where data (frequently the same data) about an employe is recorded: in personnel, in payroll, in the department where he works, and in the employe benefits department. This is just within the company. Depending on the number and kind of employe benefit plans you have, more employe data will be found at several places outside the company: with the actuary, with the thrift plan processor, with the benefit statement producer, with a bank or insurance company which administers annuity payouts, etc.

The important thing about minicomputers is that they now have all the storage and input/output devices which before were only available on the large-scale models.

Sitting at the center of all this data, and responsible for coordinating its uses, is the employe benefits department. Yet, in most cases, it is not the originator of the data, nor is it in a position to control its accuracy, since most of the recording and transcribing takes place in sections and departments not under its control. Furthermore, there is no practical way to bring benefits data under the single authority and control of any one department, since it will always have multiple sources of input and multiple uses in various parts of the organization, parts which are always going to remain functionally separate.

In many large companies today, the various records used to post data about employes are a direct reflection of this ingrained division of authority and responsibility. As with the organizational pattern, they are not integrated, and they tend to overlap. Yet, in spite of the overlapping, it is very difficult to put together a complete picture of the status of the employe's pension and other benefits as of any one data. Many companies have been doing just this job each year in order to produce the annual benefit statement for their employes and many more will be doing so in the future, encouraged by the provisions of ERISA.

For companies whose benefit records are kept as described below, and there are many of them, this is a formidable annual undertaking. And unfortunately, as soon as it is over, all of the records which were brought together to produce the statements, return to their individual pathways for normal updating and maintenance, only to be brought together again the following year, with the same difficulties.

With variations, these are the places and the methods used to record benefit and welfare plan data commonly in use at present:

1. Payroll master file. Whether the company payroll is processed in-house, or by an outside service, the master file contains the bulk of current data relating to employe benefits and welfare. Aside from the basic identifying information, it usually carries codes to indicate eligibility and participation, and various money amounts for deductions and the accumulations which result from them. Nearly all payroll systems in use today are tape sequential systems, which are updated each payroll period. The wealth of information they contain is rarely available directly on-line to those who could use it. Instead, printouts or microfiche of the status as of the last cycle is used.

2. Personnel records. These repeat the basic identifiers for each employe, such as social security number, sex, dates of birth and employment, etc; and usually carry a good deal more, such as salary history, attendance, education, skills, position codes, and so on. Typically operating with a mixture of manual and data processing systems, the personnel records are often treated as *the* correct source when errors and exceptions turn up in other records.

3. Employe benefits records. These vary a great deal from company to company, depending on the number of benefit plans, how long (if at all) there has been a separate employe benefits department, and other factors. Sometimes, when first set up, this department takes manual files previ-

Continued on following page

Says Marsh & McLennan exec

Sound, stable insurance market a key to any solution for product liability

By Robert Clements
Senior vp and director
Marsh & McLennan Inc.
New York

DURING THE PAST 12 months, the insurance market for product liability coverage has deteriorated steadily and rapidly to the point where primary coverage is almost totally unavailable for many classes of risks. The total available market capacity falls short of delivering the limits of liability considered adequate for the needs of many, if not most of our clients.

In addition, we are faced with a premium structure which more than anything else appears to reflect the current market condition in which the demand for coverage today far outstrips the ability of the industry to supply it. The cost of products coverage today is frequently much more a reflection of what the market will bear than it is of any technically sound assessment of loss potential. Therefore, it often seems excessive, even in anticipation of continued abuse of the tort system.

Although product rates may well now include a certain fat content, it is true that for many years, up to perhaps the end of 1974, they were too low. Thus, starting from a base which inadequately reflected the seriousness of the claim situation, their spectacular rise over the last two years is not merely a reflection of the surge in claim costs, but a magnification of it. Therefore, though the product liability problem is essentially a social issue, in a comparative sense, the crisis in the market for insurance has been its most traumatic aspect.

