

# Con Ed, Ford insurance plans tested

## Blackout suits hit \$10 billion

By REBECCA A. FANNIN

NEW YORK—The "Big Apple" this month marked the first anniversary of the worst power blackout in the city's history—this time with its lights on.

But Consolidated Edison Co., the electric utility whose services were downed by lightning, could remain in the dark. The utility is on the receiving end of 19,000 damage claims, 157 lawsuits and four class action suits that could ultimately cost it more than \$10 billion.

Con Edison's insurance falls far below its possible liability. Con Edison has \$50 million worth of liability insurance coverage, according to William J. Collins, Con Ed insurance manager.

Lloyd's of London carries the bulk of the insurance, Mr. Collins said. The first \$1 million of coverage is provided by Associated Electric Gas & Insurance Services Ltd. (AEGIS), the group captive insurance company formed in 1974 to

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Photo: Wide World  
Looters ravage a store during last year's New York City blackout. A government report puts the economic loss at more than \$170 million.

## Ford retains \$2 million; coverage \$100 million

LOS ANGELES—The Ford Motor Co. maintains a \$2 million self-insured retention for product liability losses involving its automobiles, up from \$1 million at the beginning of the 1970s.

In addition, the nation's second largest automobile manufacturer now purchases \$100 million of liability insurance, double the \$50 million in coverage it obtained at the start of the decade. During the 1970s the company moved from three-year policies to one-year policies and from major use of Lloyd's to heavy reliance on American excess/surplus insurers.

Documents filed by the firm in Los Angeles superior court provide a detailed picture of the product liability insurance program for one of the nation's largest companies. The material also indicates some of the insurance companies that may face large payouts in connection with the flurry of lawsuits now moving through the courts charging the Pinto automobile was defectively designed.

An 18-year-old California youth was recently awarded \$2.8 million in compensatory damages and \$125 million in punitive damages, later reduced to \$3.5 million, for severe burns suffered in an accident involving a 1972 Pinto. The youth, Richard Grimshaw, claimed that Ford knew that the Pinto gas tank was likely to

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## The inside story

### American oil syndicates

American syndicates are having a substantial impact on insurance costs for many oil rigs and offshore oil platforms, although the four American groups with a total capacity of \$165 million aren't able to participate on the huge projects in the North Sea. **Page 6.**

### Product liability ads, bills

Crum & Forster agrees to a cease and desist order issued by the Kansas insurance department that it not publish any deceptive advertisements about product liability issues. Meanwhile, the Pennsylvania senate approves a major tort reform measure. **Page 9.**

### No-fault update

Despite numerous setbacks suffered by both state and federal no-fault proposals recently, proponents of the new way to compensate auto accident victims say they are not ready to throw in the towel. For an update on the no-fault movement see **page 19.** For a chart summarizing the no-fault laws now on the books turn to **page 32.**

### Elsewhere:

- OPIC TO PAY commissions to brokers for the first time on some policies. **Page 12.**
- N.Y. FIRM encounters rough waters, consolidates benefits to cut costs. **Page 15.**
- DOCTORS ENDORSE many of their commission's cost control ideas. **Page 16.**
- CONTINUING LOSSES may sink underwriters' future hopes. London Line, **page 27.**

### Agent/Broker Profiles

A major shakeup in the ranking of the 20 largest brokers in the U.S. highlights the seventh annual *Business Insurance Agent/Broker Profiles* special report to be published Aug. 7. In addition to detailed examinations of the 20 largest U.S. brokers and the three largest Canadian companies, vital information will be provided on more than 360 other insurance agents and brokers specializing in commercial insurance. Additional copies will be available for \$2.

The people column  
page 46

Week of July 24, 1978

# business insurance

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

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## Carter aides oppose tax break for reserves, back loss period

By JERRY GEISEL

WASHINGTON—The Carter Administration, rejecting a proposal to permit businesses to take tax deductions for funds set aside to pay product liability claims, endorsed this month a Treasury Department recommendation that corporations be allowed to carryback product liability losses for up to 10 years.

"That would be an increase from the current three-year period.

A loss carryback permits a company which has been the victim of an uninsured product liability award to obtain a refund on taxes paid in past years, providing the company has a net operating loss in the current year or if the award would create such a loss.

The carryback is designed to help a self-insured company pay for retained losses. The provision would require a self-insured firm to restate its earnings as far back as 10 years.

The decision to reject the tax deduction concept, which has some support in Congress, was based on the Administration's fears that the concept was too costly and would set a bad precedent.

"If the Internal Revenue Tax Code were amended to permit deductions for product liability self-insured reserves, then there would

be a cry to permit deductions for other kinds of self-insured reserves," one well-informed source said.

For example, The Risk & Insurance Management Society and the National Assn. of Insurance Brokers are drafting a proposal that would allow tax deductions for all lines of insurance as well as pre-

miums paid to captives.

The Administration said increasing the carryback period for product liability losses would provide the same benefits to businesses as the tax deduction approach, but would result in a smaller revenue loss to the government and would be simpler for the Internal Revenue

*Continued on page 45*

## Pregnancy benefits bill faces final key hurdle

WASHINGTON—A conference committee that must tackle the controversial abortion issue is the last major hurdle for legislation that would require employers to provide equitable medical and disability benefits to pregnant women.

The House this month approved legislation requiring nondiscriminatory benefits for pregnancy by a vote of 376-43. The Senate overwhelmingly passed similar legislation in February.

However, the House bill contains an amendment that would allow employers to refuse to provide benefits to a pregnant employee who elects to have an abortion.

The anti-abortion amendment

was added to the House bill in committee in March. Since the House Rules Committee failed to schedule the pregnancy bill for floor action, the measure came to a vote under a special procedure that did not permit any amendments. Supporters of the pregnancy legislation were thus forced to accept the anti-abortion legislation.

The legislation could still be endangered if the conference committee is unable to work out a compromise on the abortion issue quickly.

The House will take its annual month-long break in August. When they return, the fall session is expected to be short due to the up-

*Continued on page 45*

# Four lawsuits demand \$10 million in N.Y. ice cream truck explosion

NEW YORK—At least four separate suits totaling more than \$75 million are pending against the Soft Fresh Freeze Ice Cream Corp.

of Brooklyn, N.Y., as a result of an ice cream truck explosion that rocked Manhattan's Wall Street district.

Lee Balter, the 23-year-old driver of the truck, was also named in the lawsuits.

Filed in Manhattan's supreme court, the suits cite "negligence, carelessness and recklessness" on the part of both Balter and Fresh Freeze—the licensed owner of the truck—as causing the accident.

New York City Police have labeled the blast the result of an "accidental explosion" that occurred after a 2.5-gallon gasoline can illegally kept in the truck for storage, caught fire. The burning gas can ignited the truck's gas tank, which in turn exploded.

The resulting blast, first thought to be the work of a bomb, sent shards of metal and glass raining through the street crowded with lunch hour pedestrians, most of whom were eagerly anticipating a long Fourth of July weekend. Although there were no fatalities, over 130 people were injured.

Additional suits are also expected to be filed in the upcoming weeks. Thus far the pattern of the existing summonses has been \$1 million for compensatory damages and \$10 million for punitive damages. Harry H. Lipsig has been named the attorney for the plaintiffs in each of the suits filed.

The attorney named for the defendant, William J. Breuer, was unavailable for comment on the case and it is not known who insures the company or the amount of coverage carried.

Also unknown is whether or not Fresh Freeze's insurance will cover the loss in light of the fact that the explosion was caused by an illegally kept gasoline storage can.

## A&A acquires Chicago broker

CHICAGO—Alexander & Alexander has acquired Paris-O'Day & Reed Inc., a Chicago insurance broker employing about 20 persons. The Paris firm has specialized in product liability, workers compensation and association business.

Frank M. Paris and Frederick L. Reed will become vps with Alexander & Alexander's Chicago office.

## errors & omissions

• Business Insurance incorrectly reported (July 10) that there was to be a hearing July 17 on the Ford lawsuit against 50 insurers over punitive damage claims. The hearing that day actually concerned an unrelated lawsuit involving Ford Motor Co.

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## for your information...

### Insurance company execs take 4 spots on commission to draft exchange rules

NEW YORK—Four of seven persons selected so far to serve on a panel that will draft a constitution and by-laws for the New York Insurance Exchange are representatives of the insurance industry. The others are a broker, a risk manager and a consultant to the insurance industry.

The four insurance industry representatives are Maurice R. Greenberg, president of American International Group; Richard Shinn, president of Metropolitan Life Insurance Co.; Charles Havens, president of the American Reinsurers Association, all appointees of Gov. Hugh Carey, and Joseph Murphy, vp and general counsel of The Continental Corp., an appointee of assembly minority leader Perry Duryea.

Other Gov. Carey appointees are L. Patton Kline, president of Marsh & McLennan Inc.; Editch Lichota, assistant treasurer of Carborundum Corp. and RIMS legislative representative, and Donald Kramer, president of Kramer Capital Consultants.

Gov. Carey was to have signed the enabling legislation for the exchange and insurance free trade zone in ceremonies at the United Nations. At that time, the names of the remaining panel members were to have been announced. Superintendent of Insurance Albert B. Lewis chairs the panel.

Mr. Havens's organization had opposed the proposed exchange and Mr. Greenberg was critical of some sections of early drafts for the legislation. However, an aide to the governor said Mr. Carey felt their concerns could be mollified by having them participate in the process of drafting the constitution and by-laws.

Mr. Greenberg is known to be a close acquaintance of the governor. Some sources had voiced concern that Mr. Greenberg had dominated the governor's selections to the panel, noting that Metropolitan Life, Mr. Shinn's company, is a partner in Transatlantic Re, a recently organized reinsurance affiliate of AIG.

It is believed that John Cox, president of INA and a key competitor with AIG, had originally been on the governor's list but later dropped. Mr. Cox said it was hard to say whether Mr. Greenberg influenced that decision.

### Test-tube lawsuit goes to trial

NEW YORK—As the world awaits birth of the first "test-tube" baby, a New York hospital and its chief of gynecology and obstetrics are on trial in a \$1.5 million damage suit brought by a Florida couple involved in a similar experiment almost five years ago.

The suit charges Dr. Raymond Vande Wiele, chief of gynecology and obstetrics at Columbia Presbyterian Medical Center, with having destroyed a day-old embryo that was to be implanted in the womb of Doris Del Zio. The embryo had been conceived in a test-tube where gynecologist Dr. Landrum Shettles mixed eggs from Mrs. Del Zio's ovarian tissue with sperm cells from her husband.

In opening remarks in federal court for the Southern District of New York, Dr. Vande Wiele's attorney said that at the time of the experiment, no one knew it was Dr. Shettles's intention to implant the embryo mixture in Mrs. Del Zio.

An attorney for the hospital said Mrs. Del Zio would have almost certainly died of peritonitis had the implantation been made. Prior to start of the case, the attorney said the 1973 experiment compared with the current pregnancy of British housewife Lesley Brown was "like comparing the Wright Brothers with the Concorde."

### Nuclear utilities get \$2 million refund

HARTFORD—The two private pools of insurance for nuclear power plants are returning over \$2 million in refunds to utilities operating nuclear power plants.

The American Nuclear Insurers and the Mutual Atomic Energy Liability Underwriters said the \$2.16 million refund on 380 policies for 1978 is based on the excellent safety record of power plants, fuel reprocessing units and fuel fabrication facilities.

More than \$13.8 million has now been returned to nuclear plant operators since 1967.

### Catastrophe losses continue to climb

NEW YORK—Catastrophe losses paid by property and casualty insurance companies continued to climb in the second quarter with payouts for the year so far reaching \$482 million as the result of 24 major storm losses.

Insurance companies have paid out more money in the first six months of the year only once, in 1974 when losses in the first six months topped \$650 million. The one-year high for catastrophe losses was also set in 1974 when payouts reached \$686.1 million.

### Theatres negotiate new program

LOS ANGELES—The Los Angeles Theatre Alliance (LATA), a group of 40 live, tax exempt-theatres, have negotiated a group insurance plan for property and casualty coverage.

According to Larry Powers of the brokerage firm of Martinson & McKinzie of Santa Ana, Calif., the firm that put together the coverage with the help of LATA president Ray Tatar, "the big shine" in the new coverage is in the third-party liability area.

Under the new policy, underwritten by American Fidelity Insurance Co., the theatres have third-party, liability coverage in the amount of \$300,000, Mr. Powers said. Covered under the policy, he said, are such things as wrongful eviction, libel, slander, host liquor and personal injury.

### Consider work ability, court says

LANSING—Ability to work should be taken into consideration along with physical condition in determining eligibility for workers compensation benefits, the Michigan court of appeals says.

The court said total and permanent disability benefits could be ended for a man who lost both hands in an industrial accident, but who was able to work as a night watchman.

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# Chicago suburb moves plan to Chicago Blue Cross

**SKOKIE, ILL.** village employees will receive medical benefits through Blue Cross/Blue Shield of Chicago beginning Aug. 1 instead of Blue Cross of Rockford. The \$10,000 life insurance benefit will be underwritten by Fort Dearborn Life Insurance Co. which is replacing Standard American Life Insurance Co. Medical benefits for the 480 village employees will remain the same as under the previous contract, paying for 120 days in the hospital and usual and customary medical and surgical expenses coupled with a \$50,000 major medical benefit.

Premium costs increased only slightly under the new contract with the single employee monthly premium going to \$33.20 from \$31.90, \$29.20 of which is paid for by the village and the remaining \$4 paid by the employee. Family coverage costs increased to \$120.09 from \$108.86 with the village paying \$105.69 and the employee \$14.40. Life insurance premiums decreased to \$4.20 from \$4.40, of which the village pays 88% and the employee 12%. The total cost of the medical and life insurance program that begins Aug. 1 is \$591,180, with the village paying \$510,300 and employees paying \$80,880. That's a 6% increase over the total cost for the year ending Aug. 1 of \$560,000, of which the village paid \$487,200 and employees paid \$72,800.

The contract with BC/BS of Chicago may be renewed at the end of the year since the board of trustees agreed that medical and life insurance need not be bid annually anymore as they had been under village policy of putting out for bid all supplies and services that cost over \$2,500. Purchasing agent Daniel W. Ryan said the board agreed to make an exception in its bidding policy after learning that "insurance claims handling is of such a vital nature that it should be approached as a 'professional' service and that annual switching of carriers was detrimental to the village."

**TWIN CITIES CARPENTERS & JOINER UNION** has purchased dental insurance for its 7,000 members from Delta Dental Plan of Minnesota at a composite rate of \$16.85 a month under a 12-month contract. Union members and their families are covered for 70% of the cost of dental treatment, including basic exams, cleaning and fluoride treatments, restorations, root canals and oral surgery, to an annual maximum of \$500. Orthodontics are also covered under the contract to a maximum of \$500 a year, but the union member must pay half the cost of orthodontic treatment instead of just 30% of the cost for other procedures. The union accepted Delta Dental's proposal without entertaining bids from any other dental insurers.

**ROCK ISLAND, ILL.** switched last month to self-funding health benefits for its 480 employees, a move which immediately cut employee costs for family protection by \$17 a month and is hoped will save the city \$50,000 annually. Coverage for a single employee is pegged at \$30 a month under the self-funded plan and will be fully paid for by the city. Family coverage now costs an employee \$12.50 a month with the city's cost set at \$72.50.

The city didn't drop Blue Cross/Blue Shield of Chicago and go to self-funding just for economic reasons, said consultant Marcellin Smith of H.H. Cleaveland Agency Inc. in Rock Island. Improved employee relations and improved claims administration, especially

with respect to coordination of benefits, is expected under the self-funded plan being administered by Kelly Associates Inc. of Chicago. Kelly Associates was chosen to administer the plan at a cost of 4.5% of claims paid over other administrators who quoted on a cost per employee. Mr. Smith doesn't consider the latter billing method equitable since it doesn't reflect claims experience.

Claims are projected at \$350,000 a year and a stop-loss policy attaching at 125% of projected claims was purchased from Employers Reinsurance Corp. The benefit structure remains the same as it was with BC/BS of Chicago, a comprehensive major medical plan with a \$100,000 maximum which

requires employees to pay 20% of their medical bills up to a \$1,000 out-of-pocket limit. Mr. Smith said self-funding with an independent third-party administering claims was chosen after considering fully insured plans, ASO arrangements as well as split-funding.

**QUALITY MUST** be maintained while costs are contained, agreed labor and management representatives speaking at a National Symposium on Dental Prepayment sponsored by the Delta Dental Plan Assn., the national coordinating agency for 47 not-for-profit corporations that underwrite dental insurance for 14 million Americans. Gilbert Laws of the United Rubber Workers said the Delta

Plan, negotiated from wages paid by Goodyear, cost union members 10.9 cents an hour. Delta was selected, he said, because the union wanted a plan that incorporated peer review and pre-filed schedules of fees submitted by participating dentists. Daniel Heslin of Rockwell International, representing management, noted that "cost containment" are buzz words with management now and warned rocketing medical care costs could make management cautious about improving existing benefits or adding new ones.

**ANOTHER INTERNATIONAL** agreement to coordinate Social Security payments and benefits between the U.S. and a foreign

country is moving ahead. HEW secretary Joseph A. Califano signed an administrative agreement with the West German ambassador to the U.S. which establishes the technical details of an agreement approved in principle already by the German government. A similar agreement was signed with Italy earlier this year and is now before Congress where time is running out on its 90 days to reject the agreement. These agreements, authorized by the 1977 amendments to the Social Security Act, basically eliminate the problems faced by citizens of one country working in the other. Those problems include having to contribute to two social security systems.

*Continued on following page*

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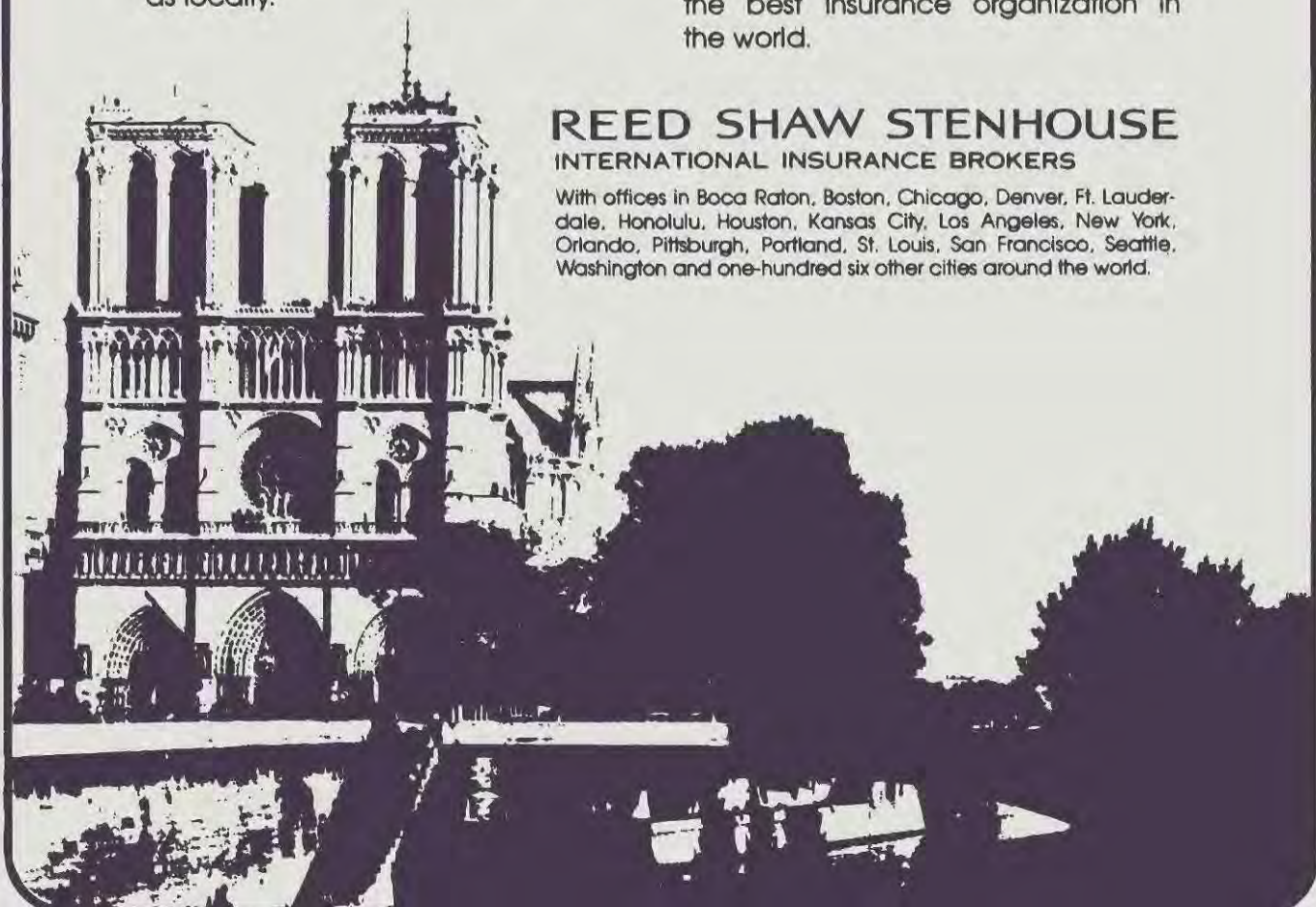
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## the benefit beat

Continued from preceding page  
tems but then upon retirement not qualifying for benefits under one or both of the systems or finding inadequate benefits if they are paid. The agreement permits the employe and employer to pay into only the system of the home country. If payments are made to both systems the agreement permits the combining of credits earned in both countries by either country in which the claimant doesn't otherwise qualify. The payment of benefits in this case is based on the proportion of total credits earned in the paying country. The German agreement restores the rights of some American citizens to make voluntary contributions to the German system.

