Benefit costs: A way down, a push up

Mandated second opinions save Prudential clients 6%

By REBECCA A. FANNIN

NEW YORK—Convinced that mandating second opinions on surgery can effectively control soaring medical costs, Prudential Insurance Co. is offering subscribers who adopt the benefit a 6% discount on group insurance rates.

The mandatory second opinion program also imposes reduced surgery benefits on clients who don't obtain a second consultation or who disregard conflicting surgical advice. Prudential is recommending a 50% reduction of benefits in such instances, but subscribers can opt for as low a percentage reduction as 25%.

The mandatory program hasn't won any new customers yet, but the insurer is in "deep discussion with a number of clients," said Eugene B. Heimberg, vp of group insurance at Prudential. Both existing and new clients can add the second opinion benefit to their plans.

Prudential also is marketing a voluntary second opinion benefit, but the voluntary program doesn't earn a 6% discount on group insurance premiums.

Meanwhile, other large group insurers offer a second surgical opinion benefit only on a voluntary basis. They argue that the mandated approach restricts freedom of choice and disrupts

Continued on page 48

Equal benefits for pregnancy can boost plan costs 20%

By JERRY GEISEL

WASHINGTON—Some employers will be socked with major premium hikes on their sick leave programs and smaller, though still substantial cost increases on their group health insurance plans when the new federal law requiring companies to offer equitable pregnancy benefits goes into effect next month.

Covering pregnancy in corporate paid sick leave plans may result in 20% premium increases, according to insurance companies' actuaries. Premium hikes of between 3% and 4% are expected for employers including pregnancy in their medical and hospitalization plans for the first time.

Companies already covering pregnancy on the same basis as other illnesses will escape increased insurance costs when the new federal law mandating the benefit equality goes into effect April 29. Employers in New York, for example, have already revamped benefit plans in response to a state court ruling that pregnancy had to be included in disability plans on an equitable basis.

Moreover, companies with fewer than 15 employes are exempt from the federal benefit mandated.

But, the vast majority of benefit

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N.Y. compromise rolls exchange back on track

By ELLIS SIMON

NEW YORK—The organization of the New York Insurance Exchange is back on the main track now that the state senate and assembly have agreed to changes in the exchange's constitution.

It appears no steam was lost while the exchange was sidetracked by earlier senate rejection of its constitution.

Insurance company and brokerage officials here expressed relief upon learning that an agreement had been reached. They now intend to proceed with development of plans for participation in the New York exchange, they said.

Successful development of a second American syndicate market in Chicago or another city seems unlikely at this time, they added, but it could be possible in the distant future, they said.

Both houses of the legislature approved changes to the constitution worked out and agreed to by Vincent Nicolosi, chairman of the assembly insurance committee, John Dunne, chairman of the senate insurance committee and Albert Lewis, superintendent of insurance.

Passage of this compromise legislation removed the last hurdle to incorporation of the exchange. In addition, the compromise moved up the incorporation date to March 1 from April 1.

The agreement also extended to 70 days from 45 days the time in which syndicates could apply for membership prior to election of the exchange's board of governors. The pact limits syndicate participation on a single risk to 10% of its surplus. And it includes as part of the assets that can be attached to a syndicate being liquidated due to insolvency the syndicates' contributions to the exchange's solvency fund.

These revisions had been sought by Sen. Dunne in late January. After an agreement could not be reached between the senator and

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The inside story

Risk manager on the slopes



Levi Strauss's Dick Soper doesn't leave his work at the office. Even skiing the slopes as a member of the National Ski Patrol System he's thinking risk management: He's the author of a new liability insurance plan for NSPS that is lowering the patrol's insurance costs for the first time since 1938. **Page 34.**

False alarms ring trouble

Security systems tied into police emergency lines are too often falsely summoning for help, forcing authorities to impose stiff rules on their use. **Page 37.**

The people column page 50

Week of March 5, 1979

business insurance

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Florida lawmakers slight work comp reform report

By MARY ELLEN McKEE

TALLAHASSEE—An unusual coalition of employer groups, insurance executives, legislators and insurance regulators here are aggressively pushing for workers compensation reform in the upcoming session of the Florida legislature.

Under the banner of the joint legislative committee, they submitted recommendations March 1 to the house insurance committee endorsing: the wage-loss concept; elimination of an impairment schedule for minor injuries, and shifting the cost of litigation in contested cases to the claimant.

But the joint legislative committee's recommendations for major revisions of Florida's workers compensation law may never get aired in the legislature, a *Business Insurance* survey of members of the house insurance committee reveals.

The telephone survey of 12 of the 18 members of the house committee which will review the proposals revealed that only one of its two supporters believes what the joint committee wants has much of a chance of passing the house insurance committee intact.

Five other representatives surveyed were adamant in their opposition to the joint committee's proposals, while five said they'd keep an open mind, but had reservations. The six other committee members were unavailable for comment.

Criticisms by the representatives of the proposals range from, "It's a hurry up offense made under much pressure to come up with a law," to "The plan is too simplistic in eliminating a payment schedule except for the most clear-cut, serious injuries."

One legislator was more vehement than his colleagues in criticizing the wage-loss proposal, "It deserves to be cut into pieces. It gives the heave-ho to the worker."

But the Florida legislature has to pass a new workers compensation law this year, having repealed the current law effective July 1, 1979.

The wage-loss approach supported by the committee takes into consideration the employe's salary before the injury and the amount he is able to earn after re-entering the work force. With this approach, the type of disability is never a factor in determining benefits, but its effect on the worker's wage earn-

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Bridge out

Insurance will pay about one-third of the $100 million needed to rebuild the Hood Canal Bridge in Port Gable, Wash. Winds gusting at 100 mph broke up the nation's longest floating salt water span. Story, page 20.

Photo: Wide World

Feds squelch FM merger plan to protect insurance markets

By KATHRYN J. McINTYRE

WASHINGTON—Commercial property insurance buyers were going to get burned by the merger of the two largest Factory Mutual System companies, according to the Federal Trade Commission which doused the merger.

Together Allendale Mutual Insurance Co. and Arkwright-Boston Manufacturers Mutual Insurance Co. would have controlled too much of two important markets—boiler and machinery and highly protected risk—the FTC determined.

Contrary to the FM companies' arguments, the FTC staff also found evidence of hefty competition between the two insurers on price and willingness to insure, said an FTC spokesman who asked not to be identified.

Based on these findings, the FTC staff informed the two companies last December that the FTC would seek an injunction against the merger that was to be consummated at the end of the year. The merger was delayed for over two months while the two sides argued its merits, but on Feb. 13 the FTC said it still opposed the merger

With an injunction against the merger and lengthy litigation assured, the two mutuals decided last month to abort the merger, executives at both companies explained.

Now, even though property insurance buyers will still have four separate FM System markets to choose from, at least one FTC staffer wonders if there isn't more about the FM System for the trust busters to investigate.

The FTC pinned its opposition to the merger on its finding that together the two largest FM companies would control at least 30% of the boiler and machinery market, making the new enlarged Allendale number one or two against today's largest B&M underwriter, The Hartford Steam Boiler Inspection & Insurance Co. In addition, the two merged companies would have controlled 30% of the highly protected risk market, according to FTC calculations.

The new company's domination in these two markets would have been illegal under the Clayton Anti-Trust Act and would have increased prices, the FTC spokesman explained.

Allendale chairman William Goodall and Arkwright-Boston se-

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Former RIMS president Bob Spencer dies at 53



ATLANTA—Robert S. Spencer, 53, national president of Risk & Insurance Management Society in 1977-78 and vp-insurance of Fuqua Industries Inc., died late last month of a heart attack at his home here.

Mr. Spencer, known nationally as an innovative risk manager, served as an articulate spokesman for his company and the risk management profession. He was frank about his views on how the insurance business worked and the role of the corporate risk manager.

Risk managers, he said, should be the "conscience of management," educating corporate executives on the problems resulting from poor workmanship and working conditions and explaining to the public how to use products safely and how everyone suffers from costly liability awards.

In his own company, Mr. Spencer used that advocacy role to create one of the most dynamic risk management departments in the country. He founded Fuqua's insurance department in 1967, one year after joining the company.

In 1972, he established a self-insured workers compensation program covering 250 employes and the same year earned the title of vp-insurance. Today the self-funded workers compensation program covers 8,000 employes.

Mr. Spencer's other achievements at Fuqua included establishment in 1976 of the Bermuda captive Fuqua Insurance Co. Ltd. and development of a benefits program considered to be one of the best in the Southeast.

Mr. Spencer had held local and national offices in RIMS since 1962. He was a former president of the Atlanta chapter, served later as national vp-conference and then first vp of the organization before becoming its president in 1977.

While Mr. Spencer was president, RIMS national membership grew by a record 20%. In addition, the organization established a research function and initiated use of computers to better assess the needs of its membership.

Continued on page 47

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for your information

Mich. launches work comp reform with study of rate making norms

DETROIT—Workers compensation reform is afoot in Michigan. The insurance department is asking the state's rating bureau to conduct 10 studies on the rate making process and the governor is expected to introduce a workers compensation reform bill soon.

The insurance department asked for the studies after insurers requested three substantial rate increases in a two-year period. The insurance department is hoping the studies will furnish it with enough information so it can suggest a more effective way to determine rates.

Statistical data gathering and analysis will be the focus of one of the studies. The department objects to the use of statistics gathered on a countrywide basis to determine one state's rates even though the workers compensation climates vary from state to state.

The accounting period, which is one type of statistic upon which rates are based, is also under insurance department scrutiny. The department supports the use of an accident year data gathering period rather than the present policy date year and hopes the study results will document its case.

The department also wants to see what effect reserve levels have on rate levels.

Details on the governor's workers compensation bill are not available, but it's believed the bill is a revised version of the one the governor introduced last year.

Tax court boots Carnation out

LOS ANGELES—It will probably be several more years before the U.S. Appeals Court rules on Carnation Co.'s case against the Internal Revenue Service, predicts Carnation's attorney.

Carnation is appealing to the next court of jurisdiction since the Tax Court refused last month to reconsider its December 1978 decision. The decision favored the IRS position on captives and disagreed with Carnation's argument defending the validity of transactions with a captive.

Carnation is seeking a court decision overturning the IRS position that captive insurance companies do not offer parent companies bona fide insurance transactions for tax purposes. Carnation's attorney, J. Patrick Whaley of Music, Peeler & Garrett, said, "Because of the backlog of cases in the appellate court, it will probably be several more years before a decision is rendered by it."

Meanwhile, the National Assn. of Insurance Brokers is prepared to "actively pursue legislative reform" to establish the validity for tax purposes of captive insurers if the appellate court rules against Carnation and captive insurers, said NAIB president David D. Holbrook.

OPIC merger announced

WASHINGTON—The Overseas Private Investment Corp. (OPIC), the federal agency that provides political risk insurance to private companies investing abroad, will be merged into a new federal agency, the White House announced last month.

The new agency, to be called the International Development Cooperation Administration, is designed to improve the cost-effectiveness of U.S. assistance to developing nations.

OPIC officials do not expect any changes in their insurance programs or in their staff personnel because of the merger into the new agency.

Congressional approval is needed before the merger can take place.

Insurance scandal lands in court

KANSAS CITY—Over 100 insurance buyers who allegedly were swindled in an excess/surplus lines insurance scheme by a St. Louis agent will now have to file in U.S. District Court for the Western District of Missouri to recover any more money.

The court is assuming responsibility for refunding money to claimants at the request of Missouri insurance division director Jerry B. Buxton who filed suit against all the parties involved. Mr. Buxton said he sued everyone involved to be sure money available is equitably distributed among the claimants.

Half of the $465, 126.61 surrendered by Donald J. Kubovchik last summer to his employer, Associated Underwriters, has been spent on new insurance for some of the apparently uninsured buyers and on premium refunds. Mr. Buxton predicted, however, that additional assets will be turned over by Mr. Kubovchik, who allegedly pocketed over $1.2 million in premiums over a two-year period instead of buying insurance for his customers (*BI*, Oct. 2, 1978).

Mr. Buxton's lawsuit names: Mr. Kubovchik, who also used the name of John E. Keiser; A.U. Agency Inc., the new name of Mr. Kubovchik's former employer; Daniel P. Reardon, an attorney and first trustee of the money surrendered by Mr. Kubovchik; the insurers of Associated Underwriters, including Reliance Insurance Co. as the fidelity bond insurer, International Surplus Lines Insurance Co. as the errors and omissions insurer and Lititz Mutual Insurance Co. as the umbrella underwriter. The suit also names all claimants, known and unknown. Among the 126 known claimants listed are municipalities, government agencies and small businesses around the country.

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the benefit beat

Machinists pact with United sends benefits higher

Machinists will win hefty increases in health, life and dental insurance if a tentative contract settlement between United Airlines and the International Assn. of Machinists is approved.

If ratified by 19,000 workers March 12, deductibles for medical coverage will be changed to a flat $200 per year from $200 per cause, said Don Kramlich, local lodge president for the IAM. Hospital room and board coverage would also be increased to $125 per day from $100 over the life of the proposed three-year pact. Payments for doctor's visits would be hiked to $15 from $10 for the first visit and to $10 from $7 for subsequent sessions. Also called for is an increase in maximum major medical insurance to $250,000 from $200,000.

Life insurance would rise to $20,000 from $10,000 in fully-paid coverage while workers would be given the option of purchasing an additional $40,000 at a rate of 40 cents per thousand, up from the current available additional insurance of $20,000.

Dental coverage including, "just about anything a dentist can do" would increase to 100% from 80% of a fixed rate schedule with maximum charges for various services doubling.

Connecticut General Life Insurance Co. underwrites the medical and dental coverage. Currently major medical insurance costs $86 per month per employe. The cost of the proposed benefit increases hasn't been determined yet.

The Council on Wage and Price Stability announced recently it was reviewing the proposed settlement because wages and benefits exceed the 7% administration guidelines. Mr. Kramlich said the union would not cut back on benefit gains, describing them as "catch-up" increases that still do not cover conventional health care costs.

More paper settlements

Paperworkers in Maryland and Virginia have ended an 11-week strike and returned to work with a contract calling for increased insurance and pension coverage. Some 2,600 workers are affected by the pact reached with Westvaco Corp., with two mills in Covington, Va., and Luke, Md.

Called for are 100% health insurance premium payments at the Luke mill and 83% premium payments at the Covington location, said Arnold Brown, international vp for the United Paperworkers Union. Previously, the employer paid only 70% of health premiums at both worksites.

In the first contract year, major medical coverage will increase to $50,000 from $30,000 and to $100,000 from $50,000 in the second year of the agreement. The maximum death and dismemberment benefit, exclusive of workers compensation, has risen to $20,000 from $10,000 at both mills. Life insurance maximums have increased to $20,000 from $10,000 and sickness and accident benefits will rise to a minimum of $115 from $100 with a $150 maximum in the first year, said Mr. Brown.

Workers also won an improved pension plan that will increase employer's contributions to $13 per month per employe from $11. In the second year of the contract, that payment will increase again to $14, Mr. Brown said. Equitable Insurance Co. underwrites the pension plan.

Luke, Md., workers also won an alcoholism treatment provision entitling them to 120 days per year of clinical treatment. The Virginia workers already have this benefit.

Furr's self-funds

Furr's Cafeterias, a publicly held corporation operating in the West and Southwest, is self-funding group medical and weekly income benefits for approximately 1,500 employes and their dependents.

Northwestern National Life of Minneapolis will provide life insurance and accidental death and dismemberment insurance for a total annual premium of $55,000 with a stop loss attachment point on all health claims at $510,000.

The stop loss insurance attachment point will be adjusted to $581,000 in May, however, when the maternity benefit changes to a full coverage plan with coverage for pre-natal and post-natal illnesses instead of a partial coverage maternity plan.

Administrative services for all claims processing will be provided by administrative and actuarial consultants Galbraith & Green Inc. of Albuquerque, N.M. The actuarial firm estimates total paid health claims for the first year of self-funding to reach $600,000.

Furr's made the switch, according to Galbraith & Green president Keith F. Kinghorn, to conserve cash and reduce the administrative operating costs of the plan. He wouldn't estimate how much the corporation expects to save as a result of going self-funded.

Firestone follows others

Firestone Tire & Rubber Co. and the United Rubber Workers said they have agreed on a plan to avoid a strike of the company when the present contract between the two expires at midnight April 20.

As a result, either Goodyear Tire & Rubber Co., Uniroyal Inc., or the B.F. Goodrich Co. will be designated the target company for upcoming contract talks.

Firestone will abide by any settlements patterned by the union and the industry if Firestone and the URW don't reach agreement, sources said. In addition, Firestone will not participate in industry mutual assistance to provide stock or payments to companies that are struck.

•

Benefit beat keeps insurance and employe benefit managers up-to-date in the employe benefit field. We'd like to know if you've made any changes. Write Kathryn J. McIntyre, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611 or call 312-649-5286.



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Senator proposes delay of PBGC guaranty plan

WASHINGTON—Rep. Sam Gibbons (D-Fla.) has introduced legislation to defer for two years the date the Pension Benefit Guaranty Corp. (PBGC) must guarantee benefits to participants of terminating multiemployer pension plans.

Under Rep. Gibbon's bill (H.R. 1788), the PBGC would not be mandated to cover multiemployer pension plans until June 30, 1981. Currently the PBGC is slated to begin mandatory coverage of multiemployer plans July 1.

Rep. Gibbons said the delay in mandatory coverage is needed to give Congress sufficient time to review PBGC's long term solution for guaranteeing benefits of collapsing multiemployer plans.

PBGC is expected to unveil in spring its proposals for insuring the benefits of multiemployer pension plan participants whose plans collapse with insufficient assets to pay the guaranteed benefits.

The PBGC reportedly is expected to recommend that it should only have to guarantee 60% of vested benefits with an absolute minimum benefit guarantee of $100 per month and a maximum of $500 per month. Generally, the PBGC pays monthly benefits of up to about $1,000 to beneficiaries of a folded plan.

But Rep. Gibbons is concerned Congress won't have enough time to review PBGC's proposals, which are expected to be extremely complicated, before the current mandatory coverage deadline is reached.

"We will not be able to understand let alone successfully resolve these issues on a hurried timetable," Rep. Gibbons said.

Some observers doubt, however, that Congress will approve a two-year extension in PBGC's mandatory coverage of multiemployer plans. One source said a one-year extension would be more favorably received.

Regardless how much of an extension PBGC receives, it's agreed a long term solution is needed to stave off a ruinous string of pension plan terminations.

In a study released in 1977, PBGC said that about 2% of all multiemployer pension plans are "experiencing extreme financial hardship" and have a "high potential" for termination in the next five years. ■

Carter completes roster of pension study group

By JERRY GEISEL

WASHINGTON—Plagued by months of delays, the President's Commission on Pension Policy finally is rolling with the appointment last month of the commission's 11 members.

Commission members include representatives from the academic community, labor unions, state legislatures, insurance companies and business.

President Carter said in June 1977 he would appoint a blue-ribbon commission to examine the scope and problems of public and private retirement plans. But the Administration ran into difficulty finding a chairman. Charles Kirbo, an Atlanta attorney and a Carter intimate, reportedly declined an offer to chair the commission.

Finally in October 1978, C. Peter McColough, chairman and chief executive officer of Xerox Corp., accepted the commission chairmanship. The 10 other commission members were recruited during the last three months.

Some observers criticize the time it took to put the commission together as well as its composition. "Do you mean to say it took this long to get these members? Surely, the White House could have done better than this," said a source in the pension consulting community.

But another observer praised the Administration for selecting a commission whose members "have a great wealth of knowledge about the pension and retirement system."

The areas mandated for study are sweeping. Among them are:

- The financial ability of public and private pension plans to meet their future obligations.
- The overlap and gaps among public and private plans in providing retirement income.
- How changes in one retirement system, such as Social Security, affect another retirement system, such as private pension plans.

The pension commission will hold regular public meetings, issue a series of interim reports and then issue a final report in the spring of 1981. Holding public meetings and releasing interim reports will give the public a good idea where the commission is going and the commission will "know what the public and policymakers expect of them," said the commission's director of public affairs.

Although it is not listed in its mandate, the commission is expected to look at the problem of women's pension rights. There has been considerable concern recently in Congress that women are shortchanged by the private pension system. Since women frequently do not stay in the work force as long as men, they are less likely to earn pension benefits.

In addition to its chairman, Mr. McColough, the 11 members of the President's Commission on Pension Policy are: **William C. Greenough,** chairman and CEO of the Teachers Insurance & Annuity Assn. and the College Retirement Equities Fund of New York; **Martha W. Griffiths,** a former Michigan congresswoman, lawyer and writer on pension issues; **Harvey Kapnick,** chairman and CEO of Arthur Andersen & Co., the huge Chicago-based accounting firm; **John Bragg,** a member of the Tennessee house of representatives, and former chairman of the National Conference of State Legislature's Task Force on Public Pensions.

Also: **Lisle C. Carter Jr.,** president of the University of the District of Columbia; **Paul R. Dean,** professor of law at Georgetown University Law School and a neutral trustee for the United Mine Workers health and retirement funds; **John Lyons,** president of the International Assn. of Bridge, Structural and Ornamental Iron Workers Union and veteran of numerous government advisory boards; **James Clark Jr.,** a Maryland state senator and chairman of the senate Pension Study Committee; **Henry L. Bowden,** an Atlanta attorney and chairman of the Board of Trustees of Emory University, and **Dorothy W. Nelson,** dean of the University of Southern California Law Center. ■

Why employee benefit communications don't always communicate.

J&H points out some expensive mistakes.

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Mistake 2: Settling for off-the-shelf approaches.
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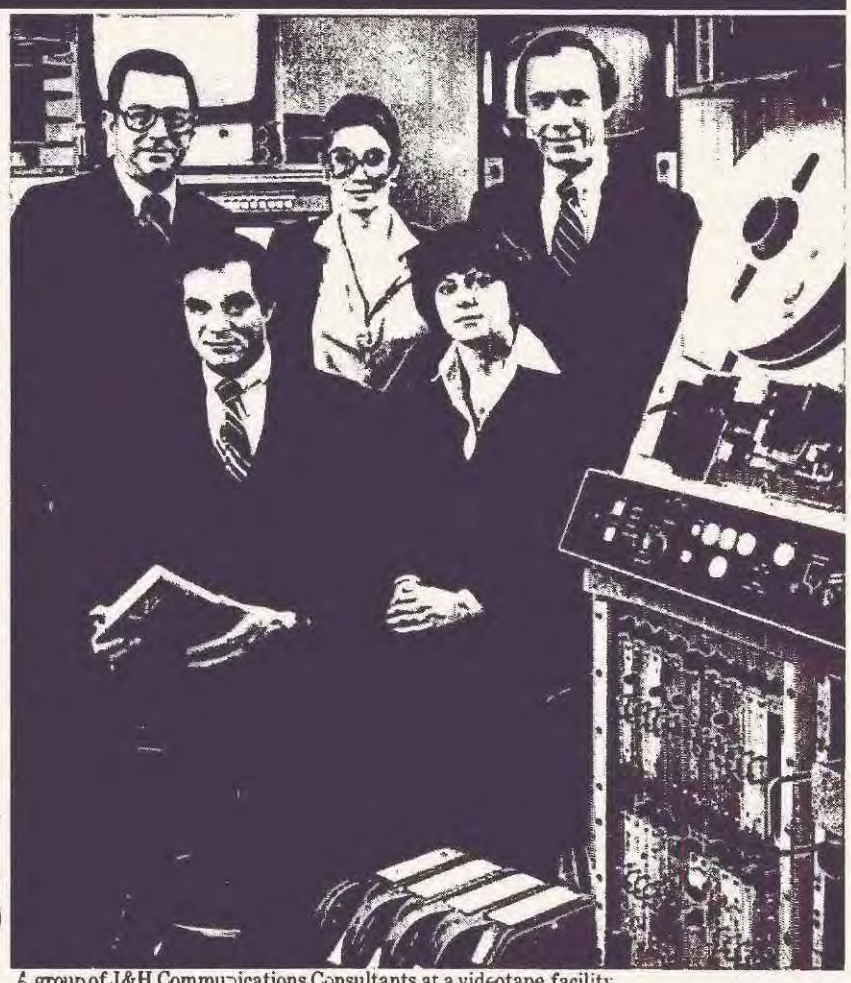
Mistake 3: Accepting one-shot solutions.
An approach that considers only an immediate problem may have quite serious long-term weaknesses.

