

American insured with AAU for Islands crash

By MARIE KRAKOWIECKI

NEW YORK—The lead insurer for American Airlines Inc. for the crash of its Boeing 727 jet in the Virgin Islands April 27 is Associated Aviation Underwriters (AAU), *Business Insurance* learned.

Alexander & Alexander is broker for the American Airlines account.

Also involved in the combined hull and liability coverage is the other major U.S. aviation pool, United States Aircraft Insurance Group (USAIG), as well as the London and French markets.

In the French market, two of the underwriters participating in the coverage are La Concorde and Reunion Francaise. They are represented by Robert Malatier of Paris, an airline source confirmed.

The Malatier group, which is also involved in the aviation coverage of Eastern Airlines, again through broker Alexander & Alexander, is gaining a reputation as a growing force in the aviation insurance market. The continental European companies it represents were said to formerly act just as reinsurers for the London market, but are now getting into net lines, or direct coverage for aviation risks.

Thomas Quinn, American Airlines' vp of taxes and insurance, declined comment on the insured value of the Boeing 727 which crashed on landing in Charlotte Amalie, the Virgin Islands, killing 37 of the 88 passengers on board.

However, it is thought that the insured hull value of the jet is in the $3 million range. One knowledgeable industry source estimated that the total reserve for hull and liability coverage would be in the low $20 millions.

Mr. Quinn said the Virgin Islands crash was the first fatal loss American Airlines suffered in more than a decade. He does not expect it to have any affect on the airline's ability to purchase insurance at competitive rates.

The last time American Airlines had a fatal accident was on Nov. 8, 1965, when all but four of 62 passengers died in a crash in Cincinnati. The airline had flown 200 million passengers in the interval before the crash last month, a spokesman said.

The Boeing 727 flight, number 625, originated in Providence, R.I. and landed at Kennedy International Airport before departing for the Caribbean resort island of St. Thomas.

Weather was not a factor in the accident. Rather, the 4,658-foot runway at the Harry S. Truman Airport in St. Thomas has been blamed by pilot groups as the cause of the accident because they claim it is too short to be safe, even though it meets Federal Aviation Administration criteria.

They also charge that two hills off the eastern end of the east-west strip where most landings come in make it even more unsafe. The National Transportation Safety Board is investigating the accident to determine whether the crew touched down too far along the runway, or whether something went wrong with the brakes or thrust-reversal system. ■

THIRD EDITORIAL ADVISORY PANEL REPORT

Property insurance plans told

AN OVERWHELMING MAJORITY of respondents to the third *Business Insurance* Editorial Advisory Panel survey prefers the replacement value form over the actual cash value form for property insurance.

In addition, the 58 companies which completed questionnaires showed surprisingly low retention levels for their fire and allied peril property coverage, considering the values reported.

Some 81%, or 47 companies, stated they use the replacement value form for part or all of their insurable property risks. Average estimated property value for this diversified group of large corporations is $878 million.

While the average property insurance premium for the respondents was approximately $712,000 a year, deductible and self-retention levels remained low, the survey of risk managers shows.

The median property deductible was $25,000 for the 33 respondents who stated they self-insure at least part of their property risks, while the median insured limit for this group was $100 million. Because some of the largest companies participating in the survey self-insure a significant portion of their property risks, the average level of retention worked out to be deceptively higher, or about $240,000.

The average deductible was approximately one-tenth of the average insured limit, or $260 million, for this group of respondents. These survey participants represented 57% of all returned questionnaires.

One respondent stated that his company self-insures all property risks, but no cost or size details were given on the questionnaire.

About 17%, or 10 of the participating companies, gave no indication that they self-insure any portion of their fire and allied peril property risks. Fourteen questionnaires could not be included because the information was incomplete.

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Week of May 17, 1976

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Chief Justice wants a new negligence payment plan

By PAUL R. MERRION

NEW YORK—U.S. Chief Justice Warren E. Burger called for new ways to compensate the victims of negligence and medical malpractice in a speech here last month on the prospects of overhauling the nation's judicial system.

Speaking at the New York University School of Law's Bicentennial Conference on American Law: The Third Century, Chief Justice Burger said one of the major problems with the delivery of justice is that "the institutions and mechanisms, such as the established courts and the administrative or regulatory agencies we have created, today impose inordinate expense and delay on the parties."

Aside from problems in the administration of criminal justice, the Chief Justice identified nine problems in the civil area, including compensation for negligence and medical malpractice.

"We must look for new ways to compensate people for injuries from claimed negligence of others without having the process take years to complete and consume up to half of the damages awarded," Chief Justice Burger said.

"We must explore new ways to provide reasonable compensation for injuries arising out of medical treatment in hospitals and by physicians without the distortion in the cost of medical and hospital care witnessed in recent years," he said.

Overall, the speech was highly critical of the American judicial system and the way it responds to the demands made by society.

The Chief Justice said there are two challenges facing the judicial system "which our whole society must face up to sooner or later.

"One is how to enlarge the availability of dispute-resolving tribunals and mechanisms while reducing unnecessary expense, complexity and delay that are now common experiences.

"The other is how we will resolve the growing tension between the concepts and traditions of democracy, on the one hand, and the growing, inexorable tendency to use the courts as a 'shortcut' for the solution of problems—as distinguished from disputes—problems that in a true democracy should be solved by elected representatives of the people."

He termed previous attempts to improve the judicial process as "tinkering" and said, "We have reached a point in history when we must have profound in-depth examination with respect to all of the legal institutions we employ.

"It is not enough to continue to employ given methods 'because that's the way we have always done it' which is often the only reason given for an obsolete practice." ■

American Home renegotiates policies

By MARGARET LeROUX

NEW YORK—American Home Assurance Co. in late April sent out provisional cancellation notices to holders of liability policies covering workers' compensation and U. S. longshoremen and harbor workers' exposures (referred to as Jones Act coverage), then rescinded them the first week in May, *Business Insurance* learned.

Renegotiations were scheduled for the following week with risk managers of offshore oil drilling contracting firms. The affected insured were expecting premium increases ranging from 25% to 50%.

The underwriter's somewhat unorthodox action—sending the policy cancellation notices directly to policyholders rather than first notifying the brokers involved—occurred during the Risk & Insurance Management Society (RIMS) conference in Los Angeles. The action sent shock waves and rumors throughout the meetings of approximately 1,000 risk managers, because American Home is the leading insurer of U.S. domestic offshore oil drilling liability risks.

"One-fourth of the world market just disappeared," one broker said.

Although the reason stated on the provisionary cancellation notices for the company's anticipated pullback from these drilling liability risks was "underwriting judgment," a spokesman for American Home conceded that two accidents in the Gulf of Mexico in late April in which 25 people were killed within eight days were a major consideration in the underwriter's action.

The two fatal accidents in the Gulf, the sinking of an Odeco oil rig during a storm that resulted in the death of 13 crew members (*BI*, May 3) and the Petroleum Helicopter Inc. (PHI) crash that killed 12 persons, "reminded us that certain types of injuries are not subject to statutory limits of liability," a spokesman for American Home said.

The provisional cancellation notices served to "put a freeze" on the Jones Act exposures while they were being reevaluated, the

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RIMS/Report

14th annual conference coverage from Los Angeles begins on page 26 of this issue.

Insuring employe benefits—page 38

Illinois bills may alter work comp law; rates rising

By JANE WINEBRENNER

CHICAGO—Insurance companies writing workers' compensation insurance in Illinois asked for a 24.3% increase in rates last month while 13 amendments were introduced in the Illinois House and Senate to reform the present workers' compensation situation.

Insurance companies, through the Insurance Services Office (ISO), have requested a hearing before the Illinois Department of Insurance on June 1 to state their case for the increase. Workers' compensation rates were increased 48% last July in response to a new Illinois Workers' Compensation law that substantially liberalized benefits.

Richard Seligman, chief counsel of the Illinois Department of Insurance, said the actual increase in workers' compensation rates since July has been about 88%. He said the insurance companies usually receive the increase for which they ask.

On the same day of the rate increase announcement, 13 bills were introduced into the Illinois House and Senate at the urging of the Joint Employers Council which includes the Illinois Manufacturers Assn., the Illinois Chamber of Commerce, the Chicago Assn. of Commerce & Industry and Illinois Coal Producers Assn.

Douglas Stevenson, the Illinois Manufacturers Assn. (IMA) workers' compensation chairman, said the proposed increase in rates was "horrible" and claimed the actual compounded rate increase is 151%. He called workers' compensation rates the "last straw" in Illinois' unfavorable business climate.

According to Ron Nelson, director of industrial relations for the IMA, the 13 bills introduced would do the following:

- Reverse the Occupational Diseases Act which now does not require a disease "have its origin" in the employment to be compensable but only be aggravated by the employment.
- Do away with the present unlimited death benefits for survivors up to 50% of the deceased's income for life.
- Restore differential rates between permanent and partial disability and temporary and total.
- Reduce the weekly disability benefits from 66% of salary to 50%.
- Require the Illinois Industrial Commission take into account prior disability when evaluating cases. (Currently compensation is due for lifetime accumulation of employe disability unless the prior disability, such as sight or hearing loss, already has been compensated.)
- Do away with automatic escalation clauses.
- Require a panel of state-approved physicians to screen cases.
- Do away with employer penalties for delays in litigation.

Several insurance companies said they have begun restricting writing of workers' compensation insurance in Illinois and the high rates have caused some manufacturers to consider moving out of Illinois. (*Business Insurance*, April 5).

Illinois state Sen. John Graham, sponsor of the workers' compensation amendments, said he expects they will be voted on by June when they get out of the Senate Committee on Industrial Affairs.

Sen. Graham said he expects some compromise can be reached with the Democratic majority. He is anticipating problems with the amendments calling for a 50% maximum of weekly pay for disability payments and the "aggravation" clause to the Occupational Diseases Act.

Gilbert Deavers, sponsor of the amendments in the House of Representatives, also expects a compromise bill before the end of the current session ending July 1.

The amendments are currently held up in the House Rules Committee but he expects them to be sent to its Labor and Commerce Committee shortly.

He agreed with Sen. Graham that the 50% of average weekly wage for disability pay is the biggest obstacle.

If the new amendments should pass and the ISO receives its 24% rate increase in the meantime, there is a procedure set forth in Illinois insurance laws for rate reduction.

According to an attorney in the Illinois Department of Insurance, hearings would have to be held again and the state insurance commissioner, Robert Wilcox, would have to prove the rates were too high.

Richard Seligman, counsel of that same office, said that up until a week before the ISO filing, he had heard insurance companies quoting loss figure deviations of 10 to 15%. "We wondered why all of a sudden the ISO asked for 24%," he said.

Jack Burke, manager of the Illinois ISO office, said the new workers' compensation law made present rates inadequate.

"At the time the new law passed, we tried to evaluate the bill based on benefit levels. Since the new law, the changes have been so sweeping it's impossible to evaluate," Mr. Burke said.

Some possible explanations of the 24% increase according to Mr. Seligman, is that insurance company actuaries found the results were worse than first anticipated and the new benefit levels required larger reserves.

A survey of workers' compensation carriers conducted by the Illinois Department of Insurance is nearly completed according to Mr. Seligman. He said its tentative results show a 10 to 12% insurance contraction since last July but he said not all companies have reported yet.

He said the insurance department has turned down an ISO rate request only once before, that in December of 1975 when they asked for 9% and received 3%, because the ISO used a trend factor for most of the rate request.

Mr. Seligman said this time the ISO is prepared to justify its use of the trend factor in workers' compensation rates which used to be a very stable area. Last December the state felt the insurance trend factor was "inappropriate."

According to one Kemper Insurance Co. spokesman, the 24.3% increase can be broken down into a 1.5% increase for benefit changes; 7.5% experience; 10% loss trending; and 5% contingency.

Another set of subcommittee hearings started in late January of this year have been extended past the March 30 concluding date. The Insurance Laws Study Commission subcommittee hearings on workers' compensation have heard testimony from major insurance company and manufacturing executives who have operations in the state.

Mr. Stevenson of the IMA said he does not blame insurance companies for raising their rates in Illinois and added that he doubts they will recover their losses.

"The increases thus far have been based on proven experience but there's been so little experience since July," Mr. Stevenson said.

While the two sponsors of workers' compensation legislation in the Illinois General Assembly are certain the law will be changed, others have not been so optimistic. The Illinois House and Senate have Democratic majorities and there is a strong labor lobby there.

Sen. Graham, however, said several Democrats have indicated to him their intention to reverse their original position in favor of the amendments.

The ISO is the sole rate filing agent for the approximately 275 insurance companies writing workers' compensation insurance in Illinois. The National Council on Compenstion Insurance computed the proposed increases.

Among the other conditions manufacturers hope to change is the Illinois Industrial Commission's authority to revoke a company's self-insured status on workers' compensation. ■

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Would pay half cost for safety/health plan

WASHINGTON—The federal government would foot half the cost of setting up a job safety and health plan only for public employes in states that do not have such plans, under proposed regulations from the Occupational Safety and Health Administration.

Currently, states that have their own OSHA plans must extend protection to state and local government workers. But states that rely on the federal OSHA program do not have to apply the standards to public employes.

"This lack of coverage has been a real dilemma to us," said Dr. Morton Corn, Assistant Secretary of Labor for OSHA. "It has left a sizeable segment of the workforce, including many workers, exposed to uniquely hazardous conditions, without occupational safety and health protection."

Twenty-three states have developed state OSHA plans that also cover public workers. That leaves 31 states or jurisdictions in which state and local employes have little or no job safety protection.

A recent ruling by Labor's solicitor's office, however, suggested that the 1970 OSHA law does allow for federal approval and funding of a state plan to cover only public employes, Dr. Corn said.

Sixteen jurisdictions have expressed interest in setting up such a plan, according to the Labor Department. They are: Massachusetts, New York, Pennsylvania, Delaware, West Virginia, Alabama, Ohio, Wisconsin, Missouri, Kansas, Montana, South Dakota, Virginia, Idaho, District of Columbia, and American Samoa. ■

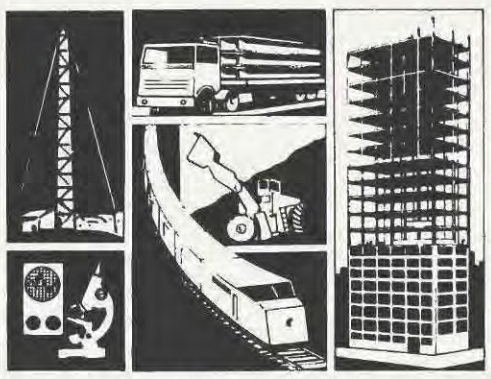
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First place winners for best communication programs to inform employes about their benefits were, left to right, Larry Ewing of Hewitt Associates, Consultants; Don Ward, Medtronic Inc. winner of the personalized correspondence category; William Mohr, American Can Co., winner of the audio-visual competition; Judith Starkey, Chemetron Corp., booklets category winner; and Richard Cromer, Hewitt Associates, Consultants.

Benefit plan communicators win BI award competition

LOS ANGELES—Owens-Corning Fiberglas Corp. of Toledo, Oh., Chemetron Corp. of Chicago, Medtronic Inc. of Minneapolis, and American Can Co. of Greenwich, Ct. walked off with top honors in the fourth annual Employe Benefits Communications Competition sponsored by *Business Insurance* magazine.

RIMS/Report

Awards were presented to the winners here at a luncheon during the employe benefits segment of the Risk & Insurance Management Society's annual conference.

Winners were selected from entries submitted by a record number of companies. Six judges who are expert communicators themselves reviewed a total of 108 different benefits communications programs submitted by 83 corporations. Entries were classified according to four categories: Booklets, personalized correspondence, audio-visual and total communications programs. The competition each year honors employers for excellence in communicating to their employes the benefits the company offers to them.

Owens-Corning Fiberglas Corp., Toledo, was the first place winner for excellence in the area of total communications. Runners-up in that category were Continental Can Co., New York City (second place), and Chemetron Corp., Chicago (third place). Owens-Corning Fiberglas, which employs 17,000 people, put together its own multimedia benefits communication program; both runners-up used Hewitt Associates, Deerfield, Il. as consultant on the program.

Chemetron Corp., Chicago, won first place in the benefit booklets category, for its indexed catalog with a benefits summary. Second place winner was Continental Can Co., New York City, and third place winner was Birmingham News, a division of the Newhouse Group, worked with Employe Communications Services Co., Birmingham, as consultant.

Medtronic Inc., a biomedical engineering and manufacturing company in Minneapolis, was judged to have the best personalized correspondence program for communicating benefits to employes. Second place in the personalized correspondence category went to Xerox Corp., Stamford, Ct. Third place winner was Pfizer Inc., based in New York City.

Consultant for the Medtronics correspondence program was Hewitt Associates. Xerox used two consultants: Hewitt Associates and Benefacts Inc. (a division of Alexander & Alexander). Pfizer put its own program together.

The best audio-visual communications entry was judged to be American Can Co., Greenwich, Ct., which is known for its communications by means of packaging and containers, as well as consumer paper products. Dow Chemical Co. U.S.A., Midland, Mi., was the second place winner for audio-visual communications, with a program produced by its own internal audio-visual department. Richardson-Merrell Co., Wilton, Ct., took third place honors in the audio-visual category.

Hewitt Associates was the consultant to audio-visual winner American Can Co. William Charmatz of New York City was the consultant for Richardson-Merrell's program.

Judges for this year's competition, drawn from the communications field in a variety of business applications, were Alvin Kracht, senior vp and account manager at Warwick, Welch & Miller, a major New York advertising agency; Bernard Finnegan III, vp of public affairs for McGraw-Hill Inc.; Roy W. Lawrence, Chartered Life Underwriter and manager of employe benefits for Ciba-Geigy Corp., and himself the first-place winner in last year's audio-visual category of the competition; Bruce Abrams, vp and director of public relations at The Continental Insurance Cos. and its parent company The Continental Corp.; Edward Moore, manager of executive compensation for CBS Inc., and Robert Vivian, vp of corporate communications for Crum and Forster Insurance Cos. ■

Lower costs plus tax advantages favor LTD

NEW YORK—The relatively low cost of long-term disability (LTD) coverage plus the tax advantages of LTD benefits to employes are factors in determining who pays for the insurance, according to a study of 113 large industrial companies conducted by Towers, Perrin, Forster & Crosby, a consulting firm.

In 44 of the companies surveyed, the employe pays 100% of the plan cost which averages between one-half and one percent of payroll. As a result, the employe does not pay taxes on the LTD benefits, the firm found.

The employe contributes to the LTD plan in 30 other companies, and the benefits are tax-free in proportion to the employe's percentage of payment toward the cost. In 22 of these companies, the employer and employe share the premium, the study stated.

Contributions are shared on pay over a stated amount in five of these 30 firms; in two other organizations, the employe pays the full cost of coverage for a specified period, after which the company shares the cost. In one company, the employe pays part of the premium until reaching a specified age after which the company pays the full cost.

The remaining 39 companies indicated they have non-contributory LTD programs, Towers, Perrin, Forster & Crosby revealed. ■



Winners in the personalized correspondence communications category, left to right, were Larry Ewing, Hewitt Associates; William Burlew, Benefacts Inc.; Don Ward, Medtronic Inc.; and Richard Harvey, Pfizer Inc. Hewitt acted as consultants jointly with Benefacts on the Xerox program, which was awarded second place.



Presented with awards for having the best total programs for communicating benefits to employes were, left to right, Richard Cromer of Hewitt Associates, consultant for Chemetron Corp.; Judith Starkey, Chemetron Corp.; T. E. Tappen, manager of industrial relations for the Pacific area, Continental Can Co.; and Ronald Kleiman, Hewitt Associates, consultant for Continental Can Co.



Winners having the best audio-visual benefit communications programs were, left to right, Dennis Green of the audio-visual department at Dow Chemical Co.; Milford Hooker, creative director of personnel relations, Dow Chemical U.S.A.; and William Mohr, American Can Co.

The CIA is thriving member of the international insurance community

WASHINGTON—The Central Intelligence Agency owns, operates and earns about $2 million a year from several insurance companies, mostly located abroad, according to a Senate committee report.

With a net worth of about $30 million, the insurance complex is by far the largest of the private companies owned by the CIA, now that two CIA-owned airline companies in Southeast Asia are being disposed of, the report said.

The agency went into the insurance business in 1962, following the Bay of Pigs invasion, the report said.

Retired CIA general counsel Lawrence Houston told the Senate intelligence committee:

"The event that brought it into focus was the death of four airmen in the Bay of Pigs. These men were not supposed to have engaged in the fighting and were training on the mainland, but when the Cubans were either exhausted or unable to fly anymore, they pitched in, went over the beach, and were shot down.

"Through (an ad hoc) mechanism we paid benefits to the family for a considerable length of time until we were able to turn it over to the Bureau of Employes Compensation.

"This was a very makeshift arrangement, and so based on that I came to the conclusion that we needed a much more formal and flexible instrument. And so after long consideration with the agency we acquired the first two insurance entities which had been in being before and then we flushed them out a little bit."

The insurance complex exists mainly for the benefit of CIA spies who are not entitled to participate in the CIA retirement plan or in the civil service retirement plan, the report said. Most of these agents are foreigners who, because of security considerations, cannot receive payments that might be traced to the U.S. government, the report added.

The insurance complex handles escrow accounts for foreign agents, writes insurance for otherwise uninsurable agency operations, and provides term life insurance, trusts and workers' compensation coverage for those not eligible for U.S. plans, the report said.

Most of the assets of the companies are held outside the U.S., the committee reported, and investments run the gamut of notes, bonds, debentures and common stocks in both foreign and domestic markets.

Currently, 60% of the investments are in long term fixed income securities overseas, 20% in off-shore time deposits in U.S. banks, and the balance in common stocks, debentures and commercial paper of various types, the report said.

Profits in excess of $500,000 have been realized in the last 12 years from the sale of stocks, the report noted.

The committee cleared the CIA of charges raised last summer by Rep. Robert W. Kasten Jr. (R-Wi.) that the agency might have used inside information to beef up the earnings of its pension funds.

Reportedly, the CIA's investment adviser did recommend some stock transactions based on CIA economic analysis, but Mr. Houston said he rejected those recommendations because the CIA had large contracts or some other relationship with the company.

The CIA told the committee there are three safeguards against the use of inside economic information: compartmentation (of functions); the integrity of the chief of the cover and commercial staff (which oversees proprietary operations); and the disclosure of portfolios to appropriate congressional committees.

A major concern of the Senate intelligence committee during the investigation was that profits from the insurance complex and other proprietary projects could be used to finance covert operations, thus keeping them outside of budget authorization and free from congressional scrutiny, a committee spokesman said.

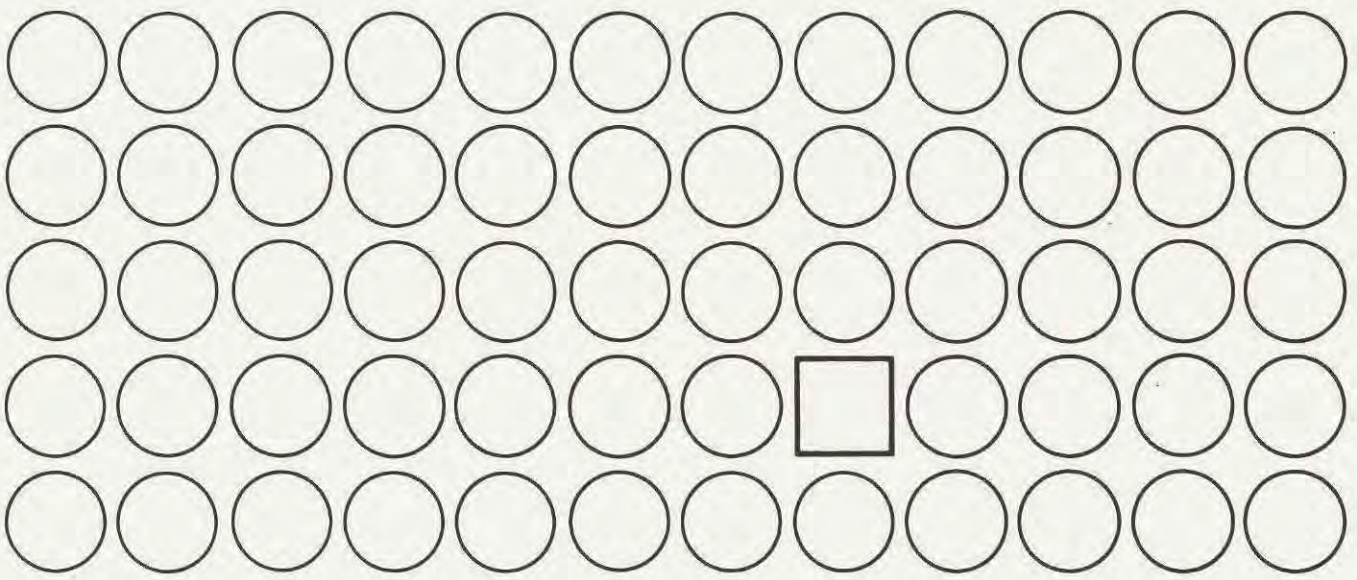
The report said that in some instances prior to 1975, profits from the insurance and investment operation went into the CIA's contingency reserve fund, for later release to operations. However, the CIA general counsel ruled in 1975 that profits must be turned over to the U.S. Treasury as miscellaneous receipts.

The committee also cleared the CIA of using financial transactions of the insurance complex to upset foreign stock markets or currencies. Even if such an effort had been made, the committee concluded, the size of the funds would not be sufficient to destabilize any market or currency.

The committee report said the CIA has a long-standing plan to use the insurance complex to establish several corporate "shells." They are legally constituted and registered companies that do very little commercial business but which can be adapted to new CIA missions. The existence of shells avoids delay in creating new corporate entities, with the complications of local laws and risk of exposure, the report noted.

In conclusion, the committee said it is mindful of the potential danger inherent in such operations, and it recommends that future oversight intelligence committees be "most stringent" when they review the insurance complex and other CIA proprietary projects. ■

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Corroon takes over Synercon

NASHVILLE, TN.—Synercon Corp. and Corroon & Black Corp. today consummated the business combination of the two companies which was approved by their shareholders on April 29.

Richard M. Miller, president and chief executive officer of Synercon, and Robert F. Corroon, chairman and chief executive officer of Corroon & Black, said that as a result of the merger consummation, Synercon is now a wholly-owned subsidiary of Corroon & Black.

Terms of the transaction involve the conversion of each outstanding share of Synercon common stock into .6412 of a share of Corroon & Black common stock. Based on the number of Synercon shares outstanding, approximately 1,005,945 Corroon & Black shares are being issued.

Synercon, based in Nashville, is an insurance holding company with operations primarily in the southeastern United States. Corroon & Black Corporation, headquartered in New York City, is an international insurance brokerage firm. ■



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Official wants policies to cover pregnancy ills

TRENTON, N.J.—A regulation that would prohibit insurance companies from refusing to cover any illness that occurs during the course of a pregnancy even though it may be unrelated to pregnancy itself has been proposed by New Jersey's Insurance Commissioner.

Commissioner James J .Sheeran's proposed regulation would define complications of pregnancy in part as: Conditions requiring hospital stays (when a pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy such as acute nephritis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity.

If adopted, the regulation would provide that no insurance company could treat complications of pregnancy differently from any other ailments under any contract of insurance.

Some of the practices of the industry that treat complications of pregnancy differently from other ailments the Commissioner said, include excluding complications of pregnancy from coverage under health insurance policies.

Other practices require longer waiting periods for coverage of complications of pregnancy to begin than for other sicknesses or illnesses and treating complications of pregnancy as pre-existing conditions, excludable from coverage when only the pregnancy pre-existed the coverage.

"I want to stop insurance companies from using a pregnancy as an excuse for not covering an illness such as a heart attack, that probably would have occurred even if the woman were not pregnant," Commissioner Sheeran said. ■

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Bar Assn. offers plan for young lawyers

CHICAGO—The American Bar Assn. (ABA), through the association's endowment group, has begun a special group health and life insurance program for its members under age 36.

Group term life, in-hospital indemnity, major medical and disability income coverages are offered on a non-medical enrollment until May 24 as a means of introducing lawyers to the plan.

New York Life Insurance Co. and Mutual of Omaha Insurance Co. underwrite the life and health benefits insurance for the 2,000 young lawyers who have enrolled in the program so far and 70,000 ABA lawyers enrolled in other endowment group programs.

The endowment office declined to say how much in premiums it pays for the programs but the cost to the young lawyers is under $100 a year. However, the medical deductible is $10,000.

Lawyers over age 36 can receive coverage at higher rates and without the medical waiver.

The program is designed specifically for young lawyers who may need additional insurance or need basic protection. The benefits in the ABA's program include: $20,000 of group term life insurance; $360 monthly disability income; $40 daily of hospital indemnification over and above existing hospital coverage; and 100% of major medical costs up to five years after a $10,000 deductible. ■

German affiliate formed

Allendale Insurance has established a branch office of Affiliated FM Insurance Co., a subsidiary, in Frankfurt, Germany. The company is licensed to write direct insurance in Germany and reinsurance throughout the European economic community. The affiliate will focus primarily on property coverage but it will include other insurance lines also. Affiliated FM Insurance Co. is now licensed in the U.S., Puerto Rico, the Bahamas, Canada and France.

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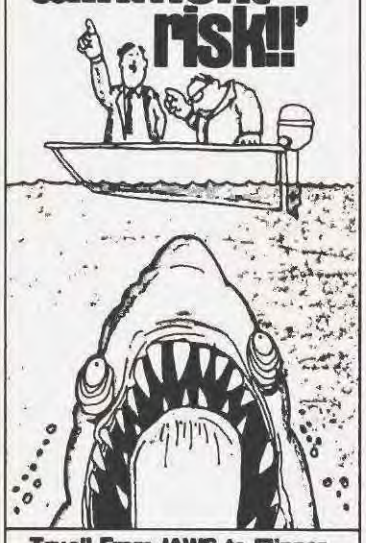
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Assets insured for replacement . . .

Continued from page 1

Nearly 97% of the respondents stated that they insure their property to value. Only two respondents do not insure to value.

One questionnaire stated that its company intentionally underinsures its property risks, while 25 said their corporations do not follow this practice.

Fewer than half of the respondents, or 20, indicated that they prefer the actual cash value form for property risks. As stated above, the vast majority use the replacement value form.

A large agribusiness company prefers the actual cash value form at most of its locations because it is "too expensive to go full replacement at all locations."

"Any real property which would not be replaced if destroyed is insured on an actual cash value basis," stated the risk manager for a company with more than $500 million in total property values.

But an insurance and financial holding company, where the replacement value form is used "99%," obviously would disagree. The actual cash value form is "rarely" used, being reserved for older buildings "where we would not replace the structure if destroyed," the respondent stated.

A metals manufacturer insures property with the actual cash value form "to minimize our insurance premium costs. Our excellent loss ratios are a major factor in the decision, i.e., replacement cost or ACV," noted the risk manager for this company with $1.4 billion in property values.

The company reporting the largest estimated property value, $10 billion, "mostly" uses the actual cash value form.

An industrial enterprise reporting over a billion dollars' worth of property insures its equipment on a replacement value basis but its buildings on an actual cash value basis, the risk manager revealed.

One respondent candidly pointed to "differing financial philosophies within operating companies" as the reason his holding company insures some property for actual cash value. "Most is covered under a replacement form," he stated.

