Task force report: Are actions recommended?

By JERRY GEISEL

WASHINGTON—Two days after the government released its massive final report on product liability, Victor Schwartz, the law professor who directed the study, was elbow deep in a controversy, trying to explain that the report's conclusions are not recommendations.

"The wording of the report is very careful," Mr. Schwartz said in a wide-ranging interview with *Business Insurance*. "It comes to conclusions, sometimes it gets fairly bold. But it never says: 'Congress, tomorrow you should do this. State legislatures, you must do that.' "

Despite that disclaimer, those "conclusions" are often indistinguishable from recommendations. For example, in discussing a possible statute of limitations against liability for consumer products, the report says: "Again, one would begin with limiting the manufacturer's responsibility in tort law to a 10-year period from the time of sale."

"If that isn't a recommendation, then I'm going to go back to school to learn how to read again," said the legal counsel for a large trade association.

When the confusion surrounding the recommendation-conclusion con-

Continued on page 57

Victor Schwartz: "With this report as a base, the states shouldn't be engaging in expenditures of large amounts of money to study product liability."

Doctors urge boycott over cost control plan

By KATHRYN McINTYRE ROBERTS

LANSING—Michigan State Medical Society is recommending that doctors in the state stop participating as full-service doctors with Blue Cross/Blue Shield.

The Michigan doctors voted to boycott participation agreements when the Blues declined to delay new reimbursement and cost control programs.

The doctors object to providing vision and hearing care according to provisions of the new United Auto Workers contracts with the big three automakers that the Michigan Blues agreed to service. The contracts allow full coverage only when treatment is rendered by participating physicians.

The doctors also object to the Blues' decision to deny non-participating doctors the benefits of improved payment schedules to take effect in January. And they oppose meeting targets for maximum physician spending beginning next year.

The Michigan medical society's action, coupled with developments in Indiana and Massachusetts, suggests doctors will reject cost control measures that steer patients to participating physicians or compel doctors

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Self-funded METs

Labor limits trusts' use of commissions

By GREG DAVID

CHICAGO—The U.S. Labor Department said this month that a common business practice of self-funded multiple employer trusts violates the pension reform law. The announcement could be a crushing blow to the trusts' flickering hopes for survival.

Pension and welfare plans administrator Ian D. Lanoff said the Employe Retirement Income Security Act (ERISA) prohibits spending employe benefit plan contributions on commissions to agents soliciting new members for the plan.

Prohibiting commission payments would cripple most self-funded multiple employer trusts, which pay commissions to agents who solicit employers to join what they argue is an employe benefit plan. State insurance officials argue that what is formed is an unauthorized insurance company.

Claude J. Dorais, a Beverly Hills attorney who has emerged as a leading spokesman for self-funded trusts, termed the Labor Department announcement in a press release "a serious matter."

"The press release represents an indication from the head of the primary regulatory authority, to which the self-funded multiple employer trusts claim to be subject, that a common practice is a violation of ERISA," he said.

Another lawyer involved with self-funded trusts said, "back to the drawing boards," when told of the announcement.

Mr. Dorais is the attorney for the organization of self-funded multiple employer trusts, the National Assn. of Trust Administrators. Mr. Dorais would not disclose what recommendations he made to the association's members.

However, another source said that Mr. Dorais warned the self-funded trust administrators that continued payment of commissions

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The inside story

Risk Manager of the Year

Ten outstanding insurance company executives and risk managers have agreed to serve on the panel that will choose *Business Insurance's* Risk Manager of the Year. Included are the president of Kemper Insurance Cos., two brokerage firm chiefs and several top-notch risk managers. **Page 2.**

- RISK MANAGEMENT consultants have insurance problems, too. **Page 6.**
- INSURERS AGREE not to cancel government liability policies in N.J. **Page 10.**
- BLACK-OWNED brokerage firm beats out M&M for part of Control Data's business. **Page 12.**
- CONSUMERS UNION calls for a new medical malpractice system. **Page 14.**
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- ARSON COSTS consumers and business $2 billion a year. RiskWatch, **page 23.**

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business insurance

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

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Mattel, M&M settle complex D&O lawsuit

By JOANNE GAMLIN

LOS ANGELES—A tentative settlement this month ended the complex lawsuit pitting Mattel Inc. against Marsh & McLennan, the toy maker's former broker for directors and officers insurance.

The settlement came as Mattel was concluding its case, depriving defendant Marsh & McLennan of the opportunity to present its witnesses. The lawsuit involved the renewal of Mattel's directors and officers insurance in early 1973.

Although the dollar amount of the settlement was sealed by the court, *Business Insurance* learned the final figure involves compromise by all parties to the lawsuit—Mattel, Marsh & McLennan, Unigard Mutual Insurance Co. of Seattle and International Surplus Lines Insurance Co. of Chicago (ISLIC).

It is believed that Marsh & McLennan and the two insurers, who participated in the D&O coverage for Mattel, will all contribute to the settlement. Informed observers say the settlement is considerably less than the $83 million in compensatory damages plus interest and $10 million in punitive damages demanded by Mattel.

In a prepared statement before the settlement, M&M denied Mattel's charges and said it expected to be exonerated after its side was heard.

In addition to the company, M&M senior vp Tom Tily and vp John Fox were named as defendants in the suit.

The origin of the lawsuit can be traced to 1975 when Mattel agreed to pay $30 million to settle five shareholder lawsuits charging Mattel had falsified its books in an effort to inflate its stock.

As part of that agreement, Mattel's three D&O insurers—Lloyd's, Unigard and ISLIC—agreed to provide $13.8 million toward the settlement. While claiming they were not informed of a class action suit filed two days before they agreed to participate in Mattel's D&O coverage, Unigard and ISLIC agreed to honor the D&O policies and eventually pay $7.1 million toward the settlement.

Since Unigard and ISLIC agreed to honor their policies, Mattel agreed to sue Marsh & McLennan charging the broker failed to tell the U.S. insurers of the shareholder suit filed March 12, 1973. The two U.S. insurers would have been excused from the $7.1 million payment if Mattel's suit had been successful.

Mattel charged in its opening statement that the Los Angeles office of Marsh & McLennan, driven by fear of competition from a local broker, practiced a policy of concealment from January to June 1973 while renewing Mattel's D&O policy. The concealment injured the two insurers, Mattel charged.

Marsh & McLennan countered the charges by saying that Mattel was a problem risk for D&O coverage in early 1973. In its opening statement, M&M said that "Mattel in 1973 had been the subject of a class action lawsuit that had been filed in late 1972. Mattel, on February 5, 1973, sent forth a press release saying that 'earnings are going to be good; business had turned around and we are in good shape.' Mattel . . . on February 23 . . . of that same month said, 'Whoops, things are not so good. We are going to suffer a loss this year.' "

Most of the witnesses put on the stand by Mattel were current and former Los Angeles office Marsh & McLennan officials.

Mr. Tily, the second M&M witness to be put on the stand by Mattel, said during his testimony that the Los Angeles office of M&M earns approximately $10 to $15 million a year in commissions and is the third largest M&M office in the country with about 450 employes.

It was also brought out during Mr. Tily's testimony that the Los Angeles office commission income

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The key figures in this case are:

- **MATTEL INC.**, the toy manufacturer, which needed to renew its D&O coverage in 1973.
- **MARSH & McLENNAN**, Mattel's major broker, which put together the toy company's D&O coverage.
- **LLOYD'S OF LONDON**, which carried most of the primary risk on the Mattel D&O policy.
- **UNIGARD MUTUAL** Insurance Co., one of Mattel's excess D&O insurers.
- **INTERNATIONAL SURPLUS** Lines Insurance Co., Mattel's other excess D&O insurer.

10 eminent insurance leaders agree to choose Risk Manager of the Year

Kemper

Smith

CHICAGO—Ten outstanding insurance executives and risk managers have agreed to participate as judges in the first annual *Business Insurance* competition for Risk Manager of the Year. The award, instituted as part of the newsmagazine's 10th anniversary celebration, is to honor excellence in the practice of risk management.

The panel of judges choosing the first-time winner of the award includes four present or former risk managers, including Thomas V. Hallett, risk manager for Pittsburgh-based Joy Manufacturing Co.; Don M. Stuart, insurance manager for Toronto-based Canada Packers Ltd.; A. Grant Whitney, risk manager for Belk Stores in Charlotte, N. C., and Waller Smith, retired risk manager for United Airlines now serving as vp of Rollins Burdick Hunter Co. in Chicago.

Representing the consulting profession is George Betterley, president of Betterley Associates in Boston, a leading risk management consulting firm. Dr. John Hall, chairman of the department of insurance at Georgia State University in Atlanta, will represent the academic community.

From several leading insurance brokerage firms comes Robert C. Nevins, president of Dinner Levison Co. in San Francisco and Allen Middleton, president of J. H. Minet & Co. of Canada.

Rounding out the panel of judges are two highly respected underwriting executives: James S. Kemper Jr., president of Kemper Insurance Cos. in Long Grove, Ill., and Therese A. Maloney, vp and assistant manager of national accounts for Liberty Mutual Insurance Co. in Boston.

Business Insurance hopes to draw candidates for the Risk Manager of the Year award from among the ranks of thousands of corporate managers responsible for controlling the risks and buying insurance for their organizations, even though they may not have the actual title of risk manager.

Nominations, which can be submitted by any reader, can include risk and insurance managers from small and medium sized firms as well as large companies. Nominees can be any age and do not need to have practiced risk management for any minimum length of time.

Judging for the competition will take place after Dec. 31, the cutoff date for submission of nominations, on the basis of the following 10 broad but definitive guidelines for assessing the excellence of the nominees' performance:

- The winning risk manager will have the technical expertise that affords a solid grasp of operational aspects of the risk management job.
- Our winner will have tackled and solved one or more major problems for his or her organization.
- The outstanding achiever will have been innovative in the application of the diverse tools of risk management and insurance.
- An outstanding risk manager will have effectively shielded his or her employer from unpleasant surprises.
- The Risk Manager of the Year will have approached and used the insurance markets creatively and effectively.
- This person will have implemented an effective risk manageagement and insurance program at the optimum cost over the long term.
- The program implemented will have included all aspects of good risk management.
- The winning risk manager will have a working knowledge of management principles, with the skill to have applied these principles effectively within the organization and/or within the risk management department.
- An outstanding risk manager will have established good working communications both within and outside the organization, affording an information flow from managers, colleagues, brokers and insurers about events impacting on the practice of risk management at his or her respective company.
- The Risk Manager of the Year will have fostered the advance of the risk management profession and its methodologies in a manner that establishes this person as a leader and pacesetter worthy of emulation by others.

Nominees don't necessarily have to fulfill all of these criteria, although the broad guidelines provide a profile of accomplishments within which performance can be measured. Individuals who've excelled in any one area, or who are worthy of recognition in several but not all of the 10 areas, will be considered by the judges.

To nominate your candidate for Risk Manager of the Year, send a signed letter on your business letterhead before Dec. 31 to Susan Alt, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611. Along with your candidate's name, we'll need all the pertinent details about your nominee, including career statistics, a discussion of your candidate's present job and the responsibilities it encompasses.

Accompanying the letter should be a nominating statement in which you explain why and how your candidate meets or exceeds our 10 standards, with as much documentation as possible.

The nominating statement shouldn't exceed five pages in length, although it needn't be that long. You may submit additional backup documentation on no more than five additional pages, including a clear explanation of the relevance of supporting materials. ■

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the benefit beat

Can firms up pension contribution in new pact

FOUR OF THE nation's largest can manufacturers have agreed to raise their monthly contributions to pensions by $1.50 as part of a recent settlement with the United Steel Workers. American Can, National Can, Continental Can and Crown-Coke Seal will raise the minimum contribution to $12.50 with an additional $1 increase in 1979. Benefits for workers who retired prior to Feb. 1, 1974, will be increased by $15 per month; as of Jan. 1, 1978, the cap on "rule of 65" benefits will be 85% of pay for workers with 30 years service plus 1% for each additional year to a maximum payout of 100% of wages.

Other pact features include a $2,000 increase in death benefits, free chemotherapy treatment, vision and dental care plans and psychiatric care benefits increased to $600 from $400. Major medical limits rise to $30,000 per year and $50,000 lifetime from $10,000 and $20,000. Survivor income benefits go up from $100 to $107.50 per month. Sickness and accident benefits were increased by $15 per week as of Nov. 1. The new rates range from $152 to $200 and additional $12 increases are planned for March 1, 1978, 1979 and 1980. Workers with 10 years service will be eligible for two years guaranteed supplemental unemployment benefits and three years unguaranteed benefits; workers with two to 10 years service will be entitled to two years unguaranteed benefits. Employes with 20 years service can retire under the rule of 65 if forced out of work by a plant closing. Wages will go up by an average $1.09 per hour over the contract's life; can industry workers currently average $7.57 per hour.

WESTERN ELECTRIC Co. Inc. has switched insurers to the Travelers Insurance Cos. from Blue Shield and Equitable Life Assurance Society. Travelers will provide the health package, which includes surgical, medical, major medical and medicare supplement at a premium of $55 million for Western Electric's 180,000 employes and their dependents. The two former carriers were dropped so that benefits could be consolidated under one company, said J. E. Twomey, secretary of the employe benefits committee at Western Electric. The change was made for efficiency, for Travelers's competitive price and because of Travelers's success in administering similar programs for other Bell System companies, Mr. Twomey said.

Under the surgical-medical portion of the health plan, Travelers will pay 90% of reasonable and customary fees for medical, surgical, laboratory and x-ray services. The major-medical portion has an unlimited maximum for all active employes, but will be subject to a deductible of one percent of the employe's basic annual salary, with a $25 minimum and a maximum of $150. Benefits have not changed by switching carriers, Mr. Twomey said. All claims will be processed at a central location in Greensboro, N.C. Johnson & Higgins is serving as consultant for the transfer of coverage from Blue Shield and Equitable.

KAISER-PERMANENTE health plan, serving 3.25 million people in six states, has received federal qualification as a health maintenance organization. Inclusion of Kaiser has boosted the number of federally qualified HMOs to 47 and the serviced population to 3.8 million from 615,000. Kaiser provides prepaid medical services in California, Colorado, Ohio, Oregon, Washington and Hawaii. Its application for federal qualification took six months to prepare, weighed over 600 pounds and when piled high stood almost six feet tall, HEW secretary Joseph Califano noted in a speech announcing Kaiser's addition to the federal fold. But HEW is streamlining the qualification process, the secretary said, by consolidating government regulation of HMOs under a director of health maintenance organizations, by issuing new regulations governing grants and loans and Medicare and Medicaid contracting and by developing guidelines for state and local planning agencies to encourage HMO development and expansion.

In addition, Mr. Califano announced he will invite the nation's 500 largest corporations to a conference in Washington on Feb. 7 to urge them to offer membership in HMOs to their employes. The conference will also give corporate executives an opportunity to cite problems with HMOs. Mr. Califano, however, heartily endorsed HMOs as a cost-saving health care system providing a quality of care "often exceeding the quality of fee-for-service care by an individual doctor." To back up his assertions, he cited statistics detailing less hospital use by HMO participants—such as Kaiser's northern California participants who use hospital days at a rate less that half that of the general population of the state.

LEGISLATION REQUIRING corporations to offer pregnancy benefits won't be considered by a House committee until early next year. Rep. Augustus Hawkins had hoped to get the bill out of his House employment opportunities subcommittee and to the floor this year. But delays in passing minimum wage legislation pushed back the committee's time table for consideration of the pregnancy bill (H.R. 5055), staff members said. A bitter fight is expected next year over a provision that would prevent employers from reducing their fringe benefits to pay for the cost of including pregnancy benefits in their employe benefit plans. The Senate, which approved a pregnancy benefits measure this fall (S.995), adopted a one-year freeze on benefits. After that employers could reduce their fringe benefit plans to pay for the pregnancy benefits.

TAX REFORMS which would slash the tax-free limit on life insurance, eliminate tax deductions for prepaid legal insurance and lower maximum pension contributions has been delayed. At a press conference last month, President Carter said his tax reform package won't be submitted until next year. Administration sources reacted to Congressional

Continued on following page

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Benefit beat . . .

Continued from preceding page
pressure that Congress would not have the time this year to consider tax reform.