Mistake 4: Ignoring your in-house talent.
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Mistake 5: Equating expense with effectiveness.
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A group of J&H Communications Consultants at a videotape facility.
Seated: Dennis McKoy, Vice President; Agnes Gioconda.
Standing: Thomas Loughrey, Joan Korn and Robert Lang.

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Fidelity writers pass on high expense ratio costs

By ELLIS SIMON

NEW YORK—The high cost of attracting business was a key factor in underwriting losses reported by fidelity and surety insurers, a *Business Insurance* analysis of 1977 insurance expense figures of the Surety Assn. of America reveals.

On fidelity lines, production expenses accounted for 25.3% of net premium earned with 19.6% consumed by commission and brokerage fees and 5.7% eaten up by other production expenses. Production expenses on surety lines ran even higher at 38.9% with 29.9% for commission and brokerage fees and 9% for other production expenses.

As a result, expense ratios on the two lines were 40.9% for fidelity and 60.4% for surety. By comparison, A.M. Best & Co. reported the 1978 average expense ratio for property/casualty insurers to be 25.8%.

The high expense costs of fidelity underwriters had been cited by critics of rate hikes being sought by the Surety Assn. on bankers blanket bond coverage. To date, 13 states have approved the filings, which would up the cost of premium paid by banks between 34% and 74% (*BI*, Jan. 22).

For 1977, fidelity insurers reported an underwriting ratio of 111%, or an 11% net underwriting loss. On surety lines, the underwriting ratio was 10% Loss and loss adjustment expense ratios on the two lines were 70.1% and 48.6% respectively.

If the 25.8% expense ratio of property/casualty insurers had applied, fidelity and surety underwriters could have had profitable underwriting ratios of 95.9% and 74.4% respectively.

At one time, fidelity insurers operated under a much lower expense ratio. A study of administrative costs during 1967-1969 showed an expense ratio of 20.5% of net earned premium.

The recent filings, structured on that study, propose a 31% expense ratio comprised of 15% for brokerage commission and fees, 13% for administrative costs and 3% for taxes, licenses and fees.

The proposed rates anticipate a 64% loss and loss adjustment expense ratio and allow 5% for contingency expenses and underwriting profit. ■

Court ruling could hike shipper work comp bills

By JERRY GEISEL

WASHINGTON—Shippers' workers compensation premiums could jump in the wake of a Supreme Court decision that sharply increases the death benefits payable under the federal longshoremen's act.

At the same time, the Court also ruled that even though Congress has eliminated mandatory retirement for civil servants, the government still can require Foreign Service officers to retire at age 60.

In a decision announced last month, the court said that survivors of employes covered under the federal Longshoremen's and Harbor Workers' Compensation Act are entitled to death benefits equal to two-thirds of the deceased workers' weekly salary.

The justices, in an 8-0 decision, rejected arguments from the Labor Department and insurers who contended that the limit in the federal law for disability benefits—$367.22 a week—also applies to death benefits as well.

The case involved an hydrologist employed in South Vietnam in 1973 by Geo Control Inc. William Rasmussen was fatally injured in Vietnam when the vehicle in which he was riding was blown up by a land mine.

As a civilian employe working overseas for a government contractor, Mr. Rasmussen was covered under the 1972 federal longshoremen's compensation act rather than under a state workers compensation program.

The Labor Department, Geo Control and its insurers, New Hampshire Insurance Co., all interpreted the 1972 law to limit survivors' benefits to the maximums placed on disability benefits: 200% of the national average weekly salary up to a maximum of $367.22.

But Mr. Rasmussen's widow argued that the only limit on death benefits is two-thirds of the worker's actual weekly salary. Since Mr. Rasmussen was earning $798 a week at the time of his death, Mrs. Rasmussen said she was entitled to $532.

The Supreme Court agreed with Mrs. Rasmussen in upholding a lower court decision. The justices said when Congress passed the 1972 act it deliberately did not place the same ceiling on death benefits as it did for disability benefits. Geo Control said the omission of the ceiling was inadvertant.

"That the omission of a maximum limitation on death benefits was inadvertant is disapproved by the legislative history of the 1972 amendments," the high court said, noting that the Senate bill on which the amendments are based proposed the elimination of fixed dollar ceilings on death benefits.

The Labor Department said prior to the decision that while the number of cases affected are relatively small, the sums involved are large and could affect workers compensation insurance premiums.

Meanwhile, in another case, the Court upheld the constitutionality of a 1946 law requiring Foreign Service officers to retire at age 60.

The justices, in an 8-1 decision, overturned a lower court decision that the requirement violated the diplomats' right to equal protection because federal employes covered under Civil Service rules aren't subject to retirement at a fixed age.

Justice Byron White, writing for the majority, said Congress, has a "rational basis" for legislating a separate retirement system for Foreign Service officers and for wanting to "avoid the risks connected with having older employes in the Foreign Service but to tolerate those risks in the civil services."

Furthermore, the retirement at age 60 policy removes from the service "those who are sufficiently old that they may be less equipped or less ready than younger persons to face the rigors of overseas duty," Justice White said. About 60% of Foreign Service officers are posted overseas at one time, but only about 5% of Civil Service employes worked abroad, generally on a voluntary basis, Justice White added. ■

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Continental Update



from
The Continental Insurance Companies
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Continental Unveils New Facility For Large Casualty Risks

The Property and Casualty Division of The Continental Corporation has introduced a new unit — Special Risk Underwriters. It will concentrate on risks that generate annual casualty premiums in excess of $200,000. During 1979, Special Risk Underwriters is expected to handle revenues in excess of $100 million

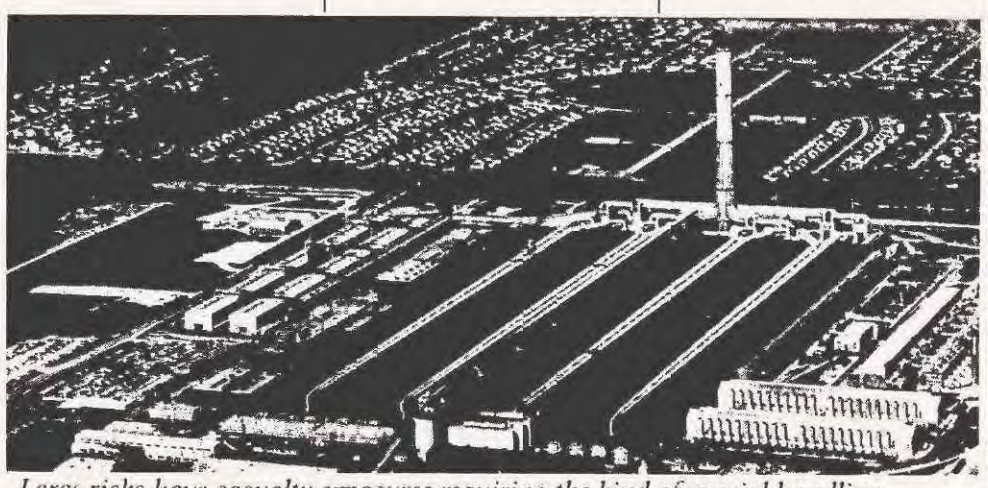
Announcing formation of the new unit, Continental Executive Vice President John H. Bretherick, Jr., said, "Large casualty risks demand advanced underwriting skills, extensive engineering and loss control services and knowledgeable claims handling, as well as careful coordination of all those elements. The Risk Planners at Special Risk Underwriters will work with Continental agents, brokers and risk managers to help identify the risks to which a business is exposed. Then they will devise financial strategies to minimize or transfer those risks."

Mr. Bretherick then outlined some of the facilities available through the new unit "If self-insurance or formation of a captive company is called for, the Risk Planner at Special Risk Underwriters will help chart the way. If an insured program is indicated, Special Risk Underwriters will furnish both primary and excess coverage. If loss control is a problem, they will have a solution. If extensive claims work is a factor, a country-wide organization is at their beck and call. Premium financing and data processing services are also readily available."

The new underwriting unit, headquartered in New York City, is headed by Vice President Mark R. Patton, an insurance executive with more than 15 years' experience in the special risk, commercial casualty and reinsurance fields. Commenting on the formation of Special Risk Underwriters, Mr. Patton said, "Our immediate goal is to establish this unit in the special risk marketplace. We have a lot to offer. Our facility will be stable, reliable, skillful and responsive to the specialized needs of the large casualty risk."

For more information contact your insurance agent or broker, or call Frank Hofstatter in San Francisco, (415) 576-8155; Gerald Tetzman in Chicago, (312) 341-2747; Neil Niehaus in Dallas, (214) 748-7351; or William Bolinder in New York, (212) 374-3214. Or you may write Mark R. Patton, Vice President, Special Risk Underwriters, The Continental Insurance Companies, 80 Maiden Lane, New York, New York 10038.

See us at the R.I.M.S. CONFERENCE April 29 – May 4
A Special Risk Underwriters representative will be in the Continental hospitality suite: (room 3607) the Presidential Suite of the Hyatt Regency, Chicago.



Large risks have casualty exposures requiring the kind of special handling and skill that Continental's new Special Risk Underwriters can provide.

Opposition in Tex.

Self-insured work comp rises on Nev. horizon

By ELLIS SIMON

CARSON CITY, Nev.— Legislation is pending before the Nevada assembly and senate that would permit employers to self-insure workers compensation here.

Meanwhile, in Texas an insurance industry trade association has come out in opposition to a bill permitting self-insurance of workers compensation there, even though the bill was largely written by the trade group's counsel.

The bill in Nevada came out of a two-year legislative study on the need for reform in the state's industrial commission, which administers Nevada's monopolistic workers compensation fund.

Originally, legislative leaders considered permitting private insurers to be licensed in the state as well, but it was decided that Nevada was not ready for a three-way system, said Rep. Joseph Dini, chairman of the subcommittee that recommended the bill.

Other provisions of the bill call for changes in workers compensation benefits, hearing procedures and eligibility requirements.

The bill would require a self-insurer to post a bond of at least $500,000. In addition, self-insurers would be subject to the same benefit requirements as the state fund and under the scrutiny of the industrial commission and insurance department, Mr. Dini said.

Only the largest employers in the state's gaming industry are expected to be able to take advantage of the self-insurance bill. Some gambling operations presently operate on self-rated plans administered by the state fund, Mr. Dini said.

A separate study is underway by Stanford Research Institute on behalf of the Industrial Commission. The study will probably repeat the findings of the legislative report, but offer details on their cost implications.

Release of the Stanford report is expected in mid-March.

In Texas, the Assn. of Fire & Casualty Cos. of Texas announced its opposition to a bill permitting self-insurance of workers compensation. The bill being considered by the house employment practices hearing was drafted by counsel to the association.

However, the bill dropped a provision in the original draft requiring self-insurers to contribute to covering the losses of the state's assigned risk pool. While the insurance industry was never in favor of self-insurance, the association agreed to remain neutral if its bill were adopted verbatim, said counsel Richard Geiger.

"The assigned risk provision was critical in our view," he said.

Insurance industry opposition "surprised" Gerald Dorsey, counsel to the Texas Assn. of Business, a main supporter of the bill. "We compromised as far as we could and gave the industry everything they wanted except for participation in the assigned risk pool," he said. "They haven't negotiated and they've been most uncooperative."

Mr. Dorsey said he remains optimistic about the bill's future despite insurance industry opposition.

Other provisions sought by the insurance industry and included in the bill were establishment of a separate guaranty fund for self-insurers and other measures to protect against insolvency.

The bill would establish the "most stringent" requirements of self-insurers in terms of qualifying and protection against insolvencies of any bill in the country, Mr. Dorsey said. ■

Johnson & Anton grows

Johnson & Anton Inc. brokerage and Charles J. Gallagher Insurance, a brokerage firm specializing in aviation insurance, have merged. Charles Gallagher is now head of the aviation insurance department of Johnson & Anton, whose offices are in San Francisco.

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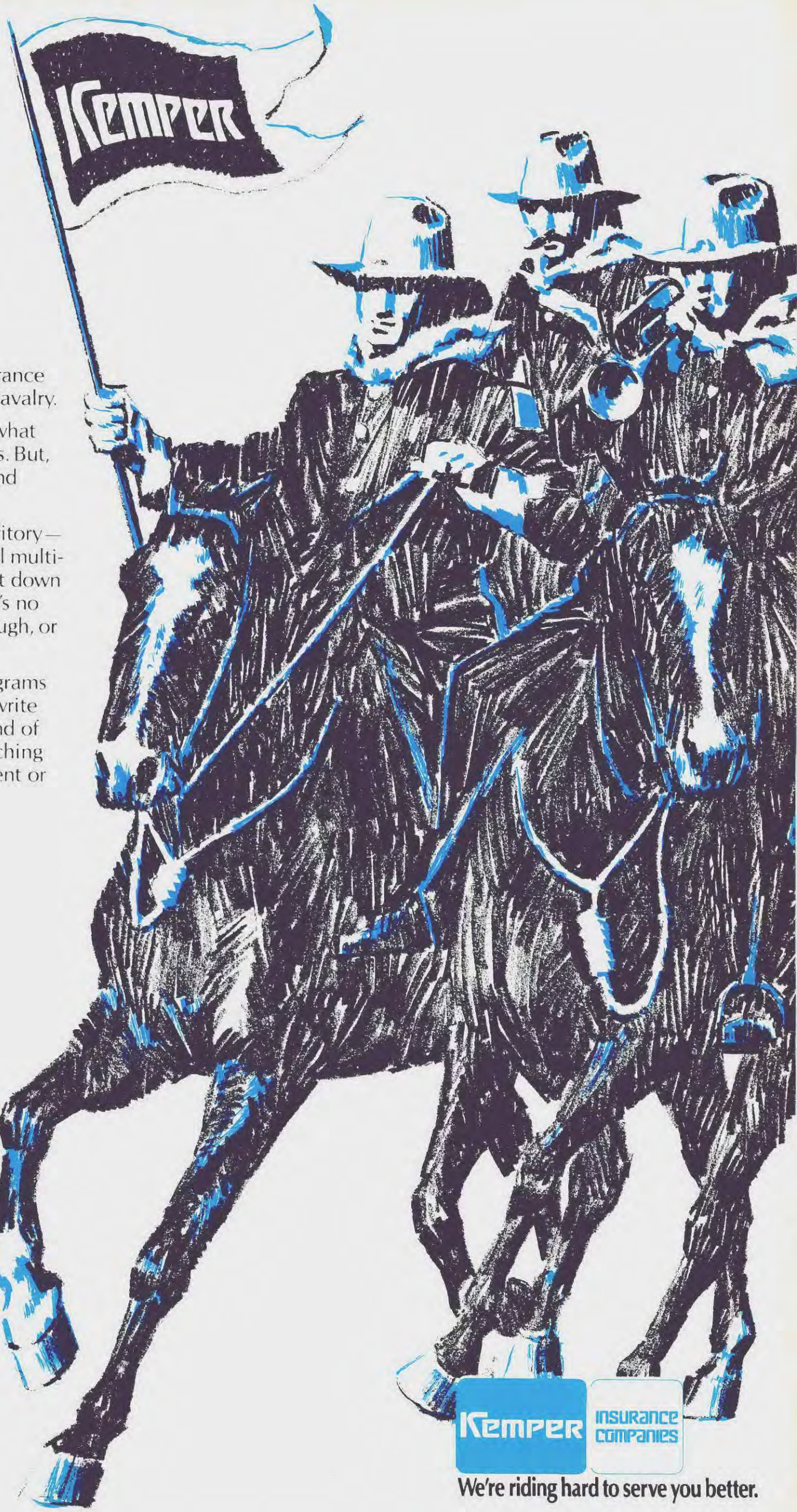
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Brokers' London links: One more, risks move

By JOHN MILLER

LONDON—Corroon & Black Corp. is exploring the possibility of linking up with Minet Holding Ltd. here by sharing the results of their worldwide business.

The committee of Lloyd's has been told that Minet will stay independent in line with current Lloyd's attitudes, which have also applied to the other broker tie-ups announced last year.

Observers are intrigued by the announcement since Minet has had a close relationship since 1974 with Fred S. James & Co. Inc. in which it has a 10% stake, while James in turn has a stake in some Minet subsidiaries.

Minet said in London Feb. 14 that it had agreed with James that this "long standing association will continue," but there is the added complication that Corroon & Black has a 35% stake in another Lloyd's broker, Glanvill Enthoven. The Charterhouse Group, a U.K. finance house which owns 65% of Glanvill Enthoven, may decide to "buy out" Corroon & Black's part in Glanvill Enthoven if terms can be agreed.

In New York, Corroon & Black announced that with respect to its existing holdings in Glanvill Enthoven, it intends to "consider all available options with the various interests involved, namely Minet, the management of Glanvill Enthoven and The Charterhouse Group Ltd."

Meanwhile, brokerage arrangements for many leading U.S. accounts at Lloyd's are now being changed in the wake of the rush to link up U.S. and U.K. brokers which began last year.

The newest move reported in London insurance circles is a decision by Marsh & McLennan to switch its Lockheed aviation account to Lloyd's brokers C.T. Bowring & Co.

It had been thought it might stay under the umbrella of the recently-merged Sedgwick Forbes/Bland Payne group. But the move is seen as an obvious incentive by Marsh & McLennan to consolidate its future links with the Bowring group, with whom its plans for co-ordinating business interests were announced last fall (*BI* Oct. 16, 1978).

Marsh & McLennan has in any case lost its previous 20% financial stake in Bland Payne under the "triple alliance" between that group, Sedgwick Forbes and Alexander & Alexander which surfaced last November.

Peter T. Wright, deputy chairman and managing director of the new Forbes/Payne combination, refused to elaborate on any account "switchings" except to say that reports of the Lockheed move were only partially correct. He declared responsibility for any changes was on the Marsh & McLennan group, as they were the lead U.S. brokers involved, and said it was too early to predict the future pattern of events.

"We must wait and see what happens this year," he told *Business Insurance*. "We've already had some renewals of business and I see no reason why Marsh & McLennan should not continue to do business with us. As far as the Lockheed account is concerned, I cannot comment, as that is a client matter for Marsh & McLennan."

The Lockheed account is transferring in two stages, according to renewal dates. The liability cover will move to Bowring in March and the airframe cover will move to Bowring in late 1979.

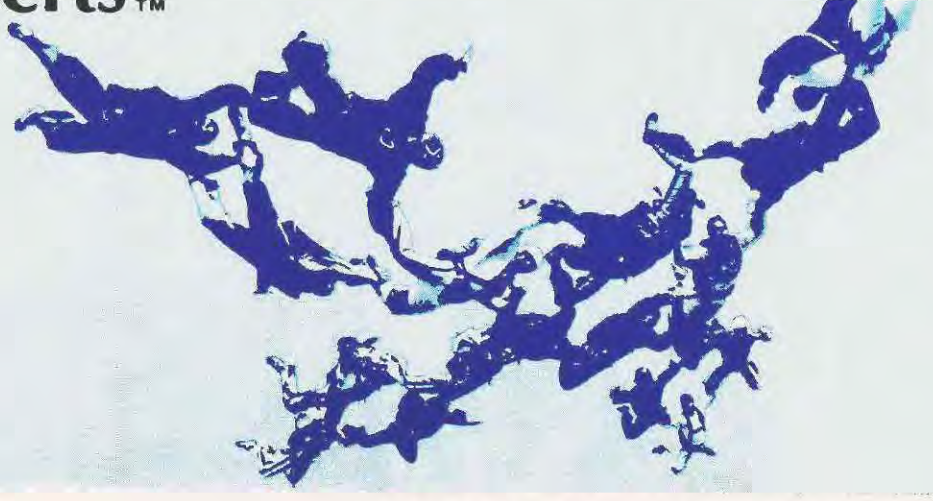
In addition, the INA treaty reinsurance account is also being moved by M&M to the Bowring group.

Sources in London say these changes have been made by individual corporate executives at M&M, but that other accounts placed by M&M in London will remain temporarily unchanged. However it is indicated that Bowring will be the natural corollary for future M&M business.

Consolidation of financial interests between Sedgwick Forbes and Bland Payne was completed Feb. 12 giving it a market value of over $400 million and annual profits of $100 million. ■

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editorial opinions

Exchange passes with a "C"

THE SCENARIO READ LIKE A script from an episode of television's Paper Chase. The crusty, old law professor assigns his 13 brightest students to prepare briefs and arguments on a controversial case. The students put forth their best efforts and the resulting presentation is logical and sound. Yet, the students omit a technical point or two and the professor flunks them.

Transfer the scene to the New York State Senate and it becomes clearer what happened to the proposed constitution and bylaws for the New York Insurance Exchange. John Dunne, chairman of the state senate insurance committee, received that document, decided changes were needed and convinced his party leaders to reject it.

Despite the protests of Republican leaders in the state senate that the rejection was for technical reasons only, the drafters of the constitution and bylaws have been stung. Talk of moving the whole concept to Illinois or another state is not surprising from people accustomed to success.

Their frustration is understandable. For nearly five months the industry elite known as the Committee of 13 and the dozens of aides at their disposal knocked themselves out to produce a draft constitution. Support from insurance industry officials and brokers attested to the quality of their efforts and artful compromises.

▪ But, they missed a couple of technical points not related to the success or failure of the exchange and their grade from the senate was "F."

While there was some merit to Sen. Dunne's criticisms, they were on matters superfluous to the exchange's operation. Had party politics not been involved—Republicans control the senate and they supported Sen. Dunne—it is doubtful a rejection drive would have succeeded. The issues would probably have been resolved in other ways.

What happened in the New York Senate is a failure of the state's legislative process. That Sen. Dunne waited until late January to issue his criticisms of the exchange, less than a week before the constitution was due in the senate, suggests he was not kept informed and not invited to contribute to the deliberations. Were that the case, Sen. Dunne's position certainly would have attracted greater support. But, Republicans in the senate chose two of the 13 drafters. And the senator never claimed he wasn't informed all along.

Superintendant of insurance Al Lewis said copies of the constitution were in the senator's hands as early as Nov. 20 and his aides sat silently through three days of hearings on the document conducted by the insurance department. Sen. Dunne said it would have been inappropriate to comment at those hearings since as a legislator he would get to review the document. But he should have conducted his own open hearings to elicit answers from Mr. Lewis and the members of the Committee of 13. In such a forum, the public could have judged the merits of the senator's criticisms. And a hearing would have enabled the public to evaluate the merits of Mr. Lewis's responses, which Sen. Dunne charged were not substantive.

▪ Changes in the constitution could have been made following the Feb. 15 deadline for rejection, either by the legislature or the board of governors, but this was rejected by Sen. Dunne, who also thwarted attempts to reach a compromise.

Sen. Dunne changed from a hero in the efforts to establish the exchange into a villain of sorts.

Sen. Dunne's actions, in the end, were uncalled for. The entire discussion of issues, including charges that Al Lewis didn't have substantive responses to Sen. Dunne's questions, should have been conducted at another public hearing.