The increased frequency and severity of losses has also revealed, or in some cases highlighted, a number of technical underwriting problems which in turn have made a contribution to market scarcity. Foremost among these are the following:

- It is extremely difficult to distribute premium equitably among the great multiplicity of products and producers in our economy. Thus, underwriters are presented with a rating problem of the severest sort, especially for smaller manufacturers and product lines which have no credible historic loss frequency. It is significant that product underwriting is much more complex and hazardous than medical malpractice where risks can be divided into homogeneous classes, and the difficulty lies almost entirely in assessing the trends in economic inflation and heightened social expectancies.
- To date, the insurance industry has not been able to develop a definition of an occurrence or event to which limits of liability and deductibles can be applied without potentially catastrophic consequences for either the insurer or the insured.
- The custom of horizontally layering coverage and the current definition of what is an insured event lead inevitably to undesirable and ultimately unacceptable complications when large losses take place. Even the most carefully drafted policies have been proven incapable of producing circumstances which allow the policyholder and his insurers to work together to defend or negotiate settlements with third party claimants. In this line of insurance where a community of interest between insured and insurer is desirable, if not absolutely essential, the insured, when faced with a substantial claim, most often finds himself locked in an adversary position with his primary and excess carriers. And not just those of one policy year, for there is frequently dispute as to which year or over how many years an occurrence took place.
- The current lack of capacity for product coverage is directly and inextricably related to the shortage of capital in the underwriting markets. The degree of this shortage, when coupled with an anticipated growth in demand compounded at 10-12% over the next few years, leads inevitably to the conclusion that even with abnormally favorable earnings the industry will not be capable of generating sufficient additional surplus internally to cope with the demand. We know from insurance history that when the market is under-capitalized underwriters give first preference to the most predictable risks. The insureds with the least calculable (and therefore most hazardous) risks, such as product and malpractice liability, will suffer most from this set of circumstances. At least that will be the case unless means such as tax incentives and freedom from the more oppressive aspects of regulation are applied to encourage new capital directly into the writing of those lines.

The principal cause of the social problem in product liability may be the shortcomings of the tort system. In addition to the aberrations inherent in many awards, it is unjustly slow to produce results and unacceptably cost-inefficient in terms of what

Continued on following page

PERSPECTIVE

Data processing . . .

Continued from preceding page

ously held in personnel and/or payroll, and builds on them. In other cases, it starts a recordkeeping system from scratch, but most of the information it keeps has been posted by both personnel and payroll.

If, in addition to a pension plan, the company also has a profit-sharing plan, an ESOP, or a thrift/savings plan, it is quite likely that there will be separate records for each of these. Frequently, one or more of these will be maintained by an outside servicer, and the employe benefits function will operate using status printouts from these systems. To make matters more challenging, the company may operate through divisions, which have varying pension plans; it will have separate benefits for salaried and hourly workers; it may have old pension plans which have been superseded. None of these situations is uncommon, but it is easy to see the potential for a multitude of records, some posted to manual cards, some on machine sensible media, all updated according to varying cycles.

This description is not complete, but enough details have been set forth to make the point: There are a great many different records involved in employe benefits, they are posted on both manual and machine sensible media, they are updated by varying means and on differing time cycles, and, most important, they are not integrated, except temporarily, in those companies which prepare a comprehensive benefit statement. Yet, permanent integration of employe benefits records, if feasible, would appear to be of great value from at least three viewpoints: economic, legal, and general administrative convenience.

From the economic standpoint, it would clearly be less expensive in the long run to administer benefits, if all this data were stored in one place, to which all users could refer when they needed information.

From the legal standpoint, ERISA already has created a push in this direction, with its requirements for disclosure, annual statements, etc; to participants. In effect, it has set up a situation where employers will need the ability to produce an up-to-date benefit statement for any participant, active or terminated, at any time during the year, rather than just once a year.

Aside from saving a lot of time now spent in bringing this information together, general administrative convenience will be well served when the personnel, payroll and employe benefits departments can each summon up the data they need for their normal operations on a CRT screen.

All three of these desirable goals can now be reached through the minicomputer/data base approach. The process of building this system will consist of setting up a basic master record for each employe, and providing linkages to a set of variable records which carry his or her accumulations under each type of employe benefit plan. The output of the payroll system will be used as the primary input of this benefits system. Other sources of input, which include the personnel and employe benefits departments, and outside servicers, will funnel their data through one control point, presumably employe benefits, and it will be used along with the payroll data to keep this one central file of all benefits information up to date.

Costs for benefits administration under ERISA may or may not be skyrocketing, but most knowledgeable observers agree that they are going up. Inflation alone accounts for labor cost increases; your own in-house personnel involved with benefits and welfare plan administration cost more every year, and the wages of people who work for your actuaries, accountants and data processing services move upward.

To this, ERISA has added its requirements for more and better recordkeeping, and between inflation and the new pension law, there is no way that plan administration costs can be kept at previous levels.