An electronics and computer producer covers buildings at replacement cost, contents at actual cash value and leased equipment at manufacturing cost. This firm has more than $1 billion in estimated total property values.

The list of replacement-value-form advocates is considerably longer. One county risk manager uses the replacement form because "to insure under actual cash value would be to suffer a significant loss because of depreciation (on older municipal buildings). The county needs replacement costs (coverage)," he stated.

A building materials supplier prefers the replacement form also, citing the "increasing cost of construction" as the reason.

The risk manager for a diversified rubber company prefers the replacement value form because it "eliminates the need to fund or budget for depreciation following a loss," he wrote, noting "simpler value calculations (which) follow going-business concepts and thereby prevent surprises at loss time and speed loss settlements." Actual cash value forms are used "only when significant functional obsolescence is involved," the respondent stated.

"We are a non-profit institution which derives no tax advantages from depreciation write-offs," emphasized a university risk manager explaining his decision to use the placement value form. "If we lose a building, we want to replace it."

A forest and paper products company with $1.2 billion in property stated: "In times of escalating rebuilding costs and with a number of older plants, we feel the replacement value form is best for the corporation."

Where inflation is a considerable factor in repair or replacement such as for buildings, machinery and equipment, and furniture and fixtures, the replacement form is used, said the risk manager of a consumer products manufacturer with estimated property values of $200 million. An actual cash value form is preferred for inventories and vehicles, however.

An exporter with an estimated $250 million in property value uses the replacement value form that is the "broadest in scope available." The risk manager wrote: "Although the property may be fully depreciated, a major loss would result in depletion of capital in addition to the lost property."

The replacement value from "is the only form which can truly indemnify our loss," said one respondent, indicating property values of $500 million. "The real value of our property lies in its productive use, not in its cash exchange value. As such, we must recover sufficient funds to replace the "productive" value," this manager reasoned.

Sixty percent, or 35 companies, said they insure business interruption under a gross earnings form, while 23%, or 12 respondents, indicated they use a form which includes contingent business interruption, the *BI* survey found.

Two companies stated they do not insure against business interruption, and 10 questionnaires did not indicate which, if any, form is used to cover the risk.

A large chemical company said it does not insure business interruption under a gross earnings form. "Coverage is included in a blanket amount covering physical damage and business interruption."

A university said it does not insure business interruption under a gross earnings form either, preferring instead to "carry it as an extra expense. With a large urban campus, only the loss of a major dormitory or a key building in the hospital complex would cause a major economic loss," the risk manager explained.

A paper products company with over $1 billion in insurable property values uses a gross earnings form for business interruption "less ordinary payroll," the risk manager wrote. "Major plants carry ordinary payroll with a 90-day limit."

"We only have extra expense coverage with no coinsurance provisions and without contingent coverage," wrote an equipment rental company with an estimated $5 million in total insurable property value.

A metals manufacturer stated that "contingent business interruption exposures are specifically endorsed. However, contingent business interruption exposure between owned plants is automatically covered by our blanket approach," the risk manager said.

A per diem form was chosen by a petroleum driller and supplier "to avoid difficulties associated with adjusting major losses." This form, which includes contingent business interruption, calculates the coverage limit based on "accounting data, maximum probable loss assessments, insurance capacity available and price."

The sales value of inventory is the basis for calculating business interruption coverage under a gross earnings form for one company with an estimated $500 million in property value.

An industrial company determines its business interruption limit on the basis of "fixed and continuing expense, estimation of length of potential interruption and lost profit potential." ■

Editor's note: Because this third survey gathered detailed information about panel participants' property and liability programs, we have split the analysis into two parts. The next installment will focus on the limits, retention and premiums for all liability risks, as well as cargo and fidelity coverages.

Method set for valuing pension funds

WASHINGTON — The Pension Benefit Guaranty Corp. (PBGC) issued a final regulation earlier this month for determining the valuation of assets of a terminated pension plan.

Plan assets will be valued at their fair market value at the date of plan termination, PBGC said. Fair market value is defined as the value reflected in a generally accepted valuation reference which is readily available to the public.

The final regulations contain a change from the proposed regulations published last December. Securities on the New York Stock Exchange, for plan terminations that occur on or after Jan. 26, 1976, and on the American Stock Exchange, for terminations that occur on or after March 1, 1976, will be valued according to data on the new consolidated stock tapes.

These tapes reflect the closing price of a stock listed on either the New York or American Stock Exchanges, regardless of whether that trade was executed on such exchanges, certain regional exchanges, or in the over-the-counter market.

The valuation of assets regulation is important because it is one of several used to determine whether plan assets are sufficient to pay off accrued benefits. If assets are insufficient, the plan sponsor may be liable for up to 30% of the company's net worth.

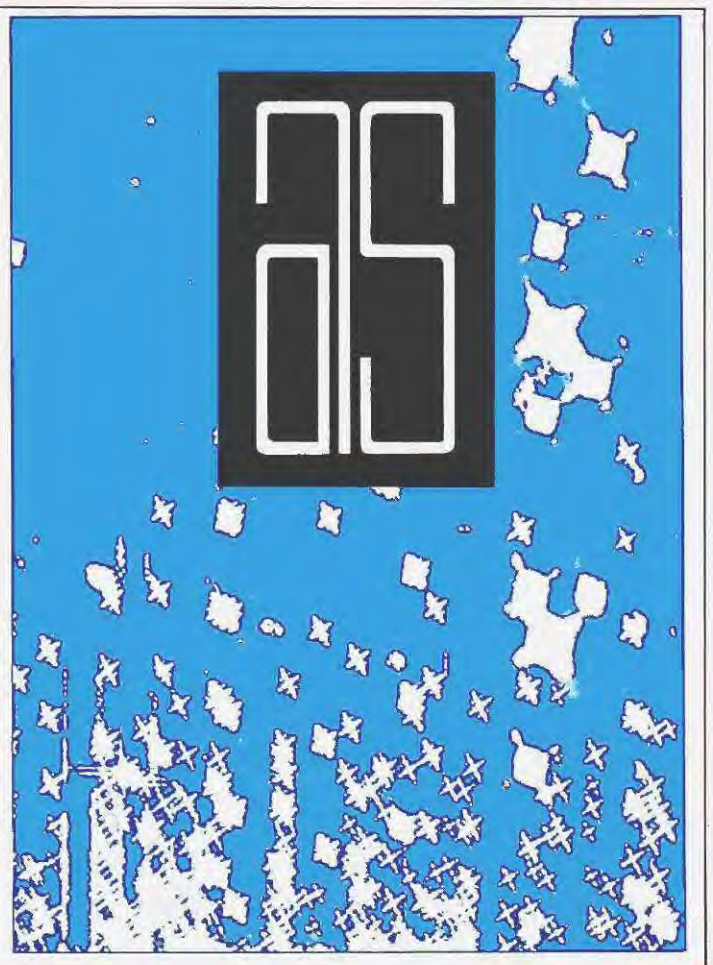
The regulation does not attempt to define the fair market value of annuities and other insurance contracts held as plan assets. PBGC said it expects to issue further guidelines for annuities not covered in the regulation.

Two more regulations are expected to be finished in May, a PBGC spokesman said. These are rules on allocation of assets among retirees and participants, and the valuation of plan benefits. ■

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editorial opinions

The price of submission

INTERNATIONAL terrorism, growing threat that it is, poses difficult problems for employers whose executives travel or live abroad. We've taken editorial stands previously in these columns against kidnap/ransom insurance because we believe that an employer should retain any risk of extortion or kidnap, being encouraged thereby to act in the most responsible manner to prevent a loss of people or money. The presence of insurance as a financial buffer, we believe, might cause a company to cooperate a little more easily with kidnappers' or terrorists' demands, which in turn encourages more kidnappings and terrorism.

In fact, just recently Owens-Illinois learned its lesson about cooperating with the demands of kidnappers against the wishes of the Venezuelan government, which has been trying to contain and prevent terrorism in that country. After Owens-Illinois learned that its Venezuelan general manager had been kidnapped and threatened with execution, the company complied with certain kidnapper demands in order to save his life.

But fast on the heels of Owens-Illinois's cooperation came news of the Venezuelan government's decision to nationalize (in other words, expropriate) all the company's operations in Venezuela as punishment for cooperating with the terrorists, and to deter other companies from capitulating in the same manner.

Obviously, this is a difficult problem. But Owens-Illinois went against the express wishes of a government trying to counteract terrorism. The manufacturer printed ads in three leading international newspapers and made payments (equivalent to $116) to each of its Venezuelan employes to comply with kidnapper demands. Incidentally, the U.S. government also has stiff laws prohibiting cooperation with kidnappers. (To date, Owens-Illinois' efforts to effect the victim's release still haven't succeeded.)

At this point, it's difficult to say how many ransoms have been paid and kidnap victims saved or lost. But we don't think it's doing the cause of justice or crime prevention any good in any country for corporations or individuals to succumb easily to kidnap/ransom demands.

A cavalier attitude

ACCORDING TO the laws of economics, when prices for a product or service go too high, consumers stop demanding and buying those products. This is just what's happening with doctors and malpractice insurance.

"Going naked" is becoming increasingly popular among doctors willing to gamble that if they don't buy malpractice insurance, either they won't be sued or if they are they can successfully "hide" their assets to the extent that their personal fortunes will not be despoiled. Physicians' outcries over the very large increases in malpractice rates have been heard loud and clear across the land, as the tales have increased of doctors in the riskiest fields of medicine being asked to pay upwards of $20,000 and $30,000 a year for individual coverage.

Granted, these rates and premiums are very high. Considering some figures we've heard on the other side, though, about doctors' annual incomes, we're not entirely convinced these premiums are unaffordable in all cases.

Furthermore, there's a very real danger that doctors who don't buy any insurance and are, indeed, found guilty of malpractice which hopelessly mangles or injures a patient—and there are a lot of doctors around who have practiced sloppy and injurious medicine—won't bear the financial burden of that malpractice. The way the American system of law works, when a person is injured through someone else's fault, the person causing the injury is made to pay.

Now some doctors are setting up trust funds and other financial protection arrangements in the event they have a malpractice claim but do not have insurance coverage. Others are doing nothing, and seem almost gleeful about the prospect that no one can get anything out of them.

We think that's wrong. Professional practicioners should not in any way be encouraged to be careless or cavalier about the harm they have the power to inflict on others.

Although more regulators and regulations are not a very palatable thought, we believe the state medical societies should mandate that all doctors practicing in a state should show a certificate of financial responsibility or a certificate of insurance in order to be able to practice medicine.

Commercial businesses often have to present these certificates of insurance or another indication of financial stability and responsibility, before they can do business with other organizations.

Perhaps doctors should be required to display, along with their medical certificates, a certificate of financial responsibility.

Policyholder's job

A WELL-KNOWN risk manager now on the West Coast but formerly in the Midwest opined recently that "it's only natural for an insurer to react negatively to new or growing risks out of fear and ignorance." He was referring to underwriters' fears of mushrooming malpractice risks.

This manager's enlightened approach to dealing with insurance companies is that it's the insurers' job to react negatively and protect their own vested interests when they're afraid but ignorant about newly-emerging trends.

But, then it's the risk manager's job to educate and inform the insurers, and indeed, the brokers, about the nature of risks and potential loss exposures posed by the operations and assets the risk manager needs to protect and insure at the best possible cost. Since the insurers themselves seldom seem to have any actual loss experience to document their fears, the risk manager must gather statistics and provide them to the insurer, in the way of "selling" the risk to the insurer, advises this particular risk manager in his most appeasing voice.

The essence of the message was wise: Don't slap at insurers for being afraid and ignorant about risks. Educate them. And then slap them if they don't respond to your insurance needs after you've done the necessary educating.

Better a carrot than a stick when dealing with the insurance industry. This philosophy might be particularly applicable now, with tight markets for liability coverage.

letters

Letters are welcome. Address letters to the Editor of Business Insurance, 740 N. Rush St., Chicago, Il. 60611.

Encouraged

To the Editor: I certainly appreciate the April 19 editorial opinion "Time For Straight Talk". I am very much encouraged by your statesmanlike position encouraging not only the small but the large insurance manager to appreciate the basics of insurance and not "decry the fact that 'being penalized' for some other policyholder's bad loss experience by having to pay what some see as unholy premiums?" As you say "isn't that part of the concept of risk-pooling, i.e., insurance?"

We certainly have always thought so.

Wilbert Kedrow, CPCU
vp, marketing, Milwaukee Insurance, Milwaukee, Wi.

Agree on threat

To the Editor: I have to agree with the letter of Harvey Rooks in the April 5 issue of *Business Insurance*. Insurance has become a threat to capitalism.

We have insureds who are small corporations and who must sell their products to the large corporations in order to survive. One requirement is that they furnish certificates of products liability insurance. We have insureds who can't get the insurance. It isn't because of their loss experience because they never had a loss.

Others are being charged surprising increases. One insured paid $750 a year for products liability. He never had a loss, not even a claim in the underlying coverage! His renewal premium is $7,800. Another insured whose products liability premium was $400 last year now pays $4,000.

As Mr. Rooks points out, the final result must be that only the big business is left. The little business will be gone and so will capitalism.

Ford Bell
Joe West Co., Tulsa, Ok.

Bob Hedges responds

To the Editor: I saw it—my name in the middle of Waller Smith's commentary, in the March 22 *Business Insurance*, on FASB 5. I *am* interested, and therefore now enter the following comments.

First, the *prime* arrow in the risk manager's quiver is loss reduction. But planned risk retention with proper regular charges for same is indeed one of the other important reasons:

(1) Given the whole collection of problems the Financial Accounting Standards Board considered itself attacking when it considered that standard, plus the

Continued on page 12

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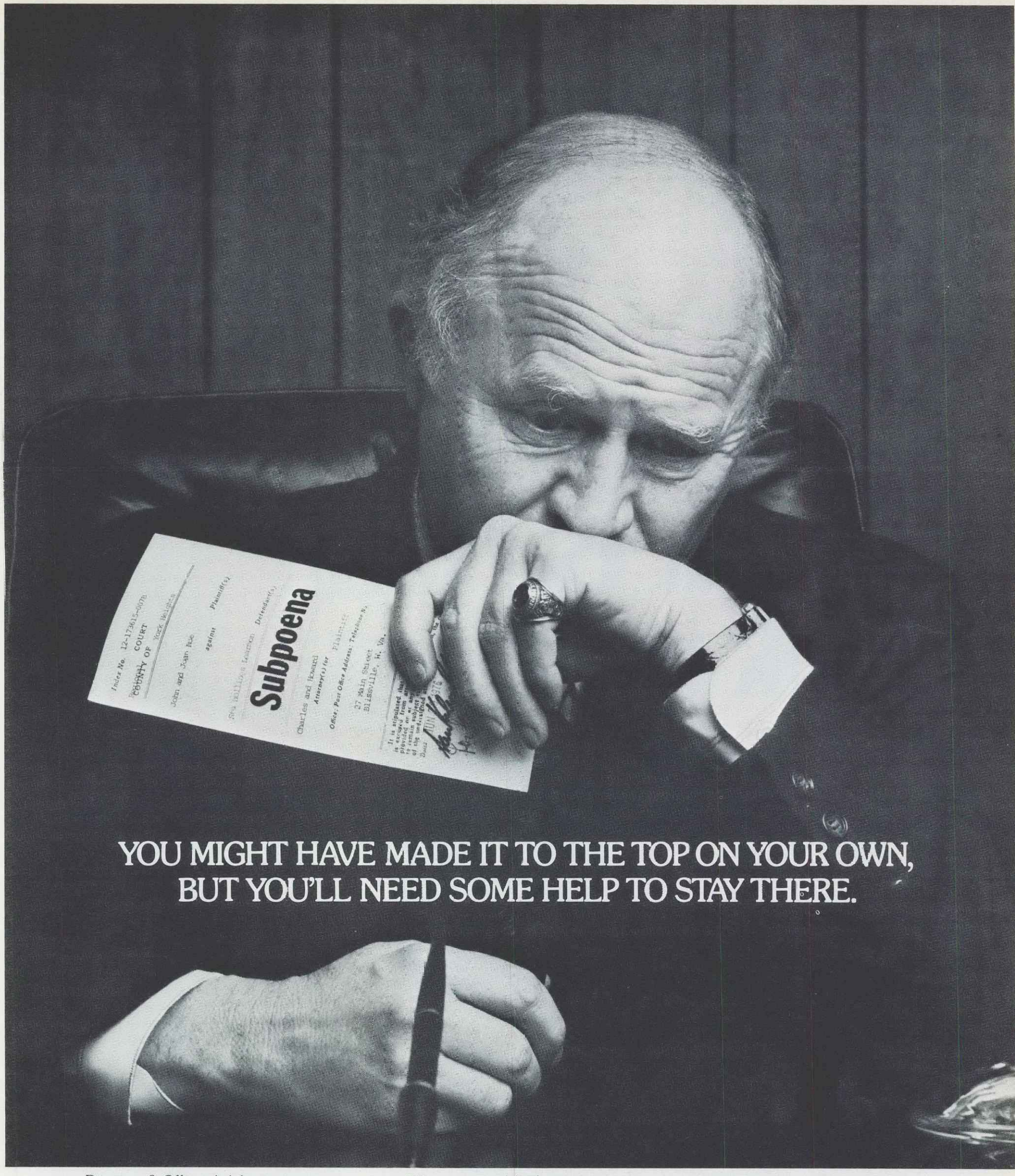
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letters

Continued from page 10

pressures and milieu around it, *and* the way accountants approach and think about accounting and its procedures—these suggested the probability of heading them off was not sufficiently different from zero to warrant great effort.

(2) As you noted, practicing insurance and risk managers did not seem greatly upset about it. Indeed, some told me it made no practical difference to them. This not only reduced the probability of effective opposition, but suggested no need for great haste in tackling the question. One of the virtues, and an important advantage of academic responsibility, is that time for thought and rethought is available, and is supposed to be taken. Indeed, this is one of the major reasons why academics should exist. So I have been leaving the question subject to incubation expecting eventually to hatch something that would speak to, and be heard by, accountants (and the SEC) in terms understood by and persuasive to them.

This desired conception has not hatched yet, but I can suggest its parentage, which says something about the eventual offspring. On one side it descends from a strong irritation over emphasis on the amount of time it happens to take the planet Earth to complete an orbit about its sun. In agriculture, this is an important period. But for *everything*? Suppose we were on the planet Pluto. Would the appropriate accounting period then be the equivalent of 248 Earth years? There *is* averaging within the standard accounting period. What is at issue might be fairly described as the question of averaging between conventional accounting periods, *or* lengthening the accounting period within which averaging is allowed.

The other parent is the existence of some regularities that do not happen to fall within the traditional one-year accounting period. But they must be well identified—not just to avoid the negative effect of abuses in use of the averaging concept but even more to create the positive result of better management (and financial reporting) by proper employment of it. But I have not had sufficient empirical evidence to be able to develop the concept properly, let alone to test and prove it. Your report of UAL's five-year averaging period ($2 million per year cost of a $10 million deductible) is the best specific example that has come to my attention.

Unfortunately, I have not had the time or other resources required to pursue the matter actively (Which means, of course, there have been other more effective demands on my time.) But I believe that demonstration of the existence of such regularities is an essential element in making an effective case for averaging costs of casualty losses.

Bob A. Hedges

Professor, Department of Insurance and Risk, Temple University, Philadelphia, Pa.

City of Yonkers

To the Editor: You can imagine my surprise and vexation when I read in your April 5, 1976, issue an interview with a Mr. Robert Bieber, County of Westchester, on the insurance problems of the City of Yonkers especially since I am the insurance administrator for this city.

Since Mr. Bieber's injudicious and inaccurate remarks could affect the marketability of the city's insurance, I feel compelled to set the record straight.

Contrary to Mr. Bieber's statement, the City of Yonkers did not experience difficulty purchasing excess coverage but did find it difficult to justify the rates considering its admittedly excellent loss experience. Unlike the County of Westchester, Yonkers does not have the legal luxury of raising its taxes 30% as did Westchester. Therefore, the costs were closely scrutinized and negotiated thereby reducing some quotes by over 100%!

The City of Yonkers has had and continues to carry excess coverage up to $15,600,000 not $5 million as quoted. Furthermore, the city has $50,000 deductibles, not $100,000.

No less than four insurance carriers covering the city have provided substantial and protracted installment payments to ease cash flow problems at no additional cost. This is excellent considering Mr. Bieber's statement that no credit would be extended.

Richard A. Kohlberger

Insurance Administrator, City of Yonkers, Yonkers, N.Y.

Editor's note: Mr. Bieber was insurance and safety administrator for the City of Yonkers from 1971 through March, 1974, at which time he became director of risk management for the County of Westchester, N.Y. His comments were based on information received firsthand through the Corporation Counsel's office of the City of Yonkers, which included letters and certificates of insurance.

Study misleading

To the Editor: The Arthur D. Little Inc. study of projected costs for national health (insurance) is mistakenly based on past experience, and therefore dangerously misleading. Human nature and economic precepts dictate that when the price for a commodity approaches zero, the demand approaches the infinite. Comprehensive national health is this type of proposition for large segments of the population.

Further, there is a hidden paradox within an emerging technology like medicine; that is, the more medicine practiced, the more pathology will be discovered. The current state of medical arts provides *no practical limit* to the amount that could be spent to effect the problem. Our entire GNP for the next decade would serve only to expand the total bill paid for medical services, expanded and enhanced though they may be.

Speaking of economic theory, when supply dwindles, prices rise . . . What happened to the cry for more doctors? Don't ask the taxpayer. He's just being asked to buy $125 billion worth of what?

L. Terry Wellman

Services Division, SDC Development Corp., Oakbrook, Il.

Worldwide services

To the Editor: In the March 8 edition of *Business Insurance*, page 70, you featured a list of insurance companies, brokers and agents which offer services worldwide. We were not included in this report.

We are one of the leading American insurance groups which have facilities throughout the world and we certainly should be included in any directory covering global services.

Carol Jenkins

International Information Coordinator, Chubb/Pacific Indemnity Group, New York, N. Y.

Editor's note: As noted in the introduction to the directory we did not attempt to list all available international risk management services. If we repeat the directory in next year's international issue you will certainly be included.

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Frank B. Hall

When you need a better solution.

Creditors demand sale of major insurance arm

LOS ANGELES—The Unionamerica Insurance Group is the golden nugget in the company of which it is a part—Unionamerica Inc., a financial services holding company which came into being in January 1974, when it split away from Union Bank of Los Angeles.

The insurance group embraces some well recognized names, such as Swett & Crawford, a wholesale broker serving major domestic brokerage firms, and Harbor Insurance Co., a direct commercial underwriter in the property/casualty area.

The problems of the two year old parent company are no secret. Peat, Marwick, Mitchell & Co., auditors for Unionamerica Inc., issued a qualified opinion on the company which was included in the firm's 1975 annual report.

The opinion said Unionamerica Inc. sustained substantial operating losses in 1974 ($18.2 million) and in 1975 ($29.4 million). As of December 31, 1975, the company's liabilities exceeded its assets, the opinion said, and added: "Continuation (of Unionamerica) as a going concern is dependent upon the continued availability of financing which, in turn, is dependent upon the company's ability to comply with the terms of existing agreements with lenders, the ultimate realization of the carrying value of assets and a return to profitable operations, as to all of which we express no opinion."

Peat, Marwick, Mitchell & Co., however, issued an entirely positive opinion on the Unionamerica Insurance Group in its separate financial report for 1975.

W.F.W. Fellows, president of Unionamerica Insurance Group, told *Business Insurance* during an interview, that the group has been profitable "for the last six months."

"I am projecting profits of between $5 and $6 million for the group for 1976," he asserted, noting that he concurs with observers who believe that the property/casualty industry is on the road to recovery from the huge losses experienced last year.

Observers close to the situation at Unionamerica Inc. told this magazine that to meet its commitments to its consortium of creditor banks the company may have "to sell a major asset." That asset, say these observers, is the insurance group.

Mr. Fellows said that his group has an agreement with the bank consortium that its income cannot be siphoned off to Unionamerica Inc. He also noted that California law has "rigid restrictions on the amount of money that can be upstreamed" from an insurance subsidiary to its parent company.

The insurance group comprises 23 companies which reported gross premium income in 1975 of $242 million.

He said that four segments of the insurance group are doing well.

They are: 50-year-old Swett & Crawford; Harbor Insurance Co.; Reinsurance Facilities Corp., a firm which acts as a reinsurance intermediary and places both facultative and treaty reinsurance throughout the United States; and the London office.

Mr. Fellows, born in England, said Harbor Insurance will be the "bellweather" for the entire insurance group in 1976. This is because, he said, he expects the direct insurance business (primary and excess of loss coverage) to recover from the devastation of 1975 more quickly than the reinsurance business.

He said it will take about 18 months for the treaty reinsurance business to return to normal. Facultative reinsurance can recover faster, he said, because it can set its own rates. ■

Benefits for banana firm widow stop

BOSTON—United Brands Co. stopped pension benefits and deferred salary payments to the widow of Eli Black, the former chairman of the company who committed suicide in February of 1975.

However, the death benefit from the group life insurance policy on Mr. Black was paid last year, according to the underwriter, the Travelers Insurance Cos.

The policy, which was brokered through Marsh & McLennan, paid a benefit tied to a multiple of Mr. Black's salary, which was $225,000. The late chairman was not additionally covered by key man life insurance. (*Business Insurance*, Feb. 10, 1975).

United Brands reported the suspension of the pension and deferred salary in its proxy statement. The benefits payments are pending an accounting by his estate for about $200,000 in advances to Mr. Black since 1970 for "business expenses."

The proxy statement said the suspension is also pending the final outcome of claims brought by the Securities and Exchange Commission against United Brands involving a payment to a Honduran government official.

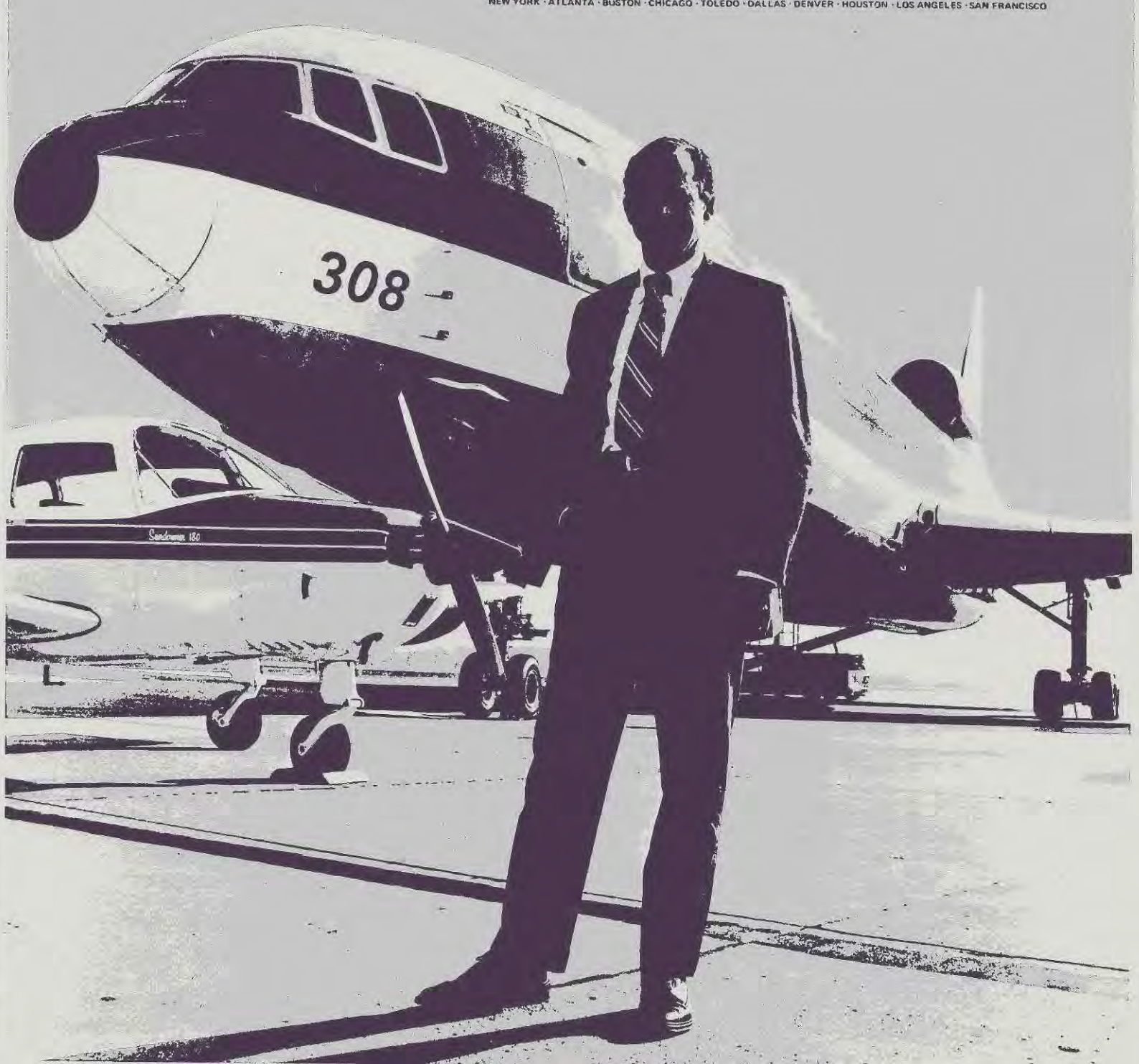
Although it was underwriter for Mr. Black's life insurance, Travelers is not connected with the $45,000-a-year pension which United Brands authorized for his widow beginning Jan. 1, 1976, but which hasn't been paid to date. ■

RBJ Florida expansion

Tampa-based Allied Insurance Agency was acquired by R. B. Jones Corp. of Kansas City, Mo., according to John W. Tucker, president and chief executive officer of the brokerage firm. Louis Rodriguez, president of Allied Insurance Agency, is slated to join R. B. Jones as vp.

Everybody's FBO. *Russ Miller is the current chairman of NATA, the National Air Transportation Associations. ☐ That figures, because he is also founder and president of AirKaman, Inc., a $20-million-a-year aviation service organization that is all things to all customers at Windsor Locks, Connecticut; Omaha, Nebraska and Jacksonville, Florida. AirKaman offers support services for everything from a single-engine Beech Sundowner to an airline Lockheed 1011. ☐ Russ learned a lot about coping with risks during WWII and the Korean War when he was flying everything from B-24's to F-100's. He wants his widespread operations covered by people who understand the inherent safeguards as well as the risks of his business. That's why he has insured with USAIG since his opening in 1961. ☐ "They are pros. They sometimes seem hard-nosed about a few of our exposures, but that's really because they're interested in our protection. They have always proven fair. And their reaction to claims is immediate." ☐ Two pros working together: AirKaman, everybody's FBO; USAIG, everybody's insurer.*

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legal brief

Unintended exclusion on bond policy does not spare bank on loan claim

FAILURE TO INDENT an exclusion clause in a banker's blanket bond did not create an ambiguity in the policy with regard to a bank's claimed loss arising out of a defaulted loan, according to a federal district court in Illinois. The court ruled that no reasonable construction of the bond would permit the bank to recover on the bond money it had failed to recover from its fraudulent borrower.

