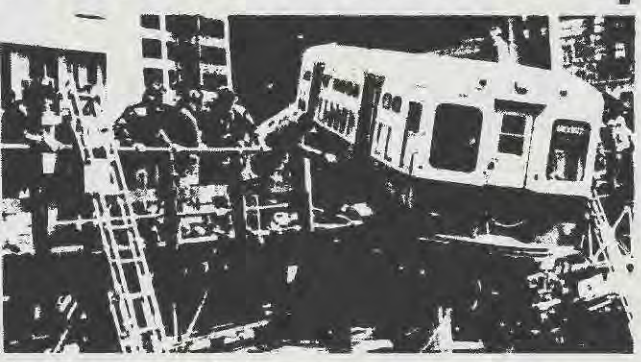
Bad accidents spark Transit Authority safety plan



CHICAGO—A rash of collisions and derailments since January has spurred the Chicago Transit Authority (CTA) to spend $25 million for new traffic safety equipment.

Investigations of the five accidents, which caused more than $80,000 in property damages, are now being conducted by a newly-formed committee of U.S. and Canadian public transportation experts. Three mishaps took place in only one month.

William Ashley, the CTA's risk manager, noted that the plague of incidents would probably not affect the agency's insurance rates. Because of CTA's $1.5 million deductible per incident, the agency's carrier has not had to cover any claims for the last 18 years.

The worst accident of 1974 occurred May 10 when one transit train ran into the back of a halted train on the same track. About 215 persons were injured, none seriously. Property damage has not yet been determined.

Eighteen days earlier, on April 22, a rapid transit accident occurred near Chicago's loop. Seventeen persons were taken to the hospital, but all were released.

On April 11, two cars from a CTA train derailed. One car was left dangling dangerously over the street. Firemen rescued passengers with snorkel equipment. Although no one was hospitalized, 22 injuries were reported.

Continued on page 2

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Week of May 27, 1974

business insurance®

the national newsmagazine for buyers of employe, property and liability protection and financial services

OUR ANNUAL Insurance Regulation issue, with stories starting on page 27 and running through page 49, provides a reference on activities of state and federal officials in the past year, looking ahead to the next.

STATE INSURANCE commissioners now have jurisdiction over health maintenance organizations in many states, with more legislatures in the process of passing enabling laws (**page 27**).

MANAGEMENT consultants McKinsey & Co. completed a report for the National Assn. of Insurance Commissioners which calls for sweeping changes in the methods of regulation and examination of insurance underwriters, to better protect consumers (**page 23**).

INSURANCE REGULATION

A FEDERAL workmen's compensation law is not likely to be enacted this year, we learned from knowledgeable Washington sources (**page 34**). And Federal Insurance Adminisatrator George K. Bernstein sees the government as a reluctant but necessary participant in markets where the private insurance industry is lacking (**page 36**).

IN A MOVE which may change insurance marketing practices, stockbrokers were given clearance by the New York Stock Exchange to sell all forms of insurance products (**page 41**).

REGULATORS are taking a closer look at employers' uninsured group benefit plans to make sure promised benefits can be covered (**page 43**). At the same time, they are scrutinizing the proliferation of 'pup' insurance corporations in their states (**page 45**).

IN OUR PERSPECTIVE section (**page 51**), commissioners Fred Mauck of Illinois and Tom O'Malley of Florida offer their views on regulation.

Administration is aiming for national health care in '74

By RICHARD L. GORDON

WASHINGTON—President Nixon last week made it clear that he wants a national health insurance program passed this year and that he is willing to compromise with Congressional backers of rival proposals in order to achieve it.

In a radio speech from the Florida White House, Mr. Nixon said, "We are not ruling out compromise where compromise does not violate the basic principles of our proposals."

The next day, Health, Education, and Welfare Secretary Caspar Weinberger told the Senate finance committee, at its opening hearing on health insurance, that two of the areas where compromise would be difficult are in the role of private insurance carriers and in the areas of deductibles and coinsurance.

HE TOLD THE committee, however, that the administration would be willing to "negotiate" on the portion of national health insurance premiums which would have to be borne by the employer in group plans.

The administration's Comprehensive Health Insurance Plan (CHIP) now calls for employers to pay 75% of the premium, calculated on the experience of the group.

Under the administration plan, employers "would probably have to pay about the same, perhaps a little more, for better coverage than they now provide . . . we believe employes will be paying a little less."

He pointed out, however, that most of the present administration cost estimates were based on price controls still being in effect for the health care industry. Congress, over administration objections, removed such controls earlier this spring.

He also made it clear that the administration definitely wanted an active role for private health insurers in any national plan.

"TO REPLACE IT (the private system) altogether would call for an unnecessary and massive increase in our federal medical care expenditures," he said.

He also said the administration was firmly committed to keeping deductible and coinsurance provisions in any final national plan.

First dollar coverages, he said, could drastically drive up costs.

Mr. Weinberger estimated that employers are now probably paying between 60% and 70% of the premiums for health insurance and said that collectively bargained plans might soon reach the administration's 75% minimum soon. ■

Bank's heavy trading loss may not be fully insured

NEW YORK—Franklin National Bank will not be totally insured under its blanket bond limits if losses incurred as a result of unauthorized foreign exchange trades reach levels of close to $40 million.

Franklin National's blanket bond cover is said to have limits of $25-30 million, with a $1.5 million deductible. This coverage would be inadequate if losses reach the high levels some have speculated may result.

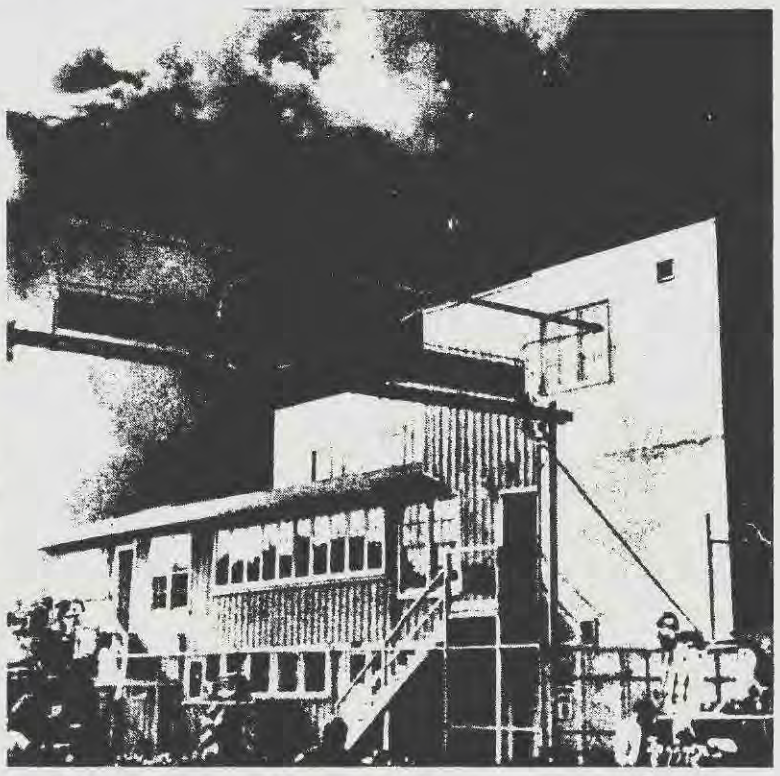
HOWEVER, a spokesman at the bank noted that insurance will "provide for a substantial portion of the loss."

The bank disclosed that losses have already reached the $12 million mark, but the bank failed to confirm the additional $27 million figure determined by an outside source.

According to insurance managers of other major banks, most large financial institutions carry a blanket bond limit of $40-50 million, much higher than Franklin National's. Franklin is the nation's 20th largest bank.

Fireman's Fund American Insurance Cos. is said to be the principal insurer, with the remainder of the risk spread between INA Corp. and Aetna Life and Casualty Co.

Continued on page 2



Film makers insured for damage, not disruption

HOLLYWOOD—Four different movie producers sustained losses in a fire that swept the old Samuel Goldwyn Studios lot here the evening of Monday, May 6, causing several million dollars damage and destroying at least three expensive sound stages.

Samuel Goldwyn Studios, (not associated with Metro-Goldwyn-Meyer) an independent, had property coverage of $10 million with Unigard Insurance Co., San Francisco, through Johnson & Higgins.

Movie industry sources said Unigard only last month took over the Goldwyn account. A Goldwyn official declined comment on speculation that Unigard would not want to keep the account following this loss. Estimates of property damage to Goldwyn focus in the area of $2 million, although the Goldwyn official said there is no firm estimate yet.

THE GOLDWYN spokesman said the firm does not have any business interruption insurance.

Goldwyn's property insurance was formerly split among several underwriters, but the primary insurer was Reserve Insurance Co.

QM Productions, an independent producer responsible for such television shows as Barnaby Jones and Cannon, had its studios completely destroyed by the fire. Scott Milne, head of the entertainment division of Albert G. Ruben & Co., brokers, said he gave QM a check for over $50,000 from Fireman's Fund American Insurance Co. on May 8.

QM, which rented several small studios on the lot, expects to rebuild on the Goldwyn site.

SID AND MARTY Krofft Productions was filming a children's series on the lot when the fire occurred. The Krofft facility was completely destroyed, and the firm does not plan to rebuild there. Krofft was insured through American National General Agencies, which represents six companies specializing in insurance for the entertainment industry. The major underwriter in that group is Pacific Indemnity Co. American National General has paid $75,000 to Krofft.

American National General also paid $200,000 to Compact Video Trucks Inc., which had several trucks on the lot doing a taping when the fire broke out. They were damaged extensively.

Production Systems Inc. also had equipment on the lot that was damaged in the fire.

Carruth Byrd Productions suffered damage to its rented studio on the lot. It was filming the Star of India television feature. ■

Transit Authority . . .

Continued from page 1

An eight-car train also derailed during rush hour on March 4, delaying service more than 15 minutes.

The first crash of the year occurred January 16 on the city's south side, when one train hit another stalled on the same track. Thirteen people were injured.

THE CTA'S investigating committee said it will study all possible causes of each accident, including mechanical failure and negligent operations. Many observers complained that the ill-fated trains were driven recklessly fast when the accidents happened, and some of the motormen were allegedly drunk or drugged. Motormen in both April mishaps and the January collision have been fired, a CTA spokesman pointed out.

As an aid to reducing judgment error, the $25 million safety system will include a signal box in every motorman's cab as well as track monitoring equipment. The system controls both the spacing and speed of trains, the spokesman said. When an emergency situation appears imminent, visual and audible warnings are blared in the motorman's cab. If the motorman fails to respond within 2.5 seconds, the system automatically takes over and brings the train to a complete stop.

Edwin Hays, manager of the CTA's claims department, said most of the personal injury claims this year have been small because the mishaps were "all bump and bruise accidents."

Mr. Hays added that none of the accidents' total claims "will reach the proportion of $1 million."

The CTA is basically self-insured, Mr. Ashley explained. Its catastrophic property-casualty coverage is underwirtten by Harbor Insurance Co. of Los Angeles. Harbor covers the losses between $1.5 million and $7.5 million for any one accident.

HARBOR WON the CTA's three-year insurance contract by offering the lowest rates when public bids were sought in 1972. Mr. Ashley said the premiums total $59,000 a year.

Last year, personal injury claims totaled about $10 million, Mr. Hays noted, costing 5% of the CTA's gross revenues. About 6,500 injuries were reported, due to accidents, robberies, heart attacks, molestations and other mishaps. Individual injury claim payments amounted to roughly $300 per incident, he estimated.

Even with the five accidents occurring between January and May of this year, injury claims are "about par," Mr. Hays said.

In the CTA's safest year, 1973, the transit agency had a combined bus and train accident rate of 6.6 per 100,000 miles of operation. Last year the CTA registered 48.2 million miles of rapid transit operation over 192 miles of track.

"You have your good years and your bad years," Mr. Hays noted. "They (the public) should get on our tails for these (accidents). We should be more safety-conscious."

The last time the CTA needed to make a claim under its insurance coverage was in November, 1956, Mr. Hays recalled. Seven persons died and 190 were injured when one train struck the rear of another at rush hour. The CTA's carrier then was Lloyd's of London.

IN THE LAST few years accidents have been decreasing, he noted. Between 1970 and 1973 the CTA experienced 6% reductions in injury claims losses each year. A good loss record still might be possible in 1974, Mr. Hays added.

One problem with the recent public transit accidents are the false claims that need to be sifted through. "We've had several phoney claims come in from people who couldn't have been there," he said. "You have to play it by ear." Many of the claims are thrown out right away because people say they were on another train, or were headed the other way.

One "punk" even said he boarded an ill-fated train at a station that doesn't exist, Mr. Hays noted.

The CTA's traffic record may soon improve with the hiring of better-qualified drivers and motormen, Mr. Hays said. The agency recently signed a new labor contract, providing experienced drivers with wages up to $12,000 a year. And this could possibly attract better employes, he explained. ■

Bank loss . . .

Continued from page 1

Corroon and Black, brokers for the bank, declined comment pending further investigation of possible fraud, as did the insurers.

Like most blanket bond covers, Franklin National's contains a dishonesty clause. Under this clause, it must be established whether the loss was sustained by an employe or official acting in a dishonest fashion.

One insurance source said, "Evidence of dishonesty is necessary. The mere fact that someone violated his authority does not necessarily prove dishonesty."

One or more persons at Franklin National acted without authority when large trades in foreign currencies were transacted, the bank said.

Commenting on Franklin National's predicament, an insurance manager for a major New York bank told *Business Insurance* that "this whole problem is pretty up in the air with all the banks. It could happen to anybody."

HE ADDED that, "somebody's going to have to do some adjuration to know if this has indeed been a fraudulent act. There is no definition in the bond for fraudulence, only one definition of employe and the other of property."

At another leading New York bank the insurance manager questioned the limits of Franklin National's bond cover. "Most New York City banks do carry banker's blanket bond limits to cover a loss like Franklin National's. I think they will probably realize this loss under the bond." ■

Move toward earnings loss cover seen

BOSTON—Disability insurance is moving in a "ground-swell" toward the use of basic economic loss coverage instead of occupational disability coverage, according to a former president of the National Society of Actuaries.

John H. Miller told a meeting here that the economic loss coverage is being coupled with increased emphasis on vocational rehabilitation by the health insurance industry.

The problem with occupational disability coverage, Mr. Miller explained, is that "it's conditional only on inability to perform a former occupation and without regard to the fact that the insured may be earning a livelihood—possibly a larger income than ever—in a new occupation."

As an example of the occupational insurance pitfall, Mr. Miller cited the hypothetical case of a neurosurgeon whose hands became crippled by arthritis. He received tax-free disability benefits to age 65 while serving as a high-salaried president in a pharmaceutical company.

One advantage of economic loss disability coverage is that it allows a person to seek rehabilitation that might lead him toward a new kind of vocation, he stated. ■

GUIDE TO FEATURES

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Variable life insurance still held up by questions about regulation

By MARY ANN CALLAHAN

NEW YORK—Variable life insurance, after spinning its wheels in the bogs of regulatory challenges since being introduced in 1969, faces still more delays before the Securities and Exchange Commission will allow its full-fledged entry into the insurance marketplace.

Industry and SEC sources indicated this month that it will be at least late summer, and possibly much later, before the SEC issues a final ruling on how VLI as an equity-based insurance product, should be regulated. So far, 17 companies have filed registration statements and prospectuses with the SEC, but none has been approved because of the regulatory questions.

VLI regulation is expected to come up at a Montreal meeting of the Society of Actuaries next week and it was on the agenda for the society's meeting in Dallas on May 23.

Nebraska insurance commissioner James Jackson, chairman of the VLI subcommittee of the National Assn. of Insurance Commissioners, said he will call a special meeting of the subcommittee at NAIC's semi-annual meeting June 2 in San Francisco. He said NAIC adopted the subcommittee's model state regulation for VLI at its last meeting in early December, but Mr. Jackson said he does not expect any major developments in the VLI sage at this meeting.

SO FAR, two states, Nebraska and California, have adopted the NAIC model, although the SEC delay in approving registrations has prevented any marketing of the policies under the law.

The latest major development, actually, came in late March when the SEC reopened hearings on a proposed amendment to the January, 1973 ruling which exempted VLI from the Investment Company Act of 1940 (which calls for disclosure of the internal operations of the separate investment account, much like mutual funds). Following the exemption ruling, however, a mutual fund group filed suit against SEC in circuit court of Washington, claiming that SEC was giving VLI proponents an edge. The case is still unresolved.

Now the SEC amendment proposes to make the exemption conditional on its prior approval of state VLI regulations to make sure they provide equal protection to the 1940 Act in the five relevant areas: uniform valuation of portfolio securities, an annual report, protection against unauthorized or improper change in investment policy, against excessive management or sales charges and protection regarding transactions with affiliates.

NAIC, however, while willing to disclose its model regulation with the SEC, and "wanting to cooperate to the extent it is possible to do so," refuses to acknowledge that the federal commission should be able to decide the VLI question. NAIC believes that VLI, as primarily an insurance product, is subject only to state insurance law; while SEC claims that the product's equity base may move it into its jurisdiction. The SEC already requires VLI carriers to comply with the Securities Act of 1933 (which requires disclosure of the policy form in the prospectus) and the Securities and Exchange Act of 1934 (which requires salesmen to be either registered or licensed brokers or dealers).

At the March hearing, Harry Walker, president of Equitable Life Assurance Society of America testified that the NAIC model was substantially equivalent to the provisions of the 1940 Act, "but in a way that recognizes the nature of a VLI policy."

THESE PROVISIONS were in the following areas; he said:

"First, the model regulation imposes on the company issuing the policies a heavy penalty by requiring substantially increased cash values if the premiums charges exceed those specified."

Second, it imposes a stringent limit on annual charges against assets in the separate account for managing the account and for mortality and expense risks."

"Third, each VLI policy must include the privilege of changing within 18 months after issue from VLI to fixed life without requiring evidence of insurability."

"Fourth, the model includes a policy provision which gives the insured a free look at the policy for ten days."

Following the March hearing, the record was left open and SEC sent a 23-page questionnaire to NAIC, going through the model regulation almost line by line and asked for answers by May 24. Mr. Jackson said that while NAIC intends to answer the SEC's questions, the project won't be ready until at least late June. Other interested parties, including American Life Insurance Assn. and the 17 insurers also were queried on the cost disclosure and sales commissions provisions of their policies, sources said, and their responses will be filed shortly.

As the regulatory fury rages around VLI, two companies, Aetna Variable Life Insurance Co. and First Variable Life Insurance Co., both domiciled in Arkansas, have begun limited and selective mass marketing (VLI) to tax-qualified corporate pension groups regulated by the Internal Revenue Service, instead of SEC. Since 1972, Aetna Variable Life has about 900 politices to 134 groups amounting to $12 million in coverage, with $330,000 in premiums, according to Ian Charlton, vp-actuary.

"Of course, every company would like to sell VLI to the general public, but until the regulatory situation is cleared up, we're going to take a 'wait and see' attitude," said a spokesman at Prudential Insurance Co. of America. Sources at Travelers, New York Life, Equitable, replied they also plan to wait until the regulatory guidelines are clarified. ■

Dividends for holders

MarketDyne Intl. Co. said that trade association members participating in commercial property, casualty, and workmen's compensation safety group programs underwritten by Pacific Employers Insurance Co. received a total of $2.8 million in dividends during 1973. MarketDyne attributed the sizeable dividends to the group plan's efforts to institute effective safety and loss control programs. A group of international financial institutions earned the highest dividend of 42.9% of premiums.

New football league buys cover for some NFL'ers

By STEPHEN GOOD

CHICAGO—Some star players in the National Football League (NFL) will have disability coverage this year—bought for them by teams in the fledgling World Football League (WFL).

The bizarre situation developed when WFL teams signed up veteran players who are required by contract to play with the NFL for another year.

Thirty-two NFL players out of the 48 who signed contracts with the new league still have to play at least one more season with their present teams. And according to one WFL team spokesman, many of these players are being covered "for our own benefit."

One WFL team, the Memphis Southmen, signed on three football greats from the Miami Dolphins to play in 1975—Larry Csonka, Jim Klick and Paul Warfield. They were obtained in a 3-year, $3 million contract package, explained Robert Giroux, the team's vp of finance. So the Southmen bought full coverage in case any of the players were disabled during their last year with the NFL.

MANY CARRIERS are involved in the coverage, Mr. Giroux said. One is Lloyd's of London.

"We covered them for anything that could happen to them," he said, whether they are on or off the football field. "We're not providing them with benefits, we're actually covering ourselves."

Mr. Giroux added that he hoped other WFL teams with big contracts were doing the same thing for their own protection.

One insurance industry source told *Business Insurance* that at least eight new WFL players are covered with disability insurance purchased by the teams. In most cases, the coverage is demanded by the player's agent, he noted. Depending on the value of the player and the size of his contract, disability insurance might cover all of the exposed payroll or a specified percentage.

In the NFL, the source added, "many players buy their own disability insurance. Only two have theirs paid by the teams and it's very expensive. But the players are most interested in having it."

As a result of this demand for disability coverage, the NFL may be prodded by its players into buying league-wide disability insurance this year, the source said. The NFL labor contract between players and managers is now up for renewal, and insurance coverage has been a sore spot in the negotiations. When the previous NFL contract expired on March 31, the players were left without coverage until the new season.

This coverage termination, seen by many players as management coercion to continue the old contract, forced the NFL Players Assn. to buy Blue Cross coverage for its members this spring (see *Business Insurance*, April 29).

The NFL players and management are currently far apart in their contract negotiations, the source noted. And a strike appears likely before the season begins. If the NFL has a late start this year, the WFL will gain more attention and fans than it ever expected.

Ted Palmquist, administrative vp for the WFL, said his new league has already set up its own insurance packages for the 12 new teams. Using the insurance broker services of Capital Conservation Corp. from Santa Anna, Ca., the league has arranged two coverage programs.

"THE FIRST one is a medical and life insurance package that's mandatory for all franchises to subscribe to," Mr. Palmquist explained. "This way benefits will be consistent throughout the league. They take the insurance through the league office.

"The second program, optional to the teams, is a general liability package. It includes stadium coverage, personal and property damage, equipment and travel coverages. The teams may take it if they wish, or they can negotiate their own."

Carrier for the medical and life coverage is the Maritime Life Assurance Co. of Halifax, Nova Scotia, a wholly-owned subsidiary of the John Hancock Mutual Life Insurance Co. A spokesman for Capital Conservation Corp. said the medical insurance has "very broad coverages," including a $50,000 comprehensive major medical and $25 deductible. A $700 maternity benefit is also part of the package, but no dental coverage is provided.

The spokesman cautioned that the coverage may change before the season starts. Although the packages were "sewed up" in February, no premiums will be paid until practice season starts June 1. The WFL has its first season game July 10.

BASIC COVERAGE in the league's optional general liability package is carried by Fireman's Fund Insurance Co., Mr. Palmquist noted. And Lloyd's of London is insuring some of the travel accident risks.

"Most of the teams took it," he added.

For teams wanting extra insurance on their star players, the WFL offers key man coverage as an option in the general liability plan. "It's up to the team, but it's a good idea for big contracts," Mr. Palmquist said.

The WFL key man coverage does not cover a player who still has one more year to go with the NFL before his contract begins with the new league.

All these WFL insurance covers are not intended to entice NFL players away from their old league, Mr. Palmquist asserted. "We have not tried to surpass the NFL or use this as an inducement to join the WFL."

THE QUESTION of legality in having one league's player insured by another league's team is unresolved, according to a lawyer for one NFL team. "There might be some question about it, but we really haven't checked into the legality of it," he said.

Meanwhile, the WFL has been taken to court by two NFL teams over the issue of signing up players for newly-formed teams before they finish their current contracts. Last month the Dallas Cowboys obtained a temporary injunction against the WFL, prohibiting the new league from signing up players who are still under contract to the Cowboys.

But in Cincinnati, the WFL recently won a similar legal battle. A U.S. district court judge ruled that an injunction sought by the NFL Bengals against WFL contract raids would "harm the public interest in fostering free competition in the marketplace for the sports dollar." ■

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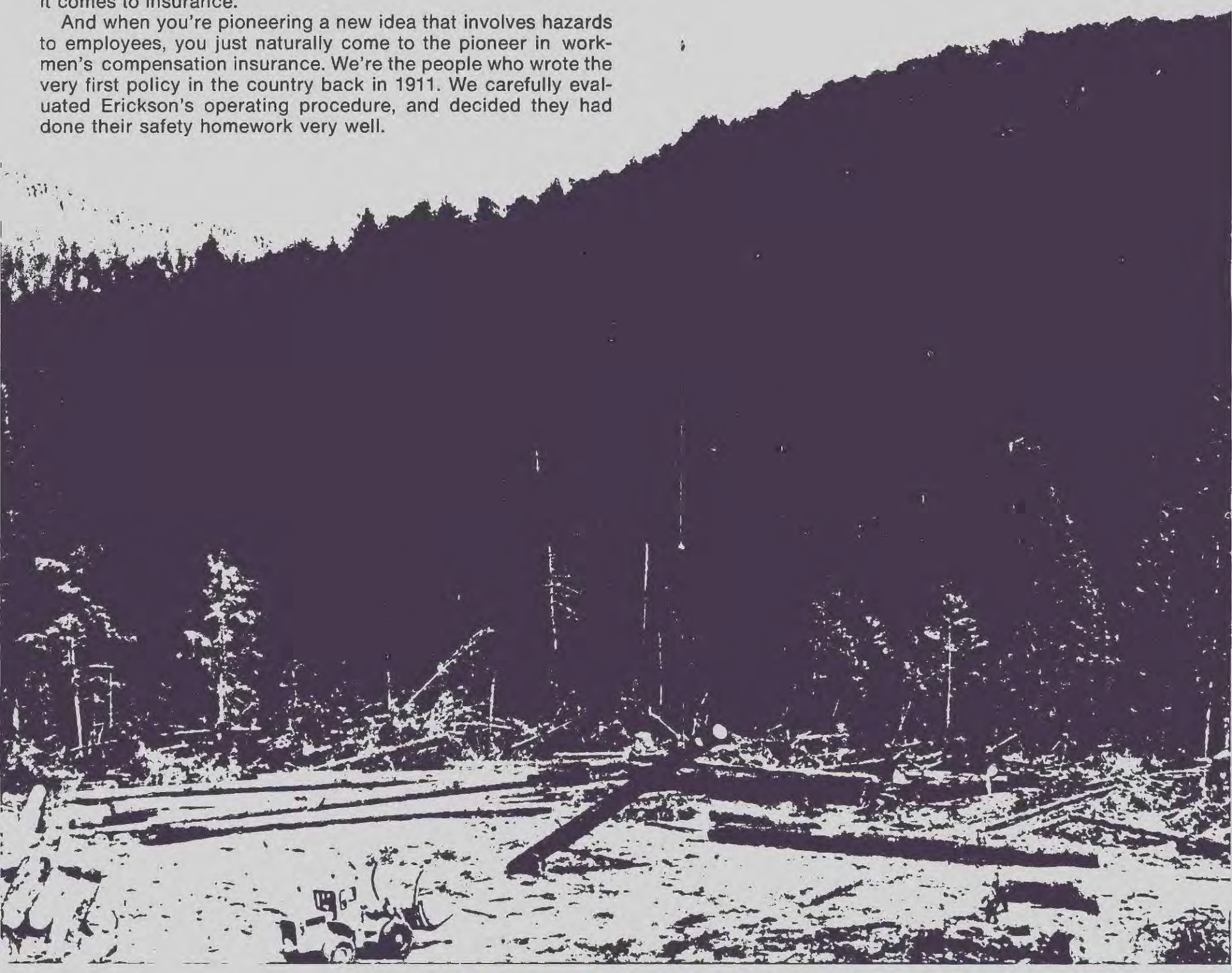

Come to the source

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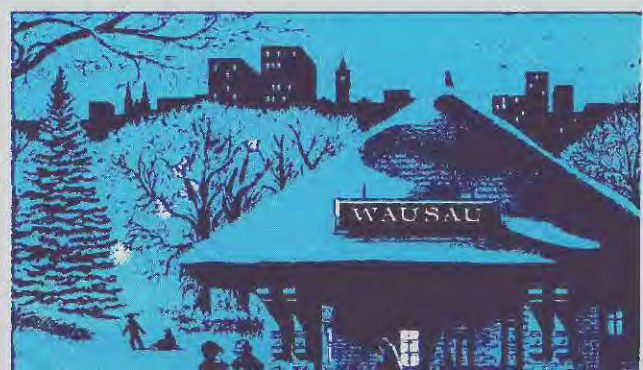


Report poor compliance with laws now in force on benefit disclosure

WASHINGTON—New pension, welfare, and employe benefit reporting requirements are now being debated by Senate-House pension conferees, but thousands of firms have yet to comply with the terms of the 1959 disclosure regulations.

A spot-check by the Labor department of a midwestern area revealed about 80% of the plans then in operation were not filing the required forms with the Labor department office of labor-management and welfare-pension reports.

"It's our feeling that there are vast numbers of people who still don't know what to do, and an equally large number of people who know what to do, but don't do it," a Labor department official told *Business Insurance*.

And while the new disclosure requirements of pension reform aren't known, plan officials are still required to file reports for 1973 under the old regulations.

The Labor department requires a D-1 form on any pension, welfare, or employe benefit plan that has 26 or more members.

SUCH PLANS include pension or other retirement benefit plans, group health, group life, group paid sick leave, group long term disability, group weekly accident and sickness, or group travel accident insurance plans.

The D-1 form includes general information such as the name of the firm, the type of plan, the group covered, how it's financed and, if insured, through what carrier, as well as the names of the trustees or administrator of the plan.

The D-1 form would also indicate the type of industry the group members are in and whether the plan is collectively bargained.

If the plan is collectively bargained and is mentioned in the labor contract, the Labor department says it would also require a copy of the contract to be filed with the D-1 form.

In pension cases, if the pension agreement is kept separate from the labor contract, then the pension agreement should be enclosed with the D-1 form.

IN THE CASE of any benefit plan, the Labor department requires a booklet or some sort of document describing benefits to be enclosed with the D-1 form.

While the D-1 form need only be filed once, it must be kept up to date and changes such as in the company name, address, plan administrator, the benefits offered, or the group covered must be filed with the Labor department on a form D-1A.

Such changes must be reported to the Labor department within 60 days after they occur.

If there are major changes in benefits, or trustees, or insurance carriers, "then I would suggest and require that a fresh form D-1 be filed and designated as an amended form," a Labor department official said.

For pension and other retirement plans, an amendment to the disclosures approved in 1973 requires a form D-1S be filed with the labor department.

The D-1S form is a simplified explanation of a plan's benefit provisions and requirements designed to increase the understanding of the plan by its members.

For plans with 100 or more participants, the Labor department requires that a D-2 annual financial report be filed which would disclose such cost factors as the amount of premium paid, the amount of benefits paid out, the cost of insurance commissions.

FOR FUNDED welfare or retirement plans, it also reports on the assets of the fund and how the assets are invested as well as the amount of new money placed in the fund.

D-2 forms are due 150 days after the end of the policy year for employe benefit plans. The Labor department says insurance carriers are required to supply their clients with the financial information within 120 days after the end of the year, giving the client 30 days to transcribe the information on to the D-2 form.

The law requires that all terminations of benefit plans, including insured plans, be reported to the department. In the case of plan terminations of funded plans, "we require a general statement on the distribution of assets," according to the Labor department official.

Such a statement could be included with the D-1A form notifying the department of the termination.

"The onus is on the firm or plan administrator to comply with the reporting requirements," Labor department officials said. The department has been unable to mount a serious effort to get the necessary forms filed, primarily through lack of funding.

The department, however, does keep track of D-2 filings for plans which have already filed D-1 forms and they have on occasion taken companies or unions to court in civil actions to obtain the required D-2 annual reports.

"All we'd have to do is go through the telephone directory and make calls and we'd find a lot that haven't filed," said a Labor department staffer.

FOR COMPANIES whose plans operate on a calendar year, the D-2 annual report forms are due by the end of this month. About 8,000 reports have been filed so far this year out of around 65,000 expected.

About 33,000 D-1S forms have been filed including hundreds from plans that had never before filed a D-1 or D-2 form. About 13,000 firms are still tardy in filing the D-1S form, although they were originally due last June 31.

Labor department efforts to collect the forms could pick up sharply in the future if it and the Internal Revenue Service, which has complete lists of all tax-exempt benefit funds, ever choose to share information.

Much of that, however, hinges on the final form of the new legislation for pension reform.

The necessary forms to comply with present law and information on how to fill them out are available at the Labor department's regional offices. ■

Insurance reserves up

Exxon Corp. reported in its 1973 annual report that the company's "annuity, insurance and other reserves" increased 9% in the last year, to $624,670,000 from $572,848,000. The addition of $51,822,000 to these reserves was more than double the addition of $23,870,000 made to the reserves in 1972.

Bar Assn. in trouble over opposition to group legal

WASHINGTON—Labor is preparing for a real fight with the American Bar Assn. (ABA) over the future of group legal services provided through closed (pre-selected) panels of lawyers, a Senate subcommittee was told this month.

"We informed the ABA at the recent Boston conference sponsored by its prepaid legal committee, that we have reluctantly come to the conclusion that we must resort to the courts for enforcement of our constitutional and other legal rights," Robert J. Connerton, general counsel of the Laborer's International Union of North America, testified.

He appeared before Sen. John V. Tunney's (D-Ca.) subcommittee on representation of citizen interests at hearings called to examine the effects of a key meeting of the ABA's house of delegates in Houston last February.