AMERICAN FLINT GLASS workers won improved insurance and pension benefits in a new three-year contract with 13 manufacturers represented by the Glass Packing Institute. The major medical benefit for 4,000 workers was increased to a lifetime maximum of $250,000 from $50,000 with $2,000 automatically restored annually. Hospital and surgical charges for maternity care for up to five days will be paid the same as in non-maternity cases. Previously the limit was $500. X-rays, laboratory work and radioactive therapy will be paid at reasonable and customary charges instead of to $250. Coverage for miscellaneous hospital charges was increased to $2,000 for 150 days from $1,000 for 120 days.

Children's treatment will now be covered from birth instead of after 14 days and until age 25, if they are unmarried and attending school full time. The lifetime orthodontic treatment benefit was doubled to $1,000, payable at 50% of reasonable and customary charges. Coverage for a hearing aid every 36 months, vision care and second and third opinions on surgery were introduced.

Pension benefits for those retiring during the contract term were improved by a schedule change in the benefit per month that is multiplied by years of credited service for the monthly benefit. Workers will be awarded $11 to $14 per month depending on their labor grades instead of a flat $10 multiplier to determine the benefit.

BABCOCK & WILCOX this month will implement two changes in its benefit program for salaried employes and two new communication efforts. The company will offer a formal salary continuation program providing two weeks of salary for each year of service up to a maximum of 13 weeks. Employes with less than 13 weeks of service will receive 50% of salary. Babcock & Wilcox is also adding a long term disability plan underwritten by the Travelers Insurance Cos. with the cost paid entirely by employes. Over 10,000 of the 12,000 eligible employes enrolled in the LTD program which provides 60% of salary up to a maximum of $5,000 a month. A disability retirement plan remains in effect.

Employe benefit manager G.E. Woodmansee also said the company will begin distributing individual benefit statements to salaried employes. The statements are being produced by Benefacts, a division of Alexander & Alexander. And a 15-minute audio-visual presentation on benefits is being sent to all field locations.

GETTING ERISA back on the track will be the objective of legislation Sen. Harrison Williams (D-N.J.) intends to introduce next year. One of the original authors told the American Council of Life Insurance that a key to solving the long term problems of ERISA would be the consolidation "of the current ERISA responsibilities of the three agencies (Labor, IRS and Treasury) into one place." Sen. Williams also said consideration should be given to adjusting or amending ERISA's preemption of state insurance laws.

PBGC'S REQUEST to delay the date when it will be required to insure retirement benefits for multi-employer plans has been approved by the House. Under the measure (H.R. 9378), mandatory coverage would not begin under the Pension Benefit Guaranty Corp. until July 1, 1979, an 18-month delay. In asking for the extension, Rep. John Erlenborn (R-Ill.) warned that PBGC might have to assume as much as $350 million in liability for pensions plans that will terminate once coverage is available. The idea is to avoid this staggering liability by giving PBGC 18 months to work out a long term solution to the problem. A similar bill is pending on the Senate floor.

Meanwhile, The House has approved a resolution (H.C.R. 369) raising the premium for termination insurance for single employer plans to $2.25 per participant from the current $1. A measure raising the premium to $2.60 per participant is exepected to reach the Senate floor soon.

CONGRESS IS MOVING steadily toward increasing Social Security taxes to bail the system out of a future bankruptcy, but the House and Senate disagree on how to do it. A bill passed by the House would increase the tax rate and the maximum taxable wage base equally for employers and workers. The maximum taxable wage would be increased to $42,600 in 1987 from the present $16,500 and the tax rate would be hiked to 7.1% from 5.85%. The corresponding cost to employer and employe on the highest taxable salary would be $3,025 each in 1987, up from the present maximum of $985. Under a bill approved by the Senate, employers would pay taxes on a higher wage base than employes. Employers would pay taxes on wages up to $50,000 in 1979 and $75,000 in 1985 while employes would pay taxes on $30,300 in 1985. Under the Senate bill the tax rate would increase to 6.135% in 1979, 6.6% in 1981, 6.65% in 1982, 7.05% in 1985. Additional increases would bring the rate to 9.2% by 2011.

Both the House and Senate bills would end double indexing, a problem that would account for half the system's projected deficit. The conference committee must now resolve the differences in the two bills.

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Benefit Beat keeps insurance managers, employe benefit managers and brokers informed of changes in programs around the nation. We'd like to know if you've made any changes or know of any important developments. Write Greg David, Business Insurance, *740 N. Rush St., Chicago, Ill. 60611 or call 312-649-5279.*

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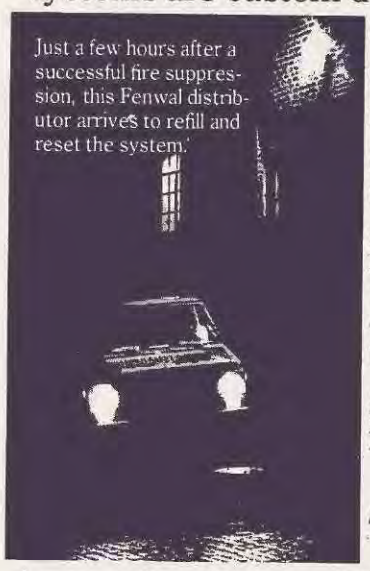

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AIA adds 2 items to tort reform plan

NEW YORK—The American Insurance Assn. added two more proposals to its model tort reform plan offered earlier this year.

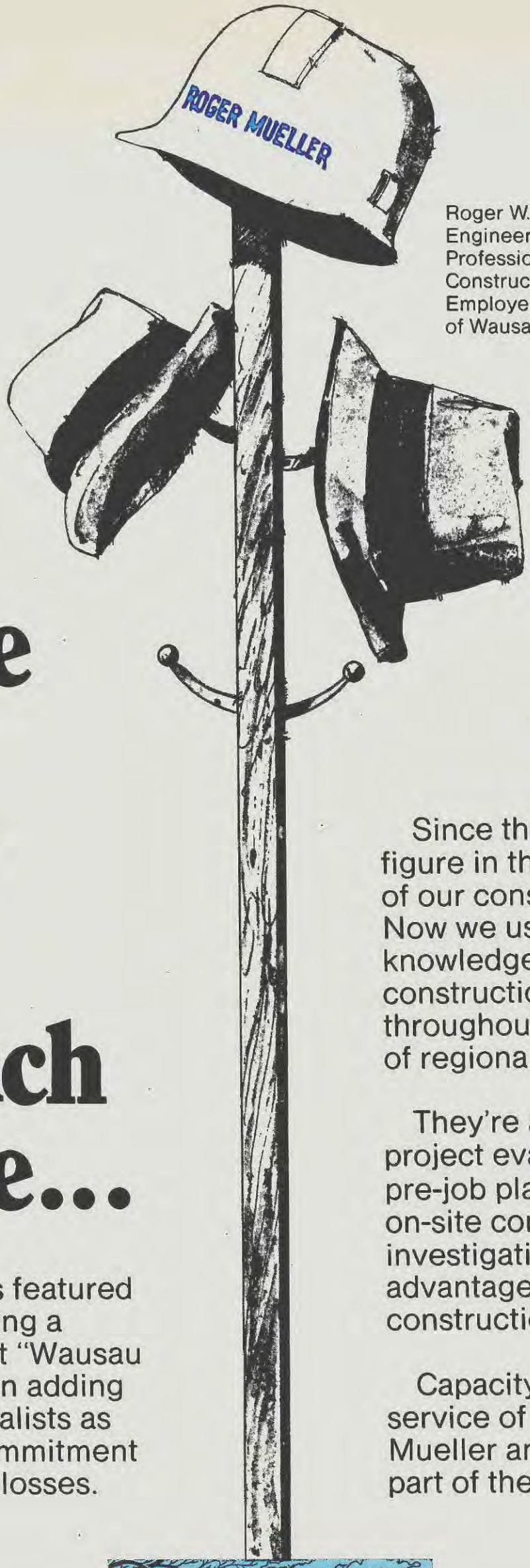
The AIA would reduce product liability awards by the amount a plaintiff had received under the workers compensation system. The plan would also abolish liens against a worker's benefits.

The association also wants to establish the doctrine of contributory negligence. Under this proposal an award could be reduced to the extent a plantiff contributed to the injury.

Other proposals in the AIA package address statue of limitations, modification of a product, state of the art, subsequent repairs and improvements, duty to warn and punitive damages. ■

NAII chairman

Robert Tebben, chairman of Pekin Insurance Co. of Pekin, Ill., has been elected chairman of the National Assn. of Independent Insurers. He succeeds George R. Walker, chairman of Concord General Mutual Insurance Co. of Concord, N.H.



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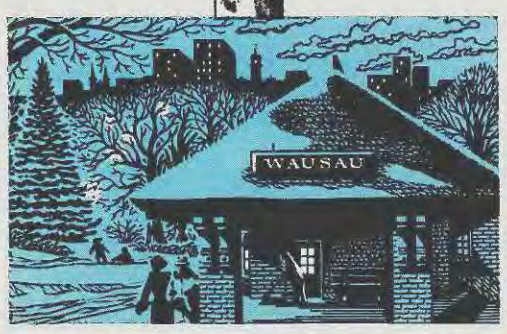

From the Partnership People

EMPLOYERS INSURANCE OF WAUSAU, Wausau, Wisconsin

E&O woes occupy consultants, too

By ELLIS SIMON

NEW YORK—If misery loves company, then risk managers and buyers of commercial insurance aggravated by skyrocketing premiums and limited markets can take comfort in knowing that risk management and insurance consultants have insurance problems of their own.

Consultants seeking errors and omissions coverage for their businesses have been plagued by the dual problems of increases of as much as 800% in recent years and continuing turnover in the market.

While none of the consultants interviewed reported that coverage was unavailable, some said they chose to go bare or self-insure because of the high rates.

"It's like they say about product liability, there's no E&O crisis, provided you can afford the coverage," said Stanley Brock of The Lukes-Brock Co. of Milwaukee. Mr. Brock called E&O insurance "excessively overpriced," noting that his premiums have increased eightfold since 1974.

Several other firms reported premium hikes ranging from 300% to 400%. Bernard A. Salwen, managing partner of S.B. Ackerman & Associates, a New York firm, said while in 1975 it cost less than $100 per consultant to provide E&O coverage, it now costs about $600.

Compounding the problem has been the limited number of insurers providing E&O coverage for consultants. A major underwriter in the field, California Union, withdrew at the end of 1976, forcing many firms to scurry in search of a new carrier.

One such firm was Crain, Langner & Co. of Rocky River, Ohio. President and treasurer David A. Langner said the best coverage the firm could come up with would provide half of the old policy's liability limit for the same premium as the original policy.

Many consulting firms have turned to Lloyd's for their E&O coverage, finding the London market to be more stable. U.S. companies enter and leave the E&O market constantly, said Alvin E. Mangold, executive vp of First Insurance Management Co. of Wyncote, Pa.

Mr. Mangold's firm's premiums doubled when it went with Lloyd's two years ago. However, since then the premium has increased by only 10% while the deductible was cut in half.

Not all consultants believe London is worth the price. Insurance Financial Consultants of Warwick, R.I., which had been insured by California Union, decided to go bare when the best offer from London would have provided liability limits under $1 million for double the $1,400 premium charged by the domestic carrier, said president John F. Fitzgerald.

As a result, Mr. Fitzgerald said he has been prevented from expanding his business because he does not feel he can absorb the additional exposure.

Consultants believe their problems stem from misconceptions held about them by underwriters. RIMCO's Robert Hughes in Houston said underwriters often use the same form for consultants that they use to write E&O coverage for agents and brokers, who have greater exposures.

"Most underwriters are not pricing based on experience, but on what other professionals are charged," said Dave Warren, president of Warren, McVeigh & Griffin, a San Francisco-based firm.

With premium hikes and limited markets have come restrictions of the type of coverage available. Virtually all E&O policies written today are based on claims made, rather than on the more desirable occurrence basis.

Mr. Mangold noted that when companies change from coverage based on occurrence to a claims made basis, they must get an endorsement making their policies retroactive for coverage of claims based on incidents that occurred prior to coverage period or face a coverage gap.

With only about 100 insurance consulting businesses operating in the United States, the field does not represent a market large enough to attract underwriters, Mr. Warren said.

However, Kevin F. Donoghue of Boston, president of a firm bearing his name and of the Insurance Consultants Society, one of two professional organizations serving the field, predicted that more insurance markets will open up to insurance consultants as their numbers increase.

Mr. Warren said that while the market is tight right now, it should loosen up in the near future as "social inflation" eases and carriers hold the line on rates to keep their profits from becoming excessive. Coverage will broaden as a result, he added.

There are other alternatives to high E&O insurance premium costs besides going bare. Ebasco Risk Management Consultants of New York have self-insured for seven years, noted Fred Abdoo, eastern regional director.

However, his firm's decision was based upon a corporate decision made for dealing with the high cost of professional liability coverage for the parent company's architecture and engineering division, he explained.

Risk Planning Group Inc. of Darien, Conn. has obtained satisfactory coverage that includes prior acts coverage through a group plan for management consultants, underwritten by American Home Assurance and marketed by Allen, Kernan & McKoun, a New York brokerage firm.

Going bare hasn't affected Benjamin Levy of Liberty, N.Y., who, after 30 years as a consultant has yet to be hit with a suit.

Jack Culbertson, president of Insurance Consultant Associates of Houston, also goes bare. "In my service contract, my liability is limited to $100, and those who don't want to sign it, I don't work for," he explained, adding that he has no problems attracting business. ■

Consumer drive support slipping

WASHINGTON—The American public strongly supports the consumer movement, but this support has slipped slightly in recent years, a 1977 survey by the American Council of Life Insurance has disclosed.

When asked how they felt about consumerism, 84% expressed support, 66% saying they were completely for consumerism and 18% saying they were more for it than against. Only 7% said they were against consumerism, while 9% did not express an opinion.

When the question was first asked by the Council in 1972, 90% said they favored consumerism and only 3% were against this social movement. ■

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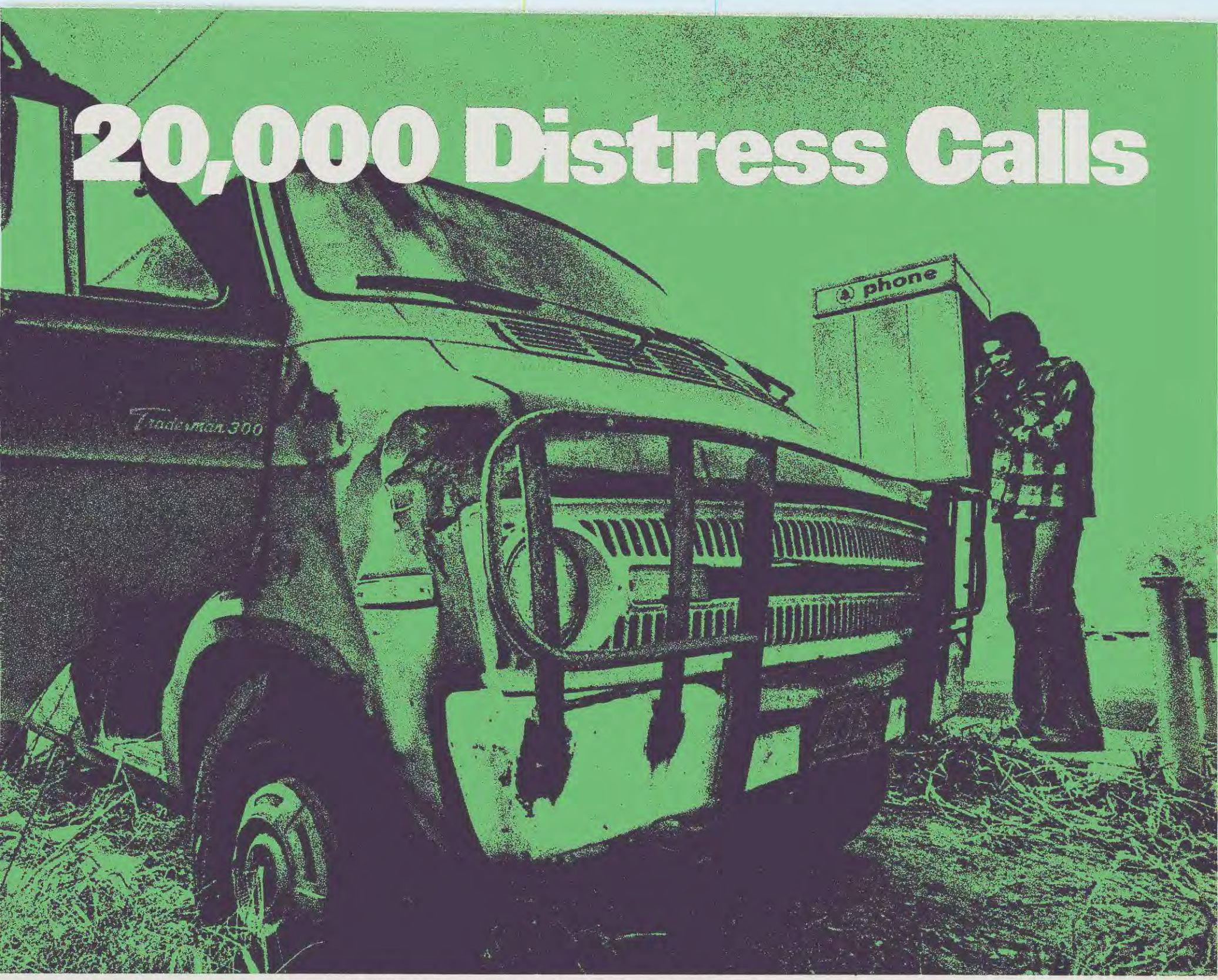

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editorial opinions

Only solid evidence can help tort reform

IN THE EVENT you feel you are about to be socked with one of those million product liability suits being filed annually, you can now rest a little easier, at least for the time being.

