Bellefonte blows whistle on agency

By JOANNE GAMLIN

LOS ANGELES—Bellefonte Insurance Co., a former captive much heralded for having successfully grown into a third-party insurer, was facing millions of dollars in losses from an association with a managing general agency.

But the large insurance subsidiary of Armco Inc. successfully bought stop loss coverage two weeks ago in London, capping its losses on unreinsured aviation policies at $50,000 per aircraft and $500,000 aggregate.

Bellefonte also obtained on March 14 a temporary restraining order against its former managing general agent, preventing Omni Aviation Managers Inc. from handling premium money on behalf of Bellefonte.

Bellefonte charged in a lawsuit filed in superior court here that its former managing general agent, writing low cost aviation hull and liability policies for small and older aircraft, misappropriated funds, converting premium dollars to its own use.

Omni Aviation Managers Inc., a 10-year old firm with offices at the Van Nuys, Calif., airport, is the major defendant in an amended complaint filed by Bellefonte. The complaint also names Omni's parent company, Upstart Eagle, and its chairman and founder, Michael S. Eisenstadt.

Bellefonte's name is on 800 insurance policies issued so far in 1979 by Omni without placing reinsurance for Bellefonte as the managing general agent had agreed to do under its contract with Bellefonte, the insurer charges.

However, no policyholder—mostly individual pilots of small craft—will be injured. The first pages of 29 policies written are part of the litigation.

As far as anyone knows, the situation with Omni is Bellefonte's first bad experience since expanding into the general insurance business in 1968 after operating as Armco's captive.

Bellefonte's amended com-

Continued on page 73

Photo: Chuck Wingis

Losses on small aircraft like these at the Van Nuys airport where Omni Aviation has an office threatened to cost Bellefonte millions. Its former managing general agent didn't reinsure the risks.

Retro penalty policies

Aviation risks dispute costs Hall $14 million

By MARGARET LeROUX

SEATTLE, Wash.—A book of 120 aviation retro penalty policies written in the early 1970s for virtually every major airline was the source of a $14 million settlement announced Jan. 12 between Unigard Mutual Insurance Co. and broker Frank B. Hall & Co.

A *Business Insurance* investigation uncovered the source of the settlement after Hall had declined to comment on the settlement except to announce it as required by the Securities and Exchange Commission.

The suit stemmed from the broker's activity as a reinsurance intermediary between the London and U.S. aviation markets. At issue was Hall's authority to act as a reinsurance intermediary in the aviation market for retro penalty policies and possibly Chinese retros.

The agreement between the broker and Unigard was reached on the eve of a trial scheduled for the High Court of Justice in London after a year of unsuccessful arbitration led to litigation.

Also named in the court action were: Philadelphia Manufacturers Mutual Insurance Co., the Lloyd's brokerage firms of Thomas E. Nelson Ltd. and Oakeley Vaughan & Co. Ltd. and more than 70 other insurers in the worldwide aviation market. Mr. Nelson acted as underwriter.

Under terms of the settlement, Unigard will receive $14 million over a five-year period from Frank B. Hall to reimburse over $12 million in losses never recovered by Unigard from its reinsurers. The broker is negotiating with other defendants in the lawsuit for contributions to the settlement. Stewart Wrightson, another Lloyd's broker on the business, is contributing $1 million.

The aviation retro penalty policies for hull and liability risks were produced by the Los Angeles office of Frank B. Hall and Allen Miller & Associates, which no longer exists. Hall agreed to pay the $14 million settlement because Hall originally produced the business.

The policies were insured by Unigard and included in that insurer's reinsurance treaty with Philadelphia Manufacturers. The policies were then underwritten in the Lon-

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The inside story

Workers shun retirement

Employes want to work past retirement age, but when they retire they will rely on corporate pensions to provide a good income. A Harris survey: **Page 49.**

Reformers tackle work comp

After two years of work, a study commission releases its recommendations for reforming Minnesota's workers compensation law to control costs. **Page 55.**

Buy direct, New York told

A state commission tells New York to bypass brokers and buy directly from insurers, but agents, who helped thwart the move before, object again. **Page 67.**

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Week of March 19, 1979

business insurance

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

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At last! Insurers divulge product liability loss data

By JOHN MAES

Tort reform advances, but business snubs Commerce's model bill. Page 66.

CHICAGO—Seven states are now collecting statistics on product liability premiums and claims in response to insurance buyers' demands over the last few years for facts on insurers' experience.

A wealth of product liability statistics will be available by year-end from these states. And Missouri has already released to *Business Insurance* some statistics filed by insurers.

In addition, the Insurance Service Office (ISO) and the National Assn. of Insurance Commissioners (NAIC) are calling on insurers to extract product liability statistics from general liability figures by 1980 and report them to the organization.

Insurers are balking at the NAIC's demand and complaining about the varying reports required in nine states so far, but they are filing the reports, in some cases belatedly.

Of the 10 states that have either passed or amended product liability reporting laws last year, seven of them—Nebraska, Minnesota, Missouri, Kansas, Georgia, Florida and Michigan—are already collecting data. Three others, Illinois, Arizona and Louisiana, require 1979 data to be filed next year.

The Missouri insurance department released to *Business Insurance* the reports of 12 major insurers which show 1978 loss ratios on product liability ranging from 2.3% to 116.1%. But Jerry B. Buxton, state insurance director, said the information is still too "inconclusive" for him to comment on what the figures indicate about premiums compared with losses.

Reporting requirements vary somewhat from state to state, but essentially they ask for: claims filed and closed during the year, the number of suits filed, the amounts of awards and whether cases were settled in or out of court. These items are in addition to figures on premiums and losses.

Missouri, Kansas, Nebraska and Florida require information on premiums and losses in all states, while Minnesota requires companies that self-insure, have no insurance or deductibles of $50,000.

Continued on page 65

Guidelines expand pregnancy benefits in dependent plans

By JERRY GEISEL

WASHINGTON—Employers whose group health insurance plans provide coverage for dependents will have to provide for the pregnancy-related expenses of employes' wives, *Business Insurance* learned.

Draft guidelines from the Equal Employment Opportunity Commission (EEOC) say that if an employer's health insurance plan covers the medical expenses of spouses of female employes, then it must equally cover maternity expenses of male employes' wives. *BI* obtained a draft copy of the guidelines before their publication.

The news that companies will have to cover the pregnancy-related medical expenses of male employes' wives in their group family health insurance plans will mean an additional increase in medical insurance premiums, say insurance company actuaries.

Some employers already face 3% to 4% hikes in their group insurance plan costs when they add equitable benefits for pregnancy for their female employes (*BI*, March 5). The actuaries would not immediately predict how much family health plan costs will rise with the inclusion of pregnancy benefit for employes' wives.

The EEOC guidelines are designed to aid employers in implementing the new federal law that requires companies to offer equitable pregnancy benefits in their group health insurance and paid-sick leave plans. The law goes into effect April 29.

However, the guidelines are only tentative. It is possible, though not likely, that a new set of guidelines will be published in late April just

Continued on page 71

Well blowout kills 5, hurts 27 AIG pays workers comp loss

By ELLIS SIMON

MORGAN CITY, La.—An AIG company insured the workers compensation risk at an offshore drilling platform that blew out and caught fire earlier this month, killing five and leaving three missing. Twenty-seven workers escaped, some with minor injuries.

The property risk was self-insured.

The AIG company wrote workers compensation coverage on the platform for Penrod Drilling Co., which had been retained to drill the gas well that suffered the blowout, said an attorney for the principal owner of the platform, Placid Oil Co. of Dallas.

Both Placid and Penrod are owned by the Hunt family of Texas, one of the largest private oil industry entrepreneurs in the nation.

Most of the property damage on the platform was to the drilling equipment itself. The platform, which has a structural value of about $15 million, probably will be salvageable, according to Armand Gutierez, an attorney with Placid.

The fire resulting from the blowout was extinguished, but the gas leak itself was not capped immediately. Red Adair Oil Well Fires & Blowouts Control Co. was retained to try to cap the well, Mr. Gutierez said.

The Adair firm is still trying, but a drilling rig, a jack-up unit, has been towed to the site to drill a diversionary well to cut off the leak, he explained. That added expense and the business interruption involved could put the loss into the catastrophic category, Mr. Gutierez added.

The fire had no effect upon 16 producing wells currently running from the platform and no environmental damage resulted from the blowout of the natural gas well, Mr. Gutierez said.

Since the platform was a fixed facility, dead and injured crew members are eligible for U.S. Longshoremen and Harbor Workers benefits that are several times higher than statutory benefits for Louisiana and Texas.

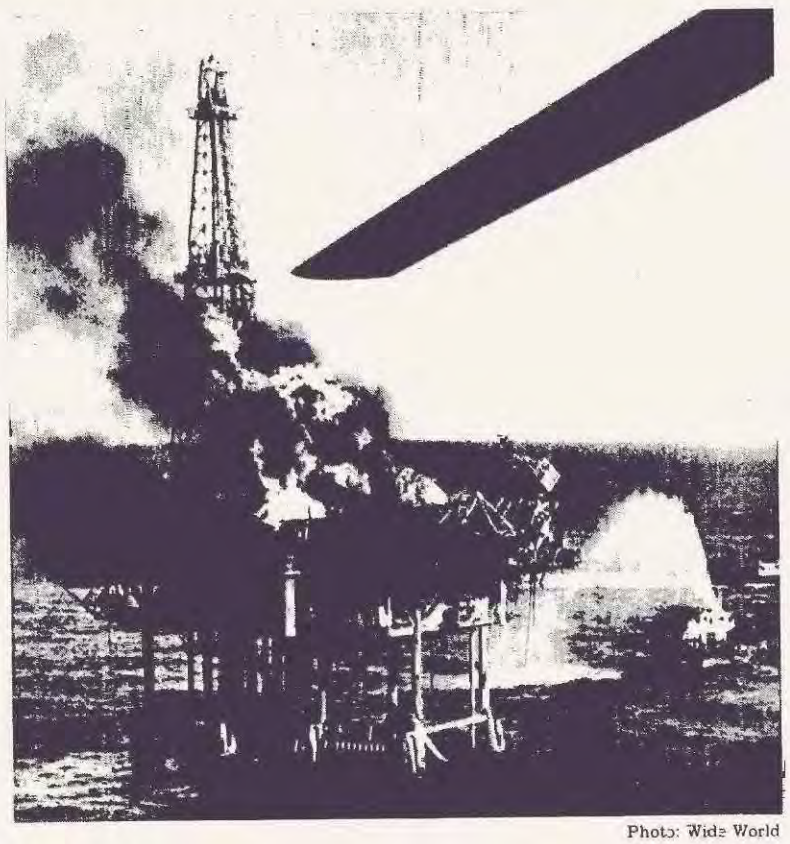

Photo: Wide World

The property exposure is self-insured on the gas well platform burning in the Gulf of Mexico. Placid Oil Co. is the principal owner.

U.S. L&H provides a death benefit of 50% of pay to a widow and 16⅔% of pay for each child up to a maximum family benefit of two-thirds of salary. There is no upper limit on death benefits. Total disability benefits under U.S. L&H run two-thirds of salary to a maximum of $396.78.

Benefits and maximum benefit levels for weekly disability payments are indexed to changes in the national average wage.

By comparison, death and total disability benefits in Louisiana run from a minimum of 20% of the state's average weekly wage to a maximum of two-thirds the average weekly wage. At present, the average weekly wage in the state is $210.88.

In Texas, the maximum benefit is $105 per week, increasing by $7 for each $10 increase in the state's average weekly wage. The minimum benefit is $21, increased by $1 for each $10 hike in the state's average weekly wage.

Had a drilling rig been involved, injured crew members and survivors of those killed could have sued Placid or Penrod under the Jones Act, because a drilling rig is considered a ship and no workers compensation exists. ■

for your information

15 Minn. firms sue state official for assignment to health risk pool

MINNEAPOLIS—3M Co., Minnesota Power & Light Co. and Northern States Power & Light Co. are suing the state of Minnesota and its commissioner of insurance in U.S. district court. They've been joined by 12 other corporations in the state.

Their beef: The 1976 Minnesota Comprehensive Health Insurance Act's provision for "assessments" of companies that self-insure their employe health benefit plans, to help pay for what is essentially an assigned risk pool providing health benefits to persons not insurable through traditional health insurance plans and not covered by employer plans.

The companies argue that the Employe Retirement Income Security Act of 1974 preempts any such provision in a state law. They have refused to pay the assessment levied by former commissioner Berton W. Heaton, who formally advised the companies that if the full assessment isn't paid "proceedings will be initiated to revoke your right to doing self-insurance business in Minnesota." (Mr. Heaton resigned Dec. 31 after state elections, but is still serving as an analyst with the insurance department.)

Claims escalate in transit fire

OAKLAND, Calif.—Claims totaling $4 million have been filed by 10 firemen injured in a fire Jan. 17 that has closed the Bay Area Rapid Transit (BART) underwater tube linking San Francisco to the East Bay area (*BI*, Feb. 5).

More than 60 claims seeking considerably less have been filed by passengers who were on board the BART train when the fire occurred. Three train cars were destroyed, 46 people were injured and one fireman died.

A claim has not yet been filed on behalf of the family of the fireman killed in this blaze, according to Leonard Russo, whose adjusting firm is handling liability claims for BART.

The business interruption loss is still unknown because the underwater tube where the fire occurred has not yet been opened. But since late February, BART has run buses across the bay at a 50 cent fare costing the system an estimated $20,000 per day on top of a $60,000 per day loss on the down line.

HMOs slice hospital stays in half

WASHINGTON—Health maintenance organizations held the hospitalization rate for their members to half the national average, according to a HEW report.

While the national average of hospital days per 1,000 Americans was 1,022 in 1978, HMOs averaged 408 hospital days per 1,000 members. That compares with 488 days of hospitalization per 1,000 HMO members in 1977.

OSHA fines steel firm

CHICAGO—The Occupational Safety and Health Administration (OSHA) has issued six citations and a $42,000 fine against the Burnside Steel Foundry Co. where a Feb. 16 explosion fatally injured four men (*BI*, March 5). Twelve others remain hospitalized.

OSHA alleged the company failed to maintain water draining systems, failed to remove slag from clogged draining pits and did not provide sufficient protective equipment. The firm was also charged with requiring employes to work where molten metal could come into contact with water or wet areas.

The blast occurred when a ladle containing molten metal tipped and came into contact with a pit of standing water. One worker who was trying to free the jammed ladle when it tipped died a short time afterward while three others died from subsequent burns and injuries.

The United Steelworkers of America is considering possible legal action against the company.

Federal work comp hearings begin

WASHINGTON—Hearings will begin this month on legislation (S.420) introduced by Sen. Harrison Williams (D-N.J.) and Sen. Jacob Javits (R.-N.Y.) to establish minimum federal standards for state workers compensation programs (*BI*, Feb. 19).

Four days of hearings are scheduled: March 27 and 28 and April 2 and 3.

A&A pursues London ties

NEW YORK—Alexander & Alexander Services Inc. said it has entered into formal discussions with Sedgwick Forbes Bland Payne Group Ltd. to achieve a formal linkage.

The nation's second largest brokerage firm said previously it intended to explore a "contractual profit sharing" arrangement once merger of Sedgwick Forbes and Bland Payne had been consummated (*BI*, Nov. 27, 1978). In addition, A&A waited for completion of its own merger with R.B. Jones last month before beginning talks with the British concern.

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Digest packs cost-sharing into liberal plan

By REBECCA A. FANNIN

PLEASANTVILLE, N.Y.—Reader's Digest showers its employes with all kinds of liberal fringe benefits, but still requires them to share the cost of group insurance.

America's top-selling magazine publisher, long regarded by other employers as a protective and almost paternalistic company, instituted the stiff coinsurance feature in its health benefit program 60 years ago at the suggestion of the magazine's founders, long before medical care costs had skyrocketed.

Though the Digest has generally been more concerned with generosity than economics, the shared-cost does help the company contain its employe benefit costs. The 3,000 employes fortunate enough to work for the Digest pay 10% of the monthly $14 group insurance cost.

"It's very sensible to split the cost," said Martha Farquhar, the Digest's employe benefits manager. "The employes are more aware of the cost of the benefits if they are helping to pay for them." It's possible, in fact, that Ms. Farquhar will recommend they be required to pay an even larger share of group medical costs.

Considering all employe benefit areas, however, other companies would probably find it difficult to match the Digest.

Last year, Reader's Digest spent $16.5 million on benefits for employes, averaging $5,500 per employe.

The average expenditure does not include money spent to maintain 80 landscaped rolling acres as a setting for the Williamsburg-style mansion that is home for Reader's Digest employes. Nor does it account for the collection of original French Impressionist artwork that adorns the editorial offices as a creative stimulus.

But apparently Reader's Digest can well afford the lavish benefits it is famous for despite the huge 48% increase in benefit costs in 1978. The Digest's publishing businesses grossed $275 million in one year, according to earlier estimates made by Forbes magazine. The Digest does not release financial figures since it is privately owned.

Reader's Digest founders DeWitt and Lila Wallace still own all the voting stock some 60 years after they created the magazine.

The two owners have been instrumental in providing its employes with the most modern benefits programs.

"We've always prided ourselves on being ahead of our time," said Ms. Farquhar. "For instance, we started profit sharing in the early '60s when it was a new concept.

Reader's Digest has also experimented with the four-day work week. Mr. Wallace gives employes every Friday in May. The founder chose May for the experiment because he liked that month best and the workload is lightest that month.

Mrs. Wallace has played a role too in transforming the magazine's offices into a cheery home. The co-founder has personally seen that the Williamsburg mansion that houses the editorial offices and the surrounding park-like area are maintained. "She's a great believer in keeping the physical surroundings pleasant," Ms. Farquhar noted.

Photo: Rebecca A. Fannin

Reader's Digest prides itself on "being ahead of our time," comments Martha Farquhar while outlining the company's generous employe benefit plans.

Aside from the more obvious fringes that greet the visitor to Reader's Digest headquarters, the magazine also provides liberal plans in profit sharing, pension, vacation schedule, life insurance and numerous other benefits to keep its workers happy.

The pension and profit sharing funds represent by far the most costly employe benefit and the most rapidly growing cost for the Digest, Ms. Farquhar said.

The company will contribute $9.5 million to the pension fund in 1979, a $2 million increase from 1978. The year before, the pension costs grew by 75%, a startling increase that Ms. Farquhar attributes to the need for additional funding because of the poor performance of the stock market, keeping up with salary increases and stepping up the funding of the pension benefit.

The Digest also sped up funding for the pension plan beyond the minimum ERISA requirements. "We're a conservative company and wanted to make certain that we're prepared. We're funding at the fastest permissible rate," Ms. Farquhar said.

The pension benefit is very rich, Ms. Farquhar said. The plan uses the following formula to calculate the benefit: 2% times the retirement salary, times the years of credited service with a maximum benefit of not more than 90% of retirement salary less 75% of social security benefits at age 65. The retirement salary is based upon the five consecutive highest-paid years out of the last 10 years with the Digest. The benefit is vested after 10 years of service.

Reader's Digest contributed $5 million to the profit sharing fund in 1978.

The company annually contributes to the profit sharing plan a percentage, depending on profits, of the employe's salary to a maximum of $25,000 and a minimum of $3,000. The most common percentage used is 12%, Ms. Farquhar said. The profit sharing is vested at a fast rate: 20% for each year of service after one year to full vesting after six years of service.

While other companies can match the Digest's profit sharing

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the benefit beat

N.Y. employes' union takes over benefit purchasing

Dental and prescription drug coverage will no longer be provided by New York state for its employes under a three-year contract worked out between the state and the Civil Service Employes Association (CSEA). Elimination of these programs and other minor "give-backs" are expected to help the state keep a lid on benefit costs.

In return for union concessions, the state will contribute $200 a year for each full time employe to a new welfare fund the union is establishing to provide dental, prescription drug and other benefits for its 105,000 members. The give-backs by the union are valued at $200 a year per employe.

Prescription drug coverage had been provided as part of the major medical program which is insured with Metropolitan Life Insurance Co. Dental coverage was purchased separately by the state.

The state is also revamping its major medical program to combine it with a primary medical plan now with Blue Shield. The new program will be put out to bid later in the year in hopes improved or equal coverage can be obtained at no more than is currently paid.

The new program will also increase deductibles to $75 per person and $225 per family from $50 and $150 respectively. Completion of the revision and selection of a new insurer is expected within six months.

Major medical increased

Maximum lifetime major medical benefits have been increased to $150,000 from $50,000 in a three-year contract negotiated between the New York Stock Exchange and Local 153 of the Office and Professional Employes Union.

The contract also provides for a major medical deductible of $100 per individual and $200 per family. Previously the deductible had been $100 per person.

Both benefits will be implemented during the first year of the contract. In the second year, the basic dental plan will be expanded to provide coverage for orthodontia, periodontics, crowns and inlays.

The dental plan is written by Blue Cross/Blue Shield of Greater New York. Metropolitan Life Insurance Cos. provides major medical coverage. The premiums are fully paid by the stock exchange. Dental coverage is on a "usual, customary and reasonable basis" with the insurer paying 80% of covered expenses.

The three-year contract, which covers 2,100 workers, provides for wage increases of 10% the first year, 6% the second year and 8% the third.

Retirement plans restructured

Kellogg Co. of Battle Creek, Mich., has restructured three retirement plans. A $160 million hourly profit sharing plan was changed to savings plan and profit sharing plans for salaried and sales employes were changed to thrift plans. An existing defined benefit pension plan was made non-contributory to serve as the primary retirement benefit.

The company decided that profit sharing plans provided good termination and death benefits, but fell short in providing the career employe with an adequate retirement benefit. Many retirees who had worked for the company 30 to 35 years and who had outlived the average life expectancy were not receiving benefits because their profit sharing benefits ran out.

Thrift and savings plans were added to provide the employes with a capital accumulation device in addition to the defined pension benefit.

Approximately $42 million in profit sharing assets will be refunded to the plan participants because the profit sharing plans were contributory and the new pension plan is non-contributory. Employes, however, will be given the option to take the refund or place it into the thrift or savings plan.

Benefits increased

Sheetmetal workers at Buckeye Manufacturing Inc. in Columbus, Ohio, have ratified a three-year contract that increases life insurance for 50 employes to $7,000 from $5,000. Also raised in the pact was sickness and accident coverage to $100 weekly from $75 which can now be collected for 26 weeks instead of the previous 13, according to union officials.

Maternity benefits were increased to $400 per pregnancy from a maximum of $200. Company contributions to the pension fund for hourly employes will rise a total of 15 cents per hour over the next three years for each worker with at least five years of service.

Prudential Insurance Co. is life and health insurance underwriter.

Pension benefits up

The 580 employes of the Crown Cork & Seal Corp. of Baltimore recently won in contract negotiations an increased benefit package that will raise pension payments by more than 25% over the next three years.

The contract between the company and the International Assn. of Machinists, which has been agreed to but not yet signed, calls for pension benefits to increase the first year to $13 per month of service from $12 now, to $14.50 the next year and $15.50 the third year.

Also included in the three-year package is an expanded eyeglass program to go into effect in October, an increase in covered orthodontic work to $750 from $500 and the issuance of a "prescription card" to retired employes over 65 that will allow them to charge any prescription expenses over $2 to the company's insurance plans.

The company pays for all of the costs of the insurance for employes. A self-insurance program covers everything but dental insurance which is underwritten by Metropolitan Life Insurance Co.

New underwriter chosen

Nappanee, Ind., has awarded a $22,000 life, health and major medical insurance contract to Crown Life Insurance Co. of Canada to cover 25 municipal employes.

Crown's bid of $22,923.36 was the lowest of six firms. Other companies bidding were: Metropolitan at $31,758.48, Equitable at $26,157.84, Occidental Life at $25,686.60, Travelers at $25,122.24 and Blue Cross/Blue Shield at $23,307.12.

Equitable had been the city's health and life insurer. Workers are covered for $5,000 in life insurance and for a lifetime maximum of $1 million on health, accident and major medical.

Pension costs equalized

The New Jersey senate has passed legislation equalizing payments to the state's pension plans by male and female employes. Passage of the measure by the assembly is expected to follow shortly, putting an end to 60 years of inequities that have resulted in some female employes paying $113 more a year than a man to the pension plan.

Pension payments by women would be lowered and pension payments by men would be increased by a maximum of 0.6% of salary, according to William Joseph, director of the division of pensions. However, increases or decreases would be more likely to average about 0.3% of salary, he said.

The legislation calls for a formula adjusting pension payments in accordance with age and salary. All persons at the same pay level and age would pay the same contribution. If there were more women than men in a particular age and salary class, pension payments by women would be reduced by a smaller amount than if men outnumbered women.

The state's pension plans cover 334,000 employes in state, county, municipal and school district agencies, about 200,000 of whom are women.

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

1979 RIMS conference focuses on innovations

CHICAGO—Innovation '79 is the name and theme of the 17th annual Risk and Insurance Management Society conference which will be held here at three downtown hotels April 29 to May 4.

The conference is offering three distinct programs on employe benefits, risk management and specific industry concerns.

The employe benefits agenda, running from April 30 to May 1, will cover cost containment, long term disability, international benefits and trends in retirement planning and funding. Dr. Hoyt A. Gardiner, president-elect of the American Medical Assn., will launch this segment of the conference with a discussion of the cost containment study recently completed by the AMA. Peter H. Turza, special counsel to Sen. Jacob Javits, will discuss Title IV and ERISA at the general session on the second day of the employe benefits program.

Funding alternatives for employe benefit programs, trends in retirement planning and funding, how to evaluate a health maintenance organization, tax aspects of executive compensation, preretirement counseling, discrimination and employe benefits and labor's view of benefits are just some of the topics of the employe benefit workshops.

Industry sessions, held on April 30 and May 1, are designed to allow risk and insurance managers in the same industry to exchange information.

A panel discussion of pricing and capacity will keynote the risk management segment of the conference beginning May 2 with panel members Leslie R. Dew, managing director of Insco Ltd. of Hamilton, Bermuda; Maurice Greenberg, president of American International Group; E.J Gordon Henry, chairman of Matthews Wrightson Holdings Ltd. of London and Robin A. G. Jackson, managing director of Merrett Dixey Syndicate of London

On May 3, five different workshop sessions will examine risk management issues.

Also on May 2 and 3 47 risk management mini-seminars are scheduled.

On the final day of the conference, May 4, RIMS will present a new program entitled, "The Future Experience: A Kaleidoscope of the Unexpected." ■

Socialist states query N.Y. on exchange setup

NEW YORK—Three Iron Curtain Countries have inquired about the possibility of participating in the New York Insurance Exchange either by establishing underwriting syndicates or as partners in a syndicate.

New York superintendent of insurance Albert B. Lewis confirmed that there had been inquiries from the socialist states, but he wouldn't name them.

Capitalization of the exchange is one of the key challenges it faces in its formative days, according to Mr. Lewis. "We need to raise $70 million," he said. That amount would be generated by formation of approximately 20 syndicates, each capitalized at a minimum of $3,550,000.

One syndicate has already been capitalized by INA Corp. The syndicate will be 100% owned by a newly created INA subsidiary called INA Reinsurance Exchange Investment Co. Inc. and has been capitalized at $3.7 million.

Underwriting management for the syndicate will be done in-house and it is likely that INA will seek partners for future expansion, said John Cox, president of Insurance Co. of North America.

American International Group has said previously it intends to form at least one syndicate. Other insurers, including The Atlantic Cos., The Continental Insurance Co. and Chubb and Son reportedly are readying plans for participation in the insurance exchange.

Meanwhile, Parkington Associates Ltd., a New York underwriting management and excess and surplus brokerage concern, said it is seeking to become an underwriting manager on the exchange in addition to a member broker.

In other developments, five of the seven members of the interim board of governors have been appointed. Three of those selected were members of the Committee of 13 that drafted the insurance exchange constitution and bylaws.

The interim governors are: AIG president M.R. Greenberg; insurance consultant Donald Kramer; appointees of Gov. Hugh Carey and members of the Committee of 13; Chubb Corp. senior vp Richard E. Stewart, Guy Carpenter & Co. president Frank J. Tasco; appointees of senate majority leader Warren M. Anderson, and attorney Jerome Kretchmer, an appointee of assembly speaker Stanley Fink and a Committee of 13 member.

Mr. Fink has an additional appointment to make. Superintendent Mr. Lewis is expected to name Harold Eckmann, chairman of The Atlantic Cos. and another former Committee of 13 member, as the seventh member of the interim board. Marsh & McLennan Inc. chairman L. Patton Kline was previously named to the board by Mr. Lewis, but Mr. Kline declined the appointment.

Had he accepted, there would have been two Marsh & McLennan Cos. executives serving since Guy Carpenter & Co. is also an M&M subsidiary. ■

Feds want more benefit report rules

WASHINGTON—Pension plan sponsors would have to furnish plan participants with benefit statements within 60 days of receiving a request for the information under proposed Labor Department rules.

The participant's accrued benefit, the percentage of the accrued benefit that is vested and the amount of the accrued vested benefit would have to be included in the statement, according to the new proposed rules.

If the participant has not accrued a vested benefit, the benefit statement must indicate the earliest date on which benefits would become vested, the Labor Department proposes.

The information used in the statement must reveal the plan participant's benefit status as of no later than six months prior to the date that he or she receives the benefit statement.

Plan sponsors can comment on the proposed regulation by writing the department by April. ■

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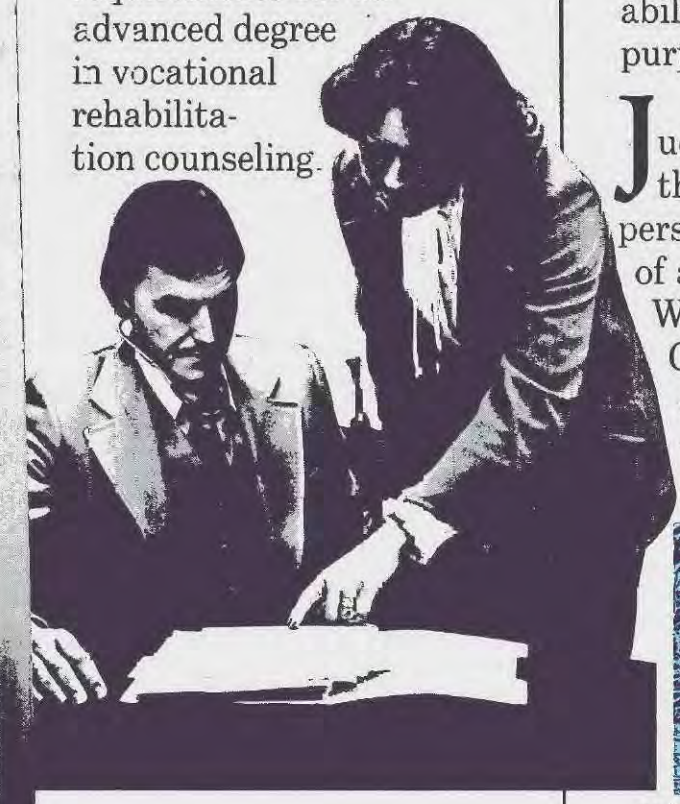
Judy Fabig of our Twin Cities region is a good example. A highly experienced R.N., Judy is now completing requirements for an advanced degree in vocational rehabilitation counseling.



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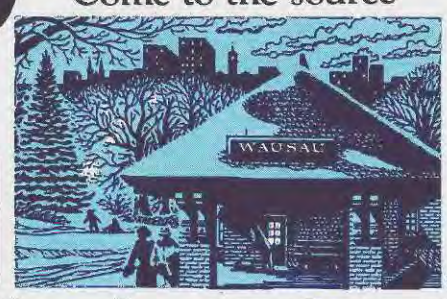

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Ford faces $10 million punitive damages plea

DETROIT—A Detroit-area woman can seek $10 million in punitive damages from Ford Motor Co. in a product liability suit stemming from the 1977 death of her husband, a circuit court judge ruled here recently.

The punitive damages request is part of a $12 million lawsuit against the auto manufacturer in which the plaintiff, Judy Kay Keyes, claims that fragments from a cooling fan on a Ford automobile caused fatal injuries to her husband in May 1977.

Roger Keyes, 25, was a mechanic servicing the 1972 Ford Torino in May 1977 when the car's cooling fan fragmented and a piece caught Mr. Keyes in the neck, severing an artery, said Barry P. Waldman, a Detroit attorney representing the widow. Mr. Keyes died a few weeks later, the attorney said.

"Ford had reason to believe the product was defective" at the time of Mr. Keyes' injury, but did nothing about it, Mr. Waldman contended. That charge is the basis of the punitive damage request, he said.

The National Highway Traffic Safety Administration is currently investigating the allegation. Ford could be fined up to $800,000 if it is determined the company knew of the defect and potential danger five years before any of the vehicles were recalled.

If it is determined there was a delay between the time the company first discovered the defect and the time the vehicles were recalled, Ford could be found in violation of federal law, a spokesman for the agency said.

Since May 1977, Ford has recalled some 1.7 million cars and trucks for replacement of possibly defective "flex fans" which proved to be susceptible to cracking and eventual fragmentation of pieces of the blade, said a company spokesman.

Ford is largely self-insured for product liability, according to the spokesman.

It's been speculated that if Mrs. Keyes wins her demand for punitive damages it could set a precedent in future product liability suits.

Ford has been named in a string of product liability lawsuits in the last few years involving its cars, losing two at the trial court level in California. ■

Supreme Court OKs suit against service contract

By JERRY GEISEL

WASHINGTON—The drive by insurers to contain rising health care costs through direct service contracts may have been thrown into reverse by a Supreme Court ruling that antitrust immunity does not extend to such arrangements.

In a case of potentially far reaching significance, a divided court ruled that the purchase of goods and services by Blue Shield is not the "business of insurance," and thus is not covered by the insurance industry's antitrust immunity.

While the case only directly involves arrangements between health insurers and pharmacies, observers said the ruling may apply to a wide array of service agreements ranging from insurance company contracts with hospitals and doctors to those with automobile repairers.

"The impact is potentially tremendous," said Michigan antitrust expert John L. Shoemaker. "The way I read the case, any service benefit plan that provides benefits for a fixed fee is in trouble. I can't see any other type of conclusion."

Insurers, though, hasten to point out that the Court only said that price-fixing agreements involving insurance companies may be subject to antitrust challenge. The Court did not rule that such arrangements are illegal.

Still, being liable to antitrust challenges could chill insurers' enthusiasm for some efforts to keep the lid on health care costs through service arrangements.

"Will an insurer even want to enter into cost containment deals and take the chance of being sued and spend $500,000 in legal costs even if it is found innocent later on of violating antitrust law?" pondered Edwin Soefing, counsel for the Health Insurance Assn. of America (HIAA) and a former senior trial attorney at the Federal Trade Commission.

"There have been a lot of questions over the years why insurers don't use their collective clout in trying to hold down rising medical costs," said a spokesman for the HIAA in Washington. "This case is a good example of one of the problems we face in trying to do that."

In the recent ruling involving Group Life & Health Insurance Co. (Blue Shield of Texas), Blue Shield asked every licensed pharmacist in the state to sign a pharmacy agreement.

Under this agreement, Blue Shield subscribers who take their prescriptions to participating pharmacies pay a maximum of $2 for each prescription. The pharmacist then is reimbursed by Blue Shield for its cost of the drug.

Blue Shield of Texas subscribers who have their prescriptions filled by nonparticipating pharmacists must pay the pharmacist the full price of the drug and then file a claim with Blue Shield. They are reimbursed for only 75% of the cost in excess of the $2 deductible.

Eighteen Texas pharmacists who didn't participate in the plan filed suit contending that the Blue Shield pharmacy arrangement is price fixing and would put pharmacists out of business who don't participate. The nonparticipating pharmacists also contended that the $2 markup Blue Shield permitted was too low to enable small pharmacists to participate.

Blue Shield countered that the pharmacy agreement constituted the underwriting of risk and as a result was protected from antitrust litigation by the McCarran-Ferguson Act, the 1945 statute that exempts insurers from federal antitrust laws in favor of state regulation.

But the court, in the 5-4 decision, said the agreements between Blue Shield and the pharmacies serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.

The McCarran-Ferguson Act applies only to the "business of insurance"—the spreading and underwriting of a policyholder's risk—rather than any "business of insurers" in which insurers make arrangements to keep their costs low, the court said. ■

Progress report.

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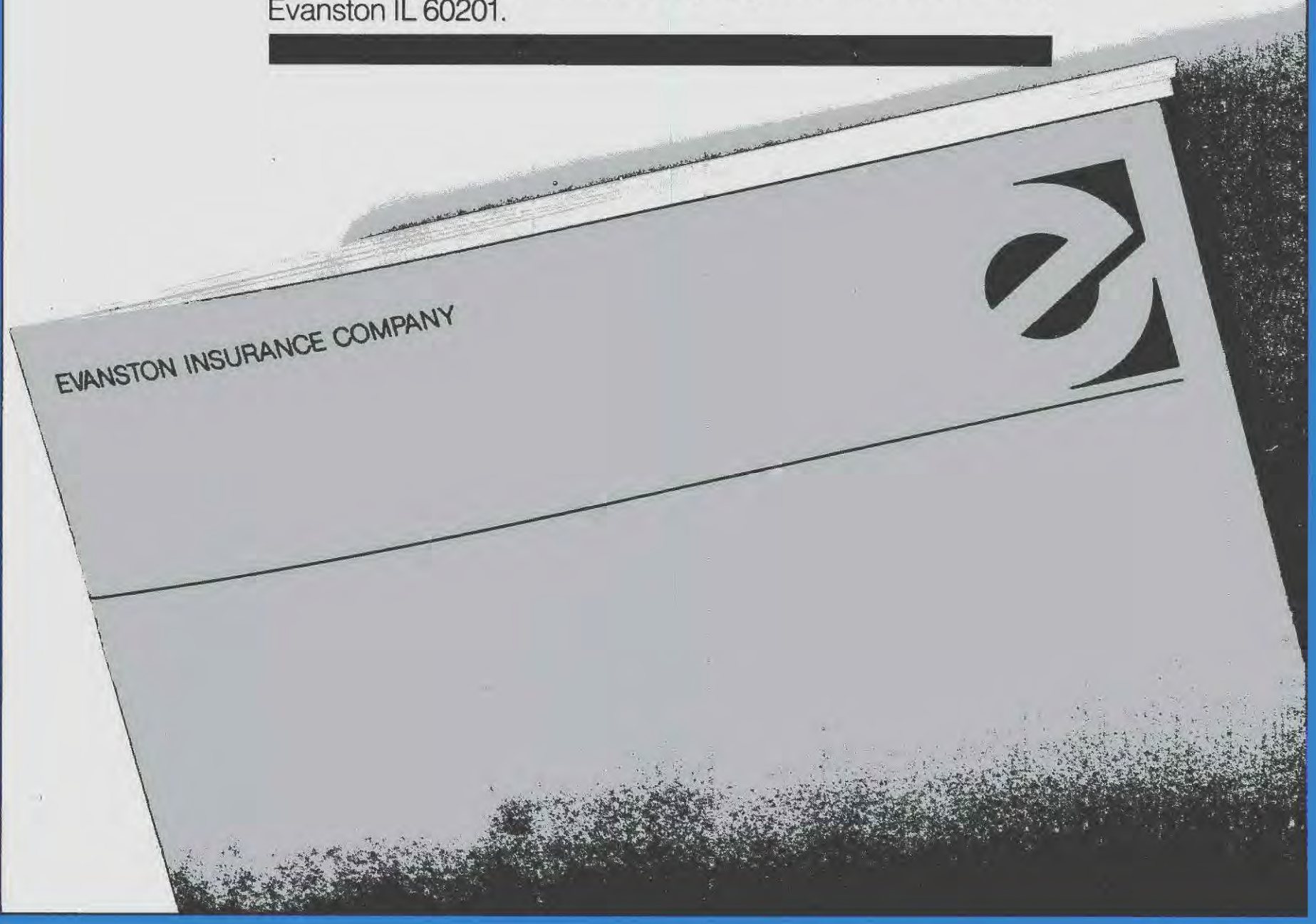
For more information on available coverages and a copy of Evanston Insurance Company's 1978 Annual Report, write to Shand, Morahan & Company, One American Plaza, Evanston IL 60201.