As a further thorn in the side of the ABA, the Justice Department warned the association that there are antitrust implications in its opposition to certain kinds of group legal insurance plans.

Bruce B. Wilson, deputy assistant attorney general, testified that the antitrust division is closely studying ABA resolutions opposing closed-panel group legal plans, which are supported by many labor unions and other groups.

THE ABA favors open panel plans, which involve payment of certain legal expenses and allow subscribers to freely choose their lawyers. ABA opposition to closed panel plans centers around the fact that these plans use, and are limited to, a group of pre-selected lawyers.

The ABA adopted amendments to its code of professional responsibility giving it the authority to "approve" future group legal services plans.

Labor officials are charging that "approval" would be restricted to "open panel" plans in which the individual has the option to pick an attorney of his choice who would be paid from group funds.

Labor wants the option kept open for legal service groups to be able to negotiate with groups of lawyers or law firms to provide services on a contractual basis and says the ABA effort to discourage such "closed panel" plans is an attempt to "corner the market."

"Counsel have been engaged by the consumer movement," Mr. Connerton said. "Preparation for suit is underway. It will be instituted on or about June 1."

THE ABA ACTION in Houston came in the wake of several steps that seemed to pave the way for group legal services as a hot new employe benefit.

The Supreme Court in 1971 settled a suit between the United Transportation Union and the Michigan State Bar Association in the unions favor by specifically allowing that "workers have a right . . . to act collectively to secure . . . lawyers to assert their claims."

The Congress last year amended the Taft-Hartley Act to allow collective bargaining for legal service plans and the conference report approved by both houses of Congress made it clear, say legal group proponents, that such plans could use open or closed panels of lawyers.

Sen. Tunney has described the future of legal group services in glowing terms such as: "Prepaid can be to legal care what Blue Cross and Health Maintenance Organizations are to medical care."

The Laborer's International Union has had an open panel prepaid legal plan in operation for members in Shreveport, La., since 1971 and has added an "HMO-type closed panel in Columbus, Oh., with staff attorneys a law firm, a back-up center and referrals to attorneys in rural areas.

Other Laborer's Union plans have been set in Washington, D.C., and in Birmingham, Al.

"By the end of 1974, plans of Laborer's Union will serve well over 100,000 members and their dependents. In 1975, that number should be at least double," Mr. Connerton said.

"WITHIN A few years, absent the present unusual circumstances, I would have confidently predicted that 80 to 90% of our 700,000 members and their families would enjoy full legal services," he said.

The ABA decision has strained what had been a good working relationship between the unions and ABA leaders on the prepaid legal question, United Auto Workers president Leonard Woodcock told the committee.

"Despite this most recent cooperation between UAW and the American Bar Association," Mr. Woodcock said, "we are aware of selfish elements within the ABA, currently and unfortunately dominant in the House of Delegates, which are more interested in the lawyer's pocketbook than the interests of the clients and the larger society.

"We in the UAW believe that it is imperative for the consumers of legal services to have a choice of plans," he said.

"THERE MUST be both open and closed panels in this country. Certainly, any national plan we negotiate will have to be open panel in certain areas of the nation where we do not have sufficient numbers of members to support closed panels.

"Moreover, we see the diversity of plans as helpful and useful to the consumer. The competition from the two kinds of operation cannot help but promote better service at more reasonable cost.

"We will not permit affected professionals, with an economic axe to grind, to use their power to call the tune," he said.

Consumer advocate Ralph Nader told the subcommittee, "Undoubtedly, there will be challenges to these new limitations on the courts and elsewhere. The only thing certain about them is that their fate is uncertain.

"Hopefully, no legislation will be required, but I do suggest that this committee give consideration to that possibility and begin considering appropriate measures that will insure the rights of consumers to organize group legal service plans according to their own best judgments as to their needs." ■

Agency acquires broker

ECCO General Agency Inc., Houston, acquired Risk Controls Inc., a national insurance broker, from The Signal Cos. based in Beverly Hills, Ca. ECCO now has offices in four major metropolitan centers.

LAST CALL AGENTS/BROKERS

On July 22, *Business Insurance* will publish its third annual Agent/Broker Profiles issue.

Last year's issue contained profiles of 500 leading agents and brokers whose business (property, casualty, employe benefits and related services) is with commercial accounts.

Those profiled last year should have received in the mail a copy of their listing as it appeared last year along with instructions as to how it should be updated for inclusion in the 1974 Profiles issue. The deadline for the return of this is June 3.

Those who were not included in last year's edition and would like to be considered this year may obtain the necessary questionnaire by writing to *Business Insurance*, Agent/Broker Profiles, 708 Third Ave., New York, N.Y. 10017. Or, if you desire immediate attention, call Ms. Judi Talit at 212-986-5050. To qualify, agencies and brokerages must have gross revenues of $150,000 or more annually, with 50% or more business from commercial accounts.

Courts inefficient for claims cases: Insurer

HOUSTON—An insurance company executive called on his industry to find a more expedient way to settle claims than by using today's court system.

"Any sizeable, sensible segment of American business is foolish to rely on the court system as the method of settling disputes that arise with its cutomers and beneficiaries," said Roy C. McCullough, chairman of the Maryland Casualty Co. of Baltimore. He told a meeting of the American Mutual Insurance Alliance and American Insurance Assn. this month that "If there are any better methods of getting on with our business, we better devise them and use them."

It would help the risk managers and public as well as the insurance industry, he added, if carriers took the initiative and developed new ways of handling claims arbitration and subrogation without remaining overly dependent on the courts.

"CLAIMANTS, insureds and long-suffering managers of claims operations would all be better served if we immediately started to work on figuring out some methods of bypassing the admittedly inefficient method of using the courts."

The present legal system for settling large claims keeps the plaintiff waiting and "the meters in the back offices of the law firms continue to click away," Mr. McCullough lamented. But he added that the lawyers and courts are not entirely responsible for the current situation.

"I think it is important that we not blame our judges nor any particular segment of the legal profession for the quagmire that the litigation process has come to," he said.

In part, Mr. McCullough pointed out, the courts are simply not prepared to handle the volume and complexity of claims cases that are foisted upon them.

One way of settling claims disputes is through arbitration, he noted. "Why should we stop with arbitration on automobile claims? Isn't the arbitration technique just as readily adaptable to the small and moderate size claims in the fields of fire and other property insurance, and in workmen's compensation?"

IN A PRODUCT liability suit where both the manufacturer and components supplier are involved, the litigation can be simplified as well, Mr. McCullough said.

"If both the manufacturer and the supplier are insured, can't we work out a standard arrangement whereby the supplier is notified, given an opportunity to contribute to the investigation and defense, or even to possible settlement, without actually dragging him into the lawsuits? . . . The relative rights of the manufacturer and the supplier can be subsequently determined in a cheaper, quicker, and more suitable forum by a less formal means of resolving any dispute." ■

Truck safety linked to slower speed

NEW YORK—The Travelers Insurance Co. opposes reinstatement of higher speed limits for trucks and urges "management commitment to safe operating practices, the selection of equipment consistent with function and safety, and effective training and supervision of drivers to insure compliance with safe operating principles."

A Travelers spokesman said that unfortunately, hazardous driving practices for truckers are rooted in economic practices like paying on distance runs, or number of trips covered.

Another unfortunate practice cited was the use of specially designed equipment, made to perform best at higher speeds.

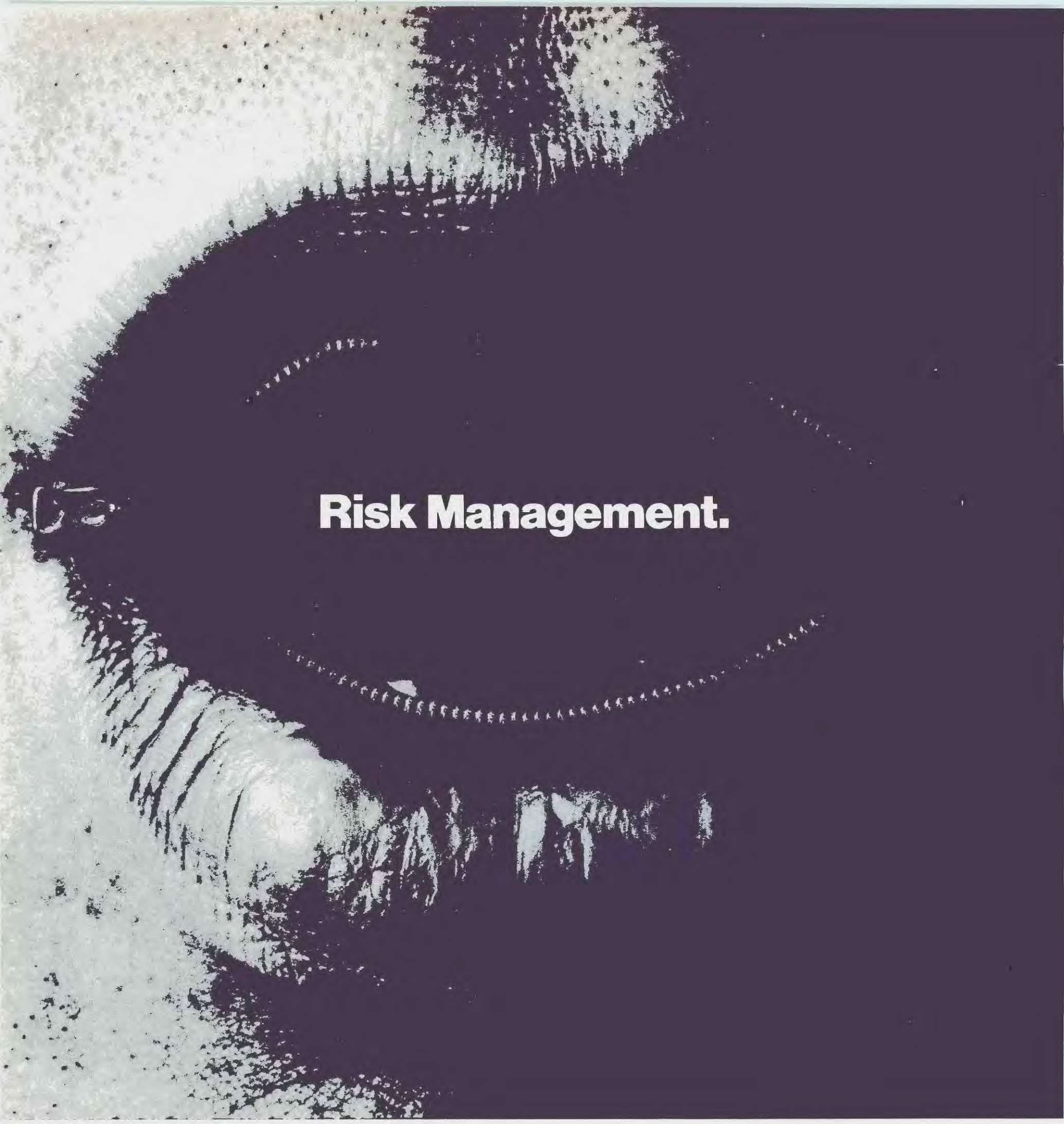
It was added that the argument for higher speeds because of design "has been accepted as an admission that many long-distance truck operator have knowingly violated highway safety laws."

Safety laws "were established in the best interest of all highway users," a company spokesman said. And lower speed limits for truckers "take into account the braking disparity between cars and trucks at higher speeds."

Citing a research study done by a major engineering manufacturer, a Travelers source said that tractor-trailer units were found to operate best at 50-65 miles per hour. ■

Agency acquisition

The New York-based Manhattan Life Corp. acquired The Richard M. Grosten Insurance Agency Inc. and The Grosten Group Insurance Agency in Los Angeles. The agencies will continue to operate as general agencies of The Manhattan Life Insurance Co. under the management of their former owners.



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washington watch

OSHA chief gives outlook, review after administration's first 3 years

WASHINGTON—As the Occupational Safety and Health Administration (OSHA) neared its third birthday last month, its chief, assistant labor secretary John H. Stender, gave the National Assn. of Manufacturers' committees on employe safety and health and labor-management relations a rundown on problem areas and future possibilities.

First, the problem areas.

Industry requests for simplification and revision of standards won't come overnight, said Mr. Stender, but OSHA has already indexed its standards by hazard and intends to index them by industry.

AND THE agency is considering a proposal to allow 90 days for comment on new proposed standards instead of the present 30-day limit, he noted.

"Let me state that nearly every request for additional time for comment has been honored," he told the NAM meeting. "There probably would continue to be requests for added time for comment even if the rule was set for 90 days."

Industry would also like OSHA to more fully price out the impact of their standards, but to do that for all standards "doesn't make sense," according to Mr. Stender.

OSHA is willing to undertake "economic impact statements" and already does take into account the cost of standards, he said. "When the standard under consideration might have broad economic consequences, we go even further.

"For example, we are now in the final stages of developing a new noise standard. As part of the research that has gone into this standard, we contracted with an outside firm to provide us with an estimated cost-to-industry study over the next three to five years of both an 85-decibel maximum noise level and a 90-decibel level. The results of this study have been made public, as is all input into the standards development process."

BUT THE expense of impact statements for all standards would be "astronomical" to both OSHA and the taxpayers.

Mandatory penalties for first instance serious violations and discretionary penalties for first instance non-serious violations will probably not be eliminated.

Mr. Stender said, ". . . there will always be some employers who would wait until inspection before making any effort to eliminate safety and health hazards if it were not for first instance sanctions."

OSHA is aware of the problem of overlapping jurisdictions, another industry criticism, Mr. Stender said, and is trying to do something about it.

"I'll be just as happy as you are," he told the NAM meeting "when our compliance officers stop bumping heads with railroad safety inspectors and fellows from the Bureau of Mines."

Mr. Stender said industry requests for on-site consultation probably could be better handled by an agency such as the Small Business Administration. And, he added, the experience of state plans which offer on-site consultation indicates "there is not a great deal of demand for it when it is available."

MR. STENDER promised the NAM commitee members that, in the future, they can expect more inspections; more standards, especially health standards; more training programs; more responsiveness from OSHA area and regional offices; more actions taken by states with approved plans; more uniformity in standards interpretation; and "more interest in what you are doing, and in the suggestions you have to offer us."

Specific job safety and health areas would include job and occupational health, with particular emphasis on toxic substances.

"To you, the manufacturing industry, this means that OSHA will be giving more attention to chemicals, fumes, and other health hazards," he said. "Already, we have nearly doubled the number of industrial hygienists on our compliance staff.

"Any company that works with chemicals or with processes that produce dangerous waste products can expect more frequent monitoring for dangerous substances.

"On the other hand," he said, "you can also expect more information about health hazards and more training in the same area to be made available."

AND OSHA will be pushing harder for voluntary compliance programs.

"I might add that employers who have established voluntary compliance programs—with internal hazard inspections and labor-management committees—on the average are found to have fewer violations and lower injury rates than firms that have done nothing."

Mr. Stender also dismissed what he called a "near-sighted" industry criticism—that OSHA does not attach employe carelessness because its standards apply only to the employer.

"First, it should be obvious that OSHA has no business disciplining your employes. That is your job. You have the responsibility of instilling safe working habits among your employes.

"Second, there is a direct correlation between safety and health conditions that exist in the plant," he said. ■

Carrier sells agency

Utica Mutual Insurance Co. said it plans to sell its wholly-owned general insurance agency, Utica Mutual Assoc. Inc. to Alexander & Alexander. The agency employs over 100 persons and has eight offices in New York state.

Pan Am is installing crash warning system

NEW YORK—Pan American World Airways said it is reacting to four major crashes of its planes in less than a year by moving swiftly to install in all its 140 airplanes a costly new warning device that may avert future disasters.

Pan Am has racked up hull losses of about $20 million coupled with the deaths of some 290 persons in the four crashes which occured in a nine-month period. Pan Am was insured through Associated. Aviation Underwriters for those property losses. The value of total liability claims filed against Pan Am as a result of those crashes is not known. The latest crash occurred last month when a Boeing 707 jetliner hit a mountaintop in Bali, killing 107. (*Business Insurance*, May 13.)

Pan Am is the second major airline to begin installing the warning system, at a whopping cost of $2.9 million. The first was Scandinavian Airlines, which is now in the process of installing the device in its 50 planes.

THE SUPPLEMENTAL warning system, designed by Sundstrand Data Control Inc., will become standard equipment on all Boeing Co. jumbo jets starting next January.

The alarm system, which cannot be bypassed or shut off by the pilot, includes a loud warbling siren which sounds a "whoop whoop" noise, a pre-recorded tape which shouts "pull up," and a flashing red light signalling "terrain."

The system is touched off by an incorrect landing approach, sudden loss of altitude near terrain, or approach of a mountain or other terrain at the wrong angle or wrong speed.

The system also warns crew members of impending danger by telling them the plane's altitude. Signals are set to trigger in time for the pilot to pull back the controls and raise the plane to a safe level.

Aviation experts at Sundstrand noted that although such a system might have averted the Bali crash, parts of the mountain angled by as much as 85 degrees. The system is designed to notify of approaching mountains with average slopes 60 degrees. A sharper angle may not allow enough advance warning of terrain for the alarm to sound.

Yet, industry experts conclude that many past crashes over the years could have been prevented had this device been installed by commercial airlines. (*Business Insurance*, Oct. 8, 1973.) ■

Exxon not covered for kidnaping

NEW YORK—Sources at Exxon Corp. told *Business Insurance* that they did not carry ransom insurance for the record payout of $14.2 million to the People's Revolutionary Army in Buenos Aires, Argentina for the release of Esso Argentina's refinery manager, Victor E. Samuelson, who was kidnapped nearly five months ago.

Despite the apparent exodus of foreign service employes from the kidnap-prone Argentina, Exxon sources said that his incident "would have no effect on employment practices" abroad in the future.

Exxon employs more than 1200 employes abroad, although one corporate source said that we do not have "terribly many. Most of our foreign operations are staffed by local nationals."

The original ransom demands from the People's Army for Mr. Samuelson's release was reported as $10 million. The amount was rejected by Exxon and was subsequently raised to $10 million plus $4.2 million in food, clothing and building supplies for flood victims in northern Argentina, according to one source.

Exxon finally agreed to pay the full $14.2 million in cash, saying that the corporation was not in any position to meet the relief supply demands. ■

Committee thrashing out compromise pension bill

WASHINGTON—Senate pension reform conferees have agreed to drop their reform bill's ban on non-qualified plans during closed door meetings this month with House conferees, *Business Insurance* learned.

The conferees also reached agreement on compromise standards for a qualifying year of service and maximum participation requirements.

The compromise pension reform bill is now expected to allow non-qualified plans but under restrictions for vesting, funding and participation and is basically the House bill's language on that question.

The agreed-upon definition for a qualifying year of service was rewritten to mean 1,000 hours worked during a 12 month period. That is a change from the Senate bill's definition of a year of service as five months during a year in which 80 hours or more were worked each month.

THE HOUSE bill would have allowed the definition to be established by regulation, rather than statute, and was supported by the Nixon administration.

"We were very glad to get rid of the original Senate definition," said a source close to the conference. "It was too rigid."

Sen. Jacob K. Javits (R-N.Y.) insisted, however, that the definition be made amendable by regulation in special cases such as those involving seasonal workers.

The compromise maximum participation requirement now would make workers eligible for pension plans at age 25 after one year's service with a "lookback" feature that would credit young employes with up to three years of service.

The compromise kills an amendment sponsored by Rep. Bella Abzug (D-N.Y.) which would have allowed employes younger than 25 to qualify for plans as long as they had three years of service.

The Senate-House conference committee began meeting May 15. Three meetings were scheduled for last week and the conferees were expected to move from participation and coverage into the areas of vesting, funding, and termination insurance.

The thorny issue of jurisdiction by the Treasury and labor departments was deferred until later.

Senate and House staffs close to the bill were predicting a smooth conference that could be wrapped up sometime next month.

The Nixon Administration, through deputy assistant Treasury Secretary John H. Hall, took the opportunity of a meeting of the Assn. for Advanced Life Underwriting earlier this month to let its opinions on the pending pension question be publicly known.

"ON THE WHOLE," said Mr. Hall, "with the principal exception of termination insurance, the Senate bill was a constructive and moderate approach to pension reform, and a bill we were reasonably happy with."

"The Senate bill was generally a good bill, except for a number of technical errors which have been corrected on the House side, and we would be pleased to see something along those general lines enacted," he said.

Mr. Hall, however, objected to the House provision for direct statutory requirements on vesting, funding, participation, and termination insurance to be administered by the labor department.

"This approach, of course, was inherently irreconcilable with the existing structure of indirect pension regulation through minimum requirements for tax qualification," he said.

"The idea is that IRS and Labor will issue joint regulations and thereafter plans will have to report to, and satisfy both the IRS and the labor department. This is one of the principal features I had in mind when I said that I wish the legislators would give a little more thought to basic economics.

"The administrative costs necessary to satisfy even one governmental agency will be great enough for smallplans; the infliction of overlapping and potentially conflicting supervision of the identical substantive rules by two different bureaucracies may be a good political way to get a bill reported when a deadlock develops, but as a way to handle a substantive problem, it is in my judgment indefensible."

A SECOND problem with the House bill, Mr. Hall said, is its impact on non-qualified plans.

"It is one thing to impose stringent prerequisites for receipt of special tax benefits, but the House bill imposes the identical substantive requirements for vesting, funding and participation whether the plan seeks to be qualified or not."

"The Senate bill is more direct. It outlaws non-qualified plans directly.

"I am not optimistic that it will be possible to preserve the legal right to set up a pension plan or profit-sharing plan which does not qualify under the code. It certainly vastly increases the sanctions for being disqualified—and the new bill has a myriad of traps for the unwary whereby this can happen.

"Not only do you and your employes lose their tax benefits, but the very maintenance of such a plan, at least under the Senate version, will be illegal."

Mr. Hall also said he was concerned that the House bill prohibits "front-loading" of benefits.

"This doesn't make sense at all, for it runs counter to the entire intent of the bill to accelerate the achievement of retirement security.

"FOR INSTANCE, the House bill prohibits a pension whereby the full pension accrues after, say, 30 years, at least if there are no early retirement provisions it likewise effectively prohibits a plan with special benefits for lower-paid workers, for with a rising pay-scale, this would be a front-loaded plan."

The administration, said Mr. Hall, also has taken "serious exception" to the Senate bill's rules on participation having itself suggested a three-year and age 30 requirement and has suggested that the definition of a "qualified year of service" be done by regulations, not by statute.

"There are some real problems with this definitional area in the Senate bill, which in essence defines a year as five months and a month as 80 hours," he said.

On vesting, he said the Administration still preferred an age-

Continued on page 62

Connecticut General opens its third HMO

BROOKLYN — Connecticut General Life Insurance Co. opened its third health maintenance organization (HMO) since 1969 last month. A professional corporation of 65 physicians co-sponsor the health care center with Connecticut General.

"Our objective is to give medical consumers convenient access to comprehensive medical care without financial hardship," said John A. Campbell, Connecticut General's healthcare program director. A fixed monthly payment should cover all typical family medical needs, the company said.

Right now there are less than a thousand people participating in the new HMO program. Connecticut General expects 15,000 enrollees by the end of the year.

Enrollment in the plan is offered through employer group benefit programs as an alternative to conventional health insurance. Monthly premiums are higher but benefits are broader, the company added.

Monthly premium for a family is $69.75 and for individuals, $25.25. In most cases, employers pay the major part of the premiums, according to Connecticut General.

THE PLAN includes: 24-hour service, health check-ups, full prenatal and post-natal maternity care, home care, psychiatric care, full hospital care, and all treatment of illness or injury by the healthcare center's physicians.

A $2 registration fee is the only additional charge to enrollees, except for a $7 house call fee and a $5 charge for psychiatric treatment.

Selected hospitals provide in-hospital care and out-of-hospital care is supplied at the new centrally located health care center. Each enrollee has his own physician, but he also has access to all specialists at the medical center, the company said.

The facilities include suites for minor surgery, internal medicine, obstetrics, gynecology, pediatrics, emergency service, rehabilitation medicine, radiology, laboratory and pharmacy.

For the treatment facilities Connecticut General is providing $2 million as start-up capital. They will handle all nonmedical aspects of the operation such as administrative services, marketing, premium collection and financial management.

Connecticut General has contributed a total of $10 million for the three HMO programs co-developed. The Columbia Medical Plan in Columbia, Md. which opened in 1969 now has 16,400 enrollees.

The Arizona Health Plan in Phoenix, opened in 1972, has an enrollment that exceeds 17,700, Connecticut General reported. ■

OSHA info director is hurt at office

WASHINGTON—Work safety's costly lesson hit home at the Occupational Safety and Health Administration last month when OSHA's information director fractured his wrist by tripping over an office typewriter cord.

Sam Sharkey, 57, a veteran newsman who has worked for NBC, the New York Times, and taught at Columbia University's Journalism school, returned to work shortly after the accident. But his writing activities have been heavily curtailed by his broken right wrist. Mr. Sharkey is right-handed.

"He bounced back rather quickly," an OSHA spokesman said.

"We had somebody down here inspecting afterward, but we can't penalize ourselves," he added. "We finally tucked the cord away so it wouldn't trip somebody else.

"It shows how simple good housekeeping could be. We were guilty ourselves of faulty housekeeping practices.

"It also shows how costly accidents can be," the spokesman noted. "We lost our best writer."■

Aetna sues their star salesman for $10.5 million

LOS ANGELES—Aetna Life & Casualty Co. filed a $10.5 million civil damage suit against its star life insurance salesman of 1973, Bert Kreisberg, of Encio, Ca., who wrote more than $100 million in new business and produced $3 million in premium income for Aetna last year.

But the problem with its top producer, alleges the Aetna suit, was that the agent and his company, Bert Kreisberg Assoc., illegally rebated premiums to customers in return for rights to borrow against the policies. Such rebates, the suit contends, are in violation of section 750 of the State of California Insurance Code which states:

"An insurer, insurance agent, broker, or solicitor, personally or by any other party, shall not offer or pay, directly or indirectly, as an inducement to insurance on any subject-matter in this state, any rebate of the whole or part of the premium payable on an insurance contract, or of the agent's or broker's commission thereon, and such rebate is an unlawful rebate."

AETNA'S SUIT alleges that Mr. Kreisberg's rebating caused Aetna $500,000 in actual damages and an additional $10 million is being sought as punitive damages. This civil action follows an administrative complaint filed earlier by California insurance commissioner Gleeson L. Payne, who also accused the Kreisberg agency of the rebating violation of section 750.

Although the Aetna suit mentions only "ten or more persons" in the last three years having life insurance written by Mr. Kreisberg, a company spokesman said the Kreisberg agency wrote 87 Aetna policies last year. These alone were worth over $100 million. The company's total new life business for 1973 was just under $2 billion.

A number of experienced life underwriters contacted by *Business Insurance* indicated that the most successful salesman in the industry averages no more than $100,000 per year. Over the last three years, the volume of Mr. Kreisberg's premium income was estimated at over $10 million.

One of Mr Kreisberg's customers named in the accusation filed by the state insurance department was James A. Collins, chairman and president of Collins Foods International Inc. The company is the biggest franchiser of Kentucky Fried Chicken restaurants and operates the Sizzler Steak House chain.

Mr. Collins bought a $5 million life insurance policy from Bert Kreisberg in 1972 and assigned Mr. Kreisberg the right to borrow on the policy. Aetna permits such assignments beginning six months after a big policy takes effect, while the customer retains death benefits for himself.

ON THE FIRST year premium payment of $100,000 for the Collins policy, the state complaint alleges, Mr. Kreisberg got a commission of $55,000, an expense reimbursement of $19,250 and borrowed $65,000, which was the cash value of the policy. The total—commission, expenses and loans—could total $139,250, leaving $100,000 for the premium and a $39,250 profit for Mr. Keisberg, according to the complaint.

Insurance commissioner Payne said a hearing on the charges against Mr. Kreisberg should resolve the question of whether the policyholders were guilty of a misdemeanor for accepting a "rebate." Other important answers being sought are whether policyholders are liable for taxes because they, in effect, received a free insurance policy in exchange for its borrowing rights, and whether there was a conspiracy to defraud the insurance companies involved.

In addition to Aetna, Mr. Kreisberg was licensed to sell insurance for Continental Assurance Co., a Chicago-based unit of CNA Financial Corp. Industry sources estimate that 99% of Mr. Kreisberg's business in recent years had been written for Aetna and Continental Assurance.

AETNA HAS since cancelled its contract with the Kreisberg agency and the insurance department is seeking to suspend or revoke Mr. Kreisberg's insurance license.

Mr. Kreisberg could not be reached for comment, but his attorney said that by serving notice with the insurance department that he desired a hearing on the charges, Mr. Kreisberg had, in effect, denied the allegations.

Industry observers note that it is the insurance company that suffers in the case of a rebating scheme of this alleged magnitude. If enough policies are sold, the immediate effect is to generate a huge inflow of dollars and a large profit the first year. The pinch for stockholders in the insurance company or mutual company would occur several years later when the policy loans had to be repaid with interest. ■

Buys Equity Funding's subsidiary

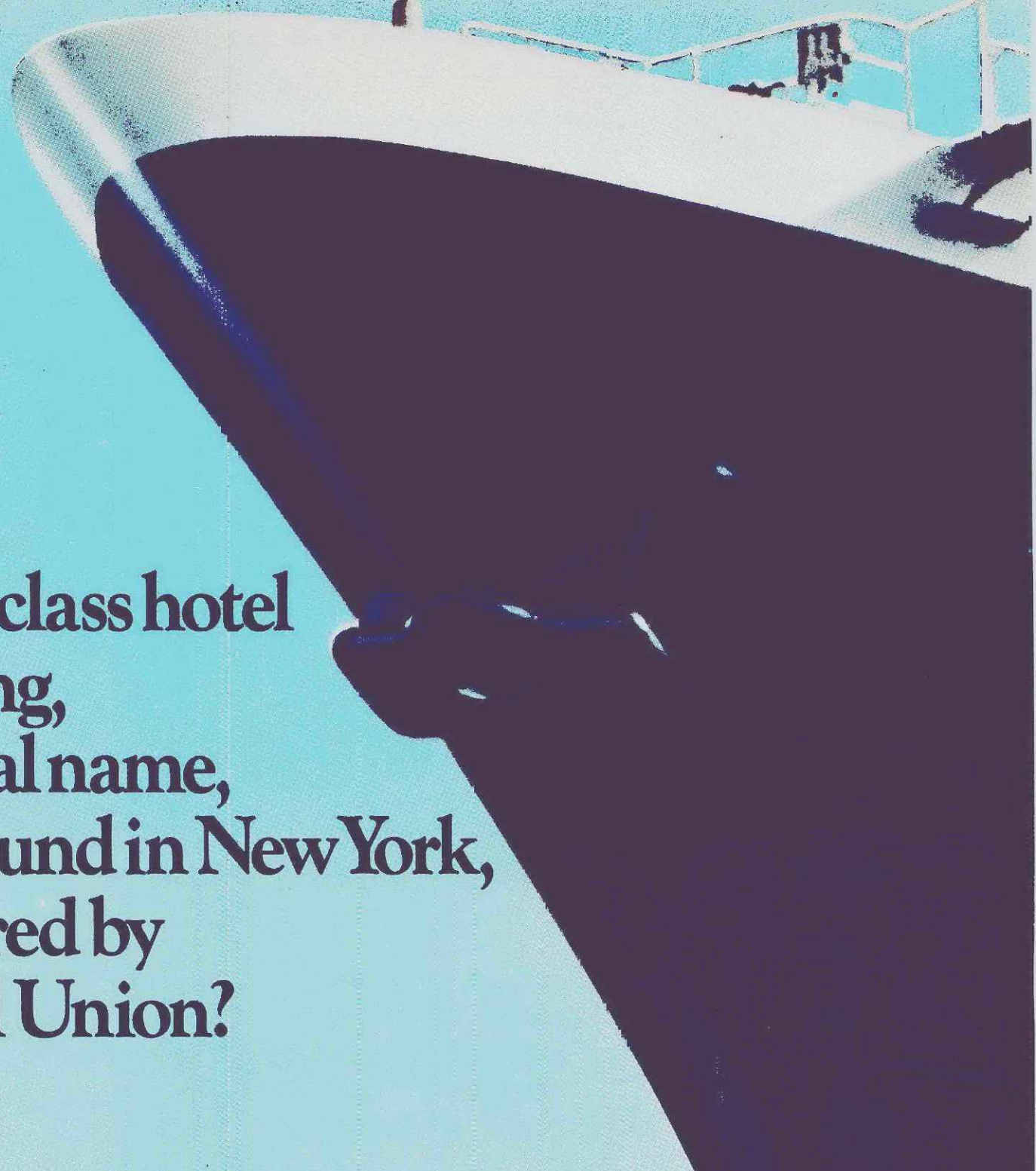
LOS ANGELES—The underwriting business of Equity Casualaty Insurance Agency, once the property and casualty insurance subsidiary of Equity Funding Corp. of America, was purchased by City American Insurance Agencies for an undisclosed sum.

Included in the purchase by City American, a multiple line insurance agency recently organized by former officers of Equity Casualty, is the business of Realty Insurance Assoc., Albaum & Norton Inc., Hillcrest Insurance Agency and Palm Insurance Agency.

PRINCIPAL OFFICERS of City American are Lou Cohen, president; Harold Albaum, vp and board chairman; Bruce Norton, executive vp; and Stanley Podolsky, secretary-treasurer. Mr. Cohen is the former president of Equity Casualty and Mr. Podolsky was controller. Messers. Albaum and Norton were most recently partners in Albaum & Norton Inc.