Your odds against being sued are better than you think.

A story in our Oct. 31 issue debunked the myth of the annual one million product claims. Following extensive research, Washington editor Jerry Geisel discovered that the figure was a figment of someone's imagination.

Whether or not the insurance industry has been guilty of exaggeration or the use of scare tactics to try to swing public opinion in favor of widespread tort reform measures limiting litigation and awards in the product liability area, we aren't sure. But it does appear that those having the most interest in tort reform—namely the insurers and some manufacturers of equipment that can cause some troublesome injuries—were all too eager to pick up wild stories without checking them.

We've all seen and heard dozens of times these illustrations of the product liability problem. Nearly every speaker on the subject in the past couple of years has repeated the anecdote about the one or two men who stupidly picked up a power lawn mower to trim a hedge, injuring one or both of them and resulting in a whopping liability award in favor of the stupid users and against the innocent mower maker.

We won't deny that the tale is a good one, or that it provided a particularly vivid picture of a problem caused by human nature that we can all understand. Clearly, our sympathies rested with the poor mower maker each time we heard the story.

It's only logical that we are saying "Tsk, tsk" about the tort system upon hearing the story, muttering under our breaths, "That stupid jerk who picked up a lawn mower deserves what he got if he isn't any smarter than that."

The only trouble with the story is that to our knowledge there isn't any proof the incident occurred. No one knows where the case originated, no one has any record of it and the person who first told the story can't remember where he read about it.

The claims figure appears to be similarly lacking in support. The best data available, from the ISO's closed claims survey earlier this year, showed that between July of last year and March of this year a total of about 25,000 product liability claims were filed. Granted, that's for only a nine-month period, but it's a far cry from the one million claims that are ostensibly inundating every conceivable type of business organization in this country. An ISO vp said recently there might be 60,000 to 70,000 product claims submitted annually.

Having poked holes in these alarmist tactics, we still think there's a need for tort reform to restore balance and equity in the legal system of compensating injury victims. We believe overwhelming evidence exists to indicate an urgent need for reforms, but we believe the public and the legislators of America will only be convinced of this need within a rational framework of open debate.

Using unsupportable evidence only serves to provide added ammunition to trial lawyers in their battle to challenge the credibility of those insurance industry officials, risk managers and others working for tort reform.

Punitive damages II: Our position stands

READERS obviously feel strongly that all or part of punitive damage awards should be insurable.

Our editorial of Sept. 19 drew an exceptional outpouring of readers' sentiments on the subject, some disagreeing with our stance that punitive damages should not be insured at all but should be prevented. We agreed with the ISO's move to exclude punitive damages from general liability insurance policies.

The flood of letters we've received . . . 11 to date . . . has been gratifying. Attentive readers have raised some good questions.

Though many of the opinions run counter to our own, we've not yet changed our mind on the issue. And other readers have agreed with our position that punitive damages for irresponsible acts shouldn't be insured.

However, the question of whether punitive damages for vicarious liability should be insurable is a particularly thorny one. The specter of liability risks that are not entirely within the power of a company or a risk manager to control certainly would indicate at least a desire to be able to insure that possibility of loss.

Many of the letters from readers have noted that punitive damages should be insurable simply because they are so often abused in the current legal climate. Such damages are requested in such a large portion of product liability lawsuits and are awarded by judges who seem to have little understanding of the meaning of punitive damages, some people reason. These readers believe insurers are taking an easy way way out of more frequent claims by excluding this coverage from their policies. Some letters have encouraged us to support reform of the tort liability system rather than address the issue of whether punitive damages should be insurable.

Indeed, the tort system needs reform. We've said this before and we'll say it again. There's too much abuse, by lawyers, litigants and judges often acting as bench-warmers for those who want to redistribute the nation's wealth.

Because the topic of punitive damages is such a volatile one, we'll have more editorial development of it in coming issues. An upcoming survey of our Editorial Advisory Panel, for example, probes the ideas risk managers hold about why the insurance industry is excluding coverage for these awards and what should be done about it.

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

Political involvement

To the editor: Many thanks to Peter Downes for speaking out ("Risk managers must understand politics, myths," Oct. 3) on the real need for risk managers to recognize and deal with the reality of the effects that politics can and does have on the risk management profession. It just makes common sense if one just picks up any insurance trade journal and reads of proposed national health care legislation, proposed tax relief for self-insured losses (SIRTs), pending tort reforms, workers compensation rate proposals and on and on.

In the past 10 years, the glut of legislation (ERISA, OSHA, no-fault auto), judicial decisions (malpractice, product liability) and regulatory pronouncements (Section 79 of the IRS code, revenue ruling 77-316 on captives) have all played a major role in the insurance industry and have in many ways fostered the growth of the risk management profession to a place of relative importance in the business world.

But we as risk managers must now go beyond simply keeping informed on what is occurring in our legislative halls and courtrooms and become involved in the shaping of our future. The sooner we realize that we are not immune from the consequences of politics and raise our voices during the decision making processes, we as a profession can move from our current stance as reactionaries to that of policy-makers and that I believe is where the future of risk management rests.

Ronald H. Stolle
Corporate risk manager, American Air Filter Co. Inc., Louisville, Ky.

Ideal risk manager

To the editor: James L. Groves, risk manager for the American Hospital Assn., in the Oct. 3 article on hospital risk management avers that the best source for a risk manager is an assistant hospital administrator-type, supported by a committee. He further believes that hospitals err in going to claims supervisors or managers from the insurance industry for their risk managers.

I would submit that this approach is very unwise. First, a hospital administrator is too "locked in" to the

Continued on page 52

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For government units

Insurers won't cancel New Jersey policies

TRENTON, N.J. — Insurance companies writing liability coverage for public entities in New Jersey have agreed to cooperate with the state insurance department and not cancel any policies while the department and carriers try to work out a solution to the problem of skyrocketing premiums in that state.

The insurance department had sought legislative approval for a six-month moratorium on carriers canceling or refusing to renew liability coverage on school districts, local governments and other agencies. However, commissioner Richard J. Sheeran has temporarily put off the need for such a measure due to the cooperation received from the insurers.

An insurance department spokesman said carrier representatives would meet with Mr. Sheeran and representatives of the public entities during the next few weeks to try to reach a solution. However, the spokesman would not reveal what alternatives were being considered by the commissioner.

Mr. Sheeran requested moratorium legislation in mid-October after carriers providing liability coverage to 23 school districts submitted rate hike requests to the department.

Skyrocketing liability premiums have also affected local governments and public agencies in the Garden State. One such body, the Delaware River Joint Toll Bridge Commission, saw its liability premium jump in one year to $175,000 from $6,000.

The urgency of the problem is compounded by constitutional limits on increasing the budgets of school districts and municipalities. In some cases, requested premium hikes exceed the overall budget increase restrictions of 5% for municipalities and 6.2% for school districts.

The moratorium, which would have been retroactive to Oct 1, was intended to "buy time" for the insurance department so it could submit to the legislature a plan for resolving the public liability crisis.

According to insurance department spokesman Tom Hooper, the department will resubmit its request for funding of a feasability study to look into operation of an insurance pool. Several persons in addition to Mr. Gold are being considered as candidates to prepare the report, Mr. Hooper added.

The insurance department would like the study to look into such alternatives as establishment of a reinsurance facility, setting up of a municipal mutual insurance fund and organization of a state insurance fund similar to ones operating in Wisconsin and South Carolina, he noted.

However, Richard Lofberg, an insurance consultant for public entities, urged changes in state laws on what constitutes public liability. New Jersey and California are the only states in the nation which entirely reject the concept of sovereign immunity, he said.

Reinsurers, who generally bear the risk on public entity liability losses in excess of $100,000, are aware of this increased exposure. Since they are not subject to state regulations they have jacked up their rates, putting the squeeze on primary carriers, Mr. Lofberg explained.

Liability rates for public entities in New Jersey are not sufficient to cover the rising cost of reinsurance, said Guy Staffa, a spokesman for Royal-Globe, the state's principal public entity liability insurer.

Staffa blamed the increased number of lawsuits and higher jury awards for the need for higher premiums. However, he would not disclose the carrier's figures for public entity liability losses in the state.

While calling the moratorium a "necessary evil," Mr. Lofberg added that it would be in effect wrongful taking of property since insurance carriers would be forced to absorb the cost of reinsurance premiums several times higher than the revenues. ■

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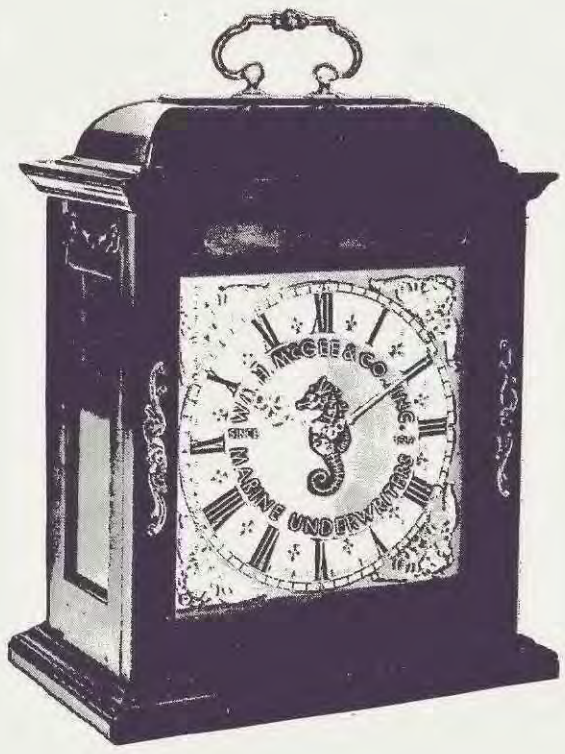

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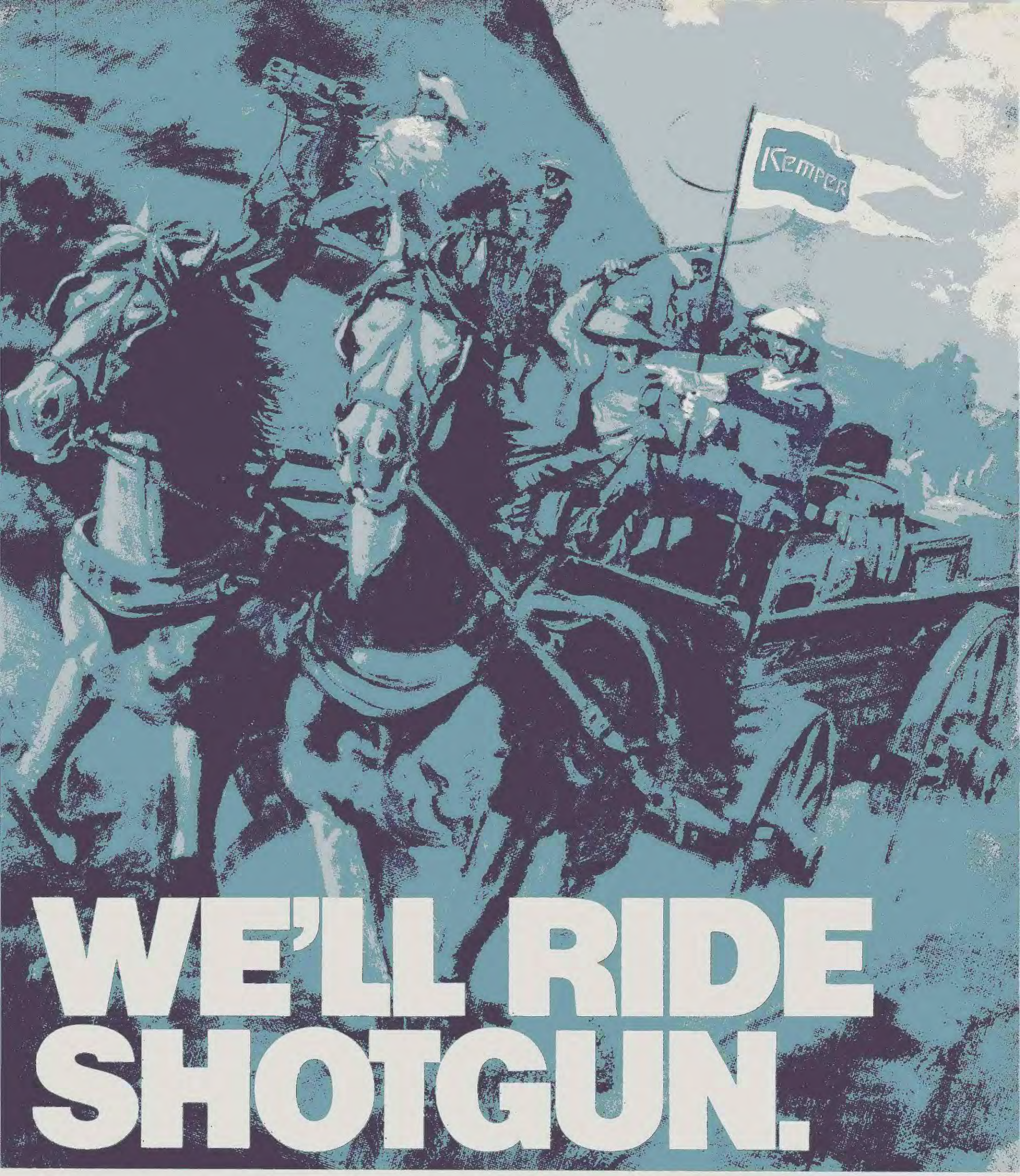

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Bowman tops M&M on Control Data risk

MINNEAPOLIS—E. G. Bowman Co. Inc. of Brooklyn won Control Data Corp.'s primary aviation product liability insurance account, pulling the business away from Marsh & McLennan which had the entire Control Data account for 20 years or more.

Bowman, a prominent black agency owned by Ernesta Procop, had been after Control Data for some time, said Robert Abrahamson, manager of risk management and corporate insurance. The broker had been trying to land part of the account by watching for an opportunity to participate in a competitive situation with other brokers.

Thus, when Mr. Abrahamson was ready to renew this segment of coverage, he called in Bowman along with M&M, Commercial Credit Insurance Services (Control Data's captive insurance brokerage subsidiary) and J. H. Minet & Co. of Canada in Montreal.

Marsh & McLennan, the incumbent, had its choice of insurance markets, using Associated Aviation Underwriters which had underwritten the account for some time.

"We really wanted to test three broker markets we've never tested before," Mr. Abrahamson said. "We've heard about Minet's reputation from a lot of people and we've known of them for a number of years. We also wanted to see what our own subsidiary could do for us. And we wanted to see how M&M would perform in a real competitive situation, since they haven't had to compete on this business for a number of years."

Control Data's aviation product liability coverage represents between $50,000 and $100,000 in premiums. Because the firm's products in the aviation field are used primarily in government aircraft, "it's not a real difficult line for us right now," said Control Data's risk manager.

Also, Control Data doesn't have any big service requirement of the broker for this line of insurance, Mr. Abrahamson noted, covering three aerospace divisions. But the risks were diverse enough to require a "great deal of work" by Control Data and Bowman to collect all of the underwriting information necessary for United States Aircraft Insurance Group to take over the account, he added.