Community National Bank of Monmouth had made loans totaling $60,000 to George Robson Gossett based on false information provided by him. Subsequently, Mr. Gossett was convicted of knowingly making false statements to a bank. Community sustained a loss of $35,000 and sought to recover this from its insurer, St. Paul Fire & Marine Insurance Co. (St. Paul).

Insuring clause B of the bond provided coverage for "on-premises burglary, robbery, offices & equipment loss or damage." Immediately following the description of coverage for "offices & equipment loss or damage" was an unintended provision excluding coverage for loan losses whether procured in good faith or through fraud. Community contended that the grammatical and syntactic structure of these provisions created an ambiguity in the policy that should be resolved in its favor as the insured. In essence, Community asserted that the exclusion applied only to "offices & equipment loss or damage" and not to the "on-premises burglary, robbery, etc." coverage.

The court regarded Community's argument as "seeking to reach beyond the limits of reason in the situation at hand." The court believed that the suggestion that the exclusion applied only to loans of furniture or equipment was "almost unworthy of intelligent and responsible persons making such argument." Consequently, the court concluded that a reasonable construction of the policy and one that is considered "crystal clear" was that the bond did not cover the bank's losses resulting from the fraudulent borrower. *Community Nat. Bk., Monmouth v. St. Paul Fire & Marine*, United States District Court for the Southern District of Ill., September 17, 1975, Morgan, C.J., 399 F. Supp. 873 (BI/01/M.-$3).

Business risks

The Supreme Court of Arkansas has ruled that the negligent sale of gunpowder by a sporting goods business was not a risk excluded from the terms of a business hazards insurance policy. The sale resulted in an explosion away from the store causing injury to a minor.

Jack Hardman, doing business as Hardmans Sporting Goods, was insured by the Farm Bureau Mutual Insurance Co. of Arkansas (Farm Bureau) for certain hazards in his business operations, including bodily injury liability. The policy excluded coverage for "products hazard" defined as "handling or use of . . . goods . . . distributed by the named insured, if the accident occurs after the insured had relinquished possession . . . and away from the premises . . . controlled by the insured."

While the policy was in force one of Hardman's employes sold gunpowder to some minors, including Joseph Lyon. The gunpowder was to be used as an explosive in a sound-making device at football games. While using the gunpowder, Lyon was injured by an explosion. Lyon sued Hardman for negligence in the sale and recovered a judgment of $38,500. Farm Bureau refused to defend Hardman on the basis of the exclusion. The trial court ruled that the insurer was liable.

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

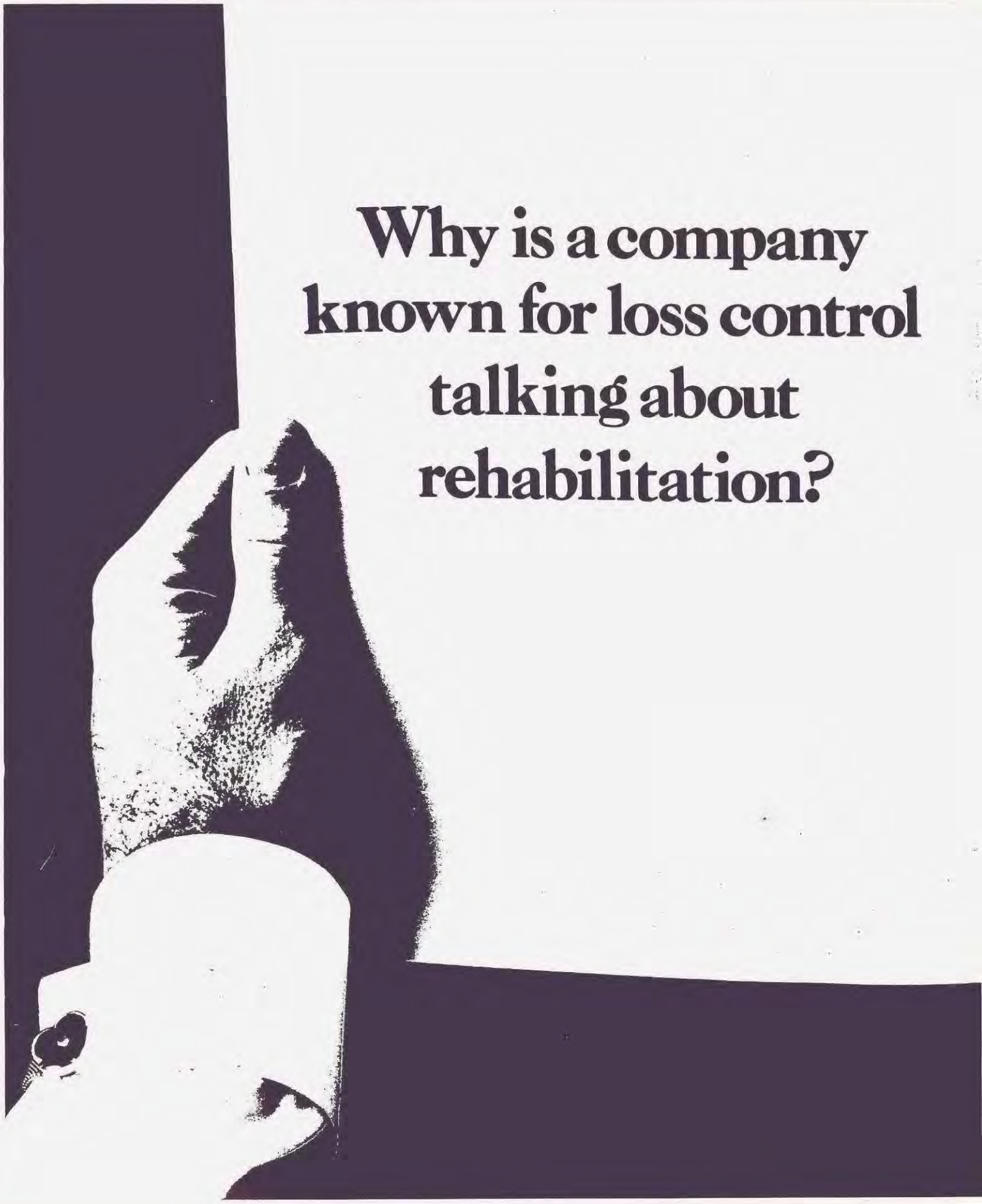
Acknowledging that this case raised a novel question not previously passed on by the court and one on which other courts were split, the supreme court concluded that the language of the exclusion clearly applied only to "products completed operations." The court noted that neither party had alleged any defect in the gunpowder purchased. Furthermore, the court emphasized that the negligence which caused the accident occurred on the Hardman premises which was insured under the policy at the time the store's employe sold the gunpowder to the minors. The court believed that this was precisely the type of risk for which Hardman purchased coverage from Farm Bureau.

Justice Byrd dissented because he believed that the policy exclusion limited the insurance company's liability only to accidents or occurrences on Hardman's premises prior to its having relinquished possession of the goods. *Farm Bur. Mut. Ins. Co. of Arkansas v. Lyon*, Supreme Court of Arkansas, November 3, 1975, Roy, J., 528 S.W.2d 932 (BI/02/M.-$3).

Comprehensive liability

A federal appellate court has ruled that warehouse contents guarded by a detective agency providing night watchman service are, during that time, in the "care, custody or control" of the agency as contemplated by a comprehensive liability policy issued to the agency. The court also ruled that any liability of the detective agency was subject to a policy endorsement limiting liability to $25,000 per occurrence, including allocated loss expense.

Burns International Security Services Inc. (Burns) contracted to provide a watchman for a warehouse owned by the Cory Corp. In August 1970 a watchman hired by Burns was assigned to the Cory warehouse set fire to the building. Goods belonging to the Stewart Warner Corp. (Warner) stored therein were damaged in the amount of $142,246. Warner recovered a judgment against Burns and both then sought recovery against Aetna Casualty & Surety Co. which had issued Burns a general comprehensive liability policy. At issue was the applicability of an exclusion in the policy for "property damage . . . to property in the care, custody or control of the insured or as to which the insured is for any purpose exercising physical control." A further endorsement on the policy provided that property damage cov-



erage on property for which Burns had contracted with others to provide protection services was subject to a $25,000 limit per occurrence.

Warner and Burns asserted that the exclusion and endorsement were not applicable to the facts of this case because ordinarily the watchman's role was very passive and except for an emergency he would not be called on to have any physical contact with any of the stored goods. This, they maintained, never placed Burns in exclusive possession of the damaged goods.

However, the court believed that there was no requirement that Burns' relationship to the property had to involve "intimate handling of each item of such property." The court emphasized that even though Burns did not exercise continuous control over the property, it exercised exclusive control over the premises for short periods. In upholding the trial courts ruling in favor of Aetna that recovery was limited to $25,000, the court pointed out that the purpose of the exclusion was to prevent a general liability insurer "from becoming a guarantor of the insured's workmanship in his ordinary operations." *Stewart Warner Corp. v. Burns Intl. Security Services Inc.*, United States Court of Appeals for the Seventh Circuit, December 8, 1975, Fairchild, C.J. (BI/03/M.-$3).

Group sickness and accident policy

Here an employe under a group sickness and accident policy paid for by General Motors brought suit against the Metropolitan Insurance Co. for an injury occurring at home while he was on strike. The policy furnished by General Motors required payment of monthly premiums by the employer and had a grace period of 31 days. General Motors paid no premiums for the policy during the period of a two-month strike at its St. Louis Chevrolet plant.

The Missouri Court of Appeals ruled that since the policy had lapsed at least seven days prior to the injury to the plaintiff-employe due to the nonpayment of the premium because of the strike, there was no coverage.

The policy in this case provided that the payment of any premium would not maintain the insurance in force beyond the day immediately preceding the next due date. Here the premium due on April 1, 1969, would have covered the employes until April 30, 1969. But the policy granted a grace period of 31 days to the employer for payment of any premium due, and during this grace period the policy would continue in effect. If the employer failed to pay any premium within the grace period, the policy would be discontinued on the last day of the grace period.

In this case no premiums were paid from April 10, 1969, through June 9, 1969, because of the strike. The premium payment due on April 1, 1969, covered the plaintiff until April 30, 1969. Since the monthly premium due on May 1, 1969, was not paid, the 31-day grace period covered the plaintiff from May 1, 1969, through May 31, 1969. Thus, according to the court, since the premiums due on May 1, 1969, were not paid by May 31, 1969, the sickness and accident insurance coverage lapsed after May 31, 1969, which was seven days before the plaintiff was injured. *Hampton v. Metropolitan Ins. Co.*, Missouri Court of Appeals, St. Louis District, September 16, 1975, Dowd, J. 528 S.W.2d 17 (BI/05/M.-$3).

Employe dishonesty

In this action a restaurant owner brought suit against the Insurance Co. of North America to recover under a policy which covered against losses sustained by reason of dishonest acts of employes. An exclusionary clause in the policy prohibited recovery for losses occasioned by dishonest acts of employes if proof was dependent upon inventory computations or profit and loss computations. The clause precluded admission of evidence of inventory or profit and loss computations only if there was no independent evidence of dishonest acts committed by employes.

A Michigan appellate court ruled that here evidence showing that customers paid restaurant bills which were not marked paid and that the restaurant manager took money from the cash register without leaving a receipt constituted evidence of the restaurant manager's dishonesty, independent of evidence of inventory and/or profit and loss computations. Since there was independent evidence establishing employe dishonesty, the court concluded that inventory or profit and loss computations could be used to help prove the amount of the loss. *NIB Foods v. Insurance Co. of North America*, Court of Appeals of Michigan, August 25, 1975, released for publication Nov. 12, 1975. Burns, J. 234 N.W.2d 725 (BI/04/M.-$3). ■

(Copies of the entire decisions described in this column may be obtained by writing to Business Insurance, *attention: Editor, 740 N. Rush St., Chicago, Il. 60611. Please enclose a $3 check made out to Cases Unlimited Inc., for each case, and specify the code number of the opinion, which is at the end of each brief.)*

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Matson hit with lawsuits for oil spill

SAN FRANCISCO—The California attorney general filed two lawsuits against Matson Navigation Co. last month in Contra Costa County Superior Court for an oil spill that occurred while one of its tanker was being loaded.

Attorney General Evelle J. Younger filed two charges on behalf of the state's Department of Fish and Game and California Regional Water Quality Control Board for the San Francisco Bay Region.

According to the state's complaints, 4,200 gallons of oil spilled into the Carquinez Strait last Jan. 17 while oil was being loaded Matson's S.S. Hawaiian, then tied up at dock.

According to a Matson spokesman, clean up costs were $350,000. The California attorney general's office said it is seeking civil penalties amounting to $33,000 and a court order requiring Matson to adopt "improved" oil handling procedures.

Mr. Younger said in his complaints that Matson personnel "were not properly supervised nor were they properly trained to handle the oil transfer process.

"The oil," Mr. Younger added, "was pumped into a tank known to have a malfunctioning gauge and the pumping was continued even after an over-fill alarm was sounded. The oil was permitted to spill for 20 minutes and it caused injury to water, fowl, marine life and plant materials in Suisun Bay and in San Pablo Bay." ■

Tennessee expansion

E. H. Crump & Co., based in Memphis, Tn., acquired Pryor, Love & Lewis Inc., Chattanooga. Crump-Chattanooga becomes the company's 14th general agency operating in eight southeastern states. The parent organization is E. H. Crump Cos. Inc.

Bond insurance means borrow power for cities

NEW YORK—Some New York state localities whose borrowing power has been crippled by investor reaction to New York City bonds have been able to save money by purchasing insurance on their tax-exempt bonds.

In fact, few New York localities have even attempted to market bonds without first buying insurance ever since the state legislature gave New York City a moratorium in November on its payment of $1.6 billion in notes.

Much of the insurance is being bought through the Municipal Bond Insurance Assn., a $4 billion consortium that has guaranteed payment on some $800 million of tax-exempt bonds.

A total of 14 New York localities have marketed MBIA-insured bonds. The MBIA will insure only issues up to $20 million, and has been very selective about accepting risks (some estimates show the association screened out nearly three-quarters of the issues of localities seeking insurance).

MBIA insurance succeeded in lowering the towns' interest costs for the bonds it guarantees. In one instance, for example, North Hempstead in Nassau County will save almost $3 million as a result of insurance it bought from MBIA for a premium of $390,000.

North Hempstead borrowed $16.4 million by selling MBIA-insured bonds at an interest cost of 5.66%, a rate 184 basis points below the estimated 7.5% the town would have been charged for uninsured bonds.

The nearly $3 million savings the town anticipates are figured out over the 9.1 year average life of the bond issue.

For the investor buying the bonds, the lower interest cost of the insured bonds means a lower yield, but also less risk.

Member insurance companies in the MBIA are Aetna Casualty & Surety, St. Paul Fire & Marine Insurance Co., Aetna Insurance Co., and United States Fire Insurance Co. ■

Bill requires medics to join malpractice pool

SACRAMENTO — Legislation which would require all California's physicians and hospitals to purchase medical malpractice insurance through a state mandated liability fund was presented to the state assembly finance, insurance and commerce committee, for public hearings to be held this month.

The measure has the support of Gov. Edmund G. Brown Jr. and Dr. Michael Frelich, United Physicians of California, leaders of the Southern California doctors' "slowdown" earlier this year.

"The doctors themselves would decide," Assemblyman Howard Berman said, "whether they want a mandatory fund, a voluntary fund or no state fund at all. A fund, however, would reduce malpractice insurance premiums to an initial average of $4,000 a year.

"Rates under the mandatory plan," Mr. Berman added, "would increase by no more than 15 per cent a year. Increases with a voluntary fund could come much more often. We have eliminated from this legislation an earlier proposal for a 'medical peace corps' in which doctor participants would provide free or low cost care to needy patients."

The California Medical Assn. said it would oppose the legislation on the basis that "a state fund would destroy doctor-owned insurance carriers."

Meanwhile, Dr. Joseph D. Sabella, president of Los Angeles-based Doctors' Co., a non-profit doctor-owned carrier, said the organization "will sign up at least 3,000 California doctors this year.

"To date," said Dr. Sabella, a San Pablo pathologist, "we have written policies for 750 doctors and are getting 50 to 75 applications a day from everywhere in California. Our permit was granted by Insurance Commissioner Wesley J. Kinder on April 15."

Premiums, he added, range from $713 for a pediatrician to $6,354 a year for a neurosurgeon. In contrast, commercial insurance carrier coverage for a neurosurgeon in the San Francisco Bay Area now is $29,000 a year; for a pediatrician it is $4,500 a year. ■

Finds trained specialists a bigger risk

MILWAUKEE—High risk medical specialists, who are usually the most highly trained, are the subject of most malpractice claims according to a National Assn. of Insurance Commissioners (NAIC) survey.

U.S. medical and malpractice claims reached $105 million since last July with 9,471 claims reported by insurance companies to the NAIC, of which one-third resulted in payments to claimants.

The NAIC survey, prepared by their committee of professional liability headed by Oregon Insurance Commissioner Lester Rawls, "indicates that injury prevention programs and professional standards review needs strengthening in hospitals."

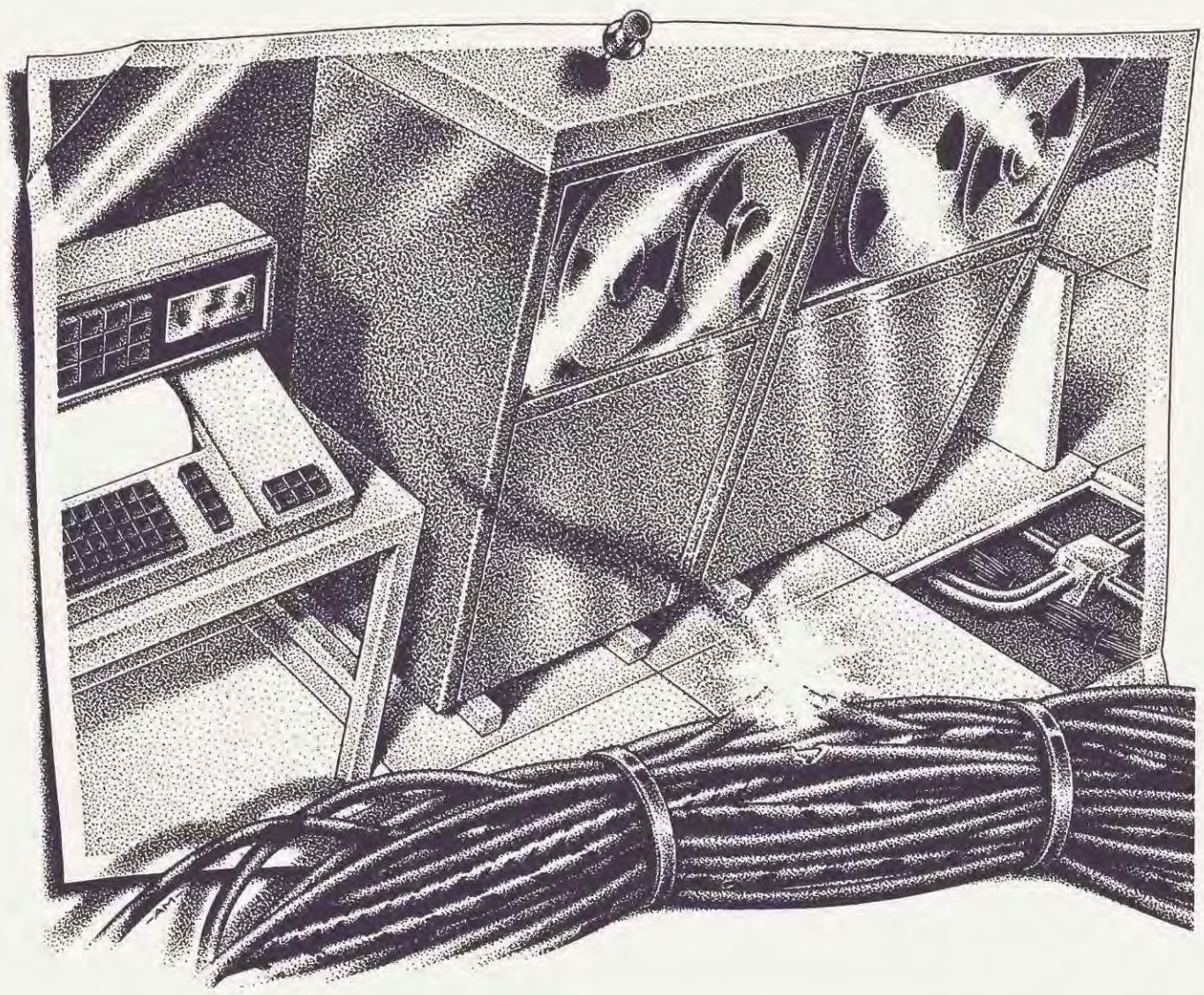
Among the findings is that fifty percent of the claims were from the industrial states of California, New York, Florida, Illinois and Pennsylvania, with New York and California alone accounting for 35% of all claims surveyed.

Real or alleged injuries received in hospitals accounted for 80% of all malpractice claims with the majority of claims against high-risk specialists providing complex care.

The survey also found that the average claim is paid three years after a malpractice incident, but nearly half of all claims are known within six months following injury. Also, 30% of the claims surveyed were for diagnostic errors, 45% for errors in treatment, and 25% for errors in planning treatment. ■

THE CASE OF THE COSTLY COMPUTER

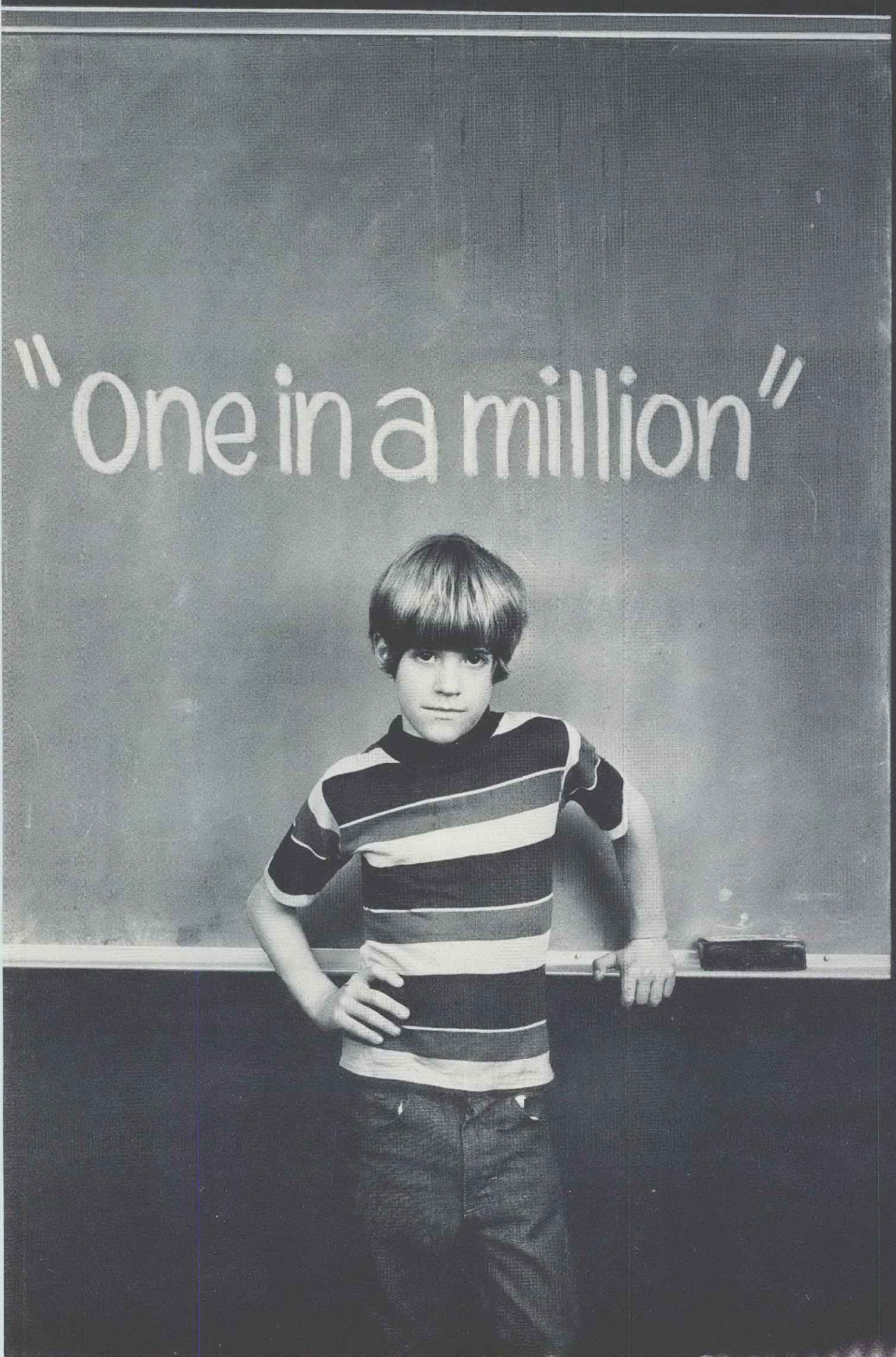
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When it comes to school insurance we never stop studying.

With feds promoting cheap crop covers, private insurers are in pinch

By TOM WALSH

DES MOINES—The nation's private crop insurers are looking for ways to manage the biggest risk the $310 million industry has ever faced—the federal government.

Industry strategists since early 1975 have been formulating legislative tactics that they hope will neutralize the stiff competition private crop insurers now face from the Federal Crop Insurance Corp. (FCIC), an agency created in the late 1930s to help farmers survive Depression-induced financial disaster. Today, the federal crop program and the investment community have the private insurers caught in a squeeze play, and the industry is scrambling to find a way to survive the crisis intact.

The scenario is basically this:

The federal crop insurance program is operated with tax subsidies that allow the FCIC to offer farmers all-risk coverages. The private crop insurance sector, not having the taxpayers to pay administrative costs and bail them out after heavy losses, has not been able to risk the tremendous exposures inherent in insuring virtually all crops against virtually all perils. Consequently, standard crop-hail policies offered by private insurers protect farmers from crop losses due to hail, wind, and in some cases, fire, but do not afford coverage against drought, flooding, insects or excessive heat.

Enter, the investment community.

Like other costs in inflationary times, the costs of farming have skyrocketed. Americas best farmland a few years ago could be had for $400 an acre; today, it's worth over $2,000 an acre. As land costs have increased, so have the other costs of farming—machinery, fertilizers and seed. The existing situation is one where the capital required for farming is beyond the means of the average farmer. Many farmers, if not most, have been reduced to borrowing funds needed to meet operating costs. Such farmers must depend on their crops to pay their debts.



All-risk insurance policies from the federal government protect growin

To secure the farm loans they have made, more and more banks are beginning to require borrowers to carry all-risk crop coverages. While a handful of private insurers—among them INA, Fireman's Fund and Reliance—have been offering all-risk crop coverages on a limited, experimental basis, such coverages are available through the FCIC at rates 25% to 30% cheaper than rates charged by private industry.

With the bankers insisting on all-risk coverages and private mutual and stock companies unable to write them, farmers are finding that the only place to take their crop insurance business is to the federal government.

"It's easy to see what's happening to the industry," said Glenn Wistey, crop and hail manager for the Farm Bureau Mutual Insurance Co. of Iowa and the head of an industry group formed to combat federal intervention in crop lines. "There's a possibility that the federal government will take over this industry, and a pretty sizeable industry, too, when you figure that our premiums last year ran about $310 million. If that possibility becomes a probability the private crop-hail industry is doomed."

The industry group Mr. Wistey heads—the Multiple Peril Crop Insurance Assn. (MPCIA)—is now trying to come up with enabling legislation that would allow the private sector to write primary all-risk coverages and use the federal government as a reinsurer to cover catastrophic losses. The Ford Administration supports such a setup, but the issue is hardly a Congressional priority. In fact, Mr. Wistey expects no amendments to existing federal crop laws until the end of 1977, when the 1973 Farm Act runs out and new thought will be needed concerning disaster relief for farmers.

Hearings on the status of the FCIC and proposals to convert its function to a federal reinsurer of private crop coverages have been held in both House and Senate committees, and legislators from rural areas have supported the logic of the industry proposals.

"But what they tell you," Mr. Wistey said, "is that they'll sponsor any bill that favors the consumer, the industry and the government equally. That's quite a lot to satisfy."

Three Senate bills and two House bills exist today that would affect current operations of the federal crop program. Three of the bills would provide repeals of current restrictions on federal reinsurance of privately-written coverages. One of those three bills sets no limit on total federal liability, while others ask for amounts within "appropriate guidelines." Three of the bills would retain the disaster provisions of the Agricultural Consumer Protection Act of 1973 while two would not.

Private crop insurers clearly favor the proposal that has come to be known as the Dole-Madigan bill. Mr. Madigan, a Republican House member from crop-rich Illinois and Senator Dole a Kansas Republican and an expert on world food needs, have jointly sponsored legislation that would provide reinsurance to private car-

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crops from many perils.

riers and would allow the federal government to reinsure not more than 75% of the average yield for the crop insured, based on a representative number of years experience.

No hearings have been scheduled on the Dole-Madigan bill however, and industry sources indicate that they'd be surprised if significant attention were given to the bill before 1977.

In the meantime, the members of the Multiple Peril Crop Insurance Assn. are banding together in what they describe as a "provisional" organization that is exploring the future of the private insurance industry in the all-risk crop coverage area. By pooling their experiences in the all-risk crop business, these 24 companies hope to agree on basic principles for underwriting multi-peril crop risks. The group also hopes to present to Congress a workable mechanism for private industry to utilize the federal government as a reinsurer of business written in the private sector.

The private crop insurers who are going the all-risk route without the benefit of federal reinsurance are few and far between. The last 10 years has seen some experimentation by the private crop/hail insurers, but heavy losses in 1974 that drove loss ratios to almost 500% also forced some companies to bail out of the all-risk business and other companies to drastically reduce their limits of coverage.

The diehards who are still writing small amounts of business are apparently hopeful that the experience they've gathered will give them a step up on the competition if federal reinsurance of private coverages become the status quo.

Fireman's Fund is one major property company that hasn't thrown in the towel on all-risk crop coverages. Although it's been burned, Fireman's Fund is at least writing enough multi-peril business to stay in the game.

"All-risk coverages are the route that this business will ultimately take," says Dwight Alverson, Fireman's Fund's vp for farm and hail coverages. 'The proper role of the federal government is a backup role—providing reinsurance protection against a real catastrophe. It's clear to me that right now the federal government is acting in direct competition with the private sector and operating at a distinct advantage, too. Supposedly, the government is not supposed to be in competition with the private sector. I believe that ultimately private industry will become involved and will be able to both make a profit and serve the farmer."

Fireman's Fund, Mr. Alverson said, was most heavily involved in the multi-peril business in 1974, when the company collected "a couple hundred thousand dollars" in premiums. Last year, exposure was limited to $150,000 in premiums and this year has been reduced to $50,000.

"The business we do write now we write very carefully," Mr. Alverson said. "We are very particular about the areas where we will write all-risk coverages. We avoid areas prone to hurricane and frost problems caused by altitude, like Idaho and the Texas Panhandle. We steer away from citrus crops; theyre too easily damaged. Good risks are generally areas in the Midwest that aren't prone to flooding. We're certainly not going to insure a crop that's being grown just on the other side of a Mississippi River levee.