Equity Funding is currently being reorganized under chapter 10 of the federal bankruptcy laws, following the disclosure last spring of massive fraud in the operations of Equity Funding Life Insurance Co. (*Business Insurance*, April 23, 1973).

In addition to its casualty and property business, City American specializes in life, health and employe benefit plans. ■



What first-class hotel is 963 feet long, bears a royal name, is sometimes found in New York, and is insured by Commercial Union?

Commercial Union insures the liner Queen Elizabeth II – and weekend cabin-cruisers with moorings from Los Angeles to Auckland. It covers the giant Massey-Ferguson works and two-man automobile repair shops; ducal mansions in England and suburban homes in Melbourne; supersonic air-liners and family automobiles. Commercial Union takes care of the small as well as the big and spectacular.

Commercial Union

Commercial Union has offices in principal cities throughout the world, including Boston, New York, Los Angeles, Montreal, Buenos Aires, London, Amsterdam, Paris, Hamburg, Vienna, Brussels, Tokyo, Melbourne, Wellington, Singapore and Johannesburg.

CU Assurance

New flood act to mean costly land use restrictions

By JOANNE GAMLIN

LOS ANGELES—"It's nothing less than revolutionary," declared Aaron Woloshin with awe.

Mr. Woloshin is an associate of the world-wide firm of Dames & Moore, a concern that acts as consultants in environmental and applied earth sciences and he's in a position to know.

What Mr. Woloshin was describing is the sweeping new land use measures embodied in the December, 1973 Flood Disaster Protection Act, a revision of the National Flood Insurance Act of 1968.

"The objective of the latest revision is two-fold," explained Mr. Woloshin.

"FIRST, IT IS to use subsidized flood/mudslide insurance rates as a lever to promote land use controls in flood plains and coastal communities. Second, it is to lower the number of dollars that have been flowing into federal disaster aid."

The National Flood Insurance Program dates back to 1968, when Congress created the National Flood Insurance Administration as part of the Housing and Urban Development department. In partnership with the private insurance industry, the Flood Insurance Administration or FIA began offering insurance for floods and mudslides (but not landslides) at subsidized rates of 25 cents per $100 of valuation.

With the subsidy came a prerequisite, however. The 1968 act required that for residents to receive the low premiums, the state and local government would have to adopt certain minimum land use measures to reduce or avoid future flood damage within their most flood-prone areas.

AT THE SAME time, the insurance industry formed the National Flood Insurance Association (NFIA). Its membership, open to all qualified companies licensed to write property insurance under the laws of a state, have kicked in more than $42 million in risk capital to support the federal program.

For each state the NFIA appoints a servicing company which writes flood-mud policies for brokers and agents who are licensed to do business with their particular state. Brokers then market the policies to individuals and businesses within the community.

It must be stressed, however, that before a business can purchase federal flood insurance its community must have qualified for the program by submitting a completed application to the FIA. Copies of adopted land use and control measures which are consistent with the federal flood program must accompany the application. Also other items pertaining to the nature and extent of flood hazards.

A COMMUNITY'S eligibility for the insurance program can be determined by the FIA in only six working days after the application has been received.

Firemen's Fund American is the NFIA servicing company in California. And Robert P. Fajardo, the company's resident secretary for commercial lines, told *Business Insurance* that while 2,900 towns did qualify for the 1968 program, the overall response was poor.

"It was an exercise in frustration," he recalled, emphasizing that the servicing insurance company derives no profit from its flood insurance activities.

That's why the 1973 revision turned tough. It mandates that communities adopt federal land use measures and thus allow their citizens to purchase flood insurance, or all construction loans from federally regulated banks and savings and loans will be withdrawn. Included in the formidable restriction are construction loans and grants from the FHA, VA and the Small Business Administration.

To be sure, with the federal land use laws on their books towns will find their options on how they develop their land to be sharply constricted. For they must either prohibit development in flood vulnerable areas altogether or else require that construction be built above the flood level on landfill or pilings or somehow be adequately flood-proofed.

"IT'S A CONCEPT that defies the deeply held conviction that a man can work his will with his own land," observed Mr. Woloshin. "A lot of people oppose mandated land use."

In fact, he indicated that his own feelings on the matter are equivocal. While he said he agrees that flood area construction should be protected, he also expressed understanding for the outrage of a developer who might have spent $20,000 an acre to build a condominium only to discover that be-

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cause it is flood-prone the land is worth much less.

In the past, developers have been eager to build on such land, convinced that the government would rush to the rescue of property owners who have been undone by floods. A study for the American Enterprise Institute by a member of the Wharton School of Finance & Government, for instance, found that many flooded-out property owners were better off after a disaster than before.

The cost of implementing the National Flood Insurance Program is in fact incalculable. The only sure thing is that it will be high.

Dames & Moore comes into this complex picture by way of its expertise in analyzing natural hazards, including landslides, faults, erosion, subsurface cavities and, of course, floods. Mr. Woloshin is a geologist.

He explained that his firm enters the act after communities have submitted their completed applications for insurance to the FIA. The FIA then has a federal agency draw up flood insurance rate maps and flood hazard boundary maps for given communities.

"WE THEN check these studies to see if they are technically adequate," he said, underlining that this is a sensitive job.

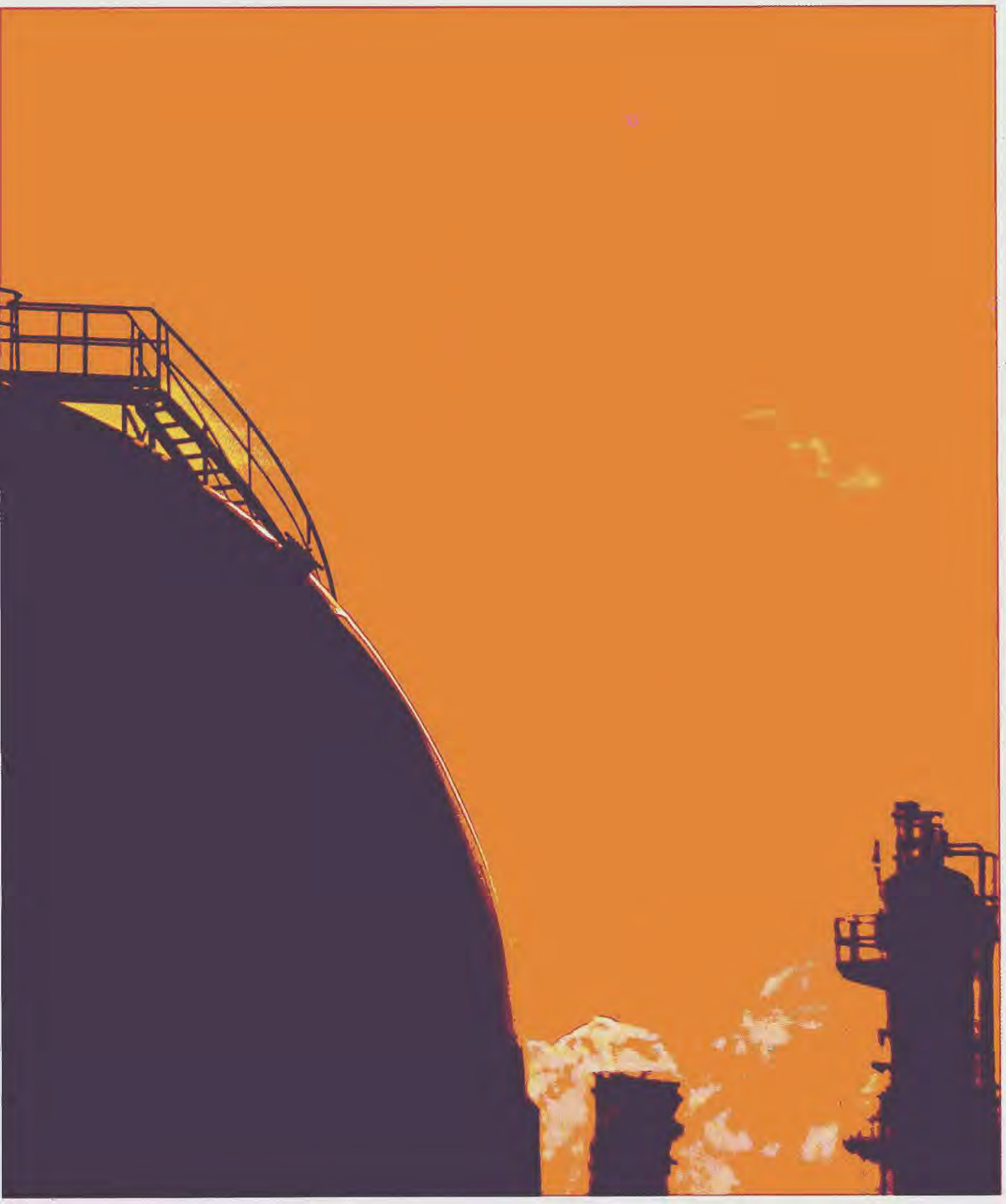
"Communities can go through the ceiling if they feel they have been mistreated in these studies," he explained. Indeed, on March 29, the FIA withdrew the flood insurance maps for a clutch of cities, including, in Califeornia, such municipalities as Huntington Beach, Oakland and Pasadena. The reason for the withdrawal, said the FIA, was that mudslide areas needed re-evaluation. For the cities involved, the action obviated the flood insurance purchase requirements.

One of the other key features in the 1973 act was the doubling or tripling of limits on the first layer of the federal flood insurance coverage. For example, while the old limit on non-residential structures was $30,000, the new limit is $100,000. For single family homes, the limit was similarly hiked to $35,000 from $17,500, at the going rate, of course, of 25 cents per $100 of valuation. All buildings in a community are qualified for the subsidy except those owned by the state.

THE SUBSIDY IS available only for present day structures already built, however. The '73 bill stipulates that new construction undertaken within a known flood hazard area will not be eligible on the theory that the buildings in the area will be properly elevated or flood-proofed and thus qualified for lower actuarial rates.

However, the applicability of actuarial rates on new construction was deferred by the bill until December 31, 1974, or the effective date of the initial rate map published by HUD, whichever is later. The bill also encompasses an emergency program. It suspends some of the required maps and studies for areas in urgent need of flood insurance.

In all, the impact of the National Flood Insurance Program will be profound, agree Mr. Fajardo of Firemen's Fund and Mr. Woloshin of Dames & Moore. ■



State awards health cover to Aetna

BOSTON—The Massachusetts state insurance commission awarded a $37.5 million health insurance pact covering 90,000 active and retired state employes, dependents and municipal workers, to Aetna Life & Casualty Co., Hartford.

Commissioner William A. Burke said Aetna was low bidder on the state contract.

Other proposals had been submitted by American Family Life Assurance Co. of Georgia, and Massachusetts Blue Cross-Blue Shield.

Aetna had held the pact since Jan. 1, 1970, with the new agreement running through June 30, 1975.

And while the commission sought to make "a slight modification" in existing public employe health insurance coverage, "no increase in the level of coverage was made, in a determined effort to hold the line on state spending."

Mr. Burke added that the commission received "no accountable" proposal from prospective carriers for paid-up employe catastrophic illness coverage under competitive bidding, and, thus, would wiave those rules "to seek a workable program by direct negotiations with qualified insurance carriers."

The option for employe participation in the Harvard community health plan—health maintenance organization—is expected to be available beginning Aug. 1 for those desiring it. ■

New teacher benefits

The board of David Douglas school district, Portland, Or., approved a wage agreement which will give teachers a 12.4% hike in wages and fringe benefits. The contract breaks down to 10.42% in wages and 1.65% in fringe benefits. The fringe benefit package will give each teacher $40 a month which can be used for life insurance, health insurance, or for tuition expenses for courses.

Trusteeship for British insurance companies

LONDON—Assets of insurance companies totalling $1.7 billion have been placed under trusteeship by the British government in accordance with new laws introduced last year.

There is no suggestion that the companies are functioning wrongfully, but the moves were made to enforce insurance regulations now in full operation.

It is anticipated that these steps will help government commissioners to make sure there are no future major collapses of insurance corporates like those which shocked the nation some years ago.

At that time several cut-rate auto insurers, such as Fire, Auto and Marine, failed, followed by the big Vehicle and General Insurance Co. collapse in 1971 with a $22 million deficiency.

SO THE GOVERNMENT introduced laws enabling assets of any insurance company formed in the last five years, or taken over by any larger financial group, to be put under special powers by the public Trade and Industry Department.

But the trusteeships, which apply to companies ranging in size all the way up to Abbey Life Assurance Co., part of International Telephone and Telegraph, are in force purely for surveillance reasons.

LONG-ESTABLISHED companies already come under government supervision. The new laws merely help officials to keep in touch more quickly with newly-formed insurance corporates, or those where changes in control take place.

Nearly 50 companies come under the scope of the new control order, which can also restrict insurance company investments, to make sure funds are readily available for policyholders.

In most cases insurance companies dominated by merchant banking groups have been placing funds for investment with their parent corporations.

The problem was highlighted when some of the smaller second-line banks met cash difficulties at one time or another through Britain's economic depression, which has lowered the value of equity stocks and caused a run on money to meet loan charges.

THE GOVERNMENT thinks it wrong that funds which must be used for policy holders, mainly in the personal life insurance field, should be invested where there might be sudden economic risks.

Investments of companies dealing in non-life business are felt to be in a slightly different category, as they have to be invested widely so as to maintain the necessary financial strength, but even these will be supervised if necessary.

Abey Life's managing director, Fred Richardson, has gone on record as welcoming the government initiative. Geoffrey Horrocks, insurance director for the firm, told *Business Insurance:* "This is a situation which is quite normal in insurance regulations. I think the U.S. has a similar rule, which requires foreign-owned corporations doing business in the U.S. to have their assets under trusteeship. We have no objection to having our assets, which now total over $850 million, being put under trustees. It does not affect the regular conduct of our business." ■

Court rules pregnancy is a disability

BOSTON—The state supreme court here ruled that work absences due to pregnancy should be treated like any other physical disability.

The ruling came as a result of an appeal of the Malden School committee and the superintendent of schools from superior court decisions. It follows on the heels of a similar U.S. Supreme Court ruling on General Electric Co.

A court spokesman said that "pregnancy is no more voluntary than disabilities incurred in the pursuit of non-essential activities with obvious risks of injuries, such as playing games or driving an automobile."

According to the court's decision, the teachers forced to resign in 1968, were entitlted only to the lost salaries. One teacher was awarded $41,144, the other $45,-399. ■

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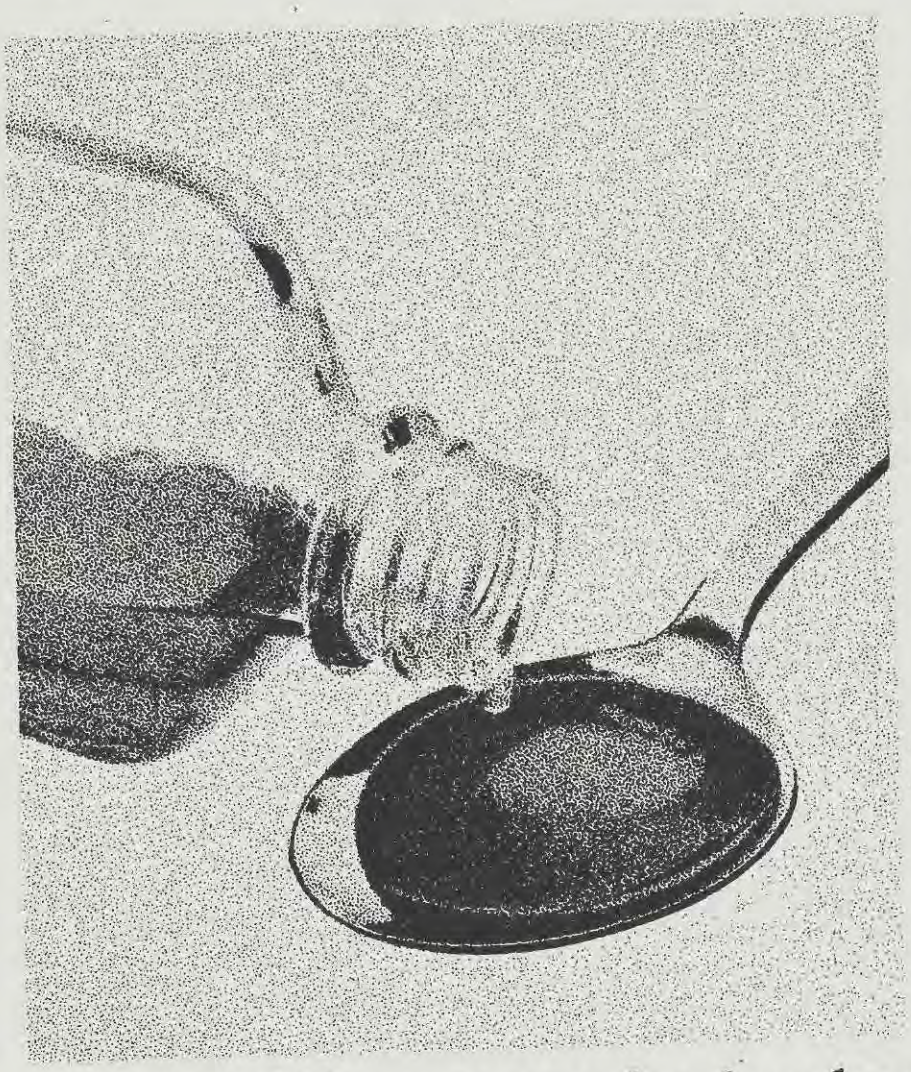

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editorial opinions

Hart-Magnuson deserves support

THE HART-MAGNUSON no-fault insurance bill, which was passed by the Senate and sent to the House early this month, deserves the support of insurance consumers and the industry itself.

The bill reported out by the Senate would prescribe minimum standards for no-fault insurance that would have to be adopted by the states. States that had not adopted some form of no-fault by Sept. 1, 1975, would be faced with the immediate imposition of the federal specifications. States that had adopted no-fault plans by that date, or those that already have them, would have four years to bring their laws into compliance.

The measure sent to the House contains most of the characteristics intended originally by Sens. Hart and Magnuson. It would provide unlimited medical and rehabilitation coverage from an insured's own company on a no-fault basis; replacement service benefits, in reasonable amounts, would be provided to accident victims; and survivors would be compensated for their economic losses.

Two late amendments were tacked onto the measure by Sen. Walter Mondale (D-Mn.): one allows group health insurance writers to compete with auto insurance writers for the medical coverage specified under the Senate bill, the other bends the no-fault principle enough to allow subrogation of claims in accidents involving heavy commercial vehicles that would be based on-fault.

The two amendments are likely to run into some opposition by commercial insurance consumers. Some, for example, express a concern that when first party benefits are paid by group coverage instead of workmen's compensation or normal fleet accident insurance there may be a tendency to let fleet loss prevention slip. Others say that allowing subrogation of claims in accidents involving heavy commercial vehicles is discriminatory and removes the law from the true no-fault concept.

We don't find these two complaints sufficient reasons to kill the bill. Rather, we steadfastly believe that the time for no-fault was yesterday and we rue the waste of a system that, in all these years past, has returned in benefits to claimants only 42 cents of every premium dollar spent.

The Hart-Magnuson bill could correct the system in three major ways. We think they're worth repeating:

- Under the present system 45% of persons seriously injured receive no payment from auto liability insurers. Under this bill, all of those insured would receive 100% of medical expenses and 100% of wage loss up to a limit of $50,000.
- Of those who suffer $10,000 in economic loss, 60% now get nothing, only 4.4% get an amount equal to or more than the loss and 85% get less than one half of the loss. Under the Hart-Magnuson measure all those injured would receive 100% of medical expenses and 100% of wage losses subject to the limit.
- Under the present system, those with under $100 of economic loss, with the use of attorneys, have received over seven times their loss. The bill would make things less lucrative for the lightly injured, but would still pay 100% of their medical expenses as well as 100% of wages lost.

Need more be said? We hope the House moves swiftly.

A new threat to profit-sharing

A NEW THREAT may be looming on the horizon for profit-sharing funds because of the beating most funds took in the stock market last year.

In contract negotiations concluded last month, for example, members of the American Newspaper Guild employed by the Washington Post voted to call it quits with the paper's profit-sharing plan in favor of a new non-contributory fixed benefit pension fund. It seems Guild employes were moved by the fact that the fund's asset value dropped 36% last year, although it was the first decline in the fund's history.

The situation at the Washington newspaper may not be typical, but we bet it's one a lot of profit sharers are sympathizing with these days. Dips of 20% in fund values are typical; ask any participant in a profit-sharing company. The grumbling is noticeable, especially now that most of those annual statements have found their way home.

The situation, for us, reemphasizes the importance of employe benefits communications. We wonder, for example, if the grumbling would be as intense if most employes had been made aware months ago, say, that the outlook for their funds was not good. Those who follow the market and participate in profit-sharing knew full well—or at least could imagine—what was happening to their funds during the past 18 months. But a majority of profit-sharers are not as sophisticated and the balance sheet must indeed have been a shock.

When it comes to benefits that are variable, benefits that depend on the fluctuations of the stock market, communications must be an ongoing thing and not limited to an annual statement, slipped embarrassingly in with the paycheck, as it was this year by many firms.

Profit-sharing has served many companies well. It has, over the years, returned a multitude of benefits to participants who have been motivated by the concept. We wonder how long an employe would stay motivated at the rate of minus 20% per year. We wonder, too, how many other employe groups would opt for another form of benefit if profit-sharing were brought to a vote this month.

As we've said, profit-sharing has served many well. Over the long haul it should continue to. At the Washington Post last year's decline was the first in a 20-year history. And that, for profit-sharing, has been the rule rather than exception. That's probably the best reason of all that employes should be kept informed about their account on a monthly or at least quarterly basis. If a fund is continuing to lose money an employe should be made aware of it. And he should certainly be told what management is doing about it.

letters

This column is a reader's forum. Letters are welcome. Address Letters to the Editor, Business Insurance, *708 Third Ave., New York, N.Y. 10017.*

Re-evaluate position

To the Editor: I have read with interest your article in the April 15, 1974 issue concerning the attack by insurance companies of the British Columbia Plan which has authorized a government insurance company in the automobile insurance field.

Why domestic insurance companies cannot see that the direction of probable movement in behalf of our federal government by way of supporting federally controlled insurance litigation such as that of Senate Bill 534 is beyond my imagination. Such federally controlled legislation is not only detrimental to the competitive free enterprise system but to members of our society, as well, and I seriously urge such carriers to re-evaluate their position.

Phillip W. Knight
President, Federation of Insurance Counsel, Miami, Fl.

Wyatt D&O study

To the Editor: Mr. Charles W. Pachner provided a recent letter to the editor on the subject of the 1973 Wyatt Directors and Officers Liability Survey (*Business Insurance,* April 29, 1974). This letter attacked the credibility of that survey with a superficial analysis of some alleged shortcomings of the survey, based on a false premise on his part.

The writer stated that corporations responding to our survey "must have reported fewer losses than a representative average," on the basis that "the survey mailing included no promise of confidentiality." This is a complete falsehood. Had the writer taken the trouble to examine that mailing, he would have found that it did contain a promise of confidentiality, a promise that has not and will not be violated in this survey or any future D&O survey we conduct. We recognized at the outset that such a commitment is essential to a survey of this nature. We were able to get a good cross section of response in our survey because The Wyatt Co. is known to be dedicated to confidential handling of data for its clients, and is not engaged in marketing or underwriting of insurance. Our D&O survey report contains no reference which would identify any individual company participating in the survey, nor has any information of that nature leaked

Continued on page 58

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States talk product safety

WASHINGTON—Representatives from every state met with the Consumer Product Safety Commission (CPSC) this month and discussed future cooperation in the area of consumer product safety.

The meeting undertook one of the tasks outlined by the Consumer Product Safety Act, working to develop uniform safety standards for consumer products and aiming to minimize regulations conflicts.

Major topics discussed at the conference included:

- prospects for each state's adoption of a model consumer product safety act;
- state and federal cooperation in the enforcement of product safety standards;
- CPSC assistance in promoting state information and education programs;
- state participation in the collection of data related to product safety;
- methods of utilizing state resources to help develop standards for consumer products.

The conference was held on the first anniversary of the CPSC's founding as a federal regulatory agency. The product safety meeting's delegates were all appointed by their respective state governors to serve as official representatives to the CPSC. ■

info for buyers

To receive literature listed in Info for Buyers write directly to the name and address accompanying each item, mentioning that you saw the offering in *Business Insurance*. Readers are welcome to submit items for possible inclusion in the column. A sample of your literature should be sent to Info for Buyers, *Business Insurance*, 740 Rush St., Chicago, Il. 60611.

• Huggins & Co. Inc. publishes a pension insurance and employe benefit bulletin once a month. The April issue was the Health Maintenance Organization-Revisited: The HMO Act of 1973. For copies and more information on the bulletin write, Huggins, Joseph Banik, 1401 Walnut St., Philadelphia, Pa. 19102.

• A folder entitled **Measuring and Monitoring Noise to Comply With the Walsh-Healey Act** has been released by General Scientific Equipment Co. The folder includes decibel charts and other information regarding industrial noise standards in workmen's compensation statutes in 36 states. For a free copy write the company, Limekiln Pike and William Ave., Philadelphia, Pa. 19150.

• The new 1974 Globe-Amerada catalog **Environmental Control Through Glass,** is now available. Specifications on a remarkable noise controlling glass are featured with recommended architectural applications to assist the architect and planner in determining the acceptable noise levels and temperature controls. To obtain this eight-page brochure write Mark L. Green, Amarko Ltd., 2001 Greenleaf Ave., Elk Grove Village, Il. 60007.

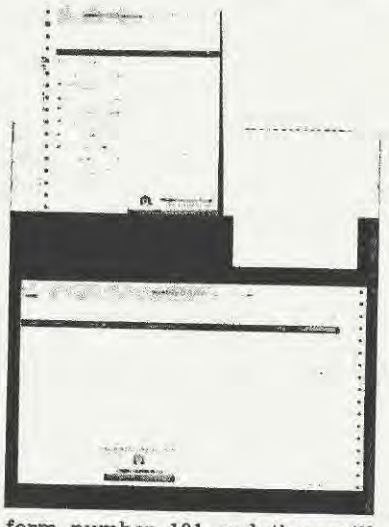
• **Flexibility in Compensation and Benefits** is the text of an address delivered before the American pension conference by Thomas H. Paine, Partner, Hewitt Assoc. In addition to the text, the material offered includes recorded excerpts from the question and answer period. A copy of the address may be obtained by writing Al Schlachtmeyer, Hewitt Assoc., 102 Wilmot Rd., Deerfield, Il. 60015.

• **Social Security as Amended December 31, 1973** has been prepared by Huggins & Co. Inc. It describes the benefit changes effective June 1974 after temporary lesser increases effective for March 1974 through May 1974. A summary of old-age, survivors and disability insurance benefits and a summary of medicare benefits are explained. Write Joseph A. Banik, Communications Services, Huggins & Co., 1401 Walnut St., Philadelphia, Pa. 19102.

• A series of books, released by the General Adjustment Bureau, tells small employers, employe representatives, insurance safety engineers, state and federal inspectors, trade associations, and others about the OSHA act. It answers questions like how to cope with its provisions, how to protect machines and equipment and how to set up a system for voluntary self inspection for compliance. For your free copy write Management Services, General Adjustment Bureau, 123 Williams St., New York, N.Y. 10038.

• The 1973 edition of the **Analysis of Workmen's Compensation Laws** has been made available by the Chamber of Commerce of the United States. The 48-page analysis charts details on workmen's compensation laws in every state, District of Columbia, Guam, Puerto Rico and the Canadian provinces. Legislative changes and judicial and administrative interpretations of laws through 1972 are part of the new edition. The 1973 edition also includes a special summary of the report of the national commission on state workmen's compensation laws. Single copies of the analysis can be obtained for $1.50 from the Chamber, 1615 H St., N.W., Washington, D.C. 20006.

• Unigard Insurance Group offers a free Occupational Safety and Health Administration record keeping service to policy holders. Triggered by routine claims, Unigard says they will make it unnecessary to complete OSHA



form number 101 and they will advise on additional information requested. For more information on the record keeping service write Unigard, Charles G. Jones, Financial Center, 1215 Fourth Ave., Seattle, Wa. 98161.

• **Organizing for OSHAct: A Management Challenge** focuses on developing a systematic managerial process aimed for OSHA compliance. The book, issued by Risk Treatment Services Co. Inc., includes a management information system, employe orientation, appraisal of conditions, decision-making tools, record keeping systems and an OSHA-oriented approach to purchasing, personnel training and product design. The cost of the book is $7.50. For a copy write James O. Matschulat, Risk Treatment Services, Six E. 43rd St., New York, N.Y. 10017.

• **Who's Responsible** is a new ten minute color sound/slide presentation that investigates a serious construction accident. A feature of this safety measure is that it allows a place to show your own problem areas. Write for a free brochure: United Safety Services, P.O. Box 27276, San Francisco, Ca. 94127.

• **Pneumatic Controls for Worker Safety and Industrial Environmental Improvement** has been made available from Ross Operating Valve Co. The report reviews some of the latest developments in double valves, two-hand control circuits, lock-out valves, mufflers and directional control valves. Write the company, 120 E. Goldengate Ave., Detroit, Mi. 48203.

• Risk Treatment Service Co. Inc. has made available to *Business Insurance* readers **OSHA What to Do? Total Loss Control the Answer.** It describes OSHA's record-keeping service inspections, SBA loans, and a total loss control program. Write Lewis C. Barbe, Risk Treatment Services, 3200 Wilshire Blvd., South Tower, Suite 1208, Los Angeles, Ca. 90010.

• Optiscan Computing Inc. is making available a brochure entitled **Occupational Safety and Health Act Compliance Officer.** It explains the advantages of automating OSHA record keeping procedures and describes the OSHA record keeping requirements. For a free copy write John Leonard, Optiscan Computing Inc., P.O. Box 10858, Houston, Tx. 77018.

• **Group Survivor Income Benefits,** available from Northwestern National Life Insurance Co., describes the company's plan which provides a continuing monthly income with an optional lump sum death benefit. Survivor benefits are expressed as a percentage of an employe's monthly salary. For a copy of the brochure write Northwestern National Life, 20 Washington Ave. So., Minneapolis, Mn. 55440.

• **This is OSHA,** a U.S. Dept. of Labor film on job safety and health, is available on a free loan or purchase basis throughout the country. The 16mm color film reports progress in the agency's first two years and covers standards-setting, inspections, training and education, state programs and voluntary compliance. The film may be obtained by free loan from any of 27 film libraries of the Modern Talking Picture Service in 19 states and D.C. For additional information write the U.S. Dept. of Labor, Occupational Safety and Health Administration, Washington, D.C. 20210.

• The Safety First Products Corp. has a brochure on its dry chemical fire extinguishers in portable, wheeled or stationary models, entitled **Interested in Fire Protection? Then Compare.** Charts are included with performance characteristics of the products. For a free copy write E. T. Robinson, Safety First Products Corp., 3684 Meadow Lane, Cornwells Heights, Pa. 19020.

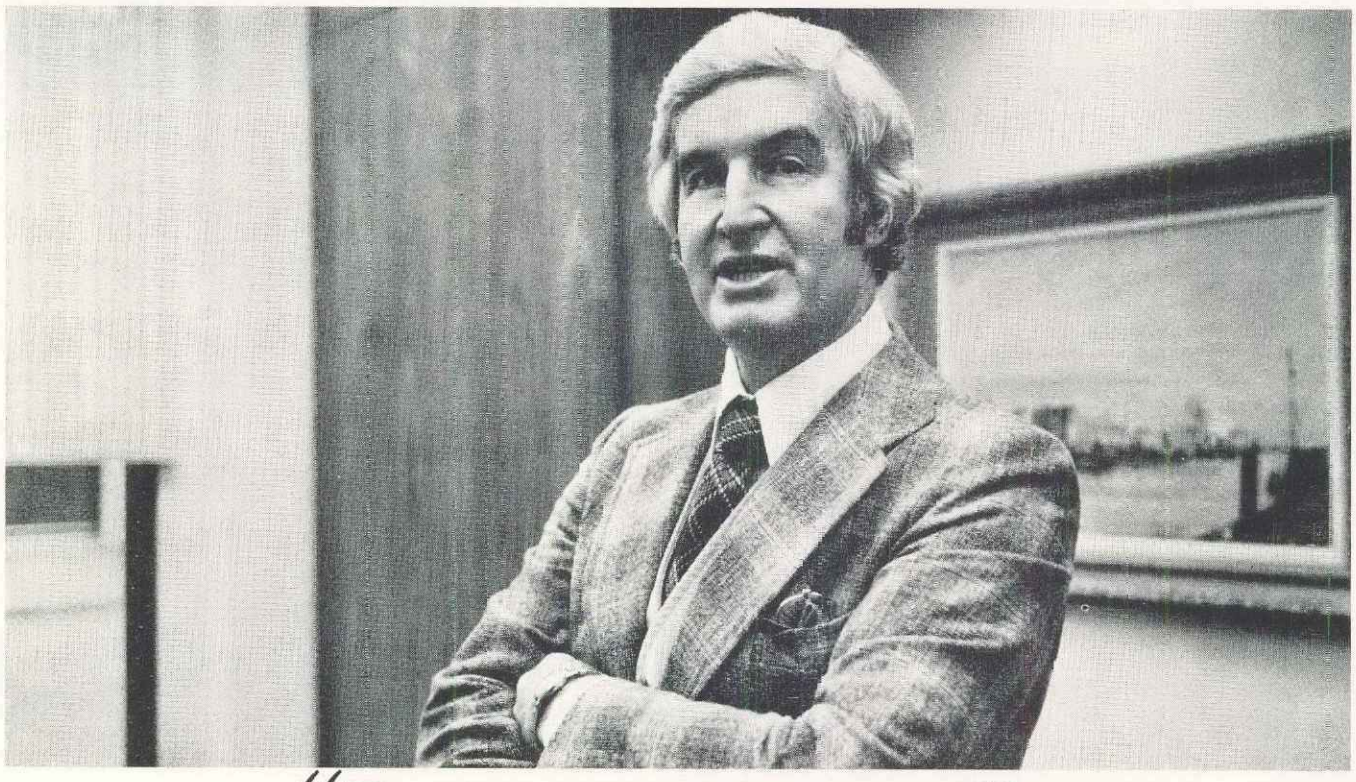
• **OSHA Consultation Services** explains NATLSCO's services; compliance program verification, special technical services, pre-compliance analyses and compliance status surveys. The brochure describes the types of problems each service can resolve and details on how their consultants work with client's personnel. For your free copy write National Loss Control Services Corp., Long Grove, Il. 60049.

