UAW benefits suit tests state law

By MARY ELLEN McKEE

The big three automakers discriminated against pregnant workers, violating Michigan law, the UAW charges. GM argues the state can't mandate benefits.

DETROIT—Lawsuits charging past discrimination against pregnant employes by the big three automakers could establish whether states can mandate benefits for pregnant employes beyond the federal requirements.

The United Auto Workers Union is suing Ford Motor Co., General Motors Corp. and Chrysler Corp., charging that the companies discriminated against pregnant employes in benefits and employment.

The companies have since altered their benefit programs to comply with the new federal mandate of equal benefits for pregnancy, but the union wants to recover for the past discrimination that was outlawed under Michigan's fair employment statutes.

General Motors, meanwhile, is countersuing, arguing that the Employe Retirement Income Security Act prohibits states from regulating the terms of group benefit plans. A favorable decision in the GM countersuit could get the automakers off the hook for past discriminatory practices and could set a precedent prohibiting states from mandating benefits beyond the federal requirements.

The lawsuits against Ford Motor Co. and General Motors Corp. were filed in January, but the UAW waited until last month to file a similar suit against Chrysler Corp. "We had been having a better rapport with Chrysler compared to the other companies and we had hoped that they would come out of the cold and away from the influence of the other auto companies," noted a union spokesman.

General Motors filed its countersuit in the U.S. district court for the Eastern District of Michigan hoping that the court will "once and for

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Week of July 9, 1979

business insurance

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

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Budget office kills Commerce-devised product risk pools

By JERRY GEISEL

WASHINGTON—The Carter Administration won't support the Commerce Department proposal to let businesses pool their product liability risks through federally chartered insurance cooperatives, *Business Insurance* learned.

The Office of Management and Budget, which must approve major domestic initiatives before the White House will act, has rejected the proposal even though business groups had recently endorsed it.

OMB turned its thumbs down because it was not convinced the plan would benefit the business community as much as the Commerce Department claimed.

At the same time, however, OMB gave the Commerce Department the green light to develop draft legislation permitting companies in the same or similar industries to purchase product liability insurance on a group basis, which the Commerce Department says could cut insurance costs, especially for smaller firms. Some states bar unrelated businesses from purchasing insurance on a group basis.

The risk pooling proposal, however, still clings to a slender thread of life.

Although unlikely, OMB could change its mind. The Commerce Department could also lobby the White House to overturn OMB's decision, but the chances of that are remote. And Rep. John LaFalce (D-N.Y.) plans to introduce the Commerce Department proposal in Congress, but the proposal's chances without Administration support are unknown.

OMB's rejection of federal chartering of insurance cooperatives came just as business seemed to be warming to the idea. The Risk & Insurance Management Society (RIMS) wrote OMB director James T. McIntyre urging the Administration to support the concept because it would "promote an ele-

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The inside story

Insurance in 2004

Buyers may shop more often through direct writers in the next 25 years, says Tom Johnson, interpreting results of a study that looks at the future of insurance in the U.S. **Page 6.**

Disability plan doubts

Disability benefits under Social Security must be cut if the fund is to have enough money to pay retirement benefits, says commissioner Stanford G. Ross. **Page 18.** Meanwhile, disabled workers collect benefits under so many plans they can get more in disability benefits than from working, finds a study by the Health Insurance Assn. of America. **Page 21.** Insurance company executives, however, dispute that other disability benefit plans pay so much as to take them off the hook for paying any significant benefits under LTD policies. **Page 21.**

John Kuhn
Industrial Ins. Agency Inc.
2600 N. Mayfair Rd.
Wauwatosa Wi. 53226

in

N.Y. exchange envies Lloyd's inside track. . .

By ELLIS SIMON

NEW YORK—When the New York Insurance Exchange finally breaks from the gate this fall, risk managers may still bet on Lloyd's of London to keep the lead as the more efficient market.

New York exchange backers aren't planning to run a tight race for business with Lloyd's in the first laps as a new market, but some are complaining that the New York market is saddled with a handicap that will send U.S. buyers more readily to Lloyd's than New York.

So far, 13 syndicates and 33 brokers have been accepted in the exchange, including some of the biggest names in the commercial insurance business.

Under the state law passed a year ago authorizing creation of the insurance exchange, direct domestic business can come to the exchange only after being "filtered" through the New York Free Trade Zone. That's a time consuming restraint.

The Free Trade Zone, which permits specially licensed N.Y. companies to write large premium and certain exotic risks without prior approval on rate or form, was created by the same act of the state legislature as the exchange.

The 13 underwriting members and 33 broker members of the exchange gather July 9 at the headquarters of Chase Manhattan Bank to elect the first board of governors for the "American Lloyd's." The underwriters will elect six of the governors, the brokers will elect two and the remaining four members will be public representatives, chosen jointly.

The fall startup of the insurance

Continued on page 48

Photo: George Poulous

N.Y. legislators didn't plan for direct access to the insurance exchange, says Albert Lewis.

. . . Illinois, Florida train to join the markets race

CHICAGO—Industry backing for an Illinois Lloyd's of London style insurance exchange is building slowly, but it is still a far cry from the unanimous approval the bill creating an exchange here received in the senate last month.

Meanwhile, a bill calling for the creation of a similar insurance exchange in Florida after its economic viability is determined by the insurance commissioner is awaiting the signature of Florida's governor. Florida's study-first approach is radically different from the way New York quickly authorized its own insurance exchange, a pattern now being followed in Illinois.

The insurance industry has remained very quiet about the developments in Florida, but it considers the study approach a much more rational and safer tactic than Illinois's, an industry observer noted.

Politicians looking to the Illinois exchange as an opportunity to bring more jobs and business into the state have strongly supported the bill since it was first introduced in the House in April. The bill, sponsored by Bernard E. Epton (R-Chicago), kept that economically motivated backing when the Illinois senate approved the bill 162 to 0 on June 27.

"Strong support up front from the industry has been so slow coming in Illinois for several reasons," said an attorney for an Illinois-based company. "Insurers and brokers, especially those domiciled in Illinois, are torn between a realization that an insurance exchange would be a very good thing for the state economically and a reluctance to mimic a concept that has not yet been tested in New York," the attorney added.

Many insurance companies also object to the low minimum premium required for entry into the Illinois exchange, which is set at $50,000 (*BI*, April 30). "That's just too low a premium to attract the kind of business a Lloyd's of London style operation should entertain," complained David E. Brown,

Continued on page 48

UAW suit rides . . .

Continued from page 1

all" settle the muddy legal question of whether states can prescribe requirements for benefit plans beyond federal requirements.

"GM's suit seeks to have the court declare that the federal ERISA precludes Michigan fair employment statutes from regulating the terms of its welfare benefit plan," said a spokesman for GM. General Motors filed the suit to force a definitive federal judicial ruling on ERISA's impact on state benefit mandates prior to the 1978 amendments to Title VII of the Civil Rights Act of 1964, the GM spokesman added.

"Since April 29, 1979, GM complied with Title VII amendments which require that disabilities caused by pregnancy be treated the same as disabilities caused by sickness and accidental injuries," the GM spokesman asserted. Spokesmen for both Chrysler and Ford echoed GM's concerns and viewpoints, but neither plans to countersue the union.

Instead, both are waiting for the federal courts, which are divided on the issue of ERISA preemption, to make a decision. "We will comply fully with whatever the courts decide is legally required in this area," said a Ford spokesperson.

The class action suits were filed in Wayne county circuit court on behalf of all current, past and future women employes at the companies' Michigan plants who have been subjected to the discriminatory practices, a union attorney explained. The union and women employes charge that GM, Ford and Chrysler have "maintained a pattern and practice of discriminating on the basis of sex in all matters relating to pregnancy," the attorney said. The discriminatory practices as outlined in the UAW suits against the automakers are:

- Limiting sickness and accident disability benefits for pregnancy to six weeks while providing up to 52 weeks of benefits for other disabilities.

- Providing extended benefits for workers affected by disabilities or complications except those relating to pregnancy.

- Failure to provide pension credits for periods of pregnancy-related sick leave lasting more than six weeks.

- Failure to permit permanent partial work restrictions for pregnant workers on the same basis as for temporarily partially disabled workers.

- Requiring pregnant workers to provide more proof of disability to qualify for sickness and accident disability benefits than they require of other workers with non-work-related temporary disabilities and greater proof of complete restoration to health for return to work after pregnancy.

- Failure to provide certain sickness and accident-related fringe benefits to women workers on leave for a pregnancy-related disability although such benefits are provided to other workers at company expense.

- Failure to provide certain benefits under the hospital-medical-surgical prescription drug programs for pregnancy, childbirth or related medical conditions while providing such coverage for other medical conditions. ■

Coming up

. . . *Business Insurance* will publish its annual Excess/Surplus Lines issue Sept. 17. In this issue, *BI* editors take a closeup look at the specialty markets for high-risk and high-limit insurance, the demand and supply of these coverages, the costs of insurance underwritten by excess and surplus insurers and the underwriting requirements for retentions and underlying coverage.

Story ideas and proposals for contributed articles are invited. Contact Susan Alt or Kathryn McIntyre, 740 N. Rush St., Chicago, Ill. 60611 (312) 649-5278.

. . . The *Business Insurance* Product Liability Score Card, detailing the progress of tort reform around the country, will be published in the July 23 issue.

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BI promotes 3 editors in weekly plan

CHICAGO—Three *Business Insurance* editors were promoted July 1, strengthening the staff in preparation for making the transition in six months to a weekly news publication, according to Susan Alt, editor.

McIntyre

Kathryn J. McIntyre was promoted to managing editor from news editor, a position she has held for eight months. Ms. McIntyre joined *BI* in January 1977. As managing editor, she is responsible for making assignments, editing, coordinating production of the newsmagazine and assuring that reporters meet their deadlines.

Strazewski

Geisel

Jerry Geisel, who also joined *BI* in early 1977, was named Washington editor. Mr. Geisel has been the publication's associate editor covering Washington since he joined the magazine.

Len Strazewski, associate editor in charge of the demographic section, Agent/Broker Topics, was promoted to features editor. He will continue to be responsible for the demographic section through yearend, and has been put in charge of planning and coordinating the Perspective section of *BI*, in which contributed articles and other types of features appear. In this position, he will also assist in planning and coordinating special emphasis issues. He joined *BI* in October 1978. ■

errors & omissions

- Richard V. Porrett is president of a consulting firm named Risk, Audits & Control Inc., incorporated in June 1978 in Wilmington, Del. *Business Insurance* had said in its May 31 issue that the firm could not be located.

for your information

Morning newspaper delivers Skylab policy to subscribers

SAN FRANCISCO—If Skylab falls on a subscriber to the San Francisco Chronicle newspaper, he/she will be covered for up to $100,000 for death or dismemberment and the same amount for property damage.

The personal injury insurance is underwritten by Lloyd's of London to an aggregate $500,000 through A.C. Newman, Lloyd's correspondent, and the property damage is covered by Massachusetts Indemnity Insurance Co., up to an aggregate limit of $1 million, through the Don Sherwood Agency.

Both policies were arranged through the Chronicle's broker here, Johnson & Higgins, for "a reasonable premium compared to the limits of exposure," according to William apHugh, insurance manager for the Chronicle. The newspaper announced the policy after its evening competitor, San Francisco Examiner, offered a $10,000 reward to the first person who brings to their offices a certifiable piece of Skylab after it falls.

Personal injury portions of the policy are in effect from July 1 to August 15 and the property portions for the month of July, "but we have oral assurances we can get extensions until Skylab comes down," Mr. apHugh said.

Self-funded trusts await letters

WASHINGTON—The Department of Labor is expected to "soon" release long awaited opinions to multiple employer trust administrators who have asked what their status is under the Employment Retirement Income Security Act.

State insurance regulators, especially those in California, Oregon and Washington where trusts have grown significantly, hope the opinion letters to be sent to the trusts will finally settle whether multiple employer trusts are unlicensed insurers subject to state law or bona fide ERISA plans, regulated by the federal government.

District courts in Arizona, Kansas and Oregon have already sided with the insurance departments ruling that the trusts were unlicensed insurers. A recent decision by a California district court, however, ruled that a trust, Insurance & Prepaid Benefits Trust, was a bona fide ERISA plan.

Trust observers, however, are now questioning whether a hard and fast decision on the trust's status was really made by the California court since the decision did not arise from a complaint from an aggrieved insured.

No grounding insurance demand

CHICAGO—Despite airline losses mounting at $50 million a week during the grounding of the nation's DC10 jetliners, airline and insurance industry sources are skeptical the event will create a demand for the applicable business interruption insurance, largely because a grounding of an entire class of airliner is so unusual.

Leading aviation underwriters at Lloyd's of London report no requests for business interruption coverage since the June 6 grounding. The policies of most major air carriers are not up for renewal until next year, "and it will be at that stage if (business interruption insurance) comes up at all," said a Lloyd's spokesman.

An executive of an airline using the wide-body jet predicted some airlines will inquire about the coverage, but will not buy it, deciding the premiums are too high. "They'll decide, 'The hell with that, we'll just take our lumps,'" he said.

But John Seear, a director with Laker Airways in London, predicted airlines will demand some type of insurance against grounding losses. "I think that it will stimulate a market similar to hijack insurance and a new market will be created."

The May 25 crash of an American Airlines DC10 near Chicago's O'Hare International Airport killing 274 persons precipitated the DC10 grounding and has altered the statistics underwriters use to assess risk possibilities. Jack H. Hine, president of the International Union of Aviation Insurers, said recently that the loss interval for losses of wide-body jets has decreased to 1.1 million flying hours compared with 2.7 million flying hours about a year before the crash.

Insurer forgives Hall's mistakes

OMAHA—Empire Fire & Marine Insurance Co. will continue doing business as usual with Frank B. Hall & Co.'s San Antonio specialty risks operation, despite Hall's discovery and disclosure that funds weren't being remitted properly to Empire and some other insurers.

Empire, with whom Hall's specialty risk operation in San Antonio placed most of its coverage, wasn't even aware of what was going on until about April, when Hall voluntarily told Empire about $2 million was owed by Hall to the insurer (*BI*, June 11).

"Nothing was amiss from our point of view, relative to our policies," said William D. Brecht, executive vp of Empire, based in Omaha. "It irritated us when we first found out, but Hall has handled it in a very ethical way. It doesn't affect in any way our willingness to work with Frank B. Hall & Co. I feel better about this now than I did some months ago."

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Florida wage-loss law

Agent lobbyists plot profit cap revision

By LEN STRAZEWSKI

ORLANDO, Fla.—Even before Florida's new wage-loss workers compensation law goes into effect next month, lobbyists for the new law are planning their campaign to revise it.

The Florida Assn. of Insurance Agents, which supported development of the wage-loss concept, now claims that the Florida legislature overreacted to the cost control mandate with an excess profit provision that is too restrictive.

"Excessive profits provisions in reform legislation is not unusual," explained FAIA legislative director Buddy McCue, "but the provision included in the wage-loss bill is unique in that it limits profits from investment income."

The profit limitation (*BI*, May 28) caps insurers' profits at an annual average of 7.5% over a three-year period, with a 5% cap on investment income earned on reserve funds and 2.5% cap on underwriting profits.

"What we will be doing is trying to point out to the legislature that reserve practices vary from insurer to insurer and are not integral to the ratemaking," said Mr. McCue. "Investment income is usually equity returned to the stockholders and varies according to the policies of insurers, some of whom intentionally reserve heavily and others who reserve minimally to keep the funds in other investments."

Limiting investment income may achieve the opposite market effect desired by the state legislature and limit the voluntary workers compensation market, according to Mr. McCue. "In my opinion the excessive profits provision will have a detrimental effect on the voluntary market and deter insurers who may want to use a retrospective rating program. The clause will send many employers into JUA," the state assigned risk pool.

The assigned risk pool already covers 40% of the state's employers, a result of a tight market that the wage-loss legislation was designed to remedy.

"Losses will be cut, of course, but the workers compensation market in Florida will not revert to an open market situation," predicted Mr. McCue.

The agents are also unhappy with the formula adopted for determining wage-loss benefits. They consider too high the guarantee to compensate a permanent partial disability case for 95% of the wage-loss if at least a 15% wage-loss is suffered after a disability.

"Agents must view this formula as too high," explained Mr. McCue, "because in some cases it will encourage employes to not to return to full-time work. Obviously it is likely that a person working only part-time can be compensated to a level that will be higher than his after-taxes income from the job full-time."

The FAIA and Associated Industries of Florida, the state employer group, had originally proposed compensation based on an 80% to 80% ratio and "fought labor tooth and nail," but lost.

Other clauses in the bill are expected to come under attack and eventually be reviewed by the courts, according to Mr. McCue. The impairment schedule going into effect this month is "peanuts," he said, and is certain to be tested quickly in the courts. "The schedule for lump sum payouts has been put on a very, very restrictive basis, limited pretty much to amputation and blindness," he explained. "The bill sets up a series of arbitrary classifications which in my opinion will get knocked out by the courts."

Classifications deemed arbitrary by the courts do not have a good track record in Florida and similar designations included in the state's no-fault automobile insurance law were overturned.

Though a shearing provision in the new law allows amendments without rewriting the whole bill, the structure of the legislation could be upset by small revisions, he observed. One likely target of the courts, however, will not influence rates and markets at all. Sure to be tested, according to Florida agents, is the provision that demands that claim appeals be filed in the 1st District Court of Appeals, based in Tallahassee.

"This provision forces travel to the capital for no apparent reason and will be tested, probably forcing a change in the appeal system to local courts," he said. ■

Limits on insurers' profits in the Florida wage-loss law are unfair, says Travelers vp James Holland (right), but plans to amend the law are underway, according to FAIA lobbyist Buddy McCue (left).

Fla. profit limits discourage workers comp underwriters

By MARY ELLEN McKEE

CHICAGO—Only one insurer so far intends to start writing more workers compensation insurance in Florida because of the new, reformed wage-loss law.

Other major insurers of workers compensation in the state first plan to learn to live with the law before loosening their underwriting. They are eager to set the new law in motion despite qualms about the harshness of some of the provisions over insurers' profits.

The new law overhauling the system to cut workers compensation costs mandates a 15% rate reduction Aug. 1 and caps insurers profits at an annual average of 7.5% over three years.

Aetna Life & Casualty, the third largest writer of workers compensation insurance in Florida, is the lone company planning to go after more workers compensation business as a result of the reformed law. The company expects to increase the number of policies it issues in Florida by 10% by the end of the year, according to Larry K. Rand, a director in the company's commercial insurance division.

"Since the bill is an experimental thing, our company does not feel compelled to go after more business in Florida," said Charles A. McCallister, vp and assistant general manager for Florida Farm Bureau Insurance Co., the fifth largest workers compensation underwriter in the state in 1978. "Even the strong proponents of the bill admit that the bill may have to be revisited several times in the legislature before it is totally workable."

"Florida provides a tremendous opportunity for both the insurance industry and employers to prove that meaningful reform can work," noted James J. Holland, director of product management for Travelers Insurance Co. "Travelers will spend its first year under the new legislation concentrating on prompt and fair payments to injured workers and trying to build a sound workers compensation market with affordable prices."

"It's vitally important to the future of workers compensation business in Florida that insurance companies display good faith now in meeting the provisions of the bill, even though some of those provisions are harsh and unfair to insurance companies," Mr. Holland said.

Mr. Holland objects to the mandated 15% rate reduction and the excess profits limitation in the law. His colleagues at Employers of Wausau, Liberty Mutual, Aetna Life & Casualty and The Hartford Insurance Group echo his doubts about the fairness of such provisions.

"Harshness of two provisions, however, should not get in the way of meaningful reform," Mr. Holland warned. "The trick is to show the legislators and business groups of the state that the insurance industry is willing to compromise when working to improve the workers compensation system," Mr. Holland said. "By displaying willingness to shape a system that works the way the legislators intended it to, the insurance industry gains credibility and leverage in the process. Once legislators are aware that the insurance industry tried to work under the legislation, years down the line they might be more receptive to reconsidering the provisions and consequently lift the profits restriction."

Unlike Mr. Holland, United States Fidelity & Guaranty Co. president Jack Moseley fears the 7.5% cap on insurers' profits on reserve funds and underwriting will threaten financial incentives for insurance companies to aggressively compete for business in the state.

"Provisions on rate reductions and profit restrictions create financial uncertainties for companies," Mr. Moseley explained. "That's just bad business."

Meanwhile, The Hartford Insurance Group is "continuing to assess the opportunities and pitfalls of writing workers compensation business in a brand new environment such as Florida," but will make absolutely no commitments about future marketing strategies or volume there. ■

the benefit beat

Rubber workers stretch wage/benefit guidelines

More than 55,000 members of the United Rubber Workers Union won substantial increases in wages, pension payments and health care benefits from the nation's tire manufacturers in a settlement that apparently far exceeds Jimmy Carter's wage and price guidelines. Three-year pacts, so far agreed to by B.F. Goodrich, Uniroyal and Firestone and still being negotiated by Goodyear, could raise compensation for employes by as much as 40% over the next three years.

The tentative agreement ended a month-old strike against Uniroyal, during which the walkout by 8,300 employes idled the Akron plant.

Under the standard plan, first agreed to by Goodrich and then by the other two tiremakers, pensions for current employes will be raised to $15 a month from $12.50 a month per year of service. For those already retired, pensions will be raised $1 a month.

The Goodrich "master plan" also raises the benefits for outpatient treatment to $450 from $300, for physical therapy to $1,150 from $750, and for major medical care to $300,000 from $200,000. The contract also provides allowances for doctor's visits at a hospital of $25 for the first day and $17 for each additional day. Costs of chiropractic care are also covered by the contract.

Goodrich self-insures its health plans and pays all the costs of the pension program for its 9,600 workers.

The contract also gave employes increased company contributions in the supplemental unemployment fund and the right to retire at age 55 with five years of service and at any age after 25 years with the company.

ASO contract

Metropolitan Life Insurance Co. beat out five other companies in a bid for an administrative services only (ASO) contract on a dental program covering approximately 67,000 civil servants of the state of Michigan. Costs of the contract for the state are estimated at $10.14 monthly for each of the 57,000 employes and their families currently enrolled in the plan.

The dental plan pays 100% of the cost of diagnostic and preventive services and 50% for restorative services but excludes orthodontia coverage. There are no deductibles under the plan and the maximum benefit is $750 yearly.

Alcohol rehabilitation

Blue Cross/Blue Shield of Greater New York has begun offering optional alcoholism rehabilitation coverage to its 2,100 experience-rated group clients. The rider provides a maximum of 30 days inpatient care and 30 days outpatient visits at approved facilities. The benefit is in addition to the five days inpatient alcohol detoxification benefit currently provided under Blue Cross/Blue Shield's regular coverage.

Employers providing the coverage will be charged 60 cents per month for individual subscribers and $1.16 per month for family coverage. The 60-day benefit will be available for two 12-month periods during a patient's lifetime.

ESOP for pensions

The Noral Corp. of Chicago has begun an employe stock option trust as a retirement plan for its 30 salaried and administrative employes. The firm, a graphic arts supplier, will make all contributions to the plan up to 15% of gross payroll based on Noral's financial performance. Under the plan, Noral takes the fund contribution, reinvests it in company stock, facilities and equipment and will be able to claim a reinvestment tax credit on capital equipment expenses along with a corporate tax credit.

Vesting in the fund increases at the rate of 10% a year and an employe is fully vested after 10 years. Under the trust, an employe earning $40,000 and fully vested could collect $100,000 worth of profit sharing, stock and stock dividends when he/she quits or retires. Unionized employes at Noral already have a retirement system and did not join the plan.

•

Benefit Beat keeps risk managers and employe benefit managers abreast of changes in plans around the country as well as other important developments. We'd like to know if you've made any changes or know of any significant development. Write Kathryn J. McIntyre, Business Insurance, 740 N. Rush St., Chicago, Ill., or call (312) 649-5286.

Mich. bar owners tap Cayman captive

By JERRY GEISEL

BAY CITY, Mich.—When liability insurance premiums began to soar a couple of years ago, Michigan tavern owners didn't drown their sorrows at the bar.

Instead, the Michigan Licensed Beverage Dealers Assn., the trade group that many of the hard hit bars belong to, began to explore alternatives to paying insurers rapidly escalating premiums.

