$21 million suits filed in club fire

By JERRY GEISEL

SOUTHGATE, KY.—Two $21 million damage suits have been filed in federal court on behalf of victims killed and injured in one of the worst nightclub fires in U.S. history.

At least 161 persons perished in the huge Beverly Hills Supper Club near Cincinnati after a fire was reportedly touched off by a short circuit in an electrical cord for a fountain pump, turning the popular club into a panic-filled inferno.

Lawyers in the Cincinnati area emphasized that the suits filed so far represent only the "tip of the iceberg" with dozens of additional suits expected to be filed in the next six months.

The 4-R Corp., owner of the supper club, faces the chilling prospect of defending lawsuits involving possibly hundreds of millions of dollars. Insurance on the building, let alone for personal liability, however, appears to be inadequate.

Although *Business Insurance* was unable to reach

A rescued patron of the Beverly Hills Supper Club tragedy is revived by a volunteer fireman.

Thomas Berger, the broker who handled insurance on the Beverly Hills Supper Club account for the Charles H. Bilz Insurance Agency of Covington, Ky., it was learned that the building and contents

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Labor assists 2 states in action against trust

By GREG DAVID

CHICAGO—With the help of U.S. Labor Department officials for the first time, two states won important court tests in efforts to shut down a self-funded multiple employer trust.

Kansas obtained a temporary restraining order in federal court in Topeka prohibiting United Health & Retirement Assn. from conducting business in that state. Oklahoma received a temporary injuction in state court in Oklahoma City prohibiting the same trust from operating there, its major base of operations.

United Health & Retirement Assn. (UHARA) is a self-funded trust claiming to be an employe benefit plan under the Employe Retirement Income Security Act (ERISA). It specializes in major medical coverage for self-employed persons, officially operates from a Washington, D.C., post office box and uses 85% of first year contributions for commissions, according to depositions in the case and a brochure obtained by *Business Insurance*.

This story continues the five-month Business Insurance investigation of the growing crisis of self-funded multiple employer trusts.

A large number of self-funded multiple employer trusts have been established in the past two

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The inside story

Crime bonds

Chubb & Son is about to issue a new crime bond policy that will replace the standard one-year discovery period with a 60-day discovery period. So far other major fidelity underwriters have not followed Chubb & Son's lead. **Page 6.**

Product liability

Businesses that self-insure for product liability losses could be eligible for tax breaks under a new proposal from Sen. John Culver. **Page 19.**

Meanwhile, an attorney tells a West Coast seminar that insurers are "crying wolf on product liability" and are about to reap "glamorous" profits. And a federal task force report says product liability settlements are not increasing as fast as the number of claims. **Page 20.**

Elsewhere:

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Week of June 13, 1977

business insurance

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

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Battle rages over bills on work comp financing

By JOANNE GAMLIN

SACRAMENTO—The problem of how to equitably finance the rapidly growing number of cumulative injury claims for workers' compensation in California is fueling a red hot legislative battle.

Pitted against Gov. Edmund G. Brown are the state AFL-CIO, a group which supported him strongly in his last campaign, and many employers.

The two bills at the center of the cyclone are assembly bill 155 and senate bill 555. The two bills, which are almost identical, in essence transfer liability for cumulative injury to the employer of the last year of employment.

In addition to Gov. Brown, supporters include the state compensation insurance fund, Industrial Indemnity Co. and a number of smaller workers' compensation insurers.

"Sure, we're supporting the bills," said J. Martin Payne, president, Eldorado Insurance Co. in Palo Alto. "We are standing at the sidelines and shouting that cumulative injury claims are a very grave threat to the California insurance industry."

Eldorado has announced that it must have a merger partner if it is to be in accordance with state insurance department regulations.

A few other insurers are even more candid. They argue they will be out if business this year if one of the bills is not passed in the current legislative session.

However, opposition to the bills is also strong. It comes from public entities, from corporate employers that are self-insured for workers' compensation and from a few insurance companies such as Employe Benefits Inc. (EBI) which are growing fast and which also self-insure their own workers' compensation exposures. EBI is also a major servicer of self-insured employers.

In addition, the state's powerful AFL-CIO is battling the legislation on grounds that it will exacerbate problems of older and handicapped people in finding jobs. This worry is shared by even the bills' supporters.

One aspect of the California cumulative injury problem which

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Case could limit litigation

By KATHRYN McINTYRE ROBERTS

FT. PIERCE, FLA.—An orthopedic surgeon, who says he was driven by "righteous indignation," fought back over a malpractice suit and won an unprecedented judgment of $175,000 against the prosecuting attorneys.

But the circuit court judge presiding over the case here has ordered the doctor to surrender $100,000 of the jury-awarded verdict or face a new trial on the issue of the judgment. Judge Royce Lewis said the size of the award granted by the jury "shocks the conscience of the court."

However, he did not grant the defendants' motion for a rehearing of the case. And if upheld, the case will establish a new standard of practice for attorneys, requiring probable and reasonable cause for filing a lawsuit and subjecting them to liability suits, according to the victorious attorney.

Dr. John Sullivan of Vero Beach, Fla., successfully sued Otis Parker and the Ft. Pierce law firm of Fee, Parker & Fee for maliciously prosecuting a malpractice suit against him 1971 on behalf of a former patient. The patient, also named in the suit, was absolved.

Both sides in the case agree the verdict could change the face of malpractice litigation and insurance for lawyers and doctors.

"If this is upheld, there will be no more frivolous filings to force an insurance settlement," predicted Dr. Sullivan's attorney, Ellis Rubin of Miami. He said medical malpractice rates should drop, but conceded the new liability of lawyers could drive up their malpractice rates.

Mr. Parker's attorney agrees the decision, if upheld, "would and should make lawyers think twice," before representing a

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Aviation renewals are called 'critical'

By MARIE KRAKOWIECKI

NEW YORK—Delta Airlines and Northwest Airlines are the first domestic air carriers to try to renew their insurance since the worst disaster in aviation history, the crash of two jumbo jets in the Canary Islands.

Delta's and Northwest's existing coverages expire July 1, *Business Insurance* learned. All other U.S. airlines are watching to see what happens to them so they can try to figure out what impact the Canary Islands crash might have on their own insurance rates.

The crash, which killed nearly 600 people on the island of Tenerife on March 27 when a Pan American Airways 747 and a KLM Royal Dutch Airways 747 collided on the ground, was expected to send the entire aviation insurance world into a tailspin.

Rate increases ranging anywhere from 15% to 40%, even for domestic airlines with good safety records, have been predicted. But so far, the only indication of what could happen to aviation rates has come from the renewal negotiations of an Argentinian and an Ethiopian airline.

Both foreign carriers managed to renew coverages, but the Argentian airline was forced to pay about 20% more than it did before despite good experience. The Ethiopian airline, which used Marsh & McLennan, had trouble with the London market in negotiations, according to reliable sources.

The Delta and Northwest renewals, which are going on right now, have generated considerably more interest here because they are more likely to mirror what will happen to the aviation insurance rates of the big U.S.-based airlines.

Delta and Northwest currently are insured by the London market and by the two largest aviation insurance pools in this country, Associated Aviation Underwriters and United States Aircraft Insurance Group.

Delta's broker on its account is the Atlanta office of Johnson & Higgins. The account manager is Dave Cassell. Northwest's broker is the Minneapolis office of Marsh & McLennan. The account executive there is H. Cartan Clarke.

Walter Peterson, insurance director of Northwest Airlines, said he did not want to directly comment on the renewal negotiations, but that he expected to tie them up by July 1. So far, he said, he personally hasn't seen any indication the crash in Tenerife will cause any major tightening of the aviation insurance markets.

Some sources had said it was possible that the U.S. markets and the French markets might pick up more business as London reacted negatively to the Canary Island disaster.

By most accounts from people familiar with the industry, the biggest problems in aviation insurance as a result of Tenerife will come, not in primary insurance, but in reinsurance and excess of loss covers. No one connected with the current renewal negotiations for Delta or Northwest would comment on this aspect, but excess of loss underwriters, especially in London, were said to be heavily hit by Tenerife and are planning substantial increases as a result.

Spokesmen for aviation underwriters commented that although the Delta and Northwest cases are the first airline renewals to come up since Tenerife, no discernible trends in aviation premium increases are likely to emerge for several months.

However, as this story was going to press, an aviation insurance industry executive pointed out July 1 is also the expiration date for McDonnell-Douglas Corp.'s insurance. Because McDonnell-Douglas produced the DC-10 airliner that crashed in Paris several years ago, the renewal negotiations and any attendant premium increases could be even more significant as indicators of the condition of aviation insurance markets than anything resulting from the Tenerife crash, the executive said. ■

Jury awards $7 mill. for hospital's error

By SUSAN ALT

HOUSTON—Argonaut Insurance Co. reportedly will cover most of a $7 million jury award expected to be made final by a state district court here in the wrongful death of a woman who died during childbirth at Southmore Medical Center in 1974.

The jury award has not been entered as yet in the court records, which would make it a final judgment, a process expected to take several weeks. Should this be done, the award would be the largest wrongful death award in history.

Southmore, owned by American Medicorp Inc. based in Philadelphia, was found guilty by the jury of gross negligence. There was no medical malpractice involved in the jury's award of $1 million actual damages to the husband, $500,000 to each of the two surviving children, and $5 million in punitive damages to them.

An official of American Medicorp declined to comment on the jury award, and would not say whether the award would be fully insured. The spokesman said he wouldn't even disclose whether there will be an appeal, although Mrs. Nadine Cook, the hospital's administrator, issued a formal statement June 3 which indicates there will be an appeal should the court finalize the jury award.

Carolyn Ann Lord, 27, died when she was administered nitrous oxide (an anesthetic gas) instead of oxygen while giving birth in a delivery room of the new hospital on its first day open for business. Southmore, one of 40 hospitals operated by American Medicorp, "unequivocally rejects the validity of the verdict," according to Mrs. Cook, who maintained that the jury "exhibited a lack of jurisprudence" in arriving at its conclusion and award.

The lawsuit filed by the family of Mrs. Lord asked for $2 million in damages but did not ask for any punitive damages, said plaintiff's attorney Marvin Peterson of the Houston law firm of Combs, Archer & Peterson. "I didn't really think the case would go all the way (to the end), but it did," he said. He declined to disclose the contingency fee he's earning, but did say that insurance had nothing to do with the amount of damages originally sought.

"We didn't even discover the limits of the insurance. Also, it is

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GUIDE TO FEATURES

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the benefit beat

Banks taps SDC to process self-funded claims

BANK OF AMERICA selected System Development Corp.'s computerized administration system to process its 150,000 to 180,000 yearly claims under the bank's self-insured health benefit program covering 35,000 employes and 40,000 to 45,000 dependents. Until now, said Ted Mason, head of employe benefits, the bank administered its claims manually, which required about 100 people. He figures to save substantially with the new SDC system to be installed this month. "Starting about a year ago," he said, "we did an informal study in anticipation of designing a system in-house. We looked at Lockheed's internal system and then at a system used by Security Pacific National Bank." Based on those examinations, Mr. Mason estimates productivity should rise to 4,642 claims processed per claims administrator per year, up from the 1,667 claims handled per person per year with the manual system. Last year, B of A paid $18.9 million in health benefit claims for its employes.

Security Pacific National Bank also uses the SDC system, paying slightly over $1 per claim paid for the 15,000 bank employes and about 30,000 dependents. Security Pacific installed the SDC system a year ago after dropping Aetna as its insurer in favor of going self-funded.

B of A will have 20 CRTs in its benefit department. System Development supplies the computer service and the software for a negotiated fee per claim paid, although phone lines and the IBM-compatible video display screens are leased from other suppliers. CRTs generally have a monthly lease cost of about $50.

Art Slotkin, vp of benefit administration services at System Development, said SDC clients have typically been able to cut their claims payment personnel by about half upon installing the SDC system. "Our clients have estimated the cost of using the SDC system runs about 1% to 2% of claims paid," Mr. Slotkin added.

FULL HEALTH INSURANCE coverage is the most important benefit young persons want employers to provide, according to a survey by the American Council of Life Insurance. Over 70% of the 2,200 persons aged 14 to 25 surveyed chose full health insurance when asked to pick three possible benefits. Free education was a distant second (chosen by 44%), followed by profit sharing and life insurance (33%), full auto insurance (26%) and longer vacations (24%). Considered less important were year end bonuses (20%) and a four day work week (21%). Of least importance to the young persons was a free lunch (3%).

YOUNG AMERICANS do not support a national health insurance program, according to the American Council of Life Insurance survey. Forty-three percent believe health insurance should be provided by the employer, while 28% favor private purchases by individuals. Another 28% favor a government-run system financed through taxes. Meanwhile, 62% believe private companies can serve the needs of the individuals for health insurance better than the government, while 31% believe the government could do a better job.

MULTIEMPLOYER PENSION benefits have been guaranteed for the first time by the Pension Benefit Guaranty Corp. (PBGC), the Labor Department agency which insures retirement benefits of terminated private pension plans, according to provisions of the 1974 pension reform law. The PBGC announced its decision in connecation with retirement benefits for about 2,700 millinery workers from three separate unions whose funds were terminated at the end of last year. Under ERISA, the guarantee of benefits for multiemployer pension plans has been discretionary so far, and could stay discretionary for any multiemployer plan terminating before 1978. The PBGC acted according to the authority it has to guarantee benefits of a multiemployer plan which was maintained for 60 months immediately preceding termination. The three union plans involved in the decision were the Millinery Workers Retirement Fund, the Millinery Designers, Foremen and Foreladies Local 92 Retirement Fund and the United Millinery Salesmen's Local 98 Retirement Fund.

INTERGROUP PREPAID Health Service Inc. is the first federally qualified health maintenance organization (HMO) in the Chicago area. Edwin Boltin, Intergroup vp, said recent certification by the Department of Health, Education and Welfare (HEW) will "open doors considerably" for growth of the currently 22,000 member HMO. Mr. Boltin projected an annual growth rate of 3,000 to 5,000 for the five year old HMO. Growth will be bolstered by federal qualification because under the 1973 Federal HMO Act, companies with more than 25 employes must offer a qualified HMO as an option to conventional indemnity insurance if properly petitioned by the HMO. In addition, Mr. Boltin said some employers indicated they were waiting for Intergroup to be federally qualified before offering it to their employes. Certification by HEW means the HMO meets all federal guidelines regarding organization, benefit packages, financial stability and the availability of comprehensive medical and surgical services. Intergroup's prepaid medical rates vary with the benefit package and the experience of the individual group, but Mr. Boltin said a general monthly charge is $30 for an employe and $90 for family coverage. Intergroup has 25 health centers with more than 400 physicians serving metropolitan Chicago, mid-state Illinois and two counties in northern Indiana.

ALUMINUM WORKERS have won a vision care program as part of the benefit improvements in a new three-year contract that will eventually cover 40,000 workers belonging to the United Steel Workers union. The vision plan provides a schedule of reimbursements and pays $20 for an eye exam every 24 months as well as

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Benefit Beat . . .

Continued from page 3

$10 for lenses, $15 for bifocals and contact lenses and $14 for frames, also every two years. In addition to increases in the amount of pensions, workers with 20 years of service who have been laid off or absent due to illness or sickness for two years will be able to receive a full pension as early as age 45. This special pension will be calculated in the same manner as regular pensions. In addition, workers will receive a supplement of $300 a month, which will be suspended if the employe finds full time employment. Other benefit improvements include emergency care benefits for 72 hours (up from 48 hours) increased maximum benefits for emergency medical expenses to $30,000 annually and $50,000 lifetime (from $10,000 annually and $20,000 lifetime), increased life insurance for each worker to $10,000 (from $8,000). The dental plan will be improved to include two exams in every 12 months if the exams are separated by 150 days rather than six months, and intravenous sedation for the removal of non-bony impactions in oral surgery. In addition, medical insurance for laid off employes will be continued even if the worker refuses an initial recall.

OCCIDENTAL PETROLEUM Corp. has altered its employe thrift plan, according to Robert F. Brooks, manager of insurance and employe benefits, to increase employe participation. Occidental announced that as of July 1 employes can contribute 10% of their annual salaries to the plan compared with 6% in the past. The company, which historically contributed 50¢ for every $1 contributed by the employe, will now contribute 80¢ for every $1. Mr. Brooks explained, however, that company matching will extend only to 6% of an employe's annual salary and not to 10%. Mr. Brooks said he does not know precisely what the level of employe participation is in the plan, although he believes it falls between 70% and 80%. He noted that another reason for altering the plan was to make it more competitive with similar programs offered by the chemical/oil industry.

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Benefit Beat keeps insurance and employe benefit managers up-to-date on what other companies are doing and informed of current developments in the employe benefit field. We'd like to know if you've made any changes. Write Benefit Beat, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611 or call (312) 649-5279.

Senate passes tough tanker safety bill

WASHINGTON — Prodded by last winter's wave of disastrous oil spills, the Senate has passed tough legislation mandating tankers to carry expensive safety and navigational equipment.

The measure represents a compromise between fleet operators and environmentalists. New tankers must have double bottoms as environmentalists had urged, but the industry was given more time to comply with that requirement.

The impact of the measure on marine insurance rates is not clear yet. But requiring tankers to be equipped with several vital safety devices should have an eventual "beneficial effect" on premiums, said William H. Rodda, president of Marine Insurance Handbook Inc. of Chicago.

Most of the measure's provisions apply only to foreign and U.S. oil tankers over 20,000 tons. Ships in that category that are built after Jan. 1, 1980, must be fitted with a double bottom. The Senate Commerce Committee estimated that adding a double bottom to a 120,000-ton tanker would boost construction costs by $2 million.

Safety and navigational aides that must be installed after June 30, 1979, for all 20,000-ton-and-up tankers include:

- A dual radar system, with short-range and long-range capabilities.
- A collision avoidance system.
- A fathometer, for measuring depths.
- A gyrocompass.

Two other costly safety features that will be required after June 30, 1983, include a gas inerting system to reduce the chance of explosion and a segregated ballast system.

To encourage ship owners to install these features as soon as possible, a tax will be levied on tankers after July 1, 1980, that have failed to add gas inerting and segregated ballast systems.

The tax, which was proposed by Sen. Ernest F. Hollins (D-S.C.), could be waived in special cases by the transportation secretary. The size of the tax has not been set yet.

Aside from specifying minimum safety equipment that oil tankers must carry, the transportation secretary is given the authority to bar ships with a history of pollution and safety violations.

The House has not taken action on the proposal. ■

Broker sets captive unit

NASHVILLE, TENN.—Corroon & Black-Cockburn Ltd. has been formed to provide expanded management services for domestic Corroon & Black captive insurance company clients.

The joint venture between Corroon & Black/Armistead Miller Wallace and Alex Cockburn & Co. Ltd. of Bermuda is headquartered in Bermuda and has a 15-person staff. Alex Cockburn is president and John R. C. Harris is executive vp.

Corroon & Black-Cockburn Ltd. provides insurance, reinsurance accounting and filing services required by Bermuda-based captive companies which do not have in-house staffs, complementing services already provided by the U.S. operating subsidiaries of Corroon & Black.

It performs many of the tasks formerly handled by Meridian, a captive management firm of CB/Armistead Miller Wallace. Meridian is now the holding company for the new firm and also operates as a broker on international insurance placement.

When incorporated in Bermuda in 1969, Meridian was used to insure the risks of clients of Ingram Armistead Wallace. That firm changed its name to Armistead Miller Wallace in 1972 and was acquired by Synercon Corp. in the same year. Synercon, in turn, was acquired by Corroon & Black in 1976. ■

Alex Cockburn & Co. Ltd. was formed in 1967 as a market reporting and consulting firm. ■

We put a MOP squarely into some policy-holders' lapse.

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Here's an example. After years of outstanding growth, the huge South Dakota Cement Plant had accumulated several property coverage policies from other insurers. All policies were burdened by "a ton of endorsements"...each complete with exclusions, exceptions to the exclusions, and exceptions to the exceptions. Until it had become difficult to tell exactly what was covered, what protection was being paid for, or even if deductibles were at a dollar-efficient level. So when added builders risk coverage was required for further expansion, South Dakota Cement hired an outside appraisal firm—*and were told that their total coverage was less than half of current replacement value.* In anybody's terms, that's a lapse!

Enter our Manufacturers Output Policy, or MOP...a versatile tool that enables us to perform some creative property underwriting. We put together a single, easily-understood policy that includes insurance on building and contents, business interruption, builders risk, contractors equipment, accounts receivable, valuable papers and miscellaneous property. With combined total coverage in excess of 63 million dollars. There are very few exclusions. More importantly, there have been no surprises. Now we have another satisfied policyholder "partner." Thanks to the "MOP" we put in their "lapse."