Undoubtedly, Sen. Dunne must have been impressed with the workings of Lloyd's. We hope his vision hasn't become too narrow. Though his desire to allow foreigners on the exchange's governing board may be sincere, we would call attention to the fact that Lloyd's doesn't have a single foreigner on its governing committee, despite the large portion of U.S. business funnelled to Lloyd's.

In the end, a compromise was worked out that satisfies everybody. This could have been accomplished sooner rather than later, without the animosities, bad feelings and frustrations that were evident in recent weeks. The sense of momentum for the exchange is too delicate to interrupt for the sake of what seemed to be a few minor issues.



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.

Bad comparison

To the editor: Re: 1/22/79 issue, "Bank execs dipping into funds drive up bond rates."

In the captioned article, Mr. Parremore of the Surety Assn. of America cites a 1967-69 study that shows administrative costs of the association representing 20.5% of earned fidelity premiums. This 20.5% is then compared with the 1978 casualty/property insurers' expense ratio of 25.8%, a grossly misleading comparison of figures 10 years apart.

In fact, the insurance expense exhibit published by the association on July 28, 1978, showed that the 1977 expense ratio was 51.6% for fidelity and 69.4% for surety!

Burton J. Carbino
Vp, Irving Trust Co., New York

Mea culpa. BI *compared apples to oranges.*

Competition

To the editor: Mr. Conboy's illustration in the *Business Insurance* letters column Jan. 22 of price cutters was most enlightening but not startling. How about one of the pillars of our insurance community—INA?

We, during the past week, encountered a situation on a package covering a fleet of nursing homes where the manual premium was $110,000 plus the cost of a $4 million umbrella estimated to be $8,000.

Our quote, a good one, was $55,000.

INA wrote the account—identical coverage—for $38,000.

What makes this just a little more interesting is the fact that INA declined the risk for another agency in recent months. During the intervening months there were no changes in the risk.

William J. Rose
General manager, Abrahamson-Meltzer Insurance Agency, Maryland Heights, Mo.

Kidnap/ransom

To the editor: Re: the article in *Business Insurance* Jan. 22, by Simon Bensimon headed "Victim of terrorism demands employer assume responsibility." The editor's note accompanying Mr. Bensimon's article was factually incorrect in respect to references to Investment Insurance Interna-

Continued on page 50

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Iran: A costly lesson in political risks overseas

By JOHN MAES

CHICAGO—The political and civil upheavals in Iran stand as a stark reminder to multinational corporations that political risks in foreign countries need to be analyzed and covered before the violence erupts.

The developments in Iran point up the dangers multinationals face not just from riots and violence, but from expropriations, contract cancellations and even terrorism and kidnapping of employes, said three risk management experts who addressed a Chicago council on foreign relations program here.

Although a variety of insurance industry observers have said insured losses were small during civil strife in Iran, multinational companies still face other losses resulting from the change of governments in Iran, said F.X. Boylan, a vp with Alexander & Alexander.

Among those are losses from confiscation or expropriation of goods and shipments even though there are no known incidents in Iran yet, said Mr. Boylan. Other risks include incovertibility of funds, war damages, contract repudiations, confiscation of personal property, export-import embargoes and defaults, both political and commercial.

Most U.S. investments overseas are insured through such facilities as Lloyd's of London, Overseas Private Investment Corp. (OPIC), American International Group (AIG), the Foreign Credit Insurance Assn. (FCIA), and the Export-Import Bank.

An analysis of the foreign insurance market prepared by Alexander & Alexander shows that OPIC, Lloyd's and AIG are the major insurers of foreign investments. All but FCIA are extensively involved in insuring overseas contracts with Lloyd's and AIG the only significant facilities for pre-shipment risks. Ex-Im Bank and FCIA are involved in pre-shipment risks to a lesser extent.

All but OPIC deal in post-shipment risks such as defaults from political or commercial causes, according to Alexander & Alexander.

But in Iran, many of the losses to come will be uninsured or at best recovery will be a long and tedious process for multinationals, Mr. Boylan said. Application of the war risk clause promises to be a particular problem, he added. And force majeure situations in contracts with Iranian interests are the norm, he said.

Another risk that has been developing abroad has been terrorism and abduction of employes. Multinationals should consider this potential hazard, said Julian G.Y. Radcliffe, managing director of the British-based Control Risks Ltd.

Mr. Radcliffe, an expert in terrorist negotiations, said his firm has handled several dozen politically-motivated kidnap cases, "with a high degree of success." But, "a lot of companies haven't given enough thought to the problem" that one of their overseas employes may be kidnapped, he said. "Corporations should get down to deciding that, 'If we have a risk here, what are we going to do about it?'" according to Mr. Radcliffe.

The decision on whether to negotiate with terrorists is a difficult one, he said. Among many corporations, there tends to be a "deep down" inclination not to deal with political abductors. But some companies have formed a committee to "deal with these philosophical decisions," he said.

Many companies go into foreign investments without giving "prior assessment" to political risks, said Gerald T. West, vp/insurance for the government-backed Overseas Private Investment Corp. "You must assume that things just don't happen. Political change has causes."

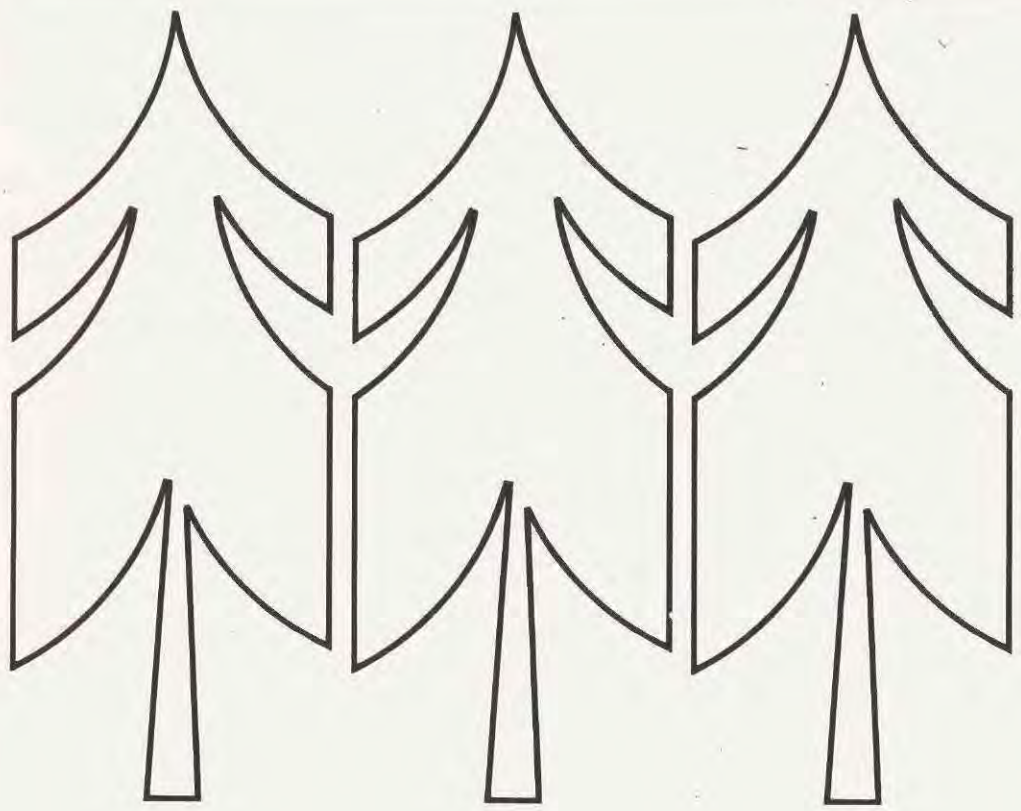
Some companies, he said, have taken sophisticated steps to forecast potential political difficulty which would be harmful to overseas interests. "But it doesn't require a lot of hardware and you don't need a Ph.D. in political science, it just takes some systematic, analytical thinking."

Each potential area of foreign investment must be analyzed for the likelihood of politically-related troubles on an individual basis. "Otherwise you may just as well throw darts at a map and say, 'The next Iranian situation will be in Ecuador,'" suggested Mr. West.

Such information can be obtained from banks, OPIC and governmental agencies, he said. "Companies need to talk to anyone who can give them information about the political risks out there to their firms," said Mr. West.

Much of the difficulty in Iran was extremely hard to anticipate, he admitted. But, he said there is little question some of the multinationals caught in the midst of the strife did a poor job of analyzing the risk. "It's difficult to generalize because it's such a cyclical thing, but it seems you couldn't anticipate a smooth transition to the shah's successor without considerable violence."

The experience of companies in Iran will probably create a lot more "awareness" of the importance of analyzing political risks, he said. "A lot of firms don't give enough thought to the question, 'What am I exposed to here?'" ■



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U.S. senator introduces product laws

WASHINGTON—Rep. John LaFalce (D-N.Y.) has thrown his hat into the product liability ring by introducing a packet of bills to ease liability problems for businesses.

Two of the bills would permit companies to take deductions for funds put aside in a special reserve to pay for product liability claims. The amount of the deduction would be determined by the Treasury Department.

Rep. LaFalce also has proposed the establishment of a special congressional insurance committee to determine what role, if any, the federal government should play in the regulation of the insurance industry.

Finally, Rep. LaFalce has reintroduced legislation that would establish a uniform product liability law.

Earlier Rep. LaFalce introduced a resolution in the House calling for a new congressional committee on insurance.

The insurance committee would conduct thorough investigations of insurance company practices and determine what, if any, role the federal government should play in the regulation of the insurance industry. ■

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Insurers span one-third of $100 million bridge loss

By HARRIET KING

SEATTLE—Insurance policies are expected to pay about $27.5 million on the loss of the 6,471-foot-long Hood Canal bridge here, not even a third of the expected reconstruction costs.

Lashed by winds gusting at over 100 miles an hour, nearly half of the nation's longest floating salt water span broke up at dawn on Feb. 13 and sank

Built in 1961 for $28 million, the bridge provided convenient access to communities such as Sequim and Port Angeles and popular recreational areas on the Olympic Peninsula. Officials say it will take at least $100 million and two to five years to replace the bridge.

The state may be able to recover about $27.5 million from insurers said Frank Maresca, assistant state transportation secretary.

The bridge was insured for $30.5 million but the policy carried a 20% deductible, meaning the state could recover a maximum $24.1 million. But the state also carries loss-of-revenue insurance, which would bring in an additional $3.1 million, Mr. Maresca said. The state hopes federal funds will cover the deductible, he indicated.

Ten insurance companies, including Lloyd's of London, hold the $30 million policy on the bridge. State officials say Insurance Co. of North America is the lead underwriter holding a 40% share of the policy. The Central National Insurance Co. and Hartford Fire Insurance Co. each underwrote 10% of the policy. Several underwriters working through Lloyd's of London together hold 22% of the risk policy.

Others listed by the state include Royal Globe Insurance at 5%; Employers Mutual Casualty Co., 4%; Trans-America Insurance Co., 3%; Northwest National Insurance Co., 2.5%; Puritan Insurance Co., 2%, and Albany Insurance Co., 1.5%.

The catastrophe started at 1:30 a.m. on Feb. 13 when high winds closed the bridge to traffic. Toward dawn, two bridge tenders stationed about one third of the way out on the bridge decided to abandon ship when their control tower tilted sharply to one side. Leaving one car stranded there, they jumped into a truck. As they undertook the wild ride to shore on the twisting pontoons, the bridge began to break up. Their control tower disappeared as one-by-one, 13 of the 360 foot pontoons, each weighing 500 tons, sank within 10 minutes.

The bridge was financed with a $30 million bond issue sold in 1957. The project was refinanced in 1963 when a $37 million bond issue was sold to meet bridge costs and to pay for ferry-system improvements. State officials say $27 million in bonds still are outstanding and that it is impossible to separate the share attributable to the bridge from the ferry-system share. The bonds will have to be paid off, despite the loss of revenue from bridge tolls.

When the bridge was under construction in the late 1950s critics questioned whether the design was sound. Competent authorities said that the span lacked an adequate margin of safety and that wave action could damage or destroy the bridge Others questioned whether any bridge could withstand the rigors of wind and tide at the entrance to the Hood Canal.

Some are questioning whether negligence was involved in the sinking. Most of the floating spans are thought to lie tangled some 300 feet down on the bottom. Water got into the massive concrete pontoons that floated the central span, causing them to sink.

The pontoons were supposed to be designed and maintained so they would not sink. Bridge personnel speculate that the high waves flipped open the covers on the 3-by-2 foot hatches, allowing water to rush in. Others theorize that as the big bridge broke up, large bolts holding the pontoons pulled out, leaving gaping holes.

The Hood Canal bridge is the second bridge disaster in the state. In 1940, the Tacoma Narrows Bridge, subsequently known as Galloping Gertie, blew away in severe winds. This was to the chagrin of the bridge's insurance agent who had pocketed the bulk of the insurance premium, thinking that the bridge was built for the ages.

But not just the Hood Canal bridge was damaged in this storm. High winds wreaked havoc through the area, toppling trees onto homes and businesses and shattering store windows. It tore the roof off a high school in Rockaway, Ore., and also the roof of the Washington State Ferry terminal in Seattle. Fishing boats sank, light aircraft were overturned in some airfields and many stores were flooded.

The American Insurance Assn. estimates insured losses of $2.5 million, excluding damage to bridges and other state or municipally owned property, were caused by the wind and flooding that hit scattered portions of Washington and Oregon Feb. 12-13. ■

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Consumers lay rocky road for tort reform

WASHINGTON—Business groups battling around the country to get state legislatures to pass product liability bills may soon find the road to tort reform a little rockier.

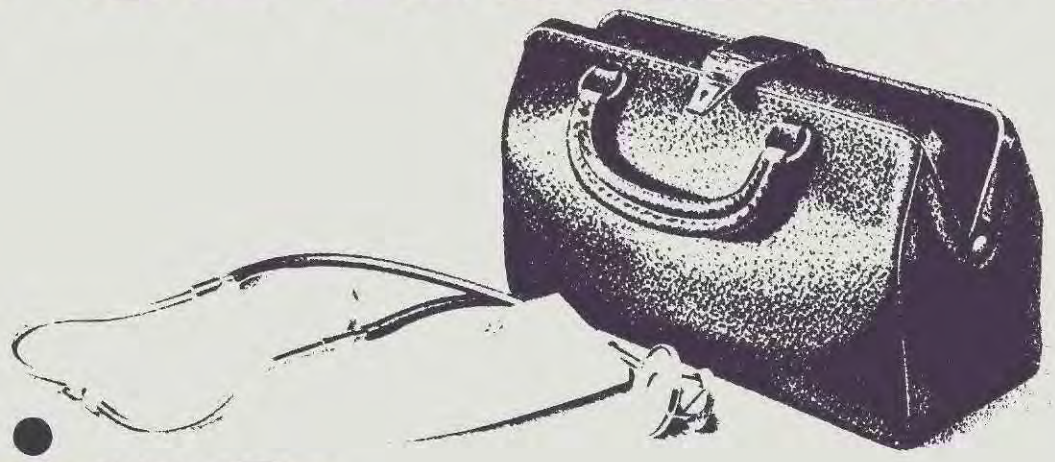
The National Consumers League (NCL), an 80-year-old, 2,000 member consumer organization, is trying to form a coalition with the nation's major labor unions and trial attorneys to fight what it calls "unjust product liability laws."

Until now, consumer groups have concentrated their opposition to product liability reform bills at the federal level. "We realize now that the important legislative battles are going to be fought at the state level and that is where we are going to concentrate our resources," said Barb Pequet, legislative director for the NCL.

Ms. Pequet said the new coalition of consumers, trial attorneys and labor organizations will not only lobby to defeat pending tort reform bills, but also will be urging states that already have passed bills to repeal them.

Over the past two years of intensive tort reform lobbying, the most serious opposition to product liability reform bills has been from plaintiffs attorney groups. Consumer groups generally have not played a very active or visible role in the 16 states that have passed tort reform bills, except in Connecticut where Gov. Ella Grasso vetoed a product liability bill last year. ■

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Conveyor equipment firms

Group captive extends success to third parties

By JERRY GEISEL

HAMILTON, Bermuda—When product liability insurance premiums began to soar in 1976, a group of industrial equipment manufacturers didn't press the panic button.

Instead, the Conveyor Equipment Manufacturers Assn., the trade group that many of the hard hit companies belonged to, hired a consulting company to search for an alternative to those rapidly rising insurance premiums. The group owned insurance company that was recommended worked so well the Bermuda-based firm will start underwriting third-party business soon.

North American Manufacturers Insurance Co. Ltd. (NAMIC) was formed on the recommendation of Corporate Risk Consultants, the consulting division of Meadowbrook Inc. in Southfield, Mich. The insurer began writing product liability and completed operations insurance for its 12 stockholder founders in February 1978.

Now, just one year later, NAMIC has not only met its objective of offering policyholders reasonable, stable coverage, but is also about to shed its "pure captive" status by underwriting third-party risks.

Blades Management Co. is taking the captive into third-party business, both insurance and reinsurance. The extent of third-party underwriting hasn't been determined yet.

"Policyholders are very pleased with NAMIC," said Morton J. Segal, president of Corporate Risk Consultants. "They have been able to save money, but more important they are now able to control their own destiny and stabilize future insurance costs, availability and capacity."

NAMIC provides policyholders with $1.5 million of primary coverage. Policyholders pay the first $5,000 of each loss, with a $10,000 aggregate annual deductible limit.

NAMIC retains $500,000 of each loss and a $1 million annual aggregate limit. Losses in excess of those limits are reinsured in four layers by more than 60 insurers and reinsurers. NAMIC also can arrange for up to $5 million in excess coverage for policyholders who want added protection.

The size of annual premiums paid into NAMIC ranges from $20,000 to $250,000 with the average premium about $100,000. The cost of NAMIC protection is equal to about 1% of policyholders' sales.

Previously, policyholders whose annual sales range from $2 million to $25 million had been paying as much as 3% of sales for product liability coverage. Mr. Segal expects NAMIC's premium flow to top the $3 million mark in 1980.

During NAMIC's first year of operations, there were only a few reported incidents, none of which appear to be significant. If the current outstanding loss trend continues, NAMIC may be able to reduce rates and increase the coverage limits, Mr. Segal said.

A major factor in NAMIC's success is its safety program. In order to become a member of NAMIC, an industrial equipment manufacturer must agree to allow its facilities to be inspected and approved by NATLSCO, the Kemper Corp. subsidiary offering technical services to self-insurers and captives.

NATLSCO also periodically conducts loss prevention surveys for policyholders and makes safety recommendations to NAMIC's executive committee. In addition, NATLSCO assists in ensuring compliance with the safety recommendations.

Furthermore, some policyholders have retained the American Legal Forum, a Toledo, Ohio-based legal consulting firm, to provide loss control lectures.

At these monthly lectures, the legal experts explain the nature of the tort litigation system to policyholders and advise each company on how to prevent negligent situations.

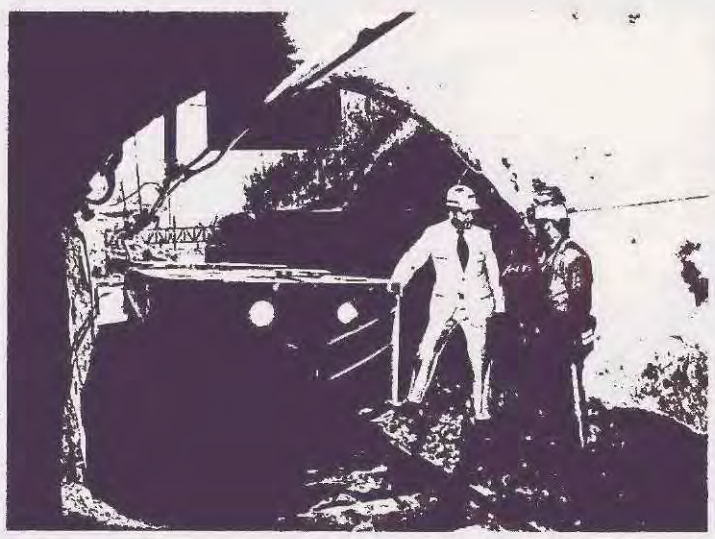
Blades Management Co. is managing NAMIC and Price Waterhouse & Co. is providing accounting services. Corporate Risk Consultants serves as on-going consultants to NAMIC's 15 holders who manufacture lift trucks, foundry equipment and conveyor equipment.

Each policyholder owns an equal share of NAMIC. Marvin Coleman, president of Conveyor Systems Inc. of Morton Grove, Ill., one of NAMIC's owners, forecasts continued conservative growth. "We are not trying to compete with insurance companies. We just want to be assured of stability of coverage." ▪

New insurance plan

Hull & Co. Inc., San Francisco excess and surplus lines brokers, offers a new insurance program for older, well-maintained apartment and hotel buildings.









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CHATTANOOGA, TN 37402

Auto industry shifts new Detroit HMO into gear

By JOHN MAES

DETROIT—A new, community-based health maintenance organization, formed through the cooperation of the Big Three auto makers and the United Auto Workers (UAW), has opened its doors.

Ford Motor Co. plans an enrollment drive this month among workers for the new not-for-profit venture, called the Health Alliance Plan (HAP), and General Motors and the Chrysler Corp. are expected to inform employes soon about the plan.

The new plan represents a merger between an existing HMO, Metro Health Services and the newly-established HAP, said its president, James Walworth. Metro Health Services, formed in 1961 by the UAW and its 75,000 members, will shift membership to the new organization, said Mr. Walworth. HAP expects enrollment to reach 130,000 in the next four years.

The new HMO is not designed for exclusive use by auto industry workers, but Mr. Walworth said he expects large numbers of future



Photo: NAEHMO

Ford benefits manager Jack Shelton is chairman of the board for the new Detroit HMO.

members will come from those ranks because between 30% and 40% of the Detroit area work force is employed by the auto companies.

"But we're wide open, it's intended for use by anybody in the community," he said. "We'll probably draw most heavily from people who find our locations convenient."

The idea for the new HMO grew out of a feasibility study commissioned by Ford Motor Co. and conducted in 1977 by Kaiser Permamente, the nation's largest nongovernmental health delivery service.

After the study found that such an idea would work, Ford, General Motors, Chrysler and the UAW mapped out plans and formed a legal committee which is being transformed into the HMO's board of directors, said the HMO's president Mr. Walworth.

Jack K. Shelton, manager of the employe insurance department at Ford, will serve as chairman of the board. "We have great hopes that Health Alliance Plan will grow and prosper while providing quality, cost-efficient care for the citizens of this area," he said at a recent news conference. "We expect that all health care consumers will benefit from the increased competition in the health care market that should result from Health Alliance Plan's success."

Although the major impetus for the new HMO came from the auto industry, which provided financial and marketing counseling as well as information on employe benefits, other local businesses such as banks, retailers, manufacturers and service organizations have become involved, said Mr. Walworth.

HAP will serve its members with seven geographically-dispersed clinic centers for primary routine medical care including physical exams, obstetrics and gynecology and pharmacy facilities. All but one of the clinics is equipped to administer eye exams.

For extended care, the organization will use the 950-bed Henry Ford Hospital and Metropolitan Hospital which has two locations in the Detroit area.

Through Blue Cross/Blue Shield plans, family health insurance coverage costs General Motors $195 per month for hourly employes while costs at Ford are $167 per month and at Chrysler, costs are $201.

Premiums have been set at $85 monthly for family basic coverage that includes unlimited inpatient hospital care, all physical services, consultations, laboratory and X-ray services and eye examinations excluding the cost of glasses, said Mr. Walworth.