Bob Wieland, chairman of the trade association's insurance committee and owner of a bar here, spent more than a year talking with consultants and management groups and surveying members' loss experiences to come up with an alternative insurance program.

The result: They tapped the captive option. A new Cayman Islands-based insurance company, National Liability & Business Assurance Ltd. (NLBA) was formed under Mr. Wieland's direction and is owned by 26 members of the beverage dealers trade group.

NLBA offers policyholders two basic types of coverage to Michigan establishments that hold liquor licenses. One provides protection against suits brought under the state's strict dram shop liability law. That law allows customers to sue a tavern owner if they suffer injuries as a result of having too much to drink in his bar. The second policy covers general liability risks, including product liability.

Both policies offer first-dollar coverage to per occurrence and aggregate limits ranging from $25,000 to $300,000. Policyholders who want more than $300,000 of protection can buy excess coverage through Ward S. Campbell Inc. of Grand Rapids, NLBA's managing general agent.

NLBA is taking the first $50,000 of risk and losses over $50,000 are insured by INA, which is writing the policies and reinsuring the lower layer with NLBA. INA also is providing claims administration and adjusting services to NLBA, which is managed by Cayman Underwriters Services Ltd.

NLBA, which issued its first policy in February, now has 175 policyholders. Mr. Wieland expects the number of policyholders to jump to about 1,000 by next February.

Premiums this year should be "quite a bit" over $1 million, Mr. Wieland said. In five years, the premium flow could be as much as $6 million coming from as many as 4,000 policyholders.

The size of premiums paid into NLBA range from $1,800 to $5,000, with the average at $2,200. Policyholders' premiums are comparable to what they were paying for coverage in the conventional market.

Insureds with the captive expect to draw savings in the future, predicting NLBA will keep premiums stable while insurers will keep jacking up liability insurance premiums for bar owners, Mr. Wieland said.

The key to keeping premiums stable is an aggressive loss control and safety program. A risk management and safety committee has been established to instruct new policyholders on how to minimize potential liability exposures as well as to advise them on how to quickly and fairly settle a claim to prevent it from turning into an expensive lawsuit.

NLBA got its start more than a year ago after 1,200 members of the Michigan Licensed Beverage Dealers Assn. contributed $100 each to begin a study of alternative insurance methods.

At the time, insurance premiums for Michigan bar owners kept "going up and up," Mr. Wieland recalled. At Mr. Wieland's bar, for example, his premium climbed from $1,200 to $8,700 over five years. Other bar owners had their policies cancelled arbitrarily, added Ike Dobre, vp and treasurer of Ward S. Campbell Inc.

As a first step in probing for a solution to bar owners' insurance problems, Mr. Wieland contacted other trade groups that recently established their own insurance companies. Later on, the Michigan bar owners hired RIMCO, a Dallas-based risk management consulting firm, to assist with the feasibility studies.

Photo: Jerry Geisel

The high costs of liquor liability coverage prompted the captive plan, says bar owner and association insurance chairman Bob Wieland.

The studies revealed that there was sufficient interest and financial support to start a group-owned insurance company. The studies also indicated that insurers may have been in some cases, "panic-pricing" their policies because paid claims only amounted to a fraction of what bar owners were paying in premiums, Mr. Wieland said.

The Cayman Islands was selected as NLBA's home because an insurance company can be set up there quickly and easily. Bermuda, the most popular offshore captive haven, is so "terribly crowded" there are significant delays in getting a group program started, said Klaus Gebhardt, president of RIMCO International.

Originally, NLBA the 2,700-member Michigan Licensed Beverage Dealers Assn. was to own NLBA. However, the plan was shelved because of the complex legal and tax problems of a non-profit association owning an insurance company, Mr. Wieland said.

Instead, it was decided that individual members of the trade group should own NLBA. However, NLBA is structured in such a way that the individual owners are not liable for losses nor can they rake in underwriting profits. If NLBA does show a profit, it will be reflected in lower premiums to policyholders rather than being distributed as dividends to owners.

NLBA was started with about $500,000 of capital and paid-in surplus. That figure already has risen to about $1 million and is expected to climb to $2.5 million, said Mr. Gebhardt of RIMCO.

Since NLBA began, several other state beverage dealers associations have expressed an interest in starting similar programs. If NLBA is successful, there is a possibility that one day there might be a national program to cover bars. ■

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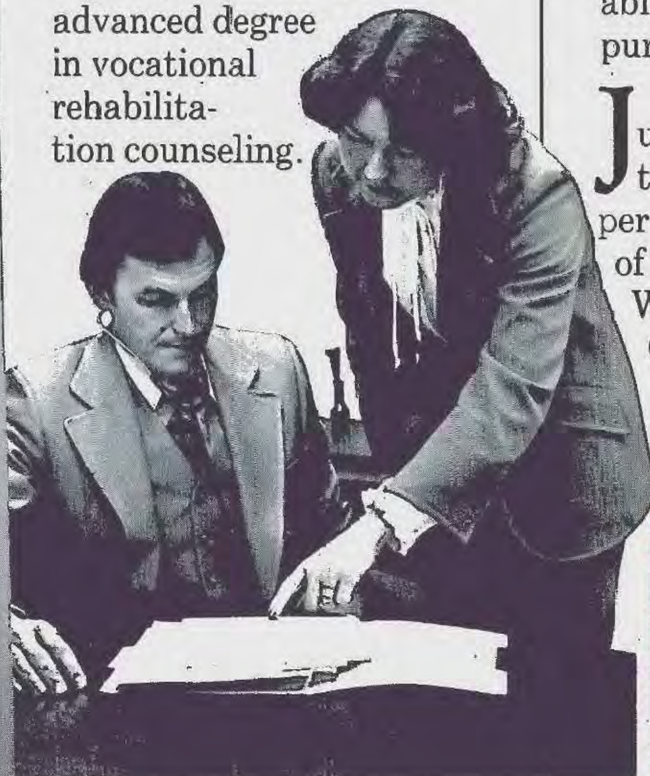

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U.S. insurers face only small losses in Iran takeover

By JOHN MAES

CHICAGO—U.S. insurers in Iran are barely wincing under the nationalization of insurance companies because their investments there are relatively small and all expect some compensation from the Iranian government.

Ironically, none of the companies carry expropriation insurance because the potential losses are small enough to fall within the self-insurance capacity of the firms, according to insurers.

Insurers not only expect payment from the Iranians for their investments but also that the government will want the American-trained Iranian personnel to continue in administrative and management roles. Few Americans have actually worked in the Iranian firms and all were evacuated during the governmental overthrow in February.

American International Group (AIG), which owns 35% of the Iran-American Insurance Co. in Tehran, stands to lose the most from the nationalization late last month. AIG invested $3.5 million in the Iranian firm four years ago when the government first allowed private investment in its insurance companies, said John Verel, director of investments for AIG.

Also holding interests in Iranian insurance companies are INA Corp. with a 20%, $300,000 investment in the Shargh Insurance Co. and The Continental Corp., which owns approximately 10% of the Hafez Insurance Co., also of Tehran. Continental's investment in Hafez totals about $750,000, according to a company spokesman.

British, French, German and Italian assets have been seized along with a Soviet insurance firm.

"We're the largest American insurance interest in Iran and our investment is quite modest to be sure," said AIG's Mr. Verel. "It's unfortunate, but it's by no means a material event to AIG financially," he said. "We will seek prompt and fair compensation to the extent our interest appears in the company."

Losing investments to nationalization is nothing new to the AIG, which has mostly small-scale interests in 130 countries, said Mr. Verel. Last year, Nigeria informed AIG it was taking control of all insurance operations in the country and AIG is still negotiating a price for sale of its interests to the Nigerians, he said. AIG's investment in a Pakistani insurance firm was also seized during a nationalization in the early 1970s, but AIG was fairly compensated, Mr. Verel noted.

Once the nationalization in Iran is complete, Mr. Verel said it's possible the government, lacking expertise, may ask AIG to continue to provide the same reinsurance, claims adjusting and engineering services it has provided its clients all along. "It happened in Nigeria and it's not uncommon after nationalization that the new owners may turn to us and ask us to provide them with management services," he said.

H. Donald Lindell, senior vp for the international division of the Continental Corp., said the Iranian moves are "much ado about nothing because it won't impinge on our balance sheet."

Continental earned its first underwriting profit from its interest in Hafez in 1978, he said.

Mr. Lindell expressed some concern whether services to clients will be disrupted or delayed by the nationalization. Although most multinational firms in the country haven't operated since the government overthrow, many local businesses such as hotels insured by Hafez are still in service. "We're concerned about how we'll be able to handle them," he said. ▪

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- ☐ Does your policy limit loss to damages by definition, and exclude non-pecuniary claims?
- ☐ Does your policy by definition exclude employee benefits liability losses?
- ☐ Does your policy include outside persons as insured fiduciaries?
- ☐ Does your policy contain a limited retroactive acts exclusion?
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editorial opinions

Rely on people, not machines

WORKERS TURN OUT shoddy goods because management expects them to, says sociologist Robert Cole of the University of Michigan. A year of studying the Japanese work environment led him to the conclusion that quality control in this country is poor precisely because more reliance is placed on inspectors and machines to produce perfect goods than is placed on workers themselves.

The more an operation relies on machines to correct problems and on inspectors to find faults, the less incentive there is for workers to do the job right, he says. Engineers, who often have the goal of designing idiot-proof systems, insult workers and show contempt for their abilities, he believes.

Though he acknowledges some inherent problems in the methods the Japanese use for involving workers in their operations, Mr. Cole thinks there's some merit in using small groups of 10 or so workers to discuss quality control and production problems within their department.

We suggest, further, that perhaps product safety committees should include workers involved with day-to-day production problems related to quality control efforts.

Kudos to double-duty execs

SEVERAL NOMINEES for Risk Manager of the Year this year were corporate executives spending only part of their time on risk and insurance management duties. Of course, many managers responsible for risks and insurance have many different jobs, including insurance and risk management programs.

We were glad to see these people nominated. Many times corporate or administrative officers practicing risk management are innovative in their problem-solving approaches. We intentionally opened up the competition when it was begun to people with myriad tasks and responsibilities, recognizing that they often do as much as anyone to further the profession of risk management. In fact, it's often said that the company president (or chairman) is the real risk manager of every firm.

Undeniably, in the evolution of many companies, it was the financial or administrative manager who saw the need for good risk management, who created a full time position for a risk manager and then brought the department along.

Though the cash conservation aspects of risk management may be more important to very large corporations, the existence of a good, workable, basic risk management program often spells the difference between life and death for smaller firms.

Three cheers for corporate executives and administrators who cope with risk/insurance management tasks along with a lot of other jobs.

Price of life

EMPLOYERS KNOW ALL too well the price of life is dear; workers compensation benefit levels reflect the rising value of lives and limbs. Now the Highway Traffic Safety Administration estimates that the cost of a life lost in a motor vehicle accident in 1975 was nearly $290,000.

Is it any wonder that more people are trying to claim against employers, manufacturers and insurers for the loss?

The NTSA figures this number includes about $212,000 in lost production and consumption in the marketplace (we assume this represents lost wages); $63,545 loss to the home, family and community; $275 for the hospital (sounds low); $160 for doctors; $925 for a funeral; $2,190 for legal expenses; $295 for handling insurance claims; $80 for accident investigation; $3,685 for losses to others; $3,990 in car damages; $80 for delay of traffic (now where did that come from?), and $130 for the coroner.

"I think it will fly Orville, but where will we park it?"

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Lloyd's can tutor

To the editor: By way of comment referring to William L. Doran's question (Letters, May 14) as to the necessity for syndicates of the New York Insurance Exchange to recruit underwriters from the London market: It seems he has not considered that the expertise developed by underwriters at Lloyd's during the past century or so reflects itself in their overall mental approach to the business of underwriting an entirely broker-produced portfolio.

For the New York exchange to emulate the dexterity, flair and flexibility that exists in the Lloyd's market is going to require the best practical assistance and tuition available. There is only one tutor that can adequately complement the technical expertise of the American system and that is people who grew up in the Lloyd's tradition of excellence. Therefore a certain amount of recruiting from London is the only sensible way of quickly acquiring the necessary ingredients for success.

For Mr. Doran to suggest that London underwriters may not be equipped to handle brokers who will exude power and exert pressure amid the din of telephone bells and the clacking of Telex machines is nonsense.

In short, the decision to combine the talents of two entirely different markets should be applauded; not misconstrued to suggest it is "an admission that the American market lacks talent and all it can supply is money."

R.A. Porter
Executive director, Sten-Re (Australia) Ltd., Sidney

Correction

To the editor: While we do appreciate the recognition of our firm in the article entitled Claims Firms Specialize in Workers Compensation appearing in the June 11 issue of *BI*, some of the information included in the heading is incorrect. My name should appear as J. A. McLain Jr., instead of James McLain. The correct telephone number is 212-374-3874. I would appreciate your publishing a correction.

J.A. McLain Jr.
Vp, Underwriters Adjusting Co., New York, N.Y.

Cartoon comment

To the editor: Your June 11 cartoon (Lawyers on the wing. . .) is irresponsibly bush league.

Joseph F. Cook
Claim manager, Pennsylvania National Mutual Casualty Insurance Co., Houston, Tex.

Course inquiry

To the editor: Your April 30 issue contained an article by Margaret LeRoux (Benefit managers attract notice, some vp titles) which mentioned Certified Employe Benefit Specialist classes at Wharton and in San Francisco.

Could you tell me where I can obtain information about courses available in the Los Angeles area?

Thank you for your help.

Ellamae McLean
Employe benefits administrator, Electronic Memories & Magnetics Corp., Encino, Calif.

Contact the International Foundation of Employe Benefit Plans, sponsor of the courses leading to the CEBS designation, at 18700 Bluemound Rd., P.O. Box 69, Brookfield, Wisc. 53005. The International Foundation is working jointly with Wharton School of the University of Pennsylvania on the curriculum.

Misrepresentation

To the editor: An otherwise excellent story on the changing role of the employe benefit manager (April 30) misrepresents my view.

I believe the function is becoming increasingly important, largely as a result of rising benefit costs and greater government regu-

Continued on page 54

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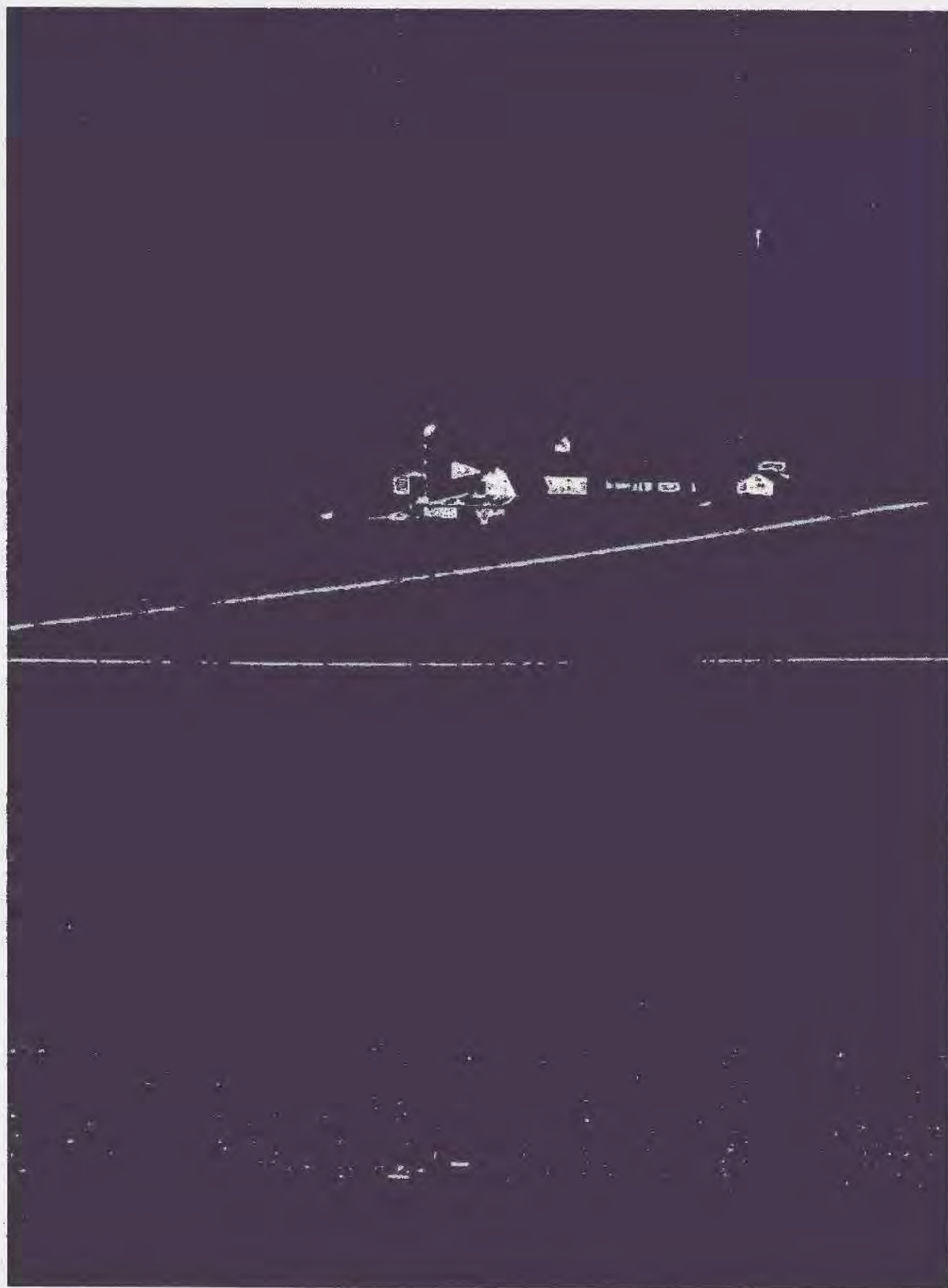

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Smithsonian provides training in museum risk management

By JERRY GEISEL

WASHINGTON—The Smithsonian Institution here, the venerable dean of American museums, leads the way in risk management, too.

About 20 museum registrars and curators spend a day here each year, not gazing up at Lindbergh's Spirit of St. Louis or ogling the Hope Diamond, but analyzing the intricacies of insurance and risk management.

Now in its fifth full year, the Smithsonian's risk management and insurance seminars sponsored by the office of museum programs have attracted more than 100 curators and registrars from around the country who shared a common goal: a thirst to understand how the insurance and risk management mechanism works to reduce costs and cut down losses.

For some registrars, a day at the Smithsonian opened up a new world of insurance and ultimately led to a reduction in premiums. "The program changed my whole impression about insurance," said Delbert Gutridge, registrar at the Cleveland Museum of Art. As a result of attending the seminar, Mr. Gutridge said he was better able to explain underwriting information to his broker which ultimately led to a $13,000 premium reduction.

The risk management and insurance workshops for curators and registrars is the brainchild of Phillip Babcock, the Smithsonian's veteran director of the office of grants and risk management.

Mr. Babcock began the biannual workshops five years ago to give curators and registrars, who usually lack risk management and insurance backgrounds, the tools to explain and protect their museums' risks.

Because museum officials often didn't understand business insurance or how to explain their risks, they were not in a position to negotiate with their underwriter, Mr. Babcock said. "If you can't explain the risk, how can you get a reasonable premium?" he asks.

To put the risk management and insurance functions in clear focus, industry experts who speak at the workshops discuss topics such as how an underwriter determines a premium, the responsibilities of the broker, the impact of small claims on premiums, how the wording of a loan agreement determines a premium and how to report changes in events that could affect coverages.

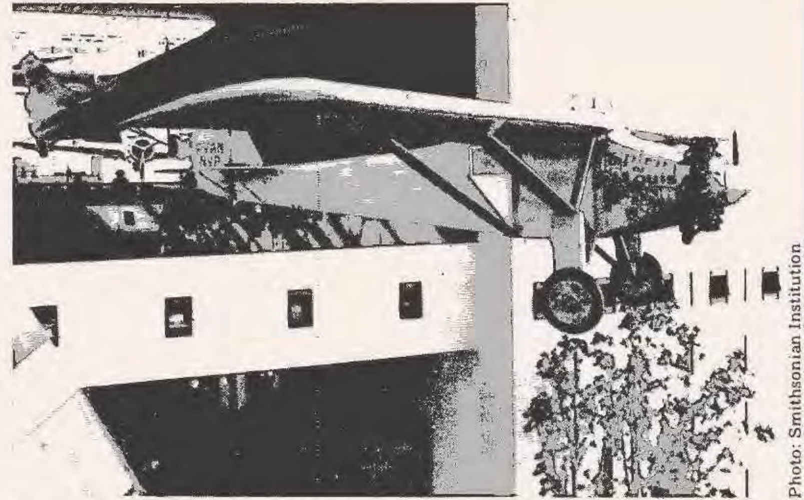

Photo: Smithsonian Institution

The Smithsonian Institution, which harbors and protects such gems from American history as the Spirit of St. Louis, teaches other museums the intricacies of museum risk management.

Above all, the seminars emphasize how museum personnel can better communicate their risks to their broker, which benefits both the insured and the insurer, Mr. Babcock points out. "Without adequate information, an underwriter can only assume the worst," he noted.

Aside from explaining the intricacies of insurance, the workshops delve heavily on loss prevention. Security experts discuss how to ship and pack exhibits to reduce transportation losses. In addition, the pros and cons of various security devices as well as the use of guards are discussed and analyzed.

Philosophical issues also are addressed. For example, rather than devote economic resources to insurance for permanent collections, a museum has to put its emphasis on loss prevention since the collections are irreplaceable, Mr. Babcock observed. "Remember, a museum's priority is protection of its objects."

Having run a successful series of basic workshops, the Smithsonian's Mr. Babcock now wants to sharpen his students knowledge. He has set up a new advanced workshop for graduates of the basic class. At the advanced classes, curators and registrars analyze museum policies on a case by case basis to see if they can determine if the policy fits the risk.

Mr. Babcock envisions that as a result of a more knowledgeable museum community, there might be a greater uniformity in museum insurance policies.

"Sometime in the future, there might be a standard 'museum policy' much as we have today a standard homeowners policy," Mr. Babcock said. Currently, there are several types of policies available which museum officials have to carefully evaluate since some policies have more exclusions than others. ▪

Hospital risk study

RIMCO Risk Management Inc. of Dallas will conduct a full risk management review and comparative study of insurance coverages for 26 members of the National Assn. of Children's Hospitals and Related Institutes (NACHRI). In addition to evaluating the effectiveness of each participating hospital's risk management program and performing a comparison of insurance programs and costs, the study will evaluate the feasibility of a group effort to control costs of malpractice coverage such as an association captive or a NACHRI-sponsored group insurance purchasing effort, said Klaus J. Gebhardt, president of RIMCO. The study should be completed in October.

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Calif. self-insurers fight odds against work comp reform

By JOANNE GAMLIN

SACRAMENTO—Workers compensation reform may yet get off the ground in California this year, according to Joseph E. Markey, legislative advocate for the California Self-Insurers Assn. (CSIA) in Sacramento.

Mr. Markey intends to push a new 'employer package' of five important reforms employers would like. To encourage labor backing the package offers substantial benefit increases, he said.

This year was supposed to be the year for workers compensation reform, according to proponents, including Clay Jackson, general counsel for the Assn. of California Insurance Cos. and state senator Bill Greene (D-Los Angeles). Sen. Greene, author of five worker compensation reform measures offered earlier this year, said at CSIA's annual meeting in February reforms could be passed this year.

"Everyone would have agreed with Sen. Greene in February," Mr. Jackson told *Business Insurance*. California has not had a major benefit boost in workers compensation benefits since 1972 and the state has not passed a workers compensation bill of any significance since 1976.

But as of late June, the chances of a good reform bill being passed had become remote. The chances are 60% to 40% against such a bill being proposed and passed, estimated Mr. Jackson.

The main reason why no real reform will be passed this year, and probably won't be attempted until 1981, is that the three principal groups that must agree on such a bill have not arrived at anything close to a consensus. The three groups are labor, management and the insurance industry, the latter two often sharing a similar perspective.

Applicants' attorneys are another potent force, usually allied with labor. They are said to be preparing their own bill.

Of the five 'employer' reforms in Mr. Markey's new bill, one is certain to upset applicants' attorneys.