**FEDERAL EMPLOYEES** around the country may be offered par-

ticipation in new HMOs starting Jan. 1. The Civil Service Commission has given tentative approval for 19 more Blue Cross or Blue Shield HMOs to be added to the network of 16 other BC/BS health maintenance organizations participating in the Federal Employee Health Benefits Program.

BC/BS involvement in the alternative health care delivery system has been steadily increasing during this decade with 48 or nearly half of the 102 BC/BS plans now involved in 66 HMOs serving 1.5 million persons. Another 14 HMOs involving BC/BS plans are in the development or planning stages. In 1970, BC/BS plans were involved in only five HMOs serving 700,000 members. Blue Cross/Blue Shield investment in HMOs has topped \$30 million and is expected to climb to \$57 million by 1980. BC/BS is involved with HMOs from providing them with administrative services to owning and operating them. ■



Photo: Wide World

**Wladyslaw Fraczek** is taken into custody after holding a workers compensation judge hostage in New York's World Trade Center.

## Man takes hostages protesting comp benefit

By RICHARD MARINI

**NEW YORK**—Very few go to the same lengths as Wladyslaw Fraczek in trying to win a workers compensation award.

Believed to be carrying as much as 80 sticks of dynamite, Mr. Fraczek, a 42-year-old Polish immigrant, held four hostages for more than 10 hours on the 36th floor of the World Trade Center here in protest over what he believed to be inadequate workers compensation benefits.

Mr. Fraczek has received almost \$6,000 in benefits since a 1975 on-the-job accident in which he lost the tip of a finger and injured his head. Since the accident he has

suffered dizzy spells and recurring headaches and has been unable to return to work.

On Monday morning, July 10, Mr. Fraczek made an appeal for increased benefits before administrative judge Louis Jerome in the workers compensation board hearing room in the south tower of the World Trade Center.

When Mr. Jerome postponed his decision on the case for two months, Mr. Fraczek announced that he had a bomb and allowed all but four of the spectators to leave the room.

**While holding** the four at bay with what appeared to be a World War II German-style hand grenade, Mr. Fraczek negotiated with the New York City police who were called to the scene.

Communication was hampered by the fact that Mr. Fraczek speaks very little English. Meanwhile, from 3,000 to 4,000 workers were evacuated from the building by police.

At about five in the afternoon, Mr. Fraczek asked for a priest, saying he wanted the hostages to receive "absolution." Police began preparations to charge the door.

But in the end this wasn't necessary. "The moment he (Fraczek) started barricading the door," Mr. Jerome, one of the hostages, said later, "my anger really rose. I grabbed a (New York) state flag and charged him with it."

Hearing the scuffle, police barged into the room and wrestled Mr. Fraczek to the ground. It was later determined that Fraczek's "bomb" was actually nothing more than a hollow cylinder containing a flattened Coca-Cola can inscribed with two verses of "God Bless America" and the poem from the Statue of Liberty which begins: "Give me your tired, your poor, your huddled masses yearning to breathe free..." In the shopping bag that supposedly held 80 sticks of dynamite was, in fact, only a knife and four loaves of black bread.

Mr. Fraczek was later arraigned on kidnaping charges.

Mr. Fraczek's case is currently being reviewed by the chairman of the workers compensation board, Arthur Cooperman. When the case comes up again in September it is likely that Mr. Jerome will again be the presiding judge. ■



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## College plans new branch in California

**LOS ANGELES**—The board of trustees of The College of Insurance of New York will establish a western division campus in Los Angeles, according to college president A. Leslie Leonard.

Dr. Leonard said that the proposed California-based division would begin with a meaningful work-study program designed for carefully screened candidates from community college and other levels who demonstrates they can be responsive to the needs of Western industry participants. He added that the program will be modeled on existing courses at the college's headquarters and would rely on user suggestion as to initial course content, facility location and instruction duration.

Statewide agency, brokerage and company fund raising efforts have begun, he said, noting that faculty selection is underway. ■

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Employers sales representative, Norm Keller, cites an example of this close day-to-day service: "We may get a call at 10:00 in the morning that Collins & Hobbs will bid a job the next day and they need builders' risk and owners' protective liability coverage."



Collins & Hobbs recently completed this building for the Tennessee Temple Schools - Harrison Gill, architect.

"We'll take immediate action to get a quotation to the policyholder so it can be included in the bid."



The insurance "partners" at Chattem Drug's headquarters, Chattanooga, Tennessee.

## WAUSAU STORY

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Left to right: Norm Keller of Employers Insurance and Selmon T. Franklin, Jr., architect for the Chattem Drug Executive Office Building.



Our Norm Keller, left, and Fred Shirley, chief estimator for Collins & Hobbs, on a current project.

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Wausau, Wisconsin

## But can't participate on huge risks

# American syndicates ease oil market

By ELLIS SIMON

NEW YORK—The American offshore oil syndicates are making their competitive presence felt when it comes to insuring drilling rigs and small production platforms, but London still calls the shots when insurance is purchased for jumbo, North Sea-type facilities.

"With the exception of the North Sea production platforms, there is enough capacity here to handle any other type of account," said John Blackman, president of the Mutual Marine Office, one of four principal American syndicates.

Total capacity of the four syndicates today is \$164.5 million. AIG Oil Rig has \$75 million, All Ameri-

can Marine Slip \$56 million, American Offshore Syndicate \$26 million and Mutual Marine Office \$7.5 million in capacity.

**Competing against** London, that capacity has had its impact felt in the market for offshore drilling rigs. Prior to 1972, when the first American syndicates began operations, London had a monopoly on this market, said Roy Williams, president of AIG Oil Rig. Since then, rates for semisubmersible rigs have dropped by half and rates on higher risk jack-up units have fallen by one-third, he added.

However, the big plums for the American syndicates have been three major drilling companies that have switched all or part of

their coverage from London—SEDCO (Southeastern Drilling Co.), Diamond M and Zapata.

A 20% savings on premium led Diamond M to transfer coverage on its 27-rig fleet from London to the American market, said treasurer Richard Nystrom. The "extremely competitive" American markets also offered better deductibles, he noted.

SEDCO insurance manager E.J. Smith reported that there were some savings but "nothing dramatic" when he placed between 70% and 75% of his company's program in the American market. SEDCO's 28-unit fleet is valued at almost \$900 million.

A spokesman for Zapata Corp. said only that his company's deci-

sion to switch was a "matter of economics."

Even drilling firms that have kept their programs in London have benefitted from the American competition as well. Ron Guidry, insurance manager for The Offshore Co., who resisted several approaches from the Americans, said London's rates for his shipshape units dropped about 10% on the latest renewal.

**Leonard Marks**, vp of Management Systems Inc., the Houston brokerage firm that placed the SEDCO, Diamond M and Zapata accounts, called the American markets an alternative that has loosened up the world market. About 15% of the U.S. drilling fleet

is insured domestically, he reported.

He added that he felt the U.S. pools were here to stay: "In all fairness to the client we couldn't place the client's business in a market that we didn't feel would be in for the duration."

While the American syndicates have captured a share of the market for drilling rigs, their capacity has not reached the point where they can take the lead on the giant production platforms currently being built in the North Sea and having values upwards of \$800 million.

The London Master Rig Slip recently raised its capacity from \$400 million to \$500 million and, as one broker noted, on jumbo risks London "controls terms, conditions and capacity."

**A significant part** of the Master Rig Slip's capacity comes from American reinsurers. Several sources estimated American participation in the syndicate to be around \$100 million. But John Kean, the reinsurance broker at Guy Carpenter & Co. who handles the account, said the amount of U.S. reinsurance was far below that. Mr. Kean would not reveal the actual figure.

Many of the American reinsurers also participate in the U.S. syndicates, noted Norman Tucker, underwriter for American Offshore Syndicate. "If you write a class of business, the more you write at the correct price, the better off you are, and by spreading the lines across all syndicates you get all of the business."

But, the dual market participation limits the capacity of American syndicates to insure jumbo risks. AIG's Mr. Williams said his syndicate's capacity for insuring giant production platforms is limited to \$15 million to \$20 million because of this, even though total capacity recently was raised from \$45 million to \$75 million.

If the American companies were to transfer their capacity from London to the U.S. syndicates this would bring the two markets more in balance, but it would not represent new capacity for the oil companies, Mr. Williams added.

**Transferring** capacity from the London to U.S. markets would actually reduce world capacity, according to Mr. Tucker, who formerly worked for the London Master Rig Slip. By participating in London, the Americans share the risk on \$300 million to \$400 million in premium versus sharing the risk on \$50 million in premium in the U.S. market, he explained.

The smart strategy for insurers would be to participate in all risks and reinsure either on a stop-loss or aggregate basis, he suggested.

Mr. Tucker added that even if the American markets were large enough to take the leading position on a jumbo risk, they would still have to create policy terms that were acceptable to London since such risks can not be written without the Master Rig Slip.

There would be little point to the Americans trying to take the lead on major risks since the best they would be able to do is match London's offer, he said.

William Lowry, president of All American Marine Slip, added that the North Sea was not the best place for an insurer to put its money. However, he noted that with establishment of Mr. Tucker's American Offshore Syndicate, many American companies that participated in the Master Rig Slip have dropped out.

Asked about the impact that a joining of American syndicate capacity with that of Bermuda-based OIL Ltd. would have, Mr. Lowry said it would "be a hell of a wedge," but it would be a "Herculean task" to corral the combined capacity. ■

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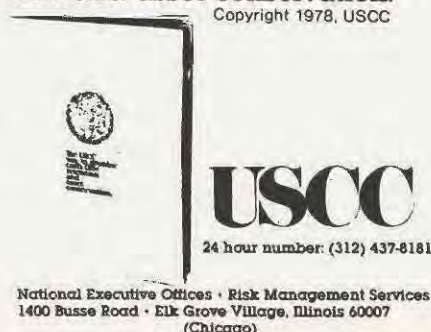
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# Insurer agrees to avoid deceptive ads

By JERRY GEISEL

TOPEKA—Crum & Forster Insurance Cos. this month settled charges that it ran deceptive and misleading product liability advertisements by agreeing to a Kansas insurance department cease and desist order that bars the company from making similar claims in the future.

The negotiated settlement eliminates the need for a formal administrative hearing by the Kansas department. Crum & Forster did not admit to any wrongdoing in agreeing to the order, but a future violation could result in a \$10,000 fine or loss of the company's license to operate in Kansas.

The Kansas department offered similar terms to Aetna Life & Casualty Co. to settle charges that its extensive product liability ad campaign is deceptive, *Business Insurance* learned.

Both ads, which were designed to explain the product liability crisis, said one million product liability claims were filed in 1976, an assertion that both Aetna and Crum & Forster later admitted was incorrect. In addition, the Crum & Forster ad said a man who used a power lawn mower as a hedge clipper successfully sued the manufacturer after he was injured. Crum & Forster has not been able to prove that such a case ever happened.

The ads touched off a sharp attack by Consumer Reports, the influential consumer publication, which charged in its July issue that the ads were "insulting and misleading." The Consumer Reports article also attacked key elements of product liability bills that have been introduced in many state legislatures as "clearly anti-consumer."

The insurance department launched an investigation of the ads after receiving complaints from the Kansas Trial Lawyers Assn. concerning Crum & Forster's advertising campaign.

## There isn't a product made that can't be misused.

Even a safety pin manufacturer may not be safe today from misuse of his product. More than ever before, manufacturers and sellers are being held responsible by the courts for product-related injuries—even when the victims contribute to their own injuries.

A man who lifted a rotary lawn mower to cut hedges injured himself. He sued the lawn mower manufacturer and won. The manufacturer of a bench saw made in 1912 with the necessary safety equipment was ordered to pay \$50,000 to a worker injured using the machine in 1971. The award was made despite testimony that a dealer rebuilt the machine without a guard.

In 1976 an estimated one million product liability claims were filed. And, in a recent eight-year period, the average award rose by 56% from \$12,000 to \$80,000. That's not pin money.

Some huge awards have actually caused plants to close and many people to lose their jobs. And the problem could get much worse.

More claims and higher awards mean, of course, higher insurance premiums.



Insurance, after all, is simply a means of spreading risk. Insurance companies collect premiums from many people and compensate those who have losses.

The price of insurance must reflect the costs of paying for those losses and the expense of handling them.

No one likes higher prices. But we're telling it straight.

**CRUM & FORSTER INSURANCE COMPANIES THE POLICY MAKERS.**

Advertisement by Crum & Forster that prompted the Kansas insurance department investigation.

At the conclusion of the investigation, state insurance commissioner Fletcher Bell said statements made in the ad, such as the lawn mower story and the millions claims estimate, were either erroneous or could not be substantiated.

In its cease and desist order, the Kansas insurance department ordered Crum & Forster to refrain from "promulgating and disseminating of placing before the

public advertisements containing untrue or deceptive statements in any manner substantially similar to the allegations made by the commissioner."

"We have said that an insurer has the right to advertise its opinions, ideologically or product-wise, but only when it uses factual and correct information," said Michael Mullen, an attorney with the Kan-

sas Insurance Department.

Crum & Forster agreed to the cease and desist order "so as not to become involved in protracted legal proceedings," said general counsel Albert Moore. The company had no plans to re-publish the ad even before the cease and desist agreement was announced.

But Topeka trial attorney Gene E. Schroer said, "Crum & Forster would not have agreed to cease and desist if they hadn't realized that they were wrong."

Legal groups also filed complaints about Crum & Forster and Aetna product liability ads with other state insurance departments although no action has been taken on those complaints. In Connecticut, four accident victims are suing Crum & Forster, Aetna, St. Paul and Travelers over their ads in U.S. district court.

Meanwhile, the Consumer Reports article sharply criticizes proposals for a statute of limitations for product liability actions based on the time when a product entered commerce.

Instead of placing an arbitrary time limit on the right of consumers to sue, juries should be allowed to take the age of the product into consideration in deciding the case, the magazine urges.

In addition, a state of the art de-

fense lets manufacturers off the hook even if an entire industry's safety standards were terrible, Consumer Reports argues.

"It makes no sense to allow a manufacturer to avoid responsibility by saying in effect, 'The other guys were just as bad,'" the magazine said. A state of the art defense gives manufacturers of dangerous products an incentive to delay safety improvements.

Consumer Reports explains its opposition to a product liability defense based on product alteration or misuse by discussing the California case where an 18-year-old youth was originally awarded \$125 million for injuries suffered in a crash involving a 1972 Ford. The jury found that the gas tank in the Pinto was defectively designed and would explode even on light impact.

Under a misuse or alteration defense, Ford might be able to avoid paying damages if it could prove the bumper had been removed or if the accident had occurred at night and the car's lights were off.

A comparative fault statute would be much fairer to consumers than an alteration or misuse defense, the magazine concludes. "Awards should be reduced to the extent that a plaintiff or other parties' negligence contributed to the injury."

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## Major tort reform bill approved by Pa. senate

HARRISBURG—The Pennsylvania state senate last month approved a comprehensive product liability reform bill despite intense labor and trial attorney opposition.

At the same time Florida Gov. Reubin Askew signed a bill (H.B. 1190) that requires product liability suits to be filed within 12 years of the time the completed product was delivered to its original purchaser. The law goes into effect Oct. 1.

The Pennsylvania measure (S.B. 585) also contains a 12-year limitation on product liability lawsuits, but makes two exceptions. The 12-year statute would not apply for products whose useful life is longer than 12 years and the statute would not apply to products where the defect is latent, as may be the case with pharmaceuticals.

The bill gives manufacturers an affirmative defense if a product was substantially altered or modified. Compliance with industry or government safety standards would be a rebuttable presumption.

Wholesalers and retailers could not be sued under the strict liability doctrine unless they also manufactured the product. In addition, evidence of post-accident product improvements would be prohibited during a trial.

Evidence of public collateral source payments, such as workers compensation and Social Security benefits, would be permitted during a trial. Separate trials would be required to determine first fault and then the amount of damages if a defendant were to be found guilty.

The proposal now goes to the House where a major legislative battle is expected, said James Buente, insurance committee executive of the Pennsylvania Chamber of Commerce in Harrisburg.

## J&H to provide aid to Bermudians

NEW YORK—Johnson & Higgins will provide two \$50,000 scholarships to allow Bermudians to study insurance at The College of Insurance here. The aid will cover tuition, room and board, books and the cost of travel for up to five years. Periodic employment at Johnson & Higgins is also included.

The scholarship recipients are expected to return to Bermuda after completion of their studies. There has been some concern in Bermuda over the lack of insurance positions for natives of the island.

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## editorial opinions

### Court's restraint

HAVING CHIDED THE judiciary branch of our government for the plethora of court-made law which has plagued business in recent years, we are pleased to see that the Supreme Court recognized recently the distinction between its role and that of our legislative bodies.

In a ruling involving the 1920 Death on the High Seas Act, the U.S. High Court respected the letter of the law as Congress passed it, declining to extend the law even though the extension might have been reasonable.

The law provides that survivors of persons killed in marine accidents more than three miles off the shoreline can recover damages only for actual pecuniary losses. But survivors of those suffering wrongful death within the three-mile limit can collect for certain kinds of pain and suffering as well.

Reversing a lower court ruling, the high court said that the statutory provisions should remain as they are, despite the lack of uniformity. Congress did not see fit, nor has it seen fit since 1920, to provide for extended damages in wrongful death cases beyond the three-mile limit, so the court said it should not tamper with Congress's choice.

This is refreshing evidence that the Supreme Court, too, sees a need to abide by the law, even when the law establishes an arbitrary rule of liability.

### Incentives for arson

ARSON, ALARMINGLY, is not about to burn itself out. Numerous studies have been undertaken at the city, state and federal levels to illuminate what is becoming a flaming problem in this country.

The results are proving to be far from reassuring. An Illinois probe characterized arson as an elusive crime, difficult to investigate, difficult to prosecute and almost impossible to convict.

Thus, the statistics gathered show arson to be one of the safest crimes to commit. The incentives to burn buildings—out of vengeance or for profit—stack up this way: Nationally, only about 10% of arson cases result in arrests, with a conviction rate of less than 1%. In Chicago, for the first eight months of 1977 there were 500 arson investigations, 290 arrests and "very few" convictions.

The Illinois commission investigating arson problems in the state and the city of Chicago accused the insurance industry of not being careful enough in their pre-underwriting investigations of policy applicants and their property. Insurers should also be more aggressive, the commission suggested, in prosecuting civil cases involving questionable fire incidents rather than routinely paying damage claims.