A Wausau
Property Insurance Story
From the Partnership People

EMPLOYERS INSURANCE OF WAUSAU
Wausau, Wisconsin

Chubb shortens crime bond discovery period

By MARIE KRAKOWIECKI

SHORT HILLS, N.J.—Chubb & Son Inc. is about to issue a new form for its crime bond policies which will scrap the standard one-year discovery period in favor of a 60-day discovery period. In some states, Chubb has already made a 60-day discovery period endorsement mandatory on the fidelity insurance policies it writes.

So far, other major fidelity underwriters have not followed Chubb & Son's lead, but this will not deter the New Jersey-based underwriter at all, its vp of the crime insurance department said in an interview.

"We're heading toward a claims-made basis in fidelity bonding even if we are the only ones who do it," Robert Lynyak declared. "It takes guts to be a leader."

Mr. Lynyak said that Chubb & Son (which is the managing agency for Federal Insurance Co., Pacific Indemnity Co. and a number of smaller regional insurers in whose names the crime bond policies are issued) is acting because it has suffered "staggering" problems in its fidelity lines.

The fact that Chubb & Son was leaning toward a 60-day discovery period in its crime bond insurance policies was pointed out by Johnson & Higgins broker Howard Boyle during a utilities industry session at the Risk & Insurance Management Society conference last month. He called it one of the most significant things to have happen to the commercial blanket crime area in the last year.

Mr. Boyle suggested that Chubb would be adamant about keeping a 60-day discovery period because one of its insureds, a major international conglomerate, filed a $2 million fidelity loss against Chubb on the very last day of the year on its one-year discovery period.

Mr. Lynyak confirmed that this indeed had happened, and he said of Mr. Boyle, "That fellow ought to know. He was the broker."

Some 80% of the dollar amounts that Chubb incurred on fidelity bonds were for losses in excess of $50,000 last year, which means severity rather than frequency of loss were crucial, Mr. Lynyak said. Last year there were 40 such claims, he said.

Over the last three years, the company's combined loss and expense ratio on fidelity bonds was 119%, Mr. Lynyak said. During 1976, the company wrote $8,860,000 in fidelity bonds (which include money, securities and forgery in a basic crime package). It earned $7,886,000 and incurred $8,596,000, for an earned/incurred ratio of 109%, Mr. Lynyak said.

Its combined loss and expense ratio was 135.1%.

The problems were made worse by an increasing number of claims from senior executives and by foreign losses. By getting rid of the one-year discovery period and substituting the 60-day discovery period on its new fidelity bond forms, Mr. Lynyak said Chubb & Son thinks it will be able to lower its loss ratio anywhere from 15% to 20%.

Other big fidelity underwriters who proclaimed that they would not follow Chubb's lead but would retain their 60-day discovery periods in crime bonds were making attractive-sounding marketing statements for their customers, but they can and would change their minds quickly if they decided it would be a good way to cut losses, Mr. Lynyak maintained.

A lot of people misunderstand the significance of the discovery period in crime bond insurance, he said. In defense of Chubb's action, he said a shortened discovery period would not shortchange commercial insurance buyers because it does not affect the actual coverage but only determines which insurance company must pay the claim.

According to Mr. Lynyak, a one-year discovery period merely gives more protection to a new insurer at the expense of the old insurer. Discovery periods, he explained, don't come into play at all unless a policy has been cancelled.

For those buyers who feel they must have a longer discovery period written into their fidelity coverage, however, Mr. Lynyak said Chubb & Son will probably allow an optional buy-back for a discovery period of up to a year, for a premium of 25% of the expiring premium level.

Whether insurance buyers and risk managers will be as sanguine as Mr. Lynyak apparently believes they should be when they find shorter discovery periods in their fidelity crime bond policies is doubtful.

At the same utilities industry RIMS session at which J&H's Mr. Boyle first mentioned Chubb's drift to a 60-day discovery period, there was distinct displeasure voiced by a number of risk managers over the way their fidelity insurance is being handled by underwriters lately.

Joseph V. Yandoli, director of insurance for the Columbia Gas System Services Corp. of Wilmington, Del., for instance, told how he went shopping for a renewal quote on his company's crime bond insurance after it had sustained a single embezzlement loss.

Federal Insurance Co. was not the insurer which had to pay the loss, Mr. Yandoli said, but the price it quoted him for the business was actually higher than the price offered by the company that did pay the embezzlement claim.

Mr. Yandoli, who was acting as chairman of the utilities industry session, urged the other company risk managers who were there not to simply go along with the price demands of fidelity underwriters like Federal (which is managed by Chubb & Son) just because "they are big in the field and get all the gravy."

According to Mr. Lynyak, Chubb's proposed new crime bond policy forms (of which he said the 60-day discovery period is probably one of the least significant features) would be filed 45 to 60 days after the end of May, and would contain all new language. ■

AIA tells storm loss

Insured loss resulting from wind, hail and tornadoes which swept through Colorado, Texas and Oklahoma in late May are estimated at $2 million by the American Insurance Assn. The storm has been assigned catastrophe number 91.

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editorial opinions

A classic case

WE COULDN'T HELP but think of some case problems included in the Risk Management 54 course when we heard of the untimely and unfortunate death of Ed Cole in early May.

As CEO of Kalamazoo, Mich.-based Checker Motors, the former head of General Motors had great plans to revamp Checker's line of cabs and turn the troubled company into a financial winner.

Mr. Cole was flying his own jet plane from Detroit to Kalamazoo when caught in a storm. The ensuing crash killed him.

A classic risk management problem. Since he was a critical part of Checker's survival and continuation, should some "risk manager" within Checker have drawn up a company policy telling Mr. Cole not to fly his own jet on company business? Would this have been practical, or even possible? (Incidentally, Checker doesn't have anyone designated as risk manager.)

In a case like this, should there have been key man life insurance purchased on the life of Mr. Cole? Checker didn't think this was necessary, and hadn't bought any.

Had anyone at Checker thought enough about how dependent the company was on Mr. Cole? We hope so. How can a financially-troubled company afford to hire a replacement for a man as illustrious and talented as Mr. Cole? Or, will they ever be able to find his equivalent?

This is exactly the kind of freak accident every risk and insurance manager has to anticipate, and hopes that he has planned for. Get out your contingency plans, readers, and perform the springtime review.

Fronting for captives

WHY ARE INSURERS so reluctant to talk about "fronting" arrangements with captives and with self-insurers? Is there something shady about these deals? Are insurers afraid state insurance regulators will somehow crack down on them as policy-issuers taking only a small part of the risk being insured?

We don't think there's any logical reason behind the desire of insurers acting as fronting companies to keep this whole topic in the closet.

At the recent RIMS conference, Bill Mortimer—a former risk manager, executive at INA and at American Risk Management—said at a session on captive insurance companies that the only topic that should have been discussed—but wasn't—was the use of fronting companies. "We couldn't get anyone to speak," he told the large audience.

It's certainly no secret that there are plenty of well-established insurers around acting as fronts for corporate clients using captives or self-insurance. Hopefully, as Bill noted, this situation will "loosen up in the future."

Using a fronting company can accomplish for a corporation the important dual goals of being able to obtain very high limits—in a liability line, for example—while keeping the cost of such coverage at affordable levels more accurately reflecting the amount of risk being put into the insurer. As the issuer of policies, the fronting insurer is providing a necessary and valuable service to a customer, since the insurer is already licensed to do business in many states and conforms to the statutory requirements.

It's just a service like any other, which can be compensated by fees or a combination of fees and premiums for the use of the licensed insurer's "facilities."

For the insurers of this country, fronting also provides some advantages, since there is ostensibly a much-ballyhooed capacity crunch underway. A fronting arrangement doesn't drain the insurers of their surpluses, required by law, because there isn't that much risk actually being underwritten by the insurance companies.

Because the self-insurer or the captive achieves access to reinsurance or excess markets through this kind of arrangement, corporate risk managers are eager for wider use of them.

It seems to us that all parties win. So why is the insurance industry being intransigent about what might prove to be a rather simple solution to the shortage of underwriting capacity.

Among the insurers we've heard are doing at least some fronting for captives are Highlands Insurance Co., American International Underwriters, Lexington Insurance Co., Ideal Mutual Insurance Co., Northwestern National Insurance Co., Aetna Life & Casualty Co., Fireman's Fund Insurance Cos., and Travelers.

We believe these companies deserve credit for responding to consumers' needs. Now let's have some open discussion of fronting programs.

Our new logo

YOU MAY HAVE noticed that with the last issue of *Business Insurance*, we changed the two lines of type appearing underneath our *BI* logotype on the front page. This magazine is adapting to changes in readers' needs and in the way they perform their benefit and insurance management tasks by changing our description to: The national newsmagazine of loss prevention, risk financing and employe benefit management.

Since *BI's* inception, it's been known as the national newsmagazine for buyers of employe, property and liability protection and financial services.

Given that insurance is only one of the alternatives to financing property and liability risks and group benefits, we wanted you—the buyers of insurance and the risk and benefit community using *BI* to help you do your jobs—to know we recognize this fact.

Because the essence of good risk and benefit management is the control of losses both before and after events which can cause financial loss, we thought that should be part of our stated purpose.

We're proud of the growth and increased sophistication of both risk management and benefit management that have taken place in nearly 10 years since *BI* was begun. We are confident the new logo description stands us in good stead for the changes that will surely evolve in our second decade as well.

letters

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

Quotation clarification

To the Editor: In the May 16, 1977, "RIMS Report" issue of *Business Insurance*, I was quoted, in an article entitled "Blanket bond easing tied to a reduction in management theft" (page 9), as using the term "embezzlement by top management." Actually I used the term "senior officer embezzlement." I realize that outside of financial institutions these two terms have become interchangeable and many may consider this simply a question of semantics. In banking, however, there is a distinct difference.

I was further quoted as saying "INA is requiring an outside audit before writing a bankers blanket bond." I did not make that statement. It was made by someone in the audience during the question-and-answer period following my remarks.

Don T. Browne
VP, First National Holding Co., Atlanta, Ga.

Making the right choice

To the Editor: Hooray for C. E. Cook and his "common sense" article. re: "Substituting Inequity for Inequity" (May 2).

At the RIMS convention held in New York, I listened over and over again to the premise "pregnancy is just like any other illness, and should be treated as such."

I consider myself to be relatively intelligent human being. It was my *choice* to give birth to two children. I certainly would never *choose* to have an illness.

Nola Rosenfeld
Director of risk management & employe benefits, Vernitron Corp., Great Neck, N.Y.

A further explanation

To the Editor: Re: Perspective —"Ways to cut costs"—May 16, 1977.

The worker's compensation checklist in the above article made reference to a number of points directly affecting premium auditing. They were all valid means of controlling premium costs, however, items 3 and 4 could use further explanation.

Item 3 referred to an overcharge due to including amounts

Continued on page 10

business insurance

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

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letters

Continued from page 8

paid to subcontractors "who of course are not employes." Actually, if certificates of insurance are not available as proof of coverage, subcontractor's employes could come under the client's WC policy coverage, and a charge on his audit is justified in most jurisdictions. The proper way to eliminate this particular cost is to require certificates of WC insurance from all subcontractors. A proper audit will then exclude their exposure, upon reviewing the certificate file.

Item 4 referred to the transition program in many states, from limited to unlimited payroll totals. It concludes with—"make sure that you are not being charged for the amounts in excess of the weekly limitations." The audit statement will reflect exposures based on total unlimited payrolls, and this is correct. If the premium on this basis exceeds the +5%, 10% or 15% allowable increase, a credit will be indicated using a class code of 0076 or identified as "Transition Credit." The actual calculation of premium under old and new payroll rules is made on separate worksheets, not normally furnished to the customer. Here again, the proper approach is to keep proper payroll records initially. If a customer's payrolls substantially exceed the old limited amounts, then he should look for the credit entry on the audit statement. If it is not there, then either his premium increase was within the allowable variance, or the audit did not calculate the credit. These situations should be followed up and resolved.

S. P. Szott
Premium audit manager, Allstate, Northbrook, Ill.

Well done!

To the Editor: I thought your reporting of the "Robin and Robert" Show at the RIMS meeting, in the May 16 issue of *Business Insurance* was nicely done!

Robert C. Goshay
Professor, University of California, Berkeley, Calif.

Deductibles

To the Editor: Your editorial opinion "A Chance to Shine" (May 30) infers that a "deductible" is the same as a "self-insured retention." This is the same mistake made by many underwriters, agents and risk managers. The two are not the same.

As an example, take a primary liability policy with a $1 million limit for each occurrence being called on to respond to a $1.5 million loss. With a "deductible" of $100,000 the carrier is ultimately responsible for only $900,000, and umbrella insurance, if available, would pay the remaining $500,000. With a "self-insured retention" of $100,000 the primary carrier would pay $1 million, the policy limit, and the umbrella carrier, only $400,000. In either event, the insured would absorb $100,000.

The "deductible" is a participating contribution by an insured toward the full limit of the policy. The "self-insured retention" is the insured's absorption above which the carrier responds for the full limit of the policy.

R. A. Zadenetz
Asst. corporate insurance manager, Pullman Inc., Chicago, Ill.

An idea

To the Editor: At the First World Congress on Product Liability held in London earlier this year, and in many conversations with visiting Americans, it never ceases to amaze me that so much time is spent fruitlessly complaining about the size of awards arising from accidents caused by defective products, but so little time is spent in preventing the accidents.

I see the advertisements in your excellent journal from insurance companies and consultants offering all types of publications (your information section is great) and hardly anybody seems to heed the advice.

If you will allow an outsider a thought, what about a "stop complaining, let's make it safe" week month or year. Your item "sue the bastards" was good, but how much better if there was no need to sue the bastards.

James Tye
Director general, British Safety Council, London

Getting involved

To the Editor: My congratulations for your "getting involved" editorial in *Business Insurance* (May 16). I have been saying this over and over again as have many others, but it means a lot more coming from a source outside RIMS.

Robert S. Spencer
President, RIMS; vp-insurance & risk management, Fuqua Industries, Atlanta, Ga.

A question of ethics

To the Editor: Is there a problem of professional integrity exposed in F. Lee Bailey's statement, quoted in the May 16, 1977 issue: "I assure you that I would never do my own taxes. But, if I'm hungry enough, I'll certainly do yours"?

W. A. Smetts
Vp, Industrial Relations, The Sterns & Foster Co., Cincinnati, Ohio

Mr. Bailey did indeed seem to raise a question about lawyers' ethics in his RIMS Conference speech.

Firm faces OSHA fine of $1,000

CHICAGO—An Illinois manufacturing company has been slapped with a $1,000 fine after defying a federal court order by not allowing field officers from the Occupational Safety and Health Administration (OSHA) to inspect the factory.

A U.S. District Court in Chicago cited the Gilbert & Bennett Manufacturing Co. of Blue Island, Ill., for contempt of court, assessed a $1,000 fine and approved a warrant to arrest company officials until they permit an inspection.

This order, however, has been lifted temporarily, to allow the company to petition a court of appeals for an immediate suspension.

The origins of the case go back to last January when two OSHA compliance officers were not allowed to enter the company plant to make a routine inspection.

The inspectors later secured an inspection warrant but again were refused entry by company officials. A third inspection attempt in April also was unsuccessful.

Dr. Eula Bingham, the top OSHA administrator, said the case was brought to the courts "to assure so far as possible safe and healthful conditions for our nation's working men and women." ■

Earthquake warning difficult, says expert

ANAHEIM, CALIF.—There is no known technique of predicting earthquakes that has even a 50% chance of success, according to Dr. James H. Whitcomb, senior research fellow at the California Institute of Technology.

Dr. Whitcomb was one of six participants in a seminar on disaster planning held at the 24th annual Western Safety Congress at the Anaheim Convention Center.

The young academician, who in 1976 made the first earthquake prediction for Los Angeles County and later withdrew it, told the seminar that China has achieved the best success in quake prediction, although even that system has not met the 50% success target.

The Chinese produced their best prediction results, he went on, by combining three techniques: Watching the pattern of small quakes; noting distortion in the ground that can precede a quake and observing weird animal behavior—snakes, for example, that emerge from their hiding places in winter only to die.

So far in Southern California, no series of small quakes has forecast a major tumbler, said Dr. Whitcomb, adding that the subject of predicting quakes is controversial, even among scientists.

Dr. Whitcomb's earthquake prediction was made on the basis of p-wave velocity.

However, if quake predictions even do develop a high degree of credibility, they will stir up a lot of headaches for the localities where the major tumblers are predicted, according to Commissioner Ezunial Burts, executive assistant to Los Angeles city mayor, Tom Bradley.

A study of the political, social and economic consequences of a scientifically valid quake prediction points to grave consequences for the community involved, he said.

"Unemployment among construction workers could grow as high as 80%," Mr. Burts said, due mostly to a sharp shrinkage in the number of construction units launched in the target area of the quake.

Furthermore, the studies show there will also be a decrease in home mortgages and business loans.

"Retail sales will slide and with them, tax revenues at a time when there will be a big increase in the demand for government services," he said.

Mr. Burts said that a recently formed Los Angeles city task force has just begun to map out plans for the devastating quake long expected in Los Angeles.

Turning to the threat of terrorism, Commissioner Ted H. Von Munden, chief, patrol division east, Los Angeles County Sheriff's department, said that kidnapping, which is profitable in Italy and in some South American countries, could be picked up by disaffected groups here in the future.

Currently, the threat of terrorism in the United States springs from two main sources, he said: urban guerillas and groups organized for crime such as the Mexican Mafia and the Black Guerilla Family as well as the Italian Mafia.

Stating his view that terrorism throughout history has often been effective in producing political change, Commissioner Von Minden said that as few as 12 terrorists can paralyze a city.

Other speakers, including Richard J. Healy, department head, security and safety, Aerospace Corp., El Segundo, Calif., stressed the crucial role of pre-planning for disasters.

A vulnerability analysis should kick off the pre-planning program, he said. Next a disaster plan should be broken into elements and the support of top management and the entire workforce obtained. Finally, the program must be tested. ■

Broker moves

R. Greenway Inc. has moved to new offices in New York. The firm is now located at 880 Third Ave., N.Y., N.Y. 10022.

Tailor benefit structure to suit you: TPF&C

By KATHRYN McINTYRE ROBERTS

NEW YORK—When was the last time you stopped navigating in the sea of ERISA, HMOs and ESOPs long enough to check how well the ship is sailing?

Consultants Towers, Perrin, Forster & Crosby Inc. have looked at how 16 companies, each with sales over $1 billion, manage their employe benefits.

And out of that study they have compiled some suggestions on how companies can review their employe benefit management with an eye for improved efficiency.

The study found that employe benefit tasks are handled in both the personnel and finance departments. However, when it came to assigning primary responsibility, 10 of the 16 companies named personnel, five named their finance departments and one said it was equally shared between the two.

TPF&C vp Don MacDougall said the most effective department to manage employe benefits depends on the organization. He advised, however, that if you haven't looked recently, benefits could be in the wrong department.

"The problem is employe benefit responsibility has developed historically in a department. It needs to be studied for where it ought to be," he said.

The 16-company survey was commissioned by a private client interested in how other companies manage employe benefits. One of the principal questions, Mr. MacDougall said, involved staffing. How many is enough?

But again, the consultants found there isn't a pat answer.

In the survey they found a range from a low of seven managers and administrators to a high of 67, with the medium at 18 and the average at 23. "Their sizes weren't that different to warrant that kind of spread," Mr. MacDougall said.

The consultants found two major factors affecting the size of corporate employe benefit staffs: Whether the program is centralized or decentralized and how much claims administration is handled in-house.

The companies with decentralized programs have smaller staffs, Mr. MacDougall explained, because they don't need as many people at the corporate level. And those with benefit responsibilities at the local plant level may only devote part of their time to benefits so they aren't counted in the employe benefits staff.

In assessing whether a program should be centralized or decentralized, TPF&C recommends that companies consider:

- The overall structure of the organization. Is it, for instance, a decentralized, multi-product company with a relatively small corporate staff?
- The number and diversity of the company's benefit plans.
- Access to a computer, which is vital to storing data for a centralized program.
- Availability of competent people at the local level to administer benefits.
- The number and degree of sophistication of the labor unions. Sophisticated organized labor demands a sophisticated corporate bargaining staff.

Previously, Mr. MacDougall noted, the geographic locations of each division would have been a consideration also. "But with modern communications, that's not as significant as it once was," he observed.

The degree of in-house claims administration is another important angle to look at when reassessing the employe benefits function, says Mr. MacDougall. "Decide which plans you should administer and which ones others should handle. It's a critical decision."

Although the more claims administration handled in house, the larger the staff, the real question Mr. MacDougall thinks should be posed is: Is it advantageous to handle the administration in-house?