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On January 18, 1978, 4.8 inches of snow fell in Hartford, Connecticut.

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BI 11

New Coast Guard regs

Liability rules for offshore pollution drop

WASHINGTON—The U.S. Coast Guard acquiesced to "as many changes as we could" to satisfy the oil and insurance industries in developing final regulations on offshore oil pollution liability and compensation, according to a senior Coast Guard officer.

The regulations, implementing Title III of the Outer Continental Shelf Lands Act Amendments of 1978, are expected to be released this month.

Business Insurance learned of some of the concessions in the new regulations. Oil and insurance industry officials testified at hearings in January that the financial responsibility standards in the proposed regulations were too stringent and that the law itself was too vague on the definition of liability.

The law makes offshore operators liable up to $35 million per facility for pollution cleanup and damages. However, the definition of "facility" was not clear, said critics, concerned that each separate pipeline, platform, well and drilling rig, could be defined as a separate facility.

The final regulations will leave the definition of an offshore facility up to the operator, said Capt. Gilbert Sherburne of the Coast Guard. Several platforms connected by pipelines and drilling more than one well from each production platform could be considered one facility, he said.

However, where the facilities of more than one operator are connected, each operator's facilities would be separately liable and would need separate proof of financial responsibility, according to Capt. Sherburne.

In addition, a platform producing oil and natural gas from different wells would be counted as two distinct facilities, he said.

The revisions in the regulations reduce the potential number of offshore facilities that will be individually liable, he noted.

That should relieve offshore operators choosing to meet financial responsibility requirements through insurance since each facility requires $35 million of liability coverage. An operator with 100 facilities would need $3.5 billion of liability coverage. Insurance industry sources say that type of capacity is not available.

In addition to insurance, offshore operators would be permitted to meet the financial responsibility requirements through self-insurance, guaranty, posting a surety bond or indemnification.

The proposed regulations required those not buying insurance to show varying degrees of financial responsibility based on the number of facilities they operated. The amounts ranged from $35 million for one facility to $50 million for five or more facilities. That sliding scale has been eliminated from the final regulation, Capt. Sherburne said.

Under the regulations, to be released this month, offshore operators must be certified for financial responsibility by Sept. 17 or face shutdown of their facilities or a fine of $10,000 per day. The deadline was delayed to allow time for startup of a "comprehensive oil pollution liability compensation fund" or "superfund."

The superfund, created by the 1976 law, would cover pollution losses in excess of $35 million per facility and would be funded up to $200 million by a three cents per barrel levy on oil produced offshore. However, the superfund is expected to take in only $40 million from oil production levies in its first year, requiring additional funding from the government.

Congress is expected to pass a bill this spring appropriating money for the superfund, according to Capt. Sherburne. Until that is enacted and the fund set up, no claims can be made against it or the offshore operators under the provisions of the act.

Operators who purchase insurance will probably try to buy coverage in advance to run from the start-up date of the fund, Capt. Sherburne noted.

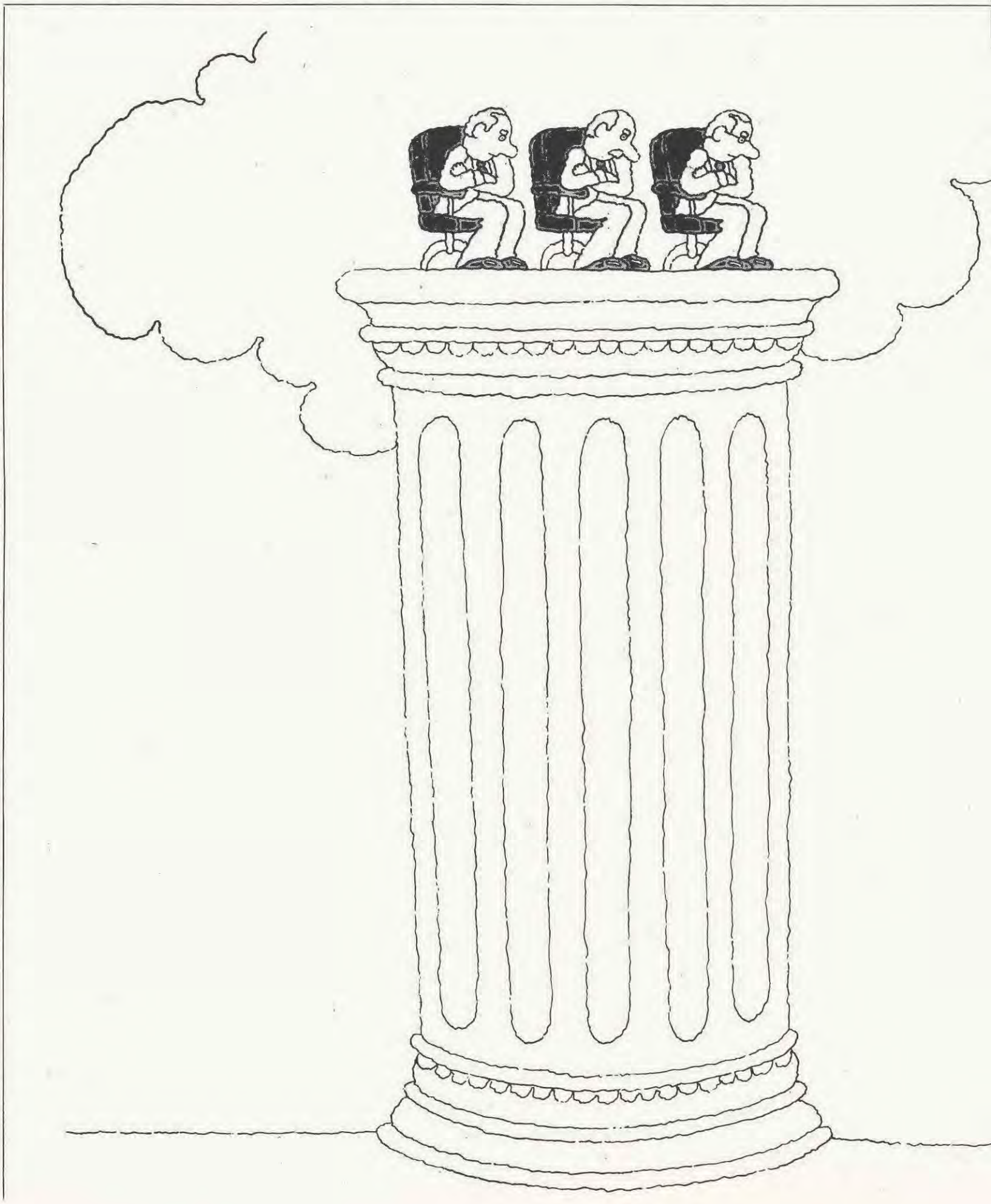
To date, only AIG Oil Rig has expressed interest in writing this coverage. The AIG-led pool has written pollution coverage against well blow-outs and other sudden and accidental losses in the past.

But the new law imposes a strict liability standard, said Roy Williams, AIG Oil Rig president. AIG Oil Rig has not yet determined how it will price the pollution risks. Mr. Williams predicted the coverage will be costly—well in excess of the three cents per barrel levy the government is seeking for its excess liability fund.

Crucial questions, such as claims procedures and whether offshore operators must compensate the government for lost natural resources (the oil itself), must be answered by the regulations, Mr. Williams said. The answers are likely to affect the pricing of the coverage, he added.

Offshore oil facilities have had a good record, causing much less pollution damage and losses than tankers.

Most large offshore oil operators are likely to self-insure the pollution exposure, predicted Charles Bailey, vp-risk management at Tenneco Inc. Small operators would be most likely to purchase insurance. ■



Each Sasse member liable for $250,000

LONDON—Members of Lloyd's syndicate F. H. Sasse & Others are being asked to kick in $250,000 each in order to pay for fire losses and computer leasing losses of $27 million suffered by the syndicate's policyholders.

Sasse's 110 members are now frantically searching for financial aid from Lloyd's or from other members of Lloyd's, appealing to the central organization with the argument that the self-regulatory system at Lloyd's failed to disclose mounting liabilities soon enough.

Sasse, it is now known, not only wrote policies covering many highly volatile risks, but it also went way over its premium limitation during 1976 and 1977, the years in which heavy losses were being recorded. Under Lloyd's rules, Sasse could only write $8 million in gross premiums during any one year. Sasse, however, recorded gross premium volume of $20 million during each of the two years.

Sasse was suspended in December 1977 for its activities. ■

June 10-13 in Chicago

BI conference slates debate on work comp rates

CHICAGO—Are workers compensation insurance rates fair?

Five experts representing the buyers, sellers and brokers of insurance will debate the answer during a face-off session at the second annual *Business Insurance* National Conference on Workers Compensation here June 10-13 at the Hyatt Regency O'Hare.

But that's just one of the topics of the three day conference designed to provide the experts and attendees with a forum to diagnose the causes and prescribe treatment for what's becoming the number one risk management headache.

During the three-day conference at six general sessions and eight concurrent sessions, speakers will dissect the problem from all angles: safety and loss control, claims, rehabilitation and the regulatory environment.

Debating whether or not workers compensation insurance rates are fair will be: William Cain, director of insurance and risk management at Dayton-Hudson Corp. in Minneapolis; Richard I. Fein, an actuary with the National Council on Compensation Insurance; Myra L. Tobin, vp in the casualty division of Marsh & McLennan Cos. in New York; Palmer App, president of the central division of Kemper Insurance Cos. in Long Grove, Ill., and Douglas Stevenson, a partner in Rooks, Pitts, Fullager & Poust in Chicago, representing the Illinois Manufacturers Assn.

What position risk managers should take on the issue of workers compensation regulation will be discussed by two outspoken risk managers, Howard T. Weber of 3M Co. in St. Paul and Michael Craig of Transcon Lines in Los Angeles. In addition, they will advise conference participants on how to counsel their corporations on the issue and if risk managers should stay involved in any corporate lobbying.

Federal regulation of the workers compensation system, which is again being considered in Congress, and federal intervention in the system, which is being proposed by two different federal task forces, will be analyzed.

Daniel M. Kasper, assistant professor at Harvard Business School, will forecast what impact federal regulation of workers compensation would have on employers, taking into consideration the different provisions the law might include.

Victor Schwartz, chairman of the task force on product liability and accident compensation in the Department of Commerce, will explain the potential impact of the provisions of the model product liability law on employers' liability for work-place accidents. The bill's provisions could potentially transfer to the employer liability for an injured worker's full wages during disability if the product associated with the injury is more than 10 years old and the employer was found liable for the accident.

Meanwhile, another task force studying work place injuries is recommending that employers be allowed to only tax deduct the average cost of workers compensation for their industry rather than the actual cost of the insurance as is now permitted. The task force's executive director Richard Bergman and employers' advocate Robert Collyer, executive assistant of UBA Inc. in Washington, will debate the merits of the proposal as an incentive to improve safety and reduce work-place injuries.

Conference participants will have their choice of attending four of eight different concurrent sessions, four each, to be held on two afternoons of the conference.

Investigating workers compensation claims and preventing fraud will be discussed on Monday by Jon Shebel, president of Associated Industries of Florida, a trade association which started a self-insured fund for workers compensation for its members. Meanwhile, Judith Stockman, director of safety for Weiser Lock division of Norris Industries in Southgate Calif., will discuss health screening as a loss control tool and answer the question, "What's an employer to do when he finds health problems in pre-employment or pre-replacement screenings?"

Funding workers compensation costs will be the topic of two other concurrent sessions the same day. Gus E. VonBolschwing of Golman & VonBolschwing and Richard Carroll of Richard Carroll & Co., both of San Francisco, will detail how an employer can fund a serious injury case using a capitalized technique versus annuities to limit the ultimate liability. At the other session, Joseph A. Destein, president of Risk Sciences Group in Santa Monica, Calif., will describe how to calculate workers compensation reserves.

On Tuesday the concurrent sessions pick up the funding theme with Robert A. Reeves vp of insurance at Hospital Corp. of America in Nashville, answering the question, "Should you use your captive for workers compensation?" Donald R. Czerniach, vp-manager of the administrative claim service department at Fred S. James & Co. of New York, will direct another session on auditing and monitoring the workers compensation program.

Preventing accidents and rehabilitation of accident victims will be discussed in the two other sessions on Tuesday. Michael Krikorian, corporate manager of safety for Brunswick Corp. in Skokie, Ill., and James Dugan, manager of safety at Allegheny Ludlum Industries Inc. in Pittsburgh, will share their expertise in safety and loss prevention in one session while Gayle C. Foster, assistant secretary for General Reinsurance Corp. in Greenwich, Conn., describes the rehabilitation effort, an often ignored tool in controlling workers compensation costs, at another.

BI's first workers compensation conference was held in July 1978, drawing 158 corporate executives and experts on workers compensation from around the country who discussed and analyzed workers compensation issues.

The registration fee for the 1979 conference is $385 for the first person from a company and 10% less for additional registrants from the same company.

For registration information write or call Sari Lipschultz, Crain Education Division, 740 N. Rush St., Chicago, Ill. 60611; phone (312) 649-5246. ■

editorial opinions

New perspective on pensions

THE IMPORTANCE of pensions isn't simply a matter of our editorial views on the subject. The University of Michigan's survey research center—the same people who study consumer purchasing plans—revealed that a majority of working people would rather have an increase in retirement benefits than a 10% pay hike, if given the choice.

Employers can infer from this that their workers know all too well what inflation will mean to them in later years. And Congress should recognize that the private pension system is viewed by employers and employes alike as a critical part of life in America. The 54% of the people surveyed who would forego a salary boost to take improved retirement benefits are looking to their private pensions, not to a bankrupt Social Security system, for income after they retire.

Jane Bryant Quinn's column in Newsweek Feb. 12 rated different kinds of pension plans. Her thesis is that one's pension benefits don't so much depend on the difficulty of the work or the amount of pay achieved, but on "where you are lucky (or unlucky) enough to work." And this just isn't fair, she maintains.

Interestingly, Ms. Quinn assigned the highest ratings to government pension plans—military, police and firefighters, civilian municipal employes and federal civilian employes—all providing extremely generous retirement pay as well as exceptional death and disability benefits. At the bottom of the list were big company plans, pensions for self-employed professionals, small company plans and workers not covered by pension plans.

Almost all public sector workers are covered by pension plans, though only about half the employes in the private sector earn retirement benefits. Moreover, most public sector pension plans contain automatic cost-of-living escalators, though few private sector plans do.

Her conclusion: It's unjust for private sector workers, with skimpier pensions, to be heavily taxed to pay for fat-cat pensions common in the public sector.

A disappointing outcome of the federal pension law was that with the 10-year vesting rule, most employers opted for "cliff vesting," requiring employes to stay at a company fully 10 years before being 100% vested in the pension plan, with full vesting in the tenth year but no partial vesting in the first nine years. Although most people count on their pension plan to take care of them after retirement, millions of people for one reason or another will never earn a full pension because they won't or can't stay with one company long enough to earn full vesting. This is a critical weakness of the pension system, one that demands legislative attention in order to help take the burden off the bankrupt Social Security system. Just as the law now allows people not covered by a pension plan to invest in an IRA, Congress should allow those covered by a pension plan but not fully vested to invest in an IRA up until the time they become fully vested (usually only after 10 years with a company).

Money invested in an IRA by individuals not fully vested to provide future benefits for themselves should be tax deductible for people earning less than, say, $30,000 a year. The amount that could be invested in an IRA should be raised to 10% of salary (the present rule) or $3,000, whichever is less. Presently the limit is $1,500, much too low to allow people to plan for their future. The $3,000 limit should also be indexed for inflation.

Doctors galore

A HOUSE OF REPRESENTATIVES subcommittee has taken a close look at the way Blue Shield plans work and doesn't like what it sees. Doctors, the study found, dominate the boards of almost all Blue Shield plans. Therefore, any effort to contain costs—hospital fees or doctor fees—is likely to be thwarted.

The study also revealed that insurance buyers are systematically excluded from the governing bodies of Blue Shield plans.

What we end up with is a system of interlocking directorates on the Blue Shield plan boards: The reimbursers of medical costs—Blue Shield—are governed by hospitals and doctors who get reimbursed.

The subcommittee suggests there ought to be a law. We don't think there needs to be another law, but some close scrutiny of both Blue Cross and Blue Shield by the Federal Trade Commission is warranted. Neither Blue Cross nor Blue Shield deserves leniency merely because of the plans' status as pseudo-public entities.

"Hey, Mr. Corporate Boss, are you trying to tell us how to control our costs. . . ?"

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, 740 N. Rush St., Chicago, Ill. 60611.

Political diatribe

To the editor: The riskWatch column in the Feb. 19 edition was such a thinly disguised political diatribe that I thought for a moment I was reading a weak imitation of Anderson or Buckley. Such reporting does not deserve a featured spot in any industry publication—if Sen. Jepsen were from any other state would the story have been written?

There are many insurance schemes which deal with remote loss possibilities. This factor alone hardly makes a plan dishonest. However, Mr. Walsh clearly implies that this is the case in his comments regarding Sen. Jepsen's plan.

In the future, I for one would prefer to see editorial comment in the editorial section, and informative, industry related comments in riskWatch.

A.E. Knowski

Oak Lawn, Ill.

Ideal correction

To the editor: As attorneys for Ideal Mutual Insurance Co., we wish to point out a significant error in your Feb. 19 article. You state that "Ideal Mutual acted as a fronting company for A&P . . ." The term "fronting" connotes acting for or aiding an unauthorized insurer in a jurisdiction in which it is not licensed. "Fronting" is an illegal activity in all jurisdictions. Ideal Mutual Insurance Co. does not engage in any activity which is illegal.

Gerald Dolman

Bennett, Ayervais & Bertrand, New York, N.Y.

Overseas risks

To the editor: Your very interesting article in the Feb. 19 issue on "U.S. firms overseas ship locally again" came in time to fortify our company's newly established office in the States.

Since a number of U.S. producers are involved in the Mideast, Near East Agencies has established an office in Houston. Our aim is to collaborate with all insurance agents and brokers in the States to give them the opportunity to capitalize on our knowledge of the local conditions and to provide them with the local policies

Continued on page 74

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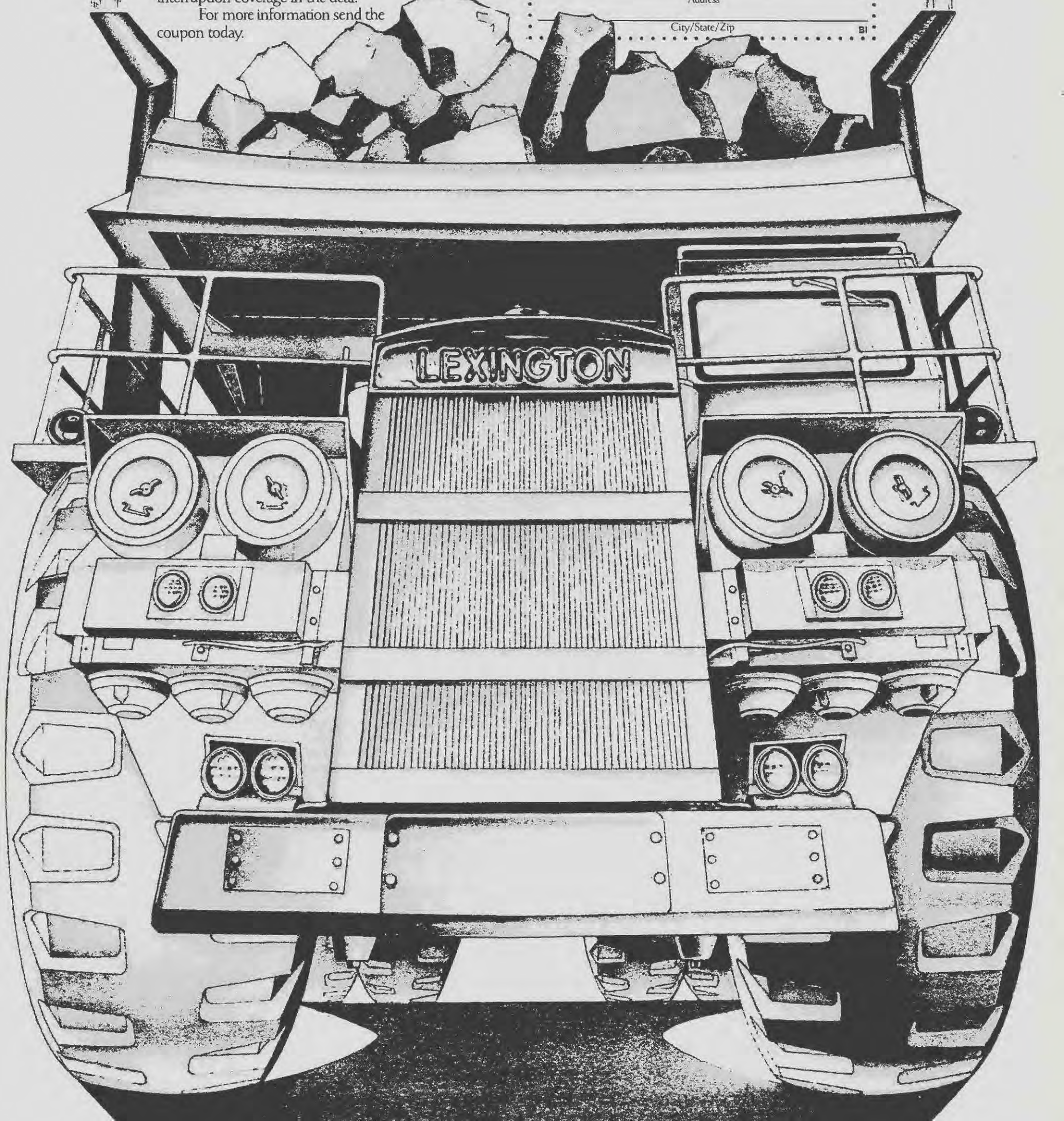


To cut costs

Md. seeks new system for employes' pensions

ANNAPOLIS, Md.—Future state employes and teachers will receive smaller pension benefits than their predecessors here if legislation aimed at controlling rising costs and improving funding of the state pension systems becomes law.

The bill was given preliminary approval on second reading by both houses of the General Assembly and is expected to be passed on a third reading shortly. Pension benefits for present employes would not be affected by the legislation.

New employes would be required to join the new system and existing employes could also choose to do so. The new system is noncontributory while the existing system requires employes to kick in 5% of their after-tax earnings.

Under the new pension plan, benefits would be based upon average salary for the three highest consecutive years while the old plan reflected the average earnings over three years of highest earnings.

For each year of service, beneficiaries under the new system would receive 0.8% of their average salary for amounts up to the Social Security integration level and 1.5% of their average salary for amounts in excess of the integration level. The existing system provides benefits of 1.82% of the three-year average salary for each year of service.

The Social Security integration level is the average of the wage base for each year of an employe's service.

Under the existing system, a retiree with 20 years of service and benefits based upon a $20,000 three-year average would receive an annual pension from the state of $7,280. If the same employe were to retire under the new system at a $12,000 integration level, annual pension benefits would be $4,320.

In addition, the new system has a 3% annual cap on cost of living adjustments to pensions while the existing system, the only state system providing cost of living adjustments, has no cap.

A 40-year projection on future pension costs showed that under the existing system, pensions would cost the state $6.2 billion in fiscal year 2021 versus $3.6 billion under the proposed changes, explained Eugene Burner of the General Assembly fiscal services department.

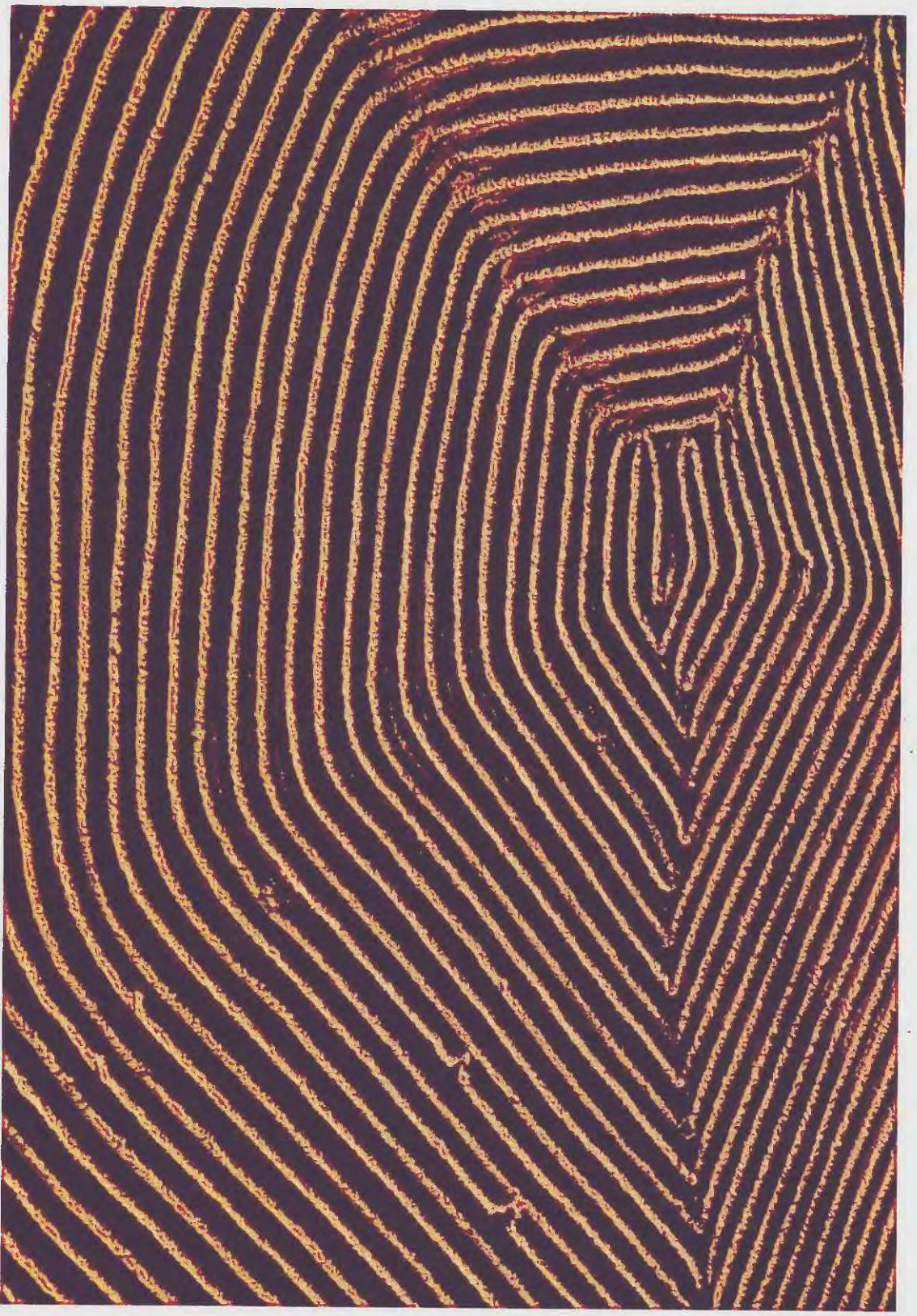
Between 35% and 40% of current pension liabilities are now met on a "pay-as-you-go" basis and this could rise to 80% by 2021 if the existing system were retained, Mr. Burner said. The new scheme anticipates the system being fully funded by 2021 as the result of increased funding now to amortize unfunded future liabilities, he explained.

The legislation calls for fiscal 1981 funding of $254.3 million compared with $222.2 million under the existing system. However, the new system should reach the break-even point around 1999 and produce increasing savings in the years to come, Mr. Burner maintains.

Under the new system, pension costs would run 11.66% of state payroll in fiscal 1981 compared with 10.19% under the existing system. By 2021, costs under the existing system could rise to in excess of 13% of payroll compared with 7.55% under the proposed plan.

Current state employes and teachers who choose to join the new system would effectively receive a 5% increase in take-home pay since they would no longer make contributions to the system. In addition, prior contributions would be refunded with 4% interest.

Maryland tried to pass identical legislation in 1978. The bill passed the Senate, but election year opposition resulted in its failure in the house of delegates. Minimal opposition is expected this time around. ■



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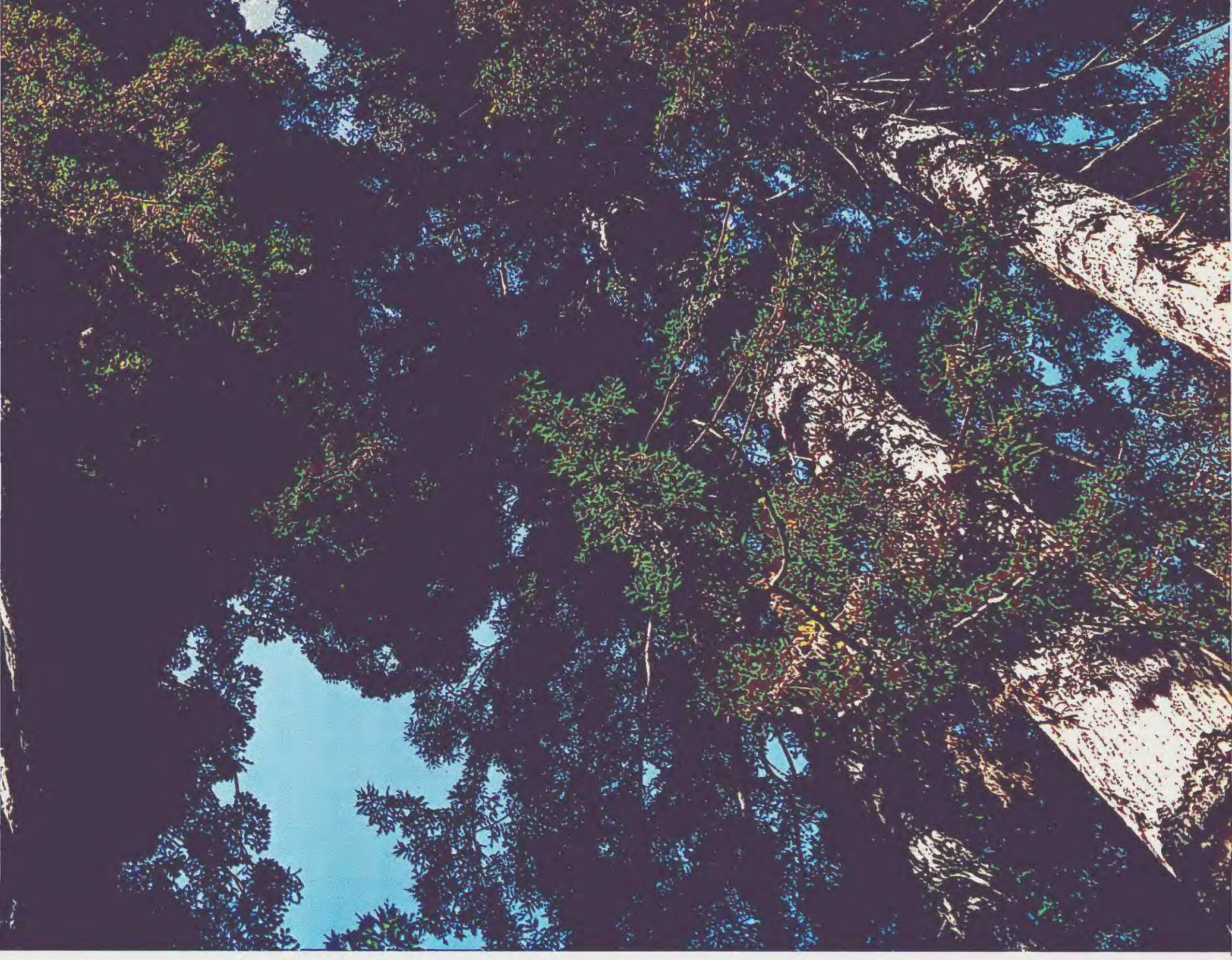

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*Employee Benefit Plan Review April 1978

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Early legal plan usage substantial, says UAW

By JOHN MAES

DETROIT—Administrators of the United Auto Workers legal services program for hourly-paid Chrysler employes report substantial usage of the plan in its first months of operation.

But union officials refuse to admit right now that prepaid legal benefits will be an issue when the auto workers and manufacturers sit down at the bargaining table soon for contract talks. There's little doubt, however, that legal benefits for all auto workers will be a future bargaining item. A union spokesman said the matter will be addressed at the UAW's collective bargaining conference next month.

The Chrysler plan, which covers 150,000 current and retired employes and their families with limited legal services, has received inquiries from 5,500 members in the first five months of operation. They "at least talked to an attorney over the phone," concerning a legal problem, said Richard Scupi, director of legal services for the UAW.

"We had anticipated usage at about half the rate we're getting now," said Mr. Scupi. He acknowledged that inquiries have been so numerous that current funding could run low if the trend continues.

If that happens, current benefits would be maintained instead of expanded in future years as was originally planned, he said.

"But we'd be more concerned about a low response," Mr. Scupi said. "If that had been the case we probably would have looked at it and said, 'We should have spent that money on something else.' There are ways to adjust to usage. A high response was what we wanted."

The program is being paid for with some $20 million in special funds set up 18 years ago by Chrysler employes as a reserve in anticipation of massive auto industry layoffs in the 1960s. Chrysler workers paid five cents for each hour worked into the fund between 1961 and 1964, but the layoff problem never developed as feared. In 1977, it was decided to use the money to finance a legal service program.

The program is designed to operate through 1982 with a portion of the fund allocated for each year. For 1979, $4 million has been budgeted. Of that amount, $1.26 million has already been spent, said Mr. Scupi.

So far, expenditures include "start up" expenses for offices, equipment, staff and the salaries of 60 lawyers. The main office is located in Detroit with other offices operating in: St. Louis; Indianapolis, Kokomo and New Castle, Ind.; Perrysburg and Twinsburg, Ohio; Newark, Del.; Elkton, Md.; Syracuse, N.Y., and Belvidere, Ill. In some of these cities, closed and open panels exist.

The plan covers legal fees for real estate matters, debt collections and garnishments, repossessions and bankruptcy along with consumer complaints and warranties, insurance problems, tax matters, will preparation and research, correspondence and other office work.

Uncontested divorces are also covered, but the plan does not extend to payment of fines, penalties and jury awards, tax preparation, workers compensation or criminal cases. There is a referral service for matters not covered by the plan. The referral fee is paid for by the plan, but not the referral attorney's fee for his or her services.

Of the cases handled so far, 18% have involved probate and tax matters, 18% involved housing and real estate affairs, 21% were for consumer-related cases and the remaining 43% involved family problems and referrals, according to UAW statistics.

When trustees conducted initial meetings to determine the benefit schedule, they considered offering full, unlimited services for all legal problems until the fund was exhausted. "Once the trustees got to work on the plan they made the basic policy decision that money was to last five years," Mr. Scupi said. ■

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Personal injury awards jump in Illinois: Report

CHICAGO—Blockbuster verdicts in personal injury suits in Cook County here could produce a record year in verdict awards in Illinois, says the Illinois Insurance Information Service in its Illinois Jury Verdict Reports.

The average judgment per successful plaintiff in personal injury cases in Cook County jumped to $84,528 for the first half of the 1978-79 court term, up from $63,066 for the full 1977-78 court term. A total of $13.7 million was awarded to 162 plaintiffs, giving the plaintiffs 49.5% of all verdicts rendered.

Driving up the average award was a $1.5 million civil rights award against four Chicago policemen accused of the assault and death of a suspected rapist.

The Illinois Insurance Information Service, an association of leading Illinois insurers, compiles jury verdict statistics periodically for its members based on information provided by the insurers and attorneys in Downstate Illinois and from statistics compiled for Cook County by the Cook County Jury Verdict Reporter.

Meanwhile, the average judgment awarded in all 102 counties in Illinois increased to $73,221 at mid-term from the average of $59,319 reached in the 1977-78 court term, pushed up by the high verdicts in Cook County. In all, $15.7 million was awarded to 215 plaintiffs, 49.1% of all verdicts rendered.

The average judgment in Downstate Illinois, all counties exclusive of Cook, actually fell to $38,659 at mid-term this year from $42,970 in the full 1977-78 court term. Verdicts for the defense are leading plaintiff verdicts in Downstate Illinois courts, with defendants winning 52% of the cases—the highest successful defense record since 1970-1 when the plaintiffs won only 46.5% of the cases at mid-term. In total, $2 million was awarded to the 53 successful plaintiffs. But the majority (79%) of the cases are traffic cases in which plaintiffs were successful only 48% of the time winning an average judgment of $22,384. Current litigation in non-traffic cases, 54% were decided for the plaintiff at an average verdict of $100,800. In all, non-traffic cases represent only 21% of the personal injury cases.

Only one of the five product liability cases brought to trial in Downstate Illinois during the first half of this court term resulted in verdicts for the plaintiff. In that trial, a bicyclist was awarded $43,000 for injuries he suffered when the front wheel of his bicycle collapsed.

Of the four malpractice cases brought to trial in Downstate Illinois by mid-term, two were medical and two were financial. The Cook County Jury Verdict Reporter noted fewer malpractice cases are coming to trial but more are being settled in Downstate as well as Cook County.

But work injuries continue to bring in awards for the plaintiffs. In six cases reported to Illinois Jury Verdict Reports, only one was won by the defendant and the average verdict per successful plaintiff was $164,040.

Wrongful death cases in Downstate Illinois are running 60% for the plaintiff. Of the 10 wrongful death cases brought to trial in Downstate Illinois, the plaintiffs won six for total awards of $328,617 and an average verdict of $54,002.

Last year at mid-term, the plaintiff was winning 30% of the wrongful death cases but the average verdict was higher at $118,333, falling to $73,750 by the end of the court term. "This may be the year when we see the lowest average verdict Downstate since the removal of the $30,000 limitation," suggests the Illinois Insurance Information Service.

Cook County Jury Verdict Reports also has compiled new verdict statistics for the calendar year. In 1978, 967 product liability suits were filed, down just 2.4% from 1977. Meanwhile, the number of medical malpractice suits filed in 1978 skyrocketed 32% to 1,102 in 1978 from just 830 in 1977. Of the 1,102 malpractice suits filed last year, in Cook County 771 were medical malpractice and 331 cited financial malpractice. ■

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Through such a program we can determine what people can do, despite any disability, and then try to find a way to return them to their original jobs or suggest ways to modify a job to make it less demanding. If that is not feasible, we direct them in securing work with other employers.

Many, many valuable individuals—who otherwise may have been left to gather dust through unemployment—have been returned to healthy productive lives in the labor market through our services. This also has saved a great deal of money for those who were involved in supporting the unemployed individual.

So if you happen to be involved in workers' compensation, long term disability, or other programs involving disability coverages, our services could save you a lot of money. For complete details, just write: Crawford Rehabilitation Services, Inc., P.O. Box 5047, Atlanta, Ga. 30302. **Crawford Rehabilitation Services, Inc.**

Retreads roll with Lloyd's liability plan

By JERRY GEISEL

LOUISVILLE—Three years ago the product liability insurance market for tire retreaders blew up.

"There was absolute chaos in the industry," recalled Ed Wagner executive vp of the American Retreaders Assn. (ARA). "We had members whose policies were cancelled even though they never had a claim. Other companies were hit with exorbitant premium increases."

But tire retreaders no longer have to worry about their insurance plan going bare. A new group insurance program has begun rolling and it will not only give the retreaders the coverage they need, but it also will save them big premium dollars.

The program, which is underwritten by Lloyd's of London, offers tire retreaders $1 million of product liability protection. Each policy carries a $500 deductible. Excess coverage is available through Frank B. Hall of California, which is managing the program.

Currently, the cost of coverage for the group plan is 10 cents per tire. However in July, the rate will dip to nine cents per tire. Prior to the program, tire retreaders had been paying anywhere from 20 cents to 50 cents per tire, when the coverage was available.

Retreading Consultant Services Inc., a Louisville firm specializing in tire and retread plan analysis, will provide loss control services. Experts from Retreading Consultant Services will inspect each retreader's factory and inspect and test the plant equipment and retreaded tires.