A federal report found the same lack of attention by underwriters for the FAIR plans in the process of investigating policy applicants and property values when issuing FAIR plan policies. This lack of scrutiny results in

routine overinsurance of poor properties and an incentive to burn for profit, said the General Accounting Office. Almost anyone can get FAIR plan insurance, regardless of character, financial background or involvement in fires, the GAO worried.

### Repondez vous

WHEN YOU HAVE an opinion about something you read—when you agree or disagree, have further information that would help put the issue into a better context or when you know the story needs correcting—do you have the courage and the motivation to speak up?

If not, you've no right to bellyache about "the press" among yourselves. If you do, you deserve applause and a lively forum for the publication of your missive. We've created two such sections in *Business Insurance*, hoping to draw out more of your opinions about stories we've written, editorial views we've voiced and topical issues of the day in your business.

You've paid us the compliment of sending more letters, enough so we now carry numerous pieces of correspondence extolling our virtues or disapproving of our content. The lengthier missives frequently appear under the "Speaking Out" heading on our Perspective pages, while most letters are grouped together in their own section beginning on this page.

It's recently come to our attention, though, that some readers believe it's counterproductive to respond to material in *BI*, for fear of spurring more stories about a subject some of you may think odious. To set the record straight, here's what letters accomplish for us on the staff of *BI*, in addition to enabling you to share ideas with your fellow managers:

- Letters help the editor to better direct the efforts of the publication's staff.
- Letters raise new questions that should be asked and answered in future stories.
- Letters put a subject into a context of the practical experience of those on the firing line—the risk managers and benefit managers who know first-hand how things work.

Have you ever noticed that one of the sections you read first in this newsmagazine is the Letters to the Editor column? Thus, we are sure you can see why we disagree with those who contend that it's better to say nothing than to shed further light on a subject better left under the barrel.

It's not our job to leave a lot of subjects under the barrel. And when we write about risk management, insurance and employe benefits, we would like you to feel free to respond to what's been said, in the interest of truth and learning.

In those instances when your opinion is your own, but shouldn't be linked with the name of your company, send us your letter without your company's name, or ask us to run the letter over your name but not to disclose your affiliation.

We understand, too, that there might be infrequent situations when you don't want your name disclosed at all. If that's the case, ask us to withhold your identity.

But keep the cards and letters coming . . .

## letters

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

### Tell the truth!

To the editor: Re: Peter Downes's article in the June 12 issue of your fine magazine.

This article, in my humble opinion, does a great disservice to the "profession" of risk management as well as the research efforts of institutions of higher education.

As you well know, a great deal of research is conducted by the use of questionnaires. This is done not only by graduate students and faculty of colleges and universities throughout the country, but also by government and trade associations such as RIMS. I know that many questionnaires are never answered; however, it is the hope of the researcher that those who do take the time and effort to answer them do so honestly. Perhaps a questionnaire should go out to risk managers asking them if they answer questionnaires as honestly as they can.

If what Mr. Downes has said is true (and I hate to think it is), then much of the information about positions and industry available today is worthless, including some of the questionnaires used by your excellent publication. Somehow I would like to know if his ideas are shared by other risk managers, but I would hesitate to send out a questionnaire to find out.

Nestor R. Roos

Professor of Insurance, University of Arizona, Tucson.

### Downes assailed

To the editor: I have been reading your newsmagazine for quite some time and find it to be informative and helpful. However, I am thoroughly disappointed that you would print an article such as the one written by Peter Downes (June 12).

I welcome criticism that is justified and well-founded; however, the "logic" employed to criticize my research and the implications flowing from this "logic" are erroneous. Mr. Downes doesn't "wish to paint everybody as black" as he is nor assert "that all risk managers are liars," but in effect that is what he has done.

Mr. Downes needs to read a good elementary book on logic and *Business Insurance* should take a closer look at the content of articles to be published.

You have performed a disservice  
Continued on page 45

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### First use of commissions

## OPIC to pay brokers for small firm policies

WASHINGTON—The Overseas Private Investment Corp. (OPIC) will pay brokers' commissions for small businesses that purchase OPIC political risk insurance to protect their new foreign investments.

The new program is a response to Congressional concerns that too much OPIC insurance coverage has been going to protect the risks of huge U.S. corporations that invest abroad while not enough was being done to assist smaller companies that want to begin overseas development projects.

The new OPIC program may not

only boost small business participation, but it also could increase the amount of insurance OPIC writes. New OPIC insurance contracts slumped last year due to lagging U.S. investment abroad, the agency said in its annual report. So the small business program could stimulate new interest in foreign investment projects.

The two-year experimental program will allow small companies to purchase OPIC insurance through their agents and brokers instead of having to go directly to OPIC as is usually the case now.

**OPIC will pay** a client's broker 10% of the first year's premium up to the first \$50,000 of premiums, 7.5% premiums between \$50,000 and \$100,000 and 5% of premiums of more than \$100,000.

In addition, OPIC will pay brokers 2% of the premium when the policy comes up for renewal. Payment of the initial commission will be within 30 days of contract execution by OPIC. For renewal premiums, commissions will be made to brokers within 30 days of the time OPIC receives the premium.

In order for an industrial company (including individuals and partnerships) to be eligible for the OPIC-paid commission program, annual consolidated revenues must be less than \$100 million. Non-industrial companies are eligible if their stockholder's equity is less than \$35 million.

OPIC will continue to accept business through brokers from larger investors, but it will not pay commissions for the big accounts.

Any broker or agent licensed by any state or U.S. territory for property or casualty insurance may participate in the program. A potential client must first tell OPIC the name of the broker that will represent the firm in its bid for OPIC insurance in order for the broker to be eligible for commissions from OPIC.

**OPIC offers** insurance for companies that want to invest abroad covering such risks as currency inconvertibility, revolution, war and insurrection and expropriation. Coverage is generally limited only to projects in countries with a per capita gross national product of less than \$1,000.

Meanwhile, OPIC reports that it issued more than \$750 million in new insurance coverage in a 15-month period ending Sept. 30, 1977, a decline from the previous two years reflecting decreased U.S. investment abroad.

Despite the drop in insurance coverage, gross income was \$54.8 million, an increase of \$700,000\* over the 1976 record of \$54.1 million.


Total insurance and finance reserves jumped to \$330.1 million compared to \$286 million in 1976.

For more information about OPIC's paid broker commission program for small business, contact Caryl Cole, vp of insurance, Overseas Private Investment Corp., 1129 20th St., N.W., Washington, D.C. 20527. Or call Caryl Cole at 202-632-8990.

### Advisory board

Nicholas Davy, director of corporate planning for Dun & Bradstreet Cos. Inc., is the newest member of the Mid-Atlantic Advisory Board for Arkwright-Boston Manufacturers Insurance Co. The board is composed of policyholders.

# We look, but do we see?



You're looking at an aerial photo of boomed logs in a Washington State mill pond. If it wasn't cropped so tightly, the peripheral landmarks might eliminate any questions.

When you're looking at insurance companies you owe it to yourself to get the entire picture there, too.

At first glance, Allendale Insurance may appear to offer basically the same services you can get elsewhere. But on the broader scope, there's more.

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## around the states

# S.C. firms fight 45% work comp hike

COLUMBIA—South Carolina employers and the state insurance commissioner are appealing a state judge's order increasing workers compensation premiums by 45%.

The increase, which is retroactive to Oct. 1, 1977, overturns a decision by insurance commissioner John W. Lindsay that reduced a rate increase request to 29% from 45%. The increase will cost employers in the state \$25 million; they are presently paying \$55 million a year in workers compensation premiums.

The judge said the commissioner abused his discretion in reducing the rate hike requested by the National Council on Compensation Insurance since the council had adequately justified its request.

Roughly 13% of the rate increase is due to increased benefits mandated by the state legislature.

### Kansas rates cut

TOPEKA—Kansas employers will be receiving a 8.4% decrease in their workers compensation premiums under an order issued by insurance commissioner Fletcher Bell. The move is expected to save employers in the state \$8 million.

Commissioner Bell previously rejected a proposed 6.8% decrease by the National Council on Compensation Insurance as inadequate since it failed to take into consideration the favorable loss experience of Kansas employers.

### Missouri immunity

JEFFERSON CITY—Missouri Gov. Joseph Teasdale has signed legislation restoring to governments some immunity from negligence suits.

"I do not feel our state or local governments have enough money to pay the judgments that could result from potential law suits," Gov. Teasdale said.

Legislative action restoring some type of protection from damage suits to governmental units was prompted by a September 1977 decision of the state supreme court invalidating the long-standing doctrine of absolute sovereign immunity.

Under the new law, effective Aug. 13, governments cannot be sued for damages except in cases where injuries occur in an accident caused by a public vehicle used in public business or by a dangerous condition on government property. The bill limits the amount of any damage claim to \$100,000 per person and \$800,000 per incident and allows governments to pool their resources to provide common liability insurance protection.

### Rate hike nixed

CHICAGO—The Illinois insurance department will hold a public hearing on a request for a 25% increase in workers compensation insurance rates in the state. The move follows the department's rejection of the rate hike for insufficient information and failure to consider recent, favorable loss information.

Spencer Kimball, a Chicago law professor who earlier overruled a portion of a requested work comp rate hike, will conduct the hearing. Illinois, which significantly liberalized benefits in recent years, has seen work comp premium increases of over 85%.

### Comparative awards

TOPEKA—The Kansas Supreme Court, holding that "there is

nothing inherently fair about a defendant who is 10% at fault paying 100% of the loss," ruled that liability suit defendants are responsible only for damage attributed to their own negligence.

The decision is viewed as a major interpretation of the state's four-year-old comparative negligence law, which is associated mainly with damages from automobile ac-

cidents. Under that law, the court is asked to fix a percentage of fault to those involved in the controversy.

### Pa. hike urged

HAFRISBURG—The Pennsylvania Workmen's Compensation Rating Bureau is requesting a 35.3% rate increase in workers

compensation premiums to generate \$247.7 million in additional premiums. The request would be effective Sept. 1 if approved.

### Deaths reduced

COLUMBUS—Industrial deaths in Ohio were cut 42% and days lost as the result of injuries and accidents were cut one-third from 1973

through 1977 because of state and federal job safety enforcement programs, the Ohio Department of Industrial Relations says.

Helen W. Evans, department director, said 256 job-related deaths were recorded in Ohio last year compared to 440 in 1973. Last year, 4.19 million man days were lost compared to 6.33 million in 1973, according to workers compensation statistics. In Ohio, 85 federal Occupational Safety and Health Administration (OSHA) inspectors and specialists are enforcing regulations.

An additional 17 state consultants help employers and workers understand and comply with federal regulations, she said. ■

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# N.Y. firm turns to consolidated benefits for savings

By ELLIS SIMON

HUNTINGTON, N.Y.—When Mark Sysler joined Instrument Systems Corp. as its director of insurance and employe benefits two years ago, about half of the company's 35-odd subsidiaries had separate employe benefit programs. As of July 1 the company's 2,200 non-union and several hundred union employes are under a master program that combines self-insurance and a group policy.

As Instrument Systems grew

from a small electronics concern into a \$150 million-plus conglomerate, it allowed subsidiaries to maintain autonomy in employe benefits and several other areas, Mr. Sysler said.

Two years of heavy losses demonstrated the need for a belt-tightening and Mr. Sysler recognized that the parent firm could save on administrative costs by consolidating its benefit programs. Total first-year savings on the new program could range from \$200,000 to \$500,000, he added.

Gaining acceptance and developing the unified program took much of Mr. Sysler's time over the past 12 months. Not only did Mr. Sysler have to convince top management, but also many of the former owners of subsidiary firms who were retained to run those units.

In some instances, the new program will mean reduced benefits for some subsidiaries, Mr. Sysler said, a difficult communication problem. However, he added that in most cases the old program was less attractive for medical benefits.

The new program, which uses self-insurance for medical and dental benefits and the Prudential Insurance Co. for group life and long-term disability, was selected over a new fully-insured program or expanding an old program with The Equitable to cover all employes, Mr. Sysler said.

"We wanted to maximize the use of our money and to get cash flow advantages and self-insurance was the most attractive," he said.

The medical plan pays 100% of the first 21 days hospital room and

board with a \$100 deductible on services beyond that and 80% payment on the first \$3,000 of expenses beyond that. The company pays 100% of medical costs above the \$3,000 based on "reasonable, customary and usual" charges.

Some subsidiaries provided Blue Cross/Blue Shield paid in full, others used a surgery schedule based on Blue Cross and still others provided 80% of the first \$2,000, Mr. Sysler explained.

In addition, the former combined deductible for medical and dental coverage has been replaced by separate deductibles. Rather than pay a percentage of dental fees, the new program provides benefits on a fixed fee schedule.

James Employe Benefit Consultants Inc., a division of Instrument Systems' broker Fred S. James & Co., processes claims at their Mansfield, Ohio, facility. One full time person has been assigned by James to handle the Instrument Systems account, noted Mr. Sysler. "If nothing else, we'll at least get consistency."

With Equitable, various people handled Instrument Systems' claims and what was accepted for payment by one claims examiner was occasionally rejected by another, he explained.

The James claims system also promises to turn around claims in as little as 72 hours, Mr. Sysler said, an improvement from Equitable which took as much as 30 days to get a claim settled.

Stop-loss coverage for Instrument Systems was placed with Prudential. The policy covers all expenses should paid claims exceed 115% of projections.

Prudential is also insurer for Instrument Systems' life and long-term disability policies. The new group life program provides three-fourths of annual salary as a benefit plus an additional three-fourths for accidental death and dismemberment.

This is a reduction from the old policy, which provided between one and 1.5 times salary as the death benefit. However, a survivor income benefit has been added, Mr. Sysler noted.

This provision provides an employe's surviving spouse with 20% of his or her annual salary until the spouse reaches age 62, remarries or dies. An additional 10% of salary is provided for surviving children until they reach age 19 or graduate from college.

Thus, an employe making \$20,000 who dies at age 35 leaving a 30-year old wife and a 10-year old child would be providing for them \$128,000 over a 32-year period plus an additional \$18,000 over nine years. "It's a form of estate planning on a group basis," Mr. Sysler said. "Up until age 60, it's a better payment than lump sum and survivors get Social Security payments on top of that."

The long-term disability program provides 60% of monthly salary with a minimum monthly payment of \$100 and a maximum of \$3,000. For employes making less than \$15,000 per year, the payments are offset by Social Security, Mr. Sysler said. In addition, a waiting period of six months is in effect before benefits begin.

Cost to employes for the disability plan ranges from \$3.38 to \$13.50 per month. The medical, dental and life benefits are non-contributory, although employes can purchase supplemental life coverage for one or two times salary.

To "sell" the program internally, Mr. Sysler began by educating the president and officers and 22 subsidiary companies about what benefits are provided and how they are provided.

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## Doctors OK most ideas of cost control panel

ST. LOUIS — The American Medical Assn. at its annual meeting here accepted most of the report on the rising cost of health care and suggested remedies compiled by the National Commission on the Cost of Medical Care.

The commission's work was sponsored by the AMA, but the report was compiled independent of the doctors' association and its policies.

The AMA house of delegates actually approved only about half of the commission's recommendations for controlling health care costs while referring the other half to its board of trustees for further study. A few recommendations were approved in principle but

were still sent to the board.

Only one commission recommendation was, in effect, rejected. The commission had proposed that physicians and third-party payers agree to the reasonableness of levels of reimbursement. In response, the AMA reaffirmed its opposition to uniform fee schedules. The delegates also referred to the board a recommendation that doctors divulge price and patient scheduling information for publication in regional directories.

**At the same meeting**, new AMA president Tom E. Nesbitt urged all physicians to cut the rate of their professional fee increases by 1% each year over the next two years.

Commission recommendations aimed at cutting health care costs that addressed physicians' professional practices were referred to the board. They included measures for "assessment and assurance of the quality" of medical care and a suggestion that third-party payers should be encouraged to experiment with ways for reducing payments for "inappropriate care." Also referred for more study was a recommendation discussing incentives for physicians to provide "appropriate" care and another that addressed "appropriate and inappropriate settings" for delivering medical care.

The commission's endorsement of the concept of planning for the distribution of health care facilities and its proposal that certificate-of-need legislation be extended to physicians offices if it proves effective for hospitals were both referred to the board for further study. The delegates also reaffirmed the AMA policy that the association is prepared to join with a state medical society that "commences appropriate legal action challenging a state certificate-of-need law that includes physicians offices."

A recommendation on the functions of a professional standards review organization (PSRO) was referred to the board as well as recommendations discussing the supply and training of new physicians. Suggestions on handling the medical malpractice claims problem were referred to the board too.

**Approved in principle**, but still sent on for further study, was a suggestion that health maintenance organizations have a right to fair market competition with other provider and insurance systems. That alternative health care plan financing systems be investigated and that hospitals be afforded incentives for limiting bed capacity were approved by the delegates but still sent to the board.

Approved outright by the AMA delegates were recommendations that consumers share in the cost of their medical care, that employers offer employees a choice among types of health care plans and contribute equally to their cost.

The AMA agreed with the commission that instead of not taxing employer-paid health insurance premiums and allowing a deduction for consumer-paid premiums, the government should institute a fixed tax credit or deduction.

The physicians also approved the commission's recommendation that capital expenditure limits, such as those proposed in the Hospital Cost Containment Act of 1977, should not be enacted.

The need to evaluate second-opinion surgery programs, to develop health and patient education programs and to encourage Americans to adopt healthful lifestyles were all endorsed by the delegates.

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From McGraw-Hill

## Computer program keeps property values current

NEW YORK—To help the insurance industry reduce the cost and simplify the process of maintaining books of insurance at current replacement values, McGraw-Hill's Building Cost Services Unit has begun marketing an insurance-to-value program.

The program has been tested by The Travelers Insurance Co. and The Hartford Insurance Co. for three years: Hartford used it for commercial accounts while Travelers tested it for residential policies, said Janet Wikler of McGraw-Hill.

Ms. Wikler said the computerized program has been used

on thousands of policies by these two companies who have signed on as customers. Several other insurance companies are testing the product, she said.

While the program is marketed for insurance companies, Ms. Wikler said the service would also be available to corporations with self-insurance programs or captive insurance companies.

"We haven't gone out looking for this business but we would make a good deal with captives and self-insurance programs," she added.

An accurate cost estimate was not available since the cost varies widely depending on the book of insurance, the variety of locations and whether the accounts are residential or commercial.

But Ms. Wikler said the service is "much less expensive than having an appraiser do the job."

**For the insurer,** the service ultimately can help reduce problems stemming from under-insured buildings such as underwriting losses and inadequate premium income, according to the Building Cost Services Unit.

Replacement cost analyses come from a computerized data base that contains the actual construction costs of thousands of recently built structures. The information reflects varying costs of material and labor and includes computer generated cost adjustment indexes to update replacement costs in different regions.

This scientific basis for updating coverage is believed to be the largest bank of actual construction costs of buildings, said Hugh R. T. Sharp, general manager of McGraw-Hill's Building Cost Services.

To assure that the program is used properly, Mr. Sharp said building descriptions fed into the computer are reviewed by a construction cost expert before being inserted into the computer.

The computer also scrutinizes the input data to determine whether the information is consistent with information it has about a certain type of building. In addition, the computer print-out is examined by a construction cost specialist.

The insurance-to-value service has become a sales aid for subscriber insurance companies because the insured is saved the time and expense of having his own appraisal completed, according to the services units.

### Richmond broker buys service units

RICHMOND, Va.—Acquisition of Hewitt, Coleman & Associates Inc. of Greenville, S.C., by Insurance Management Corp. of Richmond, Va., has been announced by the two firms. The two companies reached an agreement in principle in March.

Hewitt, Coleman is primarily a self-insurance administration firm and places excess liability coverage and bonding for self-insured clients. The firm maintains branch offices in Jackson, Miss., and Orlando, Fla.

Insurance Management Corp. is a full service brokerage firm with offices in Virginia, Florida, North Carolina, Georgia, Ohio, Pennsylvania, Alabama and Connecticut.