"In the 1950s and '60s, there was a movement to 'do it yourself—it's cheaper.' But in the last few years, companies training and maintaining people to administer, say medical claims, have found it's too much of a burden," said Mr. MacDougall. It's much more complex now, he added.

Easy access to administrative services only (ASO) contracts for companies which self-insure benefits is another reason to consider giving up in-house administration, said Mr. MacDougall.

TPF&C offers some pointers for an internal survey of the benefits organization, staff and administration.

Mr. MacDougall recommends a committee take on the job and that it include not only representatives of the benefits staff but also persons from personnel, treasury, and if the company is large enough, the general counsel. They should answer the following questions:

- Which departments are currently responsible for planning and administration?
- What are their specific tasks?
- Have all major benefit activities been identified and are they carried out efficiently?
- Is the responsibility for each activity clearly defined?
- What is the staff total?
- Do these persons also perform non-benefit duties and to what extent?
- To whom do the employes with benefit responsibilities report?
- How do the departments involved interact?
- Is there a clear understanding of who has the responsibility to originate benefit design recommendations and to make decisions?

In addition, Mr. MacDougall said, top management should be interviewed about its expectations for employe benefits. The perceptions of the people on the lines about their benefits would also be helpful, the consultant said.

What will you have at the end of the study?

Most likely, Mr. MacDougall said, you'll see the ideal way to organize, staff and administer employe benefits. "The challenge will be to marry the ideal to the existing organization. And the success will depend on top management's commitment to get the job done."

With a picture of what you would like to do, if you can't totally reorganize, the least you will be able to do is shape and develop the program through time and staff turnover, the consultant said. ■

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What can you do about it?

Help to have arson classified as a major crime. One with the same high priority for prosecution as robbery.

Push for uniform state laws on reporting, detection and investigation. Laws that would make arson harder to get away with. (Over 20% of all fires are thought to be arson, yet only 1%-3% of confirmed arson cases result in conviction.)

Work for programs to improve investigation techniques and cooperation among fire fighters, police officers and insurance investigators.

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Send for our "Enough is Enough" consumer booklet. It's full of information on the causes and the pro's and con's of some possible cures for high insurance rates. You'll find out how to register your views where they count. And how you can help hold down your own insurance costs.

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• **It's for You** is an up-dated pamphlet from GAB Business Services Inc. explaining the company's expanded emergency claims service. For a free copy write J.W. Weatherstone, Marketing and Products Division, GAB, 123 William St., New York, N.Y. 10038.

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• **Fiduciary Standards of the Employe Retirement Income Security Act** are outlined in a Labor Department booklet. When fiduciary standards are applicable, what a fiduciary is required to do and what he is not, the exemptions, a list of labor department releases on fiduciary standards and interpretive bulletins are included. For a free copy write U.S. Department of Labor, Labor-Management Services Administration, Office of Employe Benefits Security, Washington, D.C. 20216.

• **Hospital Malpractice Loss Control** at ESIS Inc. is described in an illustrated brochure. A risk management program is outlined that locates, evaluates and helps hospitals control exposures to loss. The program is offered to hospital associations, hospitals and joint underwriting associations. For a free copy write J.M. Ridgway, ESIS Inc., 4050 Wilshire Blvd., Los Angeles, Calif. 90010.

• **The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit it Together?** is a 200-page report available free from the Council on Wage and Price Stability, 726 Jackson Pl., N.W., Washington, D.C. 20506.

• **Bank's** salvage and appraisal services, monitoring services, warehouse facilities, professional salvage operation, verification of value and segregation of damage services are all described in a brief folder. For a free copy write Bank's Salvors and Appraisers, 615 First Avenue, N.E., Minneapolis, Minn. 55413.

• **Survival in the Jungle of ERISA** is the title of a reprint on the fiduciary liabilities under the retirement security act available from Howden Swann Ltd. For a free copy write Anthony C. Bova, Senior vp, Howden Swann Ltd., 6 Commerce Dr., Cranford, N.J. 07016.

• You'll be able to read **What Others Are Saying About the Hewitt-Coleman Premium Retention Plan** in a promotional booklet published by the company. For a free copy write R.P. Hewitt, president, Hewitt, Coleman & Associates, P.O. Box 3665, Greensville, S.C. 29608.

• Reducing risks, errors and costs of administration in **Employe Benefits Administration** are outlined in a publication from GAB. Computerized group claims processing at GAB is explained. For a free copy write J.W. Weatherstone, Marketing and Products Division, GAB, 123 William St., New York, N.Y. 10023.

• The need for an independent asset appraisal and the services offered by Industrial Appraisal Co. is described in an eight-page booklet. For a free copy of the brochure entitled **Industrial Appraisal Co.** write William Moorhead, Industrial Appraisal Co., 222 Boulevard of the Allies, Pittsburgh, Pa. 15222.

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• Everything you ever wanted to know about business interruption insurance is the claim of a pamphlet from the Independent Insurance Agents of Indiana. The 26-page book titled **New Profits —Business Interruption Insurance** costs $7.49. Write Dale R. Cummings, Education Director, Independent Insurance Agents of Indiana, Suite 501, The Mariott Hotel, Indianapolis, Ind. 46208.

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• How to protect computers and data processing equipment from property loss and damage is explained in Industrial Risk Insurers' **Recommended Good practice for the protection of electronic data processing and computer-controlled industrial processes.** Losses from natural disasters and man-made ones are described. For a free copy write Publications, Industrial Risk Insurers, 85 Woodland St., Hartford, Conn. 06102.

Tax breaks eyed for product liability reserves

WASHINGTON — Businesses that self-insure for product liability could become eligible for sizable new tax advantages.

Under legislation introduced by Sen. John C. Culver (D-Iowa), a business could deduct from its federal income tax funds added to a reserve designated specifically to pay for product liability losses.

Passage of the bill (S. 1611) would result in a significant revision of the Internal Revenue tax code that now prohibits except in rare cases tax deductions for reserves established to pay for losses.

Specifically, a business could set up separate reserves, not to exceed 3% of the annual gross receipts of each product it sold, manufactured, leased or distributed, to meet possible liability losses.

"This amount (3% of sales) is comparable to what the most seriously affected manufacturers are now paying in product liability insurance premiums," Sen. Culver said.

The reserve fund, in turn, could be deducted from a company's federal income tax liability just as companies traditionally have deducted insurance premiums as business expenses.

A firm could expand the reserve annually over a five-year period until the fund equalled 15% of a product's sales. That amount would be tax deductible.

The reserve funds would be used exclusively to pay for product liability losses. Withdrawals for any other purpose would be subject to a stiff penalty.

Sen. Culver said one possible beneficial side effect of the proposal is that large businesses would, with increasing frequency, drop part of their product liability coverage and opt for self-insurance.

As a result, some of the capacity in the insurance market would be freed, giving smaller firms a greater opportunity to obtain affordable product liability insurance.

Reaction to the proposal generally was favorable. "It is a step in the right direction," said Robert Bevenour, executive vp of the Nissen Corp., a gymnastics equipment manufacturer, in Cedar Rapids, Iowa.

"It seems only fair that if a company can deduct insurance premiums, it also should be able to deduct a reserve fund from its federal income tax liability," he said.

While conceding that the measure was "well-intentioned," John Thodis, director of government relations for the Michigan Manufacturing Assn., warned that short-term measures sometimes have the negative side effect of distracting attention from what he considers the real issue in product liability: fundamental tort reform.

An aide to Sen. Culver emphasized the measure is not a substitute for Mr. Culver's earlier proposal to offer reinsurance through the Small Business Administration.

"This bill is another attempt to do whatever we can to offer immediate relief to businesses hit hard by product liability availability problems," he said.

The measure now goes to the Senate Finance Committee. Hearings have not been scheduled. ■

Low award granted in DC-10 case

LOS ANGELES—A California federal court jury has awarded the parents of a woman killed in the Paris DC-10 crash only $25,000 in damages.

The amount awarded to the parents of Nancy Kalinsky is believed to be the lowest settlement in the 1974 crash of a Turkish Airlines DC-10 outside Paris.

The total amount of settlements in the case, which had been the worst airline crash ever until the recent disaster in the Canary Islands, is reported to be between $50 million and $70 million.

It is known that attorneys representing the parents had asked for compensatory damages between $5 million and $7 million. However, since the young woman was living in Europe at the time of her death, the parents' attorneys were limited to asking for damages based on the loss of "love and affection."

The attorneys are expected to ask that the award be set aside as inadequate. Efforts to win punitive damages in the case are also expected to continue.

Robert C. Packard, attorney for McDonnell Douglas, argued that the woman was worth no more than $25,000 and the jury apparently agreed.

The Kalinsky case had been reported to be the last outstanding court case from the crash which killed 346 people. However, a knowledgeable source said there apparently two more cases outstanding.

Sources had been hoping that the Kalinsky case would have been decided in an out-of-court settlement that would have included a waiver of punitive damages. This, however, did not occur.

Earlier this year, federal judge Manual L. Real ruled unconstitutional a California law prohibiting punitive damages in wrongful death cases. The defendants, McDonnell Douglas and General Dynamics, are appealing the ruling. ■

Lawyer says insurers are crying 'wolf'

By JOANNE GAMLIN

ANAHEIM, CALIF. — The insurance industry, which is about to reap "glamorous" profits in 1977, is crying wolf over the so-called crisis in product liability insurance, according to the head of the California Trial Lawyers Assn.

Addressing a product liability seminar at the 24th annual Western Safety Congress, Willie Aitken asserted that loss prevention rather than tort reform is what's needed to clear away the problem of product liability insurance.

"The response of the insurance industry (to the so-called crisis) should be the development of strong loss prevention programs and not that of a wrecking crew, destroying the rights of injured people," he said at the congress.

Contending that the threat of product liability lawsuits is beneficial to society because it compels corporations to create meaningful loss control programs, Mr. Aitken related the story of a vaporizer manufacturer that persistently refused to place a safety cap on its product until its insurer threatened to halt coverage.

"It cost one cent to put on a cap that could not be unscrewed by children," Mr. Aitken said, heaping scorn on that segment of business that appears to value money over safety measures that, in the case cited, would have prevented youngsters from being burned.

The plaintiffs' attorney also belittled efforts at tort reform that take the shape of creating a statute of limitations or that introduce the state of the art as a defense. Of the former, he said that under a 10-year statute of limitations, which is currently being debated by legislators in Sacramento, plaintiffs in the recent class action suit against manufacturers of DES would have been barred from suing. It has taken 18 years to establish that DES can cause vaginal cancer in the daughters of women who were given the drug in the early 1950s to prevent miscarriages.

He likewise dismissed a state of the art defense by stating that it means "you set up your own standards and nobody can say anything about them."

Mr. Aitken, who is with the law firm of Bradshaw & Andres, Santa Ana, noted that the way he figures it the cost of an effective loss control program should be no more than 1% of total sales of the company involved.

Defending the insurance industry was John Mader, regional manager, safety and health services, Employers Insurance of Wausau, Los Angeles, who denied that the industry is making any money on product liability coverage.

For the year ended December 31, 1973, the product liability loss ratio was 135% plus claim expense ratio to premium, meaning that for every $1 in expenses insurance companies paid out $1.35, he said.

Mr. Mader pointed out that between 1965 and 1973 there was a 686% increase in product liability awards or from an average award of $11,644 in 1965 to $79,840 in 1973.

He also said that the average loss per claims for insurers is inflating at the rate of 27% a year — that is, doubling every three years.

He said that the trouble in product liability is highlighted in the case of an 11-year-old boy who crawled on a power pylon, and got a bolt of electricity which ignited his T-shirt. According to Mr. Mader, the T-shirt manufacturer had to pay a $140,000 judgment in a product liability lawsuit, in addition to judgments paid to the plaintiff by the power company and a TV cable manufacturer.

Ryan C. Knapp, senior partner, Spray, Gould & Bowers, Los Angeles, who spoke from the point of view of a defense attorney, advised the audience that corporations either set up strong in-house safety departments complete with safety engineers at the design level or that they hire an outside certified safety professional of CSP to evaluate their product from the standpoint of OSHA regulations. ■

Settlements not growing like claims

WASHINGTON—The dramatic increase in damages sought in product liability claims has not been accompanied by a similar rise in the size of settlements.

That was the most surprising trend uncovered in the most recent survey of product liability related problems commissioned by the Commerce Department.

The report, which was prepared by Gordon Associates for the Interagency Task Force on Product Liability, is based on industry studies as well as a telephone sample of 337 manufacturers.

The survey found that the amount of damages sought in new claims jumped from an average of $476,000 per firm in 1971 to a whopping $1.7 million in 1976.

While the average amount of settlements paid per firm, including court awards, rose from $12,100 in 1971 to $28,800 in 1972, the latter figure has remained relatively constant in the last four years.

The stability in company settlements came at a time when the number of pending claims per firm leaped a stunning 600% from 3.5 claims in 1971 to 18.9 claims last year.

In what was termed a "significant development," the researchers reported that the number of new product liability claims reached an "apparent plateau" between 1973 and 1975.

The cost of product liability insurance, not unexpectedly, doubled in the survey period. The biggest increases in the cost of coverage occurred among small businesses, firms with gross sales of less than $2.5 million.

While nearly all surveyed firms with annual sales of more than $100 million maintained coverage for protection against product liability suits, 29% of small firms went "bare."

Only 3% of the small firms reported they were unable to obtain product liability coverage. Most of the small businesses said they went without coverage because either the cost of insurance was too high or they felt coverage was unnecessary.

Large firms with sales of more than $100 million reported an increase in their average deductible from $54,000 in 1971 to $334,000 last year. ■

Colleges able to find coverage, study reveals

By SUSAN ALT

WASHINGTON — Despite the appearance that many organizations are having trouble finding adequate liability insurance coverage, only a small fraction of colleges and universities around the country have encountered any difficulty.

This was a key finding, and a surprising one, in a major survey done by the National Assn. of College & University Business Officers (NACUBO) of loss and insurance experience among institutions of higher learning.

The study revealed that the members of the association are basically no worse off than the college business officers expected, and might even be a bit better off, said John F. Adams, director of the center for insurance research at Georgia State University and a past chairman of NACUBO's insurance and risk management committee.

Among other important findings by NACUBO, said Mr. Adams, were the wide geographic spread of claims against educational institutions, the immunity pattern and the trend toward greater consciousness of liability problems on campus. College business officers also retain more of their risk and do a better job of targeting coverage (selecting insurance policies that cover specific risks where claims are likely to appear) instead of buying broad, blanket coverages.

The study also showed that medical malpractice is the real liability problem for universities, in terms of the numbers of claims recorded. The largest institutions have toughest problems with malpractice, "as would be expected," said Mr. Adams.

There's a chance that this study would provide the foundation for establishment of a college and university captive, he added, since NACUBO has been studying such a move.

"But institutions are not monoliths, and won't allow themselves to be lumped with other bodies in other environments," Mr. Adams noted. "What would likely happen with a captive would be movement into it by those having the worst experience and the highest rates. Those institutions with sovereign immunity would shy away from it, and would violate the principle of spread of risk.

"My own feeling," continued Mr. Adams, "is that it's not a realistic way to solve this problem. It's more reasonable to think of forming state pools, bringing like institutions with similar environments together. And it's even better to risk-manage the institutions."

The study by NACUBO's members was undertaken in order to document the claims and loss experience of higher education, to have "numbers which could accurately describe the situation to insurers and to the colleges themselves," he said. NACUBO also wanted to demonstrate to the skittish insurance industry that these institutions do have a handle on their own risks, and to demonstrate that colleges and universities deserve a separate classification, Mr. Adams said.

"I would hope the study leads to greater retentions of risk by our institutions," he said, pointing to discrimination/civil rights as an example of an exposure area where retentions should be greater. "We spend a great deal for investigation of cases before they even become suits. Most of the incidents are settled before any insurance is called in. It's more efficient that way. This kind of retention should happen in this field, because it encourages responsibility and accountability."

On the basis of data obtained, said the NACUBO report, it seems apparent that claims and other costs are considerably less than the revenue (premiums paid) generated by the 622 colleges and universities over the three-year period covered by the study. The survey revealed that in over 95% of the cases, there were no claims for the period covered, and no resulting losses.

Nationally, the study estimated a total of 433 claims pending, with the most claims in the eastern part of the country. Institutions in the West have a higher proportion of claims. In both cases, professional and hospital malpractice were the principal causes of claims. Almost half of all reported claims filed were from the eastern region and over half of those were for malpractice.

But of even greater significance to Mr. Adams was that more than 95% of all the institutions reporting had no claims from 1973 through 1976. "The data suggest that the liability problems have been blown out of all proportions in the market place," he said in the written report.

Many of the small schools reported increases of 75% to 100% in premiums between 1973 and 1975. Several institutions reported self-insurance plans covering the bottom layer of losses (all losses less than $1 million to an aggregate loss of $3 million).

Since the survey was completed, said Mr. Adams, a number of additional schools, particularly those with medical schools and hospitals, have gone the self-insured route.

Data showed that claims settled have generally been for relatively small amounts, usually less than $10,000 and many for less than $1,000. The largest settlement reported was for under $1 million.

Defense costs have been significant, however, the NACUBO study revealed. Estimates ranged from a low of $800 to more than $500,000. ■

london line

British, U.S. plan to enforce awards worries leading insurers in London

By JOHN H. MILLER

LONDON—British and American officials are working on proposals to make enforcement of court awards less difficult.

Leading insurers in London are alarmed by proposals which they believe could result in major increases in product liability rates in the British market. Whether there will be any impact on U. S. companies remains to be seen, since those firms are already exposed to the risks.

The changes are likely to be implemented in 1978. Each country would guarantee enforcement of awards handed down by the courts in the other country.

British government representatives confirmed that for many months they have been having talks with U.S. State Department officials in Washington to draft reciprocity legislation.

Michael Payne, a prominent Lloyd's underwriter, said, "The effects of the draft convention will mean quite simply that any British businessman having any business involvement with the United States will automatically be liable to the jurisdiction of that country and all it implies.

"Product liability rates and deductibles as far as U.K. producers are concerned will have to rise substantially. I think the loading for them in the case of U.S. exposures to their products will be probably 10 to 15 times the base rate if the new laws go through."

Arrangements for legislation appear to have been made by both U.K. and U.S. governments after their civil servants had prepared a draft convention which has now been released for public debate in London.

It is believed to spring from an effort to help the U.S. business market over the possible effects of E.E.C. (European Common Market) legislation in the future.

Foreign office sources in London call it a draft convention between the U.K. and U.S. for the "Reciprocal Recognition and Enforcement of Judgments in Civil Matters."

It is subject to ratification by the two governments. After it comes into force "a judgment given by a court of a contracting state shall be recognized in the territory of the other contracting state."

Though mainly intended to help businessmen and corporate bodies in their relationships between the two countries, it has suddenly assumed new importance because of the surge in product liability awards in the U.S.

This seems to have been over looked by some of the legislators, according to insurance sources in London, for it can make export products from the U.K. more costly if their makers are suddenly exposed to the scale of heavy payouts which are gaining momentum in the U.S.

Mr. Payne, who is joint chairman of the law reform committee in the Lloyd's market, told *Business Insurance:* "Judgments in any court in the U.S. will be capable of being virtually rubber-stamped by any court in the U.K. and it is hard to find any possible advantage to British businessmen if this happens. There is noticeable lack of appreciation of the consequences so far.

"The dramatic upsurge of product liability claims in the U.S. in the past few years has affected all who have business dealings in any way with American interests. We are hoping that there will be changes in the draft convention before it becomes law, though we recognize the terms have reached a degree of finality which may be difficult to alter now."

Main effect of the new rules will be to enable claims for liability awards against U.K. manufacturers to be enforced more easily in London, but punitive damages, as distinct from compensatory damages, will be excluded.

Businessmen fear that if they make a product which is judged defective by a court in the U.S., they will have to pay heavy damages without any right of appeal.

So far they are only liable to the extent that they have assets available for seizure in the U.S. in the event of awards.

There is still a vast difference between the legal systems of Britain and the U.S. Juries were abolished in British courts many years ago for civil law-suits to avoid emotional awards.

Leading judges in U.K. courts first of all decide on the guilt or innocence of any manufacturer sued for negligence, which is kept within sharply defined limits, and then decide on the amount of damages on a careful appraisal of the loss the victim has suffered.

Mr. Payne declared, to indicate the anxieties of the insurance market, that there seems no limit to the lengths to which some U.S. courts will go in order to establish liability.