For financing, HAP has inherited some $6 million in reserves from Metro Health Services, he said.

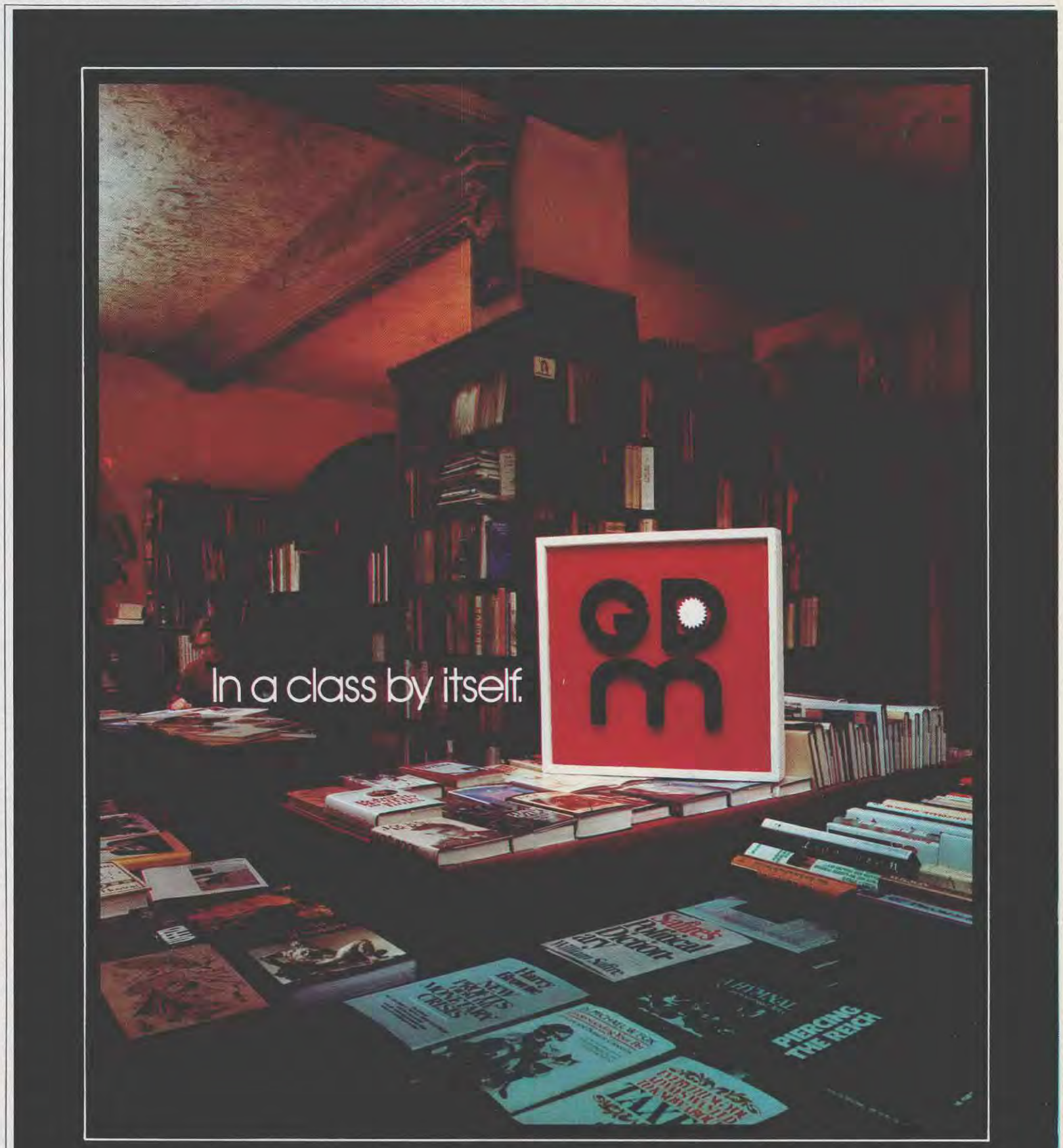
Commenting on the spirit of cooperation between the highly-competitive auto makers, Mr. Walworth said, "They're all concerned about health care costs and this HMO is a continuation of concern among the auto companies and the UAW to control those costs."

Only about 4½% of Ford's eligible employes are enrolled in 15 HMO plans in 13 states while General Motors says its HMO enrollment is about 3%.

Hale Champion, undersecretary of the U.S. Department of Health, Education and Welfare, announced federal qualification of the HAP plan during a recent visit to Detroit. ■

New marine office

Hull & Cargo Surveyors Inc., representatives of marine underwriters, has moved its Boston branch office to One Federal Street, Boston, Mass. 02110.



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Kan. official urges state version of NHI

TOPEKA—Kansas insurance commissioner Fletcher Bell is urging the state legislature to back a comprehensive national health insurance plan initiated on the state level this session in lieu of a federally initiated national health insurance program.

By administering a national health insurance program on the state level, non-productive expansion of the federal bureaucracy is avoided, he believes. Comprehensive benefits, prompt service and fair treatment of the policyholder can be easily attained by melding the facilities of private industry and state insurance regulatory mechanism, according to Mr. Bell.

The proposal is based on a model law developed last year by the National Assn. of Insurance Commissioners (NAIC) and requires mandatory availability and voluntary purchase of comprehensive benefits in benefit package prescribed by law.

The proposal also calls for mandatory deductibles of $200, $500 or $750, a 20% copayment provision, a $1,000 per individual and $2,000 per family out-of-pocket limit, the establishment of a Kansas health association to assure coverage availability and regulatory authority to administer the program.

N.C. work comp

RALEIGH—North Carolina commissioner John Ingram has rejected a 19.8% increase in workers compensation rates, but the state's rating bureau is appealing the decision.

The rate increase was rejected because it exceeded the 7% wage/price guidelines and investment income was not properly considered in making the rate calculations, said Mr. Ingram.

North Carolina's rating bureau defends its filing, insisting that the 19.8% increase was requested before the guidelines were announced and that the guidelines do not apply to the rating bureau but to individual insurers on a nationwide basis for all types of insurance combined.

An earlier 28.4% rate increase, which was to take effect Feb. 1, 1978, and the first rate increase request since 1972, was also denied by the insurance department and is still on appeal by the bureau.

Malpractice rates down

HARRISBURG—The largest medical malpractice insurer in Pennsylvania has requested a 13.8% reduction in professional malpractice rates.

The rate request is expected to reduce annual revenue for the Pennsylvania Hospital Insurance Co. (PHICO), which provides coverage for over 200 hospitals and 3,200 physicians and surgeons statewide.

This is the second reduction request filed by PHICO since April 1978 when a 4.5% slash in malpractice insurance rates was approved. Altogether the insurer has refunded over $3 million to its insured hospitals.

Fraud bureau

SACRAMENTO—Due to the rise in California of property and bodily injury claims for phoney commercial burglaries, auto accidents and thefts, the California legislature passed a law recently establishing a special bureau within the insurance department for fraudulent claims.

The bureau will gather and cross-index information from insurance companies and other sources. When it develops evidence of a crime, the bureau will automatically turn the information over to the district attorney.

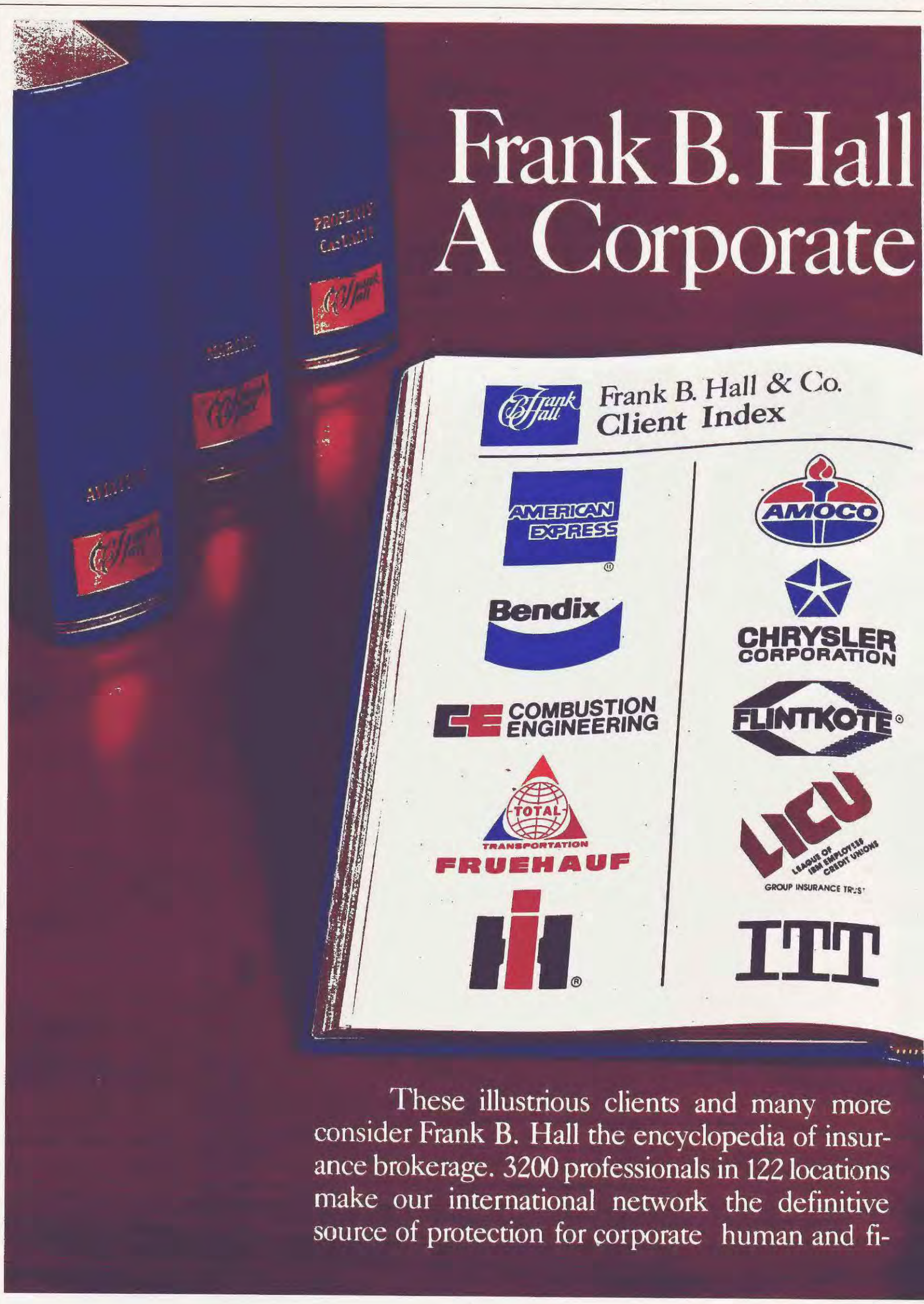
Lieutenant Glenn Sewell, formerly of the California Highway Patrol, will head the special bureau.

Double benefits

HARRISBURG—The Pennsylvania commonwealth court upheld the insurance department's efforts to require the Erie Insurance Exchange to pay no-fault benefits under automobile insurance policies to government employes.

In calculating the no-fault wage-loss payments for policyholders with government jobs the insurance company deducted the sick leave benefits given to those employes. The state's insurance department found the practice unfairly discriminatory since no similar requirement to use sick leave pay is imposed on employes employed in the private sector.

Payments to affected policyholders will bring their previous wage-loss compensation to the full value according to the no-fault law, plus interest, insurance department officials noted. ■



Suit seeks $6 million for fatal fall from park ride

By JOANNE GAMLIN

LOS ANGELES—A $6 million wrongful death lawsuit has been filed against Magic Mountain and the builders of the Colossus roller coaster for the Dec. 26 fatal fall of a 20-year-old woman from the coaster.

The suit, which asks for $3 million in general damages and $3 million in punitive damages, seeks to overturn the statutes in California that bar the awarding of punitive damages in wrongful death cases, according to Antonio Alvarado, attorney for the parents of Carolina Cynthia Flores who died last December in a 20-foot fall from the Colossus (*BI*, Jan. 22).

The suit charges negligence and recklessness, seeking $3 million in general damages from the amusement park plus three other defendants who are involved in the building or maintenance of the coaster: Valencia Recreation Enterprises Inc., International Amusement Devices Inc. and Lorenz and Williams Inc.

Another $3 million in punitive damages are asked from Magic Mountain and from Valencia Recreation Enterprises. Mr. Alvarado told *Business Insurance* that documents he has say Valencia Recreation is a joint operator with Magic Mountain of the roller coaster, considered the largest and fastest in the world.

Colossus, which was closed after the death of Ms. Flores, was reopened on Feb. 17 with new county-ordered safeguards, including seat belts and restrictions on the height and weight of riders.

Mr. Alvarado said he thinks his suit can overturn the prohibition on awarding punitive damages in wrongful death cases because he has evidence that Magic Mountain knew that the lap bars in Colossus were defective and that the coaster was not completely safe.

"We have documents from the amusement park and letters from people who assert they suffered near fatalities from the Colossus," he said.

The Los Angeles county engineer's report on Ms. Flores' death concluded that it occurred because of her unusual girth. She was 5-foot-3 inches tall and weighed 253 pounds.

Mr. Alvarado, however, said he views the report as inadequate. "The county engineer merely went to Magic Mountain and said, 'show us what you are doing,' which is like letting the fox tell who stole the chickens from the chicken coop.

A Magic Mountain spokesman would not comment on the litigation.

The suit was filed in the Van Nuys branch of Los Angeles county superior court. ■

Union alleges negligence in worker death

CHICAGO—A steelworker's local here is charging that negligence led to a Feb. 16 explosion at Chicago's Burnside Steel Foundry Co. that killed one worker and injured 20 others.

Officials of Local 1719 of the United Steelworkers of America said the company left standing water in a furnace area pit which caused the blast. The hazard had been brought to the attention of management two days before the explosion, the union says.

"The company was advised and found these things wrong and did nothing to correct them," said Leonard Moore, a staff representative for the south Chicago local.

The blast killed Steve Mihalik, 58, a maintenance worker and president of the local, said Mr. Moore. Mr. Mihalik was trying to free a jammed ladle containing molten steel when it tipped and came into contact with the water causing the explosion, said Mr. Moore. "Anywhere there is hot molten steel there should not be any water," said Mr. Moore.

The company's only comment on the incident came in the form of a prepared statement issued by an attorney for the firm. The statement said "human error" was responsible for the blast and that a preliminary investigation conducted shortly after the blast indicates "the blast was caused when a ladle of molten steel tipped over in the area next to the furnace.

"The ladle apparently tipped as a result of human error which could not have been reasonably anticipated on the part of the foundry workers in attendance at the furnace," the statement said.

The attorney, Harvey Sangerman, said the allegations by the union, "show they don't really know what was going on. We're trying to avoid public debate."

He declined to discuss the company's workers compensation insurance.

The union has not decided what if any action it will take against the company. It's awaiting completion of an investigation being conducted by the U.S. Occupational Safety and Health Administration, said Mr. Moore. ■





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• Imperial Industries, a third-party administrator of corporate benefits, explores the **federal HMO act** and its effect on employers in a 12-page booklet. The booklet highlights sections of the act, shows how to request an HMO for inclusion in a health benefit program and covers enrollment periods, employe meetings and the rules governing employer contributions. For a free copy write Imperial Industries, 3200 Wilshire Blvd., Los Angeles, Calif. 90010.

• A brochure describing the "Decor" and standard lines of automatic **fire protection sprinklers** is offered by manufacturers Viking Corp. The brochure provides the buyer with some guidelines for selecting the right sprinkler heads for varying fire protection needs and gives the specifications and performance parameters for each of the featured sprinklers. For a free copy of the brochure write for Bulletin 2-72, The Viking Corp., 210 N. Industrial Park Rd., Hastings, Mich. 49058.

• **The Emergency Planning Guide for Data Processing Centers** is now available from Assets Protection Journal. Since emergency planning is a critical defense mechanism a company has for protecting its data processing operation against disasters, Assets is offering the guide to use as an audit tool. The guide provides an emergency planning checklist, covers emergency planning concepts in detail and shows how to create an emergency plan. Cost is $10. Write Assets Protection Journal, P.O. Box 5327, Madison Wis. 53705.

• **Withdrawal Provisions in Saving Plans** is the title of a newsletter offered by Kwasha Lipton containing information about the types of withdrawals, the "Class Year" plan, a special withdrawal vehicle, more traditional long term alternatives and future trends. For a free copy write Department M, Kwasha Lipton, 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

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dates

MARCH 14-15. RIMCO Inc. will present a seminar in Los Angeles on how to reduce **manufacturing insurance costs.** The seminar will be repeated **April 3-4** in Chicago, **April 19-20** in Washington, D.C. and **April 25-26** in Dallas. Cost is $395 for each person or $345 for each person of a three-person team. Contact RCI Communications Inc., 10300 N. Central Expressway, Suite 350, Dallas, Tex. 75231; phone 214-363-9656.

MARCH 21. Rules in the **risk management process** is the subject of a conference sponsored by the Massachusetts Risk & Insurance Management Society to be held in Boston. Cost is $30. Contact Linda L. Ruthhardt, Barry Wright Corp., 680 Pleasant St., Watertown, Mass. 02172; phone 217-926-9600.

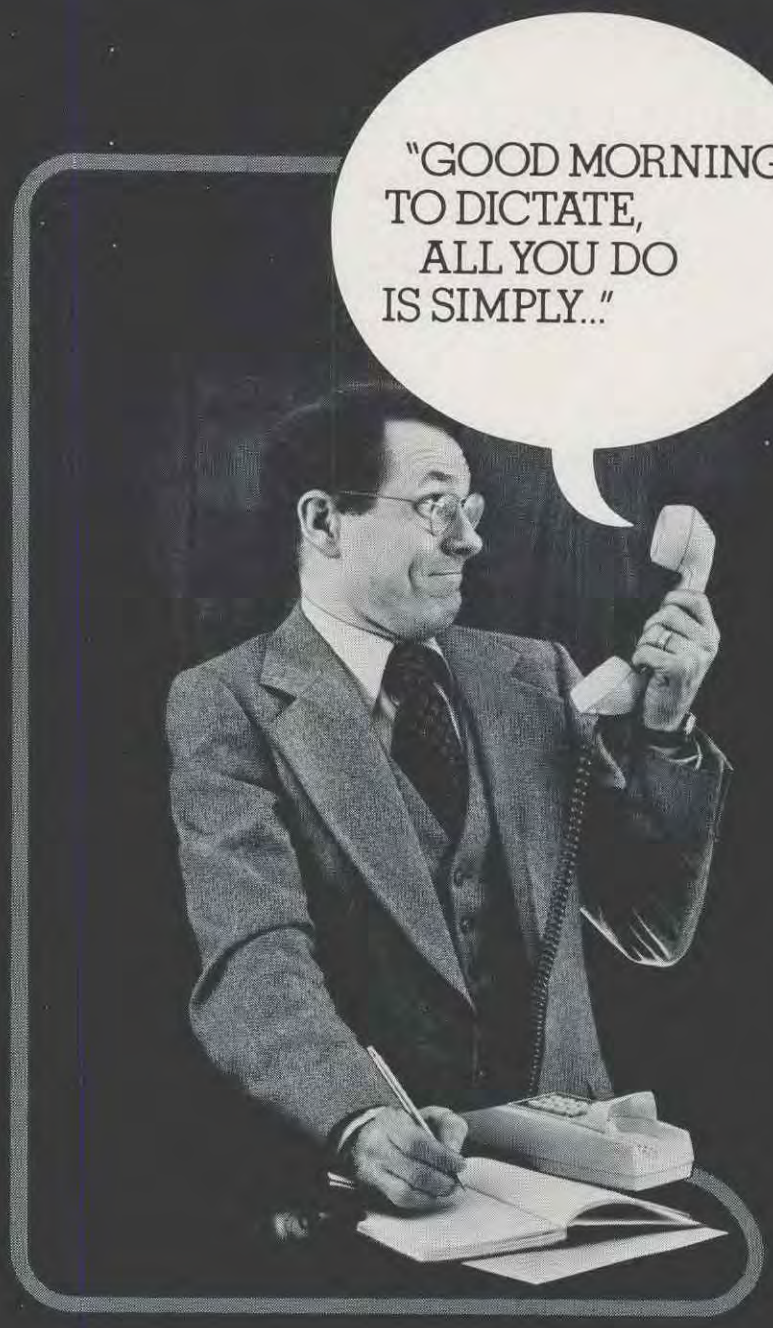
MARCH 23. The Northern California Section of the American Industrial Hygiene Assn. will sponsor a symposium on **carcinogens in the workplace** at the Kaiser Center in Oakland. Cost is $20. Contact Norman Zeiser, Standard Oil Co. of California, Safety and Industrial Hygiene, Rm. 1327, 224 Bush St., San Francisco, Calif. 94104; phone 415-894-6916.

MARCH 29. The hazards of flammable liquids and gases and proper protection methods is the topic of the 1979 annual seminar of the New York Metropolitan and New Jersey chapters of Society of Fire Protection Engineers in New York. Cost is $30 per person prior to March 15 and $40 thereafter. Contact: W. Robert Powers, P.E., Secretary, New York Board of Fire Underwriters, 85 John St., New York, N.Y. 10038.

MARCH 29-30. New Directions For Captive Insurance Companies is the title of a seminar sponsored by the Advanced Management Research International Inc. to be held in San Francisco. Cost is $495 per person and $450 for two or more. Contact AMR International Inc., 1370 Avenue of the Americas, New York, N.Y. 10019; phone 212-974-0800.

MAR. 29-30. Corporate Insurance Management is the name of a seminar to be held in Houston by New York University. Seminars will be repeated **April 26-27** in New York, **June 7-8** in San Francisco and **August 9-10** in Chicago. Cost is $495. Contact Registrar, 14th Floor, NYU Conference Center, 360 Lexington Ave., New York, N.Y. 10017.

MAR. 29-30. Transnational Management Inc. is sponsoring a conference in Miami Beach on **international product liability developments.** The future of strict product liability in Europe will be discussed, the European and U.S. product liability systems will be compared and guidelines for international product liability presented. Cost is $495. Contact Frank Orban, International Counsel, Armstrong Cork Co., Liberty & Charlotte St., Lancaster, Pa. 17604; phone 717-397-0611.



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Project diagnoses Blue Cross admissions data

By REBECCA A. FANNIN

PHILADELPHIA—Health care costs may be contained in the Delaware Valley area by greater use of pre-admission testing and same-day surgery as well as improved hospital scheduling, an analysis of Blue Cross data suggests.

Those conclusions are based on a study, the first of its kind in the nation, to determine whether hospital utilization has been excessive and to work with institutions to reduce overuse (*BI*, Feb. 5).

Collection and analysis of Blue Cross Data in Philadelphia is a project of the newly created Joint Health Cost Containment Program, which is working on several health cost containment strategies.

The study of Blue Cross data is a "tremendous step forward," said Gerald A. Gleeson, executive director of the task force. "It's a pretty darn good measuring tool. It's also the first time we've had some real figures to analyze rather than just speculate about the problems."

The Joint Health Cost Containment Program plans to meet with Blue Cross representatives several times during the next few weeks to analyze the data and devise cost containment strategies.

The working relationship between the Blue Cross and the task force was described by Mr. Gleeson as "very cooperative. "All the defensiveness that was prevalent in the beginning is now gone," Mr. Gleeson said.

"In a sense the report has raised as many questions as it has answered," Mr. Gleeson said. Some surprising findings in the report include that patients stay in the hospital much longer if they are admitted on a Friday night or Saturday versus a Sunday through Friday, Mr. Gleeson said. The task force needs to find out why this differential has occurred.