The group product liability insurance program eventually could attract as many as one-third of the ARA's 1,500 members, Mr. Wagner said. A tire retreader must be a member of the trade association in order to join the program.

The size of premiums tire retreaders will pay for the group program probably will range from $500 to $10,000, although a few smaller retreaders may pay much less, said Bill Freeborn, vp of Frank B. Hall of California in Oakland. The average premium is expected to be around $3,500.

After three years of relentless premium increases, Frank B. Hall was hired to develop an alternative insurance program. The domestic market shied away from insuring retreaders risks, so Mr. Freeborn flew to London to discuss a group program with Lloyd's.

Lloyd's was receptive to the idea of underwriting a group program. While domestic insurers got edgy when the word retreader was mentioned, Lloyd's knew that retreaders are an acceptable risk based on its own experience in underwriting a similar group program for the Tire Retreading Institute, Mr. Freeborn said (*BI*, Sept. 20, 1976).

A captive was explored, but the tire retreaders opted for the group insurance program with Lloyd's because "it gives us the coverage we need without having to make the investment that is needed to start a captive," Mr. Wagner said. ■

Ambulance insurance

Liability insurance for paramedics and ambulance drivers is available from Hull & Co. (California) Inc. of San Francisco. The package offers primary limits of up to $500,000 with excess limits and umbrella coverage available.

DOES YOUR COMPANY OFFER ON-THE-JOB TRAINING?

Many successful American companies, big and small, have found that company sponsored health and exercise programs can be of great benefit to an organization's health.

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Company programs range from health education, to exercises an employee can perform at his desk, to workouts at nearby YMCAs, to supervised activities at extensive company facilities.

A good example of the latter is Kimberly-Clark's Health Management Program. First, employees voluntarily go through extensive testing in Kimberly-Clark's multiphasic health testing facility. They receive an individualized health prescription that includes health education and medically supervised exercise in the 32,000 square-foot physical fitness facility adjacent to corporate headquarters.

Kimberly-Clark and other bold and imaginative companies realize one important thing: that fitness programs have the potential of returning enormous dividends in greater health and happiness for employees. And greater productivity from them.

It also stands to reason that if your company can institute a program to keep your employees healthy and well, your company's health care costs can possibly be lowered.

As you know, Blue Cross and Blue Shield Plans are fighting a nationwide battle to keep costs from running away.

Programs such as second surgical opinion, medical necessity programs, home care, health maintenance organizations, same day surgery, pre-admission testing and the like are in use in many Plans with positive money-saving results. As successes are achieved, the results are shared so that knowledge gained by solving local problems can be applied on a wider basis.

We're encouraged. The average length of hospital stays for Blue Cross Plan subscribers under age 65 dropped by almost a day between 1968 and 1977. That may not sound like much. But if the length of stay were the same today as it was in 1968, we would be paying an additional $1,249,869,813 a year. In addition, the rate of hospital admissions for these subscribers dropped by 4.9%, representing $554,938,847.

But controlling health care costs without sacrificing quality is a complex problem. One we all need to work on together.

While Kimberly-Clark's program is an extensive one, there are health programs to fit any company, no matter what its size.

Blue Cross and Blue Shield Plans would like to help you. If you would like more information about employee fitness programs, write for the free booklet "Building a Healthier Company," Box 8008, Chicago, IL 60680.

Watch the first telecast of the Boston Marathon, made possible by a grant from the Blue Cross and Blue Shield Associations, Monday evening, April 16, on PBS. Check your local TV listing.

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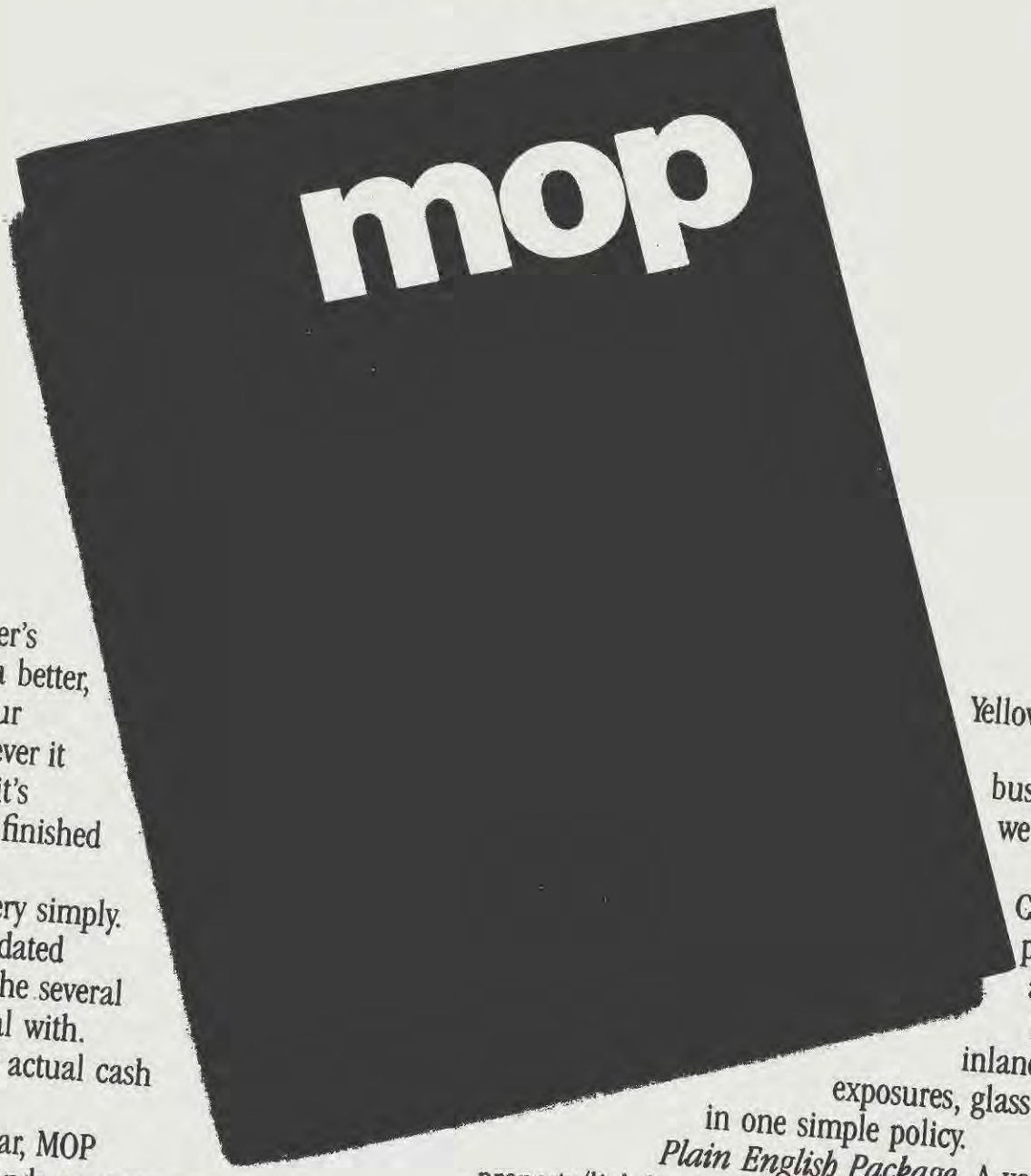

The St. Paul Manufacturer's Output Policy (MOP) is a better, simpler way to protect your company's property, wherever it is. And in whatever form it's in, from raw materials to finished products.

And you can do it very simply. MOP coverages are consolidated into one policy instead of the several you'd normally have to deal with. Property can be insured for actual cash value or selling price.

During your policy year, MOP coverage automatically expands or contracts according to the value of property covered. That way, your assets are protected in peak or slow times. Whether inventories are high or low. Whether your firm is receiving, shipping or storing materials. Or all of these. All in one policy. There's also automatic coverage for new non-manufacturing facilities without notifying The St. Paul.

What's more, there's usually no deposit premium, which lets you handle premiums on a pay as you go basis. Which, in turn, can help cash flow. Good loss experience and deductible options can keep your insurance costs down.

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Umbrella Excess Liability. One million dollars excess liability coverage on small businesses for as little as $200 per year. Can also handle larger accounts with limits up to $20 million.

Commercial Auto. The St. Paul has the expertise, people, resources and stability to back you strong in this coverage.

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46 states pay higher workers comp benefits

WASHINGTON—In 1978, about 180 laws covering almost every aspect of workers compensation were enacted by state legislatures, the Labor Department reports in an annual survey of state activity.

Forty-six states boosted weekly payments for temporary total disability. Payments now range from a low of $87.50 in Arkansas to a high of $607.85 in Alaska.

Connecticut raised the proportion of the state's average weekly production wage, upon which maximum benefits are based, to 85% from 66%.

West Virginia increased the percentage of the employe's wage, upon which compensation is based, to 70% from 66% while Delaware changed the maximum weekly compensation payable for permanent partial disability to 66% of the state's average weekly wage.

Still, not a single state has yet enacted all 19 improvements to their workers compensation laws that a 1972 national commission recommended as "essential."

States that raised the maximum weekly temporary total disability benefits during 1978 follow:

State	New	Old
Ala.	$128.00	$120.00
Alaska	$607.85	$551.86
Ariz.	$192.32	$153.85
Ark.	$ 87.50	$ 84.00
Colo.	$173.60	$161.42
Conn.	$160.00	$147.03
Del.	$154.50	$144.00
D.C.	$396.78	$367.22
Fla.	$126.00	$119.00
Ga.	$110.00	$ 95.00
Hawaii	$189.00	$179.00
Idaho	$109.80 to $164.70	$99.00 to $148.50
Ill.	$321.50	$304.21
Iowa	$265.00	$247.00
Kan.	$129.06	$120.95
Ky.	$112.00	$104.00
La.	$130.00	$ 95.00
Maine	$231.72	$220.93
Md.	$202.00	$188.00
Mass.	$211.37	$150.00
Mich.	$142.00 to $171.00	$127.00 to $156.00
Minn.	$209.00	$197.00
Mo.	$115.00	$ 95.00
Mont.	$188.00	$174.00
Neb.	$155.00	$140.00
Nev.	$212.02	$198.22
N.H.	$180.00	$169.00
N.J.	$146.00	$138.00
N.M.	$172.46	$142.59
N.Y.	$180.00	$125.00
N.C.	$178.00	$168.00
N.D.	$180.00	$171.00
Ohio	$216.00	$198.00
Okla.	$132.00	$121.00
Ore.	$224.16	$213.78
Pa.	$213.00	$199.00
R.I.	$176.00	$166.00
S.C.	$172.00	$160.00
S.D.	$155.00	$130.00
Tex.	$105.00	$ 91.00
Utah	$197.00	$183.00
Vt.	$181.00	$170.00
Va.	$187.00	$175.00
Wash.	$175.30	$163.28
W. Va.	$224.00	$208.00
Wis.	$202.00	$189.00
Wyo.	$211.15	$189.96

Source: Department of Labor, Monthly Labor Review. ■

Fire destroys Austrian store

VIENNA—Property coverage on a six-story department store that burned to the ground here last month was split among 15 Austrian insurance companies, according to knowledgeable sources.

Austria's largest department store, Kaufhaus Gerngoss, was destroyed after a fire broke out in its basement. The store was partially equipped with sprinklers and smoke detectors but the sprinklers reportedly were shut off while welders repaired an escalator.

The store burned for two days and was declared a total loss. Estimates of damages ranged from $45 million to $107 million.

Business Insurance learned Angelo Elementar Vienna and Erste Allgemeine Insurance Cos. were the lead underwriters with major shares of the risk handled by Wiener Staedtische, Donau and Bundeslandner Insurance Cos.

Minor participants were Wiener-Allianz, Riunione, Interunfall, Basler, Erste Neiperoesterreich, Heimat, Oderoesterreich, Garant, Austria and Anker Insurance Cos.

Sources said American participation on the reinsurance was minimal, if any. ■

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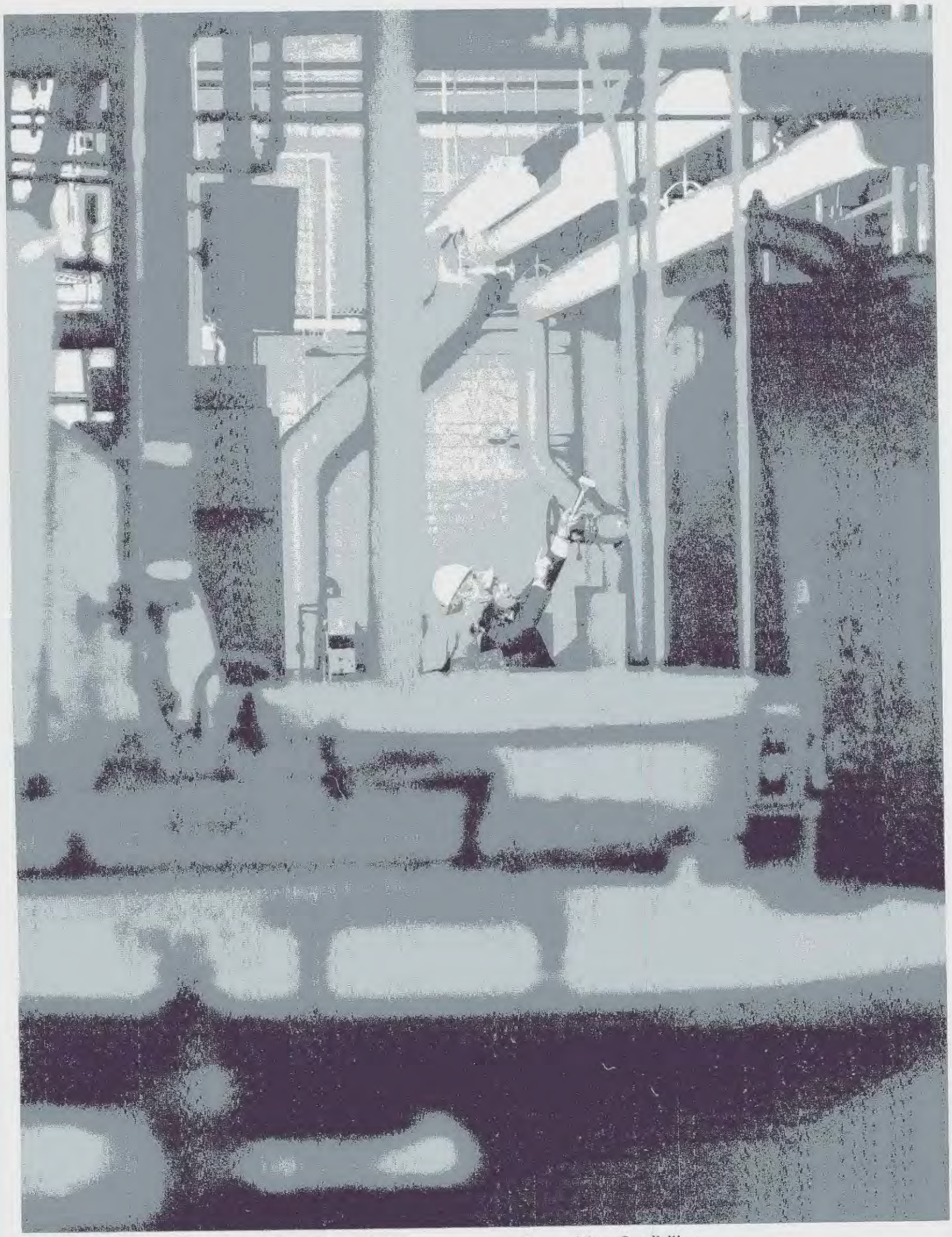

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Calif. cumulative injury claims, costs soar: Study

By MARGARET LeROUX

SAN FRANCISCO—Cumulative injury losses cost California employers more than $200 million in 1978, a 45% increase since 1976, according to a report by the California Workers Compensation Institute (CWCI).

Cumulative injury settlements, which averaged $9,027 per claim in 1978, accounted for 3% of all lost-time injuries in the state, more than triple the rate of five years ago, the report stated.

The total out-of-pocket legal expenses associated with cumulative injury cases in the 1978 study amounted to 133% of the cost of medical treatment of such injuries.

Insurers who participated in the CWCI study reported a 30% increase in new claims submitted in the first two months of 1978 than in the same time period in 1977.

Predicting a continuing increase in cumulative injury claims, the CWCI offered a series of remedies. Among them: restructure the benefit delivery process and permanent disability benefits to assure payments are directed for their intended purpose of compensation, and not, for instance, supplemental retirement benefits.

The report also recommended a more equitable method of allocating the cost of cumulative injury so the eight-hour workday is not held solely responsible for all conditions resulting from or contributed to by other factors during the remaining 16 hours of the employe's daily routine.

Although cumulative injury has been part of the California workers compensation system for 20 years, as recently as 1974 claims for cumulative injury were less than 1% of all work injuries.

Cumulative injury claims now account for 3% of all lost-time injuries in California.

The cumulative injury doctrine developed through a series of California court decisions that gave increasing recognition to the cumulative effects of job related stress and strain that precipitate a compensable disability.

The landmark decision in 1959 stated that an employe's back injury was due to the cumulative effect of work aggravating a pre-existing condition. In the words of the court, "... while a succession of slight injuries in the course of employment may not in themselves be disabling, their cumulative effect in work may become a destructive force..."

The CWCI report also found that employes receiving benefits for cumulative injuries continue to be significantly older than other injured employes: a median age of 51 compared to the average age of 33 for the injured workforce. Half the claimants are 52 years or older, the report stated, with back injuries, heart and vascular disorders and loss of hearing comprising 70% of the cases.

The CWCI concluded these findings suggest some cumulative injury dollars are being misdirected, in part to compensate for non-work related disorders and in part to supplement retirement benefits.

While heart and vascular injuries accounted for 39.9% of the total cumulative injury benefit dollars in 1978, injuries to arms, legs, hands and feet of employes (under the general category extremities) were 54% of all disabling injuries.

Back injuries made up 24.9% of all disabling injuries and 26.9% of total cumulative injury benefit dollars in 1978.

The average heart case cost $15,942, according to the CWCI, more than double the $7,127 value of an average cumulative back injury claim.

Municipal employes received 39.7% of all cumulative injury benefits paid in 1978, according to the report. Clerical and professional employes received 16.6% of the total cumulative injury benefit dollars.

They are followed by the metal working employes who received 8% of all cumulative injury benefits paid in 1978; utilities and service employes with 7.2%; wholesale and retail employes with 6.5%, and construction workers with 6.1%.

The cumulative injury loss distributions are influenced by two factors according to the CWCI: the statutory presumptions of compensability for heart trouble and certain other conditions of public safety employes, and the recent trend to permissable non-insurance by many governmental agencies.

The non-insurance or self-insured plans instituted by numerous municipalities in recent years are the principal factors in the downward shift in percentage of total cumulative injury benefits paid municipal employes from 1977 to 1978, the report suggests, because self-insurance takes the municipalities' experience out of the reported statistics. In 1977 municipal employes received 54.3% of these benefits according to the report, the following year 39.7%.

The CWCI estimated that it costs $2,202 in legal expenses to deliver $8,184 in net benefits to a cumulative injury claimant, resulting in a litigation overhead of 27%.

Almost all (98%) cumulative injury claims are litigated. The insurer's first knowledge of the injury, according to the CWCI, is almost without exception the notice of controversy from the employe's attorney.

Compromise and release agreements resolve more than two-thirds of all cumulative injury cases, the report stated. The extensive use of these agreements may also reflect the uncertainties inherent in attempting to distinguish in both a medical and legal sense, between casual effects of employment and the bodily wear and tear of everyday life, the CWCI concluded.

The CWCI recommended a reappraisal of the "liberal construction" provision of the California workers compensation law. Reasonable doubt should be resolved in the injured employe's favor, the report stated, but acceptance of that concept should not preclude an unbiased, factual determination that recognizes the rights of all parties. ■

Security group elects officers

WASHINGTON—Three new corporate officers including chairman, president and vp have been elected to the American Society for Industrial Security for 1979.

Don W. Walker, corporate director of security for Genesco Inc. of Nashville, Tenn., has been named chairman of the board; Carl L. Carter, vp of the National Bank of Detroit, has been installed as president and Albert S. Davis, currently corporate security director for Owens-Illinois Inc. in Toledo, Ohio, has become first vp. ■

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Benefit plans can sell employes on relocating

CHICAGO—The employe benefit package may become a more powerful relocation negotiating tool in the future as housing markets shrink and government scrutinizes the use of company perquisites, says an employe benefit consultant here.

Today companies are cutting back on the more elaborate means of persuading an executive to make a move such as company purchase of the employe's old house, house-hunting counseling in a new location, company car, luncheon club memberships and added prestige and titles, according to Robert James, director of employe benefits consulting services for Hay Associates in Chicago.

Instead, companies are turning to profit sharing programs, stock options, higher levels of health, accidental death and dismemberment and life insurance, free legal counseling coverage and free physical examinations to sway the executive to relocate, Mr. James maintains.

There are generally five reasons for relocating an employe: to fill an immediate need in another part of the country, to retain an employe, to enhance executive development, to challenge an employe or move a person from the corporate mainstream, the benefits consultant explained at a seminar here recently.

"Modifications in the employe benefit package is one of the easiest and most effective ways to meet the demands and the needs of the relocated employe in one sweep," Mr. James noted.

"Common to all relocation decisions and a concept which must be communicated is that financial security is the reward for making the move," the benefits consultant explained. "Without the communication of this fact, the employe benefit package can lose its impact on the executive, consequently making it the most underrated and overlooked plus in an employe relocation."

Mr. James bases his opinion on results of a recent employe benefits survey of 529 companies nationwide prepared by Hay Associates, a benefits consulting group, which reveals that benefit levels among relocated top executives increased while other employes' benefit levels remained the same or increased by no more than 1% (*BI*, Dec. 11, 1978).

Stock vehicles and equity plans are increasing right along with the benefit levels, Mr. James noted. "More executives find the prospect of capital gain much more attractive and satisfying than the status symbols of executive power once found in the company plane or car."

Another advantage in using the employe benefit package more in relocation negotiation is that the employe benefits market is not as widely diverse as current real estate markets. "Contrary to what most company executives think, benefit levels are, for the most part, equivalent nationwide," Mr. James explained.

For example, benefit costs in Texas are not really that much lower than those in San Francisco. However, the difference in cost for a house in El Paso, Tex., is much lower than one in San Francisco. "In other words, employe benefit modifications are much easier to handle in the relocation process and can be just as effective as making up the difference in real estate costs from one area to another," he said.

The only problem with employe benefits in the relocation management of companies is that it is a vastly untapped resource of persuasion, Mr. James added. "The only way that problem can be solved is to refine and improve the communication of the importance of benefits to the person designing the relocation policy of the company and to the executive trying to decide whether relocation is in his best interest." ■

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Malpractice awards up 94% in 6 years: Study

WASHINGTON—The size of the average medical malpactice award doubled over a recent six-year period, according to a just-published massive survey by the Department of Health, Education and Welfare.

In 1976, the average malpractice award was $27,708, almost double the 1970 average award of $14,281. Also in the six-year period, the size of the average award increased at twice the clip of the general inflation rate.

The HEW study is based on a survey of all medical malpractice claims closed between July 1, 1976, and Oct. 31, 1976, by nine major underwriters who agreed to supply claims information on the condition they wouldn't be identified. These nine insurers were involved in 84% of claims closed by private carriers in 1976, according to the report.

Of the 3,932 claims that were closed in the four-month period, 47% of the claims resulted in an award. Nearly all of the awards (93%) resulted in payments of more than $500 to the injury victim.

The longer it took to settle a claim, the higher the award was likely to have been. For claims settled within six months of the time they were reported, the average award was $3,607. On the other hand, for claims that took more than five years to settle, the average award was $49,090.

Only 6% of claims were settled by a trial verdict, while 37% of the cases were settled without the plaintiff having filed suit. In 53% of the cases, a settlement was reached after a suit was filed, but before a trial began.

Not surprisingly, the size of the award varied directly with the severity of the injury. The average award for an insignificant or temporary injury was $7,563, about 5% of the $145,275 average award for permanent, total injuries. The average award for a death was $57,468.

While insurers have complained about the "long tail" of medical malpractice claims, the survey revealed that underwriters' concern about the long time between an injury and when a claim is reported may be unjustified. The vast majority (81.5%) of claims are reported within two years of the time of injury. Only 2.6% of claims were reported more than five years after injury.

In addition, of the 7,370 hospitals included in the survey, 81%, or 5,945 hospitals did not close a malpractice claim in four months.

However, 872 (12%) of hospitals were involved in one closed claim, while two claims were closed at 310 (4%) hospitals between July 1, 1976, and Oct. 31, 1976.

The survey also found that malpractice claims were more likely to involve large hospitals rather than smaller institutions. In addition, hospitals in the Pacific Northwest (Washington, Oregon, California, Hawaii) were most often involved in a claim, while hospitals in the West-South Central states (Arkansas, Louisiana, Oklahoma, Texas) were least often involved in a claim.

Neurosurgeons, orthopedic and plastic surgeons were most often the target of a claim, while the fewest number of claims were filed against physicians engaged in urology, internal medicine and ophthalmology.

Surgical errors were cited in 33% of the claims and institutional errors were cited in another 32% of claims. For claims involving injuries that occurred in hospitals, most injuries (42%) were likely to have occurred in the operating room, while 24% of injuries occurred in the patient's room. ■

Another acquisition

Fred S. James & Co. Inc. completed the acquisition of George Herrmann & Co., a leading Chicago insurance firm. George Herrmann & Co., was founded in 1898. Herrmann operations will be combined with the James Chicago office. George Herrmann III was elected chairman of the board of Fred S. James & Co. of Illinois, a James subsidiary. He had been president of George Herrmann & Co. since 1952.

What The Free-Trade Zone Means To Your Operations Abroad.

Harold Christensen, AFIA President

New York's insurance "free-trade zone" is being ushered in with a good deal of fanfare and rising expectations. It offers risk managers and brokers the opportunity to employ their skills and talent in obtaining the most desirable coverage on our own shores with fewer legalistic restraints.

Subject to the terms of the law, licensed insurance companies now will be able to write primary policies on large corporate risks without the need for prior New York State approvals and a host of esoteric risks will now be able to be covered here.

For those companies with large-scale operations abroad however, the new free-trade zone will have little impact on their overseas risks. They have long been accustomed to dealing with the major international insurance organizations in New York and other parts of the country where an international free-trade zone environment has existed for as long as AFIA has been in operation — over sixty years.

But for those risk managers and brokers who have not been as involved in overseas risks as some of the multinational companies have, the new free-trade zone may, on the surface, seem to simplify their efforts. In point of fact, the opposite may be true. Licensed companies may well write overseas exposures without having the necessary overseas facilities and insureds may be lulled into endorsing their domestic policies for risks abroad, not realizing the potential harm.

It is necessary here or abroad to know the market and the services provided. And because of different regulations, laws, and customs, it is even more important overseas than domestically to have an underwriter who is trained and knowledgeable about the countries abroad with claims service and staff spread throughout the world.

This is why AFIA maintains the largest number of offices, claims services, and staff abroad of any U.S. foreign underwriter and perhaps one of the reasons why 90 of the top 100 companies operating abroad insure with AFIA.

We welcome the new free-trade zone in New York. It is a step toward lessening the restraints of government on our industry. And it is a step we heartily applaud.

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dates for buyers

APRIL 4-5. RCI Communications is sponsoring a seminar in Chicago on how to reduce **municipal insurance** costs while improving coverage. The seminar will cover general liability, public official liability, funding of risks, risk management techniques, competitive bidding and how to select an agent and broker. The seminar will be repeated **April 18-19** in Washington, D.C. Cost is $395. Contact RCI Communications Inc., Suite 350, Building V, 10300 N. Central Expressway, Dallas, Tex. 75231; phone 214-363-9656.

APRIL 4-5. Retirement Advisors is sponsoring a workshop at the Ben Franklin Hotel in Philadelphia for **pre-retirement planners.** The workshop is designed to provide information, tools and techniques for designing, updating and supplementing comprehensive retirement planning program. The workshops will be repeated **May 15-16** in New Orleans. Cost is $250. Contact Alternative Choice Inc., P.O. Box 375, Rutherford, N.J. 07070; phone 212-245-1650.

APRIL 9-11. Risk Management/ Self-Insurance for Hospitals is a seminar prepared by Aspen Systems Corp. to be held in Sarasota, Fla. The seminar will examine today's malpractice crisis and approaches to liability protection—self-insurance, risk management programs, claims management programs and a trusteed self-insurance. The seminar will be repeated **July 30-Aug. 1** in Boyne Falls, Minn. Cost is $350. Contact Registrar, Aspen Systems Corp., 20010 Century Blvd., Germantown, Md.; phone 301-428-0700.

APRIL 12-13. Business risk management is the topic of a seminar sponsored by the Society of Chartered Property & Casualty Underwriters seminar to be held in Chicago. Cost is $60 for members; $70 for non-members. Contact Society of CPCU, Providence Rd., CB#9, Malvern, Pa. 19355.

APRIL 19-20. Risk management and loss control are the topics of a Professional Risk Management—Communication seminar to be held in San Diego. The seminar is specially designed to show how risk management and loss control concepts can interact with human relations techniques and quality assurance methods to enhance patient-centered care. Legal rights, liabilities and case law will also be covered. Cost is $250. Contact PRM-Communications, P.O. Box 4475, Santa Ana, Calif. 92702.

APRIL 19-20. The University of Pennsylvania's Wharton School is sponsoring a seminar in Cleveland on how to apply scientific methods to **risk management** decision making. The seminar will explain methods for determining aggregate retention, per occurrence deductibles, severity trends and using risk aversion levels and risk adjusted costs as a basis for risk management decisions. The seminar will be repeated **May 17-18** in Atlanta and **June 18-19** in Denver. Cost is $375. Contact The Business Risk Education Center, Room 415, Vance Hall/CS, University of Pennsylvania, Philadelphia, Pa. 19104.

APRIL 23-24. The Wharton School of the University of Pennsylvania is sponsoring a two-day seminar on analytical approaches and methods for managing **political risks** in foreign investments, uncertainties in the foreign investment climate, the acquisition of political risk intelligence and the corporate strategies in the management of a political risk are examined in the seminar. The seminar will be repeated **June 11-12** in Chicago and **September 24-25** in Washington. Cost is $495. Contact Registrar, 14th Floor, Wharton RMFI Seminar, 360 Lexington Ave., New York, N. Y. 10017.

APRIL 25. The International Foundation of Employe Benefit Plans is offering a one-day high intensity institute in Chicago on current issues and problems facing trustees, administrators and advisors of joint labor-management **employe benefit trust funds.** The seminar will be repeated **April 26** in St. Louis. Cost is $90 for members and $115 for non-members. Contact International Foundation of Employe Benefit Plans, P.O. Box 69, Brookfield, Wis. 53005; phone 414-786-6700.

Oil explorer shifts brokers for services

LOS ANGELES—The promise of better service coaxed Global Marine to end a more than 20-year relationship with Marsh & McLennan and move its $4 million property and casualty insurance account to Alexander & Alexander.

Global Marine, which operates 16 offshore oil drilling and exploration vessels in locations throughout the world, also based its decision on A&A's recent acquisition of oil industry specialists Management Insurance Services (MIS) in Houston, according to Gordon Adams, risk manager.

"It wasn't a matter of price," he said. "We felt what A&A had to offer was more comprehensive than what we were getting at M&M."

Since it was founded more than 20 years ago, Global Marine had placed all its insurance through M&M. Perhaps because of the length and exclusivity of the relationship, Mr. Adams said, the company was taken for granted by its former broker. "We were looked on as a house account," the risk manager said, "the broker might have gotten complacent."

Mr. Adams also charged that the services of M&M's Houston office, with its oil industry expertise, were not made available to Global Marine. "With our new broker, we'll be serviced by offices in Los Angeles, Houston and Ft. Worth."

He emphasized the importance of MIS in Global Marine's decision to go with A&A. "MIS was one of the brokers we approached with an invitation to submit a proposal," the risk manager said.

Several southern California brokerage firms were also asked to submit a "conceptual broker services report" after Global Marine reorganized insurance responsibilities this past summer.

Mr. Adams, formerly a broker with Reed Shaw Stenhouse, is the first risk manager for Global Marine. Previously there was no one person responsible for the insurance function, he said.

After deciding to put the account up for bid, a committee of the chief executive and financial officers and corporate counsel as well as the risk manager reviewed the brokers' reports. They were assisted by C.C. "Bud" Griffin, partner with Warren, McVeigh & Griffin risk management consultants.

"We gave the brokers information on our insurance program, but didn't tell them who the underwriters were or what premiums we were paying," Mr. Adams said.

M&M's report was "quite a different program from what we had," and was among the four finalists, the risk manager said.

The new arrangement with A&A is on a fee basis, rather than the commission basis with M&M.

Executives in the Los Angeles office of M&M declined to comment on the loss of the Global Marine business. Account supervisors at the new brokerage firm said it is too early to comment on specifics of the program being constructed for the drilling company.

Global Marine's vessel coverage is up for renewal May 1. "Right now we're in the midst of picking and choosing among recommendations that were made to us," Mr. Adams said. ■

All American moves

All American Marine Slip, an underwriting syndicate of 31 insurers and reinsurers managed by the Marine Office of America Corp., is moving to new offices at 99 John St., New York, N.Y. 10038.

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

This is the second in a series.

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ESIS Profiles: Risk management's new breed.

Rita Garcia
Director, Risk Management
Castle & Cooke, Inc.

"Castle & Cooke uses a state-by-state strategy to self insure workers' comp successfully."

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PERSPECTIVE

Benefit managers: Heed the tactics of risk management in funding plans

By J. Peter Hepburn, CLU

HAVE YOU EVER SEEN the words "risk management" applied to employe benefits? We are besieged with advertising regarding "administrative services only" arrangements or third party administrative schemes, but no one is talking about the application of classic risk management theories and applying them to benefit purchase.

I think one of the basic reasons for this is that we in the benefits area have not been exposed to "risk management." Most of us in the benefits business today—as benefit managers, benefit consultants, or salesmen—have been trained exclusively in the group insurance end of the business and probably have had that training from either an insurance company or a brokerage organization. Hence, we are classically underexposed to risk management and tend to think purely in terms of insurance versus self-insurance. The concepts of tiering, or cost-effective purchasing are strange to us. Thus, I think the most effective and dramatic move any manager can make within your corporations is to obtain a good solid education in risk management.

Typical approaches

From our surveys of those attending seminars on corporate insurance management, it appears that systems you are using run the gamut from retroactive through retrospective rating plans, to the concept of cost-plus, and finally, pure self-insurance with a stop-loss agreement. We found:

- Few, if any, companies are self-funding any portion of group life insurance.

- Pooled life amounts are nearly always insured with a firm's basic life insurance carrier.
- Accidental death and dismemberment benefits are nearly always insured with your life insurance underwriter.
- Short term disability is with your life and medical underwriter, if it is insured, and not with your long term disability carrier.
- Combining aggregate and specific stop-loss coverage on your benefit programs is almost unheard of; you operate with one or the other.
- None of you are using the concept of "tiering" any of your benefit coverages.
- Most of you are uncomfortable with reserves established in your medical program and upset about reserves in long term disability.
- Specific items constituting your retention (overhead) have either shifted or increased radically over the past several years. "Risk charges" are particularly difficult for you to understand.
- You are uncertain about how closely your claim-payers are scrutinizing coordination-of-benefits provisions in your programs. Nobody is really doing a job of policing medical and LTD claims. You're just not "managing" the risk.

With these elements in mind, let's look at some of the things I think you should examine in your own benefit programs. Although the Carter administration has a proposal to eliminate the $5,000 tax-free death benefit, it is an interesting area to consider either self-funding on a pay-as-you-go basis, or pre-funding, through a 501(c)(9) trust. Regarding prefunding, you might look into "retired life reserves." I refer you to an article on the subject written by Richard A. Hess, CLU, in a recent issue of *Business Insurance*.

Other methods

Probe the life pooling formula to see whether or not you are being charged at the rate-per-thousand used on the non-pooled premium or the tabular rate established on the pooled amounts only. Pooled premium is on high amounts of insurance and in most corporations this coverage tends to be on older males. Since virtually all life rate tables charge more for males than females and skew heavily upward at the older ages, you may find a small percentage of your total life volume carrying a much higher percentage of your total life premium. I would suggest you investigate placing the pooled insurance with another underwriter on a non-participating basis. Before you do it, check with your own carrier to find out if there will be a corresponding increase in the retention area. Because the slope and level of life rates vary greatly by company, 30% savings are not uncommon.

In the life insurance area, self-insurance

Continued on page 44

Peter Hepburn is manager of Unionmutual Insurance Co.'s New York group operations. This article is adapted from remarks delivered at a series of seminars on Corporate Insurance Management sponsored by New York University.

Six steps to product liability loss control

By Spencer J. Traver

I BELIEVE THAT PRODUCT liability is a crisis despite the fact that the Federal Interagency Task Force on Product Liability Report says it is not. My reason for disagreeing with the Department of Commerce is strictly financial.

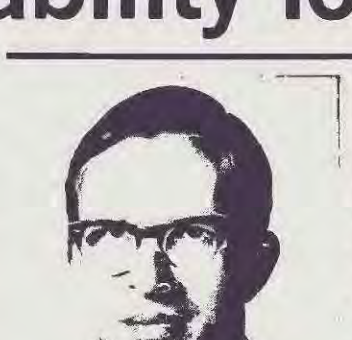
We have here a segment of business expense which is compounding by 30% per year. These statistics are based upon a closed claim study performed by the Insurance Service Office (ISO) involving over 24,400 losses. The study was released in late 1977.

To illustrate the crisis proportions of this situation, let's assume that in gross sales. At the present growth rate, these costs will represent 1.37% by 1981 and almost 2% by 1990. These are only average costs. Some business in the high hazard products field are already paying about 7% of gross sales. The average for the National Machine Tool Builders Assn. membership in 1976 was 3.1% of sales, for example.

The law has developed to the point where manufacturer's liability has been expanded beyond the point of reason. Both large and small corporations are perceived wrongly as having limitless wealth. Our society is apparently demanding a risk-free environment. From the ISO report we learn that manufacturers are bearing 87.1% of the costs; wholesale and retail business, 4.6%; construction industry, 3.4%, and service business 3%.

From this same ISO survey, we can learn which products generate the most paid claims and the relative severity of average payments. Most of these products are non-machinery products. This fact, together with the fact that the majority of losses occur within 48 months of manufacturing date, tell me that the tort reform legislation now being passed by a number of states will not do the average manufacturer much good. To the extent these new laws do help, it will be many years before we see the impact. To provide you with some ideas that will help to reduce your exposure to product liability, let me suggest that you must:

- Know the cost of warranty expense, returned goods and adjustments for each of your product groups. Restate this cost per 1,000 units, cost per 10,000 lbs. of finished goods or other suitable measure. Watch these ratios carefully. They are your first clue to potential problems and can provide management information and suggest action usually long before an injury occurs.
- Know the cost of your product liability for each of your product groups. Restate this cost, too, as a cost per unit or per 1,000 units or per 10,000 lbs. as indicated for warranties and watch the results. These costs provide excellent guides to where your problems are occurring. By way of illustration, we know of one manufacturer that had a product liability cost of $47.65 per unit for a product retailing at $9.95. This firm was able to design out the product defect for 42 cents per unit, change the retail price to $10.95 and at the same time reduce the product liability cost per unit to less than 15 cents per unit. If you can't design out the defect and the market place is too inelastic to absorb increases, consider dropping the product.
- Consider risk financing alternatives: larger deductibles, cash flow plans, paid-loss retrospective rating plans and others.
- Communicate the nature and scope of the product liability crisis to everyone in the firm. Their jobs are at stake but they can't help you if they don't know about the problem or are not accountable for its costs.
- Get involved in politics. Get your employes involved. Effective reform legislation will help a lot—plaintiff lawyers, labor unions and consumer groups are strong opponents, but the latter two groups must be educated that unrestricted product liability costs are a strong contributor to the loss of purchasing power and inflation. We must enlist their support to succeed.
- Know the law. Don't lose product cases by default because you failed to provide proper warnings, instructions for safe use, good records, good technical support to your defenders. Do you use the same sales contracts for off-spec products as you do for first line products? Did you leave the claims adjustment in the hands of your defense attorney or the insurance company or do you actively involve yourselves and your technical personnel? Does your advertising and product literature expressly or impliedly promise more than the product delivers?
- Use professional insurance brokers. Meet the leading executives of your insurers, including key underwriters for your umbrella liability. Above all, insist on complete reports of the broker's marketing efforts. Give them direct assistance in preparing underwriting presentations that cast you in the best possible light. ■



Effective reform legislation will help a lot. Labor unions and consumer groups, two strong opponents, must be educated that unrestricted product liability costs are a strong contributor to loss of purchasing power and inflation.
—Spencer J. Traver

Spencer J. Traver is assistant treasurer and director of risk management for BF Goodrich Co., in Akron, Ohio. His remarks were delivered to a meeting of the Cleveland chapter of The Financial Executives Institute.

