International clash looms in jet crash

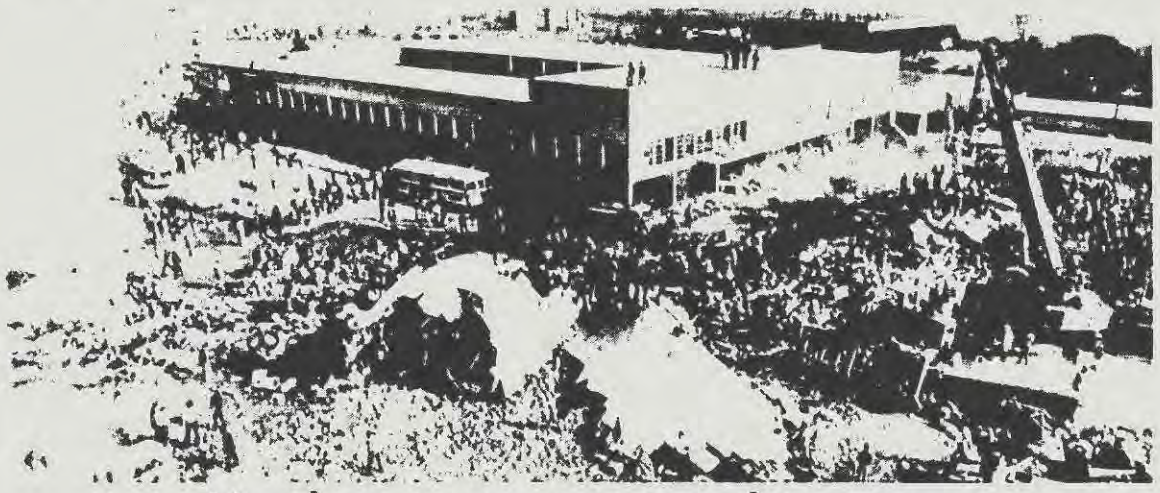

Photo: Wide World

Market expects steady rates

By RHONDA L. RUNDLE

LOS ANGELES—Mexican and American officials may be headed toward a clash to settle conflicting accounts of what caused a Western Air Lines DC10 to crash Oct. 31 after touching down on the wrong runway at Mexico City's Benito Juarez Airport, killing 75.

The first liability suit, filed the next day in Los Angeles federal court, named Western Air Lines, McDonnell Douglas Corp., builder of the jet, Benito Juarez Airport Authority and the Mexican government for negligence leading to the crash.

There was no evidence, however, that any malfunction of the DC10 was to blame for the tragic accident.

The pilot desperately tried to pull the jumbo jet back into the dense fog after sighting a parked truck blocking the closed runway, according to reports. The craft's landing gear struck the vehicle, skidded across the tarmac into a post office building, split in two and burst into flames. Twelve survivors were in the tail section, which did not burn.

Ninety percent of the hull and liability insurance for Western Air Lines is in the London market, confirmed Doug Swetts, director of insurance and pension planning for the airline. Lloyd's of London shares 13% of that package, brokered by Emett & Chandler in Los Angeles and J.H. Minet & Co. in London. The remaining 10% is with Associated Aviation Underwriters, including Western's workers compensation coverage.

Neither the airline nor its brokers would name the lead underwriter, except to say it is an English company.

Western Air Lines further declined to divulge its policy limits, saying only that insurance would be adequate to cover both liability and hull losses. Book value on the DC10 is $37 million, but Mr. Swetts would not say if Western had received a check for the hull.

Although pilot error and poor visibility because of heavy fog were tentatively blamed for the disaster, investigations have also raised questions about airport procedures at Benito Juarez.

A transcript of the conversation between the pilot, a 30-year veteran of Western Air Lines, and Mexican ground controllers contradicts a statement by airport officials denying that approach lights to the closed runway were illuminated.

U.S. aviation experts and experienced pilots speculate, however, that the captain of Flight 2605 may have tried a "side step" maneuver

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The Halloween crash of a Western Air Lines DC10 while attempting to land in Mexico City will probably not force instant aviation insurance rate hikes.

"It will take more than this to make a significant impact on underwriting rates," says Terence Atkins, a spokesman for Lloyd's of London.

Experts in this specialized market agree there's a tremendous overcapacity that is keeping rates low. "There would need to be a run of really bad accidents before many insurers would get out of it," Mr. Atkins says.

Underwriters expect about 18 to 20 turbo engine crashes a year, including two or three widebodies, declared a source at Associated Aviation Underwriters, among the largest U.S. aviation insurers.

Safety has actually been improving, he says. "The number of jet crashes every year is remarkably consistent while passenger miles flown is increasing."

Richard J. Ebner, vp of Marsh & McLennan, concurs. He doubts this loss will have any dramatic effect on aviation premiums. But recent loss experience may force insurers to return to shorter contractual periods from current three-year policies, he added.

Reluctant firms fill union prescriptions for drug programs

By STUART EMMRICH

NEW YORK—Employes gobble up prescription drug plans that make their medicine bills easier to swallow, but most employers offer them only under union pressure.

Administrative problems and costs are the biggest headaches for employers providing prescription drug plans, but employes' appreciation seems to ease the pain.

"They have worked just fabulously as far as the employe is concerned," says Robert Nossan, William M. Mercer vp. "They are by far one of the most used of any employe benefit programs when provided by the employer. They get an awful lot of action."

Other employe benefits might be more important to the employe and a far larger investment by the employer, but few others provide such instant employe gratification.

"It is just amazing that a person can walk into a hospital and come out receiving $2,000 worth of services and the employer never hears a word of reaction. But when the employe gets that $2.50 check in the mail (as a reimbursement for his prescription), he is thrilled and lets his employer know about it," Mr. Nossan says.

Any payments for prescription drugs for years were under major medical coverage. But employes who didn't have many serious illnesses a year never reached the $50 or so deductible necessary to start collecting on their insurance. Unions began to press employers for separate drug programs.

Major unions began winning drug plans about 10 years ago. The growth of the programs hasn't been dramatic in recent years. It's estimated drug plans were added to about 5% of all health and welfare plans during the first half of 1978. But the benefit is now considered standard in some of the nation's largest industries.

Uniroyal, Goodyear, H.J. Heinz, Campbell Soup, Pan American

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The inside story

Week of November 12, 1979

business insurance

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

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Ullman asks tax penalty on large health benefits

By JERRY GEISEL

WASHINGTON—While major hospital associations support Rep. Al Ullman's (D-Ore.) new bill that for the first time would impose taxes on employe's health care benefits, the nation's labor unions are strongly resisting it.

"We will vehemently oppose legislation that takes away a basic benefit from workers," said a spokesman for the United Auto Workers in Detroit. "This is a step backwards."

Rep. Ullman, the influential chairman of the House Ways and Means Committee, wants to reduce the scope of employer sponsored group health insurance plans, which he believes have removed the incentives to control health care costs.

Under his bill (H.R. 5740), if an employer pays more than $120 a month for an employe's family health insurance plan—including dental, vision and prescription benefits—the employe would have to pay federal income taxes on the amount over $120. If a company pays $140 a month for family coverage, for example, the employe would pay federal income taxes on the $20.

However, the total amount of the premium, even if over $120 a month, is tax deductible as a business expense to the employer.

A second cost restraint in the bill requires employers to offer a low-cost health plan with coinsurance, or an HMO, as well as a traditional full-benefit health insurance program. This low-cost plan would have to be offered if the company's group health plan cost the firm more than $75 a month for family coverage.

The company then would be required to rebate 90% of the difference in cost between the comprehensive plan and the low-cost plan to the employe.

If a comprehensive corporate health plan costs $140 per month and an HMO costs $70 per month for family coverage, the employe would get $63. The firm would keep $7 to compensate for the administrative expense of maintaining two plans, an aide to Rep. Ullman explained.

By amending the tax code to remove the incentives for employes to opt for comprehensive, employer-paid group health insurance plans, employes will increasingly take the plunge for low cost plans with larger deductibles or join HMOs, which typically are more cost-efficient than conventional health insurance plans, Rep. Ull-

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Rep. Al Ullman wants to reduce the scope of employer sponsored group health insurance plans to control spiraling health care costs.

Big product liability settlement precedes insurers' payments

By ELLIS SIMON

CHICAGO—Though Velsicol Chemical Corp. and Farm Bureau Services Inc. of Michigan have agreed to settle 70 outstanding product liability claims for more than $2.6 million, the question of who must sign the check hangs on the definition of occurrence.

Both firms are locked in litigation with their insurers over the definition of occurrence for farmers' losses resulting from cattle feed contaminated with polybrominated biphenyl (PBB).

The policyholders argue the "occurrence" insured by the policies was the entire period between 1973 and 1974 when cattle ate the tainted feed and had to be destroyed. That definition would provide insurance coverage under two policy years.

The insurers involved in the litigation contend the occurrence took place when the Velsicol subsidiary Michigan Chemical Co. substituted PBB for magnesium oxide in a shipment to a Farm Bureau mixing facility. The Farm Bureau mixed the PBB with cattle feed, thinking it was magnesium oxide. If the insurers win the argument over the interpretation of occurrence, coverage will be provided under only one policy year.

Such arguments about when an occurrence actually takes place are common. Policyholders involved in large losses often resort to suing insurers who try to limit the ultimate claim payout by citing a restrictive definition of occurrence. These cases are nearly always decided based on the individual facts of the situation, focusing for the most part on events leading up to and causing the losses.

Further complicating the issue is that Lloyd's of London and The Travelers Insurance Co. have paid claims based on two years of coverage. Lloyd's terms govern excess insurers above Lloyd's, said Robert F. Finke, Velsicol's attorney in Chicago.

A favorable decision for Velsicol will not necessarily double the firm's aggregate limits in the case since there were ambiguities in INA's subscription to the policy, Mr. Finke added.

However, the decision will determine whether the most recent settlements and any future awards by Velsicol will be covered by insurance, said Roger Clark, Velsicol's attorney in Grand Rapids.

Farm Bureau has exhausted its insurance limits, but a decision against one of its insurers, over the definition of occurrence could net $3 million for the Michigan co-op.

Because settling the outstanding claims has been given greater priority than the dispute between the policyholders and their insurers, Velsicol settled the claims with the knowledge of the insurers, Mr. Finke said.

In addition to the $2.6 million settlement, Farm Bureau has agreed to cancel the plaintiff farmers' bad debts, which could cost Farm Bureau as much as $700,000, said a Farm Bureau attorney.

Once total bad debt canceled is calculated, Farm Bureau and Velsicol officials will decide how the $2.6 million liability will be shared, Mr. Clark said.

Under a settlement reached early in 1976 ending litigation between Farm Bureau and Velsicol, the latter firm agreed to pay $19.6 million to Farm Bureau and 50% of PBB claims in excess of that amount (*BI*, Jan. 26, 1976). With awards to date of more than $42.6 million, Velsicol's share of PBB claims cost is believed to be running close to $30 million.

With the latest settlements, only 69 of the 955 PBB claims filed remain to be resolved. Several of these are likely to go to trial, said Grand Rapids plaintiffs attorney Gary Schenk. One trial is presently under way in Lenowee County, Mich.

In the dispute over what was the occurrence, Velsicol and its insurers are suing each other, in federal court in Grand Rapids and Cook County (Ill.) circuit court.

The Travelers wrote a $1 million primary liability policy for Northwest Industries, Velsicol's parent company, which had $28 million of insurance. Lloyd's wrote the first excess layer for $2 million. American Home Assurance Co. wrote the next $15 million layer and INA and Aetna Life & Casualty Co. each wrote $5 million coverage on a quota-share basis. ▪

errors & omissions

- In a story about a lawsuit involving the Fairchild Publications/Capitol Cities Media Inc. pension plan (*BI*, Oct. 29), National Union Insurance Co. was incorrectly reported as the former Fairchild Publications fiduciary liability insurer.
- E.W. Siver & Associates is the consultant for Henrico County, Va. An article in the Oct. 1 issue incorrectly identified the county's consultant.
- The National Employe Benefits Institute still has an office in Washington, D.C. An article in the Oct. 29 issue reporting that Steven Schanes, founder of NEBI, had closed the Washington office of Schanes Associates implied that NEBI no longer had a Washington office.

for your information

N.Y. Insurance Exchange finds a place to call home

NEW YORK—After four months of meetings by its board of governors, the New York Insurance Exchange finally has a home.

But the exchange probably won't open for business at its 59 John St. headquarters until late spring. In addition to more organizational work to be completed, the exchange must clarify its status with the SEC and IRS.

The SEC is apparently asking if the exchange must register as a security, a question more appropriately addressed to the syndicates, says exchange information officer Joseph Conroy.

The exchange has also filed a request with the IRS for a ruling on whether statutory accounting, which permits insurers to establish tax deductible loss reserves, is applicable to exchange syndicates. A decision is expected in December or January.

The IRS is also being asked by an investment banker to rule that syndicates be taxed as partnerships instead of corporations, which would allow direct flow of syndicate income to investors.

The search for a chief executive officer, however, is expected to be completed soon. Joseph Murphy, executive vp of Continental Corp. and member of the board of directors, has been said to be one of three candidates for the post, but Mr. Murphy denies it. The chief executive officer reportedly will be paid more than $150,000 per year.

Sources debate whether the delay in getting the exchange off the ground will dull investors' interest and even switch excitement to the still organizing Illinois Insurance Exchange.

Illinois names exchange board

CHICAGO—Don Kramer, the New York insurance consultant who sparked creation of the New York Insurance Exchange, is among 13 persons named to the interim board of governors of the Illinois Insurance Exchange.

Mr. Kramer's participation on the Illinois exchange will not influence the activities of KCC Syndicate Managers Inc., a firm organized by Mr. Kramer, Alexander & Alexander and Shearson Hayden Stone to manage syndicates on the New York Insurance Exchange, said A&A senior vp Gerry Curtis. Mr. Kramer added he still supports the New York exchange and intends to manage syndicates on it.

The board will draft a temporary constitution, choose staff and a facility and solicit investment, said James Skelton, Illinois assistant director of insurance, who will chair the interim board. IRS and SEC issues also confront the Illinois exchange.

The interim board will serve for up to nine months after receiving an insurance department certificate of authority, to be granted when the exchange has $4 million in capital. Illinois exchange syndicates must be capitalized for at least $2 million. Other members of the board are: Chicago attorneys Jeremiah Marsh, James Fletcher and Michael J. Merlo; Chicago insurance brokers Paul Robinson Jr. and Robert L. Dunn; Peter Van Cleave, vp and secretary of James S. Kemper & Co. of Chicago; William Haun, vp of St. Paul Fire & Marine Insurance Co.; Royal Gordon, vp of Continental Insurance Cos.; Chicago investment banker Robert Podesta; Donald E. Fisher, president of General Casualty Cos., a member of the Reliance Group, and Donald W. Montgomery, president of Celina Financial Group of Celina, Ohio.

Insurers praise nuclear report

NEW YORK—Insurers of the Three Mile Island nuclear plant say the eagerly awaited federal report on the March 28 accident should allay fears about the long range effects of radiation leaks there.

Critics of the plant had argued that the federally mandated insurance limits would not be enough to cover possible future losses stemming from the long term health effects of the nuclear accident including possible cancer. But officials of American Nuclear Insurers say the special presidential commission's report released recently rejects the notion that such health problems should be considered likely.

"There were some very positive things in the report. The commission made it clear that it saw no reason to expect to find any detectable cancer sources down the road," one ANI official said.

N.Y.C. to pay $7.8 million award

NEW YORK—New York City is self-insured for $7.8 million awarded to two Bronx children in two hospital malpractice decisions last week, said Bruce Kaplan, assistant corporate counsel.

The city admitted negligence in the cases, in which both children suffered brain damage and were left retarded as the result of treatment received in New York City hospitals. However, the city will appeal both verdicts as excessive.

The awards, made by juries in Manhattan and the Bronx, were $4.9 million to a 6-year-old boy treated in the now-defunct Fordham Hospital in 1974, and $2.9 million to an 11-year-old girl treated at Harlem Hospital in 1975.

The awards were believed to be the largest ever made for medical malpractice in New York and among the largest in the country.

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Vol. 13, No. 23—Business Insurance [ISSN 0007-6864] is published every other Monday at 740 Rush St., Chicago, Ill. 60611. Controlled circulation postage paid at Brookfield, Wis., Chicago, Ill., and New York, N.Y.

Surety bond frees magnetic hold

By RHONDA L. RUNDLE

LOS ANGELES—The trek of a "super-magnet" from Illinois to Northern California was delayed for three days by an 11th-hour request from the state of Iowa for a $500,000 surety bond against roadway damage.

The 107-ton load, thought to be the largest ever to be transported cross-country, finally started rolling Nov. 5 after Stan Jones Transportation paid an estimated $10,000 to purchase the bond from Holmes-Murphy Associates in Des Moines.

The Northern California hauling firm had purchased a $1 million public liability policy from Bellefonte Insurance Co. The agent who negotiated the contract, Paul Weenig of General Insurance Agency in Los Angeles, complained about Iowa's insistence on the bond. "It's like thumbing a nose at our insurance coverage," he said.

Photos: Mary Cairns

Transporting a 107-ton electromagnet across the country presents a multitude of potential liabilities.

The Department of Energy's super-conducting electromagnet is insured under a $3 million all-perils cargo policy, Mr. Weenig said. St. Paul Fire & Marine Insurance Co. is underwriting the policy, which has a $25,000 deductible.

The magnet has been used for 10 years at the federal government's Argonne National Laboratory outside Chicago to research subatomic particles. It's moving to a new home at Stanford University's Linear Accelerator Center in Palo Alto for use in a series of physics experiments designed to find new energy sources.

Transporting such a large load presents potential liabilities. The rig had to be specially engineered to distribute weight over a great length to avoid cracking pavement. Water, power and sewer lines under the highway could be damaged by the heavy load. If that happened, repair might require a temporary power shutdown to an entire community. The subsequent lawsuits could be enormous.

All of the Western states along the way issued permits for the transcontinental trip. But at the last minute, Iowa decided to require the $500,000 surety bond as an additional financial guarantee against possible damages.

Despite the inevitable traffic snarls sure to follow in the wake of such a load, the government ruled out both rail and water transportation. The magnet is too big to go by rail and too delicate to ship by sea. A trip through the Panama Canal would require at least four loadings and unloadings, bound to create stress on the $3 million magnet. Airbags will be used to cushion the load along the nation's highways. The estimated cost for the move is $1.5 million.

The journey will take three weeks or more depending on the weather. Stan Jones and an associate custom-designed the 140-foot rig with 18 axles and 120 wheels. (A standard tractor-trailer has 18 wheels.) The carrier resembles a very long hook and ladder fire engine, with a reel section steered separately by a second driver.

The rig will travel at speeds ranging from 3 m.p.h. to 25 m.p.h. and will take up two lanes of traffic. It can be raised up to 48 inches above the pavement to cross highway dividers and other obstacles. Because of road restrictions along the second leg of the journey, five axles and 30 wheels will be removed when the carrier passes into Wyoming. ■

the benefit beat

UAW wins higher pensions, health care at Deere

About 31,000 United Auto Workers members at Deere & Co. have won increased pension benefits in a new three-year contract ratified last month. The minimum benefit for both retired and current workers was raised to $17 a month per year of service from $16, with five increases of 40 cents throughout the life of the contract. A supplemental allowance for those who opt for "30 and out" retirement would be increased to $950 per month by March 1981 from the current $800 per month.

Workers also received several new benefits, including hearing aid coverage for current and retiring employes and their dependents; vision care coverage expanded to retired employes and surviving spouses, and medical coverage for catastrophic illness. The maximum dental coverage was increased to $1,000 per year and orthodontia payments were increased to a lifetime maximum of $850. The company pays all premiums for health insurance, which is written by John Deere Insurance Co.

UAW workers at International Harvester and Caterpillar Tractor Co. remain on strike.

Pension increase

Aetna Life & Casualty will give its retired employes a one-time pension increase of 2% for each year of retirement before Jan. 1, 1979.

About 4,600 Aetna retirees and surviving spouses will receive increases.

The increases will range from 2% to 66% per retiree. Employes retiring in 1979 and 1980 will also receive a 2% increase. The increase supplements an automatic annual 3% cost-of-living provision added to Aetna's pension plan in 1968 and will cost the company an estimated $2.4 million a year for the next 10 years.

Blue Cross rates up

Capital Blue Cross, which serves 309,000 subscribers in central Pennsylvania, has been granted a 12% overall rate increase on group coverages, effective Jan. 1. Increases range from 5.2% for 120-day family coverage to 23.3% for 30-day individual coverage.

On 30-day coverage, individual monthly rates will increase to $17.50 from $14.20 while family rates will rise by 23.2% to $40.60 from $32.95. Individual rates for 70-day coverage will increase to $18.30 from $16.85, an 8.6% boost. Family coverage rates will rise by 8.9% to $42.40 from $38.95.

Rates for 120-day coverage on individuals will rise to $18.40 from $17.40, a gain of 5.7%. Family coverage will cost $42.55, up 5.2% from the current $40.45.

The increases are the first approved by the state insurance department for Capital Blue Cross in two years.

Pregnancy benefits

New York has amended its regulations governing group health insurance contracts to no longer mandate extended benefits for pregnant employes except under the same circumstances as for any injury or illness.

New York had required that benefits covering pregnancy-related expenses be paid to workers who left their jobs after becoming pregnant. But the federal guidelines on pregnancy benefits would require employers providing extended benefits for pregnancy to provide them for all other injuries and illnesses (*BI*, Oct. 29).

Now, New York mandates that the extension of benefits beyond termination of coverage for illness, injury or pregnancy is only required when the covered person is totally disabled at the time of termination. The extension of benefits is limited to 31 days for hospital/medical coverage and 12 months for major medical benefits.

Health cover signups

The 18,830 eligible federal civilian employes who live or work in Rhode Island will be able to obtain or improve Blue Cross/Blue Shield coverage from Nov. 12 to Dec. 7. About 6% of the employes are already covered by the plans. High option coverage or the Medigroup health maintenance organization membership is available.

Under the high option plan, the $500,000 lifetime limit on maximum benefits has been eliminated and the only lid on supplemental benefits is a $50,000 limit on payments for treatment of mental illness. The program will pick up the tab for 100% of covered hospital services in a member hospital, up to 365 days; 100% of covered hospital services on an outpatient basis within 72 hours after emergency care or surgery; 100% of covered home health care, up to 90 days; 100% of customary charges for surgical and medical care such as x-rays, anesthesia and surgery; 80% of coverage for physicians' visits, prescription drugs, ambulance service and physical therapy after an annual $100 deductible, and an added catastrophic benefit paying 100% of covered supplemental expenses after a yearly $1,000 deductible.

Reconstructive surgery

South Dakota Medical Services Inc., the state Blue Shield plan, is being sued over its refusal to pay part of a claim for breast reconstruction after a mastectomy. The plan contends breast reconstruction is cosmetic surgery.

Patricia Koppmann, who filed the suit, argues that mastectomy is an amputation and that restoration of the breast is reconstructive, not cosmetic, surgery. The state Blue Cross plan had originally refused to pay the claim on the same grounds, but reconsidered and paid the hospital bills.

No date has been set for the case, which will be brought before a state circuit court in Rapid City. About 75% of the 115 Blue Cross and Blue Shield plans in the country, as well as Medicare, cover breast reconstruction.

Severance pay in Canada

Canadian employers and employes involved in a job termination should investigate the tax consequences of any proposed severance agreement, says a bulletin from William M. Mercer Ltd., employe benefit consultants.

The nature of the payment is determined by the circumstances of the employe's departure. Income tax authorities consider any benefit payment received from an employer before, during and after employment as earned employe income. But wrongful dismissal, constituting a breach of contract, may make the employer liable to pay money damages to the employe, which tax law considers non-taxable payments of capital.

The most recent federal budget, now in limbo, proposes that termination payments of up to half a year's pay should be taxed, a move apparently aimed at the tax status of payments for damage and their possible abuse, but the amendments do not state explicitly that the tax is on payments of capital, Mercer says. ■

Benefit Beat keeps risk managers and employe benefit managers abreast of changes in plans around the country as well as other important developments. We'd like to know if you've made any changes or know of any significant developments. Write Kathryn J. McIntyre, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611 or call (312) 649-5286.

Insurers fight forced structured settlements

By MARGARET LeROUX

CHICAGO—Legislation that would make structured settlements mandatory for malpractice and other liability lawsuits, favored by some attorneys but opposed by insurers, will be debated here next month.

The National Conference of Commissioners on Uniform State Laws drafted a proposal that would require juries to assess not only the size of monetary awards, but also the period over which the money be paid.

The insurance industry objects to the provision being mandatory, citing the problem of funding for inflation.

Also opposing the law are plaintiff's lawyers, who maintain that payment over a period of time would result in smaller monetary awards to their clients.

The chairman of the NCCUSL subcommittee that drafted the bill will hold a meeting Dec. 7 in Chicago with trial lawyers and insurance industry representatives to try and negotiate an acceptable approach to structured settlements.

Structured settlements are being frequently used throughout the U.S. as a means of settling malpractice and other liability lawsuits before the cases come to trial (*BI*, Aug. 20).

Instead of a lump sum, the injured person is guaranteed money over a period of time, similar to workers compensation settlements. Income is from the purchase of an annuity or establishment of a trust fund.

NCCUSL studied numerous state laws that allow judges to direct structured settlements in malpractice cases and found many discrepancies, says Phillip Carroll, a Little Rock, Ark., attorney who headed a NCCUSL sub-committee that drafted a proposal for periodic payment of judgments.

Once approved by NCCUSL, the model law will be introduced to state legislators and the group will lobby for its passage.

Similar legislation was introduced in California earlier this year by the Assn. for California Tort Reform, but the proposal was still in committee when the legislature adjourned for the year.

"The bill is still floating around Sacramento," says Los Angeles attorney James Ludlam, one of the bill's supporters. "But by the time the California Trial Lawyers Assn. gets through fooling around with it, it will be uninsurable and we'll have to lobby to defeat the law.

"The problem is insuring against inflation," he explained. "The insurance industry thinks about that and its hair stands on end."

Mr. Carroll said he doesn't understand the opposition to the proposed legislation. "There's something for everybody in this law. We're not changing the damage law; we're requiring juries to do their duty."

"I would think the plaintiff's bar would like this isolation of elements of future damages," Mr. Carroll said.

Current law states that monetary awards, based on the life expectancy of the injured person, be paid out even if that person dies immediately after the settlement.

The law proposed by NCCUSL would terminate payments upon the death of the injured person, except for future lost wages paid to dependents.

"Damages should be paid for injuries suffered," Mr. Carroll said. "If the person dies the plan isn't being suffered anymore," the money shouldn't continue to be paid.

"That's what is being done in workers compensation cases," he added, "and no one is objecting to that system."

Another feature of the NCCUSL proposal is a built-in inflation factor, basing future payments on the discount rate for 52-week U.S. Treasury bills.

"This is a pretty accurate assessment of inflation," the Little Rock attorney said.

Insuring for inflation is something the insurance industry is unwilling to do, says Fred Beck, general counsel for The Alliance of American Insurers. "With inflation so unpredictable, insurance companies would rather know they have to pay a certain amount right now," he said.

There's also the fear that liability cases could be reopened in the future if it were felt that because of inflation the injured person wasn't getting enough money, he said.

"Awarding damages related to the increasing cost of living rate is beyond the control of who is paying," Mr. Beck said. "We have trouble with the whole concept." ■

Man sues for death benefits

COALPORT, Pa.—Alan McCusker has picked up a sexual equality battle, a battle his wife fought until she was killed in a mine cave-in.

Marilyn McCusker broke tradition when she landed a job mining coal. But now her husband has been denied survivor's benefits because he's a man.

Mr. McCusker is up against an old state law that says widows, rich or poor, healthy or sick, can collect survivor benefits. But it denies benefits to ablebodied men whose wives die on the job.

Mr. McCusker decided to file suit when a Pennsylvania Mines Corp. official told him his son is eligible for about $130 a week in benefits, but Mr. McCusker is ineligible because he is capable of returning to his job as a carpenter.

Mrs. McCusker, 35, filed a sex discrimination suit against PMC subsidiary Rushton Mining Co. and got a miner's job and retroactive benefits in an out-of-court settlement two years ago. Two weeks ago, she became the nation's first woman reported killed in an underground mine accident.

"The only thing he'd (Mr. McCusker) be entitled to is a $1,500 burial fee," said Connie Mills, a legal assistant in the state workers compensation office.

"When Marilyn sued, it was with the understanding that it was for full benefits," Mr. McCusker said. "That's what this whole thing was about."

He could get unexpected help. Proposed amendments would substitute "surviving spouse" for "widow" in the present laws, said an aide to the state senate labor and industry committee chaired by Herbert Arlene (D-Philadelphia). ■

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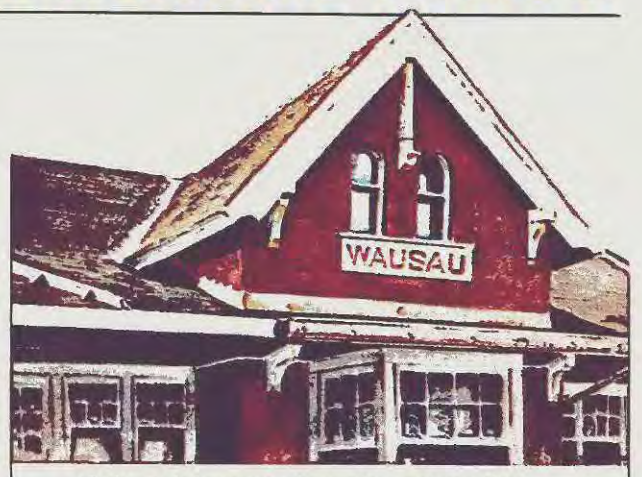

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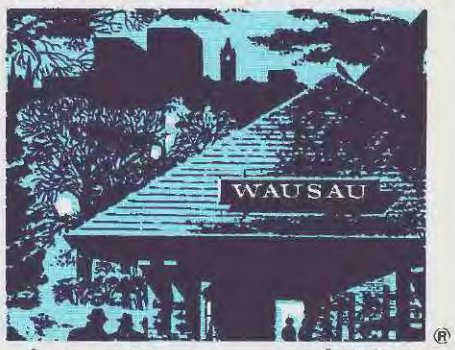

Employers Insurance of Wausau

Wausau Insurance Companies, Wausau, Wisconsin

Illinois regulators investigate broker for siphoned funds

By LEN STRAZEWSKI

CHICAGO—An insurance broker with offices in Illinois and Georgia may have bilked American Home Insurance Co. of up to $750,000 in premiums under a program for gasoline service stations.

An Illinois insurance department audit released this week cited Richard Kinst of Kinst Insurance Inc. here for holding back premiums owed to several underwriters of homeowners insurance including Underwriters Insurance Co., a branch of the Warner Insurance Group in Chicago.

The report does mention the commercial insurance premiums collected in Illinois, but the department is waiting for complaints from American Home, which is trying to recover the missing premiums, say sources.

American Home would not confirm estimates of premiums owed them by the Kinst firm. But insurer and brokerage sources, including former Kinst employes, indicate the Kinst agency may have held back as much as $500,000 in premiums paid for the American Home program and received an additional $250,000 for policies never delivered or reported to American Home.

The Kinst agencies have been reported to be floundering financially for more than a year, triggered by the purchase of a nearly bankrupt Atlanta agency, say sources familiar with the case. Mr. Kinst allegedly had to pledge accounts receivable as collateral for loans to pay his debts.

Located at his Atlanta office, Mr. Kinst was in a meeting "with a group of people who might buy the business," said an employe, and did not talk to *Business Insurance*.

Mr. Kinst's lawyers, however, told *BI* the broker denied any wrongdoing with Underwriters Agency Inc. and is countersuing the insurer, charging the firm and a former Kinst employe, Edwin P. Johnson, now with the Cermak Insurance Agency in Berwyn, Ill., conspired to steal his book of business.

Mr. Kinst's countercharges also say Underwriters stole his account records for its policyholders as well as others and sold his business to Mr. Johnson at exceedingly cheap rates, even after he offered partial payment for his debts.

Mr. Kinst's lawyers denied knowing about any debts to American Home Insurance Co. or an insurance program for gasoline service stations, though they acknowledged Mr. Kinst's agency did sell that kind of coverage.

Though the Illinois insurance department has not yet asked for restitution or revoked Mr. Kinst's brokerage license, the action is expected after Mr. Kinst responds to the department report.

"He's a very polished salesman and can tell a good story," said a former employe, "and I understand he is a man of means so he may be able to make restitution for what he owes."

In addition to the commercial premiums, Mr. Kinst allegedly owes more than $100,000 to Underwriters and additional funds to other personal lines insurers covering more than 1,700 policyholders in Illinois.

Though the Georgia agency is reportedly still in poor financial condition, the Georgia insurance department reports it does not have complaints on file and is not now investigating the office. ■

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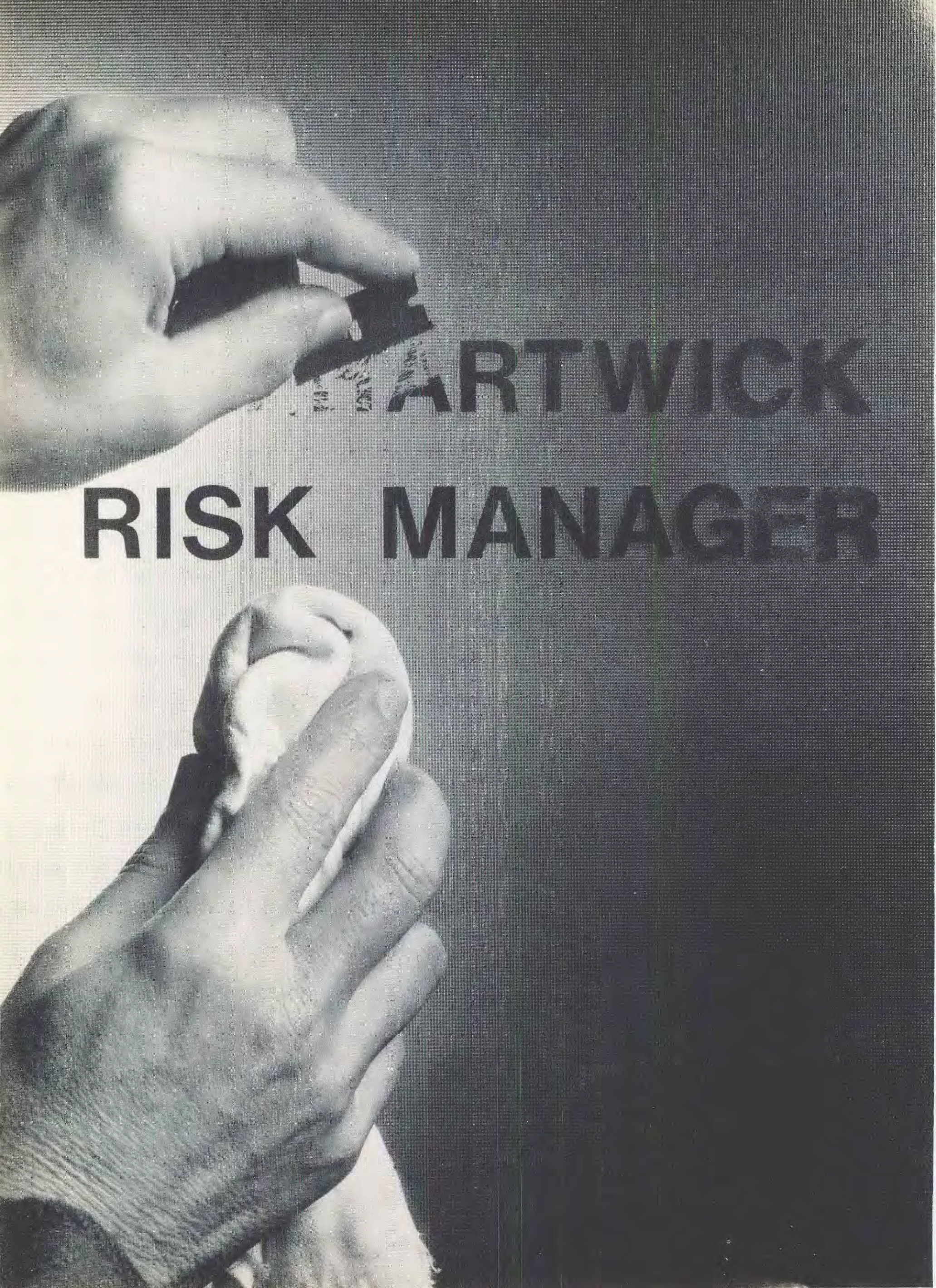
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James cuts London, taps U.S. insurers for oil drilling risk

CHICAGO—Cutting Lloyd's out of a risk traditionally dominated by the London market, Fred S. James & Co. has united six U.S. insurers to underwrite an oil field risk in the Arabian Gulf.

The move to tap domestic markets for this kind of risk—two oil rig structures designed to collect and process natural gas released in oil drilling—is particularly unusual because it presupposes a level of oil and gas expertise not usually granted to U.S. insurers.

Fred S. James has also reversed its usual procedure with this plan. Of the large U.S. brokerage houses, James is said to have the largest billings with Lloyd's.

"London brokers have always gone around the world to bring business to London, and this business in particular," explained J. Kevin Lally, James vp for marine business.

"As a consequence, perhaps the American market did not develop the expertise or the capacity to work these risks. London has had what amounted to a monopoly to handle this business for many years," he said.

U.S. insurers and brokers, however, have now developed the expertise to compete with London on oil and gas risks, he said.

A James spokeswoman declined to reveal the U.S. insurers who will share the primary layers of coverage, but explained that a list of insurers in another publication was incorrect. Lloyd's, in addition to Continental and Eastern insurers, will share the excess insurance of $100 million.

The cost of insuring the structures, which are called "10-legged jackets," was also not revealed, but the cost of construction is expected to reach $150 million.

The oil field project is expected to provide U.S. brokers and Fred S. James in particular with an entrance to the rich Arab and Mexican oil markets, business that the Lloyd's reputation for oil and gas expertise has prevented from crossing American desks.

"We are not trying to displace the London market," Mr. Lally explained. "We want our fair share. If the American market is going to expand, we have to get involved in Arab and Mexican oil."

James is also reportedly competing against Lloyd's brokers by trying to consolidate all the marine liabilities of the Abu Dhabi Oil Co. into one program—a $300 million accident policy—and attract oil rig risks away from London as the structures come up for renewal.

The U.S. brokerage has found an ally in Alexander Howden Group in London, which has experience in handling Arab business and is interested in the class of business sought by James.

"We got the opportunity to quote the business against the London market, put in a proposal with Alexander Howden and the American underwriters and took the business," Mr. Lally said.

U.S. underwriters are expected to continue to try to expand their sphere of business, said a James spokeswoman, and more programs of this kind are in the planning stages. But the road to Arab business may be paved with rocks.

James executives have been reported as being displeased with the Lloyd's dominance of this class of business and have complained about the difficulty of getting accurate information about the risks.

"We are at a disadvantage because London controls these policies so London brokers know what is being written," explained senior vp Charles R. Robbins.

"The American market has difficulty getting all the information about the risk because the market is disparate and dispersed, unlike Lloyd's.

"Lloyd's underwriters are used to getting scant information and writing a risk quickly. Here it takes more time and analysis to get things done," he said. ■

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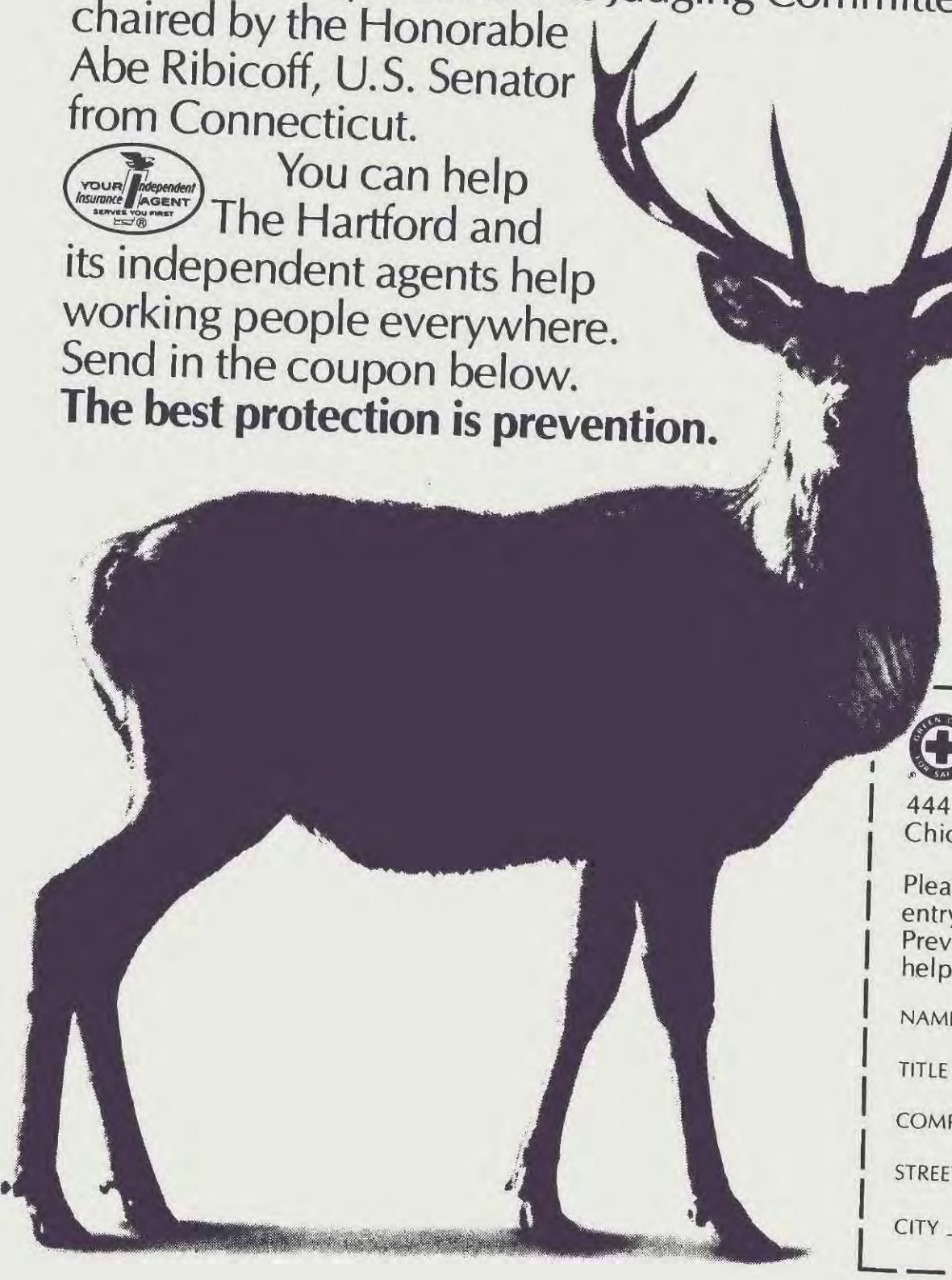

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Pa. arbitration officials want panel reform

By MARY ELLEN McKEE

HARRISBURG, Pa.—The most used arbitration system in the country for settling medical malpractice claims could be shut down by an overload of back work if state legislators don't revamp the system, say arbitration officials here.

Blaming the backlog of cases on the cumbersome size of arbitration panels, the administrators of the arbitration system are asking the state legislature to reduce the panel size to three from seven. They also want a new method for selecting panel members.

Meanwhile, the state supreme court has agreed to reconsider whether the Health Services Malpractice Act of 1975 creating the mandatory arbitration process for medical malpractice claims is constitutional. The court upheld the constitutionality of the act last year, noting there hadn't been sufficient time to determine whether the law had worked to speed claim settlements.

"Compulsory arbitration of medical malpractice claims was signed into law to speed up the settlement of medical malpractice claims, not slow it down," argued attorney Stephen M. Feldman, who has filed legal challenges with the eastern district of the supreme court of Pennsylvania. "Some of the cases that were filed in 1976 when the bill was first enacted are still unresolved. In my mind, that proves the failure of the system," he said.

Attorneys, physicians and professional arbitrators outside Pennsylvania are watching the developments and problems with arbitration very closely. Despite the problems with the organization of arbitration in Pennsylvania, it has been the most utilized of all arbitration systems in the nation (*BI*, Sept. 3).

The fate of the amendment to the Health Services Act and the eventual reshaping of the process in the amendment "is going to affect how arbitration is used in other states and in other areas, such as product liability," said Peter Ericson, deputy administrator of the Office of Arbitration Panels for Health Care.

Even the Philadelphia County Medical Society and the Philadelphia Bar Assn. are joining forces to ensure that modifications are made to the present system rather than returning to a jury trial system. In an all night meeting recently, the groups drafted a resolution outlining the changes they believed vital to make the arbitration system thrive.

In addition to endorsing the amendment before the state senate to cut the panel size, the resolution recommends: eliminating conformity to the rules of evidence; appointing a new arbitration panel for each action, barring permanent professionals from serving on these panels, and allowing each arbitration panel to determine whether a claim or the defense of the claim is arbitrary, capricious, frivolous or brought or defended in bad faith.

Following the appointment of an arbitration panel and before the date of a hearing, trial memoranda, medical records, experts' reports and opinions with other documents counsel believes relate to the issues should be submitted to each panel member, the resolution states. The resolution also advises that if nine months elapse after a certificate of readiness is signed by all parties in a medical malpractice suit, the case should be immediately and automatically transferred to a court of appropriate jurisdiction.

"It's one of the first times both groups have teamed up on the same side," said a spokesman for the Philadelphia Bar Assn. The efforts of two of the most influential and powerful groups in the state should ensure the acceptance of the amendments to the malpractice act by the Senate and eventually the governor, the spokesman said.

The cooperation of one of the state's bar associations and medical societies reflects the importance of preserving the arbitration system in Pennsylvania, emphasized Mr. Ericson of the Office of Arbitration Panels for Health Care.

The amendment awaiting the approval of the general assembly targets two problem areas of the arbitration process: the size of the panels and the way they are selected.

"We realize that there are more than two weak points in the system, but we think they are the major causes of the backlog of cases. We're trying to take one step at a time and take steps prudently," said Mr. Ericson. "It's silly to think you can revamp a system in one sweep."

Under the amendment, panels would be selected by the administrator of the Office of Arbitration Panels. Each side will then be given an opportunity to challenge one person on the list drawn up by the administrator.

Currently a list of five attorneys, health care providers and lay people are presented to each side in the malpractice case. Each side is allowed to strike two people from each category and must return its lists to the administrator. If a seven-member panel cannot be chosen after the initial weeding out process, different lists are circulated two more times. If a panel cannot be selected after three tries, the arbitrator must make the final decision on the panel.

But Mr. Feldman, the attorney challenging the constitutionality of the law creating the arbitration system, considers efforts to revamp the law a waste of time. Plaintiffs' attorneys will continue to challenge the constitutionality of the act no matter how many amendments are tacked onto the bill, he said.

Mr. Feldman, representing a Northampton County widow who was suing a doctor for malpractice in the death of her husband, set in motion the most recent appeal raising the issue of constitutionality of the malpractice act.

In this petition to the eastern district of the supreme court, Mr. Feldman noted that only four of 2,127 malpractice claims filed between Jan. 14, 1976, when the act took effect, and May 23, 1979, had been disposed of through arbitration. At that rate, claims being filed at the average rate of five a day will remain unresolved for years, Mr. Feldman charged.