Short of terminating your plans, which is not an acceptable alternative for most employers, you probably can't prevent your overhead costs from rising. In his article "Budgets, Controls for Administrative Costs Required Post-ERISA," which appeared in *Business Insurance* on Nov. 1, the author outlined an approach to discovering how much it costs to administer benefits records in the wake of pension and welfare reform.

The main point of that article was that, in spite of the fact that benefits costs are generated both internally and externally, and that internally these costs are buried in the part-time activities of employees in several departments, they can be estimated with reasonable precision by doing a little digging. The conclusion was that if nothing else was accomplished by this process, at least management would know where the benefits administration dollar is going, and this is the basis for controlling costs.

However, there are limits to what can be accomplished by working with the existing recordkeeping systems. In most cases, they are too diffuse and too redundant to allow much room for savings. Here, in the use of recent, but well proven, developments in data processing methodology, we have an opportunity to integrate benefits records, eliminate redundancies, and really control our costs while improving service. Minicomputers, anyone? ■

Mr. Morris started his own consulting firm in 1976 after five years with Johnson & Higgins as manager of data processing. Mr. Morris was manager of systems and programming for the Teachers Insurance and Annuity Assn.-College Retirement Equities Fund, one of the world's largest pension funds from 1958-1970.

M&M exec . . .

Continued from preceding page

part of the total expense is returned to injured parties. But there can be no successful long term solution which does not include the development of a sound and stable insurance market. This is true, regardless of whether the risk to be insured is strict liability, no fault compensation or some other alternative. To this end, it is important to recognize and deal with the fact that a general shortage of capital in the insurance industry and the specific lack of any sound basis in product liability for rating, policy writing and organizing catastrophe limits are all major deterrents to the development of such a market.

Even though there is ample evidence that the product liability insurance problem is severely aggravated by the foregoing considerations, most of the effort to deal with it has centered almost solely on tort reform. Therefore, early this year we began to realize the importance of becoming involved in a more broadly based and comprehensive effort to develop solutions. We are also aware of and wish to respond to the opportunity to play a leadership role in such a movement. To this end we sought and achieved the opportunity to testify before the Senate Small Business Committee and to participate on the Advisory Committee of the Secretary of Commerce and his federal task force. We also opened lines of communication and offered cooperation to other concerned persons and organizations.

Finally, in October, we convened a conference of thirty of our leading professionals in this field. This meeting ran over three days and included presentations by Professor Jeffrey O'Connell, Dr. Richard M. Jacobs and William H. Wallace, president of the Defense Research Institute. The principal objectives were to identify and develop positive courses of action for us to take, and develop an organizational vehicle for the coordination of our efforts to achieve solutions to the product problem.

Towards those ends, the conference participants produced a number of working papers. These contain many innovative and provocative recommendations ranging from tort reform through improvements in policy language to ideas for the development of new underwriting capacity. The major organizational recommendation is for the creation of a Marsh & McLennan Product Liability Council to function as the focal point of our corporate effort.

That recommendation, having received the approval of the board of directors of Marsh & McLennan Inc., is in the process of being implemented, and an announcement of the Council's membership will be forthcoming shortly. The Council will provide stimulus for our response to the other recommendations and proposals which came out of the conference. It will also become the primary mechanism through which we will relate to industry and insurer groups working in the field, the legal and accounting professions, consumer groups and government.

The Council will be made up of a full-time director, a chairman and senior representatives from each region of the country, and it will have a substantial budget against which it can draw for legal, actuarial and technical assistance. We hope and we think that the Council can exert a positive influence on this complex social issue in a field where we have special talent and experience as well as a unique position in relation to the purchaser of insurance, the insurance market and the legal community. With this goal in mind, the Council has invited comments and suggestions from all concerned persons. ■

Robert Clements is a senior vp and a director of Marsh & McLennan, Inc. with national responsibility for casualty, bonding, claims and reinsurance. Mr. Clements was recently appointed to the Commerce Department's Industry Advisory Committee to the President's Interagency Task Force on Product Liability.

SPEAKING OUT

Here is one regulator who stands out

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

I AM ALWAYS FASCINATED by the machinations of the New Jersey Insurance Department, probably because its activities are so well publicized. Acts of the New York and California departments are quite funny at times and those of the North Carolina department are positively hilarious. The Texas department stands aloof in its autocracy. The Maryland department, like most things in Maryland, is quite mediocre and just not villainous enough to be interesting. The less said about the Illinois department the better.