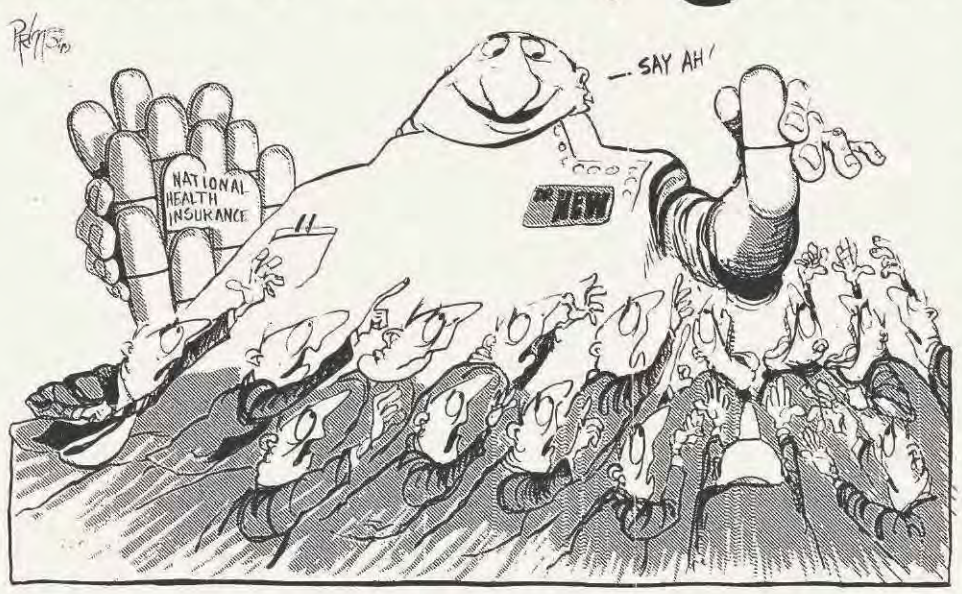
PERSPECTIVE

HEW's national health plan chart reeks of double think, generalizations

By Dennis A. Kairis

LAST WEEK A RATHER WEIGHTY document entitled "HEW Staff Department Tentative National Health Plan" crossed my desk. Despite its length, and my predisposed negative attitudes on the subject, I forced myself to examine it. As I turned page after page, I found myself growing increasingly irritated—irritated at what I judged to be contradictory statements; irritated with broad and unsubstantiated generalizations; irritated with apparently "foregone conclusions," and alarmed with what appeared to be a combination of fiscal irresponsibility and Orwellian "double think."

After regaining my composure, I wondered whether I was alone in my reaction to this document. What was the reaction of my peers, we so-called employe benefits practitioneers; of the general business community; of our elected representatives in Congress; of the average American citizen? Lacking answers to these questions, I felt compelled to try and find out. This commentary is my attempt to obtain answers.



Just a little bit much to swallow . . .

Who's funding it?

Within the first few paragraphs of HEW's draft, two comments, one following the other, piqued my curiosity. I quote: "The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated. . . . The plan should be financed through *multiple* sources, including *government funding* and contributions from *employers* and *employes*" (emphasis mine).

I enthusiastically supported the first statement, but then realized that though the intention was laudible, how could it be achieved? Each imposed governmental bureaucracy has always added burden to our economic life in spite of sunshine laws, zero based budgeting and the like. We also have never solved the problem of the lack of incentive in civil service structures compared to the bottom line (profit) orientation of the free enterprise system.

Dennis A. Kairis is director of employe benefits at Borden Inc. in Columbus, Ohio. His career in the employe relations and benefits field spans 15 years. He is a member of the Council on Employe Benefits and the Midwest Pension Conference.

Secondly, the assumption of three sources of funding, namely government, employer, employe, was an indication of a failure to understand economics. The government's only source of real money, as far as I understood, was its citizens, individual or "corporate."

Government intervention

Not nearly a page later, in the paragraph preceding and within the section headed "The Need for a National Health Plan," were the statements "Inevitably in describing the chronic problems in our health care system which justify intervention on the scale described. . ." and, "The American public has increasingly grown to feel that government has an obligation. . . ." and, "The belief has grown that the government should assure that our citizens health. . . ."

I ask, "According to what evidence? Based on who's belief?" Other than HEW's words, I perceived no national mandate demanding that the government "intervene," "guarantee," or "assure." In fact, HEW states that the majority of our citizens are well protected, and within our democracy, a majority seems to be critical.

Who pays the bill?

Further within this section a discussion of "the Inefficiency of the Health Care System" was presented. (Undoubtedly, many of the ideas were given birth to by Ewe Reinhardt of Princeton University who speaks eloquently on the economics of the health care delivery system.) Within this section, I read the following:

"The unique aspect of the health market is that neither of the parties directly involved in generating the use of services—the patient and physician—normally pays for those services. The party that pays—public or private insurance plans—has almost no control over the quantity or price of services provided. The cost implications of continuing this relationship under a national health plan would be intolerable."

I read this last sentence with interest, again nodding my general agreement. To my surprise, however, in the full explanation of the mechanics of the HEW proposal, I found: " . . . The provider would only bill the insurance firm, never the patient, . . . In addition, providers would be paid in full by the insurance plan thus eliminating bad debts and the cost of attempting to collect overdue payments from patients." In addition, the "Plan Summary" section stated that "all transactions would occur between providers and insurance plans rather than providers and patients."

I could only assume that somehow the intolerable had become convenient. If part of our problem lies in the fact that the patient never became aware of the cost of medical care, the government's procedure to eliminate him entirely certainly didn't aid in offering a solution, especially since they felt such action would be "intolerable" in the first place.

Government overkill

The role of Health System Agencies (HSAs) was mentioned several times, yet, it was evident from HEW's comments (as well as my own personal experience on an HSA board) that more leverage, strength and restructuring of the HSA organization are needed. It is interesting to note that control of health care expenditures and restructuring of the health care delivery system is already under way on two fronts: one with the evolution of the HSA structure, which is only in its infancy and just beginning to have an impact, and secondly with the rapid growth of HMO's. Should we not give these two forces some time to impact the system before we create another nightmare?

In general, HEW's draft of a national health plan struck me as marked overkill. Yes, we need to do something about the cost and availability of health care. Yes, we should pay attention to the health needs of the poor and the unemployed. But with 91% of hospital expenses now paid by third-party providers and with more and more comprehensive health coverage offered by employers, need we react as violently as this proposal suggests?

Let's not throw the baby out with the bath water. Our health care system reached its current level, not through governmental control, not through bureaucratic red tape, but through talented, dedicated and at times benevolent "free" enterprise. Courting federal control and imposing another federal bureaucracy causes me to remember some words authored over 200 years ago:

"He (the King of England) has erected a multitude of New Offices, and sent hither swarms of Officers to harass our people, and eat out our substance."

—Declaration of Independence ■

Calif. bars insurance for punitive damages

By Victor B. Levit

IN TWO RECENT CALIFORNIA cases, the California supreme court and the California court of appeal, second district, have answered a question that has been open for some time in this state. Essentially the decisions indicate that punitive damages are not insurable in California and it is against public policy to insure such damages in this state.

This decision is certain to have a great impact, since California is one of the states in which very large punitive damage awards have been made. Also, this development in a major state such as California reverses a recent trend in other states which have held punitive damages are insurable if they are not excluded. I refer to such cases as Harrell *v.* Travelers Indemnity Co. (1977) 279 Or 199, 567 P2d 1013, a decision of the Oregon supreme court, and Price *v.* Hartford Accident and Indemnity Co. (1972) 108 Ariz 485, 502 P2d 522, a decision of the Arizona supreme court.

Victor B. Levit is managing partner of the San Francisco and Los Angeles law firm of Long & Levit. The immediate past chairman of the insurance committee of the San Francisco Bar Assn., Mr. Levit has written and lectured extensively on the subject of punitive damages.

In determining whether a particular state such as California does or does not permit insuring punitive damages as a matter of public policy, it is extremely important what the specific facts of the case are. For example, if an intentional tort and not gross negligence had been involved in the decision in Oregon, the Oregon supreme court might have arrived at a different result.

Willfulness cited

In Clemmer *v.* Hartford Insurance Co. (December 1978) 22 C3 865, 151 CR 285, the California supreme court held that it would be against public policy of this state and a violation of California Insurance Code Section 533 which prohibits an insurer from insuring a willful act. "An insurer is not liable for a loss caused by the willful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others," it states.

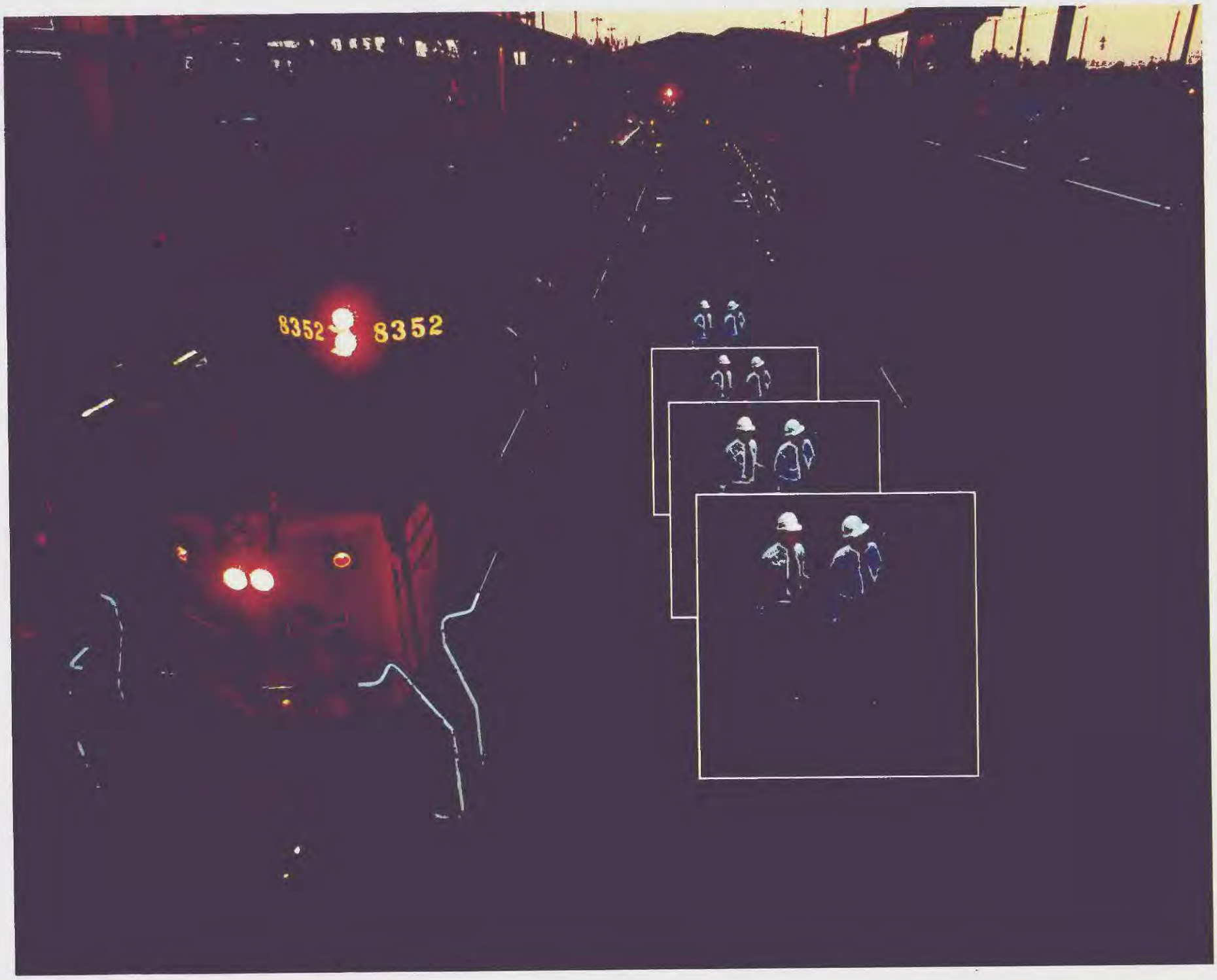
The act involved in the case was murder and the suit was brought by the holders of a wrongful death judgment against the murderer's insurer. The California supreme court rejects contention that damages are recoverable in the following language:

The court's barring of insurance for punitive damages is sure to have a great impact, since California is one of the states in which very large punitive damages awards have been made.
—Victor B. Levit

"Plaintiffs' contention that innocent victims of intentional torts should be able to recover from an insurer without regard to the willfulness of the insured clearly runs contrary to the policy expressed in Insurance Code section 533, the subject of discussion at the start of this opinion. Nuffer *v.* Insurance Co. of North America, 236 CA2 349, 45 CR 918 is cited by plaintiffs to demonstrate that an innocent third party may recover for the action of the insured's agent. Here, however, we are not concerned with an action of Dr. Lovelace's agent, but with Dr. Lovelace's own act. Hartford may not be held liable to plaintiffs for any willful act of Dr. Lovelace."

The main case which deals with this problem of whether it is against public policy to insure against punitive damages is City

Continued on page 44



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PERSPECTIVE

Punitive damages . . .

Continued from page 42

Products Corp. *v.* Globe Indemnity Co. (January 1979) CA3, 151 CR 494. The opinion states correctly that it is the first appellate court decision in this state to rule upon whether it is or is not against public policy to insure aginst punitive damages.

The insurance policy in question was a general liability policy which did not exclude punitive damages and covered "all sums which the insured shall become legally obligated to pay as damages" including false arrest or malicious prosecution. In a prior action, a judgment had been rendered for malicious prosecution against City Products for $2,725 compensatory damages and $30,000 in punitive damages. (The punitive damages were reduced on appeal to $10,000).

The punitive damages were awarded on the basis that the malicious prosecution resulted as a result of deliberate actions by the collection manager for not just one store of City Products, but for an entire area, and as such, this individual had authority to bind the corporation.

A demurrer was sustained with regard to the punitive damages and it was contended that recovery of punitive damages against the insurer violated Section 533 of the California Insurance Code and the policy of the state to award punitive damages "for the sake of example and by way of punishing the defendant," (California Civil Code Section 3294).

Punishment needed

The court concludes that the basis of the award was the willful act of plaintiff, not the vicarious responsibility for the acts of an employe and that therefore recovery is prohibited under California Insurance Code Section 533. The court also says, however, that even if California Insurance Code Section 533 did not exist, there could be no recovery since it is the policy of this state to allow punitive damages "for the sake of example and by way of punishing the defendant."

The court points out that malicious prosecution involves malice and is more blameworthy than negligence.

The court refers to the "sharp split" of authority nationwide as to whether insurance may validly cover punitive damages and then says "this issue has never been squarely addressed in any California appellate decision."

The court says the lead case in the United States prohibiting insuring against punitive damages is Northwestern National Casualty Co. *v.* McNulty (1962) 307 F2d 432, 440-441, and quotes that opinion:

"The policy considerations in a state where, as in Florida and Virginia, punitive damages are awarded for punishment and deterrence, would seem to require that the damages rest ultimately as well nominally on the party actually responsible for the wrong. If that person were permitted to shift the burden to an insurance company, punitive damages would serve no useful purpose. Such damages do not compensate the plaintiff for his injury, since compensatory damages already have made the plaintiff whole. And there is no point in punishing the insurance company; it had done no wrong. In actual fact, of course, and considering the extent to which the public is insured, the burden would ultimately come to rest not on the insurance companies but on the public, since the added liability to the insurance companies would be passed along to the premium payers. Society would then be punishing itself for the wrong committed by the insured.

Decision final

The California appellate court recognizes that both Arizona and Oregon recently arrived at different results, but points out that in Arizona and Oregon gross negligence was involved. The court concludes:

"The foregoing demonstrates that the policy of this state with respect to punitive damages would be frustrated by permitting the party against whom they are awarded to pass on the liability to an insurance carrier. The objective is to impose such damages in an amount which will appropriately punish the defendant in view of 'the actual damages sustained,' the magnitude and flagrancy of the offense, the importance of the policy violated and the wealth of the defendant. Consideration of the wealth of the defendant would of course be pointless if such damages could be covered by insurance. The onus of the award could depend entirely upon the amount of insurance . . . ."

City Product's request for a hearing in the California supreme court was denied by the Supreme Court Feb. 28.

Therefore, the decision of the court of appeal will become final. ■

Benefit plan funding . . .

Continued from page 41

has been a problem if death benefits over $5,000 were being provided. Realistically speaking, most companies do indeed provide benefits much higher than $5,000. The IRS maintained that only the first $5,000 of death benefits provided by a self-insured employer would be tax free. But that rule has recently been struck down by a circuit court which said that if a survivor's benefit program has all the characteristics of a life insurance contract, payments are taxed as if they emanated from a life insurance contract. This court decision, coinciding with a change of heart by the IRS, clears the way for self-insurance of group life programs.

Examine your costs for accidental death and dismemberment coverage. Traditionally, all AD&D is pooled. Virtually all of you are buying coverage for business travel accident as well as voluntary 24-hour accidental death and dismemberment from a specialty carrier, not from your basic group underwriter. Get a price from that carrier for your accidental death and dismemberment. You may find that you can reduce your costs as much as 50%. I have seen 6 cent rates become 3 cent rates when placed outside.

All of you have implemented long term disability plans. Does it make sense that the same information gathering unit or person could pay all of your disability income claims for less overhead than two separate entities? If you are insuring your short term disability with an underwriter different from your long term carrier, you might ask each for a quotation on the other with specific information as to cost of operation. If you are self-insuring your short term disability, you might ask your long term underwriter to give you a cost for claim administration. We find the ultimate result of coupling will reduce not only administrative costs, but as claims are screened more thoroughly, claims control can produce dramatic reductions in liability.

Stop loss

A number of you are operating with stop loss agreements. Most of you have "aggregate" schemes. Think about combining this "aggregate" with a "specific" stop loss on each claim. For example, the odds of individual claims in excess of $25,000 are remote. However, a common accident of several employes not covered by workers compensation, or perhaps one or two claims involving sophisticated medical procedures could leave you with an unusually heavy claim burden on only a few claimants. A company paying huge premiums can afford to absorb this situation, but more and more of you with $500,000 or less in premium are involved in stop loss programs whether they be retros or cost-plus, and it may be wise for you to look into covering this contingency. The cost involved should be minimal.

Tiering is rather common in your property and liability programs but I see none of it in the benefits area. At its most rudimentary, you might consider insuring the first $10,000 of any medical claim, self-insuring the next $10,000 to $20,000 and then buying excess insurance over the "buffer" layer.

Your long term disability plans are an area which you might want to self-insure losses for a number of years beyond a basic term and then buy some type of stop-loss coverage over your self-funded retention. For example, benefits payable after two or five years of disability could be self-insured.

Medical reserves

As you all know, medical reserves are established for one purpose only and that is to pay claim liabilities incurred but not yet reported or paid. At any given date this liability will normally last no longer than one year. With today's data processing sophistication, it is easy for any insurance company to do highly accurate "lag studies" so that they are reserving as close as possible to the actual run-outs. Unfortunately, many carriers do not operate with this huge type of accuracy. We frequently find reserves being handled as a percentage of premium or with a formula being applied to the lag study that is inflated. Get details on how, exactly, your reserves are established. If your medical care reserves exceed 35% of claims paid, really push to find out why they are that high. Swollen reserves sometimes indicate sluggish administration.

Federal taxation of life insurance companies is very complicated. Basically, however, some companies are taxed on their investment income while others are taxed on their gain from operations. For any coverage which tends to build up large reserves over time, you should try to find a carrier that is taxed on any gain from operations. Once large reserves are accumulated, taxes on investment income should exceed taxes on gain. State insurance regulatory laws, as well as the nature of the insured gurantee, limit the extent to which any insurance company can invest in high risk/high yield instruments. Thus, an 8% rate of return after expenses is quite good even today, but a life company earning that rate could credit only 4% to reserves. Consider "borrowing" against your reserves by a 90-day premium payment lag. Your cost of money should be only 5%—if you are now paying after the traditional 31 days, you can purchase the next 60-day float for about seven-tenths of 1% added to your retention.

Many managers are concerned about what appears to be "shifting" retentions in your life/medical program. My advice is to ask for very specific information as to each of the components of that retention. (a) Find out the percentage of change you can expect to see in the claim cost area with a significant change in paid claims either up or down. (b) Find out about interest credited. (c) Ask for detail on reductions in "risk charges" with the implementation of more pooling, retros, or stop loss provisions. (d) Be certain the premium taxes are calculated on a net rather than gross premium basis except in those states where taxes must be paid on gross. (e) Take a look at the commissions being paid. Keep in mind the commissions are not a gift from the insurance company to the broker. They are a fee being paid by you for work that has and ostensibly will continue to be done.

If you think commissions are excessive, I would ask your broker for an accounting on an hourly basis. Sophisticated brokers and service organizations are able to supply this instantly and I think that if we in the selling end of the business are to achieve the "professional" status that we seek, we should be prepared to provide you with detailed information just as your accountants and attorneys do. There is nothing sacred about handling your risk and if he is doing a bad job, replace him.

For medical care, inflation is the long term villain. Don't help it along by agreeing to price increase expectations. Use a retro agreement approach of at least the insurer's trend factor and minimize cash flow. Have them justify their factor both by the price/utilization index in general and your own policy's exposure-adjusted trend. Have your deductibles kept pace with inflation or are you still cost-sharing at a 1962 level of $100 per calendar year? Orient your plan to come in late—after $200 per person—but come in strong with reduced coinsurance. Why make the sick carry the load alone?

Present value

I think if there is a major message regarding LTD it is that you should not regard it as a casualty coverage but rather as a disability pension benefit. Similar to each pensioner, each disabilitant can expect a stream of future payments. The present value of this stream must be capitalized and viewed as a liability item *today*. There is a rather cavalier attitude by a number of people in our industry as to their ability to handle LTD on a self-funded or even "pay-as-you-go" basis and I think what follows might give you some idea as to why prudent reserving is mandated. First, the most generally accepted morbidity table we have is the 1964 Commissioners Standard Disability table. The Society of Actuaries does continuing analysis and we are finding that the '65 table is substantially understated with regard to recoveries.

This trend toward poorer recovery rates is evident in the U.S. Social Security Disability Income data as well as data from Western European countries. Coupled with a slowdown in recovery rates is a general rise in the incidence of claim. We see a strong link between our nation's economic conditions and the rate of claim. The 1970-71 slump, for example, saw an increase of 47% from a 1965-1969 base period rate of 2.76 claims per 1,000 insured to 4.05 in 1971. Such increases can be more dramatic as we view particular industries and firms. Coincidentally, the Social Security Administration has reported a 47% increase in approved disability claims from 1968 to 1974.

Do your LTD plans foster high disability incidence by providing excessive benefit levels? Try to replace 70% of after-tax income. The 10% "coinsurance element" could be less for lower paid employes. The 70% guideline suggests a decreasing benefit percentage as gross salary rises. A benefit of 60% of gross salary is a reasonable benefit level if you do not like the graded concept. The following study clearly shows the relationship between benefit level relative to pre-disability earnings and incidence of claim:

Gross benefits to gross pay ratio	Ratio actual to expected claims
Under 50%	56%
50%	71
50% — 60%	88
60% — 70%	108
Over 70%	137

Despite the volatility of LTD, many organizations are pursuing self-insured alternative because of the allure of the favorable cash flow and the somewhat tarnished interest rates many companies credit on LTD reserves held. To date, few companies seem to have consummated complete self-insurance and some have elected insurance after two or five years self-insurance. I would suggest that if you are looking at this concept that you investigate a 501(c)(9) trust, for, when reserves are placed in the trust, interest earnings accumulate tax free. Ultimately, there is the very real possibility that the interest earnings on the reserves held in a 501(c)(9) will be enough to fund those liabilities in excess of two or five years on a pay-as-you-go basis. I would advise you to be extremely careful in the establishment of a 501(c)(9) trust and to get sound actuarial advice. Fund adequately for potential liabilities so that you do not have IRS problems or possible future line-of-credit problems as the assets of the corporation could be liable for underfunding.

Ultimately, you pay your own way. You are not "laying off" claims on an insurance company. You might consider shifting carriers but, ultimately, your experience catches up.

Get specific with your own underwriter as to the job he is doing regarding claim control and, if not satisfied, investigate the marketplace. I would start by scrutinizing the type of claims control an insurance company or third party administrator has available, rather than simply price. It is very likely that a company or service organization that charges you somewhat more for services than their competitors may just win hands down on a net basis when claims control becomes more than just lip service. ■

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• The **risk classification** system in the property-liability insurance industry is the subject of a short booklet written by The Alliance of American Insurers president Paul S. Wise. Mr. Wise highlights the various political and societal challenges facing the system and defends it against recent attacks. For a free copy write P. Christopher, The Alliance of American Insurers, 20 N. Wacker Dr., Chicago, Ill. 60606.

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• A concept that has been helpful in reducing personal injury case losses is examined in a nine-page article, **Use of Annuities in Settlement of Personal Injury Cases,** which appeared originally in The Insurance Council Journal and is now available from Carroll & Co. for $1 per copy. Write Carroll & Co., 701 Montgomery, San Francisco, Calif. 94111.

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agent/broker topics

A REGULAR EDITORIAL SECTION EXCLUSIVELY FOR AGENTS AND BROKERS

Dental plans fill health gaps

By MARIE KRAKOW

PRINCETON JUNCTION, N.J.—When they get into a dentist's chair most people think about pain, not insurance agents.

Yet for the approximate 20% of the total population now covered by voluntary employer-paid dental plans, an insurance agent or broker may be the one who helped take the pain out of payments, if not procedures.

Agent and broker involvement in the marketing of group dental insurance is on an upswing from an already extensive base, say seven of the largest dental plan insurers in the nation and seven agents who sell dental plans. This is particularly true on plans for smaller businesses with anywhere from 10 to 20 employes.

In the earlier years of dental insurance, from about 1959 to 1969, it was primarily the giant brokerage firms like Johnson & Higgins, Marsh & McLennan or Alexander & Alexander that were able to make money on the new employe benefit because the vast majority of plans were purchased by multimillion dollar corporations.

Indeed, the fraternity of large brokerage firms and employe benefits consultants still dominates the marketing of dental plans for jumbo accounts covering thousands of lives. But the dramatic increase in dental insurance, which can be traced directly to the influence of labor negotiations, cracked the field wide open. For the enterprising smaller agency or even individual agent, marketing of dental insurance now offers good growth opportunities and profitability if it is handled intelligently, particularly in regions of the Southeast and Southwest where dental insurance is a relatively new employe benefit.

Commissions

Dental commissions are the same as commissions for group life, group health and other employe benefits lines in most shops, but are considerably less than commissions for ordinary life or general lines of insurance. About 75% of the time, dental commissions are paid on a regular sliding scale basis with the first year commission relatively high and renewal commissions for succeeding years much lower.

However, there is a trend toward paying dental commissions on a level scale even on larger cases, according to Joseph Walton, director of marketing for group insurance at Connecticut General Insurance Co. Marshall P. Stuart, senior vp of Clifton & Co., a San Francisco agency that has been selling dental plans for about 15 years, agrees. "You'll find that most professionals in group lines take dental commissions on a level basis," he said. A level scale pays the agent the same commission the first year as for each succeeding year.

All dental commissions are worked out as percentages of annual premium, so the first thing an agent must do in figuring possible profits on a given case is to estimate what the premium will be. A good figure to use to estimate premium is $100 per year per employe, according to Mr. Walton. Using this rule of thumb for three different size dental cases, he offered some examples of typical commissions paid to agents who sell dental plans for Connecticut General:

For a case covering 25 lives, the annual premium would be $5,000. An agent compensated on a regular sliding scale would get a first year commission of $1,000 (20% of premium) and yearly renewal commissions of $170 (3.4%) for nine years. A level scale commission for the same case would be $253 (just over 5%) each year for 10 years.

Sliding scale

The bigger the cases get, the smaller the percentage of premium is paid as commission, yet the dollar amounts may be more worthwhile. For a case with 50 lives, the annual premium would be $10,000. A first year commission on a sliding scale would be $1,750 (17.5%) and yearly renewal commissions would be $245 (2.45%). On a level scale, the commission would be $395 (3.95%) every year for 10 years.

A case with 100 lives and an annual premium of $20,000 would pay a first year commission of $3,000 (15%) on a sliding scale with a $395 (1.975%) renewal commission for nine years thereafter. The level scale commission for the same case would be $655 (3.275%) every year for 10 years.

Delta Dental Plans Assn., whose national network of local service corporations collectively writes some $600 million in dental premiums—more than any other dental carrier—says Delta agents and brokers earn commissions starting at 6½% and going down as the annualized premium goes up. For large cases the commission might be 1½% to 1¾%, while for more moderately sized cases the commission range would be in the area of 3% to 4%, according to William Sweeney, national market coordinator.

Between 3,000 and 4,000 agents and brokers are currently doing business with Delta Dental Plans, Mr. Sweeney said. One such agent, Joe Sher, is called by some the "granddaddy" of agent/broker involvement in dental insurance. He started in the field in 1960 as marketing manager on a salary/fee basis for California Dental Service, a participating Delta Plan, when it was fist starting.

"I guess I was one of the first guys in the country to promote dental care to agents and brokers," said Mr. Sher, who runs Joseph H. Sher Co. Inc., an employe benefits agency with offices in San Francisco and Newport Beach, Calif. "I beat the streets for a long time promoting dental insurance and went all over the country to get other Delta Plans moving because we needed a national structure to really make it work."

Start-up costs

It did work, and today the Sher organization sells free-standing dental contracts that account for about 25% of the firm's overall business, which totals "many, many millions of dollars of premium dollars," Mr. Sher said. He charges a flat 10% commission for dental cases under 50 lives and follows traditional commission schedules for group lines on cases over 50 lives.

The pioneer in the dental field warns that multiline agencies that want to break into the field will find start-up costs associated with dental plans can he high since an agent can put in lots of time and effort trying to develop a case and still get no immediate return. Some cases may take months to close and in general will bring in a much lower commission than most multiline agencies are accustomed to. For instance, ordinary life policies can bring big dollar rewards, with the first year premiums sometimes pulling 70% of annual premium. In contrast, an employe benefit commission can sometimes be as low as 0.5%.

However, Mr. Sher believes that a multiline agency can still turn dental business into a lucrative proposition, especially if it is used as a "door-opener" for new accounts or as a way to add coverages to existing accounts. Any general lines agency that wants to expand its employe benefits section by adding dental could always use general agency commissions to help cover start-up costs, he pointed out.

Connecticut General's Mr. Walton said the trend in the early 1970s for insurance carriers to begin selling dental insurance in plans that were separately struc-

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INSIDE

Midwestern mini-market

Grand Rapids, Mich., is featured in the first of the three-part series on growing Midwestern markets. Underwriting Systems vp Thomas Dalgleish and other brokers talk about the area's tough competition. **Page 46I.**


Dalgleish

Courts back no-swipes

Non-compete agreements are upheld in Colorado and Connecticut. Producers who took their accounts with them when they resigned are forced to pay back commissions. **Page 46C.**

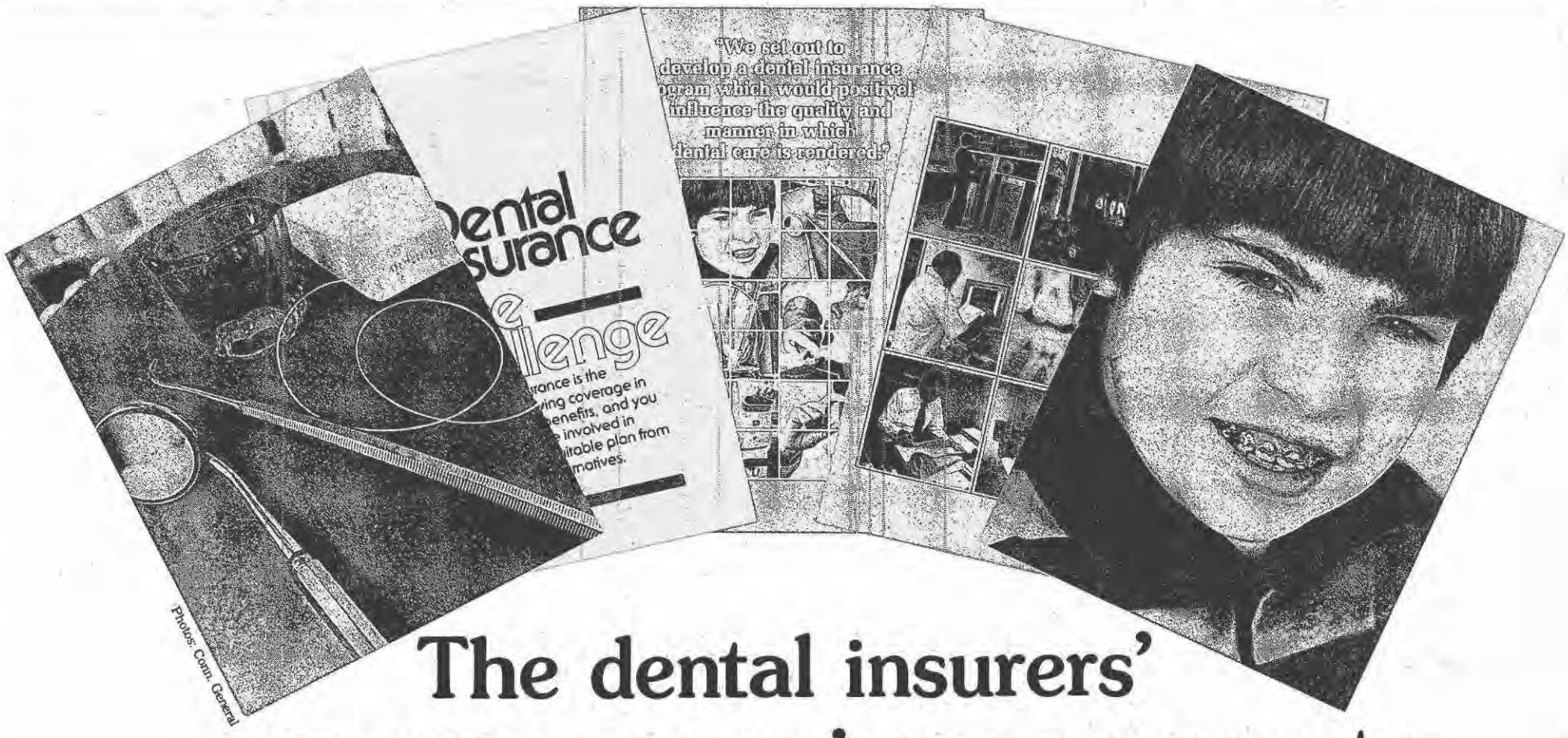
Tax service opens door

Producers who have added tax consulting services to their sales kits find closed corporate managers' doors swinging open. Nobody, including big business, wants to pay more taxes than they have to. **Page 46E.**


Bamber

Show booths boost sales

Exhibit booths at industry conventions and trade shows can be a source of mass sales, according successful agents. **Page 46G.** Booth designer George Bamber tells how to make displays work. **Perspective, page 46L.**



Photos: Conn. General

The dental insurers' programs, premiums, prospects

Here's how leading dental carriers currently view agent/broker involvement in the marketing of their dental insurance products:

Delta Dental Plans

Delta Dental Plans, which currently has more than $600 million of in-force dental premiums, does business with 3,000 to 4,000 agents and brokers across the country. The association for these 47 provider-sponsored not-for-profit plans anticipates an even higher level of agent participation during the next few years as union negotiations help dental insurance make inroads into regions, particularly in the South, where dental insurance is now rare.

Aetna Life & Casualty

Aetna Life & Casualty, with $320 million in in-force dental premiums on a total of 4,883 dental accounts, says the major marketing area for dental is the large case market covering more than 1,000 lives. In this category, said David Grant, assistant vp for corporate group marketing, there is a great deal of activity by large brokers. However, Aetna also solicits business from smaller agents and brokers through a product called "Aeconomizer," a health line including dental for the less-than-50-lives market, as well as through four additional products aimed at cases over 50 lives.

Metropolitan

Metropolitan Life Insurance Co., with $252 million of in-force dental premiums on about 300 accounts, was the only major dental carrier which said agents and brokers play a small role in producing business. The majority of Metropolitan's dental business involves jumbo accounts, many of which come directly to the company as a result of labor negotiations, with minimal involvement by brokers. Metropolitan has just introduced a new dental product called Met 50 Plus, aimed at the 50-to-200-lives market and sold in conjunction with life insurance. But the company has formally gone off the agency system and the product is sold by what it calls personal sales representatives who do not do home collections of premiums like the old agents did.

Equitable

Equitable Life Assurance Society of the U.S., with more than $250 million of in-force dental premiums, also says most of its large dental cases are developed by large brokerage and consulting firms. But agents are heavily involved in the small case market, which is now growing significantly, it adds. Equitable has two dental products aimed at smaller cases, one for accounts of 10 to 49 lives and another called EquiGroup Plus for accounts of up to 150 lives. "The majority of all new cases in that size range are produced by our agents," said John Goddard, senior vp of the group department.

The Travelers

The Travelers Insurance Cos., with $220 million of in-force dental premiums on about 3,000 accounts, including the jumbo Eastman Kodak case that covers 90,000 lives, says dental insurance is currently the most active area for its agents and brokers. New dental accounts have almost exclusively been produced by agents and brokers who made dental a successful follow-up to standard Travelers group health lines, according to Christian Paul, vp marketing for the group department.

Connecticut General

Connecticut General Insurance Co., with $200 million of in-force dental premiums on about 1,500 accounts, says agents and brokers are involved on all sizes of dental accounts but wield particular influence in the small case market of 10 to 50 employes. Joseph Walton, director of marketing for group insurance, said the bulk of CG's new dental accounts is being produced by independent agents since the company's agency force is a relatively small one and specializes in estate planning for business owners.

Prudential

Prudential Life Insurance Co., with approximately $50 million of in-force dental premiums, says its agency force of 30,000 produces about 70% of small group plans (two to 49 lives), with dental sold only to those groups with over 10 lives. Independent agents and brokers produce the remaining small dental cases. To sell dental plans to employe groups of more than 50, the company uses group marketing specialists. On these accounts, there is greater involvement by large brokers and employe benefit consultants. ■

Dental plans . . .

Continued from previous page
tured from major medical coverages greatly helped agents. Separate structuring was prompted by the major dental plans negotiated for the auto industry around that time and gave agents and brokers a way to develop new accounts without challenging existing medical coverages.

"An agent can go in and sell dental to a prospect under a separately structured plan and he doesn't have to start a hornet's nest by involving himself with other lines of insurance already sold to the account by someone else," Mr. Walton explained.

MAP

Leo A. Levine, owner of MAP Associates of Houston, Texas, is a newcomer to the dental insurance field. Deriving his entire income from the sale of group health insurance—his firm's acronym name stands for Medical Assistance Plans—he is worried about national health insurance. "How national health care could affect the incomes of those of us in the health insurance marketplace is unknown. If my income is minimized due to federal intervention, I must have another market. The market nearest to what I do is dental."

Mr. Levine plans to make dental insurance a major line for MAP Associates, adding $500,000 of premium this first year. Presently his firm is administering a dental plan for the city of Victoria, Tex., and Mr. Levine plans to start a promotional campaign on Delta Dental Plans soon.