• A 12-page booklet, **What You Should Know About Changes in the 1973 General Liability Policies,** is available from the General Adjustment Bureau Inc. Each revision of the jacket and the comprehensive general liability part is treated separately, and the exact working is shown for both the 1966 policy and the corresponding sections of the 1973 editions. Free copies are available by writing Management Services, General Adjustment Bureau, 123 Williams St., New York, N.Y. 10038.

• **Errors and Omissions for Architects and Engineers,** released by Illinois R. B. Jones, is a question and answer brochure which discusses claims and specific needs for this group of people. For a free copy write T. Cath, Illinois R. B. Jones, 175 W. Jackson Blvd., Chicago, Il. 60604.

• **A Closer Look is Sometimes Necessary . . .** is a 24-page booklet on compensation insurance by the Kemper Insurance Group. It gives a non-technical description of the pricing of workmen's compensation. Write Public Relations, D-1, Kemper Insurance Group, Long Grove, Il. 60049.

• Aetna Life & Casualty has released **Aetna's Claim Status Report.** According to the company, the CSR assists insureds who are interested in loss prevention to identify the source of accidents so they may take corrective action to eliminate claims thus reducing the costs which emanate from such occurrences. For a copy of the report write William F. Madison, Marketing Dept., Aetna Life & Casualty, 151 Farmington Ave., Hartford, Ct. 06115.



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INSURANCE REGULATION

N.Y. working to devise own tough rules on carrier profits

NEW YORK—Benjamin R. Schenck is planning something of a regulatory coup for the New York state insurance department. He and his staff are currently devising a method for measuring insurance company profits, broken down by line of insurance and by state.

And they want to make insurance companies report these annual profits to the public.

Mr. Schenck, who has been New York's superintendent of insurance since 1971, coincidentally chairs a subcommittee of the National Assn. of Insurance Commissioners which has been studying insurance company profits and investment income.

The NAIC subcommittee has also recently adopted a formula for measuring insurance company profits by line and by state, and may soon propose a disclosure regulation based on the new measurement.

NEW YORK, however, goes one step further. It proposes a profitability measurement which would include unrealized capital gains of insurers as well as realized investment income. According to the insurance department, it is the first state to push for a disclosure regulation on a by-line, by-state basis with such a measurement system.

Risk managers and corporate buyers of insurance stand to benefit by the proposed disclosure, Superintendent Schenck told *Business Insurance.*

Profits on specific policies would not have to be disclosed by insurers, Mr. Schenck explained. But he noted the disclosure regulation method would provide for a way of measuring the "reasonableness" of insurance company profits.

The disclosure would affect property and liability insurance company profits.

The state legislature, frequently an important arm in state insurance regulation, has already given Mr. Schenck's department the green light to go ahead with rules for insurance company profits disclosure.

"We have written the rules, and are going to hold a public hearing on them on June 19th," Mr. Schenck said. He added the department would take suggestions from interested parties into consideration before it revises the rules for ultimate enforcement.

ALTHOUGH THE profitability regulation is probably the newest issue the insurance department has become involved with, the regulation that is perhaps closest to its bureaucratic heart is open or competitive rating.

Open rating allows insurance companies to establish rates on a competitive basis without receiving prior approval from the insurance department.

Open rating was started on an experimental basis in 1970 at the New York insurance department, when Richard E. Stewart was acting superintendent. Because it was scheduled to expire in 1974, it sparked one of the liveliest debates in New York's legislative session last year.

Benjamin Schenck endorsed a full extension of open rating, along with many buyers of commercial insurance who said the system increased capacity in the insurance marketplace.

HOWEVER, some state assemblymen fought an unqualified extension of open rating, arguing that as applied to the new no-fault insurance system, open rating would cause auto premiums to skyrocket.

What finally emerged from the 1973 legislature was an open rating system that excluded vehicle insurance and which was extended for two years rather than four. (*Business Insurance* May 21, 1973).

The amended system went into effect Jan. 1 this year. Under it, insurers seeking to pass rates for vehicle insurance must get "affirmative approval" by the insurance superintendent, although rate changes for other lines of insurance are done solely upon a competitive basis.

At this juncture, Mr. Schenck says his department has not turned down any major filings of auto insurers. The superintendent still insists that open rating is the best system for rate setting—for auto insurance as well as property/casualty, particularly for corporate insurance clients:

"I THINK competitive rating is particularly beneficial for professional purchasers of insurance because the last thing they need is a government trying to protect them," Mr. Schenck said, adding:

"They're perfectly able to protect themselves, and can get better bargains in a competitive environment where companies are precluded from agreeing with each other about what the price will be."

California has had an open-rating system for almost 30 years, superintendent Schenck said, and it was that state's great success with the system that inspired New York to take up its banner.

Other states are apparently not rushing to join New York in making competitive rating a regulatory standard, however.

"I THINK EACH state tends to have a law peculiar to its own circumstances. So even if you would categorize some states as having competitive laws and other states as having prior approval laws, nevertheless, within each of those laws, there would be wide differences."

Open rating in New York is successful, according to the insurance department, but it has not been without controversy. Last year, for instance, critics charged that big insurance companies used the competitive system to bring premiums to "cut-throat levels" by actually charging rates so low that they were destructive of competition.

At that time, the insurance department pledged an investigation into the charges. Mr. Schenck said the results of the examination turned up no conclusive evidence.

"The results," he said, "were that we did not find widespread situations where prices were knowingly or recklessly set at inadequate levels. We did not find that that was correct. That is not to say that it might not have been an isolated instance, but in terms of a pattern or something that was serious and widespread, we did not find that."

WHEN THE insurance department conducts similar examinations in the future, it will do so with the benefit of a brand new examinations bureau, the formation of which was announced May 13th. He explained that the department was undergoing a reorganization to revitalize its regulation and enforcement activities.

In the past, insurance department examinations were carried out by examiners assigned to specific bureaus. Now all investigations will be made through the new central examinations bureau, with a staff of about 50, headed by a 46-year veteran of the insurance department, James J. Higgins.

Superintendent Schenck's department uses an eight-member consumers advisory council to advise it on competitive rating as well as other subjects of interest to insurance consumers.

Group consumers are well represented on the council. Rollyn L. Storey, a past president of the American Society of Insurance

Continued on page 28

N.Y. Superintendent of Insurance, Benjamin R. Schenck

Need help?

Have a problem with some aspect of state insurance regulation? These people at the New York state insurance department may be able to answer your questions:

David Wohlner, chief of the property companies unit —(212) 488-4130

Alvin H. Alpert, chief of life insurance companies unit—(212) 488-4030

George Gould, chief of pensions and non-profit plans unit—(212) 488-4101

Harold Sohmer, chief of fire and multi-lines insurance unit—(212) 488-4024

James W. Clyne, chief of health insurance unit—(518) 474-4567

James J. Higgins, chief of examinations bureau—(212) 488-4155

Stanley Dorf, Chief of auto and compensation insurance unit—(212) 488-4090

A complete list of officials to contact may be obtained from the New York insurance department at 2 World Trade Center, New York, N.Y. 10047.

More legislation of controls by commissioners

HMOs are regulated as insurance in an effort to protect consumers

CHICAGO—At least 28 states have taken action or are taking action to regulate health maintenance organizations operating in their states, and most are putting controls within the jurisdiction of state insurance commissioners.

The latest of these was Georgia, which joined the ranks of other states in ruling that the operation of an HMO would constitute the transaction of insurance under state laws. State commissioner Johnnie L. Caldwell said the only HMOs exempted from insurance department regulation are those singled out under the federal HMO Act (signed into law at the end of 1973) for loans, because they must be qualified under federal standards.

All other HMOs in Georgia will be required to meet the standards for insurers doing business under the Georgia Code, Title 56, he said.

THE NATIONAL Assn. of Insurance Commissioners last year drew up and approved a model bill governing the operation of HMOs. Some states have already introduced the bill and have passed it. One such state is Kansas, which has a newly-enacted law regulating HMOs.

"It is obvious that the operation of the health maintenance organization will affect a large segment of our society, and those who purchase contracts should be able to know that the HMO's advertising is truthful, and that the group is financially solvent," said Fletcher Bell, commissioner of insurance for Kansas.

CALIFORNIA commissioner of insurance Gleeson Payne told *Business Insurance* that regulation of HMOs in the state is currently under the jurisdiction of the attorney general, but may be changed to the insurance division. A proposal was made recently to alter regulatory powers over HMOs and redelegate responsibility to the health department and the state insurance division.

The final draft of the NAIC model bill for regulation of HMOs was completed in December, 1973, and was adopted by the commissioners at their annual convention in Las Vegas.

The 21-page model is paving the way for more states to start regulating the health care deliverers.

As of last fall, the states which had enacted regulating legislation included Arizona, Colorado, Florida, Iowa, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Tennessee and Utah.

Eleven other states had introduced legislation regulating HMOs, with jurisdiction in the insurance departments of the states, including Alaska, Kansas, Maine, Maryland, Michigan, Montana, Nebraska, New Hampshire, North Dakota, North Carolina and Washington.

About nine states with laws passed or pending have used the NAIC model bill early drafts as a format for their bills, so that legislation is very similar to the adopted version of the NAIC model bill. However, twelve states have HMO regulations very different from the NAIC model bill. They include California, Connecticut, Georgia, Kansas, Minnesota, New York, Ohio, South Carolina, Tennessee, Utah, Virginia, and Washington.

THE NAIC model bill has a twofold stated purpose: to attempt to provide a legal framework enabling the organization and functioning of HMOs of a wide variety, and to provide a regulatory monitoring system not only to prevent or remedy abuses but also to assist in the future improvement and development of this alternative form of health care delivery.

The model bill states that regulation of HMOs is essential because "the public has a vital interest in the fiscally sound, efficient and ethical operation of HMOs. As is the case with insurance and hospital and medical service corporations, HMOs are 'affected with the public interest.' Regulatory safeguards dovetailed to the unique nature of HMOs are essential." ■

Consultant calls for sweeping regulatory changes

CHICAGO—When the National Assn. of Insurance Commissioners met here May 21, they studied and discussed the radical recommendations of McKinsey & Co., consultants, in a report on the insurance industry regulatory system.

The expensive and extensive report, much-heralded while in progress, and only last week made public, is expected to cause a good deal of controversy in the industry, because it suggests extensive reforms.

No one in the NAIC is willing to predict whether the report will be accepted in whole or in part by the A-6 subcommittee of the NAIC and by the full group of commissioners.

BUT THERE HAS been much criticism of insurance regulators in the last few years, heightened by charges of political favoritism by regulators and examiners, and finally brought to a head in 1973 with the collapse of Equity Funding Corp., parent of several insurance companies.

Some defenders of the regulation system contend that reforms were already in progress at the time the Equity Funding scandal broke. Whether they were or weren't, the demise of an underwriter which specialized in a monumental scheme of selling (reinsuring) fraudulent insurance policies certainly hurried things along.

Fletcher Bell, insurance commissioner of Kansas and the current president of the NAIC, told *Business Insurance* that basic to regulatory reform, as stated in the McKinsey & Co. report, is "a change in the surveillance system, in the areas of market conduct and financial surveillance."

"THE MCKINSEY & Co. report will go a long way, in my opinion, to insure that states act responsibly and with dispatch in solving these (examination) problems, and preventing these situations (such as Equity Funding) before they arise," if a major portion of the McKinsey recommendations are adopted, said Mr. Bell.

"I have no idea what the reaction of the A-6 subcommittee will be, or the NAIC as a whole, for that matter. But I think it's an outstanding report, an outstanding work project. Speaking as the commissioner of Kansas, and not in my capacity as president of the NAIC, I am somewhat reluctant over some of the recommendations in the report, but overall it is outstanding," Mr. Bell offered.

One major recommendation of the report is that the zone examination system be replaced with an association review system. This is one area where Mr. Bell said there are some questions. "Some people are afraid it might not work out in practice as it does in theory. There is some concern that such a proposal would adversely affect some states that are very small and

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Profits . . .

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Management, sits on the council, Mr. Schenck pointed out.

"The various ASIM groups have been very interested in the consumer aspects, and it is a group we find gives generally pretty good advice regarding commercial buyers of insurance," the superintendent said.

ALSO ON THE insurance department's consumer advisory council is the Hon. Peter M. Pryor, chairman and executive director of the state consumer protection board.

Superintendent Schenck praised the NAIC for helping insurance regulators in each state coordinate activities. "Every state has a legal right to send its own state examiners into every insurance company whenever it wants to," he said.

"If each state exercised that right, it would be chaotic. You take a big company like the Aetna. You could have 600 examiners there at any given time if the states worked like that. But the NAIC runs a system to have one examination in which all the states which want to participate would get it all done at once."

MR. SCHENCK has views not only on what areas need more insurance regulation, but which ones need less. The insurance department has just completed an extensive study on the financial condition of insurance companies, which Mr. Schenck says taught him something.

"I think this report concludes that we spend too much time looking at the details of the financial transactions of insurance companies, and not enough time looking at the ways insurance companies treat their customers," he remarked.

"The New York insurance department could appropriately redirect some of its efforts away from determining the financial condition of a sound insurance company, and toward a more active review of the way insurance companies treat their customers," he said.

The superintendent was asked whether this would include corporate customers as well. He replied:

"Yes. But commercial accounts and corporate buyers of insurance don't need our help, quite frankly. I think in most cases they can make their own bargain and take care of themselves.

"Generally, a company that's spending $1 million a year in insurance premiums hires people that know as much about their problems as we do." ■

Fat Cat

At one time he was the best mouser in town.
Lean, hard, alert and hungry for adventure.
But not anymore. Somewhere along the line he
became satisfied with his success and got soft.
Now he's just another tubby tabby whose
best days are behind him.

Like the cat, a business organization can also
get too fat, too complacent; too satisfied
with maintaining the status quo.
Unreceptive to new ideas and challenges.

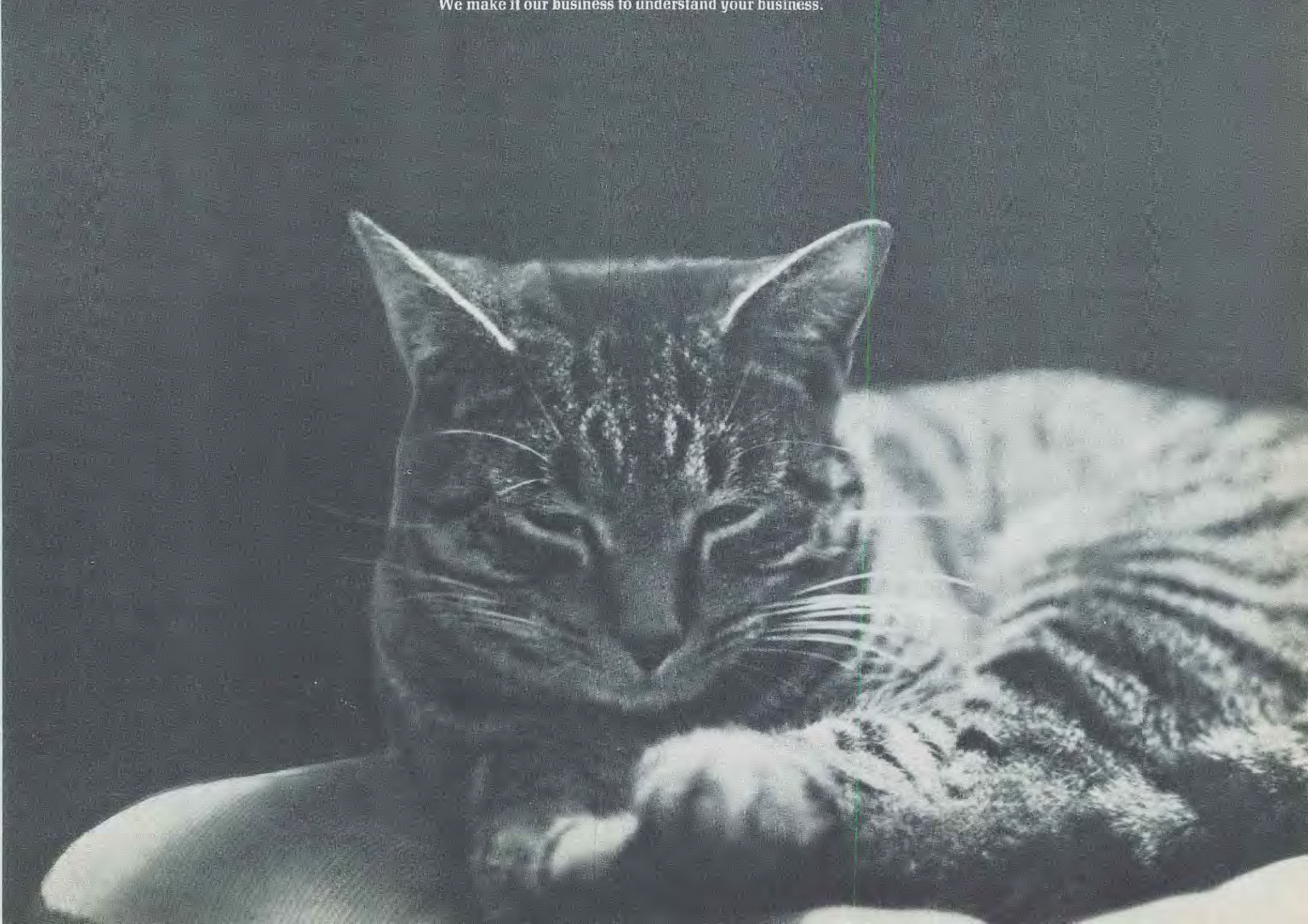
No one knows this better than Corroon & Black.
Even though we've been in the insurance brokerage
business for nearly 70 years and are proud
to call some of the biggest names in the business
world our clients, we're not standing pat.
In fact, we're as ambitious today
as the day we started.

Within the last few years we've expanded our
facilities to include 20 offices from coast to coast
and Hawaii. Each is staffed by talented people
thoroughly schooled in the complexities of
today's insurance market and constantly attuned to the
insurance needs of our growing list of clients.

Nationwide, worldwide, Corroon & Black
gives you more for your insurance dollar.
And you can bet your bottom dollar
we'll never become a fat cat.

CORROON & BLACK

We make it our business to understand your business.



CAL-OSHA's tough rules set pace for state plans

By CHARLES WINGIS

LOS ANGELES—The California Occupational Safety & Health Plan, better known as the "California Plan" or CAL-OSHA, just completed the first year of a three-year probationary period to test how well it meets standards established by the federal Occupational Safety and Health Act (OSHA) of 1970.

There appears little doubt, at least in the minds of insurance industry and state safety officials, that CAL-OSHA will pass the next two years of federal monitoring as successfully as the first. A great body of evidence, in the form of 63 years of industrial safety experience, supports the feeling that CAL-OSHA standards meet or exceed and are "at least as effective" as those of Fed-OSHA.

Following Fed-OSHA guidelines set forth in the Williams-Steiger Act of 1970, CAL-OSHA was enacted last year. Its stated purpose: "assuring safe and healthful working conditions for all California working men and women by enforcement of effective standards, and by helping employers to maintain safe and healthful working conditions."

FEDERAL MONITORING began when CAL-OSHA took over for Fed-OSHA and started investigating employe complaints, fatalities and catastrophes. The watchdog operation includes quarterly reports on CAL-OSHA enforcement activities, citations, fines and penalties. There is also a semi-annual analysis of the plan, an annual recap, plus a fiscal review of the 50/50 federal/state grants supporting the program.

Department of Industrial Safety (DIS) chief Richard Wilkins, who oversees the state plan, reports that its annual budget is just under $12 million, with equal parts of the funding coming from state and federal governments.

One of the most dramatic changes to take place since the takeover by CAL-OSHA has been the expansion of the field safety engineers, which stands at 200 or just about double what it was a year ago. Through April 3, 1974 the staff had logged 3,600 inspections, 2,100 citations written, $179,174 penalties logged, and $103,052 in penalties paid.

Commenting on the effects of more inspectors and stepped-up inspections, a state spokesman said, "There are still 450,000 work places in this state and we don't think a staff of 200 inspectors is going to have an unusual impact. Voluntary compliance with the law because it's the right thing to do, rather than fear of the law, will make the difference between success and failure for CAL-OSHA."

SAID THE SAME official, "We always thought California's record for industrial safety was pretty good over the years. Before CAL-OSHA, job-related injuries were between 100,000 and 120,000 per year and fatalities were between 675 and 700. That's based on a state population of 21 million and a work force of about 8.2 million."

The increased visibility of inspectors and the assessment of civil penalties, or "putting teeth into CAL-OSHA," has done much to convince employers that industrial safety is good business. Upon conviction of a violation that causes death or physical impairment to an employe, an employer can be fined up to $10,000 and given six months in jail. The penalty can be doubled for a second offense.

The civil penalties apply only to those assessed by the DIS. "Other sections of the Labor Code," states CAL-OSHA, "provide for various criminal penalties depending upon the type of violation and the related court decision."

Any employer served with a citation or a notice of civil penalty has the right to appeal. The CAL-OSHA appeals board consists of three members, appointed by the governor, representing management, labor and the general public.

ONE OF THE areas in which CAL-OSHA meets or exceeds federal requirements is in the offering of safety and health consulting services to any employer or employe group. Such services include information, advice and recommendations on maintaining safe and healthful work practices. Fed-OSHA has no such provision.

States Cal-OSHA, "If an employer requests consulting services, the division, when providing such services, cannot institute any prosecution nor issue any citations for a violation of a standard or order. The *exception* is when the division representative . . . finds the condition of employment or equipment constitutes an imminent hazard to the lives or safety of employes."

While employers may expect consulting assistance from the state, they are increasingly calling on the services provided by the insurance industry, such as those offered by Republic Indemnity Co. of America, Los Angeles.

Peter S. Ellis, vp in charge of Republic's loss control and safety engineering department, noted, "Most employers don't want to spend the money to call in a private consultant so they're turning to their insurance companies for help. Consultation costs are passed on to the employer in the premium, but employers have awakened to the fact that we can show them ways to save money."

ANOTHER OF THE beneficial effects of CAL-OSHA on the consulting services provided by private industry is, in the opinion of Mr. Ellis, "It's made it a little easier to get the employer to listen to you these days. We're regarded as a resource, a place to come for information, and I think it has made us much more professional in our approach to the employer's problems."

One other important difference between the state and federal plans was in the area of implementation, according to A. Ridge Friedel, manager of customer protection services for INA's Pacific Employers Insurance Co., Los Angeles.

Said Mr. Friedel, "When Fed-OSHA went into effect the inspectors zeroed in on certain target industries, hitting the worst first approach. CAL-OSHA is quite a bit more specific, with inspectors concentrating on a list of individual employers with poor safety records and high accident frequency.

"Inspectors are really getting down to the nitty-gritty when it comes to submitting their recommendations for improvements," Mr. Friedel added. "I've heard of them requiring groundings for

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electrical wall clocks, even having mounted fire extinguishers moved an inch or two to meet requirements. Sure, it may be nitpicking but these are logical laws that have been on the books for decades."

Another point on which CAL-OSHA meets and exceeds federal requirements is the bi-lingual notice posted in every work place in the state. The poster outlines in both English and Spanish the basic features of the California Plan and instructs employers and employes as to proper procedures to follow to be in compliance with safety and health laws.

THE POSTER, which has been mailed out to an estimated 450,000 employers, also lists addresses and phone numbers of DIS offices throughout the state so an accident can be reported by phone within the required 24 hours. By comparison, Fed-OSHA requires written reports within 48 hours.

In California and many other states, public employes working for the states, cities, counties, townships and school districts are covered by state rules. Fed-OSHA excludes all public employes.

INSURANCE REGULATION

California is currently in the process of revising its job safety and health standards to meet Fed-OSHA approval. Deadline for submitting the final changes for review is Oct. 31, 1976.

But beginning in September 1971 and working under a federal grant, California began making a line-by-line, side-by-side comparison of the CAL-OSHA and Fed-OSHA standards. Although no proposed revisions of the state standards were included with the comparison, which was completed in July 1972, the list of comparisons was six volumes and 2,400 pages long.

The voluminous differences between California and federal standards, in the words of one observer, were clearly anticipated by Congress. He noted, "If Congress had wanted every state under OSHA to duplicate the words of the Williams-Steiger Act of 1970, it would have stated so in the law. Instead, it just outlined the major requirements a state must fulfill to gain federal approval and remain in operation."

IN SUPPORT of this argument is the fact that a necessary and proper standard for one state may be inappropriate and weak for another. "The Fed-OSHA standards, therefore, represent a starting point and, in the cases of our more highly industrialized states, are far from adequate to meet specialized needs," he added.

In spite of critics who argue that considerable time, money and manpower might have been saved had California simply adopted the Fed-OSHA standards, proponents of CAL-OSHA are firm in its defense. They contend that the state could not afford to waste 60 years of experience in industrial safety. They point out that California standards were written for the California employer, whose operations often differ greatly from those in other parts of the country.

Including California, an estimated 20 states are expected to establish comprehensive job safety and health plans after the next couple of years of monitoring and evaluation under OSHA. Thereafter the participation of the states will be critical to the success of the OSHA program, which depends on the states for 50% of the nearly $400 million needed to administer the program every year.

Helping to implement the California Plan, by providing the public with authoritative information about CAL-OSHA, were a series of free seminars conducted by DIS chief Richard Wilkins during the past year at various locations throughout the state. Supplementing these sessions are the OSHA training programs for employes and employers presented by the National Safety Council with funds supplied by Fed-OSHA.

A TOTAL OF $190,000 was alloted to the training courses put on by the Sacramento Safety Council, which covers all of northern California, and the Greater Los Angeles Chapter and the Long Beach Chapter, NSC.

During the course of his many CAL-OSHA presentations, Mr. Wilkins stressed the need for active participation in the educational program by the employers' trade associations and their workmen's compensation insurance carriers. But he also singled out voluntary compliance on the part of the employer as being the primary ingredient in the success of the new state program.

Explained Mr. Wilkins, "I was amazed at the number of employers who came up to me after our seminars asking where they might get a copy of these 'new' health and safety standards. My answer to that was, 'Fella, we've had some of these safety standards on the books since 1917. If you think they're new maybe you'd better get out of business because you're really out of touch.'" ■

Can order reductions in casualty rates

OLYMPIA—The Washington state senate voted approval of a bill giving insurance commissioner Karl V. Herrmann authority to order reductions in casualty insurance rates.

The measure would give the commissioner the authority if it could be proven, after a public hearing, that the rates were excessive.

Sen Fred Dore of Seattle failed to get the senate to consider his proposal to require an automatic 5% reduction in all automobile casualty insurance premiums as a result of the fuel shortage that has curtailed speeds and travel. ■

Mauck: Regulations needed only where individual benefits at stake

CHICAGO—Insurance regulations are unneeded in the area of corporate risk management, except where individuals' benefits are at stake, Illinois insurance commissioner Fred Mauck believes.

Mr. Mauck said he disagrees with the American Society of Insurance Management's current statement of principles concerning the role of insurance regulation in risk management. He sent the ASIM a letter criticizing their position on regulation.

"Essentially what they said was that there should be no governmental regulation or interference in the operation of the risk management function," the commissioner noted. "I don't have any quarrel with that, but I do have a quarrel with it in group plans where the beneficiary is an individual."

IN GROUP HEALTH plans, for example, the recipient of benefits should be protected by regulations against unfair or illegal treatment, Mr. Mauck pointed out. The ASIM's position of demanding free rein for risk managers in the administration of group insurance "is very irresponsible on their part," he said.

The area of company self-insured group benefits plans should have regulations covering their financing in order to assure plan stability, the commissioner is convinced. "I don't think these plans are self-insurance at all. I think the corporation is acting as an insurance company in such cases."

He added that proposals from his department on self-insured group benefits regulation would probably be sent to the Illinois legislature next year, requiring adequate reserves be established in any plan to assure reliable coverage.

"Except in the relationship of the risk manager to the employe, I don't see any basis for intervention," Mr. Mauck said. "A risk manager custom-designs his insurance package. He knows full well what he's getting and not getting. The buyer and seller work it out for themselves.

"But in insurance you also have contracts of adhesion," the commissioner added. "That's a legal term meaning you're presented with a contract that's entirely one-sided, where the only option is take it or leave it." These contracts of adhesion are often the kind signed by the ordinary citizen when he buys coverage for his property, his health or his life.

IN THESE one-sided contractual arrangements, governmental supervision through regulation protects the interests of the relatively powerless individual, Mr. Mauck noted. While the risk manager as a consumer should be allowed to stand on his own in the free enterprise system of give and take, the individual consumer buying one-sided contracts of adhesion should enjoy the protection of an industry regulator.

"The basis for regulatory intervention is to help the person who's at a disadvantage," the commissioner pointed out.

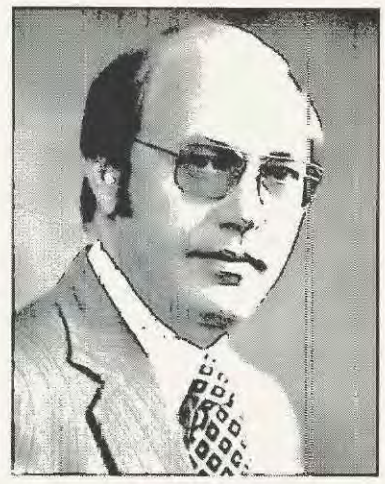
Left alone, the insurance industry has done a poor job overall of regulating itself, Mr. Mauck said. "I really believe many insurance companies have taken advantage of the existing kind of regulations to the point that they adopt the philosophy. 'If the insurance commissioner isn't going to make us do it, we don't have to do it.'

"That is an abuse of any regulating authority. It's shirking of responsibility by the insurance companies, but there are some who approach it in exactly that way."

WITHOUT THE cooperation of insurance companies in self-regulation, the state insurance commissioner has too much to handle, Mr. Mauck lamented. "It's physically impossible. The insurance commissioner cannot regulate all insurance entities by himself."

An alternative to the present system that Mr. Mauck has been contemplating "would require an entirely new insurance code." It is a system that may take ten to 15 years to evolve, he estimated.

"The most effective enforcement method is to give the wronged an opportunity for private redress—in other words taking it to court." But under the current system, an insured who feels he was wronged in an insurance contract has almost no form of redress unless he takes a complaint of fraud or negligence into a court of common law.



Fred Mauck

Mr. Mauck explained that an individual should be able to take an insurance company to court if it violates a contract or claims agreement, and the court should be able to hold an insurer liable if it doesn't meet contract obligations.

THE CONCEPT of an unbiased insurance ombudsman who would hear complaints about insurance coverage did not appeal to Mr. Mauck.

"I would never agree with the ombudsman idea. The judicial system works much better," he said. "The state commissioner is really an ombudsman now and it is not a satisfactory system."

The commissioner refrained from commenting on the recent scandal involving two sons of Chicago's mayor Richard J. Daley. John Patrick Daley and William Michael Daley were awarded Illinois insurance brokers' licenses after allegedly failing the licensing examination. "It's under investigation by both a Cook County grand jury and the Illinois Bureau of Investigation," he said.

"Last October we instituted a new objective multiple-choice type of examination," Mr. Mauck noted. "It's not harder but it requires more complete knowledge of insurance."

The percentage of passing scores initially dropped from 90% to 36% using the new test. This figure has now stabilized at 50%.

He added that many brokerage firms are pleased with the new examinations which "show them the deficiencies in their own training programs." ■

Mauck, ASIM differ over role of regulations

CHICAGO—Illinois state insurance commissioner Fred A. Mauck is at odds with the American Society of Insurance Management over the issue of where regulation fits into risk management.

Mr. Mauck told *Business Insurance* that he disagreed with the ASIM's stand on regulations earlier this year in a position paper. The commissioner said he was "disturbed that any responsible organization would take such an extreme position."

INSURANCE REGULATION

In its position paper, the ASIM stated "the society is opposed to any statutes, court decisions or administrative rulings which limit the flexibility of the risk manager to appropriately protect the interest of all parties concerned by the utilization of self-insurance or non-insurance on a partial or total basis."

The ASIM added that "in the interests of both social responsibility and in the interest of efficient financial management . . . it is imperative no limitations or restrictions be placed upon the risk manager in the selection of any or all of the aforementioned financial vehicles in the performance of the risk management function."

In an open letter to insurance commissioners, Berry L. Griffin, Jr., ASIM's current vp of conference, wrote that "any circumscription or usurpation of this principle will most assuredly have a detrimental effect on the American Society of Insurance Management's corporate members, their employes, and society in general."