One must say of each of these departments that they think they are doing an excellent job. Their viewpoint and mine rarely coincide, however, and I would personally like to see them give some thought to the consumer instead of playing at petty monarchy. Indeed, as I see it, most insurance departments are only interested in broadening their power bases and any benefit acruing to the consumer is purely coincidental.

Having got all this off my chest to my complete satisfaction, I find myself utterly astounded because I have discovered an insurance commissioner who actually knows something about the business of insurance. This paragon of virtue is none other than John G. Day, the commissioner of insurance of the Commonwealth of Virginia. I am sure that Mr. Day will pardon anybody who says "John G. who?" since, unlike some of his colleagues in the regulatory area, we have seen no published reports of any inanities he may have perpetrated.

Having learned my trade in a part of the world where rate regulation is considered anathema, I still have no use for it. Nevertheless, I recognize that it is futile to advocate its total abolition in the United States because regulation is a political fact of life. Thus it was that in a speech given at a Virginia "I" day, Mr. Day did not recommend that his department become defunct but he did suggest that there could be radical changes in its mode of operation.

What a pleasure it is to read the remarks of a knowledgeable person. When reviewing the comments made by Mr. Day it is clear that he is aware of the importance of history. He recognizes, for instance, that given certain kinds of business stress, insurance executives will tend to react in well defined ways which have been observable for centuries. From such observations, for example, the cyclical nature of the business is readily explicable. At the same time it is well understood that we are all in danger of being hamstrung by history. Mr. Day illustrates this point when he reminds us that data used to create rates may be as much as three years old before action can be taken in prior approval states. It therefore follows that any rates based on such data will probably be nonsensical.

Arising out of these reflections, Mr. Day touches upon the most significant failure of American insurance. The point was well illustrated by a small incident which happened a few years ago at the height of the streaking craze. At the time, a couple of wags applied to a carrier for coverage, and the carrier, responding nobly, said it just could not be done. Although the response was written wholly in jest it contained a most significant statement, namely that insurance was based on past experience. Since the carrier had no past streaking experience it was unable to set a rate and thus could not write a policy.

This may be said to represent a capsule philosophy of American insurance; since it has never been done, then it cannot be done. Even Mr. Day seems to retain a vestige of this state of mind when he talks of speeding up the collection of data. There is hope for him, however, because elsewhere he recognizes the need to use "non-traditional but extremely relevant information in ascertaining current economic trends." Even so, he bewails the difficulties of communicating the intricacies of actuarial science, and I am afraid he is only too right. Mention bivariate normal and Poisson distributions to an average executive, and with vague memories of an expense account lunch at the back of his mind, he may just think you are talking about oysters and fried fish.

These reflections lead Mr. Day to consider the desirability of rate stability which he thinks can be achieved over the long run. He sadly ponders the fact, however, that the insurance industry is incapable of handling itself well in good times. But this seems to be true of most industries.

We, too, as insurance managers know that in the long run it is most profitable for underwriters and clients to establish a stable, long term relationship. When times are good and markets are plentiful, it may be hard to resist the wheeler-dealers and their cut-throat prices, particularly if they have got to top management and spun their fantasies about the savings to be achieved. When the inevitable tightening of markets happens along, those conservative underwriters who have not run from the scene look better all the time. It is this kind of stability that Mr. Day wishes to see in all phases of insurance operation within his jurisdiction.

The main thrust of Mr. Day's argument is that if the insurance industry puts its own house in order in Virginia and other open competition states, it will, in effect, regulate itself with the necessity of minimum intervention by insurance commissioners. Somehow one feels that this will happen a long day hence. In fact, Mr. Day himself acknowledges that the pathway to self-regulation has been blocked by the traditional regulatory attitudes and philosophies of another type of insurance commissioner and there is no hint by Mr. Day that this state of affairs may change. After all, who would wish to be a mere civil servant when he can be king? ■

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Reducing benefits . . .

Continued from page 1

fering a flexible package of benefits determined by set costs.

Ms. Koralik, who is the chief counselor for the Conference Board's own employe benefit program, offered other suggestions to help employers rethink their strategy to coincide with the continued growth of the government's role as both a provider and a regulator of employe benefits:

- Integration of private pension plan benefits with government benefits whenever possible. For example, a pension plan that includes a 100% offset or imposes an 80% or 85% lid on combined pension and Social Security benefits is an effective posture.
- Introduction of fixed dollar minimum pension benefits rather than increasing the percentages in a pay-related formula, as a means of avoiding permanent commitments for high levels of defined-benefit pensions.
- New approaches to collective bargaining which would take the company's liability for benefit changes into consideration. Rather than negotiating only on the basis of cents-per-hour costs, employers could adopt a policy on the appropriate limits to increases in unfunded liabilities.
- Restricting benefits to those not offered by the government, or not likely to be offered under such future government programs as national health insurance. Dental plans are one good choice, and some capital accumulation plans such as profit sharing plans can be used instead of improving existing pension plans.
- Avoiding the introduction or improvement of supplemental unemployment benefits because they are generally needed just at a time when companies are least able to increase the fund.