Another agent who sees dental insurance as a hedge against federal intervention in the health care field is John Schmitt, a former pro football player who is now the president of the Oldfield Agency in Jericho, N.Y.

Even when he played as an offensive center for the New York Jets and the Green Bay Packers, Mr. Schmitt sold insurance on the side. With his sports career ended, Mr. Schmitt turned to dental insurance as a means of income security. In four years selling dental he has succeeded in introducing dental benefits to 70% to 80% of his business, including accounts with the Long Island Lighting Co. and Nassau County. "Dental insurance is the benefit that labor unions are really going after now," Mr. Schmitt said.

Regional strategies could figure prominently in agency success with selling dental insurance. Dental insurance first became popular on the West Coast, and is extremely prevalent there. On the West Coast employers who don't do dental are in the minority now," commented Clifton & Co.'s Marshall Stuart.

The Sunbelt

However, as you move East, the frequency of the dental benefit is somewhat less, and in the South it is practically a brand new item. "The prime opportunity for agents is in the Sunbelt area," Delta Dental's William Sweeney commented. "Dental benefits are just going to go crazy there."

Union negotiations are largely responsible. In Alabama, rubber workers at a large Goodyear plant recently won dental benefits, a development that "could change the entire marketplace for dental insurance in Alabama," Mr. Sweeney suggested. In addition, the influential union in Texas and the South has made dental insurance a point in its negotiations. Delta Dental expects Houston to become a very hot market for dental in the near future.

As David Grant, assistant vp in the corporate group marketing department of Aetna Life & Casualty, explained it, whenever a large employe group adopts dental insurance in a region where it did not exist before, other local groups and suppliers immediately begin to develop interest in the benefit in a kind of "fallout" pattern.

Smaller agencies in regions where dental insurance has had only shallow penetration until now may even be able to compete with the large national brokerage firms, suggests Stewart Reed, director of marketing for California Dental Service.

Mr. Reed said that while many large brokerage firms have been involved in dental plans for years, it is frequently their home office that has the expertise, with very little of the specialization filtering down to branch offices.

When some Delta Dental marketing people made a trip to Houston recently, for example, they were surprised to discover that the Houston office of William M. Mercer (the employe benefit division of Marsh & McLennan) was as unfamiliar with dental plans as was a two-person insurance agency they visited on the same trip.

Small agents

Smaller agencies can compete against the large brokerage firms for dental accounts on pretty much the same basis they compete for pensions and other group accounts.

Many dental insurers are anxious to provide sales support to agents and in some cases will also make field representatives available to assist agents in developmental sales. In addition, some companies like Connecticut General regularly sponsor dental insurance seminars for their own agents and will admit ousiders who want to learn about trends, pricing and claims administration.

"Buyers are interested in being educated and informed. Agents or brokers who take the time to really become knowledgeable about dental insurance, how it's designed and what its pitfalls are, will be very much in demand and will have a great opportunity to build new accounts," said Connecticut General's Mr. Walton. ■

Courts uphold broker's non-compete contracts

By LEN STRAZEWSKI

HARTFORD, Conn.—Written agreements preventing producers from taking their accounts with them when they leave an agency may soon bump handshakes out of the insurance industry picture.

Two recent court cases in Connecticut and Colorado that support non-compete agreements have cleared the way for written rather than verbal management protection.

An agreement similar to the Alexander & Alexander Inc. covenant introduced nationally in 1976 was upheld by the Connecticut superior court this year, awarding A&A of Connecticut Inc. over $19,000 in commissions plus interest from Bayly, Martin & Fay of Connecticut Inc.

A&A had contended that Richard C. Newman and a partner had signed non-compete agreements as part of merger and stock option plan with A&A. While employed by A&A, they had prepared and marketed an insurance plan for Wysong & Miles Co., a North Carolina manufacturer.

Mr. Newman then left to join Bayly, Martin & Fay of Conn. and received a commission check for over $19,000 from Wysong & Miles. A&A contended that the firm had never been informed of the change in agency and that the commission on the account was owed to A&A.

Mr. Newman argued that the non-compete agreements were illegal and against public policy because they lacked geographical limitations, a contention rejected by the court.

The court, however, refused to grant an injunction preventing Mr. Newman from soliciting commercial clients that had been clients of A&A during his employment there, which terminated in July 1978.

Though the original agreement had set a two-year, non-compete margin, the court said it would not grant an injunction because "no serious attack was made upon the list of customers."

An older agreement was upheld late last year in Denver by the United States district court, granting A&A over $78,000 in liability and exemplary damages.

In this case, A&A charged that a non-compete agreement established 13 years ago in Texas should have prevented a then A&A vp from taking clients with him when he established his own brokerage in Colorado.

The suit was originally filed in late 1975, two months after William S. Freberg established Freberg & Co. Inc., a Colorado corporation. In the suit, A&A said Mr. Freberg actively solicited A&A accounts for the new brokerage he was planning while he was still with A&A.

A&A also charged that Mr. Freberg had breached the contract by both neglecting to fully devote his energies to A&A and by "being engaged in other business in direct competition with and in violation of employment agreement to the damage and detriment of A&A."

The national broker sought $100,000 and 75% of the commissions on the business Mr. Freberg allegedly took from A&A in the three years following his resignation in 1975.

The employment contract containing the non-compete agreement was signed in 1966 by Mr. Freberg and the Drake, Alexander & Drake brokerage, which later became Alexander & Associates and then Alexander & Alexander Inc.

The court ruled that the contract Mr. Freberg signed was indeed valid and that "the breach of duty

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is clear and virtually uncontradicted in this case. There was a solicitation made or numerous solicitations made by the defendant . . . and those were made during his employe and they justify recovery of actual as well as punitive damages.

"The fact that he left with virtually no notice and was working on the establishment of his own competing business while an officer of the plaintiff corporation is again justification for actual damages and exemplary damages."

Judge John L. Kane also noted that the rights of an insurance broker to the skills of its officers are particularly important "in the insurance industry where customer relations in the sale of insurance is so highly competitive.

"And customers—it's most assuredly a buyer's market, which means that the skill of producers or salesmen in the insurance business is one of the most valuable things a company can have. It isn't as though they're selling something for which there is little competition . . . and as a result a salesman or a producer who has the capacity to develop good customer relations or client relations has the ability to develop expertise in particular areas of the law or the insurance industry is very similar to a specialist in a law firm with respect to his staying or leaving that firm. The value to the firm is enhanced.

"The greater the skill, the greater in my view the fiduciary relationship," said Judge Kane.

General counsel for A&A, Ronald J. Roessler, said A&A had received favorable judgment on all counts and that the insurance industry in general is moving toward non-compete agreements.

"In the past there has been a reluctance in the industry to require non-compete agreements and to rely on a handshake agreement with the employe," he said. "Now there is a trend away from the handshake.

"It's a little like a company who trains someone to operate a drill press. We don't mind if he leaves to operate a punch press elsewhere, but he should leave the press here."

Mr. Freberg denied the A&A charges and said he was "disappointed by the outcome" of the suit. ■

CU offers new small retail plan

BOSTON—Aimed at simplifying sales in the small retail market, Commercial Union Assurance Companies has introduced a new "merchants package policy" to its independent agents.

The policy, according to a company spokesman, has been introduced in California, Ohio and Georgia and will eventually be available in all states where class rating regulations allow them.

The updated agent's sales kit includes a rate manual with a list of eligible businesses and is designed so agents can quote and sell a policy in a single call, according to Commercial Union vp of commercial lines marketing Dennis J. Looney Jr. ■

Congress audits banks' insurance sales

WASHINGTON—Two recently introduced Congressional bills to prohibit bank-holding companies from engaging in insurance activities drew praise and support from the Independent Insurance Agents of America Inc.

"We are delighted to see Congressional action on this issue so early in the new Congress," said IIAA president Lee Meyer. "This legislation will permit Congress and the IIAA to pick up where they left off last October when an attempt to enact similar legislation fell just short of passage during the closing days of the 95th Congress."

The Senate bill (S-380) is sponsored by Sen. John Durkin (D-N.H.), a former New Hampshire insurance commissioner. It is a reintroduction of his 1978 bill, which was co-sponsored by William Proxmire, chairman of the Banking, Housing and Urban Affairs Committee.

The proposal currently under consideration, like the previous bill, would prevent bank-holding companies from acting as agents or brokers in the sale of property, casualty and life insurance and from engaging in the underwriting of such insurance.

The legislation, however, would permit bank-holding companies to continue to underwrite and sell credit life and accident and health insurance which have been historically offered by lenders.

Also, banks other than bank-holding companies in communities of 5,000 or less would be permitted to act as insurance agents.

"In sum, my legislation will not interfere with bank-holding company participation in those lines of

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insurance which lenders have traditionally offered, but will restrict them from venturing into sectors of the insurance business that are not their legitimate domain," said Sen. Durkin.

A similarly worded bill was introduced (H.R. 2255) by Rep. James M. Hanley (D-N.Y.) and co-sponsored by Rep. Fernand J. St. Germain (D-R.I.), chairman of the subcommittee on financial institutions.

The wording for the House bill had been ironed out in committee last year and is expected to draw support in the present Congress, boosted by the co-sponsorship of Rep. St. Germain, according to industry watchers.

Last year's legislation was endorsed by House subcommittee and full committee votes and was passed by both the full House and Senate before Congress adjourned. However, the bank-holding sections were added and then removed from a larger bank reform bill on a parliamentary point of procedure the last day of the session.

This year's legislation retains a June 6, 1978, grandfather date agreed to in committee last year.

"Representative Hanley's and Sen. Durkin's bills come not a moment too soon," Mr. Meyer said, "as the insurance agents face the imminent expansion of bank-holding company insurance activity.

"IIAA has made its number one legislative priority this year the quick enactment of an insurance prohibition," he said.

Sen. John Durkin (D-N.H.) opposes insurance sales by bank-holding firms.

If the legislation becomes law, the event will be the upshot of a long-standing battle the insurance agents' organizations have been waging on both a local and national level.

Last December Congress asked the Federal Reserve Board to impose a moratorium on consideration of applications from bank-holding companies to engage in insurance activities. The board refused and the IIAA in particular vowed to redouble its efforts to secure legislative prohibitions before the end of the next Congress.

Support and lobbying action is also being provided by other small business interest groups that feel threatened by bank-holding companies, most notably small and independent bankers, independent realtors, securities institutions and automobile dealers.

Rep. Hanley, according to legislative sources, is expected to reciprocate their support by introducing a bill with similar wording to his insurance proposal to prohibit bank-holding company involvement in areas competing with other small businesses.

The battle also moved on the local front as agents' lobbying groups worked on state legislatures seeking relief. In New Jersey, the Professional Insurance Agents (PIA) are urging Gov. Brendan Bryne to sign into law a bill that would prohibit insurance agents or brokers whose agencies are affiliated with banks or lending institutions from selling insurance on property that is security for a loan.

"This legislation is needed to protect the insurance-buying public consumer from being unduly influenced by the coercive power of banking and lending institutions, if such institutions were allowed to engage in the general insurance business," stated PIA-N.J. president Frank J. Siracusa.

The economic power of such institutions "would seriously threaten the life of the independent insurance agency system," he said.

The New Jersey bill would replace a similar state law enacted in 1975 but overturned by local courts. The court action is being appealed by the state insurance department which supports the proposed legislation.

The N.J. bill, like its national counterparts, would not prohibit the sale of insurance currently permitted for banks and other lending institutions including credit life, accident, accident and health insurance for automobile loans.

State laws prohibiting lending institutions from selling all classes of insurance have been enacted in California, Connecticut, Florida, Georgia, Kentucky, Maine, Massachusetts, Mississippi, Nevada, New Hampshire, New York, Pennsylvania, Tennessee and Vermont. ■

A&A's new tax service baits reluctant buyers

A/BT door-openers

DALLAS, Tex.—Alexander & Alexander account executives have a new way of getting in the door of potential corporate clients. It's called Property Tax Service Co. and the firm's tax consulting services have proven to be a marketing tool as well as a marketable service.

"Taxes are very voguish subjects at the present time and everyone is interested in making sure that they are not paying more than their share," noted A&A corporate vp and secretary Frank Wieczynski.

"And very often the individual in charge of corporate taxes is also risk manager so Property Tax Service Co. is a real nice door-opener into a business or corporation," he said.

Though A&A has been involved in property tax consulting since 1975 with a small operation in Lincoln, Neb., only since the 1977 merger with the Dallas-based Property Tax Service Co. has the tax assessment and negotiation services been a big enough operation to add to the A&A sales kit.

The tax services were introduced to A&A account executives in January 1978 and since then A&A has reported developing many clients for the subsidiary as well as developing many accounts as the result of selling the services.

"Talking about Property Tax Services is especially useful in places where we do not do big business now or where our direct competition is much larger than we are," said Mr. Wieczynski." "In order to see the man in charge we have to have something new and unique to talk about."

With offices in Dallas, Houston, New York, Detroit, Atlanta, Tulsa, Minneapolis and Los Angeles, Property Tax Service Co. is the only nationwide corporate tax consulting firm that specializes in property taxes, a hot national issue since the fight for California's Proposition 13.

To encourage producers to market property tax services, A&A allocates 50% of fees generated by an A&A producer through Property Tax Service Co. against the producer's new business goals.

That means, for example, if a producer's marketing by objective goals include renewing his present accounts and finding $30,000 of new business and that producer sells the property tax services for a $10,000 fee, half the fee, i.e. $5,000 is subtracted from the producer's goal.

"This is a very easy way for an account exec to make headway against his yearly new business goals without having to worry about all the calculations, marketing and underwriting involved with selling his property/casualty insurance," said Mr. Wieczynski.

"All he does is set up a meeting with the company and PTS," he explained.

Though educating and orienting the sales staff has been a problem, according to Mr. Wieczynski, the educational process has been simplified by teaching producers only what the capabilities of the new division are, not training them to make estimates or judgments.

And since A&A producers started going to bat for PTS business, the property tax consulting line has been booming, according to Jess Wade, PTS chairman.

"We were a little surprised when a giant company like A&A pitched us to join them, but since we have business is really going good," he said.

Before joining A&A new business was the result of word-of-mouth advertising and referrals, but armed with a major corporation's marketing force and the public interest in property taxes, the company has gone from fledgling to full-flying bird.

"Actually Proposition 13 is working against us because it limits property taxes," noted Mr. Wade, "but our thinking is that property taxes pump so much money into local economies that they will always be vital and necessary taxes." ■

Stalking the cagy E&O coffee gremlins . . .

By Len Strazewski

I have found it!

No, no, I'm not born again. I have merely found the culprit responsible for the insurance agents' biggest problem.

I know who creates errors and omissions. Like the rest of the insurance industry I am not surprised that the hard-working and industrious agent is not at all responsible for unrecorded binders, lost cancellation and premium notices, slow forwarding of checks to insurers and unintelligible descriptions of policies.

It was a long investigation with leads sending me down lots of blind alleys and into the backs of many dark parking garages at 2:00 a.m. I eliminated one cause after another.

The U.S. Postal Service said it was not the problem and was getting mail to agents, brokers and clients "with all deliberate speed. Especially if they stamp the envelope 'Please deliver,' " said my source.

Insurers told me that delays can't be their fault because they have taken major steps to speed policy turnaround—even though it meant laying off the kindly monks who usually copy the policies out long hand.

Agents made it clear that they could not be responsible because their record keeping was always impeccable. "Every time I issue a binder in an informal situation I always make a record of it—right here on my shirt cuff. Sometimes I use a pen if the swizzle stick is too dry," one broker told me.

Finally I got a hot lead from a local commercial agent who worked his way up from the ground floor since starting in the insurance business right after his World War II discharge.

"It's like we had it in the old Army Air Corps," he said. "There're these creatures who always mess up our hard work. Whenever we do something right, they sneak in and change it. We called them gremlins.

"But these new things are worse. They misfile letters and notices. Sometimes they take checks and hide them in the back of my briefcase so it looks like I never turned them in. Sometimes they imitate me on the telephone and issue binders."

He glanced around the pub suspiciously.

"It's them gals, that's who's doing it!"

Gals?

"Yep. They're always around when there's trouble. They're always in the office before 8:00 a.m. and still there long after I leave at 2:30 p.m.

"They even get to the mail first."

That made sense. It struck a responsive chord, as we investigators say. Whenever I examined cases of E&O, the agent had always claimed "The gal must've lost the check," or "The gal probably didn't write down what I told her to when I called her at home at 2:00 a.m."

My favorite is "The gal probably sent it to your old address. What's your address again?"

But my informant had more to say.

"It's insidious, that's what it is."

He leaned real close and spoke in a graveyard whisper.

"In fact, I am sure that they are part of a communist plot."

I was surprised. I hadn't heard that explanation from anyone about anything in a very long time. At least not since Mayor Daley of Chicago died.

What makes you say that?

"I've tested 'em, that's how. Only someone who doesn't believe in our proud free enterprise system would work for the wages I pay. Only some poor dupe of the Great Red Overmind would work long hours at a desk in the corner that is so small it presses down on her knees.

"Only a brainwashed victim of the Marxist tyrannies would work in my agency doing everything an agent does with no hope of a promotion or a real future in the industry."

He looked around again and slumped deeper into our booth. I was getting concerned. He looked like a man on the run, afraid to be seen.

What's the matter? Is someone looking for you?

"No, but sometimes THEY come here after work with my younger producers. They try to mix them up and get their minds off selling."

The solution seemed simple. I put it to him. Why doesn't he just get rid of them dirty "gals." March in and defoliate the lot of them. Isolate them before they spread. Wipe them out and make the world safe for . . .

"But who would make the coffee in the morning?" he responded.

Armed with this knowledge, I put it to the E&O experts. Is there any hope? Just what could agents and brokers do to get themselves rid of all this?

"Nothing," they said.

"These gals have been around so long they are part of the business. We've come to expect what they do. Besides, we still pay them what they were making after World War II.

"We could pay them better. We could train them to do what every agent does and then make them producers with title and responsibilities to match the work they do. We could even start writing down binders with pens instead of swizzle sticks."

It sounded fair to me.

"But then who'd make the coffee in the morning?" ■

Trade show exhibits build mass-marketing potential client roster

By ESTHER KUNTZ

A/BT door-openers

CHICAGO—Trade show and convention exhibit booths can boost mass-marketing sales, according to several agent/brokers who have made this public relations-oriented technique work.

Most firms which exhibit do so to make initial business contacts, explain their programs and pass out booklets to prospective clients. They feel it is important to have their logo on display for recognition. Later they follow up the initial contacts with a letter, telephone call or personal visit.

The use of exhibit booths is more a public relations than a sales technique, says Daniel Gorney, senior vp of corporate marketing for Benefacts, a subsidiary of Alexander & Alexander Inc. "These shows provide informal contact with clients and prospective clients."

James Bliss, president of The Bliss Agency, said he cannot quantify how well the booths succeed, but he can pinpoint sales that have resulted either directly or indirectly from their use.

Most agents and brokers agree that booths are a complement rather than an alternative to marketing through the mail and direct sales. A convention exhibit tends to reinforce a direct mail campaign done before the convention, said Arthur J. LeBlanc, assistant vp and director of research and development for the James S. Kemper Foundation.

Many agents and brokers do not feel it is worthwhile to exhibit unless they provide an insurance program for the association sponsoring the convention, in which case they are obligated to exhibit. But some firms exhibit even if another agency is endorsed by the association. "We provide insurance programs for a number of groups, but we still find competitors at the conventions," said Curtis Urbanski, president of American Insurance Marketing.

The James S. Kemper Foundation exhibits mostly through association sponsorships on a regional basis. The company provides insurance programs for many groups, including the Michigan Home Builders Assn. But the foundation also opens booths at some trade shows not under the auspices of a particular association. "We attended the Reading Air Show three years ago," Mr. LeBlanc said.

The use of exhibit booths appears to be primarily a large agent/broker marketing technique. "Most association conventions draw people from a larger geographical area than a local broker or agent can cover," said Kenneth Ford, president of MarketDyne International.

The cost of exhibiting at national conventions may also be prohibitive for small agents and brokers. The total bill for exhibiting at such a meeting can run anywhere from $10,000 to $50,000, Mr. Gorney said. But an agent or broker can exhibit at a smaller local convention or show for under $5,000.

David Vrieze, vp of Alexander & Alexander Inc., doesn't think the use of booths is limited to a particular size of agency or brokerage firm. It is important for any firm, no matter what its size, to direct its marketing at the buyers it is selling to, he emphasized. The marketing campaign should not go beyond the scope or the area of the insurance it is selling. If the company sells insurance to truckers in Iowa, it should exhibit at Iowa truckers' conventions only.

The Bliss Agency is an example

Continued on following page

Show booths . . .

Continued from previous page
of a small, specialized firm that uses booths effectively. On the brokerage side of its operation, the firm specializes in government risk insurance and concentrates most heavily on Illinois city and county governments, although it is expanding operations to other states.

The state exhibited at 10 or 12 local conventions of city and county officials in 1978 and intends to attend more in 1979. The cost of attending these local conventions isn't prohibitive because at least 80% of the cost is in personnel time, Mr. Bliss said. Less than 20% of the exhibition budget is spent on transportation and booth space.

Although some agents and brokers are exhibiting at conventions more than they did a few years ago, they say they cannot determine whether there has been an overall increase in their numbers at these meetings. Mr. Bliss said he has not noticed any significant change in the number of agent/broker booths at the conventions he has attended in the last year. "There may be some increase," he said, "but then the size of the conventions is increasing too."

But Melvin Mathews, executive vp of the Assn. of Program Managers, says, "More state and national associations have been buying insurance in the last four or five years. Consequently more agents and brokers are exhibiting."

Other experts, however, believe that although the use of booths increased several years ago, the upsurge has tapered off. "There may have been a slight increase about two or three years ago," Mr. Gorney said, "but now we see the same people at the same shows all the time."

The number of associations wanting to endorse an insurance program and the number of agents providing the programs have become relatively constant, said James C. Styer, senior vp and branch manager of the Chicago office of Reed Shaw Stenhouse, Inc.

But what may be catching on now is a more sophisticated approach to booth exhibits than there was a couple of years ago, said Donald Martin, president of Cal-surance. "I've noticed better layout in the booth, better materials and better pre-convention advertising," he said.

More agents and brokers are using self-standing designer booths instead of a simple table-top display. Mr. Bliss says he has four proposals for designer booths on his desk at the moment. "The purpose of designer booths is to create a good image," he said, "and that is the whole purpose of attending conventions."

Some firms, however, prefer to tailor the booth design to blend in with others at the show. Kenneth Lock, assistant vp of Albert H. Wohlers & Co. Insurance, said his company has several designer models. "But if other exhibitors have table-top displays, that's what we use," he said. "We don't want to be out of place."

The self-standing designer booths that Wohlers & Co. use cost between $700 and $3,500, but some more elaborate models cost up to $9,000. The most expensive booths often require hired labor to assemble, which can be costly if the convention is held in a unionized town, Mr. Lock explained.

Some displays that sit on a table top are also designed and carry the company's logo. These cost between $100 and $500. Other firms simply lay out their promotional materials on a table. Since such an exhibit doesn't occupy as much space as a designed booth, it can be set up in the registration area of a convention for about $25, Mr. Lock said.

Space rental costs for a standard booth range from $200 for a three-day convention of most professional societies, such as the Federal Bar Assn. or the Modern Language Assn., to $1,000 for a meeting of a large trade group. But some associations provide the agent or broker they endorse with free exhibit space. Because the National Restaurant Assn. sponsors Wohlers & Co., it does not charge the firm for exhibiting.

Some agents use everything from treasure chest and sweepstakes giveaways to free luggage tags to attract potential clients to the booths. Mr. Lock, who uses many of these techniques, says they cost his company about $350 at every convention, but he thinks they are essential to the exhibit.

"Most individuals aren't interested in talking to insurance people," he said. "This way we get them to come and talk to us. I think we do very well in terms of getting people into the booth area. Often our exhibit is next to that of a very large corporation and I think we compete well." ▪

Insurers hope to break even in 1979: IIAA

NEW YORK—Property and casualty insurance companies expect an underwriting profit downturn next year, but a break-even 1979, according to Independent Insurance Agents of America, Inc. (IIAA) president Lee Meyer.

Following a series of meetings with insurance company executives, Mr. Meyer reported to Texas and Louisiana agents that inflation and "ill-timed rate changes" are causing problems for the property and casualty insuranse business.

Company executives do not anticipate capacity problems of the magnitude that resulted from the 1973-1974 drop in underwriting profits, he noted.

"We were told that most of the companies believe that they have now set their agency plants and their book of business in such a position as to be able to weather the next downswing, without making any major or drastic changes," said Mr. Meyer.

"These are good signs for insurance agents," he continued, "and I do believe the companies honestly feel this way and expect to act responsively.

"I do not believe, however, that the majority of companies are really doing anything to assist us, their sales force, in holding or recapturing personal lines."

There is a strong possibility that markets will become tight in other areas where conditions are deemed unfavorable by company underwriters, Mr. Meyer said.

"Too many of our companies are looking at poor service as being commonplace and accepting it rather than striving to do a better job," he concluded. ▪

errors & omissions

• Alan L. Hagerman of the Richarson, Hagerman Agency reports that Aetna's basic profit sharing agreement does not have a life insurance requirement as he was quoted as saying in a Dec. 11, 1978 Agent/Broker Topics article. The Aetna profit sharing addendum may require support of the company life campaign, he adds.

Grand Rapids

Local leaders outmaneuver newcomer nationals

By BARBARA JEAN GRAY

GRAND RAPIDS, Mich.—This little city on Western Michigan's evergreen-lined slopes essentially put itself on the map with its furniture manufacturing ability. But Gerald Ford's hometown actually has a variety of economic gifts, commercial insurance agents claim.

And, like the mixed economic base of the area, the profile of the insurance agent community is multi-faceted.

The top two firms, each with revenues around the $1 million mark, represent both the long-standing native independents and the network-affiliated national houses. Crosby & Henry Inc. has roots reaching back to 1858 and its major officers are direct descendants of the founders. The James S. Kemper Agency Inc. branch is one of a national system of 33 offices.

Other strong contenders vying for commercial risks in the area are Marsh & McLennan Inc. and Frank B. Hall's Underwriting Systems Inc., both full line agencies.

The two "new kids on the block" to watch in this metropolitan area of a half-million people are Alexander & Alexander Inc. and Insuran-Center, a local agency which quadrupled its revenues since it was acquired by a former Travelers employe Orv Schneider, four years ago.

What's noteworthy about the alphabet house penetration of this market is that three of the four offices here started from scratch. Kemper opened its doors 40 years ago. Marsh & McLennan's nine year old office is actually a sattelite of its Kalamazoo office. A&A hung out its shingle just last July.

Only Frank B. Hall & Co. has arrived via acquisition. Last December it completed the purchase of Underwriting Systems Inc., an 18 person office incorporated in 1970.

Because there haven't been any personnel changes at the agency, the local independents don't really regard Hall as an "outsider" coming in.

"Hall really didn't come in," commented Jim Crosby III, executive vp of Crosby & Henry. "It acquired an existing agency. It has not changed from when they were acquired so there isn't any new effect they wouldn't have had otherwise. As far as M&M is concerned, there are some major accounts in Grand Rapids they can handle well. I think they're good healthy competition—nothing more and nothing less."

Market observers say that this city is a tough nut to crack, primarily because of the conservative nature of the population which has been strongly influenced by the Dutch Reformed Church and the long, frosty winters.

The national houses are undaunted by this "conservatism" argument.

"I think, all things being equal, people would like to stay with the fraternity brothers," commented M&M vp Don Martin. "But they're finding it necessary to have the services and global connections the national houses can offer."

M&M's assistant vp Ron Captain said it's precisely this conservative nature that makes competing "interesting. It's the loyalty. We have to prove ourselves every day."

Independent Jim Crosby acknowledged that the alphabet houses as a whole are tough competitors for the large industrial accounts, even though on the "average, run-of-the-mill business, they're poor competition."

This city, unlike Dallas or Houston, doesn't have a wealth of jumbo accounts and doesn't have more moving in every day.

A&A's vp Conrad Conti, who prides himself on the number and size of insurance and insurance related services, doesn't believe the capabilities are overkill for the Grand Rapids industries.

"I think most client companies could use the services and have not had the access to them before. There are several companies in this area with sales of $25 million and up. Also, the basis of our firm and our major client base is the medium-sized industry. We handle coverage for many biggies but our real strength in the market place is

A/BT markets

the ability to provide service and coverage for the $2 million and up (in sales) companies.

"I would guess that 75% of our business is in that area," he continued. "We're comfortable there and with the large national accounts, too. I don't think everybody needs everything but I think it's important that the business community is aware that things are available that can help them make their business run better.

"A businessman has to be concerned with costs. The use of our services is not necessarily high powered stuff, it's just good business."

Similarly, M&M's Mr. Captain said that his firm's global prowess doesn't limit them to jumbo accounts only (even though they're strong there, too, with at least a piece of the action on such jumbo accounts as Steelcase, Rapistan and Sealed Power) and that the office is aggressively cultivating smaller and medium-sized accounts. This does not mean unloading unnecessary services on them.

"I would like to believe that we really try to be objective in trying to help the community and help the people who need help. That can be the small account as well as the large."

For Underwriting Systems, affiliation with Hall is the green light to seek larger accounts, vp Thomas A. Dalgleish said. With the national affiliation "you have more credibility, especially if companies have plants in other states. We have a number of them where it makes sense, especially in cases of safety engineering coordination."

Two employes—one engineer and one bond man—have been added to the office to round out the service facility, he said. The firm has always been strong in construction and plans to continue to generate about 25% of its revenues in that area.

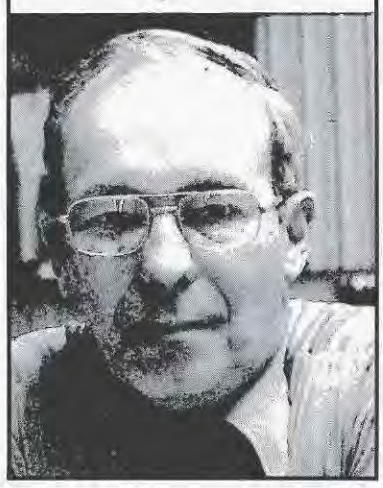
And if the alphabet houses are

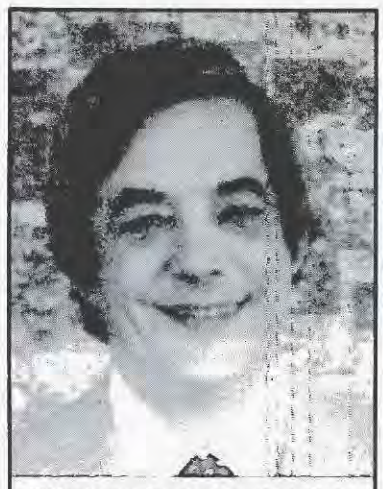
Continued on following page

Photos: Barbara Jean Gray

Underwriting Systems vp Thomas Dalgleish says his national affiliation gives him more credibility with some clients.

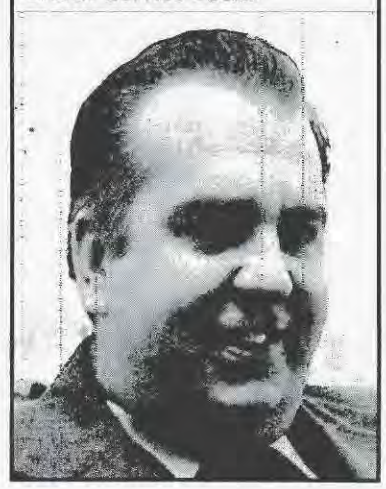
Crosby & Henry executive vp Jim Crosby III finds the alphabet houses are tough competition on large accounts.

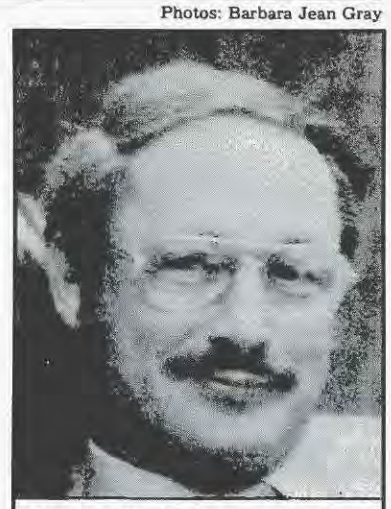




"We have to prove ourselves every day," says M&M assistant vp Ron Captain, about "conservative" Grand Rapids.

A&A vp Conrad Conti says his clients, mostly in the $2 million sales rank, are concerned with broker service costs.





Campbell Agency president Merle Barnaby targets the supermarket, bus lines and long haul trucking risks.

Grand Rapids . . .

Continued from previous page

not limiting themselves to the jumbo accounts, neither are the independents limiting themselves to the smaller local accounts.

Crosby & Henry writes some large international accounts, Mr. Crosby said, although for most purposes the firm regards Kent and its contiguous counties as its marketing area. The executive vp, a fifth generation Crosby and the firm's president, is a direct descendant of another of the founders and well established in the local community. Mr. Crosby recently served as the president of the Independent Insurance Agents of Grand Rapids as did his father some 34 years earlier. While this heritage could in some instances lead to complacency, such has not been the case for Crosby & Henry. The agent community generally regards them as a potent force in the market.

An almost meteoric growth pattern has been created here by InsuranCenter. (Its corporate name is Regen-Schneider & Associates.) Formed in 1975 when Orv Schneider purchased the three-man Regen & Lamereaux agency then writing $53,000 in commissions, InsuranCenter now employs a technique Mr. Schneider terms "total selling," has added a three-person employe benefit division and now generates more than $670,000 in volume with 17 employes.

In addition to the retail community serving the metropolitan area, this city also serves as headquarters for two specialty firms which serve an even broader geographic base.

One is McAlear & Associates Inc., an eight-year-old excess/surplus lines brokerage facility now generating approximately $36 million in premium volume.

The other is Ward S. Campbell Agency Inc., a supermarket specialist operating throughout the state of Michigan.

About 25% of the firm's $1.2 million revenues are generated in the Grand Rapids area, Campbell president Merle Barnaby estimated. Campbell has 12 agents throughout the state servicing, among other things, the 800 to 900 supermarkets the firm writes. Long haul trucking and bus lines are other lines of business for the firm. It also has the association program for the Michigan Licensed Beverage Assn. and is presently kicking off a new program for bar, tavern and restaurant businesses, Mr. Barnaby said. Hopefully, the firm's new in-house computer will have policy issuance capability for the new program.

Campbell Agency, which started out in Battle Creek in 1960 and has since purchased two other supermarket specialists in the state, instituted an employe stock ownership trust in its 16 person office here this year.

Among the new horizons for the firm is an association self-insurance program with worker's compensation as the starting point. ■

PIA asks end to disclosure rule

GLENMONT, N.Y.—The Professional Insurance Agents of New York (PIA-NY) has asked the New York insurance superintendent to reconsider requiring commission disclosures by brokers serving municipalities.

Effective last December, Regulation 87, requires disclosure of commissions by insurance agents and brokers doing business with municipalities.

PIA president Frank H. Reis complained to the superintendent that commission disclosure "invaded the private contractual relationship between company and agent; subjected producer compensation to unnecessary public scrutiny, and unfairly discriminated against professional agents and brokers."

Regulation 87 also requires disclosure of sharing producers. ■

RBH adds 6 vps; C&B promotes Schmelzle

Rollins Burdick Hunter of Southern Calif., has made a series of appointments to the vp ranks. **Derek Dunn,** RBH marketing manager, has been named vp in addition to his marketing duties and **Arthur Rasmussen, Ellsworth J. Royer** and **Gregory J. Ryan** have been promoted to vp from account executive. **Janet L. Anderson** and **Frederick Wood** were named assistant vps.

* * *

George R. Schmelzle has been named executive vp of Corroon & Black of Ohio. Formerly director of sales, marketing and operations for Atkinson-Dauksch Agencies Inc., Mr. Schmelzle became vp/general manager when the company joined the C&B Corp.

* * *

Russell M. Cortino and **Martin F. Blake III** were promoted to vps of Alper Services Inc. Both Mr. Cortino and Mr. Blake were formerly account executives with the Chicago firm.

Burrows

Palmer

* * *

George S. Burrows has been elected vice chairman of Rollins Burdick Hunter. A graduate of Yale University and an underwriting member of Lloyd's, Mr. Burrows will be replaced as CEO of RBH-Illinois by **Karl R. Palmer,** formerly president. In the Pennsylvania division, **Richard T. Harris** has been elected president and CEO.

A/BT people

* * *

Former first deputy of the New York State insurance department **Michael E. Curan** has been named executive director and general counsel of the Insurance Brokers Assn. of the State of New York Inc. Mr. Curan, who resigned from the insurance department earlier this year, was most recently counsel to Brady & Tarpey P.C.

* * *

Robert V. Hatcher Jr., president of Johnson & Higgins, has been appointed to the University of Virginia Board of Visitors by Virginia governor John N. Dalton. Mr. Hatcher, a Virginia native, resides in Greenwich, Conn. He joins the 16-member board as one of three non-resident members.

Horvath

Pennington

* * *

Markel Service Inc. has appointed **Thomas S. Horvath** resident vp and **W. Bruce Pennington** regional manager for excess surplus lines at the San Francisco, Calif., branch. Mr. Horvath was previously in charge of the firm's Dallas office and Mr. Pennington has worked in the firm's Dallas, Los Angeles and Richmond, Va., offices.

* * *

MacRobert S. Thompson has joined the Philadelphia office of Marsh & McLennan to head a newly formed unit concerned with developing major commercial accounts. He will be nominated for election to vp at the coming board of directors meeting. Mr. Thompson previously was a vp and analytical consultant with Alexander & Alexander in Philadelphia.

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We'd like to report on staff changes. Just drop a note to Len Strazewski, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611 or call 312-649-5393. We'd also like to receive pictures of those involved.

Mich. bolsters agency abuse investigations

LANSING, Mich.—Michigan commerce department insurance investigators are probing consumer complaints against more than 60 agents as part of a continuing crack down on insurance violations.

"The stepped-up priority" on insurance code violations began in the last half of 1978, according to a department spokesman, and resulted in the revocation of more than 10 licenses and lesser actions against 40 agents before the end of the year.

"We were not nearly as effective as we should have been during the last few years," noted Howard T. Spence, assistant commissioner for consumer protection, "but we have been introducing some new procedures and realigning our priorities."

The department has increased its investigative staff to six including three auditors, up from a low point of a single investigator two years ago, he said.

"We've always had a backlog of consumer complaints against agents," he noted. "But we've been stuck trading off between consumer complaints, marketing practices problems and other business complaints. We have since decided to give more priority to cases with the greatest impact on the public."

Over 100 complaints against commercial and personal lines agents have yet to be investigated, including not forwarding premiums to insurers, not informing companies that consumers have applied for insurance, misrepresentation and poor business practices.

"We have also had a few problems with busted agencies in Michigan over the past few years. As we get into researching various complaints we find that they are often symptoms of more aggrevated problems with business practices. That's why the auditors are on the staff," said Mr. Spence.

Enforcement, he noted, will be aided by a beefed-up Chapter 20 of the Michigan legal statutes that deals with unfair trade practices. "The amendments to Chapter 20 will give us some new and stronger tools to use in handling these complaints," he said.

Michigan licenses about 30,000 agents. ■

Make your booth the main show attraction

By George Bamber

THE COST OF INDIVIDUAL SALES is going up almost daily due to inflation and energy increases, but a trade show is the one place where a salesman can stand in one spot and have hundreds of customers come to him.

This makes trade show exhibiting an increasingly important source of low cost sales contact for both large businesses and small outlets. Trade show exhibiting can be as complex as a national advertising campaign or as simple as a face-to-face sale.

The best national advertising is the simplest and most direct. The best sales approach is the same: face-to-face contact between a salesman and a prospective customer as the salesman presents a desirable product and takes the initiative to close a sale.

That is the fundamental technique of trade show selling and exhibiting. Too many people get lost in the mysteries of trade show advertising. Like all advertising, a trade show exhibit must be simple and direct.