This is the proposal to increase the disability evaluation bureau (DEB), part of the state's department of industrial accidents. The proposal's aim is to reduce litigation. Under this proposal, workers compensation claimants will go to the DEB where they will be examined by independent medical examiners who decide the percentage of disability.

"If you or your lawyer don't like it, you must appear before a referee and overcome that evaluation," said Mr. Jackson. The proposal could eliminate "the vast bulk" of litigation in areas where litigators don't belong and where they find it most profitable, such as arguing over medical reports, he believes.

He said attorneys' fees are set by the Workers Compensation Appeals Board (WCAB) and are based on the amount recovered by a claimant, most of it in permanent partial disability (PPD) awards.

"The big legal issue in PPD is extended disability, which is not a legal issue but a medical issue on which the advocates make lots of money. So if you cut it down and administer it, you are cutting their income down by a substantial degree and they are howling like hell," he said.

He said the DEB proposals were developed primarily by the California Workers Compensation Institute.

The three other employer reform proposals in the new package Mr. Markey feels optimistic about are:

• Apportionment. This statutory section provides that employers should be liable for that portion of the disability caused by or attributed to work exposure. Other causes of disability such as aging, pathology, non-industrial or previously compensated disabilities would not be the liability of the employer. Therefore, they should be

Continued on following page

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Calif. work comp . . .

Continued from previous page
apportioned out of the award, said Mr. Markey, observing that this measure would affect cumulative trauma awards, an issue over which the insurance industry is eager to gain a degree of control.

- Limitation on the imposition of ratings on subjective components of disability. Mr. Markey said that the section in his new bill is lifted from the so-called omnibus bill, S.B. 465, offered early this year by Sen. Greene. The section, which also affects cumulative trauma awards, states: "Consideration also may be given to factors of disability that cannot be measured objectively, in proportion to the severity of such factors, but in no event shall consideration of such factors serve to increase the percentage of permanent disability obtained by objective elements alone, after adjustment for age and occupation, by more than 25%."
- Improvement of the penalty section. This section says that when the payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount delayed or refused shall be increased by 10%, but in no event less than $100. . ."
- Limitation on the length of training for vocational rehabilitation. At present, there is no limit on the length of time for vocational rehabilitation, which Mr. Markey contends is wrong.

Mr. Markey won't elaborate on the benefit increases in his new bill. Mr. Jackson said employers are so anxious to have a workers compensation reform bill in 1979 that they are willing to offer a package with 20 points of benefit increases worth between $500 million and $600 million.

"You can add 20% to that $500 million to $600 million to cover the cost of those self-insured or legally uninsured and you are talking close to $1 billion in up-front benefits," he said.

The savings to offset the added costs would be generated by reducing the use of lawyers and doctors, Mr. Jackson thinks.

"The real reason people want these reforms is that they need a return to stability. What these lawyers have managed to do, together with their friends in the court system, is to blow this system up so that it is not budgetable any longer," said Mr. Jackson.

What's more, he warned there is a time bomb in the form of occupational disease carcinogens staring employers in the face.

Mr. Jackson reiterated that he does not think there will be a major reform bill in 1979. He noted that he has looked at AB 1063, the bill that has Mr. Markey's spirits rising, and that he has not changed his mind about the odds against a reform bill. AB 1063 offers about a 20 point benefit increase, and embodies a new strategy in that it has management offering the benefit hike rather than labor. The whole thing thus hinges on the reaction of labor and its allied group, the attorneys.

The bill represents the penultimate chance of passing a major workers compensation reform measure in 1979; the final chance will come in August and September, just before the closing of the legislature.

Mr. Jackson's professional guess is that there will either be no bill at all or there will be a small benefits bill such as that recently suggested by the state labor federation, proposing a 4.5 point benefit increase with no reforms.

Labor views most of the management insurance industry reform proposals as too radical. Part of the labor community may not want to move on reform this year in order to increase pressure for federal proposals by Sen. Harrison Williams and Jacob Javits.

However, employers are all the more eager for a major workers compensation bill this year, Mr. Jackson added, because they are scared stiff of federal legislation. ■

Insurers compete already: Hartford

CHICAGO—Proposals to repeal or amend the insurance industry's antitrust immunity under the McCarran-Ferguson Act will fail to improve competition or help the consumer, according to Hartford Insurance Group vp Stephen I. Martin.

The proposals, he said," do nothing to assure the competitive pricing of insurance as some proponents have suggested."

A proposal to institute federal chartering of insurance companies would still allow states to set rates at artificially low levels for assigned risk plans and other residual market devices, he said.

States, according to Mr. Martin, would maintain direct price controls or establish cartel pricing pending the outcome of a federal study of state insurance regulation.

"In all but a handful of states, considerable price competition already exists among insurance companies," he maintained. ■

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State rules choke surplus lines: Broker

By STUART EMMRICH

NEW YORK—State regulators could put a hammerlock on the excess/surplus lines market if the muscle-flexing apparent today strengthens regulatory control over the market, fears a specialty market underwriter and broker.

Predicting another tight underwriting cycle for standard insurers beginning late next year—which drives buyers into the surplus markets—Bernard J. Daenzer is crusading against these increased regulatory efforts.

Michigan, for example, is considering a law to hold all excess and surplus companies operating in the state responsible for the failure of any one of them, says the president of Alexander Howden Group U.S. Inc. Most states restrict solvency laws to the admitted market, a tradition he supports.

Other states, meanwhile, are considering laws that would set maximum and minimum limits of coverage to be written by the excess/surplus market, he says. Such laws "don't let competition do its work," Mr. Daenzer objects.

A "provincial attitude" in some states now restricts new companies from entering their markets. North Carolina, Michigan, Massachusetts, New Hampshire and New Jersey pose the most potential problems for expansion of the excess/surplus market, he says.

North Carolina doesn't now admit any alien companies to do business in the state, except for Lloyd's, Mr. Daenzer said. Michigan's list of approved firms is "very restrictive" and hard to get on. North Hampshire charges surplus insurers a fee to get on the list and its producers are so complex they screen out companies, he said.

"Risk managers and the insurance industry are prepared to fight hard against any proposal to restrict the excess and surplus lines market," Mr. Daenzer declares. "Freedom to establish companies and absence of control are essential to meeting the needs of the industry and ward off any form of additional government insurance.

"It is a necessary, natural release valve to take the pressure off the standard companies in a bad cycle."

Mr. Daenzer predicts the next "bad cycle" will begin the last quarter of 1979.

U.S. insurers showed an underwriting loss in the first quarter of 1979, but investment income pulled up the combined results to near 1978 profitable levels.

Mr. Daenzer expects the next losing underwriting cycle to continue through 1982, with losses in 1981 possibly reaching a 25-year record of nearly $3 billion, he recently told the Non-life Institute of Japan.

"Despite the obvious direction of the current cycle, big discounts are being granted this year on top of similar discounts last year. This is a complete erosion of the price structure," he said.

Because it takes a few months for the impact of the discounts to be felt in the marketplace, underwriters are slow to react to the changes in results, Mr. Daenzer said. This causes other problems.

"As the results become worse and worse, the underwriter in the U.S. then faces the insatiable demand by management for cash flow," he explained. Investment return has been very high and claims reserves have become enormous; 1978 loss reserves increased 20% over 1977.

"Insurance companies owned by conglomerates and straight forward captives have put much more emphasis on the importance of cash flow. All companies have a problem with inflated budgets which adds to the demand for increased premium volume despite the bad loss trend," he said.

He also warned that a trend to reduce the present policyholder surplus of around $36 billion during the coming down cycle in the business will make it difficult for American insurers to handle demand for insurance, estimated to grow from $80 billion in premiums now to almost $156 billion in 1985.

This is where the excess and surplus lines carriers will be called in to help solve the premium income capacity problem, Mr. Daenzer said.

But hard times aren't the only times excess and surplus lines carriers are in demand, he maintains. Surveys of risk managers have shown that about half of the time they tap the excess market because the standard market won't accept a hazardous or substandard class. The other half of the time, risk managers need higher limits.

The excess and surplus underwriter's freedom in pricing and form allows it to write risks that cannot be written in the standard market, he submitted. ■

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NAEHMO elects new officers

MINNEAPOLIS—Lawrence P. Carrington, manager of benefits planning and development at American Telephone & Telegraph Co., has been reelected president of NAEHMO.

The National Assn. of Employers on Health Maintenance Organizations here also recently elected as first vp J. William Read, manager of group insurance and medical benefits plan at Chrysler Corp. Mr. Read will also serve as membership chairman.

Continuing as second vp is Robert H. Duesenberg, assistant general counsel at Pet Inc. and continuing as treasurer is Michael F. Fitzpatrick, manager of benefits for CIT Financial Corp. ■

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Disability payouts hurt Social Security, commissioner says

CHICAGO—The Social Security system is in "sound" financial condition, but the increasing cost of its disability program must be cut for it to remain effective, according to Social Security commissioner Stanford G. Ross.

The Social Security Administration needs insurance industry support to find ways to curb the excessive benefits that are paid to disabled persons that induce some to remain on the disability rolls rather than attempt a return to the workforce through rehabilitation, he said.

The number of those receiving disability benefits from Social Security doubled between 1965 and 1975 and the cost rose from $1.6 billion to $8.4 billion over the same period, Mr. Ross said recently at a seminar of the Health Insurance Assn. of America. Disability benefits now cost the government $15 billion annually and the total will probably double again by 1990.

"The costs would not disturb us if we thought the program was working well, but in fact we know this is not the case," he said. "There is a significant decline in the number of beneficiaries who recover and return to work. The administrative process for determining disability is obviously cumbersome and erratic and badly in need of overhaul."

It is "vitally important" for Congress to pass the proposed disability reform bill, Mr. Ross said. The bill would cap benefits at 80% of pre-injury income, would cut benefits to families receiving more than when the principal wage earner was working and would provide economic incentives for the disabled to return to work.

The commissioner characterized the current program as a "trap for many, with significant economic incentives for people to get on the rolls and others to stay there rather than to try to work and return to the mainstream of American life."

Mr. Ross called on the insurance industry to work more closely with the Social Security Administration and offer advice and suggestions on ways to cope with issues and policy problems. Speaking to insurance company executives, he said, the administration needs more help, "from people like you. Levels of income replacement, definitions of disability, administrative processes—all these and more are issues that directly affect your businesses and about which you have special competence."

The relationship between the insurance industry and the Social Security Administration is still "not as effective a partnership as it needs to be," he said.

Mr. Ross identified several questions before the administration which it wants comments on, including:

- Should current payroll tax rates be left in place or should ways of lowering the rates while keeping the system in financial balance be studied?
- What should be the retirement age policy?
- How can the labor market be induced to provide more job opportunities for senior citizens, the handicapped and the disabled?
- Do the present formulas for computing benefits need change?
- How should liberalizing the retirement earnings test be viewed and should Social Security be viewed as insurance protection or an annuity plan?
- Should Social Security benefits be taxed?
- How can equal treatment of men and women be accomplished under Social Security as women move away from the status of adult dependents?

Also in an address to the conference, U.S. Rep. J.J. Pickle (D-Texas) predicted the proposed bill on disability benefit reform will set the tone for discussion on how the Social Security system should operate for retirement, and how it should be funded. ■

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Overlapping disability plans encourage absentees: Study

By JOHN MAES

CHICAGO—Millions of disabled persons, many of whom could be rehabilitated, are "overinsured" by a variety of often overlapping compensation programs providing them with more income than when they worked, according to a newly released report.

Benefits that in some cases exceed 200% of the worker's gross pre-injury pay induce a worker to remain on the disability rolls rather than return to work, says the report compiled by a research subcommittee of the Health Insurance Assn. of America.

The report was released recently at a two-day conference in Chicago on disability insurance problems, the first session of its kind sponsored by the HIAA.

To cope with the overinsurance problem, the report from the insurers' group recommends limiting benefits during disability to between 55% and 65% of the worker's pre-disability income. The report does not spell out how this can be done, but a spokesman for HIAA said insurers should be encouraged to devise their own methods.

Many disability insurers already cap a disabled person's income under their insurance policies by subtracting other benefits paid the person before paying benefits to the percent of salary promised under the LTD policy. But other insurers do not consider other benefits when making LTD payments, said the HIAA spokesman, which creates the overinsurance problem.

Speakers at the conference denied that in considering other benefits before making payments under LTD policies that LTD becomes the "phantom benefit" that pays little as charged recently by an executive of a brokerage firm (*BI*, June 11).

But in illustrating the problem of overinsurance, the report also notes that some disabled workers find they are underinsured and receive inadequate compensation while disabled when compared with their salaries.

Creating the overinsurance problem are a "multiplicity of disability compensation systems" in the United States that pay benefits to short and long term disabled workers, the report states. Federal disability programs alone such as Social Security, Civil Service, Veterans' benefits and others paid a total of $24.8 billion last year to 10.4 million disabled persons and their dependants.

In addition, insurance companies paid more than $2.2 billion in benefits during 1977 to the long term disabled while workers compensation programs paid $4.2 billion in the same year, according to the report. Also, individual disability insurance covered 36.4 million persons while 40 million to 50 million received disability benefits from auto insurance policies.

"This multiplicity of programs which provide income to disabled persons makes it possible for an individual to intentionally or unintentionally have more disability income protection than needed," according to the report. "Such a person is overinsured."

"It is quite common," the report continues, "for benefits to exceed the 55% to 65% of gross income range and it is quite possible for a combination of benefits to exceed 200% of gross pay, a benefit more than three times the level needed to maintain the pre-disability standard of living."

"A few individuals, abusing the system by opting for disability while only marginally disabled or by remaining on the disability rolls longer than necessary can add more cost than would many legitimate disabilities and greatly inflate costs for everyone else."

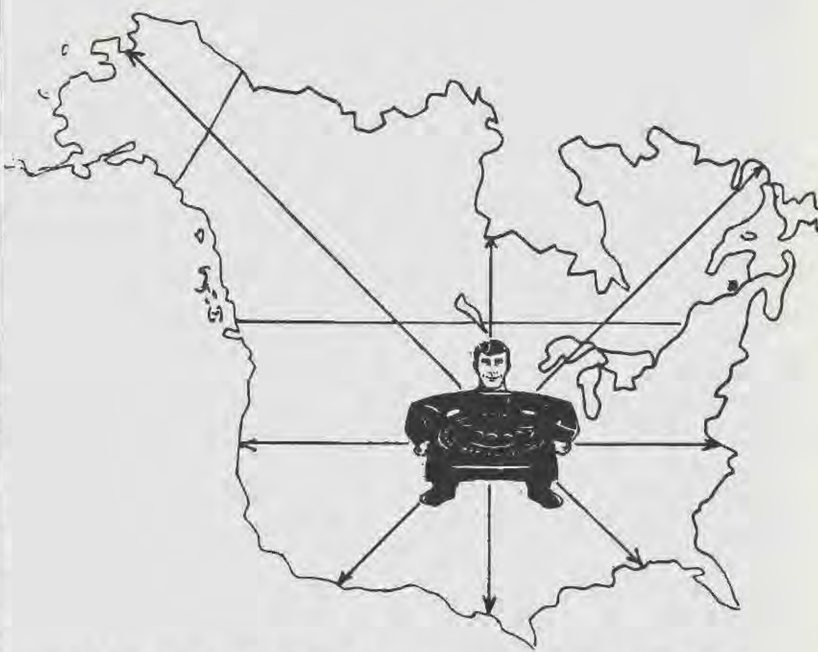
The report illustrates how overinsurance can provide a person with an income 221% higher than his pre-disability net wage. In an example, a 29-year-old man with a monthly net income of $1,034 suffers a long term disability in a nonwork related auto accident. Even without Social Security benefits, the man receives total benefits of $2,283 a month including $833 in employe long term disability insurance, $200 in credit disability insurance to cover auto payments and $1,250 in benefits from a no-fault auto insurance policy.

If the man's disabling injury occurred at work but not in an auto accident, the income replacement values could be 100% but, "although the overinsurance is reduced, it is still high enough to provide a disincentive to returning to work," the report states.

While some workers benefit from overinsurance, others find themselves inadequately compensated for a disabling injury or underinsured, according to the report. A 24-year-old computer salesman making $1,500 monthly, who, with no prior military or civil service, suffers a long term disability could get only 26.9% of his pre-injury income, because he has not worked long enough to qualify for Social Security benefits and has only $417 monthly in employer-sponsored long term disability insurance.

In recommending the 55% to 65% ceiling on the replacement value of wages, the report states, "this should be supplemented by a strong rehabilitation program which aids the transition to work. The individual who is just recovering and is facing the decision of whether to return to work will be encouraged to make the attempt rather than remaining disabled."

When such factors as the tax exemptions afforded disability income along with the absence of work-related expenses such as commuting, clothing and meals are considered, the disabled person should be able to subsist on benefits equaling 65% to 75% of the pre-injury gross pay, the report says. "Even lower benefits may be necessary in order to provide the necessary economic incentive," it says. ■



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Insurer execs dispute broker's benefit survey

CHICAGO—Insurance company executives challenged a recent survey by a Johnson & Higgins executive that indicated many benefit buyers view long term disability coverage as a "phantom benefit" that pays out little in comparison to insurers' profits.

The 7% loss ratio revealed by a limited survey was also disputed by HIAA actuary Peter Thexton who estimated the LTD loss ratio is probably more like 50%. He cited recently published figures that showed a 1978 loss ratio of 58.4% among the 25 leading insurers of short and long term noncancellable disability insurance.

V.J. Skutt, chairman of the board and chief executive officer for the Mutual of Omaha and United of Omaha, also disagreed with critics of LTD insurance. "Long term disability is a very important form of insurance. It has not been a line of coverage that has brought in a great underwriting profit to our company."

LTD may appear to be an extremely profitable line if looked at on a cash-flow basis, said Robert F. Froehlke, president of HIAA, but "the actuaries can prove that it has not been because the tail is so long." ■

Long term disability has not brought a lot of profit to Mutual of Omaha, says CEO V.J. Skutt.

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IRMC director quits over conflicts rule

By SUSAN ALT

CHICAGO—Warren Brockmeier, director of risk management services for Wyatt Co. here, has written a letter of resignation to the Institute of Risk Management Consultants, to be considered at the organization's annual meeting in September.

The resignation raises questions about conflict of interest for consultants acting in an advisory capacity to clients and about an agreement by some consultants that they won't do business with each other's clients.

Mr. Brockmeier, a charter member of the six-year-old IRMC and also a current member of the board of directors, believes he is in technical violation of two bylaws of the group and cannot comply with them.

IRMC membership requirements prohibit any actual or potential conflict of interest in the person's services or those of the firm. "For the purpose of determining qualifications for membership in the institute, an actual or potential conflict of interest is deemed to exist when the applicant or firm through which the applicant practices or any associated or affiliated interests of such firm is engaged directly or indirectly in the business of insurance or provides services to an insurance agent or broker for renumeration of any kind," the bylaws state.

Mr. Brockmeier and Wyatt Co. providing consulting services to hospitals investigating the feasibility and advisability of participating in the Chicago Hospital Risk Pooling Program, a development of the Chicago Hospital Council which Mr. Brockmeier was involved in from its inception. Wyatt Co.'s actuarial consulting division provides ongoing actuarial services to the hospital trust, which now has nine participating hospitals in the metropolitan area.

Technically, the trust functions in a manner similar to an insurance company. So actuarial services for the trust could put Mr. Brockmeier in noncompliance with IRMC's rules. IRMC's rules are designed to protect consulting clients from conflicts of interest, and Mr. Brockmeier may be interpreted to be in a conflict situation by providing services to the trust at the same time he is giving advice to potential participants in the trust.

"In the establishment of the program, we did the feasibility study for the Chicago Hospital Council, but we aren't directly involved in the management of the trust," said Mr. Brockmeier. "Wyatt acts as consultant to CHRPP on actuarial matters, reviewing the adequacy of reserve funds and premium development, and on miscellaneous matters as they arise," he added.

Mr. Brockmeier is satisfied that he is avoiding any actual conflict of interest in relation to the program. "In at least two cases that I know of—and I don't personally see all the reports that go out of this office—we've recommended that hospitals not join CHRPP. In two other more recent cases, we've provided the numbers—doing the actuarial work for a hospital joining the program, doing the premium development for participation and calculating expected losses using our computer models—then submitted our work for review to another risk management consultant who was doing the feasibility study for the hospital."

Two violations of IRMC's conflict of interest rules led to the resignation of Wyatt Co.'s Warren Brockmeier.

Mr. Brockmeier feels "eminently comfortable" with this kind of relationship, he said.

Moreover, some Chicago-area hospitals that have been clients of another IRMC member consultant have asked Wyatt to work for them related to the pooling program. Under IRMC's bylaws, Mr. Brockmeier would be expected to inform his fellow IRMC member consultant and decline to take the projects, even though the hospitals were coming to him because of his expertise in hospital malpractice, medical malpractice and liability.

Wyatt didn't decline the work, said Mr. Brockmeier. Under IRMC's rules governing professional practices, member consultants "will not accept an assignment for a client while another risk management consultant is serving that client, unless he is assured and can satisfy himself that there will be no conflict between the two engagements. He will not endeavor to displace another risk management consultant once he has knowledge that the client has made a commitment to the other consultant."

This rule has spawned controversy in the IRMC for some time. Recent Justice Department rulings on similar bylaw restrictions within legal bar associations and professional accounting societies, on the basis that they are anticompetitive and in restraint of trade, caused at least one other member of IRMC to propose that the bylaw be stricken.

IRMC represents 43 individual consultants in 17 different firms in the U.S. and Canada.

Peter Norman, principal of P.D. Norman & Associates in Vancouver, B.C., and the current president of IRMC, said the rule wasn't meant to be anticompetitive; it was designed to prevent raiding of clients by unethical competitors saying that they could do the job quicker, better and cheaper.

In Canada, he noted, the accountant's society recently received approval of a rule that states one accountant won't take over another accountant's business unless the fees are first paid in full by the client. ▪

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Fireman's Fund Insurance Cos. has reorganized its commercial insurance operations to form a national accounts and risk management services department. The new department, headed by senior vp J. Creighton White, former senior executive for commercial lines, "emphasizes our commitment to be a high-quality and diversified market in large risk casualty and risk management activities," said executive vp James J. Meenaghan.

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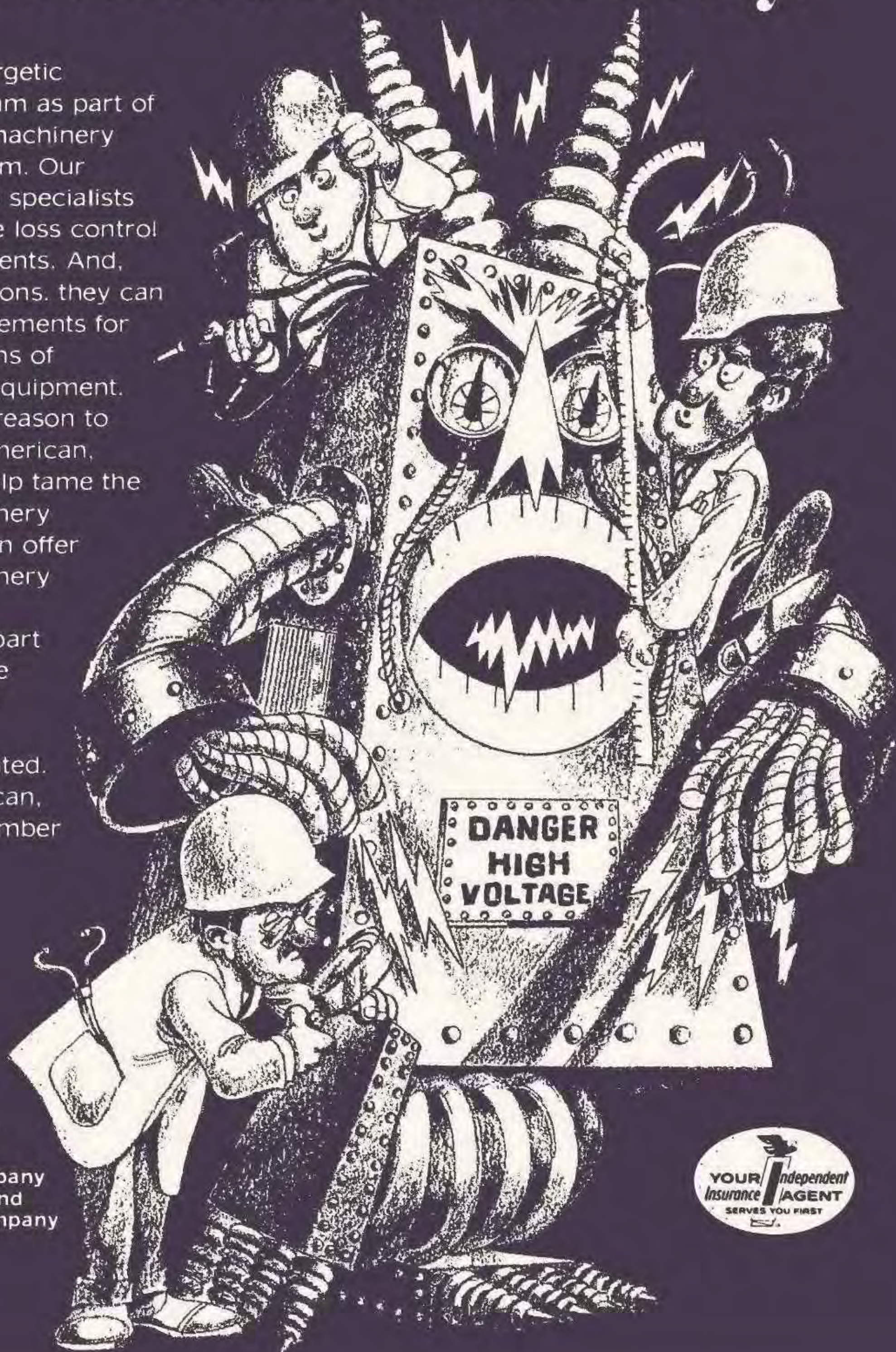

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Congress to order cap on hospital costs: Byrd

WASHINGTON—Congress will probably pass legislation this year to control hospital cost increases, says Senate majority leader Robert Byrd (D-W.Va.).