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# Despite setbacks, no-fault supporters honk success

By RICHARD MARINI

NEW YORK—Despite numerous setbacks suffered by both state and federal no-fault laws recently, proponents of the measures say that they are not yet ready to throw in the towel.

On the contrary, they claim a number of just as important—if less publicized—victories as states such as New York and Florida work to toughen already existing no-fault laws.

"On the whole, we've found no-fault to be a better system for the reparation of accident victims than the previous tort system," said John Reiersen, principal examiner of no-fault claims for the New York insurance department.

Because of this success, New York is one of several states that has opted to amend rather than repeal original no-fault laws after loopholes and deficiencies were discovered and exploited.

As amended last year, the New York law now carries a verbal threshold—the point after which tort liability can be established—instead of its original monetary threshold of \$500.

"We found that it was no serious challenge for anyone really wanting to sue to meet the \$500 threshold," explained Mr. Reiersen.

New York's verbal threshold now establishes legal recourse only for those victims who have suffered death, substantial disability or other serious injury.

The same amendment also instituted a set schedule of rates that can be charged by doctors of accident victims. This measure was designed to stop doctors who charge excessive rates of accident victims knowing they will be reimbursed.

Another victory came in Florida last month as Gov. Reubin Askew signed into law a no-fault bill that has been termed the toughest in the country. In addition to raising the minimum personal injury protection coverage that must be carried by a driver to \$10,000 from \$5,000, the new law tightens and more clearly defines the requirements necessary for a victim to sue. No longer is "pain and suffering" sufficient grounds for establishing tort liability. Now a victim must suffer permanent injury, disfigurement or death in order to sue.

But all is not peaches and cream for no-fault supporters. Critics of no-fault see the slowing of acceptance of no-fault by states as a reliable barometer measuring the public's changing attitudes toward the idea.

Massachusetts was the first state to enact a true no-fault law which became effective Jan. 1, 1971. Immediately afterward, a number of other states began to develop their own plans, many modeled after the Massachusetts law, others developing original bills. Steven H. Lesnik, vp of the Kemper Insurance Cos., estimates that, by the end of 1973, fully one-half of the motorists in America were covered by some form of no-fault automobile insurance.

But the flood of acceptance soon slowed to a trickle and then stopped completely as opponents banded together to fight further no-fault legislation. Their efforts have been remarkably successful. The last no-fault bill was passed in North Dakota effective Jan. 1, 1976.

On the federal level, the no-fault movement has also stalled. Two slightly different bills are now at various stages of debate in the two houses of Congress.

According to experts, it appears unlikely that Congress will pass either of these bills this year. In a

recent speech before a conference of insurance executives in Washington, House speaker Thomas "Tip" O'Neill blamed the backlog of other legislation for delaying Congress from acting on the measures.

But the most recent, and perhaps the most telling, blow to no-fault came when the Michigan supreme court ruled portions of that state's law unconstitutional.

In a 4-3 decision handed down in June, the Michigan court declared that the Michigan rating system does not protect the consumer

With the controversy over no-fault insurance systems continuing to swirl, *Business Insurance* assigned reporter Richard Marini to explore the status on effectiveness of no-fault auto insurance laws. A chart summarizing the various no-fault auto insurance laws now in effect appears on page 32.

from "excessive, inadequate or unfairly discriminatory" rates. The court also ruled that the existing law does not provide adequate

mechanisms for an individual to challenge "... insurance refusal, discriminatory cancellation or assignment to the 'automobile placement facility' with its presumptively higher rates."

Because the Michigan law is so similar to the federal law being considered, the Assn. of Trial Lawyers of America, (ATLA), termed the Michigan decision the "death knell" for national no-fault.

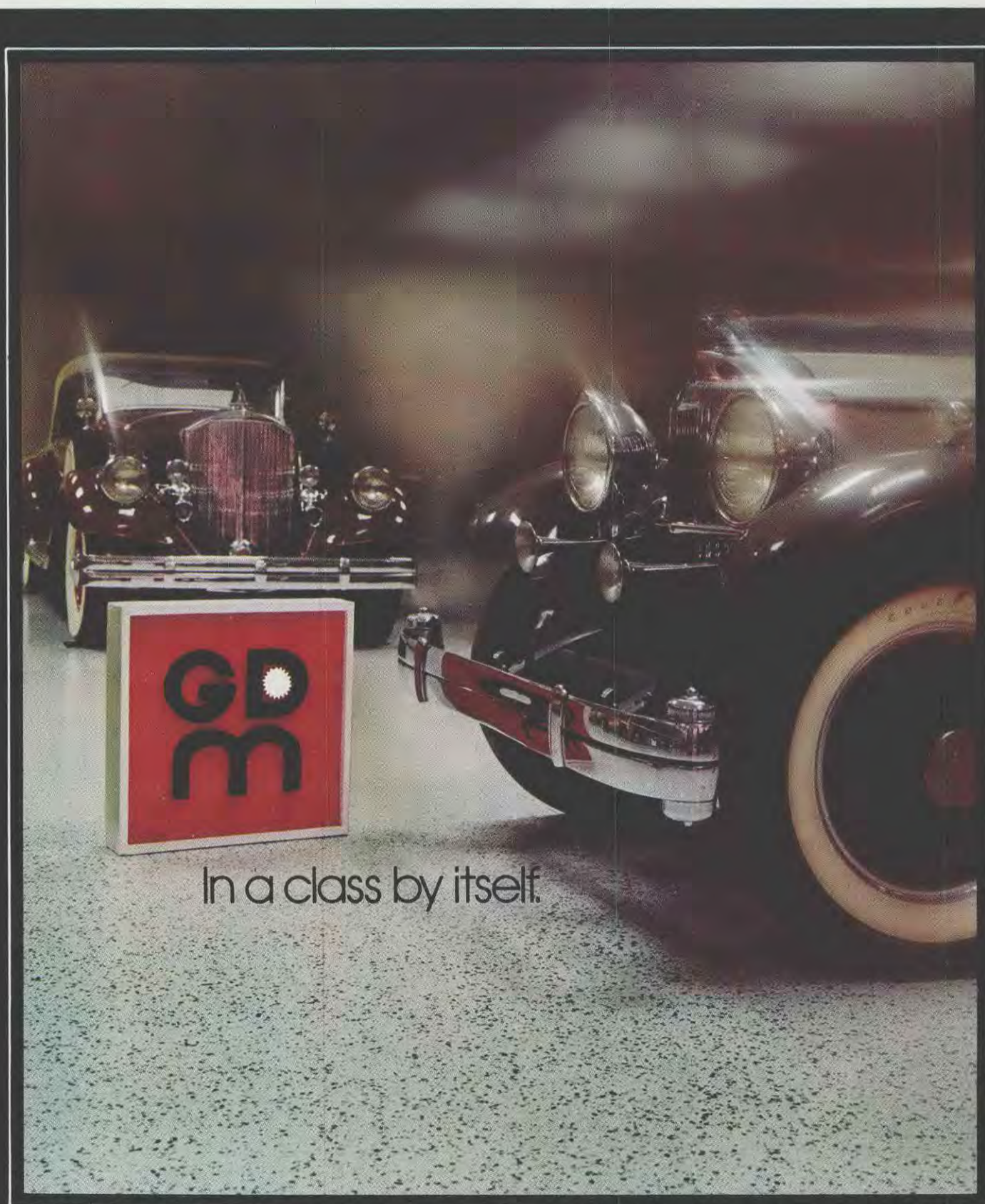
Harry M. Philo, Detroit attorney and chief counsel for the plaintiffs in the case, explained, "The deci-

sion hits the federal proposal in the head. I don't think the insurance industry can live with no-fault because they don't want close federal or state regulation."

Bruce Butterfield, a spokesman for ATLA, said that although the association actively works against federal no-fault, it has historically been in favor of no-fault on the state level.

"It's a common misconception," he said, "but we really don't oppose no-fault per se. We're in favor of first-party no-fault with no tort

Continued on page 22



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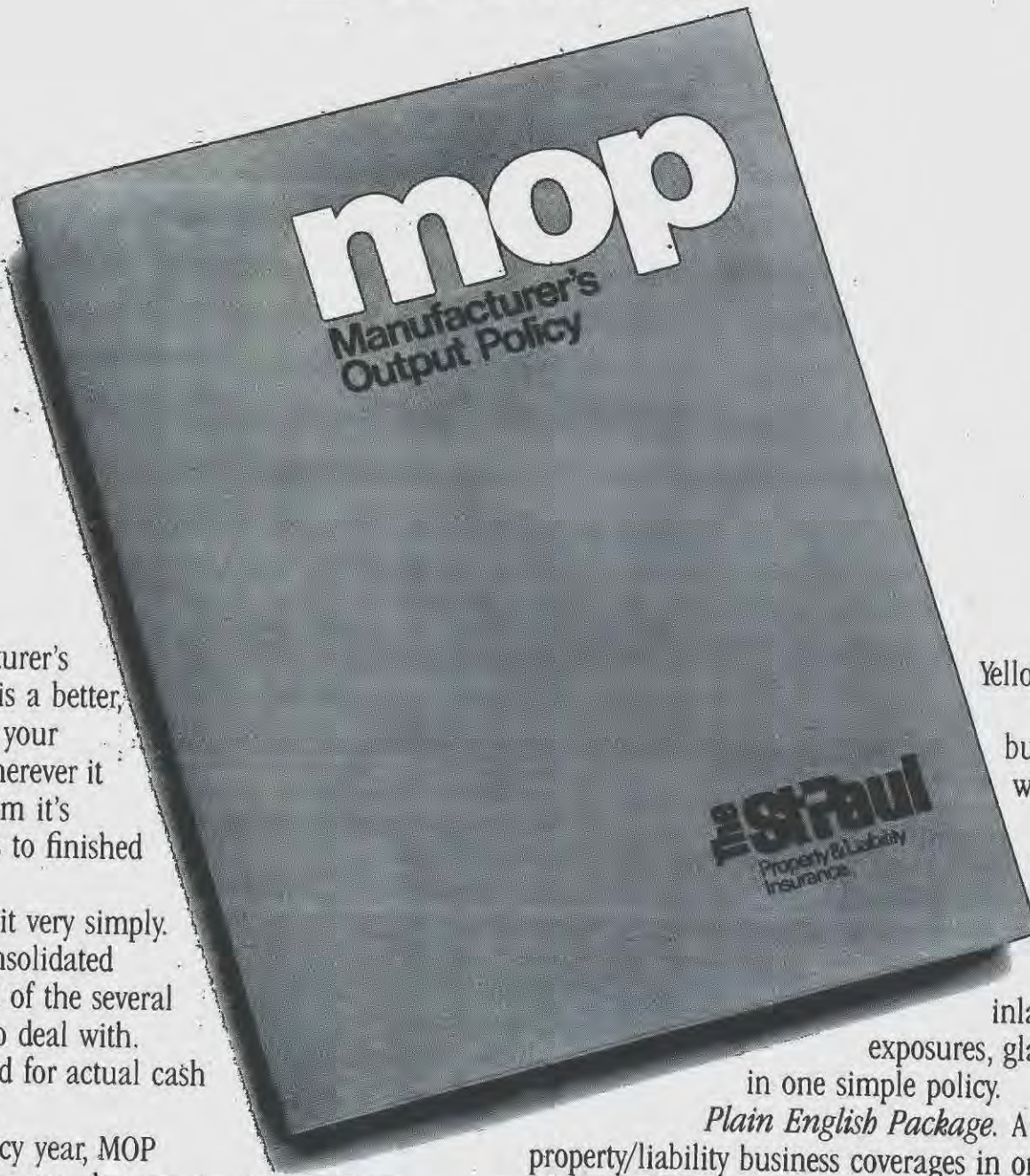
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# No-fault insurance . . .

Continued from page 19

restrictions for states. We do feel that a federal no-fault law would be a mistake because automobile insurance is a state problem that cannot be handled on a nationwide level. Differences in driving habits between urban and rural areas alone make the development of a satisfactory program for everyone virtually impossible."

John Murphy, risk manager for Avis Inc. and an active supporter of no-fault legislation, disagreed: "Talking about local discrepancies is very popular if you're an opponent of no-fault. There may be problems in developing a plan to satisfy everyone, but that's not enough reason to drop the idea altogether. Nothing is worse than the

present system which shows a ruthless contempt for the consumer. Under the tort system, the people pay for the insurance and get almost nothing in return when it's needed."

Proponents such as Mr. Murphy are keeping the fight for no-fault alive on both the state and federal level and despite the setbacks, they have some encouraging signs for eventual success.

While the Michigan supreme court has ruled against parts of the state's no-fault law, it also decided unanimously that the law itself is constitutional. In those states whose no-fault laws have been constitutionally challenged, courts across the country have

overwhelmingly ruled in favor of no-fault.

There appears to be a number of reasons why more states have not enacted no-fault, the most often cited being the determined opposition by the trial bar. Because lawyers often get from 20% to 50% of the final settlement in a liability case, opponents argue it is only natural that they, as a group, would oppose any measure limiting a victim's right to sue.

"There is no defense for the cost of trial lawyers to the premium payer, and no room for lawyers in the auto insurance field," said Avis's Mr. Murphy.

It is a popular contention among no-fault supporters that it's a disproportionate number of lawyers who are holding up further no-fault legislation.

"It's a ridiculous situation," con-

'We have no more than 25,000 lawyers lobbying around the country and in Washington and they're able to convince people that they don't want progress.'

—John Murphy, no-fault supporter

tinued Mr. Murphy. "We have no more than 25,000 lawyers lobbying around the country and in Washington and they're able to convince people that they don't want progress."

Another reason for the inaction in those states still under the tort system is the common belief that the passage of no-fault would mean the reduction of premiums.

"It's a matter of educating the people that this is just not so," said a spokesman for the North Dakota department of insurance. "Until they realize that no-fault was intended to facilitate payments rather than reduce costs, this will be a continuing problem."

On the whole, however, most states that have no-fault automobile insurance laws seemed pleased with them, according to spokesmen from the states insurance departments.

"We feel that most Kansas citizens are satisfied with the law," said Mike Mullen, chief legal adviser for the Kansas insurance department. "And generally, the premium payers aren't upset."

"Whether or not the New Jersey law is working depends on your point of view, I guess," said Thomas Hooper, director of public information for the New Jersey

department of insurance. "The official view of the department is that, yes, it's working. More people are now being paid more promptly than before, which is what the law was designed to do."

Mr. Hooper said that early findings also indicate that the New Jersey law has also eliminated many of the minor liability cases that were clogging up the lower courts before its passage.

A spokesman for the Kentucky insurance commission stated that the Kentucky law has been exceptionally successful. "No-fault was never meant to lower rates, only to guarantee swift recovery and prevent undue delay for accident victims and our law has been one of the most successful in the country in doing so," he said.

John Kellogg, assistant to the insurance commissioner of Massachusetts, one of the few states where rates have actually dropped with the passage of no-fault, terms the law a "dramatic success."

"Although our rates started to rise with inflation during 1975, today, in 1978, they are still lower than before 1970, when the law was adopted," he explained.

In North Dakota, it is generally believed that the passage of no-fault legislation in 1976 was one of the contributing factors that caused the incumbent governor to lose his bid for re-election. Although the spokesman for the state said there is still a great deal of confusion regarding certain aspects of the law, there have been very few complaints about delay in payment.

## Traffic deaths increase 4.7%

WASHINGTON—The number of traffic fatalities in the U.S. last year shot up to 47,671, a 4.7% increase over the 45,523 killed in 1976.

The Department of Transportation said increased driving speeds along with an increase in traffic fatalities were responsible for the rise in traffic deaths.

The 1977 fatality figure, however, represented a sharp drop from 1974 when 54,052 persons died in traffic accidents.

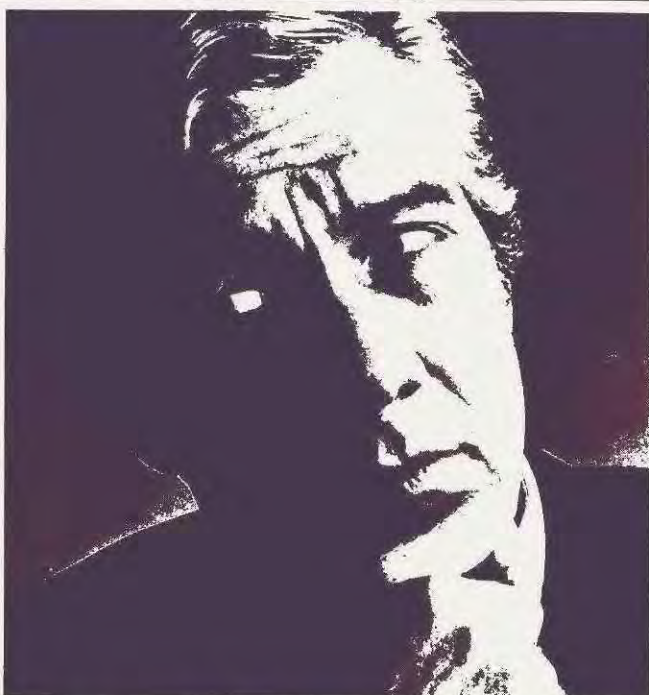
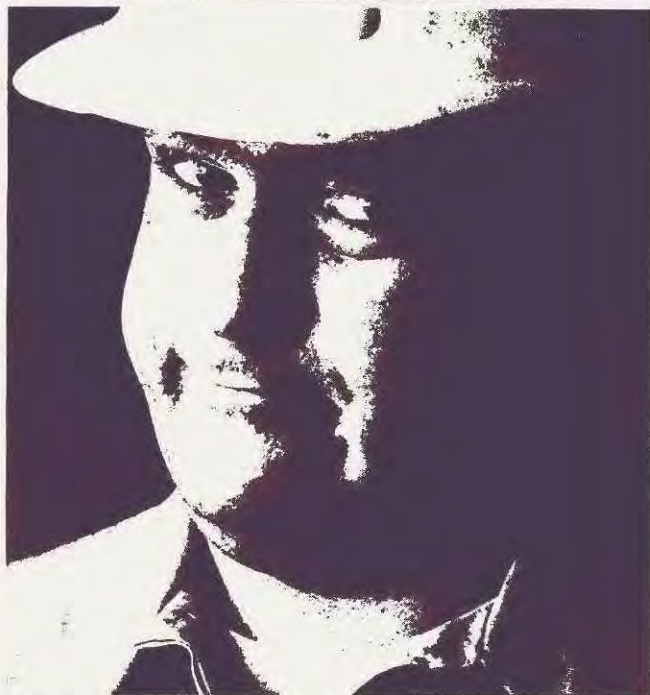
DOT said the direct economic cost of highway deaths currently is estimated at more than \$43 billion annually.