M&M was "quite upset" about losing a portion of the Control Data account, said Mr. Abrahamson, although M&M did retain the excess insurance portion of the aviation product liability business because of the larger firm's marketing capabilities and a better excess program.

Control Data wasn't as concerned about lower premiums as it was about testing the brokerage firms, but the two objectives worked hand in hand. Bowman accomplished a savings for Control Data through USAIG, getting the insurer to quote on the basis of a flat premium charge not variable by the manufacturer's volume of sales for aviation products. AAU's premium for the annual policy was an adjustable premium based on volume.

The policy provides first-dollar coverage, with primary limits of $10 million and excess limits of $50 million.

Control Data now has fewer insurers participating in the excess insurance program, using Southeast Aviation as the lead underwriter. The lead insurer, lined up by M&M, agreed to take an unusually large portion of the excess risk, said Mr. Abrahamson, surprised that any one carrier would do this. Of the total premiums Control Data pays for all aviation product liability coverage, primary coverage eats up approximately 40% of the cost and excess takes the remaining 60%.

Bowman has earned a reputation over the last five years for being very aggressive (and successful) in its pursuit of large commercial accounts. The firm boasts that it manages at least part of the insurance programs for 50 companies, 30 of them corporations in the Fortune 500 group. Bowman has picked up at least 10 of those in the last 12 months, said a spokesperson.

James E. Drake is the Bowman account executive handling the Control Data business, along with Henrietta Little, a vp of the firm. Mr. Drake was formerly an assistant risk manager for Coca-Cola. ■

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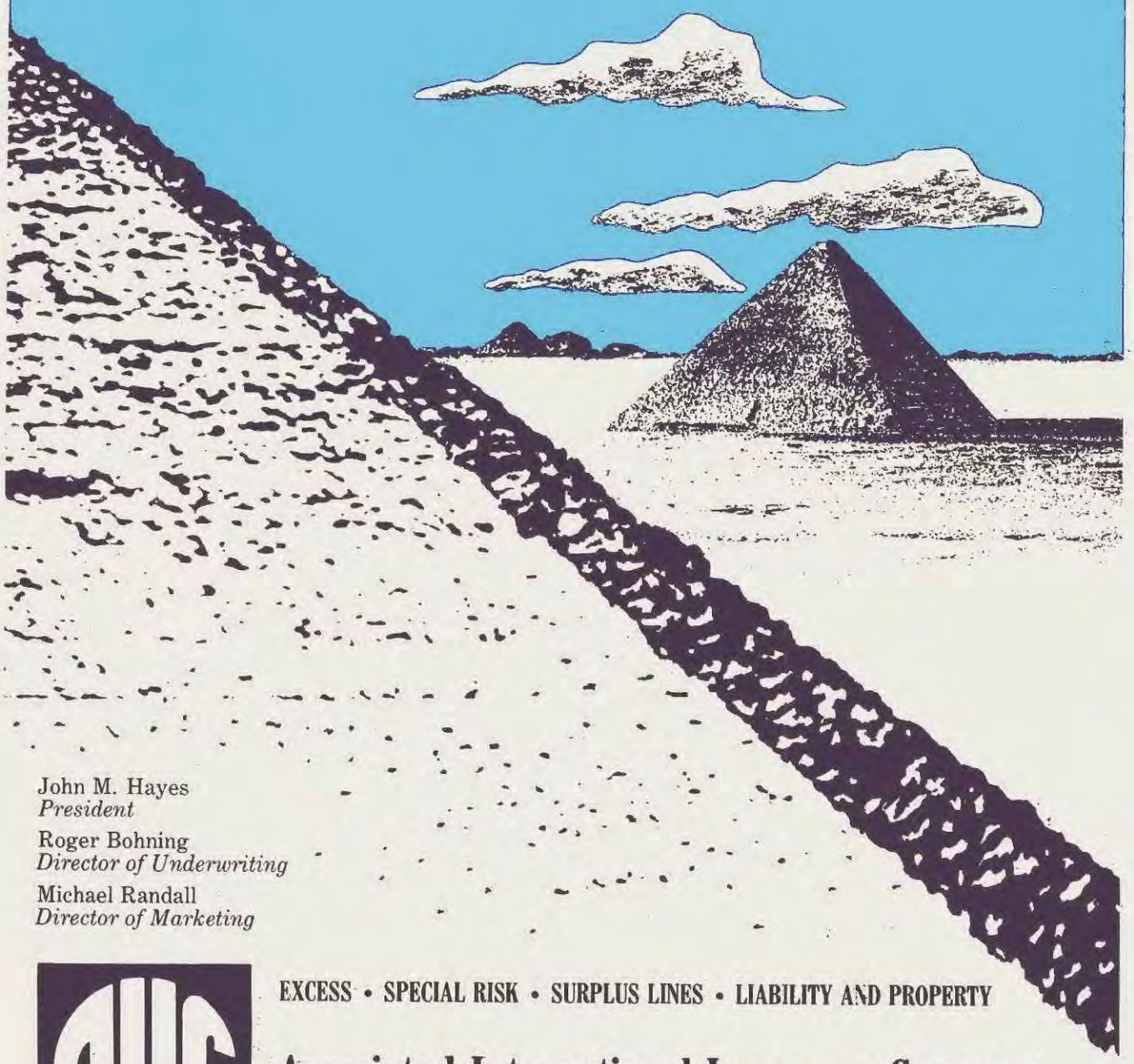

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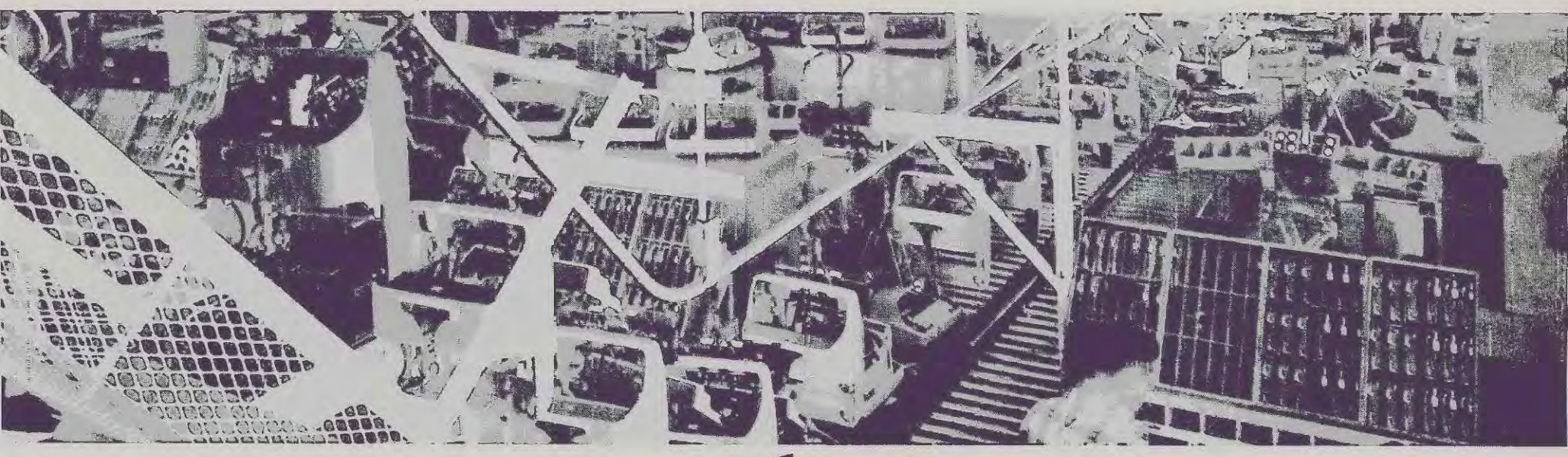

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No-fault for medicine?

Consumer group urges new malpractice plan

MOUNT VERNON, N.Y.—Make hospitals responsible for what happens in their buildings and create a modified no-fault system to compensate patients for injuries, says a respected consumer group that examined the malpractice problem.

Consumers Union, better known for its testing of products, also endorses a series of tort reforms to "lower costs without unduly abridging consumers' rights." The recommendations were presented in a three-part series in the organization's monthly magazine, "Consumer Reports."

The organization argues that a no-fault malpractice compensation system could be extended to other personal injury cases.

"The most serious malpractice problem isn't the cost and availability of insurance," says Consumers Union. "For patients, the real problem is the incidence of medical negligence itself and the difficulty of obtaining swift, just compensation for their injuries."

Hospitals would have an incentive to exercise closer supervision over doctors practicing at their institutions if they were responsible for all medical malpractice within their walls, Consumers Union contends. Doctors would be relieved of legal responsibility, although they still might bear some financial responsibility.

While Consumers Union does not want to ensnare doctors in more red tape, "the day is past when vital medical decisions can be made by individual physicians with complete independence," it said.

One way to cut through the expensive tangle of assessing negligence, Consumers Union suggests, is to establish a list of "designated compensable events."

For example, a person who contracted serum hepatitis shortly after receiving a blood transfusion would be automatically compensated. There would be no need to prove the transfusion caused the hepatitis or that the hospital were negligent.

The system could be administered by state boards much like the workers compensation system. Legislatures could determine the compensable events and the amount of compensation.

Consumers Union is opposed to any limitation on awards and to any statute of limitations that begins before discovery of the malpractice. But the organization does support:

- A limit on pain and suffering awards.
- Requiring juries to itemize awards.
- Limitations on contingency fees for attorneys. The larger the award, the smaller percentage an attorney could take.
- Paying awards in installments with verdicts linked to an inflation index.
- A prohibition on plaintiffs' requests for specific amounts of damages.
- Allowing juries to be told of payments a plaintiff has received from Social Security, workers compensation or disability insurance.
- Alternatives to jury trials such as arbitration of screening panels in effect in some states.

One of the major problems today, says Consumers Union, is that there is no competition among insurers providing malpractice coverage. One way to deal with this problem is to repeal the McCarran-Ferguson Act, which exempts insurance companies from antitrust laws, says the organization.

But rather than dwell on malpractice problems, argues Consumers Union, the medical profession must emphasize quality in medical practice. The organization supports strengthening state licensing authorities and medical review committees to weed out incompetent doctors, requiring continuing education programs and stressing programs to curtail unnecessary surgery. ■

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Pressroom safety sparks OSHA conflict

NEW YORK—A federal government study of health concerns in the printing industry is under way although some safety directors question why the study is being undertaken.

Three daily newspapers here negotiated with the inspectors, the National Institute for Occupational Safety and Health, for one year before they agreed to allow a "walk-through" inspection of their pressrooms.

Pressrooms of the New York Times, the New York Daily News and the New York Post remain to be investigated but elsewhere preliminary study results have concluded that toxic agents in the printing industry fall within Occupational Health and Safety standards.

The study is being conducted because two British and two U.S. studies earlier suggested that pressroom workers may be more subject to lung cancer than the general population, according to William Nicholson, heading the project for the Mt. Sinai School of Medicine, who has a contract with the federal government to conduct the study.

A safety director of a daily newspaper here, however, disagrees about the study's validity, saying "There isn't any info" about the harmful effects about pressroom work. "The earlier studies only suggested that more studies should be made" and did not even conclude whether newspaper pressrooms were creating part of the problem in the printing industry. But they are being investigated as part of the general printing industry study now, he said.

Mr. Nicholson contends that the printing industry is being examined because it is NIOSH's responsibility to examine various industries for health problems. "The printing industry has approximately 500,000 employes so they would require information on this industry," he said.

At the New York Post, business manager Gene Park said he has "no qualms about having the inspection made."

Mr. Park added that the Post has "never" had any instances of workers' conditions linked to workplace conditions. "We've also taken our own air samples and they fall within OSHA limits," he said.

The New York Times safety director, Harvey Siegel, said he has requested an industrial hygiene study when one worker was hospitalized with unusually low oxygen in his blood.

NIOSH and Mt. Sinai are seeking to determine possible harmful agents to press workers by both an industrial hygiene and a mortality study.

Mr. Nicholson is tracing the history of 1,700 members of the New York Pressmen's Union, Local 2, of the International Graphics and Communications Union, who were employed as journeymen from 1950 to date or death. Rates of death for these pressmen according to cause are being compared to expected rate of death per cause in the general population. Results of this study are expected by the end of the year.

Mr. Nicholson said a high ink mist exposure in pressrooms is being examined for possible trace amounts of carcinogens in the carbon black and mineral oils.

NIOSH is selecting for inspection publishing companies that "typify the industry and have a large number of employes that can be included in the mortality study," Mr. Nicholson said. Under consideration for further study are the Chicago Daily News and Donnelley Publishing in Pennsylvania.

The conflict about the inspection of the New York papers concerned the choice of Mt. Sinai to conduct the study. The newspapers contended that the laboratory's director, Dr. Irving Selikoff, was an organized labor supporter.

Dr. Selikoff is one of the world's leading—and most controversial—authorities on chemical dangers. He has been accused of alarming customers, of offending state and federal officials and of mixing science with publicity.

Dr. Selikoff was largely responsible for the recognition that asbestos is a potent carcinogen. More recently, he has been investigating the health effect of PBB, a chemical that was accidentally dumped into animal feed for Michigan farms.

The issue has been partly resolved by the newspaper's hiring of Dr. John Peters of the Harvard School of Public Health, who will review the study results as the investigation progresses.

Also included in the compromise is an agreement that the initial inspection will only be a "walk-through." If NIOSH decides to take air samples, the newspapers have demanded that they first see a "protocol under which the study will be made." ■

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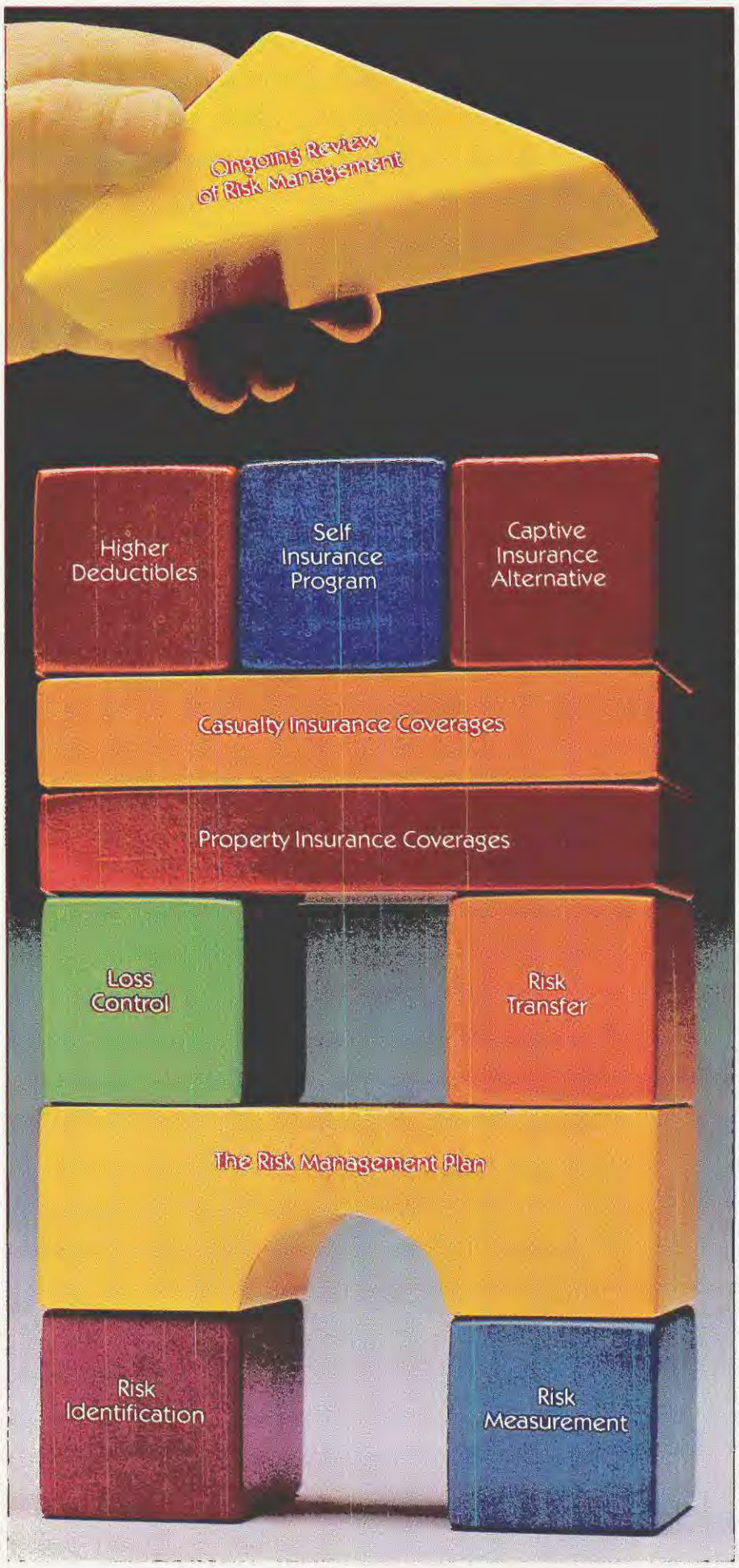


MEMO FROM MARSH & McLENNAN

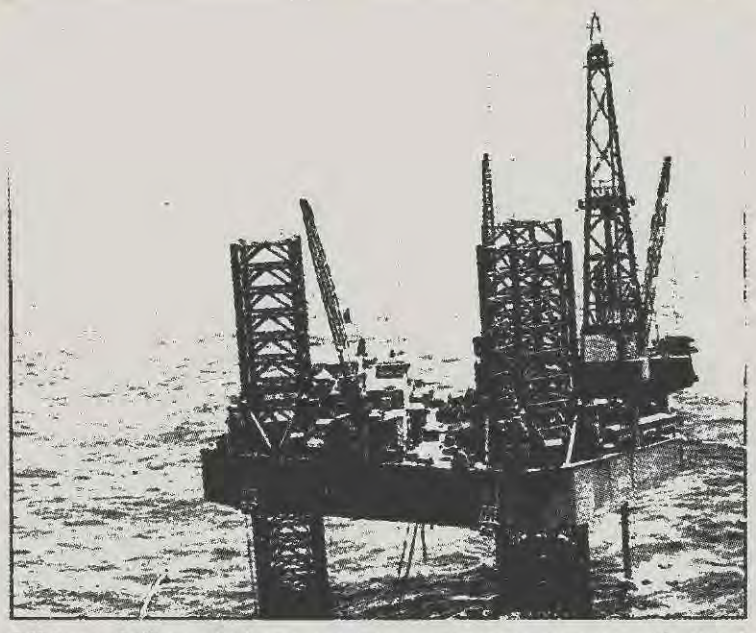
How your company may be able to obtain 'more insurance,' without necessarily buying more insurance.