The report shows that if a patient is admitted for a non-emergency surgical procedure on Sunday through Friday, the average length of stay is 4.3 days to 5.6 days. But for Saturday admission, the stay is almost double, 10.3 days.

Since non-emergency surgical procedures only account for 2.1% of all admissions, the finding is not as significant as it first appears, Mr. Gleeson pointed out.

But for surgical emergency procedures, which represent 7.8% of all admissions, the trend of shorter lengths of stay during week admissions again holds true. For Saturday admission, the number of hospital days is 7.2 compared to 5.9 to 6.9 days for an admission during the week.

Oddly, the pattern does not follow for medical non-emergency procedures, which raises further questions, the executive director said.

Other techniques to reduce hospitalization, such as pre-admission testing and recovery in convalescent facilities, could be effective cost-cutters, Mr. Gleeson said.

Statistics show that the average length of time for work-up tests in the hospital takes 10 days, when this could be lowered to seven or eight days with pre-admission testing, Mr. Gleeson said.

More frequent use of convalescent facilities is also needed, but the task force needs to consider whether such facilities are readily available, he noted.

Same-day surgery will also be studied further as a means to contain health care costs, Mr. Gleeson said. The study showed that some "hospitals seem to be very effective with same-day surgery and we're wondering why others can't duplicate it," he added.

The report focuses on 1977 Blue Cross data, using a sample of 260,000 out of 2.5 million in the region covered by the group insurer. Blue Cross data was chosen for analysis because the insurer covers 70% of the population in the region. ■

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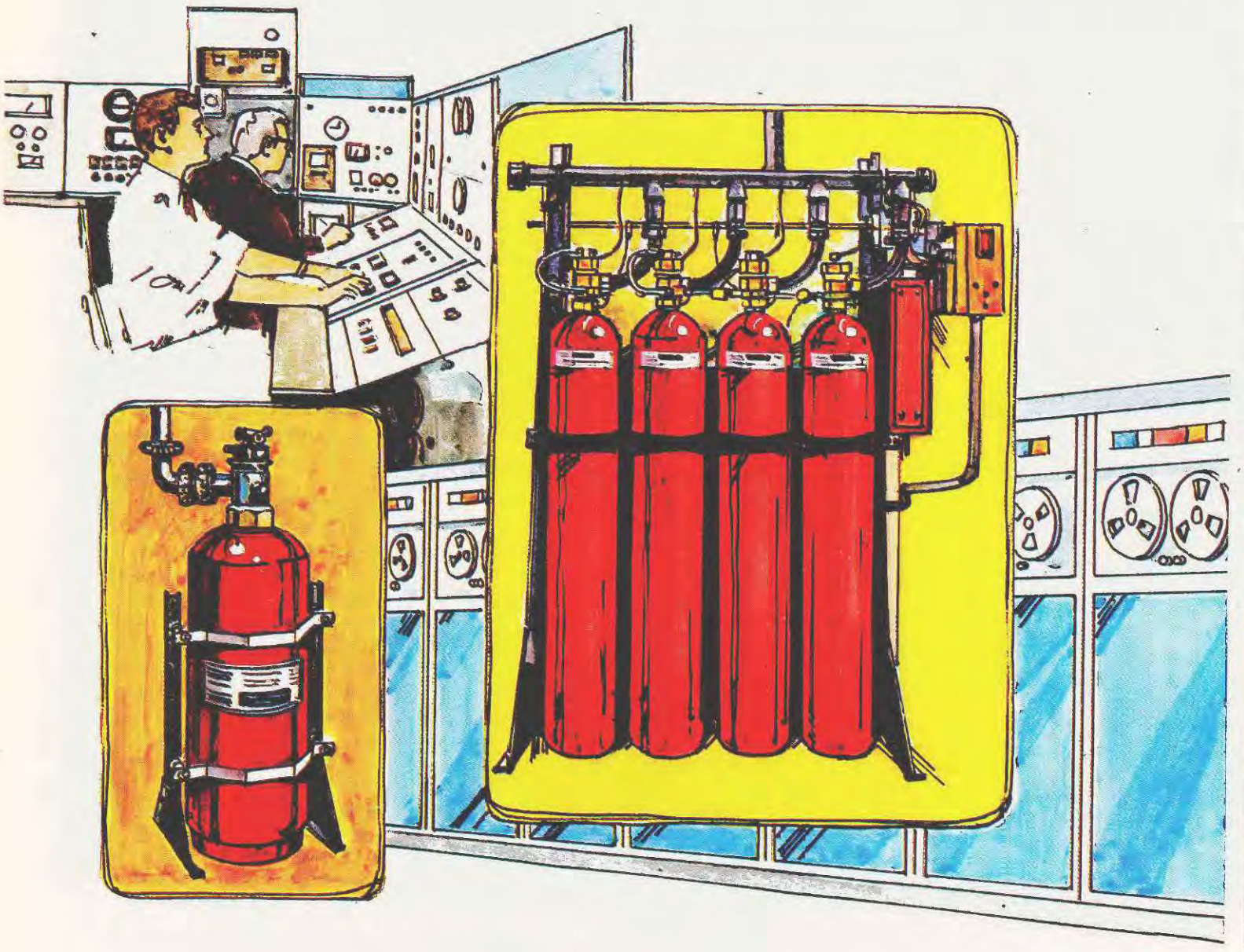
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Yellow Cab self-insures work comp

By JOANNE GAMLIN

LOS ANGELES—Yellow Cab of Los Angeles has put together a self-insured workers compensation package to solve its insurance problems.

The plan is fronted by the Insurance Co. of North America (INA) and reinsured by Hanseatic Insurance Co. Ltd., part of the brokerage firm of Bayly, Martin & Fay in Los Angeles. Annual premiums for the package will amount to about $1 million, said Thomas McSherry, an insurance consultant who put the package together for Yellow Cab.

The off-shore deal is being supported by a $1 million letter of credit to INA, meaning that the cab company can use the premium money if it needs to do this, Mr. McSherry said.

Yellow Cab, which has been fighting a stop order from the California Department of Industrial Relations issued for lacking workers compensation insurance, was hit with a $10,000 penalty assessment for failure to provide workers compensation insurance for the period of Dec. 5, 1978, to Feb. 6, 1979. The fine was accompanied by a stop order.

However, on Feb. 16, the department acknowledged that the cab company had obtained a one-year workers compensation policy with a premium of $1,002,500.

Yellow Cab vp and general manager Richard Burlingame said that the cab company intends to appeal the penalty assessment. The company has contested the stop order on grounds that it is unconstitutional because it provided no prior notice or hearing. ■

Insurance industry norms fuel arson-for-profit blazes: Study

By JERRY GEISEL

WASHINGTON—Insurance industry trade practices unwittingly are fueling the nation's growing arson-for-profit problem, a Senate staff committee charges.

After surveying 15 major insurance companies the Senate permanent subcommittee on investigations criticized insurers for failing to examine the backgrounds of risks, for not challenging suspicious claims and for overinsuring properties.

"Fire fraud losses—made possible in part by laxity in underwriting and claims adjustment procedures—continue to cost billions of dollars each year," the 21-page report said.

Arson is a low-risk crime because insurers often fail to fully pursue investigations of suspected arson, the report said. Four insurance companies told the subcommittee they might settle a claim with a suspected arsonist if investigatory costs seemed too high.

But insurers complained that they are caught in a dilemma. "On the one hand, we are being asked by state regulators and consumer groups to pay claims as fast as possible," said Tom O'Day, government relations officer of the Alliance of American Insurers. "On the other hand, we have a congressional committee criticizing us for not resisting suspicious claims. It is difficult to satisfy both groups simultaneously."

Insurance companies contribute to the arson problem by overinsuring properties, the report also charged. Former insurance adjuster Joseph Carter of Tampa, Fla., told the subcommittee that 99% of arson-for-profit involves deliberate overinsurance. Mr. Carter cited one building in Tampa that was purchased for $30,000, insured for $290,000 and then was set ablaze for profit.

But Mr. O'Day of the Alliance questions if insurance companies are guilty of overinsuring properties. "Our biggest problem nationwide is not overinsurance, but underinsurance," he said.

Arson-for-profit schemes also may be aided by lack of professionalism among claims adjustors, the report said. Mr. Carter, for example, whose 20-year career in the adjusting business included service with several major insurance companies, said he never received any formal training in fire adjustment.

Only six of the 15 companies surveyed could specify how many hours of arson detection training they required of each property claims adjustor. Five companies indicated they required no arson training for adjustors, while the remaining four insurers required arson detection training, but could not specify the number of hours of training.

Mr. O'Day said the insurance industry has been making a major effort in the last several years to beef up arson-detection training.

The battle to curb arson-for-profit is being hampered by failure among insurance companies to collect adequate fire loss data, the report also says. "The insurance companies do not know how serious the arson problem is," Ralph J. Jackson, loss prevention manager of Allstate Insurance Co., told the subcommittee, "Very few companies have been collecting information on arson."

But one insurance industry trade official said insurers have had a difficult time garnering arson statistics because arson has been classified as a minor crime. As a result, the 11,000 jurisdictions included in the FBI crime index are not required to report arson incidents to the FBI.

The report did note, however, that legal problems may discourage insurance companies from taking effective action to combat arson. State privacy laws impede the exchange of information between law enforcement officials and insurance companies by establishing grounds for slander suits against public authorities who release incriminating information to private companies, the report said.

Similarly, insurers argue that privacy laws allow an individual to sue an insurer for releasing information to enforcement officials trying to build a criminal case. In one case, Farmers Insurance Group had to pay $4 million in damages for releasing to the police facts damaging to a policyholder, said James McMullen, director of security investigations for the group.

Mr. O'Day of the Alliance said the insurance industry has been pushing for several years for changes in privacy laws so "we can more fully cooperate with law enforcement officials without fear that we are going to get struck with some big civil suit." ■

California gets tough

SAN FRANCISCO—"The toughest arson laws in the country," according to the legislation sponsor, are expected to be passed in the current session of the California assembly after approval by the senate late last month.

The laws, proposed by state Sen. William Campbell, would increase the maximum fine for an arson conviction from $50,000 to twice the anticipated or gross gain of the fire and would also increase the prison sentences for both convicted arsonists and those solicitating arsonists.

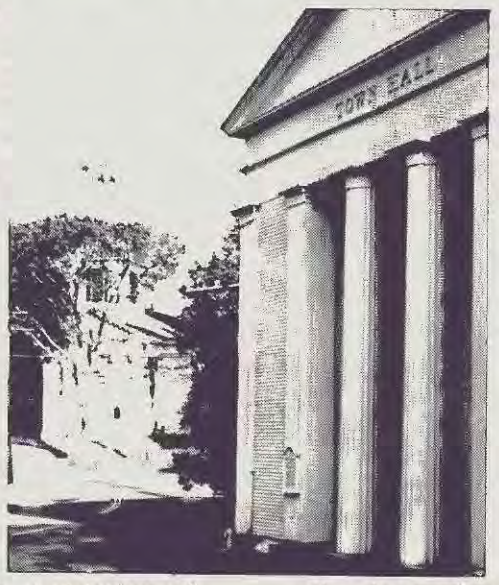
In San Francisco, where 591 arson fires were recorded in 1978, the district attorney announced creation of a full time arson investigation staff, funded by a federal grant. Heading the arson investigation effort is Thomas Crary, assistant district attorney who will work as a liaison with the San Francisco fire department on arson prosecution.

Andrew Casper, San Francisco fire chief, says the city's concern for the arson problem has resulted in a 25% increase in the arson arrest rate and a 67% increase in conviction since an arson task force was created in 1977. San Francisco has experienced a 7% increase in arson since 1977, while nationally the average increase has been 25%.

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Risk exec rescues ski patrol from liability insurance crunch

By MARGARET LeROUX

DENVER, Colo.—To an injured or lost skier, or one who's trapped in a disabled chairlift, the sight of the gold cross on the parka of the Ski Patrol is cause for relief, not for contemplation of a lawsuit.

Yet the ski patrollers have been victims too—of the liability insurance crunch until an aggressive new loss control program created by a West Coast ski patroller and risk manager paid off with lower premium rates and more coverage.

The National Ski Patrol System Inc. (NSPS) got a 24% reduction on renewal of its insurance this year for 23,500 volunteer members who patrol slopes in approximately 40 states, thanks to Richard H. Soper, director of risk management and insurance at Levi Strauss & Co. in San Francisco. It was the first time the association got a reduction in insurance premiums since it was founded in 1938 by Minot Minne Dole, who was a victim of a skiing accident. The NSPS has grown from a group of 135 patrols in 1939 to a network of 767 patrols ranging in size from 10 to 200 members.

Mr. Soper, a ski patroller at North Starat Lake Tahoe, Calif., on his free time, recently convinced the association of the need for risk management and a loss control policy. A year ago the NSPS named him national counsel on a volunteer basis to handle those responsibilities. He is assisted by Roz McIntosh, a consultant with Warren McVeigh & Griffin, and Peter Nigeman, a broker with Guy F. Carpenter & Co. Inc. Technical consulting and risk management services are provided by Risk Planning Group of Darien, Conn.

The NSPS currently carries liability insurance "in excess of $2 million," for its members, according to Mr. Soper. Primary coverage without a deductible is with National Union Insurance Co. The first layer of excess insurance is with National Surety Corp., one of the Fireman's Fund Insurance Cos. Brokers for the primary policy are Barringer & Williams, a division of Kendall Insurance Inc. in Rochester, N.H., and for the excess, Pettit Morey in Seattle.



Dick Soper, director of risk management at Levi Strauss, shares his spare time and experience with the National Ski Patrol System not only as a patroller but also as national counsel on risk management and loss control.

Not even the ski patrollers are informed of the limits of liability the NSPS carries, "although we're told we have liability insurance and it stressed that we follow certain procedures to protect ourselves," a patroller at a northern Minnesota resort told *Business Insurance*.

Basic to these procedures is the release—verbal and written—ski patrollers are instructed to obtain from accident victims. According to the ski patroller's manual, the permission of an injured skier must be obtained before assistance is given.

Although several states have variations on Good Samaritan laws to protect those who offer aid to accident victims, "we're also told those laws don't automatically shield us," another ski patroller said.

The new loss control policy of the NSPS includes: review of all ski collisions, chairlift evacuation accidents and toboggan handling accidents and other patrol related incidents; a chairlift evacuation procedure at the direction of the management of ski resorts; increasing the level of patroller proficiency and professional conduct on the hills, and making individual patrollers aware of insurance problems.

Chairlift evacuation is the responsibility of the management of ski resorts and the Ski Patrol becomes involved only at their request. Ironically, the largest liability claim ever paid by the NSPS was $15,000 to a ski patroller injured in a chairlift evacuation training program.

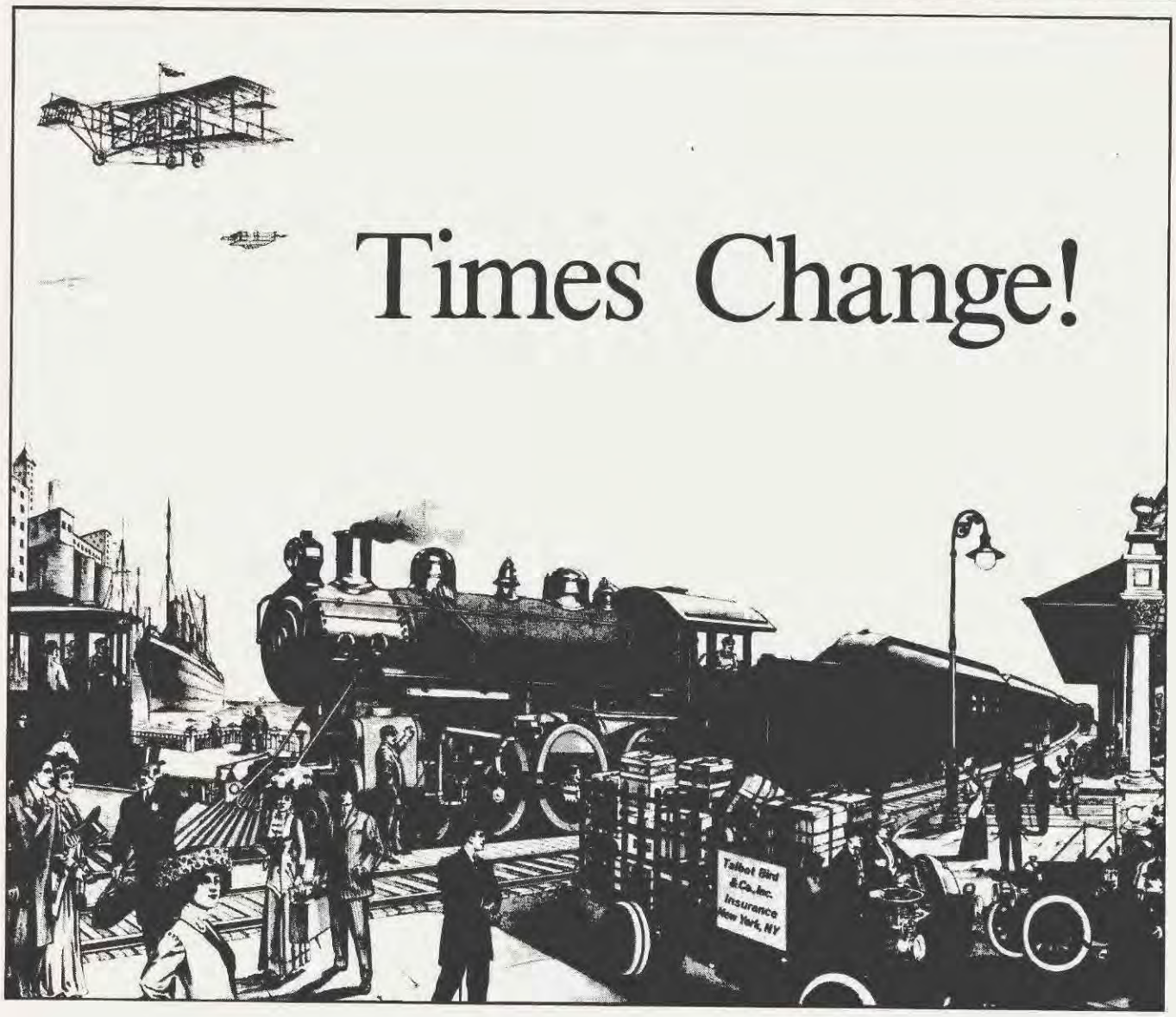
All claims involving ski patrollers are reviewed by Mr. Soper and the legal staff of the NSPS. The paperwork involved in accident and claim reports is considerable he admitted, "but by requiring more extensive information we're hoping to get a better handle on causes of claims and prevention of future occurrences."

Collisions with other skiers on the slopes is the most frequent cause of claims against the ski patrol. "We've been able to achieve a decrease in this trend," Mr. Soper said. "Our loss control efforts seem to be paying off, since we've been able to get a premium reduction and at the same time increase our limits of liability."

In an article in the National Patroller, a quarterly newspaper for NSPS members, Mr. Soper advised patrollers "to envision yourself as a patroller being examined as a defendant in an action . . . I cannot overemphasize the fact that your hill conduct as a patroller . . . will have a bearing on our insurance program," he said.

For their part, members of the NSPS must meet safety and ski proficiency standards that include advance first aid training, knowledge of pulmonary resuscitation, winter survival and safety techniques. Each ski patroller is required to take an annual eight hour refresher course in first aid and on-hill proficiency.

Ski resorts also benefit from the services of the ski patrollers. Their presence is a loss control measure in the resort owners' own liability policies, according to consultant Ms. McIntosh. ■



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Cities fine 'false alarm' owners, limit 911 service

By JOHN MAES

CHICAGO—The squad car radio crackles its instructions: "Unit 241 investigate a burglar alarm in a warehouse at Main and 10th Streets."

The officer speeds to the location, surveys the darkness for anyone lurking in the area and then examines the building for signs of forced entry.

But he finds no one except a late-working employe who accidentally tripped the building's alarm system that summoned the police. The patrolman returns to his squad car and radios back the message that is heard 95% of the time in such cases: "False alarm."

This situation may sound harmless, but it's a source of continual frustration and concern to police departments all over the country.

The increasingly security-minded business proprietor is installing security alarm devices of all sizes and description in stores, warehouses and factories. Some of them are hooked directly into police emergency telephone lines, known in many cities as 911.

Departments find themselves answering hundreds of thousands of such calls each year but about nine out of ten are false. Authorities complain that large amounts of money and police manpower are being wasted. In addition, the volume of calls received from security companies reporting alarms from "automatic dialers" clogs emergency telephone lines possibly leaving people with legitimate emergencies unable to get through, police say.

False alarms are usually triggered by improper handling by employes, faulty installation and atmospheric conditions like winds and rain that have set off many alarms, according to law enforcement authorities.

On a recent weekend in New York City, the police answered 106 false alarms in a 16-hour span at one factory alone. "One location was giving us that much trouble," said Sgt. Louis Galetta of the New York police.

A number of U.S. cities have tried to tackle the problem with ordinances and changes in police procedure, but they have achieved varying degrees of success.

In New York City, for example, the police department recently announced it would downgrade the priority assigned to automatic alarms that come into its 911 emergency telephone system. New York police receive 1,000 taped alarm calls a day to its 911 hookup, 97% of which turn out to be false, said Sgt. Galetta.

"The fact that they are a waste of time is the biggest danger," said Lt. Ralph Vanacore, of the New York police communications division. A false alarm call can sometimes tie up a patrol officer for as long as 30 minutes and when a real emergency occurs, the ability of police to respond quickly can be impaired.

Under the New York system, taped alarms will be placed last on the list of calls answered during busy periods. This will mostly affect smaller businesses having the more inexpensive alarms that frequently malfunction.

Alarms at banks, financial institutions and those telephoned into precinct stations by alarm companies and citizens will still be top priority, said Lt. Vanacore.

Other cities have tried to deal with the problem by ordinances requiring licensing and registrations of both residential and commercial systems.

In Phoenix, Ariz., for example, a local ordinance fines a security company $20 after the fifth false alarm occurs at one of its subscribing companies in a one-year period. The fine is $50 for the 10th and $100 for every bogus alarm after that, according to police.

After four false alarms, the alarm company is also sent a notice asking that corrective measures be taken and that the city be informed that this has been done, said Sgt. Charles Stankus of the Phoenix police communications bureau.

Since passage of the ordinance in 1976, false alarms in Phoenix have dropped to 17,500 annually from 21,500.

Perhaps one of the most successful ordinances is in Pasadena, Calif., which has cut false alarms by 50% since its passage.

Under the 1972 ordinance, police use a personal contact system where an officer visits a firm that has reported two false alarms in 90 days, said officer Randy Aiken, who administers the program. During the visit, police try to pinpoint the cause and suggest ways to avoid repeat offenses.

After four violations in a year however, the alarm user's permit is suspended until he produces proof the problem has been resolved, said Mr. Aiken.

"We're not trying to produce revenue or limit the use of alarms," said Mr. Aiken. "Alarms are a good thing, we're just trying to cut down on false alarm incidents."

As for the industry itself, the larger manufacturers have been trying on their own to combat the problem. Training sessions and seminars for installers and purchasers on correct installation of alarms, along with educational thrusts geared to informing employes on how to minimize false alarms are becoming more frequent, said Bernard Beerman, counsel to the Washington D.C.-based alarm industry committee for combating crime.

"We agree with the police, we do have a problem," he said. But law enforcement officials and cities must not be too heavy-handed against alarm owners lest they discourage use of a valuable crime-fighting tool, he warned.