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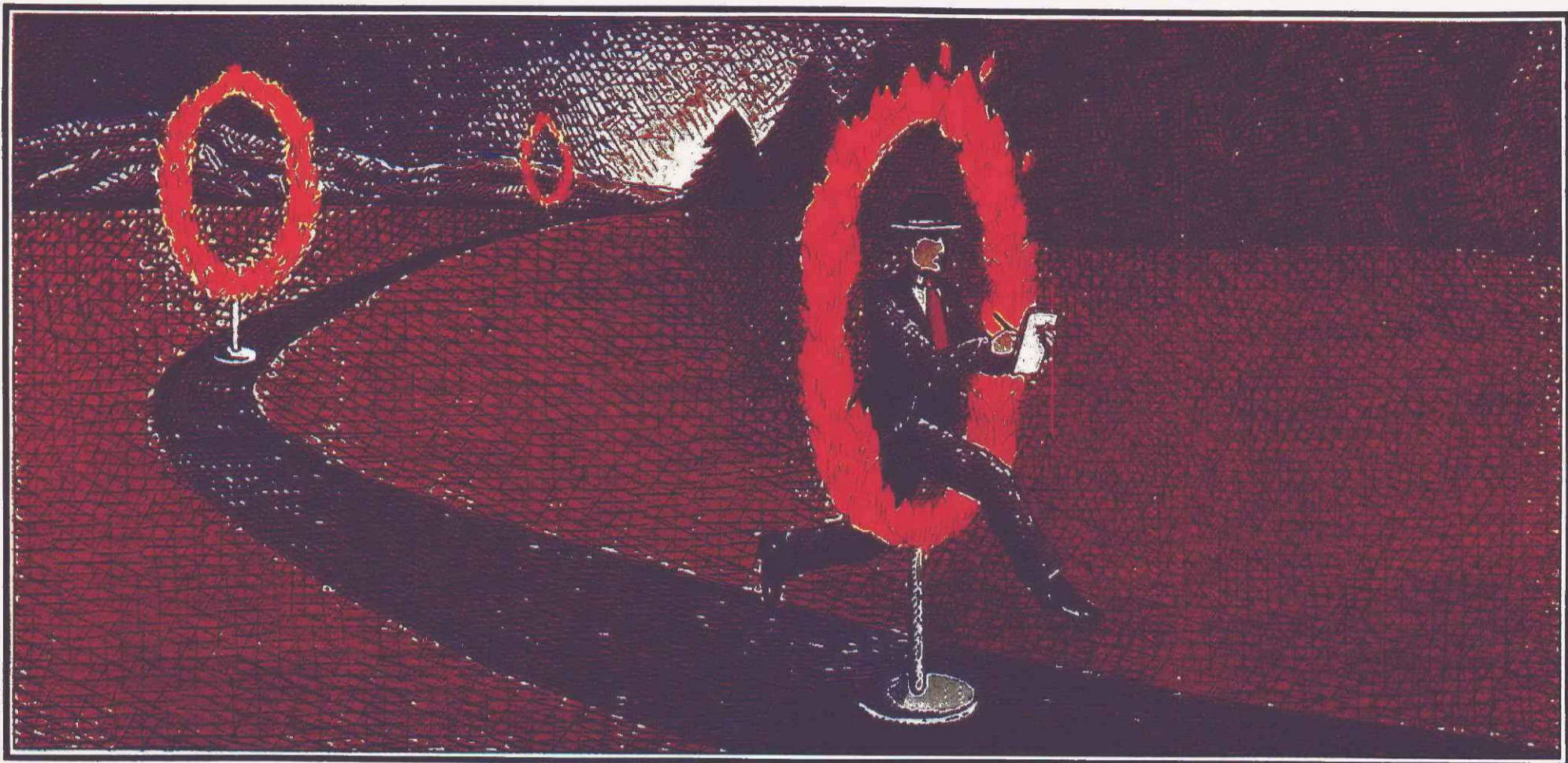
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# Handling Ins



**As claims grow in size and complexity, effective claims handling becomes more critical. And analysis of claims records can provide vital information when assessing a risk management program.**

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

Because they are experiencing larger and more complex loss and liability claims, companies are paying increased attention to the way their claims are being handled. The trend to self insurance has brought many risk managers face to face with a full range of claims handling problems. But those who rely on outside carriers for most or part of their coverage also want to be sure of their insurer's claims capability

and responsiveness to the company's own evolving needs.

A company that does business nationally, for example, needs an insurance carrier with knowledgeably-staffed service offices throughout the country, and multinational companies need the same facilities overseas. Companies with broad exposures should expect claims representatives to be informed enough to deal with many kinds of complex

claims situations.

Claims service generally is a major consideration. All claims should be acknowledged, investigated and settled promptly. If there is a plant fire in the middle of the night, an experienced claims representative should be early on the scene. The insurer should also be effective in salvage and subrogation efforts. And reports after claims are settled should be complete, accurate and timely.

## **Sensitive areas**

Liability claims, in which third parties are involved, can be particularly complex, and many—such as product liability claims—can have serious public relations as well as financial ramifications. All liability claims cannot be paid routinely without eventually raising insurance costs, but challenges must be realistic or the

# Insurance Claims

only result will be unproductive legal bills. The insurer's claims staff must therefore be aware of the legal climate, undertake rigorous cost analysis and consider the best overall interests of the insured when undertaking a challenge.

Many companies that self insure their risks also handle their own claims. Assembling a qualified staff to handle a stream of claims is a major commitment. And self-insurers, too, face sensitive claims situations.

A growing number of self-insurers have therefore decided to turn over claims handling administration to an outside firm. Such firms can usually provide a depth of professional claims personnel and statistical reports that summarize company-wide claims activity. An outside administrator can also serve as a buffer between the company and its customers when liability claims are involved, and may have more flexibility in challenging suspect claims—pursuing an employee's medical

history when investigating a workers' compensation claim, for example.

## Learning from experience

Whether a company handles its own claims or relies on a carrier or outside administrator, it is important that complete documentation on all claims be assembled and analyzed. Problem areas may be revealed—gaps or duplications in coverage, departments with unusually heavy losses, faulty record-keeping that makes it difficult to substantiate claims, or departments that are failing to keep the risk manager informed of equipment purchases or to report losses promptly, thereby jeopardizing coverage.

Many companies now assign retained losses to departments where they were incurred; when managers know losses may affect departmental profitability—and, possibly, bonuses—they will be more vigilant in preventing future losses and claims. And comparing annual claims reim-

bursments with risk management costs may suggest fundamental changes in insurance and self-insurance strategies. Experience should help set a course for the future.

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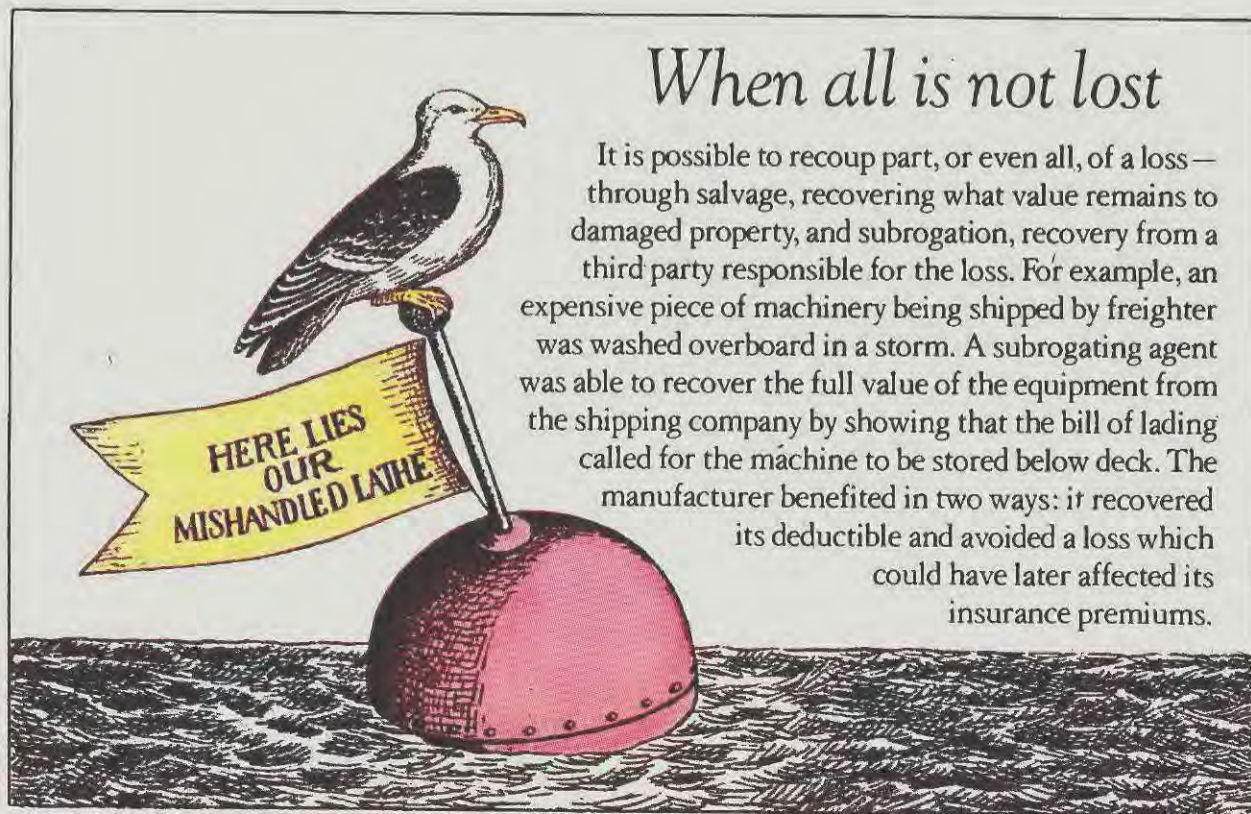
\* \* \*

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## Sasse syndicate revises claim against reinsurer

LONDON—Lawyers for the suspended Lloyd's syndicate F. H. Sasse & Others have lodged a revised claim in the U.K. high court in its dispute with Brazilian reinsurance group I.R.B. over large-scale U.S. fire risks.

The amount involved is now put at \$8.5 million, which Sasse is seeking from I.R.B. under reinsurance agreements. This figure may go higher if further settlements have to be made by the Sasse group in New York and other cities on claims under property insurance taken out on restaurants and apartment houses two years ago.

Intra Global Reinsurance Facilities of Houston, Tex., which is run by former Londoner Edward. T.

“Ted” Smith, is named in the amended claim. Sasse alleges that John Howell, former chief non-marine underwriter for I.R.B., and IRB former general manager Roberto Chievegatto both knew full well that reinsurance plans had been completed with Intra Global in 1976.

Under these plans, for which Mr. Howell and Mr. Chievegatto were “at all times acting within the scope of their authority on behalf of I.R.B.,” Sasse pleads that it got full reinsurance cover for the first \$100,000 of any policies taken out through Den Har Underwriters in Miami, Fla.

Sasse discovered that more than 600 reinsurance certificates were issued by Intra Global on U.S. risks in 1976-77 and says I.R.B. was warned as long ago as last November that it owed \$2 million on these risks, but has only paid \$500,000 so far. Further claims since then have hiked the amount due to \$8,502,803 and trial action is likely late this year or early 1979.

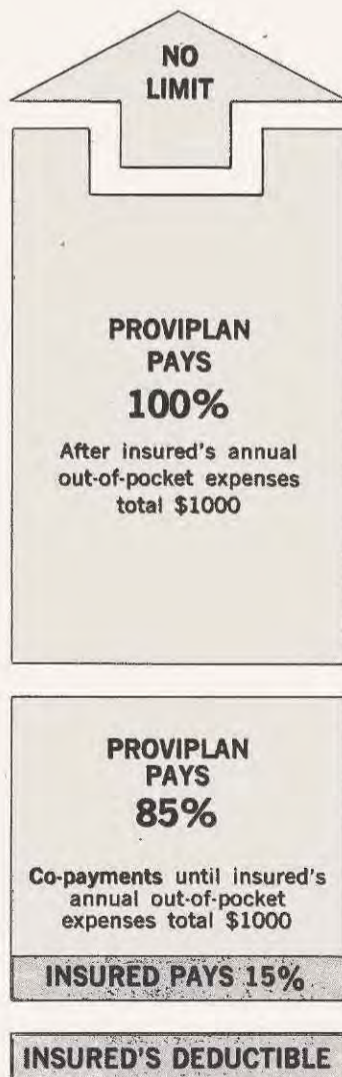
The Merrett Dixey syndicate at Lloyd's is now helping Sasse to administer the claims, which are being challenged by I.R.B.

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## dates for buyers

SEPT. 7-8. New York University will sponsor a seminar to analyze methods to combat escalating costs while protecting a company. The **Corporate Insurance Management Seminar** will be held first in New York City. It will be repeated in the following cities: Atlanta, Oct. 16-17; Los Angeles, Nov. 16-17 and Chicago, Feb. 8-9. Among the topics to be discussed will be approaches to risk management and insurance purchasing, property and business interruption coverage, minimizing claim problems, controlling fringe benefit costs, workers compensation and liability insurance and product liability. Cost: \$495 tuition plus \$65 registration fee per organization. Contact Registrar, 14th floor, NYU Conference Center, 360 Lexington Ave., New York, N.Y. 10017; phone 212-953-7266.

SEPT. 7-8. **Self-insurance and Risk Management Services** is a seminar to be presented by Practical Risk Management in Chicago. Emphasis will be placed on the practicalities of implementing, controlling and monitoring an effective property, liability and workers compensation self-insurance program. Moderators and panel members will be drawn from the professional staff of Warren, McVeigh & Griffin, risk management consultants. The seminar will be repeated in the following cities: Philadelphia, Sept. 21-22; San Francisco, Oct. 9-10; Dallas, Oct. 26-27 and Los Angeles, Nov. 9-10. Contact Practical Risk Management, Suite 205, 1700 Montgomery St., San Francisco, Calif. 94111; phone Susie, 415-433-6979.

SEPT. 18-20. The Public Relations Committee of the **Alliance of American Insurers** will sponsor their fourth annual **Conference on Company Communications**. Workshops will feature effective ways for responding to attacks on risk classification, answering red-lining charges and other public relations problems. Cost: \$60. Contact Tim Kett, Alliance of American Insurers, 20 N. Wacker Drive, Chicago, Ill. 60606; phone 312-346-5190.

## London line

## Worsening hull losses sink underwriters' future

By JOHN H. MILLER

LONDON—Hull losses are getting worse and marine underwriters cannot carry the deficit indefinitely, according to Lloyd's insurers who have been studying casualty trends worldwide.

Over 1 million tons of shipping is now being sunk annually and A. Henry Chester of the Committee of Lloyd's calls this "a wicked and cynical waste of the world's resources."

He told shipowners at a recent international conference in Athens: "It's quite impossible for any underwriter in the long term to continue to offer coverage at many

of the rates being quoted today. Shipowners are tending to increase their self-retention, but if this is the future pattern, the 1 million tons of shipping will still be lost and the consequent cost must be borne out of the total insurance funds available to the world's markets."

He said Lloyd's was surprised that some of its competitors seem to think the casualty statistics are misleading and that a change of underwriter or a downward alteration of rates would in some way alter the inevitable claims pattern.

Self-insurance is a growing trend, but he warned: "If we ever arrive at a situation where under-

writers internationally are denied the large bulk premiums available from commercial fleets, it will be very hard to provide insurance at an economic price for peripheral classes such as fishing fleets, harbor craft and many specialist vessels in the cargo trade."

## U.S. business

U.K. insurance companies broke even on their U.S. business last year, largely because of greater selectivity over the risks they were prepared to accept. Premium income stayed unchanged at \$2.25 billion, split \$1.45 billion for fire and accident coverage and \$800

million for auto policies, according to figures released by the British Insurance Assn.

Chairman William G. Haslam comments: "The U.K. company market did much better worldwide last year compared with the previous three years and reduced underwriting losses by \$180 million on global premium income of \$11 billion against \$10.5 billion in 1976."

## Large award

Appellate judges have been asked to rule on a \$450,000 damage award to a U.K. doctor whose brain suffered irreversible harm while

undergoing a minor operation at a London hospital.

It is the highest award in British legal history and will set a new level for liability cases unless it is overruled. Most compensatory awards in the last few years have been well under \$200,000.

The high court judge who made the award, Justice Peter Bristow, took the view that the victim will have to be looked after for the rest of her life. So he took future inflation into account in a move that went against other U.K. judgments.

Last year a jury in Cork County, Ireland, gave \$550,000 in damages to a 32-year-old teacher.

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*Agent representing a Multi-Media Corporation*

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For more information, contact your agent or broker, or one of our offices listed adjacent to this message.



Industrial Risk Insurers





# PERSPECTIVE

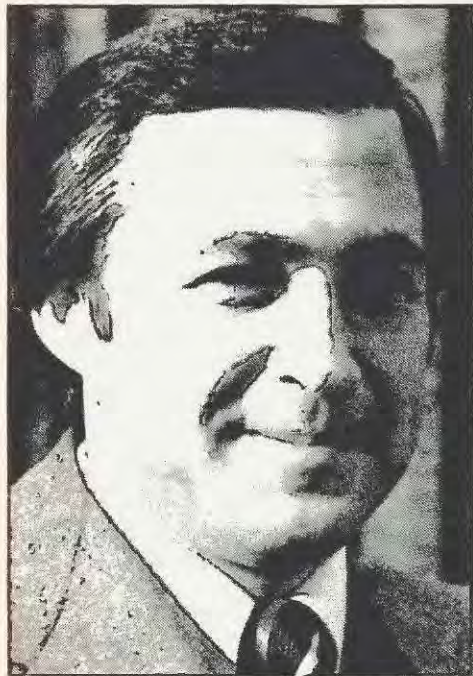
## Claims made policies . . .

Continued from preceding page  
policy period would not be covered. Given the long tail of product liability, the gap in coverage is a very real problem.

The claims made policy with a retroactive date from the original termination of the occurrence policy or from the original inception date of the initial "claims made" policy fares well until carriers change. However, once a change is made either to a new "claims made" form or to an "occurrence" form, a gap in coverage is still created as to any claims subsequently presented to the new carrier arising out of "occurrences" during the original "claims made" policy periods.

The solutions to either of the last two problems are probably not palatable to a buyer. A company can purchase continuous coverage with the same "claims made" insurer with full retroactive coverage from the date of inception of the policy. This approach is probably unrealistic based on the nature of the insurers currently affording a market—mostly e&s non-admitted markets and because some "claims made" markets are returning to the "occurrence" form, due to recent, adverse judgments requiring "claims made" insurance to indemnify on an "occurrence" basis.

Second, a buyer can negotiate with each new "claims made" or "occurrence" insurer to afford full retroactive coverage back to the inception of the original "claims made" policy. The pyramiding effect of this alternative from a premium standpoint could be outrageous if not altogether prohibitive. For example, a five-year retroactive cover could cost as much or more than the annual premium attributable to the newly placed



Some claims made policies contain an extended discovery period, but it is of little comfort, says **John Folsom** of Dinner Levison.

"claims made" policy for the current annual policy period.

Umbrella placement problems include a lack of continuity of coverage.

A few umbrella liability underwriters are reluctantly providing coverage excess of the "claims made" product liability policy on a "following form" basis. Based on the continuous changes of the umbrella market ("insurers in—insurers out") continuous coverage is an unlikely assumption, despite continuous coverage with the same "primary products claims made" carrier.

### Umbrella problems

A replacement umbrella or excess layer does not provide the retroactive coverage by virtue of being "following form." Specific recognition and additional premium will be required to obtain retroactive coverage.

When this problem is compounded with a change of the primary carrier, the gap created or pyramiding of premium

(whichever is preferred) is manifested to even a greater degree with excess placements. Considering catastrophe protection is the basis for umbrella excess placements (especially for sensitive coverage areas like product liability) the potential problem can leave the insured with totally inadequate protection.

Some of the "claims made" policies contain an "extended discovery" provision providing that if the insurer cancels the policy any claims arising from occurrences during the policy period are covered if reported, usually up to 12 months after the date of cancellation.

### Cancellations

Little comfort should be drawn from this apparent liberality since no such extension applies when the insured chooses to cancel and a change in limits of liability, imposition of a higher deductible or the quotation of a higher premium for renewal by the insurer does not constitute cancellation. Consequently, the insurer could arguably price the insured out of the coverage in lieu of cancellation without the benefit of the 12 month extension.

None of the policy forms reviewed deal with the issue of the effect of insurer cancellation on an aggregate deductible and/or self-insured retention. That is, notwithstanding the "extended discovery" provision as to the available limits of the policy there is no expressed stipulated treatment of the insured's aggregate as being pro rata for the period of the coverage. Consequently the full aggregate deductible/SIR applies first before limits of the policy become available.

One policy form excludes defense costs from coverage both as to the limits of liability and the deductible/SIR layer. Consequently, the very expensive and material costs of defense associated with the typical product liability claim are costs borne 100% by the insured not considered in satisfying the SIR/deductible layer or reimbursed or considered in the insurer's limits of liability.

The standard comprehensive general liability policy covering product liability affords the opportunity to provide the client with contractual liability (if endorsed with "blanket contractual" coverage). The standard separately issued product liability policies whether "occurrence" or "claims made" does not provide the coverage.

### Underwriting concerns

Liability assumed under contracts or agreements by the insured are specifically excluded. Buyers should be aware of this significant limitation to avoid the pitfalls of assuming the liability of other third parties with whom they might contact for resulting "occurrences" which cause bodily injury and/or property damage arising out of the sale, distribution of use of their products.