The Senate Finance Committee already has approved cost control legislation that generally would limit annual hospital cost increases to about 11.4% annually. A much more stringent bill died in committee during the last congressional session.

Speaking before a government briefing sponsored by the Insurance Information Institute (III), Sen. Byrd said hospital cost control legislation, which would help hold down the cost of employe health benefit plans, would probably be passed by September.

As long as the controls "can be implemented without an undue amount of red tape," Sen. Byrd said he would support the legislation.

The West Virginia Democrat said he also favors some form of national health insurance, especially proposals that provide protection for catastrophic medical and hospital bills. He did not indicate a preference for any of the leading proposals now before Congress.

Two other speakers gave conflicting views of the need for more federal involvement in the insurance arena. "The ideal time has come for further federal involvement in the insurance industry," said Rep. James H. Scheuer (D-N.Y.), who will hold hearings this month on product liability and consumer safety related issues. There is an urgent need to give consumers more information so they can make intelligent decisions about purchasing insurance to fit their needs, he said.

Sen. Orrin Hatch (R-Utah) however, defended state regulation of the insurance industry. State regulation "is a positive approach . . . in enhancing competition," he said.

Sen. Hatch also said that he plans to introduce legislation that would provide federal compensation for residents of southwestern states that were exposed to atomic bomb blasts conducted by the Defense Department in the Nevada desert during the 1950s.

The federal government is responsible because it knew of the dangers of exposure to the atomic tests, but failed to provide adequate warnings, Sen. Hatch said. ■

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College grant grooms locals for captives

GEORGETOWN, Grand Cayman—A captive management company here is investing in the future of this island as a captive haven and the need for trained employes to do the work.

Cayman Underwriters Services Ltd., a wholly owned subsidiary of Charter Oil Co., has established an endowment of an insurance chair at the International College of the Cayman Islands.

Finding enough qualified people to staff captive management companies is a problem plaguing companies in Bermuda now, the favorite tax haven for captive insurers. Leaders in Bermuda are pushing for a college insurance program there, but have so far failed in their efforts.

Cayman Underwriters Services' first year grant to the college of $31,250 is earmarked to establish a new insurance department to at first award an associate of arts degree in insurance after two years of study. Later, a four-year program will be established to award a bachelor of arts degree.

The grant is intended to provide an opportunity for Caymanians to enter the field of insurance company management, said John Ray, vp and managing director of Cayman Underwriters Service. "The rate of growth has been phenomenal," he said. "This step of working with ICCI to build up an educational program will help us by providing a pool of talent from which to select future employes and it will help the island by providing new career possibilities that did not exist before."

The International College of the Cayman Islands is a small, private institution opened in 1970. ■

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It's not unusual for an insurance company to offer a coverage one year and then fail to offer it the next because of substantial losses in that particular market area. After all, for an insurer to be consistent within a market, be it hard or soft, and to avoid panicking at the sight of a few setbacks, it must have the resources to provide appropriate coverages on a long-term basis. It must have the ability to be patient. It must be, to put it simply, a specialist.

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Builder denies liability for Pa. nuclear mishap

NEW YORK—In what could be the first line of a defense in the seven lawsuits naming it as a co-defendant, Babcock & Wilcox Co. maintains human error worsened the nuclear power accident at Three Mile Island.

A vp of the company that supplied the nuclear reactor to the plant owners charged recently that mistakes by plant personnel were responsible for the seriousness of the Pennsylvania accident.

John H. MacMillan, vp of Babcock & Wilcox, conceded in the brief statement at a press conference last month that the pressure relief valve supplied by Babcock & Wilcox to the plant malfunctioned. But, the problem could have been corrected "if the plant operators had reacted properly," he said.

Babcock & Wilcox has been named in seven lawsuits along with the plant's operators, General Public Utilities, and the plant's insurers, American Nuclear Insurers. The suits filed after the March 28 accident each asks for $560 million in damages, the statutory limit of liability for nuclear accidents.

Mr. MacMillan's statement was the first by any one of the defendants placing blame for the accident (*BI*, April 16). Not suprisingly, officials at General Public Utilities were skeptical.

"To specifically peg the cause (of the accident) at this time without the benefit of the facts yet to be determined would be premature," said GPU chairman William Kuhns.

"The B&W equipment design inherently demands operator response. When this is crippled by equipment failure and further confused by ambiguous water content indications, it is unreasonable at best to suggest that the equipment played no role in the accident," Mr. Kuhns said in a statement released by GPU shortly after the Babcock & Wilcox press conference.

But Babcock & Wilcox officials still maintain that their involvement in the accident is minor. "We don't believe we have any liability," a spokesman reiterated recently, "except for the valve that failed."

Of the six major contributing factors that officials have so far identified as contributing to the severity of the accident, the spokesman said that "five involved human error. The equipment performed as it was designed," the GPU official said. "It did the job it was supposed to do." ▪

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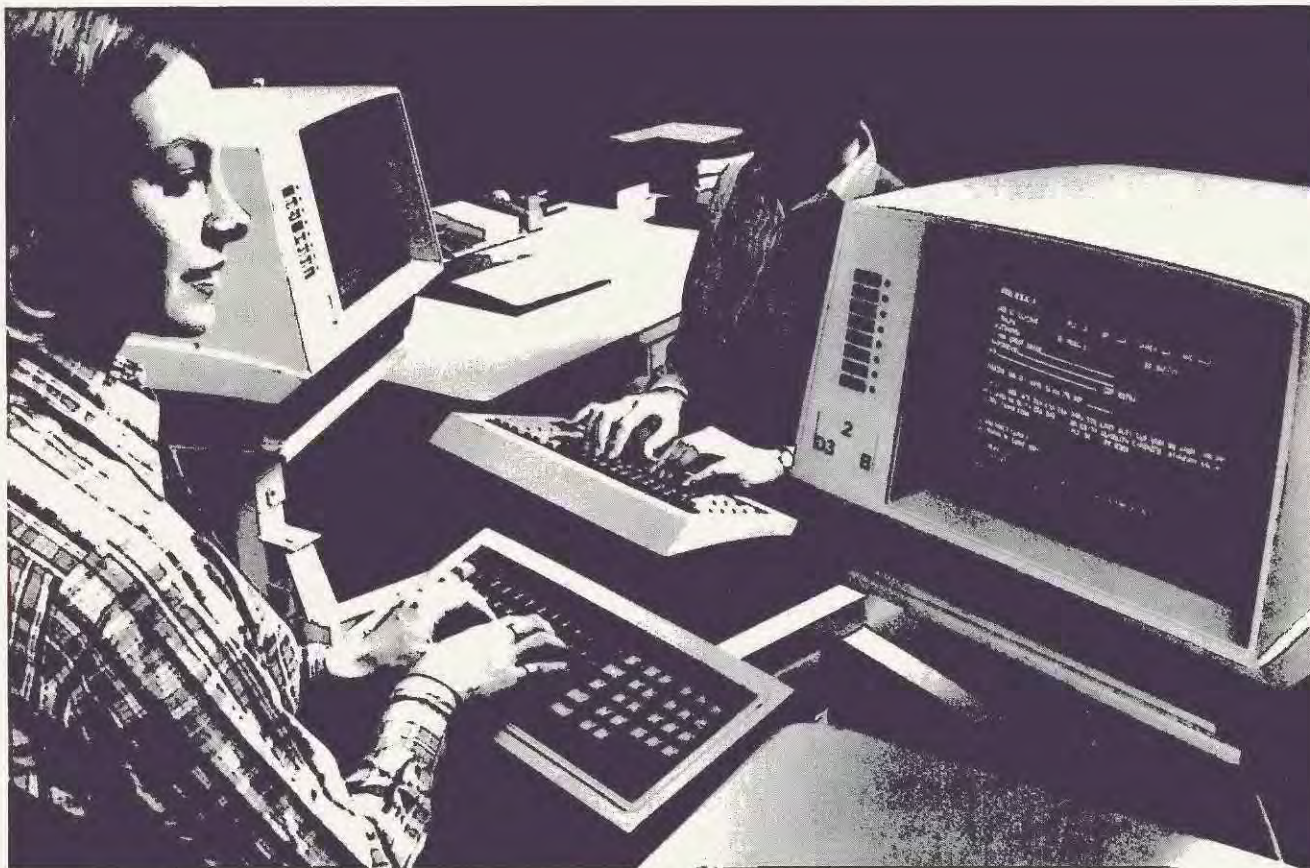

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A&A grabs $20 million new account

WALNUT CREEK, Calif.—Dillingham Corp. moved its entire property, casualty, workers compensation and marine account—including primary and excess coverage with annual premiums estimated between $15 million and $20 million—to brokers Alexander & Alexander.

The account was formerly split between Frank B. Hall & Co. and Johnson & Higgins.

A better price and computer capabilities won A&A Dillingham's business, being handled on a commission basis, according to R.W. Stephens, risk manager for Dillingham.

Dillingham will be working closely with the Anistics division of A&A.

"We are strongly emphasizing loss control; that's where the money is to be saved," Mr. Stephens said, "and we want the computer capabilities to tackle the problem."

Domiciled in Hawaii, Dillingham is involved in land development, construction, mining, maritime transportation, shipbuilding and ship repair. The corporation has two Bermuda captives, one insuring domestic risks and the other for foreign risks. The company carries a self-insured retention of more than $500,000.

The two former brokers, J&H and FBH, had split Dillingham's business between them for the past eight years. "It was time for some competition," Mr. Stephens said. "We looked at seven brokerage firms before the final competition." ▪

$6 million worth

Canadian fire losses fuel Sasse's woes

TORONTO, Ontario—Fire losses on Canadian property are compounding problems for members of the troubled Lloyd's Sasse Syndicate, reports The Financial Post here in a story by Giles Gherson.

Present Sasse members complain they are being unfairly assessed for losses on Canadian business that paid a profit to Sasse members in 1974 and 1975.

The Sasse Syndicate, which has been suspended from underwriting by Lloyd's because of huge unreserved losses on property insured mostly in the U.S., is being managed now by Stephen Merrett of Merrett Dixey Syndicates.

At the heart of the controversy involving Canadian fire losses, according to The Financial Post, is a dispute between Frederick Sasse and London broker Brentnall Beard over liability for Canadian business written toward the end of 1976 and in 1977. Brentnall Beard brokered the $22 million in fire losses that have crumbled the Lloyd's syndicate and $6 million on computer leasing insurance.

Of the $28 million losses which are bankrupting Sasse, $6 million are on Canadian fire insurance for residential and commercial property produced for the syndicate by Brentnall Beard, through its then wholly owned Canadian coverholders Deslauriers Wilkin & Associates Inc. of Montreal and Follwell Underwriting Managers Ltd. of Edmonton.

Through these two, the business was also passed to four other Canadian agents with fire binding agreements: Burns, Weld & Martin Ltd.of Edmonton; M.B. Insurance Brokers Ltd. of Winnipeg; Maurice Viens & Associates and St. Laurent Archambeau & Associates Inc., both of Montreal.

Although the Canadian fire losses of $6 million are less than one-fourth of the total losses suffered by the Sasse Syndicate, they emerged inopportunely for Sasse right after the U.S. fire losses, notes The Financial Post.

Frederick Sasse, manager of the Sasse Syndicate, realized in late 1976 that premiums written on his account by Brentnall Beard far exceeded his syndicate's underwriting capacity. He then stopped paying claims on the Canadian risks.

Although Brentnall Beard might have been expected to know Sasse's underwriting capacity, The Financial Post observes, Sasse also didn't limit the amount of business it was prepared to take through the Canadian fire binding contracts. Sasse did write a premium limit into the contract with Brentnall Beard in 1977, but the language was unclear, says Mr. Merrett.

Even though Sasse would not indemnify the claims in late 1976 and 1977, "he rather took the view," Mr. Merrett told The Financial Post, "that Brentnall Beard had gotten him into this mess and now it would have to get him out."

Brentnall Beard kept the premiums from the Canadian fire binding contracts, The Financial Post reports, and used them to settle claims on the business. The complication, as Mr. Merrett pointed out to The Financial Post, is that a broker generally has no right to settle claims without explicit authority from the underwriter because he can't determine the validity of the claims.

Brentnall Beard is said to have held $12.9 million in 1976 and 1977 premiums on the Canadian business that Sasse wouldn't take and to have paid out more claims than it received in premiums in 1977.

In August, 1978, some months after Merrett had taken over management of the Sasse Syndicate, the true extent of the problems emerged. The accuracy of the Canadian binding accounts are now being investigated by the London police fraud squad.

An investigation of Sasse's accounts by Merrett Dixey's auditors, Baker Sutton, lends considerable credence to the present Sasse members' complaints that they are being unfairly assessed for past Canadian losses. In 1974 and 1975, Sasse showed a profit—subsequently dispersed among syndicate members for those years—of $500,000 and $800,000 respectively, when it now appears he suffered losses of $300,000 in 1974 and $400,000 in 1975. The difference between the stated profits and the actual losses, $2 million, has been tacked onto 1976 losses of $3 25 million, ($650,000 of which may be recoverable from reinsurance) and 1977 losses of nearly $750,000 to produce a loss of $6 million on the syndicate's 1977 account.

It is not known how much, if any, of the loss is recoverable by the names on the Sasse Syndicate's 1977 account. The stated profits for 1974 and 1975 have long since been dispersed to the names belonging to the syndicate in those years and they have been assessed for taxation purposes. ■

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INA International, whose network of worldwide facilities is the largest of any single U.S. based insurance company, has developed a number of operating standards that should prove of interest and benefit to agents and brokers.

This is the fourth in a series.

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PERSPECTIVE

Product test records bolster defense

By George V. Karosas

MOST PRODUCT LIABILITY CASES are tried under the legal theory of strict liability in tort, which states that the injured party need only prove that the product was defective when the product left the seller's control, that this defect rendered the product unreasonably dangerous and that the defect caused or aggravated the injury.

This shifting from the doctrine of negligence to the doctrine of "defect" has led some product manufacturers to question the need for detailed records substantiating the design engineering, production and quality control processes. However, recent court decisions delineating the criteria for determining defectiveness have reinforced the need for accurate and detailed documentation on the part of the manufacturer.

In fact, the ability of the manufacturer to develop an adequate defense against product liability claims often hinges upon the degree to which he can demonstrate through formal records the activities undertaken to assure the safety of his product in the marketplace. A manufacturer or product seller must implement an adequate system of documenting design, production and quality control activities.

Photo: Mercedes Benz

Mercedes-Benz tests new automobiles and the performance of new engine designs on the firm's high wall test track in Stuttgart, West Germany.

Quality control

With the widespread adoption of strict liability by the courts, many manufacturers ask, "Why do we need to keep engineering and quality control records anymore?" Since liability is concerned with the final condition of the product, many manufacturers believe that keeping records which demonstrate how "due care" was exercised in the product design are no longer important and the expense of keeping those records could easily be eliminated.

Nothing could be further from the truth. It is true that strict liability focuses on the condition of the product and not the conduct of the manufacturer. However, refinements in the interpretation of the legal concepts of "defectiveness" and "unreasonable dangerousness" indicate that liability, even in a strict liability action, may depend heavily on the manufacturer's activities in selecting the design of the product.

The extent to which a jury agrees with the manufacturer's conclusions about that selection and the extent to which the manufacturer's design selection activities can be substantiated may significantly affect the court decision.

George Karosas, a product safety consultant for the National Loss Control Service Corp. in Long Grove, Ill., provides product safety and product liability prevention consulting services to a variety of clients in the private sector. His work at the Kemper Cos. subsidiary includes the review of product designs, instruction manuals, warning signs, quality control procedures and other management functions for their effect on the product liability exposure of the client.

Strict liability

The most frequently used definition of strict liability is taken from the Restatement of Torts, 2nd, which states that liability may be imposed for injuries caused by a product that is "in a defective condition and unreasonably dangerous." The exact meaning of this terminology has been the subject of much litigation. What a defective condition is and when a defective condition is unreasonably dangerous is the crux of virtually all strict liability actions.

The California supreme court sorted through the confusion and provided a clarified definition of design defect in a decision handed down in 1978 (Barker v. Lull Engineering, 143 Cal. Rptr. 225, 673 P.2d 443). The court said that in evaluating the defectiveness of a product design, a jury may consider: The gravity of the danger posed by the challenged design, the likelihood that such a danger would occur, the mechanical feasibility of a safer alternative design, the financial cost of an improved design, the adverse consequences that would result from an alternative design.

Since the California decision, several states have recognized the Barker criteria. Similar criteria have been proposed for determining defectiveness in the model uniform product liability law recently drafted by the Department of Commerce (*BI*, Jan. 22).

Jury analysis

These criteria are used in determining whether a design "embodies excessive preventable danger" (*Barker* op cit). The jury, in effect, is called upon to conduct a risk/utility analysis of the product to determine if the product embodies dangers which could have been prevented.

While "defectiveness" is a characteristic of the final product, the "unreasonableness" of the danger is often related to the conduct of the manufacturer in the design, production and marketing of the product. When analyzed by the jury, the reasonableness or unreasonableness of the alleged dangerous design is hopelessly intertwined with the jury's opinion of the product and the way the manufacturer produced and marketed the product.

It is imperative that the manufacturer conduct a detailed risk/utility analysis during the design stage. This does not mean a short review of the advantages and disadvantages of the product, but requires a careful and detailed analysis of critical design features. Each function and each component of the

Continued on page 33

PBGC rethinks rules for folding-up plans

By Kenneth K. Keene, FSA

FOR SOME, ERISA WORK is never done. This statement is certainly true of the Pension Benefit Guaranty Corporation (PBGC). It has been laboring long and hard to tie up the loose ends of an ERISA-mandated contingent employer liability insurance (CELI) program.

First in a series of frustrations, PBGC was turned away by private insurers. They wanted to steer clear of the risks involved in assuming potential liabilities otherwise falling on the shoulders of plan sponsors, i.e., liabilities of up to 30% of net worth of the sponsors of terminating plans.

Second, PBGC found itself running short of premium dollars to pay for PBGC-guaranteed benefits of plans which terminated since ERISA's passage and of which PBGC became trustee. Ergo: Premiums paid by ongoing plan sponsors for PBGC insurance went up, with the certainty that they would continue to do so in subsequent years. One source indicates that PBGC is now an actuarial hole to the tune of $95 million. However, if several major cases result in plan terminations—a current and future possibility—then the deficit and the required PBGC premiums could shoot up alarmingly.

Concerned that too much of the cost from employers terminating pension plans will fall on its shoulders and the shoulders of employers with healthy pension plans, the Pension Benefit Guaranty Corp. has a new idea for governing the winding-up of pension plans.
—Kenneth Keene

Alternatives

And just to make matters worse for PBGC, there is that other problem of what to do about ERISA-required guarantees and termination insurance for multi-employer plans. This is a more immediate problem demanding a drastic solution.

Kenneth K. Keene, senior vp and director of Johnson & Higgins in New York, writes regularly on employe benefit topics for these perspective pages.

The only alternative was to seek another alternative. In July 1978, the PBGC told Congress that a CELI program, as envisioned by ERISA, was "not feasible or desirable," and offered two alternatives.

Recently, it developed a third alternative, which has been the subject of discussion at seminars conducted by Matt Lind, executive director of the PBGC, and by staff representatives of that agency. It is basically this alternative which the PBGC expects to propose to Congress later this year.

As outlined by Mr. Lind, this alternative—"voluntary termination"—would allow an employer to terminate the pension plan at any time, but the employer could not get off the hook at just 30% of net worth. The employer would remain fully responsible for cleaning up any unfunded vested benefits accumulated up to the time of termination. These benefits could be funded through any of the following ways:

- At the time of termination, contributions could be made to cover vested benefits through the purchase of annuities or by payment of the proper lump-sum amounts to participants.
- Unfunded vested benefits would be amortized within 10 years or less.
- After the voluntary termination all net corporate assets (rather than just 30%) could be called upon if necessary.

The only time PBGC would become involved is when an "insurable event" occurs, such as bankruptcy or liquidation. At that time, PBGC steps in as a general creditor, with plan participants assured the guaranteed benefits.

The PBGC's side

In assessing this alternative, Mr. Lind stated that it would greatly reduce PBGC involvement, including sizable cuts in administrative and operating costs. And, higher benefits would be preserved for participants in those plans which are terminated by ongoing employers.

As it now stands, ERISA tends to encourage termination among troubled employers and in other cases where the company could make a "profit." For some employers terminating plans due to bankruptcy, there isn't enough net worth left to pay anything, let alone PBGC-guaranteed benefits. For other employers that terminate plans, 30% of net worth may be a windfall, if the 30% is far less than the amount of unfunded liability. In either situation, the funding bag could be tossed to the PBGC, whose coffer is to be filled and replenished with premium payments made by healthy, ongoing employers.

It is just these situations that the PBGC alternative is aiming to discourage, Mr. Lind tells seminar participants.

Note, however, that the Discussion Memorandum on the third alternative makes no mention of a topic dear to Matt Lind's heart. Mr. Lind would like to expand investment opportunities and encourage innovations by allowing pension funding to be accomplished on a tax-favored basis through use of book reserves. This idea of allowing pension investments to remain at work within the sponsoring company has its pros and cons. However, it is a subject to be explored in greater detail at a later date.