"We know there is a growing body of opinion in the U.S. that product liability is in drastic need of reform," he told U.K. risk managers at a conference in London. "But damages are so far being awarded on an ever-escalating scale." ■

benefit tax slants

Restricted stock plans gain popularity

By JOSEPH S. ROBINSON
Attorney-at-Law

AN OLD standby known as the restricted-stock plan is again gaining popularity. Typically, executives receive shares of stock which they cannot sell for a period of, say, five years. Should they leave the company, they forfeit their stock. In the meantime they are permitted to vote the shares and receive dividends, taxed at a maximum of 50% as "personal service income" while the stock is under restriction.

The plan has advantages to the company too. If, for example, the company awards an executive stock at fair market value (its current selling price) of $10 a share, the employer's expense is $10 a share spread over the restriction period. In a typical example, at the end of five years, if the stock stands at $50, the company takes a tax deduction of $50 on a cost of $10. Therefore, the company saves $25 (at the roughly 50% corporate tax rate on the $50 deduction). If the stock stays at $10 the tax deduction equals the cost and the company saves nothing. If the stock declines the company loses on the tax deduction.

It should be pointed out that the cost of a restricted stock plan is known to the company in advance—$10 a share in the above example. In other plans such as stock options or performance shares, the cost cannot be predetermined.

* * *

Employer Corporation was entitled to deduct its entire contribution to a qualified benefit plan even though the benefit plan was substantially overfunded. So says the Court of Appeals. *(Texas Instruments Inc., Ct. of App. 5th Cir. 1977.)*

* * *

A batch of technical changes in the 1976 Tax Reform Act is expected to clear Congress sometime this summer. Among the significant proposals affects gifts worth $3,000 or less which are made within three years of death. These would not be added back to donor's estate even if worth more when he dies. However, there's one important exception. Life insurance policies given away within those three years are added back even if the policy was worth less than $3,000 when given away. This exception, in effect, taxes to the estate of a deceased employe the proceeds from an employer's group-term life policy, according to the Internal Revenue Service.

* * *

The Tax Reform Act of 1976 replaced the sick pay exclusion with a more restrictive disability income exclusion that applies only to cases of permanent and total disability. In other words, the new exclusion contemplates retirement caused by disability.

Permanent and total disability is defined in the regulations as "the inability to engage in any substantial gainful activity as a result of any medically determined physical or mental impairment that (1) can be expected to result in death or (2) has lasted, or can be expected to last, for a continuous period of not less than 12 months."

In order for a taxpayer to claim the exclusion, he'll have to attach to his income tax return a certificate from a qualified physician attesting to his permanent and total disability. To make certification as easy as possible, I.R.S. provides a form. *(Announcement 77-43, IRB 1977-15).*

* * *

New rulings give added tax break to pensions. The limit on corporate pension plans has been raised to 100% of pay up to a new $84,525 ceiling. What's more, IRS has ruled that people receiving benefits under a deferred compensation setup do not have to pay Social Security tax on such income.

IRA "rollovers" can be very important for lump sum pension or profit-sharing payouts. By doing this, you can delay the tax on the payments until you retire; you can even prolong the tax until age 70 if you choose to put off the payments. ■

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P/c insurers report $540 million loss

NEW YORK—The nation's property and casualty insurance companies lost more than $540 million on their underwriting operations during the first three months of 1977, according to the Insurance Information Institute.

The loss compares to a $1.4 billion underwriting loss in the same period in 1976, the worst three months in the industry's history.

Investment income for the first three months totaled $1.2 billion. Net income totaled $862 million.

The institute estimates a loss on underwriting of nearly $9 billion for the last three years. ■

around the states

Court upholds Pa. order requiring 27 days of sick pay for pregnancy

HARRISBURG, Pa. — Pennsylvania's Commonwealth Court has upheld the right of pregnant women to receive sick leave pay for days lost because of pregnancy.

The court let stand a state human relations commission requirement that a teacher be compensated for 27 days of sick leave taken because of a pregnancy.

In the majority opinion, Judge Theodore O. Rogers said that disability plans that don't provide sick pay for pregnancy discriminate against women because of their sex.

The decision came in a case in which a teacher was denied pregnancy benefits because her contract excluded such benefits. The commission ordered the school district to compensate her for 27 days of sick leave, and that order was upheld by Ccmmonwealth Court.

•

FRANKFORT, Ky.—The Kentucky Court of Appeals has reversed as excessive a decision awarding a woman $30,000 damages for negligent treatment of her hair.

The state's highest court remanded the case to circuit court for a new trial to determine damages. In all other aspects, Louise M. Wilson won her case against Redken Laboratories, Inc.

The woman's hair became splotched with orange during a frosting process at a beauty shop in 1973. When attempts to correct the situation failed, the shop owner sought help from the laboratories.

The woman temporarily lost most of her hair and was required to wear wigs. She sued Redken and was awarded $245 in special damages and $30,000 for mental anguish by the lower court.

But the high court said there was no evidence of lost wages, pain or diminished earning capacity, and there was no permanent damage.

•

OLYMPIA, Wash.—The Washington senate has passed legislation that would spread liability for defective products from manufacturer to retailer.

Under current court decisions, the retailer normally is held responsible for any injury caused by a defective product and required to pay 100% of the damages.

The bill, which was sent to the House for further action, would move the state to a contributory fault concept.

Courts would decide damage awards and then pro rate the amount among the manufacturer and others involved in the production of the item, a repairman and the retailer.

Supporters of the legislation claimed that if the contributory fault concept is not adopted in Washington, retailers will not be able to afford product liability insurance and be forced out of business.

•

AUSTIN, Tex.—A bill has been proposed in the Texas legislature requiring the state to defend any employe in a lawsuit alleging negligence or civil rights violations. The state also would have to pay all damages, court costs and attorney fees—adjudged against the employe.

The legislative budget board said it could estimate the financial impact of the measure, but warned that it could be "significant." Current law requires the state to defend and pay damages assessed against employes of certain state agencies. The bill would add all state employes and include courts costs and attorney fees.

•

FRANKFORT, Ky. — A Louisville (Ky.) woman has been awarded $4,857 as part of a religious discrimination complaint against the Louisville division of the Great Atlantic & Pacific Tea Co. Inc.

The money, less any interim wages was awarded Denise Ray as part of a conciliation agreement between A&P and the Kentucky Commission on Human Rights.

Ms. Ray charged in her complaint that A&P failed to make "reasonable efforts" to accommodate her religious beliefs after her conversion to the Seventh Day Adventist Church.

She said she was fired in June 1975 from her job as part-time checker because her beliefs prohibit working from Friday at sundown to Saturday at sundown.

A&P denied the discrimination charges and said its decision to sign the settlement does not mean it admits it violated the Kentucky Civil Rights Act.

The agreement stipulated that Ms. Ray will not be required to work during any period that would conflict with her religious beliefs and will be permitted to exchange work hours with any willing co-worker. A&P also agreed to reinstate Ms. Ray with no loss of seniority.

•

SPOKANE, Wash.—An $815,700 verdict in favor of a 23-year-old quadraplegic was denied because a Spokane County (Wash.) Superior Court found the plaintiff 90% negligent in his paralyzing accident.

Because the accident occurred in Idaho, that state's law—which requires a jury to determine that a plaintiff was at least 50% negligent to recover damages—was applied in the case.

The jury was unaware of the Idaho law's application. In Washington state, had a jury found a plaintiff to be 90% negligent and the defendant to be 10% responsible, the plaintiff could recover 10% of the verdict.

The lawsuit was brought against Albert Elkins, owner of Elkins Resort, Priest Lake, Idaho, by Joseph Thayer, a Washington State University senior, who contended he dove into shallow water at the resort and struck a rock.

Thayer's attorney argued that the resort was responsible for maintaining a safe swimming area and that a swimmer should be allowed to believe the water was free from obstacles. But counsel for the resort contended a swimmer was obligated to learn the condition of the water before diving.

The jury awarded the $815,700 verdict, but found the resort only 10% responsible.

•

AUGUSTA, Maine—Gov. James B. Longley has asked the legislature to approve a bill that would require state review of all hospital rates in Maine.

The measure, which is aimed a curbing health care costs, would create a "Health Facilities Cost Review Board" that would regulate hospitals similar to the way the state currently regulates public utilities.

•

HARRISBURG, Pa.—The state Insurance Department has advised some 40,000 Pennsylvania businesses that their commercial fire and extended coverage insurance premiums will decrease over the next year.

The department approved a 3.1% decrease in rates for the 330 insurers, represented by the Insurance Services Office.

The overall rate adjustment includes a 3% decrease for commercial fire insurance coverage and a 3.6% decrease for extended coverage insurance.

The department said the changes will save a total of $2.9 million a year for the policyholders. ■

PLRB chairman

Francis P. Story has been elected chairman of the board of governors for the Property Loss Research Bureau. Mr. Story, president of Holyoke Mutual Insurance Co., succeeds Edward C. Jones, president of Iowa Kemper Insurance Co.

Dual filing of 5500s eliminated

WASHINGTON—In a move designed to end confusion and unnecessary paperwork, the government is eliminating the dual filing requirements for Form 5500, the basic annual report for employe benefit plans.

Employe benefit plan administrators and sponsors will file only one annual report for each benefit plan with the Internal Revenue Service seven months after the end of the plan year.

Under the old system, employers had to file the annual reports with the IRS and the Department of Labor on separate dates which frequently caused "confusion, delay and excessive costs," the government said.

The new filing system will be ready for 1977 return forms filed in 1978. Employers will continue to file 1976 return forms with the Labor Department and the IRS.

In announcing the new streamlined filing procedure, Alvin Lurie, an assistant IRS commissioner in the office of employe plans and exempt organizations, said: "This is the kind of thing we are doing as a practical matter, acutely aware of making multiple jurisdiction operate with a minimum burden."

In addition, employers will no longer have to file the Pension Benefit Guaranty Corp. annual report, Form PBGC-1. The questions on that form will be merged into the 5500 form.

In a related change, welfare plans, which were previously filed only with the Labor Department, will be filed only with the IRS beginning in 1978. ■

Cost control bill possible

WASHINGTON—Despite some glowing support, a senior White House official conceded it is too early to predict if Congress will pass President Jimmy Carter's hospital cost containment proposals.

"Many people thought the bill would be introduced and then would die," said Joseph Onek, associate director of the administration's domestic policy staff. "That hasn't happened. It has a fighting chance."

Speaking before a legislative update conference sponsored by the International Foundation of Employe Benefit Plans, Mr. Onek said the administration remains committed to introducing a national health insurance program early next year.

But Mr. Onek said it would be difficult to phase in the program until hospital costs are first brought under control.

Before introducing the cost control program limiting increases in hospitals' revenues to 9% a year, the administration rejected proposals to place revenue caps on only Medicare and Medicaid reimbursements.

"We were told that if caps were placed on Medicare alone, costs would be raised elsewhere," said Mr. Onek.

The mechanism for implementing the program is expected to be in place by October.

When asked what would happen if the controls fail to restrain cost increases, Mr. Onek said simply: "Then it is back to the drawing board." ■

25 Chicago suburbs urged to self-insure risks

By KATHRYN McINTYRE ROBERTS

CHICAGO—Twenty-five Chicago suburbs have sounded out the waters of self-insurance and now must decide if they're going to dive in.

They've been told by Darien, Conn.-based Risk Planning Group Inc. that they could save 25% to 39% of their insurance costs by pooling to self-insure their risks.

Financial officers in the communities were still digesting a 56-page report from the consultants on their risk and insurance problems when contacted by *Business Insurance*. They didn't want to commit themselves to self-insurance yet, but they appeared impressed with the potential savings and were indignant over past insurance costs.

"We've been gouged in the past, apparently," observed Richard Glueckert, finance director of Buffalo Grove.

The consultants found that 23 of the suburbs paid a total of $2,850,880 for property and casualty insurance during the 1976-1977 premium year. If they had jointly self-insured their risks, the communities would have paid $1,761,141—or $1,089,739 less than they paid, the consultants estimated. The self-insured cost includes administration and legal and safety engineering services as well as excess insurance, bonds and losses.

Risk Planning vp Michael G. Thistle explained the municipalities paid more for insurance than their losses would justify because "underwriters are not segregating their losses."

For instance, 23 of the suburbs paid a total of $1,595,682 for workers' compensation insurance last year, but their losses totaled only $418,637 plus $453,130 in reserve funds.

The report summarizes, "From a strictly economic point of view the villages would have been much better off if they self-insured the exposure within specified retention limits and purchased annual aggregate protection above their individual and combined retention levels."

Although the detailed examination of risk funding alternatives and specific costs is slated for a second phase of a three-phase study, the initial report suggests a pooling mechanism could retain $100,000 per occurrence and $500,000 aggregate above a village self-insured retention of $5,000 per occurrence and $50,000 aggregate.

The local governments participating in the risk management review are members of either the Northwest Municipal Conference or the DuPage Mayors and Managers Conference. Faced with mounting insurance costs—Buffalo Grove's Mr. Glueckert reported a threefold increase in as many years—the suburbs collectively hired the consulting firm for some cost-cutting advice.

Each suburb will pay from $1,500 to $1,800 for the study, based on its premiums. That rate is one fourth to one-fifth of what it would have cost them to individually hire a consultant, said William H. Muhlenfeld, executive director of the Northwest Municipal Conference.

In the third phase of the study, should the suburbs decide to continue, the consultants will assist in implementing the chosen risk/insurance management plan.

The municipalities are meeting in mid-June to vote on pursuing self-insurance. Mr. Muhlenfeld said, "It's safe to say most of them will continue this. We hope to have something operational (a self-insurance pool) by next May for workers' compensation and auto liability."

For the meantime, the initial report gives the suburban officials lessons in risk management, explaining exposure identification and risk control and outling their application.

In reviewing the suburbs' risk and insurance management, the consultants found some disturbing exposures and practices including:

- Numerous villages do not maintain duplicate records of village ordinances, resolutions of the board, tax records and other important data.
- Two instances where chiefs of police had been known to pilot aircraft within the performance of their village duties.
- For the most part, pre-employment loss prevention indoctrination is left up to the individual supervisors who may or may not instruct new employes regarding loss prevention measures.
- No standard village policy regarding employes' use of their own vehicles on village business.
- Some villages engage in oral mutual aid agreements in emergencies and most mutual aid agreements are excluded from insurance protection.
- Numerous villages are lax in obtaining certificates of insurance from entities and individuals performing services on their behalf.
- Many villages obtain their insurance agents/brokers through the bid process and the lowest bid is usually awarded the insurance program without consideration of the depth or ability of the servicing agent or brokerage firm.

In addition to the general recommendations and observations in the report, each municipality received an individual review of its insurance portfolio which included recommendations for retentions, limits and additional coverage.

Whether or not the municipalities choose to pool to self-insure their risks, Risk Planning's Mr. Thistle hopes they implement a coordinated risk management function. The consultant's report recommended each suburb could establish a committee to oversee the risk management work or appoint a person part-time to coordinate it.

And if they don't pool to self-insure, the consultant recommended that the villages consider joint insurance purchasing, not only for the financial savings possible but also for the increased bargaining power a group can wield. ■

Name change

Stephen's Financial Services, a Columbus, Ohio-based group benefit consulting firm, changed its name to Cor-Ben Consultants Inc. After studying group self-insurance for more than a year the firm is now seeking clients in a position to consider self-insurance. Because of the enormous medical premium increases in Florida, Cor-Ben recently opened an office in Miami, with a direct goal of providing ASO consulting services.

HMOs: Some tips from the Reynolds experience

By Bynum E. Tudor
Director of Employe Benefits
R. J. Reynolds Industries Inc.
Winston-Salem, N. C.

Bynum Tudor is the newly elected president of the National Assn. of Employers on Health Maintenance Organizations (NAEHMO) which already has 122 company members in just over a year since its founding. Mr. Tudor says NAEHMO's goal is to have 300 company members by early 1978. Mr. Tudor is busy these days playing host to the many corporations wanting all the latest data about how Mr. Tudor set up his HMO; he has 80 different corporations on his waiting list to come in for a visit.

THE INITIAL performance of our HMO —which is known as Winston-Salem Health Care Plan—has met all of our expectations. We at R. J. Reynolds established our HMO with the conviction that HMOs represent the coming national trend in health care and the reaction to our HMO by the plan's first members has confirmed that feeling.

We are presently serving a membership of 10,000—up from the enrollment of 6,000 when we opened our doors on July 1. Four thousand more come in July 1. And another 23,000 are on a waiting list wanting to join.

Our studies show that these members have been utilizing our Health Care Center at the projected rate of 3.8 Health Center visits per year. We also are closely monitoring hospital admissions and lengths of stay, and have found the hospital use has been at the rate of 436 days per 1,000 enrollees per year. This per day figure is substantially below the figure for our Blue Cross program.

These statistics indicate that our members are definitely accepting the HMO concept, and that they are using the health center for preventive treatment, as they should.

The response we have received has enabled us to proceed with our plans for expansion of Winston-Salem Health Care Plan. Our method is to establish a gradual, orderly growth pattern, that will allow us to add to our enrollment at a fairly fast rate, yet maintain a consistently high level of services. In line with that, we made room for 1,000 more members each in successive increments this past October 1, November 1 and January 1 and in the spring, bringing us to our present total of 10,000.

At the same time, we have been careful to increase our professional staff in proportion to the added case load. We started out with seven physicians and three physicians assistants last July. We now have nine physicians and five P.A.s, and have already signed on eight more physicians, to come on board shortly. By yearend we expect to have a staff of 20 physicians and six P.A.s.

Our goal is member enrollment of 19,000 by the end of this year, and we expect the ultimate membership figure to reach 30,000 by the time our HMO attains maturity—which should be in about two years.

Winston-Salem Health Care Plan originates all of its services in one 3-story building and initially is serving only one group—the employes of R. J. Reynolds and their families. However, I want to make it clear that this does not mean that R. J. Reynolds now is in the medical business. Rather, Winston-Salem Health Care Plan operates as a free-standing entity, apart from R. J. Reynolds. We have a diversified team of physicians and professional administrators who have shown they can render high-caliber medical treatment to our employes.

We have had a few problems, of course. The start-up of any new program is bound to have a few misfires. In our case, we have been fortunate enough to overcome them without any harmful consequences, and I would like to share a few examples with you, in the hope that they might help you to head off similar problems, or that you might better cope with them should they happen to crop up.

One of the first things we learned is that you have to allow extra lead time for the start-up of an HMO. You must be completely ready, in terms of organization, staffing and facilities; to treat people from the first minute you open your doors. It is not like putting a production plant on stream, for example, where you can iron out difficulties as you go along. When you're dealing with human welfare, you're dealing with an area of the highest importance and sensitivity. You are obliged to create a quiet, relaxed atmosphere for patients and staff from the very start. You positively cannot have any confusion or rushing around during start-up. Remember, you are in reality selling a totally new concept of health care and you've got to be in near-perfect readiness to meet the heavy expectations and demands of your first patients.

For our own part, we did not provide for quite as much lead time as we could have used. An extra two months would have been nice, and I recommend anyone starting an HMO to build that added margin into their own lead time. As it is, we met our dealine through sheer hard work and dedication on the part of our new administrative staff.

Another unexpected development was the volume of use of our Health Center from the opening day forward. Starting up in July as we did, we felt that many members would either be on vacation, or would postpone visits in favor of outdoor activities. We also thought there might be an initial restraint on the part of people in trying out our new health care concept.

Instead, we found that members were curious and anxious enough to want to test our services immediately. Many, after learning they were accepted as members in our prepaid plan, evidently postponed check-ups and treatment so they could take full advantage of our program. Again, it was hard work on the part of our staff that saw us through. I'm not saying that we were terribly overburdened, because we had calculated the size of our medical and administrative staff to handle the anticipated early case load and more. What I am saying is that we're glad we did allow for extra staffing.

Minor and inevitable adjustments had to be made on the part of both members and staff in making the new HMO concept work. People often are used to one doctor, and do not always take to the practices of a new one. So, they're liable to insist that the old way was better, and ask their HMO physicians to adopt methods similar to those of their previous doctor. During our first six months of existence, however, we received only about 25 complaints of any kind, most of them minor, and not all of them about treatment. We think that's a pretty good record.

The acceptance on the part of our members has extended to our use of physician's assistants and nurse practitioners in performing many of the routine tests. Of course, this is a radically new approach for those used to receiving all treatment from a single family physician. However, we have discovered that some of our members, as they receive treatment from P.A.s and N.P.s over the course of several months, actually come to prefer dealing with them. So the arrangement has worked out well for us.

Another success has been our unwritten

Continued on following page

In seven major areas

Actuaries are crucial in self-funded health plans

By Stephen D. Brink
Consulting actuary
Milliman & Robertson Inc.
Brookfield, Wis.