Among the underwriting concerns to be considered are the applicability of the deductible and the limits of liability, "per claim" vs. "per occurrence."

Although the product liability policy may be afforded on a "claims made" basis as to the scope of coverage provided, the deductible or SIR and limits of liability should be on a per occurrence basis.

Most standard certificates of insurance issued by insurers contain "occurrence" language. It is important the "occurrence" words be stricken from these certificates and in substitution thereof the limits of liability reflect a "per occurrence" limit on a "claims made" basis.

In conclusion it can be readily seen there are several salient negatives of a "claims made" product liability policy to be considered by the insurance buyer. Indeed, the buyer's most prudent course dictates reversion to an occurrence form at the earliest possible time and "biting the bullet" for the "buy back" period while "claims-made" protection was purchased. ■

*John P. Folsom, CPCU, is an attorney and partner since 1974 with the Dinner Levison Co. insurance brokerage firm. Alvin F. Johnson, a former vp with Marsh & McLennan, joined Dinner Levison in 1975.*

## Speaking Out

# Some further thoughts on hold-harmless pacts

By **E. P. Ahrens Jr.**

Manager of Claims  
Florida Power & Light Co.  
Miami

**A**LTHOUGH THE ARTICLE on hold-harmless clauses in your May 15 issue by Ron Almquist is articulate. I believe it is misleading in several respects.

While Mr. Almquist is correct in stating that the hold-harmless agreement transfers liability from one party to another, it certainly does not, as he relates, have any effect as to a claimant on the elements of contributory and/or comparative negligence, contribution or indemnification under tort law. Neither does it have the effect of relieving a claimant from proving negligence.

Perhaps there is a semantic problem here that simply requires clarification. If Mr. Almquist is talking about exculpatory provisions in respect to a loss suffered by the indemnitee, then he probably is correct. The greater exposure, however, is related to losses or injuries to third parties and their rights under the principles of tort law are not affected.

In the same vein, in enumerating the types of hold-harmless agreements, the one which Mr. Almquist describes as "suicidal" is again an exculpatory agreement not an indemnity agreement. As against the claims of third parties there is, to my knowledge, no more comprehensive hold-harmless agreement than the broad form.

In describing the negotiable nature of such agreements, I feel Mr. Almquist places undue emphasis on the relative bargaining strengths of the parties. While there is little doubt that the indemnitee is more often in the role of the "heavy" and normally has the bargaining edge (otherwise he would not be looking forward to the status of an indemnitee), there are some strong arguments in favor of full indemnification of a property owner who contracts for work or services to be performed on his premises.

A major, if not the predominant, liability exposure for a property owner exists as to the employees of the contractor. Given the relationship between the contractor and its own employees, as well as the control that the contractor has over the nature of the work, the working conditions of the premises and the work practices of its employees, the contractor obviously is in the best position to minimize both the frequency and severity of accidents. The burden of a broad form hold-harmless agreement is clearly an inducement to do so.

Mr. Almquist makes reference to the advancement by the indemnitee of defense costs and the absence of insurance covering the terms of the hold-harmless agreement. These are mere drafting problems and can be avoided both by proper composition and adequate insurance certification.

In the latter connection, Mr. Almquist states that "a policy of insurance and a hold-harmless agreement are both legal contracts. . . they are mutually exclusive." This is not necessarily true. If an insurance certificate is signed by a properly authorized representative of the insurance company and provides for a contractual endorsement protecting the indemnitee in accordance with the terms of the contract between the parties and therefore in accordance with the terms of the hold-harmless agreement, then the insurance company would have an extremely difficult time avoiding the obligation it has undertaken through its certified adoption of the hold-harmless agreement.

In fact, if a properly drafted certificate of insurance containing no exclusions or exceptions for the terms and conditions of the policy itself is secured, there is no need—and indeed it may be to the disadvantages of the indemnitee to do so—to "analyze carefully the terms" of the insurance policy. In my opinion, the exclusions in the contractual liability provisions of the comprehensive liability policy under these conditions do not "leave the indemnitor without insurance protection for assumed liabilities and the indemnitee with a meaningless hold-harmless agreement."

Of course, the common-law and statutes of the many jurisdictions in the United States vary considerably on this subject, and they must be referred to to determine the law in the given state.

## Risk Management Notes

# Safety of assets remains fiduciary's key responsibility

By **Warren, McVeigh, Griffin**

Risk management consultants  
San Francisco

**A** RECENT ARTICLE in the Wall Street Journal referred to some labor unions' shifting pension fund investments as political gestures. For instance, the United Auto Workers plan to remove deposits from banks with South African investments. This article ends with the note: "But unions move cautiously, fearing possible legal liability if their moves financially impair pension and other trust funds."

At the same time, A. W. Clausen, president and chief executive officer of Bank of America defends his company's involvement in South Africa by listing several

reasons:

- Leaving South Africa would not help bring about change.
- Free trade among all governments is essential to world peace and prosperity.
- American firms' presence in South Africa has had a beneficial impact on pay, working conditions, and other factors affecting blacks.
- Commercial relationships with other nations should be determined by U.S. foreign policy, not the private sector.

Both sides of this issue as well as others have their virtues, but the fact remains that a fiduciary's first responsibility is the safety of assets in his control, and the use of such assets to make political or other statements may backfire, exposing the fiduciary to possible legal liability. ■

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# PERSPECTIVE

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Colo.	4-1-74	\$25,000 (plus \$25,000 rehabilitation)	\$125/wk. (52 wks.)	\$15/day (52 wks.)	\$1,000	\$500 & Verbal	Yes, denial of the right to sue	
Conn.	1-1-73	Unlimited	\$5,000 / person / accident covering: 85% of actual loss		85% of actual loss	\$2,000	\$400 & Verbal	Yes, denial of the right to sue
Fla.	1-1-72	80% of costs	\$5,000 / person / accident covering (to \$10,000 1-1-79): 60% of actual loss		60% of actual cost	\$1,000	Verbal (recently tightened)	Property damage aspect ruled unconstitutional in 1973
Ga.	3-1-75	\$2,500	Aggregate Limit of \$5,000 covering: \$200/wk. (85% actual loss) Survivors receive what victim would have		\$20/day	\$1,500	\$500 & Verbal	None
Hawaii	7-1-74	Unlimited (including rehabilitation)	Aggregate Limit of \$15,000 covering: \$800/mo.		\$800/mo.	\$1,500	Floating & Verbal	None
Kan.	1-1-74	\$2,000 (plus \$2,000 rehabilitation)	\$650/mo. (1 yr.) Survivors receive \$650/mo. & \$12/day (1 yr.)		\$12/day (1 yr.)	\$1,000	\$500 & Verbal	Yes, a variety of reasons
Ky.	7-1-75	Unlimited	Aggregate Limit of \$10,000 covering: \$200/wk. Survivors receive up to \$400/wk.		\$200/wk.	\$1,000	\$1,000 & Verbal	Yes, passive acceptance, but active rejection needed. (Resident can reject no-fault)
Mass.	1-1-71	\$2,000	\$2,000 (75% actual loss)	\$2,000 (75% actual cost)	\$2,000	\$500 (talk of raising this to \$1,000)	Yes, property damage coverage repealed in 1976	
Mich.	10-1-73	Unlimited	\$1,000/mo. (adjusted annually)	\$20/day	\$1,000	Verbal	Yes, parts unconstitutional, discriminatory rate structure and no mechanism for challenge	
Minn.	1-1-75	\$20,000	\$10,000 for other benefits covering: \$200/wk. (85% actual loss) Survivors receive up to \$400/wk.		\$15/day	\$1,250	\$4,000 & Verbal	None
Nev.	2-1-74	Unlimited (including rehabilitation)	Aggregate Limit of \$10,000 covering: \$175/wk. Survivors: not less than \$5,000 and not more than victim would have received in one year		\$18/day (104 wks.)	\$1,000	\$750 & Verbal	None
N.J.	1-1-73	Unlimited	\$100/wk. (1 yr.)	\$12/day (up to \$4,380 / person)	\$1,000	\$200 & Verbal	None	
N.Y.	2-1-74 (amended 12-1-77)	Unlimited	Aggregate Limit of \$50,000 covering: \$1,000/mo. (80% of actual loss)		\$25/day (1 yr.)	\$2,000 (additional)	Verbal	Yes, denial of the right to sue
N.D.	1-1-76	Unlimited (including rehabilitation)	Aggregate Limit of \$15,000 covering: \$150/wk. Survivors receive up to \$255/wk.		\$15/day	\$1,000	\$1,000 & Verbal	None
Pa.	7-19-75	Unlimited (including rehabilitation)	Limit of \$15,000 Survivors receive up to \$5,000		\$25/day (1 yr.)	\$1,500	\$750 & Verbal	Yes, denial of the right to sue. (Case brought prior to enactment of law)
Utah	1-1-74	\$2,000	\$150/wk. (52 wks.) (85% actual loss) Survivors receive additional \$2,000		\$12/day (365 days)	\$1,000	\$500 & Verbal	Yes, question of whether workman's comp or no-fault benefits should be primary payment

## Mergers . . .

Continued from page 29

objectives of creating uniform pension benefits throughout the corporate structure. Uniformity facilitates intercorporate transfers by ensuring that benefits will be identical and permits coordination of the plan provisions with other corporate benefit programs such as group life and long term disability.

However, there are often sound reasons for departing from a policy of uniform benefits. Geographic differences may dictate different benefit levels, or a benefit practice unique to the acquired division may require that the acquisition's plan be adopted without modification. Where these considerations prevail, adoption and continuance of the acquired company's plan

solely for its employees may present problems in maintaining the plan's qualified status unless it can be demonstrated that the plan meets the nondiscriminatory coverage requirements of the Internal Revenue Code.

A merger of the acquired company's plan into the acquiring company's plan will in many cases offer the greatest flexibility with a minimum of financial liability. If the plan is merged into a plan in which the benefit level for service after the merger is equal to or greater than the prior benefit level and if the same employees are covered, the surviving plan and trust will remain qualified and this will not constitute a termination for either PBGC or IRS purposes.

ERISA requires a guaranty of benefit security which must be met at the time of merger or consolidation of plan assets. It provides, under Section 208, that in the event of a merger or consolidation of qual-

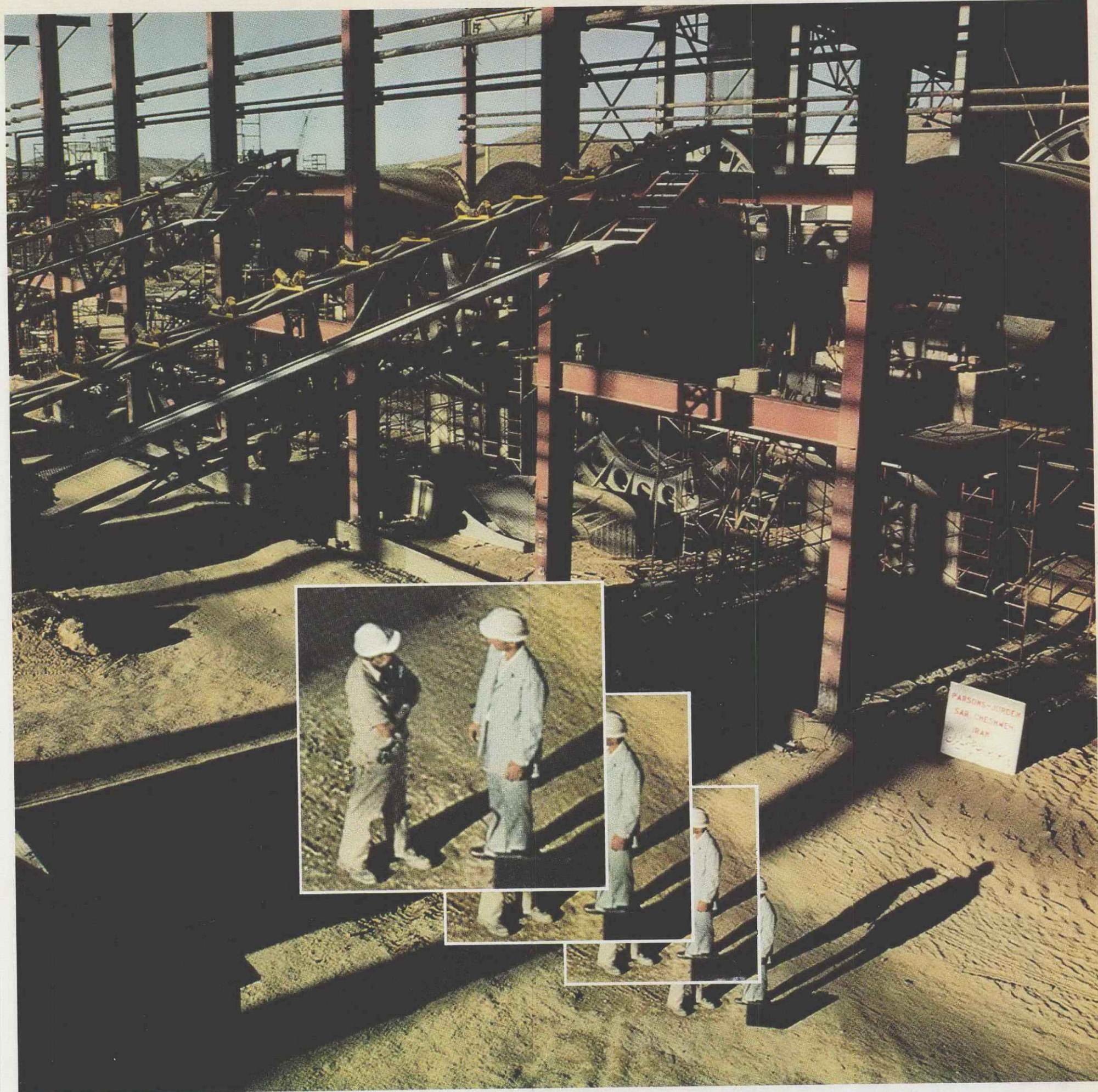
ified plans, or the transfer of the assets or liabilities from one plan to another, each participant must be entitled to receive a benefit immediately after the merger, consolidation or transfer (as if the plan had then terminated), which is equal to or greater than the benefit that would have been payable immediately before the merger, consolidation or transfer (as if the plan had then terminated.)

Section 208 created a significant roadblock to most pension plan mergers because literal compliance was impossible unless both plans were 100% funded. However, proposed IRS regulations implementing this section provide that when plans merge, it is not necessary to prepare a special schedule of actual benefits under Section 4044 of ERISA for the pre-merger and post-merger plans. (This would have required complicated calculations at great expense.)

Rather, the regulations require the special schedule only if the successor plan is terminated or spun-off within five years after the merger. It is sufficient to maintain the data needed to prepare such a schedule should there be a later termination or spinoff. An enrolled actuary must certify at the time of the merger, however, that sufficient data is available to prepare the schedule.

The corporate decision maker should insist that his legal and actuarial advisers provide a clear and understandable explanation of the options available and their cost implications before final decisions are made on the disposition of any qualified plans involved in the acquisition.

Myles Margady, a consultant in the New York office of A.S. Hansen Inc., has a law degree from the State University School of Law in Buffalo and a masters of law degree in taxation from New York University.



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# Sheltering life insurance? Beware estate taxes

By JOSEPH S. ROBINSON  
Attorney-at-Law

EXECUTIVES WHO have built up sizeable personal estates and who are provided with substantial group life insurance often seek

ways of removing the death proceeds from their estate. They should be reminded that the estate tax consequences of such insurance supplied by their company depends on whether the employee had retained any rights in the in-

surance policy. If the employee could change the beneficiary, get the cash surrender value (if any), or if he in fact transferred the policy within a three-year period before his death, the tax collector almost certainly will try to nail the estate

## benefit tax slants

for the full insurance proceeds.

In a recent situation, one executive adopted the strategy of assigning his interest in a group life insurance policy to an *irrevocable* trust, with the proceeds payable to specific beneficiaries. IRS ruled that the transfer was not a taxable gift. However, the employer's later payments of policy premiums were considered a taxable gift by the employee which qualifies for the \$3,000 annual exclusion. (Rev. Rul. 76-490).

### Keeping in trim

You are not entitled to a business deduction for a health club membership, even though your employer requires you to stay in excellent physical condition. That's the gist of an IRS ruling barring a write off by a member of a police department. (Rev. Rul. 78-128).

### Payment on termination

Suppose a long-time employee has a contract with his firm for a \$2,000 payment upon termination of employment. Actually, the firm hands him \$30,000 when he leaves. Query: Can he treat the \$28,000 excess over the agreed amount as a gift? No, says the Tax Court. This was compensation with a business purpose... deductible by the company but taxable income to the employee. (Ruestow, TC Memo 1978-147).

### Hedge agreements

While the IRS ruled favorably on hedge agreements covering disallowed salaries, it had no official position on hedge agreements covering any other disallowed payments. Thus, local IRS offices were free to decide for themselves how

to treat hedges covering disallowed travel and entertainment expenses, etc.

But now the IRS has issued rulings that allow the sole owner of a corporation and each of two equal owners of another corporation to take a business-expense deduction "for the year in which, pursuant to an enforceable legal agreement, he repays T & E expenses disallowed as deductions to the corporation." (Letter Ruling 7811004, 7811005).

### Congressional perks

Anyone who thinks that executives live high on the hog through generous fringes ought to take a look at some of the add-ons allowed congressmen. Here are some of the latter's perks that remain untaxed: A staff allowance of over \$250,000 a year for representatives, \$900,000 a year for senators; free medical treatment and access to low-cost military hospitals; 32 to 40 free round trips to the home state; fact-finding junkets; inexpensive meals in the subsidized House and Senate dining rooms. Members of Congress also get annual allowances for communications with their constituents (over \$25,000 a year), plus the franking privilege which lets them send their mail free.

### Late penalty

Under Internal Revenue code section 6652(f), a \$10 per day delinquency penalty is imposed for the late filing of the IRS annual return/report of employee benefit plans, Forms 5500, 5500-C, and 5500-K. In *Announcement 78-23, 1978*, the IRS stated that these penalties will not be assessed against any return received before Aug. 1, 1978. This delay applies to all 1975 and 1976 returns and to any 1977 return otherwise due before July 31, 1978.

In those situations where taxpayers had received proposed penalty letters or had already paid penalties for late filings, the release indicated that the IRS will automatically make adjustments and issue refunds.

### Midwife payments

A new Maryland law permits nurse-midwives to be reimbursed by health insurers the same way physicians are for home and hospital deliveries. Believed to be the most liberal in the country, the law forbids insurers from requiring that the nurse-midwife be under the supervision or orders of a physician.



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Group Insurance

## Legal brief

# Builder's policy didn't terminate on completion

A TENNESSEE APPELLATE court has refused to excuse an insurer from liability under a builder's risk policy ruling that the policy had not been terminated under its terms.

The Cherokee Insurance Co. (Cherokee) assumed liability under a policy of builder's risk insurance issued by another insurer to a construction company. The policy covered an extensive complex of condominium apartment buildings. In 1974 fire destroyed one building of the complex which had been substantially completed except for the installation of carpet, wallpaper and other decorative items. The policy had no fixed termination date for it encompassed many buildings which were added to the policy when construction was begun and removed from the policy when construction was completed and title transferred to the permanent owners.

Cherokee brought this suit against the insurer of the permanent owners seeking to have a determination as to which insurer was liable for the loss of the building. The trial court held that Cherokee was liable.

On this appeal, Cherokee argued that since the building was substantially completed this served to terminate the builder's risk coverage which was issued for protection during the period of construction. The court noted that the language of the policy set out several possibilities as to when coverage ceased: when the interest of the assured ceased; or when the property had been accepted by the owner; or when the property had been occupied; or when the policy had expired or been cancelled.

Consequently, the court concluded that the issue of completion was immaterial given the terms of the policy. Cherokee was held liable for the fire damages. *Cherokee Ins. Co. v. U.S. Fire Ins. Co.*, Court of Appeals of Tennessee, July 1, 1977, certiorari denied by Supreme Court, Dec. 15, 1977. (BI/01/Ju.-\$4).