Mr. Mauck noted that the ASIM's position paper and Mr. Griffin's letter did not touch on the issue of corporate financial responsibility to the public. And he said he was disturbed by Mr. Griffin's letter where it read, "the management of corporate risk must be free from unnecessary encumbrances of statutes and governmenal administrative rulings."

Corporate risk management should be free from government controls that are unreasonably hindering or impossible to implement, Mr Mauck said. But this does not mean governmental regulations should never be imposed on risk management. Demanding unregulated freedoms for corporate insurance, especially in the area of employe benefits programs, would be socially irresponsible, he pointed out.

The commissioner said he was disappointed in the ASIM for circulating a position paper with such extreme views. He added that he hoped the society's individual members did not all hold the same opinion. ■

New hospital cost controls requested

HARRISBURG, PA.—Although economic controls on the health industry have been lifted, Pennsylvania's Blue Cross and Blue Shield plans should continue their efforts toward controlling hospital costs, insurance commissioner William J. Sheppard said.

For the past three years the insurance department has forced the five Blue Cross plans to negotiate contracts with costs and quality controls. "I have no intention of backing away from this. These contracts have been credited with saving the public many millions of dollars," Mr. Sheppard said. "We cannot be content to stop here. Cost control is more important than ever."

It is estimated that hospital costs would rise 16% to 17% upon expiration of price controls, according to Mr. Sheppard. However, new methods of monitoring cost and quality must be developed along with positive steps to monitor fees paid by Blue Shield subscribers, he urged. ■

Passage unlikely this year for federal work comp

WASHINGTON—A bill setting potentially expensive federal minimum standards for state run workmen's compensation programs probably will not reach President Nixon's desk this year.

The reasons are numerous: the bill is new and sweeping in nature; Congressional time schedules are tight; and there is the uncertainty of Watergate and the impeachment proceedings.

The bill is S. 2008, the National Workmen's Compensation Standards Act, sponsored by Sen. Harrison A. Williams (D-N.J.) and Sen. Jacob K. Javits (R-N.Y.) in the Senate.

An identical companion bill, H.R. 8771, was sponsored in the House by Rep. Carl Perkins (D-Ky.) and Rep. Dominick Daniels (D-N.J.).

THE PROPOSAL would require state workmen's compensation programs to cover all public and private employes, cover all injuries and illnesses arising out of employment and provide for disabled workers or survivors to receive two-thirds of an employe's weekly wage.

Minimum benefits for total disability would also be guaranteed. The bill would eliminate time and dollar limits for either death or total disability payments or for rehabilitation or medical services.

It would also provide for adjustments in benefits as the average weekly wage increased.

Most of the committee work on the bill so far has been in the Senate with the first Washington hearings before Sen. Williams' Senate labor subcommittee scheduled for this month.

The Washington hearings are a follow-up to a series of "field hearings" in cities across the country; still more hearings before the Senate group here are expected later this summer.

THE HOUSE special labor subcommittee, which will handle the bill, has yet to begin hearings and committee staffers say none are planned until "late this year."

That makes any serious House action on workmen's compensation unlikely in 1974. Some representatives of big labor, a principal backer of the bill, are, as a result, restive.

"I don't know why the House hearings have to be late this year," an AFL-CIO staffer close to the legislation told *Business Insurance*. "I'm not certain the House has that much to do and the hearings would not have to be drawn out."

On the industry side, the National Assn. of Manufacturers is predicting that the bill will not even get out of the Senate committee this year.

If the bill does reach the Senate floor, there is a good possibility of a repeat of at least part of the debate that snarled the Senate for five days over passage of no-fault insurance legislation.

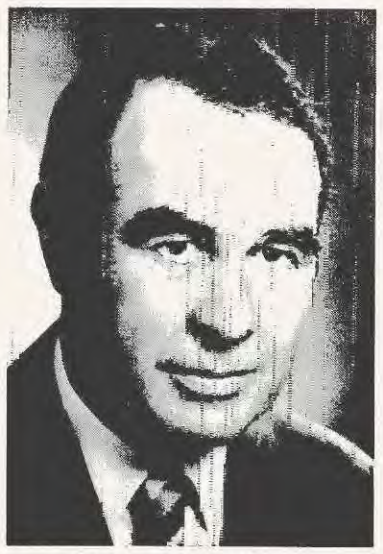
THE BROAD ISSUE is the same: Should the federal government step in with standards for what previously has been a state-run insurance program. Senate observers say it is still too early to say where the Senators will line up on that issue.

The Senate subcommittee is expected to take a step of considerable significance, however, when it costs out the bill. This procedure will probably be completed by sometime this summer and the numbers, if they're too high, could spell trouble.

There are arguments for pushing the Senate action on the bill this year, even if the House does not take action. Workmen's compensation legislation will almost certainly be reintroduced in the next Congress and passage of a bill by the Senate this year should make passage next year that much easier.

AND SENATE action would do a lot to put pressure on the House to move in the next Congress.

Delay will also give opponents of the bill time to point to more progress on the part of the states



Harrison A. Williams

Jacob K. Javits

to bring their workmen's compensation programs in line with the recommendations of the National Commission on Workmen's Compensation Laws that were written in 1972.

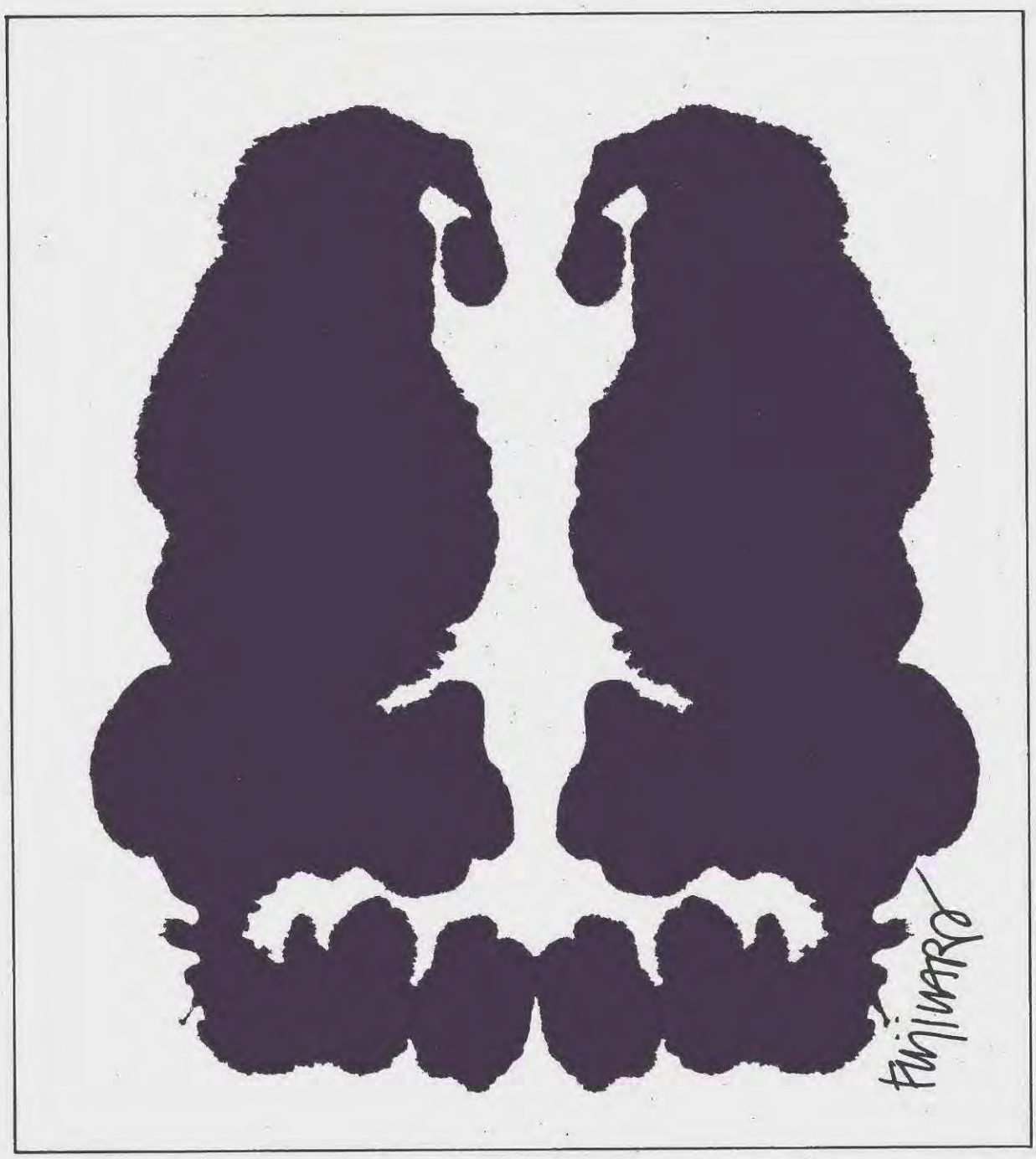
The Insurance Information Institute reported this month the states have been making progress.

Thirty-six states says the institute, meet the recommendation that there be no limitation on coverage, regardless of the number of employes on the payroll; 45 states require compensation for broad coverage of work-related diseases; 41 states meet the recommendation for full medical care unlimited as to time or amount; 23 states require workmen's compensation coverage for all businesses not specifically exempted; 17 states have a maximum temporary total disability of at least two thirds of the worker's weekly wage; and 15 states now meet the recommendation that workmen's compensation coverage include farm workers.

SUCH PROGRESS has won few converts among big labor representatives, however, and politicians hitting the campaign trail this fall can expect to be questioned about how they stand on the Williams-Javits bill.

"There's much greater reaction and interest among union members for compensation," says a Capitol Hill spokesman for a major industrial union, "especially with the growing awareness of the need for compensation in cases of occupational disease." ■

RESTING JESTERS



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There's an original way of looking at everything.

Government is 'forced to fill void' if private insurance isn't available

By RICHARD L. GORDON

WASHINGTON—The Nixon administration's "insurance man," Federal Insurance Administrator George K. Bernstein, is not an advocate of wholesale intervention of the federal government in the private insurance industry.

But, he admits, "I think the FIA or some agency like it will be around for a long time to come."

Congress increased the federal government's insurance writing and regulatory role in a big way in the late 1960s, one Mr. Bernstein doesn't particularly enjoy.

"We'd like to have less of these functions than we have now." he told *Business Insurance*. "We'd like for there not to be a federal regulatory role. The greatest measure of our success would be for there not to be such a role.

"The administration might love to depend more on the states. The insurance consumer doesn't care where he gets the insurance from—he just wants a good reliable product at a reasonable price.

"AND IF THE private insurance industry won't supply the product, Uncle Sam will," he warned.

There is, of course, ample evidence of the federal government's increasing intervention in insurance matters: no-fault auto insurance, national health insurance, pension fund termination insurance, overseas investment insurance through OPIC.

Mr. Bernstein's office, in the Department of Housing and Urban Development, is the chief underwriter for the national flood insurance program, the underwriter for the federal crime insurance program, and reinsurer for the federal riot reinsurance program.

MR. BERNSTEIN laid it on the line in explaining to the recent convention of the Financial Analysts Federation just why there is a federal presence in the insurance field.

"The insurance industry, as an industry, has initiated little in the way of substantive anticipation of or even response to the public insurance needs which evidences appropriate appreciation of the governmental threat or of the publics' eventual success in obtaining the insurance it seeks, from one source or another.

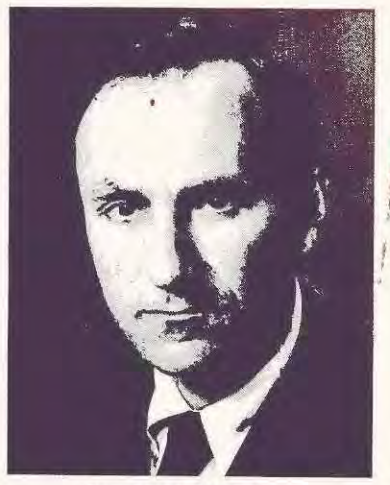
"In real life," Mr. Bernstein told the analysts, "philosophy usually succumbs to material considerations like eating, housing, and at least a measurable degree of financial security. Insurance has come to be understood by more and more Americans as helping toward these goals.

"Consequently, government at state and federal levels, has been forced to fill the void when private insurance has not been available. There is no reason to believe that this formula will change. Nor is there cause to expect that public expectation will diminish, in an era where political promises tend to escalate almost in inverse proportion to their ability to be realized."

Mr. Bernstein points to state workmen's compensation funds, automobile assigned-risk plans, windstorm pools, federal crop insurance, insurance for savings deposits, and home mortgage insurance as evidence of special risk facilities rejeced over the years by the private insurance industry.

Now the federal government, through Mr. Bernstein's office, is even considering handling underwriting for certain risks presently partially administered by the private sector.

IN PARTICULAR, says Mr. Bernstein, the federal crime insurance program is such an area. With only 22,000 policies for residential and commerical property in effect, he said, "I wouldn't describe it as strikingly successful."



George K. Bernstein

"The agents just don't exist in the inner city, and unlike fire insurance, there aren't any lenders to required it."

"We don't think it's reaching

Continued on page 37

Federal plans inspire risk management

WASHINGTON—Federal Insurance Administrator George K. Bernstein is no stranger to the debate over federal intervention in state-regulated private insurance.

Before joining the federal government in 1969, he was deputy superintendent and general counsel and first deputy superintendent of insurance for New York state.

The federal flood insurance programs he now supervises, although mainly for homeowners and small businesses, expects to have 1.5 million policies in effect in 13,000 communities by the end of fiscal 1975. Premiums are expected to reach $81 million.

The flood insurance program includes one of the most far-reaching federally inspired risk management programs ever enacted into law.

In order to qualify for the insurance for their residents, local governments must first assure the Federal Insurance Administrator's office that they are taking definite steps to reduce flooding hazards in their community and to prevent further unprotected construction in flood hazard zones.

The federal riot reinsurance programs is cutting its premiums soon, with projections that reserves will hit $94 million by the end of fiscal 1975.

A total of $9.73 million in claims had been paid as of year-end 1973, and those were paid, says Mr. Bernstein, from investment income. The plan began in 1968. ■

Fill void . . .

Continued from page 36

the people who need it most and we're exploring the possibility of a direct writing approach. We haven't yet got to the point of a governmental office where you could buy it."

Federal involvement, probably not to the extent of directly writing the insurance, inevitably follows in the wake of such proposals as national health insurance.

"WE'RE THE ONES who are forcing insurance out to the state level," he says. "Our bill (the administration's Comprehensive Health Insurance Program) requires it to be provided. We are mandating the employer to provide it so we're mandating the policy the consumer can purchase and even its form.

"If we're requiring the coverage, then we have a responsibility to see that the product is as good as possible."

"And what about integration of of benefits under some future national health insurance system," he asked. "Under national health insurance, will no-fault be the primary payer, or the national

INSURANCE REGULATION

health system? Under workmen's comp, what will be covered by the comp plan and what by national health insurance?

"These are the questions that will be asked in the future.

"We're still trying to stay out of the regulatory phases," he said. "Regulation is secondary to the provision of benefits, and even under the Hart-Magnuson no-fault bill (*Business Insurance*, May 13) the states will be the regulators, but with federal standards.

"But ultimately, that could lead to federal regulations. You can't get the name without the game."

IN HIS SPEECH before financial analysts, Mr. Bernstein said he believes "the insurance industry has the means and the capacity to provide comprehensive health insurance to the American public, but despite an impressive record of increasing private coverage, there seems to be an acquiescence by the industry in the inevitability of a governmental role.

"Comprehensive and catastrophic coverage at reasonable cost for all Americans is certainly attainable through private insurers, on a profit-making basis and without governmental coercion or involvement, but the industry has not made it generally available." ■

State begins probe of insurance companies

PHOENIX—A special Arizona legislative committee has begun a probe of the state's insurance practices, hearing proposals ranging from total competitive bidding to complete state self-insurance.

The committee, chaired by house majority leader Burton Barr, will hear testimony at a future date on:

- a measure in the state house rules committee requiring competitive bidding on insurance purchases over $1,000;
- a proposal by Rep. Barr to insure all state building through the state department of administration.

Rep. Peter Kay, termed the state's insurance practices outdated. "I say the time is overdue to be self-insured as a state," he asserted, adding that the state of Utah pays its own losses and has saved hundreds of thousands of dollars.

C. R. Krimminger, Gov. Jack Williams' aide, said the state should continue a plan known as risk management, involving safety practices to cut damages and blanket policies covering major losses. But he added that he wasn't sure he would be in favor of full self-insurance.

THE STATE BOARD of regents in May, 1972, awarded a contract to manage insurance on all $440,000,000 worth of state university buildings to a joint venture headed by the three members of the governor's insurance advisory committee.

The joint venture, called University Risk Management, of Tempe, got the bid for $82,000 although the regents' own insurance committee had recommended giving the contract to Olliver-Pilcher Assoc. of Phoenix, on a bid of $17,200, testimony at the meeting indicated.

Charles Binford, chief executive for URM, explained the firm spent 4,000 hours bringing the state's university insurance to modern standards, and said he expected it to save the state $750,000 in premiums after four years. ■

State returns 16% of work comp dollars

PHOENIX—More than 14,000 Arizona employers will share in a record $6 million dividend declared by directors of the state compensation fund.

The dividend, on 1973 fund operations, will return to employers almost 16% of the workmen's compensation insurance premiums that were collected during the year.

A SCHEDULE will be developed to return to the individual policyholder a dividend based on his premium payments and industrial accident losses.

The payments will begin in June and continue throughout the year as the anniversary dates of individual policies arrive, directors noted.

Directors approved the record dividend after auditors and actuaries advised that the state work comp fund has an adequate balance and contains reserves of $184 million to cover workmen's compensation claims and all other liabilities. ■

HMO's and disability reimbursement top regulatory issues in California

By JOANNE GAMLIN

LOS ANGELES—Two long-brewing issues have been moved to the front burner for near-term resolution by California insurance commissioner Gleeson Payne.

The first is the question of how to reimburse victims of partial permanent disabilities; the other is the larger issue of how and who should regulate California's proliferating number of HMO's, said Mr. Payne, who talked with *Business Insurance* recently, in his office high above this city.

In addition, the commissioner named two other areas which he feels demand fresh analysis. They are: Carriers who are selling property/casualty and workmen's compensation insurance on a mass marketing basis, and the burgeoning number of companies that are turning to self-insurance for group health as well as workmen's comp.

NO-FAULT AUTO insurance was yet another issue that the commissioner contended should be top-priority in the California legislature. At the same time, he admitted to deep pessimism about the chances of any meaningful no-fault bill ever being passed by the state.

Aggressive opposition to no-fault by the legal profession and some carriers, have been an effective barrier, he lamented.

Pointing out that 14% of all autos driven in the country are owned by Californians, the commissioner underlined his staunch belief that there are only four states—Massachusetts, New York, Michigan and Florida—that have no-fault laws with real teeth, and his wish is for California to join them. Commissioner Payne believes Californians are due for an automobile insurance rate decrease. Premiums paid by the assigned risk group in the state are excessive, he said. As an example, he noted that a man, aged 25, who resides in a crowded Chicano community must ante up $650 a year in premiums "for only plain vanilla coverage." He also made clear his desire that California formulate an auto insurance law that "is compulsory in name," if not in fact. He added that it should also put some punch into its present financial responsibility law.

The question of how to reimburse persons with partial, permanent disabilities will be resolved in California this year, he went on. Noting that Governor Regan has appointed a task force to make recommendations on the issue, he explained that there exists a sharp division on whether to reimburse with a lump sum or with periodic payments.

"Unions insist that a stiff finger constitutes a partial permanent disability," he said. Unions are known to be pressing for a resolution of the issue of how to recompense a person who suffers such an incident.

Commissioner Payne expressed evident concern about regulation of HMOs.

"The problem is whether the 150-odd HMOs in the state have sufficient reserves," he said. "They must be regulated."

Whether health maintenance organizations will end up regulated by the commissioner or by the state health department is still an open question.

Said the commissioner: "HMOs are a can of worms."

He voiced concern, too, about the number of smaller size companies that are hopping on the bandwagon to self-insure as much of corporate benefits as they can.

"A LOT OF smaller companies simply cannot handle this," he asserted, noting that the state does not maintain the stiff reserve requirements in group health that it does in workmen's comp. In the former a company need only obtain a certificate of exemption to go into self-insurance," he said.

"The difficulty is that people forget the long tails that go with disabilities covered by workmen's comp and even in group health," he said.

Commissioner Payne went on to note that the enormous increases in death benefit payouts demanded by the national task force on workmen's compensation could likely drive more companies to self-insurance. The task force is asking that death benefits be fixed at $79,000 as of October, 1973, and at $91,000 a year later and at $222,000 by 1977. California recently pushed up its maximum death benefit payout from $28,000 to $45,000.

He said he is also maintaining a stern eye on the purported premium savings promised by carriers seeking to sell property/casualty and workmen's compensation policies to trade groups in the state.

"I feel that the carriers must justify their lower premiums on the basis of actual cost reductions," he said.

The prime group to feel the impact of the mass marketing approach to these policies, he said, are the brokers who see their small business clients being "stolen" by carriers promising substantially lower premium costs. ■

Charge bank with violation of state code

SAN FRANCISCO—A plan by San Francisco-based Wells Fargo Bank providing participants in the bank's "Gold Account" program with $2,500 accidental death or dismemberment insurance coverage, without separate charge, has run afoul of California's insurance commissioner Gleeson L. Payne.

Mr. Payne filed an "accusation" against INA Life Insurance Co., underwriters of the Wells Fargo insurance scheme, charging violation of the California Insurance Code.

The insurance was offered to holders of the "Gold Accounts" under a master policy issued by INA to the Wells Fargo Gold Account Assn.

"This association," commissioner Payne said in his accusation, "is not an association formed and continuously maintained in good faith for purposes other than that of obtaining insurance.

"Because of this," he declared, "the policy is not a master policy authorized to be issued to an association in California."

INA, in effect, according to Mr. Payne, has issued a policy that "makes or permits a discrimination between insureds of the same class" a violation of the state's insurance code. ■

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Washington regulators move in on HMOs, rates for smaller groups

OLYMPIA, WA.—The Washington state insurance commissioner, Karl Hermann, aired at public meetings this month new regulations for health service contractors, such as the King County Medical Assn. (Blue Shield), Blue Cross, and Group Health Cooperative of Puget Sound.

"Recent legislation has given our office more authority in regulating health service contractors," said deputy commissioner Robert Johnson. "Until recently, contractors were left alone. But now, we have authority to give instructions for examinations when licensing agents, and we can say what must or must not be done in insured contracts."

The new regulations, if approved, will be more to the benefit of the consumer, Mr. Johnson said. "For instance, in the past, some contracts stated that if a person was treated for any one condition for 12 months, then in the 13th month the coverage could be terminated, just knocked out. Hypothetically, if a person sprained his neck and wore a brace for three months and continued to see a doctor for another nine months, then he could lose his coverage. Now, we'd like to change this to read a 'reasonable' period of time, not just arbitrarily one year."

In other examples, he said that often, a contractor's medical advisor was the final medical authority. "His word was binding, and not appealable. Even if a doctor said the patient needed an appendectomy, the medical advisor could say no, and that was it," says Johnson. "Our new regulation would state that a contractor can't deprive a consumer of his right to go to court or to contest an opinion."

GROUP HEALTH insurers presently restrict medical care, examinations, etc., to their own doctors and hospital. "Now," says Johnson, "we say that in an emergency, that the insurer must make a reasonable provision for emergency treatment, say, if a person is not immediately close to an insurer's doctor, or on vacation, etc. This is at least a step forward from what we have had in the past."

Contracts, too, will now have a ten-day grace period, so that "if a person is, for instance, on vacation and doesn't get his bills forwarded, he won't lose his coverage if his bill is not paid immediately."

The insurance commissioner's office has also issued a new bulletin which explains the office's interpretation of what type of business should be eligible to receive a rate reduction.

"As of May 10, we've permitted small businesses to be appraised to see if they should have a rate reduction. Big commercial accounts have their own people who can evaluate their true risks and determine reductions. But the small businessmen are out in the cold, and are stuck with the basic schedule," says Mr. Johnson.

"Now, they can have a 25% adjustment variation from the basic rates. For 60 years, we've kicked this point around, and have finally decided that a small business with good security, etc., was paying more than it should, and, consequently, was subsidizing others." This new interpretation should encourage small businesses to apply for rate reductions, he adds.

THE DEPUTY commissioner also notes that the state has taken steps to scrutinize carriers more closely to prevent more Equity Funding types of scandals. And the scandal hit close to home: Equity Funding Corp. owned stock in Northern Life Insurance Co. of Seattle, which managed to come out of the affair unscathed. In fact, Northern Life will soon accept coverage for the policy holders of Equity Funding Life Insurance Co. so that all policyholders will finally be protected. "It's the objective that we've been trying to bring about," says another associate in the commissioner's office.

Now, the office has "added one more program," which tests the accuracy of machines that test a company's reserves. "Commissioners in many states are paying a lot more attention to this matter," says an associate. "We've had our examiners talk with firms that set up the testing system. We've had the representative of one firm come out and test one of our companies on a very brief basis. We normally examine companies every three years as required by statute; but on a large company, this audit can take months, even a year because there is so much detail," says the associate. "We now hope to eliminate potential for any other similar problems." ■

State fund may become independent

SACRAMENTO — Legislation was introduced here to reconstitute the role of California's state fund in the workmen's compensation insurance scene.

State senator W. Craig Biddle wants to change the name from state compensation insurance fund to California fund and would remove the agency from the state department of industrial relations and convert it to an independent public service corporation.

Sen. Biddle's proposed new law would relieve the state of all liability for obligations of the fund and would eliminate an existing requirement that public agencies, when insured, can only insure with the state fund.

The effect of this change, according to Sen. Biddle would enable private insurance carriers to insure public agencies. The change would affect all cities and counties in California on the effective date of the law and all other public agencies within two years.

Sen. Biddle would permit the new California fund to invest in securities for insurance companies, under supervision of California insurance commissioner Gleeson L. Payne and would require the new fund to become a member of the California Insurance Guarantee Assn.

The bill's provisions are intended to clarify the fund's authority to write excess workmen's compensation and to sell contract adjusting services to self-insured employers as well as to permit the new state fund to write interstate portions of the risks of employers domiciled in California. ■

Stockbrokers get OK to sell all insurance

WASHINGTON—The Securities and Exchange Commission is holding itself at arm's length from any direct regulatory involvement in the insurance sales activities of stock brokerage firms.

The SEC had "no comment" to make officially when the New York Stock Exchange (NYSE) informed the commission in March of this year that it was moving to allow its member firms to sell all forms of insurance. Underwriting was barred.

The NYSE allowed its member firms to sell life insurance in March, 1972, and in the following year extended that insurance marketing capability to accident and health lines.

Big Board officials describe this as a "controlled entry into the insurance field" to fill the broad financial needs of brokerage clients.

THE SEC'S background role in all of this is due in large part to serious questions about whether it has any authority to enter the insurance regulatory field.

"We've taken the position," a top SEC staffer told *Business Insurance*, "that there is serious question whether the commission has any jurisdiction over exchange rules in this area.

"The sum of our power in that area would be dependent upon what the interrelationships would be between the insurance side of the business and the security side of the business."

"It's just too premature to speculate on what the SEC's future role would be," according to the SEC official.

"LET'S ASSUME, however, that a registered representative of a brokerage firm goes to a customer's living room or office to give him estate planning advice," he said. "If advice on regular security investments is mixed in, it might run afoul of the securities laws."

The SEC would be very likely to step in, he said, if the insurance operations of a brokerage firm somehow jeapordized the financial security of the firm or securities held by the firm for its customers.

Both the SEC and the NYSE said it was very unlikely the insurance operations would be tied into stock or bond underwriting by the brokerage firms.

Insurance premiums could not be used as "soft dollars" in exchange for underwriting new stock or bond issues.

"I just can't see that being done," said an NYSE official. "I can't name the rule that prevents it, but I'm sure there is one."

"You'd have the SEC climbing up and down your back," said another Big Board official. "It would be a fraudulent practice."

"THERE'S MORE than one potential for trouble here, though," said the SEC official. "There's a more direct problem where it's the insurance company saying, 'You can get our insurance company portfolio brokerage if you sell our insurance plans.'

"Mutual funds have done the same thing and the National Assn. of Securities Dealers has adopted rules to prohibit that sort of thing," he said. "There are just lots of potential tie-ins with anti-trust laws."

Whether the brokerage firms intend to make a major effort to enter the group insurance sales field for corporate buyers isn't quite clear.

Both the SEC and the NYSE say they have little interest in the details of the insurance operation of the brokerage firms, although the Big Board has the right to inspect the insurance operations of its members.

NYSE officials say 89 member firms are now engaged in some form of insurance sales. The three largest firms are Bache Co., Inc.; E. F. Hutton; and Thompson and Mc Kinnon, Auchinloss, and Kohlmeyer Inc.

Securities brokerage employes who sell insurance must be registered representatives with the NYSE and must meet state requirements and are subject to all state insurance regulations. ■

Hawaii amends its no-fault auto law

HONOLULU—The Hawaii state legislature adopted a series of amendments to the state's no-fault auto insurance law and postponed the effective date of the new law from July 1 to September 1.

Under the amendments, automobile coverage becomes primary and a threshold of $1,500 will be effective for one year, after which time the plan will utilize a different factor which would account for 90% of bodily injury claims.

A new system of open rating will also be effective for three years. Hawaii's insurance commission will monitor rates and will be authorized to intervene if rates are found to be excessively high or low.

A prior requirement that each no-fault auto insurance carrier maintain an office in each county has been modified to require only one claims office in Hawaii. In addition, each carrier will be assessed $1 per year per vehicle insured, to finance a driver education program.

THE NO-FAULT auto insurance program in Hawaii will be administered by a special commissioner, other than the insurance commissioner and whenever a vacancy occurs in the position of special commissioner, the administration will be handled by the state's director of regulatory agencies. This position now is filled by the insurance commissioner.

Hawaii's no-fault law also prohibits any carrier from establishing rates on the basis of race, age, sex, length of driving experience or marital status and a joint underwriting agreement has been substituted for an assigned risk plan in handling sub-standard risks.

The amended law mandates a 15% rate reduction which has been made applicable to all forms of auto coverage embraced within the bill and prohibits any rate increase prior to Sept. 1, 1975 unless to preserve the solvency of the carrier involved. ■

Opposition to enactment of no-fault bill

MILWAUKEE—Stanley C. DuRose Jr., state insurance commissioner, warned that if Wisconsin doesn't reform its auto accident reparation system Congress might enact legislation that would be detrimental to policyholders.

Addressing the 75th anniversary convention here of the Independent Insurance Agents of Wisconsin, Mr. DuRose warned that under proposed federal no-fault legislation, "the federal government social theorists could probably establish that a citizen in northern Wisconsin, who might be paying something like $150 per year in automobile insurance premiums, should make a contribution to the average citizen in New York City, who might be paying $500 to $600 per year for his automobile insurance."

He added that "the most unfortunate aspect of this matter is the fact that members of Congress apparently are supporting the bill on the mistaken assumption that it would bring about a decrease in premium, that it would not generate a federal bureaucracy and that it would not infringe on the rights of the states to regulate the insurance business."

Mr. DuRose said it is too bad that "all of the automobile and health and accident insurance industry, and the legal profession, did not forego their own short range interests" to support a no-fault bill drafted by a governor's task force that he headed. The bill has been shelved in the state legislature.

"The task force's no-fault bill would have paid more money to more people quicker, and on a more equitable basis, and at a lower premium charge, than the present reparation system," Mr. DuRose contended. ■

Regulators eyeing self-insured group plans

By JUDI TALIT

NEW YORK—The growing trend towards self-insured group accident and health plans, as well as state no-fault legislation, has insurance commissioners across the country working on new regulatory practices, a *Business Insurance* survey revealed.

The trend to self-insured group accident and health plans appears to have raised the most concern among the nation's insurance commissioners. Some regulators cite premium tax evasion and the lack of insurer liability and responsibility, as well as the lack of plan disclosure, as reasons they are further scrutinizing such plans.

Ohio's insurance commissioner, Kenneth DeShetler, is one regulator taking action. When companies set up self-insured plans managed by insurance companies or other agents, they "obviate payment of a premium tax, a problem that has become a concern of the state," Mr. DeShetler said.

LIABILITY is another concern voiced by the commissioners.

Bob Rowe, chief deputy of Michigan said, "more and more employers are going partly self-insured, so we're getting more concerned with the adequacy of reserves. Because the carrier often acts only as an administrator without responsibility or liability, we asked that proposals of administrative service be submitted to us and that the insured not be misled into thinking that he has insurance through the carrier."

Oregon, too, is finding problems with self-insurance. Commissioner Lester Rawls said, "the real problem with self-insurance is that bigger corporations have gone into self-insuring agreements with some companies to handle the claims and then if the company goes bankrupt, the policyholder is out."

However, Mr. Rawls says he has found a solution. "We have suggested to companies that they write out a reinsurance agreement with the carrier handling the claims so that if a company goes broke, the policyholder is not out anything. The companies have agreed to this."

WISCONSIN'S insurance commissioner, Stanley DuRose, stressed the need for stringent regulation in the states. "The whole problem of self-insured plans is a can of worms. Without proper regulation, the public is given an open invitation to self-insure their plans."

No-fault was another area that was seen as a great concern by the state insurance departments.

A spokesman for the New York insurance department said the department will soon be taking action "to make community-rated health plans exclude no-fault and lower their premiums, since one is automatically covered under no-fault and is unnecessarily given double coverage."