What's insurance all about anyway? Just one thing: shielding your assets from unexpected losses. For this protection and peace of mind, you are willing to plan for and pay a specified sum that you consider a fair price for this removal of risk.

Errors are made when you lose sight of the fact that protection is the goal while insurance is merely one means to attain that goal. It follows then that "more insurance" is not necessarily the most advantageous way to achieve a higher level of protection.

The risk management concept

The idea is to start thinking in terms of managing the multitude of risk situations, search-



Offshore drilling platforms continue to increase in cost with the first $1 billion platform about two years away.

$540 million is current limit

Is capacity available to handle $1 billion offshore oil platforms?

By ELLIS SIMON

NEW YORK—Offshore oil production platforms costing more than $1 billion are expected to be operating within the next few years. But will the world's insurance markets be capable of writing insurance for them?

Each year platforms are constructed at greater depths and higher costs. In 1976, a platform in 850 feet of water off Santa Barbara, Calif., held the record. However, a platform is being built in the Gulf of Mexico in waters reaching 1,200 feet in depth.

"Until the advent of these new breeds of installations, fixed platforms rarely exceeded $25 million in value," said Marsh & McLennan vp Leo R. Whalen. "Today it is not uncommon to see values in excess of $500 million and at least one unit is valued as high as $800 million. By 1979, a scant two years from now, the first $1 billion physicial damage exposure is anticipated."

World underwriting capacity for physical damage insurance on an offshore production facility is currently limited to $540 million, but is growing fast, Mr. Whalen said. The principal London syndicate, London Master Drilling Rig Line Slip, experienced a capacity increase from $100 million in 1975 to $284 million in 1976. This year's capacity is expected to be around $400 million, he added.

Capacity in the American market is growing, as well. Since it was organized in 1975, AIG Oil Rig Inc., one of two major U.S. offshore syndicates, has seen its capacity triple from $15 million to $45 million.

However, total American capacity is far less than that of London. All-American Marine Slip, the other principal American syndicate, has about $40 million in capacity and a smaller group, Mutual Marine Office, has capacity of $5 million, according to Bill Lowry, vp at MOAC, which manages All-American Marine Slip.

The worldwide primary capacity of $540 million has probably been tapped on several occasions. Larry McGuire, vp with Frank B. Hall in Los Angeles, reported obtaining coverage for two giant platforms, each having exposure in excess of $500 million.

Although he would not discuss its value, George Obolensky, manager of insurance for Shell Oil USA, said his company has obtained full coverage for its Cognac Platform, which at a depth of 1,200 feet, will be the world's deepest when completed.

However, platforms are currently being built with exposures that exceed world capacity. The insurance manager for a major eastern U.S.-based oil company reported that insurance shortfalls exist on two North Sea platforms that his firm partly owns.

Where shortfalls have occurred, American producers have generally turned to self-insurance to cover the difference between the actual property value and the insured account. John Cook, a Marsh & McLennan vp in Houston, noted that self-insurance has enabled producers off Santa Barbara and in the Gulf of Mexico to avoid problems faced by platform owners in the North Sea.

The capacity crunch will be felt, however, should the Baltimore Canyon off the East Coast prove to be a viable oil production area, he said. Barring the possibility of a Supreme Court injunction, exploratory drilling in the Baltimore Canyon could begin late next year, with the first large-scale production facilities being erected three to five years later.

American underwriters, because of their failure to take an interest in offshore drilling, have contributed to the capacity shortage. Mr. Whalen noted that Marsh & McLennan was able to amass only $40 million when it tried in 1975 to entice 200 members of the American market to commit capacity to the North Sea.

While the American market does have capacity which could be committed to physical damage coverage of the giant platforms, the underwriters have not had exposure experience in this field, explained MOAC's Mr. Lowry.

The American market traditionally has been reluctant to participate in the various marine markets because of their highly competitive nature, he added.

Continued on following page

ing always for the most efficient method of attaining the necessary protection. The concept of risk management in today's complex business and legal environment requires more than conventional insurance responses.

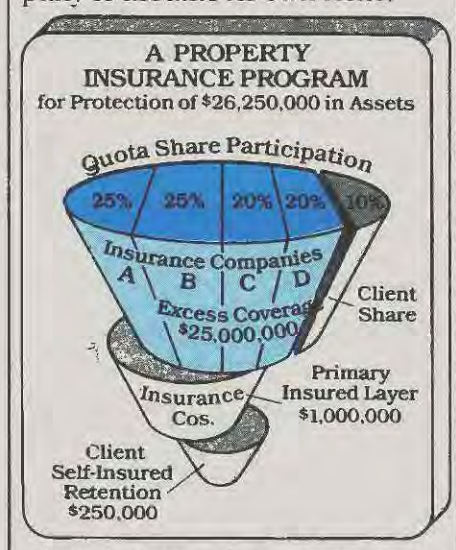
In simplest terms, risk management entails identifying risks, assigning value to them, anticipating losses and making objective decisions about what steps to take before losses occur, so that they have the least impact on the operation of your business.

Linked to this, of course, is the need to implement a meaningful loss control program which will help to prevent or reduce the incidence and severity of losses.

Two principal options are open

First of all, risks may be transferred in the conventional insurance manner. The important thing to remember here is that this decision is made only after a thorough review and examination when it is concluded that this is the correct response in the particular case under consideration. It should not be a reflex action.

Secondly, risks may be assumed by your company, either in whole or in part. A higher deductible is an obvious way for a company to assume a portion of the risk and thereby reduce the cost of purchased insurance—yet still retain adequate insurance protection against catastrophic loss. An established self-insurance program is another way for a company to assume its own risks,



while diverting the money earmarked for premiums into a separate fund to cover projected losses.

The optimum plan may very well contain elements of both(see chart) but only with expert analysis can one approach the optimum with confidence.

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Oil capacity . . .

Continued from preceding page

"They're gun shy. They've had no exposure and haven't made attempts to become exposed. Those who've had exposure; when they see the rates, they're turned off cold," he said.

However, Mr. Whalen called this attitude "a terribly short-sighted position on a class of business which, it is estimated, will generate annual premiums within the next three years in excess of the entire book of annual hull premiums in the marine market."

Many underwriters seem to be concerned with the maximum loss potential rather than the profit potential, said Walter Skwarlo, an oil and gas specialist in the Dallas office of Alexander & Alexander.

"In the case of platforms, the feeling of most owners is that if one has, say, a $100 million platform, he stands to lose $100 million, not to mention loss of production and other consequential losses," he added.

Even though offshore platforms represent large exposures, brokers trying to place coverage for them note that the odds of a total loss are minimal.

Platforms built for use in the North Sea have been designed to withstand the severest storm expected in 100 years, Mr. Whalen said. In the case of the North Sea, that meant being able to be subjected to 100-foot waves and winds in excess of 125 m.p.h.

It is doubtful that lack of capacity in the American insurance market will stop construction of offshore production platforms in the Baltimore Canyon. "I don't know whether the insurance industry will respond to the Baltimore Canyon, but if the insurance industry doesn't respond, the oil industry will find ways to cover itself," said Mr. Obolensky.

He mentioned self-insurance and use of the industry-owned captive OIL Ltd., with estimated capacity of $100 million, as alternatives to limited commercial capacity.

Mr. McGuire said American insurers should be able to accept "reasonable" lines of offshore risks through existing pools and syndicates or even for their own underwriting accounts. A company with $2 billion in property and casualty exposures could take a fairly sizable offshore exposure, he added.

Save the London market, "there's no other game in town," he said. Active participation by American insurers in offshore underwriting could give oil companies a choice of markets as well as increase capacity, he noted.

"Oil companies have only gone outside the commercial market when there is no choice," Mr. McGuire explained, "They'll make a commitment to the commercial market if the market will work with them." ■

Ohio court OKs claims-made policy

SAN FRANCISCO—A claims-made insurance policy form was upheld in July by the Ohio court of appeals, Professional Liability Reporter said in its October issue.

Pemco Inc., a producer of heart valves, had charged Lloyd's of London used vague and ambiguous language in its product liability coverage and that claims-made policies are against public policy.

Pemco had its product liability coverage with Lloyd's during the late 1960s, but didn't renew with Lloyd's in February 1970. In 1972 Pemco was notified of a claim for damages resulting from the replacement of a defective heart valve, implanted in 1968. Pemco forwarded the claim to Lloyd's, which denied the claim because it wasn't made during the policy period.

Pemco settled the claim, the journal reported, then sued the lead underwriter of Lloyd's to recover the amount of the settlement, costs and attorneys' fees. The trial court ruled in favor of Pemco, but the decision was reversed on appeal by Lloyd's.

This decision is contrary to court rulings in a number of jurisdictions which have said that the language of the claims-made insurance policies is, indeed, ambiguous. Some underwriters have said this ruling for Lyold's is not a definitive decision in the claims-made policy controversy.

But, the Ohio court said that most of the policies found in the past to be ambiguous were worded differently from the policy Pemco had purchased. The court concluded that the words "claims made" in the Pemco policy could refer only to claims actually reported within the effective policy period and were thus unambiguous.

Pemco had also argued that claims-made policies restrict freedom of contract by forcing the insured to continue coverage with the same insurer and are therefore contrary to public policy. Because there was no evidence that Pemco could not have secured continued coverage either from Lloyd's or another carrier, the court rejected this argument, said Professional Liability Reporter.

The court also noted that Pemco couldn't have reasonably expected "occurrence" type coverage from Lloyd's for the price of claims-made coverage. ■

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AFIA has opened a centralized regional office in Coral Gables, Fla., to direct the firm's operations in the Caribbean, Central America and South America with the exception of Brazil. The region activities will continue under the control of vp Fred J. Fauria, who will move from Columbia to Coral Gables to head the new office.

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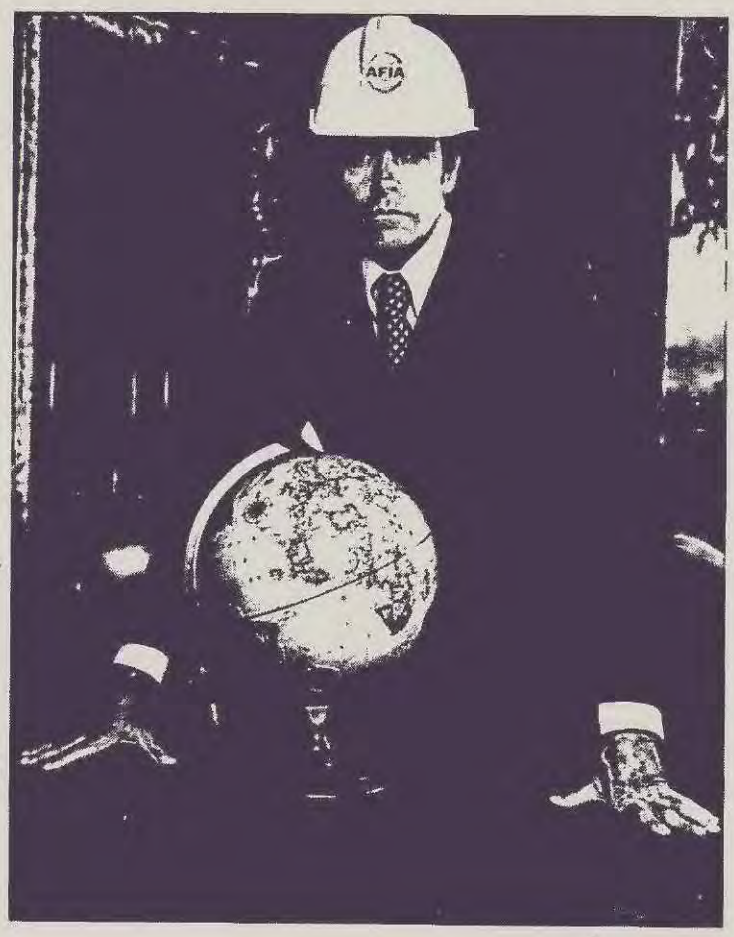

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Reinsurance problems

Light plane losses trouble U.K. market

By JOHN H. MILLER

LONDON—Losses on light aircraft and helicopter risks are causing problems in the U.K. market and as a result rates may be increased.

The effect will be felt by crop-sprayers and other business users in North America where there has been extensive demand for coverage in recent years.

But efforts by leading brokers to meet this demand have encountered resistance in the traditional aviation market because of frequent losses and the reluctance of insurance buyers to pay realistic premiums.

Capacity is still available, but some international reinsurers are pulling out of the market and have left London with substantial losses.

These may amount to between $15 million and $20 million when the accounts are finally settled.

Sources in London emphasized that all the claims have been met and that clients have lost nothing through these transactions.

Surplus lines risks from the U.S. and Canada, placed through specialist reinsurance agencies to get terms that would meet the needs of private aircraft users, are involved.

The amount of money is small compared with the overall premium flow of the U.K. aviation market which is more than $500 million a year.

But it has caused unexpected difficulties to some leading insurance brokers who relied on reinsurers outside the U.K. to meet their commitments.

They are now being forced to use their own money to pay claims from overseas clients, keeping faith with the traditional standards of the London market.

The problem has apparently arisen because private aircraft users wanted the cheapest possible rates for their coverage. This meant that brokers had to "shop around" in order to get suitable ratings in a highly competitive field.

Risks were placed through one still unnamed U.K. brokerage firm so they could be passed to a "pool" of reinsurers who in turn had connections with underwriters in various parts of the world.

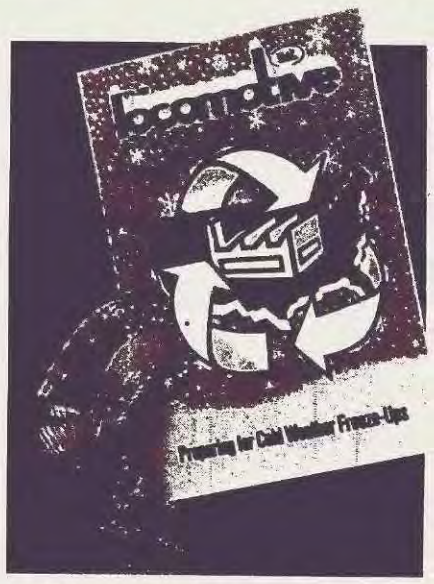
But when exceptional losses occurred and high claims had to be met, some of the reinsurers outside Britain failed to meet the calls.