Ms. Koralik predicted that future legislation will require employers to vest benefits in the event of death before retirement.

She said she thought vesting at death could be handled by making the benefit payable to a spouse at the time it would normally have been paid to the employe who died. Immediate payments would be less likely, at least at first, if the government makes vesting mandatory at death. Vested death benefits could also be coordinated with group life coverage, she said.

Ms. Koralik said it seems likely that the United States will follow a trend toward limiting the rise in Social Security benefits. However, she pointed out that based on the current rate of benefit improvements Hewitt expects pay replacement for the average worker to reach 45% of final pay by 1980. By 1990 it could be up to 50%, compared to a pay-replacement level of 33% in 1955.

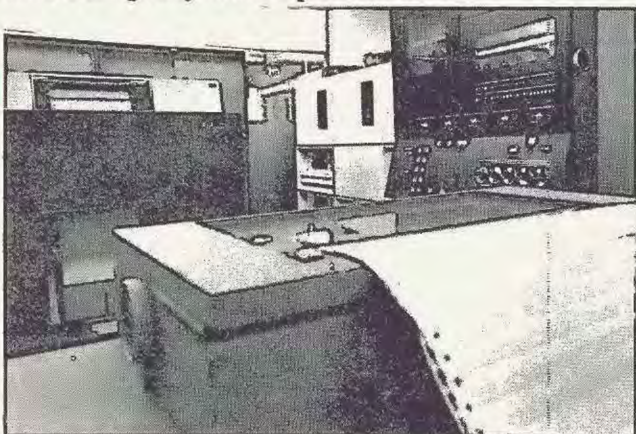
Ms. Koralik also predicted that interest in portability of retirement benefits will resurface as the public becomes disillusioned with the impact of the vesting provisions of the Employe Retirement Income Security Act (ERISA).

"**Vesting in a** fixed benefit that commences many years in the future is not the same as continuing in the same plan until retirement. Inflation takes its toll, and the value of vested benefits 20 or 30 years later looks rather small. So even though an employe may be vested, even though all service from age 25 to 65 may count under four different pension plans, his total value will be far less than if the employe had worked with one company for 40 years," she explained.

"When that information dawns upon the public, and on those in government who make these decisions, our suspicion is that we will have further moves toward, first, voluntary, and second, mandatory portability." ■

HOW THE FENWAL FIRE SUPPRESSION SYSTEM IN THIS AUTOMOTIVE COMPANY PAID FOR ITSELF IN ONLY 2 WEEKS.

At 9:03 on a Wednesday night, an electrical malfunction caused overheating, and smoke began rising in the west end of this company's computer room.



At 9:06, while the fire was still in the smoldering stage, the Fenwal Fire Supression System automatically sensed this smoke and discharged its extinguishing agent (Halon 1301).

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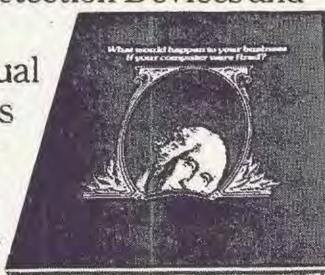

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people

Continued from page 42

General Mills Inc. in Minneapolis. Reporting to David McIntire, manager of employe benefits, Mr. Workington is responsible for the parent company benefit plans including life insurance, thrift, dental, disability and health plans. He was formerly supervisor of group insurance at Minnesota Mining and Manufacturing Co. (3M).

* * *

At 3M, **James F. Wickersham** was named group insurance supervisor, replacing Mr. Workinger. He will be involved in establishment of 3M's health maintenance organization (HMO) and reports to the group insurance manager. Another new position created in the benefits department at 3M is that of HMO coordinator. **Elizabeth Solem,** formerly involved in research with the Ramsey County health plan, was appointed to it. She will work with Mr. Wickersham.