"Generally," he said, "we are insuring against losses that are beyond the control of the farmer —either something that has never happened before or something beyond his control."

Rates for privately-written all-risk crop business, Mr. Alverson said, are figured using federal crop insurance experience and are adjusted to cover expenses. ■

Will run Defense's health program

BURLINGAME, CA. — Health Application Systems, a subsidiary of Bergen Brunswig Corp., Los Angeles, has been awarded a contract to administer the total health care program for employes of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) of the Department of Defense.

Under a Pentagon contract, Health Application Systems will act as fiscal agent for the Department of Defense by processing and paying all claims for health benefits under the CHAMPUS program in five western states. CHAMPUS beneficiaries include civilian dependents of the Armed Forces, the Public Health Service, and the National Oceanic and Atmospheric Administration as well as retired armed forces members and their dependents.

The five states where Health Application Systems will handle health care program administration are: Arizona, California, Nevada, New Mexico and Texas.

The initial Pentagon contract covers the period of July 1, 1976, to December 31, 1976, with renewal options through September 30, 1978.

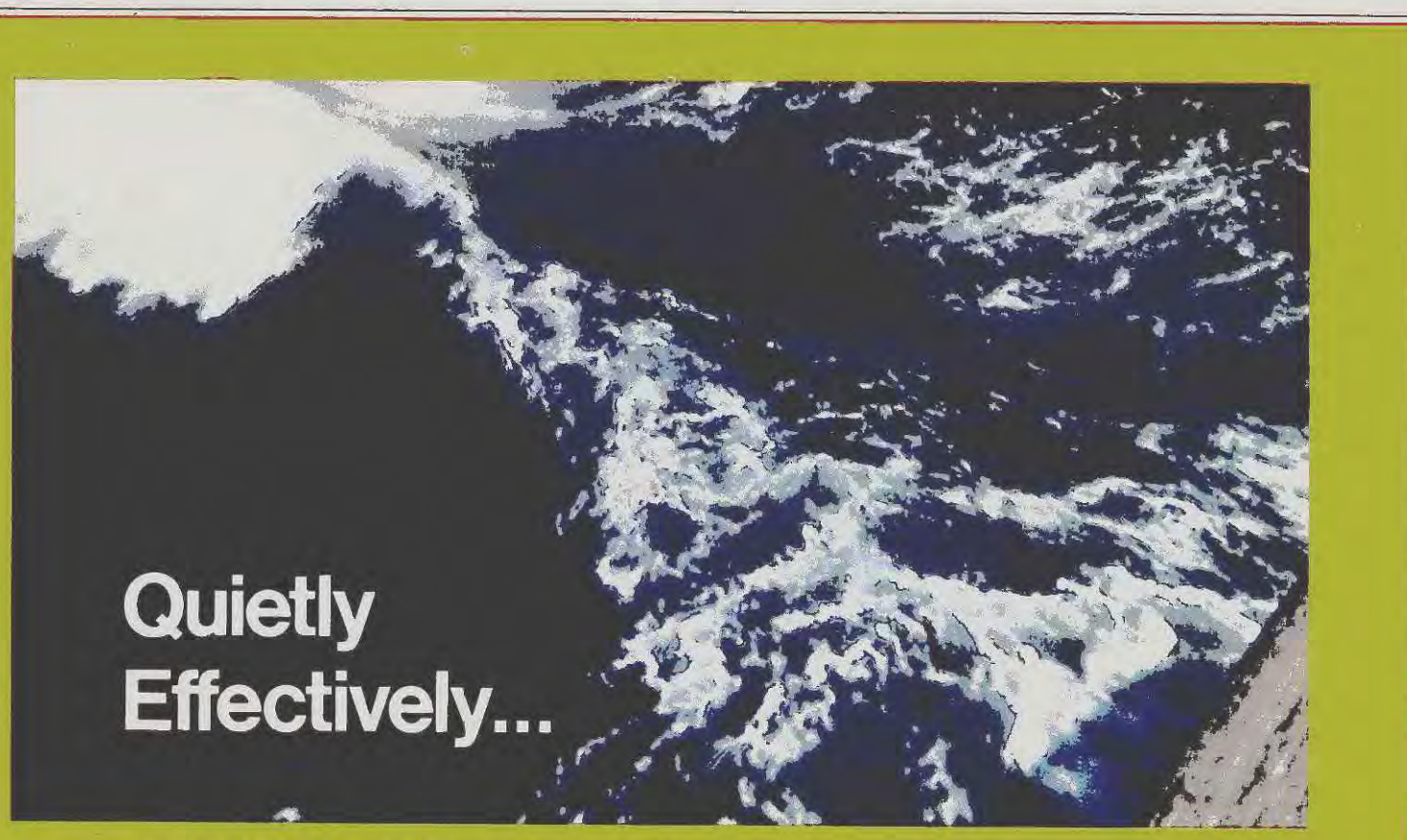
If the options are exercised, Health Application Systems' adminisrative fee will approximate $8 million for the entire period, a Bergen Brunswig spokesman said.

Health Application Systems will administer the CHAMPUS contract from a new facility, staffed by 160 employes and located in San Diego.

Dr. James Cowan, assistant secretary of Defense for Health and Environment said that the contract "may well be the first step in revolutionizing our approch to CHAMPUS contracts throughout the United States at annual savings which may well amount to $10 million eventually."

The five states where Health Application Systems will administer CHAMPUS programs make up about one third of all expenditures under CHAMPUS. Total CHAMPUS expenditures are estimated at more than $550 million in the fiscal year ending June 30, 1976.

Health Application Systems has administered health care programs for a number of states under the Title XIX Medicaid program for some time. It performs third-party programs for the states of Arkansas, Florida, Maine, Massachusetts, North Carolina and Pennsylvania. ■



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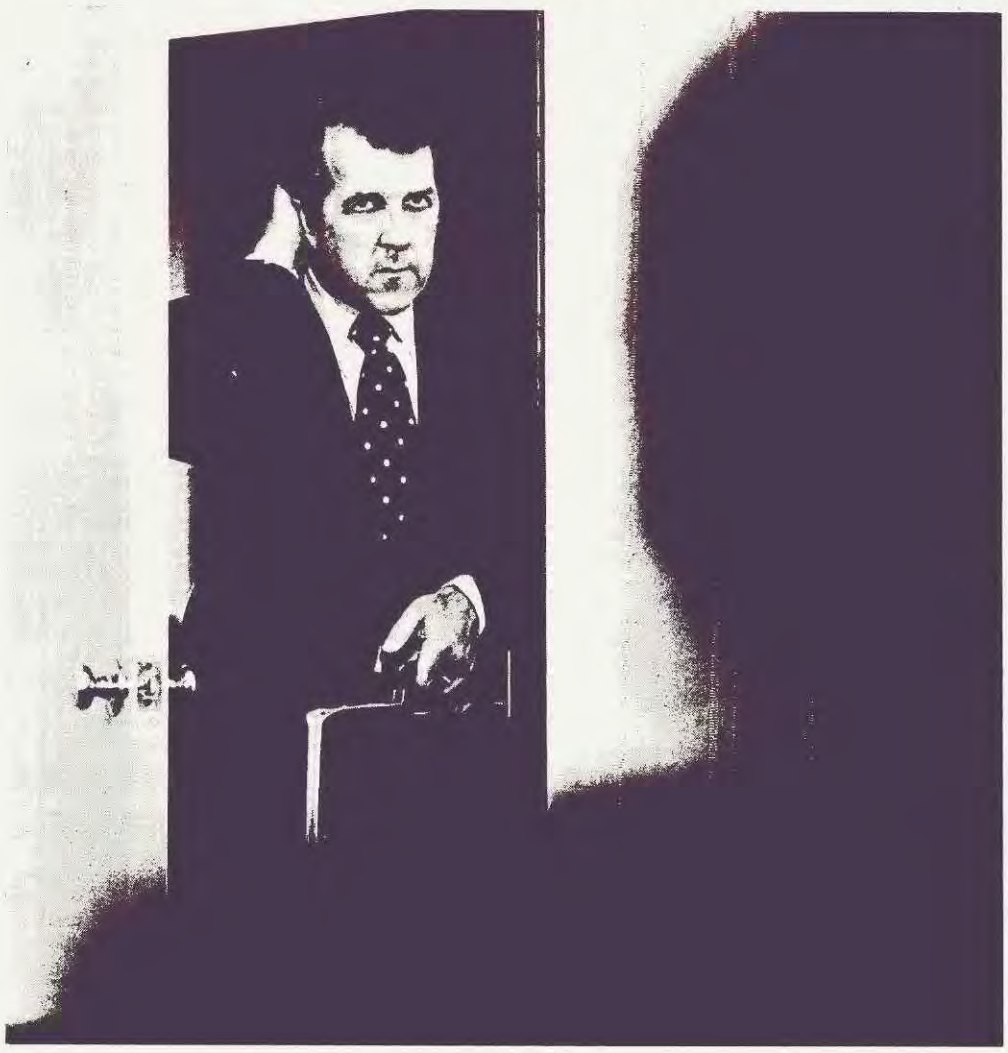
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PERSPECTIVE

Total management approach is needed for handling risks in health care delivery

"Unfortunately, malpractice claims have not always been handled with long range objectives in mind. Often a patient with a legitimate claim has no place else to go to pursue the claim but to an attorney."



All institutions or individuals providing health care need to plan for malpractice risks.

By IRVIN D. NICHOLAS
vice president
Fred S. James of California

THE MALPRACTICE insurance situation in the health services field has reached crisis proportions in some states and is national in scope. Unfortunately, it may be a symptom of more basic problems —only limited development of management techniques and a breakdown in the system of financing risk exposures.

A solution must deal with a very difficult environment:

- The public is imposing an ever stricter liability on the providers of health care including all health science disciplines.
- Patients and their lawyers are suing more often and for even larger sums.
- Cost of medical malpractice risk is paid for through a relatively small group, limited by the number of doctors. Financing the per capita cost is creating difficulties for physicians who must handle the cash flow.
- Hospitals are unable to recover the true cost of hospital care from governmental third party payors and rapidly increasing costs for malpractice risk compounds this problem.
- More regulation of the quality of care is desirable but represents an intrusion into formerly sacred ground reserved for a self-regulating profession.

Within this environment solutions have been slow to develop and have generally been short term, quick fix, keep-the-wheels-turning efforts by the legislatures of the states most affected to date. In most states, health care providers have had to absorb cost increases of over several hundred percent in some cases. In short, the system of risk management and patient injury compensation that is in effect is not working. Fundamental reform is needed. Without basic reform the current crisis can spread to other areas of casualty risk exposures.

The problem can be viewed as consisting of both operational considerations and financial considerations.

Operational Considerations

Application of risk management techniques to professional liability risk in health science disciplines has become a more accepted process. However, it is generally not a subject offered in the already crowded medical school curriculum, and today's doctors have not been exposed to risk management techniques to any great extent. It must be picked up as part of on the job training, if at all. This, along with the trigger-happy tort-oriented society, and a change to a more specialized approach to the practice of medicine which results in a more formal contractual relationship between doctor and patient has led to unnecessary tort liability claims.

The technology in medical care has made great progress and has exceeded the development of risk management techniques to control the problems new procedures can create. Formal research and development programs are needed to identify and control risk and should be part of or closely coordinated with medical research.

Unfortunately, malpractice claims have not always been handled with long range objectives in mind. Often a patient with a legitimate claim has no place else to go to pursue the claim but to an attorney. Why can't a more helpful approach to handling legitimate problems be used? A more just system of compensation, coupled with attentive claim management can distribute the dollars available for the injured on a more equitable basis.

The health care provider needs to change a traditional philosophy and consider malpractice risk as its management problem. It is not the insurance company's problem. The insurance industry is withdrawing from this line of business as an example of its independence, so as to not be involved except on a voluntary basis.

Financial considerations

As long as an institution or individual provides medical care, exposure to risk needs to be financed. It can be accomplished directly or indirectly but someone must pay the price the public places on this risk. One of the real restrictions in developing a sound financial program is determining the true cost of risk. Information needed to quantify risk is often not existant and some of the variables affecting risk (erosion of defenses and new hazards created by technology, for example) are difficult to quantify.

Under the current tort liability compensation system and any other system than can be devised, the public will ultimately

Continued on following page

Studies can indicate risks of injury by products

Human anatomy analysis is risk control tool

STEPHEN W. MEAGHER, M.D.
Boston, Massachusetts

THE VENERABLE ADAGE of "once burned, twice shy" should have special meaning for those carriers who offer products liability policies to industry. The upward trend of jury awards compels carriers to ask themselves whether or not they should continue to insure in this field. If their answer is affirmative, they must take every possible measure to weed out bad risks and properly weigh the probability of claims to be made in relation to each product accepted for coverage.

Functional anatomical analysis is an analysis of a product performed by a physician who has an expert knowledge of applied anatomy and mechanisms of injury for the purpose of determining the presence or absence of unreasonable risks of injury, preferably before the product goes into large scale production or after a product in use is known to produce one or more injuries.

Producers do not pay sufficient attention to the limitations that human anatomy places upon the users and operators of their products. They unwittingly build unreasonable risks of injury into their products such as by their failure to shield moving parts, failure to provide dual shut-off controls within left and right anatomical limitations, failure to restrict physical movements of machine operators as closely to the functional zone as possible, causing the operator to work in an awkward position by various errors of design.

Products liability carriers must require as a condition of insurance the reporting of all injuries that come to the attention of the manufacturer. With this information in hand the carrier's representative, the producer's designer and a physician qualified as above should conduct an inquiry to determine whether or not an unreasonable risk is involved and, if needed, what design change would eliminate such a risk. Mechanical engineers do not have the special skill required to perform this function without medical assistance.

Pre-production functional anatomical analysis and post-injury inquiry using the suggested team approach are the most intelligent methods available today to reduce product liability litigation.

An important element in constructing a defense against recovery in court is provided by a functional anatomical analysis, in appropriate cases, which does not expose any unreasonable risks of injury. If such an analysis does reveal one or more unreasonable risks it would obviously be of the utmost importance to negotiate a settlement before going to trial except in borderline cases or for other special considerations.

Unfortunately, in many instances an unreasonable risk is incorporated into a final design because of lack of knowledge of functional anatomy, and not because of additional cost of producing the product.

Insurers have a right to expect manufacturers to act responsibly in bringing a product to market and offering it for use to a wide variety of individuals with large ranges of intelligence, physical coordination and personality. In this regard there has been too much laxity in the past. The insurer ought to know whether or not capable consultants are being used by designers and they should also have access to consultants' reports when determining insurability.

The present method of insuring the manufacturer annually against claims during the period of insurance is archaic and foolhardy because it encourages the irresponsible manufacturer to sustain his irresponsibility. It is proper in the present climate to insure each product on its own merits after subjecting it to functional anatomical analysis, compelling correction if unreasonable risks are found and fixing premiums upon consideration of the final functional anatomical assessment. On a product by product basis the highest risk would no longer be insurable unless the risks could be reduced by modifications of design.

As regards machinery it is not enough for the manufacturer to know how well his machine will serve his customers; he must also care and know how his machines will affect those who will operate them. By acquiring a new concern for the latter, the problem of liability will be attacked in a very positive and constructive way which can only serve to alleviate the distressing trend in products liability. ■

Dr. Meagher is a senior clinical instructor in surgery at Tufts University Medical School, chief of the hand surgery section at St. Elizabeth's Hospital, Brighton, Ma., and attending hand surgeon at Boston Veteran's Hospital. He is a member of the American Society for Surgery of the Hand and his practice is limited to reconstructive hand surgery. Dr. Meager also does work in the areas of preventive job analysis, corrective tool design and functional anatomical analysis.

PERSPECTIVE

Facing up to risk problems in the malpractice climate . . .

Continued from preceding page
pay the cost of malpractice risk regardless of the financing vehicle (insurance or self-insurance). The challenge is to understand the subject of risk exposure, what the public can afford, and to develop procedures to handle the cash flow effectively.

Reform will happen when enough of the people involved want it to. Unfortunately, crisis management has become the format of reform in the malpractice area and straight-forward leadership has not prevailed. What is an effective role for the people and disciplines involved?

Insist on a more efficient system of patient compensation. The cost of risk must ultimately be paid by the general public and through their representatives and institutions they set the cost levels. The public should review the price tag it has set on the cost of risk as it is reaching a level that is more than society may be able to afford. There is considerable evidence that the public is not as prepared to pay for a high cost of risk as it is to demand it.

An informed public that understands increases in the level of performance demanded in the health sciences does not come free is likely to identify more quickly and more accurately that unlimited expansion of the cost of professional liability in the health sciences is contrary to the public interest.

Insist on adequate cash flow for financing the cost of risk. Maintain a competitive atmosphere which provides a reasonable profit for providing the needed level of service. We are seeing the results today of the cut-throat competition of the early '70s which has only delayed and increased the multi-year overall cost of risk that must be paid by the public.

The insurance industry must inform the public how it works. The current misunderstanding shows failure to do so in the past. The fact that the public action sets costs and directs insurance premium increase or decrease is not understood generally. The benefits of a healthy insurance industry are only understood by those few who suffer a loss and not by the many who pay insurance premiums. Education of the general public and how their demands translate into costs to the consuming public is essential if the demands are to be contained within reasonable bounds.

Insist on results which have a positive impact on the overall merits of the tort liability system in addition to seeking individual benefits of the attorney-client partnership.

Support the development of a more efficient injury compensation system which allocates more of the dollars available for compensation to the injured patient. Although any proposal to tamper with the jury system is met with a strong reaction, the propriety of empanelling juries who cannot always understand the complex issues in the health science field should be questioned.

Insist on a higher level of risk management and control in all health science disciplines. Although the cost of risk in health sciences has traditionally been a minor cost of care, it has the characteristics of becoming an economic problem with the potential of hindering the progressive development of procedures in the health sciences. Health care professionals must get out of the business of taking risk and into the business of defining them so that others, whose decision on risk will not expose them personally to liability, can select what risk we as a society can afford and are willing to take.

The guidelines outlined above seek leadership from the most effective sources to create the most workable system, realizing a more workable system is required one way or another and must come either on a voluntary or forced basis.

A solution to the problems we have will eventually be developed because without a solution, medical care delivery can become cumbersome and expensive. However, it may be three to seven years before we have a viable solution that will last for a while. What do health care providers do in the meantime?

Based on my experience in dealing with the operational and financial considerations of this problem for several years, it is suggested that these guidelines can be used to develop a management plan for the short run which can also have a positive effect on long range solutions.

1. Determine what your exposures are from a medical/legal standpoint, and what can be done to contain those exposures—a professionally oriented survey.
2. Determine how much risk can be funded by your organization in a one year period and over a 10 year period which won't create financial disruption—assume that risk as a cost of doing business.
3. Develop an incident data base to determine where your potential claims are coming from—an ongoing process, the need for management information.
4. Locate other institutions or individuals who have similar problems and pursue joint funding of loss levels which are causing insurance underwriting difficulties. Grouping can increase the ability to assume risk on an economically sound basis.
5. Hire or appoint hospital, clinic or office ombudsman to listen to complaints.
6. Institute a claims management ability and give it the same priority as is given accounts receivable in the administrative structure.
7. Involve all health care personnel in a program oriented to "I care" about patient care.
8. Formalize and standardize guidelines oriented to the management of risk.

One of the good effects of the current problem is more emphasis on the above guidelines. Organizations such as applied risk management now can provide alternatives to insurance purchase which has been the sole solution to handling this pressing problem. ■

Irvin D. Nicholas is vp of Fred. S. James & Co. and is responsible for the Applied Risk Management Division in San Francisco. He is former insurance and risk manager of the University of California and is past president of the University's Insurance Managers Assn. (UIMA). He has served as a member of the California Hospital Assn. Insurance Committee (CHA) and as Director of the Public Agency Risk Managers Assn. (PARMA). Mr. Nicholas is a lecturer on risk management at the University of California, Berkeley and has conducted seminars on risk management in this country and in London.



The technology involved in treating patients and delivering health care has developed faster than the techniques to deal with risks involved in using these procedures.

RISK MANAGEMENT NOTES

Fire set by workers teaches safety lesson

By WARREN, McVEIGH, GRIFFIN & HUNTINGTON
risk management consultants
San Francisco—Newport Beach

BECAUSE TORCH CUTTING and welding constitute one of the most severe fire hazards in industry, most plants have strict rules about designated areas for this work with standby firemen followed by fire watches wherever the work must be done in the vicinity of hazardous materials. The most hazardous areas are those which involve flammable liquids or fast-burning solids such as foam rubber.

A recent fire shows what happens when the rules are not enforced. Chrysler Corp. had a large packaging plant at Coventry, England, which suffered $15 million damage from a fire started by welding. A subcontractor firm failed to observe the plant precautions and set fire to foam rubber sheets which spread the fire too fast to be controlled by hand extinguishers.

Some observations which plant managers can draw from this incident are:

- Locations having multi-million dollar values of combustibles should be sprinklered. The fire report did not mention sprinklers, but since sprinklers in Europe are far less prevalent than in the U.S. we assume they probably did not exist at this plant. Fire does not respect international boundaries and sprinklers should be installed more on the basis of values at risk than fire frequency.
- Proper enforcement of cutting and welding rules is a never-ending job which should not be slighted.
- Contractors who work on your premises should assume responsibility for the results of their negligence by a hold-harmless agreement with the owner. This agreement should be supported by insurance for bodily injury and property damage liability in adequate amounts. In the case above, limits of $15 million would have been necessary.

CROSS LIABILITY

Suppose your company is an additional named insured on the liability policy of another company. An employe of the other company is injured and sues your company. Unfortunately the policy excludes employe suits so you are not protected under this policy.

Suppose now that there is a claim against you for property damage caused by your employe but the property was in the custody of an employe of the other company. Again, you would have no protection because of the exclusion of the property in the insured's care, custody, or control.

To eliminate these problems, you should have a "cross liability" or "severability of interests" clause wherever two or more companies are covered in a single liability policy. Though some writers make a distinction between them, we see no difference between the two terms and hope our readers will inform us if they know of any way in which these clauses differ in their results.

One policy we saw has separate cross liability clauses for bodily injury and for property damage. The one for bodily injury states:

"It is agreed that employes of one insured shall be deemed not to be employes of any other insured with whom they have no contract of employment."

The property damage cross liability clause states:

"In the event of damage to or destruction of property belonging to any one or more named insureds for which another named insured is or may be held liable, then this insurance shall cover such named insured against whom claim is or may be made, the same as if separate endorsements had been issued to each named insured, but the company's total liability under this insurance shall not exceed the policy limits irrespective of the number of named insureds involved."

A severability of interest clause from another policy states:

"In the event of claims being made by reason of personal injuries and/or property damage and/or advertising liability suffered by one insured herein for which another insured herein is or may be liable, this policy shall cover such insured against whom a claim is made or may be made in the same manner as if separate policies had been issued to each insured herein. Nothing contained herein shall operate to increase the company's limit of liability."

We believe this could be stated more succinctly and clearly but it does illustrate the intent.

NON-OWNED AUTOS

On a number of occasions, we have seen non-ownership liability coverage endorsed onto a comprehensive auto liability policy. Oddly enough, this actually decreases, rather than increases, coverage.

Comprehensive auto liability automatically includes "employers' non-ownership" liability coverage (though not specifically labeled as such) since coverage applies to any auto not excluded, and liability arising out of the use of non-owned autos is *not* excluded. The "non-ownership" endorsement states that non-owned commercial autos are covered only if use is "occasional and infrequent." No such limitation exists on the comprehensive auto liability form. The "non-ownership" endorsement should therefore not be used with a comprehensive auto liability form but only with more restrictive auto forms, such as the basic auto liability. ■

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RIMS/Report

Wisconsin risk manager stakes hope in public liability insurance policy

By JOANNE GAMLIN

LOS ANGELES—The state of Wisconsin has put together a single, manuscript public liability insurance policy that in the mind of its risk manager, Gordon Gronert, does away with most of the woes besetting governmental bodies.

Mr. Gronert told a public bodies industry session at the 14th annual conference of the Risk & Insurance Management Society that he concluded that a single manuscript public liability policy would be workable in Wisconsin because, for one thing, the state still retains immunities that prohibit it from being sued. State employes, however, can and have been successfully sued as individuals, he said, and when they are, the state must pick up the tab.

When an examination of the state's public liability losses disclosed that the worst year produced only $400,000 in losses, it was decided to work out a policy that would combine a $1 million per occurrence self-retention policy with excess coverage. The plan was to insure all public liabilities except aircraft.

"With that concept, we went into the market with 'controlled bidding,' that is, my brokers could not approach any underwriter without my foreknowledge," Mr. Gronert told the session.

The result, he said, was a two-layer public liability policy which combines the $1 million per occurrence retention with a $25 million excess layer and a $2.5 million annual aggregate on what the state must pay out for public liability.

Sentry Insurance Co. was chosen to underwrite the excess layer, Mr. Gronert said. Sentry wanted to underwrite the coverage, he noted, in part because it liked Wisconsin's immunities. The carrier also stipulated that it wanted the claims handling business.

He told the group he regards the claims handling work performed by Sentry Claims Service as probably the best and most economical route the state could have chosen.

"When it became known that Wisconsin was assuming a large retention in public liability, we received phone calls from insurance company claims handling people who were looking for work," he related. "If we had hired a staff, it would have cost us $50,000 to $60,000 a year in salaries."

But with the work performed by Sentry Claims Service, he said that he, an assistant, and a loss control officer can handily process claims for about $10,000 a year. The claims service organization charges $13 an hour for its work.

The policy became effective late last year, and, at this point, with five months experience on the books, only $75,000 has been put aside for claims and reserves, he said. Premiums on the excess insurance amount to $238,000 a year.

Mr. Gronert noted that much of the reticence manifested among underwriters during the bidding process resulted from the fear of medical malpractice claims. The state employs 800 doctors. Prior to the creation of the single, manuscript public liability policy, the state was paying approximately $180,000 a year for $1 million of medical malpractice coverage for those physicians.

Eventually, Mr. Gronert said, aircraft liability and perhaps even workers' compensation will be rolled into the policy.

Mr. Gronert went on to forcefully advocate the use of claims handling services. He described Wisconsin's relationship with Sentry Claims Service as "beautiful." He added: "It is wise to get into bed with the organization that is handling your claims."

The risk manager, who staunchly defended Wisconsin's property insurance fund by pointing out that "we pay about 40% of the going insurance rate on our state buildings," might have been one of the few public entity risk managers at the session who was unequivocably content.

Bob Pidcock, risk management advisor for Clark County, Nv., was another public entity insurance representative with a positive report to present.

He said that when his county put out specifications in January for companies wishing to place bids on the county's group benefits program, underwriters were invited to meet with Mr. Pidcock and his cohorts in a rap session at which "everything we, the county, would do in-house was clearly spelled out."

Subsequently, he said that Continental Assurance Co., the underwriter that submitted the winning bid, agreed to produce monthly reports on the group employe benefits program. Those reports, he said, are reviewed by Jim Banner, an assemblyman who represents Clark County and who has evinced interested in the county's insurance problems. Mr. Banner was in attendance at the public bodies industry session.

Given the unsettled conditions in the insurance industry, it is not surprising that Mr. Gronert and Mr. Pidcock were not joined by many others in their descriptions of solid underwriter relationships.

James Loeb, risk manager for Scottsdale, Az., was more typical. He told his puzzlement over a 25% premium rate boost from his life/health carrier during a session on problems in the employe benefit area. Mr. Loeb said that while his former life/health underwriter lost money in 1970, 1971 and 1972, the company was able to reduce rates in 1973 and 1974.

"We know that the malpractice problem could cause our rates to rise in 1975," he continued. "But we were also aware that the underwriter had $37,000 in estimated reserves."

Mr. Loeb said that the contract for the policy was put out to bid with the expectation that the existing underwriter, which has written life/health coverage for Scottsdale for five years, would have submitted the low bid.

"They didn't," he underlined. "They came in with a bid that was 25% higher than our existing rates, citing the instability of the insurance markets and above all, the malpractice situation.

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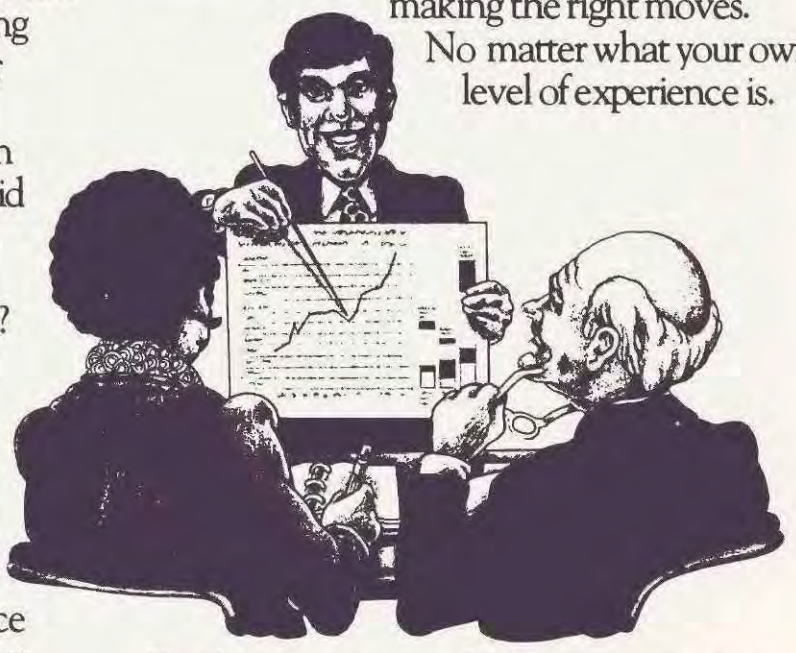
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"But what I really suspect," he said, "is that my former underwriter was not honorable in the negotiations." On the other hand, he acknowledged that it is possible that the new carrier deliberately underbid the business and that a hefty rate hike is in prospect for 1977.

Dennis G. Tweedale, risk manager for the city of Madison, Wi., was another risk manager with a supplier problem. He said he has been unable to obtain experience data from the Wisconsin Physicians Service (WPS), a health maintenance organization, which has approximately one-third of his group benefits program. Although the organization does compile experience data for individual WPS physicians, it has stubbornly refused to put together the sort of group experience data needed by his department, he said.

Another problem with WPS, he said, is an apparent over-utilization of hospitalization benefits. "I believe the doctors encourage it," he asserted.

Don Walsh of the Continental Assurance Co., Chicago, pointed to 11 problems that his company has encountered in accepting insurance specifications from political subdivisions. Chief among the problems enunciated by Mr. Walsh: The requirement that the contract be put out to bid each year and that a 90-day notice of rate change be given by the underwriter.

Mr. Walsh also said, to a chorus of objections from some of the risk managers at the session, that "minimal governmental contributions" are another woe for CNA in underwriting for public bodies.

"The state of Arizona pays $15 a month for group health programs for its employes," he illustrated.

However, Mr. Walsh agreed generally with session members that West Coast political subdivisions "are 10 years ahead of public bodies elsewhere in paying for employe health plans."

C. C. (Bud) Griffin of Warren, McVeigh, Griffin & Huntington, warned that a lot of municipalities in California at least "are a lot more solvent than the companies from which they are buying insurance."