Graphic design

I must stress that the effectiveness of the exhibit is not dependent upon the cleverness of the hardware or how much you have spent or saved each time you have exhibited. The most effective measure of an exhibit, as in all great advertising, is its ability to bring the prospective buyer in from the aisle to the exhibit area where he is confronted by the exhibit salesman.

Trade show exhibits do this with graphic design.

The first thing that a person looks for in a trade show booth is the identity of the corporation. It's best if your identity is well-known or specifically describes your goods and services. If you are not as well-known as Kodak or General Motors, you're in trouble from the start. Your booth must identify what you have for sale.

An insurance agency booth, for example, must have "insurance" properly displayed along with the name of the firm. It may help to have your insurers' names displayed prominently.

The second most compelling part of the trade show exhibit is what I call the "hook question." It is the one element of the design or copy that compels the prospective buyer to enter the trade show exhibit and ask the salesman, "Why is your product better, faster, cheaper, sooner, than anybody else's?" Then it's up to the salesman and the worth of the product.

If the graphics on the back wall are not well-designed with a visual hook question to lure the prospect into the exhibit, the exhibitor will wait in vain.

Graphic designs are best done by professionals who specialize in that field. Any good trade show builder has a graphic designer on his staff. He has to; graphic design is the most important part of what he is selling. We provide our clients with a scale model to show them exactly what the booth will look like. You should ask your designer to do the same.

Costs

Traditionally, trade show exhibiting has been an expensive form of advertising because the exhibit backgrounds were built from heavy material such as lumber, chrome and formica. The initial cost of building the exhibit today can run from $1,000 to $7,000 per ten foot unit, depending on the complexity of the exhibit. Costs don't stop there.

Use costs are considerable. To ship the lumber crates that hold a 10-foot exhibit across country can cost anywhere from $300 to $1,000 depending upon the mode of transportation. That's just to get to the exhibit hall.

Union labor to set-up and teardown the exhibit, plus various miscellaneous charges, add additional $200 to $500 to an average show exhibit use costs depending on location and services required.

If a small businessman goes to 10 shows a year and if we conservatively figure total use costs of $600 a show, that person is spending $6,000 a year to show his exhibit. His total cost of exhibiting may exceed the cost of his exhibit six times.

Effectiveness

Since neither the heaviness of exhibit hardware nor the transportation of that hardware visibly increase the effectiveness of the message or salespeople, it may seem like a tremendous waste of money. For many small businesses it has been.

Exhibit companies, however, now tend to make lighter and more portable exhibit systems that can be folded down and carried onto an airplane. Blue Thumb has made that its speciality.

Regardless of exhibit structure or graphic design, the effectiveness of any trade booth program depends upon the activeness of the exhibit personnel. If they are not actively greeting prospects, soliciting their involvement and trying to nail down leads, then, in my opinion, the exhibit program is a failure, regardless of cost effectiveness or the excellence of the design. ■

George Bamber is president of the Blue Thumb Co., a California design firm specializing in trade show presentations. He specializes in designing collapsable, lightweight booths.

Harris survey

Workers want jobs past 65, pensions tied to inflation rate

By ELLIS SIMON

NEW YORK—A majority of working Americans wish to remain employed beyond the normal retirement age, according to a study on attitudes toward pensions and retirement sponsored by Johnson & Higgins.

Most Americans, the study found, object to mandatory retirement, but believe retirees should be able to enjoy the standard of living they had while working. While private and government pension plans were viewed favorably, survey participants doubted Social Security's ability to pay future retirement benefits.

In addition, respondents favored pension plan benefits that escalate with the cost of living. Most workers said they would be willing to contribute to their plans so they could enjoy that provision.

Lou Harris & Associates conducted the study, interviewing 1,330 current employes, 397 retirees and pension executives from 212 Fortune 1,000 companies.

The findings, which suggest eventual reversal of the trend toward early retirement, do not provide a definitive prediction on how this will affect pension costs, but imply that significant savings will result when employes continue at their jobs full time and modest savings will be realized when they remain on a part-time basis.

Of the workers polled, 51% said they wished to continue working beyond the normal retirement age. Self-employed persons most favored this, with 71% wishing to do so. Among salaried persons, 53% wished to remain employed past normal retirement while 42% of hourly workers wanted to continue working.

Early retirement was preferred by 22% of those polled and 26% said they wanted to retire at the normal retirement age.

Among those wishing to remain employed, 24% wished to continue working part-time, 14% wished to continue full time at the same job, 8% wanted to retire from one job and go with a new employer while 5% said they would prefer a less demanding full time job with less pay from the same employer.

"The basic undeniable fact is that most Americans in this last quarter of the 20th century want to work for the rest of their lives," said Mr. Harris, the pollster. "They not only think such work contributes to their own mental, physical and material well-being, but they also feel they can contribute to the mainstream of American society."

Mr. Harris also noted that white collar jobs, more prevalent today than blue collar jobs, require less physical strength, enabling people to work longer. As inflation continues to erode the purchasing power of retirees, many are likely to continue working out of economic necessity, he added.

While J&H pension experts note it is difficult to project how deferred retirement would affect pension costs, life and disability insurance costs are likely to rise because of increased risk, said James G. Harlow, senior vp and director of J&H.

Group health insurance costs are not likely to be affected since employes become eligible for Medicare at age 65, he noted. However, Mr. Harlow added that companies could develop special plans to supplement Medicare benefits.

By a nearly 9-to-1 ratio, current employes oppose mandatory retirement. Two-thirds of the business executives polled also said they were against forcing people to leave their jobs because of age.

Although 57% of current employes and 61% of retirees said older people can perform their jobs as well as as when they were younger, 64% of the executives polled disagreed. In addition, 80% of current employes and 75% of retirees said employers discriminate against older workers while 57% of the executives said they did not.

"Management is going to have to catch up with the thinking of both current and retired employes or find themselves bucking the mainstream of American attitudes," Mr. Harris cautioned.

However, workers and executives agreed that retirement income should be at about the same level as before retirement. This view was shared by 81% of current employes, 84% of retirees and 82% of pension executives.

Among retirees, 58% said their standard of living was adequate or more than adequate. Pension recipients fared far better than persons not receiving pension benefits, with 76% of pension recipients reporting at least an adequate standard of living compared with only 43% of those not receiving pensions.

The desire to maintain pre-retirement living standards reflects people's fear of inflation, Mr. Harris noted.

However, in commenting on the survey, J&H noted that maintaining pre-retirement standards of living was an "optimistic" goal that "will become less realistic as the retiree to worker ratio increases in future years and inflation takes its toll.

"A more achievable goal would seem to be one where the com-

Continued on following page

Employes want benefit reports

NEW YORK—Pension executives believe a lot of pension plan information their employes want to know is not all that important for them to know, surveys conducted by Lou Harris & Associates for Johnson & Higgins show.

While 83% of current employes who read their last pension plan report said it was very important to know the current financial status of their plan, only 38% of pension executives at Fortune 1,000 companies agreed.

Similarly, 60% of employes said it was very important to know whether the company or the pension fund trustee for a professional management firm was handling investments. Only 17% of the pension executives said this information was very important to employes.

Where pension funds are invested was very important to 60% of the employes, but only 10% of the pension executives agreed and 50% of pension executives said this was not important at all. In addition, 59% of employes said it was very important to know the rate of return on investment, while 16% of pension executives agreed and 51% said this knowledge was not important.

"Employers who are reluctant to be forthcoming with such facts are going to meet mounting demands and even criticisms from their employes," cautioned pollster Lou Harris.

Employers oppose pension rules

NEW YORK—Pension executives generally oppose the pension reform law but still praise several of its provisions, according to a study conducted by Lou Harris & Associates Inc. for Johnson & Higgins.

ERISA was graded "fair" or "poor" by 61% of pension executives polled. Only 38% said ERISA was a "good" or "excellent" law. The 212 survey participants handle pension matters for Fortune 1,000 corporations.

The pension executives strongly endorsed ERISA's: joint and survivor benefits provision by an 87% to 10% majority; IRA and Keogh plan provisions by 85% to 8%, and pension eligibility requirements by 78% to 20%.

Funding and fiduciary standards were looked upon favorably by 76% of those polled. Plan termination insurance was approved by 58% of the pension executives and 55% were in favor of ERISA's investment limitations. However, 71% of the respondents disapproved of the reporting and disclosure requirements and 63% opposed the limitations on pension requirements.

ERISA was said to have increased pension costs by 54% of those polled and 57% of the pension executives complained about additional time spent on pension matters. However, the positive result of employes knowledge of pension plans was cited by 63% of the survey respondents.

Harris survey . . .

Continued from previous page
bined retirement income available from a pension plan and Social Security provides a standard of living somewhere between "comfortable subsistence and the pre-retirement standard," J&H said.

Private pension plans received high grades from employes covered by such plans, with 78% indicating satisfaction with the design and administration of their plans and 68% having a "great deal of confidence" that the plan will pay promised benefits.

However, government employe pension plans were the most favored form of pension coverage, with 36% of current and retired employes preferring this form of coverage if they had to rely on one source, compared with 27% favoring private plans and 9% desiring union plans.

Social Security was the least desired source of retirement income, among 37% of the respondents, while union plans were least desired by 24% of the respondents. In addition, 53% of current and retired employes said Social Security was the form of coverage most in need of change.

Little confidence was expressed in the ability of Social Security to pay future retirement benefits, with only 15% of current employes having a great deal of confidence while 42% had hardly any.

Among pension executives, 73% reported either some or a great deal of confidence in Social Security's ability to provide future benefits. However, 50% of the pension executives doubted the willingness of future American taxpayers to support the system's escalating costs.

Pension plans provided for government employes have a reputation for being better than private plans, Mr. Harris noted. "Employers are going to have to do a lot of selling to their employes to make a majority of them convinced their pension plans are superior to government (plans)."

"The public lacks confidence in Social Security," observed Ken Keene, J&H senior vp and director. "This reflects a lack of confidence in government's ability to manage," he added, noting that 57% of employes prefer to have their Social Security taxes invested in private pension plans.

"It is not possible to provide adequate benefits to all Americans through Social Security," Mr. Keene continued. "The responsibility for retirement benefits over a basic level should be transferred to the employe and his employer."

Mr. Keene urged expansion of the private pension system and establishment of national policy to encourage small employers to establish pension plans and allow for employe contribution.

While current and retired employes generally were satisfied with pension plans as they exist today, adjusting benefits for inflation was the most desired improvement. Pension benefits that increase with inflation were either very important or extremely important for 93% of those polled. Among pension executives polled, 86% agreed. However, only 30% of current and retired employes said their pension plans do so.

More than seven out of 10 pension plan participants said they would be willing to contribute to or increase their contribution to their pension plan if the plan indexed benefits to inflation. ■

Need alternative to FAIR plans: Exec

NEW YORK—Property and casualty insurers should study long-range residual market problems examining the "industry's capacity to deal with it and public considerations that are involved," an insurance industry expert has said.

Calling Fair Access to Insurance Requirements (FAIR) plans "temporary schemes," Richard G. Brueckner, president of the New York Property Insurance Underwriting Assn., said recently that FAIR plans have lasted longer than originally intended.

"In my opinion, it is no longer prudent to continue to operate these socially required insurance pools on a catch-as-catch-can basis. I think we should assemble all the industry and professional management help we can muster and try to fashion insurance mechanisms that will serve the needs of the public without corrupting sound principles of insurance." ■

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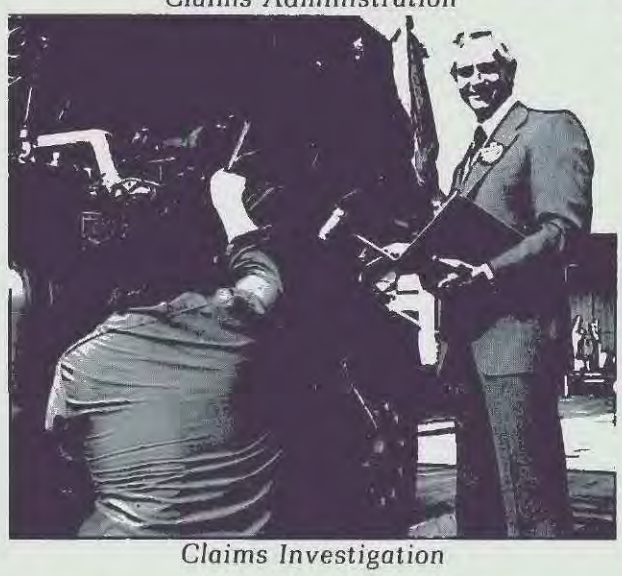

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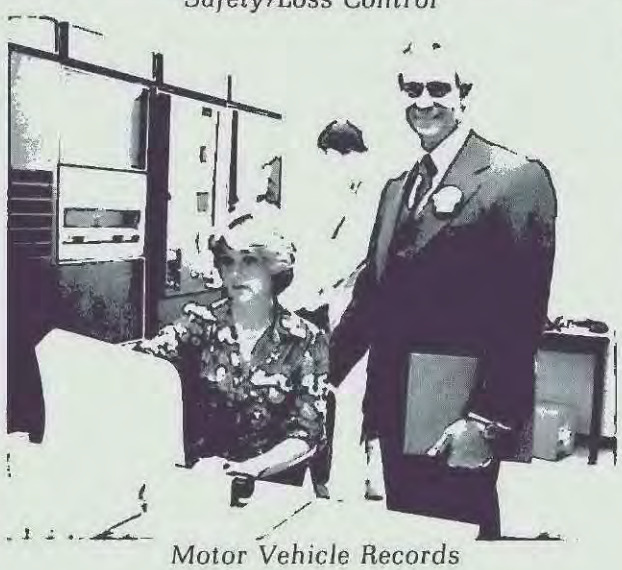

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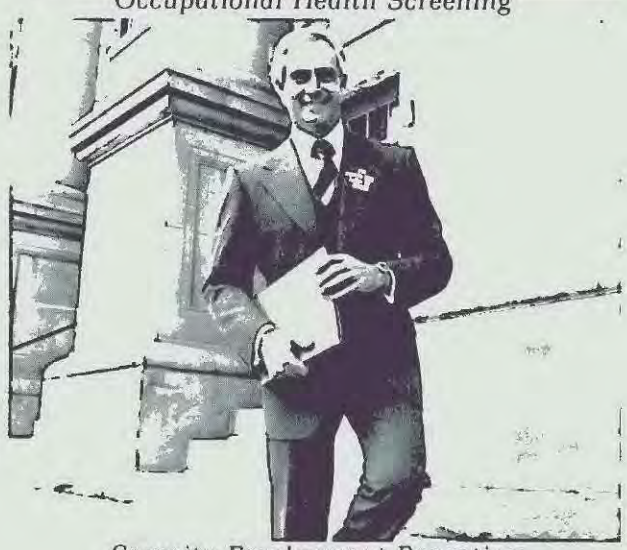

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IIAA GETS THE MESSAGE TO CONGRESS

Why bank holding companies should not sell insurance

The National Banking Act of 1916 specifically forbade national banks from engaging in any other activity but the banking business, except in communities with a population under 5,000. In those small rural towns, national banks were permitted to engage in other business activities (such as selling insurance) because these services were believed necessary to the survival of these banks in small communities.

To circumvent regulation, banks began to set up holding companies in the early 1950's. Using the cover of a holding company, which was unregulated, they were able to engage in a diversity of non-banking businesses.

The Bank Holding Company Act of 1956 sought to impose restrictions on holding companies that owned two or more banks. But, the one-bank holding companies were unaffected by the regulation. Between 1955 and 1968 the one-bank holding company increased in number from 117 to 783. Currently there are 2,027 bank holding companies in the United States operating through a total of 3,903 banks with 21,223 branches. This is a total of 25,126 bank offices. The economic power of the bank holding companies is awesome. They control $814 billion in deposits.

The consumer loses his "Freedom of Choice" and bargaining clout when credit needs are coupled with insurance sales from the same financial institution. The bank holding companies' power to extend credit is the power to coerce, and when lending institutions operate insurance agencies, they can effectively compel the placement of insurance through their affiliate.

The consumer should have the right to deal with the insurance professional of his choice. The consumer can then select the most beneficial terms and costs from among many reliable insurance companies for the best home, auto, life and business insurance coverage.

There are several bills that will protect your rights of "Freedom of Choice" by limiting the bank's incursion into the insurance business. Among these are the Hanley Bill in the House and the Durkin Bill in the Senate.

Today and tomorrow, the Independent Insurance Agents of America, Inc. will hold their Third Annual Legislative Conference at the Mayflower Hotel to discuss the Bank Holding Company bills with federal legislators.

We believe the consumer should have a "Freedom of Choice."

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Washington Post/New York Times

Why bank holding companies should not sell insurance

- When your constituents' credit needs are coupled with insurance sales from the same financial institution, they are put in an inferior bargaining position.
- The bank holding companies' power to extend credit is the power to coerce, and when lending institutions operate insurance agencies, they can effectively compel the placement of insurance through their affiliate.
- When your constituents deal with the insurance professional of their choice, they can pick and choose the best terms and costs from among many reliable companies for the best home, auto, life, and business coverage.

To preserve your constituents' freedom of choice and bargaining clout, keep bank holding companies out of the insurance business.

Support the Hanley Bill in the House and the Durkin Bill in the Senate.

Next week (March 12-13) 400 IIAA Independent Agents will be in town for their 3rd Annual Legislative Conference. Some will visit your office to discuss the Bank Holding Company bills and other legislation.

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Capitol Hill's "Roll Call"

IIAA's Third Annual Legislative Conference was held March 12 and 13 at the Mayflower Hotel in Washington. Over 400 IIAA independent agents were in attendance to meet federal legislators to discuss a broad range of legislative subjects with special emphasis on the upcoming Bank Holding Company bills.

To give the Legislative Conference "clout," a mini-blitz advertising campaign was implemented. On March 12th full page ads appeared in the Washington Post and The New York Times, the nation's two most prestigious newspapers. TIME's Washington metropolitan edition carried the ad week of March 12th. A special ad appeared March March 8th in the Roll Call Newspaper, which is distributed on Capitol Hill, to elicit backing for the Hanley Bill in the House and the Durkin Bill in the Senate.

This "government issue" advertising effort indicates a further commitment IIAA has made in combating negative legislation affecting our industry.

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around the states

Mich. defines governmental immunity

LANSING—Two recent rulings by the Michigan court of appeals reveal the court's definition of "governmental function" for which governmental immunity from prosecution applies.

In one case the court said the municipality could be sued and in another it said the state mental health department was immune from prosecution.

Citing earlier supreme court decisions that governmental agencies are only immune from prosecution while performing "governmental functions," the court said that Hazel Park could be sued by a skater injured at its community center. The skater claimed she was injured as a result of negligent supervision.

The suit had been dismissed by a county circuit judge on the theory of governmental immunity. But the appeals court said, "The operation of a roller skating program by a municipal corporation is not of essence to governing."

In another case, however, the three-judge panel ruled the state department of mental health could not be sued for damages by a state mental hospital patient who claimed he was assaulted by an attendant. The court said, "An attendant at a mental hospital serves partially in a custodial capacity," which has been interpreted previously as a governmental function.

Doctor's countersuit

SPRINGFIELD—The Illinois supreme court has turned down a petition to hear the malpractice countersuit of Leonard Berlin M.D.

Dr. Berlin will appeal the case to the U.S. Supreme Court making it the first malpractice countersuit ever taken to the nation's highest court.

The doctor and his attorneys expect to file a brief by April.

The Illinois supreme court's refusal to hear his case lets stand a 1978 decision by the Illinois appellate court that reversed a trial court decision in favor of Dr. Berlin. He had been awarded $2,000 in compensatory damages and $6,000 in punitive damages charged against an attorney, his client and her lawyer-husband for "wantonly and willfully" bringing a medical malpractice action against him.

N.J. work comp

TRENTON—Advocates contend it would correct the "inequities" of New Jersey's present workers compensation program, but opponents of the bill (A1735) assert it "is not a workable solution."

Sponsored by Assemblyman Thomas F. Cowan Sr. of Hudson County, the bill would increase weekly payments to totally and permanently disabled persons to $156 a week. Initial payments would be made out of the Stock Workmen's Compensation Security Fund and subsequent payments from the Second Injury Fund.

The Second Injury Fund is financed by a yearly assessment on workers' compensation payments made by each employer.

The measure could also extend payments to the dependents of workers who die from the occupational injury or desease for which they were receiving compensation.

Vt. work comp

MONTPELIER—Small Vermont employers will no longer have to pay an 8% surcharge on worker's compensation insurance or wait as long as several weeks before insurance coverage is granted, said insurance commissioner Stewart Ledbetter.

In addition, a new graduated schedule of agent commissions has been introduced which will result in "substantially more equitable" commissions for agents writing smaller policies.

Mr. Ledbetter said the improvements effective Jan. 1 will save Vermont employers about $200,000 annually. The changes were the result of negotiations with the National Council on Compensation Insurance.

In the past, small Vermont employers with only a few employes were usually placed in an assigned-risk category simply because insurers didn't want to write accounts when the premiums would be less than $1,000. Mr. Ledbetter said 80% of Vermont businesses pay premiums under $1,000.

Md. work comp

ANNAPOLIS—Judge Albert L. Sklar of the Baltimore supreme bench ruled that the Maryland insurance commissioner went beyond his authority in attaching a special condition last October to an order raising workers compensation insurance rates.

Judge Sklar said insurance commissioner Edward J. Birrane Jr. lacked the authority to stipulate that the 24.6% rise in workers compensation rates he granted could not apply to rates paid by private contractors while their contracts were still in progress.

But by not addressing the issue, the judge let stand another special condition which Mr. Birrane had attached to his order raising workers compensation premiums by $38 million. The commissioner had delayed imposition of the rate increase until Jan. 1.

Malpractice

HARRISBURG—The Pennsylvania Insurance Department approved a 5% increase on medical malpractice insurance rates by the Pennsylvania Medical Society Liability Insurance Co. (PMSLIC).

PMSLIC, a subsidiary of the state medical society, insures over 5,500 physicians and surgeons in Pennsylvania and is the state's second largest medical malpractice underwriter.

Even with this increase, Pennsylvania doctors will pay less now for coverage than that provided by Argonaut Insurance Co. prior to its abandoning the Pennsylvania market, said insurance commissioner Harvey Bartle III. Argonaut wrote the medical society's liability insurance program prior to 1978.

Under the old rate structure, doctors paid between $1,008 and $11,364 for basic coverage, depending upon their specialty and geographic location. The new rates range from $1,080 to $12,168. ■

Minnesota ponders blueprints to reform workers comp law

By MARY ELLEN McKEE

ST. PAUL—A Minnesota legislative study commission is recommending the workers compensation law be amended to provide for a state-operated fund to pay benefits for reopened cases, expanded retraining and rehabilitation programs and major administrative shifts.

The study commission, consisting of both public and legislative members, submitted its recommendations this month in a bill to the state legislature after two years of examining the problems inherent in the state's current workers compensation system.

Minnesota is another in a long line of states plagued with skyrocketing rates and difficulties in settling claims caused by the impact of a liberalized law. The law has forced insurers to drastically restrict their workers compensation underwriting in the state and has spurred whopping rate increase requests of 71.8% and 25.3% from the rating bureau in the past two years. (The state insurance department, however, has rejected these requests.)

The bill is expected to be introduced in the legislature this month in an effort to improve the state's workers compensation system.

Establishing a reopened case fund is vital to the financial stability of Minnesota insurers and employers, the commission states. Under the commission's blueprints, the case fund would be liable for any compensation awarded an employe resulting from the reopening of a claim if it is dated seven years from the injury or three years from the last compensation payment.

Currently, once a claim for compensation is made in Minnesota, there is no time limit on filing a further claim at a future date. This uncertainty of future liability facing insurers forces higher reserve requirements and in turn causes higher premiums, the workers compensation report explains.

"A reopened case fund would provide for the reopening of claims where justice requires, alleviate the uncertainty about reserving among insurers and reduce the higher premiums to employers which such uncertainty produces," the study commission report claims. The study points out claimants would receive benefits they were entitled to and individual insurers and employes would not have to pay for such reopenings. "Instead, an assessment on all insurers would serve to finance all reopenings, thus avoiding the necessity of considering potential reopenings in the determination of an individual case."

The kind of reopened case fund the report recommends is one similar to the one now operating in New York which is administered as part of a special compensation fund and financed by an additional percentage assessment on workers compensation insurers in the state.

Meanwhile, the commission also recommends the legislature permit an employer to register an employe's pre-existing condition with the state's "special fund" before and after an injury and waive the current pre-registration mandates. By registering a pre-existing condition, the employer avoids sole responsibility for an aggravation to any condition. The study commission thinks the special fund should pick up disability compensation in excess of 52 weeks and all medical payments in excess of $2,000.

The study commission supports siphoning investment income back into the special fund rather than in a general fund. "Returning investment income from the spe-

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Minn. work comp . . .

Continued from previous page
cial fund back into that fund will effectively lower the assessments imposed on employers for its maintenance," the report maintains.

Currently investment income earned by the special fund is placed in the general fund and results in potential benefit dollars being used to subsidize other state programs. "Growth of the special compensation fund will result in increased investment income and this income will help keep employer assessments low."

A higher quality of retraining and rehabilitation methods to speed the return of an injured employe to the workforce is also proposed in the commission's report.

The dramatic recognition of the role of retraining in cutting workers compensation costs was first suggested by the workers compensation advisory council, a separate and distinct body from the study commission, which has also studied workers compensation problems.

At the top of the list of recommendations to implement a strong and effective rehabilitation program is to immediately place any worker into rehabilitation counseling who has a permanent disability preventing him from adequately performing the job he held before the injury.

All vocational rehabilitation services, as described in the report, should return the individual to a job related to his former employment or, at least, in a nonrelated job which produces an economic status close to that enjoyed before the injury.

The commissioner of labor and industry, according to the advisory council's rehabilitation plan guidelines, would hire qualified administrators of rehabilitation programs and other assistants reporting to the commissioner of labor.

As envisioned by the advisory council and later by the study commission, the rehabilitation administrators, under the direction of the commissioner of labor, would supervise the delivery of all mandated rehabilitation services. The rehabilitation administrators should have the power to approve, modify or disapprove rehabilitation programs submitted to a review panel in order for this approach to be effective, the report maintains.

The review panel, the report explains, should consist of the commissioner of labor and industry or his designated representative and representatives of labor, employers, insurers, vocational rehabilitation facilities, physicians and medical specialists approved by the governor.

In addition to its regulatory capacity, the review panel should also be responsible for ongoing research into both physical and vocational rehabilitation and developing and molding regulations based on this data, the commission recommends.

When the employers and the insurers receive medical documentation that because of a work related injury an employe will not be able to fill the position held prior to the injury, the employer and the insurer should provide rehabilitation consultation for the employe within 30 days of the medical notice.

Consideration must be given to the workers age, education, previous work history and skills when developing a rehabilitation plan, the study warns. Before any rehabilitation program approach can be effective, the study emphatically states, disabled employes must be required to submit to all reasonable requests for examination and evaluations considered necessary to determine the need and extent of rehabilitation.

Also necessary to the success of this kind of approach to slashing workers compensation costs is the preparation of periodic progress reports on the employe to provide the department of labor, employers and insurers with up-to-date files.

Application by an employer, insurer or disabled worker for suspension of a rehabilitation program is possible under the commission's program only if one party can prove that the impairment of the worker would prevent him from moving into the new vocation. In order for a plan to be suspended, a party must prove the worker's performance shows he cannot complete the course; the worker refuses to cooperate in the program or the worker feels he is not suited for the work for which he is being trained.

Rehabilitation costs, according to the commission report, will be covered by the employer and must include the cost of vocational rehabilitation diagnosis and plan formulation; cost of all rehabilitation service and supplies necessary to launch the plan; tuition, books, lodging and travel when rehabilitation classes are out of town and any expenses agreed to by the insurer and the employer.

This proposal permits retraining by private rehabilitation agencies which are properly accredited by the commissioner of labor and industry, instead of the current practice of shifting retraining program design to the state's division of rehabilitation. "By permitting private agencies to develop retraining programs, the overall attention to and quality of retraining programs will increase, thereby enhancing the employment prospects of the worker," the study submits.

More participation of the insurer and employer in the retraining and rehabilitation process is encouraged by the commission's proposals. Currently the only input the insurer and employer has in the whole process is to object to a retraining plan developed by the division of vocational rehabilitation in a judicial proceeding. The commission also recommends that the insurer and employer choose the rehabilitation agency which will develop and carry out the plan.

Because of the conflicting estimates in litigation of the degree of disability of an injured worker, the study commission recommends that the commission of labor and industry should formulate disability schedules for an objective assessment of disability.

The study commission recommends that the department of labor and industry consult with the medical and chiropractic profession to develop a medical fee schedule and hire outside consultants to study department and industry data and record keeping systems with special attention to computer and microfilming.

Other recommendation made by the commission are:

- Change the maximum benefit level to 200% from 100% of average statewide weekly wage.
- Do not pay permanent, partial disability benefits until a worker returns to work or reaches maximum medical improvement.
- Compile a special listing of internal organs to be covered in the permanent, partial disability schedule.
- Require a second medical opinion for a list of surgical procedures.
- Limit third-party liability suits against co-workers to gross negligence or intentional acts.
- Require the compensation rating bureau to separate paid and outstanding losses in rate filings. ■

Firms in Calif. lose rights to subrogate work comp: Lawyer

By JOANNE GAMLIN

SAN DIEGO—California employers lost their statutory rights to subrogation in third-party workers compensation cases when the court introduced the doctrine of comparative liability to these suits, a respected defense attorney believes.

The legislature must now address the issue of employers' subrogation rights, attorney Clifford D. Sweet III told the 49th annual meeting of the California Self-Insurers Assn. (CSIA) here last month.

"It is ludicrous to have such a dichotomy between legislatively enacted rights and judicially interpreted remedies," he asserted. "The legislature must reassert itself as the branch of government which has the final authority in allocating the costs of workers compensation benefits in the context of third-party cases."

Other speakers focused on the subjects of comparative liability and workers compensation defense.

Comparative liability should be apportioned by superior courts and not by the workers compensation appeals board, suggested WCAB judge Mervin Glow. If the WCAB is assigned the monumental task of determining the amount of liability of the employer, the employe and the third party, it will have "a massive problem" on its hands, he acknowledged.

"Sub rosa" or secret investigations of workers compensation lawsuits remain acceptable, although they must be clearly legal, said defense attorney Sue England.

State senator Bill Greene, chairman of the industrial relations committee, also predicted the legislature will enact a significant piece of workers compensation legislation in 1979. He expects the new bill to be so thorough that additional legislation will not be needed for 15 to 20 years.

While attorney Mr. Sweet said it is the duty of the legislature to determine whether or not employer subrogation rights should be preserved, some members of the audience indicted to *Business Insurance* they are anxious to see the legislature axe those rights.

Foremost-McKesson's assistant treasurer Alan Pearce, for example, predicted that subrogation rights will be abolished. And a representative of Southern California Edison said he believes subrogation rights are no longer in the interest of large employers self-insured for workers compensation. He reasoned that with comparative liability, an employer will inevitably have some percentage of fault assessed against him.

"A large company under the 'deep pocket' theory could be on the hook for the entire judgment even if he is only 5% at fault," he argued.

However, the representative of another large firm said he believes there will be cases where the third party is assigned 100% of the fault. In these cases, the employer would benefit from having rights of reimbursement or credit.

Mr. Sweet pointed out that California's labor code gives employers independent rights against third parties for reimbursement of workers compensation benefits paid. The code also permits an employer to claim a credit in the amount of the employe's net recovery, after attorneys' fees and costs, to be applied against future liability.

But he believes subrogation will become a moot point with the coming of comparative liability because court and legal costs for many employers will far exceed what they can recover through a

Continued on following page

Subrogation rights . . .

Continued from previous page
reimbursement or credit. Mr. Pearce observed that this situation occurs more often than many employers want to believe.

The doctrine of comparative liability was extended to the workers compensation arena in California with two lawsuits, Arbaugh *v.* Proctor & Gamble and Associated Construction & Engineering *v.* Workers Compensation Appeals Board.

It was the Arbaugh case, said Mr. Sweet, that established the principle of an employer's right to reimbursement in third-party workers compensation cases only to the extent that compensation benefits have exceeded theoretical liability. Thus, in the Arbaugh case, the employer—50% at fault—was theoretically liable for contributions of 50% of the benefits of $340,000, creating a threshold amount of $170,000. Since the employer had paid only $40,000, the company was barred from seeking reimbursement, Mr. Sweet said.

The other lawsuit, Associated Construction & Engineering *v.* WCAB also known as the Cole case, was decided by the state supreme court in late 1978 in a narrow 4-to-3 decision. The high court held that employer is not entitled to either a credit or reimbursement until he has paid workers compensation benefits in excess of a threshold amount determined by multiplying the employer's negligence times the employe's damages.

Taken together, said Mr. Sweet, the two cases are detrimental to industry.

"For the first time, the extent of an employer's liability is to be measured by its theoretical liability as a defendant to the employe for pain, suffering, medical treatment and economic loss," he said. "As far as I can determine, this is totally without judicial or legislative precedent in this or any other jurisdiction."

The cases raise serious questions as to the propriety of attributing the injured workers' negligence to the employer, he said.

"Consider the situation in which an employe sustains damages in the amount of $100,000 where the employe was 50% at fault, the third party was 50% at fault and the employer was completely without fault," he posited. "Under the Arbaugh and Cole decisions, the employer would be denied both reimbursement and credit until it has paid the employe compensation benefits in excess of $50,000. To the extent that the employer has liability to the employe for $50,000 as unpaid compensation benefits, the employe reaps a double recovery. He keeps his $50,000 from the third party and gets $50,000 more from the employer.

"Alternatively, where the employer has paid $50,000 in benefits, by the time of trial, the third party completely avoids responsibility for its own wrongdoing and it would get a full credit for the benefits the employer has paid." In this case, the employer who is without fault lacks the ability to supervise or control the employe, Mr. Sweet said. What's more, in this situation the employer would have liability, whereas under the older concept of contributory liability with indemnity, he would not have any.

"To continue to attribute the employe's negligence to the employer in light of Arbaugh and Cole would appear to be totally inconsistent with the historical context of the labor code," he said.

Considering the impact of the two cases, the attorney predicted that employers will litigate the issues of liability and employe damages to attempt to set as low a threshold as possible. Employers will have to incur the cost and time necessary to produce evidence on such issues as pain suffering and future economic loss.

"With his eyes on the issue of credit, the employe understandably will not be cooperative with the employer's endeavors," maintained the attorney.

Under the WCAB, he continued, the employer will also be in a tough spot, laboring under a different standard of proof than he would encounter in a court of law. Because strict rules of evidence do not apply before the WCAB, the employer could be faced with evidence—such as hearsay—which would be jettisoned in ordinary court procedure.

WCAB judge Mervin Glow, however, denied that hearsay evidence receives much credibility in his court. Yet he agreed with Mr. Sweet that if the WCAB is called upon to apportion liability then it must be given judges who are specialists in the area of liability and damages.

Mr. Glow predicted the WCAB will not spend its time hearing cases in which the employer has no chance of reaching his threshold amount of contribution. The employer thus loses all chance for credit or reimbursement. And a trial by jury before the WCAB is out of the question, he said.

Discussing the legal limits on employers in workers compensation lawsuits, attorney Ms. England said that without fraud or other illegal activity, sub rosa investigations can be used, often effectively. But "rope jobs" in which the applicant is enticed into doing something he ordinarily would not do, should be shunned, she advised.

It is acceptable to film an applicant doing something he has sworn he cannot do, she said. For example, she related that an applicant who said he could not walk without a cane was photographed walking normally at Disneyland. Showing the court the film of his easy amble through the amusement park helped the employer, she said, since it raised serious questions about the claimant's veracity.

"However, films that do not create doubt about the honesty of an applicant should not be used," she cautioned. Ms. England noted that the showing of such a film after an applicant has admitted in court the behavior displayed on film can be harmful to an employer and can even trigger lawsuits. ■

Lawmaker seeks OSHA abolition

WASHINGTON—Rep. George Hansen (R-Idaho), a long-time foe of the Occupational Safety and Health Administration (OSHA), is again introducing legislation to abolish the controversial federal safety agency.

"The elimination of this agency would put an end—once and for all—to years of government waste and increased regulatory cost to the taxpayer," Rep. Hansen said. "By now there should be no doubt in anyone's mind that OSHA needs to be put out of its misery."

Rep. Hansen's legislation comes on the heels of a Senate committee report released last month also recommending that OSHA be abolished. The Senate report, which was drafted by Harvard University professors Richard Zakhauser and Albert Nichols, said workplace safety would not be significantly affected if OSHA were eliminated.

Rep. Hansen has introduced similar legislation in previous Congressional sessions. ■

Facts must back trauma claims, psychiatrist says

SAN DIEGO—In the evaluation of workers compensation claims citing psychiatric cumulative injury, objective and subjective material should support and not contradict each other, according to a Beverly Hills psychiatrist.

Barry G. Gwartz, M.D., who has an academic background in internal medicine and psychiatry, told the California Self-Insurers Assn. (CSIA) that unless objective data backs up the subjective description that an applicant gives concerning his condition, the latter should be regarded with skepticism.

Objective data that should play key roles in the assessment of an applicant for a psychiatric claim, he said, include pre-employment applications, early evaluation reports and medical reports. Further documents that should be scrutinized in looking at the interaction of the claimant and his job are evaluation reports, attendance records, and reports concerning pay boosts, promotions and educational leaves. Tape-recorded statements or personal memos from coworkers should also be evaluated, the psychiatrist said at the CSIA annual meeting here.

Conclusions such as the one that type "A" personalities—hard-driving, aggressive types—have the greatest risk of heart attacks should always be questioned, Dr. Gwartz said. The New England Journal of Medicine recently reported no correlation between type "A" personalities and heart disease, he noted.

Similarly, he indicated that the amount of conflict a person experiences on the job should not necessarily be assumed to be caused by that job.

Studies show that people who change jobs frequently do so for reasons of internal difficulties rather than job-related causes, said Dr. Gwartz. Thus the conflict that a worker undergoes at work cannot be said to unilaterally stem from his job. "You cannot distinguish between 30 years of living and 30 years on the job," the psychiatrist argued.

Dr. Gwartz urged that stress be more precisely defined as noxious stimuli. Under prevailing definitions, it is not possible to distinguish the physical reaction to a passionate kiss from a reaction caused by job harrassment, he said.

The psychiatrist is known to have numerous corporate and public clients, among them Sears, Roebuck & Co. A CSIA member later told *Business Insurance* that his firm has used testimony by the psychiatrist to its advantage in negotiating settlements of cumulative trauma claims.

However, psychiatry was not the only avenue that the CSIA explored at its meeting in its quest for ways to reduce cumulative trauma and disability claims. Sexual adjustment of workers of prolonged disability leaves should be examined, according to one conference speaker, and women's career aspirations should be deliberately served, according to another.

Dr. Ruth Glick, who is with the West End Women's Medical Group in Reno, Nev., urged conference participants to consider a worker's sexual activity an integral part of evaluating and handling a workers compensation claim. Workers who are disabled, say by a heart attack on the job, should be counseled on the effect of disability on sexual activity, she said.

Helen D. McCullough, president of Contemporary Management Consultants in Sacramento, told the conference that since work success is still elusive for many women, upward mobility programs designed for women workers would also diminish potential disability claims. Employers should also offer resources such as child care and consulting services to their women workers, she said.

Two other speakers addressed the subject of occupational health.

Dr. Phillip Polakoff, head of the Western Institute of Occupational/Environmental Science, is studying the effects of asbestos. He also called for studies on the impact of low-level radiation. "Is there a safe level of exposure to radiation?" he wondered.

Johns-Manville Co.'s medical director, Dr. William R. Paul, said the campaign that his company has waged against smoking has reduced smoking among workers to a minimum throughout the company. The reason that Johns-Manville has mounted an intense effort to wipe out smoking at its plants was made clear in a film shown by the medical director. The risk of cancer is 92 times greater for a person who is exposed to asbestos and who smokes than it is for an individual who does not smoke and never comes close to asbestos. ■

Realtors chart own E&O plan

PHILADELPHIA—INAX Underwriters Agency Inc., an INA Corp. subsidiary, and the National Assn. of Realtors have brainstormed a special program to provide professional liability protection for errors and omissions to the association's members.