Employer side

It was not made clear, either, during Mr. Lind's comments or in the full Discussion Memorandum whether the employer liabil-

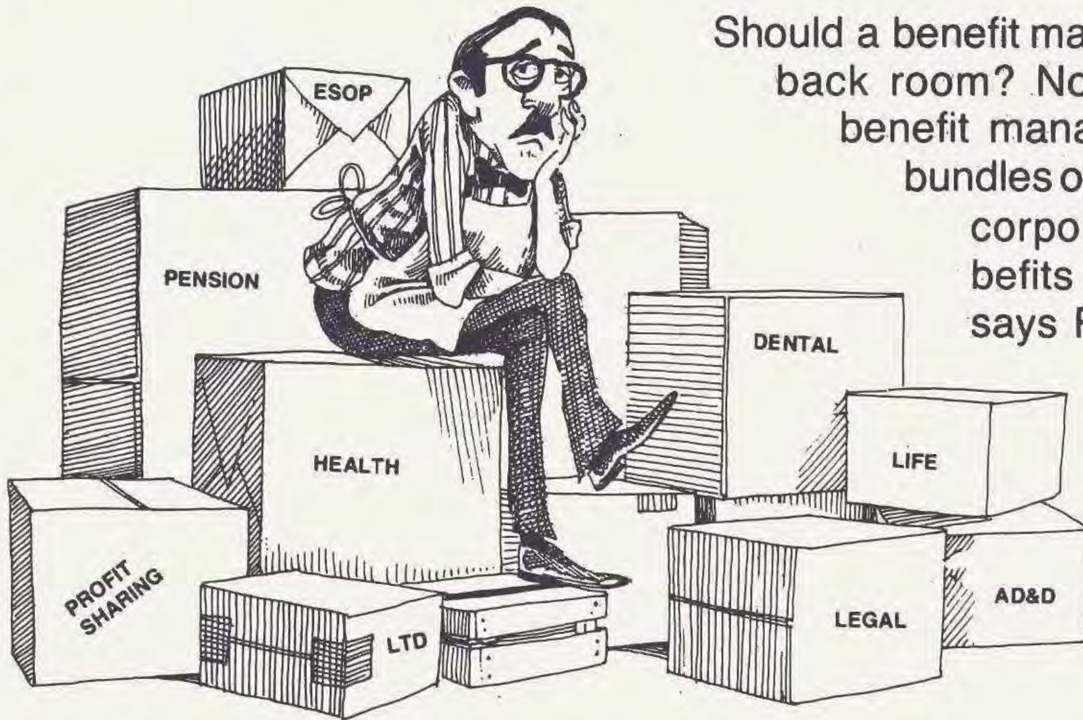
Continued on page 33

PERSPECTIVE

Benefit execs: Escape the back room

By Faisal A. Saleh

Should a benefit manager be stuck in the back room? Nope. The successful benefit manager should take his bundles of benefit plans into the corporate board room as befits upper management, says Faisal Saleh.



I have always wanted to be successful and now that I am a benefits manager I want to know who is a successful benefits manager? What does he look like?

Success means different things to different people, but if you want my opinion, to become a successful benefits manager you have to elevate your function to where it belongs, at the upper management level.

But what does that mean?

It simply means that you have to bring benefits out of the back room and put them in the boardroom.

But benefits are already a boardroom topic.

True, but who is making the decisions? Who is doing the planning? And how much is being accomplished? Benefits in the boardroom is a mere formality.

What did you mean then?

You have to make benefit planning an integral part of your company's business planning. To be successful you have to demonstrate that the benefits function can contribute to the achievement of your company's business objectives in the same manner as production, marketing, finance, etc.

But is that realistic?

You bet it is. Let me show you the potential impact of benefits on your company. Take a look at your income statement and compare total benefits cost to the net income of the corporation. For the average company the two figures will be close. If you are labor intensive, benefits costs are likely to be higher than net income. This means that if you reduce your benefits cost by 10%, your net income will rise by at least 5%. Do you see the potential impact you can have?

Let's say I want to become successful and effect the company, how do I do it? Where do I start?

There are two ways you can effect the income statement of your company. The first is direct, by reducing the cost of benefits; the second is indirect, by improving employe relations. Cost and employe relations are the two variables you need to manipulate to become successful.

How does employe relations enter into the picture?

Employes tend to perform better when they feel good about the organization they work for. These feelings are usually a function of how they are treated as far as their salaries, benefits, career opportunities and working conditions go. Most important is how they perceive their treatment and not necessarily how they are treated. You can help them feel better about working for your company through benefits.

But isn't there a contradiction in what you are saying? Can I accomplish both objectives simultaneously?

Yes you can. A costly benefit plan does not necessarily mean a good plan. Oftentimes the most popular plan is not the plan that costs the company the most.

I guess it is not that simple. If I believe what you are saying, how far can I go in reducing cost and improving employe relations?

Far enough to make you a successful benefits manager.

But what target or time frame do I shoot for?

Your target should be related to your current cost level. Project your existing cost of benefits for 18 months from now and determine your annual cost as a percentage of your cash compensation. (Two years would be too long and one might be too short.) Let's say you come up with a figure like 25%. Now let's set your target. This will depend on your judgment of how much you can improve. Most managers should be able to squeeze savings anywhere from 5% to 10%.

I have saved the company a lot of money during the past two years, as much as 5% or 7%.

Chances are you did. But you did it in bits and pieces. You lost the impact. Synergy is the key to creating the needed impact. You have to do many things at the same time.

How many benefits managers have accomplished that?

Not enough yet. Most benefits managers are busy putting out fires. A lot are administering and not managing.

What is the difference?

Administering means maintaining the status quo and only responding to limited outside influences such as new laws or severe employe crises. Managing means planning ahead...planning goals and objectives...setting timetables for completion and successfully managing the required changes. Managing involves integrating various functional areas. Most benefits problems are interrelated; design is interwined with cost and with administration as well as communications. Managing involves integrated planning. Unmanaged functions grow like a wild bush, if not trimmed periodically they'll get out of hand.

Say I decide to cut cost by 10% and to improve employe relations. What do I do?

Now comes the time to draw your master

Faisal A. Saleh, founder and a principal of Benefits Management Service in Branford, Conn., has worked in the domestic and international benefits field in former positions with a major insurer and consultant. He holds a BA from Oberlin College and an MBA from the University of Connecticut.

Office design hides security plan flaws

By Belden Menkus

OFFICE LANDSCAPE concepts have played a major role in making the office a more civilized and satisfying place in which to work. But, insufficient consideration has been given to the impact of its assumptions on office building security.

At least four features of landscaping contribute to security exposures:

• **Lack of barriers to work areas.** There is no door or other obstruction that may be closed when an office/work space is unoccupied.

• **Isolation of service areas.** Maintenance access, delivery areas, and the like tend to be placed at the building periphery or in a detached service core. In both instances, this subordinate space is highly likely to be defined by solid walls or partitions and is separated from the general traffic flow. *Result:* This area becomes as exposed to possible risk as a center city street corner at 2 a.m.

• **Centralization of administrative services.** Adoption of this practice has been accelerated by the growing move to create word processing/administrative support units. Placing copying, filing, phone answering and comparable supportive functions in a centralized activity does reduce operating costs, but it increases the exposure of proprietary and other sensitive information to compromise.

• **Modularization of telephone cabling installations.** Designed to provide additional work spaces, these vertical fixtures distribute telephone cables along with electrical wiring. Cables, typically, are routed from the telephone company service termination in the building through the plenum space on particular floors of the structure. The telephone company, typically, has serious problems in accurately accounting for and controlling their own plant installation; they may be unable to keep up with your relocation of cabling modules. *Result:* Significant exposure, especially in multiple tenant buildings, to unauthorized audio surveillance—or, wiretapping, if you wish—that is extremely difficult to detect.

However, several things can prove helpful. These include...

• Improving surveillance of service areas—either through regular unobtrusive patrols by members of the security staff, or the installation of closed circuit television cameras monitored by a central site.

• Tightening circulation control by routine verification of visitors and identities. This need not be done so as to be obvious or to appear oppressive to employes.

• Establishing close control over proprietary or sensitive corporate information. Some organizations are finding it necessary to upgrade the filing equipment in use and to selectively install document circulation, transmission and reproduction controls comparable to those used in handling military agency classified information. ▪

Belden Menkus, of Middleville, N.J., serves as a consultant in the fields of data processing, personnel, records, and microfilm.

Photo: Wackenhut

Closed circuit television cameras monitored by a central location can help remedy security problems caused by modern office design, says consultant Belden Menkus.

plan. You need 18 months for planning prior to implementation. You should spend the first six months doing your homework and preparing yourself to present the plan to upper management. It is up to you to convince management that you can do it. Most managements will listen if you can show them you can substantially increase their after-tax income. Management commitment is necessary in making any changes.

Let's say I am persuasive enough to get management approval of the plan. You still did not tell me how I can develop such a plan.

This is the technical part of the process. You have to do most of the work here. You must analyze your plan design. Are your plans popular with employes? Are they competitive? Is their cost in line with their popularity? Can you make changes that will save you money?

Sometimes change can cause employe relations problems. That's why you need a good communications effort to carry any changes through. Take a look at your pension design. Can you make changes? The group insurance benefits? LTD? Look everywhere. At first you might get discouraged, but try to be creative. Call your benefit consultant and give him the challenge of his life. Tell him what you want to do and have him help you. Just be careful not to end up paying for an expensive stack of paper that will look pretty on your shelf. Agree to pay only for results.

Review your funding arrangements. What about minimum premium or self insurance? Are you getting a good deal from the insurance carriers? Can you make changes in pension actuarial assumptions that will save you money? Is any part of your pension funds in guaranteed investment contracts? Insurance carriers can offer you rates that are 50% higher than your actuarially assumed interest rate. Dig everywhere.

Does anybody in the real world do all that and make changes of this magnitude? Can you cite any examples?

Glad you asked. Imagine a company that had a non-integrated, mandatory, contributory pension plan that most employes detested and couldn't care less if the company did away with. The company had a voluntary contributory LTD plan. Life insurance was 3½ times annual salary. For years management was afraid to make changes. They did not want to pay any more than what they were already paying; they thought any changes that did not involve adding new benefits would not be popular with employes.

So what did they do?

Eventually they made the leap. They changed their pension plan by integrating it with Social Security. The savings realized helped them eliminate employe contributions. They added a savings and investment plan at a modest matching rate with a tax-sheltered guaranteed return on employe money in excess of 9%. They reduced life insurance to two times salary and in this way many employes stopped paying imputed income tax.

LTD benefits were increased and made non-contributory. As that last change eliminated adverse selection, the rates they were paying per $100 of covered payroll dropped substantially. They applied the savings from the life insurance to the LTD and pension plans. Consistent with ERISA, pension actuarial assumptions were altered. New funding arrangements were negotiated with the group insurance carriers. Minimum premium funding was implemented and ongoing savings achieved in addition to the release of several million dollars in health insurance reserves.

A communications program was implemented. And finally, administration was revamped by working closely with the carriers and trustees, developing an administration manual and training field personnel departments in proper benefits administration.

All that was done within the framework of one plan with synergy. The company realized ongoing and immediate savings, employe relations were improved. The manager who accomplished all that succeeds. ■

Safety check records . . .

Continued from page 31

product must be analyzed, including the way it is shipped, the way it will be serviced or repaired, the way it is packaged and the way it is labeled.

The designer must be aware that in the case of a lawsuit, the plaintiff's attorney will scrutinize the amount of research conducted to validate the safety of the product. The designer must carefully appraise the risk, by evaluating the severity and probability of occurrence of injury and must balance any risks associated with the product against the benefits provided by the product. The cumulative risks and benefits must then be compared against those of alternative designs and the best feasible alternative must be selected.

Documentation of the design process should include a listing of the intended uses and what foreseeable uses and misuses can be reasonably expected. All possible failure modes should be analyzed for their effects on the safety of the product. Fault-free analyses should be conducted and retained to assess the likelihood of a hazard occurring.

Where economic trade-offs are involved, failure rate analyses and other reliability studies should be conducted and retained to substantiate the "reasonableness" of the design selections. Advantages and disadvantages of alternative designs should be compared and recorded. Cost data should be retained along with summaries of economic and competitive marketing conditions at the time the design was adopted.

State of the art

The "state of the art" must be known and records should be available to substantiate exactly what the "state of the art" was at the time of manufacture and what safety considerations were technically and economically feasible.

One other critical aspect of strict liability is that the alleged defect must be present in the product when the product leaves the control of the manufacturer. Otherwise, it usually becomes someone else's problem. In the case of alleged production defects, quality control documentation and other records relating to the adequacy of the manufacturing and inspection processes are particularly important. Such records can be used to contradict allegations that the defect was present when the manufacturer relinquished control of the product.

Design approval and safety checks should be recorded and retained, says safety consultant George Karosas.

While most prevalent, strict liability is not the exclusive theory under which recovery is sought. Negligence principles and warranty theories still may apply. Under many circumstances liability under all three theories will be pleaded.

It is important to record the business relationships and the relative responsibilities between the manufacturer, his suppliers, subcontractors and others in the distribution chain.

Principles of comparative fault are becoming increasingly popular in the state courts and were recently endorsed by the Department of Commerce in its draft of the model uniform product liability law. Under these principles, damages are apportioned according to the amount of responsibility assigned to co-defendants. Adequate documentation of the business relationship is important to establish the responsibilities of each.

Documentation has long been a management tool for controlling costs and monitoring production efficiency and worker performance. The advent of strict liability adds another reason for documentation, in addition to the documentation required for defense of claims under negligence and warranty theories of product liability. ■

Risk Management Notes

Uninsured driver plans waste corporate cash

By Warren, McVeigh & Griffin

IF YOU PURCHASE medical payments or uninsured motorists coverage, you are wasting dollars. This is true for three reasons:

- Limits purchased do not normally represent an exposure large enough to call for insurance.
- These coverages usually duplicate funds available from other sources.
- Medical payments cover costs which are not an obligation of the company. If a company has occasion to make a voluntary payment, it should decide whether or not it wishes to do so. With medical payments insurance, the payment is made almost automatically.

Medical payments insurance is usually written with low limits, typically in the range of $1,000 to $5,000 per person. The coverage (considering auto medical payments only, and not premises medical payments) will pay: Medical expenses of all occupants of owned automobiles and, medical expenses of an "insured" (includes employes), arising out of an accident, while occupying any vehicle or through being struck by an auto while a pedestrian.

Uninsured motorists coverage generally provides loss reimbursement up to statutory limits (generally about $15,000 per person and $30,000 per accident) in two situations: Where occupants of owned vehicles are legally entitled to recover from an uninsured or hit and run automobile, and where an "insured" (employe) is a pedestrian or an occupant of another vehicle and is entitled to recover from an uninsured or hit and run auto.

There are three situations where medical payments and/or uninsured motorists coverage will pay:

- Employe in a company-owned or non-owned vehicle used on company business.
- Non-employe occupying a company-owned vehicle.
- Employe (or other permissive user) operating a company-owned automobile not on company business.

Potential sources of recovery other than auto medical payments and uninsured motorists coverage for each of these situations are:

Company employe in any vehicle, on company business:

- Company workers compensation insurance.
- Group medical and disability insurance.
- Medical payments and uninsured motorists coverage from personal auto insurance.

Non-employe occupying a company-owned vehicle:

- Workers compensation coverage carried by the non-employe's employer, if the individual is acting within the scope of employment.
- Any group or personal medical or disability insurance the other individual may have.
- If the company driver were negligent, the company will be legally liable to the non-employe and the company's liability insurer will respond.
- If the other driver were negligent, that driver's liability insurance will respond.

Warren, McVeigh & Griffin are risk management consultants headquartered in San Francisco.

PBGC rethinks rules . . .

Continued from page 31

ity to fund vested benefits upon voluntary termination would have to appear on the corporate balance sheet. (Presumably, this and the larger question of total unfunded liabilities on the balance sheet will be settled by the accountants.) Yet, this is certainly a matter of concern to all corporate plan sponsors, for such a liability might jeopardize a company's credit rating, capital-raising ability and any existing—or future—loan agreements. Even today, though, investment bankers and security analysts are giving more attention to footnoted unfunded vested liabilities.

A general consensus among seminar participants seems to be that the alternative PBGC proposal would tend to discourage plan improvements and start-ups. This would be especially true in the case of small employers, whose limited financial and administrative resources often make it impractical to suffer ERISA's paperwork burdens.

Yet, the proposal might promote sound, healthy pension funds. Future plan improvements would involve a more realistic appraisal of the corporate sponsor's prospective business conditions, rather than a "promise them anything, worry about it later" attitude. Management might also develop more collective backbone bargaining.

The trade-off

While the consensus response to the alternative was not overly enthusiastic, an understanding was reached by seminar attendees of the difficulty PBGC has had in coming to grips with CELI. PBGC recognized its alternatives would take away the right of an employer to terminate a plan voluntarily with no liability other than the current "up to 30% of net worth" cost. Employers acknowledge that they would be exchanging this right to terminate for a savings in future premium dollars paid to PBGC. And for large employers, premium dollars are or may become a significant cost factor in planning.

PBGC's proposal is not final. There are several areas that still need to be analyzed, including the effect on small employers and how to account for liabilities. PBGC is seeking comments, ideas or suggestions from concerned parties. However, given the fact that a termination insurance program is in the cards, the voluntary termination alternative represents a reasonable compromise. At present, PBGC has little control over termination situations which can have severe financial implications. Under the proposal the heavy hand of government may be felt, but at least it would be basically limited to genuine hardship situations with impact for employer and employe.

In an ideal world, the proposal minimizes the drain on PBGC premium dollars, and would stop penalizing ongoing plans whose ever-growing premium dollars, pay for benefits of terminated plans. And that is not a bad thing. ■

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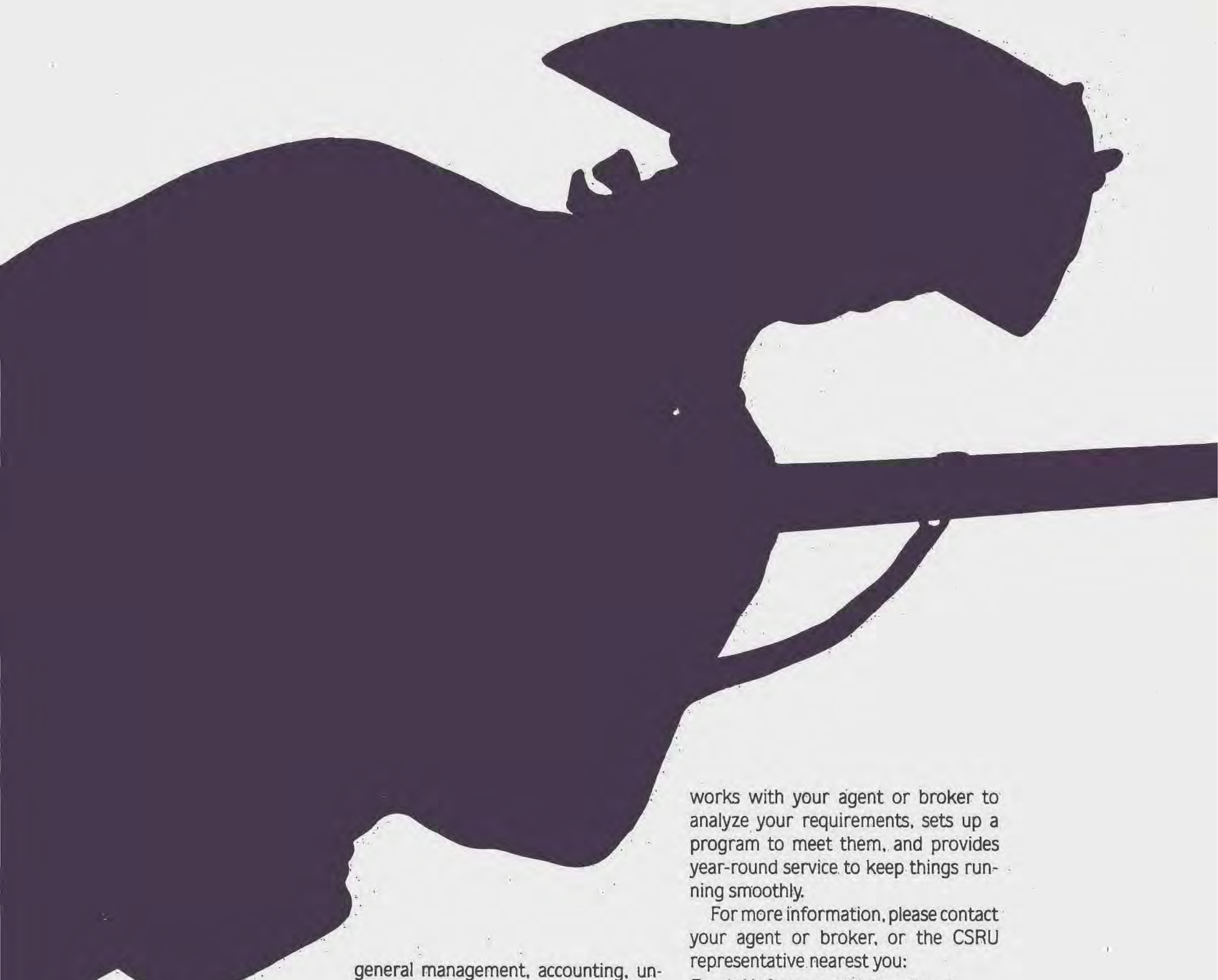

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Lloyd's tightens up membership rules as demand slumps

By JOHN H. MILLER

LONDON—Bulging with excess capacity, Lloyd's of London is tightening its attitude toward admitting new members.

Only 1,000 to 1,200 new members are expected to be admitted to Lloyd's in 1980, an increase of just 5% over its present membership of 17,400.

It's a drastic change from the last two years when well over 3,000 newcomers were allowed to join each year in order to provide extra capacity that was needed to deal with world demands for insurance.

Now there is so much competition for insurance business all over the world, both in the U.S. and elsewhere, that the demand is slackening off and profitable risks are hard to get.

This is the first indication of a new approach to Lloyd's operations for next year and possibly well into 1981. Underwriting agents in London have found that in the past 12 months they have been working at only 75% of their syndicate's capacity in some "hard to get" lines of business.

Growth of Lloyd's has exploded 100% in recent times, rising from 8,565 in 1976 to its present record total. Its estimated capacity in all markets is $4 billion to $5 billion a year.

But there have already been hints that it might be essential to cut back, notably from chairman Ian Findlay who declared last year that a steady increase in capacity is a healthy market feature, provided that it keeps in line with corresponding growth in business. Both he and other top men at Lloyd's are satisfied that slowing down membership growth is an appropriate step at the present time.

Deputy chairman Charles O. Gibb said, "Lloyd's is fully geared to meet all likely capacity demands in 1980 and is still as popular as ever. But when business is being done on inadequate rates in many areas of business, it's obviously not the right time to encourage too many people to join the market."

Although individual underwriting agencies decide how many names they should accept, similar views are being expressed by many underwriters and brokers who handle large lines of business.

A. Ronald Taylor, chairman of the big Willis Faber Dumas broking group, commented: "Our underwriting activities at Lloyd's continue to make a valuable contribution to group profits, but we received so many applications last year for membership of Lloyd's that it was felt there was danger of diluting the interests of existing names. This advice came to us from our underwriters and so we decided to restrict the number of people whom we put forward to the committee of Lloyd's for election.

"For the same reason we'll be applying even more severe limitations this year," he added. Willis Faber, which handled $1.8 billion in brokerage income last year, currently manages several syndicates at Lloyd's.

Another leading U.K. broker who agreed that there seems to be too much capacity everywhere for insurance business said it's not surprising that underwriting agencies at Lloyd's are reluctant to accept new members at present.

Other sources pointed out that when the currency levels put sterling in a weak position two or three years ago, there was an urgent need for extra premium capacity to meet dollar requirements. But now that the pound is stronger, the demand is not so overwhelming.

Extra monetary demands on new members will take effect Jan. 1, 1980. New members from overseas will have to show they are worth about $270,000 or 135,000 pounds and U.K. applicants, 100,000 pounds. Current members from overseas show worth of $200,000 or 100,000 pounds and U.K. members 75,000 pounds. ■

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riskWatch

By KATHRYN McINTYRE

Misusing rehabilitation programs invites tragedy, thwarts success

A truck driver refusing surgery for back pain is tagged a malingerer by the workers compensation insurer still paying benefits a year after the back injury. The insurer's claims manager calls a vocational rehabilitation specialist in hopes of getting the man back to work and off the benefit rolls.

The rehab specialist determines from initial visits that the pain could be more psychological than physical and wants to administer psychological tests. But the insurer vetoes the tests, presumably concerned that the test results could later leave the employer and insurer open to more liability than the case now represents.

McIntyre

The rehab expert doesn't give up, though later she thinks she should have, being so hampered in her work. She tries to line up a dispatcher's job for the former truck driver, to keep him in familiar surroundings but out of work that could aggravate the pain.

She never gets the opportunity to finish the case. The truck driver shoots his wife, killing her. The insurer's response? "Guess we can stop paying claims now."

A mother of three is dead. Three children are wards of the state. A man is in jail for murder and the insurer responds, "Guess we can stop paying claims now."

The claims manager would certainly shudder to see his reaction in print and with a moment of thought on the tragedy presumably would not have reacted with what sounds to be so flippant and callous a response. The first reaction is almost understandable, considering his day-to-day, abstract contact with so much tragedy.