DRAMATIC INCREASES in the cost of health benefit programs have caused benefit plan managers to explore alternatives to solve the problem of rising costs. Benefit plan sponsors, whether they are employers, associations or unions have always been concerned about the health of their people as well as the cost of health care. Thus, the objective of the benefit plan manager, who is responsible for the plan's operation, has been and will continue to be the availability of quality health services at a minimum cost. Self-insurance of medical and disability benefits is receiving increasing attention as a means of reducing the total outlay for health benefit programs.

The concept of self-insurance isn't anything new. In fact, long before insurance coverage was available, employers, trade associations and individuals provided for and financed their medical care needs as they arose.

As the availability and technology of medical services expanded and the potential costs increased, insurance companies assumed a large role in the financing of health care. The sponsors and managers of health benefit plans turned to the insurance companies and other prepayment programs because of their ability to spread the risk of loss through insurance mechanisms. Insurers offered the capability of handling increasingly complex benefit payments, and could guarantee the employer a budgetable level premium for twelve months at a time.

In recent years insurance mechanisms, through experience rating techniques, have shifted a substantial portion of the risk back to the plan itself. This shift has made the plan sponsor more aware of the insurer's administration charges and the charges made by the insurer for risk bearing. All of this has renewed interest in self-insurance.

Self-insurance can take many different forms. Benefits can be wholly self-insured or self-insured only up to a specified maximum with the excess covered by insurance company contracts. Possibly only a portion of the benefits will be self-insured. Benefits can be paid as a current operating expense as claims are submitted, or out of funds paid in advance. Regardless of the form of the self-insurance program, the benefit plan manager will need competent assistance from attorneys, actuaries, and administrators in the performance of his function.

Under a self-insured program, regardless of form, the plan sponsor is the basic underwriter of the plan. He will have to answer questions such as: What are the benefit payments expected to be? What are the costs of future benefit improvements? How much risk should be retained? Is the benefit structure sound? Are the assets reserved to provide future benefits adequate? Is self-insurance continuing to provide quality benefits at the lowest possible cost?

A qualified actuary, experienced in the health field is able to provide answers to these questions and many others as well. The training and skills of the actuary, long essential to risk-taking insurers, are equally essential to the risk-taking self-insurer.

All actuaries are trained in mathematics as applied to the fields of statistics, forecasting and finance. Health actuaries are particularly experienced in the delivery system of health care, the design of various benefit programs, and risk-taking arrangements. A properly qualified actuary can assist benefit plan sponsors and managers in the following areas:

Self-insurance feasibility studies: Beginning with a review of existing benefit programs, the actuary will examine the plan's risk components, such as plan benefits, demographic characteristics of plan participants and number of participants, as they relate to self-insurance and other alternative risk management arrangements. The actuary will determine the plan's cost elements as they relate to risk exposure and risk management arrangements. He can also bring attention to the long-range effectiveness of cost controls under available alternatives.

Also to be considered are the economic position and regulatory environment of the plan sponsor. Working with qualified attorneys, the actuary will review the problems of administration and other requirements under state and federal laws and regulations. Being able to quantify the plan's risk, the actuary is able to provide an objective measurement by which the plan sponsor is able to determine his ability and willingness to retain risk.

Prediction of benefit costs: Accurate predictions of future benefit costs begin with an accurate study of past experience. The health actuary is trained and equipped to make detailed statistical studies of cost and utilization for any large group of participants and their dependents. He can

Continued on following page

PERSPECTIVE

Reynolds' HMO experience . . .

Continued from preceding page
policy to be lenient with members who have gone directly to hospital emergency rooms for treatment in routine cases, rather than contact our HMO first. We consider this a good member relations move, but we have limited the practice to our first few months of existence. We are now sending out letters to all members outlining our exact policy on emergency treatment.

We decided to be lenient initially regarding these emergency room visits, because we realize that old habits are hard to break. After all, our HMO was created in the first place after R. J. Reynolds discovered that half of the Company's 15,000 Winston-Salem employes and their dependents did not have a family physician, but were using hospital emergency rooms for all treatment that they needed.

RJR investigated this condition and hospital authorities confirmed the situation. One local hospital emergency room during a single period had treated 70,000 non-emergency complaints. Of course, there was no way to determine how many of these were Reynolds' employes or their dependents, but we were confident that a large number of them were.

Why did we start our own HMO? Because R. J. Reynolds is tied closely to the community in Winston-Salem, and has always placed a high priority on maintaining good working conditions and benefits, it was only natural that RJR became intimately involved in coming up with a solution when this problem of access to high quality medical care arose.

A number of us in the company serve or stay in touch with various area-wide health planning committees, and we were aware of alternative answers to the problem. We had been familiar with the HMO concept since 1969, when some of us went up to Harvard University to look at Harvard's landmark HMO program. We found that HMOs offered a number of attractive features—including desirable control over both the quality of treatment and the associated costs, emphasis on preventive care, reduction in the use of hospitals and reliable access to high-quality medical treatment for employes.

We decided HMOs merited a closer look, so we assembled a team to investigate every major HMO group in the nation. We visited HMO operations in such widely scattered locations as New York, Arizona, Connecticut, Oregon and Ohio, often returning for more intensive examination. Slowly, we began to put on paper what we considered a model HMO—conceived from the best features of the successful HMOs that we visited.

As soon as we had the details mapped out, we presented our HMO plan to Reynolds Industries' top executives. Not only did they favor the HMO concept, they committed unlimited resources to the project—with the provision, of course, that we could justify whatever major expenditures we proposed.

Backed by this suport, we began our search for a full-time professional administrator, medical director and medical staff. First, though, we made sure our HMO's relationship with the medical community in Winston-Salem would be a peaceful one. We achieved harmony by showing that the needs of the area's populace are enough to require full employment of all existing medical facilites and that there was a shortage of certain medical specialties.

That accomplished, we felt free to pursue our recruiting. We further cemented relations with the Winston-Salem medical community by appointing as medical director, Dr. Reid Bahnson, a great guy and a past president of the County Medical Society. Our search for an executive director ended with the hiring of a man who had 10 years of corporate administrative experience, topped by service as a fellow in the HMO administrative training program at the University of Pennsylvania.

Under their guidance, we began to select a medical staff. Altogether, we have screened more than 1,000 applications, paying close attention to the quality of the schools attended and noting subspecialties. Our steadfast criterion is that our physicians be board-certified or board-qualified. Initially, we have sought professionals in internal medicine, obstetrics/gynecology, and pediatrics. Other specialties will be handled on a referral basis until they are added to our staff during the growth period.

As I implied earlier, our belief is that it is better to overstaff than to understaff. Slight overstaffing assures that HMO enrollees receive prompt and thorough treatment.

We have found this to be the case with Winston-Salem Health Care Plan and the arrangement has aided the popularity of the program. The first patients treated have been pleased enough to talk about the reception they got, word-of-mouth has been generated, and some of the employes who said they didn't want to enter the plan have changed their minds. We now predict that 85% of our Winston-Salem employes ultimately will belong to the HMO. We're at 65% right now. However, as I mentioned earlier, we will only allow more members to enroll in small numbers.

A feature of the pediatrics section is the addition of a recreation room where the children can play while waiting for an appointment.

We would recommend this method to anyone beginning an HMO. It is good marketing and even good finance to let in just a select few at the beginning. There is nothing like a little exclusivity to make an offer enticing. Limit the initial enrollment and prospective members will be beating down your doors. Throw the membership wide open and you may well realize just a fraction of the enrollment you expected. Your facilities and your staff will sit idle and your overhead costs will become unbearable.

Another move that will help HMOs to succeed is to ask your management to publicly sanction the HMO at the very beginning.

Some 22,000 of our employes and their dependents wanted initial membership, so we took all application cards and put them through a computer for random selection. But first we designed a computer program to make sure a representative cross-section of our employes would be chosen every time new members were added to the HMO. This enables us to properly analyze the depth and pattern of treatment within Winston-Salem Health Care Plan, and will help us plan and formulate load expectations when the full enrollment is achieved.

We have plenty of room for growth on the site that we picked out for the physical facility. We acquired a fairly new building on the west side of Winston-Salem to serve as the headquarters for our medical center. The structure is quite sizeable—three levels encompassing 37,000 square feet.

We completely renovated the building and brought in an interior decorator to redesign the look. Our facility shows a decidedly contemporary look, but makes liberal use of textured wallpaper and curtains, framed artwork, and comfortably cushioned bamboo furniture to produce the relaxing atmosphere that we strived for, as a part of the introductory and educational process. The informal motif is carried through to the doctors' offices and the multitude of examining rooms, to prevent them from looking cold and impersonal.

We equipped our laboratory, radiology department, minor treatment center and nurses' stations with the most advanced equipment available. Our facility also features a computerized records center that maintains complete medical histories on every member.

We intend to fulfill our promise to employes that Winston-Salem Health Care plan will do whatever is necessary to assure their health. We will readily refer our patients to any source or specialist in the nation for treatment of an infirmity.

Editors Note: Reynolds' capital outlays amounted to $2.2 million for buildings, equipment and other start-up costs. It's difficult to tell, says Mr. Tudor, just what the per-employe cost of the HMO plan is to compare it with Reynolds' Blue Cross benefit plan previously used for all employes. Reynolds has been on a cost-plus arrangement with Blue Cross, and paid claims under that plan in 1976 were $6 million. Mr. Tudor is quite sure, however, that the cost of the HMO per employe is less than the cost of the Blue Cross plan for comparable coverage.

Actuaries and self-funding . . .

Continued from preceding page
also examine experience by type of health care services, age and sex. Such studies take on an added meaning when past experience is compared to expected performance for the same period. Many health actuaries have developed data collection and experience analysis systems that are essential tools for the management of any health plan, insured or self-insured. Projection of health benefit costs depends on proper adjustment to past experience (or expected past experience if historical data is not available or not fully credible) for known trends in health care practices in the area, the benefit design and administration, and changes in the demographic characteristics of the group.

Establishing reserve levels: Adequate reserves should be accumulated to pay for claims incurred but not yet paid. Due to the nature of health coverage there often is a substantial lag between when a claim is incurred and when it is actually paid. This lag may be two years or more for major medical coverages and 30 or more years for long term disability benefits. Moreover it will vary according to specific benefit provisions, claim reporting practices, and the demographic composition of participants. The qualified health actuary has the experience and the statistical techniques to accurately estimate this liability. Establishing the reserve or liability of the plan will also be necessary for a true picture of the plan's financial experience.

Establish level of risk retention: Using sophisticated risk analysis techniques, the actuary is able to determine the probability of losses occurring in excess of various risk retention levels. He is able to predict expected benefit payments as well as the chance of fluctuations beyond a specific retention level.

By relating these items to the plan sponsor's net working capital, retained earnings, or sales, the maximum prudent risk retention level can be established for the sponsor's particular situation.

The remaining risk would be assumed by an insurance company under a stop loss or similar contract. A valuable by-product of such risk analysis is the development of the expected net claim cost for providing benefits in excess of the employer's specific retention level. The insurer's charge depends on its evaluation of the risk plus a loading for expenses, profit and contingencies. Knowing the expected value of the stop loss coverage enables the self-insured plan to decide whether to pay the loading or retain more of the risk.

Trust established under Section 501(c)(9) of the Internal Revenue Code: If the plan provides for the accumulation of claim or contingency reserves, the Employe Retirement Income Security Act of 1974 (ERISA) requires that all assets of a non-insured plan must be held in trust. A trust established under Section 501(c)(9) of the Internal Revenue Code would be most advantageous if funds are to be developed, since any interest earnings of the trust would be exempt from taxation. It appears that IRS requires contributions to such a trust to be "actuarially determined" and "reasonable" in order for the employer to claim such contributions as tax deductible. Overfunding is to be avoided since any contributions to the trust are irrevocable. Also, underfunding of the plan may be a breach of fiduciary responsibility under ERISA, although at this point there are no definitive regulations in this regard. An actuary is able to provide the benefit plan manager with a best estimate of the benefit contributions so that the risk of overfunding can be diminished.

Dual choice regulations under the Health Maintenance Act of 1973: These federal regulations require that "in the absence of a collective bargaining agreement of employer-employe contract specifying contribution for health benefits, the employer's contribution to the health maintenance organization on behalf of eligible employes or such employes and their eligible dependents, unless otherwise agreed to by the health maintenance organization and the employer or its designee, shall be based upon the total costs of such health benefits offered to the employes for the most recent period for which experience is available." Additionally, it is required that the plan adjust the experience using a reasonable allowance for inflation, cost differences for different areas of employment, anticipated changes in the composition and experience of the non-HMO participants attributable to the shift of enrollment to the HMO, and changes in benefits. An actuary is able to assist in determining these contributions as well as reviewing the overall desirability of the HMO.

Measuring performance: Ultimately, control of rising health costs may depend primarily on developing a dialogue between major consumers of health care, the plan sponsors and their participants, and the providers of health care services, the physicians, hospitals and other health professionals. An actuary experienced in measuring the components of quality health care can provide standards for measuring performance that can be useful in this dialogue. ■

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legal brief

Court upholds insurer's decision not to defend

AN ILLINOIS APPELLATE court has ruled unambiguous a provision in a comprehensive general liability policy issued to an engineering corporation. The provision excluded from coverage "bodily injury or property damage" arising out of any professional services. Thus, the court held that the insurance company had no duty to defend a lawsuit brought against the engineering corporation seeking recovery for injuries arising out of the corporation's alleged negligence.

The engineering firm was insured with United States Fidelity & Guaranty Co. (USF&G) under a comprehensive general liability policy. The policy contained a provision applicable to engineers, architects or surveyor's professional insurance excluding coverage for bodily injury or property damage arising out of any professional services performed by the insured.

John Saley brought suit against the firm seeking damages for personal injuries arising out of the firm's alleged negligence in supervising the construction of a sewer contract on which the firm had performed engineering work. The firm requested USF&G to defend but the insurer refused to do so. The firm then sought a court order that would require USF&G to defend as well as to pay attorney's fees. Although the trial court ordered USF&G to proceed with the defense, the appellate court disagreed.

The court noted that the law was clear that an insurer must defend an insured when a complaint has been filed against the insured where the allegations "are sufficient to bring the case either within or potentially within the policy coverage." Also, the court pointed out that the duty of an insurer to defend is separate and distinct from, and is broader than, its duty to indemnify the insured.

Thus, after a review of the Mr. Saley complaint and the exclusion provision, the court concluded that the allegations of the basic injury complaint at issue fit precisely into the professional liability exclusion in the comprehensive general liability policy. *Sheppard, Morgan & Schwaab, Inc.* v. *USF&G Co.*, Appellate Court of Illinois, Fifth District, Nov. 18, 1976, Eberspacher, J., 358 N.E. 2d 305 (BI/01/Ju.-$3)

Coordination of benefits

In this suit for breach of contract, a Louisiana appellate court ruled that a statute prohibiting the coordination of benefits between certain insurance policies was applicable where only group insurance policies were involved.

Karl Ermert was insured under a group health insurance policy issued to his employer by Union Labor Life Insurance Co. (Union). The policy provided for basic and supplementary major medical and health insurance for Mr. Ermert and his dependents, including his wife. Mrs. Ermert was also personally covered under a group health insurance policy issued to her employer by Lincoln National Life Insurance (Lincoln). This policy also provided basic and supplementary major health coverage. Following Mrs. Ermert's hospitalization and surgery, Lincoln reimbursed her for $2,033.45 of her $2,076.88 claim. Mr. Ermert then filed a similar claim with Union for reimbursement of the same expenses.

Union paid Mr. Ermert $668 under the basic policy provisions, but refused to pay $839.08 allegedly due under the major medical provision because of a "coordination clause" in the policy. This clause applied only to the major medical portion and prevented duplication of those benefits where an insured was also covered and paid under another group policy. The trial court ruled in favor of Union.

At issue on appeal was whether the coordination clause violated

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a state statute prohibiting a reduction in benefits in group policies where benefits had been paid under "any other individually underwritten contract or plan of insurance for the same claim determination period." Mr. Ermert contended that the coordination clause was prohibited in any individually written contract or in any plan.

The court disagreed concluding that the phrase "individually underwritten" modified both "contract" and "plan." In denying Mr. Ermert's claim for recovery, the court emphasized that the reason behind the coordination of benefits clause was to prevent the insured from recovering more than is necessary to make him whole, keep rates as low as possible while assuring full compensation to the group policyholder, and reimburse employees for their needed expenses and not enable them to make a profit out of being ill by obtaining multiple benefits for the same expenses, thereby encouraging malingering. *Ermert* v. *Union Labor Life Ins. Co.*, Court of Appeal of Louisiana, Fourth Circuit, Nov. 16, 1976, *rehearing denied* Dec. 14, 1976, Samuel, J., 339 So. 2d 927 (BI/02/Ju.-$3)

Limits of liability

In an action under a multi-peril insurance policy, the Wisconsin Supreme Court ruled that the statements of "limits of policy" in the policy could only be construed by a reasonable person in the position of the insured as exactly what they were entitled —limits of liability under the contract. But the court also concluded that the policy contravened a state statute then in force because it contained a provision limiting the amount to be paid in case of loss below the actual cash value of the property where that value constituted the basis for premium calculation.

A trial court awarded the Lakeside Plywood and Building Materials Inc. (Lakeside) $50,000

over and above the alleged limits of a multi-peril policy issued by Aetna Casualty and Surety Co. (Aetna). The claim arose out of a fire in one of Lakeside's plywood warehouses. The policy was a provisional or monthly reporting form fire insurance policy that required Lakeside to report to Aetna at the end of each month the value of property at each location. A provisional premium was paid, subject to adjustment at the expiration of the policy depending upon an average of the values which had been at risk during the policy period. The policy contained a $90,000 maximum limit of liability.

The appellate court had to answer what was the maximum limit of liability under the policy and did the policy violate a state law precluding the issuance of a fire insurance policy containing a provision limiting the amount to be paid in case of loss below the actual cash value of the property?

The appellate court concluded that the policy specifically contained an absolute limit of $90,000 and that this was not inconsistent with a reporting form insurance policy. The court emphasized that simply because "a policy has also as its purpose to fully cover the insured's risk . . . it does not follow that no absolute limits whatsoever may be imposed . . ." But here, Lakeside had reported values monthly above the limits and at the termination of the policy had paid an additional premium which was accepted by Aetna.

In the court's opinion this violated state law because Lakeside had paid a premium in excess of the limit of coverage. Consequently, the court permitted the trial court award of the excess $50,000 damages to stand. *Lakeside Plywood & Bldg. Mat.* v. *Aetna*, Supreme Court of Wisconsin, Feb. 1, 1977, Hanley, J., 250 N.W.2d 1 (BI/03/Ju.-$3)

Attorney malpractice

The California Court of Appeal, Second District, has ruled that a malpractice insurer was not required to defend and indemnify an attorney with respect to a malpractice action arising out of advice which the attorney had given prior to the time that the policies were issued. The policy specifically excluded prior acts.

The Signal Insurance Co. had provided legal malpractice insurance from September 1971 through September 1974. The malpractice action here was brought against the defendant attorney by a former client who complained that the advice which the attorney had given him in 1962 and 1963 had caused him to take certain actions. During a deposition given by the attorney in 1972, in the course of a lawsuit brought against the client arising out of the matter with respect to which the attorney's advice had been given, the attorney retracted the advice.

The court concluded that in light of the policy's specific provision excluding prior acts, the insurer was not obligated to defend and indemnify the attorney. It is settled, the court emphasized, that the time of the occurrence of an accident within the meaning of an indemnity policy is the time that the damages insured against actually accrue.

Signal argued that this doctrine applied here because, although the client did not discover the allegedly erroneous nature of the attorney's advice until 1972, the advice itself, the occurrence causing damage, had been rendered in 1962-67 prior to the commencement of the policy in 1971. *Arant* v. *Signal Ins. Co.*, California Court of Appeal, Second District, Division 2, Feb. 25, 1977, Roth, P. J., 136 Cal. Rptr. 689 (BI/04/Ju.-$3)

Fornication "therapy"

In this unique case, a practicing psychiatrist brought suit against his malpractice insurer to recover the costs and expenses incurred in defending a former patient's suit. The suit included a malpractice claim. A New York trial court concluded that since the psychiatrist knew that his fornication therapy of a lesbian patient was undertaken for his personal satisfaction, such actions did not, as between the psychiatrist and his insurer, constitute malpractice within the meaning of the policy.

To rule otherwise, the court observed, would be to indemnify immorality and to pay the expenses of prurience.

The court pointed out that the plaintiff-psychiatrist knew that his actions were for his personal satisfaction and did not constitute medical practice. Therefore, as between the plaintiff and his insurer those actions could not, the court emphasized, constitute malpractice and were never intended to be included within the protective coverage of the malpractice policy. *Hartogs* v. *Employers Mutual Liability Insurance Co. of Wisconsin*, New York Supreme Court, Special Term, New York County, Part 1, Feb. 17, 1977, Baer, J., 391 N.Y.S.2d 962 (BI/05/Ju.-$3)

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

Captive performance survey is underway

SAN FRANCISCO — Are captive insurance companies performing as the parent companies hoped they would?