If Joan Mattos, Mr. Feldman's client, had been allowed under the law to file her malpractice claims in common pleas court as she would have been able to before the enactment of the malpractice act, the case would already have been resolved, he argued.

"The figures the attorney used in this case are very deceptive," coun-

tered Mr. Ericson of the arbitration office. He admits that 2,566 claims have been filed with his office, 2,000 of which have crossed his desk in the past 18 months. "What Mr. Feldman and other attorneys don't mention when attacking this system is that 551 of those claims have either been settled or discontinued before going to an arbitration panel and 70 cases are in the final stages of preparing for an arbitration hearing.

"Naturally, it makes the system look inadequate and ridiculous when people say that of the 2,566 cases that have been filed with us only 10 cases have gone through the entire arbitration," Mr. Ericson admitted. But when the cases that have been settled or those that are ready for a hearing date to be set are considered, the situation admittedly appears disconcerting, but not impossible, he added.

Mr. Feldman finds Mr. Ericson's figures equally misleading. "If the public were to really examine the nature of the 10 cases that have actually been tried, the inadequacy of the arbitration system would be obvious," he said.

Of the 10 cases that have gone through the arbitration process, one is a suit filed against a dentist, which is not supposed to be handled by the arbitration panel but transferred immediately to a common pleas court. "Theoretically, this case should not be included in the statistics being circulated by the Office of Arbitration Panels for Health Care. It's loaded dice," Mr. Feldman complained.

Another of the 10 cases listed by the Office of Health Services to have completed the arbitration process is also suspect, Mr. Feldman said. The case involved a resident of a hospital who lost control of a circular saw when he was removing a hip-to-ankle cast from a young athlete. The athlete lost the use of his leg.

Mr. Feldman charged that all of the 10 cases that have completed the arbitration process are not the typical medical malpractice cases. All were deliberated and a final decision issued in one day, Mr. Feldman said.

Mr. Ericson and the other 28 employes of the Office of Arbitration Panels for Health Care are turning a deaf ear to the charges being made by Mr. Feldman and some of his colleagues. "No matter what statistics are used, the real issue here is the backlog of cases. And we are attacking that problem with the amendment before the Pennsylvania senate," Mr. Ericson said.

"The real question in the case is not how many panelists should serve on an arbitration panel but whether arbitration itself is constitutional," Mr. Feldman remarked. "The legal and medical communities have to analyze the medical malpractice problem and decide how and if the arbitration system does anything that the jury trial does not do." ■

Doctors to appeal ruling against arbitration unit

MIAMI—The Florida Medical Assn. will appeal a Dade County court ruling that the state's four-year-old statute establishing arbitration boards to hear medical malpractice cases is unconstitutional.

The ruling, handed down late last month by circuit court Judge Arden M. Siegendorf, would end the requirement that patients go before a mediation panel before taking their malpractice case to court.

"We feel the judge has ruled in a situation that is outside his jurisdiction," said Sam Flowers, director of communications for FMA. "This is a legislative matter."

But Florida trial lawyers cheered Judge Siegendorf's ruling for eliminating the "enormous obstacles that blocked the rights of injured patients to file claims," said Miami attorney Larry Stewart.

"It is a great day for the public," added J.B. Spence, chairman of the Florida Academy of Trial Lawyers malpractice committee.

In his decision, Judge Siegendorf said the mediation process was unfair to injured patients who sue their doctors because:

- The system bars claimants from questioning the panel's ruling, which in 80% of cases has gone against the plaintiff once the case goes to trial.
- Lawyers are discouraged from accepting medical malpractice cases because of the time and expense of going through two legal procedures.
- Claimants are required to pay panel members' expenses. Those expenses can run as high as $100 a day.

Trial attorney Mr. Spence said the three-man panels, made up of an attorney, a judge and a physician, often are inept and incompetent.

"The claim often was decided in a kangaroo court, but their findings could not be cross examined" when the ruling was appealed in court, he said.

But the medical association's Mr. Flowers said the malpractice boards are working extremely well, resulting in 92% of malpractice claims being closed without a trial.

Judge Siegendorf's decision involved the October 1975 treatment of Jack K. Kelley of Charleston, W.Va., for a back problem by Miami physician Dr. Bradley Reuben.

Mr. Kelley charged that Dr. Reuben's treatment caused a spinal disc to rupture. Mr. Kelley later filed suit in Dade County circuit court.

But before the case went to trial, it went before the mediation panel, which ruled 2-1 against Mr. Kelley. He then filed a motion in circuit court asking that the finding of the mediation panel be excluded from the civil trial, contending the panel was unconstitutional.

In his ruling, Judge Siegendorf noted the 1975 law creating the mediation panels was passed in what was termed a medical malpractice crisis, but "to the extent it ever existed (the crisis) has certainly passed," with companies writing medical insurance now recording "almost exorbitant" profits. ■

editorial opinions

Health care economy

CONTAINMENT of health care costs can only be accomplished by (a) the voluntary efforts of hospitals and employer efforts stressing preventive medicine, or (b) state regulation of hospital rates and expenses, depending on whether the speaker is pro-hospital or a self-proclaimed consumer advocate.

J. Alex McMahon, president of the American Hospital Assn., faced off against Louis A. Orsini, vp and director of consumer relations with the Health Insurance Assn. of America at the 33rd fall conference of the Council on Employe Benefits last month, each pleading respectively for less regulation and more regulation of health care providers.

It was an old confrontation with a new twist. Mr. Orsini proselytized in the name of big business (those employers who pay the health benefit bills of their workers) for more government regulation of a specific sector of business (both big and small)—the hospitals. It was an irony difficult to miss and even more difficult to explain logically. He is, to say the least, an outspoken and articulate advocate of hospital rate regulation to hold down health care costs.

Perhaps we can simply explain this paradox by saying it depends upon whose ox is being gored whether business favors or opposes government regulation.

On the other hand, Mr. McMahon, as glib a spokesman as ever there were for the health care industry, refuses to acknowledge that any fault at all for health care inflation lies with the hospitals.

He listed more than a half-dozen things business can do about health care inflation to try and hold down the size of hospital bills. Everything he mentioned has merit, but hardly offers solutions. Business has to recognize, he urged, that:

- The health care delivery system has built into it a number of "strange incentives" forcing demand for services to ever-higher levels, pushing up prices.
- Reliance on health insurance is part of the problem.
- Promotion of healthy living habits and preventive medical care would have a salutory effect on use of hospital services.
- Discussions beginning in Washington will have a bearing on the role health insurance plays in health care inflation, as the government looks at proposals to require deductibles, insist on participation in HMOs and impose ceilings on employer contributions for worker health insurance benefits.
- It's wrong to rely on more regulation of health care providers to cure the ills of the system.

Lou Orsini's outlook for the bills employers pay is pessimistic, to say the least. Next year, he predicts, employers will "see a steepening of hospital cost increases in the voluntary sector," in part because the federal government has decided it won't reimburse hospitals under Medicare for certain costs they incur, which will force hospitals to shift those costs to patients whose bills are paid by private employers, covered by private insurance.

The need is for a system of uniform hospital accounting and pricing, says Mr. Orsini, who wants federal legislation requiring hospitals to disclose prices and costs for specific treatments and services, so consumers can do some better "comparison shopping" for health care.

Taking the best of both men's suggestions, we believe insurers and employers should use their purchasing influence to obtain price and cost breakdowns on specific services from hospitals, facilitating the use of reimbursement schedules beyond those now used only for room charges. Patients and employers should have access to price breakdowns for hospitals in each city, county and state, for purposes of price comparisons on a wide range of specific services including x-rays, diagnostic tests, emergency room services, surgical rooms, anesthesiology, intensive care, oxygen, heart monitors, CAT scans, and a host of other frequently used treatment services.

Granted, this is only one small step in solving the problem of inflation in the health care system. But it is an important one in introducing an element of competition into the system, critical if for no other reason than that more of each hospital's business these days is coming from patients admitted not by family doctors but who walk into an ambulatory care facility.

At the same time as we strive for competition among hospitals, the system badly needs two other vital elements: competition among physicians and other health care professionals, and enough copayment of health care bills by private citizens that they have a stake in the economic health of the system.

letters

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

Offensive article

To the editor: Regarding the article "Thou shalt not forget these" in your Oct. 1 issue.

The undersigned and indeed a great many of the Jewish community would be appalled at Mr. Betterley's disgusting portrayal of a purported Jew in his wearing a Jewish skull cap and attempting to play Moses to a waiting audience of risk management consultants.

I find it disgusting in this day of attempting to iron out difficulties between all races that it is necessary for such conduct to go on. I do not see why *Business Insurance* apparently condones this practice by printing such a story without any type of editorial comment. Your magazine should use better sense when printing such stories. Either an editorial comment is called for to disclaim your responsibility in it, or some other appropriate comment.

I would hope that the financial insurance executives and insurance managers who attended this convention in San Diego have better practical sense than to condone this type of activity. I feel it is another example of the patent or latent prejudice that exists in the United States toward certain ethnic groups.

Peter S. Meyerhoff
Attorney, Portola Valley, Calif.

Editor's note: It is unfortunate there should be any misinterpretation of the "10 commandments for consultants." They were spontaneously prepared as a lighthearted jab at fellow consultants in the same way 10 commandments have been written for almost every occupation including teachers, lawyers, housekeepers and clergy. Interestingly enough, the Moses appellation and skullcap were given Mr. Betterley by one of the highly respected members of the Institute of Risk Management Consultants who is Jewish.

Taking exception

To the editor: I am writing you concerning an article in the Oct. 1 issue of *Business Insurance*, based upon an interview with Alan Pearce of Foremost-McKesson.

Frankly, I must take strong exception to Alan Pearce's statement concerning CIRCL, which describes the purpose of the pool becoming a "political football." The purpose of the CIRCL has never changed from the time of its inception. These purposes are to:

- Provide cost savings to the participants.
- Develop a new market.

Continued on page 88

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Published biweekly at 740 Rush St., Chicago, Ill. 60611 (312-649-5200). Offices: 708 Third Ave., New York, N.Y. 10017 (212-986-5050); Suite 1253 National Press Building. Washington, D.C. 20004 (202-638-5300); 6404 Wilshire Blvd., Los Angeles, Ca. 90048 (213-651-3710). $1.00 a copy. $20.00 a year in U.S. Foreign $5 a year additional. For first class mail add $20.00 U.K. and Canada; add $12.00 for air delivery Europe and Middle East only. WILLIAM STRONG, *vp-circulation*. PAMELA JANOUSEK, *circulation manager*; ROGER DiGREGORIO, *fulfillment director*. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 740 Rush St., Chicago, Ill. 60611 or phone 312-649-5221. Telex 25-4248; Cable CRAINCOM. Microfilm copies are available from University Microfilms, 300 Zeeb Rd., Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Rd., Wooster, Ohio 44691.

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Auto workers agree to delayed benefits in Chrysler contract

By JOHN MAES

DETROIT—Chrysler Corp., despite its current financial plight, agreed to a tentative three-year contract with the United Auto Workers that will bring pensions and benefits into parity with Ford and General Motors workers by the third contract year.

However, Chrysler UAW members made some concessions in various economic areas of the pact to bolster Chrysler's cash flow, which are expected to save the ailing firm $203 million in the next two years. Ratification is expected to be announced this week.

The union has already allowed Chrysler to defer some $200 million in payments to the UAW pension fund.

Most of the benefit concessions involved pensions, but Chrysler workers won most of the same improvements in group health and major medical insurance that Ford and GM employes won.

The pact, covering some 124,000 hourly and salaried workers, calls for pension increases totaling 70% of what Ford-GM workers will receive the first two years. But "catch-up" increases will provide Chrysler retirees on the 30-and-out system with the same $915 monthly benefit as Ford and GM retirees get by Aug. 1, 1982, according to a UAW report.

Despite the eventual parity, 30-and-out payments for a new retiree next January will be only $770 per month, $30 less than a Ford or GM worker in a comparable situation.

In basic retirement benefits, Chrylser workers will receive $14.50 per month per year of service as of Jan. 1, 1980, a lesser benefit than the $16 Ford and GM will pay. However, the rate in all three pension plans will rise to $18.25 over the life of the agreements.

In exchange for pension concessions, the UAW won other pension gains "beyond the pattern" settlement, the union said. The company agreed to invest pension funds in residential mortgages for workers and other "socially desirable" projects. Chrysler will also restrict investments in firms which "practice racial discrimination while conducting business in South Africa."

Chrysler workers won the same improvements as Ford and GM employes in life insurance, disability, sickness and accident payments, accidental death and dismemberment, dependent group life coverage, survivors' income protection, Medicare premiums, dental care, vision care and SUB benefits (*BI*, Oct. 1).

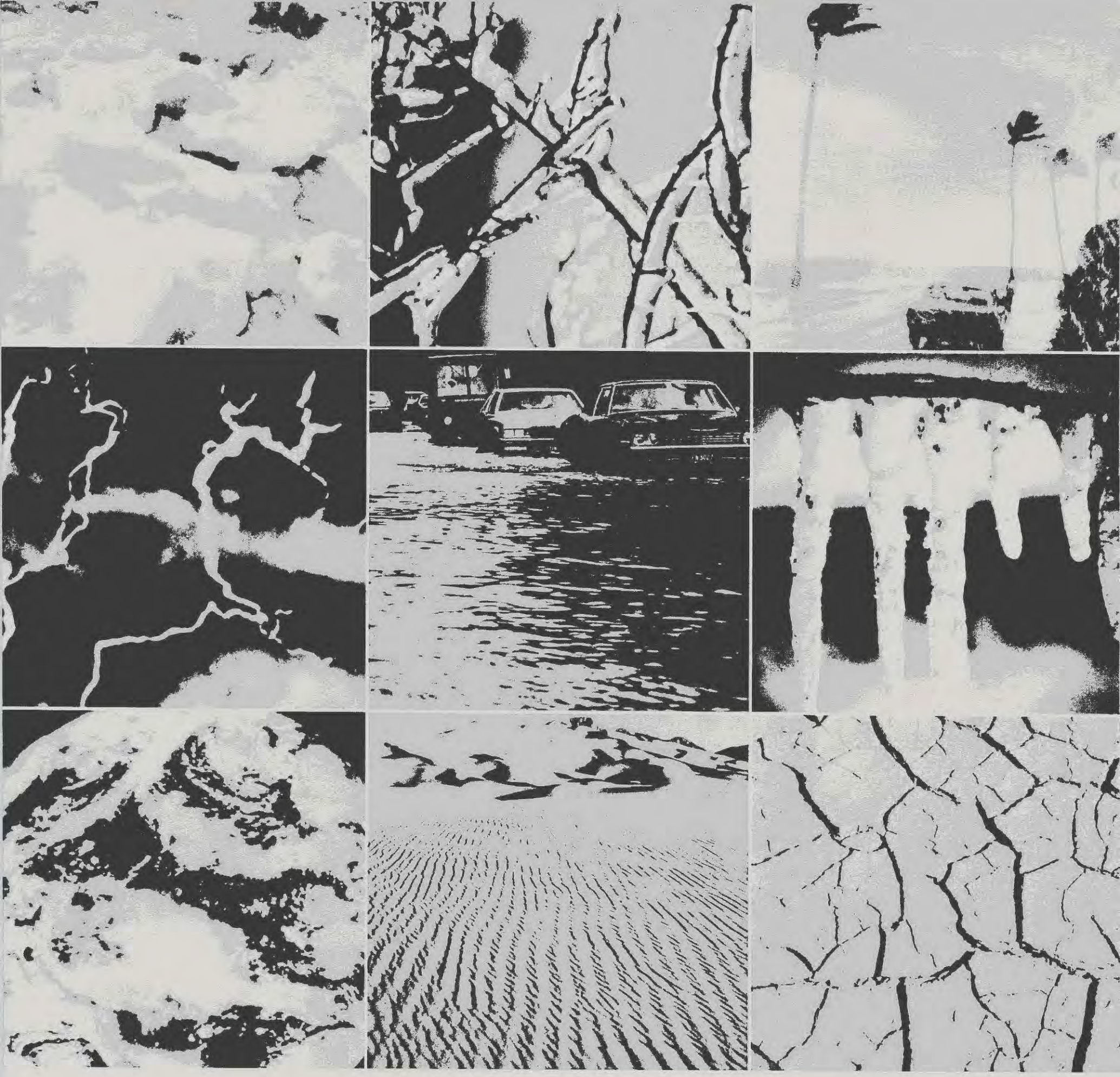
Chrysler workers did not win the same stock ownership plan as Ford-GM employes because the firm currently does not have the money to finance it. However, Chrysler agreed to form a TRASOP and will set up a stock plan similar to that given Ford and GM when the company's financial condition improves.

For salaried workers, life insurance will be increased to at least $33,000 from the current $25,000 while accidental death and dismemberment benefits will jump to at least $16,500 over the contract period from a previous $12,500.

Monthly extended disability payments will rise to at least $945 from a previous $725 for a worker with 10 or more years of service. A worker with 10 or fewer years of service will get at least $860 in benefits instead of $660 under the old pact. ■

Fischer named vp

Frank K. Fischer Jr. has been appointed regional vp of Montgomery & Collins Inc., a unit of INA Special Risk Facilities Inc. He will be responsible for establishing an office in Chicago and will supervise Montgomery & Collins's Midwest offices. He served as president of Allstate's Northbrook Excess & Surplus Insurance Co. before retiring recently.



It's snowing where it never snows.
It's flooding where it never floods.
Here's how to keep the weather from being bad for business.

It snowed in Palm Springs, California last winter. And in Georgia and the Carolinas. And in the Sahara Desert. In fact, this past August, it snowed in New Hampshire.

Heavy rains are becoming just as unpredictable. Flood control engineers who used to think that preparing for a "100-year-record" was caution itself now speak of 200-and 500-year-records.

Weather patterns are changing. And they can change your profit picture. In the first nine months of 1979 alone, underwriters paid out a record $1.6 billion in insured losses on 41 "weather-related catastrophes."

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D&O claims' incidence rises: Wyatt report

CHICAGO—One out of every nine Fortune-listed companies will be hit with a claim against its directors or officers by year-end, up from one in 11 in 1978, according to The Wyatt Co.

The average D&O claim now costs $903,229 in defense and losses, but in that average are 60% of the claims closed without payment. Payments made to claimants average $1.2 million.

These are among the conclusions of Wyatt's 1979 directors and officers and fiduciary liability survey of 1,669 U.S. corporations. With its five previous surveys, Wyatt has become the most respected source of information on directors and officers liability insurance.

The surveyed companies have assets from less than $10 million to more than $2 billion and represent all segments of U.S. business.

The average cost of a D&O claim is down from the average in the 1978 survey, but Wyatt suggests the decrease may be attributable to the reporting or nonreporting of large costs. The average of 60% of claims closed without payment is consistent with the 1978 survey.

But more D&O claims are being filed each year; the increase in 1979 compared with 1978 is 21.6%. Since 1971, the number of D&O claims filed has increased steadily from nine to 83 in 1978.

Of the 369 claims reported by 236 of the surveyed firms, 215 or 58% were covered by D&O insurance. Respondents were uncertain if coverage existed for 81 or 22% of the claims. No insurance covered 64 or 17.3% of the claims, with 24 claims involving incidents outside the policy coverage and 40 occurring when no insurance had been purchased.

The 7.5% of the 320 claims falling outside the scope of purchased insurance is an increase compared with the 1978 survey results, when 5.9% of the claims were outside the coverage.

The increase "may be due to exclusions attached to D&O policies in recent years, including exclusion of illegal payments to public officials, antitrust violations or claims arising out of real estate investments," suggested Wyatt's Warren Brockmeier, author of the survey.

In 195 of the 369 claims, individual claims were reported to be reimbursable by the corporation and 22 partially reimbursable. In 35 or 9.5% of the claims, individual claims were not reimbursable. But in 108 or 29.3% of the claims, reimbursement of individual claims remains undecided compared with uncertainty of insurance coverage for 22% of the 369 claims.

"In spite of criticism of the vagueness of coverage under D&O policies, it appears that the D&O policy is equally certain in its coverage as corporate bylaws or indemnification agreements," Mr. Brockmeier says. Only about 10% of all claims, however, will fall under the individual D&O section of coverage compared with the corporate reimbursement section.

More than a third (140) of the reported claims are still open waiting trial, and 17 have been tried but are being appealed. Ninety-seven or 26% of the claims were closed by settlement, 64 or 17% were closed by litigation and 42 or 11% were dropped by the claimant.

Projecting that 60% of claims will be closed with no damages paid, Wyatt estimates that the ultimate claim distributions will fall with 9.9% paid for less than $20,000, 8.1% for $100,000 to $200,000, 5.3% for $20,000 to $50,000, 4.3% for $50,000 to $100,000 and 3.5% for $500,000 to $1 million. While 2.3% of all claims will be paid for $2 million to $5 million, only 1.1% will get damages of more than $10 million, Wyatt says.

To cover these losses, almost three-fourths of the participants reported carrying an insurance policy with a split deductible instead of a single deductible, a trend that has grown steadily since 1973.

A split deductible has a fairly modest deductible applicable to the liability of each individual director or officer, an aggregate limit on the total of such deductibles arising out of any one occurrence and a separate deductible applying to the coverage for the corporation for reimbursement to directors and officers.

The majority of all companies with assets of more than $15 million used a split deductible in the 1979 survey compared with the majority of companies with assets of more than $25 million in the 1978 survey.

The most common split deductible applying to individual liability is $5,000 (48%) and $10,000 (35%). Half the companies using a split deductible choose $20,000 as the aggregate deductible, with 11% choosing $10,000, 10% choosing $25,000 and 16% choosing $30,000.

The deductible for corporate reimbursement under the split deductible is scattered from $20,000 to more than $100,000 with 10% choosing $20,000, 21% choosing $25,000, 20% choosing $50,000, 15% choosing $100,000 and 11% choosing $75,000 or more than $100,000.

Those carrying a single deductible most often choose $20,000 (38%), $5,000 (24%) and $10,000 (17%).

These figures represent only a modest change in deductibles compared with the 1978 survey. The single deductible increased just 3%, and under the split deductible the individual deductible dropped 2%, the aggregate deductible increased 1% and the corporate deductible increased 10%.

Above the basic deductible, 53.8% of the companies accept a 5% retention on losses up to $1 million, up from 51.3% in 1978. But only 18.5% of the companies accept a 5% retention on losses up to the policy limits, down from 21.8% in 1978.

The most frequently reported policy limit is $10 million, as it has been since 1976 when $10 million replaced $5 million as the favored limit of coverage. The average limit in the 1979 survey of $10.4 million is a 10.4% increase from 1978.

Almost 25% of the 1,337 participants in the study carrying D&O insurance had limits of $15 million or more, compared with 20% last year. The highest reported limit was $75 million, with 16 companies reporting limits of $50 million or more, twice the number in the 1978 survey.

Classed by industry, the largest 100 industrials tend to carry the highest limits averaging $26.1 million, followed by the utilities carrying an average of $24.5 million and the next largest 100 industrials carrying an average limit of $20 million. Life insurance companies carry the lowest average limit of $12 million.

Premiums paid for D&O insurance, generally underwritten by the excess/surplus market, remained unchanged for 40.7% of the surveyed companies. Another

15.7% of the companies reported premium changes of less than 5% up or down. Only 7% of the companies reported premium reductions of 5% to 80% while 36.6% reported premium increases ranging from 5% to more than 300%.

The most frequent premium increase was 5% to 20% (11.3% of companies), followed by 20% to 40% (10.8% of the companies). Thirty-seven companies reported premium increases of more than 100%.

Within industries, finance and leasing companies have suffered the highest premium increases recently and premiums charged utilities are going up because of emerging environmental action issues.

D&O premiums charged merchandisers have leveled off from the sharp increases after W.T. Grant went bankrupt and was sued. Premiums charged manufacturers may be going down.

Generally, premiums are back to the 1974 level after dropping in 1975 and 1976 in the heat of competition for D&O business. The good D&O risk still enjoys some competition for its account, Mr. Brockmeier notes.

But organizations with higher policy limits are experiencing premium increases of about 20% because losses have penetrated policy layers of more than $5 million. Companies with apparent problems with stockholder suits, public litigation or other matters spurring D&O claims have sometimes experienced sharp increases in premiums.

Wyatt concludes, however, that the general level of premium adjustment by underwriters is not excessive. But Mr. Brockmeier also warns that if a sharp recession affects the general economy, sizable losses may ensue and general premium levels may rise sharply.

Now, the average premium paid for D&O liability insurance ranges from a low of $3,066 for $1 million of coverage purchased by a company with less than $10 million in assets to $184,538 for $40 million of coverage purchased by a company with over $2 billion in assets.

As would be expected, the premiums generally increase with company size and amount of insurance purchased.

For example, companies with assets of between $150 million and $250 million pay an average of $10,546 for $3 million of D&O insurance, $15,291 for $5 million of coverage, $24,596 for $10 million of coverage, $33,923 for $15 million of coverage and $27,809 for $20 million of coverage.

Companies with over $2 billion in assets pay an average of $43,524 for $5 million of coverage, $69,273 for $10 million of coverage, $114,460 for $20 million of coverage and $124,325 for $30 million of coverage.

American International Group continues to dominate the insurers underwriting D&O insurance with 29% of the primary policies and 27.4% of the excess policies. Swett & Crawford and CNA are holding their shares of the market in the top six underwriters. Swett & Crawford has 15.5% of the primary policies and 9.8% of the excess. CNA has 11.5% of the primary policies and 4.3% of the excess.

Crum & Forster is growing steadily in D&O insurance, particularly among small and medium sized companies. It has 12.1% of the primary and 18% of the excess market.

MGIC has increased its D&O underwriting to 5.1% of the primary policies, especially for financial institutions. Midland is underwriting more D&O insurance for hospitals, but has only 1.4% of the primary policies.

Lloyd's of London, the best known traditional D&O underwriter, is losing more of its share of both the primary and excess insurance market, except for very large accounts.

Its primary market share is down to 10.5% from 13% last year and its excess market share has fallen off to 23.1% from 26.3% last year. Before 1978, Lloyd's underwrote more than a third of the excess D&O insurance policies reported to Wyatt.

But Lloyd's is still a major reinsurer of the domestic D&O insurance underwriters, Mr. Brockmeier notes.

By industry, AIG is the major underwriter of D&O insurance for construction and real estate, insurance companies, manufacturers, merchandisers, petroleum, professional services, publishing and communications and utilities. It also dominates in the market for companies with more than $25 million in assets.

Swett & Crawford is the major underwriter for transportation companies. MGIC dominates the banks and Midland the hospitals. Crum & Forster Group dominates the companies with less than $25 million in assets with 25% of the policies, but AIG is close behind with 22% of the market.

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The 1979 Wyatt Directors and Officers Liability and Fiduciary Liability Survey can be obtained for $60 from The Wyatt Co., 5600 Sears Tower, 233 S. Wacker Drive, Chicago, Ill. 60606.

Profile of a claim

The larger the corporation and the more diversified it is, the more likely it is to be hit with a directors and officers liability claim, The Wyatt Co. says.

Directors and officers of a publicly held company also are three times more likely to be sued than those of a privately held corporation, Wyatt notes.

The two most frequent allegations in D&O liability claims are that the directors and officers made misleading representations (21.4% of the claims) or that they colluded or conspired to defraud (13.6%).

Other allegations made in claims reported to The Wyatt Co. include civil rights denial (7.9%), antitrust violations (7.6%), failure to honor employment contract (6.5%), improper expenditures (6.2%) and breach of duty to stockholders (6%).

The largest percentage of D&O liability claims (40.4%) continues to be filed by stockholders. The next largest source of claims is employes or former employes (18.2%).

Fiduciary liability claims grow faster than D&O: Wyatt Co.

CHICAGO—Although the number of claims filed against directors and officers continues to overshadow fiduciary liability charges, pension-linked claims are beginning to grow at a faster rate, according to a Wyatt Co. study.

More than 50% more fiduciary liability claims—48—were reported this year to the consultant than last year in its annual surveys of trends in directors and officers liability insurance.

The number of D&O liability claims reported increased by only 11.8% in the same period, although Wyatt estimates D&O liability claims are increasing 21.6% annually.

Measuring susceptibility to each type of claim, Wyatt says susceptibility of all companies to fiduciary liability claims is now 2.6%, up 73% from 1.5% last year. In comparison, susceptibility to D&O liability claims is 14.1%, but only 17.5% higher than the overall susceptibility of 12% in the 1978 survey.

As would be expected, the larger the company the more susceptible it is to fiduciary liability claims. While manufacturing companies reported the largest number of claims, the percentage of claims for manufacturers is not significantly different from that of other types of companies, Wyatt notes.

Of the 48 claims charging corporations violated their fiduciary duty for benefit plans as established by the pension reform law, 31 are covered by insurance. There is no insurer for five claims, three fall outside the policy coverage and four may or may not be covered. There was no insurance information about two of the claims.

Thirty-seven claims were filed by employes or former employes. Only three were filed by the families of employes or former employes, one was filed by the government and four claimants were not identified.

Administrative error and breach of duty under ERISA were each cited in 15 claims, the most frequently made charges. Failure to honor an employment contract was charged four times and misleading representation and improvement investments were each charged three times.

Almost a third of the claims—15—were closed with settlement, but 18 are awaiting trial. Only three were closed by litigation and seven were dropped by the claimant.

Defense costs in the eight settled claims totaled $100,805, or an average of $12,601 per claim. The two litigated claims cost an average of $19,000 to defend and the five dropped claims cost an average of $4,759 to defend.

Of the eight open claims, an average of $15,437 has been spent to date defending each of them.

Within the sketchy returns on damages paid, 12 claims were closed without payment and 10 were closed for less than $20,000 in damages. Only two claims won damages of between $20,000 and $50,000.

Of the various methods for insuring against fiduciary liability claims, purchase of a separate fiduciary liability policy was chosen by 64.2% of the surveyed companies, almost the same as last year. Only 10% of the respondents carry fiduciary liability as an endorsement to their directors and officers liability insurance policy, which otherwise excludes fiduciary liability. No coverage for fiduciary liability claims was reported by 16.3% of the companies; 2.3% of the companies carry the coverage as an endorsement to their comprehensive general liability policy and 1.7% rely on an unendorsed D&O policy.

The favored limit of coverage is $1 million (24.8%) or $5 million (13.1%). The highest reported limit was $65 million. Of the 822 organizations reporting in both 1978 and 1979, 702 held their limits constant, 15 reduced limits and 105 increased limits, especially those with less than $1 million. ■

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University to appeal finding of sex bias in its pension plan

DETROIT—Wayne State University and its insurer will appeal a U.S. district court ruling that the university's pension plan discriminates against women retirees.

Judge Robert DeMascio ruled earlier this fall that Wayne State's pension plan, which is operated by Teachers Insurance Annuity Assn. and College Retirement Equities Fund of New York, is discriminatory because even though men and women contribute equally to the plan, the women receive smaller benefits than men.

At issue was whether the pension plan can pay smaller pension benefits to women since studies show women on the average live longer than men and thus receive pension benefits over a longer time.

In an almost identical case, a U.S. court of appeals in Boston ruled that Colby College's defined contribution plan was discriminatory by offering women smaller pension benefits than men (*BI*, Feb. 5).

A resolution of the issue of equal contributions for unequal pension benefits is not expected until the Supreme Court rules on the issue.

The Wayne State and Colby College decisions, however, affect only colleges that maintain similar pension plans. Most employers in the private and public sectors maintain defined benefit plans in which the monthly retirement benefits for men and women lack sex distinctions.

But at Wayne State, when an employe retires, the college purchases an annuity from TIAA-CREF with the pension contributions made during the employe's years of employment.

The monthly annuity benefit that a woman receives is smaller than a man's monthly benefit even though the same amount of premiums had been contributed. Wayne State contended the difference in annuity benefits is based on the actuarial fact that women live longer after retirement than men and thus collect pension benefits over a longer time.

But Judge DeMascio ruled the Wayne State plan violated the Civil Rights Act of 1964, forbidding sex discrimination in employment practices and compensation.

Although women as a class may outlive men as a class, there is no assurance that any individual woman employed by Wayne State would fit the generalization on which the monthly annuity benefits were based, he said. As a result, sex discrimination was involved since an individual woman might not outlive an individual man, yet she would receive smaller monthly benefits.

Mildred Peters, a professor of education and one of the women who sued, estimated her monthly pension benefit might be as much as 17% less than that of a man who earned a similar salary and who had been employed the same number of years. ■

Cover increases with cost index

SAN FRANCISCO—Fireman's Fund Insurance Cos. has developed a new version of its Val-U-Gard commercial property endorsement that automatically increases property coverage as local cost indexes increase.

Under the original Val-U-Gard endorsement, policy limits were increased quarterly by a fixed percentage established by the policyholder, the broker and Fireman's Fund.

By increasing policy limits automatically as cost indexes increase and by eliminating the coinsurance clause, Val-U-Gard II prevents underinsurance of property.

Property eligible for the new endorsement includes buildings, furniture and fixtures, equipment and other contents.

The minimum amount of the insurance must equal 80% of the property value. ■

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Bankers' conference

Banks heat up competition for corporate benefit trusts

By JOHN MAES

CHICAGO—Competition among banks for corporate benefit trust business, developing as more banks get into the service and employers look for investment managers, is expected to heat up over the next several years.

Banks are stepping up their activity in benefit trusts, expanding not only pension plan management but also management of trusts for various employe benefits such as health and disability plans.

"I'm extremely optimistic about the growth for banks in employe benefits," said W. Humphrey Bogart, senior vp and trust officer for Republic National Bank of Dallas, at the recent American Bankers Assn. Conference in Chicago.

Republic National currently has $5.8 billion in total trust assets, $3.9 billion of which involves pensions and benefits such as profit sharing, savings plans, tax exempt 501(c)(9) trusts, group health insurance and life coverage. Employe Stock Ownership Plans and Tax Reduction Act Stock Ownership Plans are included, he said.

Other bank executives agreed benefit trust business as well as trusts for property/casualty risks, is attractive.

"It's a good business move and it's not complicated from an investment standpoint," said Lee J. Steiden, vp and trust officer for Citizens Fidelity Bank and Trust Co. of Louisville, Ky.

Citizens Fidelity deals with self-insured companies whose plans pay long term disability, major medical and retirement benefits, Mr. Steiden said. The bank has also taken on a $4 million medical malpractice trust set up by a religious organization.

"We had nothing of this type five years ago, now we have 10 plans and we don't even market the service," Mr. Steiden said. Many employers are seeking out banks so they can invest self-insured reserves, he noted.

At Northern Trust Co. in Chicago, benefit business has also been on the increase, said vp D. Quigg Porter Jr. Northern's specialty is the master trusts, in which a company with different plans in different banks consolidates them into one trust.

Northern is one of only four or five financial institutions in the country that offers employe benefit master trust accounts, Mr. Porter said. Currently, Northern has about $9.2 billion in employe benefit assets on deposit.

The Mercantile Trust Co. of St. Louis reports it has taken on between 150 and 200 new benefit trusts in the last three years, 29 of them so far this year. Mercantile specializes in multiemployer trusts and has about $2.5 billion in benefit assets on deposit, bank officers say.

It's not just the large bank and trust companies in urban centers that handle benefit trusts. Smaller community banks, even though geographically isolated from the mainstream of large corporations, are picking up some of the business, said James W. Penn, senior vp and senior trust officer for the Citizens National Bank of Decatur, Ill.

Employe benefits account for about 25% of the bank's trust business, Mr. Penn said. The bank seems to be attracting smaller, younger companies in rural areas. "We won't get a lot of major companies' pension business. But we will get a lot of the growing, successful business. We've got a lot of entrepreneurs who are looking to make money."

The growth is partly because businesses are looking for alternatives to conventional investment channels such as the stock market, which has proved to be unpredictable, Mr. Penn said.

Benefit trusts are nothing new to banks, said Republic National's Mr. Bogart. Many have handled pension trusts for 40 years, but only in the last several have they become such a large part of the business.

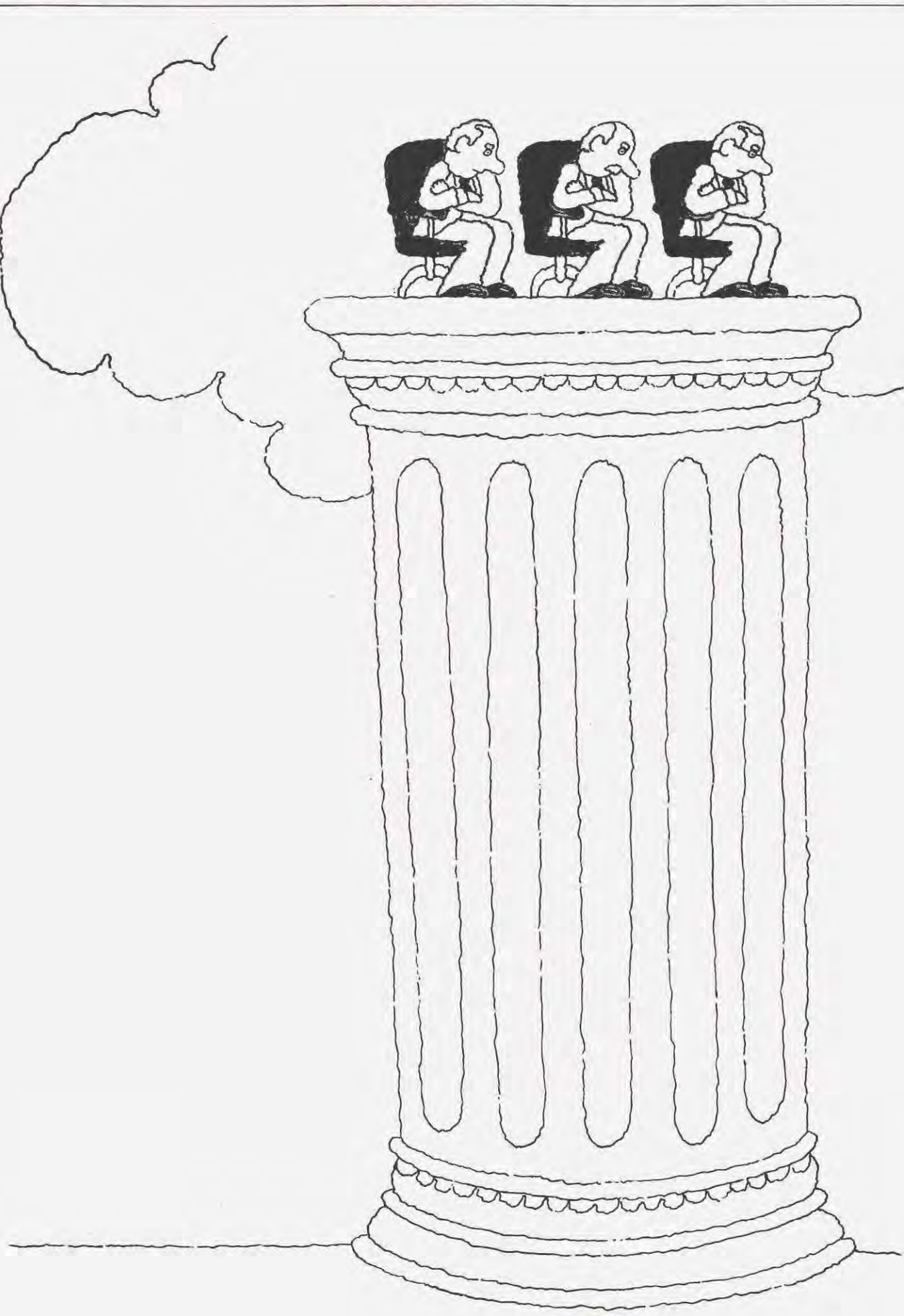
"We've been involved in it since the 1940s but we were nothing to spit at until the 1970s," he said. Now, with 66% of its trust division assets in employe benefits, the bank has set up a specially staffed employe benefits division to handle the business.

The move has not been without cost, bank executives say. Some banks have had to shift large numbers of employes with proper expertise into trust departments to service accounts.

Banks in the benefit trust business have also had to learn enough about ERISA to comply with government regulations in the handling of pension funds, said Mr. Porter of Northern Trust. The banks must develop sufficient computer capabilities to handle accounting, record keeping and other financial management tasks associated with large trusts. "That's been the biggest problem," he said.

Competition will become stiffer as more banks enter the field, predicted Mr. Bogart, whose bank handles plans from all over the Southwestern U.S. along with some national business. Eventually, however, some institutions will drop from the running because they will be unable to "distinguish themselves," or simply can't make a profit on benefit trusts.

Banks and trust companies that will thrive on this new line of business will be those able to handle the widest range of benefits and provide the most services, Mr. Bogart said. "The clients are going to go to somebody who can do it all instead of being bounced to consultants to handle their 501(c)(9) trusts and TRASOPS," he said. ■



Safety pros receive award

PARK RIDGE, Ill.—Three occupational safety professionals have received 1978-79 Professional Paper Awards from the American Society of Safety Engineers here.

The awards recognized the authors of outstanding professional/technical papers published in Professional Safety Magazine.

Winners were Charles F. Dalziel, professor emeritus at the University of California, Berkeley; second place, Charles V. Culbertson, vp for loss prevention, Marriott Corp., and third place, Dr. Jack B. ReVelle, manager of safety and facilities for Ducommun Metals Co., Los Angeles. ■

Congressman to propose IRA expansion

IRAs "represent the most crucial leg of the retirement tripod," says Rep. John Erlenborn.

CHICAGO—Calling Individual Retirement Accounts one of the foremost strengths of a retirement program, Rep. John N. Erlenborn (R-Ill.) says he is drafting legislation to encourage even further development of IRAs.

Mr. Erlenborn said the legislation would increase the income tax deductions for contributions to IRAs, which would encourage more workers to save for their own retirement. The legislation would also allow tax deductions for individual contributions to corporate retirement plans.

Addressing a conference of the American Bankers Assn. here, the congressman said such a move is important to supplement private pensions and Social Security if workers are to enjoy a comfortable standard of living during retirement.

"Far too many breadwinners rely too much on benefits they hope to get from Social Security and employer-sponsored pension plans while neglecting saving and investing on their own," he said. "Individual retirement initiatives represent the most crucial leg of the retirement tripod."

Too many workers assume Social Security will provide "financial independence" during retirement, he said. But Social Security benefits fall far short of a comfortable sum, he said, because a worker retiring at 65 will receive a maximum of $503.40 monthly. With the 50% spouse benefit, the maximum would be $755.10 per month and "most people would get smaller benefits than our hypothetical couple."

Even when Social Security payments are coupled with company or union-sponsored pension plans, the retirement benefits would only provide about 50% to 60% of pre-retirement earnings at a time when financial planners estimate 75% to 80% replacement is needed to offset inflation, he said.

"If living costs increased at half the current rate, or 7% annually, the purchasing power of a $10,000 pension would be reduced to approximately $5,000 within 10 years. In 20 years, real income would drop to roughly $2,500," he said. "Inflation undercuts all these sources of retirement income; it gnaws at fixed pension benefits; it outstrips interest on individual savings and slashes real return on investment."

Mr. Erlenborn also said he is working on legislation to establish a single agency to administer ERISA requirements. The agency, to be called the Employe Benefit Administration, would take ERISA jurisdiction away from the Internal Revenue Service, the U.S. Department of Labor and the Pension Benefit Guaranty Corp. "It will pull together the scattered responsibilities and ease the complexity, confusion, delay and duplication we have experienced with multiple administration."

On other pension-related issues, Mr. Erlenborn said he favors pension benefit integration as a first step toward a uniform, national pension policy. The current multiplicity of private and public pension plans provides overlapping coverage for some workers, while other workers receive insufficient coverage.

However, legislative action on pension plan integration would have to be "gradually phased in" over a period of years and perhaps as much as 20 to 30 years for public plans, he said.

"The idea behind benefit integration is to establish as a goal a certain percentage of pre-retirement earnings and coordinate the payment of pension benefits to achieve this goal. Integration would inject a measure of consistency into a national pension policy," he said.

"By the same token, integration would relieve the burden on some employers who are paying excessive contributions toward a company-sponsored plan as well as the 50% share of Social Security."

Mr. Erlenborn also said he favors elimination of ERISA's summary annual report requirement for welfare and pension plans. ■

Bill seeks IRA increase

WASHINGTON—Sen. Harrison Williams (D-N.J.) has introduced a bill (S.B. 1925) to raise IRA and Keogh limits and eventually tie them to the Consumer Price Index.

The bill would raise the permitted individual IRA contribution to the lesser of 20% of compensation or $2,000, beginning in 1980. Now employes can set aside the lesser of 15% of compensation or $1,500.

In following years, the contribution level would be linked to the inflation rate. Spousal IRA levels would also rise to $2,400 from $1,750 the first year and then be indexed.

For Keogh plans, the deductible limit in 1980 would increase to 20% of compensation or $10,000 from 15% of compensation or $7,500. The Keogh limit would stay at $10,000 until the IRA limit reaches $5,000. Then Keogh contributions would always be twice as high as the IRA level.

Sen. Williams said the purpose of the bill is to "encourage more saving for retirement by American workers." ■

Medical malpractice underwriting losses worry INA executive

CHICAGO—Continuing medical malpractice losses and red underwriting ink aren't getting the attention they deserve, says an underwriter.

Peter Foley, executive vp at INA Special Risks Facilities Inc. and head of the company's venture into professional liability underwriting, says he's concerned about the continuing underwriting losses insurers are reporting on medical malpractice.

INA started writing medical malpractice insurance about 18 months ago; Mr. Foley joined INA this summer from Gulf's Bermuda insurance subsidiary, Insco, where he was vp for casualty underwriting (*BI*, May 14).

Mr. Foley's concern over industry experience in medical malpractice risks has spurred him to put together a "specialty claims operation" at INA for the risk that will include legal talent. "We're going to do it differently from other insurers," he says.

INA's annual premium volume on medical malpractice, directors and officers liability, which it began underwriting a year ago, and errors and omissions insurance for various professionals is about $75 million. A couple large accounts inflated the premium volume, but INA doesn't want to grow too fast in the current competitive market and is targeting only $90 million in premiums on these specialty risks in 1980, Mr. Foley said.

Other insurers and court reports also indicate the incidence and severity of medical malpractice claims are continuing to rise.

St. Paul, a major underwriter of medical malpractice insurance, reports that claims filed per 100 physicians it insures were up 12% in 1978 from 1977 and that the damages sought increased 18% in the same period. As a result, premiums will be hiked in 20 of the 29 states where St. Paul underwrites the insurance, the company says.

Statistics from federal courts also show the incidence of malpractice claims is rising.

Medical malpractice complaints filed in federal courts during fiscal year 1979 increased by almost 30% over the previous fiscal year, according to the Administrative Office of the U.S. Courts.

In fiscal 1979, which ended June 30, 500 medical malpractice cases were filed in U.S. district courts around the country, a 29.9% increase compared with fiscal 1978 when 385 malpractice complaints were registered.