The policy will offer coverage for real estate agents and brokers, insurance agents and brokers, real estate appraisers, property management agents, notaries public and consultants.

Under the policy, a firm, its principals and its employes can be covered up to $5 million with a $1,000 minimum deductible. Higher deductibles are available.

Prior acts coverage up to the limits of the policy and extended coverage up to three years after the cancellation date can also be provided in the program. ■

benefit tax slants

Most benefits fall under 7% wage cap

By JOSEPH S. ROBINSON
Attorney-at-Law

All private companies and all units of federal, state and local government have been asked by the Council on Wage and Price Stability (CWPS) to operate within certain wage and price limits.

The foundation of the wage aspect of the Administration's guidelines is a 7% ceiling on annual boosts in wages and employe benefits. The standard applies not only to gross wages and salaries but also to incentive pay and increases in employe benefits. All forms of executive compensation such as bonuses count as pay. In fact, any form of compensation that must be reported under the Internal Revenue Code is covered. Thus, job perks also are included. The combined increase in all forms of compensation above the levels in effect in the base quarter is limited to 7%.

For pension plans that pay specified benefits at retirement, cost increases arising from changes in funding methods, amortization periods, actuarial assumptions or plan experience are not counted as pay-rate changes. But cost increases due to the adoption of improved benefits, wage or salary changes, or other changes within the employer's control are included as pay-rate changes.

With respect to deferred compensation, bear in mind that such pay plan is considered as compensation in the year received, not in the year the company sets aside the money.

The Administration's proposed budget for fiscal 1980 lists a number of items related to employe benefits. As to the taxation of fringe benefits, the chief areas of concern relate to company products or services either at discount rates or without charge whatsoever.

Convention expenses

Employer reimbursements received by an employe for his wife's expenses at a convention were held to be taxable income to him with no offsetting deduction where there was no business reason for her presence at the convention *(Fenstermaker, TC Memo 1978-210)*.

Assignment of earnings

Some executives think they can escape taxes on their future earnings by assigning the income to a "family trust" that uses the money to take care of personal expenses. Predictably, that tactic continues to get exactly nowhere with the courts.

Benefit taxes stalled

As a result of P.L. 95-427 *(reprinted in IRB 1978-46, 11)*, IRS is precluded from issuing in final form any fringe benefit regulations relating to the inclusion of a benefit in income between May 1, 1978, and Dec. 31, 1979. Further, regulations may not be issued in proposed form if their effective date is on or before Dec. 31, 1979. The law also provides that, in 1979, the tax treatment of commuting expenses will be governed by the rules in effect before Rev. Rul. 76-453 was promulgated and that employes will not have to include in gross income the value of meals furnished by an employer on business premises or lodging if the food or lodging was supplied for the employer's convenience.

Lump-sum distribution

An employe who participates in both a profit sharing and a pension plan can roll over the distribution of his entire interest from one plan into an IRA, and elect 10-year averaging treatment on the lump-sum distribution from the other plan, provided that the interests are received from the two plans in separate taxable years. If, however, the payouts from both plans are received in the same taxable year and all or (under the 1978 Revenue Act) part of one distribution is rolled over into an IRA, the employe may not elect the 10-year-averaging treatment with respect to the remaining funds.

In Letter Ruling 7842049, the aggregation rule applicable to special averaging, the lump-sum distributions is explained in terms of seven situations involving different treatments of plan distributions. As stated in that ruling, a recipient of a distribution cannot use the special 10-year-averaging method unless he combines all amounts received in any taxable year which might be eligible for the special averaging system into a single lump-sum distribution. Consequently, if a taxpayer wishes to accord different treatments to distributions from a profit-sharing plan and a pension plan, he must be sure that the distributions are received in separate taxable years. ■

Pa. officials fine agent for bribery

PHILADELPHIA—An insurance agent here charged with bribing an insurance department official here for the state's insurance coverages has been fined $12,000 and suspended from operating for 90 days by the insurance department.

The action came three years after the agent, James H. Pye Jr., allegedly gave a $12,900 kickback to Frank J. Barbera, former deputy secretary of the insurance department in an attempt to win the state's business.

Mr. Barbera pleaded guilty to the scheme in February 1976, but Mr. Pye has never admitted his guilt. Mr. Pye sought a court injunction against discipline by the insurance department, claiming that he had been granted immunity.

The state's supreme court recently upheld a lower court ruling that Mr. Pye had never been granted immunity against any disciplinary action by the insurance department.

Mr. Barbera has allegedly been involved in other kickback schemes dating back to the late 1960s, a state insurance department spokesman said. Criminal actions have been brought against Mr. Barbera in federal court by the state attorney general. ■

legal briefs

Worker is totally disabled if can't do old job: Court

Is an airplane pilot who was 100% disabled from performing his former occupation "totally disabled" under the terms of a group insurance policy? A Michigan appellate court concluded that he was because the coverage afforded under the policy looked to the work performed by the employe for this employer.

After long service as an airplane pilot for GM, Raymond Chalmers suffered a severe heart attack in 1971. Although he recovered, his pilot's license was permanently suspended as a result of the heart attack. Mr. Chalmers was covered under a group insurance policy issued by Metropolitan Life Insurance Co. Under the policy, benefits were provided for total disability if the insured was unable to engage in any gainful employment or occupation for which he was reasonably qualified by education, training or experience. Metropolitan denied Mr. Chalmers' claim for benefits. The trial court found for Mr. Chalmers.

Metropolitan's argument on appeal was that although Mr. Chalmers was no longer able to get a pilot's license there were many jobs that he was physically qualified to do. The court concluded that the policy provision with regard to disability was ambiguous especially as to the meaning of "reasonably" qualified. The court believed that Mr. Chalmers' education and training was geared to his preparation for the specialized occupation of airplane pilot.

"It is this particular occupation," the court said, "for which plaintiff is reasonably qualified." Any other interpretation of the policy would, in the court's opinion, be to interpret the policy as extending very limited coverage. *Chalmers v. Metropolitan Life Ins. Co.*, Court of Appeals of Michigan, Sept. 21, 1978 (BI/01/A.-$4).

Professional liability

A physician brought a suit against his professional liability insurance carrier contending that the insurer was obligated by the terms of the policy to defend against an action for alienation of affection. An Oregon appellate court held that public policy prevented an insurer from providing such coverage.

The physician had a professional liability policy with St. Paul Fire & Marine Insurance Co. from 1971 to 1974. In 1975 the physician was sued by Daniel Hannan who claimed that in 1973 the physician intentionally and negligently engaged in a course of activity with his wife designed to obtain her affections and which alienated her affections from Mr. Hannan.

Mr. Hannan further claimed his wife abandoned him causing their marriage to terminate in divorce. The physician tendered the complaint to St. Paul but the insurance company denied any obligation to defend. Subsequently the physician settled with Mr. Hannan and brought this suit. The trial court ruled for St. Paul.

The appellate court said that under the public policy limitation against insuring for intentionally inflicted injury or damage, it was not sufficient that the insured's intentional acts have resulted in unintended harm. The acts, the court said, must have been committed for the purpose of inflicting harm applies or the public policy against insurability applies.

Because the elements of alienation of affection constitute a claim that someone intentionally inflicted an injury or damage, the court said that public policy prevents the insurer from providing this coverage. *Eberdt v. St. Paul Fire & Marine Ins. Co.*, Court of Appeals of Oregon, Oct. 30, 1978 (BI/02/A.-$4).

Group life

A beneficiary under a group life insurance policy sued to recover accidental death benefits covering state employes. An Oklahoma appellate court held that where there was a significant variance between the terms of the master policy issued to the state and the booklet explaining policy benefits furnished to the employes, the rule that ambiguities or conflicts must be resolved in favor of the insured was applicable.

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

Otis Evans, an employe of the state highway department, died of a coronary occlusion caused by over-exertion while working. Mr. Evans was covered under a group insurance policy for state employes issued to the state requiring that accidental bodily injury under the policy to be evidenced by a "visible contusion or wound on the exterior of the body." However, the informational booklet given to employes simply said payment would be made for loss of life. The booklet also said no payment would be made for losses resulting from disease of the body. Mr. Evans' widow filed a claim which was denied by Lincoln. The trial court also ruled against her.

The appellate court reversed the decision because of the variance between the master policy and the booklet furnished the employes. Since the booklet made no mention of "visible contusion or wound on the exterior of the body," the court held that the booklet was controlling. However, the court also decided that a trial was necessary to ascertain whether Mr. Evans' death was accidental, a fact which had not been considered by the lower court. *Evans v. Lincoln Life Ins. Co.*, Court of Appeals of Oklahoma, Sept. 19, 1978 (BI/03/A.-$4).

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

london line

Minet and James untie financial binds

By JOHN H. MILLER

LONDON—Lloyd's brokers Minet Holdings hope to retain close insurance links with Fred S. James & Co. even though Minet is pooling future business interests with rival U.S. brokers Corroon & Black.

Minet is untying its financial connection with Fred S. James, however, in order to clear the way for its new U.S. business commitments.

Minet will sell its 10% holding in James by the end of April for $9 million in cash and also the return of the 31% stake which Fred S. James has held in Minet James International, an international insurance broking group active outside North America and the U.K.

But U.K. finance chief executive of Minet, Brian Chapple, says: "We want our long-established relations with Fred S. James to go on normally and see no reason why this association should not continue."

One reason for his comment is believed to be that so far there is no sign of James linking-up with any other U.K. broker to keep in line with the trend already set by Marsh & McLennan and Alexander & Alexander. James can still place its U.S. clients' business any way it wishes.

The Corroon & Black deal, Mr. Chapple explained, was achieved because of the philosophy mutually held by both brokerage groups that stronger associations between North America and the U.K. were desirable. But he was silent when he was asked why Minet's had not gone in with its long term associate Fred S. James.

Stockbrokers Kitcat & Aitken speculate: "It had seemed natural that one day Minet would go in with Fred S. James, and for the present it must be presumed that the latter group has no desire to follow its larger and, now, smaller competitors into such a trans-Atlantic pooling of interests. Minet operates in over 100 countries throughout the world, but the importance of the U.S. market will enable it to handle a rapidly expanding volume of business when Corroon & Black re-examines its relationships elsewhere in the London market."

Capacity crisis foretold

Sir Henry Mance, a former Lloyd's chairman, predicted there will be a capacity crisis in the early 1980s to financial experts at a conference on new U.S. markets.

"There is strong likelihood that if there is a recovery in international trade, world premium income will rise faster than U.S. premium income," he said. "If that is so, it's most unlikely that insurance as is presently constituted could cope with that increase without severe problems."

He based this estimate on an increase in world trade of 5% yearly over the next four to five years and an accompanying rise of 5% through inflation.

This will bring world premium income to between $230 billion and $250 billion, an increase of $100 billion, or 60% over that period, he told the conference organized by stockbrokers Laing & Cruickshank. Estimates by a U.S. banking group had put the U.S. share of this at $118 billion by 1982, an increase of $35 billion.

Lloyd's commission

Lloyd's is taking a new look at itself after criticism last year about some of its old, established rules for controlling its underwriters and brokers in the present state of international competition.

It has reacted to these attacks by setting up a commission to report later this year on whether any major changes in its traditional constitution are necessary.

A senior U.K. lawyer and academician, Sir Henry Fisher, heads the probe and seeks evidence by the end of March for consideration.

There will be wide opportunity for investigation of Lloyd's activities, as the commission has been asked to study the constitution of Lloyd's, the powers of Lloyd's committee and, in its own words, "any other matters relevant to the inquiry."

Procedures for settling internal Lloyd's market disputes, such as those which arise between brokers or underwriters, will also be examined. The method of electing the committee of Lloyd's and its powers over all members of the market will be closely scrutinized.

Four leading members of Lloyd's will sit on the commission to account for various market activities: Norman R. Frizzell, Lloyd's broker; Gordon W. Hutton, head of its marine association; A. Bruce Gray, of the non-marine market, and Thomas B. Langton, underwriting agencies. In addition, there will be outside members: Robin Broadley, merchant banker, and David Watt, director of the Royal Institute of International Affairs, as well as Sir Henry Fisher, a former U.K. judge who is now president of Oxford University's Wolfson College.

The commission hopes to publish its report later this year, but some of it may be confidential.

Efforts to maintain the world standing of Lloyd's have been welcomed by Henry White-Smith, chairman of its insurance brokers' committee, who pointed out recently: "The whole basis of Lloyd's rests on good faith, but the danger is that by creating more legislation you destroy the good faith itself. We must recognize that good faith works well when business conditions are good, but it can get strained when business becomes more difficult.

"Imposition of outside control might be far more destructive than self-discipline and self-control. If the Lloyd's system is to continue, the boards of Lloyd's broking companies must ensure that standards of integrity are priorities above all else."

Anti-crime conference

Road transport operators in the U.K. are planning to attend an anti-crime conference at the 1979 seminar of the International Cargo Security Conference in Montreal May 17 and 18. Jack Brown, chairman of the U.K. Road Haulage Assn. vehicle security committee, estimates that crime costs his members $200 million a year. ■

book review

Product liability 'myths' pop up in print—again

By JERRY GEISEL

Students of product liability have had a difficult time separating fact from fantasy. Grossly inflated claims and stories of product liability cases that never happened have stymied the search for understanding.

A new book, "Products Liability: Who Needs It?" by Gene Sullivan, executive manager of the Western Assn. of Insurance brokers, doesn't offer much help to anyone seeking a thoughtful, analytical look at the product liability issue today.

Like so many others before him, Mr. Sullivan inflates the recent increase in the number of product liability cases. He says the number of product liability lawsuits jumped from 50,000 a year in 1960 to 500,000 in 1972 and is expected to rise to one million in the 1980s. Where Mr. Sullivan came up with his figure is unclear, but he apparently is unaware that the American Insurance Assn. as early as 1976 labeled the million-cases estimate as "ridiculous."

Mr. Sullivan fails to cite his source for other statistics, casting doubt on their validity. In explaining why an injured consumer might be likely to file a claim against the manufacturer, Mr. Sullivan says plaintiffs are winning 52% of product liability cases. This statistic flies in the face of the Insurance Services Office massive study of product liability claims, widely believed to be the best statistical source on product liability problems facing manufacturers, which found that the defense wins 75% of products suits.

The book is short on analysis. Mr. Sullivan devotes considerable space to the rise in $1 million product liability awards, a factor in higher insurance premiums. But he fails to note that by the time the appeals process is exhausted, a plaintiff often receives a fraction of the initial award. The ISO report found that plaintiffs on the average receive $3,500 each by the time product liability claims are finally settled.

There is excessive reliance on secondary sources, such as newspaper and magazine articles, and insufficient use of primary sources. Mr. Sullivan has all but ignored the final report of the Interagency Task Force on Product Liability, published in November 1977. Such an omission is puzzling since the 500-page final report is recognized as the most balanced explanation of the product liability environment.

Risk managers, though, will find useful Mr. Sullivan's guide to reducing the number of product liability suits through loss prevention programs. Similarly, Mr. Sullivan gives some thoughtful advice of what a company can do to strengthen its defenses when challenging a product liability suit in court.

Another section gives an incisive analysis of the key cases that led to the court's adoption of strict liability. Cases are cited for easy reference in a law library.

Mr. Sullivan discusses a number of solutions to the product liability problem, including a shift from the tort litigation system to a no-fault system. Surprisingly, Mr. Sullivan fails to analyze the nationwide movement spearheaded by business groups to change the tort law as it affects product liability.

It would have been interesting to know Mr. Sullivan's views on what effect the new tort reform laws might ultimately have on manufacturers' product liability insurance premiums.

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Products Liability: Who Needs It? by Gene Sullivan, $12.75. The National Underwriter Co., Cincinnati, Ohio, 1979.

riskWatch

By JERRY GEISEL

State product liability tort reform tailspins into a national debate

Two years ago, a revolution began to sweep state legislatures around the country. At first slowly, and then with dizzying speed, legislatures under heavy pressure from the business community passed bills making sweeping changes in tort law as it affects product liability.

This legislative revolution is unprecedented for several reasons. Traditionally, courts, not the legislatures, have laid the framework for the application of tort law. Moreover, legislative changes were debated or passed at a snail's pace. It has not been uncommon for a state legislature to take five years to enact a comparative negligence statute.

Geisel

But there's nothing snail-like about the tort reform movement. In two years, 16 states have passed comprehensive bills and more states are likely to follow suit this year. In some cases, states have approved bills that make enormous changes in the law after barely two months' consideration.

For some interest groups, the states can't act fast enough to make what they see as long overdue changes to restore balance and equity to the legal system. But tort scholar Victor Schwartz, the Commerce Department official who directed the Interagency Task Force on Product Liability, is concerned that in at least one case, a state assembly may have acted too quickly and passed a bill without being fully aware of its significance.

In Ohio, many of the house legislators who voted for a comprehensive product liability bill, which later died in the senate, lacked a full understanding of what kind of changes they were voting for, Mr. Schwartz said before a Commerce Department hearing.

Especially alarming to consumer groups was the bill's potential to put tort law back 50 years. Others might disagree with Mr. Schwartz's observation, but regardless of the Ohio bill's merits, state legislators undeniably have awesome power over the legal environment. They can reasonably be expected to weigh the product liability equation before giving their approval to legislation. Even on the most basic aspects of tort reform, compelling arguments are made by consumers and manufacturers.

■ Should manufacturers be responsible for their products for a fixed number of years after the products are manufactured or sold? Without such a time limitation, manufacturers can be hauled into court 20 years, 30 years or even longer after the product is made. This long liability tail enormously increases liability risks and makes it difficult, if not impossible, for companies to obtain reasonably priced product liability insurance, business groups contend.

By cutting off a manufacturer's liability after a fixed number of years, manufacturers will lack the incentive to produce safe, long lasting products, consumer groups counter. Instead, it is better public policy to hold manufacturers liable for the useful safe life of their products.

Manufacturers insist it is only fair to shield them from liability if their products were made in conformity with existing technological processes. How is it possible to do better than what is technologically feasible, manufacturers ask.

Allowing a state of the art defense will result in more unsafe products flooding the marketplace, trial lawyers and consumers contend. For example, a manufacturer may rely on the most advanced technology to produce a product, such as a nuclear-powered automobile engine, but the product still could be unreasonably dangerous because nuclear technology still is in a relatively primitive stage, runs the counter-argument.

Nearly all state laws include an alteration-of-product defense for manufacturers, protecting them if the product was altered or modified after it left their control. This is only fair, they maintain. Consumers, however, are concerned that some alteration-of-product defenses passed by the states have been loosely drawn. In Connecticut, for example, consumers said the alteration provision was so broadly worded that a manufacturer would be absolved of liability even if the product alteration had nothing to do with the cause of the accident. Business groups disagree that such an interpretation could occur.

The Commerce Department has tried to seek the middle ground between these competing interest groups with its model bill.

Product liability . . .

Continued from page 1
above to file individual reports on product liability experience.

Mr. Heaton said these types of companies are considered to be insurers. If they don't report or have failed to meet the March 15 deadline, they could be assessed a fine of $10 per day for every day of default.

The idea of requiring self-insured companies to report product liability losses is to get as much information as possible, said Mr. Heaton. With some companies self-insuring or not insuring at all for product liability, "we wouldn't be getting the whole picture of losses."

Few companies subject to this requirement have reacted so far, but there have been a lot of inquiries about various details. "There have been no serious objections raised that I know of. There have been a couple about more government surveys, but you're going to get that anyway," he said.

Information submitted to Missouri insurance officials so far is "about half of what we anticipate," said Mr. Buxton. The actual deadline for filing has passed and some companies have been "quite dilatory" in reporting. But new reports are coming in daily, he said.

The statistics released for 12 major product liability carriers in Missouri show direct premiums earned, direct losses incurred including those incurred but not reported (IBNR) and loss ratios for 1978.

According to the figures, Lumbermens Mutual group had premiums of $524,668 and losses of $337,737 with a loss ratio of 64%. The Ranger & Pan American group reported premiums of $194,000, losses of $4,391 and a loss ratio of 2.3% while Employers Mutual Casualty Co. showed premiums of $258,159, losses of $52,085 and a loss ratio of 20.1%.

The first figures

Millers' Mutual Insurance Assn. of Illinois reported premiums of $235,492, losses of $14,225 and a loss ratio of 6%. Bituminous Casualty Corp. had $461,714 in premiums, negative $92,191 in losses and a loss ratio of zero because of higher loss reserves than claims ultimately cost, according to Missouri figures.

Also, Ohio Casualty Insurance Co. reported $10,362 in premiums, $7,733 in losses and a loss ratio of 74.6% while the American Insurance Co. had $709,989 in premiums, $158,267 in losses and a loss ratio of 22.29%. Fireman's Fund Insurance Co. earned $204,315 in premiums, incurred $71,816 in losses and had a loss ratio of 35.15% and Maryland Casualty Co. had $775,580 in premiums but had negative losses of $9,662 due to loss reserves and a zero loss ratio.

Also reporting in Missouri were Aetna Life & Casualty Co. which had premiums of $706,395, losses of $99,547 and a loss ratio of 14.09% and Royal Globe Insurance Co. with premiums totaling $641,486 while losses were $744,678 for a loss ratio of 116.1%. Employers Mutual Liability Insurance Co. of Wisconsin reported premiums of $741,388, losses of $243,361 and a loss ratio of 32.8%.

ISO tries

In the other states, officials said company-by-company information was still scarce and would be released in aggregate reports later this year.

ISO, the industry's major rate making organization, has developed a statistical coding method that insurance companies can use to segregate product liability premiums and losses.

Michael Ruback, manager of industry relations for ISO, said it is hoped the procedure will be adopted industry-wide to ensure more accurate reporting for rate making purposes. Another reason would be to satisfy criticism that statistics have been meaningless because there is no uniform standard for insurance companies to follow.

"It was never much of a problem," said Mr. Ruback of product liability losses. "It was easier to include them in general liability and commercial, multi-line packages. But then the crisis hit and a lot of questions were raised. Insurance companies couldn't give a good, sound answer so we established this new statistical code and it breaks out product liability as a separate area."

The ISO method refines the reporting of multi-line insurance statistics where between 20% and 30% of product liability information is contained and not reported separately but rather as part of the larger multi-line package, said Sheldon Rosenberg, an associate actuary at ISO.

Insurers' concerns

Also attempting to obtain product liability data is the NAIC which has added a blank for product liability premiums and losses to the annual statement it designed for insurance companies to report yearly finances to state regulatory agencies.

But the Alliance of American Insuers, a major trade association, will ask a subcommittee of the NAIC to rescind the reporting requirement arguing that the already bulky statements would be needlessly "cluttered" with "meaningless information," said an attorney for the alliance.

"The data we have is as good as that which would be produced with a new line on the blank," said the attorney Richard P. Hefferan, referring to statistics that have already been compiled by ISO as well as its new statistical plan.

While the controversy continues, companies insuring product liability say they are doing what they can to comply with state regulations but the job has not been easy.

A major problem has been inadequate time to prepare specific reports to comply with the variety of state laws, said Tony Rezoski, an assistant director in the product management division of The Travelers Insurance Co. "One state would ask for information in a certain fashion whereas another state would ask for something with a little different twist," he said. "You just can't press a button and have the information." ■

Seminar set on reinsurance

DALLAS—A three-day fundamental reinsurance seminar will be offered at the University of Dallas March 20-22.

The program will study the essentials of reinsurance in light of recent market developments. Seminar participants will discuss existing opportunities in reinsurance.

Guidelines will be offered to benefit insurance company management on reinsurance and pointers on captive companies, specialty insurers and reinsurance pooling will be specified.

Tuition for the seminar is $375.00.

Further information may be obtained from: University of Dallas, Management Laboratories of America Inc., Irving, Tex., Risk Management Institute; phone (214) 438-1123, ext. 360. ■

Tort reform drive

N. Dakota acts, 17th state in 2 years

By JERRY GEISEL

WASHINGTON—The nationwide drive to solve product liability problems with tort reform shifted into high gear this month as North Dakota became the 17th state in the last two years to pass reform legislation.

Montana and Idaho also may be on the verge of approving legislation and business leaders around the country believe that by the end of the year another 10 states will have passed product liability reform measures.

Business groups say they have patched up internal differences and now are presenting a united front to state legislatures in their battle to get bills passed. During the first two years of the tort reform movement, rivalries among businesses often were a major reason why so many measures died.

So far, the new Commerce Department model product liability (*BI*, Jan. 22), which is designed for possible state adoption, has not had a major effect on the tort reform drive. "A lot of people don't even know about the Commerce bill," says Joe Kelly, staff assistant of the Iowa Manufacturers Assn. in Des Moines.

It appears the states will continue to go their own way and pass their own versions of tort reform without relying exclusively on a federal model.

The North Dakota bill (H.B. 1075), which received final Senate approval this month on a 41-9 vote, requires product liability suits to be filed within 11 years of the time the product was first sold or 10 years from the date of manufacture.

The bill, which received the backing of 20 state business groups, gives manufacturers a stronger defense if a product was manufactured in accordance with government safety standards.

Furthermore, manufacturers cannot be held liable if the product was altered or modified after it left their control and the alteration was a "substantial contributing cause of the injury." A plaintiff who seeks more than $50,000 for injuries can only request "reasonable damages," the bill says.

"A united business community was the key factor in getting the bill passed," said Elmer Klipstein of the North Dakota Product Liability Council.

The bill now goes to the governor's office, where Gov. Arthur Link has not yet indicated if he will sign it.

In Montana, a compromise measure that would bar suits after eight years from the time of manufacture has received senate approval, but it faces a stiff fight in the house. A similar situation prevails in Idaho.

In Arkansas, the senate has given approval to compromise legislation that requires product liability suits to be filed three years from the time of injury. "We think we are going to get this bill through the house," says George Brewer of Associated Industries of Arkansas in Little Rock.

In Missouri, a measure that requires suits to be filed five years from the time a product was first sold and bars punitive damages in a product liability suit faces an uphill battle, according to Dave Sanders, supervisor of industrial relations for Associated Industries of Missouri.

In nearby Iowa, a new, comprehensive product liability reform bill has a better shot at passage than previous bills, all of which died in committee during the last two years. "Legislators now are more aware of just what product liability is," observes Mr. Kelly of the Iowa Manufacturers Assn.

North Carolina's new product liability bill, which would bar suits 10 years after a product is manufactured or six years from the time of first sale, has a "fighting chance" of passage, says Bill Gill, secretary-treasurer of the North Carolina Product Liability Task Force.

Elsewhere around the country, bills have been introduced in Alaska, California, New York, Texas and Washington, but the outlook on all those measures is uncertain. ■

Business groups reject Commerce's model bill

By JERRY GEISEL

WASHINGTON—After its initial burst of enthusiasm, business support may be dwindling for the Commerce Department's model product liability bill.

The Risk and Insurance Management Society (RIMS) says the model bill should be "rejected" and the U.S. Chamber of Commerce urges the Commerce Department to redraft the proposal "to achieve truly meaningful reform."

The Alliance of American Insurers, a major industry trade group, doubts the proposal can achieve one of its stated goals: the reduction or stabilization of product liability insurance costs.

Legal and consumer groups also object to the bill. The Commerce Department said it is reviewing the 2,000 pages of commentary it has received on the model bill. The bill is expected to be revised by June 1.

RIMS lashed out at the proposal, warning that if the model bill were adopted by the states it would "create a system which will increase both litigation and its costs."

The model bill would undermine workers compensation laws by making the employer liable in excess of compensation levels for some workplace injuries, RIMS said.

RIMS further criticizes the model bill for failing to recognize that punitive damages do "not belong in the same action in a civil proceeding. If punitive damages are appropriate, they should be tried in a separate action, with criminal evidence rules."

The 81,000-member U.S. Chamber of Commerce says the model bill, if enacted, "may increase disputes and enhance, rather than reduce, the incidence of unwarranted lititgation." The Chamber intends to draft its own model bill.

Under the Commerce Department bill, a manufacturer generally would be liable only for the "useful safe life" of its products. The Alliance of American Insurers says "It's application could give rise to a situation in which two different juries determine two different periods of 'useful safe life' for two identical products manufactured at approximately the same time."

On the other hand, the Alliance supports Commerce for advocating that damage awards be reduced by the amount a plaintiff receives in compensation from a public source.

The Alliance applauds Commerce's stance that damages for "pain and suffering" generally be capped at $25,000. But the Alliance warns that this provision might not survive constitutional challenges.

The Assn. of Trial Lawyers of America said the Commerce Department should first complete its examination of insurance ratemaking practices before attempting to change the tort law. ■

Panel urges New York to buy direct; agents object

By STUART EMMRICH

NEW YORK—A special state investigation commission, charging that for years brokers have received commissions on state insurance policies for which they do no work, recommends that the state bypass brokers and buy directly from the insurance companies.

The state tried that once in 1975, but stopped the practice after insurers and brokers objected. Abandoning the practice in response to industry pressure is also on issue now.

The controversial recommendation, contained in a 44-page report released earlier this month, is again being criticized by a state organization of insurance agents who are worried about their business.

The report of the Temporary Commission of Investigation, the third in a series on insurance dealings in the state, charges that although the state Office of General Services did almost all the work in obtaining policies for state agencies—from the first step of determining needs to going over the final contract—agents earned the commission fees through the patronage of party bosses. Between 1971 and 1974 up to $600,000 a year was spread around to political favorites: the report says.

Although annual commissions paid to brokers has dipped to about $18,000 in the past four years under controls imposed by Gov. Hugh Carey, the commission argues that state funds are still being misused.

"The state has significantly reduced both the number of brokers receiving commissions on state policies and the total annual amount of dollars given to them," says the report. "However, the state has not been able to extricate itself completely from the practice of paying some brokers who perform no services on the policies for which they receive insurance commissions.

"Waste has been the central issue in the investigations. The payment of commissions to non-working insurance brokers is in our view unacceptable, particularly in these days of economic stringency," the report says.

The commission sees the issue as cut and dried—stop paying fees to people who do no work. But the insurance brokers object.

"We are not opposed to the report itself," says John Jordan, executive vp of the Independent Insurance Agents of N.Y., "but we don't agree with the recommendations."

Mr. Jordan conceded that political cronies have been paid commission—a practice his organization condemns—but argued that the remedies proposed by the state investigation commission are impractical, if not illegal.

IIA of N.Y. is particularly incensed at suggestions that local governments develop in-house brokers to deal with insurers, he said. It would be nearly impossible for smaller governments to afford full time employes who have the needed expertise in the insurance field, IIA of N.Y. argues.

Governments need the "experience of local brokers and trained agents who know the markets," said IIA president Ed Lucie of Long Island's Nassau County.

Staffers of the state's Office of General Services who purchase insurance for New York are "highly competent, but I can't quite see these two men handling all the state's business," added Mr. Jordan.

Officials of the IIA also charge one of the commission's suggestions may violate state insurance law.

At issue is whether the commissions earned on the state's insurance handled by employes in the Office of General Services can be funneled to the state treasury. The IIA contends that employes of the state, acting as brokers for the OGS, cannot return to state coffers fees earned as commissions. That violates the state's anti-rebate law, the association says.

But Eric Seiff, chairman of the investigating commission, says legal staff in the state's insurance department said OGS could perform the services of a broker without a license and the payment of commissions to OGS would not violate the anti-rebate law.

The state tried in 1975 to bypass brokers and were successful at first, saving close to $600,000 in commissions, according to the report. But then the insurance companies and the state agents' association joined to protest the arrangement.

Three insurers—Aetna Life & Casualty Co., The Travelers Insurance Co.and Hartford Fire Insurance Co.—refused to do business with the state unless brokers were used

A compromise was reached in early 1976 whereby commissions were still paid to agents, but at greatly reduced rates of between 0.5% and 5% of the premium instead of the previous maximum of 25%.

Eight of the major insurance companies underwriting policies for the state were assigned a broker to oversee their transaction with OGS: Aetna Life & Casualty Co. was assigned broker A.J.M. Agency Inc., Merchants of New Hampshire was assigned broker National Preferred Risks; Federal Insurance Co. and Hartford Steam Boiler Inspection & Insurance Co. were assigned broker Hanstein Berardi & Lawlis Inc.; Hartford Fire Insurance Co. got Parker Brokerage Co. Inc.; Travelers Insurance Co. and Peerless Insurance Co. both got broker Judd Associates and a conglomerate of companies worked with broker Fuller & O'Brien Agency.

Two other insurers—Continental Insurance Co. and Home Insurance Co.—at first agreed to deal directly with the state, but in February notified state officials that they too would want to work through a broker.

This "reduced commission" system, which both sides agree is better than the abuse-ridden patronage system of years past, is still strongly opposed by the special state investigating commission.

The report argues that "even though the current administration has greatly reduced both the number of non-working brokers and the total amount of unearned commissions given to them, the state's own broker has testified that most of the brokers perform no necessary services on the policies for commissions received and the state acquiesced to the combined will of brokers and carriers, paying again for services it already provides through the state brokers in the OGS bureau."

Interestingly, with the state commission and the independent

Continued on following page

Regulators covered-up in ski-lift disaster: Paper

CHICAGO—A two year investigation into a fatal ski tramway accident at Vail, Colo., by the Chicago Tribune reveals that a government agency went along with a cover-up of facts pointing to safety negligence by operators of the ski area, the paper reported.

Meanwhile, the U.S. Forest Service, the agency under attack, has asked the inspector general of the U.S. Department of Agriculture to review the accusations.

The ski area is insured by Lloyd's of London. No one involved would comment about whether the Tribune report will prompt further investigations by the insurer into the accident.

The Tribune reported that the Forest Service, which is responsible for ensuring safety of ski facilities on public land, accepted an altered document during its investigations of the March 26, 1976, accident at the Vail ski area. The accident killed four people and injured eight.

Deleted information, which the Tribune obtained from an identical but unaltered Vail Associates document, shows that company officials knew five weeks before the fatal accident that two of the cable's 24 outer wires had broken in the area of one of the tramway towers and were sticking up in the air and that another wire was working loose.

Information deleted from the document also shows that shortly after learning about the breaks, Vail Associates lift-operations manager called several cable experts for advice, including Charles Dwyer, the Forest Service's chief tramway engineer.

The document in question was picked up from Vail Associates, the Tribune reports, by Forest Service manager Ernest Nunn, about 10 days after the accident.

Mr. Nunn told the Tribune that he sent the document to George Tourtillot, who headed the Forest Service investigation. In a cover memorandum dated April 7, 1976, and hand printed on Forest Service stationery, Mr. Nunn acknowledged the missing information on the document.

Mr. Nunn, who was not an official member of the Forest Service investigation team, said that he suspected the missing information was "very important." He also claimed that there was some indication that maintenance people had told superiors about the cable breaks well before the accident.

The unaltered accident report also indicates the safety devices were circumvented to allow more people to ride the gondolas and ski-lifts, according to the Tribune.

The Tribune maintains its investigation uncovered a case study of how public safety can be jeopardized when government regulating agencies develop "relationships" with the industries they are supposed to police.

In this case, Vail Associates leases about 9,000 acres of public land from Forest Service and pays the agency fees from 1% to 5% of gross receipts, the Tribune report adds. Thus both the ski company and the federal agency have a financial interest in the number of people who ride the gondola and dozen chair lift systems up to the slopes. ■

Agents object . . .

Continued from previous page

agents at odds over almost everything in the report, they agree on one thing: The amount of money involved is not the crucial issue.

"We are not really arguing that you can save that much money," says commission chairman Mr. Seiff. "But you can spend it more responsibly."

IIA president Mr. Lucie says his group is "a professional organization that is opposed to anything that would be to the detriment of the American agency system, whether it involves $5, $500 or $500,000."

Two previous reports by the special commission's investigation of the state's insurance policies showed widespread abuses in two New York counties.

The commission found that officials in Northern New York's Broome County were routinely picking brokers to share in commissions where they did not work. That led to another investigation in Nassau County, where Mr. Seiff said his office found one broker taking in "hundreds of thousands of dollars." The commission found that this broker was doling out 20% of those commissions to other brokers whose names were given to him by top county officials (*BI*, Oct. 30, 1978).

These investigations, besides creating a stir, also apparently brought about some changes. Broome County is now involved in a self-insurance program, according to Mr. Seiff. And Nassau officials are now committed to an investigation of their procedures to decide what changes they have to make and what safeguards they need to implement.

The latest report on the state's insurance policies is being sent to the governor and the state for possible action, said Mr. Seiff. He also has talked to the state's attorney general, for a possible investigation of anti-trust action against the insurance agents.

The state investigating commission can only investigate and report; it has no powers of enforcement. ■

Workers want pension increases

ANN ARBOR, Mich.—A majority of workers would prefer a boost in retirement benefits rather than a 10% pay increase if given a choice, a recently published survey found.

According to a survey of 2,000 working men and women conducted by the University of Michigan's Survey Research Center, 54% of those surveyed would opt for an improvement in retirement benefits and forgo a salary increase.

The survey also revealed that 51% of workers thought their medical plans should be improved. About one-third of workers covered under group dental plans favored a hike in dental benefits.

A whopping 83.9% of surveyed workers said medical and hospital coverage were the most important benefits they received. The next important benefit was sick leave with full pay followed by life insurance.

The percentage of workers covered under group health insurance plans jumped to 78% in 1977, the year of the most recent survey, from 72% in 1969 when the university published its first survey. ■

Large, stock companies

Insurers overstated assets, Illinois study reveals

By MARY ELLEN McKEE

CHICAGO—Many large, publicly traded insurance companies have misstated their assets and reserves from 1974 to 1976 and are probably continuing the practice into 1979, a study of 434 companies nationwide reveals.

During the three-year period surveyed by the Illinois department of insurance, 28.7% of the large, stock companies were found to have losses which exceeded their reserves by more than 15% of their net worth. By contrast, only 19.6% of the mutual insurance companies writing more than $100 million in annual premiums were in the same position.

"In nearly every case, underreserving has been more frequent and in higher magnitudes among the large stock companies," said Kenneth W. Smith, the study's author and deputy director of the property-casualty division of the department of insurance. "As many as one out of 10 stock companies were underreserved by more than one-third of their net worth," notes the study, which was prepared by measuring loss reserves set aside in a particular year against actual claims incurred.

Twenty-four percent of the large mutual companies were found to be overreserved, according to the study. This might have occurred to lessen year-end payouts—compared with only 13% of the large stock companies, Mr. Smith maintains. "If you look at losses on a two-year span, where more of the litigated claim losses could occur, those companies are probably even more underreserved than the figures indicate."

The study also found that in 1975 nearly half or 43.6% of the stock companies surveyed and writing more than $100 million in premiums maintained loss reserves that were significantly less than needed to cover their actual losses. Those losses were sustained in automobile liability, general liability, product liability and workers compensation. "This situation should be of major concern to both regulators representing policyholders as well as stockholders," the study maintains.

Even though loss reserves trends of 121 of the large stock companies improved slightly in 1976 when both the stock market and insurance profits improved, the study maintains that these improvements developed only because of the large increases made in 1975. As a class, the study notes, the large stock companies still understated income during 1976 in order to correct much of the deficiency in 1975 loss reserves, the study indicates. Consequently, the study found that 2.38% of the industry's 1976 premiums were required to fund annual loss reserve development in 1976.

By maintaining inadequate loss reserves, the companies are able to overstate their assets and earnings in their annual and quarterly reports to stockholders, according to the study.

"In general, loss reserve accuracy deteriorated between 1974 and 1976, making the true financial condition of many insurers seriously disguised, especially if current practices continue unabated," warns the study's author.

Based on these "rather disturbing results," the department of insurance is planning to study 1977-1978 loss reserve data this summer to determine how much the practices revealed in the 1974-1976 study are still being used by the industry.

Since loss reserves are the single most important measure of an insurance company's ability to stay in business, grave questions will have to be raised concerning these practices, said Richard L. Mathias, the Illinois director of insurance. This will have to be done, the director added, even though stock related activities do not fall within the regulatory powers of the department.

Meanwhile, an official of the Securities and Exchange Commission assures that his office has requested a copy of the study and is closely evaluating and investigating its findings.