The Northern California chapters of the Risk & Insurance Management Society (RIMS) and the Society of Chartered Property & Casualty Underwriters (CPCU) have launched a joint project hoping to find that out.

A research committee representing both groups is surveying 185 companies operating captives—both offshore and domestic—asking them to compare results with expectations, their reasons for forming a company and any contemplated future changes.

Dick Kostyrka, senior insurance representative at Kaiser Aluminum & Chemical Corp. and chairman of the research committee, said the survey is intended to "measure expectations with what the captive is producing." The committee intends to share the results with the risk management world, Mr. Kostyrka said.

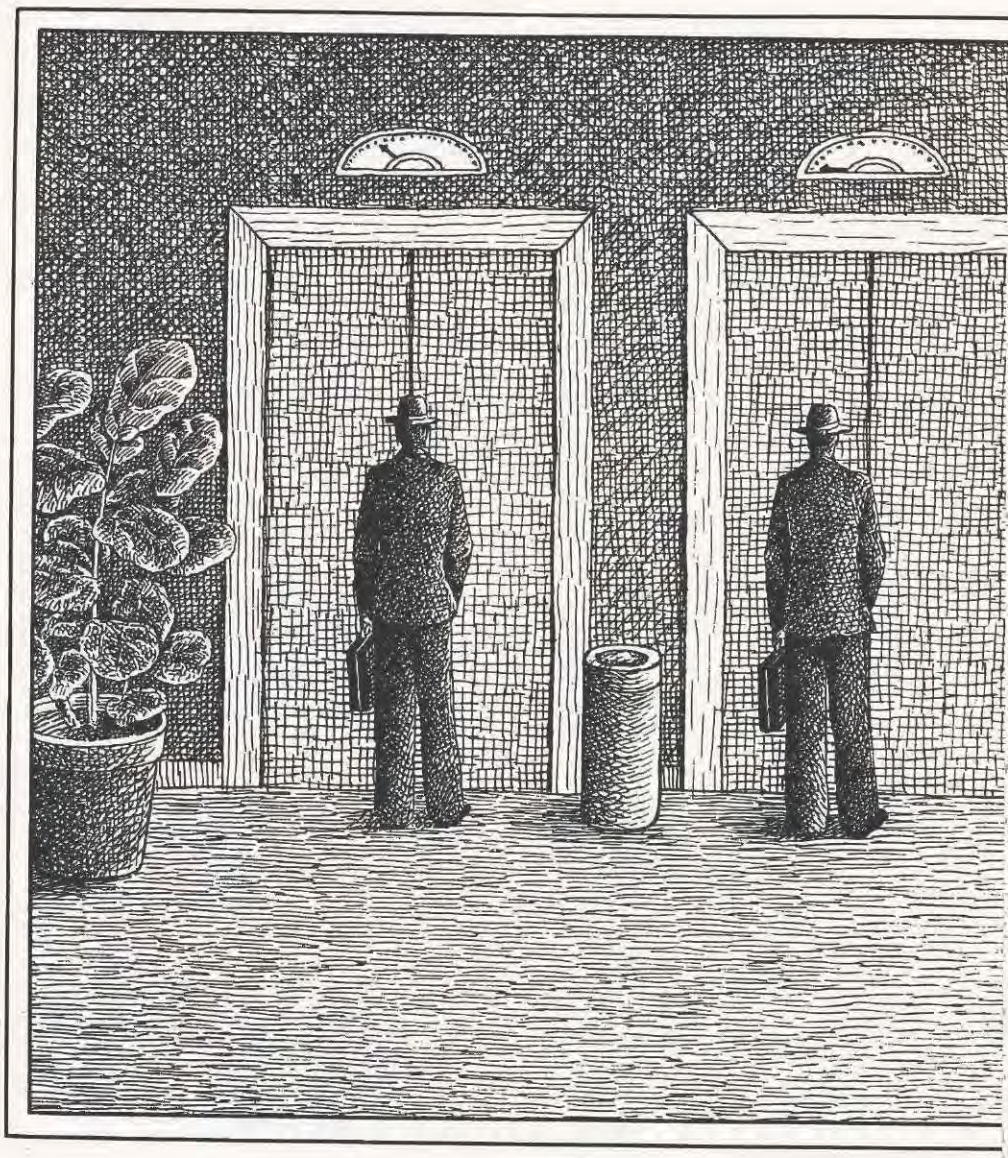
The survey was mailed the end of May and the study group is hoping to publish the survey results the end of July.

Although the group believes they have sent the survey to all companies with established captives, if they missed you they want to know. Write the Joint RIMS/CPCU Research Committee, c/o The Insurance Education Assn., 300 Montgomery St., Suite 905, San Francisco, Calif. 94104. ■

Employee

Employer sponsorship of a variety of voluntary insurance coverages, supplementing company-paid group plans, can mean lower insurance costs for employees and can build goodwill for the company.

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



In 1976, American employers paid out an estimated $300 billion for employee benefits—equal to almost a third of payroll dollars.

Employee benefit costs—for such benefits as pensions, paid vacations and group medical and life insurance plans—are rising almost twice as fast as wages. In the ten years ending in 1975, benefit costs grew 165% while wages and salaries rose 85%. U.S. employers spent an average of $76.62 a week for employee benefits in 1975, contrasted with $28.88 ten years before.

Such expenditures have become accepted as an integral part of the cost of doing business. This is particularly true of premiums for group insurance against illness, accidental injury, disability and death, as well as retirement or pension plans.

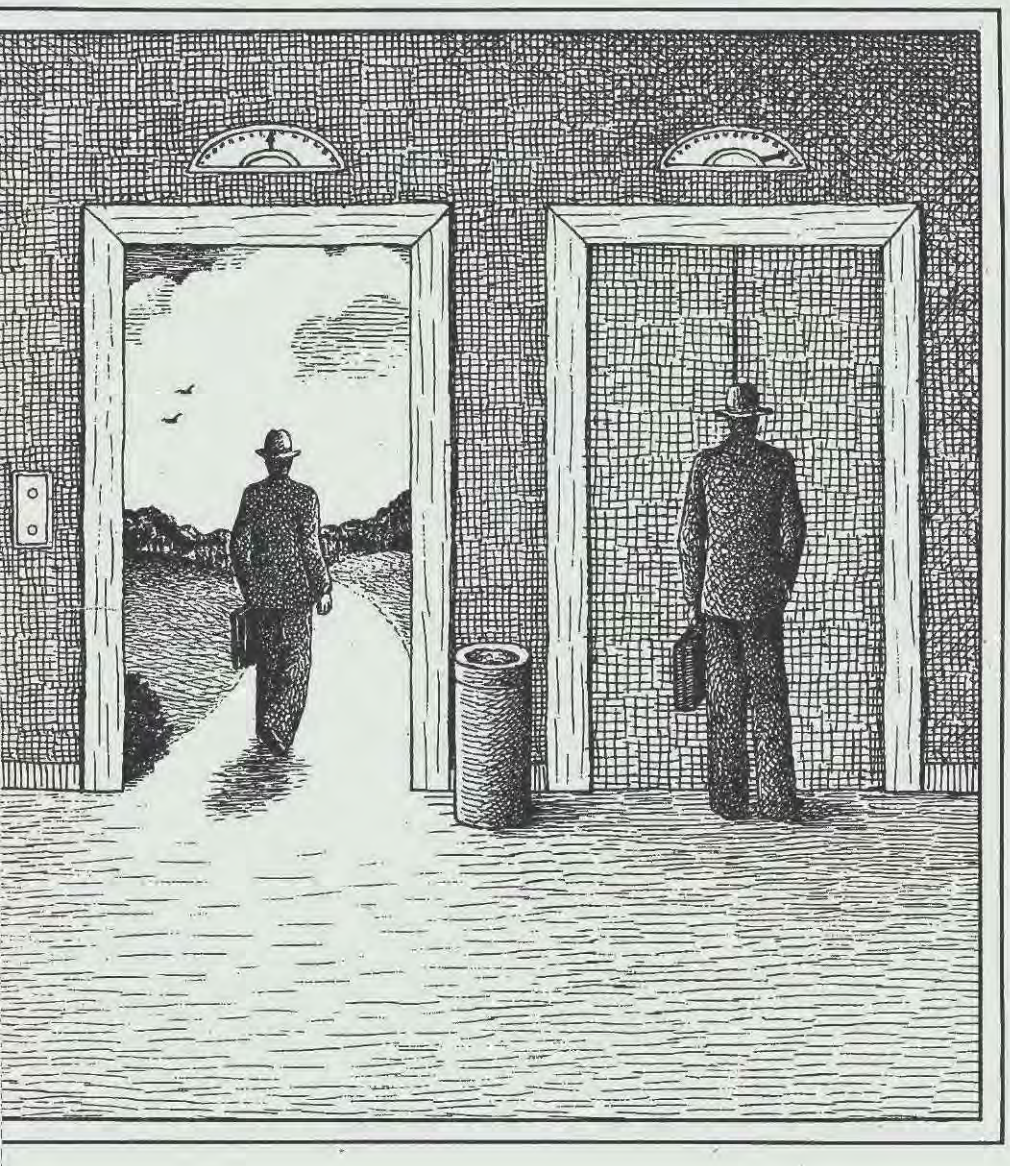
But in addition to these basic benefits which meet fundamental needs of employees generally, there are other needs for protection which may be more important to some employees than to others, depending on their circumstances. These needs are not as closely tied to jobs and income as are those covered by group insurance. Traditionally, such needs are provided for by the individuals themselves.

An example is life insurance beyond that afforded by a group policy. This need may be felt most strongly by younger married employees with children—people who have not yet been able to set aside large cash reserves. On the other hand, older employees may want to accumulate paid-up insurance or supplemental income for retirement.

Payroll deduction plans

Insurance meeting such needs can readily be made available for purchase by a firm's employees on a voluntary basis. The entire cost is usually

Benefits



borne by the employee through payroll deductions, although an employer can contribute to the cost if so desired.

Among the coverages which a company can sponsor are term life, whole life and family life insurance; accidental death and dismemberment; long-term disability; and hospital indemnity.

Although the insurance programs are offered to all of a firm's employees as a group, coverages are individual. Each employee is free to buy or not and, in most cases, to choose the amount of protection and options desired.

Saving money on premiums

Because solicitation, billing and administration are handled on a group basis, with premium payments collected through automatic deductions from paychecks, important cost savings can be realized. Those savings are passed along to employees. The payroll deduction feature is also a budgeting convenience for the employee.

Moreover, company-sponsored presentations of costs and benefits afford the individual an opportunity to assess insurance needs that might otherwise be neglected. In itself, this can constitute a worthwhile service for employees.

Making voluntary insurance available to employees at reduced cost can contribute to more stable and long-lasting employee relationships. Life insurance agents and brokers can be helpful in implementing voluntary protection programs.

As a fuller discussion of voluntary benefits from an objective standpoint, the life insurance affiliates of INA have prepared a booklet entitled, "Voluntary Employee Benefits: Some Professional Considerations." Copies may be requested by writing INA Corporation, 1600 Arch Street, Philadelphia, Pa. 19101.

* * *

INA and its affiliated companies operate around the world with major interests in property and casualty insurance, marine and aviation insurance, life and group insurance, reinsurance and risk management services.

INA insurance products and services are made available through selected independent agents and brokers—professionals with a comprehensive knowledge of insurance needs and solutions.

INA

Insurance Professionals

Allianz limits operations for '77, but plans expansion for next year

LOS ANGELES—Allianz Insurance Co. will limit its operations to California this year. But the property/casualty company, which opened its doors in January, will undertake gradual expansion into other states beginning in 1978, according to Dr. Wolfgang Schieren, chairman of the board of Allianz-Versicherungs-Aktiengesellshaft of Munich and Berlin, Germany.

Allianz Insurance Co. (AIC) is wholly owned by Allianz of America, a holding company which is a subsidiary of Allianz-Versicherungs-Aktiengesellshaft.

Dr. Schieren was addressing a meeting called to celebrate the official opening of the administrative headquarters of Allianz Insurance Co. on Wilshire Blvd., Los Angeles. The five-story Wilshire Crest building, 6435 Wilshire Blvd., was sold to Allianz in April for more than $1.7 million.

Dr. Schieren noted that due to the severe market conditions in the insurance industry, Allianz could write millions of dollars in premiums during 1977.

"But this would not provide a desirable foundation for a new company," he said, noting that during the first years of operation, Allianz' primary objective is to develop professional standards of service for its clients and to establish a solid foundation for future expansion of its commercial facilities.

Consequently, controlled growth will be the insurer's posture during its early years, he said. Dr. Schieren noted he expects the approach to enable Allianz to meet its goal of establishing professional facilities with stable operations in all 50 states and to develop "significant" property and casualty premiums in five to seven years.

He said that Allianz' capital and surplus has been boosted to $25 million. The company has an underwriting capacity of up to $100 million.

Frank E. Raab, president of Allianz and former president of the Insurance Company of North America (INA), told the same gathering that the world confronts an underwriting capacity crisis.

"The forces of inflation, growth values and the emerging (Third World) nations have created new demands exceeding the capacity of the world's insurance carriers," he said, adding that even underwriters at Lloyd's of London have been compelled to reduce acceptance of new business on account of capacity limitations.

Mr. Raab said that a major infusion of capital into the domestic insurance industry is needed in order to increase its worldwide underwriting capacity.

The parent company, Allianz of Germany, is the largest insurer of life on the European continent and the largest insurer of non-life risks in Europe. Its investments told $8 billion and premium income is $2.8 billion. It employs 23,500 persons. ■

riskWatch

By MARIE KRAKOWIECKI

New survey raises the question: Are the results worth the effort?

Esther Peterson, President Carter's special assistant on consumer affairs, ordered 650 copies of "Consumerism at the Crossroads," a survey commissioned by Sentry Insurance Co. and conducted by Louis Harris & Associates in collaboration with the Harvard Business School.

Her office told me she did this because the survey supports one of her pet projects, the establishment of a consumer protection agency, and Ms. Peterson wanted to send a copy to every member of Congress.

Krakowiecki

Besides the 650 copies that were distributed by the White House, Sentry Insurance says it sent more than 4,000 copies of the survey to corporations, including all the Fortune 500 firms and the second 500 firms.

The survey included a lot of information about consumer attitudes toward the insurance industry, including the fact that the American public, on questions of product liability, "is significantly less demanding than consumer activists on what the number and size of awards made in courts in recent years would suggest."

The report went on to observe that the public essentially believes accidents resulting from the negligence of the victim rather than from the negligence of the manufacturer should not result in claims against the manufacturer.

■ If insurance companies would offer a service to evaluate the safety of a firm's products and certify those with high standards, the survey noted, there would be a substantial market for the service and the insurance industry could even become an ombudsman between the public and business.

I wonder. I'm beginning to get skeptical about how much concrete use risk managers can make of survey suggestions like these. Why should any risk manager ask, much less pay, the insurance industry to become an "ombudsman" for his firm?

One of the other findings of the survey was that senior-level business managers are the one group which is the most out of touch with consumers. That would include most of the top brass in the insurance world, as far as I can tell.

To paraphrase a point raised by Dr. Michael Hogue of the insurance department of the Wharton School of Business, there seems to be little difference between the idea of a new service to evaluate product safety and the service that has existed for years from Underwriters Laboratories.

Dr. Hogue, incidentally, was the co-author of the last public opinion research effort commissioned by Sentry Insurance, which surveyed the attitudes of business people toward commercial insurance.

I asked him whether he or his colleague and co-author from the Wharton School, Douglas Olson, have heard of any company making any policy or procedural changes as a result of their research.

So far, he has not heard of a single action taken as a result of their ambitious effort, which was released last year under the title "Business Attitudes Toward Risk Management, Insurance and Related Social Issues." (*BI*, Oct. 18, 1976).

■ With the exception of a new insurance policy it designed in plainer language as a result of its 1974 study of homeowners' and auto insurance, Sentry itself was not able to cite any specific changes that it has instituted because of the three public opinion research projects it has sponsored in the U.S. so far.

I don't mean to knock Sentry, or any other firm that embarks on an information-gathering effort to improve the industry. In fact, I think the idea is splendid. What is not so splendid is that little use appears to be made of such data after it has been gathered, with a few notable exceptions like Esther Peterson's use of the survey to promote a consumer protection agency.

Robert Ellis Smith, editor of a Washington newsletter called "Privacy Journal," put it very succinctly when I spoke to him this month.

"We seem to have a hysteria to gather information. And the normal procedure seems to be to compile it, issue a press release about it, and then make no social changes," Mr. Smith, a former president of the *Harvard Crimson*, said.

"I think the problem of the age isn't to gather any more information but to make use of what we already have."

I agree. And I'll bet many risk managers would, too.

15% hike proposed for contractors' bonds

By MARIE KRAKOWIECKI

NEW YORK—The Surety Assn. of America will propose rate increases to boost premiums for contractors' performance bonds 15% to 20%, according to the nonprofit rating bureau's general manager, Elver T. Pearson.

The association also hopes that rate changes and policy form changes already implemented over the last year will help turn around the bad financial results its member companies suffered in 1976, particularly from fidelity losses on commercial bank bonds.

Fidelity and surety lines both suffered underwriting losses in 1976 and the Surety Assn. is worried about a worsening capacity shortage in the entire bonding industry, particularly for performance bonds covering smaller contractors.

The new rate filings, which were scheduled to be mailed to various states in late May, were an attempt to respond to basic laws of supply and demand, Mr. Pearson said. They were based not on what might be desirable for one or a few member companies but on long range industry results, he added.

During the association's annual meeting in May, Mr. Pearson dramatized the industry's problems with bids like those taken for the Chicago Metropolitan Sanitary District storm and sewer tunnels.

"There are several other large contracts being considered in New York and by the Corps of Engineers and Bureau of Reclamation. Given the difficulties of delivering bonds in the range of $200 million to $400 million, it may be that we should make a concerted effort to push for bond penalties below 100% of contract price," he suggested.

There already is a law, the Miller Act, which authorizes contracting officers to require performance bonds of less than 100% when it is in the best interest of the government to do that, but few contracting officers have been willing to write bonds in lesser amounts, he explained.

The federal General Accounting Office has recommended 100% bonds because fidelity and surety underwriters don't have any price concessions in their rating structure which would make it in the best interest of the government to require a lesser bond.

The Carter Administration's $4 billion job program, which contains heavy commitments to public works projects, will increase business opportunities for the surety industry, another participant at the meeting predicted.

Melvin L. Stark, senior vp of government affairs for the American Insurance Assn., said, "Performance and payment bonds will be required and these extra government expenditures hold challenge for competition in the surety arena."

About a quarter of all insurance-related legislation now being introduced throughout the nation deals with surety, Mr. Stark said, adding that many of the measures will create bonding obligations in private or government operations.

One thing the Surety Assn. definitely does not want to see become a common practice is a shift to owner-controlled contract bond programs, in which the utility company or sponsor of a big construction project tells the contractors bidding on the business what surety company they have to use.

Under the owner-controlled program, the risk manager of a firm that is building gets to deal with the surety company of his choice rather than with different surety companies for each contractor that bids on the business.

This approach was strongly suggested, at least for companies that have big projects, by Howard Boyle, an assistant vp of Johnson & Higgins, during a utilities industry session at the annual Risk & Insurance Management Society conference in April.

Mr. Boyle said an owner-controlled program gives a risk manager more say in controlling rates based on negotiations and it offers the advantage of pre-qualification of contractors.

The J&H broker said the Surety Assn. fights against owner-controlled contract bond programs because producers for surety companies have complained about them.

Mr. Pearson of the Surety Assn. agreed that the group opposes owner-controlled programs, but he said Mr. Boyle was wrong in stating the reason why. It is not the producers who have created the opposition, Mr. Pearson said, but the nature of the programs.

He said surety underwriters don't like the arrangement because it forces contractors to sever the fiduciary relationships they have developed over the years with surety underwriters of their choice who are intimately familiar with the contractors' work.

By insisting that a single surety company be used, Mr. Pearson said, the owner firm may actually weaken the surety industry's ability to perform properly. One centrally-located surety firm cannot be expected to provide as accurate a measure of the character, capacity and performance ability of contractors located all over the country as local surety companies which have established long working relationships with regional contractors can.

Mr. Pearson said a risk manager who insists on an owner-controlled contract bond program may actually lose his company money in the long run, even if he saves money on the surety premium.

The reason is that the financial information that contractors are required to file with the surety firm selected by the owner is so detailed and confidential, that many contractors don't like to give it out to anyone else in addition to the surety firm they already work with.