### Faulty Construction

The Supreme Court of Minnesota has ruled that the settling of an apartment building because of faulty construction, which, at most, only involved negligence, was an "occurrence" within the terms of a liability insurance policy issued to a construction company.

Terrace Enterprises Inc. (Terrace) and Doerfler Construction Co. Inc. (Doerfler) were corporations under the sole ownership and control of Virgil Doerfler. Terrace secured a construction loan to finance the building of an apartment complex. Terrace contracted with Doerfler to construct the complex. Doerfler retained the excavation and carpentry work but hired subcontractors to aid in the construction. A testing and engineering laboratory was engaged to test the soil at the site preparatory to construction.

The laboratory recommended that the project be stopped or slowed until the soil conditions improved for laying the footings and the foundation. It also recommended that certain procedures should be undertaken because of the need to protect the soil and concrete from freezing. Doerfler proceeded with construction; however, the building settled and threatened to collapse. Remedial work was performed costing \$37,000.

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

After completion, Terrace sued Doerfler to recover these additional expenses. Doerfler tendered the defense of the suit to its general liability insurer, Ohio Casualty Insurance Co. (Ohio). The insurance policy covered "occurrences" which were defined as "an accident, including injurious exposure  
*Continued on following page*

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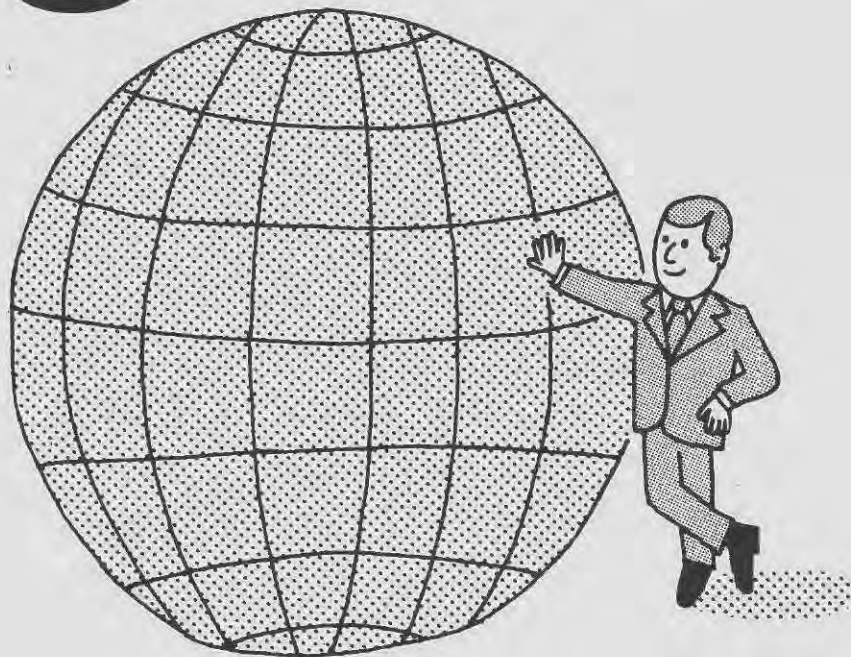
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# legal brief

Continued from preceding page to conditions, which results... in... property damage neither expected nor intended from the standpoint of the insured." Ohio declined representation asserting that the policy did not provide coverage for the damages alleged. The trial court ruled against Ohio.

The appellate court concluded that although Doerfler was aware of the freezing conditions, it had taken precautions that failed to adequately protect the soil and concrete. While such conduct was perhaps negligent, the court emphasized, it was not reckless or intentional.

Thus, the court believed that the settling was an "occurrence" within the terms of the policy and required Ohio to defend the suit. *Ohio Cas. Ins. Co. v. Terrace Enterprises Inc.*, Supreme Court of Min-

nesota, Aug. 26, 1977, rehearing denied Jan. 4, 1978. (BI/02/Ju.-\$4).

## Bankers blanket bond

This suit, brought by a bank against its insurer under a bankers blanket bond, involved more than \$2.6 million in losses sustained by the bank on a series of ship loans. A federal district court ruled that the fact that an attorney/board member of the bank was not hired by a formal resolution of the board of directors, would not preclude a finding that the attorney was retained by the bank as their ship loan counsel and was thus an employee within the meaning of the bond.

The Midland Bank & Trust Co. (Midland) was covered under two bankers blanket bonds issued by the Fidelity & Deposit Co. of Mary-

land (F&D) with primary coverage of \$750,000 and excess coverage of \$1 million. Both bonds indemnified Midland against any loss sustained through any "dishonest, fraudulent or criminal act" of an employee. Midland incurred substantial losses because of actions, over a two-year period, of its president and an attorney member of the board of directors.

A long series of loans, arranged by the attorney and placed by the president with Midland, involved knowingly listing renewal loans as new loans and then assuring the board there were no delinquencies; authorizing unsecured ship loans in direct violation of board instructions, and knowingly making false reports, oral and written, not only to their fellow directors but also to the state banking department.

F&D rejected a claim on the bonds asserting that the attorney was not an attorney employed by Merchants for he was never paid a

fee and thus was never retained by the bank to perform legal services. However, the court believed that the absence of a fee did not necessarily negate an employment relationship of an attorney-client.

Thus, the court held that, under the facts of this case, the attorney was in fact retained by Merchants to perform legal services and was an employee of the bank within the meaning of the bonds. Finding the losses were sustained by Merchants because of the dishonest and fraudulent acts of both the president and the attorney, the court held F&D to the total coverage of both bonds in the amount of \$1.75 million. *Midland Bank & Trust Co. v. Fid. & Deposit Co. of Md.*, United States District Court for the District of New Jersey, Sept. 29, 1977. (BI/03/Ju.-\$4).

## "Occurrence" defined

Does "occurrence," as defined in liability insurance policies, apply

only to damages resulting from negligence? A federal district court has ruled that, in the absence of any explicit language to the contrary, an "occurrence" limitation of an insurance policy applied equally to damage resulting from acts of negligence or from a breach of contract.

This case was originally brought by a utility against the Ecodyne Corp. for damages allegedly resulting from a failure in design as well as from utilization of inadequate materials in two cooling towers. The suit was based upon breach of contract. Ecodyne was covered under certain insurance policies issued by American Motorists' Insurance Co. and Lloyd's of London. Ecodyne claimed that the policies protected it against the utility's claims and had the insurance companies brought into the suit.

The policies applied to "occurrences" during the policy period. "Occurrence" was defined as "an event or continued repeated exposure to conditions which result in injury or destruction during the term of this policy." The insurance companies sought to be dismissed from the suit.

In reading the language of the policies, the court pointed out that no distinction was made between contract or tort coverage. Thus, the court concluded that both negligence and tort liability were covered.

Nevertheless, the court dismissed the insurance companies from the suit because there had been no showing that the damage here stemmed from an "occurrence." *Gulf States Utilities Co. v. Ecodyne Corp.*, United States District Court for the Western District of Louisiana, Dec. 15, 1977. (BI/04/Ju.-\$4).

## Dental care exclusion

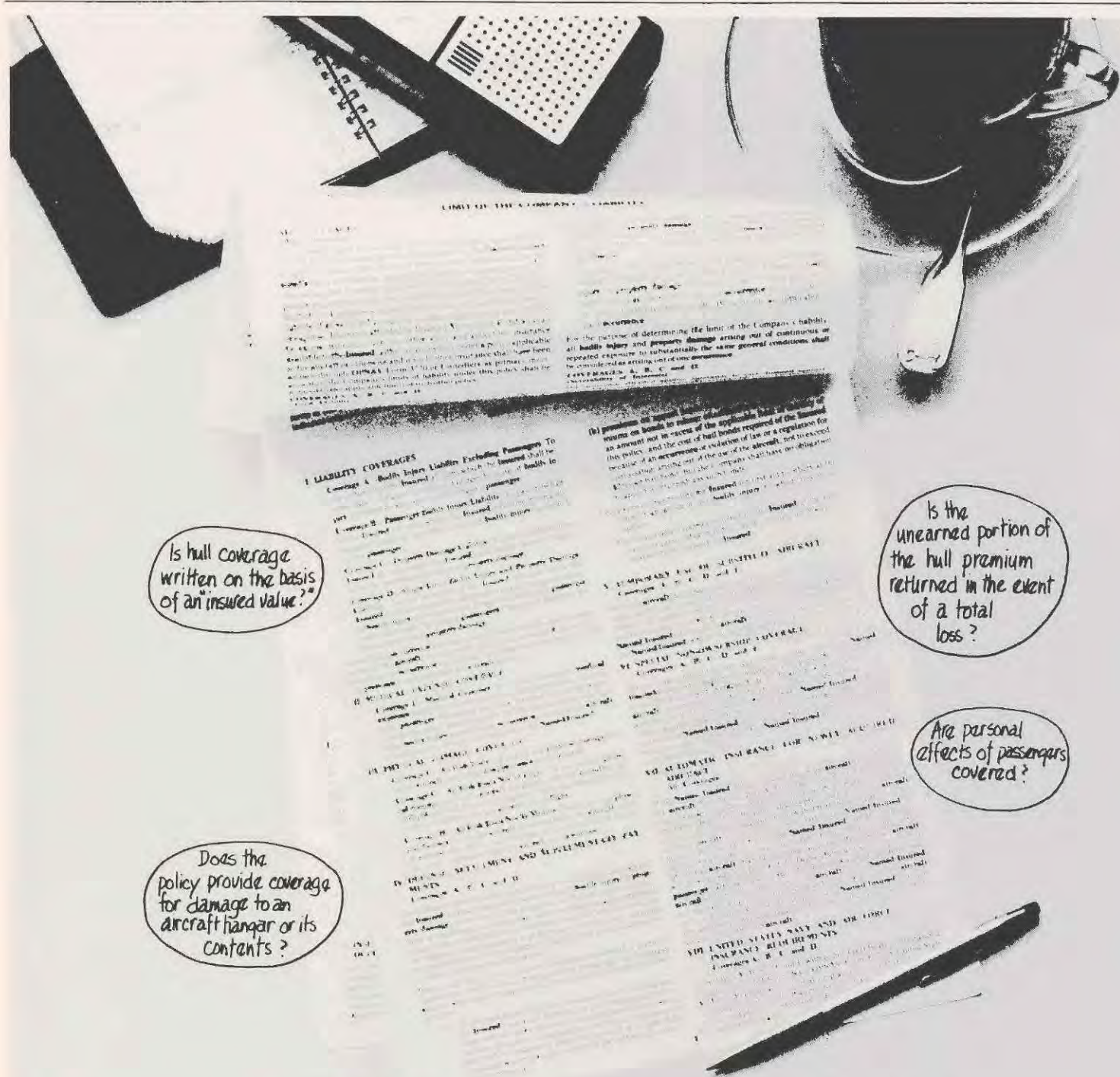
The Supreme Court of Vermont has ruled that the treatment of a malpositioned jaw did not fall within an exclusion for "dental care and treatment" in a group medical care policy even though the work was performed by a dentist. The court concluded that as the exclusionary clause in the policy was susceptible to two different meanings, it was bound to adopt the construction most favorable to the insured.

Melanie A. Simpson was insured under an employee group medical care policy issued by State Mutual Life Assurance Co. of America (State Mutual). The policy excluded coverage for "dental care or treatment" except for treatment for the repair of damage caused by accidental bodily injury. Ms. Simpson consulted a physician because of certain symptoms. The physician diagnosed her condition as caused by an uneven tension in the jaw muscles and referred her to a dentist.

The dentist confirmed the diagnosis and treated Simpson with medication and the installation of an oral prosthetic device. Simpson submitted a claim, including \$3,150 for the dentist's services, to State Mutual which rejected it. Simpson sued and recovered a judgment against the insurer.

The court believed that the phrase "dental care and treatment" was susceptible of a number of constructions from a restrictive to a broad definition. Thus, the court adopted the construction most favorable to Simpson by holding the treatment did not fall within the exclusion. *Simpson v. State Mut. Life Assur. Co. of Am.*, Supreme Court of Vermont, Dec. 6, 1977. (BI/05/Ju.-\$4)

(Copies of the entire decision may be obtained by sending a check for \$4 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the number for each opinion.)



Is hull coverage written on the basis of an insured value?

Is the unearned portion of the hull premium returned in the event of a total loss?

Are personal effects of passengers covered?

Does the policy provide coverage for damage to an aircraft hangar or its contents?

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## Con Ed program . . .

*Continued from page 1*

provide liability insurance for public utilities.

Lloyd's and several other British companies insure Con Ed for an additional \$19 million in excess of the AEGIS limit, Mr. Collins said.

The third layer of coverage, which provides \$30 million liability coverage in excess of \$20 million, is shared by Lloyd's, American Sentinel, Lexington Insurance Co., American Home Assurance Co. and Northeastern Fire Insurance Co., Mr. Collins said.

In addition, the utility self-insures \$500,000 of the coverage.

Because of the blackout last year, Mr. Collins said Con Ed lost the \$30 million blackout or brown-out coverage in excess of \$20 million when the policy was renewed in January. Con Ed is now insured for only \$20 million for interruptions of service.

Under the utility's tariff (the compilation of rules and regulations for providing service), Con Ed is not liable for losses resulting from service failures caused by ordinary negligence or causes beyond its control. However, if the courts find that Con Edison was willfully negligent or grossly negligent, the utility could be held liable for the losses.

### Court decisions

It is conceivable then that the utility's liability could be limited to zero, according to a Con Ed spokesman. The spokesman said it is normal for utilities not to be held liable in cases of ordinary negligence.

In small claims courts, in Manhattan and Brooklyn, however, 19 cases have been decided against the utility without proving gross negligence. Judge Myriam Altman of Manhattan civil court ruled that the utility would be held liable unless Con Ed proved that it wasn't negligent.

The Con Ed spokesman said the judge's ruling skipped the issue of gross negligence. Con Edison is appealing the 19 small claims court cases.

The appeals court decision, which is expected by the end of this year, could have bearing on future court decisions in larger cases, according to Howard B. Weinreich, an attorney in the Bronx, N.Y., who has filed "friend of the court" briefs in small claims court.

Those larger cases are 157 lawsuits asking for a total of \$26 million and four class action suits brought for more than \$10 billion.

Of the 19,000 damage claims filed for by customers of the utility, 112 were tried. Of 112, 57 were discontinued or dismissed, 36 were in favor of Con Edison and the remaining 19 were against the utility.

### Class action suits

One of the class action suits, brought by a chain of men's clothing stores, asks for \$306.7 million in damages from Con Edison and New York City for merchants whose stores were looted.

When the lights went out last year for almost 25 hours, riots and looting erupted, which eventually cost the city \$120 million, according to a comprehensive study prepared by the Library of Congress. Total social cost, including damages from looting and rioting, various emergency services, repairs, cleanup and replacement, cost \$136.8 million, according to the study.

The federal study calculated that economic losses in utility costs, spoilage and other government costs amounted to \$172.7 million.

Since the blackout, Con Ed has taken several steps to improve its

services and prepare better for emergencies. The improvements have been made at the cost of \$10 million.

Although the utility first claimed that the blackout resulted from an "act of God," several of the improvements have been made to correct mistakes that others charge led to the blackout last year on a warm summer night.

The utility added supervisory personnel to monitor the transmission cables and repaired a long-broken teline into New Jersey to allow the utility to tap Jersey power during a crisis. In addition, Con Edison installed warning lights in Manhattan to warn of slow current from Upstate New York and a storm watch system so that the bulk of power can be drawn from within New York City rather than upstate. ■

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# Ford's insurance . . .

Continued from page 1

rupture on even minor impact, greatly increasing the risk of fire in an accident. Both Ford and Mr. Grimshaw are appealing the award.

Ford says in the lawsuit it filed here that two other cases have been filed against it asking \$10 million in punitive damages, while a third asks for 5% of the company's net worth as of Dec. 1, 1978. Meanwhile, two young girls were burned to death last month in Ohio in an accident resembling the Grimshaw case in California.

Ford's suit asks the California courts to decide whether 50 of its insurance companies must pay for the punitive damage awards. The automaker says that its insurers have already informed the company that they will not cover the punitive damage judgments. The insurers could be arguing that the Grimshaw case shows the award was made against an intentional act and intentional acts are not covered by insurance policies.

A spokesman for the Ford Motor Co. declined to clarify several details in the documents filed with

the court. "Because the case is pending, we prefer not to reveal details of our insurance coverage," the spokesman said. However, an appendix attached to the Ford lawsuit here gives a detailed account of the company's automobile product liability insurance program from the early 1970s to the present program which will expire on Dec. 15.

Ford carried a \$1 million retention for product liability claims from April 1, 1969, until Dec. 15, 1975, according to the court documents.

A \$1 million insurance policy over the self-insured retention was provided by Lloyd's of London and 10 other foreign insurers from Jan. 15, 1970, until Jan. 15, 1972. At that time The Home Insurance Co. assumed the role as Ford's first excess policy insurer, a role it continued under two separate policies until Dec. 15, 1976. The first Home \$1 million policy was in force from Jan. 15, 1972, until Dec. 15, 1975. The second policy was for one year from Dec. 15, 1975, until Dec. 15, 1976.

## \$4 million layer

Lloyd's and 11 other foreign insurers provided a \$4 million layer of insurance above the \$1 million Lloyd's policy from Jan. 15, 1970, until Feb. 14, 1973. That policy was succeeded by a \$4 million layer provided by Lloyd's, Turegum Insurance Co. and two American excess insurers, First State and Lexington, which expired on Feb. 15, 1975.

At the beginning of the decade, Ford purchased a \$15 million layer of insurance above \$5 million from Lloyd's, the Institute of London Underwriters and a large number of foreign and American insurers. A \$30 million layer in excess of \$20 million was obtained from American Employers' Insurance Co. on Dec. 15, 1969, and ran until Dec. 15,

1972.

On Feb. 14, 1973, Ford obtained a \$15 million layer in excess of \$5 million from Lloyd's and several other insurers including Aetna Casualty & Surety. This layer succeeded the similar layer that Lloyd's and a number of other companies had been providing.

During the first six months of 1972, the documents appear to indicate, Ford restructured its program and increased its coverage to \$100 million above its self-insured retention.

First State Insurance Co. provided a \$30 million layer of insurance in excess of \$20 million from Feb. 15, 1972, until Dec. 15, 1975. This policy appears to overlap with identical coverage furnished by American Employers Insurance Co. from Dec. 15, 1969, until Dec. 15, 1972.

## Increased coverage

Effective July 1, 1972, Ford was able to increase its coverage to \$100 million. The Home Insurance Co. provided a \$25 million layer in excess of \$50 million from July 1, 1972, until Dec. 15, 1975.

Ford obtained that next \$25 million layer in excess of \$75 million from First State Insurance Co. of Boston and five other insurers. The final \$25 million layer in the \$100 million program involved International Surplus Lines Insurance Co., The Home, Continental Casualty Co., Appalachian Insurance Co. and American Motorists Insurance Co.

Ford moved to 12-month policies with Dec. 15 renewal dates for its insurance program on Dec. 15, 1975. The 1975-76 program also marks the first appearance of Northbrook Insurance Co., the Allstate excess and surplus unit that would play a key role in the Ford program over the next three years.

The automaker assumed a \$1.65 million self-insured retention on Dec. 15, 1975, according to the documents. Since Ford did not indicate an expiration for the reten-

tion, it is possible that Ford spent this year attempting to find a buffer layer to reduce its retention to the \$1 million it had earlier assumed.

The Home provided the first \$1 million layer of excess insurance from Dec. 15, 1975, until Dec. 15, 1976, the time period for all the policies in this program. Northbrook furnished a \$4 million layer in excess of the Home policy, along with Lloyd's and a series of 10 other companies.

The 10 other companies that participated with Lloyd's and Northbrook included Dominion Insurance Co., North Atlantic Insurance Co. Ltd., Turegum Insurance Co., London & Edinburgh General Insurance Co. Ltd., Slater, Walker Insurance Co. Ltd., Royal Belge Incendie Reassurance Society Anonyme D' Assurances, SCAN Reinsurance Co., Bellefonte Insurance Co., Yasuda Fire & Marine Insurance Co. Ltd. (U.K.) and Mentor Insurance Co. Ltd. (U.K.).