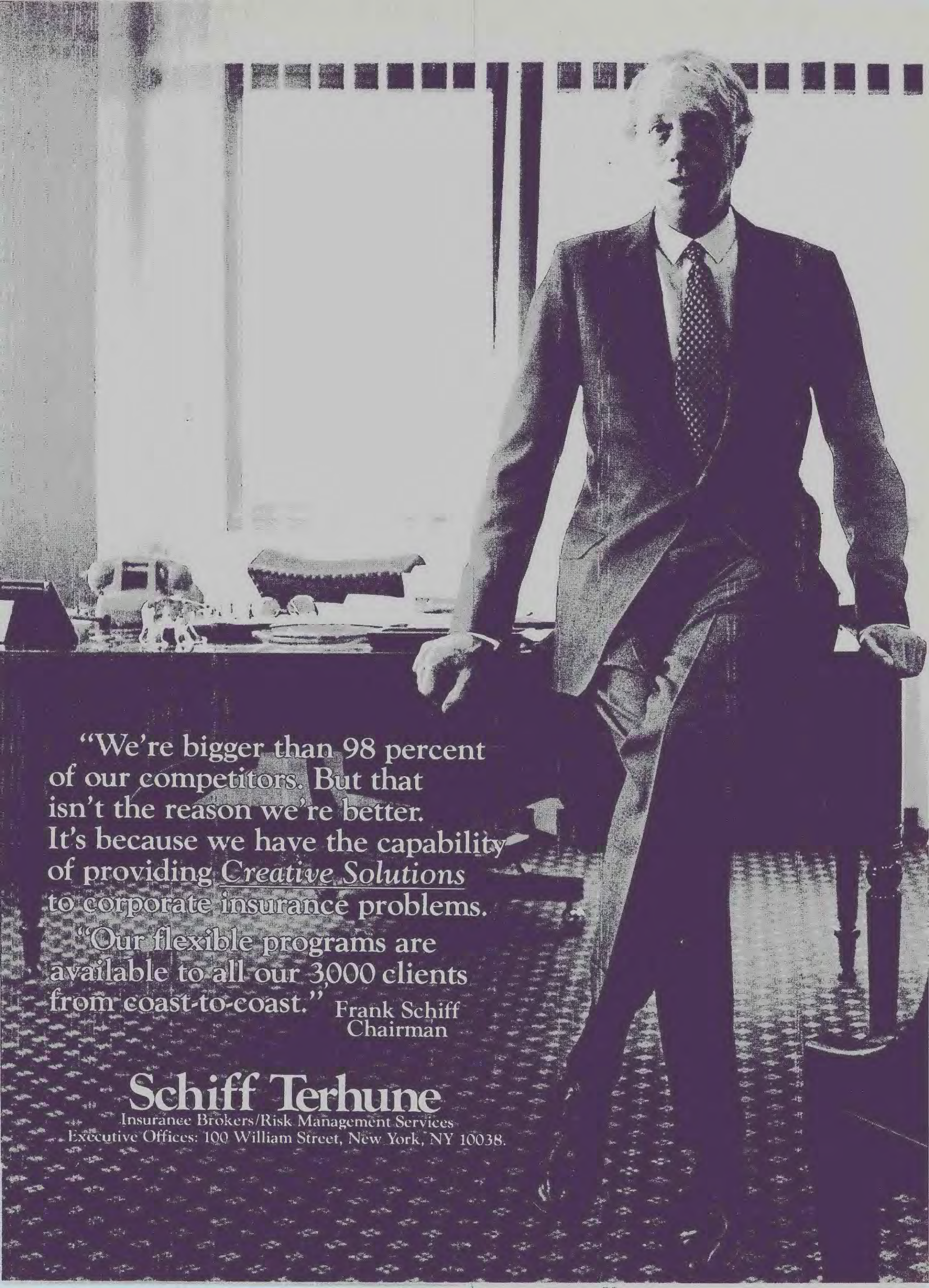
However, the 500 cases filed in fiscal 1979 represent a sharp drop from the 633 cases filed in fiscal 1976, the first year such records were collected. ■

Profit Sharing Council officers

SAN FRANCISCO—The Profit Sharing Council of America, an association of more than 1,400 large and small U.S. companies with profit sharing plans, has elected new officers and directors.

The officers for the coming year are: chairman of the board, Roger D. Mulhollen, vp, corporate personnel, Johnson's Wax, Racine, Wis.; first vice chairman, Roland T. (Jim) Messinger, manager of benefits, J.C. Penney Co., Inc., New York; second vice chairman, Ronald A. Stockdale, executive vp and secretary, West Coast Grocery Co., Tacoma, Wash., and treasurer, Richard A. Andersen, vp, First National Bank of Chicago.

Directors elected to a three-year term are: Theodore D. Bower, tax attorney, Sears, Roebuck & Co., Chicago; Harriet L. Elliott, vp-secretary, Elliott Glove Co. Inc., Oconto, Wis.; George W. Jensen, plan administrator, The Southland Corp., Dallas, Tex.; Richard A. Liebig, president, Moorman Manufacturing Co., Quincy, Ill., and William D. Meyer, assistant secretary, Carter Hawley Hale Stores Inc., Los Angeles. ■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OSHA proposes shorter time limit for reporting workplace accidents

WASHINGTON—The Occupational Safety and Health Administration has proposed requiring employers to report serious workplace accidents more quickly.

Under the proposal, an employer would have to inform the Labor Department within eight hours of any workplace accident in which an employe dies or in which five or more employes are hospitalized. Currently, employers have 48 hours to report serious accidents.

Comments on the proposal should be sent by Nov. 15 to: Docket Officer, Docket S-125, Room S6212, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210.

Meanwhile, in another OSHA development, the federal safety agency is calling on the business community for assistance in developing new safety standards to protect workers against the hazards of working in confined spaces such as tanks, boilers, pressure vessels, manholes and trenches.

Among the areas where OSHA is seeking public comment are: how should confined spaces be defined and classified for regulatory purposes; what support personnel are necessary and what procedures should be used for rescuing injured workers and what is the safe minimum oxygen level in confined spaces.

Comments on possible confined space regulations should be sent to: OSHA Docket Officer, Docket S-019, Room S6212, U.S. Department of Labor, Washington, D.C. 20210. The deadline for comments is Dec. 15.

Politics of abortion stalls exemptions from OSHA visits

WASHINGTON—Legislation to exempt many small employers from annual safety inspection by the Occupational Safety and Health Administration has been stalled by the politics of abortion, but is expected to pass Congress.

Both the Senate and House had given tentative approval to legislation introduced by Sen. Richard Schweiker (R-Pa.) that would shield 90% of employers with less than 11 employes from safety inspections by OSHA.

The Schweiker proposal was attached to a federal appropriations bill. An amendment sharply limiting federally paid abortions for poor women also was attached to the appropriations measure in the House.

The Senate has refused to accept the House language on abortion, preferring milder abortion restrictions. Efforts to reach a compromise have stalled, suspending action on the OSHA inspection proposal as well as the appropriations bill itself.

It's considered likely, though, that sometime within the next month the abortion controversy will be resolved and the appropriations bill—with the Schweiker OSHA proposal—will be given final legislative approval.

The Schweiker amendment, which is backed by a coalition of small business groups, would bar OSHA inspectors from randomly conducting safety checks of small firms with less than 11 employes and that have compiled an annual injury incidence rate of less than seven for every 100 employes. The rate is figured by dividing the number of injuries by the number of employes and comparing it to a rate base of 100.

However, OSHA could continue to conduct health inspections at the smaller firms and also could make safety inspections in response to employe complaints.

The Administration has not actively opposed the Schweiker amendment; it is, however, against other anti-OSHA proposals, such as one advanced by Sen. Frank Church (D-Idaho), who wants OSHA to cease all small business inspections.

Other congressmen want to go even further. Rep. George Hansen (R-Idaho) annually has introduced legislation to abolish the controversial safety agency, but that radical proposal never has drawn widespread support.

Meanwhile, OSHA officials say that despite persistent reports, there are no current plans to issue a new standard this year limiting the amount of noise workers can be exposed to in an average workday.

In 1974, OSHA proposed that employe exposure to noise over an eight-hour day be limited to 90 decibles a day, with higher noise levels permitted during shorter periods of time.

Some business groups fear a final OSHA noise standard could lower the noise level to 85 decibles, which could cost businesses billions of dollars in engineering changes, according to OSHA's own estimates.

However, an OSHA spokeswoman said no decision has been made on setting the noise standard at 85 decibles or any other level. ■

Group life up

Group life insurance set up under new or revised group contracts in July totaled $9.08 billion compared with $7.14 billion a year earlier. Industrial life insurance purchases in July were $518 million, compared with $494 million a year earlier. Total purchases in July were $35.5 billion, compared with $28.7 billion a year earlier. Group life insurance purchases were $127.6 billion from August 1978 through July 1979, compared with $121.5 billion a year earlier, and industrial purchases were $6.05 billion, compared with $6.25 billion. Total purchases were $435.5 billion, compared with $393.2 billion. All figures are face amounts of insurance purchases.

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Insurers underwrite more ASO plans, health study shows

WASHINGTON—Insurers are underwriting more administrative services only contracts and minimum premium plans for employers attracted to self-insurance, according to the 1978-79 Source Book of Health Insurance Data published by the Health Insurance Institute.

About 14% of total 1977 insurance company group business is represented by ASO arrangements and minimum premium plans. These arrangements comprised 12% of total insurance company group business in 1976 and less than 5% before 1975.

Private insurers paid a total of $43.1 billion in health insurance benefits during 1977, 10.6% more than in the previous year and nearly 10 times the amount paid a decade earlier, the report says.

The rising cost of medical care, expansion of benefits and higher utilization fueled the increase in benefits paid, the study says.

Medical expense benefits, which include payments under hospital, surgical, physician's expense and major medical insurance, totaled $38 billion in 1977, 11.4% more than 1976. Insurers paid $17.6 billion and $20.4 billion was paid by Blue Cross/Blue Shield and other hospital-medical plans.

At the end of 1977, some 179 million persons were covered by hospital expense insurance, a 22% increase since 1967. More than 167 million had surgical expense insurance, a 20% growth in a decade. More than 160 million had physician's expense coverage and 139 million had major medical cover.

Nearly nine out of 10 civilian workers—82 million—had some form of disability income coverage. About 65 million were covered by short-term protection from insurance policies or other formal arrangements, and 19 million were covered by long term policies. More than two million were covered by both.

About 54 million persons were protected by dental insurance by the end of 1977, and 32 million of these were insured by group policies, three times the number five years ago. Blue Cross/Blue Shield covered five million and the remaining persons were covered by either dental service corporations or union self-insurance trusts.

Approximately one out of every six civilian, noninstitutional Americans was admitted to a community hospital in 1977. Community hospitals, defined as nonfederal, short term general and special hospitals, account for 83% of all hospitals and handle more than 92% of all admissions. An average of 93,900 persons entered community hospitals each day in 1977 for a total of 34,273,400, a 12% increase over 1972.

During 1977, health insurance premium income of all private insuring organizations amounted to $51.9 billion. Insurance companies earned $28.7 billion in premiums in 1977; Blue Cross/Blue Shield and other hospital-medical plans amounted to $23.2 billion.

In the public sector, the amount of health spending has grown to 42.1% of total national health expenditures (public and private) in 1977, from 33.1% in 1967. Federal expenditures for health care are more than double state and local expenditures and account for more than 12% of all federal spending, up from 5% in 1967.

The majority of federal health spending, 84%, is for services to seven major groups: low-income individuals and others eligible for Medicaid; persons older than 65; military personnel and their dependents; veterans; federal civilian employes; native Americans, and workers who sustained medical expenses for on-the-job injuries while covered by workers compensation.

Nearly 3.3 million federal employes and annuitants were covered, as well as more than six million dependents. Total expenditures for civilian health programs totaled nearly $1.7 billion. ■

House panel to study longshore bill

WASHINGTON—A congressional committee will begin hearings this week on legislation designed to reduce the skyrocketing cost of the federal Longshoremen's and Harbor Workers Act, which is drowning shipping and stevedoring companies.

Legislation introduced by Rep John Erlenborn (R-Ill.), to be taken up by the House Education and Labor Committee at hearings Nov. 13-15, would trim benefits and fill loopholes in the act that have pushed up costs to staggering levels.

"The introduction of the Erlenborn bill (H.R. 2448) is a recognition that some members of Congress are aware of the need to counterbalance generous benefits with reasonable controls to curb overutilization of the system," says Les Cheek, vp-federal affairs for Crum & Forster.

Shipping and stevedoring companies are finding it difficult to afford and sometimes find insurance to cover their exposure under the federal act, said a spokeswoman for the Alliance of American Insurers, an industry trade group.

The Erlenborn measure, backed by an informal alliance of insurers and employers, would reverse recent court decisions that have extended the scope of the act to cover a huge class of workers.

In one such decision, the Supreme Court ruled that the longshore act covers not only sailors injured at sea, but also applies to maritime workers injured while stripping cargo in dockside warehouses (*BI*, July 11, 1977).

That decision was a bitter and costly blow to terminal operators, since benefits payable under the federal act are more than double the benefits payable under many state workers compensation programs.

Rep. Erlenborn's bill would take the sting out of that 1977 court decision by specifying that the reach of the federal longshore law only extended to the "point of rest," the spot where the cargo comes off the ship and is put on the ground.

In another court decision that sent a collective shiver down the spines of insurers and employers, the Supreme Court ruled earlier this year in the "Rasmussen case" that widows are entitled to up to two-thirds of the deceased workers' weekly salary (*BI*, March 5).

Rep. Erlenborn's measure would limit survivor's death benefits to the maximum placed on disability benefits: 200% of the national average weekly wage, subject to a weekly maximum of $426.26. Since some maritime workers are extremely well paid, making as much as $800 a week, the cost savings resulting from the new limitations on death benefits would be substantial.

Elsewhere, the measure would limit annual increases in compensation benefits to 3%. The current limit on benefit increases is based on increases in the national average weekly wage. This indexing of benefits to salary increases is resulting in costs going "right through the ceiling," says Crum & Forster's Mr. Cheek.

Finally, the measure would place a flat $100,000 limit on all cases except those involving total permanent disability or death. There is no such limit now. ■

Benefits can't be lost when plans merge: IRS

NEW YORK—Benefit plan participants can't lose under final IRS regulations governing mergers and consolidations of plans and transfer of plan assets and liabilities.

The rules, finalized recently, require that the benefits a participant would receive from the plan, if terminated immediately after a merger, consolidation or transfer, must be equal to or greater than those he would have received if the plan had terminated immediately before, according to Johnson & Higgins's benefit newsletter.

The requirement is effective for changes in plans occurring after Sept. 2, 1974.

A merger or consolidation is defined as the combining of two or more plans into a single plan. In a single plan, all assets are available to pay benefits to employes covered and their beneficiaries.

A single plan may be funded with allocated insurance contracts, have different benefit structures for employe groups, use more than one plan document, invest its assets in more than one trust or annuity contract or maintain a separate accounting of assets for cost allocation purposes. A plan is not a single plan if a portion of its assets is not available to pay benefits to all covered employes or beneficiaries.

Generally, a merger of defined benefit plans meets the requirements if each plan has assets sufficient to cover the present value of all accrued benefits. A spinoff (splitting) of a defined benefit plan is satisfactory if all the accrued benefits of each participant are allocated to only one of the spunoff plans and each plan has assets at least equal to those that would have been allocated if the plan had terminated before the spinoff.

For defined contribution plans, a merger or spinoff is satisfactory if each participant's account balance after the merger or spinoff equals his balance before, and plan assets equal participants' total account balances. ■

RBH acquisition

Rollins Burdick Hunter has acquired The Horton Agency Inc. insurance broker in Oklahoma City. The agency is now Rollins Burdick Hunter of Oklahoma Inc.

Model bill rejects time limit on liability of manufacturers

By JERRY GEISEL

WASHINGTON—In its final version of the model product liability bill, the Commerce Department rejects the business community's plea that a manufacturer's liability be cut off after a fixed number of years from the time a product was sold or manufactured.

Instead, the department is sticking to its original recommendation that makes it tougher for injured consumers to collect damages 10 years from the time a product was put into use, but still leaves manufacturers potentially liable in suits involving very old products.

But most employers and insurers will welcome the department's decision to drop a provision in an earlier draft of the bill that for the first time would have linked product liability suits to the workers compensation system. The reversal on the workers compensation issue was reported exclusively in *Business Insurance* (Oct. 15).

"All that would have done is take the problems that have arisen in product liability and dumped them into the workers compensation system with the result of instead of reducing transactional costs, you actually increased them," said Dennis Connelly, counsel for the American Insurance Assn.

The final bill also revises the section on comparative responsibility, spelling out in greater detail that the consumer's right to recover damages is limited if the product was misused, altered or conformed with government safety standards.

Reducing awards to the extent a product was misused is "very helpful," said L. West Shea, treasurer of the Material Handling Institute, a Pittsburgh-based research group. "No longer is there a blank check on recovery."

The model bill, published Oct. 31 in the Federal Register, is designed for state action. It is an attempt to end current inconsistencies from state to state in the tort litigation system, a factor insurers say causes uncertainties in measuring product risks and contributes to increased product liability insurance premiums.

Uniform state product liability laws would give insurers the predictability they say is needed to assess and quantify product exposures, the Commerce Department says.

But whether state legislatures will support the final model bill remains to be seen; the first bill had only limited impact.

Connecticut's new product liability law incorporated much of the first model bill. But three states that enacted product liability measures after the first model bill was unveiled in January—Alabama, North Carolina and North Dakota—took radically different approaches to tort reform than the Commerce Department suggested.

The Wisconsin legislature, however, has been waiting for the publication of the final model bill before taking any action to amend its tort law and other states with pending product liability bills may take a closer look at the final bill than the earlier draft.

Victor Schwartz, the Commerce Department official who directed drafting of the model bills, hopes the measure "will be given close attention by large states where there are a lot of product liability claims and momentum will develop to pass major sections which will help stabilize the product liability situation."

But the department's decision not to cut off all employers' liability after a certain number of years is bound to fuel controversy.

Business groups, in their letters to the department commenting on the first model bill, contended liability has to run out after a fixed period of time after a product was sold—probably 10 years—in order to give the predictability insurers say they need to measure risk.

"Our position is that a fixed statute of repose is needed to cut off the so-called long tail problem," said Reg Beane, director of government affairs for the Risk & Insurance Management Society. "We think (a statute of repose) is critical and any legislation should have it. They have not addressed a critical area," he said.

A Commerce Department spokesman, who said he understood this argument, countered that a fixed statute of repose could in some instances unfairly deny compensation to an injured consumer. For example, if the period of liability began from the time a product was manufactured, as some business leaders advocate, a plaintiff could be barred from compensation simply because a defective product was stored in a warehouse and not put into use until after the liability period expired.

In the final model bill, the department has tried to strike a compromise between consumer advocates, who oppose liability time limits, and business groups, who favor limiting liability to a specific time.

The department recommends that 10 years from the time a product is first used it would be presumed non-defective, requiring the plaintiff to provide "clear and convincing evidence" that a product defect caused an injury.

However, in cases where the injury is caused by prolonged exposure to defective products, the 10-year limitation on suits would not apply.

In another controversial area, the department removed a provision that would have dramatically altered the workers compensation system by allowing an injured worker to collect full wages from his or her employer, rather than just the workers compensation benefit, and prohibiting him or her from suing the product manufacturer.

That drastic alteration of workers compensation would have applied to accidents occurring more than 10 years after the product that caused the injury was first

Victor Schwartz, the Commerce Department official who directed the drafting of the model bill, hopes it "will be given close attention by large states where there are a lot of product liability claims and momentum will develop to pass major sections which will help stabilize the product liability situation."

sold.

Increasing the liability of employers by allowing some injured workers to collect the full loss of wages worried insurers, who warned that adding new exposures could force huge hikes in workers compensation premiums.

The Commerce Department accepted the insurers' argument, noting that workers compensation boards that determine the amount of damages are not equipped to determine whether a product was defective or not, a department spokesman said.

The final bill makes it clear that a product liability award can be reduced to the extent consumer misuse or unsanctioned product alteration contributed to an accident. Awards also would be reduced by the amount of compensation an accident victim receives from public sources such as Social Security.

The model bill also establishes that a manufacturer does not have to warn of obvious dangers in using a product.

As in the earlier draft, wholesalers and distributors generally no longer would be caught in the product liability net. They would only be liable if the manufacturer were insolvent or if they were given a reasonable opportunity to discover a product defect that caused an accident.

To reduce the backlog of product liability cases in the courts, the bill recommends all cases in which the damages are less than $50,000 be resolved through binding arbitration. Arbitration boards would consist of an attorney or retired judge, a lay person and an expert in the field in which the accident occurred.

Manufacturers still could be punished by a punitive damage award if they showed a "reckless disregard" for product users. Although juries would decide if punitive damages should be imposed, the amount of damages would be determined by a presiding judge.

Before deciding whether to award punitive damages, a court would be expected to consider the financial condition of the manufacturer as well as the effect of the "misconduct" on profits.

To cut down on the number of unjustified product liability suits, the model bill recommends that a plaintiff or defendant or their attorneys participating in a frivolous lawsuit or defense be forced to pay legal costs for the opposing party.

The model bill takes aim at pain and suffering awards, imposing a $25,000 cap on such awards unless a plaintiff suffers permanent serious disfigurement, impairment of bodily function or permanent mental illness.

Finally, the bill requires that an injured plaintiff file suit two years from the time of injury and that manufacturers' liability does not extend beyond a product's "safe life."

Still to come is a comprehensive study on insurance rate making practices. This study, known as the "Barrett Report," is expected to be published at the end of the year, Commerce Department officials say. ■

See our ad on page 6

House panel seeks changes in risk retention legislation

By JERRY GEISEL

WASHINGTON—Members of a House panel considering the Administration-backed Risk Retention Act want several problems cleared up before taking action on the measure that permits businesses to pool their product liability risks under a federal charter.

Rep. James Broyhill (R-N.C.), a member of the consumer protection and finance subcommittee that has jurisdiction over the pooling legislation, wants written assurances from the Treasury Department that contributions to the pools are tax deductible.

Rep. Matthew Rinaldo (R-N.J.) is worried that trade associations sponsoring federally chartered product liability pools might require members to purchase other association services as a prior condition for participation.

Mr. Broyhill and Mr. Rinaldo voiced their concerns when Congress began the first of what is expected to be a series of hearings on the proposal drafted earlier this year by the Commerce Department.

Insurers are expected to outline their opposition to the plan later.

Government sources are optimistic that the pooling legislation will be approved by the full House committee before the year is over. But the picture remains much more uncertain in the Senate, where the Commerce Committee has yet to schedule hearings.

During the House hearings Oct. 18 and 19, an informal alliance of business trade groups such as the National Assn. of Manufacturers, the National Machine Tool Builders Assn., the Machinery and Allied Products Institute and the Risk & Insurance Management Society made a strong pitch for the legislation, but also asked for changes in it.

Federally chartered pools "offer capital goods manufacturers relief from (insurers') panic pricing and other inequitable insurance rating practices," said James Mack, public affairs director of the machine tool builders.

Pools "will be of significant assistance to small to medium sized manufacturers with escalating product liability insurance premiums and policies with larger deductibles or retention levels," added Reg Beane, director of government affairs for RIMS.

Drafted by the Commerce Department and endorsed by the Carter Administration, the proposal would allow firms to band together as "risk retention groups," pooling all or a portion of the participants' product liability exposures.

The risk retention groups would be exempt from state insurance regulations and instead would be regulated by the Commerce Department.

Before deciding whether to allow a risk retention group to operate, the Commerce Department would review the group's assets, reserves, loss prevention efforts and management expertise.

Premiums paid into the risk retention groups would be tax deductible if spreading and sharing of risk satisfies Internal Revenue Service requirements, according to the Commerce Department. Rep. Broyhill wants these requirements spelled out in greater detail.

By tailoring insurance regulations to meet the needs of businesses forming their own insurance cooperatives and allowing them the same tax deductions companies are given for purchasing insurance from commercial insurers, more competition will be injected into the insurance marketplace, the Commerce Department believes.

The department says risk retention pools will counteract a major factor contributing to the nation's product liability problems: panic pricing by insurers.

Several congressmen asked how many businesses would likely participate in a risk retention pool, but no one could answer.

Another Commerce Department proposal to control high-priced liability insurance—creating a model product liability law to end the current uncertainties in the tort law—was unveiled last January and revised and published in final form late last month. **(See story p. 34.)**

While the business groups testifying before the subcommittee overwhelmingly favored the risk retention legislation, they also urged the House panel to consider several revisions in the proposal.

Mr. Beane of RIMS, for example, opposed giving the Commerce Department the power to regulate a risk retention group's management expertise or loss prevention efforts.

Instead, the Commerce Department's regulatory authority should be limited to setting standards for reserves to pay claims, while "free market conditions, such as the self-interest of participants and pressure from excess and reinsurance markets, should be left to regulate all other functions of these risk retention units," Mr. Beane said.

Mr. Mack of the National Machine Tool Builders Assn. recommended the subcommittee add a provision making it clear that annual reports filed by the risk retention groups would be kept confidential and be exempt from the Freedom of Information Act.

An exemption from the 1974 law that opened up many federal records to public scrutiny is needed, lest the Commerce Department become a "fishing pond for plaintiff's lawyers, who can obtain the information they need through the use of proper discovery methods," Mr. Mack said.

Mr. Mack also said he found it puzzling and perhaps hypocritical that some insurance groups have opposed the risk retention proposal (*BI*, May 14). "They (insurers) testify in Washington that there is no problem, yet in the various state legislatures they sound the alarm of a product liability crisis. They refuse to provide coverage that over one-half of our members can afford and in the next breath they tell our members that they don't want them to help themselves."

But Rep. John LaFalce (D-N.Y.), who also testified before the subcommittee, said the opposition of some insurers to the federal pooling arrangements was to be expected. "Considering one of the purposes of the bill—the promotion of competition among providers of product liability coverage—this opposition is not surprising." ■

INA office

Insurance Co. of North America has established an office in Las Vegas to serve agents and policyholders in Southern Nevada.

Royal Globe ruling sparks threats of suits

By RHONDA L. RUNDLE

LOS ANGELES—Insurance companies report a swarm of letters from claimant attorneys threatening action against them under the controversial Royal Globe decision.

The decision by the California supreme court basically opened the door to third-party actions against a defendant's insurance company for violating California's unfair claims settlement statute (*BI*, May 14).

A recent San Francisco superior court case also cited the landmark decision of Royal Globe vs. Superior.

But efforts to overturn the Royal Globe decision with legislation have so far failed. A bill (S.B. 483) to overturn the decision went down in defeat 10-6 in the assembly ways and means committee in the closing days last month of the state's 1979 legislative session.

The bill's sponsor, Sen. Robert G. Beverly (R-Manhattan Beach), says he's talking with insurance contacts to decide whether he will ask the fiscal committee to reconsider it when the legislature resumes Jan. 7.

The bill passed the senate June 1, but "ran into a buzz saw in the assembly," Sen. Beverly said, "where it was heavily opposed by the Trial Lawyers Assn. and some consumer groups."

In a slightly revised form, the measure might fare better next time around, said Steve Seymour, legislative liaison for the Assn. of California Insurance Cos. The group represents about 25 property and casualty underwriting firms. "Several legislators wanted to amend S.B. 483 to preserve first party rights, if any, that may have been created by the Royal Globe decision," Seymour said.

Gov. Jerry Brown hasn't yet taken a stand on S.B. 483, says Robert Moore, legislative assistant to the California chief executive. "He is aware of the issue and will take a closer look if the bill is revived."

The Royal Globe decision is opposed by the insurance industry because it opens a Pandora's box of new and vague liabilities for insurers.

The state's high court ruled that a plaintiff may sue the defendant's insurance company for violation of section 790.03 of the state's insurance code dealing with unfair claims settlement statutes. Previously, third parties needed an assignment of rights to sue an insurance company directly.

Royal Globe also determined it was not necessary to show a pattern or course of action by an insurer to establish violation of the unfair claims settlement statutes. A single incidence, out of 15 enumerated acts specified in section 790.03, could constitute bad faith.

The single violation doctrine opens the door to policyholder suits against an insurer if bad faith can be shown, judged by a single violation of the unfair practices act.

Although industry eyes have been sharply focused on the potential for the Royal Globe decision to unleash third-party actions against defendants' insurance companies, one of the first trial cases to cite the decision is a first-party case.

California FAIR Plan Assn. won an action brought against it by a policyholder, Zef Lejak, under the Royal Globe decision, says John B. Hook, partner in the San Francisco and Los Angeles law firm of Long & Levit that represented CFPA.

The jury accepted CFPA's contention that the policy was void because the policyholder exaggerated his claim and made false statements on his sworn proof of loss and sworn examination. The jury also found there was no bad faith on the part of the insurer in the adjustment and investigation of the loss and in the settlement negotiations preceding the filing of suit.

Although the cost of fighting its policyholder through three and one-half weeks of trial and more than five years of preparation exceeded the policyholder's demand, Mr. Hook said his client believed the intensive defense was worthwhile in order to discourage false claims.

Mr. Hook, who represents many insurance companies, said his clients are "seeing more and more phony and inflated claims accompanied by threats of bad faith and complaints to the insurance department, made in order to 'blackmail' insurance companies into paying such claims."

Other industry experts agreed. "We have had reports from insurance companies receiving many claims letters that make 'oblique references' to Royal Globe," said Mr. Seymour with the Assn. of California Insurance Cos. The gist of these letters is that "unless you settle now, we will deem you in bad faith under Royal Globe."

The implications of Royal Globe go even further. "California liability insurance companies can now look forward to increased expenses for its adjusters in providing full investigation of claims in order to protect themselves from claims of bad faith," says Frederick J. Fisher, vp and manager of Miller & Gilbert of Southern California, a claims adjustment firm based in San Francisco.

"We have changed our claims practices as a result of Royal Globe," Mr. Fisher continued. "When we settle a claim now, not only is the defendant on the release, but also the insurance company and our office."

In addition, Mr. Fisher foresees an increase in litigation which presumably will also contribute to an increase in liability insurance premiums. There may even be an application to reinsurance, he says.

In a curious footnote to S.B. 483 and Royal Globe, the Los Angeles Herald Examiner and Harry Boyd, general counsel for Swett & Crawford Group, traded editorial ripostes in the paper's pages from July through mid-September.

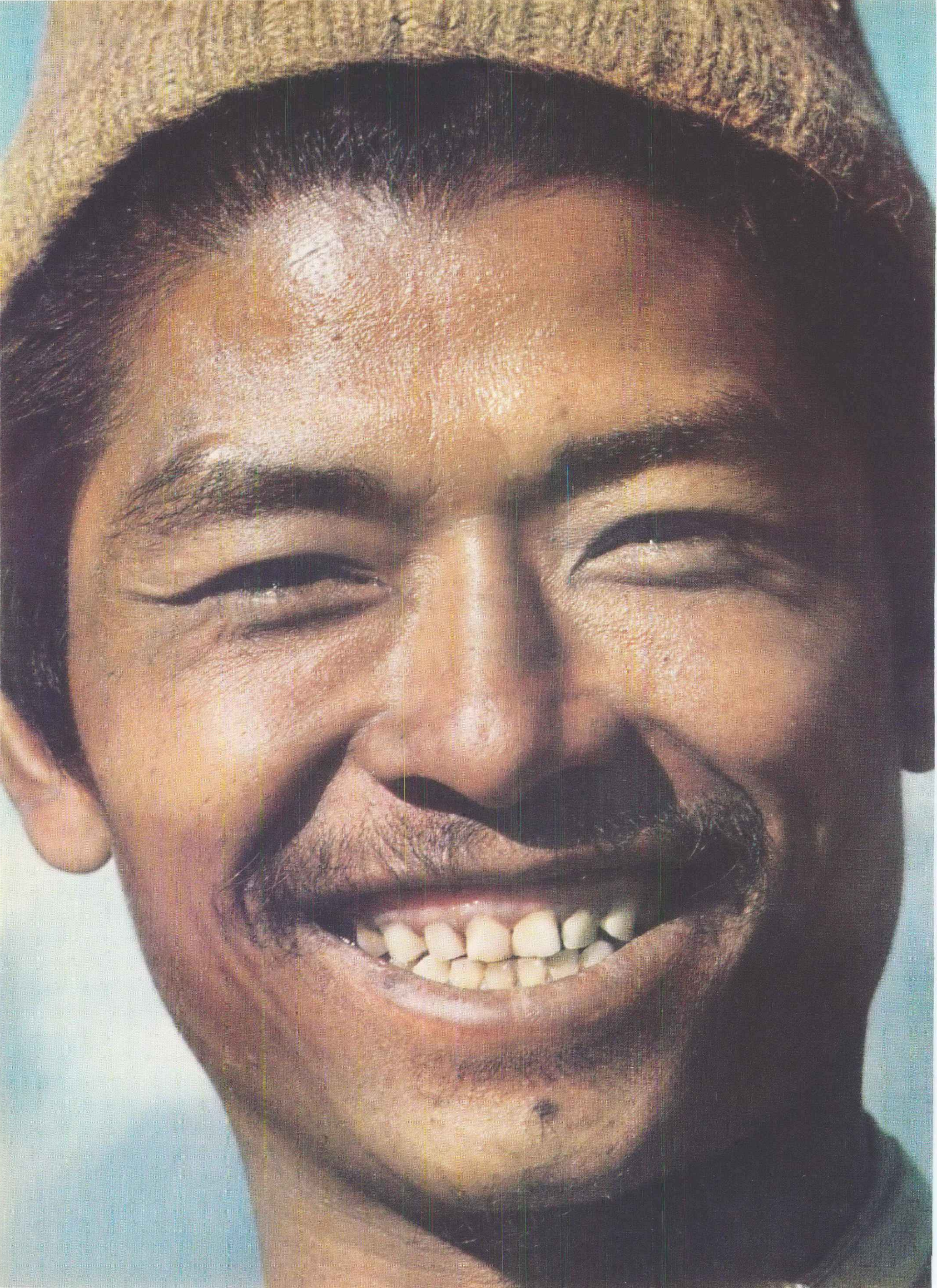
The Herald Examiner editorialized vehemently against S.B. 483, saying it was "a bill meant to deprive the people of California of the best legal tool they have to force insurance companies to deal fairly with policy claims."

Responding to a series of pro-S.B. 483 editorials, Mr. Boyd wrote published letters criticizing both the paper's apparent misunderstanding of the proposed law and its accusation of evil intent.

"I was less disturbed by their stand on the bill than by their unjustified attack upon an entire industry," Mr. Boyd said. ■

$12.5 million losses

Wind and hail in storms that struck parts of Texas and Kansas on Oct. 15-16 and Oct. 21 caused insured losses estimated at $12.5 million, the American Insurance Assn. says.



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Employers fuel product litigation: Lawyer

NEW YORK—Employers should stop "siccing" employes on product manufacturers to recover workers compensation subrogation liens, argues a leading product liability defense attorney.

More product liability trials are being won by the defense than by plaintiffs, but defense costs often run several times greater than the value of a claim, said Daniel J. Ryan of LaBrum & Doak, a Philadelphia law firm.

A great deal of this expense results from employers and their workers compensation insurers seeking to shift the cost of workplace injuries back to vendors who supplied the products years before, he said.

Mr. Ryan, chairman of the Defense Research Institute, a consortium of attorneys and insurers involved in the defense of product liability suits, made his remarks at the 10th annual Product Liability Prevention Conference sponsored by several safety and engineering societies.

Most jurisdictions permit subrogation of compensation claims expenses against product manufacturers and other third parties, Mr. Ryan noted. And employers and their insurers assist and often encourage employes to file a suit against manufacturers.

"Subrogation liens for workers compensation should be done away with," Mr. Ryan said. "Insurance carriers should bite the bullet and recognize the original intent of workers compensation."

The Commerce Department had originally provided in its model product liability bill that workers compensation be the sole source of compensation for work place injuries involving products, but dropped that provision in response to objections from insurers (*BI*, Oct. 15).

Defense costs are a major problem in product liability cases, Mr. Ryan said. Cases against entire industries, such as asbestos, have created "unbelievable" legal expenses, Mr. Ryan said. The cost of defending asbestos claims has run 18 times greater than the total paid out in claims settlements and awards, he contended.

Virtually every defense law firm in every major city has established separate departments to deal with such cases. Law firms have found themselves forced to take depositions by committee to control expenses and time, he said.

In Philadelphia, where Mr. Ryan practices, "there isn't a courtroom big enough" to house all the attorneys involved in one of these cases, he said.

Other cases involving more than one defendant have proven costly as well. Attorneys for each party often battle among themselves and try to shift blame elsewhere.

Mr. Ryan cited one case in which three days of unsuccessful negotiation to achieve a settlement left the parties less than $10,000 apart. Witnesses had been flown in from as far as Japan in anticipation of a trial that was put off because of the time wasted on negotiations. Between $25,000 and $30,000 had been spent in vain on legal expenses, Mr. Ryan noted.

Defense attorneys have deployed special settlement techniques in such cases to transfer the cost of a claim to another defendant. Defense counsel for one defendant offers the plaintiff a settlement and assists the plaintiff's attorney in seeking recovery from the other defendants, he said.

Should the plaintiff's attorney win the case, he refunds the settlement to the defendant who assisted him. If the plaintiff's attorney loses, the plaintiff keeps the settlement offered.

Mr. Ryan said use of special settlement techniques was "reprehensible and wrong," but said he had used a variation of the technique on occasion.

The Federation of Insurance Counsel has proposed that a single counsel be employed in multiple defendant cases and that insurers arbitrate among themselves their portions of any settlements or awards, Mr. Ryan noted. But, he doubted this proposal would be adopted because many defendants have retrospectively rated and self-insured programs.

Carefully selecting expert defense witnesses in product suits, is important, Mr. Ryan stressed. Experts on one subject who diversify and testify on another should be avoided, he said. Top experts on a topic, however, sometimes are not desirable witnesses because they are inarticulate, arrogant or suffer from "stage fright," he said.

Mr. Ryan said he prefers to hire a generalist to work with a specialist and have them "learn from each other so they can put together a defense that's articulate and technically competent."

Plaintiffs' attorneys tend to hire generalists who are easy-mannered and likable witnesses, Mr. Ryan said. Developing background files on such witnesses is beneficial to the defense since "hopefully the witness will have testified often enough (on different products) for the defense to be able to show he's a prostitute." ■

New officers

The Insurance Library Assn. of Boston has elected new officers and trustees for the following year. Officers are Maurice H. Saval of Maurice H. Saval Inc., president; Frederick J. England Jr., immediate past president; Stephen J. Paris, vp; Tobelynn Gerard, secretary, and Miles J. Leavitt, treasurer. New trustees are Margaret Black of Marsh & McLennan and Richard L. McDowell of Suffolk University.

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Lloyd's woes fail to dampen optimism of British brokers

NEW YORK—Despite giant computer leasing insurance claims and the failure of the Sasse syndicate, Lloyd's of London hasn't lost its dry, whimsical British optimism, according to a London broker association executive.

In a wide-ranging chat with Alan Teale, secretary of the British Insurance Brokers Assn., *Business Insurance* learned that few issues shake brokers' faith in the stable marketplace of Lloyd's.

"One of the greatest areas of concern in the next decade will be the need for good, effective product liability insurance," said Mr. Teale. Europe, through a European Economic Community proposed directive, is moving closer to absolute liability for manufacturers, but that will not be bad if "sanity is allowed to prevail," he said.

The U.S. experience in product liability litigation is a "legend unto itself" from which Mr. Teale and his members would like to see Europe spared.

The influence on the EEC by manufacturers and insurers will result in directives on product liability that will be "fair to everyone," Mr. Teale hopes. Members of the British Insurance Brokers Assn. are "not unhappy" with statements coming out of the EEC (*BI*, Oct. 15), whose guidelines are expected to be worked into the laws of member nations, he said.

The insurance markets have said price of coverage will not be prohibitive, he noted. "We're satisfied that a full understanding of the situation exists among British insurance companies and underwriters at Lloyd's."

The insurance industry will meet challenges it currently faces, Mr. Teale said. Excessive competition, major catastrophes and international recession will result in only a temporary downturn, he noted.

Lloyd's will "right itself" from problems such as the computer leasing claims and failure of Sasse syndicate, he predicted. Although Lloyd's problems seem huge, so were the challenges of Hurricane Betsy in 1965 and the Harrison syndicate which collapsed in 1921 from writing financial guaranty contracts, Mr. Teale noted.

The fact that fewer names are being added at Lloyd's this year than in previous years reflects the 350-year-old institution's efforts to right itself, he added.

Although he declined to speculate on what course the New York Insurance Exchange will take, Mr. Teale predicted its existence will benefit the international reinsurance broker. Asked whether he foresaw exchange syndicates following London's underwriting lead at first, he said that would depend upon who the exchange underwriters are and their philosophies.

"The amount of expertise on both sides of the Atlantic will develop as it chooses," he said.

Link-ups of large American brokers with their U.K. counterparts will not result in major disruptions to the British market, Mr. Teale predicted. The link-ups "make sense" because of brokers' need to respond to growing international nature of business, he added.

Although there is likely to be some replacement of brokers handling certain accounts, it will not be much different from the type of account changes that occur regularly, he said. "As each unit gets together, it will encourage people to direct their programs elsewhere." ■

Bellefonte move

The Bellefonte Cos. plans to consolidate its treaty and facultative reinsurance activities in suburban Cincinnati, effective Jan. 1, 1980. Originally, the firm planned to keep its treaty reinsurance operations in Middletown, Ohio, and facultative reinsurance in San Francisco, but decided the business could be operated more effectively from a single location.

Non-life coverage

Stagflation pushes up loss ratios, study says

NEW YORK—Stagflation and more intense competition for a less rapidly growing business volume pushed loss ratios higher worldwide for many types of non-life insurance, reports a study by North American Reinsurance Corp. here.

Australia, France, Switzerland, Denmark, Japan and Spain registered higher loss ratios from 1973 to 1977, the period covered by the study, while loss ratios improved after 1976 in Austria, Canada, Italy and the U.S. In West Germany, the loss burden declined slightly in 1977 after a substantial increase the previous year, while it remained steady in the Netherlands.

The insurance industry's underwriting results from year to year portend future rate development, with bad underwriting results pushing rates up and good underwriting results pushing rates down.

But underwriting results were less affected from the rising loss ratios than might be expected, the study contends. Only in Spain and Switzerland did the underwriting result deteriorate in 1977 compared with the previous year. Over the five-year period, Australia, Canada and the U.S. registered the best results, with Great Britain and Japan following.

The report attributes the positive underwriting results to the fact that deteriorating loss ratios were overcompensated by the decline in the expense ratios. Surpluses from runoff profits on loss reserves of previous years also helped.

According to figures available, the 1978 underwriting results in Great Britain, Japan, the Netherlands and Switzerland improved over the previous year. The remaining European countries showed differing tendencies in the various branches, with the overall trend being rather unfavorable. Severe competition which set in last year on the North American insurance branches has already led to an increase in average loss ratios.

The report makes the following observations about the various insurance branches:

- Marine hull and cargo insurance suffered from a continued pressure on premium rates which no longer correspond to the growing risks. Austria, Canada, Denmark, France, Japan, Spain and Switzerland registered the worst results in 1977, and the earnings situation is unlikely to return to normal in the near future.
- The fire insurance loss ratio declined slightly in most countries, partly because there was no accumulation of serious losses. Premium rates for industrial fire business again declined in many places, mainly a reflection of increased competition and a modest amount of new business because of recession. Canada, Denmark, the Netherlands, Spain and Switzerland registered clearly improved loss ratios in 1977. In the remaining countries, except Italy, the loss burden was slightly below or near the previous year's levels.
- In 1977, growing crime rates led to a deteriorating loss ratio in all countries covered except Switzerland and the U.S., compared with the previous year. In most countries the measures taken by insurers to adjust premium rates and terms of cover to the changing risk factors turned out to be inadequate.
- The majority of countries observed high loss ratios in 1977 for general third-party liability insurance, particularly Canada, Spain and Switzerland. Australia, Japan, Italy and the U.S. had more favorable loss ratios.

General third-party liability insurance was particularly affected by numerous major losses which are greatly subject to inflation because of their relatively long settlement periods. ■

Tornado losses

Insured losses resulting from a tornado in Louisiana Oct. 23 are estimated at $1.77 million by the American Insurance Assn. The heaviest damage took place near Lake Charles. The storm was assigned Catastrophe Number 36 by the Insurance Services Office, which monitors catastrophes.

Risk execs criticize proposal for fire insurance monopoly

By RHONDA RUNDLE

LOS ANGELES—Corporate risk managers in California are perplexed and mildly shocked by a League of California Cities' study examining creation of community-funded fire insurance monopolies within their jurisdictions (*BI*, Sept. 17).

Cities lack both expertise and financial means to manage the complexities of corporate insurance, insurance managers agree. Sophisticated packaging such as blanket coverage, umbrellas and self-insurance would wreak havoc with municipal underwriting efforts, they emphasize.

Under the plan, municipal fire department services and fire insurance would be provided as a package (*BI*, Sept. 17). Premiums paid by private and business residents would be used to defray the cost of fire protection and would go up or down with the loss history and cost of fighting fires. Corporations that self-insure, though, could face added municipal assessments.

Proponents call it the key to aggressive community risk management, since local loss performance could be directly linked to premiums. They stress that municipal fire insurance would not create a bureaucratic monster and that MFI would use private insurers for technical and administrative services.

"It's hard to see how it could work," says Woodrow Anderson, director of risk management at the University of California. The nine UC campuses, he points out, are insured against fire losses under one blanket policy with a $6 million deductible. He questions what allowance MFI would make for self-insurance. Total premiums would be higher if campuses were forced to insure separately.

Private fire departments are another complication. Although most University of California campuses rely on city services, some fund their own fire departments. In Santa Cruz, for instance, the nearest station is rather far away, Mr. Anderson explains, so UC maintains its own on campus.

Mr. Anderson doubts whether MFI would be a fair shake for business and industry. "Such a program would probably be designed so that business picks up a larger share of the costs," he suggests. "And whereas homeowners would most likely get full coverage, we'd get only partial protection."

"I don't think it's for Disneyland," comments Saville Williams, director of insurance for Walt Disney Productions. He points out that some rides at the Magic Kingdom cost more than $100,000 per square foot to build. He doubts Anaheim would or could insure such high values.

Harold Harshberger, who handles insurance for Hunt-Wesson Foods in Fullerton, is similarly skeptical. "I don't think any city could compete with private insurance companies for the kind of coverage we've got," he declares. "It's one thing to charge for fire protection services; it's another for cities to get into the insurance business.

"Although we're self-insured up to a point, we already pay a lot for our insurance package," Mr. Harshberger continues. "Our product liability and business interruption insurance would cost significantly more if we had to buy them without fire insurance."

The same goes for earthquake insurance, extended coverage and theft, points out Bob Beth, director of risk management at Stanford University. Placing these kinds of insurance would be difficult and probably expensive without grouping them with fire coverage, he notes. Unlike the UC system, however, Stanford would not be affected by MFI because the campus is outside any city jurisdiction.

Several of the risk managers contacted by *Business Insurance* were unaware of the MFI study. Their first reactions to the idea ranged from mild disbelief to outrage.

What would happen if a city's loss experience proved bad, they asked. Would the town merely raise taxes?

One insurance manager from a large construction company in Northern California charged all insurance is a ripoff anyway, so MFI wouldn't be any worse than other forms.

"What a disaster if costs actually went higher than when private insurance was available," another said.

Others questioned rating structures, replacement cost versus actual cash value recovery and claims adjustment in contested cases, all issues yet to be resolved by proponents of the plan.

The MFI concept is still very much at the fact-finding stage, stresses Clark Goecker, assistant director of the League of California Cities. A committee of about 15 city officials, attorneys, fire chiefs and insurance company representatives has been set up to study the pros and cons of MFI and will make recommendations to the league's executive board next February, he reports.