He went on to strongly urge public entity risk managers to compile their own data bases. Information supplied by insurance companies, he said, "is not usable." ■

F. B. Hall in Pittsburgh

Frank B. Hall & Co., the fourth largest insurance brokerage firm in the U.S., opened an office in Pittsburgh. Bryan C. Hondru, vp, was appointed to manage the new office. Previously, he was in charge of the employe benefit department in the firm's Philadelphia office. Frank B. Hall has 61 offices in the U.S. and abroad.

Prefer managing risks to underwriting them

LOS ANGELES—"Insurance companies are chasing the big corporations with their big risks into the establishment of captives," according to Robert Spencer, vp insurance, Fuqua Industries Inc., Atlanta, Ga.

Mr. Spencer was one of three speakers to lead a mini-seminar on captives at the 14th annual conference of the Risk & Insurance Management Society which was held in Los Angeles.

The insurance executive who was joined by David L. Cassell, vp, Johnson & Higgins, Atlanta, Ga., and by Joe Fahys of General Reinsurance Co., Greenwich Ct., also told the group that insurance companies are now tending toward providing risk management services rather than being risk bearers.

Mr. Cassell of J&H told the seminar that in his view medium-sized concerns which are too small to go the captive route are, in his opinion, in a real bind. "I feel sorry for them," he said.

Companies that qualify for the establishment of captives, he continued, are those with casualty insurance premiums in the neighborhood of $1 million and with property premiums in the area of $500,000.

Underscoring the fact that soaring premiums were indeed on the minds of risk managers in the audience—which was probably why they were in the seminar in the first place—was the fact that when a risk manager observed that his premiums for casualty insurance fell below the $1 million a year level, another insurance man in the audience cautioned: "Wait 'til next year."

Even though Mr. Spencer admonished the group that "captives should not be done only for premium savings," it was apparent from questions from the audience that spiralling premiums were much on the minds of those at the seminar.

A number of risk managers voiced their opposition to having their premiums hiked not because their company's experience was bad but because the experience of their industry was poor.

Mr. Spencer explained that in his opinion a captive should not be used as a surrogate for self-insurance.

"In our workers' compensation program, for example, we self-insure in all states where it is permissible; in Texas and New Jersey where self-insurance is prohibited we are 20% insured," he said.

"This section of our workers' compensation program has gone into our captive," he continued. Mr. Spencer noted that a small portion of his casualty insurance program is currently held in his corporation's captive. He added that he anticipates that more casualty insurance will go into the captive in the future.

Mr. Spencer said that a captive should not, in his view, be used for first dollar coverage.

Corporations that are contemplating the establishment of a captive should think of domiciling them in Bermuda, advocated Mr. Cassell. Among its first rate advantages, he said, are an absence of restrictions on accounting procedures and investments. Mr. Cassell also mentioned the modest capitalization, between $120,000 and $150,000, needed in Bermuda.

A spokesman for the Isle of Guernsey told the group that taxes on a captive in his island run around $600 a year, less than in Bermuda. The Isle also boasts "a legal structure, you know," a stable government and status in the common market, according to the spokesman.

Gary Kelly of Royal Globe Insurance Co. of New York, a member of the audience, expressed skepticism about the ability of corporate captives to handle reinsurance.

Agreeing was Joe Fahys of General Reinsurance. He related that General Re will do business with few captives of U. S. companies that approach his company. "Almost without exception, they need professional help from the outside," Mr. Fahys said. ■

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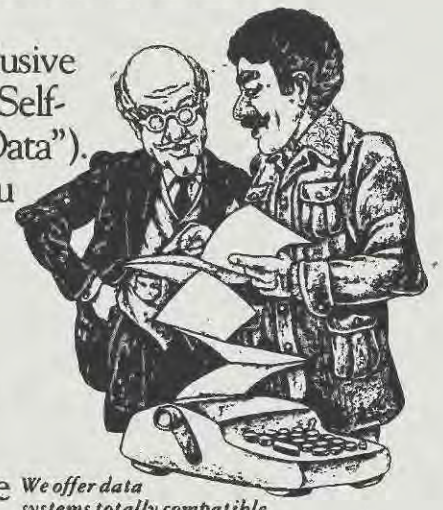
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Annuity cheaper than big malpractice award

By MARGARET LeROUX

LOS ANGELES—The high cost of malpractice and liability judgments has prompted risk managers to look at annuity settlements, described as "cheaper and easier on the cash flow," by a participant in an industry session at the Risk & Insurance Management Society (RIMS) conference here.

RIMS/Report

An interest in the malpractice issue brought together members of two sessions, hospitals and universities, for a special discussion of the problem. It was at this special malpractice session that the use of annuities, agreements by insurers to make periodic payments that continue for the lifetime of the recipient, was brought up.

Stanford Parker, risk manager for Loma Linda University, explained that the use of annuities in malpractice case settlements in California has become more popular since enactment of the state's malpractice law, referred to as AB1, late last year.

The law states that a judge in a malpractice case can direct that the settlement be made through an annuity, although there is no requirement that he do so.

"You don't need enabling legislation, however, for an annuity," a California broker involved in several annuity settlements, later explained. "I don't know of any state in the union where you can't use an annuity in malpractice settlements."

By using an annuity, a malpractice case can be settled for far less money by the defendants and the insurance company, while the plaintiff (or malpractice victim) can be assured a lifetime benefit, a broker with Walker & Co., a Los Angeles firm representing the California Hospital Assn. explained.

"It's also a method by which the insurance company can close the books on a malpractice case," he added, thereby solving the long tail problem of malpractice cases.

The broker cited two examples of annuity settlements involving liability cases and their corporate defendants.

Walker recently arranged an annuity settlement for an auto accident case naming the Ralston Purina Co. as defendant, the broker said.

The victim was a permanent paraplegic as a result of the accident and was seeking a $3 million judgment against the company.

An annuity providing the 25 year old victim with a monthly benefit for the rest of his life was purchased for "approximately $800,000" the broker noted, a considerable savings from the amount originally sought.

Walker is currently researching the possibility of an annuity settlement in the $7 million liability judgment against ITT-Sheraton Corp., the broker said. The case involved a youth injured in a swimming pool in a Sheraton hotel (*Business Insurance*, June 2, 1975). The case is on appeal.

The major markets (life insurance companies) interested in writing annuities for malpractice and liability settlements include Manufacturer's Life Insurance Co., INA and National Fidelity Life Insurance Co., speakers noted.

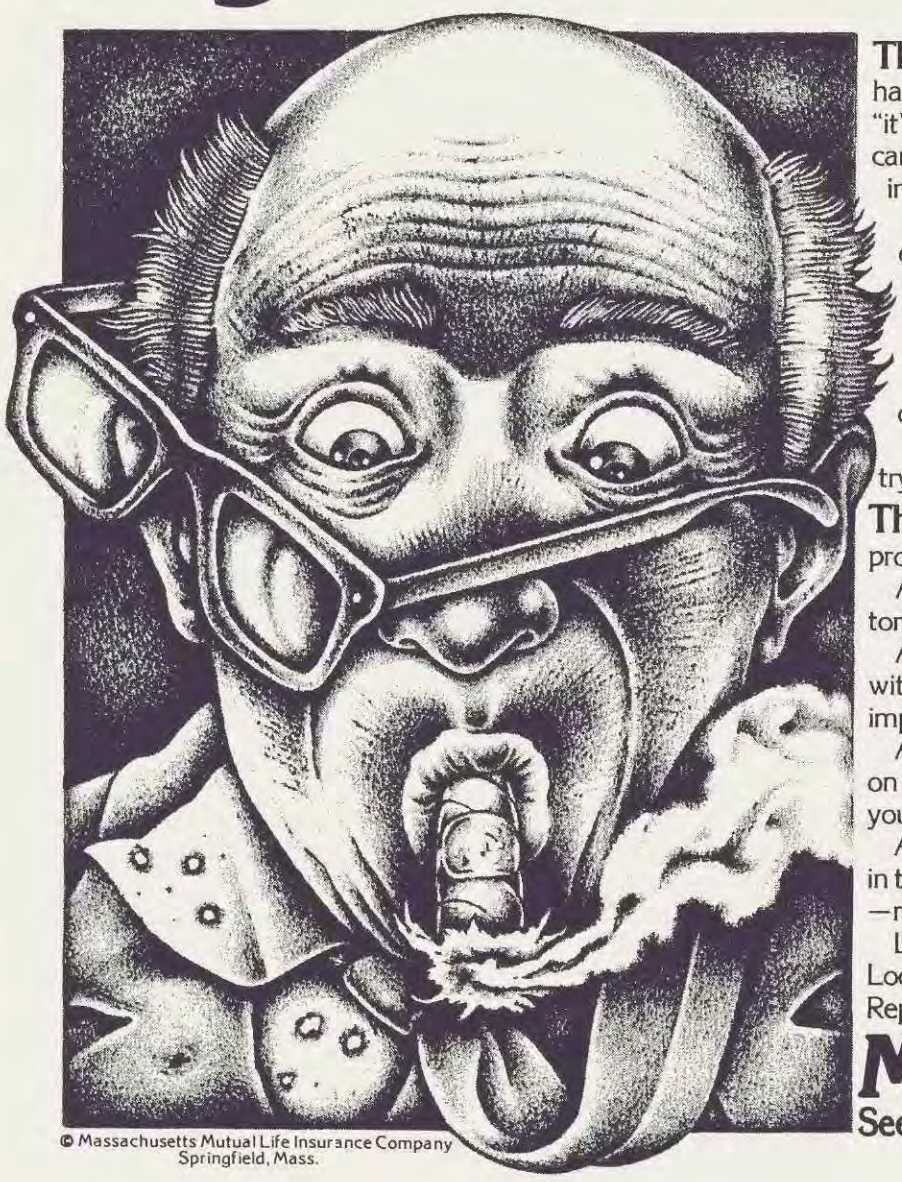
"An annuity settlement in malpractice cases is an idea whose time has come," another insurance industry source noted, "I expect to see more use of them in the future." ■

Too bad Charlie!

A $3.2 million vessel, with $100,000 worth of tuna aboard, was abandoned after it sank at the mouth of the Columbia River, Washington. Fireman's Fund Insurance Co. insures the Bettie M, owned by Bumble Bee Fish Co., Astoria, but claims that its responsibility does not include removal of oil or cargo. The U.S. Coast Guard had demanded that 7,000 gallons of diesel oil remaining on the tuna boat be removed. The ship went aground in mid-March.

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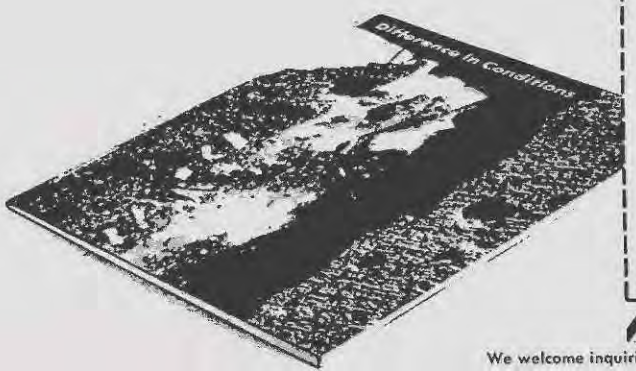
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Punitive damages may be excluded from reinsurance treaties in future

LOS ANGELES—There is a trend toward reinsurers writing exclusions on coverage of punitive damages into their treaties.

And when they do, the primary carrier must follow suit, warned Clinton H. Greene, director of underwriting in the national accounts department, Aetna Life & Casualty, Hartford, Ct. He later told *Business Insurance* that he knows of one reinsurer who has already written this restriction into a reinsurance treaty.

Mr. Greene was addressing a mini-seminar on "The Risk Management Approach to Punitive Damages," which was part of the 14th annual conference of the Risk & Insurance Management Society held here.

On the panel with Mr. Greene were Evan Sorby, assistant vp, Marsh & McLennan, Seattle; Dave Lentz, vp of benefits/risk management, Federal Cartridge Corp., Minneapolis, Mn.; and Andrew C. Meuwissen, CPCU, director of corporate risk/employe benefits, the Peavey Co., Minneapolis, Mn.

RIMS/Report

Mr. Greene joined Mr. Sorby in warning the audience that the exposure to punitive or exemplary damages is rising rapidly.

Mr. Lentz strongly advised risk managers at the seminar to scrutinize their policies to see if their primary and excess liability carriers agree on the definition of how they will handle punitive damage claims. Real difficulty can arise, he pointed out, when an excess liability underwriter declines to cover a punitive damage claim while the primary carrier has committed itself to take this action.

"I learned that it's best to buy primary and excess liability coverage from the same underwriter," Mr. Lentz asserted.

Mr. Sorby, however, offered some reassurance when he said that "in the absence of a court precedent or a statute in the jurisdiction in which the lawsuit is being brought, it is reasonable for the insured to assume that the insurance company will defend and pay a punitive damage claim."

"You have to become concerned about punitive damage claims whenever there is outrageous conduct," continued Mr. Lentz, "such as that found in malice, fraud, gross negligence or wanton disregard for the truth."

Areas where punitive damage exposure is on the rise, he said, include breach of contract, libel and slander, and, of course, product and medical malpractice liability.

Mr. Lentz went on to call fiduciary liability "a can of worms." Although there have as yet been no fiduciary liability lawsuits containing punitive damages brought under the Employe Retirement Insurance Security Act (ERISA), he said that attorneys are confident that such suits will arise in the future.

"Vicarious liability" in which an employer is liable for the actions of an employe is another area of widening exposure, he said.

Mr. Greene noted, at the same time, that it is becoming true that an employer is not held liable unless the defendant employe's superior can be shown to have ordered the action for which the employe is being held liable. He observed that a common area of "vicarious liability" comes about when an injured employe turns to suing a third party manufacturer because he is barred by workers' compensation laws from taking legal action against his employer.

Libel and slander are becoming an area of greater exposure, it was said, in cases where it can be shown that an employer "discriminated" against an ex-employe.

Job termination must be handled with caution, the risk managers in the seminar were advised.

However, "there is very little a risk manager can do in the insurance area to protect his corporation against punitive damage lawsuits except to be sure that the limits on the company's liability coverage are adequate," said Andrew C. Meuwissen, director of corporate risk and employe benefits, the Peavey Co.

Outside of that, he said that risk managers must examine the attitudes of their insurance companies, from the primary level on up, toward defending punitive damage claims.

Risk avoidance, nevertheless, can play a crucial role in preventing the filing of punitive damage lawsuits, he said.

Mr. Meuwissen said that chief among the risk avoidance tactics which a risk manager can follow is the preserving of detailed records which can be employed in the defense of a liability claim.

"Of course," he quickly added, "records can be a two-edged sword." Records which appear to be detrimental to a defense action should be deliberately discarded, he indicated.

Mr. Meuwissen further pointed out that in lawsuits there "is no such thing as a personal file—every file, including those of in-house legal counsel, can be subpoenaed."

Mr. Greene cautioned the group not to keep humorous comments in the documents which are being preserved for possible defense purposes. He said it is easy for opposing attorneys to turn the fun and games against the defendant corporation.

Warning labels are a crucial tool in risk avoidance, asserted Mr. Lentz. Still, he noted that companies like his own, which manufactures ammunition, can have problems in placing the warning label.

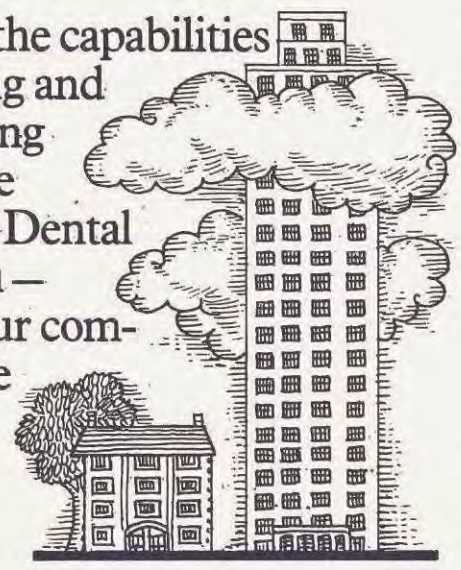
Product recall, another risk avoidance tactic, can run into trouble when vendors refuse to cooperate, said Mr. Lentz. To avoid such problems in the future, he said his company now requires all its vendors to cooperate in product recall actions. ■

Caterpillar benefits

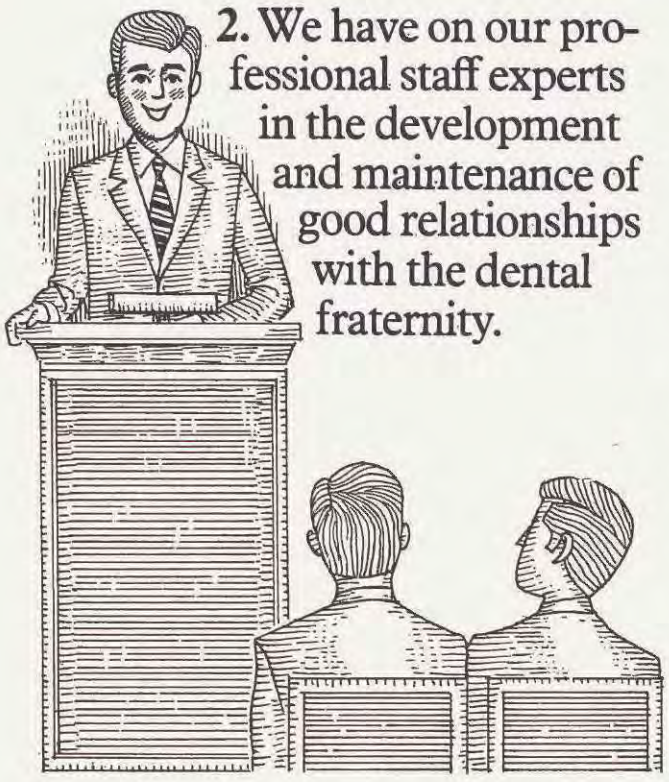
A total of $48.5 million was paid by Caterpillar Tractor Co. in 1975 for group insurance benefits for employes and dependents in the Peoria area, according to Jack Ziegler, manager of employe benefits. Costs included $33.3 million for hospital, medical and prescription drug benefits with $16.9 million paid to area hospitals for claims; $6.1 million to area dentists under the company's dental plan; $3 million for life insurance and accidental death and dismemberment benefits; and $5.8 million for weekly disability and long term disability benefits.

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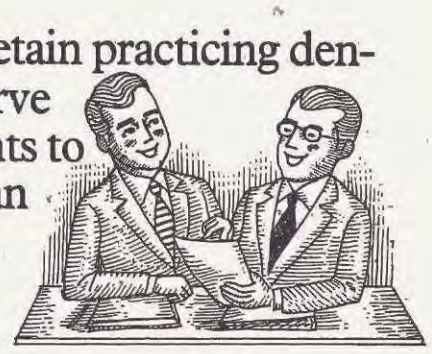
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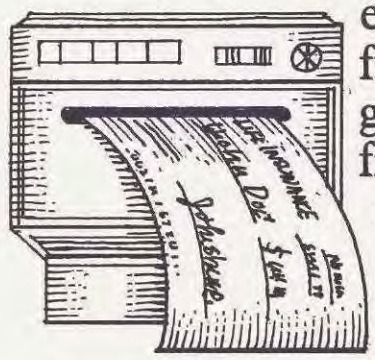
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Avoid crisis bargaining with careful research

LOS ANGELES—"Be prepared" may be a good motto for the Boy Scouts but it is equally meaningful for an employe benefit manager who participates in labor union negotiations.

That's the message that Earl G. Mink, savings plan manager for group insurance, Lockheed Aircraft Corp., Burbank, Ca., brought to a mini-seminar on the role of the employe benefit manager in negotiating with labor unions. The seminar was part of the 14th annual conference of the Risk & Insurance Management Society.

Mr. Mink, who said that he personally participates in labor union negotiations that involve employe benefits, told the seminar that "the major role of the employe benefits manager is research."

The point is to avoid "crisis" bargaining, he asserted.

He said the employe benefit manager must be intimately acquainted with research information in order to discuss and dissect it in detail at a moment's notice during a negotiating session. The research itself should include what competing corporations are doing in the benefits area and what the costs are on proposed changes and improvements in the employe benefit program under discussion.

"We give a complete presentation, including hisotrical data, of our employe benefit program during our labor negotiations," said Mr. Mink, noting that health care costs are rising steeply everywhere, including the federal government, where he said employe health costs are up about 30%.

Being on the inside of what is occurring in the employe benefit area in other companies in an industry group is essential for any corporate executive who is part of a management team engaged in union negotiations of benefits, he underlined, elaborating:

"When a union negotiator says that ABC Co. is doing thus-and-so, the company representative must be able to respond that 'yes,' it does offer this coverage, but it does not do something else, and if you (the union) want the stated new benefit, you must be prepared to give up something else."

Mr. Mink added that although he is not directly involved in claims, he makes it a point to stay abreast of what is happening in that area too.

Projections of the cost of proposed benefit improvements, he continued, must be at the fingertips of participants in group health labor negotiations.

"You cannot be in a position to have to go back to the carrier," he warned, adding:

"Sometimes, there are only two to three hours in which to become informed on the cost of projected health benefit improvements."

As for the selection of a benefits underwriter, he said that Lockheed, not the union, does the selecting.

Stabilization of group health costs is a natural goal of all corporate negotiators, Mr. Mink went on. He said that Lockheed Corp. uses cents-per-hour negotiations to introduce stabilization into negotiations.

"We tell union negotiators that we will buy whatever dental care coverage they want for a given limit, such as eight cents an hour over a contract period of say, three years," he said. "That is, of the total health care package under negotiation, we will provide whatever dental care benefits the union wants which fit the cost parameters of eight cents an hour."

Naturally, a company must make a good faith effort at negotiation, he went on. However, he pointed out that just because a company puts a program on the negotiating table doesn't mean that it has to yield these benefits in the final contract.

Mr. Mink urged that company negotiators acquiesce when a union representative makes a request to examine a certain document.

The Lockheed group insurance officer also advocated that corporate negotiators pay close heed to the language of the final employe beenfit contract. The language, he said, must be "foolproof."

A member of the seminar asked whether representatives of the benefits underwriter should be allowed into the bargaining sessions.

Mr. Mink replied that while the insurance representatives should be nearby in order to be available for questioning, they should not participate directly in the negotiations.

One reason for this, volunteered a member of the audience, is that "'underwriters are apt to give away too much." ■

OSHA inspections

March inspection figures for the federal Occupational Safety and Health Administration totaled 7,487, reflecting a slight increase over the March 1975 figure of 7,273.

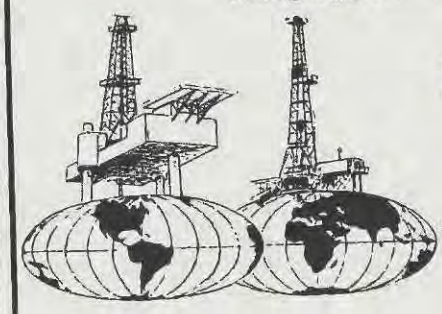
The inspections resulted in a total of 6,361 citations covering 31,985 violations, the bulk of which were classified by the Labor Department as "non-serious."

About $420,000 in penalties was proposed by OSHA for the 30,753 "non-serious" violations, with nearly $448,000 in penalties for the 704 "serious" violations.

Year-to-date inspections totaled 24,043 at the end of March, with nearly $1.3 million in penalties proposed.

OSHA inspectors found 528 "willful or repeated alleged violations—imminent danger."

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Berry Griffin bows out regretfully

RIMS chooses Gentry to succeed Sullivan as new national president

LOS ANGELES—Ralph E. Gentry, insurance manager for the Times Mirror Co. here is the new president of the Risk & Insurance Management Society. He succeeds Daniel E. Sullivan of Northern Telecom Ltd., Montreal.

Elected with Mr. Gentry at the RIMS 14th annual conference in April was an executive committee for 1976-1977 including Robert S. Spencer, vp of insurance for Fuqua Industries, Atlanta, as RIMS first vp.

Other vps elected for specific duties were: William P. Stouffer of Federated Department Stores, Cincinnati, as conference vp; C. J. Spivey of Charlotte Mecklenburg Insurance Advisory Committee, Charlotte, N. C., as communications vp; C. Paul Kipp, of U. S. Gypsum Co., Chicago, as industry and governmental relations vp.

RIMS/Report

Also: Ronald H. Kaiser of Lavino Shipping Co., Philadelphia, as research and education vp; Paul H. Ozan, assistant treasurer of American Greetings Corp., Cleveland, as member affairs vp and secretary; and John Robert James of Chemical Bank, N. Y., as vp and treasurer.

Each of the new RIMS officers gave a report on his area of concern at the society's annual meeting held during the conference. A high school band from Torrance, Ca. played a tune introducing each speaker. Appropriately, no one in the audience seemed to recognize the band's rendition of "We're in the Money" which preceeded treasurer James's announcement that the executive committee of RIMS is ready to suggest a "nominal" membership dues increase.

Mr. James told the meeting that although by March 31 RIMS showed a net gain from operations in the form of a 25% increase in income compared with the previous year, the society still needs new income after two years of loss.

Separately, Mr. James told *Business Insurance* he did not know how much the "nominal" dues increase might amount to, but that it would not be large enough to stir any kind of "controversy."

Members in 1974 had protested when RIMS (then the American Society of Insurance Management) voted to increase annual dues from $65 to $100, following ASIM president William Altstaetter's proposal that they be increased to $200 (*BI*, Oct. 14, 1974).

Reporting on the society's membership drive, which started in mid-October of 1975, vp Paul Ozan said RIMS got 110 new members for an increase of 5%, and now has a total membership roster of 2,250. In addition, the society added its 50th and 51st chapters during the year, in Manitoba and Orange County, Ca.

The first non-member of RIMS to make a report at an annual meeting was William Goodall Jr., chairman of the board and chief executive officer of Allendale Insurance Co.

He told the risk managers that the insurance industry shares with them an "increasing concern" over the cost of insurance, and suggested that 1976 is "a good year to breathe more life into loss control."

His company will be asking risk managers about ideas for audio visual methods to educate line operations personnel to better involve them in loss control.

Illustrating Mr. Goodall's remarks were slides of wild animals which his company uses in advertising to draw a comparison between "endangered species" and endangered insurance coverage. The North High School Band apparently got its song sequences mixed up, and as an introduction to new RIMS president Ralph Gentry's remarks to society members, it struck up a few stanzas of "You've Got to Talk to the Animals."

Mr. Gentry urged the RIMS members to increase their publishing activity this year, particularly by submitting stories to the society's monthly magazine, Risk Management.

Another plea for more active professional involvement by risk managers was made at the meeting by Richard L. Rottman, president of the National Assn. of Insurance Commissioners and insurance commissioner of Nevada.

Commissioner Rottman charged there was a lack of communication between risk managers and state insurance commissioners, and he urged that some "grass roots" contact between RIMS members and state regulators be initiated this year.

He told the audience they had a vital stake in many of the issues the regulators deal with and that the regulators needed their input, particularly in dealing with questions of insurance company solvency, types of proposed rating laws and market availability of insurance coverage.

"Some markets you found aren't very stable," Mr. Rottman said. "You must work with regulators to see which are stable. It doesn't look good for you to keep rolling over coverages."

In what appeared to be an attempt to rouse the RIMS members to a challenge for the coming year, Mr. Rottman charged that the NAIC "hasn't seen any serious efforts by your group to encourage insurers outside of Factory Mutual to pool resources and to research on loss prevention."

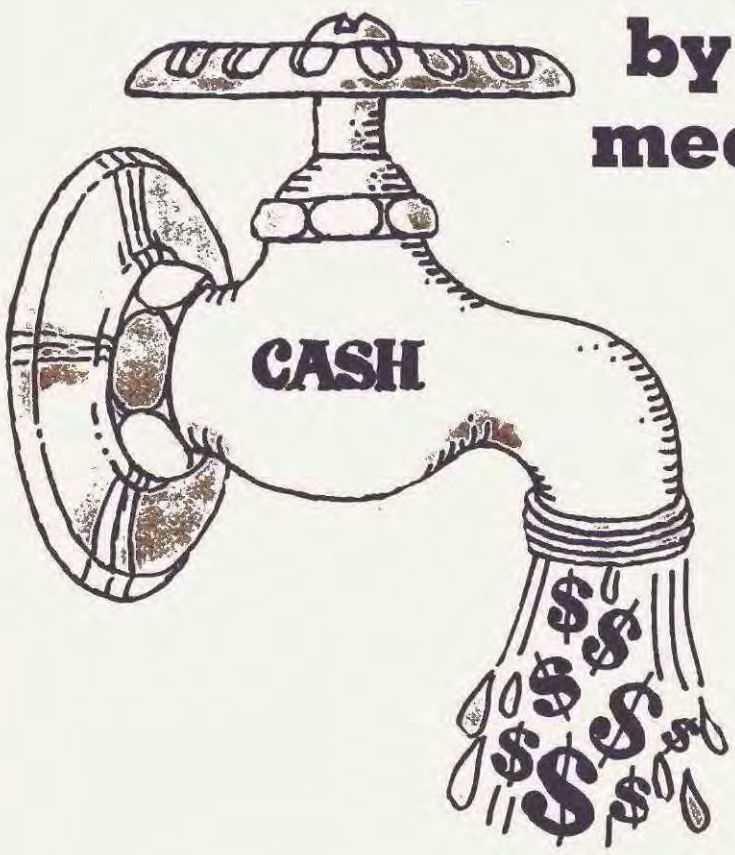
He warned that in the liability area, the crisis proportions of the malpractice situation would just be a forerunner of what could evolve, and he told the RIMS audience they could help chart the course of future reform if they would seek some involvement with state regulatory authorities.

Also addressing the annual meeting was Robert W. Daum, Jr., president of the Society of Chartered Property & Casualty Underwriters (CPCU).

Mr. Daum, speaking on professionalism, commented that risk managers participation in the CPCU society is "not impressive." He estimated that out of more than 8,000 CPCU members, just a little over 1% represent the business of risk management. He proposed a closer working relationship between RIMS and the Society of CPCU to improve those figures.

Continued on following page

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Continued from preceding page

Mr. Daum said the Society of CPCU has developed a more detailed code of professional ethics dealing with both specified and unspecified ethical conduct. Commenting on corporate ethical behavior in general, Mr. Daum said the insurance industry now faces a serious conflict of interest situation with the bankruptcy of Pritchard & Baird, a reinsurance intermediary.

"In my opinion many of the problems leading up to this regrettable situation in what was once one of the respected names in the reinsurance business can be set right at the doorstep of those same conflicts of interest—the combination of reinsurance broking and underwriting management," he said.

"While there were many other problems of recordkeeping and alleged mismanagement, I am convinced that the ability to competitively quote conditions and price and then have the market or a substantial portion of it under the same control, is wrong."

One departure from the usual procedure at the annual RIMS meeting was an announcement that Berry L. Griffin Jr., corporate risk and benefits manager of Baker International Corp., would be stepping down from the executive committee of RIMS after four years.

Mr. Griffin, who served most recently as RIMS first vp, was in line to become RIMS president this year, but his duties at Baker, where he has begun a new job, will prevent this.

Giving over the presidency to Ralph Gentry, Mr. Griffin gravely remarked that "a new job and the presidency of RIMS don't mix." ■

Acquire N.Y. brokerage

California-based Emett & Chandler acquired J. S. Frelinghuysen Corp., a New York brokerage firm, and its reinsurance company, Hudson Treaty Service Corp. Both are subsidiaries of Fidelity Corp., Richmond, Va. Emett & Chandler is a wholly owned subsidiary of Pinehurst Corp., Los Angeles, an insurance service and reinsurance company.