Ford purchased a \$15 million layer in excess of \$3 million from Aetna Casualty & Surety, National Union, Lloyd's, Midland Insurance Co. and six other insurers. It is not clear whether the overlap between this layer and the Northbrook layer is a typographical error in the documents or part of the program.

The \$30 million layer of insurance in excess of \$20 million was obtained from six companies, including First State, Midland, Granite State Insurance Co., Highlands Insurance Co., American Bankers Insurance Co. and International Surplus Lines. The Home provided \$25 million in excess of \$50 million and then joined the Highlands, Continental Casualty and three other insurers on the final \$25 million layer for this period. The three other insurers on the highest layer were Appalachian, Insurance Co. of Pennsylvania and American Bankers.

Ford moved to its present \$2 million self-insured retention in the program covering Dec. 15, 1976, until Dec. 15, 1977. At that time it

consolidated its first two excess policies as the Northbrook Insurance Co. provided a \$5 million insurance layer over the self-insured retention.

## Excess layers

First State, National Union, Lloyd's and six other insurers furnished a \$15 million layer in excess of \$5 million in this program. Among the six were two insurers not previously on Ford's risks: Puritan Insurance Co. and Mutual Fire, Marine & Inland Insurance Co. Nine companies participated in the \$30 million layer in excess of \$20 million including International Surplus Lines, Insurance Co. of Pennsylvania, National Union, Lexington, Midland, Granite State, Aetna, Puritan and Highlands. The Home, Drake, Puritan, Midland, Lexington, American Reinsurance, Hartford Accident & Indemnity and Granite are among the eight insurers that furnished the next \$25 million layer over \$50 million. Seven insurers were involved in the final \$25 million layer in 1976-77, including The Home, Highlands, Affiliated FM, American Reinsurance, First State, Federal Insurance Co. and American Insurance Co.

Ford's current insurance program runs from Dec. 15, 1977 until Dec. 15 this year. The \$2 million self-insured retention is continued as is the first \$5 million excess insurance policy with Northbrook.

The Allstate unit joins National Union, Puritan, Prudential Reinsurance, Midland, Columbia Casualty and Lloyd's in a \$15 million layer excess of \$5 million. Eight companies provide the \$30 million layer in excess of \$20 million while nine companies participate in the \$25 million layer in excess of \$50 million and seven insurers provide the final \$25 million layer.

The documents do not indicate whether the policies were on an occurrence or claims made basis, or if the policies changed form at anytime.

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## Ford's current program

**\$2 million  
\$5 million excess of primary  
\$15 million excess of \$5 million**

Self-insured retention  
Northbrook Insurance  
National Union Fire Insurance  
Puritan Insurance  
Prudential Reinsurance  
Midland Insurance  
Columbia Casualty  
Lloyd's  
Northbrook Insurance

**\$30 million excess of  
\$20 million**

International Surplus Lines  
National Union Fire Insurance  
Prudential Reinsurance  
Granite State Insurance  
Insurance Co. of the State of  
Pennsylvania  
Midland Insurance  
Highlands Insurance  
Puritan Insurance

**\$25 million excess of  
\$50 million**

The Home Insurance  
Granite State Insurance  
Prudential Reinsurance  
American Reinsurance  
Midland Insurance  
Hartford Accident & Indemnity  
Highlands Insurance  
Columbia Casualty  
Puritan Insurance

**\$25 million excess of  
\$75 million**

The American Insurance  
The Home Insurance  
First State Insurance  
Affiliated FM Insurance  
Federal Insurance  
Prudential Reinsurance  
Columbia Casualty

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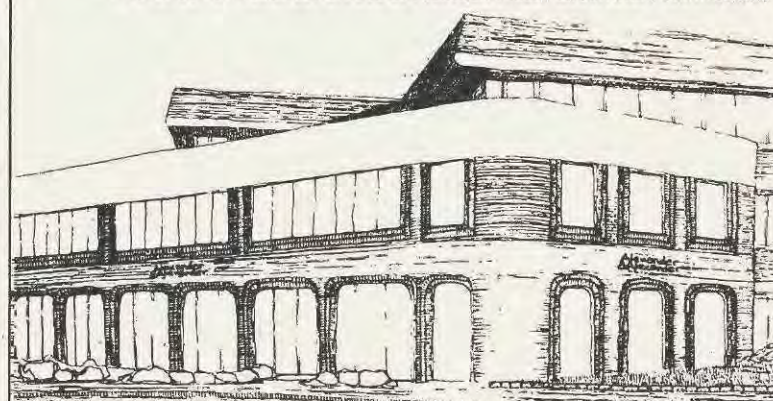
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# Administration plan . . .

Continued from page 1  
 nue Service to administer.

In addition, increasing the carry-back period would result in a better use of business capital since capital would not be segregated in a low-yield special product liability reserve fund.

The Administration recommended that the Commerce Department draft a model product liability law for adoption by states. In drafting the model law, the Commerce Department would decide such issues as how long a manufacturer should be responsible for its products and if compliance with legislative safety standards is an appropriate defense against liability. Although the Administration didn't give a deadline on when the draft bill is to be completed, it is understood that the Commerce proposal will be ready by early 1979.

The Administration also directed Commerce to prepare a provision that would, in effect, make workers compensation the sole source of recovery for workplace injuries. If

a defective product contributed to the workplace accident, the manufacturer of the product would contribute to the workers compensation award.

For example, if a defect in a product contributed 50% to the accident, the manufacturer might pay 50% of the award, with the worker's employer picking up the other half.

## Self-insurance

Finally, the administration called for a report that would evaluate whether product liability insurance problems would be eased by facilitating the formation of self-insurance groups—a hint that the Administration might favor changing the rules making it easier to set up captive insurance companies in the U.S.

The Administration's recommendations come more than 30 months after the federal government first began to get involved in product liability. L. William Seidman, then former President Ford's

assistant for economic affairs, instructed the Commerce Department in January 1976 to perform a crash study of the product liability problem after hearing complaints of Michigan manufacturers.

## 2 reports

In December 1976, an interagency task force on product liability reported that there was no multi-industry nationwide product liability crisis. In November 1977, the task force in its final report said there were three major causes of product liability problems: "panic pricing" by insurers, manufacturers producing unsafe products and uncertainties in the tort litigation system.

In April, the Commerce Department unveiled an options paper on product liability at which time it urged the Administration propose that business be allowed to deduct \$100,000 annually for funds paid into a product liability self-insurance reserve.

The Carter Administration's recommendations are the first time the executive branch has taken a position on product liability issues. ■

# Pregnancy bill . . .

Continued from page 1  
 coming November congressional elections. If not enacted by the end of this year, the bill must retrace the entire legislative path in the new Congress convening in January.

Despite the scarcity of time, backers of the proposal still believe Congress will pass the bill. "Since the bill has gotten this far, approval is likely," said Kathy Miller of the American Civil Liberties Union.

The National Assn. of Manufacturers, which is opposed to the bill in its present form, acknowledged that the bill has a chance of passage. But NAM director of human resources and equal opportunity Annette Fribourg said she was surprised that it has taken Congress so long to resolve the pregnancy benefits issue one way or the other.

Sources said support for the proposal slumped when the anti-abortion amendment was attached to the bill in the House Education and Labor Committee.

After the amendment was tacked on, the National Organization of Women and other women's rights groups dropped their support. The ACLU, while continuing to support the bill, is opposed to the anti-abortion amendment.

## Compromise needed

Sources said it is likely that the Senate would accept the House version of the bill.

But a member of the Senate Human Resources Committee speculated that a "conscience amendment" might be acceptable to the Senate. Under such an amendment, employers would not

be required to include abortion in benefit plans if they had moral or religious objections to abortion.

Under the House bill, employers do not have to give a reason for denying abortion benefits. "An employer could decide not to cover abortion just because the company didn't want to pay for it, not because of religious convictions. The Senate won't accept that," said a committee source.

However, both Senate and House bills would require employers to include pregnancy in their disability plans on the same basis as other sicknesses. An employer that does not have a sick leave program would not have to pay pregnancy disability benefits.

## Other limitations

The bill also would prohibit paid sick leave programs that limit benefits for pregnancy to a shorter period than other disabilities.

In addition, medical and hospital plans would have to be revamped if they covered pregnancy on a different basis than other sicknesses.

The legislation would go into effect six months after it is enacted into law. Employers could not reduce their employee benefit plans for one year after the bill's enactment or until the end of a union contract to pay for the cost of pregnancy benefits. ■

# letters

Continued from page 10  
 to the risk management profession by printing this article.

Mary Finnell

Carson City, Nev.

## Florida pools

To the editor: We read with interest your June 12 story on the AIF fund in Florida, which claimed that this fund is the first "that will cover all risk categories in the State."

We would like to correct this statement since the Florida Construction, Commerce and Industry Self-Insurers Fund, which has been active as a self-insured fund since 1959, began in 1977 to accept preferred risk businesses in all classifications of business, industry and commerce. The FCCI

Fund, with premiums in excess of \$10-million and over 900 member firms, provides advance discounts of from 10% to 14% and this year afforded members with no losses an additional 12% refund.

Gilbert Waters

Administrator, Sarasota, Fla., Florida Construction, Commerce and Industry Self Insurers Fund

## Oops

To the editor: I was particularly intrigued with the percentage increase in benefits stated in your editorial on "Work comp benefits" (April 17). The increase, from an average of \$70 (actually \$64) in 12/70 to \$170 in 1/78 was stated as being an increase of 265%. While it is true that \$170 is 265% of the original \$64 value, the change from \$64 to \$170 is only an increase of 165%.

Evelyn Giovinazzo

Staten Island, N.Y.

Good catch, Thanks.

# people

Continued from page 46

lins Foods, Mr. Poveromo will report to the vp and treasurer. His duties entail the purchase of employee benefit coverage in conjunction with the industrial relations department. He will also head all safety activities. Collins Foods is the largest franchise of Colonel Sanders fried chicken.

\* \* \*

Craig Collings, former vp-insurance for the Western Growers Assn. in Newport Beach, Calif., will become a senior consultant for Ebasco in Newport Beach late this month. Mr. Collings, who had been with the growers association for four years, said he may oversee part of the Growers business as part of his activity at Ebasco.

We'd like to report on staff changes in your risk management or employee benefits department. Just drop a note to Rebecca A. Fanin, Business Insurance, 708 Third Ave., New York, N.Y. 10017 or call 212-986-5050.

# Our excess/surplus report is scheduled for Sept. 18

The winds of change are blowing in the insurance markets, as competition among the primary, more traditional insurers soaks up more risks and forces fewer buyers to run to the excess/surplus lines markets for coverage.

Some excess/surplus specialists are finding their submissions dropping by as much as 50%. Others are sure the excess and surplus markets will remain important to corporate insurance buyers over the long-term, but may play a secondary or "support" role once again in the next year or two.

We'll take a close look at these developments and the outlook for users of excess/surplus lines insurers in our annual Excess/Surplus Lines issue, scheduled for Sept. 18. We'll survey these specialty insurers about areas where their services are still in demand. And we'll present an overview of what's happening to prices in the excess/surplus markets now that insurance coverage is more readily available.

Watch for this special report. Ideas and suggestions for stories and contributed articles are invited. Call or write Susan Alt, Business Insurance, 740 N. Rush, Chicago, Ill. 60611; 312-649-5278.

## Booke merges with Ala. firm

WINSTON-SALEM, N.C.—Booke & Co., a leading employee benefit consulting firm, is merging with John N. Corey Co. Inc. of Birmingham, Ala.

Booke president Walter Steffen said the Birmingham retirement consultants would continue to operate as a division of Booke. John N. Corey, who headed the firm, has been named vp of Booke and resident manager of the Birmingham division.

The merger brings the total number of Booke & Co. offices to four. ■

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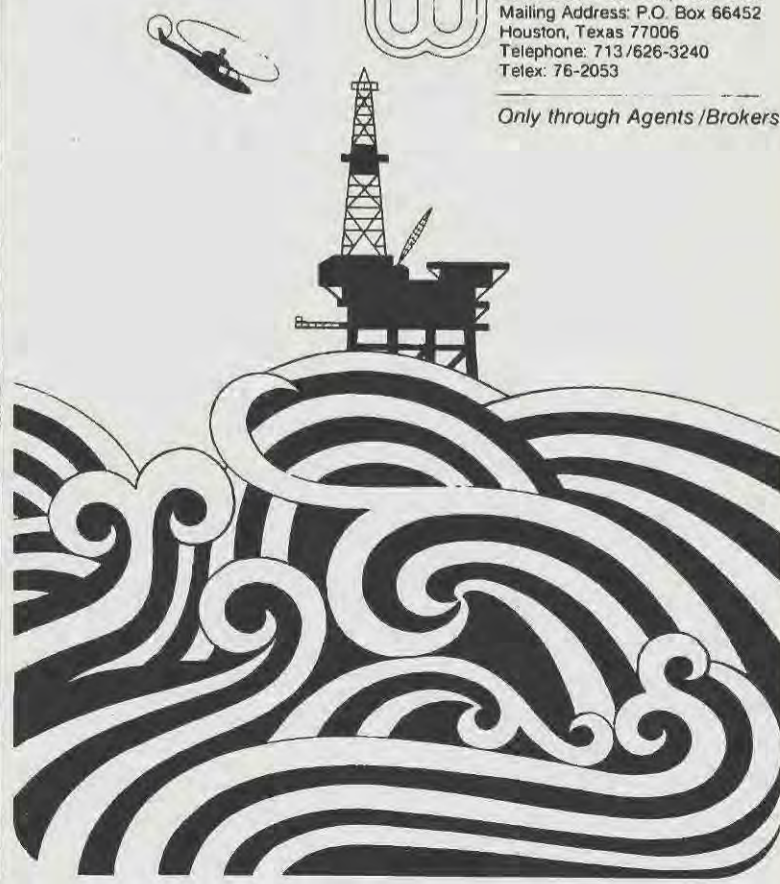
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## people

# Union Camp taps Watson as manager of insurance

Union Camp Corp. of Wayne N.J. has appointed **John G. Watson**, 37, director of insurance. Previously, Mr. Watson spent 10 years with the American Cyanamid Co., also in Wayne, as assistant insurance manager. In his new position, Mr. Watson reports to Harold Hoss, treasurer of Union Camp. Mr. Watson replaces **Ronald Cavalli**, 39, now corporate director of compensation and benefits planning. Replacing Mr. Watson as assistant insurance manager for American Cyanamid is **Murray A. Goldberg**.

**Carl A. DiSalvo**, 48, has been promoted to general manager for the newly created risk manage-

ment department of the Crouse-Hinds Company of Syracuse, N.Y. While his new responsibilities include the safety of personnel and conservation of property for Crouse-Hinds, Mr. DiSalvo continues to perform the duties of his former position as corporate insurance manager. As before, Mr. DiSalvo reports to Robert B. Welsh, vp-finance and treasurer. Mr. DiSalvo worked in various safety and insurance positions for several other firms before joining Crouse-Hinds in 1975.

After a search of almost 2½ months, Signal Cos. of Beverly Hills, Calif., has named **Daniel**



DiSalvo

**Hilder** as its new risk manager. Mr. Hilder replaces Ross L. Oliver,

whose departure was reported previously. Mr. Hilder was risk manager for UOP Inc. of Des Plaines, Ill., a subsidiary of Signal. He has been with UOP since 1965. Mr. Hilder said that it is still uncertain whether he will continue to handle the risk management duties for UOP from his new position in Beverly Hills or whether a new risk manager will be sought.

In a new position at McDonald's Corp. in Oak Brook, Ill., **Thomas B. Garlando**, 40, has been hired as assistant risk manager. He reports to risk manager Jerry Lane. Mr. Garlando previously worked on the

McDonald's account at Frank B. Hall in Columbus, Ohio, for four years. The McDonald's account was recently centralized into Chicago after being serviced regionally.

The Friendly Ice Cream Corp., of Wilbraham, Mass., has appointed **Richard F. Nicoll** as risk insurance administrator, a new position. Mr. Nicoll will report to Raymond N. Hunt, manager of financial planning and analysis for the Friendly Corp. Prior to this appointment, Mr. Nicoll spent 1½ years as risk manager for the Baystate Medical Center in Springfield.

**William Kortz**, 42, is the new corporate insurance manager for the Chromalloy Corp. of St. Louis, Mo. Mr. Kortz joined Chromalloy in May after working 4½ years as claims manager for the R.B. Jones Corporation in St. Louis. His responsibilities include handling the corporation's insurance program and he reports to Tom Monroe, vp of finance. Mr. Kortz's appointment comes after the retirement of Paul Boevingloh, former insurance manager.

The decentralization of risk management functions at Schlumberger Ltd. has created a chain of new positions. **William D. Hughes**, 31, the former risk manager at Schlumberger, left the company to join Estee Lauder in a newly created position as risk manager to centralize the cosmetic company's insurance activities. Mr. Hughes, who reports to James Graham, vp of treasurer operations, coordinates domestic and international risk management, which were formerly handled exclusively by risk managers at both locations.

To replace Mr. Hughes at Schlumberger, **William D. Dodge**, 40, has been named risk manager for two of Schlumberger's companies, Sangamo Weston Inc. and Heath Co. Risk management at these two companies was formerly handled by the holding company Schlumberger Ltd. in New York. Mr. Dodge said risk management was decentralized to make the function more responsive to the operating units. Mr. Dodge is working with controllers, who have been given additional risk management duties, at the operating units to develop, implement and manage a comprehensive risk management and safety program. The risk manager reports to D. K. Grevengoed, controller and treasurer of Sangamo Weston.

Mr. Dodge previously was division insurance administrator for Lockheed Georgia, a division of Lockheed Corp., in Atlanta. At Lockheed Georgia, **Jerry W. Hayes**, 35, has replaced Mr. Dodge as insurance administrator in the financial staff department with property and casualty insurance duties. Mr. Hayes previously was insurance coordinator in the employee benefits department. **Beverly J. Clark**, 33, has assumed Mr. Hayes's prior position, handling auto and dental insurance and retirement plans. Both Ms. Clark and Mr. Hayes report to Robert E. McGoldrick, financial staff manager.

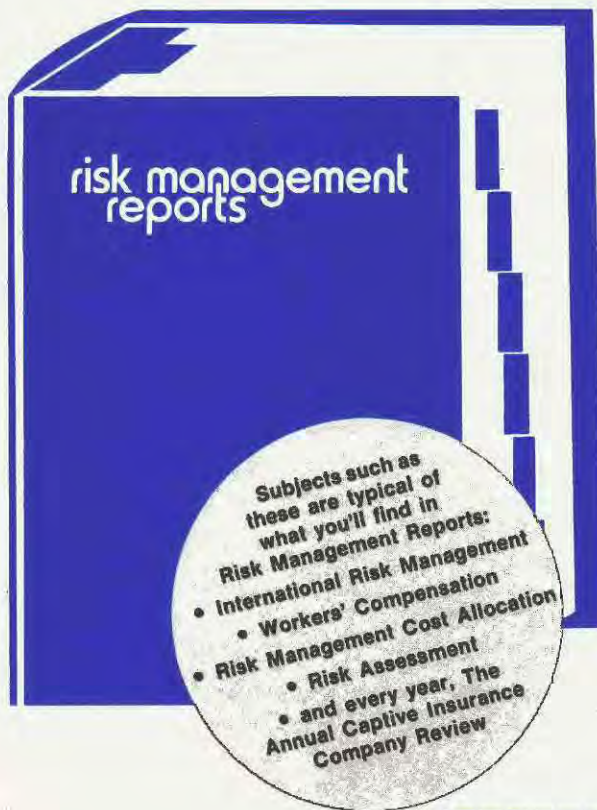
**Victor Poveromo**, formerly insurance manager for Hilton Hotels Corp. in Beverly Hills, Calif., has been named the first director of risk management and safety for Collins Foods in Los Angeles. The position is effective July 31. At Col-

Continued on page 45

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