* * *

Barbara Akk, 30, is leaving Cerro-Marmon Corp., Chicago, at the end of January to take over as risk manager for the County of San Diego, Calif. Ms. Akk was assistant risk manager at Cerro-Marmon where her replacement has not yet been named. The position in San Diego was open for about six months and was recently reorganized. The risk manager had been part of the department of special services but now will be under the county auditor/controller. Ms. Akk will be responsible for putting together specialty services and projects in workers' compensation, safety engineering, property casualty programs and establishing risk management policies. She had been with Cerro-Marmon for three years.

* * *

Larry Davidson, 35, was named compensation/benefits specialist at G. D. Searle & Co. in Skokie, Ill., a new position. Responsible for the design and implementation of new plans and the renewal of existing pension, group medical, life and disability plans, he reports to William Meehan, manager of benefits. Mr. Davidson was a consultant with Professional Financial Services Inc., Mansfield, Ohio.

* * *

At W.R. Grace & Co. in New York, **James O. Lott** was named insurance supervisor, reporting to Charles Krauter, assistant treasurer and director of risk management. Mr. Lott, formerly with Pueblo International Inc. in New York, will assist Mr. Krauter with Grace's corporate insurance program.

* * *

Rita J. Lindley, 27, was named insurance representative, a new position with Inland Steel Co. in Chicago. Claims handling and general litigation are her primary responsibilities and she reports to the insurance manager. Ms. Lindley came to Inland from Underwriters Adjusting Co., a division of Continental Insurance Co., where she was an adjuster.

* * *

Sara Mullady joined the employe benefits staff of Champion International Corp. as a benefits analyst. She joins a staff of three benefits analysts involved in ERISA compliance, communication of benefits plans to employes and development of new benefit plans. Ms. Mullady was formerly on the benefit staff at Olin Corp. and Otis Elevator Co. ■

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Tight market . . .

Continued from page 1

are fairly stable lines. But fidelity insurance is becoming difficult to maintain.

"A client has a fidelity bond running year after year with a one year discovery period. Suddenly he gets notice that it's changed to a 60-day discovery period and it's on a take-it-or-leave-it basis," said Mr. Silver.

Only three of the consultants interviewed now see signs of the market easing. Among them was Jim Marshall, an associate of Edward W. Siver & Associates in St. Petersburg, Fla. "The market is tight—no question. But we see indications it is opening up."

He said insurers are re-entering the market in his area. And he's heard of two insurance companies whose profits will allow them to "loosen up their underwriting." He admitted, however, "It won't be like the market prior to 1974—not the cutthroat competition."

Charles T. Tagman Jr., principal consultant with the George Betterley Consulting Group in Boston, Mass., said, "The market is still tight but those with one year renewals from 1976 are not seeing that much of an increase. It's a reasonable increase, some at 15% and 20%. If a company went through a major renewal in the last 18 months, there should be only moderate increases in their premiums this year."

But Mary Lou Kirk, a consultant with Crain, Langner & Co. in Cleveland, Ohio, said, "I've been hearing for nine months that the market is going to open up. I haven't seen any indications of it."

The consultants agreed the insurance market runs in cycles, but predictions on when it will change course ranged from summer 1977 to two years from now.

Mr. Anderson of Corporate Policyholders Counsel spoke for the majority when he said, "It's a scramble to keep stuff together."

Though the consultants complained of substantial increases for all types of third party liability, they repeatedly mentioned product and professional liability as the prime problem areas.

"Say *products* to an underwriter and he isn't there anymore. He's gone on a coffee break," said Mr. Brock. "Companies are reluctant to enter into new product risks," he added.

Even established companies are losing their coverage. A client of Mr. Brock with a clean product liability record for 40 years can't afford the price of an umbrella policy anymore. The lowest quote was more than the company's net profits.

Ms. Kirk offered an example which ties together the current problems of second and third tier companies. A manufacturer with only one general liability claim in 12 years will pay this year 57% of last year's profits for insurance. The primary insurance company dropped the limits it would underwrite to below $500,000, while the umbrella insurance company wanted its lower limits increased. The manufacturer was forced to go to the excess and surplus market to fill the gap. The cost of the buffer layer almost equals the combined cost of the primary and umbrella policies.

For professional liability policies, particularly malpractice, consultants said some doctors are paying more in premiums than the coverage of their primary policy just to get into the excess market.

Cancellations appear to be increasingly common. Mr. Silver said, "Companies are being cancelled frequently and without explanation."

Bud Griffin, partner in Warren, McVeigh, Griffin & Huntington in Newport Beach, Calif., conceded, "I'm not surprised by cancellations—especially where there's any product exposure."