Consequently, rather than divulge this sensitive information, the contractor may decide not to bid on the project at all. If enough contractors feel this way, the owner may be cutting out a good portion of the competitive bidding on his business, and may miss out on a low price. One low bid missed on a big project may represent much more money lost than the owner could expect to recoup in premium savings, Mr. Pearson said. ■

Mission name change

E. R. DeRosa, president of Mission Insurance Group Inc., formerly Mission Equities Corp., said the new corporate designation was chosen to more accurately describe the company's exclusive activity in the commercial property and casualty insurance field.

Officials aid states . . .

Continued from page 1

years. The trusts usually provide medical and health benefits, file with the federal government as employe benefit plans under ERISA and argue they are exempt from state regulation.

But the Labor Department has not yet ruled whether the trusts are covered by ERISA and its preemption of state laws, nor has it issued any regulations governing their activities. State insurance regulation has often been frustrated in the courts, leaving the trusts in a regulatory vacuum.

Two large California trusts have collapsed this year, leaving thousands of persons with unpaid medical claims that may total $7 million.

Two Labor Department officials entered the UHARA case after the Oklahoma insurance department obtained a subpoena for Luis Martinez, a Labor Department compliance officer based in St. Louis. Eventually, James E. White, a deputy regional solicitor for Labor based in Dallas, testified in Kansas that it was his personal opinion that UHARA was not an employe benefit plan under ERISA.

In the absence of official action by the Labor Department, the Oklahoma and Kansas cases will provide an important precedent for other states attempting to regulate the self-funded trusts as unauthorized insurers. These states can now subpoena Labor officials to disclose information they have accumulated in their study of the trusts and their views on whether the trusts fall under ERISA.

Many Labor Department officials, both in the field and on a task force in Washington studying the issue, believe most of the self-funded trusts do not fall under ERISA and should be regulated by the states.

Investigation of UHARA

The key figure in UHARA appears to be Charles J. Bazarian, an Oklahoma City insurance agent who owns Central Management Systems. Also involved are the trust's attorney, Christian Menthrup of Kansas City, and C. L. Johnson of Austin, Tex.

Mr. Bazarian declined comment on the case. Mr. Menthrup and Mr. Johnson could not be reached for comment.

According to Michael Mullen, a Kansas insurance department attorney, 85% of first year contributions to UHARA are paid to Mr. Johnson. Mr. Johnson sends 70% of the total contribution back to Central Management Systems. Mr. Bazarian then pays the agent selling the plan 40% and a general agent 10%, a total of 50% to soliciting agents.

It is unclear what duties Mr. Johnson performs for the 15% he retains. Mr. Bazarian keeps 20% of the contribution.

Fifteen percent of the first year contribution is used to pay claims and administrative expenses. According to an attorney with the Oklahoma department, an actuary for UHARA testified that at least 20% of first year contributions would be needed to pay claims if the trust were to be solvent.

In addition to the contribution, Mr. Mullen said participants are required to pay a $30 membership fee. Mr. Johnson, Mr. Bazarian and Mr. Menthrup each receive $10 of that amount. Mr. Menthrup's share is his compensation for the legal services he provides the trust.

The trust has a 24-month waiting period before preexisting conditions are covered. There is only one rate for each geographic area for persons aged 19 to 64. One actuary who has worked on multiple employer trusts says such an arrangement encourages adverse selection, by overpricing desirable risks.

The trustees and organizers of the trust are James F. Tilford and William F. Bonadio. Participants to the trust sign a proxy allowing Mr. Tilford or Mr. Bonadio to represent them at the trust's annual meeting at the undisclosed Washington, D.C. home office unless the participant appears in person, according to the brochure obtained by *Business Insurance*.

Such an arrangement would serve to prevent participants from removing the trustees of the plan, according to insurance regulators.

Mr. Tilford and Mr. Bonadio are employes of Mr. Bazarian at Central Management Systems. They are also Mr. Bazarian's brothers-in-law, according to the Kansas insurance department's Mr. Mullen.

Regulatory action

The Labor Department and several state insurance officials began investigating UHARA in late March. A *Business Insurance* investigation begun at the same time uncovered Mr. Bazarian's name. But Mr. Menthrup, in a telephone interview in April, denied that either Central Management Systems or Mr. Bazarian had any connection with UHARA. Later in the same conversation Mr. Menthrup said he "assumed" Mr. Bazarian was involved in marketing the trust.

A *Business Insurance* reporter who visited the Washington, D.C. office where the trust is officially headquartered found only a switchboard operation that would not give out any information on UHARA.

Oklahoma and Kansas filed suits against UHARA in May as an unauthorized insurer. A source close to the case said the Oklahoma department was stymied by the Labor Department's failure to cooperate with the state's investigation. An Oklahoma court handed down a subpoena for Mr. Martinez to obtain the information the federal agency had from its probe of UHARA.

At that point the Labor Department decided to cooperate with the state. Mr. White, the Labor solicitor based in Dallas, said he was assigned to help Mr. Martinez prepare for his testimony.

"It was my conclusion that this program was not subject to ERISA and therefore was subject to state law," Mr. White said.

The significance of the Labor Department's cooperation was underscored by an attorney for several self-funded trusts who emphasized that the department could have fought the subpoena.

A hearing on UHARA was held in federal court in Topeka, Kan. on May 26. Mr. Martinez testified on the factual information he had obtained. Mr. White, as an expert on ERISA, testified UHARA was not covered by the law. The judge later issued the temporary restraining order against the trust's operation.

The next day, Mr. Martinez testified at the state court hearing in Oklahoma City. Mr. White was prepared to repeat his testimony but he was not called to testify. The judge there issued a temporary injunction the following Tuesday.

One Labor Department official said UHARA's solicitation of self-employed persons makes it a clear example of a trust not covered by ERISA since the law is concerned with employer-provided benefits.

Other trusts that are careful to solicit only employers are much more difficult to deal with, the

official continued.

Sources in the Labor Department have previously told *Business Insurance* that the majority of task force members studying the issue favor a ruling that most self-funded trusts are not employe benefit plans under ERISA. Such a ruling would pave the way for state regulation.

The exception would be benefit trusts marketed to employers that are members of an association formed for purposes other than to obtain insurance. But several sources have said action to issue such regulations has been held up by the Labor Department solicitor's office.

Groups formed

Meanwhile, two private groups have organized to coordinate lobbying efforts and draw up self-imposed guidelines for the trusts.

The National Assn. of Multiple Employer Trusts (NAMET) was founded in late May in New Orleans by 10 trusts, including UHARA. The group has retained Claude Dorais of Miller, Dorais & Wheat, a Beverly Hills law firm that represents a number of self-funded trusts.

Mark Killebrew, president of the group and administrator of Protective Benefit Assn., said the group has tentatively adopted a series of standards which would limit compensation(although no figures have been agreed upon), require actuarial review and begin consideration of a stop loss fund.

"One of the objectives of NAMET is to reduce commissions for all the trusts," Mr. Killebrew said.

The high commission structure of several members of NAMET concerns state insurance officials. Two trusts, Employe Security Benefit Assn. and Continental Employe Benefit Assn., are linked to a Bellevue, Wash. firm known as Benefit Services Corp.

The trusts, which have been sued as unauthorized insurers in several states, pay the selling agent 25% of first year premiums, with another 25% divided by three other marketing levels. Benefit Services Corp. takes 22% for administration, leaving 28% to pay claims.

Employe Security Benefit Assn. has also apparently engaged in a deceptive practice. In a marketing letter to its agents obtained by *Business Insurance*, the trust says, "Some time ago the Department of Labor sent its regional director to our home office to meet our management team and look over the operation. They went away very impressed."

Walter Slater, Labor deputy regional director based in San Francisco, said the statement is untrue. A compliance officer, not the regional director, did evaluate the trust, but he never said he was impressed, according to Mr. Slater.

The other group hoping to become involved in self-regulation is the American Society of Professional Administrators. According to Steven E. Schanes, newly-appointed executive director, the group includes 27 contract administrators who work with multiemployer and single employer benefit plans and some insured multiple employer trusts. Several members have been approached to work with self-funded trusts.

Mr. Schanes is the former executive director of the Pension Benefit Guaranty Corp. and now heads an employe benefit consulting firm specializing in ERISA bearing his name.

The society has become alarmed by the problems in the self-funded trust area, Mr. Schanes said, fearing the difficulties will sour employers on all trusts. ■

Hospital . . .

Continued from page 2

not allowable in Texas to even make mention that there is insurance, or else a court decision is reversed. But I don't believe there's any doubt that American Medicorp, a New York Stock Exchange company, has adequate funds to cover this. It is one of the largest hospital chains in the U.S."

Mr. Peterson went on to say that $2 million had been sought "only because of the attitudes and conduct of the hospital's administrators. In the end, I believe what made the jury angry was the way different people in the company kept pointing fingers at one another."

Four separate corporate entities were found guilty by the jury, all American Medicorp-realted: American Medicorp Inc., the parent company; Southmore Medical Center, a subsidiary; American Medicorp Development Inc., the building subsidiary; and Medicorp Management Inc., the hospital operating subsidiary. Other named defendants excused from liability by the jury were Hark-On Corp., a Houston mechanical contractor; Lambert Construction Co., the general contractor for the hospital; Ohio Medical Products Co., the supplier of the medical gas system; and Pierce, Goodwin & Flanagan, the hospital's architects.

The trial lasted about three weeks, said Mr. Peterson, with most of that time taken up with the defense after only about two days of presentations by the plaintiff.

The hospital's gas lines into the delivery room had been reversed when installed, causing an attending physician to cut off oxygen to Mrs. Lord during childbirth although the person administering anesthetic thought that the nitrous oxide gas was being cut off. When a patient is about to be brought out of an anesthetic, pure oxygen is administered while the anesthetic gas is stopped.

According to Mr. Peterson, federal regulations require hospitals to perform final tests before newly installed equipment is used, to make sure it works properly. He said there is a machine that can be used to test anesthetic gas lines, although the hospital admitted during trial that it hadn't performed such a test. Mrs. Lord was only the second expectant mother to give birth in the hospital after it opened its doors for business. Her child survived. Her delivery was reported normal until the time when she died.

The hospital began operation without receiving any certificates of completed work from the general contractor or any other contractors, Mr. Peterson maintained. He said the hospital administrators countered this charge with the defense that they had received oral assurances from contractors that the work was completed, although the contractors denied that there had been any assurances and showed that they were continuing to work on the premises still under construction.

Only one previous delivery had taken place in the room, but the mother hadn't required anesthesia, said Mr. Peterson. About an hour after Mrs. Lord's death, a nurse tested the gas line and reported the problem, although this was not reported to the patient's physician or to the medical examiner, said Mr. Peterson.

The hospital reported cause of death as pulmonary embolism, and the medical examiner who performed an autopsy included this on the death certificate but said he could not confirm this cause of death, Mr. Peterson added.

American Medicorp declined to discuss its case in further detail. ■

Cumulative trauma battle rages . . .

Continued from page 1

is not disputed, at least among employers, is the amount of abuse taking place under the present system. Ernest E. Debs, who retired in 1974 as a Los Angeles County supervisor, for example, in April received a $30,000 award from the state workers' compensation program because he persuaded a judge that he had suffered heart damage from his incessant disputes with another supervisor, Baxter Ward.

Prior to the Debs' claim, the widow of former District Attorney Joseph Busch won $45,000 by claiming that his death in 1975 was partially produced by the stress and strain of his job.

Nor is there much argument about the assertion that cumulative injury claims are exploding. According to Industrial Indemnity Co.'s, estimates, such claims now account for 15% to 20% of the insurance industry's disability claims.

Based on these trends, Industrial Indemnity estimates its 1976 cost of cumulative injury claims for the industry of $118.6 million will triple to $347 million by 1981.

Added to all this is the cost of defending these claims, noted Mr. Payne of Kidorado Insurance. He said that for his company defense costs can often exceed the cost of the award.

Existing law in California limits the liability for occupational disease and cumulative injury to those employers who employ a worker during the five years immediately preceding either the date of injury or the last date on which the employe was employed in an occupation exposing him to the hazards of occupational disease or cumulative injury.

The assembly bill would change this for all occupational disease or cumulative injury claims filed after Jan. 1, 1978, reducing the period from five to four years. Beginning Jan. 1, 1979, and thereafter on the first day of January for each of the next two years, the period of liability would be decreased by one additional year. The liability period would be one year by Jan. 1, 1981.

In addition, the assembly bill would repeal another section of existing law known as the "single employer exception." If a worker is employed by a single employer for more than five years, liability for cumulative trauma is extended to the full period of employment and to all the carriers in that period.

"Discriminatory and contrary to sound economic policy" is what a study being used as a basis for the bills calls the single employer exception. The study, done by two finance professors, is called "Cumulative Injury, Workers' Compensation and the Internationalization of Social Costs: The Case of California."

The senate bill differs from the assembly bill only in that it speeds up the phase-in of the one-year liability period, meaning that the liability period would be established by Jan. 1, 1980, and not one year later as in the assembly measure.

Heading the opposition to the bills is the California Self-Insurance Assn. Joe Markey, who works as a lobbyist for the group, charges the bills are designed to diminish the attraction of self-insurance, to transfer the liability of cumulative injury claims to self-insured entities and to reduce carrier reserves so that they—the insurers—can easily leave California.

At present, an insurer desiring to depart the state must leave behind reserves large enough to cover incurred-but-not-reported (IBNR) losses, he said. With the passage of either of the bills reserve requirements will be drastically reduced, Mr. Markey said.

He also charged that the bills are designed to help the state compensation insurance fund out of its reported financial difficulty.

The state fund, which is sponsoring the Senate bill, disputes the charge. It says that public entities are opposing the bills because under the present system they can "lay off their cumulative injury claims onto the state fund.

"We think the bills, if passed, will be unconstitutional because they disturb the contract between the employer and the insurer," said Donald Reedy, deputy director of contractual relations for the Los Angeles Unified School District.

The school district last year went self-insured for its workers' compensation.

He went on to say that he foresees nothing but financial woe for the huge district, which is already struggling to comply with a court order to desegregate its schools, if the bills become law.

"We shall have to cut support services, eliminate jobs and/or reduce educational programs," elaborated the official, adding that the district went self-insured in workers' compensation last summer in order to obtain upgraded claims administration service. He said it did not take the action in order to transfer liability for cumulative injury claims to the state fund.

Supporters of the legislation state that under current law they cannot calculate the cost of cumulative injury claims, Mr. Reedy went on to say. "But how do they expect self-insured employers, without actuarial expertise to do this?"

The study on cumulative injury was done by Alfred E. Hofflander, professor of finance at UCLA and David Shulman, assistant professor of administration at University of California in Riverside. It reported that under the "single employer exception" rule it is impossible to allocate exposures fairly among different insurers. If a worker files a successful cumulative injury claim for the year 1962, for example, the carrier is caught in a trap due to the fact that benefit levels set for that year are far lower than those established for 1977.

Because the insurer cannot go back to the 1962 employer and demand more money, it has only the option of charging the loss against 1977 business, the study said. "However, this cannot be done since the rating system requires that losses be charged against the year incurred."

It also notes that only data from claims reported with 3½ years from policy inception is used in determining the relative rates to be charged different industries and types of employers.

Beyond this, the study says that even today, not all of the 1962 reported losses are in and that the total amount of outstanding losses for that year will not be known for several more years.

Consequently, the study concludes that a new financing mechanism is necessary to allocate the costs of cumulative injury. And it advocates a "claim made" method whereby the last employer picks up all the losses.

Foremost among the benefits of this system, says the study, is that the full brunt of cumulative injury claims would be placed on the last employer who presumably would be compelled to make investments to lower these costs.

Other advantages of a claims-made system would be that cumulative injury costs would swiftly enter the rate making process, claims would be paid faster, overhead costs would be reduced and the rating system would be more sensitive to changes in the definition of cumulative injury.

Finally, the study notes that a claims-made system is in use in 35 states and is supported by the federal task force. ■

Labor asks ideas for better forms

WASHINGTON—The Department of Labor is asking employers for comments and suggestions on how to improve the basic reporting form for filing employe benefit plan details under the Employment Retirement Income Security Act.

Comments on the reporting form, which is better known as Form 5500, should be sent in triplicate to the U.S. Department of Labor, Room N4647, Third and Constitution Ave., NW, Washington, D.C. 20216.

Comments on the reporting regulations should be also sent to the Labor Department, Office of Regulatory Standards and Exceptions, Annual Reports Regs, Room C-4526, Pension and Welfare Benefit Programs. ■

Surgeon's fight . . .

Continued from page 1

claimant in a malpractice suit. But Stephen McAlily of the West Palm Beach law firm of Brennan, McAlily, Albury & Hayskar argues his client represented a valid case.

His client's law firm, however, has only $50,000 of insurance. As a result, he said "economic compulsion" might force them not to appeal the case if Dr. Sullivan surrenders $100,000 of the judgment. An appeal, Mr. McAlily fears, could result in costing his client the entire $175,000.

Mr. Rubin said he and Dr. Sullivan were "shocked by the turn of events," and have not decided if they will surrender more than half the jury-determined award or opt for a new trial on the issue. Mr. Rubin and Dr. Sullivan could appeal the judge's order to surrender part of the verdict.

Dr. Sullivan's suit against Mr. Parker was in response to a malpractice suit Mr. Parker filed in 1971 against him on behalf of a former patient. The patient, James I. Terry, charged Dr. Sullivan had implanted a steel rod that was an inch too long when setting his broken arm in 1970.

Commercial Union, Dr. Sullivan's insurer for six years, wanted to settle the claim out of court. Convinced he was not negligent, Dr. Sullivan said he refused to settle it.

On Nov. 8, 1971, when the malpractice trial was to begin, Mr. Terry and Mr. Parker dropped the suit. Mr. Parker maintains the suit was dropped because 78-year-old Mr. Terry had suffered heart attacks and his family didn't want him to go through with the trial.

Dr. Sullivan's attorney, Mr. Rubin, said that although the suit was dropped, his client could still charge Mr. Parker and his firm with malicious prosecution because, "It's malicious prosecution when a suit is filed only to obtain a settlement—when one maliciously sets the law into motion. Dr. Sullivan's reputation was ruined and his medical malpractice insurance cancelled."

Commercial Union notified Dr. Sullivan on Dec. 29, 1971, that he would not be insured as of Jan. 1, 1972. "They said they were cancelling me because of my 'recalcitrant attitude,'" the surgeon recalled.

The insurance company was investigating the surgeon's accusation but was unable to comment by press time.

Dr. Sullivan practiced medicine in 1972 without malpractice insurance.

"I lived through hell," the doctor said, "And it was only this year I've been free of the year I went bare because of the four-year statute of limitations," he added.

He is now insured through the Florida Medical Assn., paying an annual premium of $8,000.

Since Mr. Terry's malpractice case could have been re-opened, Dr. Sullivan conceded he waited for the statute of limitations to run out before filing his suit for malicious prosecution.

Dr. Sullivan also had to search six months for an attorney who would take his case. "Lawyers stick together more than doctors do, and malicious prosecution is one of the toughest things to prove in law," the 21-year-veteran surgeon said.

The Sullivan decision, Mr. Rubin explained, says that the standard of care for a lawyer is, "Before filing suit, he must research the law and the facts to the extent that there is probable and reasonable cause for filing a lawsuit against a potential defendant. Futhermore, the attorney must have an honest belief that a tenable claim existed on behalf of the plaintiff." If a lawyer falls below this standard, says Mr. Rubin, then he may be found liable for damages.

Before the Sullivan decision on May 27, Mr. Rubin said, lawyers were "considered absolutely immune and not legally liable for the consequences of filing an unjustified lawsuit for a client." He explained that Dr. Sullivan's suit, charging the attorneys with malicious prosecution, was the first jury trial and verdict on this point in U.S. legal history.

However, other doctors around the country have taken the offensive in response to malpractice suits against them.

Last year a radiologist at Skokie Valley Community Hospital in Illinois was awarded $8,000 by a jury which agreed a former patient, her lawyers and her husband were guilty of willful and wanton misconduct in filing a malpractice suit against him.

In that malpractice case, Dr. Leonard Berlin had been sued by Mrs. Harriet Nathan of Wilmette for failing to find a small fracture in the little finger of her right hand when he supervised an X-ray. Dr. Berlin sued her and her attorneys while the case was pending and although the medical malpractice case was dropped, Dr. Berlin continued with his suit.

The jury's decision to award Dr. Berlin $8,000 is on appeal.

Dr. Berlin's attorney, Wayne B. Giampietro of the Chicago law firm Lightenberg, DeJong, Poltrock & Giampietro, said although the legal technicalities of his client's case differ from those in Dr. Sullivan's, "The idea is the same."