This put the responsibility back on the leading international brokers in London, who decided that they would settle all claims themselves and try to recover their money from the other insurers later.

Large sums are being put in reserve by some U.K. brokers to meet these demands and rates for this class of business may have to rise as a result.

Major airlines, in a completely different category of international risks and insured through more traditional markets, are not affected. ■

This free booklet can help prevent you from having frozen assets this winter.



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Cancer threat less with age?

LONDON—Doctors in West Germany are contemplating the use of older workers for industrial employment which might expose them to carcinogenic substances, according to reports reaching the German Metalworkers' Union.

Protests are being made against the proposal, which has been discussed by an advisory group within the labor ministry. The German government stresses that no action has been taken to bring it into force.

Trade union officials fear that in some chemical plants older workers have already been exposed to such risks without being made aware of them. It is believed that two major chemical groups already select older employes for work which might lead to cancer rather than expose younger personnel to the risk at an early stage in their lives. ■

riskWatch

By REBECCA A. FANNIN

Insurers must share the blame for the $2 billion arson problem

Want to become a millionaire? The arsonist does and he knows he can quickly and easily.

He just capitalizes on insurance company shortcomings and collects claims money. It's well publicized among arsonists that the insurance industry fails to check insured property for past problems with arson, rarely challenges fire claims and sometimes over-insures property, factors encouraging arson for profit. That's what the National Fire Prevention and Control Administration says despite the insurance industry's claim that "we're not just handing over money."

Fannin

Insurers, however, shoulder much of the $2 billion in property losses caused by arson each year. They paid an estimated $1.2 billion last year, an amount that threatens to increase by 25% annually.

But the greatest crunch comes for buyers of fire insurance. In fact, an estimated one-third of the $7.3 billion that businesses paid in fire insurance premiums went to cover arson losses last year.

Consumers and businesses, then, are paying dearly to help arsonists make a profit. And insurance companies seem to be tempting the arsonists by failing to stunt the growth of what is described as this nation's fastest growing crime.

Insurers by their sheer neglect have allowed landlords, for instance, to over-insure property. Landlords can transfer ownership of their property on paper only, convince the carrier that renovations will follow and then increase their insured limits. They can also overinsure when the insurer fails to investigate property before insuring it, said Dick Palumbo, a former Bronx fire marshall who is now the arson program manager at the National Fire Academy, a part of the federal governnment's National Fire Prevention and Control Administration.

Insurance companies have also been blamed for failing to investigate each property claim for evidence of arson. "They just don't have the finances to check every one," said Robert Lukowski, a retired New York City fire marshal who now heads the American Standards Testing Bureau's fire-arson department. "The investigation can cost more than the claims so they'd rather just pay it," he added.

Even when claims are investigated, the time and effort may not be worth it. Mr. Lukowski notes that property loss adjustors are seldom trained as arson investigators. "They just pick a cause and make it fit," he said. "None of them has investigative background. They just jumped into the field and have become qualified in court as experts."

Poor investigation is most likely to occur in rural areas. Here, the local fire department may never even learn of the fire. But the insurance company does through a claim, Mr. Palumbo said. "They send out their adjustors and write a check right on the spot."

Wide publicity surrounding such cases as the alleged arson-for-profit ring in Boston is bringing arson from backstage into the spotlight. Public adjustors, local arson squads, insurance company representatives, former fire department chiefs and attorneys allegedly operated the Boston ring, hiring arsonists to set an estimated 35 fires causing $6 million in damage during its four-year life.

The arsonists would strike, usually torching a multiple-unit dwelling, after fire insurance was increased to reflect renovation that never occurred.

Insurers and fire prevention associations are now arming themselves to combat arson losses. They're beginning to train adjustors to become arson detectors and are building a data bank to learn what areas of the country and what industries are hardest hit.

At the Factory Mutual System, experts are finding that three areas give them arson problems: apartments, property in unscheduled locations such as in branch offices and in-yard storage. "Almost 40% plus of our losses occur in these areas," according to Harry Merrow, a staff engineer.

Philadelphia Manufacturers Mutual Insurance Co., part of the FM System, is learning that it's been lucky. "Large industries aren't primary targets for arsonists," said Donald Moore, president of the company.

At State Farm Fire & Casualty Co., "The real small claims like grease fires in the $3,000 to $4,000 range are almost a thing of the past,"said Richard Aaberg. Mr. Aaberg also noted that as his company is "getting better in detecting arson, we are finding more and more of it."

Lower levels are proposed for DBCP

WASHINGTON—The Occupational Safety and Health Administration (OSHA) has proposed a further reduction in the permissible exposure level to DBCP, a soil fumigant that has been linked to sterility in males.

The OSHA proposal calls for slashing the exposure levels to one part per billion parts of air (ppb); an earlier emergency standard issued Sept 9 had placed the acceptable exposure level at 10 ppb.

The proposal also prohibits eye and skin contact with the chemical

Written comments on the proposed final rule should be submitted by Dec. 2 to the Docket Officer, Docket No. H-061, Room S6212, U. S. Department of Labor, 3rd and Constitution Ave. NW, Washington, D. C. 20210.

Public hearings will begin on Dec. 13 at the Labor Department. ■

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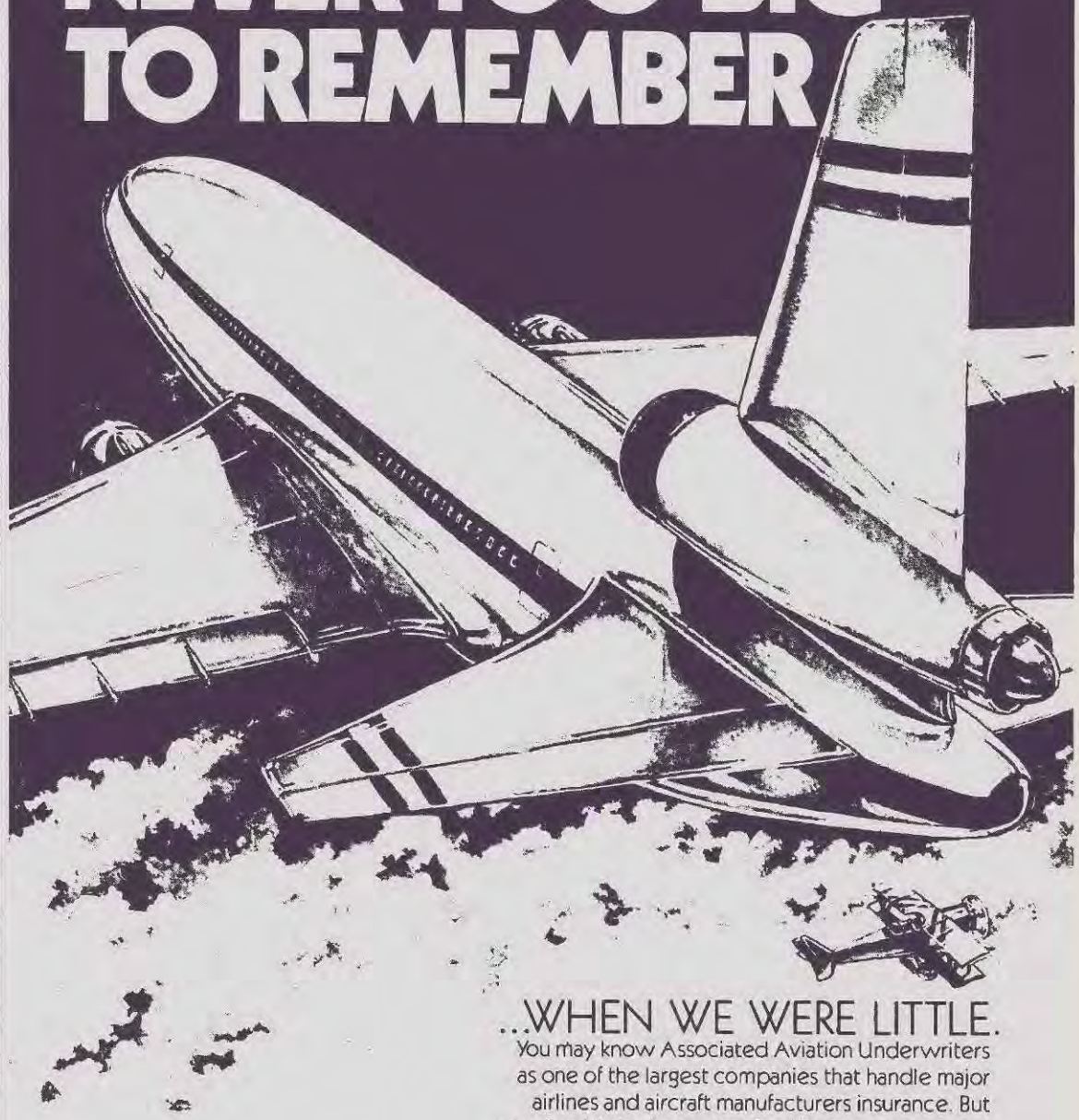

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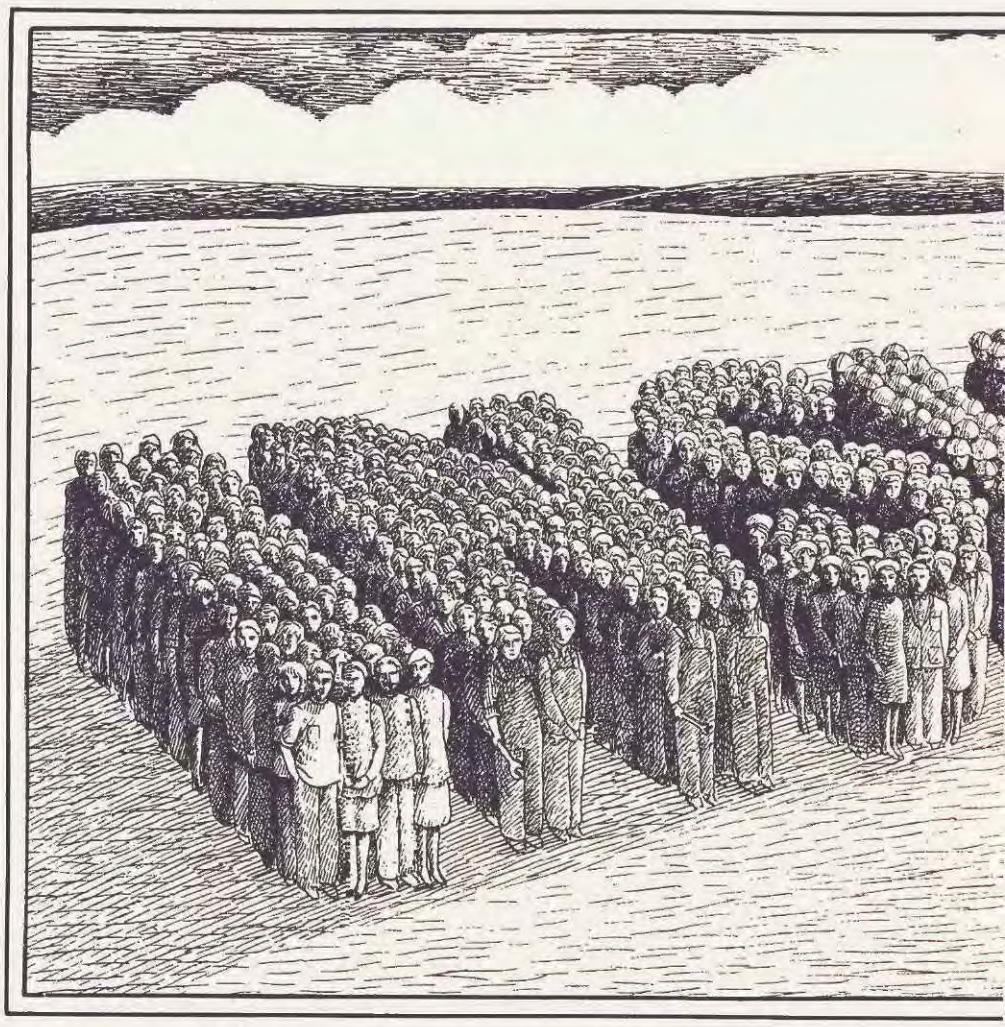
Safety

Firms affiliated with trade associations or other business groups may be able to reduce insurance costs through safety group plans.

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



The idea of business insurance policyholders receiving cash dividends resulting from lower than expected losses over a period of time is not a new one. In the last few years, however, a variation of this principle has emerged in the form of "safety group" plans and has experienced rapid growth. It is estimated that over 30,000 businesses today purchase commercial package and workers' compensation insurance policies under safety group plans.

The attraction of safety groups is twofold. They offer a way for small and medium size business firms to obtain the benefits of safety and loss control programs which they might not otherwise receive. And if the group's combined annual loss experience is sufficiently favorable, there is a possibility of dividends being paid to policyholders. This affords an opportunity to counteract the increasing cost of commercial insurance.

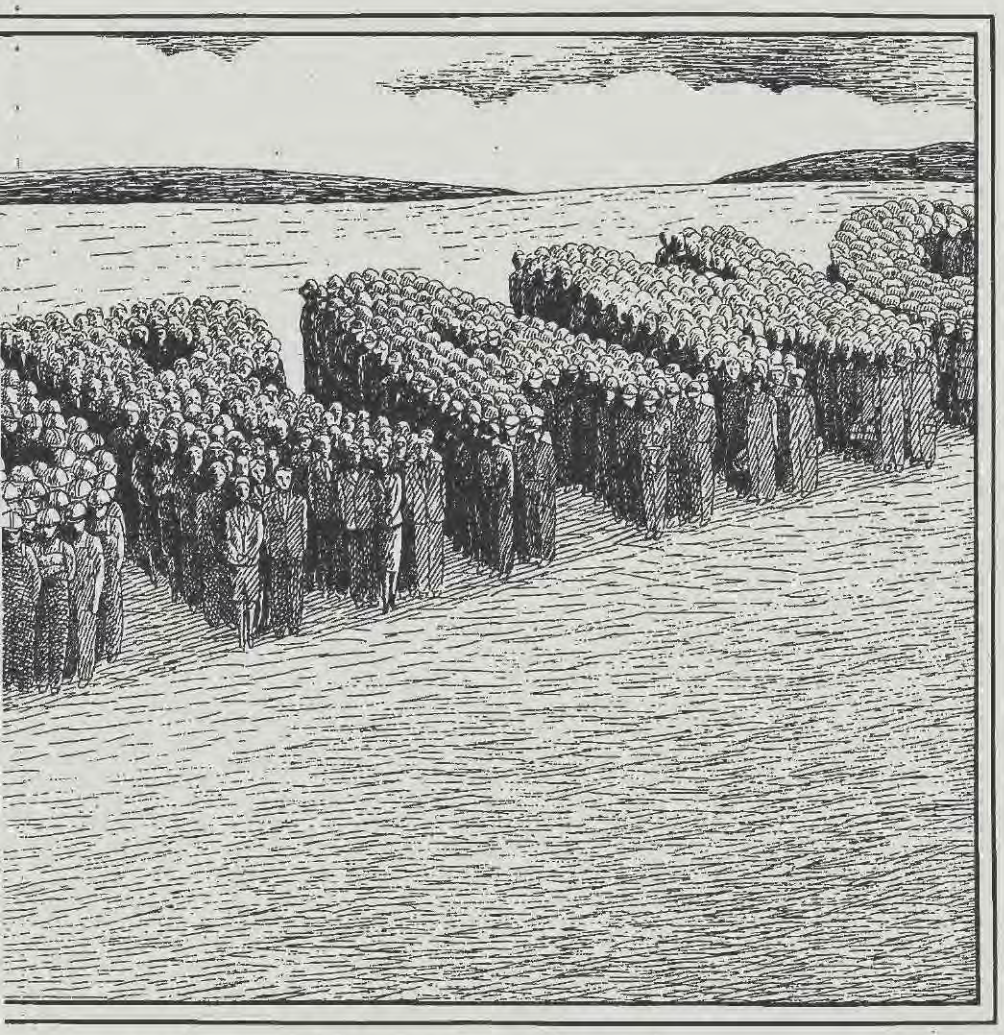
Dividends, if declared, may run from 1% of the premiums paid up to 25%; in some cases even higher percentages have been received by groups with excellent loss experience. It should be stressed, however, that dividend payments are not guaranteed, and legally may not be. Also, dividend payments can be made only by an insurer commonly referred to as a participating insurance company. In declaring dividends, the insurer takes into account its own financial performance as well as the group's loss experience.