Mr. Beerman opposes fines and penalties for false alarms because they are "inequitable" and, "would force the mom and pop-type grocery stores not to have an alarm system."

More cities should adopt ordinances like Pasadena's that emphasize corrective measures and not fines, he suggested. ■

More often than not, police responding to an alarm hooked up to a city's 911 emergency line are merely responding to yet another false alarm.



Photo: Paddock Publications



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PERSPECTIVE

Tax court ruling threatens to tack more benefits on exec's estate bill

By George C. White, CLU

Executive benefit plans should be reviewed in light of a recent tax court decision to prevent unnecessary estate taxation.

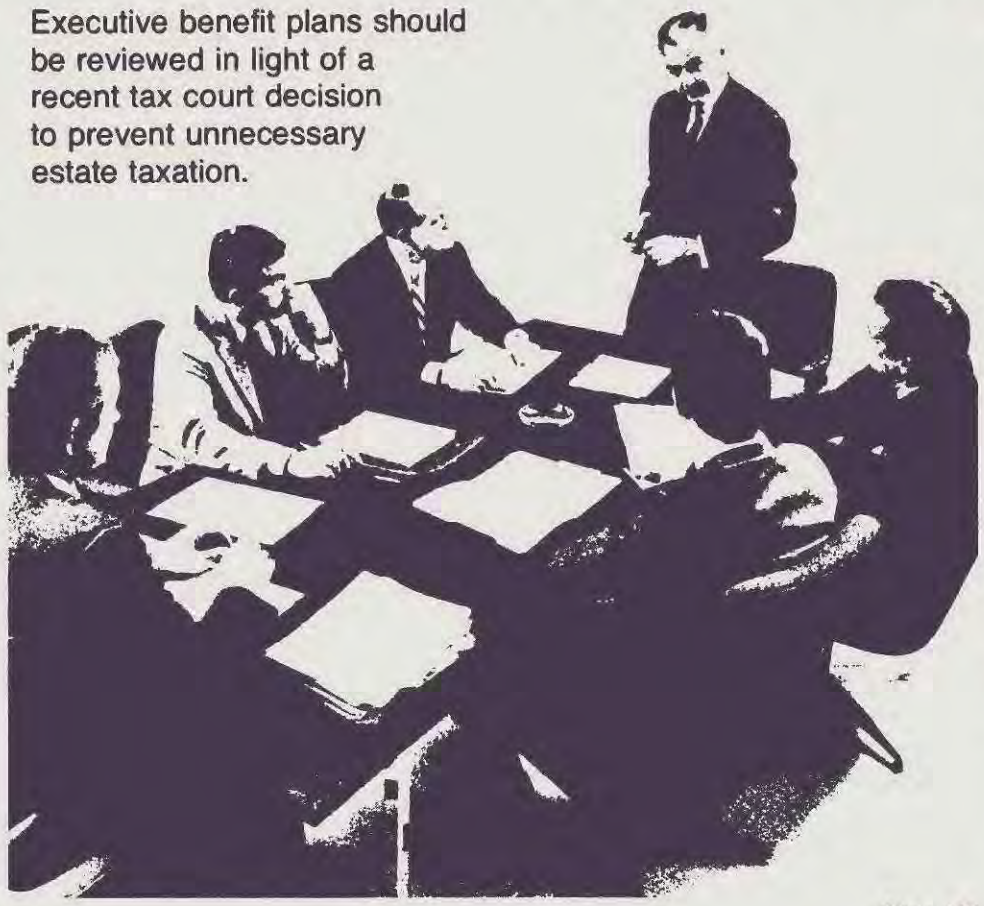


Photo: AIG

IS THE CASE OF SCHELBERG, 70 TC No. 67, Aug. 16, 1978, a benefits time bomb?

Internal Revenue Code Section 2039 mandates inclusion in a decedent-employe's gross estate of the present value of any survivor's benefit, to the proportionate extent of the decedent's contributions toward the death benefit's purchase price.

Specifically, inclusion of the death benefit's present value in the employe's gross estate is predicated on:

- Survival of the employe's beneficiary.
- Existence of a contract or agreement for payment of the post-mortem benefit.
- Receipt of annuity or other (post-employment) payment by the decedent, or the enforceable right of the employe to receive any such payment.

Under Section 2039 employer contributions are deemed to have been made by the employe, except as to qualified retirement (e.g., pension, profit-sharing or stock bonus) plans. Wages or other pre-retirement compensation paid or payable to the employe are not treated as "lifetime payments." Pure death benefits (i.e., those standing alone) would be excluded.

Death benefit only

In recent years, there has been a marked interest in the use of "death benefit only" (DBO) plans, partly on account of the never-ending effort of companies to devise new and/or improved tools to attract, retain and motivate executives. As such, a DBO plan can be an additional "golden handcuff" to lock a valued executive to the company. This is notwithstanding that in their most conspicuous manifestation as group survivors' income benefits (SIBs), such plans may provide optimum death benefits during any employe's years of greatest need.

The effort to segregate lifetime payments to the employe from death benefits to his/her beneficiary has, in general, failed to result in the exclusion of the value of the post-mortem payment(s) from the decedent-employe's gross estate, even where ostensibly separate arrangements provided each benefit. Thus, except where one of the plans is qualified (Rev. Rul. 76-380), separate plans will be "grafted together" by IRS even if the death benefit plan did not mandate inclusion in the gross estate.

W. V. Schelberg, an IBM executive, was a participant in that company's employe benefit programs, which generally included group life insurance benefits, a pension under a qualified retirement plan, sickness and accident income benefits and benefits under a total and permanent disability income plan. The group life insurance benefits consisted of group term life insurance and an uninsured and unfunded survivor's income benefit entitling the decedent's widow to a monthly income under the survivor's income benefit plan. Each of the separately administered, non-contributory plans was adopted at different times.

At his death, neither Mr. Schelberg nor any beneficiary had received payment under either the retirement or disability plan, nor were any benefits payable under the sickness and accident plan. Actuarially, Mrs. Schelberg's monthly survivor's income benefit of $1,063 had a present value of $94,709 at her husband's death.

Is it an annuity?

At issue was whether Mr. Schelberg's rights under the disability plan (which nominally provided only-preretirement benefits) should under Sec. 2039 be considered an enforceable right to receive an "annuity or other payment" so as to mandate inclusion of the $94,709 in the estate of Mr. Schelberg.

In concurring with IRS, the Tax Court held that under an "aggregate of rights" concept the decedent's rights under the disability plan together with the beneficiary's under the survivor benefit plan were components of a single employe benefit program. In distinguishing the Schelberg case from Rev. Rul. 77-183 (involving temporary sickness and accident benefits), the court noted that under IBM's total and permanent disability income plan benefits would be granted to an employe only after it was presumed that the individual would never be able to perform further services for the company—in effect, transmuting such disability payments into a post-employment lifetime benefit that would constitute an "annuity or other payment" pursuant to Sec. 2039.

Further, in responding to the fact that Mr. Schelberg's terminal illness lasted only one week and that he neither received nor could have claimed benefits under the disability plan, the court commented that Mr. Schelberg had the "right to receive" disability payments within the meaning of Sec. 2039, because under the regulations a decedent can possess the right to receive a payment even though events—as in this case—may result in no payments ever becoming

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George White is an independent consultant in the fields of executive benefits and personal financial planning. He lives in Massapequa Park, N.Y.

Insurance exchange rules beg for trouble

A serious conflict of interest exists in allowing insurance companies to be members of the N.Y. Insurance Exchange if the exchange is to compete with the licensed industry. Lacking the protection of the state guaranty fund, the exchange's financial stability is in question.

By Henry Salfeld

THE NEW YORK Insurance Exchange Inc. was created by a law enacted by the New York legislature in June 1978, which added a Sec. 425-a to the Insurance Law. According to Sec. 1. sub- sec. 2., a Committee of 13 was appointed which, under the chairmanship of the superintendent of insurance, drafted the constitution and by-laws of the exchange. After three public hearings in December 1978, the revised constitution was submitted for approval to the legislature at the beginning of January 1979. The matter is now pending, and unless the constitution is disapproved, "the exchange shall have full authority to function" on and after August 1, 1979. (The proposed constitution was rejected Feb. 13 by a 35-23 vote.)

This is not the place to analyze in detail the provisions of the law and the 89 pages of the constitution, but only to call attention to some of the more important problems that should be resolved before the exchange starts operating.

Limited liability

The exchange has been incorporated persuant to Sec. 201 of the New York Not-For-Profit Corporation Law. The profit, if any, will be made by the underwriting and broker members constituting the exchange. The underwriting members shall be an underwriting syndicate consisting of individuals or corporations as partners. Generally the syndicates will be limited partnerships and, according to a statement made at the public hearing Dec. 18, 1978, it is assumed that the general partner(s) will be incorporated. Unlike Lloyd's of London, the syndicate members will therefore all have limited liability for the risks they insure. Insurance companies may and will also be members which is an anomaly as the exchange is supposed to be in competition with the licensed insurance carriers. This is also different from the Lloyd's rules, which do not permit insurance companies to be members of an underwriting syndicate, and involves a serious conflict of interest.

A question to be resolved is that of supervision of the financial stability of the members and their constituents. This applies not only to a review of a partner joining a syndicate but requires a continuous watchfulness, even though the constitution provides for substantial paid-in capital and surplus to be provided by underwriting members (Art. VII, Sec. 6), and a security fund to be known as the NYIE Security Fund Inc. (Art. XIII). According to Sec. 4 of Art. XIII, the initial contribution of each underwriting member to the fund is $500,000. The fund is the only protection in cases of financial difficulties as sub-sec. 8 of Section 425-a of the insurance law provides that the obligations of the exchange and its members "shall not be covered by any of the New York State security and/or guaranty funds."

Article VII, Sec. 1-b of the constitution requires that a broker member of the exchange be a licensed New York insurance agent, broker or reinsurance intermediary and each individual licensee, a sub-licensee or insurance or reinsurance intermediary "shall have been actively engaged in the insurance or reinsurance business as a principal occupation for no less than three years." Newly organized corporations may become members provided the sub-licensee complies with the aforementioned requirements. Sub-sec. 6 of Sec. 425-a limits the investment of agents, brokers and intermediaries in exchange members. Those who do not wish to assume the financial obligations of broker members may become associate brokers. The requirements are otherwise the same.

Lacks definition

However, the only ones who are unrestricted as to placement of business with the exchange are broker members. "An associate broker shall be permitted to transact business on the exchange through a broker member or, upon certification to the board (of governors) that the placement is solely for his own account, may place business directly with an underwriting member." The constitution does not define what constitutes business "for his own account." (Article VII, Sec. 2)

Important is the requirement of Sec. 5 that "each broker member or associate broker shall maintain a principal office in New York State." Article I, Sec. 4-e. defines a principal office as "an office. . .located within the State of New York for the purpose of transacting business on the exchange. Such office shall be a place where officers and qualified personnel who are engaged in administration, underwriting, claims, policyholders' services, marketing, accounting, record keeping and other supportive services are located." This includes the average non-New York broker unless he

Continued on page 42

Henry Salfeld is a consultant to New York-based Frenkel & Co., insurance brokers.

PERSPECTIVE

Not so 'simplified' appraisal clause promotes litigation of property claims

By Robert A. Krause

FOR 30 YEARS I HAVE CONSULTED, appraised, managed risks and supervised claims as an independent businessman. I have been retained by both insureds and insurers as a "disinterested appraiser" on over 800 property insurance disputes.

There can be no question as to the amount of experience, knowledge and information which is mine in connection with the statutory fire insurance contract as it relates to "appraisal" when disagreements exist as to value and loss. There is apparently activity on behalf of the insurance industry designed to remove the phrase "actual cash value" from the appraisal arbitration portion. Lines 123 through 140 of the statutory conditions read as follows:

"Appraisal. In case the insured and this Company shall fail to agree as to the ACTUAL CASE VALUE or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately ACTUAL CASH VALUE and loss to each item; and failing to agree, shall submit their differences, only to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of ACTUAL CASE VALUE and LOSS. Each appraiser shall be paid by the party selecting him and the expenses of Appraisal and umpire shall be paid by the parties equally."

The insurance industry refers to the new property insurance contract, which has eliminated determination of actual cash value, as "simplified." The appraisal" clause in this new contract reads as follows:

"Appraisal. If the named insured and the Company fail to agree on the amount of the loss, either can demand that the amount of loss be set by Appraisal. If either party makes a written demand for Appraisal, each shall select a competent independent appraiser. Each shall notify the other of the selected appraiser's identity within twenty (20) days of the receipt of the written demand.

Base deception

"The two appraisers shall select a competent, impartial umpire. If the appraisers are unable to agree upon an umpire within fifteen (15) days, the named insured or the Company may petition a judge of a Court of Record in the state where the insured premises is located to select an umpire.

"The appraisers shall then set the amount of the loss. If the appraisers submit a written report of an agreement to the Company, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any two of these three shall set the amount of loss.

"Each appraiser shall be paid by the party selecting that appraiser. Other expenses of the appraisal and compensation of the umpire shall be paid equally by the named insured and the Company."

I consider such base deception to be a mockery of the entire purpose of "appraisal." Under the "simplied" form an assured would have to to go through the worthless procedure of having his loss established via appraisal, and then be left with a worthless determination, wrongly called an award, as the insurance carrier under an actual cash value policy is not required to pay the amount of loss or damage if the actual cash value is less than loss and damage and could arbitrarily take the probable stand that the actual cash value is but a mere fraction of the amount of loss damage. The assured is then put into the unfortunate situation of having to retain counsel and institute litigation which could take an additional five years or more to resolve.



An appraiser's work, illustrated here, is vital to settlement of property claims. Appraisal/arbitration is the only practical method available for a timely and satisfactory hearing and resolution of all levels of insurance dispute, says the author. Removing the phrase actual cash value from the appraisal/arbitration portion of the statutory fire insurance contract is a detriment to the insured.

Photo: U.S. Dept. of Commerce

Empty contract

This "simplied" form allows one party to the contract, the insurance company, to be the judge, jury and, yes, the executioner. Only those with a special interest, who see profit in the inability of their policyholder to withstand a long siege, would have the temerity to remove from a contract of adhesion the only element within it that might serve to equalize the strength of the potential disputants.

And then, to call such an empty contract simplified. Simplified for whom? Certainly not for the insured. What person after a loss, without his factory, business or his home, faced with a five-year or more delay of justice or 25 cents for the dollar of his due will think it simplified?

Appraisal/arbitration is currently considered the only practical method available which holds promise of timely and satisfactory hearing and resolution for all levels of insurance dispute.

What more graphic definition of "bad faith" could there be than for the insurance community, through their underwriters and legal departments, to abuse the understanding of the laymen by flaunting the word "simplified" as if to imply the insured was getting a better value. I am opposed to the removal of the phrase "actual cash value" from the appraisal/arbitration portion of the statutory fire insurance contract. Removing it would, in fact, be a detriment to the insured and a guarantee of a lawsuit rather than a simple method of resolving differences as now exists. ■

Robert A. Krause, president of a company bearing his name, is an internationally known expert in insurance appraisal and loss, consulting on insurance need and risk exposure, pioneering in changing the habits of America's methods of buying fire and casualty insurance. He is, by his own words, "a destroyer of the great myth, the naive allusion that insurance is a guarantee of protection." His operations are headquartered in Southfield, Mich.

Risk exec plots a clear path to success

The road is rocky, strewn with obstacles our society has deposited. Identifying resources, determining insurance needs, forming a partnership with corporate experts shoring up the team and sharpening one's skills are the sign posts that show the way to effective risk management.

By Barbara Garrow

- Multimillion dollar product liability awards!
- Weekly workers compensation benefits in excess of $600!
- The ridiculous pursuit of the government, the courts and labor unions to bring about a utopic risk-free society!

THESE ARE JUST SOME of the obstacles the risk management program strives to surmount.

Unless you are running your business in a self-sustaining underground cavern, you are very much aware of the problems associated with maintaining an affordable, effective risk management program. "Effective" is a key word. One obstacle a risk management program cannot surmount is the lack of backing and cooperation of top management. The risk manager would be, in effect, trying to operate a machine with one of its parts missing.

To convince top management to share your concerns, to be flexible and to consistently give you the required support is to get green light to implement creative efforts to combat insurance premium uncertainties. The general management truism that a problem identified is half-solved certainly applies.

Inflation-affected claim payments, administrative costs and profit loading all contribute to the profit-pinching insurance premiums we pay. These are in addition to societal and environmental factors.

Retention tests

Premium reduction and resource protection decisions have to be part of a total plan, with maximization of cash flow a weighty consideration. Top management commitment and stewardship are required to make these important decisions. The risk management techniques available (in addition to the popular insurance technique) are: avoidance, loss control (ideally prevention), noninsurance transfers, and retention (commonly termed self-insurance).

Three comments relating to retention:

- Its lure results, in part, from the fact that an insured will always save money over the long pull by retaining any exposure unless the insurer has greatly underpriced its product, because insurance premiums always include expenses and profit loading, in addition to some expected loss allowances.
- Its implication brings to my mind the old analogy of the chicken and the pig walking down the road one morning when they came upon a diner. In the window was a sign that said "Ham and Eggs Our Specialty." The chicken said, "Come on, let's have breakfast." "No thanks," said the pig. The chicken persisted. "Absolutely not," said the pig. "With you that's a contribution, with me it's a total commitment."
- Ignorance of a loss exposure (or underestimation of a loss exposure) results in inadvertent retention. Realization of this fact usually brings on an attack of what I term "mayday myopia." The cure is usually an unplanned outlay pulled out of cash flow.

A recent Xerox Corp. ad summarizes the need for predecision data quite well: "All ideas come from information. All discoveries begin with it and all decisions are based on it." Before you can prudently decide which techniques make the most sense, you have to remove most of the mystery through disciplined quantitative data development and analytical efforts. Only then can you employ the qualitative conceptual efforts against the remaining mystery.

Resource inventory

First, identify each of your company's resources as to:

- Category (property/casualty/employe benefits).
- Mini-max loss likelihood (as to frequency/severity).
- Possible causes of loss (natural/human/economic).
- Replacement/restoration costs.

Second, place these resources into one of the following four protection need categories:

Insurance is essential, because of legal or survival requirements. (Workers compensation, fire and general liability are examples.)

Insurance is desirable, because of cost-effectiveness and convenience. (Transportation insurance is an example.)

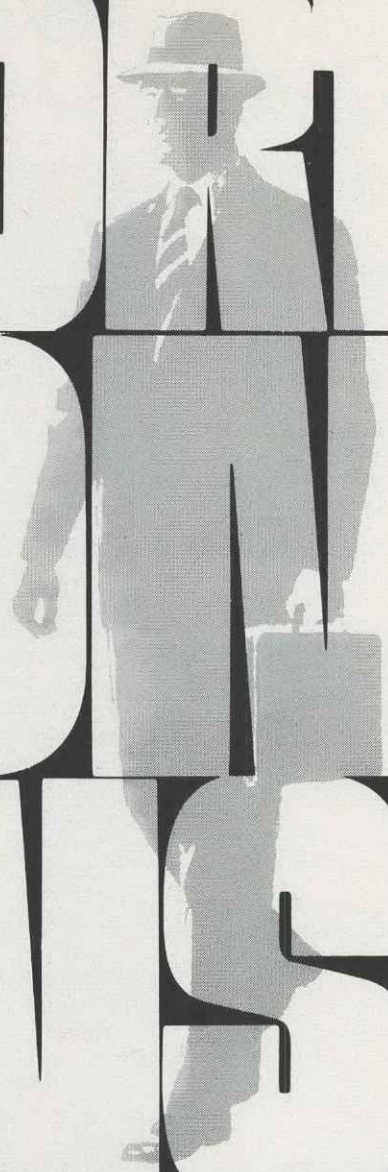
Insurance is available, although less likely to be purchased because there is no threat of severe economic impact. The only exception is when the benefits of insurance outweigh the premium cost. (Credit insurance is an example for certain types of businesses.)

Insurance is unavailable (or unaffordable), because of great potential severity coupled with unpredictability. (War risks,

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Barbara Garrow, who formerly wrote under the name Barbara Fisher, is corporate insurance administrator for SGL Industries Inc. in Haddonfield, N.J.

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PERSPECTIVE

Tax court . . .

Continued from page 39
payable.

Whether IRS will continue to succeed in casting so wide a net is conjectural. Insofar as the author knows, there has been no appeal on the Schelberg matter. In any event, it is the author's view that the rationale of this case could extend far into other accepted executive benefits. That some of these apprehensions may prove groundless does not vitiate his concern, since it is manifestly worse to bury one's head in the sand in the face of possible hazards.

Review warranted

Thus, in addition to obvious parallels to Schelberg in the case of like disability benefits, the following warrant review:

- Incentive compensation plans which may provide post-retirement payments that might be viewed, in part, as other than compensatory (e.g., various phantom stock and performance share plans, in which incremental values attributable to appreciation might be payable).
- Stock option plans, which customarily permit the limited exercise of options (and/or of any tandem stock appreciation rights in the case of many non-qualified stock options) following termination of employment.
- TRASOPs (which prior to the 1978 Revenue Act did not have to be a qualified retirement plan), providing benefits to the terminated participant.

The above might be viewed as exotica, though some may even enlarge upon the list. No one should, however, deny that long term (i.e., total/permanent) disability coverage is almost universally accepted in major companies—bringing full circle the Schelberg issue. Does this mean that wherever there is a long term disability plan, the effect of an insured's assignment of his/her group life coverage is a nullity insofar as estate tax exclusion of such death benefits is concerned?

Tactics offered

The estate tax problem is not only most manifest where there is a co-existent, long term disability benefit plan, but is compounded when either plan is uninsured. It should not be inferred from this that various funded or unfunded self-insurance media/techniques have no place in the benefits spectrum—particularly where the covered group consists of other than a company's "top-hat" executives. However, when one regards the variety of selective "bonus" insurance arrangements which can provide life and/or disability protection that is superior to either self-insurance or group coverage (particularly in the light of tax law), it is difficult to justify lack of consideration of personalized insurance alternatives.

To immunize DBO arrangements from estate taxation:

- There should be no benefit from any post-retirement lifetime plan (except if it is qualified).
- Temporary disability benefit plans must be distinct from permanent ones, so as to reinforce the above.
- Consideration should be given to separate and individual life and/or disability insurance contracts, provided through selective "bonus" arrangements.

Schelberg merely being one of the latest incarnations of the hazards of tax-wise planning, in the light of ever-changing law and economic conditions, it is incumbent on benefits managers to continually monitor the company's benefit package. ■

IRS attacks medical deductions

Special from the Peat, Marwick, Mitchell & Co. Insurance Newsletter, January 1979

AN EMPLOYER ESTABLISHED a medical reimbursement plan for employes and their dependents covering hospitalization, surgery, dental and major medical costs. Originally, the employer insured the program and deducted the insurance premiums as an ordinary and necessary business expense. Several years later, the employer decided to self-insure the medical reimbursement plan and have it administered by the former insurer on a fee basis.

The employer established a reserve for the estimated amount of liability for unpaid medical treatment claims provided to employes during the year. The amount of the reserve was computed for the emloyer by the insurance company based on a lag study utilizing prior experience. The technique proved accurate—the reserve approximated the amounts actually paid.

The employer deducted the reserve as an ordinary and necessary business expense. As you may gather, the IRS disallowed the deduction on the premise that the "all-events test" had not been met. Technical advice was requested and an adverse ruling was recently issued to the employer.