Surdam of Polaroid wins Cristy award

LOS ANGELES, CA.—Theodore C. Surdam, senior financial analyst for Polaroid Corp., Boston, was named winner of the Risk and Insurance Management Society's (RIMS) 1975 Cristy Award at the 14th Annual Risk Management Conference here.

The award is presented annually by RIMS to the recipient of the Associate in Risk Management Diploma receiving the highest grade average in the three exams leading to the designation. It honors Jim Cristy, chairman of the RIMS education committee when the joint Insurance Institute of America/RIMS program in risk management was formed.

Mr. Surdam, a graduate of Northeastern University and member of the Boston RIMS chapter, has been with Polaroid since 1969. Prior to that he worked at Sanders Assoc. and Ford Motor Co.

Previously Cristy Award recipients include: Dennis Tweedale, City of Madison, Wi. (1974); Jack K. Biddick, Parker Pen Co. (1973); O. J. Sopranos, Amsted Industries (1972); Thomas R. Frank, Allied Van Lines (1971); William E. Baribault, The Price Co. (1970); William J. Dundas, Wisconsin Electric Power Co. (1969); H. C. Hervey, Texas Eastern Transmission Corp. (1968); and, Joseph T. Gormally, Pennsalt Chemical Corp. (1967). ■

Swiss reinsurance

Rhine Reinsurance Co. Ltd., described as a new kind of reinsurance company in Switzerland, was formed in Basle in March. The Company has a fully paid-up share-capital of Swiss Francs 10 million and a contributed surplus of Swiss Francs 3 million. Shareholders include: The General of Berne Insurance Co., Berne; Limmat Insurance Co., Zurich; Patria Life Insurance Co., Basle; Calidad Insurance Ltd., Hamilton; Hansa Mutual General Insurance Co., Stockholm; New Rotterdam Insurance Co. Ltd., Rotterdam; Vakuutusosakeyhtio Pohjola, Helsinki; Polaris-Norske Sjo Forsikrings-Aksjeselskapet, Oslo; and IRM International Reinsurance Management Ltd., Basle.

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After reporting oil spill, take aerial photographs

By MARIE KRAKOWIECKI

LOS ANGELES—Vessel or terminal operators involved in cleaning up an oil spill have a number of steps they can follow to efficiently manage the loss situation, risk managers at a maritime industry session were told.

Martin P. Detels Jr., an attorney specializing in maritime law, outlined a plan of action for dealing with large oil spills. Speaking at the Risk & Insurance Management Society's annual conference last month, Mr. Detels stressed that the first thing to do is immediately report the spill to the Coast Guard and the Environmental Protection Agency.

The Department of Justice seems serious in its intent to jail polluters who fail to report a major spill, the lawyer warned. Following the reporting function, a risk manager should consider taking aerial photographs of the parameter of the spill at frequent and regular intervals.

He explained that first estimates of oil amounts are usually five or more times lower than the actual amount of pollution. It is almost inevitable that claims will be filed charging a certain amount of property damage and damage to wildlife sustained within a given area.

RIMS/Report

By having a supply of aerial photographs, the risk manager can pinpoint exactly where damage has occured due to the spill at measured times after the incident. The Fish & Wildlife Service of of the U.S. Department of the Interior uses aerial photographs, he said, of the entire Pacific flyway. By having a trained analyst view the pictures, the government is supposed to be able to tell how many birds per square mile are in the area. Risk managers could make use of a similar technique with aerial photos for their own purposes.

In cases where there is any question of divided responsibility for the spill, Mr. Detels cautioned that both parties should sign a legal clause.

The clause would provide for a sharing of the cleanup costs, but without either party admitting liability for the spill. Then later, whichever party is judged liable can reimburse the other.

Vessel owners should give some consideration to filing a complaint for limited liability, Mr. Detels suggested. While maritime laws do not provide limited liability for oil spill cleanup costs, the very act of filing forces claimants to file for damages in the same district.

When the case comes up for trial then, there will only be one lawsuit which can be brought against the vessel owner (incorporating all the complaints) rather than a hundred separate complaints filed in different places. This greatly simplifies the legal situation for the vessel owner, although there is no real way he can expect to be granted limited liability.

Some public relations actions the attorney suggested included feeding, transporting and housing people like National Audubon Society members who come to the scene of the spill to help save the affected wildlife. It is highly unlikely that any insurance company would question expenses related to a response program like that, the lawyer pointed out.

A claims office for people who have suffered losses from a major spill should be opened up to serve both as a safety valve for their frustrations, and for an investigative tool for the risk manager.

Also, if a spill occurs in a marina area where other vessels are docked, it is a good idea to go in immediately and clean up all the hulls. This eases the public relations problem, which is usually severe, and is also much cheaper for the company than if it has to absorb the costs of repainting later.

All these steps are after the fact, but Mr. Detels also gave the group a number of suggestions on how to set up a risk management plan for managing oil spill cleanups before they happen.

He recommended an industry approach like that of the Clean Sound Cooperative, a 15-member Seattle group of refineries, oil terminals and oil transport concerns which join together to have a service contract with a clean-up contractor for spills.

The cooperative also owns additional cleanup equipment of its own and has a stock of communications equipment for use in spill situations.

In addition to adopting such an industry approach, Mr. Detels said every shore facility should have a formalized plan for the day when there is an oil spill. The facility should have an inventory of equipment, technical personnel to be called upon, and like the Seattle group, should occasionally do a "dry run" of actions to take in the event of a spill.

Finally, risk managers with spill exposures should make every effort to get research and scientific information on the pre-spill nature of the environment and the possible impact of a spill. Knowing in advance just how many birds, oysters, clams and the like live in and around the waters which may be polluted will help clarify claims of possible damages which could come up later, Mr. Detels told the meeting. ■

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Pays cost of 2nd opinion

WASHINGTON—An experiment to determine how much nonemergency surgery is really necessary—often cited as a cause of soaring health costs—is going on at several Blue Cross plans which are offering to cover the costs of obtaining a second opinion.

If the second doctor disagrees with the first, the plans will then pay for a third opinion, including the physician's fee, x-rays and laboratory tests.

The new benefit is currently available to select groups in the Blue Cross plans of the Greater New York metropolitan area, Northeastern New York, and New Hampshire/Vermont. Blue Cross plans in Massachusetts and Michigan will offer the experimental benefit beginning in June, and several others are considering such a program.

The object of the experiment, according to the Blue Cross Assn., is to determine if the second or third opinion will cut down the number of operations, which would result in significant savings and better care by eliminating unnecessary surgery. ■

Benefits hit plateau; heralds consolidation and shift in emphasis

LOS ANGELES—The biggest news in the growth of employe benefits for 1976, according to a leading consultant, is that there is no major new development.

Rather, the benefits field will be experiencing a period of consolidation. This is in sharp contrast to the mushrooming speed with which new programs and innovations had been introduced during the last decade.

Speaking before a general session on employe benefits at the 14th annual conference of the Risk and Insurance Management Society here in April, Thomas H. Paine, a partner of Hewitt Associates, New York, predicted that within the next five years the portion of compensation that goes to benefits will actually decrease as workers' demands are more urgently directed to pay instead.

"This does not mean no money will be going into benefits. Benefit dollars will increase. But there will be less of a percentage of benefits increases, and the balance will be shifting between benefits and net pay," Mr. Paine explained.

Dental plans and employe stock ownership plans, or ESOPs, were two types of benefits Mr. Paine singled out as being of most "topical" interest to companies right now because of the tax advantages they offer and competitive pressures to attract employe favor.

On dental plans, collective bargaining pressures are also major factors in their development and cost. A typical plan will cost a company about $10 to $12 per employe per month. On large collective bargained dental plans, the cost rises to something more like $20 per employe per month.

The tax reduction act of 1974 which allows companies to take credit on contributions they make during 1975 and 1976 in setting up ESOPs for their employes have created some incentive for tax reduction ESOPs, Mr. Paine said.

Yet he said they haven't spread very far because of greater restrictions, particularly in vesting requirements. He predicted that interest in the tax reduction type ESOP will fade unless Congress changes the law governing them and extends the period of time companies have incentives for tax reductions beyond the current two-year limit. Companies can currently take credit for 1% of their contribution investments in such an ESOP divided by the amount of covered payroll.

Other types of ESOPs by which companies can raise capital on a totally tax-free basis will flourish, however, the Hewitt partner predicted.

"This type ESOP may become a relevant benefit over the next decade," he said, because they make stockholders of employes, and thus cater to fears of certain corporations that capitalism will fail unless employes take a more direct interest in corporate growth through stock ownership.

Between now and 1980 the business environment is likely to be favorable, with the working population increasing and the nonworking population remaining stable. But it will take at least until 1980 for the net purchasing power of the American worker to reach the same level it was at back in 1972, Mr. Paine said, a major reason benefit growth will bow to concerns involving direct pay increases.

By 1980, he also predicted, Social Security will replace over 50% of pay for retiring employes, and government involvement in public pensions will increase through provisions of the Employe Retirement Income Security Act.

In the private retirement sector Mr. Paine expects fewer increases in pension benefits, more integration with Social Security and more "caps" placed on retirement benefits.

However, he thinks a trend toward higher death benefits in pension plans will develop, and that there will not be a swing back to career average pay formula benefits from the final pay average benefit formulas now popular.

Capital accumulation benefits (including ESOPs) and defined contribution plans which permit employes to use the money from their benefit in a number of ways in addition to the pure retirement benefit will gain popularity, he feels.

And there should also be a shift to more fixed income guaranteed funds rather than those depending on equity investments.

Mr. Paine said there is a possibility that flexible benefits may gain some ground during the next five years, as would educational benefits (in which the employer helps defray the cost of key employes' children's college expenses).

However, he told *Business Insurance* in a separate interview that Internal Revenue Service rulings which make such educational benefits taxable to employes as compensation would probably prevent educational benefit plans from gaining a wide base. The reason they would catch on at all, he thinks, is that the dramatically increased costs of college educations would make employes welcome the benefit despite the fact they would be taxed for it.

Mr. Paine also said he expects that the social impact of the women's movement between now and 1980 will bring about a trend to improve maternity benefits which recognize maternity as an "illness" under group plans.

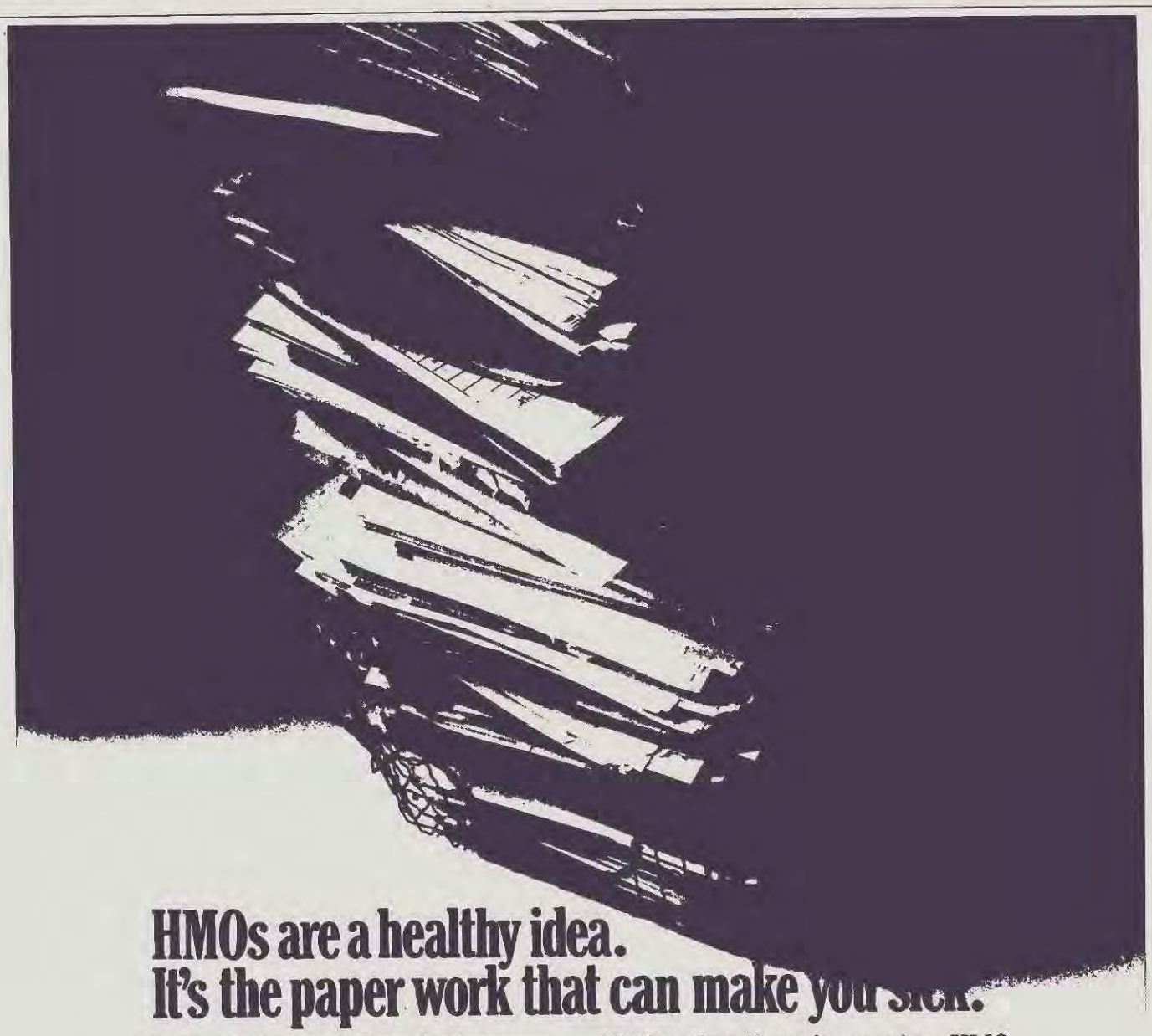
For group life plans and pension benefits, the women's movement will probably also be responsible for forcing the insurance industry to adopt unisex mortality actuarial tables which will change patterns of benefits payments across the country. ■

President's award goes to R. L. Storey

The Risk and Insurance Management Society (RIMS) gave its 1976 President's Award to Rollyn L. Storey, Director of Risk Management and Real Estate for the SCM Corporation, New York.

Mr. Storey, RIMS president from 1970-71, received the society's highest honor at the 14th Annual Risk Management Conference in Los Angeles last week. The award is given for "outstanding contributions to the field of risk management and to the Society."

Mr. Storey, CPCU, is presently a vp of the Risk Studies Foundation. He was cited for his part in developing the Insurance Institute of America's Diploma Program in Risk Management by the Cleveland and New York Chapters and for more than 15 years of service to RIMS.



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Insurance executive sees HMOs as a key to health cost containment

LOS ANGELES—Steady growth of Health Maintenance Organizations (HMOs) will provide a "valuable option" to the health fee system and help control and contain inflated health care costs according to one insurance company executive.

Prudential Insurance Co. of America senior vp John Kittredge, in reviewing current national health insurance (NHI) and HMO proposals, said Congressional attention is now "clearly turning to cost-containment."

Mr. Kittredge spoke before the Risk & Insurance Management Society's 14th annual conference in Los Angeles last month.

"Many people fear that continued prepaid escalation of medical costs may cause the present system to collapse," he said, "and be taken over by a hastily conceived, jerry-built Federal system.

"Many experts believe that a great deal more could be done to improve the health of the nation by educating our population to take care of itself, rather than by concentrating on the curing of ills after they have already been incurred," Mr. Kittredge said.

RIMS/Report

Three of the principal NHI Senate Bills were reviewed by the Prudential executive: The Kennedy-Corman Bill, the Burleson-McIntyre Bill, and the Long-Ribicoff-Talmadge Bill. Each of the bills recognizes the need for the availability and accessibility of care regardless of the individual's financial status and for the fostering of HMOs.

Even the more conservative Ribicoff proposal, which provides coverage for medical expenses exceeding $2,000 or hospital services over 60 days, could contain unforeseen costs and consequences.

"Advocates of the catastrophic approach point to it as a way of protecting individuals against very high expenses, without putting an undue load on the medical care delivery system," he said. "This might well be the case for the first year or two, but it is difficult to conceive of the Bill as not becoming a political tool in subsequent years with the effect of the deductible being gradually removed.

"I strongly suspect that over a period of years the United States would back into a comprehensive plan which wasn't really designed as one but was reached as a result of political maneuvering," Mr. Kittredge said.

According to Mr. Kittredge, HMOs will grow steadily, but slowly, in the future and the HMO Act of 1973 has "acted to slow the development and expansion of HMOs" by its number of requirements and standards.

"These requirements made it difficult for HMOs to compete with other insured plans, since providing the required benefits involves such a high price tag that the product often was not salable," he said.

While it is unlikely there will be a National Health Insurance Plan by the end of 1977, Mr. Kittredge does expect amendments to the HMO Act will be enacted soon, which will "remove some of the barriers to growth and development of HMOs."

According to Mr. Kittredge, the probable final bill will: Require dual choice only where an employer has 25 employes in the HMO's service area instead of the current dual choice for every employe.

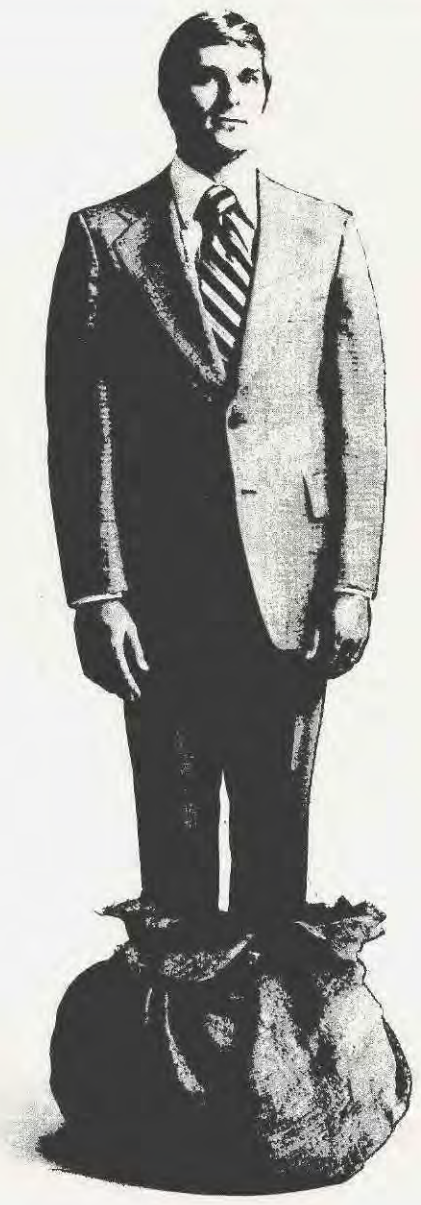
The proposed amendments will fine employers who do not offer dual choices; permit the HMO discretion as to whether it will offer supplementary services, including alcohol and drug addiction treatment; and will limit open enrollment requirements, such as those persons without evidence of insurability, for new HMOs until they reach a minimum size and are operating profitably.

Mr. Kittredge recommended that employers offer HMO coverage to their employes even though the HMO may not be qualified. "In this way, you may be able to review the activities of HMOs to determine the quality of care which they provide and the way in which they treat your employes. Federal qualification of an HMO does not in itself assure a high quality of care."

While the NHI bills in Congress are very different, they all would foster HMOs through financial assistance.

Areas where the NHI bills do differ are on amount of benefits, financing of those benefits, the number of options available, and the role of private insurers.

According to Mr. Kittredge, Congress is realizing that "even the least expensive NHI plan has a pretty sizable price tag attached to it," and that there is a real "need to strengthen the medical care delivery system." ■



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Ad is ruled 'prejudicial' in injury case

MILWAUKEE—County Judge Ralph G. Gorenstein offered Karl K. Prussion a new trial or a higher award in a personal injury case after a juror brought a "prejudicial" newspaper ad into the jury room.

Judge Gorenstein said the ad was "extraneous prejudical information that was improperly brought to the Jury's attention."

The case of the prejudicial ad developed after the jury had found Mr. Prussion 30% negligent and awarded him $55,098. He had sued Patricia A. Reed and her insurance company, Home Insurance of New York, for injuries sustained when he was struck by her car while walking on a public street. The jury found Ms. Reed 70% negligent.

Mr. Prussion's attorney, William A. Denny, asked for a new trial after he learned about the newspaper ad in the jury room.

The ad, for Crum & Forster Insurance Cos., was in the March 4 edition of the Wall Street Journal. It was an attack on high jury awards and said, in large print: "The jury smiled when they made the award. They didn't know it was coming out of their own pockets."

The juror who brought the ad into the jury room, the jury foreman and other jurors swore in affidavits that their verdict had not been influenced by the ad.

But Judge Gorenstein thought otherwise and told Mr. Prussion he could have either a new trial or the award would be raised to $111,168. ■

Auto cover expected to click as employe benefit

LOS ANGELES—True group mass merchandised auto plans will be a benefit wave of the future despite serious drawbacks of cost and varying levels of employe participation now plaguing them.

This was the message in a review of mass merchandising by James Newton and Donald J. Zuk at the 14th annual conference of the Risk & Insurance Management Society held here.

Mr. Zuk, a Johnson & Higgins vp involved in J&H's "Payduct" auto and homeowners mass merchandising program, compared the current position of true group mass marketed insurance plans to group medical coverage around 1946.

At that time, he pointed out, individuals bought their own medical insurance. The accepted practice now is for employers to provide the benefit in a group plan. Mr. Zuk thinks mass merchandised auto coverage will catch on as an employer-provided benefit in much the same way in the coming years.

Mr. Newton, risk manager for Fuqua Industries in Atlanta, Ga., remarked that the potential also exists for mass merchandised auto plans to become the subject of collective bargaining negotiations. He believes unions may eventually push for the benefit for their members in much the same way that labor has been instrumental in getting dental plans in its contracts.

Right now, the biggest drawbacks from a risk manager's point of view in setting up mass merchandised auto plans for employes are cost and tax considerations, speakers noted.

A typical plan purchased under a single group insurance plan for a number of independent individual risks on a guaranteed issue basis is about $10 to $20 per month per insured, a rate many employers find prohibitive.

And, depending upon what state the program is written in, even though the employer makes contributions to pay the premiums of a mass merchandised auto plan for employes, the Internal Revenue Service taxes the employes for that amount the same way it taxes their salaries.

A major problem in making a true group mass merchandised auto insurance plan work is getting adequate employe participation so there is not an adverse selection problem.

In giving an historical perspective of generally dismal results with mass merchandised group plans, Mr. Newton and Mr. Zuk pointed out that many plans written in the early 1970s had participation levels of less than 5%. One plan which J&H administered, Mr. Zuk said, failed because its participation dropped below the 5% mark, and the broker encouraged the employer to drop it. Mr. Zuk said J&H runs one true group mass merchandised plan that has a 35% participation level, and is "delighted" with that amount.

Key considerations in assuring adequate participation levels for the plans include low turnover of the employe group for which the plan is intended, a central location for the group, and willingness on the part of an employer to permit a broker to do on-site counseling for the employes who are insured, even if the employer is not paying for the benefit.

The status group of mass merchandised plans is still shaky today, but not because the concept is a new one. As Mr. Newton told the conference session, the first mass merchandised auto plan was developed back in 1925 when Chrysler used the approach for owners of its cars.

One reason group mass marketed plans have not worked as well as they might, was that insurance companies marketing the plans looked on them mostly as a sales tool and thus, did not provide adequate cost controls, risk analysis or administrative back-up.

Some 15 or to 20 insurance companies tried to jump on the mass merchandising bandwagon in about 1970, and most of them did so poorly that the majority have since pulled out of the market. Only a handful of insurers, notably Insurance Co. of North America and Commercial Union Assurance, still offer competitive programs.

CNA was one of the insurance companies singled out as having had heavy involvement with mass merchandised plans, only to see the business flounder because it didn't have a good computer system or administrative controls.

Mr. Zuk described how J&H "lived to rue the day" it got involved in producing mass merchandised business for CNA in the early 1970s, because the broker lost some of its control over clients' relationships in the process.

The administration became muddled, and client complaints started rolling in for J&H. It was at this point J&H made a decision to stay involved with group mass merchandised plans, but to handle all administrative details and computer back-up work inhouse, in order to work directly with the client/buyer.

J&H's resulting Payduct system is completely automated and has been in effect for two years now. J&H believes it is one of the best programs available by today's standards, but it still is in the red and has all the weaknesses of individual policies, because it is based on individual rating.

J&H's basic intent is to be ready and waiting with a smooth, profitable administrative system when true group mass marketed plans gain in popularity. ■

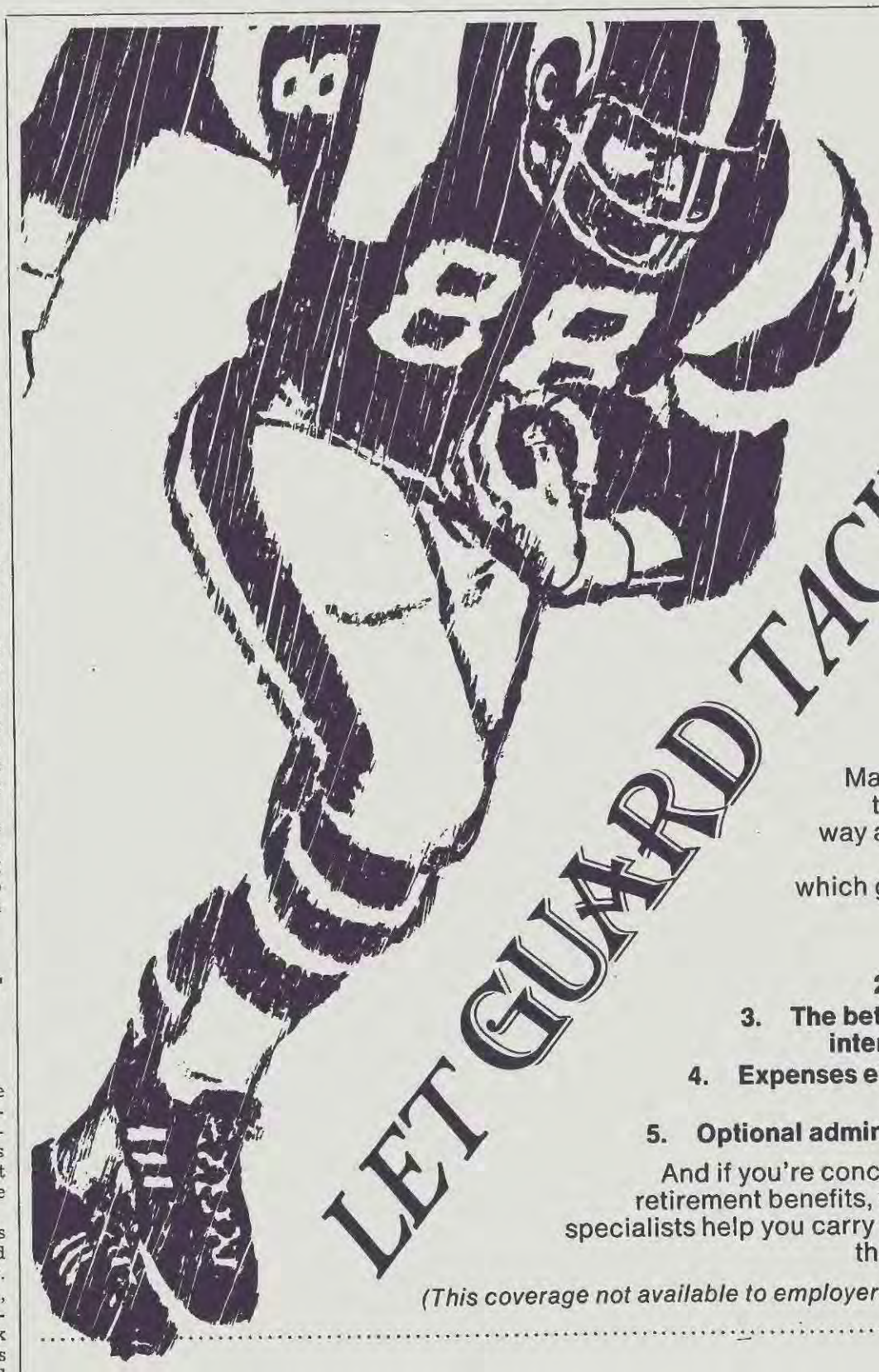
Insurance for export sales

WASHINGTON, D.C.—The Foreign Credit Insurance Association (FCIA) and the Export-Import Bank of the United States insured 43 medium-term export sales totalling $29.4 million in the first two weeks of April.

The FCIA coverage provides protection against commercial and political risks of non-payment. The risks are pooled with FCIA, a consortium of 53 private insurance companies and Eximbank which covers the political risks and reinsures some commercial risks.

The sales went to 21 countries in Asia, Africa, Europe, Latin America and the Middle East. Among the products covered are railroad car parts, earthmoving equipment and locomotive parts.

The FCIA says most of its policies are designed for the small export of manufactured goods with a low unit value that sell on less than 180-day terms. ■



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Traditional insurer role shrinks as benefit costs rise

By JOANNE GAMLIN

LOS ANGELES—Spurred by the fact that employe benefits now constitute between 30% and 35% of total employe compensation, the funding approach to employe benefit programs is being rapidly transformed.

RIMS/Report

Brian T. Sinclair-Whitely, vp of Group Management Services, Nashville, Tn., told a seminar on cash flow funding and risk sharing programs that there are four methods used by corporations to enhance premium cash flow and shrink the amount they pay to group life/health underwriters.

"The result has been a gradual erosion of the traditional insurance company role in the large group insurance market and a corresponding increase in the direct role played by employers in the risk and money management of their (employe benefit) plans," Mr. Sinclair-Whitely told the seminar, which was part of the 14th annual conference of the Risk & Insurance Management Society held here.

Group Management Services is a division of Blair, Follin, Allen & Walker Inc., which is part of Synercon.

Mr. Sinclair-Whitely detailed the following risk-sharing methods used by large corporations:

• Delayed premium payments: Under this approach, the traditional 30-day grace period is extended to 90 days longer. Mr. Sinclair-Whitely said "this is the equivalent of releasing the regular case reserves since the insurance company must dip ito its reserves to pay claims at the point where the premiums last received are exhausted."

• Retrospective premium discounting: A well-known approach which can be combined with delayed premium payments, according to Mr. Sinclair-Whitely. Here the underwriter discounts its monthly rates in advance by a specified percentage, usually 10%, which approximates its premium margin for unusual claim fluctuations. At the same time, there is an agreement which says that if the discount premium is not sufficient to take care of claims and to adjust reserves and cover the retention and pooling charges, the insured will pay the amount of the deficit at the end of the policy year. Often, there is a ceiling on the policyholder's liability, said Mr. Sinclair-Whitely, which is "equal to the premium discount, so the policyholder will not pay out more than the undiscounted premium rates would have developed, based on participation in the plan."

• Cost plus: The underwriter provides its services at their actual cost, plus a mark-up for overhead and profit margin. This plan is fully insured and fully reserved. The major advantage of a cost plus plan is control over cash flow.