Safety groups are usually formed through organizations already in existence—trade associations, associations of franchise holders, groups of churches or schools which reflect characteristics and interests shared in common—although it is not necessary to be a member of the association or group in order to join the safety group. Examples are associations of retail druggists, of electrical contractors, of appliance dealers, of restaurants.

Standard rates and premiums

After a safety group plan is developed, individual members of associations who indicate interest in the plan are contacted by insurance agents. (There is, however, no requirement that every member join, and no obligation on the part of the insurance company to provide insurance for every

Groups



member wishing to participate.)

Those who want to join and who are accepted by the company acquire individual policies at standard rates and premiums. Most of the business insurance is provided in the form of industry package policies; an exception is workers' compensation, which is usually written separately. These comprehensive policies are intended to provide broad protection for specific kinds of businesses while eliminating needless duplicate coverage.

Vital to safety group plans is adherence by each accepted member to safety standards—loss control measures—which apply to the group as a whole (hence the phrase "safety group"). Some members will meet these standards as a matter of course, while for others needs may be pointed out by a loss control specialist.

Safety can pay

Effective loss control techniques are instrumental in establishing above-average results for any given safety group. And favorable results can in turn make possible the payment of policyholder dividends.

The dividend rate, of course, is likely to fluctuate from year to year, reflecting each year's varying loss experience for the safety group involved and the insurance company's overall results. Dividends are expressed as a percentage of the premiums paid by members, so that a 20% dividend would mean a payment of $200 on a member's annual premium of $1,000.

It is estimated that there are some 40,000 business and trade associations of all kinds in the United States today. One insurance industry projection is that by 1980 as much as 25% of all commercial insurance will be written under safety group plans.

An organization can apply for inclusion in a safety group through any insurance agent or broker. As an objective discussion of safety groups, INA has prepared a booklet entitled, "Safety Groups: Some Professional Considerations." Copies may be requested by writing INA Corporation, 1600 Arch Street, Philadelphia, Pa. 19101.

* * *

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Steel mill insured despite 'quake risk

By JOHN H. MILLER

LONDON—Record insurance coverage of $700 million for a Mexican steel mill has been placed with Lloyd's and other makets, including some in the U.S., in spite of the fact that it is in the middle of a historic earthquake zone.

It is believed to be a tremendous beakthrough in this form of catastrophe coverage, for the plant is on the notorious San Andreas fault which runs through San Francisco.

Despite major difficulties in placing the risk, underwriters finally accepted it after receiving a guarantee that special risk management techniques will be used in its construction to reduce seismological perils.

Revealing this new move in earthquake coverage, Barry Blacker, the U.K. broker who fought off opposition by some capacity sources to accepting the risk, told *Business Insurance:*

"We were brought in right at the design stage, so that everything possible can be done to build the steel mill in the proper way. As a result, we overcame the problems for excess of loss cover which we partly faced in some areas of the market.

"Basic cover is placed worldwide, with the U.S. taking a 6% to 7% share through its own markets and an even larger proportion through U.S. companies underwriting in London. There is also considerable cover on this level in Lloyd's and other centers.

"But it was when we came to look for specialist excess of loss cover that we had to search for the best response. Fortunately Lloyd's underwriters were able to provide substantial shares on these special reinsurance protections, as well as participating on a direct basis.

"If it had not been for this very specialized area of operation, the risk could not have been placed in London and I think it was Lloyd's flexibility in providing these protections which was the key to completing the risk."

Mr. Blacker, who is a director of H. Clarkson (Overseas) Ltd., part of the Clarkson insurance group, estimates that between 15% and 20% of the risk is covered through help from U.S. insurance companies.

But the key to the whole affair is the way in which Clarkson cooperated with the plant construction experts in assessing the risk potential so that insurers could have the fullest information about their potential exposure.

It enabled a rating structure to be formulated that surprised many insurance representatives who had expected that the Mexican government would have to take some of the cover.

Criteria were developed which may be of tremendous value to other insurers who are asked to cover industrial plants in earthquake-prone areas.

"Exactly the right use of risk management concepts was adopted by us in approaching the problem, and seismological knowledge was used as well," Mr. Blacker said.

"The risk we were asked to place was on the Las Truchas steel mill, 60 miles north of Acapulco, which has been programed for completion in two stages to produce 4 billion tons a year by 1982.

"It is Mexico's largest ever industrial project and is located on the geological fault zone known as the Circum-Pacific which includes the San Andreas fault.

"But it had to be sited close to the source of its raw material, which is why it became a frightening insurance risk. Adding to the 'quake hazard is the fact that it sits just below a huge hydroelectric scheme from which vast amounts of water can pour if the reservoir dam is breached."

Finally the information was assembled that enabled the London market to be approached so as to provide both the capacity and a suitable rate structure.

It is believed to be the largest potential catastrophe risk ever placed in the world market, with the brokers placing the risk as reinsurance for the Mexican government company Aseguradora Mexiciana S.A. ■

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No-fault bill dead again 'till next year

WASHINGTON—Two key House and Senate committees have shelved federal no-fault auto legislation for the current session of Congress. Action on the measure, which is stalled at the committee level in both houses, now will not begin until January at the earliest.

Committee staffers said the extraordinary long debate on airbags and airline deregulation legislation pushed back the timetable on no-fault.

Optimism on the bill's chances of clearing Congress remains guarded. One committee staffer said House and Senate votes on the measure will be squeakers, but the bills would be passed. She conceded, however, that very opposition from trial attorney groups is "virulent. They are effective, very well-financed groups."

The Carter administration's backing of no-fault is viewed as a definite plus, though no one is willing to say if support from the administration will be a deciding factor in getting the bill through Congress.

Under the legislation (H.R. 7701 in the House, S. 6601 in the Senate), each state would be required to adopt a no-fault automobile insurance plan that met or exceeded the federal no-fault guidelines.

If a state failed to adopt a no-fault plan that met those guidelines, the federal plan would automatically go into effect.

The federal guidelines would allow a civil action to be filed if an injury suffered in an automobile accident resulted in permanent scarring, disfigurement or loss of bodily function.

In addition, legal action would be allowed if an injury prevented the victim from taking part in his usual actiivties for more than 180 days. Prior measures placed the cutoff at 90 days.

In the Senate, no-fault is pending in the Commerce Committee. In the House, the measure rests with Rep. Bob Eckhardt's (D-Texas) consumer protection and finance subcommittee. ■

Unnatural deaths declined in '76

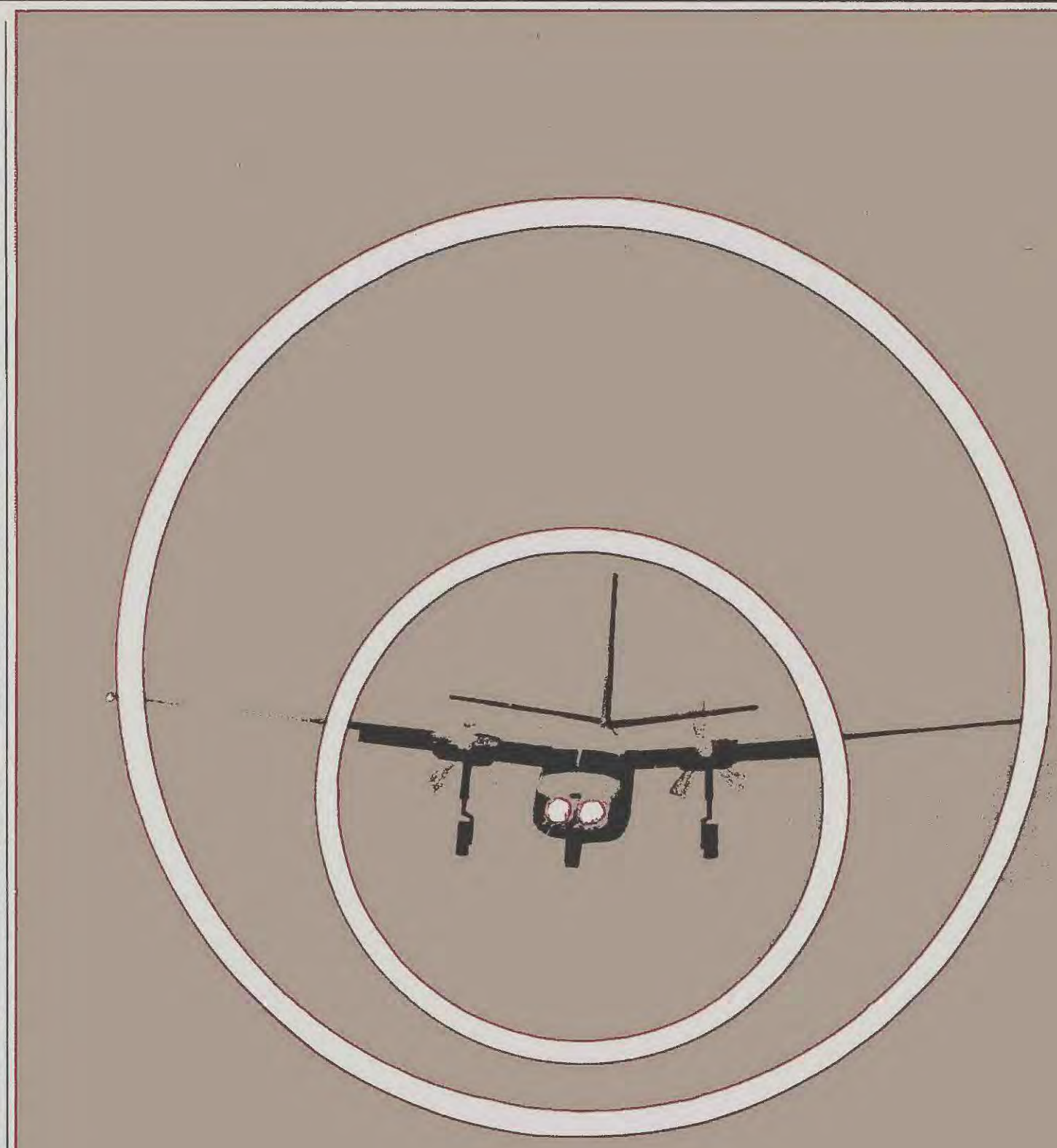
WASHINGTON—Deaths not due to natural causes—accidents, suicides and homicides—declined slightly in 1976 as a cause of death among ordinary life insurance policyholders, reports the American Council of Life Insurance.

In all, 8.6% of ordinary policyholder deaths were due to accidents, suicide and homicide, compared to 8.8% in 1975 and 1974, and to 8.9% in 1973 and 1972, the life insurance council said.

Motor vehicle accidents were responsible for 3.1% of deaths in 1976, with 2.9% attributed to other types of accidents. Suicide was given as the cause of 1.8% of deaths, while homicide accounted for 0.8%. ■

Life premiums

Premiums paid by policyholders accounted for 77.9% of every dollar received by U.S. life insurance companies in 1976, according to the American Council of Life Insurance. Insurance company investment earnings and other income produced the remaining 22.1% of money received.



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At The St. Paul we feel Enough is Enough.

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Arson fires cost over $1 billion last year. Who pays for this billion dollar bonfire? We *all* do.

When somebody decides to put a match to his business it is tough to prove. When arson for profit can't be proven, the insurance company has no choice but to pay. All of us contribute to these soaring damage claims by paying more for our own property insurance. Because insurance is merely sharing a risk among many.

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Help to have arson classified as a major crime. One with the same high priority for prosecution as robbery.

Push for uniform state laws on reporting, detection and investigation. Laws that would make arson harder to get away with. (Over 20% of all fires are thought to be arson, yet only 1%-3% of confirmed arson cases result in conviction.)

Work for programs to improve investigation techniques and cooperation among fire fighters, police officers and insurance investigators.

Write to state officials.

Tell insurance commissioners, police and fire department officials that you would like to see some changes made.

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For more facts circle 125 on reply card

ESOPs to take off, consultant predicts

CHICAGO—There will be 1,000 employe stock ownership plans (ESOPs) operating in America in two years—five times as many as there are today—predicts the executive vp of the nation's second largest ESOP consulting firm.

Mike Specht of National Shareholders Corp. says the recent Internal Revenue Service and Department of Labor regulations governing ESOPs and public acceptance of the concept are setting the stage for dramatic growth.

He is stumping the country with missionary zeal to spread that message, promoting seminars National Shareholders Corp. is conducting around the country. The seminars focus on the operation of an ESOP, the plan's advantages and the new regulations

The regulations are "totally positive," Mr. Specht said, and are not as restrictive as when first proposed in July 1976. The regulations:

- Permit an ESOP to hold different types of employer securities including non-voting common stock and preferred stock. The use of non-voting stock is important to employers who want to retain voting control.
- Permit the employer and the ESOP to have a right of first refusal over company stock that is not publicly traded. This protects small, closely held corporations.
- Delete the requirement for an independent fiduciary in loan transactions.
- Make clear that the voting rights owned by an ESOP do not have to be passed through to the plan participants.
- Permit conversion of a pension or profit sharing plan to an ESOP.
- Delete restrictions on the purchase of life insurance by the ESOP.
- Contain rules on the administration of an ESOP which engages in a loan transaction. The rules do not affect corporate leveraging, just ESOP leveraging.

National Shareholders Corp. recommends 95% of the time that its clients finance through the corporation, not the ESOP, so both principal and interest on a loan can be paid with pre-tax dollars, Mr. Specht said. But when special circumstances require financing through the ESOP, the proper procedure for doing so is now known.

The Los Angeles-based consulting firm, which has had a hand in establishing over 100 ESOPs, sees its market as companies with 50 to 500 employes. The company specializes in ESOP design and installation, including a three-hour presentation to the employes. It does not handle appraisals or administration but will arrange for the appraisal and help its client find an administrator.

The seminars, winding up in the next month in the West, are moderated by Mr. Specht. Speakers include National Shareholders Corp. president and tax attorney David H. Nelson and experts drawn from local banks, appraisal companies and the accounting firm of Ernst & Ernst.

Reference material, including an ESOP textbook, is covered by the $75 registration fee along with lunch.

Though tax and cash flow advantages in themselves make an ESOP attractive, an employer should recognize an ESOP as an employe benefit plan that motivates employes, Mr. Specht emphasized. By definition, the money is invested in company stock and is not subject to the prudent man rule of diversification as other plans are, Mr. Specht noted.

But in all his enthusiasm, Mr. Specht admits an ESOP isn't for everyone. A company needs at least 25 employes and a $300,000 payroll to support one, he suggested. Companies that don't want an employe benefit plan, don't need money or whose shareholders have no desire to give away stock should not consider an ESOP, he said.

But other than that, Mr. Specht believes that an ESOP is "the third employe benefit plan that should be explored as an alternative to profit sharing and pension plans."

•

For further information on the seminars, contact National Shareholders Corp., 626 Wilshire Blvd., Suite 840, Los Angeles, Calif. 90017; phone (213) 628-1804.

Spotlight on HMOs

With the push behind health maintenance organizations accelerating this year, every employe benefit manager is facing the tough decision of when and how to use HMOs. In a comprehensive story in the Dec. 12 issue, *Business Insurance* associate editor Kathryn McIntyre Roberts will look at the state of the HMO movement, how benefit managers are coping and how the HMO act is working.

BI editors will also examine the work of employe benefit consultants and update pending legislation in Washington in its spotlight on benefits.

Watch for *BI*'s special employe benefits issue, **Dec. 12.**

Life companies

There were an estimated 1,750 U.S. legal reserve life insurance companies in business at the beginning of 1977, four more than the previous year, the American Council of Life Insurance reports.