Grace Gianforte, the Chicago-based, private vocational rehab expert in this experience, might not have been able to prevent the violent act. But who knows what might have happened if she had been called to work on the case a year earlier, right after the accident, or if she had been allowed to administer the psychological tests as she wanted.

The rehab expert tells the story to illustrate how rehabilitation is still misunderstood and misused. "The case was a year old," she grimaced. "Insurers still try medical intervention first. Then they try to settle the claim. Then they try rehab. You have to reverse the order."

Indeed. Any risk manager who has taken even a cursory look into rehabilitation programs knows early involvement is the rehab experts' first commandment. If the rehab specialist doesn't get on the case soon after the injury, the worker wallows in his injury, pain and anger. The longer it is before someone tries to help, the less likely the chance of successful rehabilitation.

It's so obvious and logical. Why the delays?

Ms. Gianforte doesn't think anyone is making a conscious decision to delay ordering rehab services but rather the employer and insurer assume that if rehab services are needed, the attending physician will order them. It's a false assumption. "I've never had a referral from a physician," the counselor of 15 years says. "Doctors can't appreciate the vocational implications of injury."

The rehab expert, though, comes into a case asking, "Is there any medically verifiable impairment? Does it prevent him from returning to his old work? Any work?" If the effects of the injury are so debilitating that the worker is unemployable in private industry, Ms. Gianforte advocates that the insurer structure a settlement that will set the person up in his own business.

If the roadblock to returning to work is psychological, "it's more difficult to manage and much more of a challenge to treat," she admits. But it can be dealt with, if her hands aren't tied. She looks for the source. Is it the lost job? The lost contact with people? Perhaps losing a portion of income, mobility and freedom are contributing factors. Or maybe it's a lost sense of self, guilt and frustration that are sending the person into depression and pain. A need for special equipment or care may have been overlooked; the needs of the family may have been ignored.

The rehab expert discovers the source of the psychological pain and works with the injured worker to treat it. But when it's an average of 18 months after the injury before the rehab expert is called—according to the Illinois Industrial Commission—the job is tougher.

If the doctors aren't referring injured workers to rehab specialists and the insurers are waiting too long before calling for help, it's obviously up to the employer to demand prompt rehabilitation of injured workers.

Pullman's bond is one-fourth of damages asked by city

NEW YORK—A $25.6 million performance guaranty bond on Pullman-Standard is probably the only insurance protecting the firm against a $112.3 million suit filed against it and Rockwell International Corp. as a result of defective New York City subway cars.

New York filed suit against the two firms in mid-June charging breach of contract and warranty in the manufacture of 754 subway cars. Since March 1977, 1,058 faults have been found in the motor mounts and side frames of 618 cast-steel undercarriages on which the cars ride.

The undercarriages, or trucks, were manufactured by a Rockwell subsidiary under contract to Pullman. The suit, filed in state Supreme Court here, charges that the cracks in the trucks represent a "significant danger of a derailment."

Existence of the guaranty bond, underwritten by five subsidiaries of The Continental Corp., was disclosed by Bruce Kaplan, chief assistant corporation counsel for the City of New York. Mr. Kaplan said the city intends to file for recovery under that bond.

Product liability coverage for either Pullman or Rockwell is not expected to be involved in defense of the city's lawsuit since the suit does not allege bodily injury or property damage.

Mr. Kaplan said he was told by Pullman attorneys that Rockwell International has agreed to indemnify and hold Pullman harmless for claims resulting from the trucks. A spokesman for Pullman declined to confirm this.

However, in a press release, Pullman stated: "This peremptory action by the city will undoubtedly expand to extensive, vigorous and prolonged litigation, possibly involving a substantial number of Pullman's suppliers and subcontractors under the R-46 contract."

The spokesman said Pullman intends to file a counterclaim against New York but would not disclose what allegations would be included in that claim.

It is not clear whether indemnification by Rockwell or other subcontractors would supercede Pullman's guaranty bond. ■

Calif. mutual lowers rates for its doctors

PASADENA, Calif.—Physicians and Surgeons Insurance Exchange of California, a doctor-owned company providing professional liability protection for the medical profession, has lowered renewal rates for second, third and fourth year physicians and surgeon members.

The reductions will vary depending on medical specialty classes and the number of years insured, according to the company, which began reducing rates April 1.

"After careful study of the claim reporting pattern experienced by medical professional liability insurers since 1975, we have determined that a reduction in the amount of premium required for second, third and fourth year insureds is in order," said a company spokesman.

Coupled with the renewal rate reductions, the Exchange has reduced the premiums required of new first-year policyholders rated in five of the organization's eight rating groups. Rates were reduced between 17% and 25%.

The exchange said its experience does not support reductions for doctors assigned to the remaining three high-risk groups. ■

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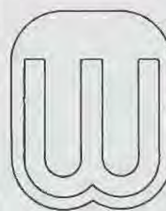

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legal brief

Minn. court pins liability loss on confusing Allstate policy

THE SUPREME COURT of Minnesota ruled that reference in a business insurance package policy governing limits of liability for employe dishonesty to a limitation on "total" liability and a reference in another section to limitation on "annual" liability raised a reasonable doubt regarding the limitations of liability.

Columbia Heights Motors was engaged in the sales and service of automobiles. In 1973 Allstate Insurance Co. issued the company a business package policy providing several types of coverage including general liability, garage liability, automobile liability, automobile physical damage, loss of business income and loss or damage to property.

During the policy period, the company sustained a loss through the dishonest activities of one of its employes as follows: 1973-74, $1,543; 1974-75, $31,386, and 1975-76, $29,820.

Both the general conditions and the insurance agreement used the word "aggregate" to refer to an annual limitation on Allstate's liability. But the insuring agreement and the table of limits of liability, read together, limited Allstate's liability for any particular year to $25,000.

The motor company claimed the policy covered the loss up to $25,000 per year for each of the three years. Allstate claimed maximum liability was $25,000 for the entire policy period because the loss was caused by only one employe. The trial court ruled for the insured.

The appellate court agreed that the policy was subject to more than one interpretation and if it were to accept one interpretation, that of the insured's appeared to be more reasonable. However, the court said it did not have to decide which interpretation was more accurate because the several policy provisions created a reasonable doubt of the liability limits. Reasonable doubt as to the meaning of the language of an insurance policy, the court said, must be resolved in favor of the insured. *Columbia Heights Motors v. Allstate Ins. Co.*, Supreme Court of Minnesota, Jan. 12, 1979 (BI/01/Jy.-$4).

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

Workers compensation

An employe injured in an automobile accident while returning home from a trip to his employer, where he had gone to drop off a required medical release authorizing him to return to work after a prior industrial injury, was within the "special mission" exception to the "going and coming" rule, says the California supreme court.

Elliott Weitzman suffered an industrial injury in February 1976 while employed by a rapid transit district. In order to return to work, Mr. Weitzman was required by the district to obtain an unrestricted medical release from his physician. On Sept. 28, 1976, Mr. Weitzman obtained the release from his physician and took it to the district office. He was told to report to work Sept. 30.

Enroute to his home from the district office, Mr. Weitzman was injured in an automobile accident. In this proceeding, Mr. Weitzman claimed benefits arising out of the second accident. The workers compensation appeals board awarded him temporary disability benefits. His employer appealed.

The employer's principal contention was that the Sept. 28 accident did not arise out of or occur in the course of Mr. Weitzman's employment and hence no award for disability could be predicated upon its occurrence. However, the court concluded that the second injury clearly was occasioned by the earlier compensable injury and was sustained in the course of following the employer's instructions flowing out of that earlier injury. "In bringing the clearance to RTD in advance of the date of his resumption of work," the court said, "Mr. Weitzman was acting at his employer's behest." *S. Cal. Rapid Trans. Dist. v. Workers Comp.*, supreme court of California, Jan. 18, 1979 (BI/02/Jy.-$4).

Group health

An insured sued his insurance

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company to recover benefits for nursing care under a group health policy. A Louisiana appellate court ruled that where the custodial care exclusion in the group policy was ambiguous with respect to whether nursing care constituted "custodial care," the trial court correctly charged the jury that the exclusion did not apply to the major medical coverage for nursing care.

G.L. Paret was covered under the policy issued by Blue Cross of Louisiana. Basic coverage excluded convalescent, custodial or sanitaria care or rest cures. The major medical endorsement included the services of a registered professional nurse and of a licensed practical nurse. The major medical endorsement stated that the exclusions of the basic coverage were applicable to the endorsement except where they conflicted.

Mr. Paret suffered a stroke in June 1975. He was hospitalized and later released by his physician with the stipulation that he have constant attendance by skilled nurses on a 24-hour basis. Mr. Paret did receive round the clock care from a series of licensed practical nurses who gave him shots and took his blood pressure. In this suit, Mr. Paret asked for more than $50,000 for the nursing care. The insurer, in turn, sought reimbursement of $55,000 that it claimed it had paid by mistake. A jury found for the insurance company.

The appellate court said that nursing services constituted a major medical supplement to the basic coverage and if they are excluded under certain circumstances, the policy should make the exclusion clear. The court concluded that it was not at all clear that "custodial" nursing care was excluded.

Even if it were excluded, the court believed that the care Mr. Paret received here was beyond that of merely watching a patient to see that he does himself no injury. Thus, the court held the insurer liable for the claimed benefits and denied its request for reimbursement of benefits paid. *Paret v. Louisiana Health Ser. & Indem.*, court of appeals of Louisiana, Dec. 20, 1978 (BI/03/Jy.-$4).

"Churning" accounts

A federal district court in New York held that a claim of "churning" by customers in their complaint against a stockbroker brought the suit within the coverage of a brokers blanket bond. The court said that "churning" was a deceptive device that fell within the fidelity provisions of the bond.

H.S. Equities Inc. (HS), a stockbrokerage, employed Michael Frank as a registered representative. The Hartford Accident & Indemnity Co., at all times relevant here, insured HS under a brokers blanket bond against any loss "through any dishonest, fraudulent or criminal act of any of" HS's employes.

Mr. & Mrs. Odessey sued HS and Mr. Frank in 1969 claiming that Mr. Frank churned their securities accounts, engaged in unauthorized transactions and made fraudulent misrepresentations to them. HS retained a law firm to represent them in this suit and notified Hartford. Hartford elected not to defend the Odessey action. Subsequently, HS and Mr. Frank settled with the Odesseys and notified Hartford. HS brought this suit against Hartford to recover the amount of the settlement and attorneys' fees.

The court said that if the facts alleged in the Odessey action had been proved, they would have established the existence of dishonest or fraudulent acts as those terms were used in the bond. Thus, the court concluded that the allegations of misconduct contained in the Odessey complaint brought that suit within the coverage of the bond. Since Hartford has an opportunity to defend but declined, the court held the insurer liable for the settlement and the attorneys' fees.

The court rejected Hartford's claim that a set-off should have been allowed for the commissions that HS made on the transactions in the churning of the Odessey accounts. The court said that the bond did not require that the loss should be balanced against past profit. All that was required under the bond, according to the court, was that the loss be due to the dishonest or fraudulent act of an employe. *H.S. Equities, Inc. v. Hartford Acc. & Indem. Co.*, U.S. district court for the Southern District of New York, Nov. 22, 1978 (BI/04/Jy.-$4).

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

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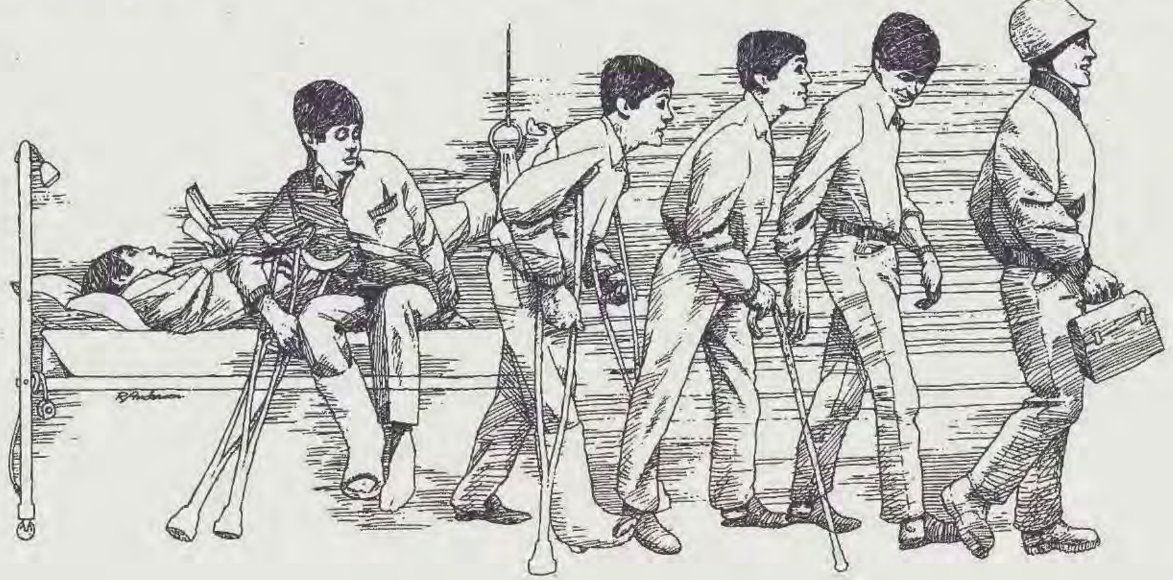

london line

U.K. insurers predict no crunch if Europe adopts strict liability

By JOHN H. MILLER

LONDON—If European countries adopt strict liability, judgments for injured persons' costs aren't expected to skyrocket so much to restrict liability insurance markets as happened in the U.S., a report by Lloyd's and U.K. insurers says.

The European Economic Community is considering stricter rules against defective products, raising concern among multinational firms that export to EEC countries that huge judgments such as those reported in the U.S. will occur, thus restricting liability insurance markets.

But a joint body of Lloyd's and company insurers promises that insurance cover will be available up to substantial limits, although higher rates might apply to high risk products such as pharmaceuticals.

The U.K. Accident Offices Assn., which represents Lloyd's and company underwriters, said recently, "Various proposals have been made, both in the U.K. and the rest of Europe, for a change in the law whereby producers would be strictly liable to pay compensation for personal injuries caused by defective products.

"Concern over the effect of such a change in the cost of insurance has been fostered by the dramatic increase in product liability claims in the U.S.

"But we're firmly of the opinion that the extreme cases in the U.S. are more attributable to its legal and economic background, as well as social background, than to the precise doctrine of strict liability. Court procedures, the contingency fee system for lawyers, awards of punitive damages and other legal aspects are different in the U.S."

Any change in product liability rules is unlikely to have any significant effect in Europe, "although some impact on rates is inevitable," the association said.

Leading U.K. underwriters, however, say there will have to be much greater risk control, especially over new products, if stricter "no-fault" laws are adopted. There will have to be an especially careful watch on the development risk of pharmaceuticals, it's noted.

Insurers in some areas, however, have speculated that changes in British laws in the next two or three years will make it easier for consumers to get compensation for defective products. Rates might rise as a result by 33% for low-grade risks, 50% or more for medium risks, and 100% plus for high risks.

Industrial leaders still oppose any major changes in regulatory provisions for bad products. Sir John Methven, director general of the Confederation of British Industry, takes the view: "The public has the right to protection from unfair treatment by manufacturers, but proposals to extend liability are totally unreasonable and it would be better if government and industry got together to fix standards of safety and manufacture."

New insurance centers

New international insurance centers are being planned by leading U.K. groups venturing into places such as Hong Kong and Bahrain.

The C.T. Bowring group, which is finalizing a business link-up with Marsh & McLennan, is part of a new reinsurance company in Hong Kong set up in association with two well-established local business firms. Other backers include Chubb Corp. from the U.S. and the Ming An Insurance Co. of Hong Kong, part of China's state-run insurance organization.

At the same time, two U.K. insurance groups, Hogg Robinson and Prudential Assurance, are joining a consortium based on Saudi Arabian financial interests to start up a new insurance company in Bahrain called Saudia International Insurance Co. It will develop insurance business on construction projects and other big developments in that oil-rich area, but will also cover marine, aviation and other non-life risks.

Broker responds

Malcolm Pearson, head of Lloyd's brokers Pearson Webb Springbett, has defended himself vigorously against criticism that he acted too strongly in pursuing suspicions of fraud over a massive claim for fire damage to 301 Fiat autos in the cargo vessel Savonita in 1974 (*BI*, Jan. 8).

He represented the Italian insurance company SIAT, which initiated reinsurance claims against the London market for $711,643 in order to recoup its losses over payments to the Fiat group for the damaged vehicles.

When inquiries into the affair led to the suspicion that a Naples, Italy, dealer might have bought the damaged autos at much below their true value, Mr. Pearson took legal advice and kept underwriters informed of the position.

The consequence was that the bigger broking group, Willis Faber Dumas, took over the SIAT claim and finally got the market to agree to a settlement of around $543,000.

There was an internal quarrel over the actions of the Willis Faber group. A special Lloyd's commission of inquiry cleared them of exercising undue pressure on marine underwriters to settle the reinsurance claim.

Emphasizing that he acted at all times on legal advice, Mr. Pearson has now formally replied to Lloyd's: "My duty was to inquire whether my suspicions over the claim were well-founded, even though I was about to put our largest account into jeopardy, and to co-operate with all parties in the investigations.

"I was not prepared to ignore these, nor stand aside and see the claim paid without taking any action. It is not clear to me how professional duty can differ from public duty when fraud is suspected. I can only say that my brokerage firm forfeited its largest account because we stood up for the underwriters concerned and for what we still regard as the best traditions of integrity in this market.

"I do not find crusades and campaigns dishonorable things. Perhaps there are not enough of them nowadays, but I certainly care very deeply about many things, and Lloyd's is one of them." ▪

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Florida regulator investigates, fines unlicensed insurers

TALLAHASSEE—Florida insurance commissioner Bill Gunter is pursuing, fining and publicizing action against insurance companies found doing business here without a license.

A $1,000 fine was assessed last month against American Druggists Insurance Co., an Ohio-based company specializing in professional liability coverage.

A $5,000 fine was assessed earlier against a Bermuda-based company and its fronting insurer was fined $3,500.

An investigation by the department of insurance revealed that American Druggists sold a comprehensive professional liability policy to the Pinellas County Sheriff's Department without being authorized to solicit that kind of coverage in Florida, the department said.

Soliciting insurance without the approval of the department of insurance can be grounds for the revocation of a certificate of authority to operate in Florida.

However, a joint settlement stipulation issued by the department of insurance and signed by the American Druggists stated that the company would agree to the fine and comply with the Insurance Code.

Law Enforcement Insurance Co. Ltd. (LEIC) of Hamilton, Bermuda, specialists in civil liability coverage for members of law enforcement agencies, was fined $5,000 for issuing professional liability policies from Nov. 1, 1977, through Sept. 30, 1978, to members of the National Sheriff's Assn. without a license to operate in the state.

When LEIC agreed to stop issuing the policies, Ideal Mutual picked up the business in Oct. 1978, underwrote the LEIC policies, but reinsured 95% of the risk with LEIC without the approval of the department of insurance. Ideal was fined $3,500.

Meanwhile, the National Sheriff's Assn., said to have waged an aggressive ad, brochure and mail campaign bringing business to the two companies, was not fined, but ordered to stop soliciting business on behalf of the two companies.

LEIC and Ideal Mutual refused to comment on the settlements. But an attorney with Florida's insurance department said that both companies agreed that they were violating separate sections of the state's insurance code and would pay the fines without any delay.

When the charges of the insurance department first hit the desks of LEIC, a stock company, it insisted that it was not doing business in the state. Instead, it claimed, it was merely launching direct mail solicitation and as such did not come under the purview of the state's insurance code. Later, however, the Bermuda-based company admitted to its wrongdoing along with Ideal Mutual.

The activities of both LEIC and Ideal Mutual were uncovered when the department received an "inordinate" number of complaints from members of the insurance industry and inquiries from consumers. ▪

RIMS chapter elects officers

PORTLAND, Ore.—Jack Fee of Publisher's Paper Co. is the new president of the Oregon Chapter of the Risk & Insurance Management Society.

Other officers of the chapter for 1979-80 term are: Antienna Gates of Louisiana Pacific Corp., executive vp; Randal Wilson of Portland General Electric Corp., vp-secretary/treasurer; Cynthia Rimkus, ESCO Corp., vp-communications; Rollin Hogge of Pope & Talbot, vp-special projects and John Miller of Consolidated Freightways, vp-national director.

Kathy Panther of Northwest Acceptance Corp. was elected historian. ▪

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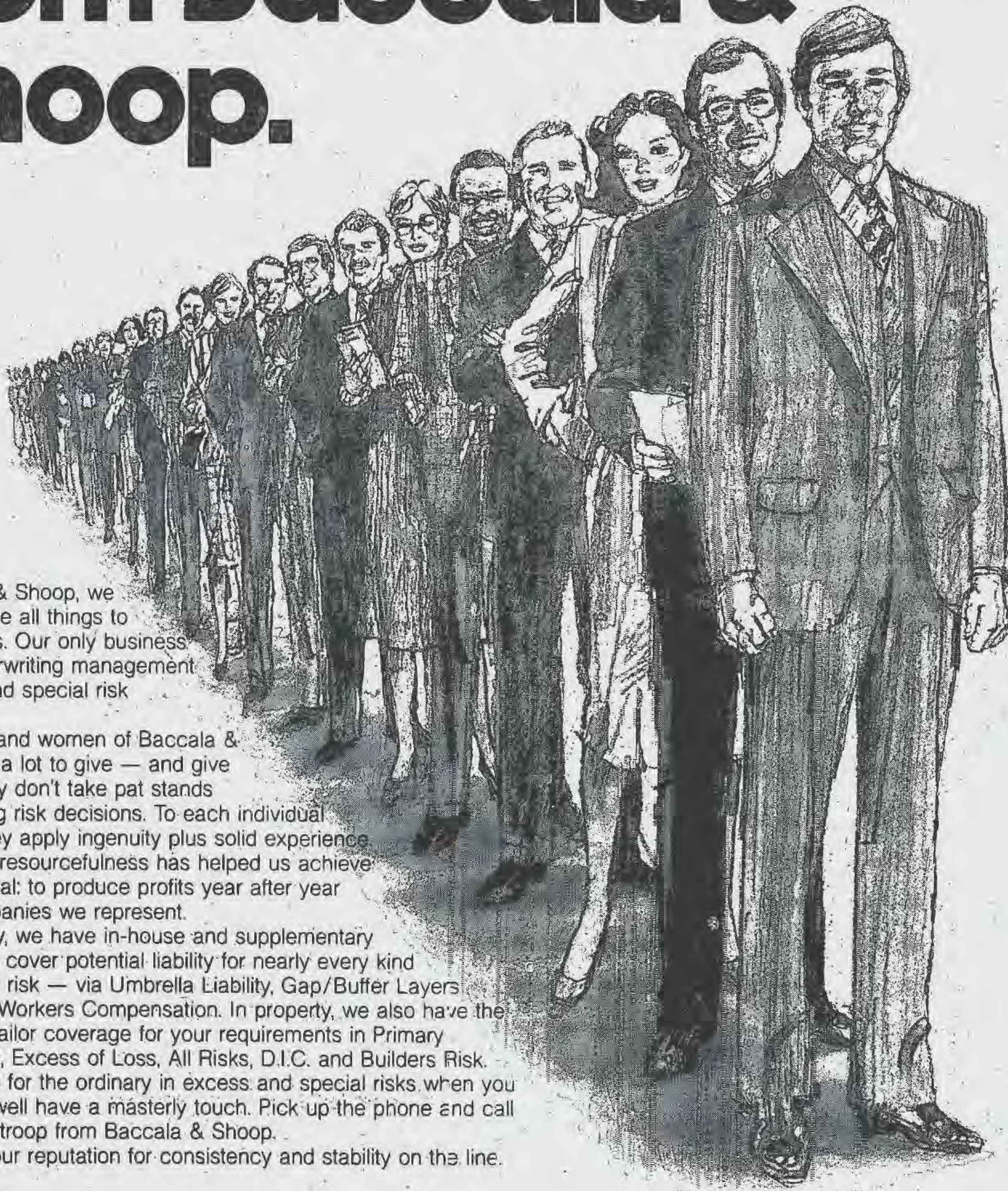

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Conn. governor signs tort reform bill

HARTFORD—Connecticut Gov. Ella Grasso has signed into law legislation (H.B. 5870) that contains the major provisions of the U.S. Commerce Department's model product liability bill.