The committee is considering the political, financial and legal feasibility of the plan. Some members reportedly question the legality of the proposal, believing it violates restraint-of-trade laws. If the committee recommends the league pursue the plan next year, some sort of enabling legislation will have to be drafted and a legislator found to sponsor the bill.

Also due early in 1980 is a federally funded study on MFI commissioned by the Institute of Local Self-Government, a Berkeley-based independent research outfit. This report will provide a theoretical framework, whereas the league committee's approach is more practical.

Insurance companies have been quick to see their interests at risk in the MFI proposal. On Oct. 16, a group of insurance industry representatives met in San Francisco to discuss MFI and initiate discussion with both the League of California Cities and the Institute of Local Self-Government.

W. Victor Slevin, western regional vp of the American Insurance Assn., was selected chairman of the all-industry steering committee.

Continental relocates

The Continental Insurance Cos. has relocated its Southeastern regional and Atlanta branch offices to the Peachtree Summit complex in Atlanta. Also headquartered in the building will be affiliates The National Life Assurance Co. of Canada, Underwriters Adjusting Co., Marine Office of America Corp., London Guarantee & Accident Co. of New York and Loyalty Life Insurance Co.

Deferred compensation gains popularity

NEW YORK Deferred compensation plans are increasingly important parts of employe benefits packages as firms look for ways to protect key executives against the combined ravages of inflation and heavy taxation.

The popularity of these plans, which put off raises or other increased benefits for employes until they retire, has grown as employers try to offset the diminished buying power of the dollar in ways that keep top employes from bolting to another company.

Proponents of the deferred compensation plans argue they allow employes to shelter the growth of money they might receive in a raise, reaping greater benefits in the future, while giving employers several distinct tax advantages.

Increased interest in these plans has spurred a growth in firms that specialize in helping companies establish the somewhat complex and tricky programs for their employes.

Among the more successful such firms is the Greenwich, Conn.-based Executive Compensation Systems Inc. It's not the best known in the business and not the largest, but it illustrates how outside consultants are used by large companies.

And its growth is indicative of how popular the trend has become.

In less than a year, the firm has gone from no clients to more than 35. It is still adding new companies, some of them in the Fortune 200, at a rate of three or four a month.

Company president Richard Mayer, 48, and executive vp Robert Ward, 35, market what they call a life insurance contract between the employer and the executive covered under the Executive Supplemental Income Plan. The company makes the premium deposits and carries the cash value as an asset on its books. The company is the applicant, owner and beneficiary on one or more key executives' lives.

For the covered employes, the contract provides substantial pre-retirement death benefits, supplemental retirement income and no current taxation on the benefits.

"If a guy is making $100,000 and you give him a $20,000 raise, he is only going to see 40% of that after taxes," Mr. Mayer explained. "If the company instead puts that money away in a tax-free shelter, the employe will have two and a half times what he would be taking home waiting for him when he retires."

The demand for plans like the supplemental income plan has been "just incredible," says Mr. Mayer, particularly when executives argue that normal pension programs are not designed with their best interests in mind.

Mr. Mayer says this supplemental income program offsets the "inequalities" of a qualified pension plan, which is designed to meet the retirement needs of a wide group of wage-earners and not to specifically take care of top executives or the "profit center," as Mr. Mayer calls them.

Once Executive Compensation convinces an employer that this program should be set up, its staff meets with company executives to find out the benefits they want and what they are trying to accomplish financially with the program. They usually work with in-house lawyers, actuaries and accountants to devise a way to accomplish these ends.

The consulting firm works on a commission basis, with the state-regulated fee set at one year's insurance premium. The commission is paid out in annual increments over a 10-year period.

The program, which can be set up for any number of executives ranging from as few as five or as many as 100, offers executives disability income before age 65, and supplemental income at retirement or salary continuation to the remaining spouse in the event of death before retirement.

The employer's benefits are a complete cost recovery of tax free dollars, minimal capital exposure, deductible benefits when paid and, perhaps most important, a tax leverage created by the company depositing a full dollar instead of the executive's net dollar. The dollar is invested on a sheltered basis and there is no income going to the employe during the sheltered investment period.

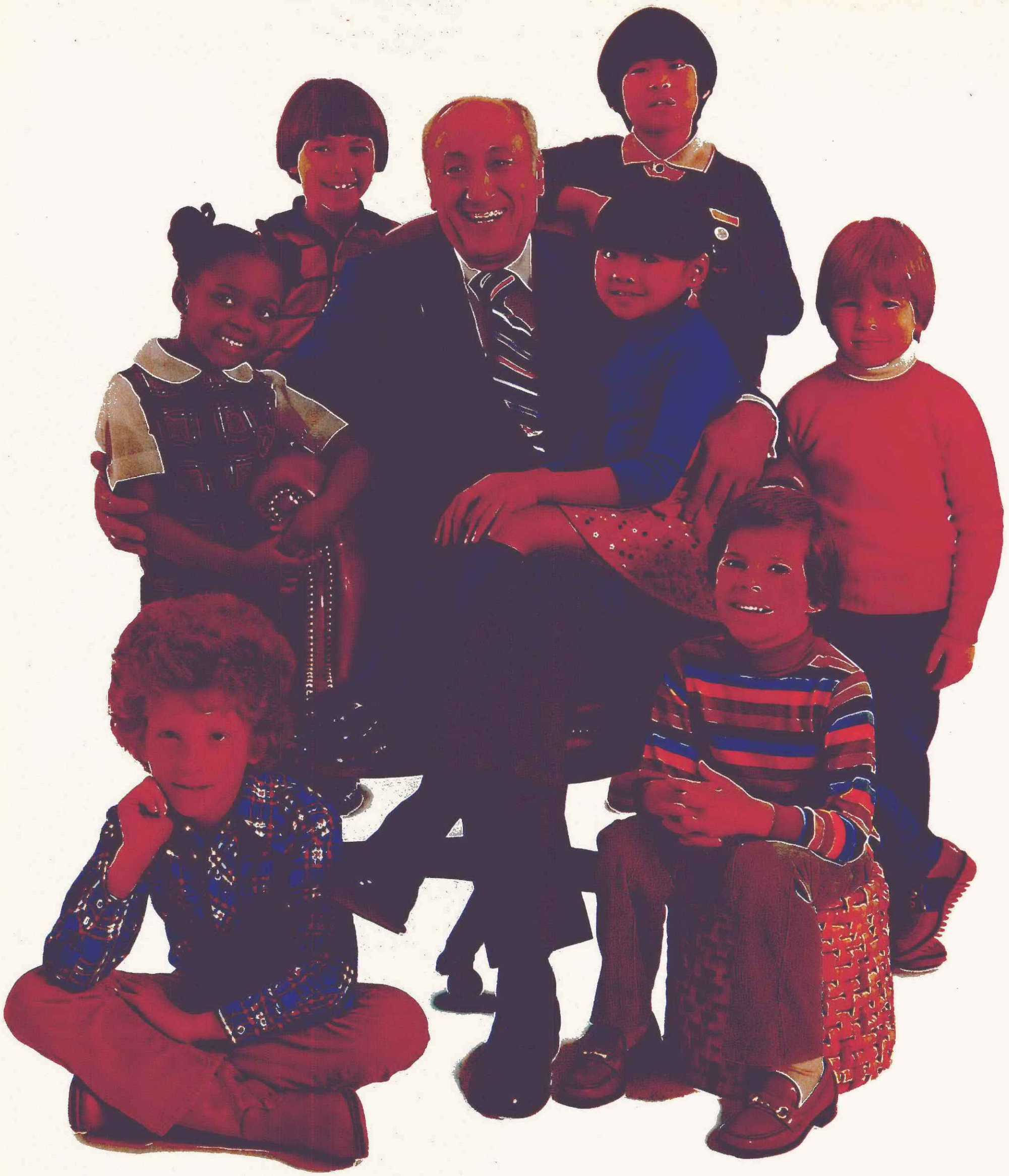
One of the major hurdles in setting up a successful program is preventing the account from being set up in any way that can be construed by the IRS to be paying benefits to the employe before death or retirement, or so-called constructive receipt.

To avoid this, the plan has stringent penalty provisions that would prevent the employe taking advantage of all of the benefits if he left the company before retirement.

Another drawback is that if the company folded, the employe would not only be out of the raise he passed up, but would have to stand in line with other creditors to try to recoup the money in the supplemental income fund. ■

Computer coverage

Kemper Group and the Harleysville Mutual Insurance Co. have introduced computer policies for small businesses. The Kemper form covers a computer system worth up to $1,000,000 and covers up to 10% of the face value of the policy per loss on materials used with the computer, as well as expenses incurred to maintain normal operations. The Harleysville all-risk package policy is designed for businesses who rely on outside computer services and includes property coverage for owners and lessees of equipment.



International Year of the Child 1979

Albert J. Tahmoush, Chairman and CEO of Frank B. Hall & Co., Inc. with some of our "neighborhood kids". In this, International Year of the Child, we have millions of good reasons to continue our growth strategy... most are under ten years of age.

Pierre, Mohammed, Chueng, Hans, Maria, Sean, Tess and A.J. discuss growth strategy.

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Tire maker appeals strict liability lawsuit to Supreme Court

By LESLIE MILLER

CHICAGO—Uniroyal Inc. is appealing a question of strict liability to the U.S. Supreme Court.

The tire manufacturer argues that it should not be held liable for an injury allegedly caused by a tire it did not make even though the tire bore a Uniroyal trademark.

But the Illinois supreme court ruled last January that Uniroyal can he held liable for the injury because it licensed another company to use its trademark. At least three other states have ruled similarly.

John Darill Connelly was seriously injured in an automobile accident Nov. 1, 1970, after the tire on his car blew out. The tire bore the name Uniroyal and Mr. Connelly, who is now a paraplegic, sued for $3 million.

But Uniroyal did not actually manufacture the tire; it had merely granted a foreign subsidiary the right to use its trademark. The subsidiary, Englebert Beligique S.A., tried to excuse itself from court by arguing it had nothing to do with Illinois since it had no office, agent, store or even telephone number within the state.

The appellate judge ruled, however, that it was not unreasonable to require Englebert to defend its action in Illinois. The subsidiary enjoyed the benefits and protections of Illinois law when it sold several thousand tires here and it committed a tort by placing a defective product in the stream of commerce. Thus, the long arm of the law plunged Englebert Beligique into Illinois waters.

Neither was Uniroyal exempt. Uniroyal owned 95% of the outstanding shares of Englebert and had management control over them. The plaintiff argued that Uniroyal is responsible for the whole enterprise.

When the Illinois supreme court overruled the appellate court, it said Uniroyal, as licensor, can be held liable. It stopped short, however, of imposing vicarious liability on Uniroyal because the two companies were virtually autonomous in their operation. They did not share offices, employes, facilities or insurance companies.

The Illinois supreme court remanded the case to the circuit court, which had ruled that Uniroyal can be held liable. But Uniroyal is appealing to the Supreme Court. The case has not yet gone to trial.

At least three other states—Pennsylvania, Wisconsin and Indiana—have held the owner of a trademark liable for injuries under the doctrine of strict liability. Strict liability in these cases has been interpreted to include everyone along the chain of distribution, from manufacturer to consumer.

"The major purpose of strict liability is to place the loss created by defective products on those who create the risk and reap the profit by placing a defective product in the stream of commerce, regardless of whether the defect resulted from the negligence of the manufacturer," said Justice Goldenhersch of the Illinois supreme court.

Others argue that such an interpretation expands the intended scope of strict liability. "Strict liability is based upon the language of the Restatement of Torts. . .(It) was intended to apply to the seller—one directly involved with the sale of the product—and not to someone occasionally involved," maintains Don Hirsch of the Defense Research Institute. "The sale, according to the restatement, is to the ultimate consumer."

The standards for applying strict liability are being lowered as well, Mr. Hirsch said. The standard is that the product must be unreasonably dangerous when it leaves the seller's control, more dangerous than the consumer would expect it to be during normal use. More lenient interpretations of "unreasonably dangerous" are, in effect, expanding the definition of strict liability, he said. ■

Insurers oppose Calif. workers comp bills

By RHONDA L. RUNDLE

LOS ANGELES—California employers should be penalized when employes are injured by machines from which the employer has removed the safety guard or similar device, a state assemblyman contends.

Assemblyman Bruce Young (D-Los Angeles) has proposed a bill (A.B. 1231) to increase by 50% workers compensation benefits paid to employes injured because an employer made unsafe equipment modifications.

Another bill (A.B. 697), also sponsored by Mr. Young and supported by union contractors, would change the rating formula for workers compensation in California to hours worked from wages paid.

Both bills were opposed by the insurance industry during hearings held Oct. 24 by the legislature's workers compensation subcommittee.

Mr. Young argues for penalizing employers who alter equipment in an unsafe manner, pointing out that now under case law the manufacturer is held responsible for injuries caused by the product. Mr. Young says he wants to shift liability from the guiltless manufacturer who produced a safe tool to the blameworthy employer who altered the product to step up production.

"It's a mistake to introduce tort into the workers comp system," argues Joe Markey, legislative advocate for the California Self-Insurers Assn. A plant foreman can't be everywhere at once to prevent employe misuse or modification of equipment, he says. After an accident, however, there could be a question of negligent supervision.

"The purpose of workers compensation is to provide reasonable benefits without regard to fault," observed Edward Levy, assistant counsel for the Assn. of California Insurance Cos., arguing against penalizing employers for altering machines. The bill seems to negate that doctrine, he said. "Workers compensation was never intended to be a substitute for damages."

Negligence cases against employers are tough to win in court, testified a lawyer from the California Applicants Attorneys Assn., because a plaintiff must prove "serious and willful misconduct." The bill introduces a clearer, stronger standard for employer negligence.

Insurers also argued the bill would increase claims.

Assemblyman Young stipulated that the language of A.B. 1231 would be tightened to protect an employer who modifies equipment to make it safer. He agreed to redraft an open-ended clause in the bill that includes "failure to observe routine care and maintenance" as machinery modification.

Gov. Jerry Brown vetoed a similar bill (A.B. 18) last September, saying it was unnecessary. New principles of comparative negligence established in a recent California Supreme Court decision, Daly vs. General Motors Corp., can protect manufacturers against liability where the product has been modified after sale," he explained.

Assemblyman Young's bill to change the rating system to hours worked from wages paid would create administrative chaos without improving fairness in the rating system, insurers argue, but unions support the bill.

Jim Woods, representing the California federation of the AFL-CIO, called A.B. 697 "a simple question of equity. The system does not treat people the same," he stressed.

Mr. Woods contends union-shop employers pay substantially higher premiums than their non-union competitors although the risk exposure and benefits are the same. In time, this inequity would translate into a business disadvantage for employers who pay higher wages, he said.

Spokesmen from the roofing, construction and plumbers unions also argue that their members are better trained in safety procedures on the job and therefore actually report fewer accidents and claims.

"We don't think so," counters Bob Gowdy, vp at Industrial Indemnity. Loss ratios are about the same in union and non-union shops, except among roofers, he said. In that trade, losses are mysteriously greater among higher-paid workers, he said.

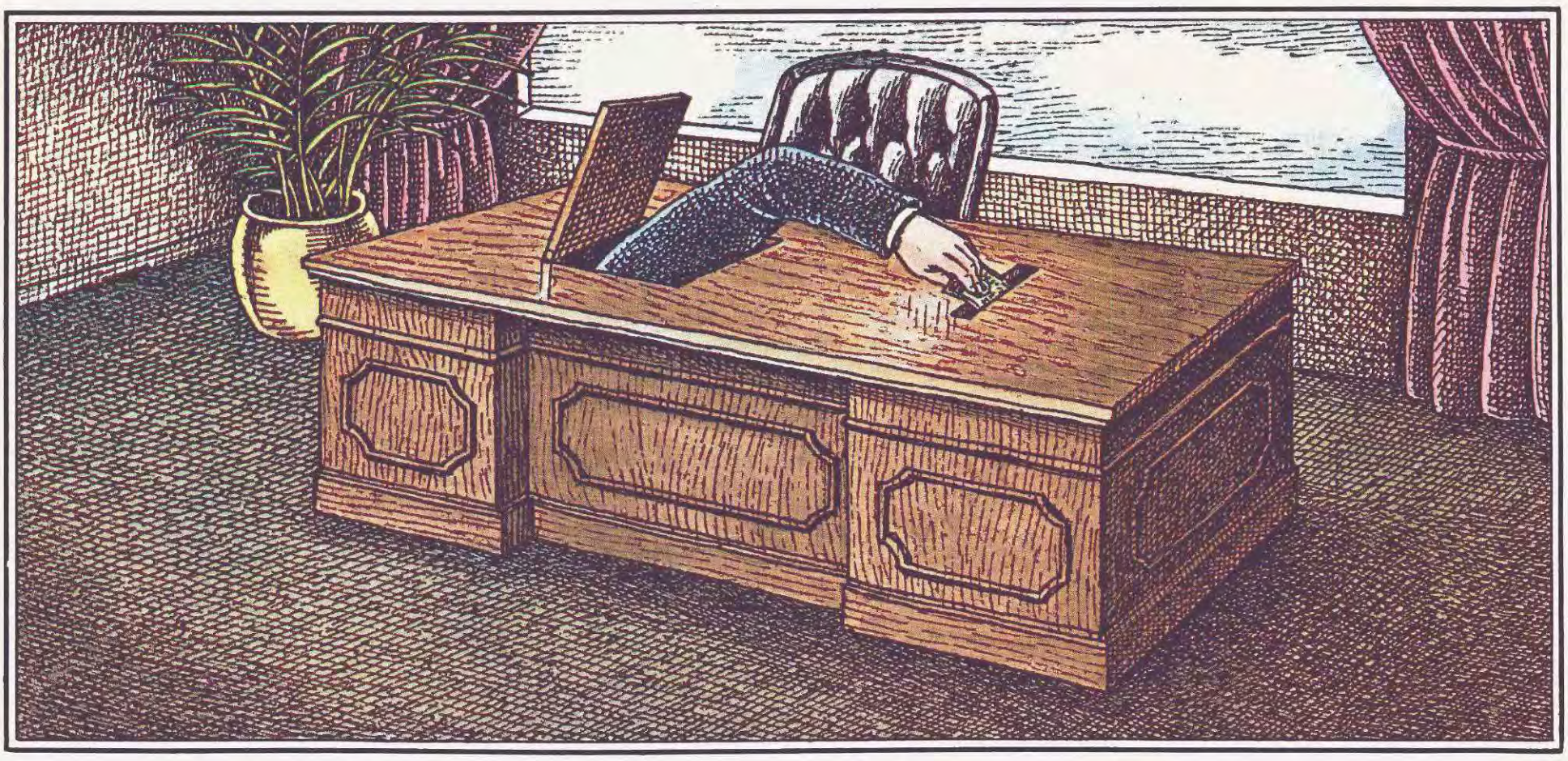
Experience modifications and other factors in the complicated ratings formula result in a fair premium contribution from different employers within the same industry, Mr. Gowdy said.

The Workers Compensation Insurance Rating Bureau of California also opposes the rating bill. In a lengthy report petitioned by two construction industry groups, the bureau found there is indeed equity among employers in the total premium collected. It also cited added record-keeping burdens, administrative disruption and possible increased abuse of the system as further reasons not to change the premium basis. ■

Risk consultant

A new risk management, consulting and services firm, Risk Alternatives Inc., has opened in Austin, Tex., and will operate throughout Texas. Audits, feasibility studies, self-insurance, administration and captive formation and management are among the services offered. Ross B. Blumentritt, CPCU, CLU, is president, and Jack W. Hoffman, CIC, FMS, is chairman of the board. The two were with an independent insurance agency, Southwest Insurance Assn. of Austin Inc., since 1973 and before that were with Employer Insurance of Texas.

Self-Funding



Companies which set up a special tax-exempt trust for funding employee benefits, such as health, accident and disability insurance, may realize substantial reductions in costs compared with conventional insurance plans.

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

It is no news to corporate management that outlays for employee benefits have been accelerating at a rapid pace and are likely to continue to do so.

Overall, the cost of providing employee benefits has been increasing at an average rate of 14% a year, going from less than $2 billion in 1950 to an estimated $60 billion in 1978. Benefit plans can cost as much as 35% to 40% of the amount paid in salaries. At many companies, health insurance for employees has become the single most expensive item that the company buys from an outside supplier.

How long can this continue? Since it is the function of employee benefit plans to cover rapidly rising medical costs and to replace lost job income, and since inflation places increasing pressure on employees' real income, they may expect benefit payments to rise accordingly. On the other hand, corporations – which must bear the brunt of the premium costs involved – are looking for sound financial alternatives.

One way now coming into wider use is through benefit self-funding.

No reserves versus reserves

The most direct self-funding technique involves paying claims (for example, hospitalization claims) directly out of the company's cash flow. No reserves for future claims are set aside. And since no premiums are paid, it is possible to save the cost of the premium taxes otherwise payable by the insurance company.

The firm, in effect, becomes its own insurer on a pay-as-you-go basis. However, stop-loss insurance is usually purchased to protect against unexpectedly severe claims experience. Because of ERISA restrictions, such self-funded plans may be suitable only for companies which pay all premiums and do not require employee contributions to their plans.

For many other companies, a tax-exempt trust may be the

Employee Benefits

most satisfactory form of self-funding. This type of trust is essentially a vehicle for setting aside funds and building up reserves through investment. It is limited to voluntary benefits, in contrast to those benefits, such as workers' compensation, which are mandatory under federal or state law. Such a trust may be established and administered so as to qualify for exemption from federal income tax.

A tax-exempt trust is set up to fund a formal plan, drawn to meet the specific needs of an individual company. Employer and employee contributions are turned over to the fund's trustees, who also pay claims and expenses and invest excess funds. With a qualified fund, employer contributions are deductible as business expenses, and benefit payments are generally not taxable to employee recipients.

Shelter from taxes

And most important, the investment income of the trust (other than unrelated business income) is ordinarily not subject to federal income tax.

The result may be a substantial reduction in costs for a plan funded through a trust as compared with traditionally insured plans – particularly on coverages which develop large claim reserves, such as long-term disability. All of which may net out to lowered expenses for employee benefits.

To achieve the potential premium savings involved, self-funding of employee benefits appears to be most worthwhile for companies with over 1,000 employees, although smaller companies also gain under the right circumstances.

In any event, the potential benefits of self-funding should be weighed against cost-cutting plans offered by insurers, such as experience rating and minimum payment plans, which can substantially reduce premiums and increase cash flow while providing full insurance company services.

Administering the plan

Once the decision to self-insure is reached, most businesses find they will have a need for administrative services furnished by a professional outside supplier. These services include consultation on the establishment of a benefit plan, its planning and design, and the creation of a tax-exempt trust.

After the plan is in operation, claims administration becomes the most important function of the outside administrator, together with the preparation of booklets, documents, government reports and other communications. ESIS, one of the INA companies, can supply these services to business through its employee benefits division.

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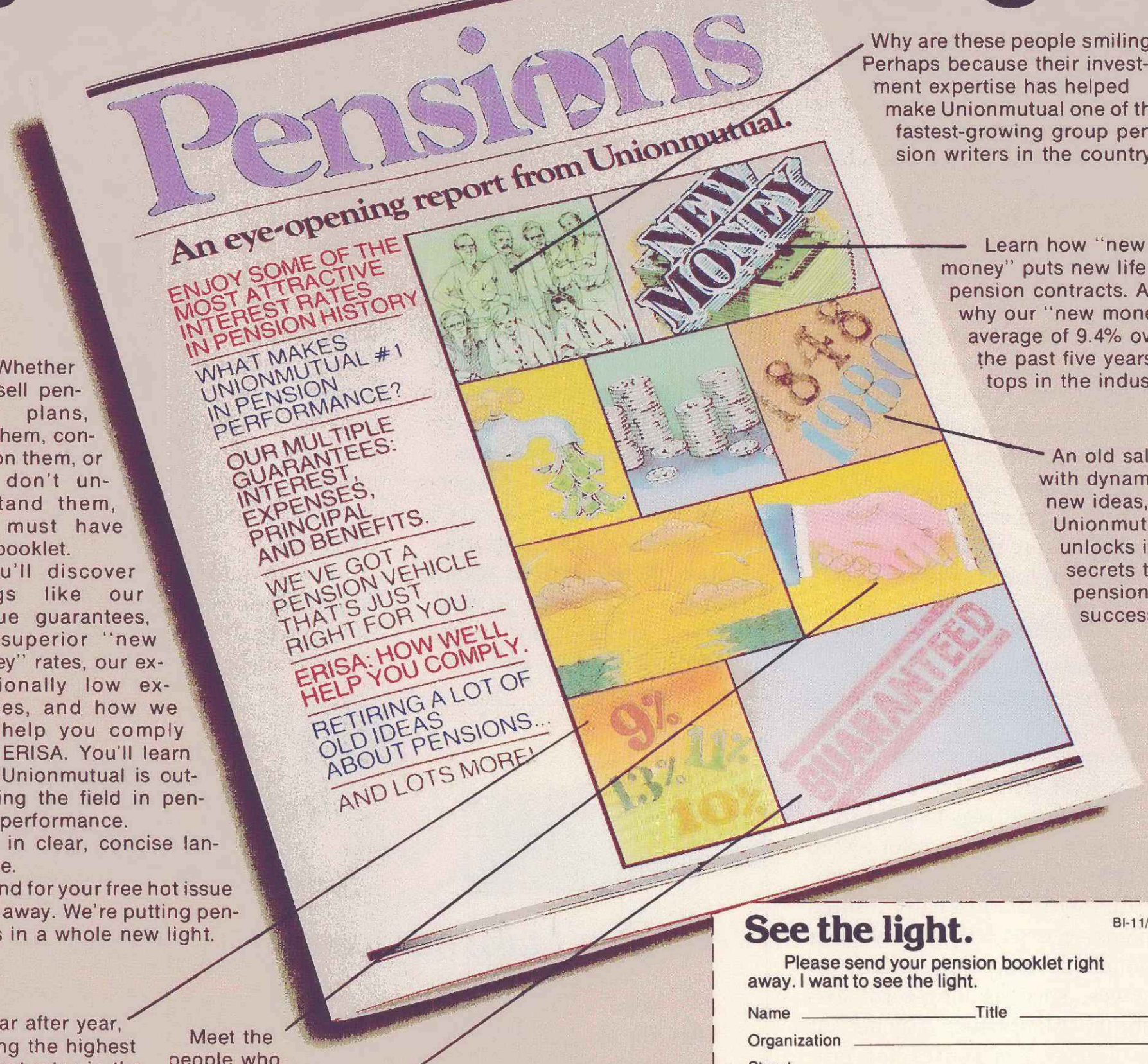

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PERSPECTIVE

The ups & downs of federal regulation

With the fortunes of employe benefits and pension plans riding the winds of government regulation, employers are looking at Washington with confusion, say Perspective writers Mr. Lutz and Mr. Keene.

Benefit programs take their lumps from zealous government agencies

By Alton E. Lutz

THE REV. TIMOTHY S. HEALY, S.J., president of Washington's Georgetown University, was the guest speaker at the prayer breakfast during the annual meeting of the National Chamber of Commerce. He thinks it is time we get together to oppose government regulatory proliferation. Otherwise, the results will cause business to become "homogenized like so much oatmeal, all the same color with nothing to distinguish one from the other except for the size of the lumps."

Elaborating upon that simile, unless we can achieve adequate restraint, the regulatory agencies in their zeal will try to beat out those lumps and remove even that minor residue of distinction. The important point to remember is that those lumps of individuality or differentiation hold the genes that underlie choice, experimentation and innovation. They are the hallmarks of freedom and competition, profit and loss.

Alton E. Lutz, CLU, FLMI, is group underwriter with the Independent Life & Accident Insurance Co.

Consider the manner by which unrestrained regulation has increased the medical portion of benefit costs. Too often, the soaring cost has been attributed to inflation alone. Both state and federal regulations affect the employer's liability, thus cost, for medical benefits—states through regulation of the insurance industry (group insurance contracts) and federal through civil rights legislation.

More expenses

Stimulated by the specter of a federal takeover of insurance regulation, state regulation in recent years has seen a crescendo of responsibility placed upon employers' group insurance plans. In many states employers are now forced, through group insurance, to support state institutions for mental, drug and alcoholic services that once were entirely tax supported by the public at large.

The incidence of expense, when distributed over the populace, is not a burden on anyone. When an individual employer is obliged to pay these expenses through his plan, the results are quite different. The insurance companies' costs are passed along through rate increases, as every employer is painfully aware.

Some states now require employers to provide continuation of group insurance benefits to terminated employes for several months, regardless of the reason for termination, unless they have or get other insurance. The mere requirement that the ex-employe pay the full group premium (through the employer) to have this continuation of full group benefits does not nearly compensate the employer for the added expense and liability to his plan, because of the adverse selection inherent in such a privilege being extended to all terminating employes.

Why should it be the employer's responsibility to provide such protection to ex-employes who have gone to work for his competitors in the labor market, while they are in the waiting period for benefits under their new employer's plan?

Profit motive

Other states have decreed that subrogation is not to be permitted in group insurance contracts. Thus medical expenses as a result of auto accidents must by law be paid double in those states, creating a profit motive and disincentive to control medical expenses.

I know of one instance where a mere typographical error increased both medical benefits (cost to plan and revenue to provider) and liability claim as a result of an auto accident. The victim suffered a head gash that required 25 stitches. The surgical bill submitted to Blue Cross indicated 250 stitches. Not only was the doctor overpaid, but the liability claim was substantially enhanced for the recipient as a result of this "evi-

Continued on page 56

FASB offers 'bonus' for pension managers

By Kenneth K. Keene

AS WE MOVE INTO THIS SIXTH year of ERISA and leave the '70s, the Financial Accounting Standards Board proposes a special bonus for benefit managers and others who are concerned with pension operations. The bonus is two pension accounting proposals which are to be implemented for plan years beginning after Dec. 15, 1979.

The FASB has released a revision of the exposure draft "Accounting and Reporting by Defined Benefit Plans." This involves ERISA- and non-ERISA-covered private sector and public employe plans, whether they are funded or not. The other exposure draft, "Disclosure of Pension and Other Post-Retirement Benefit Information," would be an amendment of Accounting Principles Board Opinion No. 8 relative to employers' financial statements.

Kenneth K. Keene, FSA, is senior vp and director of Johnson & Higgins in New York.

The proposal for plan accounting is a modification of an exposure draft released in 1977 that was designed to "provide information, within the limits of financial accounting, that is useful to plan participants in assessing the security with respect to receipt of their accumulated benefits." The FASB was swamped with approximately 700 letters of comment on that proposal. After analyzing those comments, the FASB has come up with certain improvements to make the proposal more palatable.

Financial statement

One change involves the intended uses of the pension plan's financial statement. Although the statement would continue to focus on the information needs of participants, it is expected to be useful to others, such as present or potential investors or creditors of the employer. In its present form it is doubtful the average plan participant can absorb, or even wants to understand, the plan's financial statement. A sample statement for just one pension plan of an employer, complete with footnotes, takes up 13 pages in the appendix to the proposal.

The FASB apparently recognizes that the average participant will be unable to understand the accounting ramifications of the plan. It suggests that plan administrators supplement their required statements with brief explanations of matters thought to be important to participants. In a priceless understatement, the FASB admits that "participants . . . may need to be educated" to understand the information in the statement.

The puzzling thing about the FASB proposal on plan accounting is its lack of clarity on how it is to be used. The exposure draft states:

"This statement does not require the preparation, audit or distribution of any financial statements. This statement is applicable only to financial information that purports to be in accordance with generally accepted accounting principles. Whether a plan prepares such information, whether and by whom that information is distributed, either in part or in total, is audited and to whom that information is distributed, are issues that are not properly within the scope of this statement."

Catch-22

There is a Catch-22 effect here. If a plan is to avoid these accounting procedures, any statement would be qualified (an accounting "no-no") in that it does not meet generally accepted accounting principles. On the other hand, if a plan is to meet such principles, it must add cumbersome and costly administrative, accounting and actuarial procedures to the collection of ERISA requirements already imposed on plan sponsors.

The FASB refers to the Louis Harris pension surveys, which Johnson & Higgins

Continued on page 56

PERSPECTIVE

Communication eases the buying process

By M.J. Melneck

ADVERSARY RELATIONSHIPS exist between the risk manager and the agent, between the agent and underwriter and even between the underwriter and his or her company.

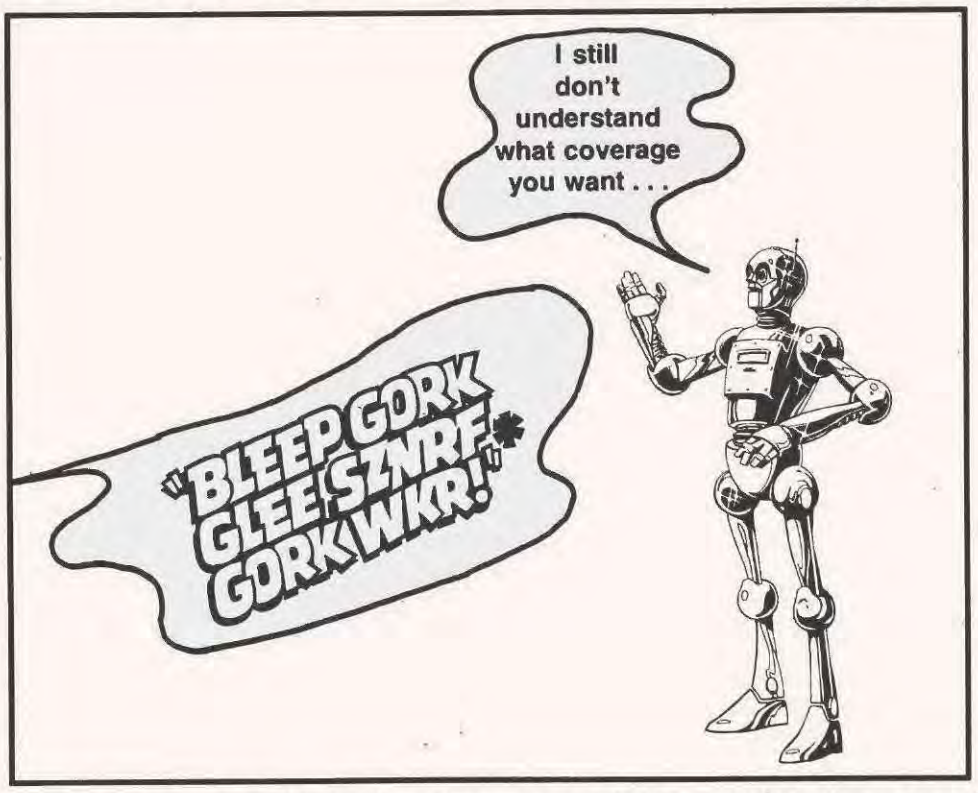
The proof lies, first of all, in the increased number of errors and omissions claims brought against agents by clients, but can be documented in other significant ways as well.

But clear, uncomplicated, mutual understandings can permeate the entire cycle of the insurance buying process, resulting in happy, satisfied insurance buyers, agents, claims adjusters, loss prevention engineers, underwriters and the entire underwriting/company hierarchy.

The key is free release of information by all parties concerned with the ultimate insurance contract. This is not to say that family skeletons and the minutes of executive sessions should be aired; seldom, if ever, is either matter germane to the real issue: the quick acceptance or rejection of risks under terms and conditions acceptable to the parties.

There is no acceptable reason, although there are thousands of excuses, why adequate information can't be collected and passed on the first time around.

In communicating with "high risk" groups such as long haul truckers and demolition contractors, I have discussed specific areas of those operations over which owners, fleet and risk managers have direct control that immediately bear on insurance premiums. Once their attention is captured with an honest and reliable hook—saving money—I can discuss agents, claims and claims adjusters, loss prevention engineers (they don't always make inspections on the day the paint rags are piled next to the welding cart), company philosophies, common sense and other equally important matters.



M.J. Melneck, who has been a senior underwriter, a home office underwriting manager and a vp of a managing general agency, now writes and teaches at the University of Arkansas at Fayetteville.

Talk money

Although money isn't the most important consideration in an adequate insurance program, it is the centerfold—the part most buyers want to see first.

I tell truckers how liability and physical damage rates are built. Many of them don't know, for instance, that they can pass through high-rated zones without paying premiums that reflect terminal stops within them. I tell them that new, expensive equipment will be expensive to insure, that bad drivers, poorly maintained equipment, low deductibles and bad loss records will all be reflected in higher premiums or outright declinations.

Insurance buyers do understand when it's explained why the physical damage market has all but disappeared, or why the premiums for hospital and other malpractice covers sometimes exceed the policy limits. Anyone who ever has any explaining to do, from an agent having to decline payment of a homeowner's claim to a chief executive defending a speculative acquisition, knows that when all the cards are played face-up, the game can be played quickly, accurately and fairly.

Info ladder

The information, naturally, comes from the bottom of the ladder—from the risk. But the need for that information comes from the top, from the company. There is no reason for an agent not to know what supplemental data underwriters might require when a given risk doesn't quite fit neatly between slots A and B. No, Virginia, there isn't really a Complete Application—he's a mythical beast.

The old "knowledge is power" line gets taken to heart by those who've never heard the adage, but who know that as long as someone owes them even a share of information, they can bury a file for a while. What really gets buried is the risk, which, somewhere along the line, is a person.

There needs to be a network whereby information can be exchanged through lines of communication that are never closed. Risks need to know, for example, that there are very few markets for certain lines, that companies have profiles—that they entertain certain classes and perhaps do not entertain certain others. And companies, underwriters and agents need to know that their customers know this.

If companies, through underwriters and agents, will put the word out, they'll get the word back. It can work, and it does. ■

Speaking Out

Medical malpractice fever cools

By Robert L. Westin

THE ARTICLE "'80s medical malpractice crisis will break mutuals: attorney" published in your June 25, 1979, issue, causes me to wonder if James E. Ludlam has a working knowledge of the claims made medical malpractice concept from a rating and accounting point of view. If the doctor-owned companies had stayed with the "occurrence" policy form, most of his observations would have merit. California's five companies offer only claims made policies.

One would expect that Mr. Ludlam's association with the California Hospital Assn. and the Farmers Insurance Group would give him credibility. Yet, he is quoted as having "observed a rise in the frequency and severity of malpractice lawsuits in the last 12 months." It is significant to note that the June 15, 1979, edition of "CHA News," published by the California Hospital Assn., contained the following announcement: "CHA will reduce professional liability insurance premiums for hospitals.

"For two months earlier this year, April and May, CHA cut in half the premium for the primary (or basic) layer of group professional liability insurance. The CHA Executive Committee has now approved a similar premium reduction for July and August. Participating hospitals will not have to pay a total of $5.8 million, because the *frequency and severity of claims have been less than projected*" (emphasis added).

When one considers the fact that Farmers writes "occurrence" coverage for the CHA, its reduction of premiums seems to belie Mr. Ludlam's observations. It is also interesting to observe Farmers' medical malpractice experience for the past three years (**See Chart A**).

This illustration doesn't seem to support his profession of an increase in severity and frequency.

Consider also the following California statistics published by the Board of Medical Quality Assurance on all paid claims of more than $3,000 reported by insurance companies, uninsured licensees or their counsel, clerks of the court and hospital administrators (**See Chart B**).

In 1976, 96.5% of all paid claims were less than $200,000. In both 1977 and 1978, 94.4% were $200,000. Considering a drop of 25% in the total number of claims in 1978 vs. 1976, it can hardly be concluded that the 2.1% increase in the number of claims of more than $200,000 supports Mr. Ludlam's prognostication of doom.

Perhaps the success of the doctor-owned companies presents a threat to the near-monopoly enjoyed by the Farmers. It is estimated that California's doctors have saved more than $200 million in premiums for 1976 through 1978. In addition, they received more than $9 million in policyholders' dividends, all while accumulating more than $222.4 million in assets and $79.1 million of policyholders' surplus. Members of the California Hospital Assn. must be asking the question, "Why not us?"

Robert L. Westin, CPCU, is president of Physicians & Surgeons Insurance Exchange of California.

Chart A

	Earned Premiums	Combined Loss and Expense Ratio	Underwriting Profit
1976	$47,616,000	113.2%	($6,395,000)
1977	$53,737,000	87.6%	$6,684,000
1978	$47,660,000	96.1%	$1,810,000

Chart B

	1976	1977	1978
Total Dollars	$32,237,837	$37,449,399	$29,753,785
Mean $ Reported	$ 41,705	$ 54,196	$ 51,300
Size of Payments			
$3,000—29,999	543	425	376
$30,000—99,999	142	170	123
$100,000—199,999	61	57	49
$200,000—499,999	20	31	23
$500,000—999,999	7	7	9
$1,000,000 & over	0	1	0
Total	773	691	580

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PERSPECTIVE

Business takes its lumps from regulation

Continued from page 53

dence" of the severity of the accident and injury.

At least the EEOC has backed down on its decree that some employers must provide continued coverage to all terminated employes and their families without charge or any other restrictions regardless of their ability or inability to work merely because they once offered continuation of pregnancy benefits for employes or their dependent wives when conception occurred while the employe was insured through the employer's plan. This interpretation contradicts the enabling legislation and is proof of the lack of restraint, or even an ability to follow explicit directions.

Expanded statement

The provisions of the Senate bill leading to Public Law 95-555 (the pregnancy amendment to the Civil Rights Act of 1964) were incorporated in the conference substitute, and the Senate bill included this statement:

". . . .fringe benefit programs must treat women affected by these conditions equally to other employes on the basis of their ability or inability to work; and that nothing in section 703 (h) of the Act may be interpreted to permit otherwise."

Compare that explicit statement with Q. and A. 29 and 30 of the Final Interpretive Guidelines published by the EEOC in the Federal Register April 20, 1979:

29. Q. If an employer's insurance plan provides benefits after the insured's employment has ended (i.e., extended benefits) for costs connected with pregnancy and delivery where conception occurred while the insured was working for the employer, but not for the costs of any other medical condition which began prior to termination of employment, may an employer (a) continue to pay these extended benefits for pregnancy-related medical conditions but not for other medical conditions, or (b) terminate these benefits for pregnancy-related conditions?

A. Where a health insurance plan currently provides extended benefits for other medical conditions on a less favorable basis than for pregnancy-related medical conditions, extended benefits must be provided for other medical conditions on the same basis as for pregnancy-related medical conditions. Therefore, an employer can neither continue to provide less benefits for other medical conditions nor reduce benefits currently paid for pregnancy-related medical conditions.

30. Q. Where an employer's health insurance plan currently requires total disability as a prerequisite for payment of extended benefits for other medical conditions but not for pregnancy-related costs, may the employer now require total disability for payment of benefits for pregnancy-related medical conditions as well?

A. Since extended benefits cannot be reduced in order to come into compliance with the Act, a more stringent prerequisite for payment of extended benefits for pregnancy-related medical conditions, such as a requirement for total disability, cannot be imposed. Thus, in this instance, in order to comply with the Act, the employer must treat other medical conditions as pregnancy-related conditions are treated.

Flagrant disregard

It is quite clear from the above that the EEOC had used something in the regulations it drafted to flagrantly disregard the intent of Congress clearly expressed. That something is the statement that benefits or compensation cannot be reduced in order to come into compliance with the Act (Q. and A. 32). They had not only stated that extended benefits for pregnancy cannot be reduced, but also went on to state that extended benefits for other conditions must be increased, regardless of a person's ability or inability to work. This is the "vice versa effect."

To reiterate, the congressional action said nothing about increasing other benefits to equal pregnancy, and very clearly stated that the act may not permit disregarding the ability or inability to work as a basic criteria. Since the old extended benefits for pregnancy applied, where appropriate, regardless of the ability or inability to work, the intentions of the EEOC to not only continue such a disregard, but to extend such disregard to all other conditions as well contradict the legislative history.

In applying this vice versa reasoning, we see them beating out the lumps in the oatmeal, and in the process leaving it with a taste that is foreboding. Left unchanged, such interpretations are the harbinger of similar successive repercussions of federal regulatory proliferation, rather than the restraint and reform so badly needed. Such restraint and reform are needed not only on the federal level, but in the states as well.

Anti-regulation bills

No wonder that Rep. Elliott Levitas (D-Ga.) and others in Congress have introduced several anti-regulation bills this year. State legislators should follow suit. If the proliferation of state insurance regulation should be reflected by continued lack of restraint in the federal agencies, as demonstrated above, the results will be disastrous indeed.

In his message, the Rev. Healy said we should join together to stop overregulation. Since he is in neither business nor government, we should give special heed to his objective perspective on the Potomac.

How better can business in general, or the insurance industry in particular, help the reformers than to offer such evidence as this against crude and hasty government regulation? Whether or not this incidence of abuse of power affects your company or your plan directly, you should let your congressmen know you expect them not to condone such actions and that they must support regulatory reform. ■

FASB presents pension 'bonus'

Continued from page 53

commissioned earlier this year, in support of its proposed plan accounting. The FASB mentions the Harris survey finds that 83% of private plan participants reading their last pension plan report thought it was very important they know the current financial status of the plan.

However, the Harris survey also says, by a margin of 78% to 16%, that employes are satisfied with the design and administration of their plans. Their apparent desire for more financial information is surely not meant to require complicated financial statements in the accounting sense. The average plan participant already has too much information thrown at him which, if read at all, is beyond comprehension.

The FASB also quotes the Harris finding that 93% of employes reading their last report thought it was very important they know how certain it is that they will be paid their pensions. There is no great problem here. The survey shows by a margin of 93% to 6% that employes do indeed have confidence that their private pensions will be paid. The existence of ERISA, with its PBGC guarantees and its standards of funding and disclosure, is an important factor in support of this favorable attitude.

The FASB derives considerable support from the Harris survey for its effort to demand public plan reporting. The Harris survey found that public plan compliance with private plan regulations is favored by current and retired employes by a margin of 68% to 14%. And 93% of business leaders concur. Of employes covered by public plans, compliance is favored by a margin of 65% to 18%.

Major impact

The rub here is that application of ERISA-type requirements to public plans, many of which are seriously under-funded, could create pressures for a hugh increase in current taxes or a reduction in promised benefits, or both. This is one of the reasons that the politicians will shy away from the issue as long as they can.

The exposure draft would require interest rate assumptions for valuing accumulated plan benefits which "reflect the expected rates of return of plan investments applicable to the periods for which payment of benefits is deferred." If taken literally, this would force the use of a series of interest rates for different durations of benefit deferral—a complex and expensive calculation. But it is very likely that an averaging technique would be adopted in practice.

Even so, relatively minor changes in the interest rate assumption from one year to the next could have a major impact on the indicated value of vested and accumulated benefits. Many managers may be disconcerted by the magnitude of interest-related changes, particularly increases in the unfunded figures in the absence of plan improvements. The use of short term swings in the outlook for investment return will insert a new element of uncertainty when complying with these accounting rules.

The amendment to APB Opinion No. 8 is a step in the right direction. The requirement that accumulated and vested benefits be valued at rates of return reflective of the return on existing plan investments limits the utility of the amendment, however. This would tend to confuse and mislead creditors, investors and other users as rates of investment returns may shift erratically from one year to the next.

Analytical tool

But if this problem is solved, the end result will be an important analytical tool for financially oriented users of the statement. There is a vital need to determine the value of accumulated and vested benefits on a reasonably comparable basis from one year to the next and from one company to another. This would do much to squelch the negative and uninformed comments coming out of Washington and elsewhere relative to the financial integrity of private pension plans.