But Mr. Tagman of the Betterley Group said, "I'm not seeing as many non-renewals as a year ago. There's been an improvement. We can get an indication on a renewal 15 days before expiration rather than 30 days late."

Consultants were also at odds over whether or not large companies have the same problems in the marketplace as medium sized and smaller companies. Some said larger companies offer enough profit and prestige to attract insurance companies more easily.

Others argued that insurers are shying away from larger companies because they don't want to tie up so much of their surplus with fewer, larger risks.

"I don't find underwriters are really competitive for the big accounts," said Arthur M. Clark, consultant with The Wyatt Co. in Chicago.

Nevertheless, all agreed the big companies have the funds to combat the commercial insurance crunch in ways not so accessible to the smaller companies.

"They can hire safety engineers and better people for risk management. They can retain risks and they are better able to absorb fluctuations in cost," said Mr. Griffin. Larger companies can also go to Bermuda to establish a captive, others said.

Mr. Silver noted, "A small manufacturer can only stand a certain

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Consultants on insurers

Consultants don't have very kind words for insurance companies and their erratic performance.

"I think insurance prices are like the prices of gasoline, coffee and natural gas. There's a real reason for tightening and increases, but they are taking inordinate advantage of what would be an unfortunate situation anyway," charged Leonard J. Silver, president of First Insurance Management Co.

"I hope the insurance industry will get itself in order and charge what they really need," said Mary Lou Kirk of Crain, Langner & Co.

But Charles Tagman of the George Betterley Consulting Group doesn't foresee any lasting solutions. Predicting that the market is already on the upswing, he added, "I also can predict it will get worse again."

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increase in the cost of insurance to remain competitive in his market.

As a result, small and medium sized companies are scrambling for ways to cut costs. Most often they are assuming more liability.

Although insurance companies are dictating increased deductibles, insureds are also asking for them to reduce premiums. Consultants noted most deductibles have been too low anyway.

Mr. Silver admitted, however, that some of his clients would be financially hurt if they suffered losses the size of their deductibles. "But," he explained, "you have to measure the cost of insurance versus the risk."

Some companies are carrying less insurance on the top side, either because insurers won't sell them their previous coverage limits or because they can't afford the premiums.

Beyond higher deductibles, companies are looking into self-insurance. "We tell our clients they should not insure when they can afford to pay the loss. We're pushing self-insurance wherever we can," said Mr. Anderson of Corporate Policyholders.

There is also a growing interest in captives, especially association captives, according to the consultants. But they are wary of this development.

"A lot of companies are looking at captives. But we have tried to have them ride along on some kind of normal basis. The pendulum will swing back and when it does we don't want them involved in some kind of exotic plan that doesn't really serve their needs," said Mr. Anderson.

Many of the consultants said captives are not a viable alternative for these companies because their premiums are not large enough to warrant one. Some said premiums should total $500,000 before a company should consider a captive; others suggested $1 million.

There was also concern over the uncertain tax status of captives and a wariness of the captive management experts who are advocating them. Mr. Silver suggested, "A company setting up a captive should get objective professionals to do it. There are too many people selling captives just like another product."

Access to the reinsurance market may not be any better for a company with a captive either, warned many consultants.

"My understanding is that many (captives) are having the same trouble with reinsurance so it doesn't appear to be the solution even if the firm is large enough," said Mr. Cox.

The consultants complained about adverse selection in association captives. These group captives attract larger companies with larger risks and the consultants fear smaller companies—with less cash flow—will end up paying for the losses of larger companies.

Group purchasing of insurance was mentioned as a preferred alternative to association captives.

Inflated insurance costs are focusing more attention on risk management, although consultant were divided over whether or not medium sized companies need a full-fledged department.

"The higher the costs go, the sooner a risk management department is justified," said Donn P. McVeigh, partner in Warren, McVeigh, Griffin & Huntington in San Francisco.

Others countered that although the size of current premiums makes a risk management department appear necessary—and risk management is certainly a good thing—there are not enough problems to keep a risk manager busy. "The problems just aren't all that complicated," said Mr. Anderson.

He is finding that instead of setting up a risk management department, "Companies are making use of people they have who know the operation—like the comptroller—and having him work with a consultant."

The consultants agreed companies need to focus on risk management somehow—including safety engineering and controlling losses.

"Companies should make sure they are doing everything in their own shop to make their risks look good," said Mr. Anderson. "And they ought to be sure they have the best type of representation they can get—someone who really knows the market."