The measure limits the liability of manufacturers to only the "useful safe life" of their products and reduces awards by the amount of workers compensation benefits.

Last year, Gov. Grasso vetoed a product liability bill that was considered more favorable to manufacturers than this year's measure which goes into effect Oct. 1.

Mich. work comp

LANSING—Michigan employers will pay an average of 14.3% more for workers compensation insurance under new rates approved by acting insurance commissioner Jean Carlson.

The approved rate increase is 2.2% less than had been recommended by an independent hearing officer and only a little more than half of the 25.4% insurers had requested if the rate hike were to take effect after Dec. 1, 1978. The rate increase approval is less primarily because the commissioner cut the requested trend factor from 1.575 to 1.429.

The rates, which will increase insurers' income by $79 million, will take effect as soon as insurers file for the new rates in accordance with the commissioner's conditions of approval. Insurers had hoped the new rates would be approved retroactive to Dec. 1, 1978, claiming the increases were needed because of poor loss experience.

Mass. recognizes stress

BOSTON—The Massachusetts supreme judicial court held that employes unable to work because their jobs have led to mental or emotional disorders are entitled to collect workers compensation.

Employes are eligible for compensation, the court said, if their incapacitating mental or emotional disorders were caused by "specific stressful work-related incidents."

The court ruled in the case of Joseph Albanese, a former foreman for the Atlantic Steel Co. in Everett, who was diagnosed as having "a chronic anxiety state mixed with depression."

His problem, the court said, was attributed to stress on the job when friction developed between Mr. Albanese as supervisor of the plant's shipping operation and the workers after unionization efforts began in 1967. Additional friction was caused by the plant manager's activities, the court said.

W. Va. work comp

CHARLESTON—The West Virginia supreme court has ruled that temporary total benefits for an employe may be terminated by the workers compensation commissioner without holding a hearing, but the employe must be given prior notice and the opportunity to submit additional evidence.

The commissioner, not a doctor, ultimately decides the degree of disability based on medical data and the date for ending temporary total benefits.

Map use wanes

DALLAS—Texas's little-used Market Assistance Program for product liability will renew its publicity efforts to attract new applicants, but directors say the program will probably be discontinued later this year if the campaign fails.

The MAP program, set up in August 1977 to help find insurance for product liability risks, has received only one application for coverage so far this year. The program received 35 applications in 1978.

Applications are scarce, said executive committee chairman Bill Huff, because product liability insurance is still too expensive for many companies to afford through any market mechanism. "We can deal with availability, but there's nothing we can do about affordability," he said.

Less publicity of the program could be a factor in fewer applications, Mr. Huff noted. He will meet with the state board of insurance in September to recommend whether or not the program should be continued.

Punitive damages

LANSING—Liability insurance policies sold in Michigan may not exclude coverage for punitive damages, according to a guideline from the insurance department.

All liability policies are being reviewed by the department for the exclusion and any policy carrying the exclusion since June 1 is being disapproved, the department said.

The insurance department determined that excluding coverage for punitive damages denies expected and deserved coverage and cannot be accompanied by a premium reduction because the reduction would be impossible to calculate.

N.J. work comp

TRENTON—New Jersey's 175,000 insured employers will pay an average of 8.5% more for workers compensation insurance under new rates approved for July 1.

That's an estimated $39.5 million more for the 230 workers compensation insurers in the state, according to the state compensation rating and inspection bureau.

The increase is needed, according to the bureau, because of higher costs of medical services and because court decisions have expanded the definition of compensable events.

Vt. ski area wins

MONTEPELIER—The Vermont supreme court upheld a Rutland superior court verdict in favor of Sherburne Corp. in a negligence lawsuit brought against the ski area by a young boy in 1975.

Sherburne Corp. runs the Killington Basin Ski Area, where Brett Green was injured in 1975 when he skied into a utility pole on the East Glade Trail.

Mr. Green's family had tried to raise the issue as to whether a utility pole in a ski trail was an "obvious and necessary danger" that should be assumed by the skier. But the supreme court upheld the lower court's handling of the case, noting the utility pole was an "obvious, observable obstacle" rather than a hidden danger to the skiers. ■

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Group liability plan buttonholes handful of clothing makers

NEW YORK—Despite potential savings of as much as 25% on product liability insurance rates, fewer than 10 of the 100 members of the National Outerwear & Sportswear Assn. have taken advantage of a new association program.

But Mort Bauman, executive director of the association, said the program, underwritten by the Puritan Insurance Co., is generating "a lot of interest" among manufacturers. He expects the number of participants to grow by the end of the year. NOSA's members are manufacturers, producing primarily coats and jackets.

"This is a thing you build up. It takes a while to get started," he said of the two-month-old program. Although only eight association members have joined the plan, around 60 others have asked for rate estimates.

NOSA's members range in size from $1 million in annual sales to $600 million in annual sales, with the average size being in the $10 million to $20 million range. Of the eight companies that have signed up so far for the Puritan policy, most are small, although a couple fall into $10 million annual sales category, Mr. Bauman said.

The rates individual members pay under the association plan vary from state to state, but the average savings is around 15%, Mr. Bauman said. Some manufacturers have had their costs reduced by as much as 25% and others haven't been able to save any appreciable amount, he added.

The standard product liability policy includes limits of $500,000 per occurrence and a $1,000 deductible, according to Mr. Bauman.

NOSA decided to seek out the association plan because members "felt they were paying too high a rate for the risk involved," he said.

The plan was also put together after retailers, skittish about their potential risk, pressured the manufacturers to obtain liability policies that would protect them as well, as additional insureds, Mr. Bauman said.

"The retailers are demanding it. They want to make sure they are covered," Mr. Bauman said. Retailers have been especially concerned about potential lawsuits arising out of clothes that might have caught on fire and injured the wearer, particularly after the Triss case a few years ago, when inflammable material was ordered off the market by the government.

Cases have also been filed against manufacturers for such things as a young boy strangled to death when the hood of his jacket caught on a tree branch, Mr. Bauman said. ▪

Las Vegas self-insures

LAS VEGAS—The city of Las Vegas has named Integrity Insurance, Rochelle Park, N.J., as its municipal liability excess insurer over a new $100,000 self-insurance program, effective July 1, according to Ted Willstead, risk manager.

He said that Integrity Insurance is the city's first excess municipal liability insurance carrier.

The premium on the excess coverage is $188,500 according to a spokesman for Warren, McVeigh & Griffin, Newport Beach, Calif., which acted as consultant on the program.

The first dollar coverage previously purchased from the Hartford Insurance Company cost the city a total of $391,500 a year, for the same $5 million limits now provided under the self-insurance and excess program.

Las Vegas's annual paid losses, said Mr. Willstead, are between $15,000 and $20,000, with annual reserved losses of $50,000 to $54,000.

He said that out of eight excess carriers evaluated during the selection process, only Compass and Admiral offered coverage above a self-insured limit. ▪

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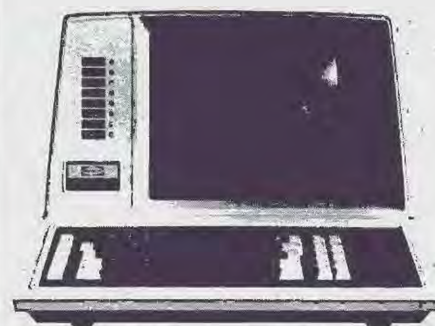

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book review

Boss talk: 'I can shout, don't hear you'

By Z'EV KRONISH

Communication for Supervisors and Managers
By Lyle Sussman and Paul D. Krivonos
Alfred Publishing Co., 227 pp., $9.95

For many years, J.P. Morgan walked to work daily with a neighbor who sold life insurance. One day the salesman expressed disappointment over Mr. Morgan's failure to give him any business.

"You never asked me!" the financier responded.

A singular concept, communication is easily taken for granted. It's not farfetched to describe the process as the blood stream of the organization, pervading all levels, up to the higher echelon of management, down to subordinates and across to those who hold similar responsibilities. This book's theme is that the manager can improve the quality of performance by grasping the communication idea.

The authors warn against assuming that the receivers of any communication is a sponge "passively soaking in the message." If the response is less than expected, it's not that someone is slow but due to the fact that communication is a complex process involving overload, distortion and other dysfunctions.

Misunderstandings occur because meanings elude the participants. Ambiguity is a major cause of communication breakdown. And then there are those who simply don't listen; they're distracted by all that's happening around them.

"As messages travel up the hierarchy from the lowest to the highest levels, distortion is an ever-present danger." The sender transmits an idea, but the receiver's perception alters the message. Language in itself is a major barrier to universal understanding, particularly in the case of upward communication, from subordinate to supervisor.

Feedback is one way to reduce distortion. By treating communication as a dynamic process—akin to a game of ping-pong—it is possible to progress as an effective administrator. For feedback to work, the sender has to deftly tune in to the reaction and the receiver to cooperate by sharing ideas and thoughts. In a sense, communication is always in flux; it is a continuous motion.

The authors observe that anything you do, as well as what you say, has the potential to communicate. Your facial expressions can influence your message. One bit of advice: Say it well rather than often. To be effective, it helps if you gain insight into the receiver's personality. You should know something about the other individual's motivation and attitude.

Is it better to put your message in writing or present it orally? Oral communication works better when a response is needed quickly because "feedback obtained in face-to-face situations is more immediate." Issues can be resolved rapidly. The authors praise "warmth" as a factor favoring the oral route. Intimate contact can induce a receptive atmosphere.

Kinesics, a concept popularized by Julius Fast in the early 1970s, views body action as a unique element in communication. Messrs. Sussman and Krivonos observe that touching can add a vital dimension to the verbal message "I like you." Nonverbal cues rate attention; they're apt to give useful clues of real feeling. Watch the face for your first hint of the receiver's reaction. Eye contact will positively prod feedback. Posture is a clue.

As a non-verbal cue, timing offers its own special message. A job applicant who arrived 15 minutes early was judged by participants in a study the book cites to be a dull person while someone 15 minutes late was viewed as incompetent. The punctual applicant was "perceived as the most sociable and composed."

Listening habits, the authors say, are the cause of many awkward predicaments. Cultivate these useful skills: Tune into what's being said; focus on the main idea; don't be sidetracked by trivia; withhold rash judgment.

The authors present only one side of the listening phenomenon. Good listening technique, a persuasive instrument to a winning personality, brings many rewards. In subtle ways listening power can achieve results.

Too much information leads to suffocation, the authors warn. The distress, known as overload, produces a negative response. They suggest that the way to control overload is for the receiver to set up a priority system and for the sender to carefully examine his selection of messages.

The solution Messrs. Sussman and Krivonos offer doesn't go far enough. The formal atmosphere in the workplace dampens meaningful expression and the informal channels are insignificant. The authors devote two chapters to knowing and reaching the receiver. Their emphasis is misplaced. The communication hang-up doesn't stem from the receiver's characteristics.

To communicate effectively, employes require training sessions because people are inhibited and incapable of expressing ideas freely in the corporate environment. On the one hand, communication skill is a learned behavior, which the authors stress, but the goal is thwarted by the employes' inability to let go. The basic barrier is an imprisoned personality.

Effective communication is the aim but success depends on a therapeutic approach that utilizes the technique of the game. Communication, corporate growth and individual enhancement go hand in hand.

●

Z'ev Kronish, who holds an MBA from the College of Insurance, has handled risk management and benefits administration at the corporate level.

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Risk pools . . .

Continued from page 1

ment of competition in the market place which would be beneficial to all commercial buyers of insurance."

Allowing businesses to form their own risk retention pools "would eliminate the highly subjective ratemaking now imposed on our industry," wrote William C. McCamant, vice chairman of the board of the National Assn. of Wholesaler-Distributors, in his letter to Mr. McIntyre.

Trade group lobbies

This support, however, came a bit late in the day, a government source said. "If 12 very important business leaders who knew who to call in the White House would have lobbied for the proposal, indicating that it was an important measure, it might have made a difference," the source observed.

Insurance trade associations lobbied against the Commerce plan (*BI*, May 14), but their opposition did not play a role in OMB's decision to reject the proposal, a source said. Of far greater significance to the OMB was the lack of immediate broad-based business support.

Most business groups have said the plan may have some merit, but they wouldn't officially endorse it until they saw it and reviewed all details.

The Commerce Department, however, wouldn't release the complete proposal. Victor Schwartz, chairman of the interagency task force on product liability and accident compensation, said the plan couldn't be published until OMB gave its approval.

"It's the old Catch-22 situation," said Commerce Department senior legal adviser Don Smiegiel, who drafted the plan. "You can't expect business to support something they haven't seen, but we weren't allowed to publish the proposal."

Some business groups won't give up. "We shouldn't let it die," said Bob Friedlund, chairman of the Material Handling Institute's product liability steering committee. "Small business and some large firms need this kind of help."

State-exempt

Under the Commerce Department proposal, firms could band together to form insurance cooperatives or "risk retention groups" pooling all or a portion of the participant's product liability exposures. They would presumably operate in the U.S. like group captives now do in offshore tax havens and would be exempt from state insurance regulations. Instead, they would be regulated by the Commerce Department.

Before deciding whether to allow a risk retention group to operate, the federal government would review the group's assets, reserves, loss prevention efforts and management expertise.

Premiums paid into the risk retention groups would be tax deductible so long as there was sufficient spreading and sharing of risk to satisfy Internal Revenue Service requirements.

The Commerce Department believes state regulation, with its high capitalization requirements, has blocked businesses from uniting to cover their product liability exposures through pooling arrangements.

By tailor-making insurance regulations to meet the needs of businesses forming their own insurance cooperatives and allowing the same deductions companies now are given for purchasing insurance from commercial insurers, the Commerce Department believes more competition would be injected into the insurance market. ■

N.Y. insurers dissolve assets

BROOKLYN—A New York supreme court judge has ordered the liquidation of Consolidated Mutual Insurance Co. and its subsidiary, Long Island Insurance Co.

The two Brooklyn-based insurers have been in state insurance department rehabilitation since November, when Consolidated Mutual was declared insolvent and Long Island was found to be financially impaired or lacking the required surplus.

Claims against the two defunct companies will be covered by the New York guaranty fund and those of other states where the insurers were admitted, said the New York insurance department. ■

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Continued from page 1
associate general counsel for Kemper Insurance Cos.

Ideally, an insurance exchange should handle reinsurance business, direct insurance on risks outside the U.S. and unusual domestic risks, Mr. Brown explained. "The low premium requirement and the provision allowing a broker to submit business below the $50,000 premium level if that risk was turned down by two insurance carriers just won't attract good exchange business," Mr. Brown noted.

"Having business turned down by two carriers is not uncommon at all," Kemper's general counsel explained. "Therefore, what you have in the Illinois exchange is a vehicle in competition rather than a complement to the insurance industry nationwide," Mr. Brown asserted.

"The Lloyd's of America idea is a romantic notion that just won't die," mused W.J. Gilmartin, senior vp of CNA Insurance Co. "And quite honestly, a vehicle which can bring more jobs, more insurance expertise and more business into Illinois can certainly do no harm and is a very difficult concept to oppose," Mr. Gilmartin said.

Consolidating underwriting brains under one roof can also produce astounding by-products, Mr. Gilmartin chuckled. "Consolidation like that will undoubtedly lead to greater flexibility and innovation in the industry."

Mr. Gilmartin and Kemper's Mr. Brown are also worried that this country does not have the underwriting talent to support two exchanges to handle the foreign and facultative reinsurance risks. Other Illinois-based companies fear that the bill creates too much temptation for the insurance department to meddle in the insurance industry.

Florida, on the other hand, is taking no chances. "An insurance exchange in our state's coming-of-age as the financial gateway to Latin America," said Florida's insurance commissioner Bill Gunter. "But it's important that we understand all the implications of such an undertaking before we commit our effort to establishing an exchange," he added.

Already the Chambers of Commerce of Miami and Tampa have enthusiastically bid for the exchange to be in their cities, Mr. Gunter boasted.

The Florida exchange, when it gets off the ground, is expected to deal primarily with large foreign risks, parlaying Florida's cultural, economic and geographic ties to the Carribean and South America. ▪

N.Y. envies Lloyd's

Continued from page 1
exchange comes when property/casualty markets are coming off the end of an upward underwriting cycle and entering a downward trend. Athough rates are now competitive, exchange underwriters say this softness allows the fledgling market to develop slowly so its facilities will not be swamped when demand for its capacity increases.

While the New York Insurance Exchange is free from regulation for foreign risks and reinsurance, it is "shackled when it comes to taking the risks of the American commercial consumer," complains Robert Clements, executive vp of Marsh & McLennan Inc.

Because of compromises made in developing the insurance exchange and Free Trade Zone, "the commercial consumer has more access to Lloyd's and all other nonadmitted markets than to the New York Insurance Exchange," he said.

Of 300 risk managers recently polled by M&M on their attitudes toward regulation, 76% favored permitting the New York Insurance Exchange to compete freely on direct business and reinsurance of domestic accounts (*BI*, June 25).

Essential concession

To permit direct access to the New York Insurance Exchange would be contrary to legislative intent, counters Albert B. Lewis, New York superintendent of insurance. "What happens to the insurance companies that pay premium taxes and share in the cost of assigned risk pools and running the insurance department?"

"The exchange never would have flown if we left direct business in," recalled Hilliard Feldman, president of Schiff Terhune International Inc. "The insurance companies wouldn't have permitted non-regulated competition."

It was not until after this and other concessions limiting broker control of the exchange underwriting syndicates that American International Group president Maurice Greenberg shifted from opposing to strongly supporting the insurance exchange. Other insurers followed suit after the companies gained a majority position on the Committee of 13 that drafted the exchange's constitution and bylaws.

State insurance department regulations on how business can move from the uninterested Free Trade Zone companies to the insurance exchange are still being drafted.

The New York Free Trade Zone has been in business since September of last year, but its writings to date have been minimal. In the first quarter of 1979, Free Trade Zone companies wrote premiums of $1,185,000 under the special law, the insurance department said.

Of that amount, $864,000 was written by seven companies of American International Group, the main supporter of the Free Trade Zone concept. The balance was written by Agway Insurance Co., a subsidiary of the Syracuse-based Farmers' Cooperative.

The 12-member board of governors of the New York Insurance Exchange who will be elected July 9 can "make or break" the fledgling risk-taking organization, according to New York superintendent of insurance Albert B. Lewis.

The board will consist of two governors chosen by the broker members, six governors chosen by the underwriting members and four public representatives jointly elected by the brokers and underwriters.

Interest in the positions is running high, with several brokers and almost all syndicates reported to have nominated candidates. Hilliard Feldman, president of Schiff Terhune International, reported being "plagued" with phone calls from brokers seeking support for their candidacies.

Broker candidates

Among those most often mentioned as candidates for broker governors are: David H. Winton, senior vp of Johnson & Higgins; David Holbrook, executive vp of Marsh & McLennan; Gerard Curtis, senior vp of Alexander & Alexander, and Robert L. Sanford, president of Smyth, Sanford & Gerard and the Insurance Brokers Assn. of the State of New York.

Persons most mentioned as candidates for underwriter governors include: Maurice R. Greenberg, president of American Interna-

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tional Group; Richard Stewart, senior vp of Chubb & Son; John Cox, president of Insurance Co. of North America and Donald L. Kramer, president of KCC Syndicates Managers Inc. and the principal architect of the exchange.

Nominees for public governors reportedly include: William J. McGill, retiring president of Columbia University; Frank T. Carey, chairman of IBM; Frank E. Barnet, retired chairman of Union Pacific Corp.; C. Douglas Dillon, former Secretary of the Treasury and Jerome Kretchmer, attorney.

Dunne blocked

John Dunne, chairman of the New York senate insurance committee, had been nominated as a candidate for public governor by two broker members of the exchange. However, superintendent Mr. Lewis blocked Mr. Dunne's nomination by issuing an emergency regulation that prohibits public members from being associated with the insurance industry, even in a government function.

Foreign and domestic facultative business and catastrophe treaty reinsurance are likely to be the mainstay of the insurance exchange's activities in its formative years, said Ian Heap, president of Crum & Forster Managers Inc. The firm manages its parent company's syndicate.

Mr. Heap, whose firm also provides underwriting management for captives, indicated captives could participate in syndicates on the insurance exchange, but he declined to predict when.

Some critics of the exchange have charged that starting it when insurance markets are highly competitive will prevent the exchange from getting off the ground. But, "what seems to be the worst time is also the best time," said Mr. Heap.

The property/casualty industry is shifting from a good underwriting cycle to a poor one, but "people are more enthusiastic coming off good times," he explained. "People won't join a capacity market in times of trouble."

Once the exchange opens, brokers will almost certainly use it, said David H. Winton, senior vp of Johnson & Higgins Inc. "To ignore a legitimate new market is to not do your job as a broker."

Because the market is soft, the exchange may reject business to remain profitable, he continued. "When there is undercapacity, the exchange will go like wild-fire," he said.

Since the original syndicates are capitalized almost entirely by existing insurance companies, the syndicates won't underwrite to a three-to-one premium to surplus ratio just for the sake of volume, Mr. Winton added.

Underwriting members of the insurance exchange and their parent companies or managers are: AIG Multi-line Syndicate Inc., AIG; Allianz Syndicate Inc., Allianz Insurance Co.; Aneco Syndicate Ltd., Aneco Reinsurance Co. Ltd.; Chubb Syndicate Inc., Chubb & Son Inc.; Crum & Forster Syndicate Inc., Crum & Forster Corp.; The First New York Syndicate Corp., W.J. Burt Management Inc.; Frank B. Hall (N.Y.I.E.) Inc., Frank B. Hall & Co.; J&H WF Syndicate A., Johnson & Higgins, Willis Faber (USA) Inc.; The Maiden Lane Syndicate, Continental Corp.; North Star Syndicate Inc., General Reinsurance Corp.; Pan Atlantic & Others, Pan Atlantic Group Inc.; The Realex Group N.V., KCC Syndicate Managers Inc., and the 1792 Co., INA Corp.

Broker members

Broker members of the exchange are: AAMET Inc. (Alexander & Alexander); Arthur J. Gallagher & Co. of New York Inc.; Block, Earl & Co. Inc.; Delaney Offices Inc.; E.W. Blanch Co.; Eagle Brokerage Corp. (Schiff Terhune International); F.J. Wilkes & Co. Inc.; Frank B. Hall Co. (Overseas); Fred S. James & Co. of New York Inc.; Guy Carpenter & Co. Inc.; Hamond & Regine Inc.; Herbert L. Jamison & Co.; Hirsch Wolf & Co. Inc.