The all-events test is a "two-prong" test. First, all events must occur which determine the fact of the liability. Second, it is required that the amount of the liability can be determined with reasonable accuracy. The employer argued that the fact of the liability becomes absolute or fixed when the employe receives medical services. The technical advice held that the liability becomes fixed when the employe submits satisfactory written proof of each charge for which benefits are being requested. The employer countered that the amount of the medical reserve could be determined with reasonable accuracy for its employes as a group. The IRS maintained that it is necessary to compute the reserve on an individual basis.

It is our view that the IRS position is incorrect. In fact, it appears to be contrary to Revenue Ruling 67-129 where it was held that incurred but not reported death claims are "fixed liabilities reasonably ascertainable in amount." It is possible that the adverse ruling position of the IRS may encourage employers to insure their medical reimbursement plans with an insurance company.

Further encouragement for insured medical reimbursement plans was provided by the Revenue Act of 1978. Effective for taxable years beginning after 1979, employes must include medical expense reimbursements in taxable income if the plan is discriminatory and self-insured. Benefits provided by an insured plan are not includable in taxable income, even if discriminatory.

Success . . .

Continued from page 40
riot and nuclear exposures are examples of unavailable; product liability and malpractice are examples of unaffordable for certain businesses or professions.)

Now use the insurance protection your company currently has, along with its annual cost, as a benchmark. This would also be an excellent time to take a hard, critical look at the insurance companies, brokers, consultants, agents, and suppliers of any other related services you are currently using. Do you feel completely confident in every one? If not, here's your opportunity to plan to bring in some fresh blood as soon as practicable.

Obviously, you know it's impossible to put together by yourself the program your company requires. On the other hand, you're spending your jealously guarded time—you owe it to your company to surround yourself with the best in the business. Preventing your company from suffering the loss (or series of losses) it cannot survive is no turnkey feat in our inflationary economy. Your company people and the "help" you have on board have every obligation to be a "protection partnership," all professional, knowledgeable in their field, and with an eye to the future. (Make that both eyes to the future.)

Partnership goals

Purposes of the partnership are:

- To develop a comprehensive risk management program.
- To negotiate the best insurance quotes available in the marketplace, considering larger deductibles or excess insurance to lower overall premium charges, wherever practical.
- Determine the feasibility of alternative protection techniques where insurance may not be the best protection method.
- Reduce risks.
- Prevent losses. (This will lower the non-compensable hidden, contingent costs of losses as they relate to manpower and business operation.)
- Reduce the severity of probable losses by maintaining a comprehensive loss control program with accountability at the supervisory levels.
- Monitor and analyze the results of your risk management program at defined and emergency intervals.
- Consistently implement the desired additional and corrective action.

Top management's personal role in the protection partnership will be of more value by the use of any or all of the following current awareness techniques:

- Keeping well informed through trade periodicals. (*Business Insurance* and The John Liner Letter are excellent examples.)
- Active participation in a professional organization (such as RIMS) where you have the opportunity to exchange ideas, pose questions and explore the practicality of new concepts.
- When considering an unfamiliar insurance carrier, checking its financial and service strengths in a manual such as A.M. Best & Co's. (For manufacturing companies, a local workmen's compensation bureau can provide information about the kind of service to expect from carriers.)
- Awareness of premiums paid, losses incurred, property values, sales by year broken out by product line, yearly payrolls and any other data required for proper maintenance of a program.
- Having readily available a synopsis of every policy purchased as well as a follow-up system for policy expirations.
- Ascertaining the point at which the company could benefit by total retention (self-insurance) programs.
- Being present during negotiations with underwriters when important risks are involved and your input would be a valuable negotiation asset.
- Questioning the accuracy and/or rationale behind insurance company decisions, broker selections, sharp premium hikes, loss control recommendations, workers compensation rate assessments and experience adjustments.

All right, you've analyzed, categorized, dug into your history, shored up your team, sharpened your awareness and now you're ready for some nuts-and-bolts decisions. This is the point where you provide not just for today's concerns but for tomorrow's. Tomorrow's uncertainties need not be shocks if your team's efforts include monitoring forecasts and trends. Unfortunately, top management will always have to watch the watchers to make sure they're paying attention. ■

Troubles . . .

Continued from page 39
is prepared to organize a full service New York corporation with sub-licensees having the required experience.

According to Sec. 425-a, the purposes of the exchange created by the act of 1978, shall be: To provide a facility for the underwriting of reinsurance of all kinds of insurance, direct insurance of all kinds of risks located entirely outside the United States, and risks which shall have been submitted to and certified as having been rejected by a committee representative of insurers licensed in the so-called free trade zone created by the same act. This provision has been repeated in Article 1, Sec. 2 of the constitution.

There is no comment at this time on the authority to write reinsurance.

However, there are problems regarding foreign risks. A question asked at the Dec. 18, 1978, hearing as to whether Puerto Rico is located outside of U.S.A. has not yet been answered.

Foreign countries

As the risk must be located "entirely" outside the U.S., the exchange cannot issue worldwide policies which include coverage in U.S.A., but it apparently can write risks in Canada.

What has also not been clarified is the paramount question regarding licenses required by foreign countries. The fact that the State of New York has given authority does not also give the exchange or rather its syndicates the right to insure risks in countries that permit the issuance of policies only by insurers specifically licensed by the proper department of such foreign government.

According to Article IX. Sec. 1 (II) of the constitution, an exchange contract shall be issued in the name and for the account of those underwriting members which have subscribed to the risk being insured and "in no event shall the exchange be a party to an exchange contract or have any liability thereunder" (Article 1X. Sec. 1-d.). It, therefore, appears that the underwriting members require such admission abroad and the procedure to be followed may be similar to that for Lloyd's of London whose syndicates are the parties liable under policies to which they subscribed.

Other states

Domestically, the exchange can only write the same type of risks for which insurers have been licensed to issue policies in the so-called free trade zone (Insurance Law Article 16-d). This conclusion results from the provision that such direct insurance may only be written if the licensed carriers have rejected the risk. It is the interpretation of the insurance department that such rejections only refer to risks which the free trade zone carriers decline for underwriting reasons and not because their free trade zone license does not comprise the particular type of risk.

As the relief from filing requirements under Insurance Law Sec. 168-d only applies to risks located in New York State and subject to the jurisdiction of the New York insurance department, the regulations to be issued must clarify whether the authority of the exchange also comprises risks partially located in New York and rejected, as well as others not listed under Sec. 168-d, sub-sec. 5.

The free trade zone presently is a name for an unorganized group of insurance companies licensed under Sec. 168-d. There is, therefore, no committee that can certify to the rejection of a risk by such insurers. It will be up to the superintendent of insurance to issue regulations on the organization of such committee and under what circumstances and in what form it can certify to a rejection. To how many underwriters must the risk be submitted for approval? Does non-acceptance of a proposal due to a supposedly excessive premium constitute rejection?

Once these and some other problems have been resolved, the exchange may be a desirable and viable institution able to accomplish the purposes for which it was enacted. On the other hand, prominent New York legislators did have second thoughts about the organization and due to the restrictive conditions of its constitution other states may organize exchanges to operate on a nationwide basis. ■

What's up in the industry

Roaring broker growth could hit skids in 1979

The major U.S. insurance brokers closed out 1978 with continued record-breaking revenue growth, but analysts are forecasting slower growth in 1979 with competitive insurance markets cutting into commission income and growth.

Marsh & McLennan, the largest U.S. broker, generated $453.5 million in commissions and fees in 1978, up 11.9% from $405.4 million in 1977. Alexander & Alexander, the second largest U.S. broker, closed out 1978 with $289 million in revenues, up 21.5% from 1977's revenues of $237.9 million.

While A&A grew faster than M&M in 1978, Chicago-based analyst Harvey H. Bundy III of William Blair & Co. believes "Marsh & McLennan is in a better position to weather the more difficult environment of the next year than most of the other major brokers." M&M is strengthened by "its book of major national and international business and unique capabilities within the industry," the analyst says. "We are also heartened by the apparent controls which exist over operating expenses."

A&A, however, is headed for "an appreciable slowdown in the company's growth for 1979," predicts Drexel Burnham Lambert in New York. "Trade sources suggest that competition is particularly keen in medium sized risks, Alexander & Alexander's traditional forte."

Interestingly, Drexel Burnham expects demand for insurance by commercial buyers to counterbalance falling premium rates and shore up broker growth. "This elasticity of demand seems to reflect itself in a willingness or an ability of the client to purchase more cover when insurance costs are level or falling off. It is a counterweight of indeterminate magnitude to rate change," the analyst says.

Among other leading U.S. brokers, 1978 showed: 29% revenue growth at Frank B. Hall & Co. Inc. to $192.4 million in 1978 from $149.2 million in 1977; 22% revenue growth at Fred. S. James & Co. Inc., to $143 million in 1978 from $116.9 million in 1977; 17% revenue increase at Rollins Burdick Hunter, to $56.5 million in 1978 from $48.3 million in 1977, and 18% growth in gross revenues at R. B. Jones Corp. to $30.3 million from $33.7 million in 1977.

—Kathryn J. McIntyre

FM company pays fire loss of $34 million

EDISON, N.J.—A business interruption and property insurance policy underwritten by Arkwright-Boston Insurance Co. fully covered a $34 million fire loss suffered by Supermarkets General Corp. here recently.

The fire destroyed the supermarket's warehouse and its contents. The cause of the fire hasn't been determined, but it was learned the sprinkler systems apparently weren't operating efficiently.

"I never heard of a property insured by the Factory Mutual System being completely leveled. Usually the sprinklers are able to dampen the fire," said Richard Martin, treasurer of Supermarkets General.

The company carried a $25,000 deductible on the property insurance policy, Mr. Martin said.

Estimates of the loss were difficult to obtain because the company is still figuring the replacement value of the warehouse and its contents. The warehouse was 260,000 square feet, said underwriter Frederick J. Bumpis of Arkwright-Boston. ■

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Risk execs rate captives, brokers

Inflation to cut insurers' profits: Study

By ELLIS SIMON

NEW YORK—A high inflation rate this year is expected to spoil a repeat performance of the insurance industry's spectacular 1978 results, but rates will continue to drop, a survey of property/casualty insurance executives reveals.

The inflation rate will exceed 10% predicted insurance executives surveyed by Kramer Capital Consultants Inc. Claims costs will rise as a result and competitive pressures will prevent rates from increasing to cover rising costs, according to the Kramer study.

Meanwhile, a limited survey of risk managers by Kramer shows 40% are using captive insurance companies and risk managers self-insure approximately 42% of their corporation's property/casualty exposures.

Underwriters and brokerage executives from across the country participated in the Kramer study to measure competition in the property/casualty industry. Both stock and mutual company executives were included and the participants' companies account for 50% of the nation's underwriting capacity, according to survey director Gloria Vogel.

Competition has intensified in all major lines with the exception of homeowners, the survey found. General liability lines have seen the greatest increase in competition and workers compensation, which has seen limited improvement in profitability, was also becoming subject to competition.

Most intense competition was found to be on medium to large sized national accounts for high premium and high exposure risks.

General liability rates, which have been subject to the sharpest increases, are expected to drop during the next 12 months, survey participants indicated. Although underwriters predicted a slight increase in liability rates (2.4%), brokers foresaw a significant drop in rates (12.7%). The composite weighted average calls for a 5.2% reduction.

Rate reductions on property and homeowners lines are expected to continue and workers compensation rates are expected to increase, but not as fast as previous years.

Rate cutting on commercial property and homeowners lines already had adverse effects upon the profitability of the lines, but the reduced earnings were offset by greater profits on general liability, workers compensation and personal auto.

While rate cutting and rising inflation could result in a downturn in the underwriting cycle, the Kramer study is hopeful that the next downturn will not be as severe as the last.

Insurance companies have become financially stronger, increased capacity and more readily secured reinsurance, the survey noted. In addition, many companies reported recovering business from non-admitted markets.

As a result of the 1974-75 insurance crunch, the industry has reduced its exposure to investment risks. The majority of survey participants said stock market investment was down from previous years and an average 68% of their investment portfolios could be sold without loss. Only 40% of insurer surplus was invested in common stocks.

In the separate study of risk managers, the Kramer organization found that 40% of the responding risk managers operated captive insurance subsidiaries. In addition, survey participants said they self-insured approximately 42% of their exposure, primarily for workers compensation, general liability or through high deductibles on property/casualty coverages.

However, the limited number of respondents prevented the survey of risk managers from being statistically valid, Ms. Vogel said.

All respondents operating captives said their facilities were in Bermuda. The majority of these captives were managed by the insured's broker or an independent management organization.

A combination of commissions and fees to pay brokers was used by 55% of responding risk managers. Only 36% of the risk managers said they relied solely on commissions to compensate their broker. Risk management, loss analysis and engineering services were the most frequently purchased services from brokers.

Service was found to be the key factor in selecting a broker. Coverage availability and price were the main determinants in selecting an insurer. Risk managers said they were more inclined to switch insurers than brokers for price.

Asked to choose from a list of 25 insurance companies, risk managers indicated they were most familiar with INA Corp., AIG, Fireman's Fund Insurance Co., The Home Insurance Co. and Lloyd's. American General, General Accident, NN Corp. and Ohio Casualty were least familiar to the respondents.

Risk managers said the best markets for commercial lines were provided by AIG, Chubb Corp. and INA Corp. Lloyd's, St. Paul Cos., AIG and CNA Financial Corp.were said to provide the best specialty line markets. INA Corp., AIG, Aetna Life & Casualty, Hartford Fire Insurance Co., The Home, Liberty Mutual and Travelers were said to provide the best service.

From a list of 22 brokers, risk managers were most familiar with Alexander & Alexander, Johnson & Higgins and Marsh & McLennan. The same three firms were said to provide the best service. ■

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OSHA warns of surprise visits

WASHINGTON—Inspectors from the Occupational Safety & Health Administration can enter an employer's workplace armed with a warrant without ever having been refused entry, according to new rules announced by the Labor Department.

"It may be desirable for us to seek a prerefusal warrant for an inspection where the travel distances are great, or in situations where it is possible to predict that a refusal or other interference with the conduct of an inspection is likely," said Eula Bingham, assistant secretary of Labor who heads OSHA.

The Labor Department clarified its use of warrants to inspect workplaces in response to a Supreme Court decision requiring OSHA to secure a search warrant to enter a workplace without the employer's consent. ■

Pregnancy benefits . . .

Continued from page 1

plans will have to be overhauled with major cost increases because they either provide inequitable pregnancy benefits or do not even include pregnancy as a covered benefit.

A Prentice-Hall survey of 123 firms published earlier this year found that more than half the firms surveyed (65) failed to cover pregnancy on the same basis as other disabilities in their sick leave plans.

Cost variables

For some companies, the cost implications of covering pregnancy will be "brutal," said one insurance company actuary.

School districts, which have often excluded pregnancy from their benefit plans, are expected to be hit with the biggest premium increase because of their high percentage of young, female, married employes. Some schools may find their premiums rising by as much as 15% to 20% or even more for including pregnancy in their group health insurance plans, said one actuary.

These premium hikes will be especially grim news for California school district complaining their budgets already have been slashed to the bone in the aftermath of Proposition 13.

To discover how much it will cost employers to cover pregnancy in their benefit plans, *Business Insurance* interviewed actuaries at several major Eastern insurance companies.

As a condition of providing cost estimates, the actuaries asked that the names of the insurance companies they worked for not be disclosed. They were concerned that some employers might misinterpret the information given as hypothetical examples and believe that the insurer was giving price quotes that would apply across the board to all companies.

Many variables will affect just how much an employer will have to pay for pregnancy benefits, the actuaries hastened to point out. The experience of the employer, the percentage of females employed, the average age of the females, the geographic area where the company is located and the range of existing benefits offered will all affect the cost of adding pregnancy to benefit plans.

For example, firms with a high percentage of young, married females will find their cost increases to be substantially more than firms with a smaller percentage of women workers or if the females are over age 40.

Disability costs

Similarly, firms that already provide some pregnancy benefits, though not on the same basis as other disabilities, will find their costs going up much less than firms that have failed to provide any pregnancy benefits.

With these qualifications, the actuaries gave several specific examples based on information in their underwriting files to give employers a rough idea of how their costs might increase.

The actuary at a Hartford-based insurance company assumed that the employer currently maintains a disability plan that provides an employe with two-thirds of salary for up to 26 weeks of illness following a one-week waiting period. The employer's workforce is 25% female with an average age of 35. The females earn an average of $12,000 a year.

If the firm employs 100 employes, the company's paid sick leave costs would increase $3,400 a year or $34 per employe. If the firm has 500 employes, its annual costs will rise $15,500 annually or $31 per employe.

Finally, if the company employed 2,500 workers, its paid sick leave program premiums would jump $62,500 a year, or $25 per employe. But among these three examples, the employer's total disability premiums would climb by about 20%, the actuary said.

The cost hikes for including pregnancy in employer paid group health insurance plans also will be substantial. In calculating the cost increase for covering pregnancy in a group hospital and medical plan, the actuary again assumed that a firm's workforce was 25% female with an average age of 35.

Medical costs

The existing group plan covers all hospital expenses during any one 120-day period, including usual and customary surgical charges. Under the major medical portion of the plan, the employe pays 80% of hospital and medical expenses with a $100 deductible.

A company maintaining such a plan for 100 employes and now adding pregnancy for the first time could find its premiums increasing $1,150 a year or $11.50 per employe. The firm with 500 employes would be faced with a premium increase of $5,500 annually or $11 per employe.

Finally, the company with 2,500 employes could expect to pay an additional $26,250 in premiums or $10.50 per employe. The percentage increase in premiums would range between 3% and 4%.

However, employers maintaining the same plan but who elect not to cover abortion may find some slight premium savings, an actuary said. Under the federal pregnancy benefits law, an employer will not have to provide medical and hospital benefits to a worker who has had an abortion unless the woman's life was endangered by the pregnancy.

The employer will be required to offer health insurance coverage to a woman whose abortion resulted in medical complications. Furthermore, 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.

Insurers said there will be no problem in excluding abortion from group health insurance plans.

The law does not require an employer who doesn't currently provide a paid sick leave program or medical plan for his employes to provide pregnancy-related benefits to employes. ■

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Exchange rolls . . .

Continued from page 1

insurance superintendent Mr. Lewis, Mr. Dunne convinced the Republican leadership in the Senate to reject the proposed constitution.

Another revision sought by Sen. Dunne would have permitted foreigners to occupy one-third of the seats on the exchange board of governors. Under the compromise, no more than one-third of the seats could be held by foreigners. But, the governors would also have to amend the constitution to permit foreigners to serve since presently the constitution restricts membership on the board of governors to U.S. citizens.

"When Lloyd's allows U.S. citizens on their board, we will allow the British on our board," predicted Mr. Lewis.

Both the superintendent and an aide to Sen. Dunne expressed satisfaction with the agreement. "We feel good about it," said Bob Mackin, aide to Sen. Dunne. "It's a very reasonable agreement and we're glad to see the exchange off and running right away."

"Thank God they got their show together," said Robert Sanford, president of the Insurance Brokers Assn. of the State of New York. "The politicking was abominable to those of us in business for business's sake and I'm delighted its behind us."

Had an agreement not been reached by March 1, the major brokers planned to meet to consider moving the exchange to another location, said L. Patton Kline, chairman of Marsh & McLennan Inc.

Chicago had been the most mentioned site as an alternative location for the exchange. Other locations mentioned included New Jersey, Connecticut and Louisiana.

"We wouldn't back Illinois unless it became apparent that New York wouldn't go," said Mr. Kline. "At no time did we want to play off Illinois against New York. There can only be one exchange effectively and we're pleased it's in New York."

Only one needed

"I can't see Chicago at this point providing the same kind of market that New York can," said Richard Whynot, senior vp at Commercial Union. "If one exchange can be successful, that's about all we can stand. Two exchanges here would be like having Lloyd's of London and Lloyd's of Birmingham."

Although the news of the legislative agreement pleased industry sources, no one is prepared to predict the success of the New York Insurance Exchange. Start-up is likely to be slow and will come at a time when the reinsurance markets are glutted.

"The Exchange's early business won't be significant compared with what now goes across the pond (to London)," said Mr. Stanford of the New York brokers association. "It will take a number of years for them to get moving before they can cut into Lloyd's."

Although the state insurance department predicted 14,000 new jobs would eventually result from the exchange, no more than 2,200 are likely to be created during its formative years, said Mr. Mackin.

With the reinsurance market as "glutted" as it presently is, exchange underwriters will have to be careful not to get involved with a lot of "distress business" floating around, said Gerry Curtis, deputy managing vp for Alexander & Alexander's New York office.

In addition, international business will be a new area for most American underwriters and the exchange "will have to step in gingerly and slowly," he cautioned.

Restrictions on the exchange's writing direct U.S. business are "unnecessary impediments" to the exchange's future growth, said Mr. Kline. This could result in insureds using fronting companies to gain access to the exchange for facultative reinsurance, he added.

Several insurance companies that participated in the drafting of the insurance exchange constitution, including AIG, INA Continental and the Atlantic Cos., said they intend to participate in the exchange. Most, however, said they could not disclose their plans at this time.

AIG plans syndicate

AIG will capitalize at least one exchange syndicate and probably manage others, said vp and counsel Patrick Foley. INA president John Cox said his plans were pending approval from his board of directors.

The large brokers said they intend to become broker members of the exchange and some have announced plans to provide syndicate management services, as well. Johnson & Higgins in January announced entry into this business through a joint venture with its London correspondent Willis Faber Dumas.

Officials at Marsh & McLennan and Frank B. Hall said their London affiliates, C.T. Bowring and Leslie & Godwin, respectively, are likely to become involved in providing syndicate management.

A&A is presently conducting an "exhaustive study" on the feasibility of becoming syndicate managers, said chairman Ken Soubry. The firm will apply to become a broker member, he added.

Mr. Sanford said his firm, Smyth, Sanford & Gerrard, intends to become a broker member and anticipates placing business on behalf of small brokerages outside of New York. Syndicate management would not be feasible for a small firm such as his, he said.

One insurance industry source predicted most major companies will eventually participate in the insurance exchange in one form or another. The companies are presently "lining their ducks up in a row," he said.

How hospitable a business climate is developed by the interim board is a key concern to those considering participation, Mr. Kramer said. Issues such as limitations on the number of syndicates, open access to the exchange and its administrative procedures will be determining factors for some concerns, he said.

Governors' tasks

The seven-member interim panel will include two appointees each by Gov. Hugh Carey, senate majority leader Warren Anderson and assembly speaker Stanley Fink. Insurance superintendent Mr. Lewis will name the final board member.

One of the board's main concerns is likely to be obtaining professional management to process applications, handle funds and develop a budget, negotiate for office space and implement systems and controls, Mr. Kramer predicted.

Brokers and others seeking to attract individual investors to participate in syndicates will have to develop prospecti that meet Securities and Exchange Commission requirements, noted David Winton, J&H senior vp and director.

Each syndicate seeking investors will have to do this separately, unlike Lloyd's, which has one SEC filing for prospective U.S. names, Mr. Winton said. This is necessary because syndicates are members of the New York exchange while individuals are members of Lloyd's, he explained. ■

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FM merger off . . .

Continued from page 2

nior vp George West disagree with the FTC's reckoning of market shares. Their determination of the HPR market, for instance, "begs the question of Lloyd's, captives and layered programs, as well as the potential of the HPR market," Mr. Goodall said.

In determining the boiler and machinery insurance market, the FTC pegged the entire market at $260 million, which Mr. Goodall criticized as being far too low. Together, Allendale and Arkwright-Boston would have held $85 million in premiums on boiler and machinery policies, with Arkwright-Boston the bigger B&M underwriter at $55 million.

The federal regulator's determination to fight the proposed merger was also bolstered by the hefty competition they found between the two companies.

"It was a good argument they made originally that there was no competition between them," the FTC source admitted. "It almost convinced us to pass on their merger."