But what if the market doesn't change soon? The consultants see their clients continuing to seek alternative methods for handling their risks. Then when the insurance market finally turns around, predicted Mr. Clark, "There will be a lot of money not available to the insurance companies. People won't abandon self-insurance and associations in a couple of years." ■

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NEW YORK—The nation's property and liability insurance companies suffered an underwriting loss of $2.3 billion in 1976, according to estimates by the Insurance Information Institute.

The $2.3 billion loss is divided into a statutory loss of $1.75 billion and $545 million in dividends. The 1976 figure follows losses of $4 billion in 1975 and $2.6 billion in 1974, for a three-year total loss of $9 billion.

The III said net investment income for 1976 rose 19.3% to $4.77 billion from $4 billion. The companies' consolidated policyholder surplus, used as a measure of an insurer's financial strength, totaled $23.5 billion at year's end, an 18.7% increase over the $19.8 billion at the end of 1975. ■

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Conglomerate appoints MacCorkle to risk staff

Glenn A. MacCorkle, 38, has joined United Technologies Corp. in Hartford in connection with a major reorganization to deal with the conglomerate's rapid expansion. Mr. MacCorkle will be risk manager for planning, responsible for analyzing the company's property/casualty exposures. He reports to Bob Hugel, assistant treasurer for risk and insurance management, who is in charge of the six-person corporate risk management staff. Mr. MacCorkle was formerly insurance manager for Kaiser Cement & Gypsum in Oakland, Calif. As part of the reorganization splitting risk management and employe benefits, **Ray Willis** was named assistant treasurer in charge of employe benefits administration. Mr. Willis was previously manager of employe benefit consultants at Peat, Marwick & Mitchell.

Mr. MacCorkle's insurance responsibilities at Kaiser have been assumed by Bob Jones, director of corporate purchasing. Mr. Jones said he had previously held Mr. MacCorkle's position and that his current title would be director of corporate purchasing and insurance.

* * *

Dorian Weiss, 30, has been promoted to risk and insurance manager of Hospital Affiliates International Inc. in Nashville, Tenn., a hospital management company. Mr. Weiss joined HAI early in 1975 and said his promotion from insurance manager to risk and insurance manager, a new position, is a reflection of the continued expansion of his department.

* * *

Tom Cannan has been named corporate manager of employe benefits at Whittaker Corp. in Los Angeles, replacing Bob Kropf, who resigned early in 1976 to join the consulting firm Olanie, Hurst & Hemrich in Los Angeles. Mr. Cannan, formerly on the employe benefits staff at Rockwell International Corp. in Pittsburgh, reports to George Hunter, vp for industrial relations. Mr. Cannan will be responsible for all phases of employe benefits administration.

* * *

Dan Heslin, 42, has been promoted to director of the employe benefits for Rockwell International's western region based in El Segundo, Calif. He was formerly on the corporate benefits staff in Pittsburgh. He reports to Edwin McManus, staff vp at company headquarters.

* * *

Paul B. Harvey has been promoted to the position of insurance manager at Litton Industries in Beverly Hills, Calif. The move followed the resignation of James P. Lang, who accepted an executive position with Johnson & Higgins in Los Angeles where he will be involved in setting up a new risk management department. **Bob Thurston,** manager of pensions at Litton, will assume some of the pension work formerly done by Mr. Lang. Mr. Thurston reports to John Martin, vp of finance.

* * *

Judith M. Lindenmeyer, 35, has been named risk manager at Sealy Inc. in Chicago. Formerly the company's insurance and administrative manager, Ms. Lindenmeyer said she will be responsible for all risk management, employe benefits and pension plan in the newly created position.

* * *

Richard A. Siegrist was named manager, insurance and claims and **John P. Cummings** was appointed product safety analyst at Owens-Illinois Inc. in Toledo, Ohio. Mr. Siegrist, formerly supervisor for casualty insurance and benefit planning at the Harris Corp., will be responsible for administration of insurance coverage, claims and self-insurance programs and will assist with Owens' captive insurance company, Owen Insurance Co. in Bermuda. No replacement at Harris has been named. Mr. Cummings, who has a PhD in chemistry and law degree, will provide staff coordination on product safety matters and will work with the legal department on product liability cases. He was formerly with Owens' glass container research and development department. Both report to Richard S. Johnson, director of risk management.

* * *

Geoffrey S. Workington was named assistant manager of employe benefits, a new position at

Continued on page 38

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