The question of carrier primacy under no-fault was brought up by a number of commissioners.

OHIO'S Kenneth DeShetler said that when no-fault coverage is fragmented, split between more than one carrier, "often people are caught in the middle as to who has responsibility" for payment of claims.

"That's why we like to have a complete package sold," he said. "With fragmented coverage it makes for the opportunity of each carrier to deny responsibility and this happens often enough. The general thrust of insurance then is to write more and more in packages, avoiding the loopholes," Mr. DeShetler added.

A similar confusion of primacy was seen in the state of Wisconsin. Mr. DuRose believes "no-fault is a serious consideration of accident and health, particularly if you get into a bill passed by the

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Senate in Congress where you've got some language that would tend to show accident and health as the primary insurer. The policyholder would then say that the auto insurer is the primary carrier. The language, unfortunately, generates giving option to elect which carrier is primary."

Oregon noted that this problem did not hold true for them. The insurance department head there said eastern states have a problem because the Blues in the east want to be considered the primary carrier. However, this is not the case in Oregon. He said, "Blues here don't want to be primary carriers."

Other hot issues mentioned in the accident/health area included advertising regulations and minimum benefit standards.

However, many insurance commissioners said that this type of regulation has had more of an effect on individual plans than groups.

Pennsylvania's William Sheppard said that "as far as I know, the model NAIC act was only designed for individual minimum standards, but other states may have applied the same thing for groups."

Mr. DuRose, in enacting a law for the state of Wisconsin, tied in the advertising requirements along with minimum standards.

"A YEAR AGO, in a rewrite of the advertising regulation, we put in a requirement that the advertising for insurance must contain an outline of coverage and exclusions. In addition, carriers must show in the literature the kinds of coverage in terms of the eight defined covers."

However, Mr. DuRose said, "people are generally confused on accident and sickness insurance. What the industry needs is to get things simplified into basic language and basic coverage."

California has gotten involved in regulating both minimum standards and "advertising guidelines, regulations that are pretty sterile, giving examples and detailed analysis of what is required," according to Gleeson Payne.

Concerning an extension of minimum standard requirements beyond the scope of regular accident/health coverage, William Sheppard of Pennsylvania said his department is looking into it. "The public is pretty good about keeping to adequate coverages and the like on basic coverages, but there may be a need to enforce minimum standards on new types of programs, like dental care," he said.

Oregon's Mr. Rawls noted that his state is regulated a little differently than the others. "We regulate all the Blues, even the Kaiser program." ■

'Growing need for state regulation, implementation of laws': Educator

By MARY ANN CALLAHAN

NEW YORK—A continuing trend of federal standards, like workmen's compensation and no-fault guidelines, which demand state-by-state implementation and regulation is on the horizon, according to Robert W. Strain, dean of the College of Insurance and former Texas insurance commissioner.

In an interview with *Business Insurance*, Dr. Strain said he expects a growing emphasis on consumerism, a greater regulatory thrust in the area of insurance solvency in the wake of the Equity Funding incident, as well as in rate-making, policy forms and wording and insurance marketing practices.

He added that he also hopes legislatures will increase their appropriations to insurance departments, since only 4% of the premium tax dollar presently goes to the insurance departments. The rest goes into the state's general revenue fund, he noted.

"THE NEW insurance commissioner, as policeman for the insurance industry in his state, is tossed a tremendous responsibility, to say the least," Dr. Strain said. "While he is usually intelligent, capable and willing, he often does not begin with the important technical orientation necessary and has to learn as he goes."

The new insurance commissioner can enroll in a unique, practically-oriented one-week program, now in its eighth year, directed by Dr. Strain and highly praised by the National Assn. of Insurance Commissioners.

"The commissioners gain perspective from first looking at the forest of insurance before seeing how each tree fits in it," he said. The courses cover the gamut from property/casualty to life/health to rate regulation to the impact of economic and environmental forces on insurance. Other courses include those on consumerism, the Washington outlook, insurance accounting, taxation and finance, managing a state insurance department and a seminar on auto insurance, because "the auto insurance industry accounts for about half of the nation's total premium volume," he said.

In addition, the College of Insurance offers an annual two-week training program for junior insurance examiners on state regulatory staffs, this year from June 17 to 28, he said, with emphasis on execution, efficiency and effectiveness, Dr. Strain said. So far, 30 examiners from 13 departments have signed up this year, he notes. Both courses are given on a non-profit basis, with no insurance industry contributions and students are reimbursed for their expenses by their respective departments.

"IT IS A unique opportunity for insurance department personnel to get a solid backgrounding in keeping with their governmental responsibilities," Dr. Strain said, "and if we hadn't met with NAIC to draw it up I don't think anyone would offer this kind of necessary education of insurance regulators."

Robert W. Strain

As an insurance commissioner in Texas for three years, and an insurance educator, Dr. Strain has a comprehensive overview of the industry and a friendly relationship with a number of the experts.

The faculty includes New York Supt. of Insurance, Benjamin R. Schenck, George K. Bernstein, federal insurance administrator, Daniel J. McNamara, president of Insurance Services Office, Lorne R. Worthington, former Iowa insurance commissioner and vp in planning & development at Preferred Risk Mutual Insurance Co., Richard E. Stewart, senior vp at Chubb & Son Inc. and formerly president of NAIC and a former New York superintendent, and Robert E. Dineen, NAIC consultant and like Mr. Stewart also its former president and a former New York superintendent.

Dr. Strain credits the NAIC's new McKinsey & Co. study on insurance department practices which calls for a refinement in accounting, for the increased popularity of the program this year. The shadow of the Equity Funding scandal may also have helped make insurance departments more aware of the need for enlightened regulation and examination, he added.

"ACTUALLY, one of the best things to happen to the insurance public came as a postscript to Equity Funding," he said, "because 46 states have passed insolvency fund regulations which protects the insured of a bankrupt company by assessing other insurers."

"It's obvious that the more a commissioner knows at the beginning, the more effective he will be," Dr. Strain said, "and while a number of commissioners are lawyers, most law schools offer only one course in insurance law—and this usually stresses legal aspects rather than business practices. None of this gives the commissioner a real orientation to the technical side of the insurance industry and its regulations."

However, he said he thinks a lawyer who gets some additional training in insurance law is probably the ideal candidate for commissioner. "If you take a commissioner from within the insurance industry it's likely he is only going to know insurance from either a sales point of view or maybe only specialize in property/casualty or life/health."

A hazard of hiring a commissioner, Dr. Strain noted, is the almost unavoidable fact that if he does his job well, the industry will offer him a key company post after two to three years—along with a more attractive salary than the state budget will allow. "It's been a source of criticism over the years, but it's almost unavoidable," he said. ■

States troubled by increase in growth of 'pups'

By JUDI TALIT

NEW YORK—Insurance commissioners in states where there has been a history of disproportionate tax differentials between domestic companies and foreign companies revealed to *Business Insurance* that they have been experiencing severe tax revenue losses due to the rise of pup carriers set up to operate so they are entitled to an exemption from premium taxes on "foreign" business.

It was inferred by many of the insurance heads interviewed that pup companies were set up by national carriers in states where they do a great deal of business to avoid paying the tax. However, it was noted that it is very difficult to know the motives of the incorporators responsible for setting up a pup.

In allowing pups to domicile in the states, insurance departments presumed that they could offset the loss of revenue (in exempting the pups from paying the tax) through sales and real estate taxes paid by the company, along with the taxes paid by employes.

HOWEVER, this was not the case. In Illinois alone, when pups were allowed to domicile in the state, it "lost $5 million in premium taxes because the companies avoided paying the 2% premium tax," according to Kenneth Smith, supervisor of the Illinois property and liability unit.

He noted that pup companies were first noticed in the state six or seven years ago, but did not have much impact on tax revenue then. However, during the last three years, the entire operation snowballed and each consecutive year has seen an increase in pup companies.

Mr. Smith added that this came to a halt last year when the insurance director, Fred Mauck, was forced to take action and stop the issuance of licenses to these companies.

Illinois discovered that 21 pup companies were set up in the state since 1968, owned directly or indirectly by a foreign parent. Of these property and casualty insurers and life insurance companies, all were deficient in maintaining records in the state. Action was taken by the insurance director asking the companies to either redomicile or maintain all records in the state of Illinois. (*Business Insurance*, Aug. 13, 1973.)

IN A REPORT issued by the Illinois insurance department it was noted that "levying of domestic premium taxes is not unusual. Only seven states, including Illinois, completely exempt all domestic insurers from the payment of premium taxes." One of the purposes cited by the department for allowing domestic exemption was to foster growth of the Illinois industry.

However, it was discovered that in setting up a pup carrier staffs and offices did not increase and it appeared that all executive and investment decisions were made through the parent office.

According to the insurance department there, "annual statements of such pup companies often yield little but zeros since the premium and liabilities can be totally reinsured by the parent."

In an attempt to counteract the growth of pup companies in Illinois, a bill was introduced in January which would have imposed a 2% premium tax on domestic, foreign and non-profit insurers. However, it was defeated, according to the Illinois insurance department.

However, another attempt was made in April with the reintroduction of state house bill 927 which requires all domestic insurance companies, except fraternal benefit societies, to pay a 2% premium tax, if they fail to comply with Illinois insurance regulations governing pups.

IN OTHER words, all domestic companies must underwrite, issue policies, and conduct operations in the state of Illinois if the policyholders are residents of that state.

In addition, officers and personnel responsible for the company's operation, books, records, administration and annual reports must be kept in the Illinois office.

Oregon's insurance commissioner, Lester Rawls, said his state does not share Illinois' problem. Mr. Rawls said that three or four years ago a law was enacted in the state permitting the establishment of pup carriers. However, they were not granted domestic status, and consequently not eligible for premium tax exemption.

The commissioner added, however, that they are having problems with those companies, set up prior to the law, which are still eligible for exemption.

The premium tax for the state of Oregon was quoted as 3.5% for foreign companies, but the commissioner said that "domestics are not responsible for paying this."

He added that the state does have a retaliatory tax, which makes foreign companies operating in Oregon responsible for paying local taxes rather than those in their home states.

Ohio's commissioner, Kenneth DeShetler, explained that that state has essentially the same problem as Illinois. He preferred to keep his comments to a minimum since the state is currently involved in litigation with two such pup companies.

"DOMESTIC companies have the choice of two kinds of tax scales, both of which are substantially less than foreign premium taxes of 2.5%," Ohio's commissioner said.

Ohio does have "a law aimed at taxing the pup company" according to Mr. DeShetler, but the problem in Ohio is essentially one of status of those companies set up prior to 1972, when the law was passed.

The litigation currently going on in that state concerns precisely that question—retroactive status for the pups. The commissioner said that they were sued once before by one company and the state lost.

The state of Wisconsin "is sympathetic towards pups if there is regulatory compliance for statutes governing such a corporation, which means full disclosure of the people involved in the operation, along with the confidence that all the principles were backed up," according to insurance commissioner Stanley DuRose.

In that state, rather than imposing a premium tax on domestics, the companies are subject to an income tax statute.

Unfortunately, in citing a test done some years ago, the com-

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OSHA finds opposition to state plans a problem

By STEPHEN GOOD

WASHINGTON, D.C.—By 1975, the Occupational Safety and Health Administration (OHSA) expects to have 30 states operating their own plans. But OSHA's drive to hand authority over to the states is turning into an uphill battle.

It is unlikely that more than five states will take over OSHA administration this year, according to Barry J. White, OSHA's associate assistant secretary of regional programs. And one state is expected to give its authority back to the federal government.

Union opposition to state-run OSHA's, and a steadfast reluctance by some "hard core" states to accept OSHA responsibility, has saddled Washington with 20 plan-less states, Mr. White said.

Five states still haven't submitted any plans for federal approval or passed any enabling legislation.

At the other end, 21 states today have both approved plans and enabling legislation, Mr. White pointed out. Five others have approved plans and need state legislation to make them operative. Four states passed legislation, but are waiting for their plans to be okayed by Washington. And 15 states have submitted their plans for review, but lack enabling legislation.

FOR A STATE'S plan to be approved by OSHA, it must outline safety and health standards at least as strict as those established by the federal government. Once a plan is approved and money is appropriated, the state takes over OSHA administration and enforcement.

But the federal agency still "monitors" state operations, Mr. White explained. And states operating plans also receive matching funds from Washington as an incentive to continue their programs.

Despite this monetary bonus, Montana is dropping its state-run plan July 1. "This year the legislature didn't appropriate the funds," Mr. White noted. He added that a few of the other states could do this in future years if their legislatures hold back the money. Federal OSHA would then begin administering those plans again.

Virginia has been another problem, Mr. White said. The state's plan "is almost rejected because it is based on an exclusively criminal sanction system. Under such a system they would have to take violators to court and prosecute every case to the end."

FEDERAL OSHA is based on a civil sanction system, Mr. White explained, where fines can be levied by agency inspectors if employers violate established standards. Cases can still go to the courts under the civil sanction system, but only after the avenues of appeal within the agency have been exhausted.

Virginia may seek a ruling from the department of Labor if its plan is rejected by OSHA, Mr. White said. "They have alleged they will go to the Supreme Court if they have to."

In a few states like Pennsylvania, where labor unions have a strong influence, state OSHA plans are having trouble getting off the ground. The unions want a federally-controlled OSHA, Mr. White noted, because they fear the state plans will be significantly weaker with less effective enforcement.

"We don't think so," he said. "(OSHA's chief John) Stender once said the unions look back on worse times. We look forward. We never leave the state. We're always in there monitoring. And if a state plan gets into trouble, we can take back the initiative.

"Generally, labor believes the federal government can do a better job than the states," Mr. White explained.

ALTHOUGH national unions complain about state OSHA weaknesses, "We're not getting that many complaints from local union people," he added. A program called CASPA, or Complaints Against State Program Administration, has been set up to gather criticisms from individual union locals.

So far, local unions seem to be relatively happy with the effectiveness of their state plans, Mr. White said. And if they become disgruntled, "they know they can complain to somebody."

ANOTHER REASON why the national unions might want OSHA centered in Washington, Mr. White noted, is so they can concentrate their lobbying influence on one agency. If they had to work with OSHA in each state, this lobbying power would be diffused.

A recent criticism made by United Auto Workers president Leonard Woodcock that work injury rates have not decreased under OSHA (*Business Insurance*, May 13, 1974), is a "can of worms," Mr. White said. "We don't really know whether it's going up or down."

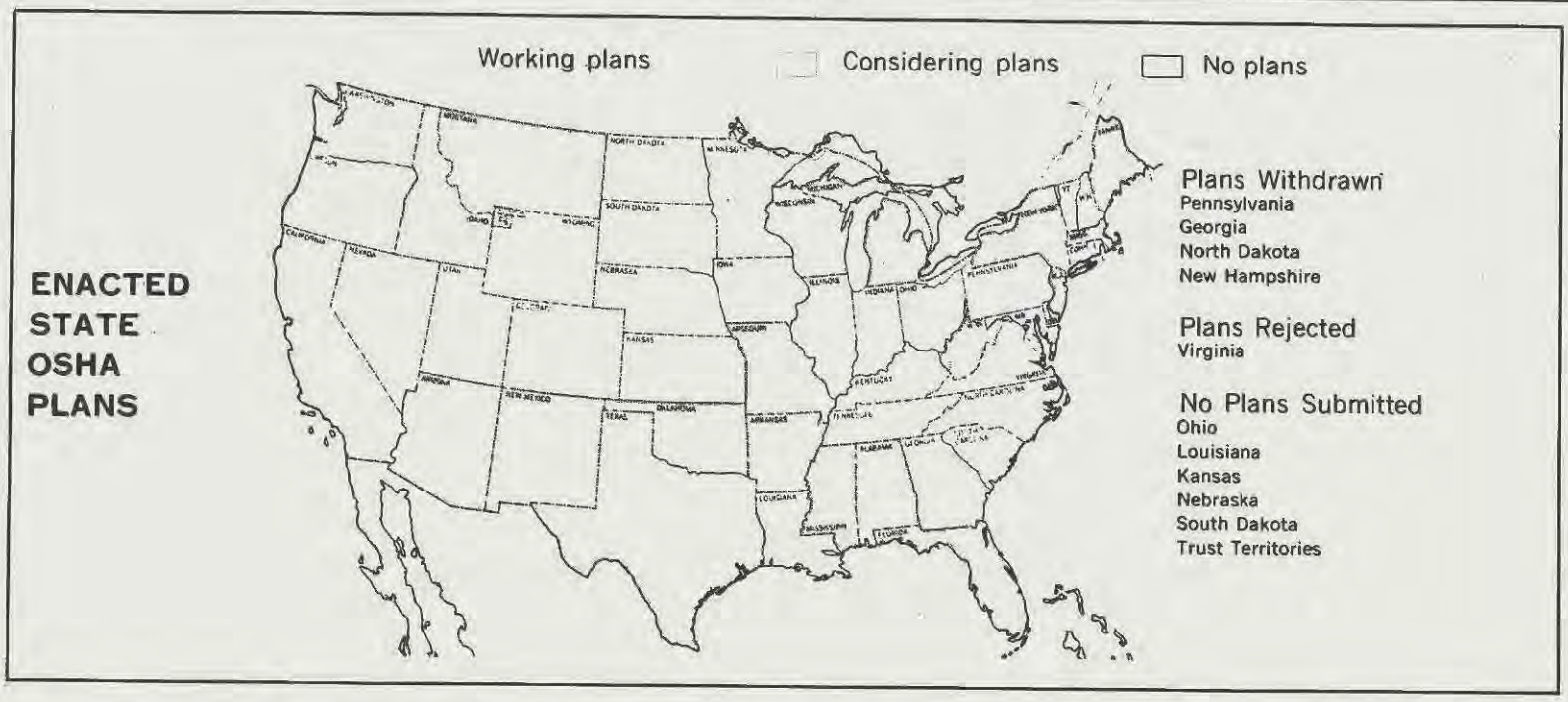
The first full set of work injury statistics compiled by OSHA came out last summer, covering 1972. This summer the 1973 statistics will be released, and OSHA's effects may be somewhat apparent. But four or five years might be needed, Mr. White pointed out, before statistical reporting arrives at a consistency where injury rates show true trends.

WHILE OSHA is having its trouble with some of the national labor unions, "by and large we're very pleased with the reaction of employers," the official commented. "They are trying. It's very rare that you find they don't care about OSHA."

About 25% of the employers inspected are found to be complying in full with OSHA standards, Mr. White said. Another 25% are in need of "very minor corrections." Many of the other employers receive one or two citations for hazards, but only about 1% are caught with willful violations.

The insurance industry also supports OSHA on the federal as well as state levels. "They're most cooperative with us," Mr. White noted. "They're our allies. Some of them think OSHA's great because it adds to their own emphasis on work safety and health."

During the next year, OSHA will be putting more emphasis on health standards, Mr. White said. Most states will probably leave the promulgation of health standards up to the federal OSHA, he added, because "there is an enormous cost in coming up with these health standards." ■



Carrier asks for state supervision

AUSTIN, TX.—Insurance commissioner Don B. Odum recently decided to continue state supervision of the Republic National Life Insurance Co., Dallas' largest life insurer.

The commissioner's decision came after a surprise move by the carrier at a hearing April 29, when Republic National requested the state continue supervision of its investment practices.

Representing Republic National, attorney Will Davis told the commissioner that stockholders, reinsurers and group policyholders will be reassured if the period of state supervision were extended. Earlier, when Republic National was first put under supervision on Feb. 27, Mr. Davis reportedly called the move "completely unwarranted."

REPUBLIC NATIONAL was originally placed under supervision when the carrier's auditors Peat, Marwick, Mitchell & Co. said big losses could occur in mortgage and real estate loans. The company boosted its ready reserves from $7 million to $23 million to cover any losses. And soon afterward, the Securities and Exchange Commission stopped all trading of Republic National stock, (see *Business Insurance*, March 18). Trading of common stock reportedly has been resumed.

After approving continued supervision, Commissioner Odum named insurance dept. attorney Herbert Crook as a supervisor over the company. Mr. Crook was assigned to help Republic National recover company assets that were "wrongfully used, taken or wasted or misappropriated."

Mr. Odum also approved a recommendation by the carrier's directors to reorganize the investment committee.

Republic National was ordered to make up a plan for "orderly disposition, upgrading or correction of any investment that is deficient." Commissioner Odum said the state supervision will continue until he believes the requirements specified for improving Republic National's finances have been achieved.

Mr. Davis noted that the carrier, with more than $11 billion worth of life policies in force, faces no danger of insolvency. ■

Aviation underwriter tells growth in plan

Avemco Corp., Bethesda, Md., said it now writes group personal accident insurance for 175,000 members of the Aircraft Owners and Pilots Assn., which has over 180,000 members. Further, the "Times Ten" group accident insurance program which allows AOPA members to increase their $700-$1,000 basic policy ten times was purchased by 42,466 AOPA members in 1973, versus 38,860 in 1972, Avemco said. Total group accident insurance in force for AOPA members is now $500 million. Avemco said it is "confident" of its place as the leading insurer of general aviation aircraft in the world, with "no available evidence that any insurer or group of insurers directly writes more than the 30,407 aircraft insurance policies issued by Avemco in 1973." The firm noted that a higher than normal number of policyholders had serious accidents last year because of increased use of aircraft.

Critic assails regulation of rates, underwriters

By SUSAN ALT

CHICAGO—In a highly critical dissertation on the property-liability insurance industry and its regulators, Massachusetts Institute of Technology professor Paul L. Joskow calls for:

- elimination of rate-setting procedures;
- regulatory changes which would encourage creation of better risk classes, so fewer "shortage" situations would occur;
- regulators to fulfill roles as consumer protection agents;
- mandatory insurance against bankruptcy for all insurance companies;
- elimination of barriers to direct writing, speeding up the transition away from use of agents wherever possible.

Mr. Joskow, an assistant professor of economics at MIT, believes in open competition on rates, and commended California for paving the way for open rating. California has now been followed by New York, Illinois, Florida, Ohio, Connecticut and Indiana, he noted.

HE DOES NOT like the American Agency System.

Nor does he believe regulators have done the most effective job of aiding and protecting consumers and stimulating insurance company competition.

Mr. Joskow's research paper was delivered last fall at a Dartmouth seminar on regulation and public utilities. It subsequently appeared in the Bell Journal of Economics and Management Science, published by American Telephone Telegraph Co. (Reprints are available.)

Without going into the details of Mr. Joskow's lengthy analysis of the property-liability marketplace, complete with complicated formulas, he concludes among other things that "the property insurance industry has all of the structural characteristics of a competitive market." Mr. Joskow believes that this makes any kind of rate-setting regulatory mechanism unnecessary, and that, indeed, such rate regulation may even impede competition.

"The argument has been that rate making in concert through rating bureaus is a necessity to insure the public and the industry against 'destructive' competition and large numbers of bankruptcies," he points out. "There does not seem to be any reason why this industry should be more unstable than others as long as fraudulent practices are guarded against and proper consumer information is provided for," he rebuts.

California's no-filing, or open rating, regulatory statute has operated effectively since 1947 and takes the speculation out of such a suggestion, Mr. Joskow states. The California commissioner functions mainly as the overseer watching to see that "the free market works . . . as the regulator of prices."

THE PRIOR approval regulatory process employs a meaningless profitability criterion which does not necessarily "protect" consumers, Mr. Joskow contends. To the contrary, he goes on to say, "regulatory commissions have given only limited recognition to (the) consumer information problem. Under the prior approval system, regulation seems more concerned with making sure that rates are 'adequate' than with encouraging consumers to take advantage of lower rates where available."

New York, he notes, was one of the first states to recognize only recently that publication of price differences between insurers is essential for an open competition system to work "in a way which would promote 'adequate' and not excessive insurance prices through competitive market forces."

ALONG WITH a recommendation that the prior approval rate regulation systems be abolished, replaced by no-filing open rating systems, Mr. Joskow suggests that state insurance departments shift to a role as providers of consumer information and consumer protectors. "The greatest possible amount of price information should be put into the hands of consumers," he says. "Handbooks listing representative rates for all major underwriters should be provided," he urges.

Furthermore, state insurance departments should continue performing regular audits and enforcing minimum capital requirements, as well as mediating consumer complaints against insurers "and by publicizing the names of companies which have consistently poor payoff policies," Mr. Joskow believes. He also believes the consumer protection function should include standardization of basic policy forms and contract provisions.

But Mr. Joskow suggests that all underwriters be required to carry "complete insurance against bankruptcy."

Bankruptcy rates should be geared to the insolvency risk of the companies themselves as determined by semiannual audits of their operations, says Mr. Joskow, to encourage insurers to maintain reasonably healthy risk-loss ratios. Such "insolvency insurance" with flexible rates would be better than any state fund, he says.

THE INSURANCE regulatory process has been the primary cause of supply shortages, says Mr. Joskow, and the additional factor of inadequate risk classes has meant that there are sometimes shortages of supply of insurance at the same time there is excess capacity.

"The contention here," he explains, "is that supply shortages exist because regulatory authorities have refused to allow the creation of enough truly homogeneous risk classes. Rates determined on the basis of average historical losses for a particular class may be profitable for a 'typical' risk.

"However, as long as risk classes are not homogeneous from the viewpoint of insurers, and insurance underwriters can differentiate between 'good' risks and 'bad' risks within a particular class, no risk will be treated as 'typical,'" he reasons. "On the contrary, most insurance companies will attempt to insure the good risks first and may or may not insure the bad risks."

For the American Agency System of delivering the insurance product, Mr. Joskow has no love. He sums up his views with the analysis that the agency system is "extremely inefficient, costing consumers hundreds of millions of dollars per year."

"The social costs of current laws forbidding agency companies from writing existing

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Monitors on fuel shortage and its effects to continue

ATLANTA—The chairman of the energy crisis task force of the National Assn. of Insurance Commissioners took issue recently with claims by the insurance industry that the fuel shortage is ended.

In an industry advisory committee report to the task force, the insurance industry took the position that the energy task force is no longer needed and should be discontinued as soon as possible because the gas shortage is over.

NAIC vp Johnnie L. Caldwell, insurance commissioner of Georgia, however, as chairman of the task force, said "We do not believe, according to our information, that the oil crisis is over as the report argues. We still find gasoline shortages in many areas."

HE ALSO took issue with the auto insurance industry's stand that it will not have windfall profits because the declining number of claims could be offset by increased accident severity.

"We told the advisory committee that we did not believe the fast-track monitoring system and the task force's monitoring job have run a proper course at this time. In the future we will re-evaluate it, yes, but at this time we do not feel it should be disbanded," Commissioner Caldwell stated.

The figures on which this opinion is drawn are inconclusive and may reflect accidents from before the height of the energy crisis, because of a lag of up to six months, Mr. Caldwell added. His feeling is that claims statistics for the months during the height of the energy crisis actually reflected accidents which had occurred in the summer and fall of 1973. Mr. Caldwell expects that with the extension of the NAIC task force, evaluation of accidents and claims arising out of the critical November through January period will occur when the next report is issued about May 15.

So far, only two state commissioners have demanded that underwriters lower auto insurance rates as a result of fewer accidents and deaths during the energy crisis. Oklahoma and Rhode Island rates were lowered

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Critic . . .

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customers should be more thoroughly studied and an equitable scheme for phasing out independent agents devised," he suggests. "The need for the independent agent per se appears to be nonexistent," he declares. He believes that agent associations should be prevented from taking any action against insurance companies which attempt to switch to direct writing.

Mr. Joskow defines the costly and unnecessary independent agent as one who derives his income from commissions on policies actually sold. "There is no reason to believe," Mr. Joskow states, "that truly independent insurance consultants, charging fees directly to customers with insurance problems, would not thrive with the elimination of the agency system," a healthy sign since "the choice would then be left to consumers, and fees charged would not necessarily be tied to premium volume generated."

MR. JOSKOW criticizes agents for being poorly trained and lacking day-to-day experience in handling tricky insurance problems, rendering them unable to provide the specialized insurance counseling sometimes called for, and often used as an argument for retention of the agency system. "The kinds of things which the small independent agents handle well are the standard recurring day-to-day insurance coverage applications," and these are precisely the things direct writers do well, says Mr. Joskow. "That agent often does little more than fill out a preprinted form and act as a go-between for the customer and the insurance company," he adds, describing this middleman function as "redundant" in today's insurance market.

As a sales person, the agent has had little incentive to obtain the best coverage at the best price for a customer since his commission usually varied directly with the size of the premium. Mr. Joskow is critical of this failure. "This is less of a problem for large customers since there is some competition among agents for customers' business," he goes on to note. "Even here information imperfections probably keep the market from working very effectively," though, he concludes. ■

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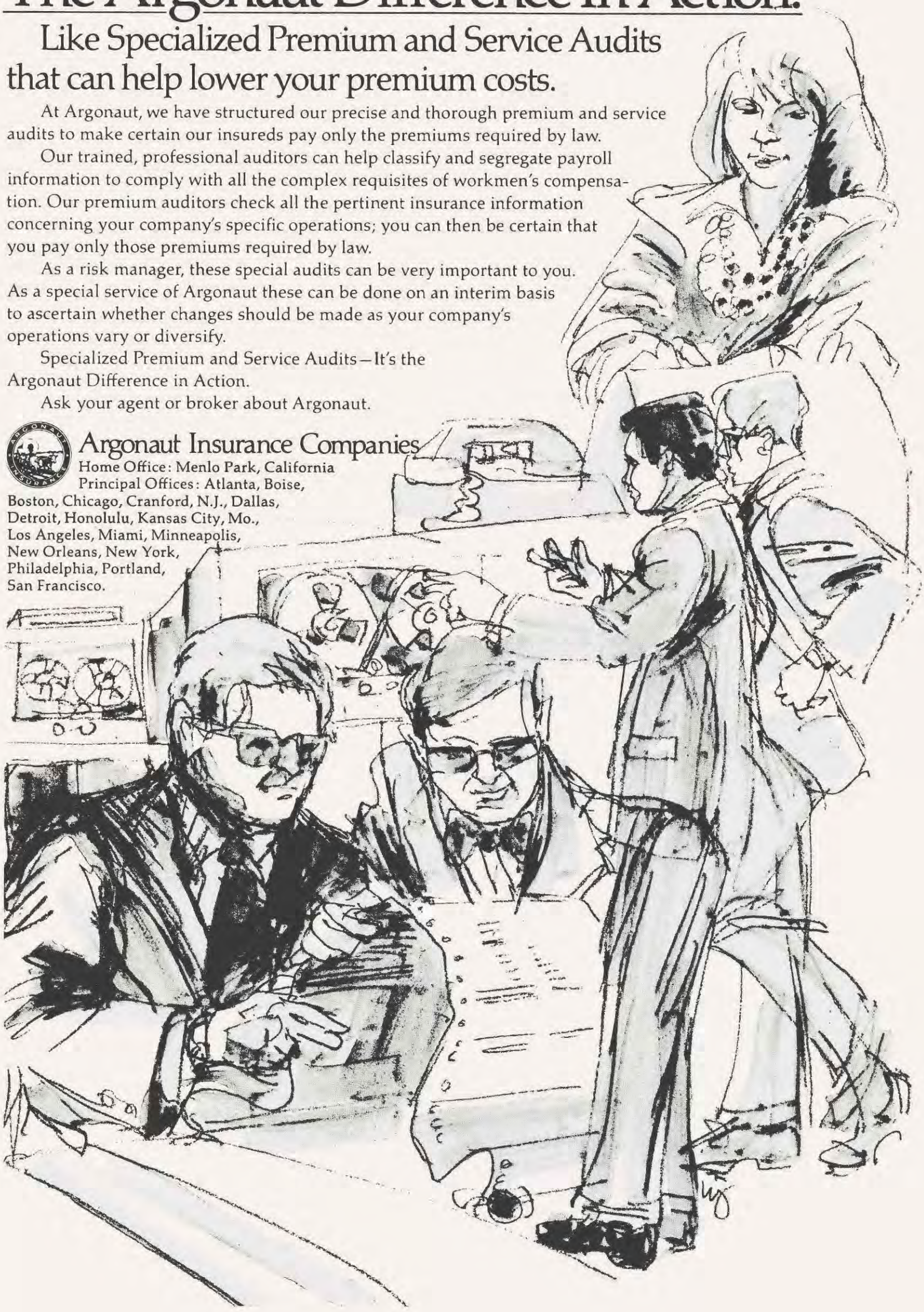

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business insurance PERSPECTIVE

State regulations needed for insurance mass-marketing ads

"I adopted stringent rules and regulations after a public hearing reguiring full disclosure of all information in the advertising and sale of health policies."

Thomas D. O'Malley

By THOMAS D. O'MALLEY
Insurance Commissioner and Treasurer
State of Florida

APPLICATIONS AND ISSUANCE of insurance policies sold by mass marketing methods in Florida must be taken by and delivered through a licensed agent or solicitor. This gives the commissioner better regulatory control over the actual sale to Florida consumers. It also prevents the insurance transaction from being totally completed through the mails.

A couple of years ago Florida, like other states, was saturated with the marketing of accident and health insurance through the mass media. Advertisements offered a myriad of hospital policies with low down payments and six or seven figure benefits when a person became hospitalized. Inquiries and complaints to our 21 consumer service offices mounted side by side with buyer confusion, mostly from senior citizens who could least afford to purchase insurance without full disclosure of the restrictions as well as the benefits.

An immediate result was that legal proceedings were instituted against a company and a well known television artist who was found under Florida law to be soliciting insurance without a license.

A long range result was the beginning of health insurance reform in Florida. Companies were required to refile more than 50,000 previously approved individual health insurance forms, many outdated and unused, for a complete review and comparison of benefits and exclusions. We issued guidelines and any policy forms sold in the state after January 1, 1973 had to conform with guideline standards.