Tracking Dr. Sullivan's case is a suit pending in Baltimore, Md., brought by a gynecologist against a former patient, her ex-husband and their lawyers who had unsuccessfully sued him for medical malpractice. They charged Dr. Clifton Presser had failed to warn his patient of the side effects of birth control pills. But the suit was dismissed by a Baltimore County Court judge.

Dr. Presser is now suing for $1.2 million, charging the malpractice claimants and their attorneys with "malicious use of the civil process."

Mr. Rubin predicts his client's successful suit in Florida will prompt attorneys to take new precautions with malpractice cases. Before even filing a malpractice case, Mr. Rubin said an attorney will want to secure two written opinions—one from a medical expert saying the doctor had committed malpractice and another from an expert malpractice attorney saying there is probable and reasonable cause to sue.

Mr. Rubin says he believes Mr. Parker was found guilty of malicious prosecution because he didn't have those documents in his files. And, he said, "The jury represented the current public feeling about lawyers, phony claims and inflated insurance rates."

Ironically Mr. Terry's suit was the first malpractice suit Mr. Parker, who retired this year, ever prosecuted in his 40 years as a trial lawyer, his attorney said.

Mr. McAlily was shocked by the jury's decision in the case, reached after a week-long trial and five hours of deliberation. "I would have borrowed money from the bank if someone would have bet me on this decision," Mr. Parker's lawyer said. ■

Nightclub fire . . .

Continued from page 1

probably were insured for only $1.25 million.

The first $600,000 of property coverage on the immense, luxuriously furnished building whose value may have easily exceeded $2 million according to some observers, was obtained through the Kentucky FAIR Plan, a state-regulated insurance pool.

Under Kentucky law, all insurance carriers writing property coverage in the state must assume the risks of companies unable to obtain property protection in the conventional market. Participation is based on premiums written in the state.

The 4-R Corp. fell into that category when it lost its coverage after a $1 million 1970 fire and went to the FAIR Plan for help.

In addition to the $600,000 coverage on the building, 4-R Corp. also obtained $400,000 of FAIR Plan insurance for the club's contents, said Joseph Smith, manager of the Insurance Services Office in Louisville.

The 213 insurance companies writing fire coverage in the state will not, however, have to shell out $1 million to pay for the destroyed club. A reserve, established from revenues collected on an earlier special 1% surcharge on all property insurance written in the state, still has enough money to pay for the loss so insurance carriers will not be assessed, Mr. Smith said.

Aside from the FAIR Plan coverage, 4-R Corp. obtained a $250,000 property policy from American Reserve Insurance Brokers-Atlanta Inc., a supplier of excess lines. The broker on that account is Crump London Underwriters in Memphis, Tenn.

In addition, informed sources indicated 4-R has a $100,000-$300,000 liability policy with CNA, although this could not be confirmed with CNA's Cincinnati branch office.

A CNA spokesman, however, did say that CNA underwrote a $17,000 property insurance policy for a small shop adjoining the supper club which was also destroyed.

There also were unconfirmed reports that American States Insurance Co. of Indianapolis provided liability coverage for a $300,000-$1 million layer. A spokesman for the company's Cincinnati office said: "Well, yes, we are involved. Other than that I would prefer not to comment."

A probable outgrowth of the disaster at the sprawling nightclub is tightened Kentucky fire codes.

Gov. Julian Carroll, who was shocked when informed that the supper club did not have an automatic sprinkling system, indicated he would press for legislation that would remove a loophole from a 1973 fire code exempting existing buildings, such as the Beverly Hills, from installing sprinkler systems.

"There is no question a sprinkler system would have saved lives," said Kentucky insurance commissioner Harold B. McGuffey. He added that future legislation would make it mandatory to install sprinklers in all buildings, new and old, where large numbers of people congregate.

Aside from charges that 4-R Corp. failed to install a sprinkler system, the suits charge the owner with negligence by failing to maintain clear exits and unobstructed paths to the exits.

"We have indications that the aisleways were stacked with tables and chairs," said William Hillmann, a lawyer for one of the plaintiffs. "It is the type of thing that never should have happened."

The suit also contends that the club owner:

- Failed to provide outside storage facilities for flammable liquids. Five thousand gallons of oil were stored in the basement under one of the club's largest entertainment rooms, Mr. Hillman claimed.
- Failed to provide an adequate number of exits and entrances.
- Did not install a warning device designed to alert patrons and fire officials of fire.
- Failed to instruct employes in the use of fire safety equipment and to instruct employes in procedures relating to fire drills.

At a press conference, however, Southgate Fire Chief Dick Riesenberg said that the investigation so far had not disclosed any evidence of improper exit maintenance or negligence on the part of the nightclub management.

The city of Southgate, a town of 3,200 people located four miles south of Cincinnati, and the state of Kentucky also were charged in the suits with failing to conduct periodic fire inspections and establishing or enforcing occupancy limits.

Commissioner McGuffey however, said that the "record will show that we carried out our duties and responsibilities."

Victor Fox, an assistant attorney general, said the state probably would resist any suits seeking damages. "How can someone say it was negligence on the state's part to tear down walls and inspect the wiring behind the walls," he said.

Mr. Fox said he expected the state to seek dismissal of all court action on the grounds that a Kentucky statute has delegated a board of claims, and not the courts, to have "exclusive jurisdiction" in cases where negligence on the part of the state is the proximate cause of injury. The state, he added, does not have liability insurance.

The Associated Press reported that the fire began at about 7 p.m. and that an alarm was not sounded until two hours later. Investigators concluded that at best, an alarm wasn't turned in until at least 15 minutes after flames broke out in a private dining room. When several employes discovered the flames they tried unsuccessfully to extinguish the fire using portable equipment.

The club's estimated Memorial Day weekend crowd of 3,500 began to leave when thick, black smoke rolled in, causing a mass panic and a wild scramble for the exits.

Most of those who died were choked to death by smoke before they could find the exits after the lights went out.

Firemen were hampered in reaching the scene by traffic jams that blocked the long, winding road leading to the club.

The fire raged out of control for four hours, reducing to a charred shell the most popular night spot in the Cincinnati area that had featured such stars as Carol Channing and Pearl Bailey. John Davidson, the singer scheduled to appear the night of the fire, escaped without injury.

The Southgate tragedy was the worst nightclub fire in 35 years. In 1942, fire swept through the main dining room of Boston's Cocoanut Grove club. The crowd panicked and dashed toward the club's 11 exits, nine of which were locked. Many of the 491 victims were trampled to death. ■

people

James A. Fagan of Raymond Intl. dies

James A. Fagan, assistant vp and insurance manager at Raymond International in Houston, died last month after a long illness. He was 58. Mr. Fagan spent his entire career with the engineering and heavy construction company. He joined the firm in 1939 as a mail clerk, organized the company's insurance department in 1955 and was elected assistant vp in 1975. He earned a bachelor's degree from Pace College while working full-time at Raymond International. Mr. Fagan has not yet been replaced, a spokesman for Raymond International said.

* * *

Wayne R. Bergstrom, formerly corporate insurance director at Twentieth Century Fox Film Corp. in Los Angeles, has been named risk manager for Vetco Inc., in Ventura, Calif. It is a new position, effective June 6. He will report to Ron Cullis, senior vp, finance. Mr. Bergstrom's duties include property/casualty insurance and the financial side of employe benefits. He had been at Twentieth Century Fox for three years and prior to that, worked in the insurance department at Amcord Inc. in Newport Beach. Vetco Inc. designs, manufactures and markets proprietary equipment for worldwide use in exploration and production of offshore and onshore oil and gas. A fast growing concern, it reported sales of $10 million five years ago and expects to report sales of $400 million in three to four years.

Twentieth Century Fox had not replaced Mr. Bergstrom.

* * *

Martin Brown, 28, has been promoted to the position of insurance manager of Vornado Inc., west coast division in Whittier, Calif., replacing Donald Shelton who resigned.

Mr. Brown joined Vornado last June as employe benefits manager. Prior to that he worked for P. M. Services in Newport Beach, Calif., a third-party administrator and a subsidiary of Pacific Mutual Life Insurance Co.

His duties include group benefits, property/casualty and workers' compensation insurance as well as state disability and Vornado's welfare fund.

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to People, Business Insurance, 708 Third Ave., N.Y., N.Y. 10017 or call (212) 986-5050.

Farm co-ops explore pooling risks

KANSAS CITY, MO.—The insurance committee of the National Council of Farmer Cooperatives met in Chicago May 17 to discuss the preliminary steps it would take towards studying the possibility of pooling their umbrella liability risks.

The eight to 10 people present at the meeting elected John Hogue, risk manager for Farmland Industries based here, chairman of a team which will explore the idea of methods to be used in such a pooling arrangement, as well as benefits that could be derived from it.

"Rather than go the product-liability-only route, we decided to take a broader approach, since we haven't had products liability claims and incidents that are a real problem, although we're all experiencing much higher umbrella liability costs," said Mr. Hogue.

The committee of the National Council will undertake its own study, without calling in any brokers or consultants, said Mr. Hogue, estimating that the task will take a minimum of 90 days to complete.

Mr. Hogue said the idea of pooling excess liability risks was first discussed at a December meeting of the insurance committee. "Some of the regional cooperatives have experienced premium increases of three, five and even 10 times their prior costs," he said. Most regional cooperatives carry limits of $5 million, $10 million and as high as better than $25 million, he noted.

"This whole program would be structured for the levels over the primary cover," he explained, noting that it could pick up from the $1 million limits or any level where the primary policy leaves off, to provide coverage up to catastrophic levels.

Such a pooling program could take many forms, said Mr. Hogue.

He suggested a pooling arrangement for collective purchasing could provide beneficial leverage in negotiating insurance coverage by working directly with the underwriters. ■

dates for buyers

June 20-24: Third Annual Benefit Plan Administrators' Institute at Carnegie-Mellon University in Pittsburgh, sponsored by Charles D. Spencer & Associates of Chicago. Intended for both newcomers and experienced benefit plan technicians, topics range from the design, administration and financing of health care programs, through HMOs and cost containment, to the nuances of integrated and offset pension plans and pre-retirement counseling. Cost is $365 for the week and $230 for either the pension or health session. Contact: Charles D. Spencer & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606; phone (312) 236-2615.

June 21-23: Symposium on seeking solutions to the product liability problem in Southfield, Mich., sponsored by the Society of Manufacturing Engineers. Topics include how to avoid product liability lawsuits through design, materials selection and engineering and how to lessen or negate judgment when litigation is instituted. Cost is $210 for members, $250 for non-members and includes session materials, luncheons and coffee breaks. Contact: Michael G. Tolzdorf, program administrator, Special Programs Dept., Society of Manufacturing Engineers, 20501 Ford Rd., Dearborn, Mich. 48128; phone (313) 271-1500.

June 22-23: How to reduce your construction insurance costs while improving your coverage, a seminar in Houston sponsored by MCI Symposia Inc. in cooperation with RIMCO Inc. Also offered July 13-14 in Los Angeles, July 20-21 in Atlanta, Aug. 3-4 in Philadelphia and Aug. 17-18 in Chicago. Cost is $395 and includes all sessions, workbooks and meeting materials. Contact MCI Symposia Inc., 51 Bank St., Stamford, Conn. 06901; phone (203) 359-4166.

June 23-24: Seminar on hospital professional liability risk finance in Stamford, Conn., sponsored by the risk and insurance management consulting firm Risk Planning Group Inc. For those involved in financing a hospital's malpractice exposure, the seminar will review the commercial insurance market, standard professional liability contracts, self-insurance, joint underwriting associations and association captives. Cost is $245 and includes attendance at all sessions, lunches and a hospital risk finance workbook. Contact Micki Briskin, seminar coordinator, Risk Planning Group Inc., 24 Old King's Highway South, Darien, Conn. 06820; phone (203) 655-9791.

June 26-28: Annual meeting of the National Crime Prevention Assn. in Washington, D.C. focusing on crime prevention efforts of community organizations, business and industry, law enforcement and private citizens. Executives from insurance, security, banking and other industries will discuss how private business can unite with government and private citizens to reduce the opportunity for crime. Cost is $95 for members and $120 for non-members. Contact the National Crime Prevention Assn., 985 National Press Building, Washington, D.C. 20045; phone (202) 393-3170.

Hudson of Lloyd's worried

LONDON—The rising cost of U.S. product liability awards concerns Sir Havelock Hudson, chairman of Lloyd's, after his return to London from his recent American tour.

"If awards on the present scale continue, the cost of product liability insurance is going to skyrocket. The problem can become worse, because legislation on product liability is currently being drafted in the E.E.C. field in Europe. This is inevitably going to be influenced by U.S. attitudes.

"In my view, the attitude of the general public to tort actions is quite wrong. People have a right to expect that, for instance, the tragic loss in an air crash of a father should not leave his family destitute.

"But if people want to possess immense wealth as a result of a personal tragedy, then it is up to them to insure themselves. The present Warsaw Convention scale of awards for aviation liability is far too low, and it should be possible to increase them to something that will be reasonable for people in distressing circumstances.

"But if a young man of 20 is killed, it is illogical to pay an award as if he was president of General Motors. If he expects to become an earner on that scale, then he should take out his own insurance." ■

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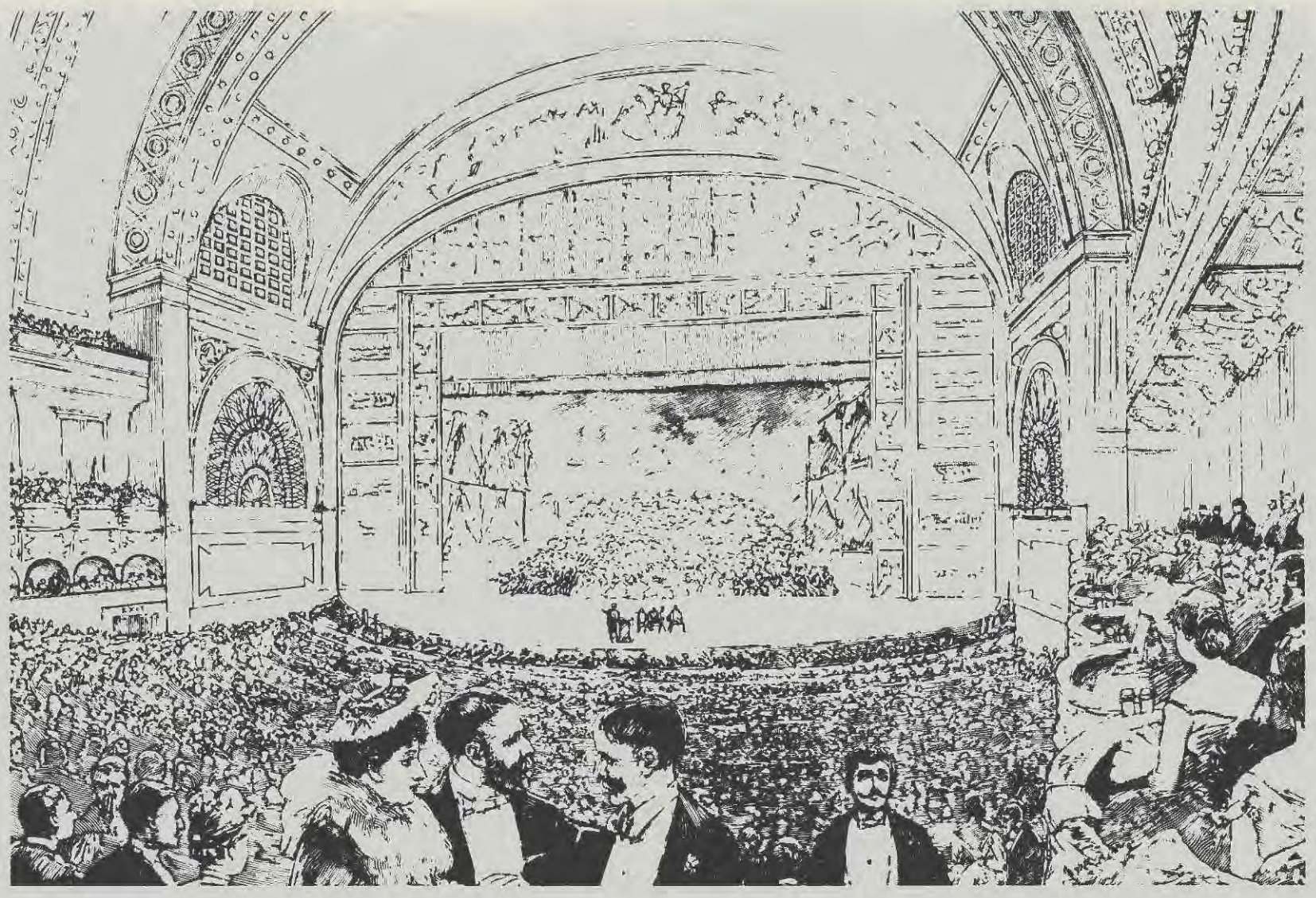

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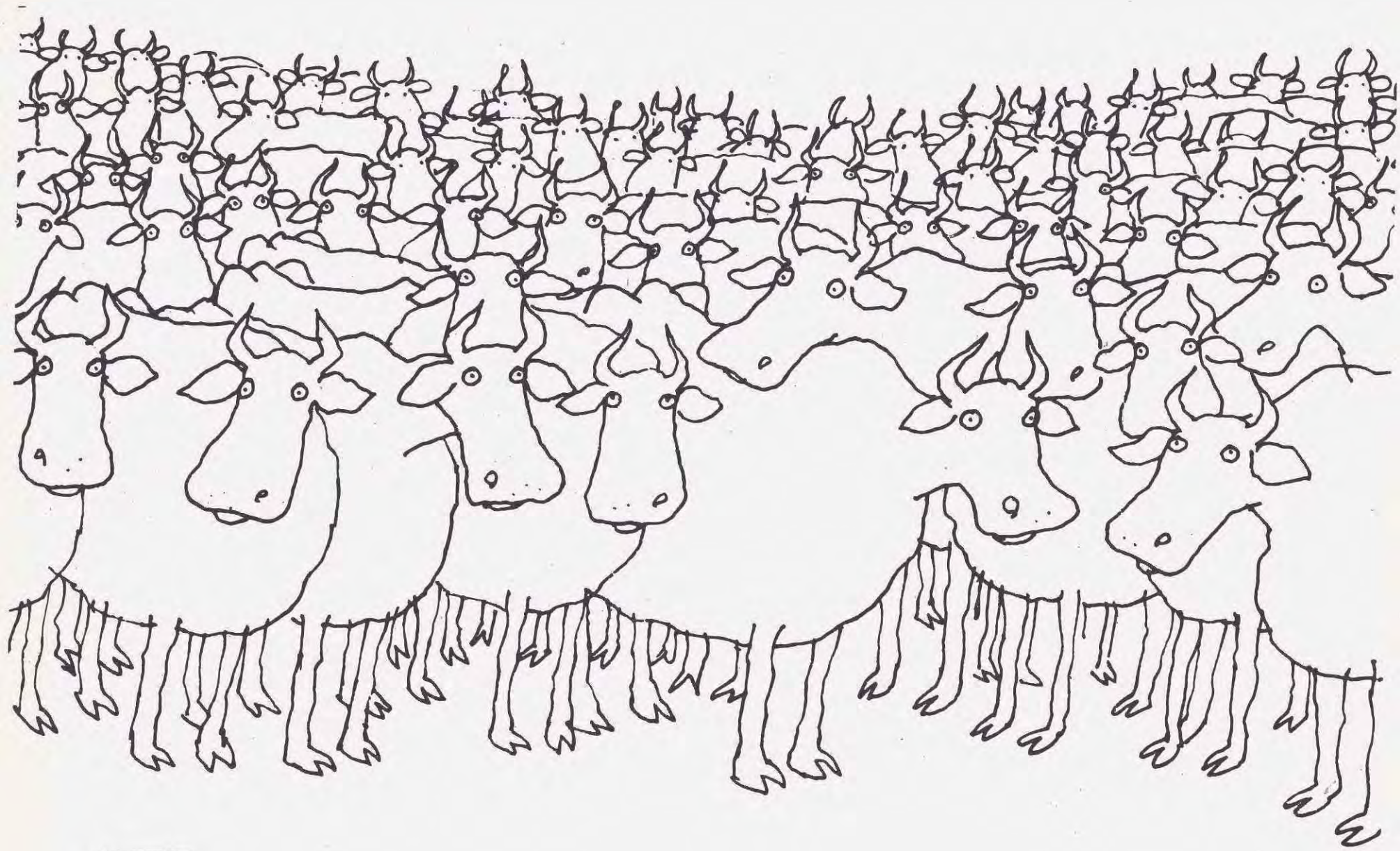

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