The amendment is an interim one until another FASB project, "Accounting by Employers for Pensions," is completed. It may be a warm-up for the ultimate pension accounting move: forcing pension assets and liabilities onto the corporate balance sheet. Even now, many financial analysts and potential investors subtract unfunded vested benefits from net worth when valuing a company. The next step may merely formalize the concept. In the process it may take into account the unfunded value of accumulated benefits and not just the vested benefits.

The proposed amendment to financial statements would require the additional disclosure of:

- The actuarial present value of accumulated plan benefits.
- The actuarial present value of vested plan benefits.
- The plan's net assets available for benefits.
- A description of significant actuarial assumptions and asset valuation methods.

Employers with more than one defined benefit plan would have to group those plans whose actuarial present value of accumulated benefits exceeds the net assets available for benefits, and vice versa. Within each grouping, the total value of vested and nonvested benefits would be shown separately.

Although top management may object for other reasons, required disclosures for other post-retirement benefits such as life insurance appear administratively innocuous. However, this could easily change later on. In the long run, such benefits will probably have to be disclosed in a manner analogous to those now being suggested for pension plan accounting. ■

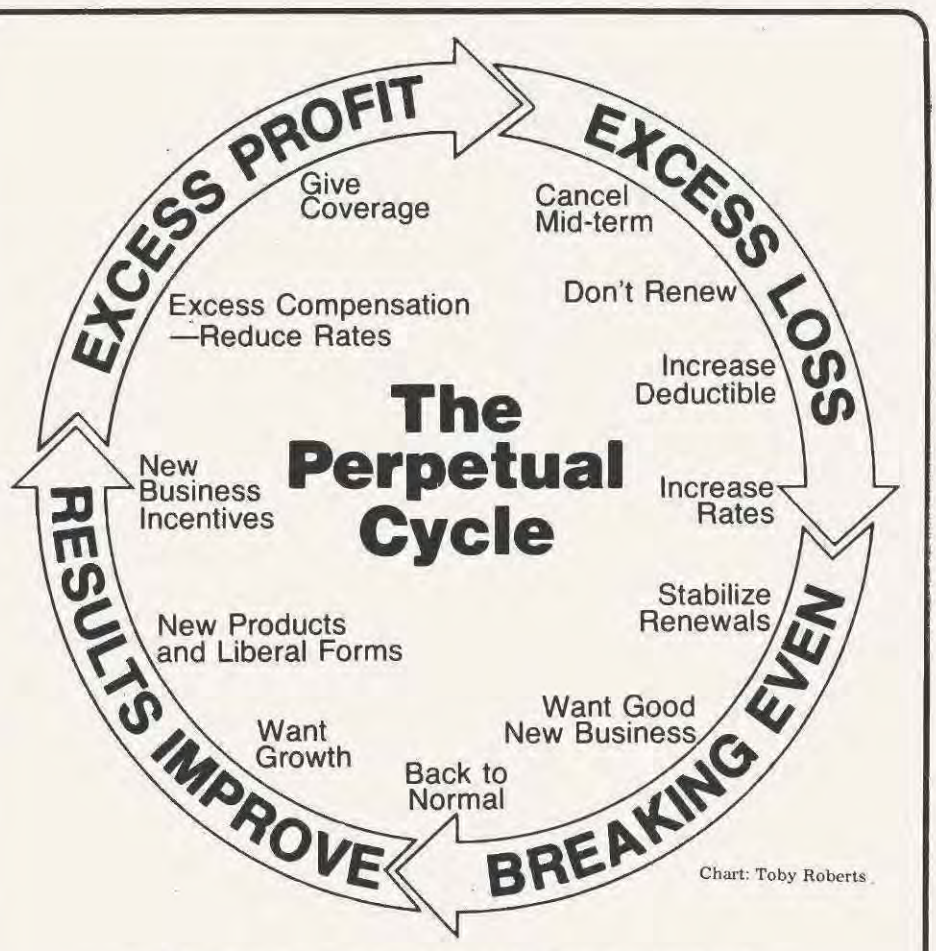


Chart: Toby Roberts

Where are your insurers on the mythic business cycle?

IS THIS THE INSURANCE MARKET cycle that scares the industry? H&W Insurance Services, an Encino, Calif., excess/surplus brokerage, is surveying underwriters and asking them to mark their position on the "mythic insurance cycle." H&W will tabulate and publish the survey results later this year, according to partner Joseph F. Weckerle.

london line

Laker Airways plans suit over grounding

By JOHN H. MILLER

LONDON—Laker Airways, a big British independent airline that runs competitive "cheap rate" flights to the U.S., is planning to file a $28 million lawsuit in the U.S. over losses suffered when DC10s were grounded worldwide after the crash in Chicago last May.

Laker had no grounding insurance and had to make alternative arrangements for its passengers, causing the airline to lose substantial revenue.

Chairman Sir Freddie Laker, who has been consulting lawyers both in the U.S. and Britain, says he will not sue McDonnell Douglas. It is expected his main target will be the Federal Aviation Administration, who ordered the grounding.

British Caledonian Airways, another independent airline, is planning similar action.

Broker division

Lloyd's broker Willis Faber Dumas has formed an oil and gas division after successfully recruiting three new executives from a major rival in this field, Sedgwick Forbes Bland Payne.

The new directors, Donald Payne, John Turner and Gordon Newman, have been placing risks in the U.K. and international markets for some of the most expensive offshore oil operations.

Interest in broking offshore insurance has been stimulated by developments in the North Sea and in the seas around China.

"Rates are coming under pressure in offshore risks as various markets outside London are adding considerably to available capacity," said Mr. Payne, managing director of the new division.

Suit against Lloyd's

Lloyd's marine insurers are facing a $23 million lawsuit in the U.S. over the sinking of an oil platform in the North Sea in January that was on its way to Brazil (*BI*, Feb. 19).

The platform, built by J. Ray McDermott & Co. of New Orleans for the Brazilian state oil company Petrobas, capsized while being towed on a barge provided by Oceanic Contractors, a McDermott subsidiary, from its construction site in northern Scotland.

Three-fourths of the insurance on the offshore platform was carried in the London market, with 25% reinsured in the U.S.

In its lawsuit filed in New Orleans, the McDermott group charges Lloyd's and various insurers have failed to meet any demands for recovery of the losses. Lloyd's syndicates allege the towing was unsafe.

U.S. cycle dropping

The U.S. underwriting cycle still seems to be on the way down, says insurance analyst Derek Chambers of the U.K. stockbrokerage Kitcat & Aitken. But he believes the current cycle and the last one differ in which lines are deteriorating most sharply.

Intensive rate cutting is hitting such lines as commercial property, general liability and excess and surplus business, he says, but auto is less subject to competitive pressures.

Group disciplined

Lloyd's has begun disciplinary proceedings against the Christopher Moran broking group after it was reported that it might not have complied with the terms of a binding authority over reinsurance facilities.

Although no losses have been suffered and the group's accounts are in order, Lloyd's wants to determine whether any of its bylaws may have been broken by the group or a marine insurance syndicate, No. 566, run by Herman Hedley Agencies, with which the group has been associated.

U.S. investment

Commercial Union is planning to inject another $60 million into its U.S. business in a bid to reassert the muscle it had before pulling out from loss-making lines in 1975.

Commercial Union will use its investment to strengthen its surplus and to expand data processing and claims retrieval services to improve agent/broker facilities.

"We're adopting a new strategy for our activities after trying it out for several months," said Cecil Harris, U.K. executive director concerned with North American operations.

"We're giving more underwriting authority to agents and more authority to settle claims. Much of our effort in the past year has been devoted to personal lines to give agents closer contact with us and better returns for them.

"Our aim is to segment the market and give our agents the right products at the right price to attract the best business. At the same time we're also developing a new strategy for commercial lines, which represent about two-thirds of our portfolio and which have been reasonably profitable during the past two years."

Commercial Union's premium income from the U.S. rose 11% in the first six months this year, covering both personal and commercial lines. But it lost an estimated $25 million on underwriting in London, because of the severe winter losses and the cost of restructuring its U.S. activities.

Traders sue

New Zealand trading firms have filed a $5.6 million suit against U.S. and Belgium insurers in hopes of recovering damages for produce, including large quantities of onions, that was damaged on its way to overseas buyers.

The suit, filed in San Francisco on behalf of Auckland export trading group Mason & Porter and New Zealand Distributing Co., concerns an "inherent vice" clause in insurance contracts covering such goods, according to the Brentnall Beard group in the U.K. ■

Command performance

The Michigan Health Care Cost Containment Coalition, an alliance of industry, labor and the health care field, was called in for a "command performance" on the current proposed legislation affecting Blue Cross/Blue Shield.

State Rep. Richard Fitzpatrick (D-Battle Creek), chairman of the house insurance subcommittee, said he asked the coalition to draft language for the cost containment part of the bill.

The panel had largely lain dormant since an earlier legislature formed the coalition to study the problem of unused hospital beds in Michigan, he said. The group's recommendations resulted in legislation eliminating 1,400 excess hospital beds in 1977.

Excess beds drives up hospital costs because they encourage hospitals to admit patients who, under other circumstances, might not be judged in need of hospitalization.

The coalition is made up of representatives of Ford Motor Co., General Motors Corp., Chrysler Corp., the United Auto Workers, the AFL-CIO and Blue Cross/Blue Shield of Michigan.

Political pressure expands bill to regulate Mich. Blues

By JOHN MAES

LANSING, Mich.—An effort to change the structure of its board of directors has turned into a nightmare for Blue Cross/Blue Shield of Michigan officials who face the prospect of much more state regulation than they bargained for.

BCBSM has sought legislation to allow reductions in the size of the board, but political pressure from consumer, industrial and political groups seeking greater regulation of the plans has broadened the legislative scope of the proposal.

"What went in as a two-page document has come out as a 40-page document," said Richard Femmel, vp/communications for BCBSM.

The current bill, if passed, would require BCBSM to place political appointees on the board and would cap the amount of yearly reimbursements to health care providers. Also, BCBSM would be required to demonstrate progress in cost containment or risk state intervention.

BCBSM basically doesn't object to state monitoring and possible regulation of its cost-control programs, but opposes further regulation on the structure of its board of directors, said Mr. Femmel. And BCBSM objects to prohibitions against development of new administrative services only contracts (ASO) with self-insurers.

The bill, however, is still tied up in the insurance subcommittee of the Michigan house of representatives and will probably not become law until later this year or early in 1980.

BCBSM is "most concerned" about the part of the bill that empowers the governor, senate majority leader and speaker of the house to appoint voting members to the board of directors. Such a move would unnecessarily thrust politics into the operations when the board of directors is already customer controlled, Mr. Femmel said.

The current 47-member board includes 59% customer or user representation from unions, corporations and individual plan subscribers. The reduction in membership to 28 would increase the subscriber control of the board to 75%, Mr. Femmel said.

Restricting BCBSM from developing new administrative services only contracts with self-insurers would be an unfair restraint of BCBSM's ability to compete in the health care field, Mr. Femmel said. That provision is designed, however, to keep BCBSM from monopolizing the area, Michigan insurance commissioner Richard A. Hemmings said.

The cost containment portion of the bill was drafted by the Michigan Health Care Cost Containment Coalition, a group representing the "Big Three" automakers, the United Auto Workers, the AFL-CIO and BCBSM.

The coalition, set up by an earlier legislature to study the problem of excess hospital beds in the state, was asked by Mr. Fitzpatrick to draft the cost containment provisions.

Jack Shelton, manager-employe insurance department at Ford Motor Co. and chairman of the coalition, said the proposal would hold increases in reimbursements to health care providers to the general rate of inflation.

BCBSM would be allowed to devise its own cost control measures but the insurance commissioner would be empowered to impose his own measures if the efforts prove unsuccessful. "What we're saying is rather than having a rate authority, let's put the pressure on the provider class to provide a program to keep the costs in line," Mr. Shelton said. "That's what we think will work."

But BCBSM contends its 70 cost containment programs cut health care costs in the state by 9% last year, or $466.7 million, compared with a 1977 cut of $428.7 million.

Mr. Femmel said BCBSM also rewards hospitals, doctors and other providers whose costs decline and is studying the possibility of expanding the program to psychiatric care providers.

The proposed bill has been the center of considerable controversy in heavily industrial Michigan where BCBSM has 5.3 million corporate and private subscribers that generate $2 billion in yearly premium income. Mr. Femmel said 58% of Michigan's working population is covered under BCBSM plans, with 43% of the plans' total business involving the auto industry.

BCBSM officials view the bill as an "intrusion" of government into the affairs of private business.

But state legislators and insurance officials see the measure as far from a nightmare. They argue such a law is in the public interest, is necessary to control skyrocketing health care costs and needed to increase the voice of the consumer on the BCBSM board. ■

agent/broker topics

A REGULAR EDITORIAL SECTION EXCLUSIVELY FOR AGENTS AND BROKERS

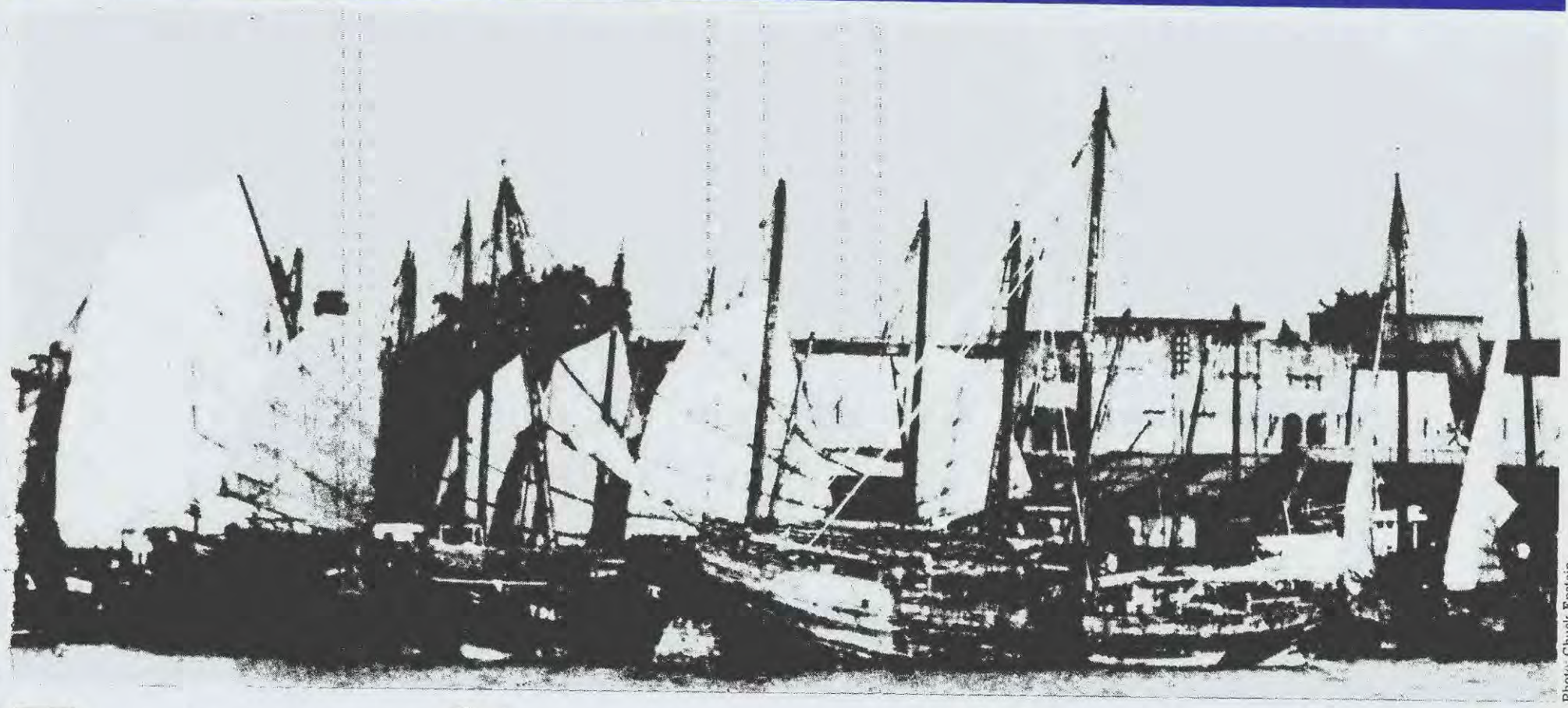


Photo: Chuck Epstein

Fortune floats on China trade

"With the re-establishment of China-American relations the Orient once again beckons—tantalizing American business with glimpses of rich opportunity. Its gigantic and varied geography . . . its vast population . . . its virtually untouched natural resources . its great need for industrial development . . . all contribute to China's mystique as a new market Western goods and services." AIG brochure on Chinese insurance ventures.

By DAVE GALANTI

CHICAGO—China. For most people the word conjures up visions of rice paddies, vast terrains and the Great Wall.

For U.S. brokers and insurers, however, China is a one-billion-person untapped market for products and insurance. That statistic alone makes the market potentially appealing to American business. Marsh & McLennan, Alexander & Alexander and Frank B. Hall & Co. all have shown an interest in brokering Chinese insurance business. It could be marine insurance on exports like handicrafts and raw materials, aviation insurance, or reinsurance agreements with the People's Insurance Co. of China, the monopoly insurance company of the People's Republic.

They're not alone. Smaller brokers with a historic interest in marine or international insurance, such as Wright & Co. in Washington and Nausch, Hogan & Murray in New York are also looking into Chinese business.

Among insurers, American International Underwriters believes it is leading the pack, but readily admits it is looking over its corporate shoulder to see what other large international insurers will do.

This interest is unusual because both brokers and insurers realize the profit potential will be relatively small for some time. Trade between the U.S. and China last year barely topped $1 billion. By 1985 that total will grow to only about $5 billion (See related story, page 58E).

If money isn't the sole attraction, could it be the mystique of China?

"It isn't everywhere that you can talk about a market of a million people," says John Cizek, executive vp of the aviation division of Frank B. Hall & Co.

"Chinese officials feel that they can reach an industrial peak in the year 2000 similar to that reached by Japan in 1979," Mr. Cizek adds. "Nobody really knows whether they can do that or not, but to do it, the foreign capital will have to be there. If that capital is there, the insurance market will be there as well."

It's deceptively easy to break into the Chinese insurance market, according to trade regulations. All you have to do is make arrangements with the People's Insurance Co. of China, an insurer with 800 employes—pared from some 45,000 before the revolution. But the work comes in making those contacts, say representatives of insurance interests who have been there.

Houghton Freeman, executive vp of AIU/AIG Corp., who was born in China and a resident of many years in the Far East, has been to China three times since relations between the U.S. and China warmed. His goal was to gain familiarity with the new China and pave the way for relations between PICC and AIU.

"To realize what we went through, you have to realize what the PICC does," Mr. Freeman says. "About all they insure are import and export cargos, plus hulls and aircraft that call at foreign lands. They don't provide basic property insurance or lines like workers compensation because that type of insurance doesn't exist inside the People's Republic."

Until recently, therefore, the main contact any outside insurance interest had with the PICC was to arrange or accept reinsurance on risks insured by the PICC. Before U.S.-China conditions changed, these agreements were usually made via Japanese or English interests. The agreement AIU eventually signed with the PICC gives AIG part of the reinsurance action as well, Mr. Freeman says.

When AIG looks at the future, however, it sees another market—basic insurance coverages for fully or partly foreign-owned risks within China.

"The PICC recognizes that when the outsiders come in, they'll want some kind of insurance," Mr. Freeman says. "Our arrangement with them calls for us to be able to provide some of that insurance. The PICC will welcome our business and act as our claims representative within China. What they're asking in return is to be able to pick up a piece of the action—usually anywhere from 5% to 10%."

AIG is prepared to offer insurance ranging from political risk insurance to basic auto, says Mr. Freeman. "We tell the brokers here that we'll provide the insurance that they would ordinarily need for a venture of this type," he adds.

If there is a fly in the ointment, it is in a Chinese law passed recently to allow American interests to form joint ventures in China. The law permits foreign interests to control from 25% to 100% of these ventures, but insists that Chinese insurance interests provide the basic insurance.

AIG is aware of the law, Mr. Freeman says, but it is waiting to see its effect. "Although the PICC is interested in someday providing basic risk coverage, right now it doesn't have the expertise to do so.

"The insurance will have to come from somewhere and we'll be happy to advise them whenever they need help," he says. Although they have partial ownership in three insurance companies in Hong Kong and Singapore that write some basic risks, they don't have the people yet who can write these lines on a large basis.

"We've offered to have their people come over here to take insurance courses, but they haven't sent anyone yet. They said they're not quite ready," Mr. Freeman adds.

If the PICC isn't quite ready, neither are all the big brokers as excited about China as AIG seems to

Continued on page 58J

SIDE

Brokers play Marco Polo

Taking a play for China cargo insurance may mean looking foolish for awhile. But then most heroes have looked foolish, says Len Strazewski. **Page 58D.**

Agency aims for independence

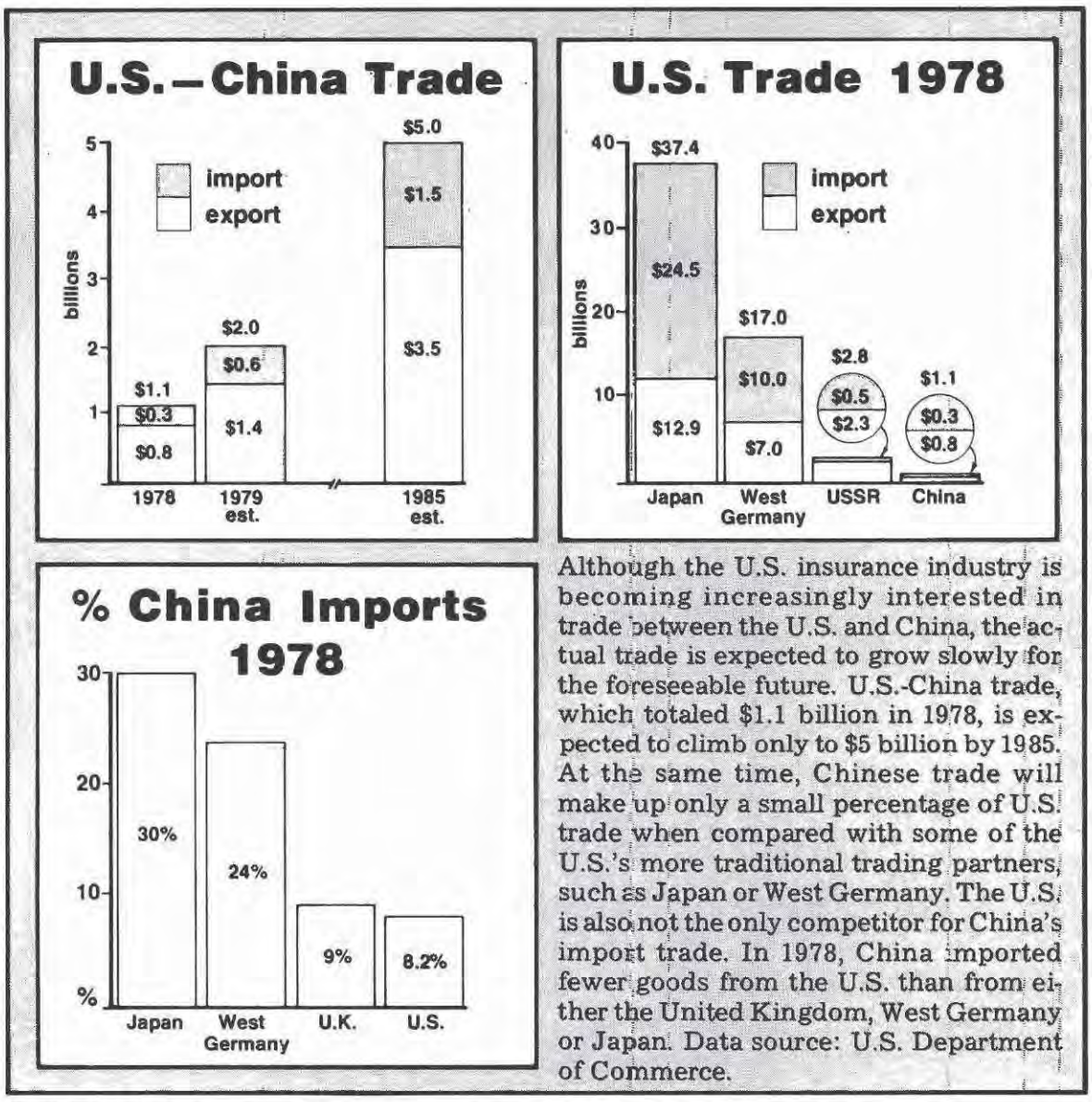
Wisconsin's Robertson-Ryan and Associates run more of a producer co-operative than a profit-center, sharing staff and accounts freely. **Page 58F.**

Lobbys seek regulation clout

Big brokers and small agents groups have joined the lobbying bandwagon with federal and state research programs. **Pages 58H and 58I.**

Photo: A&A

A&A's Fobert Moore (left) is learning the Washington ropes.



Although the U.S. insurance industry is becoming increasingly interested in trade between the U.S. and China, the actual trade is expected to grow slowly for the foreseeable future. U.S.-China trade, which totaled $1.1 billion in 1978, is expected to climb only to $5 billion by 1985. At the same time, Chinese trade will make up only a small percentage of U.S. trade when compared with some of the U.S.'s more traditional trading partners, such as Japan or West Germany. The U.S. is also not the only competitor for China's import trade. In 1978, China imported fewer goods from the U.S. than from either the United Kingdom, West Germany or Japan. Data source: U.S. Department of Commerce.

Charts: Toby Roberts

Trade with China will grow slowly, U.S. officials say

WASHINGTON—Despite a five-fold increase in China-U.S. trade over the next five years, it appears it will be some time before commerce between the two nations reaches trade levels comparable to those between the U.S. and its more traditional trading partners.

Trade between the U.S. and China last year equaled only about $1 billion, or an average of $1 for every man, woman and child living in the Asian nation, according to the U.S. Department of Commerce's Industry and Trade Administration.

Comparatively, the U.S. and the U.S.S.R. shared $2.8 billion in trade in 1978. West Germany and Japan fared even better with the U.S., sharing $17 billion and $37.4 billion, respectively.

Trends don't indicate much of a change for the future between China and the U.S.

"We see a gradual increase in the trade between the two nations, but it won't be anything spectacular," says N.R. Chen, a China trade specialist for the Industry and Trade Administration.

"We expect that by 1985, the trade should be somewhere around $5 billion.

"Of that, about $3.5 billion will come from U.S. exports of agricultural products—such as wheat, corn and soybeans—and machinery and other industrial items, particularly oil exploration equipment.

"The Chinese want to begin to export light industrial products so they'll buy the machinery that makes that goal possible," Mr. Chen said.

As for exports, Mr. Chen says they will be limited to a few items, particularly in the near future.

"They've started selling us crude oil in limited amounts," he says, "but mostly we'll be buying food, handicrafts, antiques and textiles.

"It's safe to say that for the next few years, at least, the balance of trade to China will be in our favor," he added.

Experts aren't sure of China's ability to spend large amounts of money on trade and industrial improvements, Mr. Chen says. Without these finances, it will be hard to pay for increasing levels of exports.

Also, China's limited money isn't all going to the U.S.

"We have to face competitors in trading with China," Mr. Chen says.

"For instance, France and the United Kingdom each signed long-range trade agreements with the Chinese for $13.6 billion and $14 billion, respectively."

As a result, the U.S. probably will only be able to snare a small portion of China's trade with foreign nations. ■

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Polo breaks new ground on the road to China

By Len Strazewski

WE DON'T GET many people in the office who carry shovels over their shoulders, so when he walked in he raised a bit of a ruckus. The receptionist always sends unusual people straight to me because she assumes they are brokers.

She's usually right. Risk managers speak only when spoken to. Insurance company officials speak only in press releases and formal statements. Consultants always come dressed for lunch.

But you can expect anything from brokers. As people who listen to problems all day long, brokers get to be very adaptable and free-wheeling. It's not all that unusual for a broker to jump on a plane to London to set up some unusual coverage—like cargo coverage for a batch of marble for a Saudi oil sheik. Or disability coverage for a canine movie star.

Okay, it is unusual. But it happens and only brokers know how to take those situations in stride. In fact, the only situation that makes brokers more excited than a bizarre risk to place is an untapped opportunity for new business.

So I shouldn't have been surprised when this shovel-carrying broker announced he was going to dig a tunnel to China to get first crack at this giant new/old market.

"It's the biggest opportunity to come to the industry since World War II," he said, "and I don't want to miss out. A direct route is best and if I'm first I'll get the lion's share."

Pretty heady concepts for someone whose name I don't know, I replied.

He held out his hand—the one that wasn't holding the shovel.

"Polo's the name," he said, "and I'm out to open up China for this industry just like my ancestor brought the wonders of China to Europe."

Your ancestor?

"Yep. And namesake. I'm Mark Polo, great-grandson-to-the-29th-power of Marco Polo."

With this, I smelled a story. I have talked to all sorts of brokers in the year that I have been working exclusively on this section of *Business Insurance*. Some producers were hypesters trying to convince me programs that had been going for 10 years were suddenly new and "innovative" because they managed to get a comma removed on an insurer's policy form.

Some were quiet and scholarly, true students of insurance who could close their eyes and recite forms, rates, requirements and techniques from a file in their minds. Others came looking to me for advice; a mistake, because I know only what people tell me.

But I've never interviewed a direct descendant of a famous Italian explorer.

Sit down, Make yourself comfortable. Let me hang up your shovel.

"I'll keep it, thank you. I have a lot of digging ahead of me."

He sat down and honed the shovel blade as he spoke. His words had the spice of the Orient. "We've been missing the boat for a lot of years, you know. All this Cold War battling with Communist countries. Think of the markets we've been missing."

He leaned back in his chair and a faraway look crept into his eyes.

"There's over a billion people in China and thousands of miles of natural resources," he continued. "With Western trade, you know those resources are going to open up and that marine and aviation coverage are going to be booming."

Of course, I replied. When Coca-Cola goes somewhere, can McDonald's and Double-Mint gum be far behind? And Gloria Vanderbilt designer jeans? And SuperGlue?

"Yep."

But isn't it true, I added, that trade between China and the United States is going to be tiny for at least the next decade? The Commerce Department says to expect only $5 billion in trade by 1985. We do as much business with China as we do with Ecuador. Do you want to dig a tunnel to Ecuador, too?

"Nope. There's something special about China, though. It's mysterious, that's for sure. And I've always had the feeling that the U.S. made a mistake in the way it dealt with China after the revolution. I suspect that the recent Presidents have felt that way, also.

"Besides, new business is new business and I can't refuse to pass up any opportunity. With these soft market conditions, it's all I can do to keep premium volume up to last year."

I sympathize. Inflation and crazy market cycles are no joke to brokers. They cause profits to ride a roller coaster and make long-range planning for both broker/managers and their clients almost impossible.

But is China the way out?

"I don't know," Mr. Polo replied. "But it's got to be different than it is here. And I could use a change of scenery. The U.S. business climate is getting me down."

It's chancey. You could lose your shirt. Your fellow brokers may wind up calling you a fool. I wouldn't do it.

"I suppose you wouldn't," he replied, looking me in the eye. "But then I haven't seen many Strazewskis in the history books." ■

RBH in Hawaii

Chicago-based Rollins Burdick Hunter Co. has established a new subsidiary, Rollins Burdick Hunter of Hawaii Inc., and has opened an office in Honolulu.

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Milwaukee brokers brew co-op agency

Photo: Dave Galanti

"We follow a ruggedly individualistic pattern here," says Jack T. Ryan, cofounder of Robertson-Ryan & Associates.

MILWAUKEE—The producers of Robertson-Ryan & Associates here share their technical knowledge and staff much like they share the hallway plaque that announces their firm.

Among the names on that plaque are the 15 producers that work in the Milwaukee-based brokerage, from founders Jack T. Ryan and A.D. Robertson to relative newcomer Jim Boyce. One of the nameplates is still empty, but it won't be for long.

"We have one—no, make that two—more people coming on soon," Mr. Boyce says with a laugh. "We don't know what we're going to do about that sign."

The sign reflects more than the number of producers that make up Robertson-Ryan. It's also a symbol of the management style practiced

A/BT local leader

within—a style that places a great deal of emphasis on individual effort and success.

Robertson-Ryan producers function more like a friendly co-op, sharing support staff but maintaining control of their own books of business. But instead of competing against each other as individual "profit centers," the agents pass on extra business to their colleagues.

Robertson-Ryan producers proclaim success with their organization. Although its style may be far different from that of Alexander & Alexander or Marsh & McLennan, within its metropolitan Milwaukee territory Robertson-Ryan is a recognized part of the insurance establishment.

"We follow a ruggedly individualistic pattern here," says Mr. Ryan, who helped form the brokerage in 1960. "We're not an ABC house, or an independent broker who sold out to one. We're a group of producers who all own our own books of business and are relatively free to come and go as we please."

If that is an unusual way of running a brokerage, the Robertson-Ryan people say that's just fine with them. For the more latitude and power they believe they can give to their associates, the more they believe the entire brokerage will benefit.

"Although my name and Mr. Robertson's are the ones on the company logo, we constantly think incentives here," Mr. Ryan adds. "We share everything: contingencies, perks, whatever. Everyone has a piece of the action." They also share costs—45% of each producer's commission is taken to pay for technical staff and overhead.

Robertson-Ryan began when the two founders decided they weren't pleased at the local agency they were both working for, which was founded by Mr. Robertson's father-in-law.

"We found we had two choices—we could stay or we could leave," Mr. Ryan says. "We decided to leave. With his (Mr. Robertson's) background in engineering and mine in law, we felt we could succeed."

However, they decided that whatever became of the new brokerage, it would succeed on the basis of individualism. And it has remained the same through the succeeding years, which have seen premium volume grow to an estimated $12.5 million in 1979 from $1.2 million in 1960.

"The only security we have is in ourselves," says Mr. Boyce, who joined Robertson-Ryan one and a half years ago. "Some people might be frightened by the independence here. But there's really no gamble, because the same qualities that can make you successful at the national brokerages can make you even more successful here."

Mr. Boyce adds that he believes he has the best of two worlds in his job. While he owns his own accounts, he can sell insurance full time because all technical work is passed along to the broker's 23 technical and clerical staff members for underwriting and processing.

"One of the facets here is that we retain our independence on one hand, but we have a feeling of unity on the other," says Elwood E. Juckem, executive vp and general manager. "You can sell as much as you can, but there are also enough experienced producers here so that no matter what comes up, someone has seen something like it and can lend a hand."

Vp John Kuhnmuench agrees.

"I was on my own for a while," he says. "I had a part-time person and I did some of my own billing. When Jack (Ryan) contacted me, it really took a load off. Before, I had to do rating on my own; now I have qualified people to do it for me."

And having the time to sell really helps, Mr. Boyce says.

"When it comes right down to it, everyone has to buy insurance," he says. "And in the end, what you're selling to these people isn't an insurance form, it's you."

As further evidence that Robertson-Ryan is indeed a co-op, Mr. Ryan added that many people in the insurance industry don't believe him when he tells them nei-

ther he nor Mr. Robertson draws a salary.

"We also don't try to force people to stay here if things aren't working out," he adds. "We don't get messed up with non-compete contracts or anything like that. As long as a producer doesn't owe us money, he can take his files and go."

Robertson-Ryan carefully recruits the producers it invites to join the organization. Integrity, initiative, courage, education and a desire to be an individual all count highly in choosing a new associate, Mr. Ryan says.

"The person has to be motivated," Mr. Robertson says. "That's because here you will make as much as you want, but it will depend on how much you want to work. We want a producer to work hard, but we'll also take care of his accounts if he decides to leave for a couple of weeks."

Mr. Juckem says the brokerage's gross income—expected to reach $1.4 million this year—has grown about 80% since 1974. The increase is because of the addition of new brokers and expansion of accounts. Commercial insurance for small and medium sized accounts makes up about 85% of its business.

As for competition between members, the associates admit it exists, but say it rarely gets out of hand. "I think a problem where two producers have wanted the same risk has only happened once or twice," Mr. Robertson says. "If it does happen, we sit down and decide which way is the best way to do it from the customer's angle.

"But there's so much potential business in this area, you don't have to eye another associate's business," he adds. "In fact, we try to shovel a lot of new business to our younger producers to get them going."

Photo Dave Galanti

"There's so much potential business in this area," says A.D. Robertson, president.

The younger producers are important to Robertson-Ryan's future, Mr. Ryan says. Although the national houses have made many offers to purchase the brokerage, the associates say they plan to stay local.

"A few years back, we looked around at the future of Robertson-Ryan and decided to bring some younger people in," Mr. Juckem says. "Rather than get to a certain point and sell out to an alphabet house, we decided to develop the continuality of the organization and stay local."

"The benefit of this comes in the relationship with our carriers," Mr. Boyce says. "Our reputation is excellent because they know we're going to continue to be here providing them with the business they like."

Robertson-Ryan producers say they have as good an access to markets as the national houses do. On their own turf, they add, they believe they can beat the national brokerage 90% of the time.

"I think with many of the big accounts going self-insured, the big national houses will eventually see our kind of business (medium to medium-large commercial and industrial risks) as the thing they'll need to come after," Mr. Boyce says.

"But on that kind of a local basis, it's one on one. We feel we have as good a number of markets and as good a group of technical people as they do. And they just can't call on risks with premiums of between $5,000 and $10,000 because their costs kill them. That's why I think we'll succeed in the end." ■

Brokers join NAIB

Two brokers have joined the ranks of the National Assn. of Insurance Brokers. Hagedorn & Co., a New York City brokerage, and the Nordstrom Agency of Minneapolis, Minn., were approved for membership at the governing committee's recent meeting.

A&A studies federal government game

Photo: A&A

"Most people in government really don't know how our industry works," says Robert Moore (left) of A&A.

WASHINGTON—Alexander & Alexander's Robert Moore believes you have to know how to play a game before you can think about winning.

So the A&A director of government relations has been studying the rules of governmental decision-making before taking any stands on issues. He's talking to government officials, participating in the Conference Board think tank and looking at the various factors and factions that make up the process.

This careful examination is crucial if the government and industry affairs office he is establishing is to be a success, Mr. Moore says. For he believes the nation's second largest broker can take knowledgeable stands on insurance issues only after it knows all possible sides of those issues.

A/BT

His approach reflects his 10 years of background in organizational analysis and management, including time spent as emerging issues systems coordinator for the Conference Board, associate professor at the University of Maryland and congressional consultant and adviser to the U.S. Senate and House of Representatives.

"I think it's important for business leaders and government officials to develop a more objective way of looking at the nation's problems," Mr. Moore says. "I think that's why President Carter was elected in the first place. The voters were saying that we needed to work together to solve human problems. The energy crisis has served further notice that we as Americans really do have things in common.

"I think A&A thinks this way, too. We believe in the process of looking at a problem and addressing it realistically. We believe that if we don't work to come up with the solutions to problems ourselves, others will. So if we want to help make those decisions, we have no choice but to study them."

Next year, corporate plans call for Mr. Moore's department to take a more active role in the Washington scene. The office will emphasize becoming aware of insurance-related issues early in the game, so A&A will have sufficient time to react. The office will also do research, similar to that done already in providing selected information about conditions in Saudi Arabia to A&A decision makers.

But for the immediate future, at least, Mr. Moore is working on getting his feet wet and learning the rules of the game.

"Most people in government really don't know how our industry works," he says. "They don't know what brokers do, in large part because we've never had the occasion to explain it to them.

"At the same time, we in business have to come to realize that it takes an enormous amount of time and patience to work in Washington," Mr. Moore adds. "The business community is used to working quickly. This puts them out of sync with the civil servants who draft the nation's rules and regulations. We can't continue to overlook this."

Nevertheless, he believes civil servants and legislators are willing to listen to the business world.

"Their business is information and their job depends on how accurately they do their job. These people can't afford to ignore the information our or any industry can provide to them," he says.

"But if we don't tell them, they'll never know about us," Mr. Moore adds. "One of the dangers of this situation is that those who vote on important issues won't really know all sides of that issue. We feel A&A will do a better job if we can provide that information."

That's why A&A opened the Washington office, president John Bogardus says.

"We know we already have a presence in Washington through our trade organization, but we don't feel this office is a duplication," Mr. Bogardus says. "A&A is large enough now to need a presence of our own.

"The intent of that office is to become involved earlier in the decision-making process on insurance issues," he adds. "However, we want to go into other areas of public policy as well. That's why we lend Mr. Moore part time to the Conference Board—it's a sacrifice to us, but it's a contribution we feel we should make."

Mr. Moore expects his department's role will increase in two ways. More A&A managers will travel to Washington to talk with public officials about evolving issues. Also, the department itself will spend more time taking stands on issues.

The participation will stop short of formal lobbying, however.

"I think our way of coming at the problem of federal regulation and insurance problems is unique," he says. "But I think it is important. What has happened so far has not only been an education for me, but many A&A managers as well. That's what this office is trying to achieve." ■

IIAI official slips aces up his sleeve in lobbying plan

SPRINGFIELD, Ill.—Jay Shattuck is hoping that when he spreads his lobbying cards out on the table, the deck will turn up all aces.

Mr. Shattuck, director of government affairs for the Independent Insurance Agents of Illinois, is directing an effort he hopes will revitalize the association's program to maintain regular contact between state legislators and agents who live in their districts.

If the Agent Contact/Elect System works, the IIAI will have more than 400 agents on call, each able to discuss insurance issues with his district legislators and push for pro-association legislation.

The first key issue facing ACES is a proposed state rating law being promoted by the Illinois insurance department. The agents are seeking to avoid a state rating board with a rate ceiling like those in other states.

"In order to have a successful legislative program, you have to have an effective grass-roots program," Mr. Shattuck says. "Unfortunately, this part of our program in the past hasn't been as successful as we would have liked."

The major problem such efforts faced in the past, Mr. Shattuck adds, was a lack of grass-roots participation in Chicago and the Downstate regions. ACES's aim is to continue the strong participation of midstate Illinois agents while enlisting more recruits in the other two regions.

"We want to ensure that every legislator hears from an ACES member at least once a month," Mr. Shattuck says. "The goal is to let the legislator know that he has someone he can turn to for information on agencies or insurance in general.

"In addition, if something comes up in the legislature that we're interested in, we can use the ACES agents to get our message across."

Although agents in California have begun to use a similar system of district-based political action (*BI*, June 25), Mr. Shattuck says the IIAI plan is based on a similar system used by the Illinois Assn. of Realtors. The realtors' plan is well suited to the IIAI, which lists a membership of 8,000 agents in 1,650 agencies, he says.

Mr. Shattuck is now stumping the state to urge the IIAI's 60 local boards to enlist an ACES representative for every legislator in their areas. The goal is to eventually enlist 400 to 500 agents, but Mr. Shattuck admits success depends on how many Chicago agents decide to participate.

"The problem is that about half the general assembly comes from Chicago and we don't have that many agents who actually live in these districts," Mr. Shattuck says. "We want the ACES agents to actually live in the area that their particular legislator comes from, so the legislator will know he is being contacted by a constituent who has a vote and a say in district affairs."

As in similar efforts elsewhere, one major goal of ACES will be to stop efforts that the association views as leading to the overregulation of the insurance industry.

The push for a rating law is a response to consumer demand, Mr. Shattuck says. Currently, Illinois is the only state without a rating law.

"The consumers want a rating law and we can see the handwriting on the wall," Mr. Shattuck says. "We haven't had one since 1971, when a law similar to that used in California expired.

"What the IIAI has been seeking is a return to that kind of law, where companies would be free to file any particular rate, but there would be a defined procedure for consumer objections. The alternative could be formation of a rating board with a rate ceiling, which we think is too restrictive." ■

A/BT

Galanti joins BI as A/B writer

Agent/Broker Topics, the demographic section of *Business Insurance* written exclusively for agents and brokers has added a new writer with producer expertise.

David Galanti, formerly managing editor of the Z-A Producer, a newsletter published by Zurich-American Insurance Co., is the new associate editor for A/BT. He will be the section's featured writer and help coordinate content and graphic presentation.

Mr. Galanti formerly worked as a reporter for the suburban sections of the Chicago Sun-Times and holds a M.S.J degree from the Medill School of Journalism at Northwestern University.

BI features editor Len Strazewski will continue to oversee Agent/Broker Topics in addition to coordinating the Perspective section and assisting in the planning of special issues.

Photo: Mary Cairns

Dave Galanti

Brokers hope to acquire in developing trade with

Continued from page 58A

be. Although they all eye that big number—one billion people—several brokers are taking a more cautious attitude.

"We're interested in China, but we feel that trade there is going to develop slowly," says Alexander & Alexander president Jack Bogardus. "It's not going to be an important factor for us for a number of years.

"Our role will evolve as the '80s progress," Mr. Bogardus adds. "It all depends on what China is willing to do in terms of insurance. We can take care of the goods going in, but the goods going out are different, since they have the PICC. You also have to be flexible because the overseas insurance business changes quickly.

"I would be surprised if the U.S. brokers spend a great deal of time in China in the next few years," he concludes. "But we should stay close to the subject and we will."

At Marsh & McLennan, senior vp Robert Solomon says his firm will wait-and-see, too.

"Yes, we would like to be in that market," Mr. Solomon says. "A lot of our clients have an interest in the area and we want to be where our clients are. But we have no plans to open an office there or anything like that."

Market mystique

Matt Hogan of Nausch, Hogan & Murray in New York says China is a country like any other. A lot of the interest there, he says, is because of the mystique built up over the years. Still, he says he's interested in the market for marine insurance.

"At this point, the situation is gray as to what you will and won't be allowed to do by the Chinese government," says executive vp Mr. Hogan. "But in the area of marine insurance, the restrictions are bound to be less because the insurance already is international in nature. Most of the exposure isn't located in any country.

"We'd like to get involved (in China), but the growth will be slow. We'll look at the situation and pick and choose what we want to do," he adds.

For Wright & Co. of Washington, D.C., which brokers many international accounts, the emphasis is on laying the groundwork for China-related business, president Frank L. Wright says. Mr. Wright adds he hasn't been to China yet, but has talked to an acquaintance who has.

"I think people are talking a lot about China, but you have to remember that China is just opening the door a crack," Mr. Wright says. "Everyone thought that Coke would go over and sell a lot of cola because of the number of people they have over there. But most of those people just don't have the money to buy a lot of cola.

"There's a good market in any developing country for insurance," he adds. "But it remains to be seen how big the China market will be. We have built into our philosophy a need for insurance. The Chinese have not."

Still, Frank B. Hall's Mr. Cizek thinks the market is there.

"The Chinese have always been in the reinsurance business abroad, particularly with the English or other Asians," he says. "With the new relations with China, we hope to see American brokers and companies exchanging reinsurance with China. I think they're very interested in working with U.S. brokers."

Competition growing

And although he admits that setting up a Frank B. Hall office in China wouldn't pay, sooner or later U.S. business is going to have exposures in China and therefore need insurance.

"There's going to be that need and they're going to call their broker to take care of it," Mr. Cizek says. "We should be prepared to meet those requests."

And the markets will be there for those brokers to turn to, AIG's Mr. Freeman says.

"We're not creating a great big China department, but we're watching the situation closely," he says. "We've done just about all the groundwork we can and we know the Chinese want to do business with us."

fortune China

Competition is growing, he said.

"Most of the American insurers have been to China at least once," he adds. "The PICC has been very nice to them. Then there are always the Japanese and English companies to consider. But I think we'll get our share or a little more. The early bird gets the worm."

But even Mr. Freeman tempers his enthusiasm somewhat.

"Nobody knows how much trade and development they really can afford," he says. "Figures are bandied about but no one is seeing the contracts. They just don't have the bucks yet.