SHORTLY THEREAFTER I adopted stringent rules and regulations after a public hearing requiring full disclosure of all information in the advertising and sale of health policies. These spell out the standards required to protect the consumer of health insurance mass marketed through the news media. For example, companies cannot compare unlike policies, make incomplete or unfair comparison of policies, or offer reduced or deviated initial premiums. Negative features such as two-year waiting period must be stated as prominently in the ad as favorable aspects of policies offered.

Life insurance rules, similar to the health rules, also adopted after a public hearing, established for the first time in Florida guidelines regulating advertising of life and annuity contracts, including prepared sales talks by agents.

Currently, insurance department analysts are making in-company examinations of 11 health companies to review their claims-handling and advertising practices. These companies had the largest number of complaints registered against them by policyholders during 1973.

I am also asking the 1974 legislature to take a hard look at policy benefits and premium charges. One proposed bill would give me, as insurance commissioner, the authority to adopt rules that would establish minimum standards for the benefits offered in individual and family coverages. Another would allow the commissioner to establish definitions for "excessive, inadequate or unfairly discriminatory" applicable to accident and health insurance rates. A bill, which was also introduced last year, would establish a post-assessment life and health guaranty fund to protect Florida insureds should a company become insolvent. We have such a fund for property and casualty companies which includes automobile insurers, and it is only fair that people should also be protected for possible failures of life and health companies as well.

OTHER PROPOSED legislation would provide additional benefits to employes under life and accident and health group contracts. Insurers replacing such contracts would be required to assume cover-

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Nuisance, nonsense, necessity: All can characterize regulations

"There is no doubt but that the primary purpose of regulation is the enhancement and preservation of the financial stability of insurance companies . . ."

BY FRED A. MAUCK
Director of Insurance
State of Illinois

INSURANCE REGULATION. Is it a necessity, a nuisance, or nonsense? I am suggesting that insurance regulation is all of those things. It is a necessity because insurance indeed has become indispensable in our complex society. It is a nuisance because the thrust of regulation often is misdirected or misapplied. And it is nonsense because certain essential economic relationships that may have a significant impact upon policyholders and security holders are not regulated at all.

There are, I believe, serious problems with insurance regulation as it is accomplished in every state in this country. Some of these problems are the result of not understanding or incorrectly defining the purpose of regulation. Some are attributable to archaic and deficient statutory structures within which regulation must be accomplished. And some are caused by the sheer inadequacies of insurance departments.

If you refer to any general text on insurance, you will find under the section dealing with regulation a statement that the basic purpose of regulatory activity is "to protect the policyholders." And you will discover that the textbook goes on to say that this protection is accomplished principally by way of financial examinations of insurance companies that are designed "to prevent insolvencies." I find that characterization of insurance regulation to be curious—and misleading. There is no doubt but that the primary purpose of regulation is the enhancement and preservation of the financial stability of insurance companies, and for a very good reason. The insured—the consumer—pays his money to the insurer in return for a promise to pay the insured or his beneficiary upon the occurrence of a loss or the happening of an event in the future. If the insurer is financially unable to keep that promise when the loss or event occurs, the essence of insurance is defeated and the economic stability that insurance supposedly affords is eliminated.

HOWEVER, THE REGULATORS—and the insurance industry and some insurance scholars—have oversold the scope and ability of the regulatory apparatus to protect, by stating that the purpose of financial examination is "to prevent insolvencies." The simple fact is that no insurance regulator can prevent company insolvencies, nor can he insure against insolvencies. The very best he can do is to detect impairment or insolvencies relatively soon after they occur and then take appropriate action to mitigate against losses by policyholders and company auditors and, secondarily, stockholders.

I will readily admit that it would be possible to structure a system where a business failure in the insurance industry would be an impossibility, but such a system would drastically alter the private enterprise philosophy that presently underlies insurance regulation and would undoubtedly involve governmental financial guarantees. I do not propose any such alteration—I do not believe in its presumptions—but I do suggest a strong necessity for every regulator to appraise candidly his ability, both in terms of statutory authority and practical capacity, to engage in the effective regulation of company financial affairs and protection of consumer trust. I believe that this kind of an appraisal produces these results.

First, the statutory authority of the regulator over company financial affairs does not permit his intervention in the conduct of the business operations until the company is in the red—or, at least, very near the red. In either case, the damage has been done long before the regulator is given authority over the problem. This is particularly inappropriate in view of the development over the past few years of relatively sophisticated financial testing techniques that can fairly accurately identify a company that is headed for trouble.

Second, the traditional means of monitoring the financial affairs of insurance companies—the triennial departmental examination—is outmoded, ineffective, and inefficient. The odds are against a triennial "head-to-toe" examination being

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business insurance PERSPECTIVE

Regulations...

Continued from preceding page
age of all certificate holders without evidence of insurability. An employe could also convert his coverage to individual status under certain conditions.

Under Florida law only bona fide groups of employes can be insured under group contracts as groups are prohibited from being formed solely to gain a reduction in premium or preference in coverage.

Meanwhile two years ago I issued guidelines interpreting mass merchandising of property and casualty insurance as the sale of insurance to a group of people when individual underwriting is permitted and premium reductions are allowed based on a reduction of expenses. This includes wrap-up insurance plans.

Advertising and solicitation materials must contain at least in substance the following statement: "The reduced rates at which this insurance is sold are based upon expense savings and not membership or employment in any group or organization."

If the plan uses dividends, a statement must be included that "dividends may not be guaranteed."

Mass merchandising of policies in Florida must be sold under the direction or through a licensed agent or solicitor. A full disclosure of all features of the insurance plan must also be made to these prospective insureds.

Interpretative guidelines were issued on group merchandising of automobile insurance only allowing a reduction in cost because of expense savings as well as expected loss savings. Every member of the group is automatically eligible for insurance. An employer, under a true group plan, may contribute to the premium based on one vehicle or some other such fact. However, group automobile insurance may not be sold when its purchase by the insured is contingent upon the purchase of some other type of insurance, product or service.

"Under Florida law only bona fide groups can be insured under group contracts as groups are prohibited from being formed solely to gain a reduction in premium . . ."

MY STAFF IS IN the process of revising these guidelines, clarifying them and adding two new ones. These should be finalized in the very near future.

In Florida, state employes are covered through payroll deduction under a comprehensive basic hospital and major medical policy with maximum benefits up to $200,000 per individual. Rather than a self-insured plan, the group is underwritten through a commercial carrier with the state paying a portion of individual policy premiums.

Individual employe automobile insurance is also available under group plans of commercial carriers for agencies or departments within state government, also through payroll deduction.

On the other hand, fire insurance on state buildings and contents, the state's fleet liability insurance and workmen's compensation are all under a self-insured type plan.

The division of risk management handling this operates much like an insurance company. It operates funded self-insurance programs for workmen's compensation on state employes, fleet automotive liability insurance on the state's owned, nonowned and hired vehicles, as well as fire and extended coverage on all state-owned real and personal property and some rental insurance when required by the mortgagor.

The Florida Casualty Insurance Risk Management Trust Fund, created by the same legislature, self-insures casualty coverages. The old Florida Fire Insurance Trust Fund that for many years insured state buildings and contents against fire was absorbed by the new risk management division.

A loss prevention bureau coordinates loss prevention programs throughout state government and should serve to reduce losses consequently reduce the cost. ■

Thomas D. O'Malley was inaugurated as treasurer of Florida in Jan., 1971. In that position, he also serves as state insurance commissioner and state fire marshal. Prior to his election Mr. O'Malley served two terms on the board of commissioners for Dade County. He also served as vice mayor.

Nuisance . . .

Continued from preceding page
adequate to detect serious disease in a human being in time to save his life. And it most certainly is not adequate to discover terminal financial problems within a business enterprise. This is especially true when that examination fails to explore one of the fundamental life support systems. Yet, in the case of insurance company examinations, it has been the practice to audit around the company computers, not through the computers. Over the past year, the Illinois department made a decisive breakthrough in preventive financial medicine. One of our new procedures involves usage of a computer software audit program that will permit us to audit the computer system itself rather than auditing the computer's print-outs. Another requires the performance of a thorough, competent audit by a qualified independent practitioner at least once every year.

THIRD, IN ORDER TO carry out the responsibility to monitor company financial affairs, the regulator must involve himself in more than financial reports and balance sheets. For this reason, such matters as entry into the market by new companies and new investment groups desiring to form companies have been subject to regulation. At the same time, insurance codes have been structured so as to remove from the regulator's jurisdiction indirect actions that can produce the same potentially adverse consequences as regulated direct actions. An example of this can be found in the Illinois Holding Company Act for insurance companies, which essentially is the same as the model act formulated by the National Assn. of Insurance Commissioners.

Although that act gives the insurance regulator some authority over the insurance holding company structure, and particularly over changes in the ownership of the holding company which, in turn, owns the insurance entity, the act provides that the regulator has no authority over the ownership of the holding company if it "is either directly or through its affiliates primarily engaged in business other than the business of insurance." If there is any merit in attempting to restrict or control entry directly into the insurance business, it is ludicrous to have a loophole large enough to accommodate a Mack truck that effectively removes the exercise of such control from the regulator.

As important and as fundamental as financial regulation may be, there is another basic purpose of insurance regulation that remains somewhat ill-defined but has gained widespread public attention over recent years. This function of insurance regulation has to do with the business relationship between the policyholder or prospective policyholder and the insurance company. Its goal is to produce some sort of essential fairness or equity in the insurer-insured relationship. This concept of promoting fairness has resulted in statutes and regulations establishing minimum standards for the handling and disposition of claims, "codes of conduct" for the advertising, solicitation, and sale of insurance and other trade practices, rate regulations to establish the premium cost of property and casualty insurance, and various programs attempting to find a way to make "essential" types of insurance available to persons that the private segment deems uninsurable, such as the automobile insurance assigned risk plan and the fire insurance FAIR plan.

"Some regulatory efforts are diametrically opposed to the purpose of promoting company financial integrity, and some . . . have produced unexpected side effects that are not in the best interests of the public . . ."

As commendable as many of these programs and regulations may be, there is no underlying rationale to these attempts to promote fairness. Perhaps even more important, some of these regulatory efforts are diametrically opposed to the purpose of promoting company financial integrity, and some of these efforts have produced unexpected side effects that are not in the best interests of the public and, particularly, insurance consumers. Rate regulation is an example of a conflict between the principle of financial solidity and the principle of price fairness or reasonableness. If the price level is squeezed or held down, financial stability may be affected. If prices are allowed to move upward to counter faltering financial stability, price reasonableness may be sacrificed.

CREDIT LIFE INSURANCE regulations establishing a maximum "commission" to the group policyholder (the financial institution or the retailer), and regulations establishing maximum first-year commissions to an agent, are examples of fairness-motivated rules that had unexpected effects. In both instances, the maximums soon became the marketplace minimums, thereby producing sanctioned levels of compensation that were anticompetitive and detrimental to the interests of the intended beneficiaries of regulations, the insurance consumers.

LEST I GIVE THE impression that all efforts in the area of promoting fairness miss their mark, let me relate some examples of new initiatives within our department that I believe are on target. We have formulated comprehensive claims practices rules for the handling of automobile insurance claims. These rules were the result of a two-year study of the actual practices of insurers and establish as minimums those practices and procedures that were being followed by companies that were treating their policyholders and claimants fairly and considerately. Our existing regulations for health insurance advertising and our proposed rules for life insurance advertising and solicitation are designed not only to eliminate deceptive and misleading practices, but also to promote disclosure of relevant information in an understandable fashion.

EVEN IN THE CASE of well-founded fairness rules, there are inherent limitations as to their effectiveness; limitations that are the result of the relatively small size of insurance departments compared with the hugeness of the insurance industry. As a consequence, every insurance regulator must engage in selective enforcement and, to a great extent, his success in promoting industry-wide fairness turns on his skill in selecting targets.

My discussion to this point has been simply a brief—and somewhat oversimplified—description of existing patterns and problems of insurance regulation. I would now like to turn to a consideration of changes in the nature of insurance regulation that I believe must come about if the basic purposes of regulation are to be promoted effectively.

First, I think the regulator must begin to promote a competitive marketplace for the insurance business. Instead of utilizing the present theory of third-party judgmental determinations as to appropriateness of marketplace conduct, the regulator, and the underlying statutes that give him authority, should adopt a theory that allows basic determinations to be made in an open, competitive market. The key to this kind of a change lies in formulating disclosure rules that will provide the insurance consumer with enough basic information and knowledge about insurance companies and products to allow him to exercise informed judgment in making an insurance purchase.

Too many persons simply do not understand even the basics about insurance, and too many persons simply have no concept of how to go about comparative shopping for insurance. Our forthcoming buyers' guides and our life insurance disclosure regulations are steps toward implementing this new approach.

I DO NOT WANT to give the impression that informational techniques can replace all standards presently found in insurance codes. Many of these standards are absolutely essential. But, I believe that a new mechanism must be found to enforce those standards. At the present time, the insurance regulator is the only person who can require compliance with those minimum standards of business conduct. The most efficient and effective means to accomplish compliance is by creating private causes of action so that the consumer or claimant who has been wronged by the action or inaction of a company or its representative can obtain an appropriate remedy. My second suggested change, therefore, is to provide private remedies, as well as regulatory authority, in insurance codes.

As I survey the activities of insurance regulators in all states, there are indications that these two new directions are emerging. Insurance departments are providing more information about companies than ever before, and, as a result, competition within the industry is becoming more keen. The idea of private remedies is reflected in some no-fault acts, where interest penalties or treble damages are provided in the event the insurer does not promptly pay a bona fide claim. I believe that the next several years will see increasing utilization of these new theories of regulation in all states. And one thing that I am quite sure about is that you will definitely see them in Illinois. ■

Fred A. Mauck was appointed to the office of director of insurance for Illinois on February 15, 1973. Prior to that, he was an attorney, practicing primarily in the areas of real estate and general corporate law. Mr. Mauck received his B.A. from Trinity College and his J.D. from the University of Chicago Law School. He is a member of the American Bar Assn., Chicago Bar Assn., and the Chicago Council of Lawyers.

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london line

Kidnap-ransom cover becoming a normal part of business at Lloyd's

LONDON—World-wide kidnap-ransom risks are now being handled as readily and efficiently as war risks at Lloyd's. Some Lloyd's underwriters are regularly making markets in this kind of coverage in the busy market.

Premium income from ransom cover runs into millions of dollars a year. And much of the business comes from leading U.S. industrial, commercial and professional corporations, *Business Insurance* learned.

Over 10% is being placed through one internationally-known firm of Lloyd's brokers, with a worldwide reputation for placing aviation, marine, banking and other specialized risks.

This particular broking group is reluctant to be named because of the "low profile" it feels should be maintained over this kind of coverage. But the group is known to be placing up to $5 million coverage on any one loss and $10 million annual aggregate for multinational organizations.

Rates for the cover vary according to the area in which covered corporate executives are traveling, or are located, for their firms.

The basic situation in the London market seems to be that top brokers are prepared to meet any requests from regular clients for kidnap-ransom cover, as a normal part of their business.

But they emphasize that there is no question of "gambling on human lives", or of having any dealings with kidnappers so as to make extortion demands more frequent than they already are.

MOST UNDERWRITERS take the view that the main purpose in the design of coverage against political risks must be to provide protection for the assured against any perils excluded from all-risk policies provided by the underwriter concerned.

Lloyd's feels that knowledge of kidnap policies might increase the risk.

But as long as governments of any countries directly concerned do not object to this form of cover, underwriters are now satisfied that they are right to offer it to those who face such financial risks.

Losses to underwriters on policies outstanding are thought to be substantial. Many incidents which have never made headlines have ended in pay-outs by undercover negotiators for the corporations involved, which in turn lodged claims with Lloyd's underwriters, market sources said.

Demand for this class of business, in which many major U.S. firms have shown interest, will continue to increase as long as the risk of political extortion exists in any corner of the world.

The U.S. domestic market is participating to an increased extent in the KRE (kidnap/ransom/extortion) marketplace, sources have indicated. Indeed, one authoritative source told *Business Insurance* that an estimated 50% of current kidnap-ransom business is being handled in the U.S.

But the London market, and particularly Lloyd's, will benefit if the U.S. market keeps on growing, according to this source, who suggests that some American insurers are already looking into reinsurance facilities in London.

Overall, the market is extremely fluid and further big developments can be expected.

STEPHEN MERRETT, a leading war risks underwriter, recently told the London Insurance Institute: "Owners and operators of aircraft are entitled to such protection as we can provide. There is no reason why underwriters at Lloyd's should not provide ransom cover for airlines as long as proper legal safeguards are adopted.

"But they should bear in mind that cover which is too easily available for too large an indemnity is likely to encourage the commission of crime.

"They should not allow themselves to be placed in an active or decisive position in the event of a threat of this type, but should merely wait on the assured's best endeavors to resolve the situation, whether in the event of a hijacked aircraft this ends in claims for damage or ransom, or hopefully to the aircraft being returned without damage," Mr. Merrett said.

* * *

TWICE IN THE past year the two societies which give British doctors effective self-insurance against medical liability claims have found themselves in a tussle with U.S. courts.

One case involved a woman who sought $300,000 damages in New York state after slipping on the deck of a cruise liner. The second involved a woman who brought a product liability suit against two pharmaceutical firms in the U.S. over their birth control pills.

The outcome illustrates the way in which medical men in Britain react to negligence lawsuits.

The woman who sued for $300,000 brought her action for pain and suffering, but the Medical Defence Union in London felt the damages were too high so it broke its rule of not becoming involved in U.S. litigation and entered a defence to the claim. The claim was finally settled by the shipowners without the union's consent, however, so that the shipping company bore all the legal costs.

Also, when the Medical Protection Society found that two leading British doctors were being asked to testify in a U.S. court as expert witnesses on the birth-control pills, it claimed they should be exempted as equally good evidence could be obtained in the U.S. and that a serious breach of confidence might be involved. It won its case under a 117-year-old English law which allowed the expert witnesses to point out they were not parties to the lawsuit.

Both these organizations have been in existence for many years

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to protect doctors against professional liability lawsuits. But they are facing rising costs, and at least one of them has been forced to review its arrangements with corporate reinsurers.

Since 1971 the Medical Defence Union, with more than 72,000 members, has been reinsured only with Lloyd's and is responsible for substantial sums before the benefits of the Lloyd's policies become available. The amount outstanding in this connection at the end of 1972 was $1.2 million. The Union's substantial assets allow membership fees to be only $60 a year for worldwide cover except for the U.S.

The Medical Protection Society has more than 57,000 medical members with much the same subscriptions.

* * *

J. H. MINET, a leading Lloyd's broker, introduced a personal insurance policy covering accidental death or dismemberment of airline passengers involved in skyjackings.

The coverage, which is based on a no-fault concept, is purchased by individuals traveling out of Britain on international flights. The policies are being sold at desks in Heathrow and Gatwick airports, lasting for the duration of a journey.

The coverage, underwritten by Lloyd's, was added to the personal travel accident insurance policies as a result of Minet's finding that many travelers were asking whether in-flight insurance covered hijackings, said John Howes, aviation director at Minet, who noted that these are personal accident policies.

"There is no question of the policy being used for payment of ransom demands," he said. "Travelers or their dependents retain legal rights to sue airlines for damages if they are involved in any catastrophe."

Minet may start offering similar coverage for sale at Far East airports, but has no present plans to enter the U.S. market with the broader insurance, *Business Insurance* learned.

Skyjacking coverage is included with other benefits in the overall policy, and it is not treated as a special risk. These policies cover death or injury while in transit, including any death or injury resulting from a hijacking. War risks are excluded. The policies also provide up to $250 for miscellaneous expenses resulting from hijackings, such as loss of travel amenities.

* * *

PAINTINGS STOLEN in the $20-million art robbery from millionaire Sir Alfred Beit April 26 have been found safely by police after checking rented homes in Cork County, Eire. Insurance companies who had offered a $240,000 reward for them refused to pay ransom demands by IRA sympathisers. Detectives have preferred charges of theft against militant Bridget Dugdale, a doctor of philosophy, who was arrested for explosives and arms offences in the area.

The paintings include works by Vermeer, Goya, Velasquez and Rubens, and were traced to a cottage which the woman had used. Decisions over who gets the reward will be made later, as normally police in Britain are not permitted to receive money for recoveries made in the line of duty.

* * *

MANAGEMENT OFFICIALS are being advised to control fire risks more effectively in Britain, where fire losses last year rose to the record peak of $440 million.

John A. C. Greenwood, chairman of the Fire Protection Assn. told *Business Insurance*: "Inflation and the growth in sophistication of industrial processes, which involve more use of energy, are factors which have led to this rise.

"Need for fire prevention is not restricted to Britain. The F.P.A. is expanding its activities in Europe and elsewhere, and we want to play a greater role in developing the concept of fire protection. But only management can control its own fire risk."

Chemical plant fires tripled in damage cost to $30 million, so special seminars are being held for the industry to advise on how to combat fire and explosive perils.

* * *

MAJOR CAUSES of plant injuries are to be checked in a special four-month campaign throughout British industry by the Royal Society for the Prevention of Accidents.

The society will compile a list of reasons for many of the 250,000 injuries suffered annually by employes, and will focus risk management attention on how to prevent them.

According to its latest survey, more than 50% of industrial injuries among plant operatives can be blamed on four simple mistakes which ought to be easily rectified.

They are respectively: personnel falling while at work, people stepping on, or striking objects, accidents caused by falling objects and materials, and accidents caused in the handling or lifting of products. The theme of the campaign will be: "Safety standards must not be allowed to drop." ■

Premiums down 3.8% for miners

HARRISBURG, PA.—Insurance commissioner William J. Sheppard approved an overall 3.8% premium decrease for the Coal Mine Rating Bureau of Pennsylvlania. The bureau represents 21 insurance companies.

At the same time Commissioner Sheppard announced mine operators will receive a weekly wage benefit increase to $159 from $150. If the benefit increase had not been granted, the commissioner said, the premium decrease would have been larger.

THE PREMIUM decrease will save mine operators about $326,000 in 1974.

Most workers will receive a premium decrease, he explained, but there will be some increases in a few of the rates. The largest increase is 2.48% in the bituminous mining classification and the largest decrease is 16.23% in the surface mining culm and coke classifications.

"Coal mine operators can realize even greater savings by setting up and maintaining sound loss prevention programs. Those operators with rates based on loss experience can receive much lower rates by running safe mining operations," Commissioner Sheppard pointed out. ■

Hall to consolidate

Frank B. Hall & Co. Inc., New York, said it is embarking on a program to create a holding company with four major subsidiaries. One subsidiary will be a retail insurance brokerage company with forty branch offices. Another is the group of specialty companies providing insurance services. The third is the international division and the fourth will be the reinsurance division, which will be expanded.

Attorney foresees subrogation in work comp broadening exposures

LOS ANGELES—Subrogation, the legal right of the employer and his carrier to sue to recover funds paid out in settlement of a workmen's compensation case, could eventually result in a vastly broader base of exposure in these cases, according to Herbert Lasky, an attorney who spoke here at the Accident Prevention Symposium.

He said the California Labor Code details a variety of methods which an employer or workmen's compensation carrier can use to recover losses in workmen's comp cases if it can be proven that the accident was the responsibility of a third party.

"IF IT SHOULD happen that an employer had no accident except those which were shown to have been caused by a third party that employer can boast an accident-free record in workmen's compensation cases," he explained.

For this reason, he said, it is vital that employers instruct workers who investigate accidents to write accident reports that take note of product claims that can be used in subrogation cases.

Mr. Lasky further noted that under the law of strict liability, the only type of contributory negligence which could prevent an employer or his carrier from recovering occurs if the third party can prove that the employer willingly assumed the risk that resulted in the accident in question.

THIS IS NO simple task, the attorney indicated. "It means that the third party must prove that the employer was aware of a specific defect and that that defect, in turn, created the danger that resulted in the injury.

"The employer's knowledge of product claims can be crucial in these cases," he underlined.

Outside of cases involving subrogation, Mr. Lasky speculated that CAL-OSHA may eventually eliminate the charge of serious and willful misconduct that can be made against an employer in workmen's compensation cases "because of the agency's requirement for posting of information to employes and otherwise facilitating the investigation of employe complaints."

This could make the claim that an employer knowingly maintained unsafe conditions virtually obsolete, he contended. ■

Doctor fees to rise slowly after controls

CHICAGO—Ned F. Parish, president of the national association of Blue Shield plans, said he believed physician fee increases would be held down through voluntary efforts after wage-price controls were ended April 30.

"Our actuaries are expecting physician fees to increase 4% to 5% on an annualized basis," he commented. "We know this is less than what others are predicting, but physicians are being asked to show self-restraint, and we believe they will."

MR. PARISH said the Blue Shield plans are offering their assistance to medical organizations and added, "we believe that physicians will work with us to achieve our mutual goal of containing the cost of medical care within reasonable limits."

Congress' lifting of the wage price controls was welcomed by the health care community "as well as most other segments of society," the Blue Shield president stated. Physicians' fees are now expected to undergo "an initial round of increases" but he added that "we expect them to level off during the course of the coming year."

The expected jump in fee levels is due to a doctors' restricted fee increase of 2.5% under the Economic Stabilization Act, Mr. Parish noted. Inflation in general, he observed, climbed at a much steeper rate during the wage-price controls.

KEEPING DOWN the fee increases will be no easy feat, Mr. Parish added. "In effect, the demise of the Economic Stabilization Act will lift the lid on a Pandora's box of economic unknowns that we must now deal with."

A spokesman for the American Medical Assn. told *Business Insurance* that it too has recognized the impending problem of controlling the increases in physicians' fees without wage-price controls.

"We have urged 'take it easy, you guys,' in our statements, the AMA spokesman quipped.

According to an AMA publication, doctors are being asked to raise their fees, if they must, using the consumer price index as an inflation guideline. Last year's consumer price index reflected an inflation rate of 8.8% ■

FMIC sees commercial mortgage cover growing

FMIC Corp., Greensboro, N. C., said its programs for commercial mortgage insurance have been growing, with lenders and purchasers of all types of commercial and industrial properties—shopping centers, free standing commercial buildings, factories, warehouses, hotels and office buildings—now insuring their mortgages.

Nationalization idea spurs insurance competition

TORONTO—Although the Ontario government here has said it presently has no plans to nationalize the insurance industry, Claude Bennett, the provincial minister of industry and tourism, suggested last week that even the vague threat of a potential takeover seems to inspire private carriers, agents and adjusters, to improve the competitive pricing and efficiency of services.

Mr. Bennett, a licensed though presently non-practicing independent insurance agent, noted that "the province of Ontario considers itself . . . among the most progressive jurisdictions in the insurance industry in North America. He made his remarks at the 12th annual American Society of Insurance Management conference last week.

"It appears possible, for example, that within the next year there may be no-fault automobile insurance here," he said, noting that no-fault has the backing of the Ontario law reform committee.

A FORM OF limited no-fault presently pays a death benefit of $5,000 to the surviving spouse and an additional $1,000 to each dependent under age 18, he added, with total disability payment up to $70 a week until the injured person can return to work.

Although auto insurance is not legally required, about 95% of Ontario's car owners are insured, with over half covered in excess of $100,000 and another 35% to 40% with $200,000 coverage, he noted. Drivers without insurance must pay $40 to a provincial fund when they purchase or renew their licenses, he added, with money from the fund used to reimburse up to $50,000 the victims of uninsured vehicles in cases where the driver is unable to pay. That driver's license is then cancelled until he makes a satisfactory arrangement to pay the fund, Mr. Bennett said.

Any person with a driver's license can get insurance in Ontario, with all insurance companies subscribing to an assigned risk facility for substandard risks, he noted.

"The same is true of fire insurance coverage, although hazardous areas and some classes of risks warrant a higher premium," he added.

Mr. Bennett cited agents' declining commission percentages especially in auto insurance as an example of the new competitive spirit in the industry, with "the commission on auto premiums reduced from 25% to 12.5% and in some cases down to 10% in the last 25 years, due largely to increased costs in material and labor and higher demands in court settlements."

AS A RESULT of public support for faster claims processing, adjusters now contact insureds and claimants within hours instead of days, Mr. Bennett said.

"In the past year, the agents' association has been setting up a consumer liaison telephone line in major centers throughout the province to provide free, professional insurance advice," he noted. "It is somewhat similar to legal aid but it is different in a very important aspect—it is conducted within an industry."

Each major community also has within its local insurance organization a consumer liaison committee which will follow through on the insurance problems called in on the telephone.

Because of the challenge of nationalization, "now more than ever, companies, agents and adjusters must offer the best of service at competitive rates or the consumer will demand that the government take action," Mr. Bennett concluded. ■

Val-U-Guard raises limits 3% quarterly

SAN FRANCISCO—A new commercial property endorsement was developed by Fireman's Fund American Insurance Cos. to keep policy limits "in step with inflation" and to eliminate coinsurance clause penalties.

Called the Val-U-Gard endorsement, the new program automatically increases policy limits by 1% to 3% quarterly and cancels out the coinsurance clause to provide 100% payment of all partial losses.

"If an insured buys a policy with the typical coinsurance clause," explains Fireman's Fund vp Richard C. Carniglia, "he has to keep coverage to the percentage stated in the clause, which could be 80, 90 or 100% of the actual value of the property.

"If he doesn't," Mr. Carniglia pointed out, "payment of partial losses will be reduced proportionately. That could work a hardship for the policyholder who can't order larger policy amounts every few months during periods of rapid inflation."

The Val-U-Gard endorsement does this automatically. Mr. Carniglia believes it is the only product on the commercial market that combines all the features needed to do the job successfully.

The insured and the underwriter must establish three values when the new Fireman's Fund endorsement is issued: value of the insured property; ratio of insurance to value; and the quarterly rate of automatic policy limit increases (between 1% and 3%) to keep up with the rate of inflation. ■

letters

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from our office.

The assertion that our participants somehow represented the cream of the crop is simply not true. As an example, 21% of the Fortune 500 companies responded to our survey, and that 21% sample included 18% of the companies in that listing that operated in the red in 1972, and that 18% accounted for 26% of the total red ink involved. Other checks indicate that the 1973 Wyatt survey included a proportionate share of losers as well as winners. It is not true that companies in receivership are excluded per se from the survey —we have means of communicating with the receivers and as a matter of fact one of the major bankruptcy situations has responded to our 1974 survey, now in process.

The statement that our questionnaire may have been completed by someone unaware of claims made is an insult to the principal financial officers of the participating firms, to whom the questionnaires were mailed, and the risk managers to whom these questionnaires were most frequently referred. I am sure that Mr. Pachner is aware that the D&O policy covers claims made during the policy term, and not occurrences taking place during that term. Our survey sought information on the same basis, and surely the principal financial officer and the risk manager would be aware of claims made, even if not aware of an occurrence which may give rise to a later claim.

It is true that there is a long tail to pay out on D&O claims, leading to difficulty in establishing reserves. As a matter of fact, this slow payout means greater profitability to underwriters. Assuming a 6% investment return, the payment of 25% of the premium in taxes, commissions and underwriting expenses at inception of the policy, and the payment of 75% of the premium in losses and adjustment expenses spread out evenly over the six following years, underwriters would make a 19% profit on a combined loss and expense ratio of 100%.

IN ANY EVENT our survey report did not attempt to determine the past loss ratios of underwriters. That is information which only they can determine, and which they still have decided not to release. Our projections were aimed at determining the loss ratio projected by the average premium levels reported on current policies, loss frequencies, and average ultimate level of loss cost. We felt that corporate executives are much more interested in the propriety of current premium levels than in past history of underwriters. By Mr. Pachner's own letter, he admits that underwriters substantially increased rates in 1969 and have experienced favorable (undisclosed) loss ratios since then. If premiums are now reduced by competition from new markets, an appropriate balance will have been restored.

I share Mr. Pachner's view that cut-throat competition may result in market instability. One of the best means of avoiding such cut-throat competition would be by such influential brokers as Mr. Pachner joining in pressing for underwriters to release appropriate loss data, again without violating confidences by reference to individual cases. Then the market can properly judge correct premium levels.

The release of aggregate loss and premium data would not be of significant value to plaintiff's attorneys as alleged by underwriters, or at least it would surely be of far less value than the effect on the public climate of the scare tactics of many brokers and companies in selling D&O insurance.

A better course than truly drastic further cutting of D&O premiums would be the development of clearer and more definitive policy wording, and such improvements in coverage as a counterpart to the superseding suretyship provision found in fidelity bonds, so that an insured who has an incurred but undiscovered claim situation can change carriers without losing coverage for that situation. We are cheered by Mr. Pachner's encouragement to accumulate more data on a broader base in the current and future surveys, and hope he and other brokers will encourage their insureds to supply that data.

Warren G. Brockmeier
The Wyatt Co., Chicago, Il.

Mr. Pachner replies: *I note that Mr. Brockmeier has elected not to comment on the weak statistical base of the 1973 Wyatt Survey loss ratios—premiums taken from less than 300 policies; losses form 50 claims with 58% of those synthetically accelerated from reserved to paid status—as the net result of 6 438 inquiries. I also introduced, for the first time, an (unofficial) indication of London market D&O loss ratios on older and more matured claims, pointing out that a period which initially seemed profitable (1963-68) eventually deteriorated to over 100% loss ratio.*

I was mistaken in another part of my letter, and readily admit that the transmittal letter used in the survey mailing, which Mr. Brockmeier made available to me, clearly promises confidentiality. Far from being a false premise going to the heart of my remarks, as Mr. Brockmeier would like to believe, it partially affects only the "arguendo" portion of my letter, which points out that even if the statistical base were credible, the survey answers relating to claims would be unrealistically low.