• Minimum plan: Known as the Cat-Met plan, the approach was developed in 1962 by Caterpillar Tractor Co. and Metropolitan Life Insurance Co. Here, the employer self-insures the major portion of medical coverage, often up to 90% to 95% of anticipated claims for any policy year. The underwriter then assumes the liability for all claims that exceed this point.

Mr. Sinclair-Whitely said that under this approach the excess coverage is "normally determined on a monthly basis.

"For example, if the expected claims are $3 million for a policy year and the trigger-point was set at 90% of expected claims, the monthly trigger-point would be 1/12th of 90% of $3 million or $2,700,000" or a monthly payment of $225,000.

"The employer would not be liable for aggregate claims that exceed the $225,000 monthly cap," he said.

He went on to note that premium taxes are paid only on the insured portion of minimum premium plans, "although some states are taking action to end this advantage."

Under the Cat-Met plan, he added that underwriters set up reserves for both the noninsured and the insured portions of the plan.

"While only the jumbo group cases normally entertain the minimum premium approach, I believe some carriers will consider this arrangement for any group health plan with over $500,000 in annual health premiums," Mr. Sinclair-Whitely said.

He noted that under the Employe Retirement Security Act, (ERISA), details of the funding of a minimum premium plan would probably have to be disclosed to employes.

Corporations with such plans, he said, had hoped that the override provisions of section 514(b) of ERISA, which exempts self-insured plans from state regulations, would apply to minimum premium plans.

"However, the weight of opinion now seems to be that because some element of insurance is involved with minimum premium plans, they are not exempt from state regulation under ERISA," he said.

Mr. Sinclair-Whitely also took up the subject of premium waiver life insurance reserves. He said insurance companies generally set up a reserve equal to 75% of the face amount of each employe's life insurance continuing under the premium waiver provisions of the group policy.

He went on to suggest that corporations wishing to boost cash flow might limit the period for which group life premiums of totally disabled employes can be waived to one or two years.

"In this way, all premium waiver reserves established for an individual would automatically be returned to the corporation at the conclusion of the one or two year period and act to reduce paid claims in the year in which the reserves are released," Mr. Sinclair-Whitely said.

As for the premium waiver reserves held by the underwriter, he pointed out that a corporation can negotiate their release and self-insure all outstanding premium waiver liability.

He advised his audience to be sure they receive an annual listing of employes continuing on premium waiver, together with the amount of released reserves.

Employers with self-insured group benefit plans, he went on, should be aware of the fact that ERISA does not pre-exempt a state from taxing a self-insured plan on some basis other than premiums.

"By illustration, a tax could be applied to the claims paid under a self-insured plan," proposed Mr. Sinclair-Whitely, adding he believes Connecticut levies a 2.75% tax on benefits paid from self-insured plans in that state.

Insurance companies that will provide administrative services only (ASO) contracts on group health programs for insured allowing them to provide group life and accidental death and disability (AD&D) coverage should be heeded, he advocated.

Stop loss coverage on group health plans is much cheaper, he explained, when it is purchased through the underwriter which supplies group life and AD&D coverage. ■

Forming risk management committees

LOS ANGELES—Special interest associations are starting to form risk management committees where none existed before, the chairman of one such committee told *Business Insurance* during the 14th annual conference of the Risk & Insurance Management Society.

Joseph P. DeMarinis, chairman of the risk management committee of the International Bridge, Tunnel and Turnpike Assn. (IBTTA), explained that groups are beginning to realize that even though their individual exposures are different, their risk and insurance problems are the same, and they need a forum to discuss them.

The IBTTA, for instance, has members from all over the world with "trillions" of dollars of property value exposures. One member alone, the Port Authority of New York and New Jersey (for which Mr. DeMarinis is manager of the risk management division), has exposures of about $1,100,000,000.

But even smaller members represent substantial property values according to IBTTA director and risk management committee member Kenneth Pearson. Mr. Pearson is risk manager for one such member, the Massachusetts Port Authority, or Massport, with exposures of about $250 million. And the IBTTA's Washington office reports it has 90 active members in locations ranging from Japan to Australia, New Zealand, Spain, France, Scotland, England, Canada and the United States.

"We will need a closer tie with RIMS," Mr. DeMarinis suggested during a luncheon at the conference. He would like to see the national risk management organization help groups like his in getting speakers and setting up programs to educate toll facility management groups deal with their exposures.

The IBTTA already runs some sessions, he pointed out. In Boston this spring, 300 people attended an IBTTA workshop hosted by Mr. Pearson of Massport. But Mr. DeMarinis would like to see the risk management function of the group expanded with the help of RIMS. ■



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Mere notification no substitute for liability

LOS ANGELES—Merely notifying state authorities of an oil spill does not relieve vessel operators of their liability for reporting such damage, a Coast Guard representative said.

In fact, the Coast Guard can fine a company $10,000 for not immediately reporting a spill to it, and can arrest a vessel master who so fails to discharge that notification duty.

Just telling state officials about the spill and assuming they will follow through on reporting it to the Coast Guard is not enough, a maritime industry session at the 14th annual conference of the Risk & Insurance Management Society was told.

A Coast Guard spokesman visited the session, which was chaired by Tom Redican of the Dillingham Corp., Hawaii, and outlined vessel owners' responsibilities and liabilities in the event of a major oil spill.

The Coast Guard classifies any spill of 100,000 gallons or more as major, and selects that figure as the point at which it will mobilize its own forces to run clean up activities.

Actually, the Coast Guard prefers a company to conduct its own clean up operations and is not particularly interested in the contractual arrangements, such as those pertaining to insurance coverage for a spill.

Mr. Redican said the question of contractual arrangements can be a major problem for risk managers in such a case, however, because when more than a couple parties are involved with responsibility for a spill, none of them are willing to do anything unless it's in writing, but the Coast Guard expects immediate action.

One way a vessel owner involved in an oil spill can be sure of discharging his responsibility in reporting the damage is to call a toll-free phone number staffed around the clock by the Coast Guard's National Response Center, the group was told.

The number, which ideally should be posted in various locations on board ship in case of a spill is 800-424-8802.

Although the Coast Guard bears the ultimate responsibility for clean up operations in major spills (there were 32 during 1974, the last year with available statistics, the Coast Guard said) it actually prefers it if a company does the clean up operations itself.

Dillingham Corp. has done a major study on clean-up procedures which is excellent, the Coast Guard spokesman told the group.

He pointed out that if the owner doesn't clean up properly, however (in such a way as to protect the surrounding environment), the Coast Guard will step in to do the job and then bill the offender.

Moreover, the group was told, if the government causes damage to private property in the process of cleaning up after an oil spill, the polluter will be billed for the costs. ■

Persistent lack of loss data criticized by feds

MILWAUKEE—The federal government might require insurers to provide more loss data to state regulators if the problem of insufficient data persists, a top federal insurance official said.

Regulation by state insurance departments is being hampered by what J. Robert Hunter, acting administrator of the Federal Insurance Administration, called "a lack of significant data sufficient to enable state regulators to effectively regulate the business."

Citing medical malpractice as "the most glaring example," Mr. Hunter told a meeting of the Independent Insurance Agents of Wisconsin earlier this month that no data exists to determine the cause of losses in many insurance lines.

The data problem, Mr. Hunter said, is "in terms of vital, public interest . . . the closest thing to a perfect vacuum that man has ever created and the public interest demands that data be available at least for loss prevention purposes."

Mr. Hunter also said that the insurance industry is healthier now, along with the rest of the economy. "Things are getting better fast," he said. "The corner has been turned by the property-liability insurance industry."

The FIA official said that "excessive rates to the consumer's detriment will be politically devastating." He called upon the insurance industry not to overreact to the bad news of last year but to look ahead to good results. ■

Increases for 1976 work comp top 13%

NEW YORK—Substantial premium increases for workers' compensation insurance, above the 13% increase of 1975 are predicted for 1976, according to Willard J. Gentile, retired vp of the New York Compensation Insurance Rating Board.

In a speech before the New York Chapter of the Society of Chartered Property and Casualty Underwriters, Mr. Gentile said this increase was in addition to increased indemnity costs anticipated as the result of pending legislation in the state legislature.

The proposed New York state legislation would increase the maximum weekly benefit for permanent partial disability.

The legislation provides for Social Security offset as against widows' benefits only, up to 50% of a widow's survivors benefits under the Social Security Act.

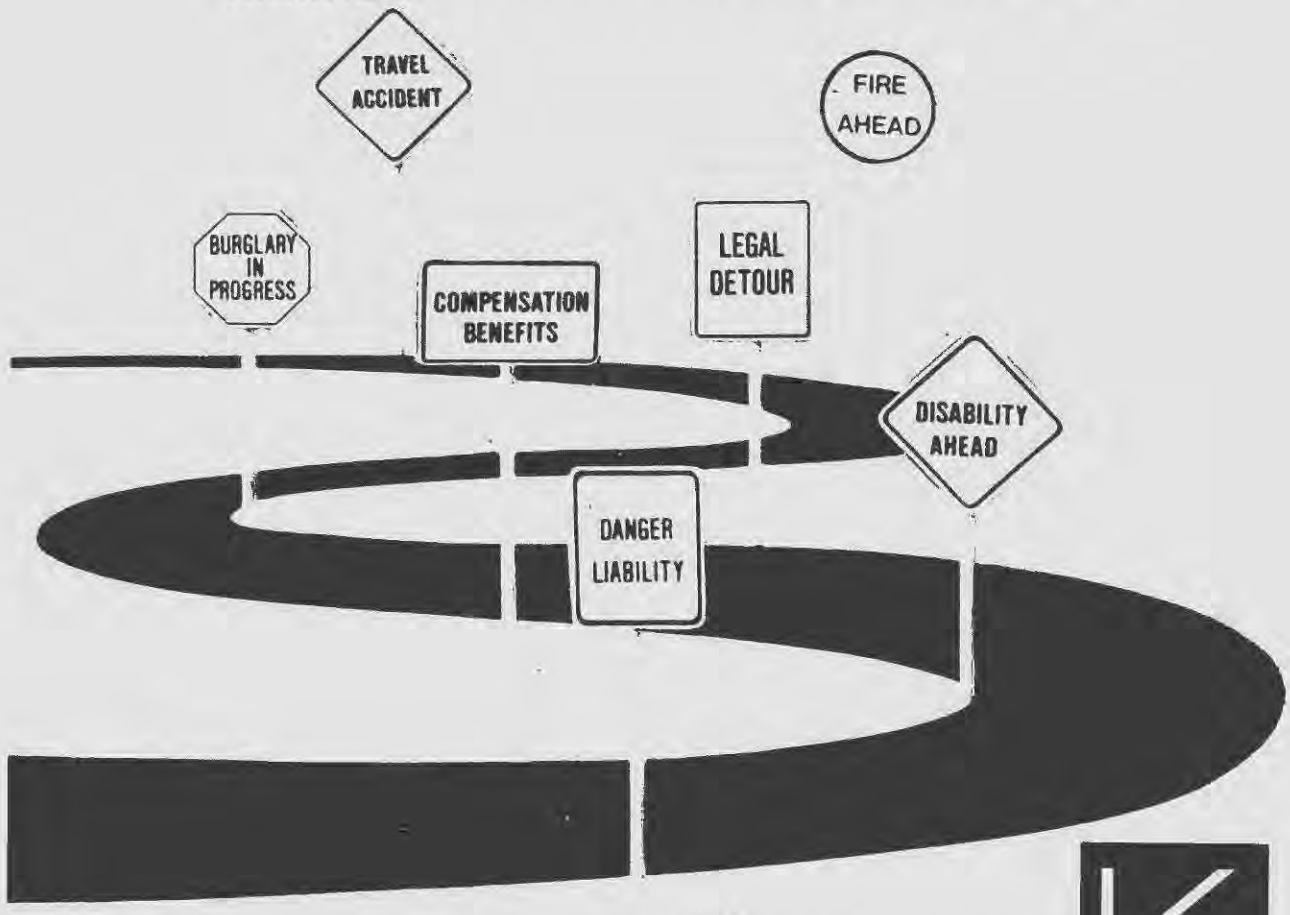
Other legislative proposals provide mandatory coverage for all employes to remove the concept of hazardous employment from the law.

Other changes include specific extra-territorial coverage, increases independency benefits for surviving children up to age 25, elimination of sex discrimination against widowers and increased funeral benefits. If adopted, these amendments, Mr. Gentile said, would increase the 1976 premium level.

Some other adopted changes, he explained, include an increase in eligibility for three year fixed rate policies to $300 per year, a requirement for actual payroll audits on policies with an annual premium of $3,000 and the New York adoption of total payroll as the workers' compensation premium base. This requirement is already in effect in 33 states and the District of Columbia. ■

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American Home . . .

Continued from page 1
spokesman explained.

Claim settlements in workers' compensation have been rough in cases involving longshoremen and harbor workers, American Home president Elmer Dickinson said in an interview. He explained the provisional cancellation as "a normal situation to try and cover our exposure."

The problem is increasing costs, Mr. Dickinson said. "The cost varies tremendously depending on the individual account."

Premiums will be renegotiated on an individual basis, American Home's president said. "Increases will not be made on an across-the-board basis."

The executive said from that between 13 and 18 domestic accounts will be involved.

It was "unfortunate" the provisional cancellation notices were sent out during the RIMS conference, Mr. Dickinson observed. "When there are so many risk and insurance managers and brokers all in one place, rumors are bound to start up."

The aspect most speculated upon as triggering American Home's action was reinsurance.

Many of the risk managers and some brokers attending the RIMS conference wondered if American Home's Jones Act exposures is Act exposure had been cancelled.

Both the underwriter and two of its reinsurers denied this was the reason for the provisional cancellations. "There has been absolutely no cancellation of reinsurance," Mr. Dickinson said.

A spokesman for American Reinsurance Co., American Home's major reinsurer, said, "It was American Home's decision . . . we don't participate in that particular book of business."

At General Reinsurance Co., a spokesman acknowledged that "we did participate in a few of those risks . . . but we didn't initiate any cancellation of reinsurance." To say that American Home's action was caused by the loss of a reinsurance treaty is false, the General Rinsurance spokesman said.

Reinsurance for American Home's Jones Act exposures is handled on a facultative basis, the American Reinsurance spokesman said.

The premium increases expected to result from American Home's policy renegotiations with its domestic insureds will also affect the entire support industry of the U. S. oil industry, a major petroleum industry insurance broker observed.

Though the anticipated premium hikes are still hypothetical at this point, he said, "There's tens of millions of dollars involved." ■

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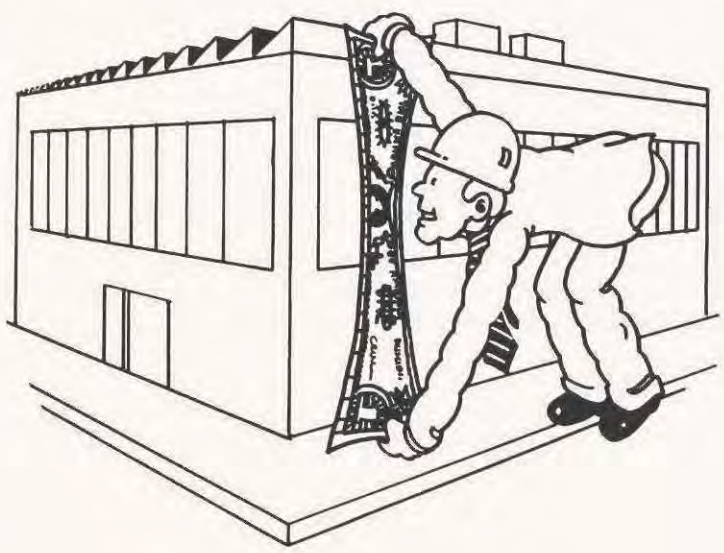
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Ships going wrong way now reported

LONDON—Swimming upstream may be commendable if spawning salmon are doing it, but British and foreign ships sailing the wrong way in the Dover Strait Traffic Separation Scheme are now reported to marine insurers.

As of April, the British Department of Trade supplies insurers with monthly reports of the names of such vessels, most of them trawlers, watched by the British and French radar surveillance stations.

Insurers will take the reports into account when assessing the fleet's safety record and determining insurance premiums. If the wrongway ship is justified by special circumstances or cannot be identified, its name will not be released the Department said.

The Dover dilligence is mandatory for ships of seven countries and will be mandatory for all contracting states next year when the revised international regulations for preventing sea collisions is enacted.

West German ships are the biggest offender with 22% of the 8,743 ships contravening the scheme, mainly because of the high number of their vessels using the strait. ■

Keep kidnap cover under highest wrap

LOS ANGELES—Kidnap and ransom insurance for corporate executives is essential for most businesses, one Lloyd's underwriter contends, but its existence must remain secret.

RIMS/Report

The underwriter, Anthony A. Cassidy, director of Hudson & Vernon Ltd., told a Risk & Insurance Management seminar on executive protection programming last month that kidnap insurance does not go against the grain of public policy. Mr. Cassidy spoke at the RIMS 14th annual conference.

Mr. Cassidy said Lloyd's policy is not "to put anyone in a position where, because of insurance, they are able to pay either a larger ransom or a ransom quicker."

He added that corporations involved in kidnapping or extortion attempts must first pay any ransom from their own resources; notify and cooperate with police; and keep the existence of insurance a secret or face possible policy cancellation.

"So may we accept that, professionally handled, kidnap insurance is no more likely to increase kidnapping than burglary insurance increases theft, fire insurance increases increndiarism, or life assurance increases murder or suicide.

"Although kidnapping as a crime is difficult to implement successfully, it has one great lure for the ambitious criminal or terrorist group—it is, of all crimes, probably the most efficient in extracting the highest return. Because kidnapping can, in effect, unlock vaults which no burglar can penetrate, convert into cash securities which in paper form have no value to other than to their registered holders," Mr. Cassidy said.

Among the criteria used in evaluating risks are the familiarity of the company's name; the size of the company which may influences its vulnerability and ransom in kidnap treats; the type of industry the company is engaged in; and the geographical distribution of plant and personnel.

"Even where a company has no staff resident overseas heavy travel exposure to high-hazard areas must be borne in mind," he said.

Mr. Cassidy also recommended that kidnap insurance be extended to all employes, not just exposed persons. "The exposed persons will to a very large extent determine the premium, so that it is comparatively inexpensive to include all other employes. Argentina and Italy still represent the greatest risk today but kidnapping seems on the increase throughout Europe, Central America, Ethiopia and Malaysia."

Secrecy is essential when handling kidnap and extortion insurance because ". . . if you reveal the existence of such a policy to other than those who must know of it, you are inviting attack from outside the ranks of your own employes and to collusion from within."

According to the Lloyd's underwriter, generally ransom demands can top $20 million in Argentina; $5 million in Italy and $1 million in Europe.

As an example, a company with assets of $25 million wanting to insure its top four executives and their families and a "medium heavy" risk would pay $37,500 annually to cover all four in Argentina for $1 million with a $25,000 deductible.

The same coverage for an Italian risk would cost $33,000 and a 10% coinsurance clause for coverage for six months. Additional coverage up to $5 million would cost 500% more in Italy and about 200% more in Argentina. ■

Sell subsidiary

California-based Emett & Chandler, an insurance brokerage firm, sold its Indianapolis subsidiary, The Herman C. Wolff Co. Inc., to Alexander & Alexander Inc., the nation's third largest brokerage firm.

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Company can save on group costs by finding new plan for worker who quits

LOS ANGELES—When an employe leaves a company, the benefits manager can cut department costs by having the broker seek new markets for the individual's insurance coverage.

By doing this instead of automatically converting the worker's group benefits to an individual scheme, a company can beat some of the high fees for conversion which group carriers currently charge.

This approach has already been successfully implemented by AMF of White Plains, N. Y., and was part of an overview of the changing role of the benefits manager which was given to an employe benefits session at the 14th annual conference of the Risk & Insurance Management Society.

Gerard Kraemer, AMF's director of employe benefits, outlined an 11-point program for effective benefits management which stressed the concept that the benefits department could be a profit center for the corporation.

He illustrated many of his remarks by explaining what AMF's benefit department has been doing. For example, he said AMF discovered that workers leaving the company could frequently get a better deal on individual benefits coverage if a broker found new markets for them than if they converted their existing insurance.

The company began asking its broker to try out other markets for terminating employes, and in the process managed to realize significant savings on conversion fees, which Mr. Kraemer said typically might run about $65 per every $1,000 of benefit converted.

Alexander & Alexander continues to cooperate with AMF in helping to place new coverages for individuals leaving the company, Mr. Kraemer said.

One reason even a broker of national stature will agree to do this is because it can get commissions from the new markets it finds for the individual policies, he explained.

AMF's benefit department is heavily committed to establishing long range planning goals, including cost estimates, before new benefit programs are actually implemented, Mr. Kraemer said.

Although the firm currently doesn't have a dental benefit program, for instance, the department has conducted a thorough study of several different types of dental plans, and feels it could put one in "tomorrow" if necessary with advance knowledge of just how much it would cost.

The AMF benefits director would not comment on when he expects the company to actually make such a move, but he told the group that based on his department's analysis, a plan started this year might cost about $40,000 to $50,000. The same plan, if it were delayed for five more years would probably cost $75,000 to $80,000 to start.

One direct result of AMF's long range goal planning is the employe thrift plan started in 1975, Mr. Kraemer said. Back in 1969 his department undertook a study of the company's pension programs and felt they were lacking. The thrift plan proposed to fill the gap at the time was made operational last year and met the success forecast by the department's study.

The AMF benefit department is also given the opportunity to supply the firm's pension committee with information about the actuarial assumptions of the retirement plans for which the committee makes investment decisions.

The benefit department has no direct say over whether the investment managers running the pension fund should be first, but it does give the pension committee input on the actuarial side of the managers' performance. Mr. Kraemer said if a manager consistently performs poorly or erratically, he is then removed by the committee.

The 11-point program Mr. Kraemer suggested to the RIMS group to implement a more effective benefits management program dealt with administration, including organization and operations procedures; communications to employes; design of new plans and redesign of existing plans; integration and consolidation of plans so that there is only one plan to do a single job; proper methods, particularly for data processing personnel, in getting government filings in on time; and the above-mentioned long-range planning.

He also discussed the importance of maintaining competitiveness in benefit programs; informing top management of trends and developments; and setting parameters and providing advice for union negotiators.

The ninth element of Mr. Kraemer's program was cost controls, and he suggested wide use of audit claims procedures both within the company and within the carrier's claims department.

Compliance with ERISA is developing as a major factor for benefits managers, Mr. Kraemer said. He urged companies to follow AMF's lead in forming ERISA compliance committees which include representatives from personnel, treasury, tax, legal and controller's departments.

Finally, the benefits department must be prepared to deal with international benefits, at least in the sense that it should be ready to monitor developments in overseas operations and keep abreast of how social trends there will affect benefits.

Mr. Kraemer's discussion of the corporate benefits manager's new role was the opening speech of the RIMS employe benefit program. In his remarks, the AMF benefit director said the benefit function must change from that of being an appendage to clerical duties, to being an administrative and management function with formalized procedures and consistency. ■

Union wins counseling

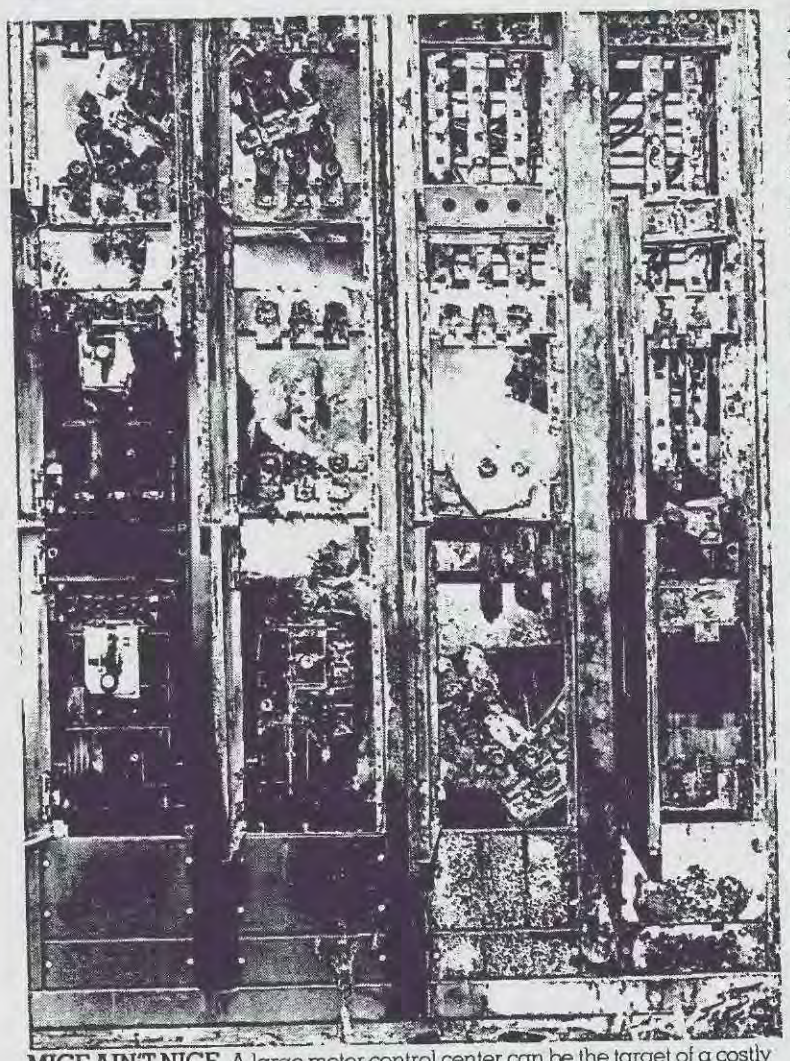
Pre-retirement planning programs received the support of the Retail Clerks International Assn. this month.

The union's executive board will encourage all local unions and their negotiated retirement plans in the implementation of the programs for their membership.

Among the recommendation are graduated work weeks during the final years of employment, mandatory paid pre-retirement planning classes and voluntary post-retirement counseling.

Union president James T. Housewright said the membership benefits department of the union and the gerontology department of Antioch College in Maryland will be responsible for providing guidance in developing and implementing the programs.

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Ban on captives, use may be removed soon

LOS ANGELES—A barrier to hospitals' use of captives or self-insurance funds for malpractice coverage may soon be removed, with the expected revision of Bureau of Health Insurance (BHI) provisions which at present effectively bar these measures, a hospital industry session at the Risk & Insurance Management Society (RIMS) conference was told.

The provisions, contained in section 2160 of the Medicare provider/reimbursement manual do not recognize payments to a self-insurance fund or captive as reimbursable expenses.

Since hospitals depend on Medicare, Blue Cross and Blue Shield (the Blues follow the same guidelines as the BHI) for 80% to 90% of their income, any change in BHI provisions which release them from dependence solely on the malpractice insurance market would result in big dollar savings, most hospital risk managers agreed.

The BHI provisions do allow hospitals to use a nominal deductible, but are "geared to traditional insurance practices," a spokesman said. "For that reason we're reviewing our position."

The expected revisions will be distributed "for purposes of preliminary discussion sometime this month," he added.

The BHI provider/reimbursement manual does contain provisions for reimbursement of losses paid out of a self-insurance fund, but these are contingent upon the fund being approved by the Social Security Administration. (The BHI is a department in the Social Security Administration).

Hospital industry sources say they know of only two such self-insurance funds that have been approved by the Social Security Administration.

The BHI sets forth a number of provisions a self-insurance fund must meet before it can be reimbursed for payment of losses. These provisions may be adapted as guidelines for hospitals' use of self-insurance or captives in the future, the BHI spokesman said.

Among the provisions are the following: The fund must be totally segregated; it cannot be commingled with any other hospital fund. Contributions to the fund must be on an annual basis. The hospital must give extensive details on assets covered by the fund. ■

Limit on aggregate for banker's blanket bond

LOS ANGELES—Aggregate limit of losses during any policy year for banker's blanket bond policies was one of the suggestions proposed by John C. Harden, vp, Chubb & Son Inc., at a seminar during the 14th annual Risk & Insurance Management Society Inc. (RIMS) conference.

RIMS/Report

"We may very well be reaching a point where reinstatement of any loss in excess of a rather nominal amount in comparison to the bond liability will be subject to underwriters' approval," Mr. Harden told a group of banking industry risk managers.

He told the risk managers to preserve the markets that are left and to come back to a product attractive to the insurance industry, "You've got to become more involved in the solution."

Involvement on the part of risk managers, Mr. Harden noted, means higher deductibles.

"Instead of applying rules like 1/100 of 1% of deposits as a deductible guide. . . . I think it makes more sense to talk about some percentage of your average loan losses over the past several years or your reserve for loan loss," the vp continued.

A future change in banker's blanket bond policies Mr. Harden predicted, is full termination of coverage without benefit of discovery period when a bank fails.

"I do not think that it's necessary for the Federal Deposit Insurance Corp. (FDIC) to have 12 months to recoup its losses from the bond carrier," he said. "If the FDIC has too many losses, they already have the most equitable means to solve their problem through assessments of the entire banking industry."

The preservation of the bank bonding industry could outweigh the advantage to the FDIC of having a bond giving a discovery period applicable to relatively few situations, he noted.

Mr. Harden charged that the banking industry hasn't done enough in the area of loss control.

More credit/audit work prior to making loans, better alarms, and more emphasis on employes following operations manuals could help cut losses, he said.

The vp warned that increasing liability limits on the part of individual bank risk managers could create an industry-wide capacity problem.

Though each of the insurers is taking considerably larger limits of liability for its own account, Mr. Harden said, the policyholder surplus backing up these commitments is substantially less than it was a year or two years ago.

"The industry is now in a position where one total loss to one of the 14,000 banks would produce a loss ratio in excess of 100% for an entire year for the entire insurance industry in banker's blanket bonds, he said.

"There are at least some of you out here who, in effect, do not really need us as banker's blanket bond underwriters," Mr. Harden said. "To you our product is a luxury item."

It's the smaller banks, the vp conceded, that have the problem getting adequate bankers' blanket bond coverage.

Mr. Harden concluded that bank risk managers are going to have to share potential losses to a far greater extent than what is being done at present.

"If you can't afford to and we can't afford to continue "as is", he said, "then there's something very basically wrong with the banking structure." ■

Windstorm damage

High winds, hail, tornadoes and flooding April 18-21 caused extensive damage in parts of Oklahoma and Texas. The insured loss was estimated at $2.5 million, according to W. D. Swift, vp, Property Claim Services, American Insurance Assn. The major damage was in Texas, where flooding in the Dallas and Houston areas caused an estimated insured loss of $1.5 million. There also was damage in Texas and Oklahoma.



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Nuclear risks hinge on five sequential factors

LOS ANGELES—Nuclear reactor accidents could happen as a result of sequences involving five different factors, but there is no single factor that can dominate potential reactor accident risks, an official of the U.S. Nuclear Regulatory Commission said.

Saul Levine, the NRC's deputy director of the Office of Nuclear Regulatory Research, told a mini-seminar on power plant nuclear insurance at the 14th annual conference of the Risk & Insurance Management Society that reactor safety really hinges upon "considerable defense in depth" against dependencies of these five factors.

They include the probability of some "initiating event" such as pipe failure; the probability of the failure of a single safety system such as the emergency core cooling system; the probability that the reactor's containment mode would fail, weather conditions; and the population density which is exposed to the reactor.