The study also found that far fewer companies—both stock and mutuals—writing less than $25 million in annual premiums were underreserved. Fewer small stock companies are publicly traded; many are family-owned and, therefore, the study submits, have less incentive for management to overstate their income.

Loss reserves are set by statute at no less than 60% of the company's premium volume for automobile insurance, general liability and product liability. The loss reserve requirement for workers compensation business, however, is set at 65% of the company's premium volume.

"Overall, the industry's surplus, most of which is its reserves, hasn't grown at the same rate as its aggregate unpaid losses," Mr. Smith contends. "What we are saying is that a great deal of attention needs to be paid to this area."

"It would appear that improved reserving techniques or more conservative applications of old techniques is called for," the study maintains. "If something is not done, loss reserve development will consume increasingly larger shares of policyholder surplus and commensurate protection."

The study concludes with an appeal to stock insurers, especially those which are members of publicly traded holding companies or which are publicly traded themselves, "to establish loss reserves independently of extraneous considerations." ■

Individual plans for retirement up

WASHINGTON—The number of Individual Retirement Accounts (IRAs) leaped dramatically in 1977, according to statistics released last month by the Internal Revenue Service.

The number of IRAs went to 2.5 million in 1977 from 1.9 million in 1976, a 31% increase. Since 1975, the number of IRAs has about doubled, the IRS says.

Under the law, a taxpayer not covered under a corporate pension plan may contribute up to $1,500 annually into an IRA. ■

Reader's Digest . . .

Continued from page 3

and pension plans, the magazine is much more liberal than most with other benefit plans.

For instance, the vacation schedule is so generous that it is "hard to use up all the days," Ms. Farquhar said.

Reader's Digest seems to provide for almost all the needs of its employes. It offers them heavily subsidized cafeteria meals, inexpensive transportation to work, physical fitness reimbursements, dental care and tuition reimbursement.

Reader's Digest spends $250,000 yearly to rent 15 charter busses to transport workers to and from the office. That subsidy reduces the employe's cost to only $2 weekly.

The company's annual expense for the cafeteria benefits amounts to $900,000 so the employe need only pay $1 for a hamburger and beverage.

To encourage workers to be physically fit, the magazine pays the entire membership dues to athletic clubs up to $150. In addition, the Digest pays $50 for medical exams for employes 35 years or older with two years of service.

The dental plan, which the company started in 1975 before dental insurance became a popular benefit, pays 100% for diagnostic and preventive services, subject to a $25 deductible for individuals and $50 for families. Reader's Digest pays 50% for major restorative work and 50% for orthodontic care up to a $500 maximum per individual. No deductible applies for orthodontia treatment.

The medical plan also encompasses many of the newer benefits, including payment for second opinions for surgery, home care and out-patient services. The magazine offers employes a health maintenance organization, Westchester Community Health Plan, which 140 Digest employes have elected in two enrollment periods.

The Digest strongly supports the HMO as a means of controlling health care costs, at a time when health insurance expenses have become known as the "most notorious sinner around in employe benefits," Ms. Farquhar said.

Because of "horrendous" increases expected in medical costs this year, Ms. Farquhar is considering recommending that the company increase the employe's contribution to the cost of insurance.

Hospital benefits provided by Blue Cross cover up to 21 days of hospital care in full and up to 180 at 50% of the hospital charges. Private room rates are reimbursable to the employe on the same schedule as semi-private.

Metropolitan Life Insurance underwrites surgical-medical and major medical benefits for Reader's Digest. In the hospital, medical care is paid in full for up to 365 days for doctor services where surgery is not required. The plan also pays the full amount for charges during a stay for surgery when doctor services besides a surgeon's are needed or when doctor visits related to medical complications during pregnancy are necessary.

The major medical plan pays 80% of all medical expenses up to $5,000 and most medical expenses above $5,000 up to a maximum of $100,000. A deductible of $100 applies for the plan.

The magazine's life insurance plan is also a rich benefit. The plan pays 100% of basic annual earnings for employes with less than one year's service up to 300% for pension plan members with 10 years or more service. ■

Pru targets tough surplus lines risks

CHATHAM, N.J.—Prudential Insurance Co.'s new excess and surplus lines subsidiaries will cut their teeth on two of the tough lines remaining from the casualty crunch: product and municipal liability.

A surplus lines company can best meet the unanswered needs constantly faced by the insurance industry, said Ross C. Cowan, president of the new firms, Gibraltar Casualty Co. and Dryden & Co. Dryden & Co. is a New Jersey-licensed excess and surplus lines broker that will provide underwriting management for Gibraltar Casualty Co.

Low frequency, high risk products, "the types of products traditional insurance companies will not insure," is one area the Dryden-Gibraltar combination intends to concentrate on, said James Vaughan, director of casualty underwriting for the venture. Dryden provides both claims-made and per occurrence forms, he added, and primary and buffer layers.

In addition, the firm is developing a product to cover the gap resulting from transition from claims made to per occurrence coverage, said Roger J. Consolla, Dryden vp in charge of day-to-day operations.

The firms have also chosen to concentrate on municipal and public liability risks, another area where rates have skyrocketed while availability of coverage has shrunk.

New York State, faced with capacity shortages in both public entity and product liability, waived a one-year waiting period in approving Gibraltar as a surplus insurer for these lines, noted Freeman Bowers, assistant vp-casualty underwriting.

Gibraltar is an approved surplus lines company in approximately 25 other states.

"The climate is right in this country for the flexible, true underwriter—the guy who deserves the name underwriter, who thinks about exposures and tries to find reasonable coverages," said Mr. Cowan.

In his other role as head of Prudential Reinsurance Co.'s facultative department, Mr. Cowan was often approached by risk managers and insurance buyers who wanted Pru Re to take their hard-to-place risks. But, as a reinsurer, the company's ability to respond was limited. "Although we could and do reinsure captives, we couldn't tell an insured to form a captive just so he could be reinsured by Pru Re," Mr. Cowan said.

Now, Pru Re can better respond since it backs up Gibraltar through a heavy reinsurance treaty. The excess and surplus lines company was capitalized at $10 million and the great majority of Gibraltar's premium will be reinsured by Pru Re. ■

Broker contracts with London

SAN FRANCISCO—Sherwood Insurance Services has obtained a property insurance contract with Lloyd's of London and other firms, a first step in Sherwood's development of an underwriting division, company officials announced.

"In the near future we hope to have underwriting authority for a licensed California company, thus giving us complete in-house facilities to add to our wholesale brokerage activities," said Frank J. Fischer Jr., executive vp and underwriting manager. ■

Pregnancy benefits . . .

Continued from page 1

before the law becomes effective. If a new set of guidelines is published, only minor, rather than substantive changes are expected to be made.

The guidelines are not regulations; they do not carry the weight of law. However, courts often have used such guidelines as an important precedent in resolving legal actions.

The initial guidelines are published in a question and answer format covering the most frequently asked questions that employers have raised about the new law. EEOC staffers said they have been flooded with calls from employers concerned and confused about the pregnancy law.

While employers whose group health insurance plans provide coverage for dependents will have to offer equitable pregnancy benefits to employes' wives, they will not have to provide pregnancy benefits to an employe's children.

Furthermore, if an employer does not currently provide coverage for dependents, he would not be required to pay the pregnancy-related expenses of his employe's wife.

Effective date

The guidelines for employes' treatment under the new law include that if an employe gives birth before April 29, but is still unable to work on or after that date, she is entitled to the same sick leave benefits available to other employes. Similarly, health insurance benefits must be provided for an employe even though her pregnancy began before April 29.

An employer may not single out pregnancy-related conditions for special procedures for determining an employe's ability to work. For example, an employer could not require a written statement from the pregnant employe's physician concerning her inability to work if the employer does not require written statements from physicians for other sicknesses and disabilities.

An employe who has been absent from work because of her pregnancy must be allowed to return to work while pregnant if she recovers. An employer cannot require her to remain on leave until after her baby is born.

Unless the pregnant employe on leave has informed her employer that she does not intend to return to work after giving birth, her job must be held open for her return on the same basis as jobs are held open for other employes on sick leave or disability leave, the EEOC says.

An employer cannot refuse to hire a pregnant woman as long as she is able to perform the major functions necessary to her job.

However, employers can deny health insurance coverage for pregnancy if the woman was pregnant before she was hired and if the company also denies medical and hospital coverage for employes with other pre-existing conditions.

Employers cannot reduce other benefits to pay for the added cost of including pregnancy in their benefit plans until Oct. 31, 1979, or until the expiration of a collective bargaining agreement, whichever comes later. Unions are expected to resist efforts made to reduce benefits as the price of including pregnancy in corporate plans.

All plans affected

Coverage provided by a corporate health insurance plan for other conditions must also be provided for pregnancy-related conditions. For example, if a plan covers the cost of a private room for other sicknesses, it must cover the cost of a private room for pregnancy. In addition, if a health insurance plan covers office visits to physicians, pre-natal and post-natal visits must be covered, according to the EEOC.

If an employer gives employes a choice of several health insurance plans, each plan must cover pregnancy-related conditions. An employe with a single coverage policy cannot be forced to purchase a more expensive family coverage policy in order to receive coverage for her own pregnancy.

Although the law requires employers offering a disability plan to include pregnancy benefits on the same basis as those for any other sickness, it does not require an employer not providing a paid sick leave plan to begin such a plan to cover pregnancy.

The law also outlaws paid sick leave programs that limit benefits for pregnancy to a shorter period than other disabilities. An employer could not, for example, limit disability benefits to six weeks for a pregnancy while providing up to 26 weeks of benefits for other illnesses, as some plans now do.

More significantly, medical and hospital plans will have to be revised if they cover pregnancy on a different basis than other sicknesses. An employer could not, for example, limit hospitalization coverage to $500 for pregnancy-related expenses while paying up to 80% of expenses for other illnesses. Benefits must be provided equally under the law.

Companies without medical or hospitalization plans will not be required to begin such plans under the law.

Employers will not have to provide hospital and medical benefits to a worker who had an abortion unless the woman's life was endangered by the pregnancy. But employers will be required to provide health insurance coverage to a woman whose abortion resulted in medical complication. Employers will only have to pay for the complications, not the abortion.

However, employers will have to provide sick leave or disability benefits to an employe who has an abortion even when the abortion was not needed to save the woman's life, the EEOC says.

Furthermore, the law doesn't prevent employers from voluntarily providing full benefits for any employe who has an abortion. ■

Aviation risks . . .

Continued from page 1

don market by Thomas E. Nelson with Hall acting as a reinsurance intermediary through Oakeley Vaughan.

The policies were eventually placed in the worldwide market with more than 70 companies, including pools involving Allendale Mutual Insurance Co. and Public Service Mutual Insurance Co.

Because 1974 was such a disastrous year for the aviation industry, "this book of business was heavily hit," said Robert Seery, vp at Unigard. When, in mid-1975 it was apparent claims weren't being paid by Philadelphia Manufacturers and Thomas Nelson, Unigard began arbitration in London against the reinsurers, he said.

Philadelphia Manufacturers at first claimed that the Nelson syndicate didn't have authority to issue the policies, but this claim was later dropped from the lawsuit, according to sources involved in the negotiations.

Another issue became important as arbitration was broken off: "known loss." Philadelphia Manufacturers is said to have claimed that Hall issued the policies even though some of the airlines were known to have had losses.

At Unigard, Mr. Seery said, the loss charge "wasn't a viable issue. There was only one policy, issued to Air France, where you might construe that a known loss was involved and that policy was ceded retroactively," he said.

Chinese retros

The aviation retro penalty policies involved in the settlement with Hall were not "Chinese retro" or "reverse retro" arrangements, according to Mr. Seery. "We combed the files and could find no evidence that these policies were of the Chinese retro type," he said. The term refers to pairs of policies written on an airline's retro credit for hull and liability. One policy provides ascending graduated benefits reimbursing retro adjustments for losses paid; the other half provides similar payments for a reverse schedule in the event no losses occur. The California Department of Insurance ruled in 1974 such policies "were in the nature of gaming agreements" and therefore illegal. Frank B. Hall signed a consent order and paid a $1,000 fine.

Unigard, however, never defined what it meant by retro penalty policies. A number of knowledgeable sources in the aviation industry on the West Coast said the policies involved in the Hall settlement could well have been Chinese retros. "As far as I'm concerned, it's the same thing," one West Coast aviation broker said. "I'd have to believe there were some Chinese retros involved in this incident," said a Los Angeles aviation underwriting executive.

The sources explained that after the California insurance department ruled that Chinese retro policies were not insurance, brokers and underwriters involved in these policies changed the policy's name.

It's perfectly legitimate for an airline to buy something called record credit insurance to insure that it will get some retro premium back at the end of the year, said one source. But what the insurance department objected to was playing both sides, eliminating any chance of loss.

Another issue in the litigation between the insurer and broker was a $1 million payment which Hall claimed was a loan made to Unigard.

Unigard satisfied

"Unigard never borrowed a dime from anyone," Unigard president Jay B. Porter told *Business Insurance*. The amount refers to money Hall advanced to Unigard on losses in their general book of business, he said.

Mr. Porter said the company was satisfied with the terms of the settlement with Hall. "It shows how reinsurance works. . . . The policyholders got their losses paid; we sat down and negotiated and came to a settlement."

According to one of the negotiators, settlement was reached "because the case was getting so complex, with so many defendants involved, it would have resulted in a trial of at least a year and cost in the millions of dollars."

Unigard no longer writes excess and surplus lines of insurance. Mr. Porter said the company has withdrawn from the market since 1974. "We still do business with Frank B. Hall," the Unigard president said. "We don't feel there was any impropriety in the situation," he added. ■

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Expanding direct writer of large industrial accounts is adding to its Valley Forge marketing staff. The successful candidate will have a minimum of 3 years B & M marketing experience and become an integral part of a team holding a record of continuous growth. The incumbent must have a thorough knowledge of B & M coverages, successful sales record and strong desire to succeed.

An attractive salary package including a comprehensive benefits and bonus program will be provided. Send resume to: J. W. Sullivan, PHILA. MFRS. MUTUAL INS. CO., 8 Executive Mall, Box 824, Valley Forge, Pa. 19482.

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RISK MANAGEMENT SPECALIST

Major Forest Products firm has immediate opening for a specialist in risk management in its corporate insurance department located in the northwest United States. The candidate we are seeking will have a degree in business administration along with a minimum of five (5) years experience in worker's compensation, property, public liability and related insurance programs. Candidates should also have the ability to communicate across organizational lines. Compensation will be commensurate with experience. Excellent benefit program. Replies, including salary history, may be sent in confidence to:

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Large progressive international agency seeks individual with minimum 5 years property/casualty experience. Requires involvement in marketing general liability and property coverage insurance for national clients and prospective major accounts. Requires excellent communication and marketing skills and experience with large Agency or National Broker. Prefer college graduate with major or minor in insurance.

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CHIEF EXECUTIVE

of its new captive management company

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Candidates should possess a sound knowledge of all aspects of captive management and should have a minimum of five years experience in an executive position in a similar company.

The successful applicant will be required to reside in Nassau, Bahamas and should be willing to travel.

The position presents a challenging opportunity to head a new company specifically incorporated for captive management in the Bahamas where government encouragement coupled with readily available peripheral services indicate a potential for exceptional growth.

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Applications accompanied by a resume will be treated in strict confidence and should be submitted to:

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(Commercial Property)

Kemper Insurance Companies has an immediate need for an experienced Fire Insurance Specialist who is sales oriented.

The ideal candidate will have 3 or more years of Fire Rating Bureau experience and possess a Bachelor's degree or equivalent, preferabbly in FPE.

Position will entail marketing, field underwriting, fire rate engineering, and property loss prevention involving medium to large processing risks (non-HPR) with heavy producer and client contact.

We offer a very competitive salary commensurate with experience, a full range of benefits and a COMPANY CAR. Qualified candidates, please send detailed resume including education, experience and salary history, to:

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Well established large agency located in medium sized Midwestern city, is looking for new head of its placement department. Present department handles all medium to large casualty & property placements. The applicant should have a minimum of five years experience in underwriting large accounts and be able to effectively handle negotiations of rates, premiums, terms with underwriters. Ideal candidate would probably have two or more years with major insurance company and two or more years with a large agency. Excellent salary, automobile, profit sharing & opportunity for ownership.

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Due to the unprecedented growth of our firm, particularly in our life area, we are seeking candidates for the following positions

• International Marketing Manager

The successful candidate must have a minimum of 5-7 years experience in employee benefits and show a successful achievement record in sales and management. Must be willing to eventually relocate abroad.

• Deputy Director of Group Management Division

The successful candidate must have 6-10 years experience in employee benefits and a good track record that includes marketing management and recruiting. Must be willing to travel.

Both positions offer salaries commensurate with experience, excellent comprehensive benefits package and opportunity for personal and professional growth.

Interested applicants are invited to forward resume, indicating position applying for, with salary history and requirements or call Mr. Jerry Wilson, Professional Recruiter at

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WALL PERSONNEL ASSOCIATES, INC.
170 Broadway
New York, N.Y. 10038

Bellefonte charges . . .

Continued from page 1
plaint, filed March 7, charges Omni with fraud, breach of contract, breach of fiduciary duty and negligence. The original complaint, filed in mid-February, concerned itself solely with the dispute between Bellefonte and Omni over termination provisions of their 1978 management agreement.

Diverted funds

Bellefonte, charging fraud, alleges that:

- Omni wrongfully converted and used unearned premiums for its own purposes;
- Omni issued policies, collected premiums and kept the premiums for its own benefit, "without notifying plaintiffs of the policy issuance and without forwarding earned premium dollars to Bellefonte and reinsurers."
- Omni's failure to reveal the omitted facts from the policy premium and loss accounting summaries misled Bellefonte, believing that continual adverse loss experience suffered by Omni's reinsurers wasn't out of the ordinary, considering the type of risks relative to the premiums charged.

Bellefonte charges that Omni intentionally made its premium loss accounting summaries misleading with the idea that Bellefonte would come to rely on them.

"I am shocked by these allegations," Omni founder Michael S. Eisenstadt told *Business Insurance*. The charges are "totally unfounded and without basis in fact," he said. Mr. Eisenstadt also defended Omni's accounting to Bellefonte and said that it has always been 100% correct.

With Bellefonte's amended complaint was an affidavit from a partner of Ernst & Ernst, the accounting firm which states than on Jan. 17 a federal grand jury subpoena was served on his firm demanding all documents in regard to the work performed at Omni. "The FBI agent who contacted me informed me that the subpoena was issued as part of an investigation into the affairs of Omni," Martin Nachimson, the Ernst & Ernst partner, states in the affidavit.

Mr. Eisenstadt acknowledged that a federal grand jury subpoena was issued, but he insisted that its purpose was never made known.

According to a draft of legal documents obtained by *BI*, Omni launched its association with Bellefonte and its sister company and co-plaintiff, Compass Insurance Co., in January 1975. The amended complaint relates that under the written management agreement of 1975, Bellefonte acted as the fronting company, while Omni issued policies and obtained reinsurance for Bellefonte's benefit equal to 100% of the liability risk covered in the policies.

Management agreement

Adverse claims experience, with actual incurred liabilities exceeding premiums, occurred almost from the start of the association of the two firms, the complaint states. In February 1978, the two firms executed a second management agreement, amended to allow for termination upon shorter notice than under the old agreement. Under the 1978 agreement, Bellefonte was entitled to between 3% and 4.25% of the net premiums as a fee for issuing the policies, as well as 2.5% of the net premiums for advance tax reserves.

The lawsuit states that on or about Oct. 25, 1978, Omni confirmed to Bellefonte the 1978 agreement would be terminated, effective June 30, 1979. However, "Omni further stated, in said notice, that termination would be effective Dec. 31, 1978, if Omni failed to implement certain specific accounting, financial and electronic data processing controls and procedures to Bellefonte's satisfaction," the suit says. Up to this point, these procedures have not been implemented, Bellefonte's amended complaint states, adding that it does not believe that they will be in the future.

Therefore, the complaint says that on or about Feb. 20, 1979, Bellefonte notified Omni that the 1978 agreement was terminated.

In its original complaint, Bellefonte said that it sent telegrams to approximately 2,800 brokers and agents of Omni, informing them that Omni did not have authority to issue or write Bellefonte policies for 1979 and that there was no reinsurance for any such policies for the current year. In its amended complaint, Bellefonte says 800 of its insurance policies have been issued by Omni this year with limits up to and including $1 million.

"There is no reinsurance as required under any management agreement for any Bellefonte insurance policies by Omni in 1979," Bellefonte charges.

Bellefonte has asked the court for a preliminary injunction to halt Omni from issuing any policies in Bellefonte's name or the name of its sister company. In an affidavit supporting the injunction request, Peter Alfred Duck, director of Cayzer Steel Bowater International Ltd. in London, which handled Omni's London brokering last year, said that by the third quarter of last year it was evident that 1979 renewal among London reinsurers would be "exceedingly difficult because of a drastic deterioration in underwriting results." Indeed, Mr. Duck indicated he never succeeded in obtaining reinsurance for Omni's policies.

Omni responds

Mr. Eisenstadt said that although his company is no longer writing any insurance, it has 78% of its reinsurance treaty in place. Cayzer Steel Bowater placed only 27% of the reinsurance treaty, he said, while Omni placed the rest in such countries as Australia, Belgium, Mexico and the United States.

"There was 100% of the reinsurance placed but Bellefonte refused to intercept," he said. Mr. Duck's affidavit supports this assertion, noting that the lead London reinsurer withdrew after he saw the telex sent by Bellefonte to Omni on Jan. 17.

Last month, Omni filed its own lawsuit for declaratory and injunctive relief against Bellefonte's original complaint. That suit traces the controversy between the two entities to Omni's position that the management agreement either must be terminated according to the terms of the agreement or must continue until June 30, 1979. The agreement provides that any party may terminate the agreement at any time by giving at least 90 days written notice and that the liability of Bellefonte will continue until the expiration of each policy, but no longer than one year from said termination date, whichever is sooner.

Accountant's report

Omni's lawsuit accuses Bellefonte of establishing a managing general agency agreement with Aviation Office of America on or about Feb. 12, 1979, primarily to put Omni out of business.

Besides Bellefonte's charge of misappropriation of funds, Omni also allegedly failed to keep its books and records in order. Three affidavits of Martin Nachimson of the Los Angeles office of Ernst & Ernst indicate the accounting firms believes Omni lacked adequate accounting controls and was in drastic need of a qualified controller. The accountant also noted Omni's habit of preparing checks for payment of claims and related expense at the time the amounts were entered into the "loss history" and credits taken in the settlement statements. Yet not all the checks were actually issued and certain ones were held in Omni's possession for extended periods, according to the affidavit.

The accountant also said his inspection of Omni's financial records showed the firm's operating expenses exceeded total premium commissions by more than $5 million from January 1975 to September 1978.

The state department of insurance began conducting an investigation into the Bellefonte and Omni arrangement in September, said a spokesman, describing the investigation as "intense," requiring the services of a full time investigator. "Currently, the case is in the legal department for review and disciplinary action."

The department is confident Bellefonte's solvency is not in jeopardy and that the public will not be harmed, he added.

Records show that the department moved in 1974 to halt the business of a former entity, Omni Aviation Reinsurance pool. The department noted that the books and records of Omni "were so carelessly or improperly kept. . .as to make it impossible to conduct a proper audit."

Other disputes

The litigation with Bellefonte is not Omni's sole dispute with an insurer. *Business Insurance* has learned that Omni is engaged in an arbitration proceeding with its former fronting company, National Indemnity Co.

"When Omni completes this proceeding, it must face battles with the two fronting companies that preceded National Indemnity," said an informed source, adding: "And to find a new fronting company will take a long time."

Omni, which has reportedly written as much as $30 million of business during better times, fired almost half of its workforce, in recent weeks. Mr. Eisenstadt acknowledged that his firm has pared its employe staff dramatically during the last few weeks, going from a high of 108 employes down to 60. ■

Pension agency offers solutions

WASHINGTON—The Pension Benefit Guaranty Corp. (PBGC) is proposing a sharp reduction in the benefits it's scheduled to guarantee participants of terminating multiemployer pension plans.

The PBGC also wants to hike the premium it charges for termination insurance for multiemployer plans and wants to allow plans that are in financial trouble to boost their employe contributions or reduce benefits.

The PBGC proposals, sent to several congressional committees that have jurisdiction over pension issues, represent some of the PBGC's long term solutions to prevent a collapse of the nation's many ailing multiemployer pension plans.

Under a key PBGC proposal, the federal agency would only have to guarantee 60% of a participant's vested benefit, with a minimum monthly guarantee of $100 and a maximum monthly benefit guarantee of $500. Under ERISA, PBGC is supposed to guarantee vested benefits subject to the currently monthly maximum of $1,073.86.

PBGC also wants to hike the cost of termination insurance to $2.60 per plan participant, up from the current 50 cent per participant premium. ■

people

N.Y. Port Authority posts Vasquez as risk exec

Corrado Vasquez has been promoted to manager of the risk management division at the Port Authority of New York and New Jersey, replacing the retired Joseph P. DeMarinis. **Najib A. Budeiri** replaces Mr. Vasquez as assistant manager. Three other newly created positions at the Authority also have been recently filled: **Joseph J. Luby,** to administrator of insurance and workers compensation programs from supervisor of insurance programs; **Howard Silfin,** to administrator of maintenance evaluation engineering programs from maintenance evaluation supervisor-mechanical and **William M. Connell,** to administrator of safety and environmental programs from employe safety supervisor.

* * *

James Buhl has been promoted to manager from assistant manager of the group insurance program at Crown Zellerbach in San Francisco, replacing S.S. Philbrick, who retired after 23 years in the department. A reorganization of the department also resulted in two other promotions: **Barbara Peoples** was given the title of supervisor of group insurance accounting and **Cheryl Chiene** was promoted to group insurance analyst from the pension department.

* * *

Indian Head Inc. of New York has appointed **Lawrence A. Johnes** vp and treasurer of the company. Mr. Johnes, who comes to Indian Head from Manufacturers Hanover Trust where he was senior vp in charge of that company's leasing corporation, will be responsible for risk management, corporate financing, bank relations, cash management and taxes. His prior experience includes staff and line positions at Citicorp and CBS's Holt Rinehart Division. An accounting graduate of Brooklyn College, Mr. Johnes also holds an M.B.A. in finance from New York University. He replaces Ralph S. Brown Jr., who resigned.

Johnes

Cederholm

* * *

American Chain and Cable Co. Inc., of Bridgeport, Conn., recently reorganized its insurance department, naming **Warren B. Cederholm** manager of risk and insurance. Mr. Cederholm has been with the company 10 years and holds a B.S. degree from the University of Connecticut. Previously manager of risk and insurance, Mr. Cederholm is a member of the Bridgeport Tax Forum, Manufacturers Assn. of Southern Connecticut Tax Committee and the Tax Executives Institute.

* * *

Lou Mongeluzzi has joined Lionel Corp. in New York as corporate risk manager from assistant director of insurance for A&P in Northvale, N.J. He will report to Ward Cavanaugh in that position. Mr. Mongeluzzi has a B.B.A. degree in finance from City University of New York. He replaces Sheila Roberts, who has moved to Columbia Pictures.

* * *

Richard P. Wilber has joined Middle South Services of New Orleans in the newly created position of manager of risk finance and insurance. Mr. Wilber, most recently at the brokerage firm of LaMair-Mulock-Condon of Des Moines, Iowa, will report to Conrad Faulk. Before joining LaMair-Mulock-Condon, Mr. Wilber was corporate manager of insurance and claims for Kroger Foods. He is a graduate of NE Missouri State University.

* * *

Time Inc. of New York has hired **Marsha Vovak Springut** as its new assistant insurance manager, where she will be reporting to Richard Newcomb. The position is one that is being filled after several years of going vacant, according to Mr. Newcomb. Ms. Springut recently left Royal Globe Insurance Co. of New York, where she was underwriter for special accounts. Before that, she was a casualty writer for Employers of Wausau. Ms. Springut is in the process of completing her M.B.A. work at New York University. She has an M.A. from Boston University.

* * *

Clifford Searcy has been named insurance manager of Dart Industries Inc. in Los Angeles, reporting to Eugene F. Johnson, newly-named director of corporate insurance as reported. Mr. Searcy has been manager of insurance at P.R. Mallory & Co. Inc., a new Dart subsidiary acquired in January. He replaces John Oddy, who left Dart in early February to join Carnation Co. in Los Angeles. In an earlier item, Mr. Johnson was incorrectly said to have replaced Mr. Oddy. The company's plan is for Mr. Johnson to replace in early 1980 William A. Miller as vp-insurance, when Mr. Miller will leave the insurance department for another job within Dart.

* * *

Richard M. Hlatki has just joined Phillip Morris in New York in the newly created position of manager of insurance planning and research. Mr. Hlatki, 30, joins Phillip Morris from ABC Inc., where he was manager of accident prevention and property protection. In his new position, Mr. Hlatki will be in charge of risk management and new insurance needs of the company. Reorganization of the department also resulted in the promotion of assistant insurance manager **Robert Magendorf,** 36, to manager of insurance management. Both men report to Paul Goldschmidt, director of insurance.

* * *

Kirk Martin has been named corporate insurance manager for Wyatt Cafeterias Inc., in Dallas, replacing Charles Cone, who resigned. Mr. Martin, 28, comes from The Travelers Corp. where he spent six years in claims and commercial underwriting.

* * *

Simon P. O'Leary recently joined ARA Services of Philadelphia as benefits administration manager, reporting to Howard Kentfield, director of corporate benefits. His responsibilities include the management of all existing benefit plans such as savings and profit sharing, medical, HMO, life, disability, service award, vacation, holiday and paid time off. He will also handle annual ERISA filings and compliance with other existing legislation. Mr. O'Leary comes to ARA Services from Chilton Co., where he was benefits manager.

* * *

Dale E. Graves has been elected a director of each of First Farwest Corp.'s three insurance subsidiaries: First Farwest Insurance Co., Farwest American Assurance Co. and National Hospital Assn. Mr. Graves, who has been with First Farwest of Portland, Ore., for 10 of the past 12 years, currently is a corporate vp with responsibility for the group insurance operations and claims departments.

•

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

Letters column . . .

Continued from page 12

required there.

The increasing trend toward admitted insurance in the Mideast requires the U.S. producer to be present in that area to continue giving his clients the best service they deserve. The producer has to keep his image and follow his clients wherever they establish themselves.

This entails heavy responsibilities: expenses for travel and accommodation, high salaries for qualified personnel in the Mideast, time and effort. Only a handful of the largest international brokers can afford this and then their services are usually limited to one or two employes. At best the U.S. producer enters into joint ventures with local agents whereby an agreement is reached to split commission. The practice of giving the local insurances in the Mideast to the international carrier in the States does not give the producer the prestige he desires as the local employes of the branch or agency in that area cannot give the personalized service the broker would want for his clients.

Near East Agencies are well established in the Mideast. Near East Agencies are ready to act on behalf of the U.S. producer who needs local admitted insurance in the Mideast by providing the full facilities and services of their offices and professional personnel.

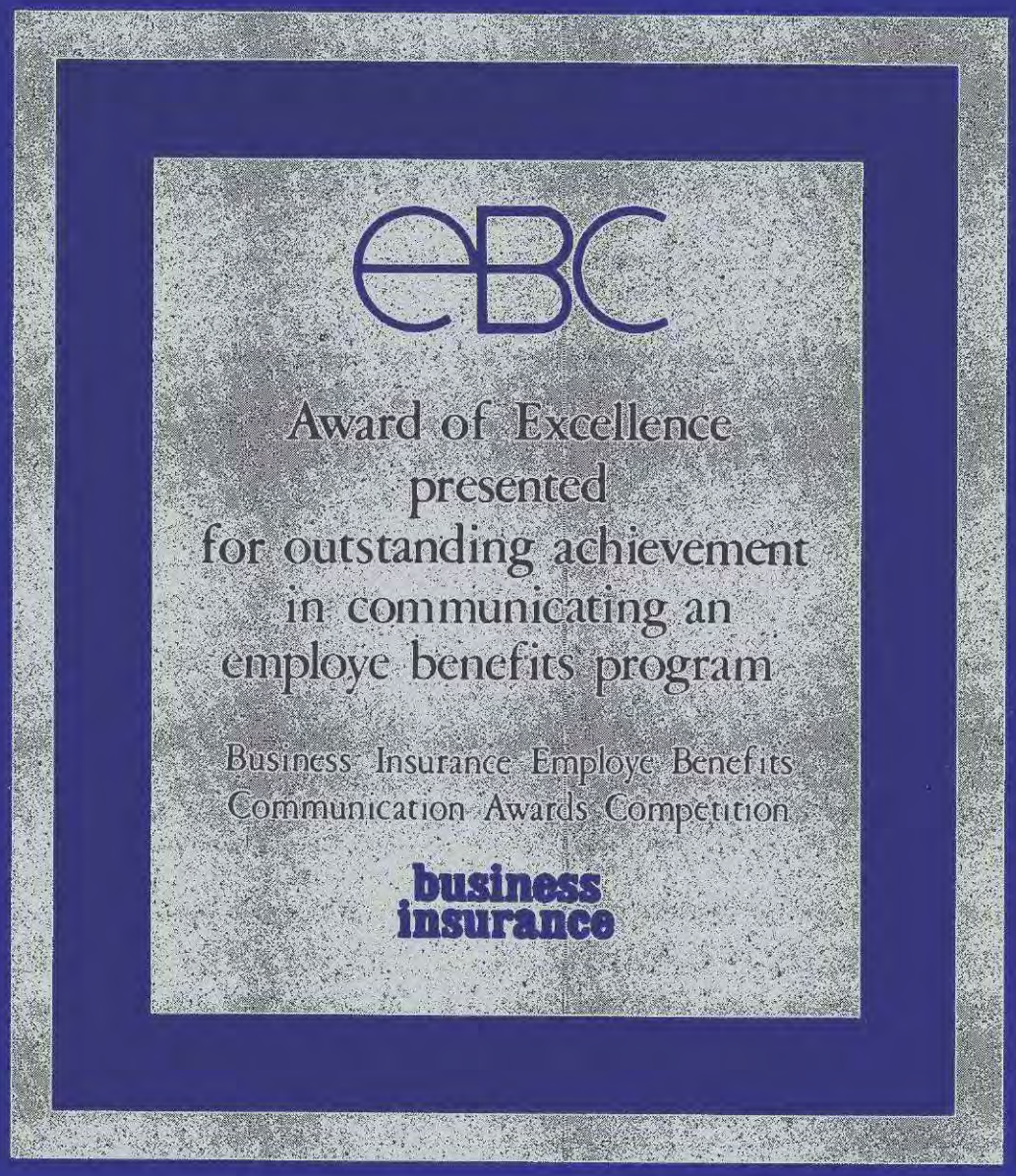
This will benefit the producer by giving him the opportunity to capitalize on the local expertise of Near East Agencies, save time, money and effort on servicing his client's needs in the Mideast and keep his usual commission on all local admitted policies.

J.T. Sliheet
Near East Agencies (U.S.A.), Houston, Tex.

errors & omissions

• Arthur W. Ericson is the vp and associate actuary for Prudential Insurance Co. of America who was quoted on the new Prudential group legal insurance plan in California in the Feb. 19 Benefit beat column. His name was misspelled due to a typographical error.

• A&P purchased inland marine coverage in the Belgium market, not fire insurance as reported in the Feb. 19 issue of *Business Insurance*. The policy was written by the Belgium Underwriting Organization.



The 1979 Business Insurance awards presentation for outstanding achievement in communicating employe benefits programs will be made at the luncheon during the fall conference of the Council on Employee Benefits. Place and date: Fairmont Hotel, New Orleans, October 4th.

A panel of employe benefits managers and communicators, selected by Business Insurance, will judge programs in the following categories: Booklets...Personalized Correspondence...Audio-Visuals... Special Projects...Total Communication Programs.

Entries will be accepted for the seventh annual competition between March 1 and April 30. The competition is open to all companies in the U.S. and Canada and has no restrictions as to the size of the company.

For more information, to obtain rules end entry forms and to submit your programs, call Ronnie Drachman, Awards Coordinator, 212/986-5050 or clip the coupon and send it to us as soon as possible.

Employe Benefits Communication Awards Competition

Mail to: Benefits Communications Awards · Business Insurance · 708 Third Avenue · New York, N.Y. 10017

Yes, I am interested in entering our communications program(s). Please send me _____ entry blank(s) and the competition rules.

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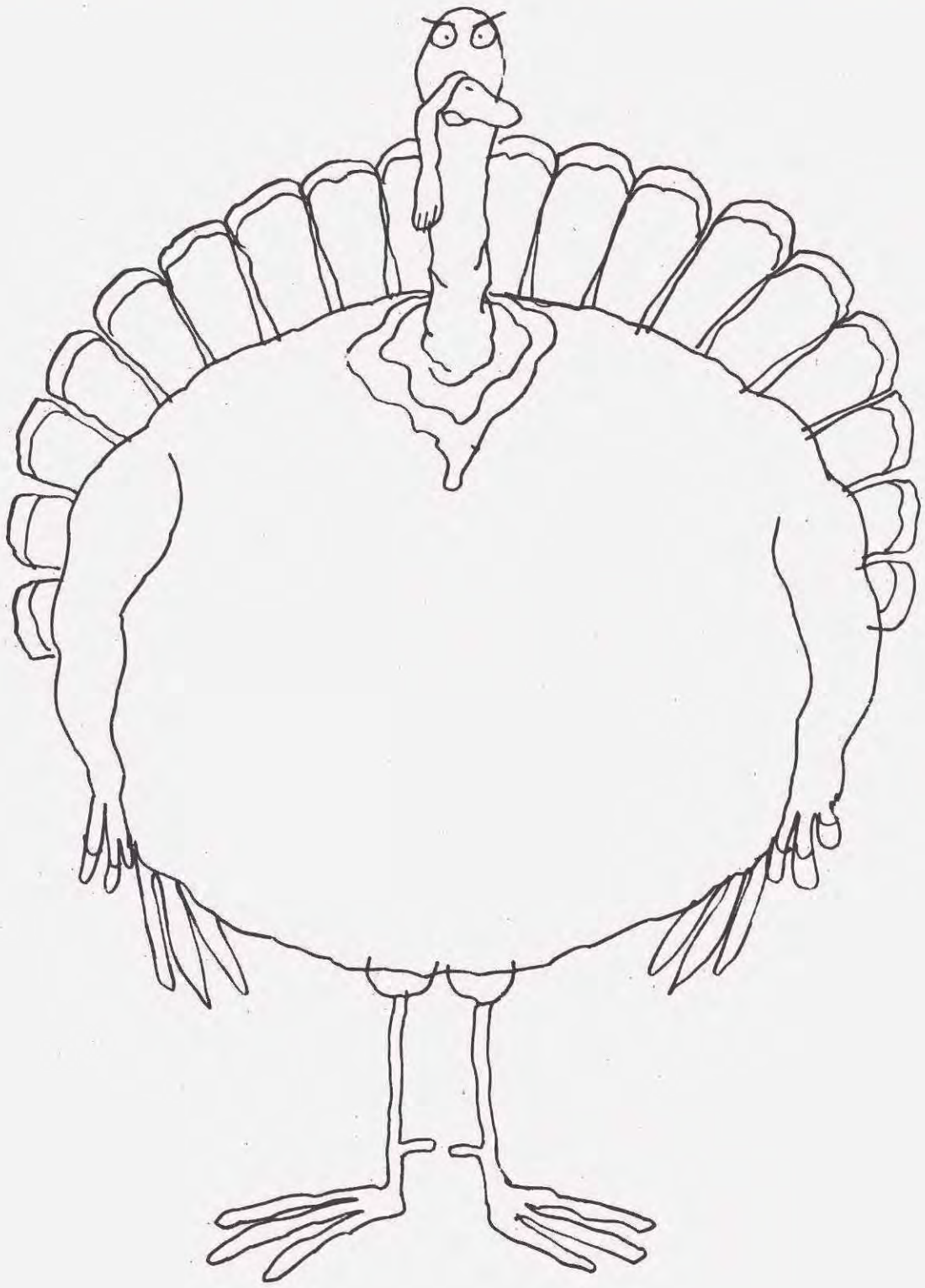

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