I suggest that for the 1974 survey, the questionaire itself should also contain the confidentiality message. In any event, I doubt that directors or officers will consistently agree to document claims made against them for survey purposes.

To answer the various other points raised could prove more diversionary than informative. Like early evening election returns, the 1973 Wyatt Survey provided the best information available at the moment, but conclusions based on such meager returns should not be taken as gospel.

Acquisitions reported

Robinson-Conner Inc., Erie, Pa.-based insurance agency, said it purchased Insurance International Inc. in Pittsburgh, and will operate it as a wholly-owned subsidiary. Insurance International and Thomas McCaffrey Co., another Pittsburgh agency owned by Robinson-Conner, will merge their operations.

* * *

Resolute Insurance Group, Hartford, Conn. based subsidiary of Triumph American Inc., said it acquired two general agencies in Fayetteville, N.C. Triumph American is an insurance holding company. The agencies acquired were United Underwriters Inc. and Universal Insurance Service Inc., previously owned and operated by E. Bruce MacFadyen.

Regulatory changes . . .

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have very small examination staffs . . . they might not be able to participate in examinations of out-of-state insurance companies. The large states with more people available for examinations of out-of-state companies will have more input than the small states," he noted.

He believes another recommendation of note in the newly-released report in that there be established a system of independent reporting by reviewers. Mr. Bell is also in favor of the recommendation that costs of examination be covered by assessments levied on domestic insurance companies being examined, rather than assessments on both foreign and domestic firms.

McKINSEY & CO. found that only 44% of the states analyze financial statements of insurance companies in a systematic way. "Although the NAIC early-warning system for property-liability companies has been designed to help fill this gap, only 4% of the state insurance departments use it as a primary tool and 73% use it infrequently or never."

One of the areas particularly lacking in the present system of examinations is analysis of underwriters' reinsurance agreements, the consultants found.

And reflecting recent trends toward conglomerate and holding company acquisitions of insurance companies, McKinsey found that few commissioners are satisfied that their statutory authority is adequate to cope with holding company problems such as:

- milking of the insurer by the parent firm through dividends or exchanges of assets;
- use of the insurer's funds or credit for questionable purposes;
- short-term transfer of assets to conceal financial difficulties.

McKinsey & Co. suggests that primary responsibility for financial condition surveillance should rest, as in the past, with the domicile state. Primary responsibility for market conduct surveillance, however, "would rest with each state with regard to both foreign and domestic companies in its own market," the report stated.

Among the market conduct "problems" which McKinsey would like to see regularly dealt with are unfair sales and advertising practices which would include misrepresentation of policy benefits, terms, or conditions by failing to disclose limitation, exclusions or reductions.

Another market area needing checks is unfair underwriting practices, which would include discriminating unfairly in the selection of risks, failure to give adequate notification for cancellations or nonrenewals, and failure to make premium refunds in accordance with the policy, McKinsey recommends.

Unfair rating practices is a third area of conduct in the marketplace needing surveillance, the consulting firm outlines. Complaints to be checked and administered in this category would include charges of rates different from those filed, and discriminating among individuals in the same class in determining dividends or in payment of dividends.

The fourth area of market conduct to be scrutinized would be unfair claims practices by underwriters, including misrepresentation of claimants' rights under the policy, underwriting at the time of claim, forcing legitimate claims to litigation and pressuring claimants to accept prompt but unreasonably low settlements.

KEY ELEMENTS of the market conduct surveillance system, which McKinsey & Co. foresees could be a primary indicator of fundamental trouble in an insurance company, would be a complaint analysis system coupled with a system for scheduling targeted field examinations which are tailored in scope and depth to the nature of the problems being checked.

Examiners should particularly watch for companies with a high number of complaints in relation to their size, specific lines of business with a high incidence of complaints and, overall, the most frequent causes of complaints, McKinsey suggests. ■

Loews bid for CNA

CHICAGO—The Illinois department of insurance scheduled a hearing for Thursday, June 6 to consider Loews Corp.'s application to acquire a majority interest in CNA Financial Corp.

The hearing, to be held in Springfield, is in answer to an application by Loews to acquire 20 million CNA shares through a tender offer to shareholders.

Fred Mauck, director of the insurance department, said the hearing will determine if the effect of the acquisition:

- would be to substantially lessen competition in the state;
- might jeopardize the financial stability of CNA or prejudice the interests of its policyholders;
- would result in a material change in CNA's business or corporate structure or management which would be unfair or unreasonable to policyholders and not in the public interest;
- would result in control of CNA by persons whose competence, experience and integrity are in the best interests of the policyholders and the public. ■

Compromise bill . . .

Continued from page 12

weighted vesting rule such as the Rule of 50 "because it benefits the older workers who need it most.

"The alternative rules proposed, including the Senate rule (which requires 100% vesting after 15 years, with 25% vesting after five years) tend to waste pension dollars by providing vested sums to young people, who don't need them and won't use them for pension protection.

He said the three alternative vesting proposals in the House bill had the net effect of weakening the vesting standards "by allowing a plan to choose the least costly, and therefore least effective rule."

The administration has some deep concerns about the effects of portability, although Mr. Hays says there is "no true portability" in the Senate bill.

"No provision allows or requires transfer of unvested pension credits between jobs. What is allowed is such transfer, on a voluntary basis, of vested credits. This can be done under current law.

"As a voluntary system, the portability of provisions are relatively harmless and would be very little used. They do, however, set up a new bureaucracy and may become the entering wedge for true portability."

BUT WITH THE myriad types of retirement plans now in existence, "mandatory portability is unthinkable unless some kind of rigid conformity is imposed upon the system. We do not want to see that day come, for the ability to tailor retirement plans to the particular needs of the particular business is one of the private retirement system.

"We oppose the portability provisions. We are pleased that the House has decided to strike this title and we hope the conference will follow suit.

He said the administration is also "strongly against" the termination insurance plan in both the House and Senate bills.

"This is really business failure insurance. We have studied this subject, we believe as carefully as anyone has, and despite the superficial appeal of termination insurance, every scheme we have seen or been able to devise suffers from incurable defects.

"The central issue is whether losses on plan termination will in the last instance rest with the insurance fund or with the employer. If you make the employer liable for such losses, this will help protect the fund from abuse, but it will saddle the employer with a liability he and his creditors never expected or bargained for.

"Booking of this liability may trigger default clauses in trust indentures and loan agreements, precipitating employer bankruptcies and the very losses of pension rights we work to guard against.

"WHAT IS THE answer to losses of vested benefits on plan terminations? First, better funding and fiduciary standards, vigorously enforced. Second, we should face the fact that the real problem with plan terminations is not that an employe doesn't get a certain level of pension benefits. . . . The real problem is that the employe in a defined-benefit plan has been led to expect a fixed level of pension. He may not read, still less comprehend, the fine print, under which pensions are payable only to the extent funded, and under which a particular order of priorities for payout on termination of an underfunded plan is provided.

"Despite all this, it is now clear that we're going to get some form of termination insurance. Thus for the first time, the price of setting up a defined benefits plan is not merely the deposit in trust of the actuarially-computed amounts expected to be necessary to meet the pension promised, but the employer's underwriting, in effect, of the stock market, assuming personal liability for the pensions expected by his employes.

"We hope this will not lead to trouble, but we are aprehensive about what can happen in the event of a serious economic decline, with stock values tumbling and employers in economic difficulties.

On fiduciary standards, the administration prefers the Senate version which bans self-dealing, as opposed to the House bill, which allows them if consideration is adequate.

"This is too much of a license to cheat, since there is no foolproof way to value such assets as closely held corporate stocks or real estate." ■

Shortage . . .

Continued from page 49

about 5% late last year, and are holding to the reduced rates.

"Other states have talked about it, and some commissioners have written letters suggesting that insurers reevaluate auto insurance rates, but as far as I know, none has actually ordered rates down," Mr. Caldwell said.

The insurance industry representatives on the task force's advisory committee have indicated that one reason the fast track monitoring system should be disbanded is that there are antitrust implications in such close cooperation by competitors. To this argument, however, Mr. Caldwell reacted that "as a commissioner and as a lawyer, I do not feel that there is any need for concern about antitrust because we are endeavoring to obtain information necessary to regulate the insurance industry. They (members of the advisory committee) are doing this at the direction of the commissioners on the special task force, not of their own free will."

HOWEVER, in a letter sent to all state commissioners, Mr. Caldwell said the task force advised the advisory committee that it will consider any legal memorandum submitted which deals with this topic.

The insurance industry committee told the task force in its lengthy report that individual state rate regulatory authorities should not utilize the effects of the gasoline shortage, which it contended has ended, as a basis for auto insurance rate reductions.

"While we concur . . . with the observation that the report cannot serve as a foundation for establishing future rates, we do not believe the gasoline shortage has ended or that an individual commissioner should not consider the shortage as a relevant factor in discharging his rate regulatory responsibilities," Commissioner Caldwell noted as the reaction of the task force to that statement. ■

Marsh & McLennan opens in New Zealand

Marsh & McLennan International Inc. opened an office in Auckland, New Zealand. The branch will specialize in risk evaluation and loss prevention, general insurance services, employe benefits and actuarial services.

Benefit tax slants

Court rules employe contributions to pension funds taxable income

By JOSEPH S. ROBINSON
Attorney-at-law

SUPPOSE EMPLOYES are asked to kick in a percentage of their salary to their pension which is automatically deducted from their paycheck. The employer matches the contribution, dollar for dollar. Query: Are the withheld portions of employes' salaries currently taxable to the latter? The IRS claims it is. But the employes feel otherwise. So the matter is thrashed out in court. Incidentally, the employes just happen to be working for the Internal Revenue Service.

The court rules that IRS employes must include these withheld amounts in their current year's income even though such amounts are not actually or constructively received. The court disagreed with the taxpayer's contentions that the mandatorily withheld portions should be treated the same as employer contributions to the plan (which are not taxable).

On the basis of existing statutory provisions and relevant case law, the court concluded that the withheld salary paid into the retirement plan is includable in an employe's compensation for income tax purposes.

SICK PAY: The IRS is having second thoughts about its position that disabled employes can take the $100-a-week tax exemption only until they reach the early retirement age set by the employer. Up to now, the government would fight a disabled worker who insisted upon the exclusion until mandatory or normal retirement date. However, since several courts have agreed with the employe, the IRS seems to be persuaded and will probably go along with the $100 per week tax shelter on disability benefits received between early and normal retirement ages.

IN A PREVIOUS ISSUE, we reviewed *Rev. Rul. 73-338* in which an employer purchased an existing insurance policy from the employe for its cash surrender value and transferred it to the pension trustee as part of the employer's required contribution to the plan. When the employe died, the insurance proceeds were paid to the trustee who in turn turned it over to the insured's widow. It was decided that the transfer-for-value rule did not apply and the death benefits escaped income tax to the beneficiary.

Now we have a variation of the fact pattern wherein the employe directly assigns his life insurance policy to a profit-sharing trust as a voluntary employe contribution permitted by the plan. The death proceeds of the policy continued to be payable to the employe's beneficiary with the cash surrender value going to the employe upon retirement or termination of employment.

The IRS holds that, here too, the transfer of the employe's policy was not for valuable consideration within the meaning of the tax law. *Reason:* The insurance proceeds were payable to the employe's designated beneficiary as before. So there was no significant change in the beneficial ownership of the life insurance policy, warranting a change in the tax-free status of the proceeds. (*Rev. Rul. 74-76*).

A profit-sharing plan can provide that upon retirement, a participant may have his account turned over to him in two parts—half in a lump sum and the balance in periodic annual installments. The trouble is that such a method of payment can deprive the retiree of a valuable tax break. This was demonstrated by one situation in which the IRS denied capital gains treatment for the lump sum payment because only half of the total amount was paid in one year—the balance being left in the qualified trust for future distribution. In order to be entitled to capital gains treatment, the trust must distribute the entire account in one year. (*Rev. Rul. 72-242*).

Capital gain treatment could have been preserved for at least part of the payout if handled a little bit differently. The key to the above ruling appears to be the retention by the trust of a portion of the participant's account. Therefore, if the trust purchased a commercial, nontransferable annuity with one-half the account and handed over the balance in a lump sum, there would no longer have been an account balance held by it. So with a slight variation capital gains could have been achieved for the lump sum distribution. (*Rev. Rus. 65-267*). ■

City appeals verdict

Because it would be paid from the city's self-insurance fund, San Francisco city Attorney Thomas M. O'Connor plans to appeal the largest verdict ever awarded against the city for a Municipal Railway accident, a record $1.75 million given to former school teacher Anne Tagore. A superior court jury voted in favor of Mrs. Tagore, a 36 year-old Phi Beta Kappa graduate of Southern Methodist University, who allegedly was "left mentally incompetent" after she was struck by a Muncipal Railway bus while she was crossing Market St. in 1971.

Growth of 'pups' ...

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missioner noted that "it was fairly clear that on the average, company profit and loss ratio, under the income tax statute would produce less revenue for the state than a premium tax."

The commissioner said he isn't sure "if pup carriers are detrimental to the public."

HE DID STRESS, however, that "it's up to legislation to close the tax loopholes." It is a legislative matter and not a regulatory one, he added.

As long as pup carriers keep their books in Wisconsin or receive permission from the commissioner to move them, pups are granted domestic status.

However, he added that if the books are not kept there, it generates a problem of sorts.

"We have been doing this case by case under the provision of the rehabilitation and liquidation statute. One ground under the statute allows liquidation of a company if the company has removed books and records from the state without the commissioner's permission," Mr. DuRose said.

CALIFORNIA'S insurance commissioner said, "We don't have laws favoring pup carriers, which were actually set up to circumvent the premium tax law. We tax our domestics the same as foreign, 2.35%."

In Michigan, the only companies granted tax exemption are those who have their home offices there "as defined by the insurance department," according to Michigan's chief deputy, Bob Rowe.

He said that "We want insurance companies to come to Michigan, but we want them to be real."

New York seems to be experiencing the opposite problem than the other states surveyed.

Insurance companies have been making quick exits from the state due to the high domestic tax put upon them by regulatory statutes.

Lawrence Monin, first deputy superintendent, said that "almost 40% of direct premiums have been deferred out of state" because domestic companies have been forced to pay a higher premium tax than foreign subsidiaries.

Originally, the higher tax was imposed in hopes of raising New York's tax revenue, but a multitude of property companies have instead made an exodus out of the state.

THE DEPUTY said that New York life insurance companies were responsible for payment of a 2.25% premium tax and property companies a 2.58% tax. Foreign companies pay a lower premium of 2%.

With hopes of alleviating the growing problem of exiting New York companies, Mr. Monin said that New York is trying a new approach.

"We'd like to impose an income tax and scale down the premium tax," he said.

He added that his state does have a retaliatory tax, "so most states are kept down to a uniform 2%." ■

Allstate is charged with 9 violations

TALLAHASSEE, FL.—Allstate Insurance Co. was charged with nine violations of state statutes by the Florida insurance department.

The violations ranged from overbilling group auto plans to using unapproved rate schedules.

"Charges of this nature could go anywhere from a fine to probation, suspension or revocation of the license," said Thomas Brown, assistant insurance commissioner. "They've been given a period of time to respond and then a hearing will be set."

THE CHARGES ARISE out of an examination by the insurance department of Allstate's St. Petersburg regional office last December. They alleged that Allstate:

- wrongly classified business-owned pickup trucks in a category that cost more in premiums;
- issued package policies to small businesses without itemizing individual rates or providing a written explanation for the total premium;
- overcharged employers in group employe auto coverages;
- used an unapproved rating schedule;
- charged erroneous premiums in 41% of the policies examined, and erred as well in computation of premiums for all large liability policies;
- cancelled policies without the required 45 days' notice;
- varied rates in policies up to $1 "in order to coincide with agents' quotations."

Mr. Brown told *Business Insurance* Allstate could be fined $250 for each occasion when one of these violations was committed. If the violations are proven willful, fines could run as high as $1,000 each.

A spokesman from Allstate said the company is making its own investigation of the alleged violations, and would respond to the insurance department when its study was completed. ■

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For more details, call Don Walsh at (212) 986-5050. Or write: Business Insurance, 708 Third Avenue, N.Y., N.Y. 10017

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Business Insurance publisher, Alfred Malecki

Best total communication program awards were presented at the 12th annual ASIM conference in Toronto to (from left) Richard Harvey of Ptizer Inc., first place winner; Frank Bradley of Coats & Clark Inc.; and Phil Bamforth of Marsh & McLennan, consultant for Coats & Clark Inc.

State draws up new rules for regulating sales and ads

SALEM—Prospective Oregon life insurance customers soon will be guaranteed detailed information about their insurance purchases and the state insurance commissioner will have the authority to disapprove any insurance advertising material he finds misleading or deceptive.

The new rules being drawn up by the state come as a result of approval by the 1973 legislature giving the insurance official wider powers to regulate insurance sales practices.

The law covers all fields of insurance, but life insurance is the first area to have new rules applied by commissioner Lester Rawls.

A hearing on the life insurance rules is scheduled for late May, at which time Mr. Rawls expects to get some complaints from the life insurance industry, which has generally been subject to less supervision than other fields.

ONE OF THE rules that Mr. Rawls is particularly pleased with requires a life insurance salesman to identify himself to the prospective customer as an insurance agent.

Although it is not a widespread practice, some insurance sales people use a back-door method of selling insurance by using titles such as "estate planner," "financial analyst," "financial planner," "investment adviser" or others that cloud the primary intention of selling life insurance.

It also will be necessary to inform the customer promptly of the name of the insurance company represented.

The agent will have to provide the customer, before or with delivery of an insurance contract, a dated written proposal describing the key elements of the contract. This includes provisions such as a suicide clause that would reduce the death benefit, the meaning of and time limit of the incontestable provision, the face amount of the basic benefit and separately stated premiums for each additional supplemental benefit provided in the contract.

The advertising rules are intended to prevent the use of misleading or deceptive statements, and also to prevent use of words or phrases "the meaning of which is clear only by implication or by familiarity with insurance terminology." ■

Awards for the best personalized correspondence went to (from left) Richard Harvey of Pfizer Inc.; Don Hoy of the First National Bank of Chicago; Mrs. Eugenie Bodenhoff of first place winner Hunt-Wesson Foods Inc.; and George Heiring of Hewitt Assoc., consultant for the first and second place winners.

Winners of the benefits communications competition for booklets included (from left) George Heiring of Hewitt Assoc. accepting for Squibb Corp. and his own firm as consultant; Eileen Kroegher of Equibank N.A.; David Caughlin of first place winner DeSoto Inc.; and Mary Dougherty or Towers Perrin Forster & Crosby, consultants for Equibank.

Hunt calls for improvement in no-fault

OKLAHOMA CITY—The no-fault bill, passed by the U.S. Senate this month and now on its way to the House, is an issue that has created a lot of feedback. Joe B. Hunt, insurance commissioner of Oklahoma, isn't one to keep quiet when there is something to say.

"The name no-fault sounds good," he said, but the "no-fault plan has some faults." These faults need to be corrected, if and when the state of Oklahoma considers the passing of no-fault legislation."

The Hart-Magnuson bill requires all states to adopt some form of no-fault legislation by Sept. 1, 1975 or face immediate imposition of the federal specifications (*Business Insurance,* May 13, 1974).

"Under the plan, what is to keep the irresponsible driver from violating laws and causing accidents because they could not be sued?" For instance, if a drunken driver runs into your car, you would have to look to your own insurance company to pay, the commissioner said.

"THERE IS nothing in the bill to keep your company from surcharging your costs on an accident like that and nothing in the bill to keep the company from cancelling an insured," Mr. Hunt added.

"If the federal government gets into the picture they will be taxing the insurance companies," Mr. Hunt said, naming another problem he sees in the Hart-Magnuson no-fault bill.

A tax of this sort could do away with the automobile insurance premium taxes now being collected by the states, Mr. Hunt pointed out. Oklahoma, at times, could not meet their payroll if it was not for the taxes collected from the insurance companies, the commissioner said. ■

Murphy Oil sells carrier to subsidiary's captive

Murphy Oil Corp. recently sold its captive insurance company, Enterprise Insurance Ltd., to Mentor Insurance Ltd. of Hamilton, Bermuda. Mentor Insurance is a wholly-owned subsidiary of Ocean Drilling & Exploration, 51% owned by Murphy Oil. The combined capital and surplus of Mentor Insurance and Enterprise Insurance totals $10,062,300.

As angiosarcoma

By VALERIE MACKIE

AKRON, OH.—The seriousness of the newly-acknowledged occupational disease called angiosarcoma—caused by exposure to vinyl chloride—is growing.

Firestone Tire & Rubber Co. recently said an employe's death in 1969 was found to be attributed to angiosarcoma. B. F. Goodrich also said two of its employes are now living with the disease.

This brings the total number of occupationally-caused cases among plastics manufacturing workers to 14. The disease is a rare form of liver cancer, usually fatal within a year, and related to the use of vinyl chloride monomer in the production of polyvinyl chloride (*Business Insurance*, Feb. 18).

In an effort to stabilize the chemical scare, the Occupational Safety and Health Administration (OSHA) issued a temporary emergency standard reducing vinyl chloride exposure to 50 parts per million (ppm) in the atmosphere from the previous 500 ppm standard. Federal scientists and unions, however, are continuing to fight for exposure levels in amounts too small to measure.

SO FAR THE safe exposure level to vinyl chloride has not been determined. But laboratory tests by the Industrial Bio-Test Laboratories for the Manufacturing Chemist Assn. revealed mice developed liver cancer when exposed to the 50 ppm exposure level.

Two hundred rats, hamsters and mice were exposed for seven hours a day, five days a week for six months. According to preliminary results of the study, none of the rats or hamsters contracted angiosarcoma.

Six mice died but only two of the deaths were traced to angiosarcoma of the liver. The remaining four deaths were traced to neoplasm.

THE MANUFACTURING Chemists Assn. also sponsored last summer a mortality study of the vinyl chloride industry by Tabershaw-Cooper Assoc. The company collected information on several thousand individuals who have worked for more than a year in the industry. The results were released this month. Dr. Irving R. Tabershaw told *Business Insurance* that the study shows "vinyl chloride may be an agent that induces cancer in multiple areas." He explained there seems to be an increase of cancer in the lungs, brain, lymph glands and even the buckled cavities (mouth) as well as the liver.

At least two other studies, one in Italy and another in the U.S., reported that laboratory animals exposed to vinyl chloride concentrations of 50 ppm failed to develop any tumors. But another experiment to assess prior findings and arrive at a more definitive answer is underway involving the exposure of 300 animals to 50 ppm.

On the basis of the Industrial Bio-Test Laboratories' findings, the ALF-CIO Industrial Union Department claims there is no safe level of exposure and they are pressing for a safe emergency

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grows as a work hazard, more employers react

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standard of "no measurable concentration."

"It can't be done," asserted T. C. Walker, president of Firestone Plastics in Pottstown, Pa. I doubt if any plant in this country could get their vinyl chloride exposure level as low as that, he said. "If they call for a zero standard the industry will shut down. It's a wonderful idea, but unrealistic."

THE PLASTICS industry is a big one. About seven billion pounds of vinyl chloride resins and compounds are produced each year in 37 plants in the U.S. Some 6,500 workers are potentially exposed to the chemical.

"If the plants are shut down, about one million people will be unemployed," Mr. Walker added.

Under the law the National Institute of Occupational Safety and Health (NIOSH) is required to issue a permanent standard within six months of the issuance of a temporary emergency standard. OSHA is currently collecting all information on the subject and alternatives to the proposed standard.

What they are trying to do is put together an environmental impact statement on exposure to vinyl chloride. After the statement is released the public will have 45 days to comment.

NIOSH recommended that any employe exposed to a measurable concentration of vinyl chloride should wear protective clothing and use an air-supplied respirator. Air-sampling procedures have also been recommended.

ANYTIME THE vinyl chloride monomer (VCM) exposure level exceeds 50 ppm, employes at Firestone are required to wear respirator masks, Mr. Walker said. "We have respirator stations all over the plant."

A majority of the time Firestone operates without respirators, Mr. Walker pointed out. OSHA recommended that the respirators only be used as a temporary crutch or tool, he explained.

B. F. Goodrich told *Business Insurance* that "we are doing everything we can to reduce the vinyl chloride exposure level. Right now we are considerably below the required 50 ppm in all our plants."

Because the exposure levels change constantly, plastic plants are in charge of monitoring the atmospheric content around the clock. "Soon we will rely on a permanent measuring instrument, but in the interim we are relying on personal monitors and meters," Mr. Walker claimed.

ANOTHER STEP Firestone took to reduce the exposure level in their plants was to revise the vessel venting procedures.

About seven years ago a study disclosed workers who cleaned the vessel pots where the chemical liquid was turned into plastic suffered from a peculiar hand condition. Blood vessels and finger bones took on strange distortions and a tingling feeling persisted. In an effort to correct the problem workers received a supply of air and a body covering.

Firestone has reduced the need for employes to enter the vessel by using high pressure water to clean them.

Plastics workers who died of angiosarcoma have averaged about 17 years exposure to the chemical, Mr. Walker stated.

"We started reviewing our medical records the day we heard about the four deaths in Louisville," Firestone's medical administrator said.

The same group that checked out the plant in Louisville asked to look at our plant in Pottstown, Mr. Walker said. So the Communicable Disease Center, NIOSH and the Department of Health in Harrisburg have been looking at 27 years of employe medical histories. "Since some employes worked only ten years and left the company—this is taking a lot of time," he explained.

As another precautionary measure Firestone started a medical surveillance program in April. All employes exposed to the chemical receive a pulmonary function, blood tests, x-rays, and a complete physical with medical history.

ANGIOSARCOMA is not listed in the workmens compensation law yet as an occupational disease but most state laws give considerable latitude as to what is compensable. Goodrich, the hardest hit in the plastics industry with five deaths and two living with the disease, is self-insured. The amount paid to the beneficiaries will depend on what the Kentucky state workmen's comp law was at the time of each death, a Goodrich spokesman said.

The 14 vinyl chloride-related deaths have caused a stir in areas other than the plastics industry. The Environmental Protection Agency late in April issued an unusual emergency order halting the sale of thousands of pesticide spray cans. The order covers 28 aerosol products that contain vinyl chloride as a propellant. The ban covers 19,000 cans including: Brulin Bug Bomb, Rexall Ant and Roach Killer and Walgreen Ant and Roach Killer.

In another area, doctors are trying to determine if meat wrappers can develop severe asthma after using polyvinyl plastic that, when heat-sealed, produces fumes. Three female workers developed severe respiratory problems when they began cutting polyvinyl chloride film with a hot wire in meat wrapping operations, doctors reported. ■

Fear vinyl chloride scars in short time

NEW YORK—With 14 confirmed cases of angiosarcoma resulting from long term exposure to vinyl chloride already known, including one in England, the New York Academy of Sciences heard more bad news this month.

Dr. W. K. Lelbach, of the University of Bonn, announced that he suspects that one of his patients may have developed the liver disease after only two-and-a-half years' exposure. The shortest exposure known to have caused a confirmed case of angiosarcoma is six years, with the average at least 12 years' exposure.

Further, Dr. P. Serk, of the National Institute of Arthritis, said he found that even when diseased workers were removed from the hazardous vinyl choride environment, the scarring of the liver increased. He said he diagnosed the patients' ailment through serial biopsies.

DR. H. POPPER of the National Institutes of Health said he is pessimistic about the use of standard liver function testing to diagnose the occupational disease, and urged development of new methods for early diagnosis. Dr. Popper, who has studied precursor symptoms to angiosarcoma, said he expects that a test for fibrosis, rather than a liver biopsy may be the best method of detection.

All three, as well as a number of other international experts, addressed a two-day conference on the vinyl chloride hazard and related occupational diseases, which the New York Academy of Sciences co-sponsorded with the American Cancer Society, the National Institute of Environmental Health Sciences, National Institute for Occupational Safety and Health and the Society for Occupational and Environmental Health. ■

dates for buyers

June 2-5: Insurance Accounting and Statistical Assn.'s annual meeting will be held at the Palmer House, Chicago. Subjects will cover accounting, data processing, statistics, management and supervision. Write E. C. Carlson, Insurance Accounting and Statistical Assn., 406 W. 34th St., Kansas City, Mo. 64111.

June 2-6: Municipal Finance Officers Assn. will have its annual convention in Las Vegas at the Las Vegas Hilton. Write the association, 1313 E. 60th St., Chicago, Il. 60637 (312-324-3400).

June 2-8: National Assn. of Insurance Commissioners annual meeting will be held at the San Francisco Hilton Hotel. One of the issues will be the effects of the energy crisis on the industry. Write the NAIC, P. O. Box 3902, Rincon Annex, San Francisco, Ca. 94119 (415-392-3185).

June 3-6: International Foundation of Employee Benefit Plans will host a Canadian series of one-day seminars in Halifax, Toronto, Edmonton and Vancouver. Employe benefit trust fund problems related to deliquency in contributions will be the subject. Write the foundation, P.O. Box 69, Brookfield, Wi. 53005 (414-786-6700).

June 4-5: Chicago State University will present a seminar on the Consumer Product Safety Act: how to protect your products from liability, at the Pick-Congress, Chicago. Techniques for compliance will be featured. Write the university, Management Program in Business Administration, 95th St. at King Dr., Chicago, Il. 60628.

June 10-11: The Society of Chartered Property and Casualty Underwriters' New Mexico chapter is sponsoring a seminar on agency management, administration and planning, at the Airport Marina Hotel, Albuquerque, N.M. The program is divided into three sessions: the agency, the accounts and the future. Write Jim Reed, Society of CPCU, Box 566, Media, Pa. 19063.

June 10-13: The National Assn. of Insurance Women will meet for its annual convention in Cincinnati, Oh. at the Netherland-Hilton Hotel. Write Betty Jean Conley, Public Relations Committee, 4223 Center St., Royal Globe Insurance Co., Omaha, Nb. 68105 (402-588-3400).

June 11: Huggins & Co. Inc. is presenting a briefing session on health maintenance organizations in Chicago at the Executive House. The session will include an overview of HMOs, a description of the HMO benefit packages and how an HMO is organized. Write Sandy Middleton, Hay Assoc., 1845 Walnut St., Philadelphia, Pa. 19103.

June 13-14: The American Management Assn. will host a seminar on how to increase profits through self-insurance, in New York City. Write AMA, 135 W. 50th St., New York, N.Y. 10020 (212-586-8100).

June 13-14: American Management Assn. is having a seminar on product liability, in New York City. Write the AMA.

Brokers are negative on federal memo

SAN FRANCISCO—A memo from the Federal Insurance Administrator requiring private carriers to meet federal standards for flood insurance has drawn objections from the Western Association of Insurance Brokers, based in San Francisco.

Federal flood insurance has been required under the Flood Disaster Protection Act of 1973, beginning last March 1, before federally supervised banks and savings and loans can write home mortgages.

Other construction projects or property acquisitions involving federal funds are also required to purchase the federally subsidized flood insurance protection.

THE BROKERS association charged that a federal requirement that private carrier policies must be certified by state insurance commissioners before being acceptable in lieu of the federal policy, inhibits the spread of private carrier flood policies.

Among other things, the federal standards for flood insurance require that the policies be noncancelable and guaranteed renewable.

The association said the federal standards would inhibit broker efforts to encourage more private carrier flood insurance policies that would also include all catastrophic natural phenomena, such as earthquake, landslide, mudslide, wave wash and the like.

The federal flood insurance is sold through designated insurance companies in each state. A total of about 350,000 policies have been sold, with about 50,000 for commercial or industrial buildings.

The maximum limit of coverage at the present for commercial and industrial properties is $200,000 for a structure and $200,000 for contents. ■

people

American Can dept. revamp

American Can Co., Greenwich, Ct., reorganized its employe benefits department. **E. C. Ecker** was promoted to director of benefit plans from manager of benefit plans. **Don A. Smith** was named benefit operations administrator. He was formerly administrator of retirement plans. And **John E. Prescott** was named benefits planning manager. He was previously administrator of group insurance plans. Mr. Smith now has responsibility for administering group insurance plans.

* * *

Thomas L. Potter was named to the newly-created post of corporate insurance manager for Weil-McLain Co. Inc., Dallas. Mr. Potter was previously with Collins Radio Corp. for ten years, most recently as corporate manager of insurance and retirement. Collins is a division of Rockwell International Corp. Mr. Potter's administrative post has been eliminated at Collins, and the West Coast regional insurance office of Rockwell will now handle those administrative responsibilities.

* * *

William G. Cain joined Kane-Miller Corp., Tarrytown, N.Y., as corporate director of insurance in charge of property/casualty lines. Mr. Cain was formerly assistant corporate insurance manager for Federated Department Stores in Cincinnati, Oh. No replacement at Federated has yet been named. At Kane-Miller, Mr. Cain succeeds **Anthony Ian,** who was promoted within the corporation to another department.

* * *

W. Michael McDonald joined Instrument Systems Corp. in Huntington, N.Y. as director of insurance and employe benefits, succeeding **Lawrence Geneen,** who left the company to join Johnson & Higgins as an account manager. Mr. McDonald was formerly assistant insurance manager for Richardson-Merrell Inc., a spot which has not been filled. Instrument Systems Corp. is a conglomerate with annual sales of $225 million involved in producing entertainment systems for jumbo jets, and other products ranging from mattresses to satellites.

* * *

William Burnham was named assistant insurance manager for Textron Inc., Providence, R.I., replacing Alan G. Passante who was promoted to corporate insurance manager early this year, as reported. Mr. Burnham was formerly with Marsh & McLennan in Boston.

classified advertising

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