"I agree that the mystique of China may play a role in the insurance industry's interest in China. Then again, even though the purchasing power may not be there, a billion is still a lot of people." ■

Photo: Chuck Epstein

China trade, expected to involve local handicrafts, will probably grow slowly, say U.S. brokers.

Vp praises standard life form

CHICAGO—Standardized service forms may soon take some of the trouble out of handling personal lines, said Jack E. Bobo, executive vp of the National Assn. of Life Underwriters.

Following the success of a universal beneficiary change form, "accepted by all but a tiny handful of companies," the life insurance branch of personal lines is now ready for universal forms for other services, he told the Life Office Management Assn. meeting here.

"Eight years ago, NALU's compensation committee, while considering the question of agent profitability, tackled this problem. They concluded that there were two ways to improve agent income: paying the agent more money for the same work or simplifying the work methods to make the agent more efficient," he explained.

The idea of universal forms an agent could use no matter what company he placed the coverage with "seemed like a good idea," Mr. Bobo noted, "One which would be to everyone's benefit, policyholder, company and agent alike. It seemed then, as it seems now, that such standardization would not only improve methods within our industry, but would also serve as a response to increasing criticism being leveled by consumerists."

The beneficiary form was the first slow step, he noted, that "tested the water and found it fine. And now it's time to take the plunge and develop the universal form," Mr. Bobo said.

Another LOMA speaker, B. Larry Jenkins, chairman and CEO of Peoples' Life Insurance Co., agreed life insurers must help agents improve efficiency by streamlining insurer methods.

"Increasingly the pressures of inflation have caused all of us to reexamine how we run our businesses. Most of us are exploring or introducing new markets and products," he said, "with an occasional eye cast to the possibility of taking on new lines of insurance."

But new products need to be sold by agents, he noted.

"If we expect the agent to get ahead and stay ahead through new markets, new products and new sales techniques . . . then perhaps we will need to be assured that we are applying new approaches in administrative operations to match them," he concluded. ■

Pinehurst Corp. targets Archer for CEO

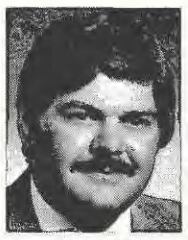
Richard A. Archer, formerly president and CEO of Frank B. Hall & Co. brokerage, has joined Pinehurst Corp. as CEO of the Pinehurst Insurance Services Group. He has also been named director and vice chairman of the board of directors. Mr. Archer, who left Hall in 1977, is a former president of the National Assn. of Insurance Brokers and the National Assn. of Surety Bond Producers.

* * *

Theodore C. Mahl, former president of the Professional Insurance Agents of California and Nevada, has joined Ray J. Havert in the Mahl-Havert Insurance Brokers Inc. Mr. Mahl will continue as a national director of the PIA.

* * *

Robert L. Young is now senior vp of self-insurance services of the



Young

Nash

national sales division of Fred S. James & Co. Inc. in Chicago. Previously vp of the division, he has managed James's self-insurance services since 1971.

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Carl I. Nash, formerly of his own agency, has joined San Francisco-based Dinner Levison Co. in the firm's Newport Beach office. Mr. Nash began his insurance career in

A/B/T people

life insurance in 1965 and entered the property/casualty business in 1966.

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Meeker-Magner Co., a suburban Chicago brokerage, has announced that **Roger C. Brach** and **Roy D. Carter** have joined the firm as account executives. Both employes were formerly with Lansing B. Warner in Chicago.

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The Great Lakes Agency in Chicago has added several new staff members including: **Max R. Clay** as vp for mass-marketing operations, **Kent J. Thoney** as vp for administration and treasurer, **John W. Rowan** as ad director of marketing, **Patricia A. Revolt** as director of human relations and **William C. Brown** as vp. **Frank J. Parmentier** has been elected senior vp and member of the executive committee and remains responsible for administration of international business.

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Matthew F. Reilly has joined Alexander & Alexander as manager of compensation. Formerly senior compensation adviser at the W.R. Grace Co., Mr. Reilly will work from the A&A New York office. Also at A&A, **David McGovern Jr.** has been appointed president and national sales director for Benefacts Inc., a subsidiary.

* * *

Associated Insurers, a Raleigh, N.C., brokerage, has named **Barbara Burnett Knight** office administrator. A North Carolina native, Ms. Knight comes to the firm from outside the insurance industry.

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John A Fenimore has been appointed assistant vp in the commercial insurance division of John Burnham & Co. in San Diego, Calif. He had previously been senior account manager and will supervise special accounts and marketing placements in his new position. He formerly worked for Consolidated Mutual Insurance and Security of Hartford Insurance in New York.

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S. Kornreich & Sons Inc. has appointed **Ken Wallace** executive vp. He will be responsible for marketing administration and day-to-day office operations. Mr. Wallace formerly worked for R.B. Jones in New York.

* * *

Arthur J. Gallagher & Co. has named **Walter F. McClure** corporate vp in charge of marketing branches. With the promotion, Mr. McClure assumes responsibility of managing the broker's network of branch offices.

* * *

Raymond L. Hayes, vp of James S. Kemper & Co. in Chicago, has been appointed director of the National Assn. of Insurance Brokers. He was named to the job to fill the unexpired term of **Richard S. Winzer,** who resigned. Mr. Hayes is manager of national accounts for Kemper.

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We'd like to report on staff changes. Just drop a note to Dave Galanti, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. We'd also like to receive pictures of those involved.

PIA chief plans new rate system

BOSTON-Blaming the present class-average rating system for producing excessive price-cutting for commercial risks, the new president of the National Assn. of Professional Insurance Agents said he would strive to promote a more price-conscious industry by making rates more reflective of risk.

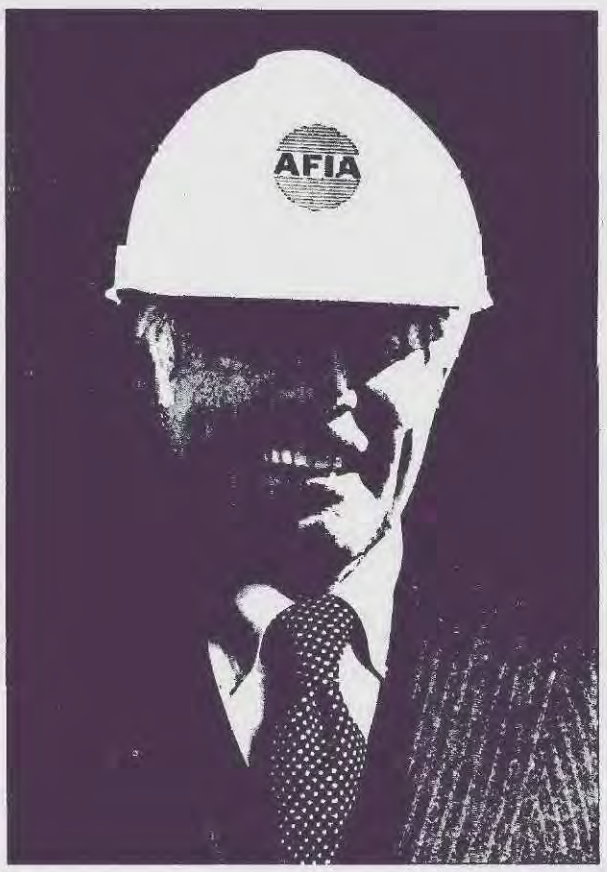
Russell A. Howard, FMS, of Auburndale, Mass., said the PIA and the American Assn. of Insurance Services will join forces to develop a new simplified hazard analysis of rating risks.

The system will be one "of measuring the loss potential of specific risks through a few simple calculations," Mr. Howard said. The system would develop the pure premium aspect of the risks and would then be subject to individual company modification to meet its expense needs, he added.

In other action at the annual PIA convention, agents were told that a joint research project by four insurance associations suggested agents should use direct billing as much as possible to promote greater efficiency. At the same time, however, a survey found the majority of consumers want agents to handle their billing.

Thomas C. Watson Jr., CPCU, FMS, was named the Professional Agent of the Year at the gathering. The president of Watson Insurance Agency of Gastonia, N.C., was cited for his "willingness and ability to tell the industry's story whenever and wherever possible," said the award. ■

Is He Your Loss Prevention Specialist Overseas?



There's more to a loss prevention program than maintenance and a fire extinguisher. But in many plants and warehouses overseas, local managers may not know how to proceed, or with whom, or are too concerned with today to worry about tomorrow.

But the modern risk manager has to worry about tomorrow. And loss prevention is one of his best weapons in protecting his company's assets and controlling insurance costs.

In fact, whether a plant is located in a far-flung outpost or in an industrial complex, AFIA's staff of loss prevention specialists are on-the-spot to help you both here and abroad.

AFIA's engineers know the building and fire protection standards in the United States and overseas. They've been trained to integrate the best of each in an overall loss prevention program taking into account local conditions and resources.

And because they work with hundreds of different situations, they have the broad experience necessary to help the risk manager make loss prevention part of his insurance program overseas.

Their work is one reason why 90 of the top 100 U.S. companies operating abroad insure with AFIA.

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around the states

Pa. safety officials won't be prosecuted

HARRISBURG, Pa.—The Pennsylvania supreme court has ruled that eight state safety officials are immune from criminal prosecution on charges related to a fire that killed 12 persons.

"Quasi-judicial immunity insulates officials of a state agency from criminal liability and prosecution . . ." wrote Justice Rolf Larsen for the majority.

A Wayne County coroner's jury recommended involuntary manslaughter charges against the officials after a November 1978 fire at the Allen Motor Inn in Honesdale, contending the officials were criminally negligent for not shutting down the hotel. The deadly fire occurred 14 months after the building was cited for fire safety violations.

Wayne County Coroner Robert Jennings had said he planned to file the criminal charges but defense attorneys obtained a court order blocking prosecution until the validity of the charges could be examined.

Defense attorneys argued the officials were immune because of the judicial nature of their jobs, even though they worked for state agencies and not the judiciary.

In a dissenting opinion, Justice Robert N.C. Nix Jr. said he had "difficulty in accepting that the coroner's findings establish the requisite causal relationship for criminal responsibility for the unfortunate deaths in this case."

But Justice Nix contends the case should have been allowed to go to trial because "it is abundantly clear that there is an absence of any exceptional circumstances demanding our intervention at this stage."

Liability reduced

SPRINGFIELD—Illinois Gov. James Thompson has signed into law legislation that significantly reduces the exposure of state wholesalers and retailers to product liability suits.

Under the measure (H.B. 2658), which earlier cleared the state legislature by wide margins, nonmanufacturers generally can no longer be sued under the theory of strict liability as long as they did not manufacture, design or have knowledge of a defect in the product.

However, wholesalers and retailers still can be brought into a product liability suit if the manufacturer of a defective product no longer were in business.

Similar legislation has been approved in eight other states: Arizona, Colorado, South Dakota, Kentucky, Nebraska, Tennessee, North Carolina and Georgia.

Work comp cut

OLYMPIA—Gov. Dixie Lee Ray has announced that employers and workers in the state of Washington may be paying $65 million less for workers compensation insurance next year.

The governor's staff announced the proposed reduction averaging 18% in employer-paid premiums and 12.4% in those paid jointly by workers and employers. Washington employers pay workers compensation premiums to the state accident fund, but have the option of requiring workers to pay premiums to the medical aid fund.

Actual rates will fluctuate with the risk classification and accident records for various industries. A hearing on the proposal is set for Nov. 20.

The governor's office said the reduction "comes at the end of a long period of struggle" by the state department of labor and industries to eliminate a deficit in the two trust funds that peaked at $183 million in mid-1977. For the first time in history, the two funds are sound.

Hospital suit

CHICAGO—Michael Reese Hospital and Medical Center here is preparing to appeal to the Illinois supreme court an appellate court ruling defining X-ray radiation as a product and holding the hospital liable for its adverse effects.

The plaintiff charged the X-ray treatment for inflamed tonsils in 1947 and 1951 caused his thyroid cancer years later. A lower court dismissed his charges of medical malpractice and negligence against the hospital.

The appeals court ruled the hospital could not be found liable if the treatment were considered a medical service, but when it is considered a product, the hospital is responsible for warning patients of its potential dangers.

Request revised

OKLAHOMA CITY—The National Council on Compensation Insurance has revised downward its request for a workers compensation rate increase in Oklahoma, seeking an overall 1.1% hike.

In November 1978, the NCCI filed for a 9.7% boost that would have increased the total premium by $16.3 million, but withdrew its application in July. The current rate request takes into account President Carter's anti-inflation program, the NCCI says.

Rates for the manufacturing group would decrease 1.6%, the contracting group showed a 7.9% decrease and a 10% increase is planned for all others under the new rate request.

Rate reduction

HARRISBURG—The Pennsylvania Insurance Department has approved a 12% reduction in commercial fire rates and a 16.8% increase in extended coverage rates charged by the 339 companies using Insurance Services Office tariffs for commercial property coverage.

The action, effective Dec. 15, reflects an overall 9% decrease in property insurance costs for commercial policyholders and will result in a $10.7 million decrease in revenue for insurers, commissioner Harvey Bartle III said.

The insurance department requested the rate reduction after monitoring loss experience and other statistical data relating to

commercial fire coverage, he added.

The department refused to grant a zoning change that would have resulted in commercial policyholders within the Pittsburgh city limits being charged higher rates than their neighbors in the rest of Allegheny County.

Statute of limitations

OLYMPIA—The Washington supreme court has ruled that the statute of limitations in medical malpractice suits doesn't take effect until the defendant "discovered or reasonably should have discovered all of the essential elements of her possible cause of action."

Washington law places a one-year statute of limitations on medical malpractice and product liability lawsuits.

The high court ordered a new trial for Lana Ohler, 26, who contended she was blinded at birth after being given too much oxygen in a Tacoma hospital. A Pierce County superior court had thrown out her claim against the hospital, contending she should have filed the suit within a year of reaching 18. She filed the suit at age 22.

Rape ruling

WASHINGTON—The U.S. Supreme Court has upheld a ruling that rapes committed by intruders at a job site are work-related and barred the victim from seeking damages for negligence.

A former District of Columbia teacher, who was raped by two non-students when they found her alone grading papers in her classroom, filed a $1 million damage suit against the city. The suit charged that the city had negligently failed to provide safe working conditions although it knew or should have known that teachers were endangered. A guard hired by the school was absent on the day of the attack.

The District of Columbia workers compensation law requires an employer to pay for medical expenses and loss of earnings resulting from job-related personal injury, but excludes compensation for humiliation, mental anguish and pain, which the teacher said she suffered and on which she based her lawsuit.

Blues rate hikes

HARRISBURG—Blue Cross of Greater Philadelphia and Capital Blue Cross have been granted rate hikes of 18.5% and 14.3%, respectively, by Pennsylvania insurance commissioner Harvey Bartle III.

Greater Philadelphia's nongroup program boost took effect Nov. 1 for 137,000 subscribers and will generate $10.5 million. Group plan rates use the same rating factors as nongroup and thus automatically receive commensurate raises when nongroup rates are raised, Mr. Bartle said. The plan had sought a 24.5% boost.

Capital's increase, effective Jan. 1, 1980, for 309,000 subscribers, will provide $7 million. Capital had sought a 17.1% increase.

Capital's 65-Special plan, which pays the Medicare deductible, also received a 13.7% increase, although it requested 21.4%. The boost takes effect Jan. 1 and will generate $1.7 million from 157,000 subscribers. The government raised the Medicare deductible to $180 from $160.

Disabling accidents

CHARLESTON—West Virginia ranked highest in disabling accident frequency among the nation's 18 major surface mining states in 1978, statistics filed with the state supreme court show.

The statistics were included in a case filed by a Logan County surface miner challenging the authority of the legislative rule-making review committee. The figures were drawn from the U.S. Department of Labor and Mine Safety and Health Administration, said attorney Daniel F. Hedges. He listed major states as those with 1.5 million or more employe hours.

West Virginia's frequency rate for nonfatal injuries per million man-hours equaled 24.80, on 262 injuries for 10.56 million employe hours. Missouri, with a frequency rate of 23.28, was second.

Kentucky actually led the nation in the number of injuries with 472, but it was ranked sixth because its rate was 18.14, helped by 26 million man-hours of work reported. Pennsylvania was ranked fifth in rates, 19.04 for 19.32 million man-hours, although it ranked second in actual injuries with 355.

Figures from the West Virginia workers compensation annual report show that in 1978 there were 1,461 strip mine accidents reported, for 5,710 employes, meaning the state had 255.87 injuries per 1,000, Mr. Hedges said. ■

legal brief

Md. court rules flood not an accident

A SPECIAL APPELLATE court in Maryland ruled that a flood was not an "accident" entitling a policyholder to recover damages under "named perils" policies.

This case involved several insurance policies covering specified perils, issued to Simkins Industries by Lexington Insurance Co. and Continental Casualty Co. An exclusionary clause provided that the policy did not cover loss or damage from flood. But the exclusion clause did not apply to loss or damage by fire, sprinkler leakage, explosion or "accidental result from flood."

Simkins suffered substantial damages from flooding caused by tropical storm Agnes, the largest flood to occur in that area. Both insurers denied coverage. A trial court ruled in their favor.

On appeal, Simkins argued that the unprecedented destruction of its property resulting from the flood constituted an "accident" and was, therefore, covered by the policy. However, the court pointed out that the language on which Simkins relied "was no more than an exception to the broad exclusion of flood damage from coverage under the policy."

The court said that because there was no evidence that the damage to the plant was other than the expected result of a flood of that dimension, that damage was excluded from coverage. *Simkins Industries v. Lexington Ins. Co.*, Court of Special Appeals of Maryland, May 9, 1979 (BI/01/N.-$4).

Policy rescission

A federal court ruled, in a death benefit claim under a group life insurance policy, that a provision in the policy requiring a written rescission by the employe did not prevent the parties from orally rescinding the policy by mutual agreement.

Joe Freeman was covered under a contributory group insurance policy, including life insurance, issued by Metropolitan Life Insurance Co. to his employer. The policy provided that the insurance continued to apply until rescinded by the policyholder in writing.

Subsequently, Freeman informed his employer that he did not wish to continue the insurance and requested a refund of premiums paid. The employer requested him to rescind in writing and although he promised to do so, he never did. Freeman received and negotiated a premium refund check. In November 1976, the employer notified Metropolitan that Freeman was no longer covered under the plan.

Freeman was killed in an accident in early 1977. His widow, who had been named as the group insurance beneficiary, filed a death benefit claim. Metropolitan denied the claim and the widow sued. The court dismissed her suit.

While acknowledging that the parties could orally mutually agree to rescind the insurance despite the policy clause, the court concluded that in this case there was a signed writing which evidenced Freeman's ratification of the coverage cancellation. The court said it was clear that Freeman endorsed and negotiated the check aware of the policy cancellation. Therefore, the court agreed the employer had properly struck his name from its insurance rolls. *Freeman v. Metro Life Ins.*, United States District Court for the Western District of Virginia, April 19, 1979 (BI/02/N.-$4).

'Unloading' clauses

Unloading of a vehicle is complete, according to an Illinois appellate court, when, following removal of the material from the vehicle, the deliverer has finished handling it. Thus, the court held that an accident occurring after a concrete bucket was filled did not result from unloading of the truck and was not covered under the auto policy.

Employers Mutual Casualty Co issued an auto policy to a ready-

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

mix concrete company. A general contractor contended it was entitled to be defended and indemnified under the policy against a personal injury suit brought against it by employes of a subcontractor. The policy covered bodily injury arising out of the use, including loading and unloading, of any automobile.

The employes were burned after a crane bucket containing cement came into contact with electric wires. The concrete company trucks had transferred the cement to the crane bucket just before the accident. The trial court ordered Employers to defend the contractor.

The appellate court disagreed. The court believed that unloading or delivery was completed in this case when the cement was transferred to the crane bucket. Furthermore, the court noted that it was the custom of the business that delivery of concrete to a purchaser was completed when the concrete was placed in the first receptacle provided it at a construction site. *Estes Co. of Bettendorf v. Emp. Mut. Cas. Co.*, Appellate Court of Illinois, June 12, 1979 (BI/03/N.-$4).

Murder on vacation

The South Dakota supreme court held that a death was "in the course of" a decedent's employment when he was murdered while on vacation in revenge for actions undertaken in the course of his duties as a police officer.

William Bearshield, a police officer for the city of Gregory, had numerous contacts with Norman Blue Bird and his brothers in the course of his duties. Shortly before his death, Bearshield had been on duty in the jail where Blue Bird's mother was serving a sentence. Blue Bird resented Bearshield and had threatened and attacked him.

In July 1976, Bearshield went on vacation with his family and attended a camp powwow. Bearshield's family returned home, but he remained overnight sleeping in his car. Bearshield was stabbed to death by Blue Bird while asleep.

Mrs. Bearshield applied for a death benefit but was denied. However, a trial court awarded her benefits.

On this appeal by the city, the sole issue was whether the injury arose "in the course of" Bearshield's employment so as to qualify for workers compensation.

The appellate court concluded that where there was an unbroken course beginning with work and ending with injury under such circumstances that the beginning and end are connected points of a single-work related incident, the requirement of "in the course of employment" had been satisfied.

The court emphasized that Bearshield's employment, by its very nature, exposed him to injury of an unusual sort, i.e., a fatal assault by a revenge-seeking youth. "This type of injury," the court said, "knows no particular location or working hours." *Bearshield v. City of Gregory*, Supreme Court of South Dakota, April 19, 1979 (BI/04/N.-$4).

Benefit coordination

This suit was brought by a husband to recover medical benefits allegedly due under the terms of two group medical insurance certificates. A federal court held that the insurer did not have to prove the husband was aware of the limitations contained in the certificates and group policies.

Seymour Weiss, an attorney, and his wife were covered by two Continental Casualty group medical policies issued by two organizations. Both policies excluded recovery for any loss to the extent that benefits were paid by Social Security.

In addition, the policies contained coordination of benefits clauses, so their benefits plus all benefits under all other plans for the same expenses equaled the total expenses.

Weiss sought to recover $25,000 in medical costs incurred during his wife's terminal illness. He admitted that all of the medical costs had been paid by Medicare and Blue Cross/Blue Shield, with some minor exceptions.

Under these circumstances, Continental refused to pay the claim. Weiss sued.

Weiss's principal argument was that he was not bound by these clauses unless Continental proved that he was aware of the limitations and the effect of the limitations was explained to him. The court pointed out that as the two organizations that obtained the policies had more bargaining power than an individual in negotiating for insurance coverage, the need to protect the individual purchaser from overreaching by an insurance company was minimized.

Furthermore, observing that Weiss was an attorney, the court noted that the advertising brochures clearly notified him that the policies contained certain exclusions and coordination of benefits clauses.

Because Weiss admitted he had recovered all, or nearly all, of the medical costs from other sources, the court said it would be inequitable to require the insurer to demonstrate that Weiss was aware of the limits and exceptions. *Weiss v. CNA*, U.S. district court for the western District of Pennsylvania, April 24, 1979 (BI/05/N.-$4).

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Copies of the entire decision may be obtained by sending a check for $4 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the number for each opinion.

dates for buyers

NOV. 28. Kwasha Lipton will sponsor a seminar at the Waldorf-Astoria in New York on **guaranteed investment contracts.** The seminar will cover the features of GICs, their application to defined benefit plans and defined contribution plans, employe communication reports and provide a survey of what is available. Cost is $125. Contact Kwasha Lipton, Harry Bremer, P.O. Box 1137, Englewood Cliffs, N.J. 07632; phone 201-567-0001.

NOV. 28-29. The University of Wisconsin-Extension Management Institute is sponsoring an advanced course in **property and liability insurance accounting.** The preparation of an annual statement, interpretation of financial statements and the correlation of various company functions with the overall finances of an insurance company are some of the topics on the agenda. Cost is $175. Contact Joyce Stout, Programming Assistant, Management Institute, University of Wisconsin-Extension, 432 Lake St., Madison, Wis. 53706.

NOV. 28-29. Corporate Systems Corp. is sponsoring a seminar in San Francisco on how **risk management** information systems can be used to control insurance costs. Case studies of successful risk programs will be profiled and data base control, risk cost evaluation, trending and forecasting will be examined. Cost is $345 per person and $295 for a team of two or more. The seminar will be repeated **Dec. 5-6** in Atlanta. Contact Corporate Systems Corp., P.O. Box 31780, Amarillo, Tex. 79120.

NOV. 28-30. Risk Management in Hospitals is a seminar to be held in Phoenix. Sponsored by the American Hospital Assn., the seminar will cover planning and organizing a risk management program, use of patient care data for loss prevention, physician involvement in risk management, training a staff for high-risk areas and application of liability control in hospitals. Cost is $185 for members, $235 for non-members. Contact Arline Sax, American Hospital Assn., 840 N. Lake Shore Drive, Chicago, Ill. 60611; phone 312-280-6000.

NOV. 29-30. The American Society for Industrial Security is sponsoring a seminar on **computer security** to be held in Arlington, Va. Implementing a computer security program, investigating computer related crimes and the future of computer technology are topics to be discussed. Cost is $165 for members, $215 for non-members. Contact ASIS, Education and Seminar Programs, 2000 K Street, N.W., Suite 651, Washington, D.C. 20006; phone 202-331-7887.

NOV. 30-DEC. 1. Risk Planning Group is presenting a two-day seminar on the **Cayman Islands as an alternative domicile** for U.S. owned captive insurance companies. Regulatory requirements, concerning capital, taxes, accounting and financial reporting will be discussed. The meeting will be limited to 125 participants. Cost is $425 and the program will be held on Grand Cayman Island. Contact Risk Planning Group Inc., 722 Post Rd., Darien, Conn., 06820; phone 203-655-9791.

DEC. 2-3. Employer Contributions and Delinquencies under ERISA is the title of a seminar to be held at the Doral Country Club in Miami, Fla. Sponsored by the International Foundation of Employe Benefit Plans, the program includes discussion of fiduciary responsibility for effective collection of employer contributions, recent legal decisions, payroll audits and Department of Labor audits, collection procedures, collective bargaining agreements and trust documentations. Cost is $270 for members, $345 for non-members. Contact International Foundation of Employe Benefit Plans, P.O. Box 69, Brookfield, Wis. 53005; phone 414-786-6700.

DEC. 3-5. Creativity in Communications is the theme of *Business Insurance's* third annual Employe Benefit Communications Conference at the Ritz-Carlton Hotel in Chicago. Cost is $310 with a 10% discount for additional registrants from the same company who register at the same time. Contact Sari Lipschultz, Crain Educational Division, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5246.

DEC. 3-7. Basic Safety Management, an International Safety Academy course focusing on the principles and **practices of safety management**, will be held in Houston, Tex. The course covers such topics as how to design an effective safety management program, how to get the most out of inspections, accident investigations, group meetings, fire loss control and other methods and an update on OSHA. Tuition is $440 or $400 for each of three or more from the same company. Contact International Safety Academy, P.O. Box 19600, 10575 Katy Freeway, Houston, Tex. 77024; 713-932-9400.

ARSON.

The fastest growing crime in the United States isn't murder or armed robbery. It's arson. People setting fires for thrills, spite, revenge, or profit. Last year, the loss in terms of property came to more than one billion dollars. An increase of more than 500% in the last ten years.

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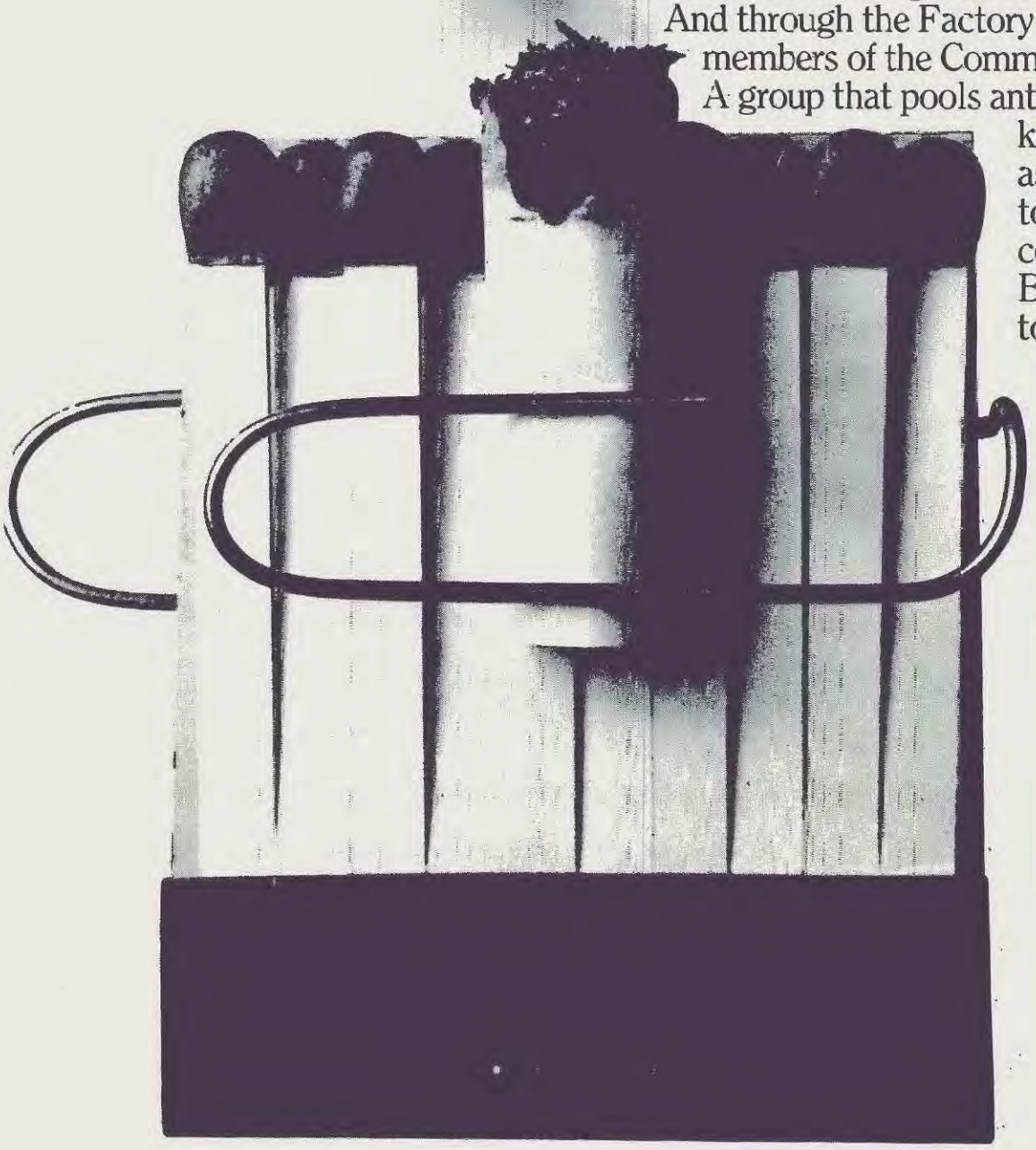
And through the Factory Mutual System, we're members of the Committee to Combat Arson. A group that pools anti-arson data and technical know-how, and provides assistance to those working towards its prevention and control. At Arkwright-Boston, we're working hard to take the profit out of arson.



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benefit tax slants

Change in life insurer penalizes employe

By JOSEPH S. ROBINSON
Attorney-at-Law

FOR ONE REASON or another, an employer sometimes changes the insurer underwriting its group life plan. But doing so can innocently trigger a potential tax trap at the expense of employes.

When an employe assigns ownership interest in his group life insurance to his spouse or other beneficiary, he can sometimes save a lot of money in death taxes. Unless he dies within three years of the assignment, the proceeds of his insurance will remain outside his taxable estate. However, should he die within three years, the death benefit will then be included in his estate.

A new Revenue Ruling, 79-233, creates problems in this area. If the company drops the group life plan for any reason and substitutes a new one in its place, by assigning his new ownership interest, the employe starts the three-year rule all over again.

The ruling dealt with the case of an employe who assigned his interest in a group term policy to his spouse in 1971. At the same time, he made a written agreement to assign any future life insurance coverage, too.

Early in 1977, his employer dropped its group policy to buy coverage from another insurer. The employe then assigned his interest in the new policy, which was identical to the old, to his spouse. Later that year, he died.

The IRS ruled the second assignment wasn't effective until 1977 and, therefore, proceeds of the policy were included in the employe's estate.

Even though the 1971 written agreement might have been legally enforceable, IRS says the transfer of the employe's interest in the policy didn't occur until 1977.

Retirement plans

A permissible method of tilting a plan toward a company's executives is to "integrate" the plan with Social Security. Precise integration methods are set forth in Revenue Ruling 71-446, which also specifies rules covering the situation in which an employer has more than one plan.

In a new revenue ruling, IRS extended its previous ruling to cover certain cases involving more than one employer. The tax law provides that for purposes of the integration rules, all employes of a controlled group of corporations must be treated as employed by a single employer.

IRS reasoned that when these employers maintain more than one plan among them and each of the plans is fully integrated to the maximum extent permitted, if the same employes may be covered by two or more plans, the plans do not integrate properly and will not satisfy the tax law.

Although this is a logical extension of IRS's previous ruling and appears to be supported by the law, it can have far-reaching implications for employers who belong to controlled groups maintaining more than one retirement plan.

If your company is a member of such a group, it might be wise to suggest a reexamination of the group's retirement plans to make sure they are not overintegrated in light of this new ruling. By doing so, you may avoid having your plan disqualified at a tax cost that could prove disastrous.

Early retirement

In this era of mergers and takeovers, executives are often in a bind as to how to deal with their own future. However, those executives who are over age 50 should do some special calculating and take stock of all the built-up cash values in their old company's benefits plan. At age 55, for example, executives who opt for early retirement often get more than they expected.

If a pension plan provides for 40% of final pay at age 65, it might pay 20% or 30%—or even 40%—at 55. Profit sharing or matched dollar plans may have heavily built-up values and in some cases a cash payment in lieu of a stock option is made to an executive forced out by a merger.

One advantage is that lump-sum pension or profit sharing funds, no matter how big the sum, can be "rolled over" into an Individual Retirement Account. With an IRA, an executive can defer taxes until retirement and pay tax yearly as he withdraws the cash.

Restricted stock

A corporation transferred some of its common stock, subject to a substantial risk of forfeiture, to one of its key employes. The stock was not transferrable before the lapse of the substantial risk of forfeiture. The employe did not elect to include the fair market value of the stock in gross income in the year of transfer.

The risk of forfeiture lapsed in a later year and the stock had appreciated in value from the time of the transfer to the time of the lapse of the risk of forfeiture.

The IRS held that the fair market value of the transferred stock at the time the risk of forfeiture lapsed is includable in the employe's gross income for the year in which the risk lapses. When the risk lapsed the stock was made available to the employe without any substantial limitation or restriction and was available to be used by the employe at any time. So the fair market value of the stock at the time is considered wages for tax purposes. (Revenue Ruling 79-305) ■

NAS expands legal coverage

SANTA MONICA—NAS Insurance Services here has expanded its business legal expense coverage.

The policy covers prior acts, with no time limit; directors, and legal defense expenses incurred in the deductible of an errors and omissions or liability policy. Cover is available under five plans. ■

riskWatch

By RHONDA RUNDLE

Disaster communications prove worth in quake

Seconds after an earthquake that was 6.4 on the Richter Scale hit Imperial County last month, hundreds of Southern California hospitals sprang into action. A powerful signal knocked out the silencer on their emergency radios, switching all units on alert. Staffers readied blood, bandages and other medical supplies; they counted empty beds and prepared to admit as many disaster victims as possible.

As it turned out, the Southland disaster plan never swung into high gear since almost all 90 victims were treated on the scene. In a more serious catastrophe, however, this prompt response would have saved lives and averted needless suffering.

Rundle

The need for a master disaster plan struck members of the Hospital Council of Southern California after Hurricane Camille carved a path of destruction through four Southern states in 1969, killing 256.

Although hospitals acted heroically, broken communications severely impeded their effectiveness. Phone lines were downed or overloaded. Urgently needed supplies were misdirected or lost. In the ensuing chaos, victims were sent to the same few hospitals, hopelessly overtaxing available staff and supplies.

This experience taught the council that a secure communications network would be the linchpin of a successful disaster plan. Members contacted suppliers of radio equipment, and one—Motorola—custom-built a simplified system with a telephone handset replacing the standard microphone. Most of Southern California's 240 hospitals made the $3,000 purchase and instantly tuned into the Hospital Emergency Administrative Radio network.

HEAR broadcasting is coordinated through a central station, initially located in the offices of the hospital council. All units keep the radios on constantly, but may switch to silence when they choose. In the event of an emergency, a radio signal dialed from any phone in the network automatically overrides the silencer and allows the emergency message to be broadcast.

While local hospitals installed equipment, the council polished its master plan, linking city ambulances, heliports, hospitals and other emergency services. Then it began to call regular multi-hospital drills.

In June 1970, HEAR staged a mock earthquake. Technical bugs were worked out of the network and hospitals learned how to help each other better.

Eight months later came the real thing. A 6.5 temblor, the strongest to strike Southern California in recent years, destroyed large sections of Sylmar in the Northern San Fernando Valley. Telephone lines went dead. Communications in and out of Sylmar were in disarray.

The network flashed into action. Mobile units were rushed to four hospitals in the heavily hit area. Within half an hour, helicopters arrived on the scene to evacuate critically ill and injured patients. Soon after, 1,167 patients were transferred to other facilities. More than 2,000 disaster victims were sent to various Valley hospitals outside the Sylmar destruction zone.

Food and bandages were collected from contributors all over Southern California and distributed to hospitals treating earthquake victims.

The violent shaking that accompanies massive quakes triggers premature birth in many pregnant women. Extra incubators in Los Angeles had been pinpointed as part of the master plan and were rushed into needy hospitals.

The quake also burst pipes and cracked storage tanks, creating a serious water shortage. Council coordinators borrowed huge tanker trucks from local beer breweries and transported water into the quake zone.

The council's plan performed like clockwork. Before the relief effort ended, county personnel moved into the council's offices to direct emergency traffic via HEAR.

Today, L.A. County mans the network, coordinating communications among all county emergency services, including the fire and police departments. The channel is routinely used to announce smog alerts, to transfer blood supplies and to alert hospitals to fires, serious automobile accidents and other incidents.

News of HEAR spread to other cities after the 1971 quake and many metro areas adopted similar radio alert systems. Although natural disasters are one risk we can't prevent, the Sylmar quake lesson shows us there's a lot we can do to minimize our losses.

Brain-damaged boy to get $1.8 million

PHILADELPHIA—The city of Philadelphia has agreed to a $1.8 million out-of-court settlement in a negligence suit brought by the family of a boy who suffered brain damage after nearly drowning in a municipal pool.

The city is self-insured for the loss.

The boy, Patrick Donnelly, was 5½ when he was rescued from the pool and revived by a lifeguard and the fire rescue squad. The child, now 11, suffered "severe brain damage that reduced him to a spastic quadriplegic," although he can be expected to live to age 60, said Robert C. Daniels, the boy's attorney.

The settlement "was a very fair and reasonable figure under the facts of this case," said city solicitor Sheldon L. Albert. The cost of care for the boy, now in a care home, averages $16,000 a year, his attorney said.

"It's a lot of money, all right," Mr. Daniels said. "But I don't think it's an exorbitant figure, considering the expenses the child is going to incur. When you think of the care costs over 60 years and inflation, it (the award) makes sense."

Mr. Albert said the settlement was the largest award in his eight years as city solicitor. ■

Archdiocese finds self-funding a godsend

"Self-insuring is the only way to go," says John T. Mahoney of the Archdiocese of Baltimore.

By JERRY GEISEL

BALTIMORE—Self-insuring workers compensation has been a godsend for the Archdiocese of Baltimore.

Since the archdiocese joined the ranks of the self-insurers in July 1977, it has racked up savings that now total more than $289,000. It's no surprise then that the motto of the archdiocese's director of insurance, John T. Mahoney, is: "Self-insuring is the only way to go."

A quick look at the arithmetic explains how the self-insured savings have unfolded. During the first year of the program, the cost of claims and excess insurance, which the archdiocese buys to cover losses of more than $150,000, totaled $52,000. Had the archdiocese purchased insurance to cover all its workers compensation exposures, its bill would have been $193,000, or $141,000 more than it paid by self-insuring.

And the savings keep growing. In the last fiscal year, self-insuring workers compensation saved the archdiocese an impressive $148,000. With Maryland workers compensation rates expected to go up by another 18% soon, Mr. Mahoney believes self-insuring workers compensation will continue to reap bigger and bigger dividends.

Thanks to a comprehensive safety program, automobile liability insurance premiums have also been kept under control. This year the archdiocese paid $88,000 for a $500,000 combined single limit liability policy with The Hartford to cover its 445 vehicles. That's an increase of only 4.7% from the previous year, a manageable increase in times of double-digit inflation.

The archdiocese self-insures auto physical damage, charging parishes $100 per vehicle to cover losses. The cost of physical damage insurance purchased from insurers probably would be double, Mr. Mahoney estimates.

Against liability losses, Mr. Mahoney buys a $500,000 comprehensive general liability policy from The Hartford and an excess policy from The St. Paul Cos. for the $500,000 to $15 million layer.

With a self-insured workers compensation program and high self-insured retentions for property risks, a vigorous loss prevention program is a must. Since 1977, Mr. Mahoney has begun a systematic effort to equip parish buildings with smoke detectors. "If smoke detectors prevent just one loss a year, they are worth the cost," he says.

Each month, Mr. Mahoney prepares a bulletin "with headlines in red to get attention," outlining tips to prevent losses.

But Mr. Mahoney doesn't rely only on bulletins to get the safety message across. He credits the archdiocese's insurance inspectors from Aetna Life & Casualty and The Hartford with keeping him closely informed of possible safety hazards.

"We have a couple of million people passing through the churches each week. That could mean a lot of slips and falls. But we don't have many claims," Mr. Mahoney says proudly. Following insurance inspectors' recommendations prevents losses, Mr. Mahoney says. Recommendations include tightening loose bannisters, repairing or replacing chairs with weak supports and keeping stairs clear.

Self-insuring workers compensation is just one way Mr. Mahoney has been able to hold down increases in the archdiocese's $3.2 million insurance budget. Property insurance premiums, for example, have been slashed by 40% in some cases, thanks to a consolidated purchase program.

Under the program, the archdiocese buys one master policy from Aetna to cover the replacement value of the archdiocese's 915 buildings. The policy, which has a $100,000 deductible, costs the archdiocese $207,000.

Each parish then reimburses the archdiocese for its share of the premium and pays a small additional premium to build up a $500,000 fund to cover losses falling within the deductible layer.

If the parishes purchased individual property policies, as they did in the early 1960s, their property insurance costs would be substantially higher, Mr. Mahoney observed. For example, one Baltimore parish would have to pay $1,108 if it purchased property insurance alone. Under the archdiocese program, equivalent coverage only costs the parish $513, Mr. Mahoney said.

Loss prevention also means keeping an eye out for the unusual. For example, Mr. Mahoney discovered that priests transferred to new parishes often left garments stored in attics of their old parishes, which posed a fire hazard. Mr. Mahoney alerted maintenance staff to clean out the attics regularly and remove the discarded clothes.

Mr. Mahoney regularly analyzes claims to spot patterns to prevent those claims from turning into big losses. The 23-year veteran of the insurance industry noticed an unusual number of employes developing back strains. Looking more closely, Mr. Mahoney determined that employes working in the archdiocese's rest homes most often had back strains. The back problems, it seems, developed when employes who lacked sufficient strength helped patients out of bed.

Mr. Mahoney now sees to it that employes with back problems are transferred to less strenuous jobs before a minor strain can turn into an expensive, long-drawn-out workers compensation claim.

Mr. Mahoney also has found new ways to lower costs of the archdiocese's group health insurance program covering 3,700 employes. Under a "cost plus" plan with Blue Cross/Blue Shield of Maryland, the archdiocese reimburses BC/BS for all claims incurred, plus a fee of 8%. This saves the archdiocese about 5% or $40,000 on health insurance. ■

How many people are you paying to gather dust?

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

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

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

Panic buying levels off: Product liability report

TALLAHASSEE, Fla.—Panic buying of product liability insurance appears to be leveling off but there is more evidence of defensive pricing by insurers, say Florida insurance regulators.

Statistics gauging the nationwide activities of Florida product liability insurers between 1975 and 1978 show a decline in the ratio of written to earned premiums, indicating less growth in the sale of product liability insurance.

In 1978, written premiums were 5.3% greater than earned premiums, a decrease from 8.5% in 1977 and a steep drop from 16.1% in 1976, the height of the crisis period in product liability insurance. In 1975, written premiums were 12.2% greater than earned, the figures show.

"This may be due to the stabilizing of previously increasing prices for coverage and perhaps to the leveling off of panic buying of products coverage," the report said.

But the coverage has also become higher priced. Paid losses made up only 14.4% of earned premiums in the last two years, but in 1975 the total was 38.6%. Paid losses ate up 23.8% of earned premiums in 1976, the report said.

A steady drop since 1976 in year-end reserves to cover incurred but not reported losses is another indication of the higher, defensive pricing trend. At the end of last year, reserves for IBNR losses were 46.5% higher than they were at the start of the year.

The 1978 total is less than half of the year-end level for 1976, when reserves were 108.5% higher than at the beginning of that year for IBNR. In 1977, the year-end level was 67.6% greater and in 1975, year-end reserves were 42.4% greater.

In another category, the insurance department said underwriting and investment income equaled 21% of the earned premiums of product liability insurers last year. This represents a sharp rise from 14.3% in 1977 and 2.3% in 1976. In 1975, insurers experienced a bad year, losing 20.9% of their earned premium level from investments and underwriting.

Underwriting and investment income totaled $117.2 million last year, about one-third from investments alone, the insurance department said.

Between 50% and 55% of every premium dollar is available for loss payouts, the report said. Product liability has an "unusually" high loss adjustment expense ratio of 19% of earned premiums, about three times as much as that of workers compensation. ■

Blues set up cost control plan in Mich.

DETROIT—A new health care plan, designed to induce physicians' efficiency and cost control, is being set up here by Blue Cross/Blue Shield of Michigan.

The plan, to be called the Primary Care Network, is essentially a cross between a health maintenance organization and an independent practice association but has a unique funding structure, said Richard Femmel, vp/communications for BCBSM.

Participating doctors will be paid on a per-capita basis from funds set aside in a pool instead of by the traditional salaries or fee for service reimbursements.

The system will provide an efficiency incentive for the doctors and lead to lower health care coverage rates because half of any surplus funds at the end of each year will be distributed among them, Mr. Femmel said. If doctors overspend the fund, they must assume half the loss.

"It will give the physician incentive to hold down utilization and be more efficient," Mr. Femmel said. "We see it as a way to hold down health care costs."

The pilot program will be available to groups of workers at the same rates they pay for HMOs and fee for service contracts.

The project will be tested in the Detroit metropolitan area, Mr. Femmel said. BCBSM has already advertised for participating doctors and has had good response. ■

Offshore oil operators won't be shut down

WASHINGTON—The Coast Guard is not taking action against Outer Continental Shelf oil operators who can't buy insurance coverage to certify them against pollution liability.

Domestic and British insurers have declined to write policies under the Outer Continental Shelf Lands Act Amendments of 1978 that would in effect make them guarantors against pollution damage caused by policyholders. Insurers fear they would be subjected to unlimited liability (*BI*, Sept. 17).