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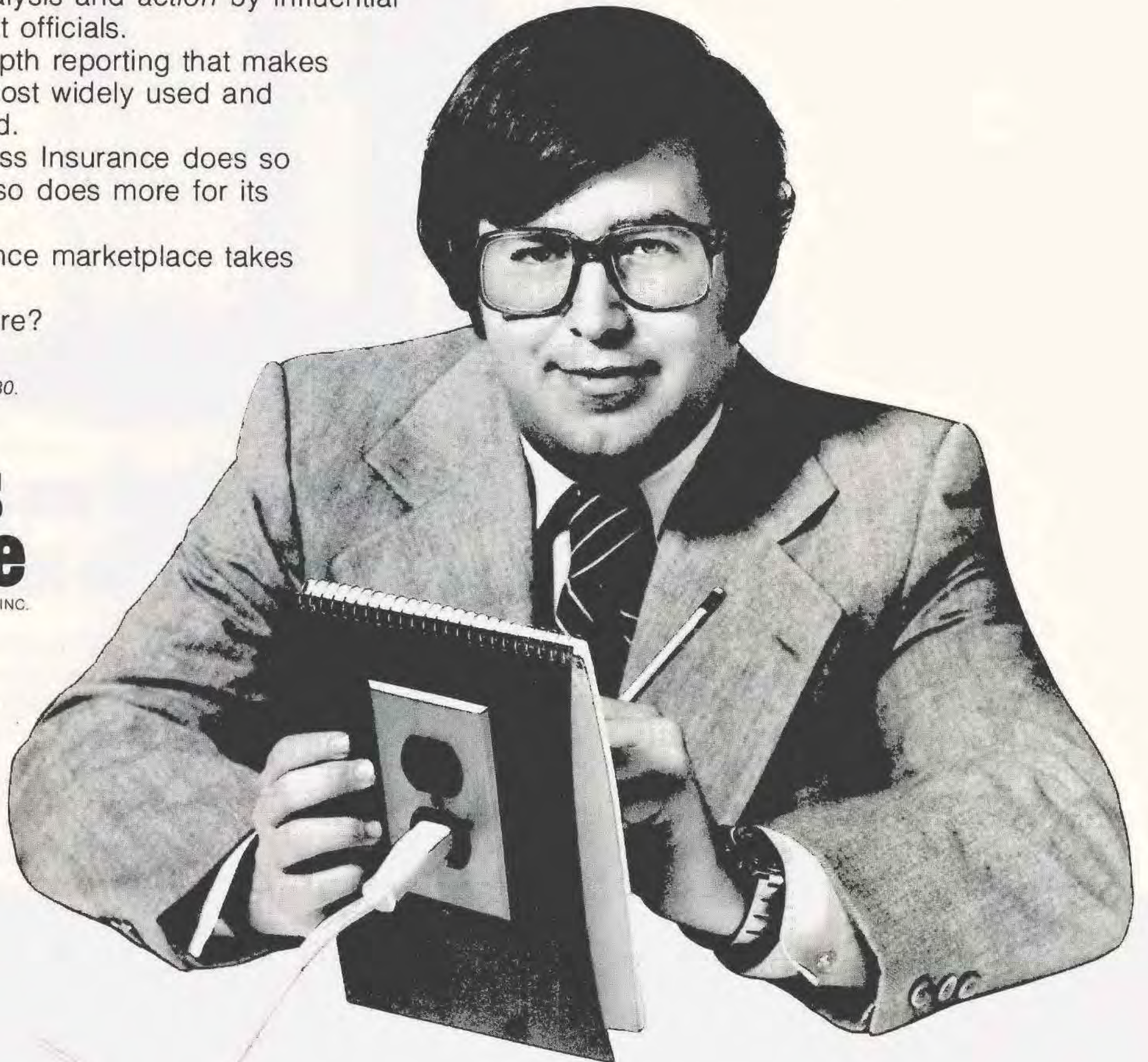

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Long Island towns ignore 2 proposals for pooling risks

By STUART EMMRICH

NEW YORK—Towns in Long Island's Suffolk County aren't interested in pooling risks to save money.

Towns and municipal districts have nearly ignored the county's two risk sharing proposals, baffling county officials. This disinterest in any risk sharing arrangement is contrary to the trend around the country for municipalities to team up and share their risks to cut costs (*B1*, Jan. 8).

Pooling workers compensation risks could have saved the municipalities an estimated $6 million on the $20 million now spent.

The county first offered to set up a pooling arrangement for interested municipalities. When that fell on deaf ears, the county offered to allow the municipalities to join Suffolk's self-insurance program. But again the response was decidedly underwhelming.

Informational meetings earlier this year about the proposals had been well attended, prompting the county to send out 217 forms asking the various political subdivisions—towns, fire districts, school boards—to detail their experiences and exposures so the groundwork could begin. Only seven completed forms were ever returned.

"We were shocked. We knew this had worked well in other places and we couldn't believe that no one seemed to want to do it here, especially after we had those meetings," said Michael Natale, assistant insurance manager for Suffolk County.

None of the responses came from the towns or fire districts, just from a few school districts and small villages. The invitation to join the country's self-insurance program only piqued the interest of a few small towns with staffs of only 30 or 40 people.

"It just seems like there is no interest in it, although we don't know why. Frankly, we thought a lot of people would want to do it," Mr. Natale said.

"Apparently, some of them felt as though they had filled out forms before and nothing ever came of it. And even though they hadn't done this with us before, they just didn't feel like going through the same process again," he said he learned by talking to several of the disinterested districts.

When the pooling proposal died, the county held another series of meetings for local officials and suggested they might be interested in joining the Suffolk self-insurance program. It has been several months since that last proposal went out and still no takers, however, Mr. Natale said.

"I have yet to see any response. No one is pursuing it," he said. "It might have something to do with the idea of Big Brother. They look at it as the county trying to usurp their power," because joining the self-insurance program would also mean combining other functions.

The county self-insures the first $250,000 of each workers compensation loss, up from the $150,000 retention first set in 1975. The county also carries $350,000 per occurrence deductibles on its auto and general liability insurance for estimated annual savings of between $2 million and $3 million.

Mr. Natale said the offer for municipalities to join the program "is still open" but added he doubted if anything would come of it now. "I have to say that I am not particularly optimistic at this point. I am a bit disappointed because we put a lot of time and effort into this." ■

Storm damage

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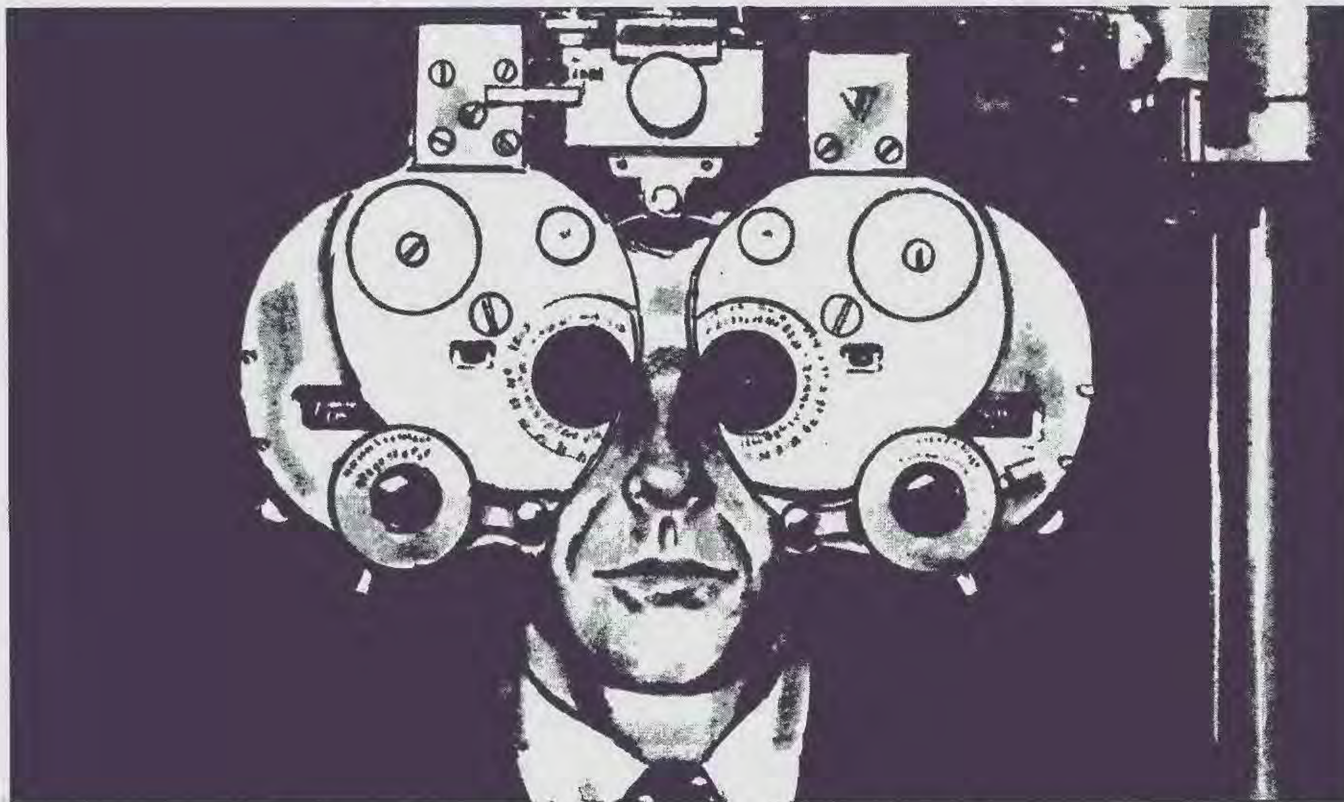

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Health planners plot 'holistic' benefit study

SAN FRANCISCO—A holistic approach to employe benefits is the long range goal of a survey by William E. Hembree, director of Health Research Institute (HRI) here.

Extensive questionnaires being sent to the Fortune 1,000 corporations, government entities and other companies by HRI ask what benefits the companies provide, what they're doing to control costs and who they think should be responsible for health care costs.

When survey results are tabulated sometime this fall, Mr. Hembree hopes some different, non-traditional approaches to health care will be proven to be cost effective.

The HRI survey asks a lot of questions that haven't been asked before, the director said. For example, does the company provide any "wellness" incentives, such as stop smoking programs? Does it give credit, or time off or cash for sick time not taken? Bonuses for less than expected medical costs?

Among the 23 alternative care treatments survey participants are being asked if they provide or reimburse for are: EST, hypnosis, yoga, rolfing, massage therapy, biofeedback training and psychosynthesis.

The survey also asks for the respondent's attitude toward national health insurance. "We're asking for serious consideration of the question, 'Who is responsible for the health of employes?' " Mr. Hembree said. "We're trying to shift this responsibility for health care from the medical profession to the shoulders of employes and employers."

Once the survey data is compiled, HRI can function as a clearinghouse for innovation in the employe benefits and health care fields, according to Mr. Hembree.

HRI, a non-profit group including the former consultant of Hewitt Associates and two of his associates, is also studying the benefit programs of 50 major companies that use non-conventional cost containment practices. In addition, Mr. Hembree plans to interview the 26 largest group health insurance companies to determine what they're doing to help policyholders reduce costs of employe benefit plans.

"When the survey is completed, the information will be available to all the participants and anyone who's interested," he said. "This isn't competitive information ... we want to provide a data base for alternative methods of health care." ■

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Presentations: Tuesday/September 11
- The Report of President Carter's Antitrust Commission—What Does it Say?
- What Are the Short and Long-Term Implications of the McCarran-Ferguson Act Granting Immunity to the Insurance Industry?
- An Analysis and Discussion of the Proposed Product Liability Risk Retention Act of 1979

(Tuesday Afternoon Workshops are the same as those on Monday Afternoon.)

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- An Analysis and Update of Recent Internal Revenue Rulings Including the Carnation Company Decision and the Long-Range Effect Upon Formation of Offshore Captives
- Risk Financing and Cost Containment Alternatives to the Formation of Captive Subsidiaries
- Panel Discussion: How Will A Prolonged Oil and Energy Crisis Impact Upon the Insurance Industry?

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Conn. utility boosts Maddox to risk exec

Ernest J. Maddox has been appointed risk manager of the Stamford, Conn.-based Citizens Utility Co. Mr. Maddox was promoted to the newly created position after a year as risk management specialist for the utilities company and its subsidiaries. Mr. Maddox, 40, has been with Citizens Utility for a year and reports to Budd Schwartz, treasurer. His responsibilities include risk identification and analysis, insurance program development, claims supervision and coordination of the company's safety programs.

* * *

W. Michael Houston has been hired as assistant risk manager by Dallas-based Texas Instruments Inc. He replaces Spencer Brewer, who resigned to go to Dresser Industries as reported. Mr. Houston, 29, was an insurance analyst for the Phillips Petroleum Co. in Bartlesville, Okla., for the past 3½ years. At Texas Instruments, he will report to Hugo Hines, corporate risk manager. Mr. Houston has a BBA in finance from the University of Texas and a JD.

* * *

John W. Roberts has been appointed to the newly created position of assistant claims manager for the University of California's nine-campus system. His duties will include overseeing the handling of workers compensation claims as well as being responsible for the university's self-insured property programs. Mr. Roberts, who will report to Robert Dressler, systemwide claims manager, spent the last few years working for such companies as Aetna Casualty & Surety Co., Fred S. James & Co. and the Industrial Indemnity Insurance Co.

* * *

Donald R. McCarter has joined Gulf States Utilities Co. in Beaumont, Texas as coordinator of loss prevention. Mr. McCarter, 47, was for the past nine years engineering supervisor in the High Point, N.C. and Houston offices of Industrial Risk Insurers. In the newly created position, Mr. McCarter will be responsible for reviewing and planning fire protection systems in the company's nuclear and other power plants. He will report to Olice Steward, manager of risk management services.

* * *

The city of Aurora, Colo., has hired **John McHugh**, 33, as its new risk manager. He replaces **Judy Adams**, who resigned to take a similar position for Alameda County in California, as reported. Mr. McHugh was most recently property insurance manager for the city of Allentown, Pa. In his new position, which will include coordinating the city's safety and risk management program, Mr. McHugh will report to Gail C. Johnston, city clerk. Mr. McHugh is a graduate of Lehigh Univ.

* * *

Michael Krikorian has left his position as corporate safety manager for the Chicago-based Brunswick Corp. to form a new business as a management consultant for safety, occupational health and hygiene, security; executive protection and product safety. The new firm will be located in Orlando, Fla., and will also offer recruiting services for health and safety professionals. Brunswick has not yet filled the vacancy left by Mr. Krikorian's resignation. He organized Brunswick's safety and occupational health departments after joining the firm in 1963.

* * *

Curtis "Kitt" Logan has joined All Risk Corp. of Winter Park, Fla., as manager of the employe benefits department, reporting to company president Robert Atkins. Mr. Logan, 43, comes to the newly created position after 20 years with The Travelers Insurance Co., the last eight as manager of the group department. In his new position, Mr. Logan's duties will include the design, implementation and servicing of insured and self-insured group health, life, salary continuation, profit sharing and pension plans for All Risk Corp. employes and clients. He has a BS degree from Auburn University.

•

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to Stuart Emmrich, Business Insurance, 708 Third Ave., N.Y., N.Y., 10017 or call 212-986-5000. We'd also like to receive pictures of those involved.

Letters column . . .

Continued from page 12

lation. Among our clients—predominantly large employers—there is a clear understanding that employe benefit matters can have substantial impact on the entire organization. For this reason, decision making on employe benefits is frequently a team effort. In my experience, the benefit manager is usually a strong member of the team, working with top management to ensure that benefit decisions support organizational goals and objectives.

In no way do I consider the management of employe benefits a purely "technical function."

Claude Kordus
Partner, Manager, western region,
Hewitt Associates, Lincolnshire, Ill.

Flawed opinions

To the editor: The article by Steven N. Schrenzel, CLU, on ". . . new estate planning options" (*BI*, May 28) under the '78 Revenue Act is flawed in my opinion by the following:

• Neither prior to nor since the '76 Tax Reform Act has there been any possible exclusion from estate tax of proceeds attributable to the participant's contributions, or ". . .receivable by or for the benefit of. . ." the decedent's estate. The author fails to make this clear, which may be a snare for the unwary reader.

• There is no provision for fragmenting a lump sum distribution, so as to enable a distributee of a portion of such payment to elect estate tax exclusion of his/her share irrespective of any election by the other distributee(s).

• The gift tax exemption of amounts attributable to employer contributions existed in prior law and is not a new development.

• The reference to "sample estate tax calculations. . ." without reference to the minimum "unadjusted" marital deduction of $250,000 is over-simplified, notwithstanding the accuracy of Chart II. This is not mere cavil, since consideration of the marital deduction together with the estate exemption equivalents (i.e., where the payee is the surviving spouse) reveals that the comparison of estate and income tax consequences often is a mere exercise in futility.

• No mention is made of the new Code Sec. 402(a)(7), which enables the participant's surviving spouse, on receiving a lump-sum distribution from a qualified plan, to roll over all or part thereof to an IRA. This omission, in my opinion, is critical because it ignores "the third alternative" in any lump-sum distribution paid to the surviving spouse on account of the employe's death.

Instead of the "either/or" alternative posited by the author, by combining the new estate tax exclusion provision of Sec. 2039(f) with the above IRA rollover provision, it is evident that a surviving spouse may enjoy the best of both worlds—achieving the following:

• Exclusion of the proceeds from the participant's estate.

• Avoidance of current income tax on so much of the proceeds as are rolled over.

• Sheltering of earnings on rolled over amounts from current income tax.

• Ultimate taxation of benefits at lower brackets, owing to the spreading of income (e.g., over lifetime) once IRA distribution commences.

In effect, if circumstances warrant such election, the tandem use of Secs. 402(a)(7) and 2039(f) amounts to an interest-free loan by the government in the amount of the taxes which are deferred—to as late as the surviving spouse's age 70½.

Finally, it might be noted that, under Sec. 2039(e), any amounts payable on the death of the surviving spouse may possibly be excluded from the latter's estate for tax purposes, if such distribution was in the form of an "annuity" (i.e., payable over at least 36 months). Thus, a surviving spouse may enjoy the best of all worlds!

George C. White, C.L.U.
Massapequa Park, N.Y.

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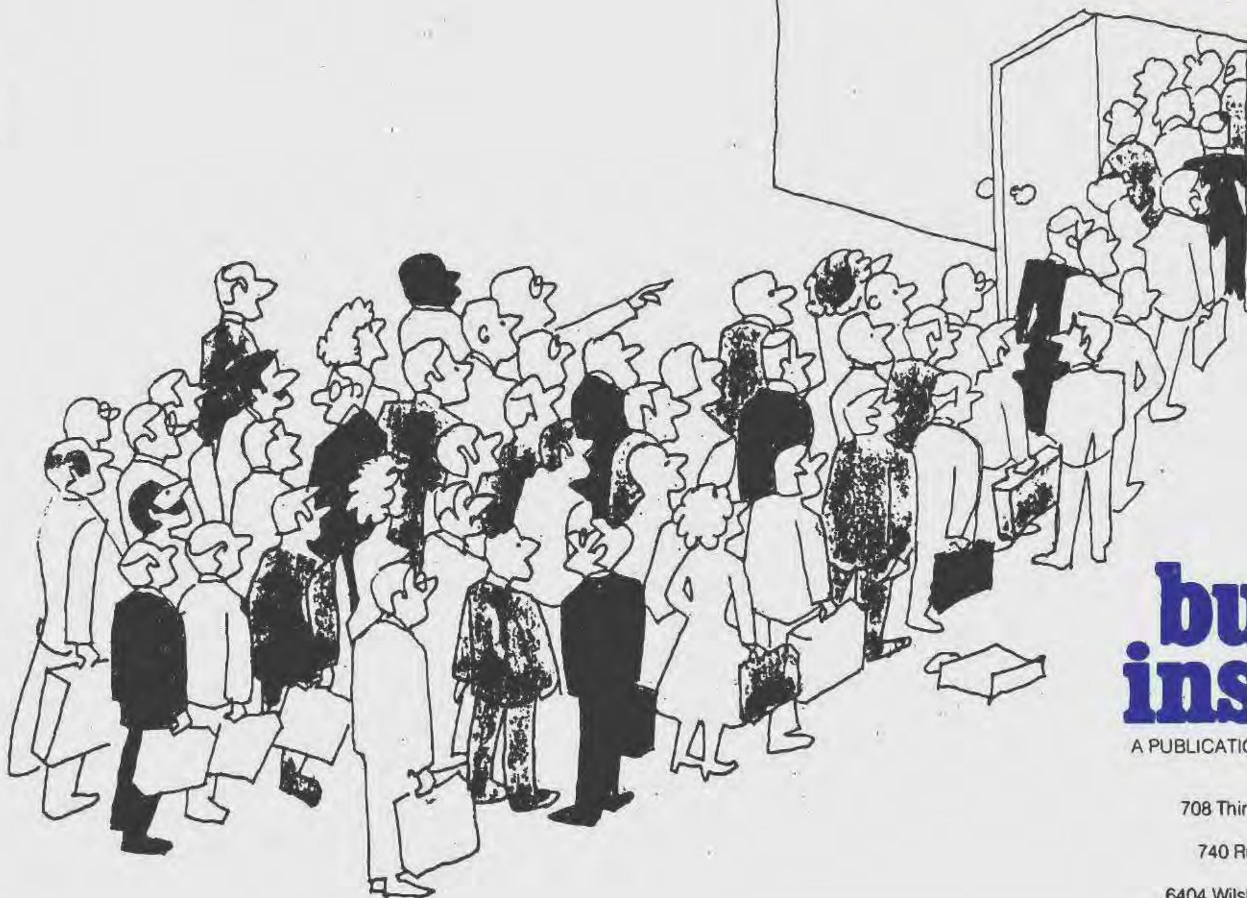

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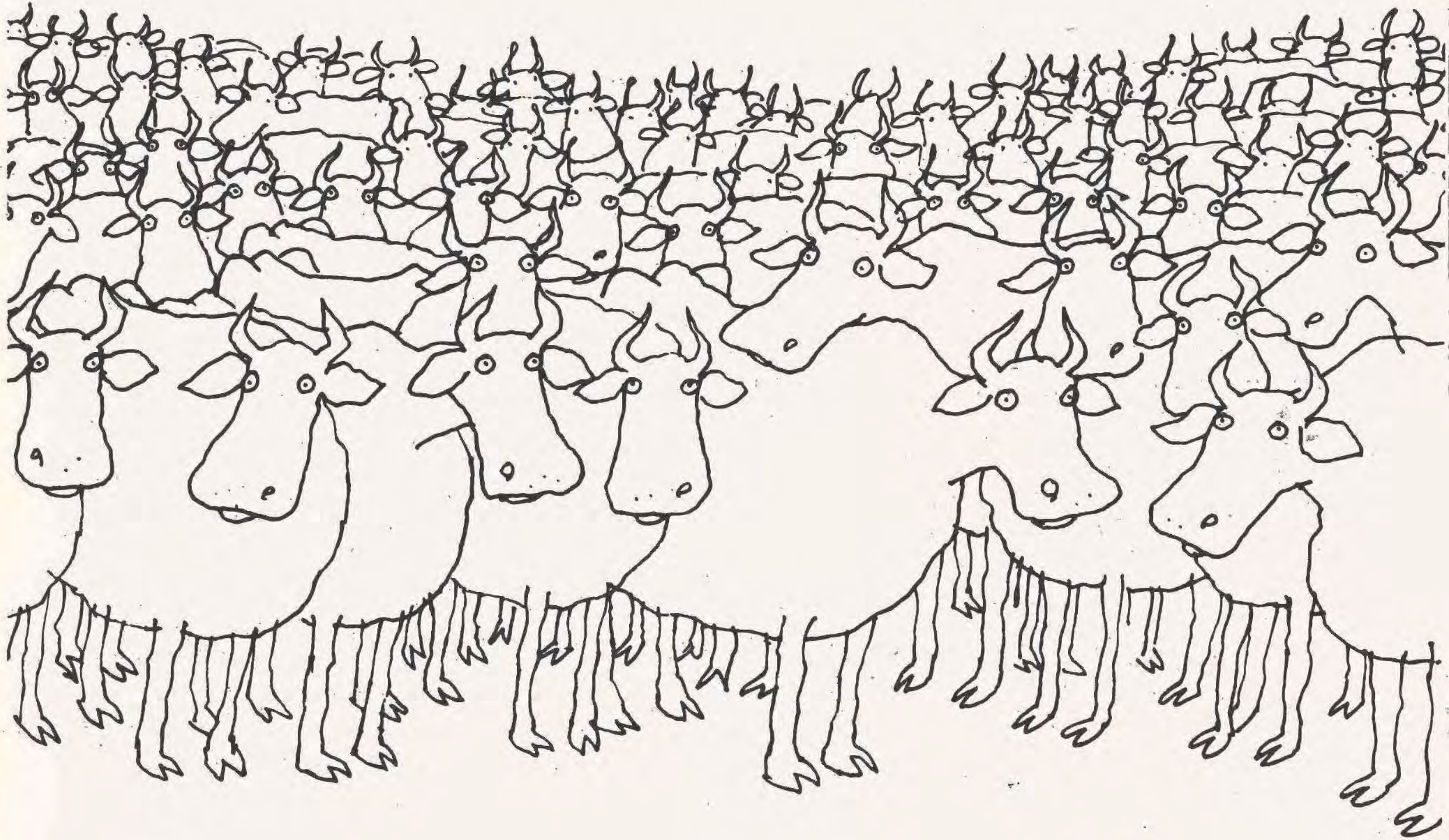

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