But documents filed with the FTC under the Hart-Scott-Rodino Act "showed incredible competition between the two with prices all over the lot," the FTC source said. The cooperation between the FM companies on engineering, loss adjustment and rate making instead of limiting competition between them actually increased it, the source suggested. Buyers are offered essentially the same service but at different prices determined by different underwriters at the two FM companies, he explained.

In addition, the FTC found evidence that Arkwright-Boston will underwrite risks that Allendale refuses, the spokesman said.

Now the argument of existing cooperation among the FM companies is gnawing at the conscience of the FTC staffer. "I'm interested in investigating the system," he said. "But I don't know if I can get anyone else interested. It's just a thought at this point. We're being expansive because we're happy (we stopped the merger)."

The McCarran-Ferguson Act, however, probably immunizes the FM System from any further federal regulation of its activities, admitted the FTC source.

"They didn't mention cooperation among the FM companies to us," said Allendale chairman Mr. Goodall when asked about FTC interest in the FM System. "We hope they'll leave us alone to do our business now."

Arkwright-Boston senior vp George West isn't concerned about additional FTC investigation. "The way we operate has been going on for a very long time. I don't know how we could operate without the strength of each other."

Few insurance buyers or brokers objected to the proposed merger last summer and the policyholder/owners of both companies overwhelmingly approved it. "Often you don't see buyer reluctance to a merger. They don't care. They pass the price on," the FTC spokesman said. ■

Spencer . . .

Following his term as RIMS president, Mr. Spencer remained a visible figure, speaking at seminars on topics such as risk management, cash-flow techniques and self-insurance programs. In addition, he headed an ad hoc RIMS committee that worked with the Insurance Services Office on revisions to the comprehensive general liability policy.

"Mr. Spencer was exceedingly well-liked throughout the society. His death will be a severe blow to the membership," said C. Paul Kipp, current president of RIMS. "His death was a definite loss, not only of a personal friend but of an individual who made very significant contributions to the society."

"His progressive thinking will be missed," said J. Al Friday, vp-insurance at Colonial Stores Inc. in Atlanta.

Mr. Spencer was a native of Red Oak, Iowa, and a graduate of the University of Iowa. He leaves his wife, Charlotte; two children; his parents, Mr. & Mrs. Ralph M. Spencer of Red Oak, Iowa, and two brothers.

The family asked that contributions be made to the Georgia Heart Assn., 2581 Piedmont Road, NE, Atlanta, Ga. 30324, or Church of St. Andrew, in Atlanta. ■

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Second opinions . . .

Continued from page 1
a patient's relationship with the physician. Furthermore, the group insurers said the benefit reduction feature of the Prudential plan is unfair because a subscriber might forget to obtain the second opinion and learn only after surgery is performed that he will receive a reduced benefit.

Competition interested

But Prudential's competition doesn't deny that the mandated approach probably saves more benefit dollars than the voluntary plans under which the client has to be constantly reminded of the second opinion benefit and still often fails to consult other surgeons.

Despite these objections, Metropolitan Life Insurance is experimenting with a mandatory program for an employer in the Midwest. Travelers Insurance Co. and Connecticut General Life Insurance said they would try the mandated method if any employers are willing to participate in the test.

Prudential has launched an aggressive marketing plan to sell its mandated plan in order to "improve the quality of health care and at the same time offer a moderately cost effective" tool, Mr. Heimberg said.

"We plan to prove to everyone that it is viable," he added. Prudential also intends to build up a larger data base to determine more accurately how cost effective the mandated approach is, Mr. Heimberg said.

Evidence cited

In backing mandated second surgical opinions, Prudential has relied on research compiled by Dr. Eugene G. McCarthy Jr., professor of public health at Cornell University Medical Center and known as the "grandaddy of second opinion."

Prudential also was convinced of the benefit cost saving potential of second opinions by his own home office experiment, Mr. Heimberg said. While the test used a voluntary second opinion feature, Mr. Heimberg said it found that approximately 30% of those who sought a second opinion did not receive confirmation and therefore did not have surgery.

Dr. McCarthy's research has shown a substantial savings among five groups of workers in New York City who have a mandated second opinion benefit.

For the 180,000 workers represented by New York City's Building Services Employes Union, the largest group Dr. McCarthy has monitored, a $4 million savings in hospital bills occurred during 1977 and 1978. Major medical bills were reduced by another $1 million during those same two years, Dr. McCarthy said.

Costs controlled

Data from the five groups, which represent 271,000 workers, show that hospital and medical costs have gone up only 2% to 3% compared to 16% in other groups, according to Dr. McCarthy. The total health care savings is high, he added, because 40% of the overall health premium goes to pay surgical procedures.

Viewed in a different manner, the data showed that for every dollar spent on obtaining a mandated second opinion, $8 is eventually saved by eliminating unnecessary surgery, according to Dr. McCarthy.

Dr. McCarthy's study of second opinions on surgery found savings in three areas. The number of surgical claims for the five groups was reduced by 12% to 15%. That percentage was derived by comparing claims incurred three years after the mandatory program was begun with claims incurred three years before the program was started.

The second savings resulted from the number of permanently deferred surgical operations. Of those obtaining a second opinion, approximately 18% of the first opinions weren't confirmed. Of that 18%, Dr. McCarthy said, 75% didn't have the surgery performed in the next two years.

Although other experts have said that the data needs to be tracked for five years to determine whether surgery was performed after a conflicting consultation, Dr. McCarthy said the two-year tracking period is sufficient because 85% of those who receive a confirmation on surgery have it performed within four months.

The third component of the savings was derived from having surgery performed in ambulatory surgical facilities instead of hospitals. In 5% of the second opinions offered, the confirming surgeon recommended that the operation be performed outside the hospital, Dr. McCarthy pointed out.

The potential savings offered by a second opinion benefit is extremely important in light of the fact that surgical procedures have been climbing four times faster than the population during the 1970s, Dr. McCarthy noted. In comparison, he added, surgical procedures during the previous 30 years progressed at the same rate as population growth.

Dr. McCarthy projected that the surgical rate will climb even faster during the 1980s.

Although Dr. McCarthy avidly supports the mandated second opinion benefit, he dislikes Prudential's policy of reducing benefits if the patient goes ahead with surgery without another doctor's confirmation.

The programs Dr. McCarthy oversees only penalize the patient if a second opinion isn't sought.

"I object to the Prudential policy because the second opinion is meant to be a consumer program and shouldn't make an economic judgment of which physician is right," Dr. McCarthy said. "The right of the patient to make that judgment shouldn't be affected by a penalty."

The penalty isn't necessary anyhow, Dr. McCarthy added, explaining that in seven of eight cases where the individual is told not to have surgery by the second surgeon, the patient takes the second surgeon's advice.

The Prudential program does, however, offer a third opinion free of charge, in order to break a tie between the first and second consultation.

Voluntary results

Dr. McCarthy is also enthusiastic about voluntary second opinion programs. Results of the voluntary program at the three big auto companies showed that 31% of the group didn't receive confirmation and that 80% of that 31% have not had surgery yet. The test was begun in July 1977 and Dr. McCarthy plans to follow up on the results for another 36 months.

Criticism of Prudential's mandatory plan came swiftly from competing group insurers who offer only the voluntary method.

The Prudential's policy of reducing benefits means the "client is just getting the sleeves out of Prudential's vest. In other words, not getting much," said George Cheney, vp at Travelers.

"I pity the poor guy who a year after the mandatory program is started, forgets to get second advice and then learns he gets a reduced benefit," he added. ▪

States approving discount

NEW YORK—Prudential's mandatory second opinion program, which it began marketing in January, is currently available in 28 states and the District of Columbia.

Some states, including Connecticut, have raised questions about the insurer's policy of penalizing patients with a reduced benefit for getting surgery without a second opinion or a confirmation of the operation's necessity.

The states Prudential's program is available in include: California, Colorado, District of Columbia, Florida, Illinois, Kentucky, Louisiana, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, Ohio, Oklahoma, Tennessee, West Virginia, Wisconsin, North and South Dakota, Rhode Island, Missouri, Delaware, Alabama, Indiana, Arizona, Arkansas and Oregon.

errors & omissions

• An editorial cartoon in the Jan. 8 issue contained the name T.O.P. Insurance on a sign above two gasoline pumps used to illustrate the sale of insurance coverage coupled with services. The name of T.O.P. was chosen by the cartoonist not knowing that there is a real insurance/service company named T.O.P. Inc., launched in 1969 as a wholly owned subsidiary of Life Investors Inc. in Cedar Rapids, Iowa. The real T.O.P. provides credit life insurance and credit disability insurance to credit union members who take out loans. The cartoon didn't intend any kind of slur against T.O.P., which isn't listed in any insurance directories checked in advance.

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Wage-loss plan can trim work comp abuse: Study

TALLAHASSEE—A newly released study of workers compensation claims prepared by a Florida employers group should sell the wage-loss approach to even the most steadfast opponent, says its author.

The study of permanent partial disability claims proves that as long as impairment is used as a criteria for awarding compensation benefits, the problem of workers compensation will still exist, explains Associated Industries of Florida vp and general counsel Mary Ann Stiles. Impairment ratings also slight the severely injured workers and cause a mountain of problems for Florida's business community, Ms. Stiles added.

"The system in Florida is too subjective and has too many loop holes which reward the claimant with a minor injury who finds his or her way to an attorney's office," Ms. Stiles remarked.

One of the claims examined by Associated Industries involved a person who lost 10% of the use of a finger and should have been entitled to three weeks of compensation. However, the study shows that someone who loses 10% of the use of a finger is often compensated for 10% of the loss of the use of a hand. The worker consequently reaped 17½ weeks of compensation, creating an overpayment of 14½ weeks.

The study also revealed that of the 412,000 claims filed in 1977, 3%, represented permanent partial disability and of that 3%, 89% involved disability ratings of 10% or less.

Associated Industries found there were so many disability ratings for 10% or less not because a doctor has determined the disability rating, but because it seems to be "the rule of thumb" to settle a case for a 5% to 10% disability rating when a doctor has found no or only a small percent of disability.

In cases studied by the Florida employer group where no disability had been found by a doctor, a settlement was based on an impairment rating of 1% or more in 28% of the cases. Of the 28% who received benefits without the doctor's impairment rating, 98% were represented by an attorney.

Another reason for so many disability ratings in the 10% or less permanent disability area was that in most cases where a doctor did find a disability rating, 68% of the cases studied were paid out at a higher percent of permanent rating than given by the doctor. Thirty-two percent of the cases in the closed claims study were paid out in accordance with the doctor's impairment rating. But the cases settled with a higher doctor's rating, attorneys represented 76% of the cases, the study says.

In 37% of the cases surveyed, the carrier had already accepted the permanent partial disability rating as found by the doctor and had begun to pay out that permanent partial disability rating before the case was settled. However, the insurer eventually paid additional percentages of disability higher than that found by any doctor. Of this 37%, attorneys represented these employes in 88% of the cases.

"Payments for these additional physical impairment ratings based on subjective information has become a very expensive process for the employers of Florida," Ms. Stiles observed. "Associated Industries is not trying to cut benefits to the injured worker who loses income because of his injury; it only wants to stop the generosity of benefits attitude that has permeated the entire workers compensation system."

Based on the findings in this study, Associated Industries maintains the true solution to this abuse of the workers compensation system is to pass an actual wage-loss concept with benefit limitations and to eliminate physical impairment ratings. ■

Florida . . .

Continued from page 1

ing ability is.

An injured worker would receive medical payments and temporary compensation until he reaches the stage of maximum medical improvement. After medical improvement is reached, the wage-loss approach provides a two-step system for compensating the permanently injured workers. It would furnish a lump sum payment determined by the medical severity of the permanent impairment, which will be determined by a physician.

Two-step system

The physician's rating would be based on medically accepted standards such as those contained in a guide published by the American Medical Assn. As a result, periodic payments would be based upon the claimants proven record of actual wage-loss.

In one of their preliminary reports, the committee states that establishing standardized criteria and incorporating a two-step system for compensation eliminates unnecessary litigation and "doctor shopping" by some claimants to obtain excessive benefits.

The amount of benefit payments and the length of time for which insurers are obligated to pay, however, remains one of the major unsettled issues legislators must tackle.

Other suggestions

The joint committee has also voted for a system totally discarding payments made on any kind of schedule for broken arms, fingers, or other minor injuries. Only disfigurement, amputation or loss of sight would be directly reimbursible under the committee proposal.

Other recommendations of the joint legislative committee are:

- Define permanent partial impairment as "any anatomic or functional abnormality or loss after maximum medical improvement or recovery, which is stable or nonprogressive and which results from the injury."
- Place the responsibility for rehabilitation of the employe with the insurance company and employer. The employer and insurer must provide the employe with "appropriate training and education for suitable gainful employment following an injury.
- Provide rehabilitation services for 26 weeks, extend it to an additional 26 weeks if the injury warrants and extend the service beyond this time only at the insurance company's request.
- Allow a claimant to file a claim for medical payments up to one year after he reaches maximum medical improvement.
- Utilize a "peer review" system to monitor medical care to evaluate its necessity, quality and cost.
- Claimant must pay all litigation costs in contested cases. ■

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people

Keltz checks in as risk exec at Sheraton Corp. in Boston

At Sheraton Corp. in Boston, **Geoffrey H. Keltz,** 37, has been named director of insurance and risk management and **Marcia Mackintosh** has been hired as assistant insurance manager. Both report to vp and treasurer Hardy Hasenfuss. Mr. Keltz previously was manager of the Hobbs Brook Agency in Waltham, Mass. Ms. Mackintosh was account executive assistant at Alexander & Alexander Services Inc. in Boston. Mr. Keltz replaces **C. Dickey Dyer IV,** who joined Frank B. Hall in Boston as vp and senior account executive.

* * *

John F. Roskopf, 30, was named to the newly created position of risk manager-casualty for G.D. Searle & Co. in Skokie, Ill. He was formerly at Bliss & Laughlin in Chicago for two years as manager, corporate risk and insurance. At Searle, he reports to Eugene Bader, director of risk management, and is responsible for the pharmaceutical manufacturer's entire casualty insurance and self-insurance program, foreign and domestic. Bliss & Laughlin hasn't yet hired a replacement.

* * *

Brian L. Foltz, 37, has joined Economic Laboratory Inc. in St. Paul as director of corporate risk management, reporting to treasurer Peter Wandmacher. He previously was corporate risk manager for Green Giant Co. in Minneapolis, and has changed jobs because Pillsbury Co. is acquiring Green Giant. Risk management at Green Giant probably will be handled by Carolyn Polkinghorn, who was hired last fall as insurance manager, Mr. Foltz said. At Economic Laboratory, Mr. Foltz replaces Dennis L. Ness, who joined Control Data Corp., as reported.

* * *

At S&H Insurance Co., a part of the insurance services division of the Sperry & Hutchinson Co., two promotions were made. **Richard W. Bender** has been promoted to senior vp while continuing to serve as treasurer and assistant secretary. He joined S&H in 1976 as chief financial officer. **Lynda R. Katsakos** has beer. promoted to assistant vp, continuing her responsibilities as assistant controller.

* * *

Earl "Tommy" Miller, 42, has joined Commercial Metals Co. in Dallas as director of risk management, a newly created position. He left Gardner Denver Co. in Dallas where he was corporate risk manager because the company is being merged with Cooper Industries in Dallas. At Commercial Metals, he reports to chairman of the board, Charles Merritt. Previously, risk management responsibilities were fragmented, Mr. Miller said.

* * *

Steven Ray Benedict, 23, has joined ET Barwick Industries Inc. in Atlanta to help review and possibly revise insurance for the company. He reports to Brett Beazley, director of information systems, who previously handled insurance. Mr. Benedict is a recent graduate of the University of Georgia's risk management program.

* * *

In a newly created position, **H.F. Christadoro,** 38 has been named insurance manager for the petroleum services divisions of NL Industries Inc. in Houston. He is responsible for locally coordinating insurance and loss control functions, reporting to risk manager John Harrington, who oversees insurance for the company from New York. Previously, Mr. Christadaro was a senior financial analyst in the controller's department for Exxon Corp. He has also worked for Exxon's captive insurance company, Petroleum Casualty.

•

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Letters column . . .

Continued from page 14

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Julian G. Y. Radcliffe
Managing director, Investment Insurance International (Managers) Ltd., London, England

Benefit consulting

To the editor: Another copy of your May 29, 1978 issue crossed my desk today. . .as one did some months ago. Many of us at TN&W are sorry that your listing of "18 employe benefits firms" did not include Tillinghast, Nelson & Warren.

Although TN&W is perhaps best known for its services to many of the nation's largest insurance companies, we also have a very large, very effective and very capable employe benefits division. The services of our greatly expanded communications division include the planning and production of all kinds of communication services, print and audiovisual.

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riskWatch

By JOE CAPPO
Crain News Service

Actuaries' figures don't add up if you subtract discrimination

The story, if it appeared at all, was buried amidst the cemetery of sensational stuff and popular puff that the newspapers call news.

It was not front-page fare. And to be sure, the story was not the kind of visual experience we have come to expect from the 10 o'clock news. Nonetheless, it eventually might affect hundreds of thousands of persons.

A small New England liberal arts college had a pension plan for its employes. All employes contributed to the plan at the same rate. But when it came time to collect pension benefits, the monthly payments received by male employes was larger than the monthly payment received by female employes.


Cappo

As reported in *Business Insurance*, a U.S. court of appeals ruled that it is discriminatory for an employer to operate a plan in which men and women contribute the same amounts, but in which women receive smaller benefits.

Similarly, in a 1978 case, the U.S. Supreme Court held that a pension plan could not require a woman to make a higher contribution in order to receive the same level of benefits received by men.

Are these open-and-shut cases of blatant discrimination against women? Not really. There are many who say that there is good reason for women to pay more in pension contributions, or to receive less in benefits, than men.

The reasoning goes like this: Women live longer than men on the average. They will collect these monthly benefits over a longer period of time. When all is considered, women employes on the average are getting just as much as the men.

Are you convinced? That seems to be a pretty tight argument. Who can fault and actuarial formula in which benefits are equally distributed to men and women? The practice is based on hard, cold numbers and on sound business sense, but not on discrimination.

Pardon me, but I disagree.

There is no question that the practice is discriminatory to women. It is discriminatory by the mere fact that the operators of a pension plan would set out in the first place to compare the average longevity of men and women.

Why use sex as the differentiating factor between employes? Why not, for example, use race? If black employes generally do not live as long as white employes, then they should receive higher monthly benefits. . . only to make the total benefits equal.

Fat employes don't live as long as thin employes; maybe they should get higher benefits too. Maybe smokers should get higher monthly benefits than non-smokers. Maybe drinkers should get higher monthly benefits than teetotalers.

Ridiculous? No more so than trying to equalize the benefits paid on the basis of sex. In this society, however, we have chosen to point out the male-female differences. It is neat and easy to do.

But now that women are moving into the work force in such great numbers, I wonder how accurate the actuarial projections are. Perhaps it is true that the average housewife might live longer than the average steeplejack.

Does anyone know, though, whether the average female steeplejack lives longer than the average male steeplejack; or whether the average female professor lives longer than the average male professor?

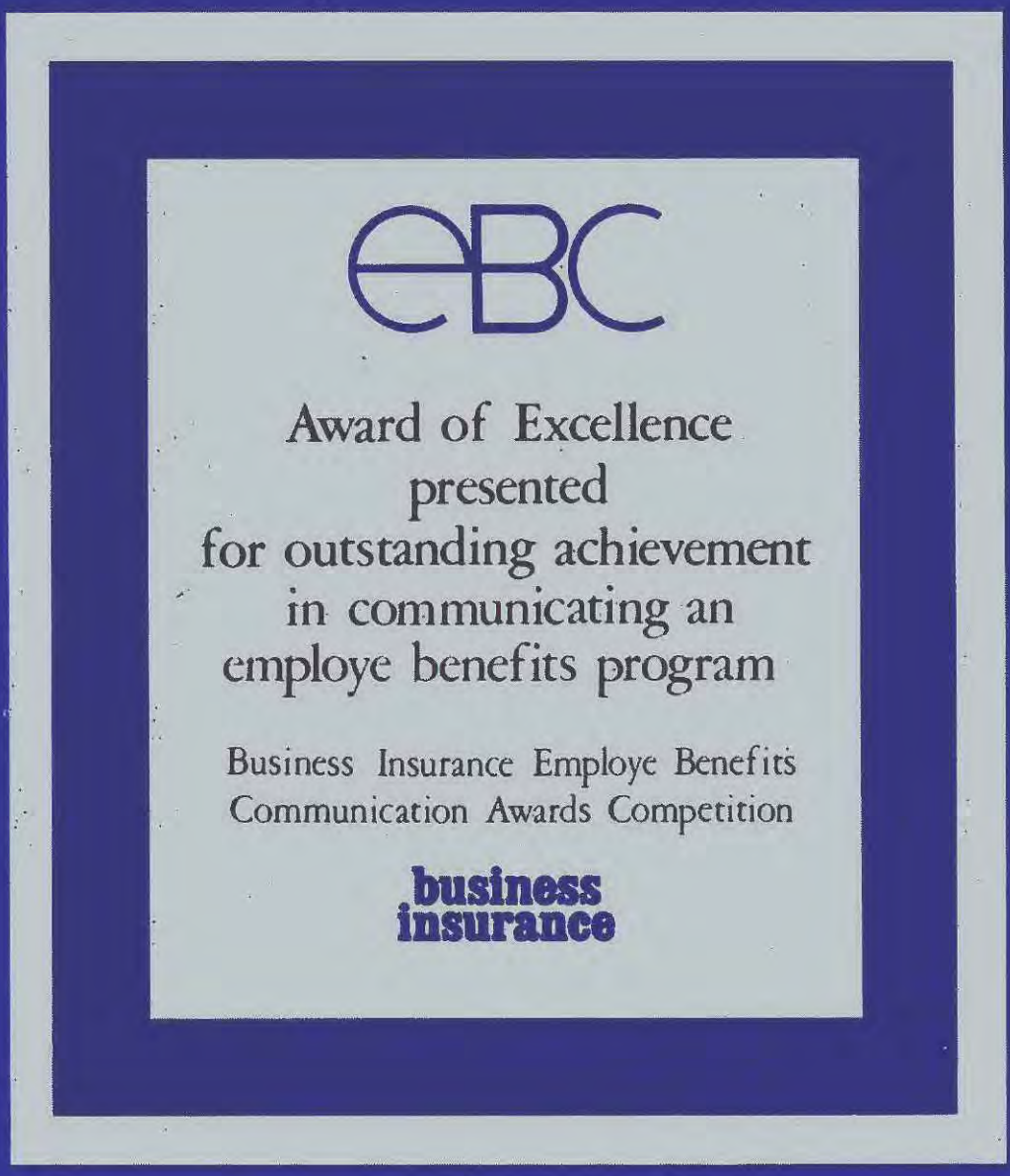
Do women live longer than men even if they are subjected to the same physical risks, the same punishing elements, the same financial pressures and the same on-the-job stress as men?

I don't pretend to know the answers to these questions. And I would welcome a response to them from the actuarial wizards.

I suppose it can be argued that this kind of discrimination against women really isn't intentional or malicious. It has just evolved that way. True. But I think it may be the most insidious form of discrimination because it is the kind that is imbedded deeply in our minds, our society and our business.

It has become part of our way of life. Many women simply accept it because they don't even recognize that they are being discriminated against. As far as most men are concerned, they don't care.

Joe Cappo is editor-at-large of Crain Communications Inc.



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.

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T. Irvin, executive vice president, tells how A&A works from a client's point of view:

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