The amendments require all operators in the Outer Continental Shelf to demonstrate financial responsibility for $35 million through purchase of insurance, self-insurance, a surety bond, indemnification or guarantorship. Congress is to establish a $200 million "Superfund" to cover pollution cleanup costs of more than $35 million.

LeBouef, Lamb, Leiby & MacRae, attorneys for Lloyd's of London, interpreted the law to give the Superfund subrogation rights against operators and their insurers. On their advice, Lloyd's declined to write the coverage, as did AIG Oil Rig and All American Marine Slip.

Under the amendments, offshore oil facilities that fail to become certified could be shut down.

"Without insurance market availability, we can't require Outer Continental Shelf people to be certified," said Coast Guard Capt. Gilbert Sherburne.

LeBouef Lamb and the Coast Guard have appealed to Congress for changes in the law to clarify the posture on unlimited liability. Sen. Edmund Muskie (D-Me.), chairman of the environmental pollution subcommittee, and Sen. Jennings Randolph (D-W.Va.), chairman of the Committee on Environment and Public Works, have appealed to British and domestic insurers for additional information before taking action.

Although the committee chiefs have not decided whether they will support legislation on the matter, there is "no disagreement that Congress never intended that there be unlimited liability" for insurers, said Phil Cummings, chief counsel to the Committee on Environment and Public Works.

If legislation is deemed appropriate, it will be easy to arrange, he added.

In addition to going the congressional route, the Coast Guard is seeking an interpretation from the U.S. Attorney General's Office that the law did not mean unlimited liability for insurers, Capt. Sherburne said. ■

Suits seek $371 million in oil spill

DALLAS—Lawsuits pending against Southeastern Drilling Co. stemming from the Campeche oil spill seek a total of $371.1 million, says Irving Davis, SEDCO vp-taxation.

The suits were filed in response to an Oct. 23 deadline set by a federal judge for bringing action against the company. A SEDCO request to exonerate the company or limit its liability to $300,000 is still pending in court (*BI*, Oct. 15).

In addition to a $155 million class action suit filed against the company on behalf of South Texas fishermen, shrimpers and crab and oyster operators, class action suits each asking $100 million have been filed by area hotel interests and Willacy County residents.

The state of Texas has filed suit seeking $10 million in damages plus $100,000 for cleanup costs and the federal government is seeking $6 million for cleanup costs.

SEDCO's Rig 135 was drilling in the Bay of Campeche when its well blew out June 2. Although oil continues to flow from the well, a metal plate installed over the blowout several weeks ago has reduced the flow to the point experts believe it can be eventually capped.

Permargo, the Mexican drilling company that had leased the SEDCO rig, and PEMEX, the state-owned Mexican oil company operating at the site, were also named in the class action suits. Texas named Permargo in its action, as well.

SEDCO does not expect to be found liable in the case and has said it would be indemnified by Permargo, which would be indemnified by PEMEX, Mr. Davis said. ■

NAEHMO starts scholarship fund

MINNEAPOLIS—The National Assn. of Employers on Health Maintenance Organizations Foundations has established a scholarship fund in honor of the late John J. Boardman Jr., one of the nation's leading authorities on HMOs.

Contributions to the scholarship fund are being accepted from individuals as well as corporations. All contributions are tax deductible.

Mr. Boardman, executive vp of Kaiser Foundation International and Kaiser-Permanente Advisory Services, was known internationally for his knowledge and skill in organizing prepaid health-care services and facilities.

For additional information about the scholarship contact NAEHMO Foundation, 1134 Chamber of Commerce Building, 15 S. 5th St., Minneapolis, Minn. 55402. ■

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• AIG Risk Management is offering a brochure entitled **Going the Captive Route: It Isn't "Business As Usual."** The brochure outlines AIGRM's insurance management capabilities in the captive field. For a free copy write AIG Risk Management Inc., 70 Pine St., New York, N.Y. 10005.

• Do you need more information about the coordination of benefits for HMOs? If so, Personnel Research Associates is offering an employers' **HMO service newsletter** designed to keep you up-to-date about the subject. For a free copy write Richard D. Quinn, Personnel Research Associates, 49 Oakridge Rd., Verona, N.J. 07044.

• A detailed brochure describing the **analytical services** of Clayton Environmental Consultants Inc., a technical service arm of Marsh & McLennan, is available. Analyses of gas chromatography, atomic absorption and emission spectrophotometry, X-ray diffractometry, microscopic analysis and method development are included. For a free copy write Clayton Environmental Consultants, 25711 Southfield Rd., Southfield, Mich. 48075.

• The National Assn. of Public Insurance Adjusters is offering a 12-page booklet outlining action to take if a **fire or an allied catastrophe** occurs. Presented in a question and answer format, the booklet explains complex policy requirements and how to deal with the insurance company adjuster after a fire or allied casualty. For a free copy send a self-addressed envelope with postage to National Assn. of Public Insurance Adjusters, Department 207, 404 Clifton Ave., Clifton, N.J. 07011.

• The **self-insurance services** available from Aetna Technical Services are described in a new 28-page brochure. It includes an elaboration of the company's claims and loss control activities and discusses special issues such as workers compensation, auto fleet, general liability, professional liability, product liability and bond/fidelity insurance. For a free copy of the brochure write Aetna Technical Services, 151 Farmington Ave., Hartford, Conn. 06156.

Send your info

Business Insurance is seeking items relating to employe benefits insurance for the Info for Buyers column in the special Employe Benefits issue. The Info for Buyers column provides *BI's* readers with easy access to explanatory brochures, studies, reports and other sources of information helpful to their jobs. The items must either be free or for a nominal cost (less than $10). Persons wishing to submit material should send a copy of the brochure, information on where it may be obtained and the cost to Mary Ellen McKee, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611, no later than Nov. 26.

• The 1979 edition of the **Life Insurance Fact Book** is available from the American Council of Life Insurance. The book provides information on the average amount of life insurance coverage for each insured U.S. family, payments to beneficiaries, policyholders and annuities over the past year, assets of life insurance companies and the number of people covered by pension plans administered by life insurance companies. For a free copy, write American Council of Life Insurance, 1850 K St. N.W., Washington, D.C. 20006.

• Are your **burglar alarm systems** installed properly? Are they maintained? These are a few of the questions discussed in an Underwriters Laboratories brochure. For a free copy write Robert Van Brundt, manager of public information and education services, Underwriters Laboratories Inc., 333 Pfingsten Rd., Northbrook, Ill. 60062.

• Kwasha Lipton is offering a newsletter giving an overview of **guaranteed investment contracts.** Accounting procedures, basic features of the contracts which include single or recurring deposits, recoupment, termination provisions and expense charges are examined. For a free copy write Kwasha Lipton, Department M, 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

• Pension Planning Co. Inc. has prepared a newsletter describing the management of **health insurance costs.** For a free copy write Pension Planning Co. Inc., Communications Department, 355 Lexington Ave., New York, N.Y. 10017.

• **The Service Directory** published by Brown Brothers Adjusters lists the location and 24-hour telephone numbers of the company's 49 offices in the seven Western states. For a free copy write Vernon Neufeld, Brown Brothers Adjusters, 545 Sansome St., San Francisco, Calif. 94111.

• Gay & Taylor, insurance adjusters, is offering a new package describing its services for self-insurers of **automated reporting of loss statistics,** claims management, claims adjusting and loss control services. For a free copy write Mary S. Bolton, manager, marketing research, P.O. Box 1410, Winston-Salem, N.C. 27102.

• The advantages of incorporating **loss recovery services** into a risk management program are outlined in two 12-page promotional booklets, The USSC Way to Increased Cash Flow Protection and Asset Conservation and Heavy Equipment and Truck Salvage. For a free copy write Underwriters Salvage Co., James C. Boyd, vp, 1400 Busse Rd., Elk Grove Village, Ill. 60007.

• The Industrial Indemnity Co. of San Francisco has developed a series of general bulletins about **fleet loss control.** Management direction and support, driver orientation and training, vehicle inspection and maintenance and accident investigation records are discussed. For a free set of bulletins write Industrial Indemnity Co., Home Office Loss Control Department, P.O. Box 3660, San Francisco, Calif. 94120.

• **Risk Management for the Smaller Company** is a 45-page booklet available from the Assn. of Insurance Risk Managers in Industry & Commerce (AIRMIC Ltd.). Cost is $7.50. Write R.A. Muckles-

ton, Risk Management, Oak Cottage, High Road, Chipstead, Surrey CR3 3QP, Britain.

• Fenwal Inc.'s line of **fire detection devices** including ionization and photoelectric smoke devices and ultraviolet flame detectors is described in Industrial and Commercial Fire Detection Devices. For a free copy write John C. Lowrey, Fenwal Inc., 400 Main St., Ashland, Mass. 01721.

• **About Health Care Costs** is a 19-page color brochure from U.S. Administrators. Among the topics considered are implementing quality assurance, medical, dental and drug plans and workers compensation. For a free copy write Samuel X. Kaplan, president, U.S. Administrators, 3540 Wilshire Blvd., Los Angeles, Calif. 90010.

• How to protect computers and data processing equipment from property loss and damage is found in Industrial Risk Insurers's **Recommended good practice for the protection of electronic data processing and computer-controlled industrial processes.** Losses from natural disasters and manmade ones are described, including dates and amounts of damages. Also included is a glossary of computer terms. For a free copy write Robert F. Quagliaroli, Publications Department, Industrial Risk Insurers, 85 Woodland St., Hartford, Conn. 06102.

• **New Concepts in International Employe Benefits** is a brochure briefly summarizing the people and products of American International Life Assurance Co. Free copies are available by writing L.D. Phillipps, International Benefits Coordinator, American International Life Assurance Co. of New York, 102 Maiden Ln., New York, N.Y. 10005.

• Best Says We're Best is a promotional brochure from American Home/National Union which discusses the companies' **inland marine** coverages. It includes a list of the companies' branch offices. For a free copy write: Product Information, Corporate Communications, American International Group, 102 Maiden Ln., New York, N.Y. 10005.

• The U.S. Chamber of Commerce is offering its latest analysis of **workers compensation** laws in the U.S., Guam, Puerto Rico and Canada. The analysis lists mandated benefits and provides a reference of workers compensation administrators and commissioners in the 50 states. Cost is $6 for single copies, discounts for bulk orders. Write for publication number 5913, Chamber of Commerce of the United States, 1615 H St., N.W., Washington, D.C. 20062. ■

Searle program silences hearing problems

Photo: Mary Ellen McKee

Although few hearing loss claims have been filed at G.D. Searle, Daniel Cacchione plans "to nip hearing problems in the bud."

By MARY ELLEN McKEE

SKOKIE, Ill.—G.D. Searle employes can hear themselves think above the din in the company's five North American plants, and Daniel Cacchione vows to keep it that way with a hearing conservation program.

Noise levels in each of the North American plants are monitored to be kept within the standards set by the Occupational Safety and Health Administration, emphasized Mr. Cacchione, manager of industrial hygiene for Searle. But management at Searle was determined to go the extra distance and start up a program "to nip hearing problems in the bud," he added.

Generally, the pharmaceutical plants register noise levels much lower than those of other industries and Searle has never been burdened with workers compensation claims for hearing loss. But that's not the point, Mr. Cacchione said. "Why should a program be implemented only after it becomes a problem for the employe and for the company?"

Experts have counseled, however, that companies should be concerned about potential increased costs of workers compensation from hearing loss claims. This is especially important in Illinois, they say, where the benefit for occupationally caused hearing loss is liberal.

But the Searle program, begun in June, was designed in the true spirit of industrial hygiene, with the overall health of the employe as the top priority, Mr. Cacchione said. The program reaches 900 employes.

Unlike many other companies with hearing programs, Searle is allowing each of the five North American plants to adapt the program at its own speed and in its own way, Mr. Cacchione said. "We aren't standing behind them to make sure they follow my program to the letter. That would be counterproductive," he added.

Instead, the Searle hearing program is tailored to the individual plant facilities by the people in that facility. Searle's plant managers took the basic package constructed by Mr. Cacchione, informed him what aspects of the package would not work in an individual plant and then brainstormed with him to find alternatives.

For example, only a few plants could meet the requirement to have a nurse administer the audiometric test; the other facilities did not have a full-time nurse on staff. In those facilities, at least two employes completed a course certifying them to give the test. The certification enabled them to give the test and check the audiometric equipment, but they are not authorized to diagnose the test results.

The program is divided into four basic categories, Mr. Cacchione explained. First, Mr. Cacchione and plant production employes toured each facility to test the noise levels and reduce them as much as possible. Recommendations on noise level reductions were made during meetings with plant managers and then followed up with a memo from Mr. Cacchione's office.

His recommendations have ranged from putting up signs alerting employes to high noise areas in the plant that require ear protection devices be worn to engineering noise out of the actual machines. "Engineering noise out of machines, however, is very time consuming and very expensive," said Mr. Cacchione, admitting that he makes this recommendation infrequently.

Next, Mr. Cacchione and his associates checked each sound booth before the audiometric testing began to avoid any discrepancies in the testing procedure. The booths will be checked annually by an octave band analyzer to ensure that a satisfactory Hertz range (250 to 8,000 Hz) was achieved in the booth.

"If the testing equipment or the sound booth is off at all, testing is done in vain," Mr. Cacchione said. "It's like any other scientific test, you must keep a tight rein and an eye on the controls for accurate results."

Consequently, the audiometric equipment is checked by the certified professional at the plant or consulting firms every six months. And Mr. Cacchione plans to check the sound booths for Hertz levels annually.

The next part of the program, and the one considered by Mr. Cacchione to be the most critical, is the actual audiometric testing. The test results administered by the certified professional at the plant is reviewed by a medical professional—certified audiologist, otologist or medical doctor.

Employes working in areas of the plant registering below 85 dBA (decibles on the A scale) will not receive another audiometric test until leaving the company. Employes in work area scaling levels from 85 to 90 dBA are checked annually, while employes working in jobs with noise levels over 90 dBA are given audiometric tests every six months.

"Ideally, the company will try to reduce the noise levels in the work

environment below 90 dBA," Mr. Cacchione noted. But until the preferred noise level is reached, the employes will be required to wear ear protective devices, be limited in the hours they can work in a specific area and be tested every two to six months if necessary.

"Noise levels reaching 90 dBA are really taboo," Mr. Cacchione said. "We'd work as hard and as long as possible to bring that noise level down."

Any employe hired after June received a hearing test before official employment. If the employe was placed into a job with noise levels below 85 dBA, he was required to take another test before leaving the company.

For employes with hearing losses ranging from 0 to 15 decibles (considered negligible by most hearing professionals), the results are filed away.

When hearing loss is greater than 15 decibles, the audiogram is forwarded following a retest to a consulting medical professional. The professional is required to interview the employe, conduct his own tests (generally more comprehensive than the audiogram given at the plant), analyze the results and then discriminate between a noise-induced hearing loss or functional hearing loss caused by a disease or drug.

If the medical professional, equipped with the employe's background, job description and test results, finds the hearing loss may be occupational in nature, the company automatically transfers the employe into a different area of the plant. "But the employe is always transferred into a position offering the same salary," Mr. Cacchione said.

In some cases, when the hearing loss is not severe enough to warrant a job transfer, an employe is required to wear a hearing protection device at all times.

Mr. Cacchione does not expect the costs of the program to exceed more than $200,000 this year. Each audiogram is reviewed for $2.50 each and the more extensive, sophisticated testing can be done for $25 to $30 each. Costs usually exceed $25 for additional tests needed because of discrepancies in the previous tests. An exact figure on these additional tests is impossible to compute since the final cost really depends on the kind of tests given, Mr. Cacchione said.

After five months of testing, none of the employes shows hearing losses severe enough to be transferred out of his or her present jobs. And only about 25% of Searle employes show hearing losses exceeding 15 decibles.

"Even if all of the employes tested below the 15 decibles cutoff point, I would still feel this kind of program is justified. It doesn't pay to tamper with the health of the employes," Mr. Cacchione noted. "If the program does anything, it boosts the morale of the worker and improves the relationship between the corporate headquarters here and the outlying facilities. You can't put a price tag on that." ■

Commercial premiums grow: Exec

CHICAGO—Premium volume in the commercial insurance market will grow much faster than in personal lines and will be 25% higher by 1985, predicts Robert A. Leibold, president of Allstate's new subsidiary looking for increased commercial sales.

Speaking at a session of the society of Chartered Property/Casualty Underwriters here, Mr. Leibold said the estimated property/casualty written premium volume for industrywide commercial lines will be $46.9 billion for 1979, or 13.8% higher than the $41.2 billion projected for personal lines. But within the next five years, commercial lines insurance will produce $83 billion in annual premium volume while the total for personal lines will be $70 billion, reflecting 25% faster annual dollar growth for commercial lines, he said.

Not only is that an encouraging sign for Allstate and other commercial carriers, but "our long-range growth goals for Allstate could not be achieved without recourse to this gigantic commercial market," he told the CPCU gathering.

Currently, Allstate's share of the personal property/casualty market is about 10% but its share of the commercial property/casualty business is less than 1%, he said.

Mr. Leibold is president of Northbrook Property & Casualty Insurance Co. ■

Municipal risk sharing pools receive strong support in N.Y.

By ELLIS SIMON

NEW YORK—Support for municipal risk sharing pools in New York is so strong that at least one insurance trade association opposing the option expects enabling legislation to be passed in 1980 despite insurance industry objections.

Public entities in New York seeking to tackle their liability insurance woes are looking to the legislature for the right to include pooling in their game plan. At present, New York permits only conventional insurance or self-insurance on an individual basis.

But municipal risk sharing pools have sprung up around the country in the last few years, providing public entities in California to Kentucky with an alternative risk funding method (*BI*, Jan. 8).

New York officials are demanding the same opportunity to try risk pooling. All local governments testifying during five days of hearings on pooling held jointly in mid-October by three assembly committees favored the concept, said Paul D. Moore, an aide to the ways and means committee.

Insurance industry trade groups such as the American Insurance Assn., Alliance of American Insurers, Professional Insurance Agents of New York and the Independent Insurance Agents Assn. of New York spoke out against pooling at the hearings. But a spokesman for the Independent Agents conceded enabling legislation is likely to pass in 1980.

The legislation probably would be based on the recommendations of a study by ways and means committee staffers. Their report, due in December, will reflect a survey of municipalities, testimony at the hearings and visits to municipal risk sharing pools in Texas California and Illinois.

"Comprehensive legislation enabling local governments to meet all insurance needs" is likely to be recommended in the study, Mr. Moore said. Such a bill would probably permit pooling, he said, and could include tort reform.

Municipalities favor pooling as a means to control insurance costs, particularly for general liability coverage. Between 1975 and 1977, Middletown, a city of 22,000, saw its liability premium rise to $242,000 from $36,000, Mayor Myron Perry testified.

Mr. Perry, who chairs the Committee for the Organization of Self-Insurance Pools, told legislators pooling would realize first-year savings of 10% for his community.

Freeport, which saved $300,000 by self-insuring in 1978 for workers compensation, general and automobile liability would save an additional $124,000 as a result of pooling's economies of scale, said Mayor William H White, a broker by profession. The village of 40,000 would also be able to obtain higher limits of excess coverage, he said.

Insurance industry critics of pooling proposals charge there would be no savings since pooling would require "the assemblage of the persons necessary to run an insurance company." Further, they say, rates for municipalities are coming down by as much as 20% for some townships.

Supporters of pooling point to the cyclical nature of insurance rates and the lack of municipal specialists within the insurance markets. "For too long, municipal insurance has been the stepchild of the insurance industry," testified Cecilia M. Tymann of the New York Conference of Mayors.

"Industry spokesmen themselves have told us that even the simplest statistics about municipalities and their insurance records cannot be provided without extensive, time-consuming and costly research. No full-scale, industry-sponsored risk management programs have been developed and utilized. No aggressive search by the insurance carriers for municipal insurance business has taken place," she said.

Industry groups warn that unregulated pools could become a drain on taxpayers if strict funding standards are not adopted. "We must oppose any purported cost cutting technique, such as pooling, that refuses to stand on its own and which has access to general taxpayer funds," said John G. Prios, past president of the state's independent agents.

A large-scale pooling plan developed by Weber/Euclid of New York, consultants for the pro-pools organization, calls upon participating public entities to make up part of their losses from future revenues. The Weber/Euclid plan establishes four layers of coverage and groups participants by size and services provided. Each municipality would have a self-insured retention and would participate with other members of the subgroup in a shared excess retention layer. The entire pool would provide excess coverage above that layer and additional excess insurance would be purchased from conventional sources.

Although losses paid by the entire pool would be fully funded, losses paid at the shared layer would only be partly funded. Participants having losses at this level would have to reimburse the subgroup fund over a four-year period.

The ways and means committee must still decide how it proposes to regulate municipal insurance pools, Mr. Moore said. "We want some regulation, but don't want to tie them down so much that they can't function properly.

Regulation by the insurance department would give the risk-sharing entities access to the state guaranty fund, but would also subject them to department reserve, rating and reporting requirements. Such an entity would not be a self-insurance pool, but a reciprocal insurer, several sources pointed out.

Unlike a pool, the reciprocal would not have to be capitalized, said Weber/Euclid's Mr. Carter. Guaranty fund-type mechanisms can be built into a pool, he added.

A reciprocal is a more prudent alternative to self-insurance pools, said Lawrence O'Brien, executive vp of Associated Risk Managers of New York, an Albany-based consulting firm. He had recommended creation of a reciprocal in a study for the Conference of Mayors.

Autonomy from insurance department regulation would be one of a pool's biggest drawbacks, he said.

In addition, pooling would require comprehensive legislation since it would mean one municipality would be, in effect, paying the losses of another, he noted.

The legislature should let the municipalities decide for themselves whether they want to participate in a self-insurance pool or form reciprocals, said Ms. Tymann of the mayors conference. ■

Pa. regulator seeks financial standards in risk pooling bill

HARRISBURG, Pa.—Pennsylvania insurance commissioner Harvey Bartle III wants any legislation permitting governments to pool workers compensation risks to include financial standards.

The Pennsylvania house is considering legislation to permit political entities to form self-insurance pools for workers compensation (H.B. 1516) and the senate is considering a bill (S.B. 715) to allow all employers, both public and private, to form such pools.

Commissioner Bartle, however, is warning legislators that self-insurance pools would attract the cream-of-the-crop employers, the safer risks, leaving industries with poorer loss experience to buy insurance from private companies or from the government-run State Workmen's Insurance Fund. Rates for such employers then would be driven up, he said.

Financial standards and examinations of self-insurance pools must be included in any legislation authorizing their creation, Mr. Bartle said in testimony before the house labor relations committee. "I must emphasize that the solvency of workers compensation providers is absolutely critical, and that any system of workers compensation must assure the financial capability of the entities required to pay the compensation," he said.

Mr. Bartle recommended that if the general assembly authorizes self-insurance, the law should also set minimum financial standards, require examinations and audits of the pools and establish a procedure for spreading the risk in case of catastrophic loss.

"While we favor any means to lower insurance costs which provide proper safeguards," Mr. Bartle told the committee, "the administration believes that before H.B. 1516 or any other such bill is enacted, the effects of such reforms on the entire workers compensation system must be seriously considered."

Mr. Bartle noted that several steps to control workers compensation costs in Pennsylvania are already being taken, including his appointment of an independent actuary to evaluate the workers compensation rating system and Gov. Richard Thornburgh's appointment of a blue ribbon panel to study SWIF. ■

Injured boy may receive $3.39 million

CARLTON, Minn.—A Moose Lake boy partially paralyzed after he was hit by a ball from a baseball pitching machine could receive as much as $3.39 million over the next 60 years in an out-of-court settlement.

Mark Gassert, 11, lost use of his legs and left arm when he was struck in the head by the ball Aug. 3, 1977, at Moose Lake High School.

The settlement, consisting of a $250,000 lump sum and monthly annuities beginning at $1,000, will be shared by the defendants in the suit, said Gene Halverson of Duluth, the attorney representing the St. Paul Fire & Marine Insurance Co.

The defendants were the school district, insured by St. Paul; the manufacturer of the machine, Advance Machine Corp. and its now dissolved subsidiary, Commercial Mechanism Inc., insured by Universal Insurance Co. Ltd. of Canada; the wholesale distributor, Dudley Corp., insured by The Home Insurance Co., and C.Z. Wilson of Duluth, the retailer, insured by Northwest National Life Insurance Co.

The youngster was standing near the machine when its pitching arm discharged a ball that struck him in the head. ■

Benefits increase faster than pay: Study

NEW YORK—Benefits increased faster than cash compensation for the average salaried employe from mid-1978 to mid-1979, reversing the trend of faster wage increases the year before, says consultant Hay-Huggins.

Non-cash compensation increases ranged from 9% to 18% while cash compensation increases were 6% to 16%, reports the 1979 Hay-Huggins Noncash Compensation Comparison.

Industrial company employes received the highest increase in benefits, ranging from 13.4% to 17.1%, while cash compensation increases ranged from 7.2% to 13.8%.

Financial institution employes got benefit increases from 10.5% to 16.9% and cash raises from 8.6% to 16%. Service organization employes' benefit increases were as low as 8.9% but as high as 17.8% with raises ranging from 6.4% to 9%.

The national survey of 500 employers conducted from March to June also showed:

- Benefits continued to equal 30% to 40% of salary in the typical range of pay levels.
- Comprehensive major medical plans continue to replace base health care plans that are supplemented by major medical plans.
- More companies are offering HMOs as a health care plan option.
- Dental plans are increasing, with half the participating organizations offering dental coverage.
- 501 (c)(9) trusts to fund welfare benefits are growing; 16% of respondents have them this year, up from 11% last year.
- Use of non-qualified stock option plans is increasing at the expense of qualified plans.

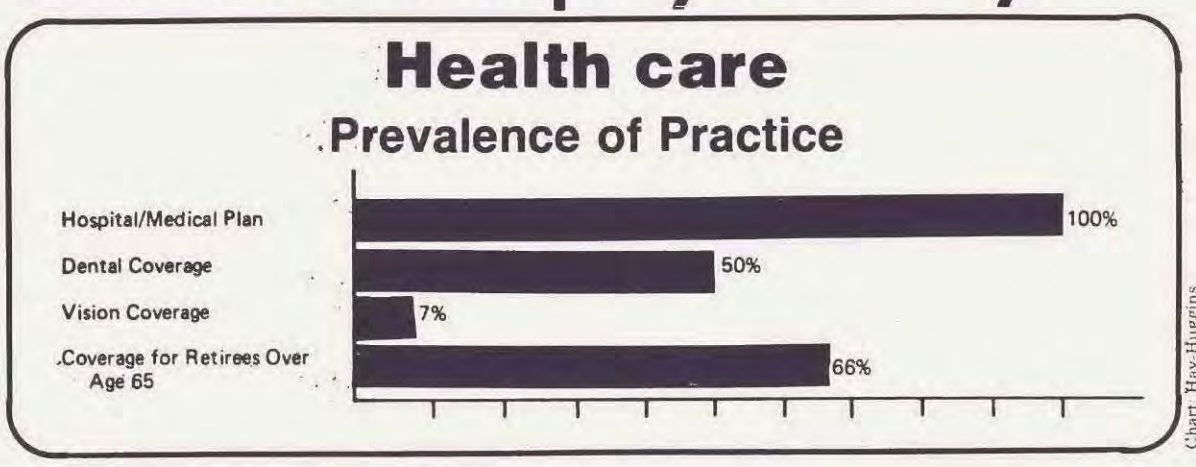


Chart: Hay-Huggins

The salary equivalent of noncash compensation increased for those at the lower end of the $20,000 to $100,000 annual salary scale, while remaining constant or decreasing for those at the top of the scale during 1979.

Within industrial companies in 1979, the average salary equivalent value of noncash compensation for an employe earning $100,000 per year was 29.4%, the same as in 1978. However, for the employe earning $20,000 per year, noncash compensation accounted for 38.0% of salary in 1979, up from 35.8% in 1978.

The value of noncash compensation for employes of financial institutions earning $100,000 per year was 31.6% in 1979, down from 33.1% in 1978. However, for the employe in the $20,000 per year range, noncash compensation accounted for 39.5% of salary in 1979, up from 38% in 1978.

Service organizations reported results similar to those of financial institutions, with noncash compensation accounting for 29.5% of salary in 1979 for $100,000-per-year employes, down from 30.1% in 1978. The $20,000-per-year employe, however, experienced an increase in the salary equivalent of noncash compensation in 1979 to 38.5% of salary, up from 36.2% in 1978.

For those earning $30,000 to $70,000 per year, the salary equivalent of noncash compensation decreased as salary increased, but fell within the ranges noted above.

Noncash compensation measured includes: death benefits, sick leave, disability income, health plans, pensions, deferred profit sharing and thrift plans (including ESOPs and TRASOPs), holidays and vacations, Social Security, workers compensation and unemployment insurance. Where benefits were financed partly by the employer and partly by employe contributions, only the employer-funded portion was counted.

Comprehensive major medical plans were provided by 38% of survey respondents in 1979, compared with 34% in 1977 and 26% in 1975. Comprehensive plans are thus gradually replacing the traditional combination of a basic hospital-surgical plan supplemented by a major medical plan.

Although comprehensive plans are typically more responsive to inflationary cost increases, they also lend themselves more easily to cost-sharing devices such as coinsurance and front end deductibles. Theoretically, this means the employe has more incentive to control costs, since he must share the expense.

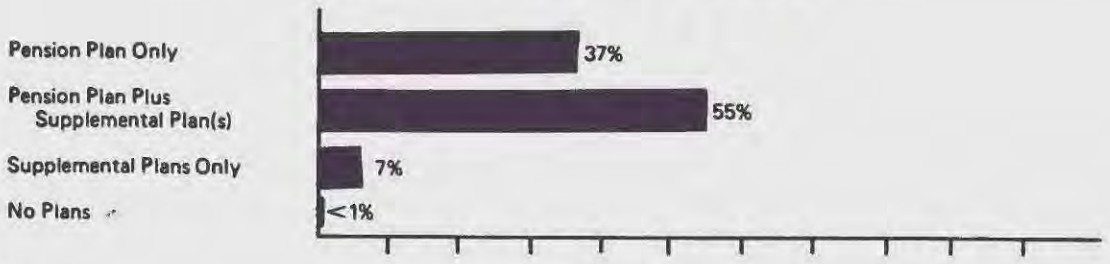
As an optional form of health coverage, HMOs were offered by 44% of 1979 participants, up from 30% last year.

Increasing costs are also behind another trend in health plan practices: the shift away from a surgical expense schedule and toward a "reasonable and customary" basis of reimbursement. In 1979, surgical expense schedules accounted for 30% of plans reported, a sharp decline from 41% in 1978. The reasonable and customary plan has an automatic cost-of-living escalator in an inflationary period, which maintains the adequacy of benefits

Sickness & Disability Income

	1979	1977	1975
Uninsured Short Term Sick Leave Plan	96%	95%	94%
Long Term Disability Plan	94%	90%	86%
60% or More of Monthly Pay (Flat % Benefit Plans)	71%	72%	66%
Maximum Monthly Benefit			
No Maximum	19%	16%	19%
$2500 or More	43%	38%	31%
Less than $2500	38%	46%	50%

Pension Plans
Prevalence of Practice



Charts: Hay Huggins

without need for constant plan revision. On the same hand, it is almost always more expensive than a fixed schedule.

For 73% of reporting organizations in 1979, the lifetime maximum for health care benefits was $200,000 or more, as opposed to 61% in 1978 and only 25% in 1975.

Group dental plans were provided for 50% of respondents' employes in 1979, compared with 44% in 1978 and 24% in 1975. However, only 7% of employers offered vision care plans in 1979, an increase of 1% from 1978.

Maternity expenses were reimbursed on the same basis as other types of hospital confinement by 86% of the 1979 NCC respondents, an increase from the 43% who reported this type of reimbursement in 1978. Similarly, maternity was covered by 72% of disability income plans in 1979, an increase from 54% in 1978.

Some of the plan modifications were attributed to the Pregnancy Amendments to the Civil Rights Act, which require that employe benefit plans treat maternity expenses as other health care needs and disabilities as of April 29, 1979. Some survey participants, however, had not made the plan modifications required during the survey period.

Changes in company life insurance plans were expected to be made by survey participants, because of age discrimination act amendments raising the allowable mandatory retirement age to 70 in January.

However, since the Department of Labor's benefit guidelines under the act were not published until May, survey participants could only express anticipated changes in their plans.

Intending to provide full life insurance coverage to active employes up to age 70 were 56% of participants while the remaining 44% said they would use an allowable percentage reduction schedule for years worked past 65.

A total of 69% of employers that intend to reduce coverage favored an 8% reduction per year after 65, which is in keeping with regulation guidelines.

Although pension accruals may be frozen at normal retirement age, more than 50% of employers had made provisions to increase pension benefits for employes who continue working. Additional service credits would be granted by 20% of survey participants; 21% will count extra years earnings and 12% will increase benefit amounts actuarially because of postponed retirement.

In surveying capital accumulation plans, the survey found real growth only in ESOPs and TRASOPs. Of the shareholder-owned companies that could offer them, 18% noted one or the other, including one firm that offered both. This compares with 16% in 1978 and 6% in 1977.

Thrift plans, on the other hand, leveled off in 1979 with 37% of participants reporting them versus 36% in 1978.

The proportion of organizations with profit-sharing plans remained constant at 23%, but deferred-only arrangements increased to 64% in 1979 from 56% in 1978 while cash-and-deferred dropped to 36% in 1979 from 44% in 1978.

Repercussions of the Tax Reform Act of 1976 are continuing in the stock option plan area. The act requires all qualified stock option plans to be phased out by May 21, 1981. The number of shareholder-owned companies in the survey offering only a qualified plan continues to drop—14% in 1979, down from 19% in 1978. Concurrently, 27% reported only a non-qualified plan in 1979, as opposed to 20% last year. ■

Group life purchase

Group life insurance purchased under new or renewed contracts totaled $12.6 billion in August, compared with $8.26 billion a year earlier. Industrial life insurance purchases were $487 million, compared with $518 million a year earlier. In the 12-month period ending in August, group insurance purchases totaled $131.9 billion compared with $120.6 billion in the comparable period a year earlier, and industrial purchases were $6 billion, compared with $6.3 billion last year.

Revisions being made

Metzenbaum proposal still lies dormant

By JERRY GEISEL

WASHINGTON—Sen. Howard Metzenbaum's (D-Ohio) long-awaited legislative initiative to amend the McCarran-Ferguson Act can't seem to get off the ground.

For months, the Ohio Democrat has said he would introduce legislation amending the 1945 law giving insurers immunity to federal antitrust law in favor of state regulation.

Early this summer, Mr. Metzenbaum's staff circulated a draft copy of his proposed McCarran-Ferguson repeal bill. However, at a hearing this fall on state insurance regulation, Mr. Metzenbaum, in what one insurance industry lobbyist called "the most extraordinary statement I've ever heard at a congressional hearing," said the staff bill did not necessarily reflect his views.

That statement sent his staff scurrying to close whatever gap exists between Sen. Metzenbaum and his aides on the exact form a McCarran-Ferguson repeal bill should take. Revisions to the draft copy bill are now being made, but there is no timetable on when the finished product will be introduced in the Senate, said Metzenbaum aide Sandy Kemp. "The issues are very complex and there are a lot of comments (from insurers) we want to analyze," he said.

The final bill that does emerge, however, is expected to resemble the draft measure, informed sources say. That proposal sets minimum federal standards to ensure full availability and affordability of property/casualty insurance to eliminate possibly unfair discrimination. It targets so-called abuses in personal lines but would interject federal regulation of insurers.

The draft measure would bar joint gathering of expense information and joint claim adjustment expense trends and projections.

The measure would also bar the collection of statistical loss data on age, sex, race and marital status and would prohibit the use of sex distinctions in setting individual policy rates. "Insurance policyholders deserve the presumption of being considered ordinary risks until they demonstrate otherwise by their own actions," said a staff summary of the draft bill.

The bill also forbids insurers to charge higher rates for property insurance because of location. This provision would result in a "radical restructuring" of the classification and territorial systems to reduce the disparity between high loss urban areas and low-loss rural and suburban areas, says Les Cheek, vp-federal affairs for Crum & Forster.

"Frankly, it is an attempt to redistribute income in the insurance mechanism from the haves to the have nots," Mr. Cheek adds.

The measure also would forbid insurers to "refuse to make available, cancel or fail to renew personal property/casualty coverage which it generally provides except in cases where a risk is objectionably uninsurable." The draft bill does not spell out what "objectively uninsurable" means.

Insurers would be prohibited from discriminating in rating because of personal habits, appearance or occupation. "Does that mean alcoholism and drug addiction cannot be taken into consideration with respect to auto insurance rates?" pondered Jim Kimble, counsel for the American Insurance Assn. "It suggests lifestyle information cannot be used in underwriting."

The staff bill would give the states two years to amend their laws to comply with the federal standards. If the state did not comply by then, the federal standards would go into effect and be enforced by the U.S. attorney general.

Every three years, the state would have to recertify its compliance with the federal standards with a new federal agency, the Insurance Regulation Review Panel, which would be located in the Justice Department.

To date, there has been slight interest in Congress in Mr. Metzenbaum's proposal. "I think at this point, Congress's plate is full and Congress isn't feeling the kind of pressure that would warrant their moving in on the insurance business," Mr. Cheek says.

Another insurance industry lobbyist is even more blunt about the possible impact of the Metzenbaum legislation: "It's a hollow threat," noting that of the 535 men and women in Congress, only two, Sen. Metzenbaum and Rep. John LaFalce (D-N.Y.), favor making substantive changes in the system of state insurance regulation.

Even a recent General Accounting Office report that found major shortcomings in state regulation (*BI*, Oct. 15, Oct. 29) failed to stimulate much interest in Congress. At a hearing where GAO officials testified on the report's findings, only two senators—Sen. Metzenbaum and Sen. Strom Thurmond (R-S.C.)—showed up. And Sen. Thurmond made a strong pitch for state regulation, extolling in some detail its purported virtues. ■

Profit cycle to rise in '81: Poll

NEW YORK—The underwriting profit cycle will start to turn up sometime during 1981, most likely in the second and third quarters, says a poll of the 400 Society of Insurance Research members.

But one-fifth of the respondents believe significant improvements will not occur until 1982.

The report also indicates that commercial auto and multiperil loss experience is expected to worsen. The major concerns for property and casualty insurers next year will be underwriting results and inflation. Inflation, operating costs and national health insurance will be major worries for life and health insurers.

The society's membership is composed of insurance research and planning professionals in insurance companies, colleges, government, trade associations and consulting firms. ■

Ill. hearings to study work comp insurers' cost control efforts

CHICAGO—In its attempt to make Illinois workers compensation insurers control rising costs, the state's insurance department and the industrial commission will have week-long hearings to appraise the insurers' efforts so far.

A rate order issued by the insurance department in July stated the insurers' efforts to trim waste in the workers compensation system would have to be evaluated before any future rate changes could be granted.

"These hearings were scheduled so we could get more specific about what insurers should be doing to control costs," said Philip R. O'Connor, acting director of the Illinois department of insurance.

The industrial commission and the insurance department, which share authority over the entire workers compensation system, will look at the extent of cost control measures already taken by the insurers and then try to chart some standards by which to judge serious cost containment performance.

U.S. Fidelity & Guaranty Co., Aetna Life & Casualty Co., The Travelers Insurance Co., Employers of Wausau, Liberty Mutual, CNA Insurance Co. and the Kemper Insurance Group say they will cooperate with the two state agencies in the hearings. They refused, however, to comment about whether they considered the hearings necessary.

"The time has long passed when insurers or anyone else can look upon workers compensation simply as a cost-plus operation," noted Rebecca Schneiderman, chairman of the industrial commission. "Each and every actor in the system—the workers, the employer, the union, the doctors and the lawyers—must accept some responsibility to contain costs."

An attorney for a workers compensation insurer, not domiciled in Illinois called the hearings another opportunity for the insurance department to spin its wheels. "Workers compensation underwriters have been trying to keep a lid on costs long before inflation caused medical costs to climb. We're a step ahead of the department," he said.

The industrial commission and the insurance department have been working with insurers and representatives of employers and workers analyzing issues to be explored in the hearings.

The issues to be considered include methods for monitoring and improving an insurer's development of plans for reemployment of injured workers, prompt payment of benefits and medical expenses and review of those medical expenses. Causes of litigation will also be examined.

Dr. Kenneth Tannenbaum of the Health Systems Group in Ann Arbor, Mich., has been appointed hearing officer. Dr. Tannenbaum has served as special hearing officer in two previous hearings that resulted in setting cost containment standards for nonprofit health insurers.

The hearings will be at 10 a.m. Nov. 26 in Chicago in the auditorium on the lower level of the People's Gas Building, 122 S. Michigan Ave., Chicago, Ill. ■

Rehab report service offered

ATLANTA—Equifax Services Inc. has introduced a new service for insurers or self-insurers requiring a professional evaluation of the rehabilitation potential of disabled individuals.

Rehabilitation Management Service combines comprehensive screening and assessment with an objective appraisal of rehabilitation potential. After studying the recommendations, the insurer has the option of using Equifax's case management services, in which an Equifax specialist acts as liaison between the insurer and the independent rehabilitation facility. ■

Uninsured museum loses $10 million

Photo: Wide World

The Bradley Air Museum in Connecticut, destroyed by a twister last month, is uninsured for the $10 million loss.

WINDSOR LOCKS, Conn.—Tornadoes in New England are almost unheard of, so the Connecticut Aeronautical Historical Society chose not to insure against them.

But the unexpected occurred here Oct. 3 and the society, which runs the Bradley Air Museum here, now wishes it had insurance.

About half of its 60-plane collection of relics from World War II and more recent clashes was destroyed and several more planes were damaged by a surprise tornado that left this city in shambles.

It would cost about $10 million to replace the destroyed aircraft, said society president George Clyde, who, ironically, is an assistant vp at Aetna Life & Casualty Co. in its Hartford home office in personal property/casualty lines.

Purchasing full value insurance would have been too costly, he explained. The premium would have equaled 60% to 65% of the museum's operating budget of $180,000, he said. In addition, a total loss was never anticipated.

Mr. Clyde said he would not be surprised if the directors chose to purchase some insurance for the remaining aircraft as a result of the storm, but added that he doubted it would be for full value.

The society intends to rebuild as many planes as it can and has received offers of assistance from air museums around the country and the U.S. Air Force. Several sources, including the Air Force, have volunteered surplus equipment to help the museum rebuild its collection.

Surplus equipment is a principal source of airplanes for collections of museums like Bradley. But Bradley also purchases some craft and "scrounges" to find others, such as planes that might have crashed and been abandoned somewhere, Mr. Clyde said.

But airplanes that are donated or hauled away from a field do not come without a price tag. Volunteer crews must be sent, sometimes to as far away as Arizona, to dismantle the aircraft and crate and ship the parts to Connecticut.

For a typical craft that could run as much as $15,000, Mr. Clyde said.

In addition, many of the airplanes destroyed at Bradley were one of few of their type remaining in the United States. A B17 bomber of World War II-vintage was one of five left in the U.S., he said.

Extensive damage was done to the plane's fuselage and the museum considers it a total loss, Mr. Clyde said. But Air Force officials who have inspected the craft said it could be rebuilt, he added. ■

Adjusters still probe explosion

COVE POINT, Md.—Adjusters are still investigating damage caused by an explosion at a liquid natural gas substation here last month, but owners of the plant say they don't expect the total loss to go beyond $10 million.

The explosion, which killed one man and injured another, shut down for 13 days a $300 million plant owned by Columbia LNG Co., a Delaware-based corporation that provides electric power to Washington, D.C., and Baltimore utility companies.

The plant has reopened, but is operating at diminished capacity.

Columbia LNG officials said they haven't yet determined the losses caused by damage to the plant and the loss of revenues from the shutdown.

The company doesn't carry business interruption insurance, but it has a $50 million per occurrence property insurance policy underwritten by Industrial Risk Insurers, said Columbia LNG insurance manager Joe Yandoli. The company has a self-insured retention of $25,000, he said.

The amount of benefits to be paid because of the accident weren't available. Mr. Yandoli said the death benefit paid for the man killed during the explosion will equal four times his annual salary.

The explosion at the terminal for Algerian gas coming into the United States, caused by a mechanical failure of a pump seal, prompted an investigation by the National Transportation Safety Board.

Some critics have charged the explosion was the first indication of possible safety problems at the plant, but Columbia LNG officials disputed that suggestion. "If there had been anything unsafe about the way the plant was built, I don't think the NTSB would have allowed it to reopen," said one Columbia spokesman.

But the board's investigation still has failed to satisfy those who wonder how the liquified gas was able to seep from the faulty pump seal to an electrical substation more than 100 yards away by following an electrical conduit between the two points.

Rep. Edward Markey (D-Mass.) has called for a congressional investigation of the accident. ■

Negotiations continue

Lloyd's to resettle tobacco damage claims

By STUART EMMRICH

RALEIGH, N.C.—Lloyd's of London has agreed to resettle claims paid to more than 900 farmers who suffered damage to their tobacco crops because of a herbicide-tainted fertilizer they used. Lloyd's will also continue negotiations with 300 other farmers who refused to accept its estimate of their losses.

The recent concession by Lloyd's, excess insurer for Borden/Smith-Douglass, manufacturer of the contaminated fertilizer, comes after months of complaints over the handling of claims by farmers who contend they suffered destruction of 10% of the state's tobacco crop (*BI*, Sept. 17).

Payments so far to the North Carolina farmers have been estimated at about $15 million and are expected to go somewhat higher. Borden has a self-insured retention of $500,000, company risk manager Russell Drake says. Affiliated FM Insurance Co. covers the next $10 million and an additional $250 million of insurance is underwritten for Borden by Lloyd's of London.

Mr. Drake said he doubts the ultimate losses will reach the $40 million limit on the first layer of the excess coverage.

North Carolina officials recently reported that Borden paid $2 million out of its own pocket to cover some of the losses. Mr. Drake disputed that figure, but he wouldn't comment on any assertions made by the state's insurance department.

The relationship between state officials and Borden and its insurers has been less than cordial these past few months as both sides have tried to settle the matter.

State insurance commissioner John Ingram has said several times he thinks the insurers and adjusters have not been as thorough as they might have been in handling claims, adding at times he thought farmers were being cheated out of payments. Borden officials have said they thought the state's conclusions and statements to the public over the matter have been somewhat less than accurate.

Mr. Ingram is now considering whether or not to revoke Affiliated FM's license to do business in the state because of what he charged were wrongdoings in its handling of claims. He promised a decision within 30 days after hearings on the issue were held in October, but has so far issued no ruling.

The company can at least expect "some sort of disciplinary action," he said last week.

The alleged wrongdoings by the insurance company, including some claims denials that Mr. Ingram charged were unwarranted, spurred the insurance commissioner to press Lloyd's to reopen the settlement process this month.

Farmers who have already been paid for losses to this year's tobacco crop want payments for what they see as damage to next year's crop caused by the remaining presence of some of the contaminated fertilizer in the soil. They also want reimbursement for deductions they contend were unfairly made by Affiliated FM when adjusting the losses.

Farmers of other crops may also be eligible for payments since evidence has turned up that the same fertilizer may be responsible for other damages besides those to the tobacco, Mr. Ingram said.

Lloyd's has also agreed to partially settle with 300 farmers disputing the losses attributed to them "to put money in their pockets now" while they work out an ultimate resolution with insurers, Mr. Ingram said.

Farmers involved in the tobacco controversy have praised the insurance commissioner. "There would have been 1,200 farmers bankrupt," if Mr. Ingram hadn't conducted the investigation of the summer damage, one farmer said.