Mr. Levine demonstrated a number of risk equation factors based on interaction between the five factors. He used "event trees" which were incorporated in the controversial study of reactor safety, WASH-1400, to quantitatively illustrate his points.

(Mr. Levine was one of the scientists who helped Dr. Norman C. Rasmussen of the Massachusetts Institute of Technology in preparing WASH-1400 before it was distributed for public comment in 1974).

The first task of WASH-1400, he told the mini-seminar, was to identify every way, each called an "accident sequence," in which radioactivity could be released from the reactor to the environment.

Event trees, a techniques borrowed from decision theory, were used to define these accident sequences, he explained. An event tree starts with some postulated initial failure and then defines a set of reactor safety systems which, if they were to fail in certain combinations, could release radioactivity from the reactor to the environment.

Mr. Levine said that the likelihood of WASH-1400's having overlooked a sequence that could contribute significantly to the accident risk was "quite low," and that in the public comments received on the study, no accidents were postulated which had not been considered.

The key prediction the study made, and which Mr. Levine repeated for the RIMS group, was that the probability of a core melt, or the worst risk of a reactor involving heat imbalance and. escape of radioactivity, is one chance in 20,000 per reactor year.

Addressing himself to the question of sabotage at nuclear reactor sites, Mr. Levine said risks from that source could not be quantified the same as those due to internal failure or external forces. He said the study group felt, however, that no saboteur could cause accidents worse that the largest predicted already in WASH-1400 because saboteurs could not affect all the elements (such as weather conditions) that contribute to them.

However, Mr. Levine said reactors had "poor security requirements" in past years and that the NRC had experts do a study on sabotage in reactors. During the last five years, with national consciousness focused increasingly on the question of terrorism, steps have been taken to increase security at reactors.

Two improvements in security requirements have been introduced by the NRC's Office of Standards

eral counsel for the Nuclear Edison Co.; Joseph Marrone, gen- Development headed by Robert Minot. A third is expected.

The mini-seminar, which ran on two separate days, also featured presentations by H. Fred Christie, senior vp of Southern California ergy Liability—Property Insurance Assn. (NEL-PIA), and Gerald G. Fain, chairman of the committee on insurance and indemnity of the Atomic Industrial Forum and governmental affairs coordinator for Stone & Webster Engineering Corp., Boston. ■

Overinsurance seen as clue

SAN ANTONIO—One way insurance companies can help combat the serious arson rate is to "watch for policyholders who overinsure their property," believes Gerald Schappe, deputy fire marshal of Texas.

Arson losses are "more than 13 times greater than they were in 1964," he told a meeting of National Assn. of Independent Insurers.

Mr. Schappe criticized law enforcement agencies for their "tendency . . . to downplay the seriousness of the crime." The fire departments think arson should be handled by law enforcement agencies because it involves criminal investigation and police departments believe it should be worked out by the fire departments, he commented.

One reason for the increasing rate of arson is that "arson is committed in connection with other crimes," Mr. Schappe said. "When used to cover burglaries or murders, the perpetrator is tried for those crimes." ■

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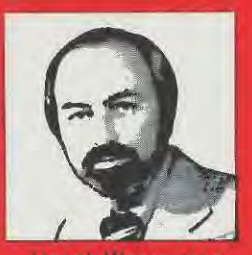

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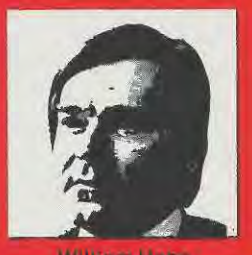

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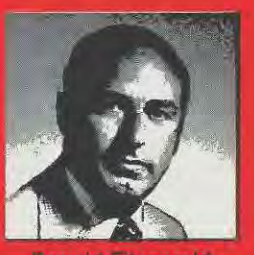

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8:30 am—9:50 am: REGISTRATION. Pick up your seminar materials and get ready for two days of information-packed sessions.

9:50 am: WELCOME. *Susan Alt,* Editor, *Business Insurance; Edward J. Bride,* Vice President, Editorial Services, *Computer World.*

10:00 am: FACILITIES PLANNING: WHAT TOP MANAGEMENT NEEDS TO KNOW. You learn what steps you can take in the planning stages to minimize computer operations risks from *Robert H. Courtney,* Director of Data Security and Privacy, IBM Corp.

11:15 am: EMERGING RISKS—CLOUDS ON THE HORIZONS. *Robert V. Jacobson,* Assistant Vice President, Chemical Bank, reviews areas of increasing risk which threaten to become major management concerns, such as theft, sabotage, physical loss, and illegal access.

12:15 pm: LUNCHEON. Take this opportunity to get acquainted with your fellow registrants. Exchange ideas and information.

1:30 pm: RISK ROUNDTABLES. Three concurrent sessions—attend the one of your choice. The sessions repeat at 3:30 pm so you can attend a total of two.

EMPLOYE DISHONESTY. *William A. Mahoney,* Vice President, Marsh & McLennan Inc., tells you how to handle a fidelity loss when the computer is involved.

AUDITING THE COMPUTER. How to make sure the computer program does ONLY what it is supposed to do . . . discussed by *Joseph J. Wasserman,* President, Computer Audit Systems Inc.

ERRORS & OMISSIONS RISKS. An examination of the many problems inherent in providing data processing services for customers, including quantifying the possible errors and omissions exposure, types of insurance available and user problems that have been experienced.

3:30 pm: RISK ROUNDTABLES. Repeat of above sessions. Attend the one of your choice.

5:30 pm: RECEPTION. Join your fellow registrants for cocktails and stimulating conversation.

6:15 pm: DINNER.

7:30 pm: NEGOTIATING THE COMPUTER CONTRACT. *Roy N. Freed* of the greater Boston law firm of Pollock, O'Connor & Jacobs tells you how a properly negotiated lease contract is one of the most effective means of obtaining relief from a problem with a computer equipment supplier.

FRIDAY, JUNE 18

9:00 am: HOW TO PREPARE FOR BUSINESS INTERRUPTION. *Paul W. Miles,* Executive Vice President, I. Berman Co., discusses the risks involved in a computer stoppage interrupting your company's operations and how you can effectively plan for recovery.

David Warren, CPCU, Partner, Warren, McVeigh, Griffin & Huntington, tells you how to fund business interruption losses through insurance and self-insurance so you get the money you need to get back in business.

10:30 am: LOSS PREVENTION ROUNDTABLES. Two concurrent sessions. Each repeats at 1:30 pm so you can attend both.

RISK MANAGEMENT: DATA TRANSPORTATION & NETWORK COMMUNICATION. *Rees S. Himes,* Assistant Vice President, Marsh & McLennan Inc., identifies and discusses various kinds and causes of losses through transporting and telecommunicating data and tells of ways to minimize and control losses.

CASE STUDIES OF COMPUTER RIPOFFS. *Donn B. Parker,* Senior Information Processing Analyst, Information Systems Group, Stanford Research Institute, takes an in-depth, eye-opening look at two examples of the computer as a tool of the corporate criminal.

12:30 pm: LUNCHEON. No speaker, so take advantage of this opportunity to discuss areas of mutual interest with your fellow registrants.

1:30 pm: LOSS PREVENTION ROUNDTABLES. Repeat of 10:30 am sessions. Attend the one of your choice.

3:30 pm: HOW TO IMPLEMENT A GOOD RISK MANAGEMENT PROGRAM. Panel members *William D. Hahn,* Principal Consultant, George Betterley Consulting Group, *Donald P. Fitzgerald,* Manager of the Management Consultant Services Division of Ernst & Ernst, and a corporate client discuss the nuts and bolts of establishing an effective and workab e risk management program for data processing exposures.

4:30 pm: ADJOURNMENT.

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Bethlehem's safety audit lowers injury frequency

PITTSBURGH—Back in 1965, safety training at Bethlehem Steel Corp. seemed to be doing its job —during a two year instruction period on supervisory safety responsibilities there was a marked and steady decline in Bethlehem's disabling injury frequency rate.

Then, the injury experience curve started its climb upwards again. To reverse the unexpected trend, Bethlehem started in November 1965, an auditing of its safety program. Since then, the frequency of disabling injuries has been in consistent decline.

R. L. Kesling, director of the safety and workers' compensation division, industrial relations department of Bethlehem Steel Corp., outlined how his safety program audits are carried out.

According to Mr. Kesling, injury frequency and severity rates by themselves are too unpredictable to tell a safety director what he needs to know about accident prevention progress.

"These rates are often erratic and, even if not erratic, they don't tell us whether the accident prevention tools are being used as they were designed to be used. Only auditing tells you if your accident prevention tools are being used—and used properly," he said.

Check sheets, physical inspection, and employe interviews are among the tools used to audit a safety program that assigns jobs and responsibilities to specific persons.

In Bethlehem's case, the audit provides a check on accident prevention program sections: Accident investigation, job safety analysis, job safety training, planned safety observations, corrective procedures and physical inspections.

In a large plant such as is used in the steel industry, auditing is done on a departmental basis. A review of the accident rate of all departments determines which ones will be audited—usually the one with the highest Occupational Safety and Health Administration (OSHA) lost workday incident rate.

In smaller operations, audits can be made of an entire plants' safety program.

Usually five persons make up an audit team for a steel plant departmental audit, according to Mr. Kesling. Two are operating or assistant superintendents from other plants; two are safety engineers and one is from the home office safety and workers' compensation division. Usually the supervisors are from the same departments of different plants.

Before the audit team actually begins its checks, it familiarizes itself with the department's organization, accident reports and supervisors. It tries to establish which positions produce the highest number of injuries and which employes for any job experience correlation, he noted.

The check sheets determine if the accident prevention tools are being used as frequently as required. To complete the check sheets, the team interviews hourly-rated employes and supervisors and studies the safety activity records.

Internal audits can be used also, according to Mr. Kesling. A plant manager names an audit team made up of operating and safety personnel. Another type is where the department head selects a team from his supervisors to audit a section of his department.

The major purpose of the audit is to determine whether higher departmental supervisers are carrying out their responsibilities.

"After a number of these audits had been made, it became apparent that the same weaknesses in the program were common to most of the audited departments. These were then made known to all operations, so that each could check their procedures and correct them where necessary," Mr. Kesling said.

The written report made by the audit team should list the findings and recommendations of the audit team for each of the safety program tools, including the unsafe acts and conditions observed.

The report is then discussed with the head of the audited department and his staff members. They then meet with the plant manager. It is up to the plant manager and department head to decide what action will be taken. One unexpected byproduct of the program has been the education of the audit team.

"After a week of searching for weaknesses in other peoples' accident prevention efforts, they see how their own programs can be improved and return to their own plant with ideas and changes for their safety programs," Mr. Kesling said.

The accident investigation form establishes whether every accident is being investigated and the report completed. Accident descriptions are checked to see they are clear and complete and all causes are being found and reported. The team determines whether proper actions are being taken to eliminate the accident causes.

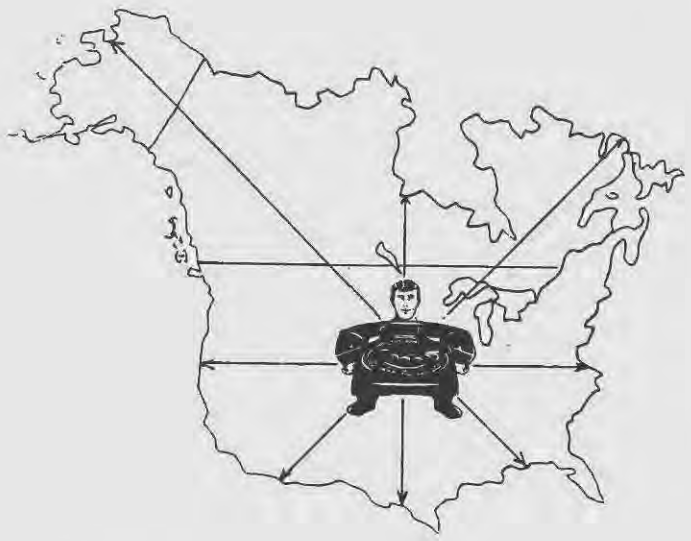
In the job safety analysis check, the team reviews the number of jobs analyzed, the quality of the job safety analyses, and whether analyses are used for employe training and job planning.

The auditing team also checks for the frequency of personal contact and group meetings. Employes are asked to recall a recent personal contact and what they remember from it.

The fourth Bethlehem check sheet determines the adequacy of the planned safety observation and inspection programs. Again, employes are interviewed to determine their knowledge of the job hazards.

Each first-line supervisor has a specific safety inspection checklist for his area. Adequate procedures to insure correction of reported unsafe conditions are also inspected. ■

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Kaiser-Aetna appoints new risk manager

Horace B. Sturtevant, 58, joined Kaiser-Aetna, Oakland, Ca., as risk manager on May 1. He replaces **Lawrence J. Bell,** who left the company, and **Rosemary Clark,** who performed Mr. Bell's function on a temporary basis (*BI*, April 5). Ms. Clark reportedly plans to leave the company in 90 days. Mr. Sturtevant reports to the manager of systems and internal controls and is responsible for property and casualty coverage, including workers' compensation, insured employe benefits and safety/loss control. Previously, he was corporate insurance manager at San Francisco-based Fibreboard Corp. No replacement has been named there yet. Kaiser-Aetna is a partnership between Kaiser Aluminum and Chemical Corp. and Aetna Life Insurance Co.

* * *

V. Gordon Clemons, FMC Corp.'s assistant treasurer and risk manager was promoted to division manager of the company's Avicel division in Philadelphia. Currently, Mr. Clemons is straddling both his Chicago-based risk management function and his new responsibilities at the specialty products and chemicals division until a replacement for his former job is found.

* * *

American Home Products Corp., New York, created the position of assistant director-international employe benefits and hired **David J. Pegg** to fill the post, effective May 10. Mr. Pegg reports to **Nathan Smith,** assistant vp-director of employe benefits, who previously performed the function among his other duties. Mr. Pegg was formerly senior international benefits advisor at Mobil Oil Corp., New York. At American Home Products, Mr. Pegg is responsible for the planning, development and implementation of all international benefit programs, including funding considerations and arrangements for the underwriting of insured international benefits. Mr. Pegg supervises the overseas program though the actual administration is done at each foreign location. He also reports on proposed changes in the benefit program submitted by overseas locations. American Home Products has 23,000 employes abroad in 40 countries.

* * *

On June 1, **Bryant W. Walker** will take over as safety director for PPG Industries Inc.'s coatings and resins division, Oak Creek, Wi. Mr. Walker currently is safety engineer in the company's chemical division. He will report to the employe relations manager at the new job. PPG Industries declined to tell *Business Insurance* whom Mr. Walker replaces, except to say that his predecessor left the company.

* * *

Paul F. York has stepped into the new position of corporate insurance manager for Dairymen Inc., a Louisville, Ky.-based milk marketing cooperative with 7,800 farm members. Mr. York, 26, is responsible for all property and casualty insurance coverages for the cooperative. In addition, he handles employe benefits for Dairymen's 3,500 workers, assists in administering the pension plan and works on affirmative action programs. In about six months, Mr. York expects to become active in labor relations negotiations. He first reports to Dairymen's director of personnel relations. Together the two men report to the vp-finance. Prior to joining Dairymen in February, Mr. York received his MBA in risk management and insurance from the University of Georgia, Athens.

* * *

Ray Partain, 36, was appointed Austin Industries Inc.'s first full-time risk manager, effective May 17. He formerly was risk manager at Daniel International, Columbia S.C. RIMCO Inc., Dallas, had performed risk management duties for four years for the Dallas-based heavy construction company and recommended that a permanent position be established, according to **William S. McIntyre,** president of the consulting firm. RIMCO continues to manage Austin Industries' newly-formed insurance subsidiary, British-American Insurance Co., Dallas. The Texas-based captive writes property and casualty coverages for Austin Industries and "affiliated operations." Mr. Partain will handle the risk management function for Austin Industries and reports to the financial vp.

* * *

Peter J. Babin will take over as manager, risk management and insurance at The May Department Stores Co., St. Louis, effective June 1. Mr. Babin, formerly district manager in the Worcester, Ma. office of Connecticut General Insurance Co., replaces **J. Larry Fiedler,** who left May Co. in mid-May to establish the new St. Louis office of Johnson & Higgins. Mr. Fiedler had been risk manager for May Co. since 1969. Mr. Babin will report to the executive vp and controller of the retail firm and manages a two-person department.

* * *

Named administrative coordinator at Levi Strauss Co., San Francisco, is **Jane Barrie.** In her newly-created position she reports to the director of risk and insurance management. Ms. Barrie is responsible for administering all U. S. workers' compensation programs and overseeing claims activity. She was formerly with Fred S. James & Co., San Francisco, and holds a degree in risk and insurance from the University of Minnesota.

* * *

Otis Elevator Co., New York, named **W. Michael McDonald** corporate risk manager, effective April 26. He heads up an 11-person department and is responsible for property and casualty risks as well as employe benefits. Mr. McDonald replaces **Jesse Pagonis,** who left the company nearly six months ago to join Foster Wheeler Co., as reported (*BI*, Nov. 3, 1975). Mr. McDonald was formerly director of insurance and employe benefits for Instrument Systems Corp., Huntington, Long Island, where he worked for two years. No replacement has been named by that company yet.

* * *

Sarah S. Woo was named assistant administrator of business services and campus insurance and risk management coordinator for the University of California, Los Angeles, replacing Myron M. Bell, who retired. Ms. Woo's appointment was effective April 15. She was formerly an attorney in private practice. ■

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dates for buyers

May 23-26: One hundred sessions and 300 speakers presenting papers on accounting, data processing, statistics and management are planned for the 54th Annual Conference of the Insurance Accounting and Statistical Association. Held at the Marriott Hotel in New Orleans, all aspects of insurance will be discussed in the presentations. For more information, write Mr. E. C. Carlson, Insurance Accounting and Statistical Association, 406 West 34th Street, Kansas City, Mo. 64111.

May 25-27: National Safety Council, Los Angeles—Over 70 safety, health, training and communication seminars and 200 exhibits will be offered at the 23rd annual Western Safety Congress and Exhibition. Pre-registration cost is $12 and $15 at the door of the Anaheim Convention Center. Contact the Greater Los Angeles Chapter, National Safety Council, 3388 W. 8th St., Los Angeles, Ca. 90005; (213) 385-6461.

June 8-9: Nuclear Insurance Consultants—Insurance and risk management from mining to disposal of nuclear waste will be the topics of a nuclear insurance and indemnity workshop held in New York City. Construction, fire protection, inspections, nuclear liability problems, and the international aspects of nuclear insurance are some of the planned discussions. For further information write Nuclear Insurance Consultants, 1221 Avenue of the Americas, New York, N. Y. 10020.

June 14-16: American Society of Safety Engineers—The professional development program features talks on OSHA by Morton Corn, assistant secretary of labor, safety communication, safety audits, and fire prevention for the safety professional. The conference will be held at the Hyatt Regency hotel in Atlanta. Hotel Reservations must be made through the Society Headquarters by May 24. Registration fees are $150 for members and $200 for non-members. Contact ASSE, 850 Busse Hwy., Park Ridge, Il. 60068.

June 16-17: Cleveland Chapter of the American Society for Industrial Security—A regional seminar held in Independence, Oh. will discuss security procedures in handling terrorism, bombings, executive protection, and labor disturbances. Security products and services also will be displayed. The seminar is aimed towards security personnel in industry, international corporations, and educational facilities. Cost is $50 for ASIS members and $65 for non-members. For more information contact the chairman, James Reid, President, Tri-County Police Inc., 11220 Snowville Rd., Cleveland, Oh. 44141.

June 16-18: Minnesota Counties Assn. and Hennepin County Cooperative Purchasing Participants—Risk management for governmental organizations will be examined at this seminar limited to 60 registrants. Nestor Roos, insurance professor, and Joseph Gerber, assoc. professor of insurance, both from University of Arizona, will discuss first and third party coverages, risk identification and evaluation and legal aspects among other topics. The June 16 conference will be held in Mankato, Mn., costing $123 and a June 21-23 seminar will be held at Island View Lodge, Gull Lake, Brainerd, Mn. costing $105. Contact Sheldon Weinberg, Hennepin County Risk Management, A2309 Government Center, Minneapolis, Mn. 55487, (612) 348-3147.

June 17-19: BUSINESS INSURANCE and Computerworld magazines—Protection and insurance of computer risks is the subject of a seminar held in Chicago at the Drake Hotel. Speakers will include computer operations planners, risk management consultants and insurance specialists. Business interruption insurance, disaster recovery and security management are some of the topics covered. Registration is $275 before June 1; after, $325. Contact Computer Protection/Insurance Seminar, Crain Educational Division, 740 Rush St., Chicago, Il. 60611.

July 18-21: American Bankers Assn.—Risk management, coverages and markets for bank executives will be the topic of a seminar in Boulder, Co. conducted by bank insurance and risk management officials. Banker's blanket bond insurance, trust department errors and omissions and safe deposit liability are among some of the subjects covered. Contact Edgar Armstrong, assistant director, Insurance and Protection Division, American Bankers Assn., 1120 Connecticut Ave., N.W., Washington, D.C. 20036, (202) 467-4048.

July 19: International Foundation of Employee Benefit Plans—A one-day program to define and interpret the requirements of all ERISA regulations will be held at the Plaza Hotel in New York; at the O'Hare Hilton in Chicago on July 20; and at the St. Francis Hotel in San Francisco on July 21. Administrative procedures and recordkeeping are some of the topics covered. The cost is $60 and $80 at the door. Contact the International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wi. 53005, (414) 786-6700.

Majority of health care thru HMOs

CHICAGO—Health Maintenance Organizations (HMOs) "will be the means through which the majority of health care will be delivered in the future," New York's Insurance Commissioner said in a speech before the Health Insurance Assn. of America late last month.

Thomas A. Harnett, commissioner, said the primary reason was "the ability of HMOs to cut costs without decreasing quality" by treating patients "in appropriate facilities with proper personnel."

Other reasons the commissioner cited included:

HMOs are not deterred from the treatment of individuals by lack of coverage; since there is no fee for individual service there is no resistance to first-symptom care.

This type of care, he said, "is the key to health maintenance and the prevention of more prolonged, more serious and more expensive illnesses." ■

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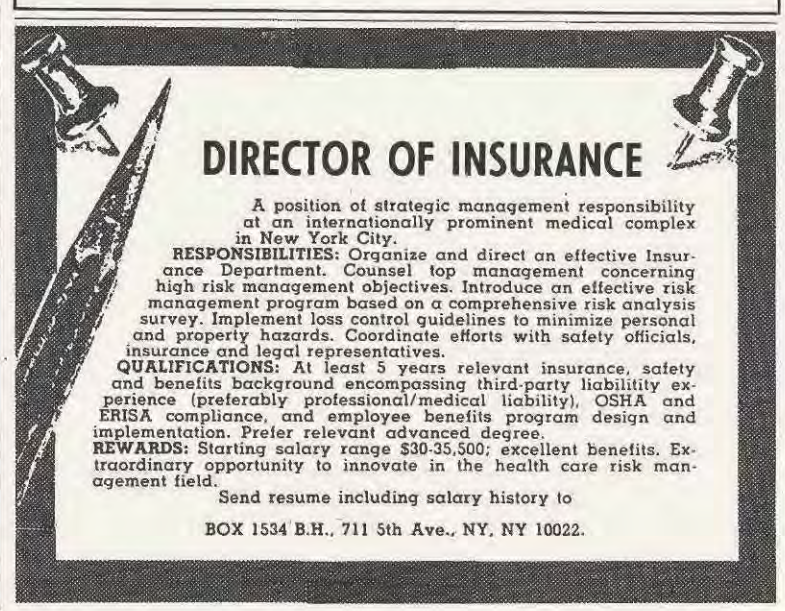
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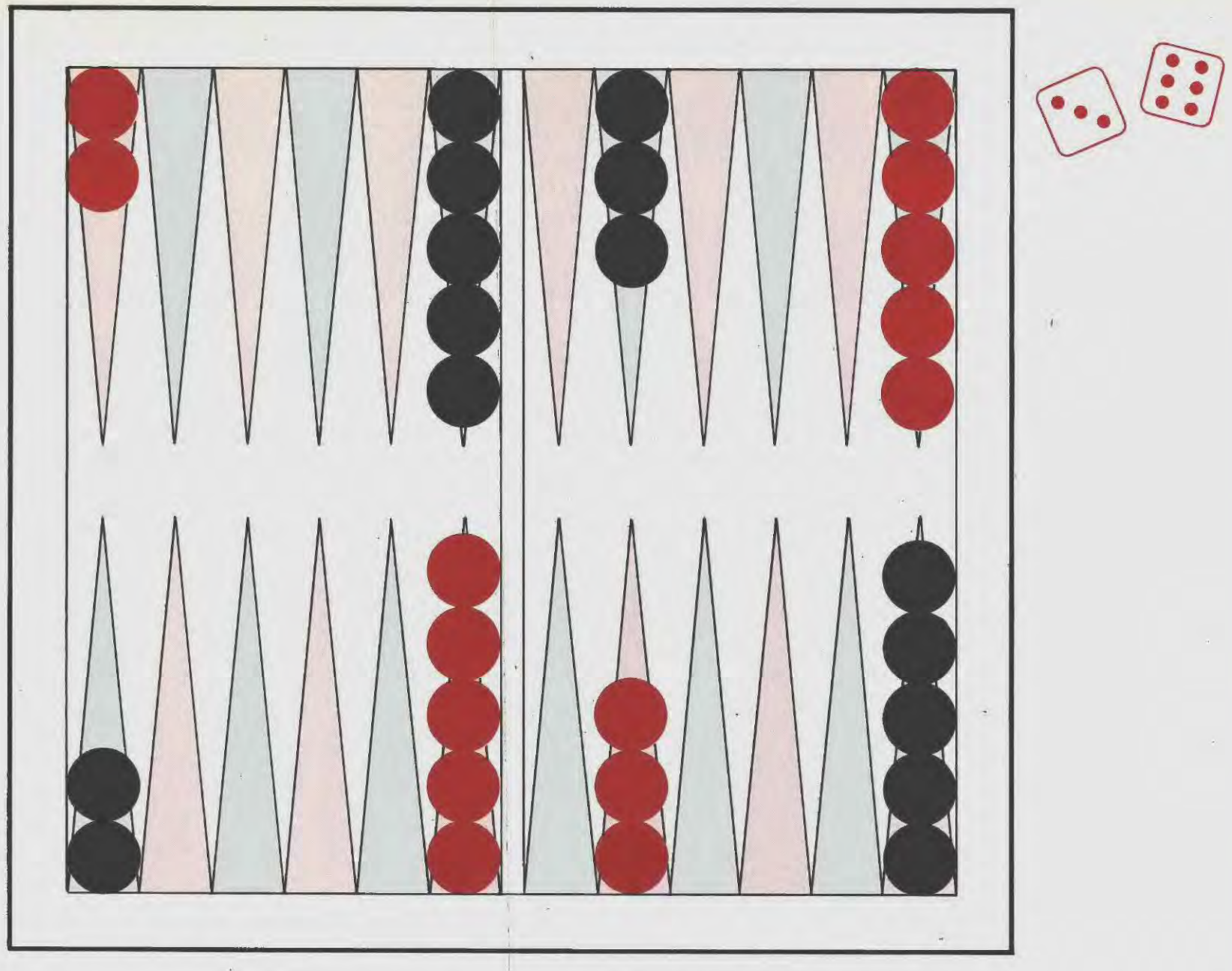
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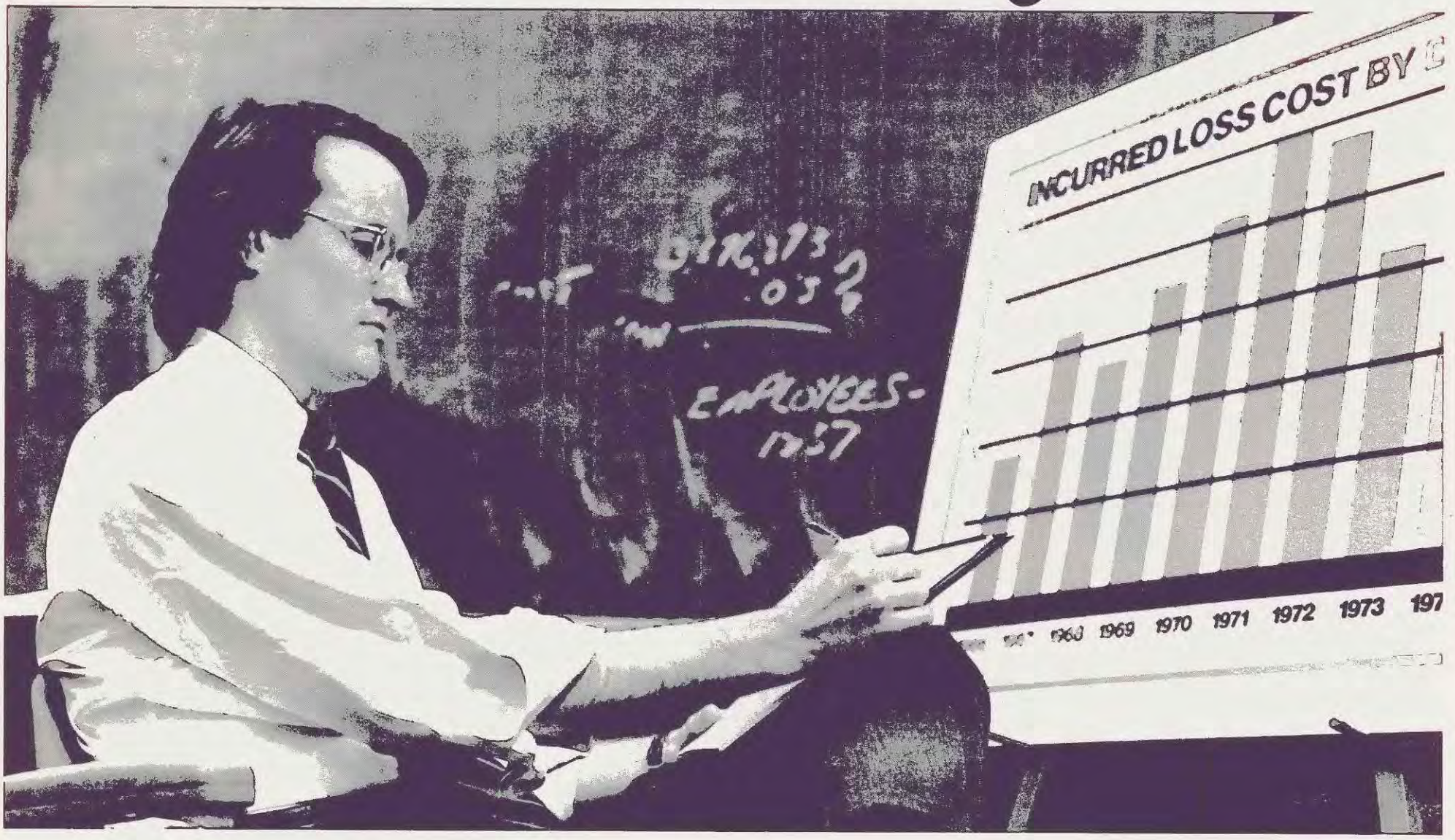
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