The farmers are also calling for an overhaul of the state insurance laws to provide a greater regulation of insurers operating in the state.■

OPIC covers political risk

WASHINGTON—The Overseas Private Investment Corp. (OPIC) has provided a political risk insurance package to cover a $75 million oil exploration and development project being undertaken in the Sinai peninsula by Gulf Oil Egypt Ltd., a subsidiary of Gulf Oil Corp.

The Gulf enterprise is the third energy project insured under OPIC's expanded program to encourage exploration for new petroleum sources.

The three petroleum contracts issued to date, including projects in Jordan and Ghana, represent a total insured investment of $145 million.

OPIC is the federal agency that provides political risk insurance to U.S. companies investing in less developed countries to protect the investor against expropriation, currency inconvertibility and physical damage caused by war, revolution or insurrection. ■

Letters column . . .

Continued from page 14

- Generate additional capacity.
- Provide a flexible insurance program for the participants.
- Provide the insurance affiliates with outside insurance.

The two insurance programs undertaken by CIRCL (the primary casualty policy and the first-excess casualty policy) have achieved these goals for their participants without any connotation of the program becoming a "political football."

Richard S. Thompson
President, Corporate Insurance & Reinsurance Co. Ltd., Hamilton, Bermuda

New perspective

To the editor: I have read with interest your Perspective article of Oct. 1, by Bruce E. Dizenfeld concerning the responsibility of all parties toward premium financing.

The author has done an excellent job in summarizing the responsibilities of the insured, agent, financing organization and insurance carrier concerning involvment in a premium financing plan. In particular, his examples have indicated that far too often we exercise the sin of omission in our responsibilities in determining whether or not we have fulfilled our requirements as professionals, regardless of whom we represent—the insured, the independent agent or the insuring organization.

Speaking on behalf of the insurance carrier, we feel it is our responsibility only to receive the premium from the insured through the agent, without determination as to where the premiums are coming from. Perhaps with Mr. Dizenfeld's excellent capsulation of the problem, we will all benefit from his expertise.

Nelson J. Nix
District manager, Lumbermen's Underwriting Alliance, Indianapolis, Ind.

Deep concern

To the editor: I read your editorial opinions of Sept. 17, 1979, "Give buyers more facts," with amazement and deep concern.

You are most condescending when you state, "We'd like to be able to say all excess/surplus operators are honest as the day is long."

It appears because of your editorial position you can act as God and pass judgment discriminatorily as you may interpret a situation. Some serious damage has been done with reflection upon the entire excess/surplus industry.

Your editorial related to your interpretation of the shifty and crooked excess/surplus brokers, yet you deemed it proper to include the reinsurance firm of Pritchard & Baird fiasco. By the same token you could have encompassed the entire insurance industry and you might have found some problems emanating from that area also. Does that mean that all apples in the basket are bad?

There are over 1,000 E/S underwriters in the country, yet by inference in mentioning five brokers you have tarred the entire E/S program.

To say that I'm aghast and appalled in the manner in which you handled this situation is putting it mildly.

Joseph Distel
Past president, American Assn. of Managing General Agents, West Hartford, Conn.

E/S rebuttal

To the editor: I have read your Sept. 17 Excess & Surplus Lines issue with a combination of interest and concern.

I feel that some of the statements therein are somewhat gratuitous and perhaps slanted. I take strong exception to the cartoon on the face page with the heading "E/S Sidewalk Sale." On behalf of my own firm, I find this offensive, and to make matters worse, inaccurate. Although some of the excess and surplus carriers, because of the soft standard market, have been much more flexible in the past year than they were in the tight market of a few years ago, this flexibility and competitiveness should not be misinterpreted by members of the press to involve arbitrary rate cutting. Your comments in the cartoon about "Product Liability - ½ Price" is a total distortion of the E/S market, particularly on small and medium-size risks.

You suggest, on your editorial page, that state insurance departments should require simply (!!!) that "all excess/surplus brokers file annual statements" giving certain certified data. I question why you single out the E/S broker in this regard. You may or may not be aware that your statement regarding "commission and fee volume" may be technically in violation of any regulations and/or law in this regard, in the absence of requiring this same provision of other entities in the insurance mechanism.

Further, you presumably are not aware that premium volume is reported to insurance departments, particularly in the New York state insurance department, on an annual basis by route of affidavits filed each year. In addition, these affidavits are evidence of "specialty lines written," hence your suggestion in the latter regard is totally superfluous as I see it. Until N.Y. insurance law is modified in this regard, which we hope to do, "markets represented" cannot include "nonadmitted carriers."

This is technically in violation of the insurance law; however, I have some personal disagreement on behalf of my firm as to why this provision ever appeared in the New York insurance law. "States in which the firm is licensed" is a matter of public record, as well as the names and background of the firm's principals.

I recognize that the business of *Business Insurance* is to sell the magazine through the medium of provocative articles; nevertheless, I caution you that this should not be done by gratuitous, exaggerated and sometimes inaccurate statements. Freedom of the press, to my understanding, is a relative term by judicial review; this freedom should be circumscribed by restraint and objectivity in all instances. I trust that future issues of your magazine will exercise this restraint to some degree.

Gerard J. Nolan, CPCU,
President, Parkington Associates Ltd. and president, N.Y. State Excess & Surplus Lines Assn. Ltd.

Name wrong

To the editor: Recently two articles have come to our attention which obviously were a mix-up between our company and Bankers Life and Casualty Co. of Chicago.

Our company is a mutual insurance company based in Des Moines, Iowa, and we have no relationship with the many other companies which have "Bankers" in their names. Since we were the first of the Bankers companies and our assets are somewhat like three times more than all of the other "Bankers" companies put together, the confusion is unfortunate. Alas, it happens all the time.

My suggestion is that if you are going to name our company, you use precisely the same name we do in communications, "The Bankers Life of Des Moines."

W.J. Walsh, APR
Director of public relations, The Bankers Life of Des Moines, Des Moines, Iowa.

ERISA standards cover arbitrators: DOL

WASHINGTON, D.C.—Corporations may have to add pension dispute arbitrators to those covered by fiduciary liability insurance because of an advisory opinion issued by the Department of Labor.

The opinion holds an arbitrator liable to the fiduciary standards under ERISA. Although the opinion applies to a specific case and is not an across-the-board ruling, it has upset arbitrators who work with ERISA issues.

"It is going to be a serious problem," said Richard Bloch, executive secretary for the National Academy of Arbitrators. "If someone wants us to come in and arbitrate in a pension dispute, we are going to be very reluctant to take it unless insurance or some sort of indemnification is provided."

Insurers will probably be willing to add arbitrators to corporate fiduciary liability insurance policies, however, explained Robert Lynyak, vp in charge of the fiduciary liability coverage for Chubb & Sons/Federal Insurance Co.

"We haven't been asked yet to cover an arbitrator," he said, "but I think insurers are going to be willing to follow the currents of business and provide coverage if the exposure doesn't appear too great."

The Federal Insurance fiduciary policy already covers anyone "who may be construed as an outside fiduciary," Mr. Lynyak said, and so may already be interpreted to cover arbitrators depending on how the DOL ruling is finally explained.

"Right now it seems that the DOL is only saying that arbitrators should be held to the same standards as a fiduciary, not become fiduciaries," Mr. Lynyak said. "In either case, we can probably do it with a simple endorsement to our present form."

The Labor Department opinion was in response to a request by the board of trustees of a pension trust. Their arbitrator declined to serve until his status was resolved.

The department held that "by deciding a question of a participant's entitlement to benefits under the plan, (the arbitrator) would be acting as a fiduciary under the plan because he would be exercising discretionary authority respecting the management and administration of the plan."

A previous advisory opinion, issued a year earlier by the DOL, stated the arbitrator in that instance was not a fiduciary because he was not exercising any discretionary authority and did not appear to be performing any fiduciary functions as defined in ERISA.

The distinction between the two rulings appears to lie in whether the arbitrator is dealing with the collective bargaining agreement or the trust instrument itself, said Alice Everitt, special assistant in the director's office at the Federal Mediation and Conciliation Service.

"The previous rule of thumb with which we have been guiding arbitrators is that if the arbitrator is dealing only with the collective bargaining agreement, he is 'home free,' and is not administering fund assets," she said.

"Under the later ruling, if the arbitrator is dealing with a question of the trust instrument itself, then he is a fiduciary."

"So far," Mr. Bloch said, "labor arbitrators aren't wild about that sort of liability.

"Most of them feel it is silly to assume that responsibility because they are only interpreting the plan to pull two parties out of a deadlock."

The Department of Labor has no plans to make an across-the-board ruling, a spokesman said. But with their fiduciary status uncertain, many arbitrators are refusing to serve in cases where they may have to deal with ERISA and pension plan questions.

"None of the good arbitrators are taking these cases in light of the DOL's recent ruling," Ms. Everitt said.

Mr. Bloch also said arbitrators are refusing such cases unless they can get insurance.

Both he and Ms. Everitt said the matter is complicated by the fact that arbitrators can't get good insurance on their own.

"No one will insure them," Ms. Everitt said. "Lloyd's of London will, but at a high premium.

"I think that insurance companies are worried about the competence of arbitrators to decide an issue under ERISA," she said, "because the law is so complicated. ERISA arbitration is extremely difficult.

"Nobody ever thought about arbitrators when ERISA was written," she noted. "Arbitrators were not even mentioned.

"Our own position (at FMCS) is that arbitrators are definitely not fiduciaries, for a number of reasons. You have to have a tie-breaker.

"An arbitrator only has an obligation to look to the trust agreement for guidance and not to set guidelines, procedures or standards. An impartial umpire's purpose is to avoid paralysis and to allow the administration of the trust to go forward."

However, she suggested one way out would be for trustees to have a court appoint an arbitrator during a dispute.

She said there is some feeling that if an arbitrator is appointed, he would be considered an officer of the court and not subject to DOL action. ■

RIMS forms new group

NEW YORK—The Risk & Insurance Management Society has formed a special group for new risk managers.

The New Risk Managers Group is open to individuals with five years or less direct risk and insurance management experience who presently hold a direct risk and insurance management position. Members must be employed by a firm belonging to RIMS.

The goals of the new group are to provide peer group interaction and innovation; promote professional education and research; recruit qualified individuals into the field of risk and insurance management; promote involvement in RIMS activities.

The group plans to conduct a yearly seminar in conjunction with the annual RIMS conference; publish a quarterly newsletter; publish "Guidelines to Your New Risk Management Position"; submit results of research efforts for publication in Risk Management magazine, and coordinate summer internships for college students. ■

people

Dommel takes on Fuller responsibilities

James H. Dommel, 43, has been named risk manager for the H.B. Fuller Co. in St. Paul, Minn. He replaces **Donald R. Steffen**, who was promoted internally to a sales position. Mr. Dommel was risk manager for International Multifoods in Minneapolis, Minn. No replacement has been named for him. Mr. Dommel has a bachelor's degree in math and a master's in administration from the University of Northern Iowa. He will report to the controller of Fuller's U.S. division, Gene DeLaune.

* * *

Robert Graham, former insurance administrator for General Dynamics Corp. in Quincy, Mass., has been named risk manager for Riverside County, Calif. Mr. Graham, 42, reports to Robert Fitch, county administrator. He has business degrees from Massachusetts Maritime Academy and Northeastern University. No replacement has been named for him at General Dynamics.

* * *

Edith Lichota has been named manager of insurance and risk management for Kennecott Copper Corp., based in New York, and its subsidiaries worldwide. Before assuming her new position, Ms. Lichota was assistant treasurer of insurance and benefits for Carborundum Co., a subsidiary of Kennecott. She will report to Peter Brengel, treasurer. She has B.A. and law degrees from Case Western Reserve University in Cleveland.

* * *

The Erie, Pa., firm of Zurn Industries Inc. has named **Richard Petrowski** as benefits manager. Mr. Petrowski, who will report to Warren Weber, vp of personnel administration, was previously benefits consultant for Contrcl Data Corp. in Minneapolis. He has a B.S. degree in economics from the University of Wisconsin and a J.D. degree from William Mitchell Law School in St. Paul, Minn. **Angie Guggenberger Nelson** has been named benefits consultant for Control Data. Previously, she was director of medical services and research at Minnesota Medical Assn.

* * *

JoAnn Sullivan has been promoted to corporate insurance administrator at Boehringer Ingelheim Ltd. in Ridgefield, Conn. In this newly created position, Ms. Sullivan will assume responsibility for the financial administration of consolidated reporting of employe benefit premiums for BIL/USA and its subsidiaries. Her duties eventually will include assisting the administration of other aspects of the insurance program, especially the property and casualty areas. Ms. Sullivan will report to Lawrence J. Salerno, director of insurance and safety. Ms. Sullivan previously was a general accountant for the company. She expects to receive a B.B.A. degree in accounting from Pace University in Pleasantville in June 1980.

* * *

Planned Parenthood Federation of America Inc., based in New York, has named **Robert Doyle,** 37, insurance manager. Mr. Doyle, who will report to vp of finance Bert Gibson in his new position, was previously insurance supervisor for Amax Inc. in Greenwich, Conn. He has a B.S. degree in economics from St. Peter's College.

* * *

James B. Clifford has been named manager of benefit operations for the New York-based American Express Co. Mr. Clifford, 36, was promoted to the newly created position after working as a supervisor of financial reports for the company. In his new job, he reports to Margaret Gagliardi, director of employe benefit planning and administration. Mr. Clifford has a B.A. degree in accounting from St. Francis University and a master's in finance from St. John's University.

* * *

Donna M. Crouch has joined Sheller-Globe Corp. in Toledo, Ohio, as risk analyst. She will be responsible for administering corporate insurance programs including property, casualty and group coverages. She attended Stautzenberger College of Business and the University of Toledo. Ms. Crouch previously worked for Questor Corp. and the Lucas County auditor's office.

* * *

Oscar A. Price was promoted to director of corporate compensation and benefits for Sambo's Restaurants in Santa Barbara, Calif. He succeeds **Tom Holgate**, who left the company to join William A. Mercer Inc., a benefits consultant. Mr. Price has been with Sambo's for two years as manager of compensation. He reports to the vp of personnel administration.

•

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to Mary Ann Matlock, Business Insurance, 708 Third Ave., N.Y., N.Y., 10017 or call 212-986-5000. We'd also like to receive pictures of the people involved.

Deductible credit plan introduced

CHICAGO—CNA Insurance has introduced a new money-saving plan for architects and engineers professional liability insurance.

Under the "deductible credit plan," policyholders will be able to save money for the time of the claim. The policyholder may apply the credit to lower the deductible on the claim as much as 50% or lower the premium by purchasing a higher deductible amount.

To be eligible, the policyholder must have earned a current loss credit of at least 10% and have been in CNA's program for at least one year. The amount of the deductible credit will vary from 10% to 50%, up to a $25,000 maximum. ■

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Mexico and U.S. investigate jet crash

Continued from page 1
commonly used in Mexico City and other airports during bad weather.

It's speculated that using the instrument landing system and approach lights of runway 23-Left—closed for repairs—the ill-fated crew failed to complete the maneuver by switching at the last moment over to the parallel runway 23-Right, where they were assigned to land.

Shedding doubt on that scenario, however, was an unconfirmed report by Ramon Alvarez, chief of air traffic controllers for the Federal Aviation Administration's Southwest region.

In Mexico City to investigate the crash, Mr. Alvarez reportedly told UPI the only lights shining when Flight 2605 approached were those on the correct runway. The approach lights on 23-Left were shut off, he said.

"The important thing is that he (the pilot) never should have come down until he saw the runway lights," Mr. Alvarez reportedly said, suggesting the crew did not have the runway clearly in view before attempting to land.

Spokesmen at both the FAA and the National Transportation Safety Board stressed that Mr. Alvarez's opinion is his own and does not reflect the conclusions of either agency.

A public affairs officer in the IAA's Forth Worth office also said Mr. Alvarez had been misquoted. The investigator was unavailable for comment when *Business Insurance* tried to confirm his analysis of the crash.

Total dollar liability from the tragedy will be significantly less than in two recent U.S. air disasters involving an American Airlines DC10 in Chicago and a Pacific Southwest Airlines jet in San Diego, legal and insurance experts say. Those flights were nearly full and carried a large proportion of young businessmen.

Worldwide treaty

Western's flight from Los Angeles to Mexico City carried only 87 persons, including 11 crew members. Called the "Night Owl," the discount flight typically carried many Mexican citizens returning home after a U.S. visit.

The passenger manifesto lists 36 Mexicans, 19 Americans, seven others and 12 of unknown nationality. Two remaining passengers were unaccounted for.

Western Air Lines is expected to invoke the Montreal Agreement to the Warsaw Convention, a worldwide treaty that limits liability to $75,000 per passenger on international flights. This protection, however, does not extend to other entities, including airport authorities and aircraft manufacturers.

In instances of proven "willful misconduct," these limits may be overturned, attorneys point out. The legality of such limits has also been questioned in at least one U.S. court. In a 1967 case, Burdell vs. Canadian Pacific Airways, a Cook County (Ill.) circuit court judge declared the Warsaw Convention unconstitutional, reports John Kennelly, a noted aviation litigation specialist in Chicago.

Higher settlements

Hurtado vs. Superior Court also established five years ago that Mexican citizens have a cause of action against U.S. citizens in American courts in cases of conduct that wrongfully takes life, points out Elizabeth Walker, an attorney with the San Francisco firm of Gerald C. Sterns.

Even without such litigation, however, attorneys for insurance companies say survivors' families may collect more than the $75,000 allowed by treaty. After the Tenerife collision of two jumbo jets in the Canary Islands, for instance, underwriters for the airlines cooperated and some settlements exceeded the limits of the Warsaw Convention, says Los Angeles attorney Paul Engstrom. Amounts also went higher after the crash of a Turkish Airlines DC10 near Paris, Mr. Engstrom says.

The first lawsuit stemming from the crash was filed Nov. 1 in Los Angeles federal court. Mrs. Genoveva Diaz of Los Angeles is seeking $1 million in damages for the wrongful death of her 18-year-old daughter, Martha Montana.

Commercial activity

Attorney James H. Davis, representing Mrs. Diaz, may proceed against Mexican authorities on the basis of a federal statute enacted in 1976, says Robert Wooten, an attorney in the law offices of James H. Davis. The Sovereign Immunity Act permits an American citizen to sue another nation's government if "the foreign sovereign is engaged in a commercial as opposed to sovereign activity," Mr. Wooten says.

Running an airport, Mr. Wooten affirms, is definitely a commercial activity. If a U.S. court rules in favor of the plaintiff, it can order a writ of execution levied against the assets of a foreign power.

Mr. Davis recently invoked this legal rule in an unsuccessful effort to enjoin OPEC from future price-fixing. He failed to establish jurisdiction in the U.S. courts.

The International Federation of Airline Pilots Assn. rates the Benito Juarez airport with a "red star" because it lacks a runway visual range system—a device similar to an electronic eye that enables air traffic controllers to measure visibility at the beginning of the runway.

The federation's most critical rating is a "black star," meaning the airport is critically deficient. A "red star" is the next most serious and an "orange star" the least critical.

There are 250 airports around the world with a red star rating in addition to Mexico City. In the United States, only Los Angeles International Airport carries a black star. ■

Cessna settles lawsuit for nearly $5.6 million

By JOHN MAES

CHICAGO—Cessna Aircraft Corp. has paid close to $5.6 million to the surviving families of the victims of a 1977 crash of a Cessna airplane in a settlement believed to be the largest ever paid in a product liability suit by a general aviation firm.

The payments were made out of court to the families of executives of a Mobile, Ala., freight company who were killed in the in-flight breakup and crash of a Cessna Conquest near Greensboro, Ala., on Nov. 15, 1977.

Cessna's major product liability insurer is Associated Aviation Underwriters with excess insurance underwritten by Lloyd's of London.

Killed in the crash were the president of Mercury Freight Lines, his wife, the company's vp, auditor, the corporate pilot and a Cessna dealer, all passengers aboard the ill-fated plane. Also killed was the Cessna pilot at the controls.

The cause of the breakup was tied to faulty design of the tail, said Broox Holmes, attorney for the plaintiffs. The trimtab actuator maneuvering device on the left side of the plane began causing vibrations, which in turn caused the tail to flutter and break from the twin-engine turbo prop while it cruised at 18,000 feet, Mr. Holmes said.

The victims were on a demonstration flight of the plane, which the company was considering to buy, Mr. Holmes said.

In the subsequent lawsuit, Mr. Holmes said, the plaintiffs contended the accident was because of the faulty design of the trimtab actuator. The suit, filed under the Alabama extended manufacturer's liability doctrine, was settled out of court on the second day of trial.

The accident led to the grounding of all Cessna Conquests for several months. The system was redesigned, and the plane's airworthiness was reinstated by the Federal Aviation Administration.

But last May, there was another incident involving failure of the actuator system and the plane was grounded again. Only a few of the aircraft have been re-certified for airworthiness.

In 1977, Cessna paid a $900,000 award to the family of a San Francisco man killed in the crash of a Cessna. The jury in Reno, Nev., found the company negligent in not providing proper restraint systems such as seat belts or shoulder harnesses. ■

Data processing policy offered

LOS ANGELES—The Allianz Insurance Co. is offering a new all-risk package policy that covers electronic data processing equipment, data, media, extra expense and business interruption.

New equipment is covered up to $250,000 for 90 days after acquisition; equipment moved to a new location is covered for 90 days and up to $250,000 per location, and duplicate and backup data and media stored at a separate location are also covered up to $25,000 with higher limits available.

The new policy is designed for heavy users of EDP equipment such as banks, insurers and manufacturers. ■

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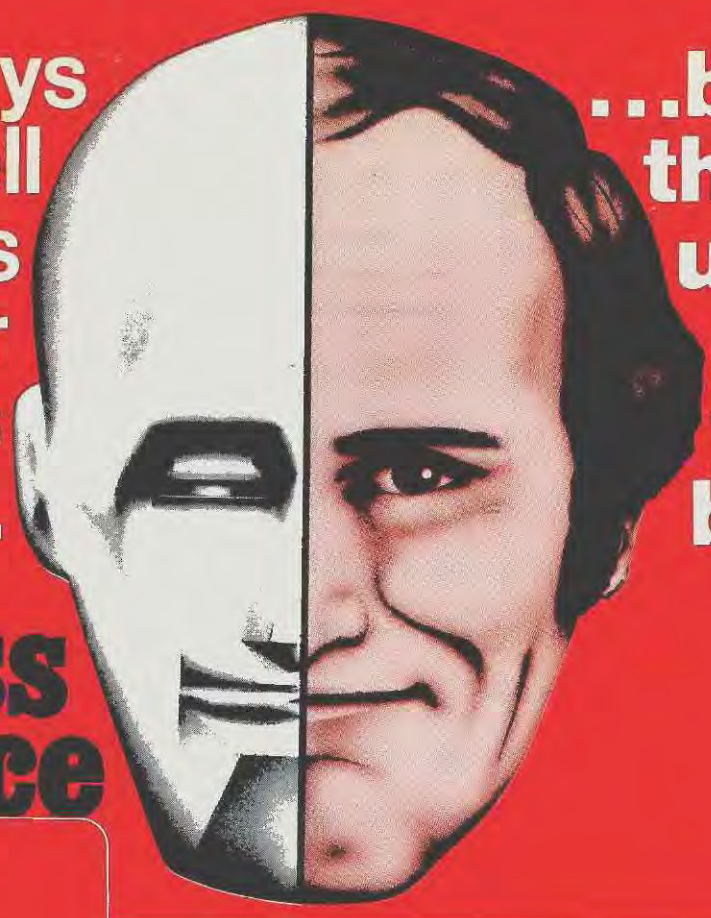

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Registration fee includes admission to all Conference sessions and functions, complete resource materials including a workbook, planned luncheons and reception.

Hotel accommodations and travel arrangements are not included and must be made separately. Registrants automatically receive hotel reservation forms with their Conference confirmations.

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PROGRAM

MONDAY, December 3

8:15 am: Registration. Enjoy coffee, rolls and our display of print materials from the 1979 Business Insurance Employe Benefit Communications Awards Competition.

9:00 am: Creative Benefit Communications—An Overview. Exciting audio-visual presentation by Peter Iversen, President & Chief Executive Officer, Iversen Associates, and John Kerney, Jr., President, Emcom Group Inc.

9:15 am: Creative Benefit Communications—A Marketing Approach. Keith L. Reinhard, Executive Vice President, Director of Creative Services, Needham, Harper & Steers Advertising, Inc., talks about communicating with employes as benefits "customers."

10:45 am: Concurrent Sessions. Attend the one of your choice to discuss specific challenges in depth.

- **Packaging Your Communications—Media And Their Uses.** Judith A. Karam, President, Karam & Versch.
- **How To Avoid Litigation Arising From Language.** Robert W. Ridley, Partner, Forster, Gemmill & Farmer.
- **The Potential For Generic Communications.** John Kerney, Jr. and Robert J. Ellis, Communications Consultant, Eastern Division, William M. Mercer Inc.

12:45 pm: Luncheon/Program Screening. View audio-visual entries to BI's Awards Competition as lunch concludes.

2:00 pm: Daring To Say It Right And Daring NOT To Say It At All. Audrey Zale Cramer, Staff Assistant, Office of Program Operations, and Sarah W. Casseday, Public Information Specialist, Pension Benefit Guaranty Corp., discuss the language of benefit communications.

3:15 pm: Concurrent Sessions. Repeat of morning sessions; attend the one of your choice.

5:15 pm: Reception.

TUESDAY, December 4

8:15 am: Coffee, rolls and review BI competition entries materials.

9:00 am: How To Make A Successful Benefits Presentation. John A. Connellan, President, The Executive Technique, tells how to utilize personal presentations as "selling" opportunities.

12:00 noon: Luncheon/Program Screening. View additional audio-visual program entries.

1:30 pm: The Mechanics Of Putting Your Program Together. Three consecutive general sessions on specific areas of program implementation.

- **Tailoring The Program To Your Company.** Philip Murphy and William S. Miller, Employe Communications Specialists, Emcom Group Inc.
- **Developing The Graphic Approach/Working With Suppliers.** Peter Iversen.
- **Developing A 5-Year Communications Program.** Curtis L. Snodgrass, Vice President, Principal, Towers, Perrin, Forster & Crosby.

4:30 pm: Discussion & Questions.

WEDNESDAY, December 5

9:00 am: You Be The Judge. Herbert Zeltner, Group Vice President, Crain Communications Inc., evaluates communications programs along with a panel of registrants and speakers.

12:00 noon: Adjournment.

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Send a letter of application, resume and three letters of reference to: Reid A. Holland, Assistant Dean, Kirkhof College, Grand Valley State Colleges, Allendale, MI 49401. (616) 895-6611.

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Ullman seeks benefit tax

Continued from page 1
man believes.

"As cost-sharing becomes wider spread, the selection of costlier benefits will certainly be determined by economy, rather than popularity," Rep. Ullman contends. When employes pay a greater share of health care costs, they use the health care delivery system more carefully, deflating the demand for services, he adds.

Hospital groups endorse the proposal as a means of curbing demand for health care services, which they believe is the real culprit in the continuing escalation of U.S. hospital and medical care costs.

"We are positive about the idea. The concept has real merit," says Michael Bromberg, executive director of the highly influential Federation of American Hospitals. "The measure is a way of putting some restraints in consumer demands for health services without cutting benefits."

Effect on NHI

"The measure will add competition by requiring consumers to look at price," observes John Horty, attorney for the Council of Community Hospitals, a Pittsburgh-based trade group.

Since the measure has just been introduced, it is too soon to tell how Congress will react. But some business lobbyists believe the Senate and House may look at the plan more favorably than a huge national health insurance plan.

"There could be a feeling among conservatives and moderate members in Congress that this (establishing benefit limitations through the tax code) is the way to go to avoid national health insurance," says Jan Ozga, associate director of health care for the U.S. Chamber of Commerce.

But Steven Schanes, president of consultants Schanes Associates in San Diego, disagrees. Considering the current fight over national health insurance, he says, it's inconceivable legislation that would inflict monetary penalties on employes with health plans would be passed.

Consultant Kenneth Keene, a senior vp at Johnson & Higgins, believes the Ullman bill has a "zero chance of passage. It's too radical . . . I can't see Congress supporting legislation that would impose taxes on a benefit that goes to millions of voters," he says.

Mr. Keene also wonders if higher co-payments will reduce demand for health services. "When you are dealing with an individual's health, money is no object."

Administrative problems

Major employer groups such as the Chamber of Commerce and the National Assn. of Manufacturers say they are studying the Ullman bill and hope to come up with positions soon. The chamber's Mr. Ozga says the feedback he is getting from members is that the proposal in theory may be a "heck of a good idea," but in practice employers could be hit with administrative problems associated with maintaining two benefit programs.

Theresa Stuchiner, a partner with Kwasha Lipton, the Englewood Cliffs, N.J., consulting firm, also believes the proposal could impose administrative problems on employers and wonders if tampering with the tax code is the right vehicle to control health costs. ■

RIMS adds 3 new chapters, expands international services

NEW YORK—The Risk & Insurance Management Society continued to grow in 1978-79, adding chapters in Northern Alberta, Iowa and North Florida to bring its membership to 3,072, according to the RIMS 1979 annual report.

RIMS' influence on the international scene has been growing as well. The society developed a risk management seminar for the Paris-based International Chamber of Commerce's triannual World Congress in October 1978, and another is in the works for Nov. 15-16 in Paris.

Five RIMS members as well as insurance industry representatives are serving on a committee on insurance problems sponsored by the U.S. Council of the ICC. The panel aims to ease restrictive national policies.

Back in the U.S., RIMS has maintained its liaison with business and industry groups. Members continue to participate on an Insurance Services Office committee to revise the comprehensive general liability policy. RIMS has continued its insurance market liaison meetings with IRI, Sentry, Protection Mutual, Connecticut General and Philadelphia Manufacturers Mutual, as well as the first such session with a broker—Johnson & Higgins.

In addition, RIMS has agreed to perform administrative services for the Captive Insurance Cos. Assn., which include maintaining its membership list and assisting CICA members in planning meetings.

The annual RIMS conference, "Innovation," drew a record number of delegates—2,850.

Risk Studies Foundation Inc., a not-for-profit division of RIMS devoted to research in risk and insurance management, awarded a grant to the Northern California chapter of RIMS and the Society of CPCU for a joint study of captives that will measure how effectively captives have met their objectives. Results are expected later this year. RIMS contributed $13,500 and $15,000 to the Risk Studies Foundation in 1979 and 1978, respectively.

The RIMS balance sheet shows both revenues and expenses on the increase, with total revenues of $1.73 million, compared with $1.47 million in 1978, and expenses of $1.7 million, compared with $1.36 million.

Membership dues brought in $295,032 in 1979, compared with $263,045 the previous year. Publications brought in $403,111, compared with $291,295 in 1978, and the conference received $940,313, an increase from $831,498.

On the expense side, general and administrative costs declined to $202,253 from $203,500 in 1978, and executive referral costs rose to $26,957 from $19,952. Conference expenses increased 36.5%, which the report attributes to increased attendance and the new evening event. Risk Management magazine expenses rose 25.9%; government and industry relations increased 1%; memberships increased 84% and education and schools increased 2.2%. ■

N.J. self-insured or liability

TRENTON—The state of New Jersey is self-insured for liability in the deaths of four elderly patients of the Marlboro, N.J., Psychiatric Hospital who apparently died of food poisoning last week, said Robert Hunt, special assistant for insurance and loss prevention for New Jersey.

In addition to the deaths, 131 other patients and workers became ill at the facility after eating a meal of roast chicken and gravy served at noon on Oct. 28.

Autopsies performed on two of the victims failed to determine the causes of death, although the results were consistent with food poisoning. ■

Unions demand prescription drug plans

Continued from page 1

Airways, Proctor & Gamble and the auto manufacturers have all added prescription drug programs under union pressure in recent years. Prescription drug plans have also been set as bargaining goals by the American Federation of State, County & Municipal Employes for Cincinnati city workers and by the National Oil Bargaining Committee for its talks with the oil industry.

Of Blue Cross/Blue Shield subscribers, 9.5 million have the prescription drug program compared with 30 million who only have coverage under major medical plans. The drug benefits, which usually include employe copayments of 50 cents to 75 cents, have been showing "steady growth" in the last few years, a Blue Cross/Blue Shield spokesman said.

Although the amount of out-of-hospital prescriptions paid by private health insurance—a drug plan growth indicator—reached only 8.1% in a 1976 survey conducted by the Social Security Administration, that result is almost double the one reported in 1970.

Prescription drug programs are different than most insurance programs because there is no danger of a catastrophic loss the company needs to protect the employe from, consultants say.

"The need for this insurance is not one of risk avoidance," says Richard Ostuw, William Mercer vp. "It is simply to provide the employe an administrative benefit and get these things paid."

Predictable costs make the plans attractive to employers. An average family can expect to run up a pharmacy bill of perhaps $5 four or five times a year.

Prescription drug plans, however, are far from a hot ticket item in the field of employe benefits. While the much more visible dental care programs were added to or expanded in 19% of all health and benefits plans in 1978, the drug programs were only added to 5% of the plans, according to the Bureau of National Affairs.

And there are those who say they might be more trouble that they're worth.

"It is nothing more than a pain. It is a nickel and dime benefit," says Richard Kroczynski, manager of employe benefits at Uniroyal. Although he says the company "has no problem with it," he concedes it is a less than attractive benefit from the standpoint of the employer and probably would never have been added to benefit plans if the union had not forced the issue.

James Harlow, senior vp at Johnson & Higgins, says the prescription drug plans—which he concedes have some merits—will probably never be added to employe benefit packages unless a union really pushes for them.

Stumbling block

"It is going to be done where required and negotiated. It will not be done voluntarily by employers," he said, adding he thought the next few years would bring a continuing gradual growth in the number of plans.

The biggest stumbling block to the programs is the high costs involved in administering them. Pharmacies pay between an extra 19 cents and $1.86 to process claims for the drugs paid through insurance programs, say some estimates.

A recent survey by the Health Information Designs Inc., sponsored by the American Pharmaceutical Assn., reported there were at least 16 extra administrative functions required in filling prescriptions paid for through insurance programs, compared with direct payments, and that the average cost to the pharmacy for completing these functions was $1.67 per prescription.

The report shied away from recommending that any specific surcharge be added to the cost of prescriptions because of this expense, but said pharmacies need some relief, both from the additional expense and paperwork involved.

The pharmacists' average fee to fill a prescription is estimated at $2.60 by the Pharmaceutical Manufacturers Assn.

The cost of a prescription drug program varies depending on the method of operation.

Mr. Kroczynski says Uniroyal has to pay the insurer of the program 59.7 cents for each prescription processed.

Two methods

"It is really kind of a nonsense benefit when you look at the high administrative cost involved," says Mercer's Mr. Nossan. "The employes file for everything they can, every $2 or $3 claim, so the administrative expense can get fairly high."

But the administration is the secret to making these plans work, notes Mr. Harlow of J&H. "If you can set up a program so that claims can be paid off en masse, it is a good benefit."

Two general methods are most widely used in administering the prescription programs:

- An ID card an employe brings to a participating pharmacy allows him to buy a prescription for a $1 or $2 charge. The rest of the bill is then sent to the insurer of the program by the pharmacist for reimbursement.
- An employe fills out a reimbursement form after he has purchased his prescription for a return of about 75% of his cost. Some supporters of the plans recommend this option as an incentive to keep costs down.

Both plans work best, benefit consultants say, if a large number of employes are located in the same general area and several local pharmacies agree to provide the service at discount rates.

Other employers have found alternatives to the high cost of administering the program by using mail-order houses where possible. **(See related story.)**

Some firms place a cap on the amount of benefits paid out during a year or on the dispensation of medication for illness. A standard limit is a 30-day supply for one medication.

Others limit certain types of prescriptions; birth control pills, for instance. The drug plans also do not pay for prescriptions administered by hospitals because those are covered under major medical insurance plans.

Employe contributions to the insurance premiums are extremely rare, although most plans have some sort of cost-sharing requirement when prescriptions are filled.

Uniroyal leads the way for prescription plans

NEW YORK—Uniroyal is practically the grand old man of prescription drug plans.

For the past five years, the firm has been offering two prescription drug programs to its hourly wage employes and some salaried employes.

Under a program administered by the Metropolitan Life Insurance Co., Uniroyal employes use an ID card to purchase for only a $1 copayment prescriptions at one of a network of local pharmacies. The pharmacist keeps the $1, sends a bill to Metropolitan that includes the cost of the drug and an additional service charge for dispensing the medication, typically $1.25.

Uniroyal reimburses Metropolitan for the full cost of the prescription and the pharmacist's fee and also pays the insurance company an additional 59.7 cents for each prescription order it administers.

In 1974, however, the company started a pilot program to see if it could cut costs. The new option allowed retired wage employes to waive the $1 copayment if they used a mail-order firm for their prescription drugs. The program was limited, however, to maintenance drugs because of the time involved in shipping.

A year and a half ago the company looked at the figures from the program and saw it was "saving an amazing amount of money"—more than 5 cents per every pill purchased.

Buoyed by the savings, Uniroyal opened the program to all wage employes as an option and last month added the 2,500 salaried employes who had been on the Metropolitan drug program.

Employes have the option to use either plan, the mail-order house for maintenance drugs and the Metropolitan plan for immediate purchases.

"They save the buck and even pay for the postage," employe benefits manager Richard Kroczynski said of the new program.

The company realizes savings because the Pennsylvania mail order house, Pastor's, deals in great volume and because an estimated 35% of its drugs are generic brands, he added.

Plans such as the one followed by Uniroyal often have some restrictions. Uniroyal, however has no overall limit on benefits, but does put a 100-day supply limit on prescriptions.

Safety award competition open

CHICAGO—The National Safety Council and The Hartford Insurance Group are jointly sponsoring a safety competition leading to cash prizes for the best papers presenting new accident-reduction techniques.

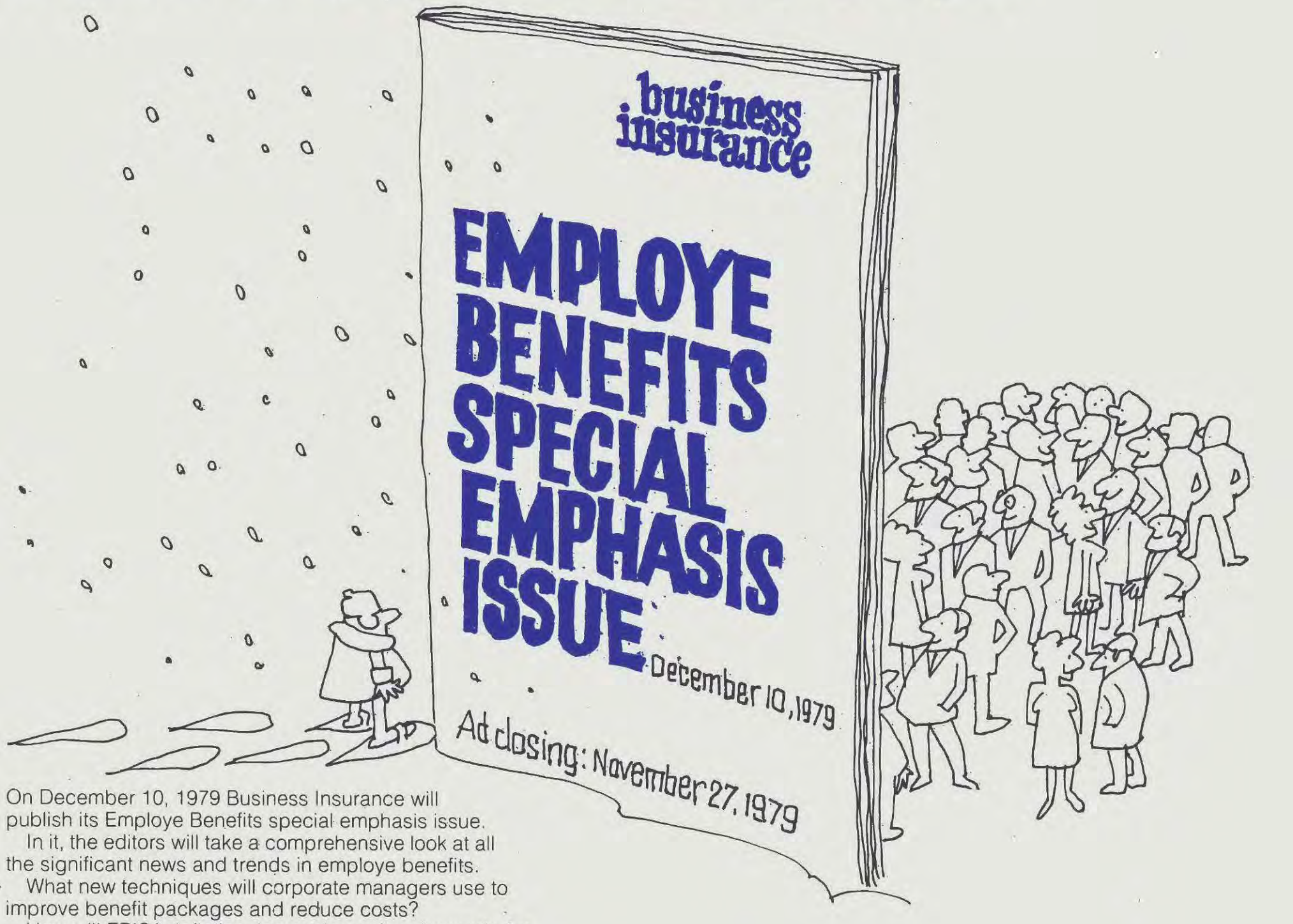
The Hartford has put up a grant of $600,000 to finance the competition being organized by the National Safety Council. A total of 77 cash prizes will be awarded to winners of the safety competition, including three national prizes of $15,000, $12,000 and $10,000. Awards will be presented at the National Safety Congress here in October 1980.

Entries for The Hartford Loss Prevention Awards Competition are being accepted by the National Safety Council through May 1, 1980. Anyone is eligible to enter. Entries must be maximum-1,500 word papers about any commercial or occupational safety problems except traffic safety. Papers may describe programs, procedures techniques or any other aspect o techniques or any other aspect o safety management. The judges will choose three national winners along with first, second and third place winners in each of eight geographic regions who will win $1,500, $1,000 and $750 respectively, and 50 other merit award winners winning $250 each.

The Hartford Insurance Group and the National Safety Council have established criteria for entries in the competition.

Entrants must prepare submissions on the authorized entry form which may be obtained from Administrator, The Hartford Loss Prevention Awards Competition The National Safety Council, 44 N. Michigan Ave., Chicago, Ill 60611.

When the employe benefits marketplace gets together this December, don't be left out in the cold.



On December 10, 1979 Business Insurance will publish its Employe Benefits special emphasis issue.

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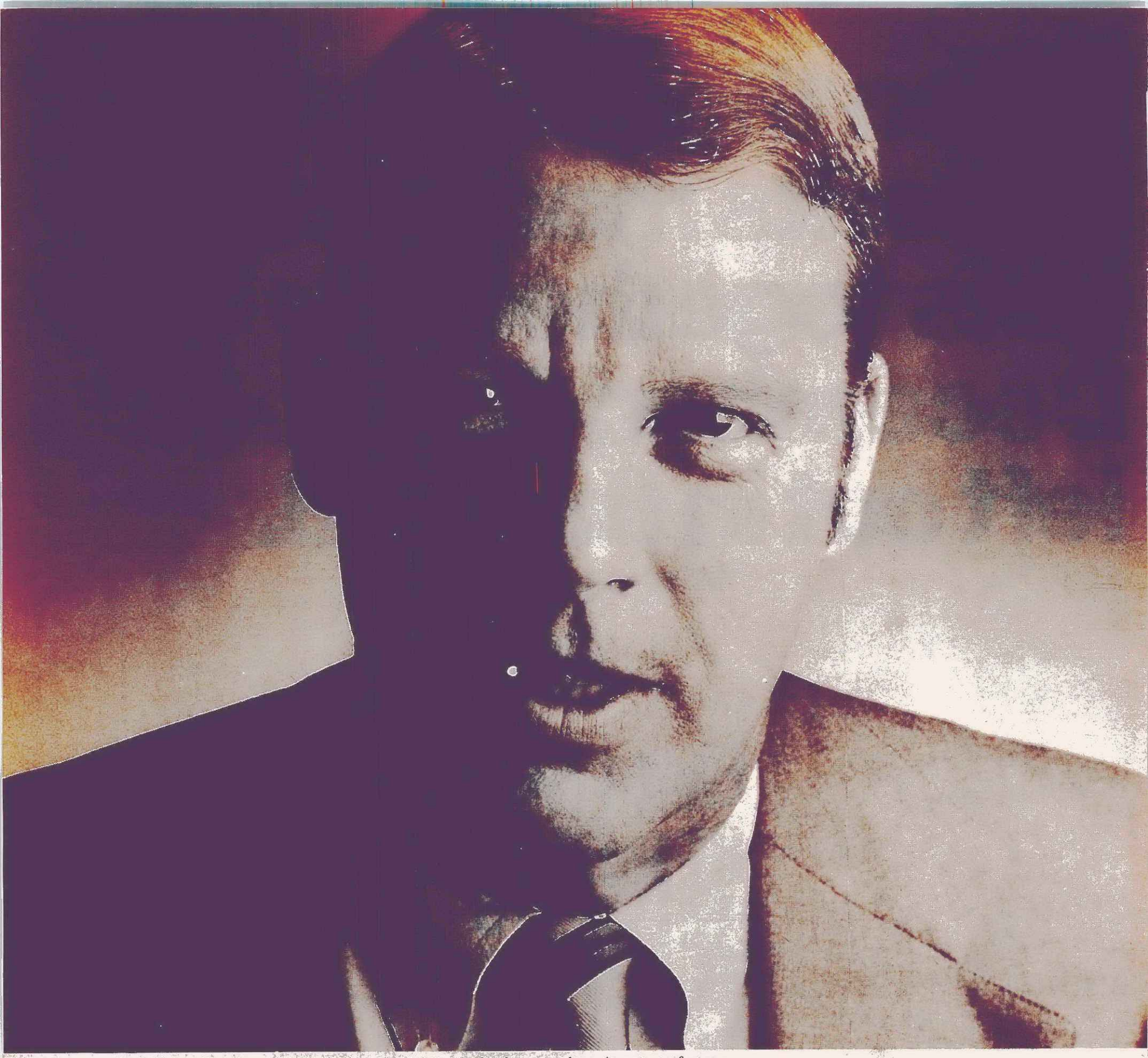

Jack Bogardus, president, tells how A&A works from a client's point of view:

"If we're going to help clients protect current assets and safeguard future growth, we must be a full-fledged member of their financial teams."

"The business of managing corporate risks is in a state of constant change. Our response to this volatile environment is an ever-deepening commitment to act as extensions of our clients' financial departments. The challenge we face together is how best to ensure the client's business growth as emerging economic, technological, legislative and social forces come into play. To do this, we developed several highly sophisticated, computer-based techniques. Their applications are complex, but the result is simple: they help enhance the client's bottom line—now and in the future. And that's what we think our value as a team member is all about."

Working from a client's point of view is our way. From our top management to the men and women in over 110 cities here and overseas. That means working as allies, solving business problems together.

We think our dedication to acting as an ally of the clients we represent is a big reason why A&A has become a worldwide leader in the insurance and financial services business. We have the facilities, expertise and strength to act as effective allies. We work from a client's point of view, whether the corporation is large or small.

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