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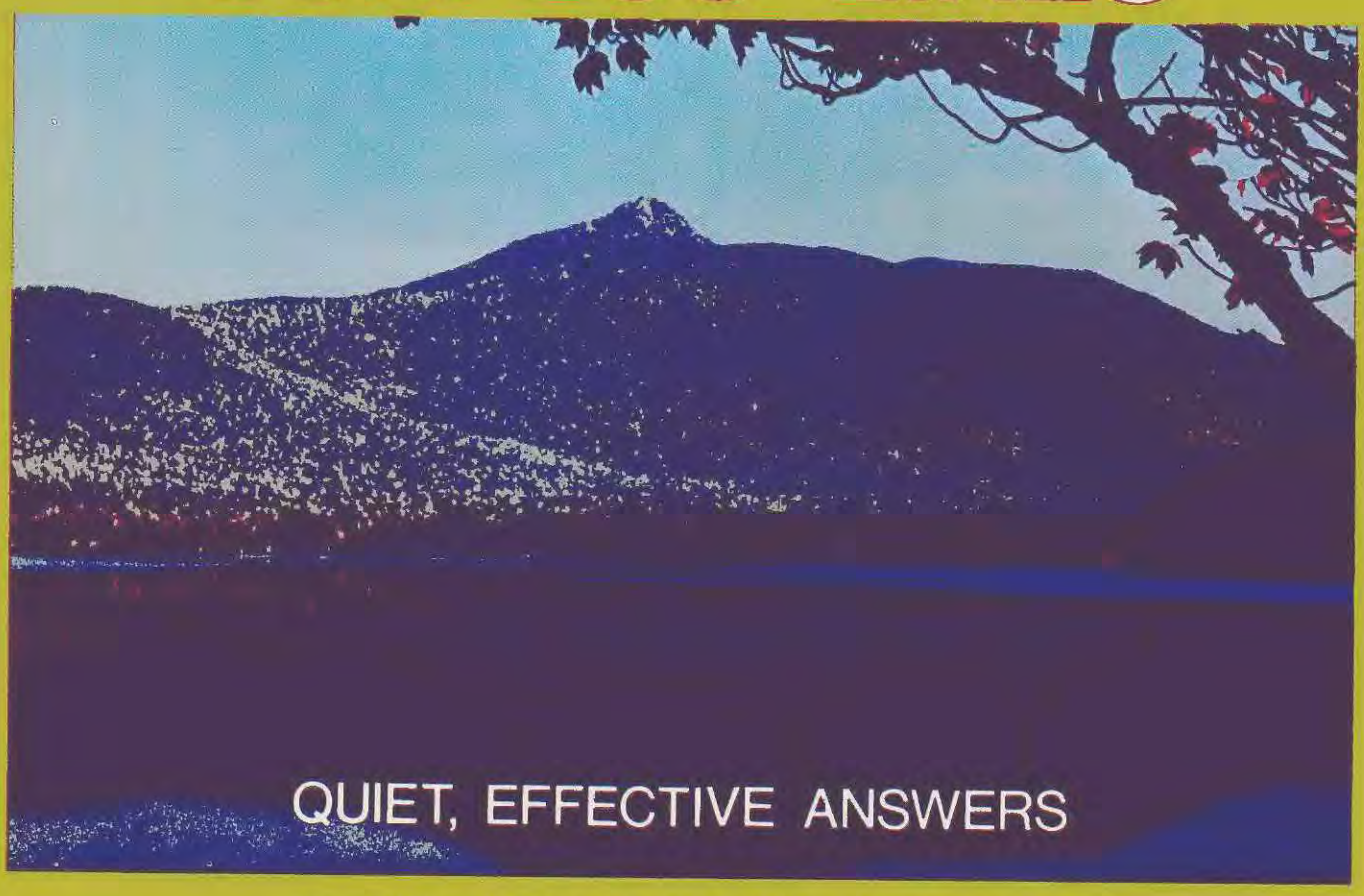

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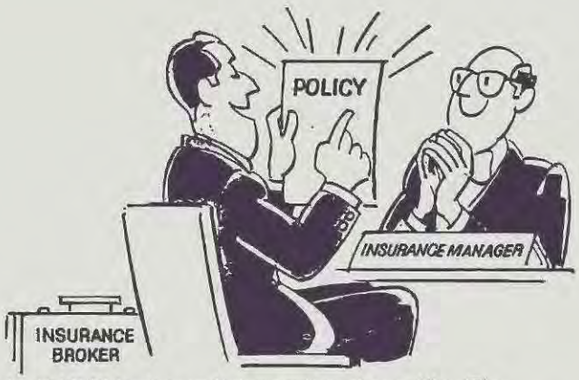
The sad history of an insurance broker who sold a fiduciary liability policy based on price.



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4. "You're the guy who told me that all Fiduciary policies are just about alike. I depended on you as my expert. You had better report this to your E & O carrier. We aren't going to stand for a loss. Especially when it was *your* fault."

5. "Gentlemen, I'm sorry but it looks like you're stuck for an uninsured loss. We depended on our broker's advice and apparently, he was wrong."

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N.Y. racing scandal

'Ringer' may have rung Lloyd's bell

NEW YORK—Lloyd's of London may have been taken for $150,000 in a betting and insurance fraud scandal involving the alleged switching of an imported live champion Thoroughbred horse for a dead also-ran.

The scandal centers on a winning entry in the ninth race Sept. 23 at Belmont Park, which paid $116 on a $2 bet and resulted in a payoff of at least $77,000 for one bettor. Betting and insurance records of several other imported horses, racing in other states, are also under scrutiny.

Authorities believe the winning horse in the Sept. 23 race entered under the name of Lebon, may have been a faster horse named Cinzano, which supposedly died in June on a farm in Muttontown, N. Y.

Shortly after Cinzano's reported death, a $150,000 blood stock insurance policy on the horse, underwritten by Lloyd's, was paid out to Joseph Taub. *Business Insurance* was unable to learn the identity of the broker who placed the policy in London.

Both Cinzano and Lebon were brought into the United States from Uruguay in June by Dr. Mark Gerard, a New York veterinarian. The two horses were delivered to Dr. Gerard's farm on Long Island, where Cinzano was reportedly destroyed after being injured.

According to The New York Times, attorneys for Dr. Gerard have confirmed that he was the big winner in the Sept. 23 payoff on the Lebon entry.

Since both Lebon and Cinzano were recent entries into the United States, neither horse had a lip tattoo required of all Thorobreds running in this country. In addition, Cinzano was never officially registered and photographed by the Jockey Club, a regulatory agency for horse identification in the United States.

However, the horse entered in the Sept. 23 race as Lebon had a complete set of identification charts registered with the club. It has yet to be determined whether the horse entered as Lebon was instead Cinzano.

Officials at General Adjustment Bureau of Jericho, N.Y., the firm approving payment of the claim, would not comment on the case except to say that it was "premature" to call the matter an insurance fraud, pending completion of the district attorney's investigation.

A spokesman for Nassau County District Attorney Dennis Dillion said his office would have no comment until the probe is completed.

However, at an Oct. 31 hearing on whether Dr. Gerard should be suspended from racing, the state racing board said information contained in an insurance report filed by the veterinarian on Cinzano was "false and misleading."

Records on several other horses brought into this country are being probed for possible "ringer" substitutions. These include two other horses brought here from Uruguay by Dr. Gerard in 1975: As de Pique II, recently running at Monmouth Park in New Jersey, and Enchumao, which broke down and was put to sleep on a Florida track in February.

Enchumao's last owner, Michael F. Wettach, said a $10,000 blood stock policy written by Lloyd's covered the horse. ■

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Director unnamed, scope unclear as retirement commission stalls

Crain News Service

WASHINGTON — More than four months after President Carter announced he would act "very quickly" to appoint a blue-ribbon retirement commission, all that exists is a general consensus on who the director should be and a file of suggested commissioners.

Officials at the White House and the Office of Management and Budget all say that Charles Kirbo, the Atlanta lawyer who is a close friend and confidant of the President, is the only contender for the chairmanship.

One report said that Mr. Kirbo has been officially offered the chairmanship, but other sources denied it.

"There's no firm decision as far as I'm aware," said the OMB official in charge of setting up the commission.

Selection of someone to direct the commission is holding up progress on naming other members and on focusing on the commission's purpose. It is not clear, for example, whether the main emphasis will be federal and other public plans, with private plans being studied only as they relate to Social Security, or whether the private pension system—and particularly the administration of ERISA—will take center stage.

One source said Mr. Kirbo is very concerned about the implementation of ERISA.

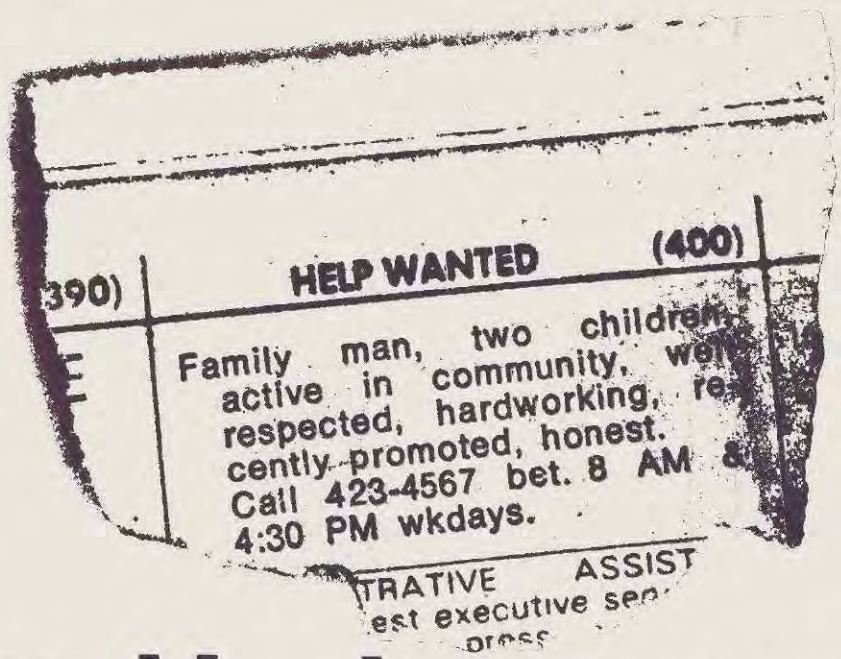
However a White House official who is currently in charge of the project indicated that the main emphasis would be how the federal government interacts with retirement programs.

"There will be no major relook at ERISA," said Frank Raines, assistant director of the Domestic Policy Council. "The only question in our minds is how the government gets involved."

Mr. Raines said the two primary areas of study would be the public pension system, including federal programs, and the "relationship of Social Security and private pensions."

According to Mr. Raines, the White House is concerned about the adequacy of benefits in public funds, funding, the relationship of Social Security—"double dipping, triple dipping, quadruple dipping"—and the cost impact.

He said the commission would probably have a two-year charter. ■



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agent/broker topics

Goals vary, but brokers cement Lloyd's ties

By BARBARA JEAN GRAY

CHICAGO—Blessed be the tie that binds.

And happy are the U.S. brokers who are contractually affiliated with London brokers.

The reasons for formal link-ups with Lloyd's brokers across the big pond are as diverse as the U.S. brokers themselves. They may be cementing relationships for reasons of investment, for better communication with London, for a presence in Lloyd's own city, or for diversification purposes.

Whatever the reasons, the solidification process has been increasing over the last five years.

The relationships are different from other foreign ventures because the underwriters at Lloyd's of London may accept business only through one of the 260 Lloyd's brokers in London.

Most recent is the association between Alexander & Alexander Services Inc. and Alexander Howden Group Ltd. Together, the second largest publicly held broker and the large U.K. reinsurer have agreed to form Alexander Insurance Services (Bermuda) Ltd.

The joint venture will be a holding company, Alexander Insurance Services, with two wholly owned subsidiaries. Alexander Underwriting Agencies Ltd. will be underwriting agents for Hemisphere Insurance Co. Ltd., a wholly owned subsidiary of A&A and for Trent Insurance Co. Ltd. a subsidiary of Alexander Howden Group Ltd.

The operation will be underwriting reinsurance from the London market produced primarily by Alexander Howden, explained Robert A. Gielow, senior vp of A&A and head of the risk analysis and management group. All of the reinsurance premium will be coming from London.

The venture is currently accepting business in Bermuda for 1978 and will become effective Jan. 1, he said.

"We feel that by joining with Alexander Howden in this on a 365-days-a-year basis, we're strengthening our position of obtaining good insurance business and having the opportunity to respond to what we hope is more profitable to the reinsurance market," Mr. Gielow said.

"It is a response to the growth in the reinsurance market and to the desire to write more reinsurance out of the London market. By joining with somebody, we feel we're insuring a continued path of reinsurance business to our own hemisphere.

"Competition for third-party reinsurance is becoming acute."

The U.S. broker with the most ties with London brokers is the largest in this country, Marsh & McLennan. In 1972 its holding company, Marsh & McLennan Cos. purchased a 20% equity interest in Bland Payne Ltd. The remaining 80% of the London broker is held by the Midland Bank Ltd., the third largest bank in the UK.

"It's a financial investment," said Marsh & McLennan Cos. president Robert J. Newhouse Jr. Bland Payne is one of the three principle London brokers of a total of 20 with whom the U.S. firm places business. The return on investment has been "exceptional. All London brokers have done well partly due to the devaluation of the pound. From a financial standpoint, it has been extremely satisfactory and as a communication link with everyone in London."

In one equity interest purchase that goes from East to West, C. T. Bowring & Co. Ltd. this year purchased a 20% interest in Victor O. Schinnerer & Co. Inc., one of the three companies in the Marsh & McLennan Management Co. Schinnerer is an underwriting manager of excess and surplus lines.

"The rationale there is that Schinnerer, which has been in professional liability, wanted to expand to other excess and surplus areas and felt a link would be advantageous in line with its plan to expand beyond professional liability," Mr. Newhouse said. The remaining interest of Schinnerer is held by M&M.

Additionally, the nation's largest broker has two joint ventures with London brokers. Seven years ago M&M, Bowring and other investors bought an equity interest in Intercontinental Reinsurance Co. in Bermuda.

More recently, M&M plus other investors, including Bowring, formed the Tower Hill Insurance Co. Ltd. to underwrite business in London with premiums available for reinsurance through captives. M&M has 35% of the Tower Hill Insurance Co. and Bowring has

Continued on following page

Links to London

Insurance agents get involved

Citizens approve rates in Kentucky

By BARBARA JEAN GRAY

FRANKFORT, Ky.—What did the Kentucky Auto Dealers Assn. think of the practice of rating their garage dealer liability coverage by number of employes rather than by payroll, asked the Insurance Services Office and a citizen regulatory board.

The change would mean a rate increase for some auto dealers and a rate decrease for others.

The auto dealers replied that the new method was okay.

This joint meeting of commercial insurance buyers and the board last July was one of the first official acts of the new property/casualty board. The "audience participation" was the brainchild of George C. Rupert, the insurance agent on the board.

Kentucky's regulatory board, created by an executive order of the governor, consists of seven citizens drawn from a crosssection of occupations. Insurance commissioner Harold B. McGuffey chairs the board but votes only in case of tie. Kentucky is the latest of at least three states to place regulatory authority in the hands of citizens.

ISO felt the status of a rate revision should be held confidential, Mr. Rupert said. But the attorney general felt that the regulatory board meetings were covered by Kentucky's "sunshine law" which requires open meetings.

"I decided to take the position of the consumers' advocate on the board," said the president of Rupert-Hager-Crowell Agency Inc. in Ashland. "My position is not being a watchdog for the agents. There's nothing to watch. My idea is to improve the public's image of insurance in toto.

"It's a whole new dimension and I view things quite differently. Being exposed to the nuts and bolts has given me a little better appreciation for the companies who present rate filings with proper details behind them and with a more credible base.

"For example, there has been a great deal of criticism on the National Council on Compensation Insurance rate filings and there has been a considerable amount of publicity.

"The one thing I have learned in all the time we have been pondering these filings is that theirs appear to be the most credible rate increases I have seen. To me as an insurance person, the one thing of great importance is that the insurance business maintain credibility with the legislature, the public and itself.

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"I like credibility. In the insurance business people are too loose with facts; often there's no substance. I think this is why the insurance business in general is in trouble with the public. If there is one thing the insurance business needs it's to be credible about its right to make a profit.

"We need more self-regulation. We're regulated by people not in our business, strangers to the insurance business."

Serving on the board "an opportunity to do some little bit to make the insurance process work better."

Hager-Rupert-Crowell in Ashland, Mr. Rupert says, is a "large family agency that used to be a small family agency. Among the approximate 20 other employes are his brother and father.

Mr. Rupert accepted his two-year appointment from the governor with some reservations.

"I get my license from the department and I am subject to the regulations. It might seem to be awkward, but one thing I think the insurance industry needs is input from a broad spectrum of the business. The service we render is more valuable than any awkward positions which could arise and there have been no problems so far."

Kentucky's regulatory board is subject to legislative approval at the next January session. Its members were appointed by Gov. Julian Carroll, as was insurance commissioner McGuffey.

The order identifies the sectors of the public from which the board members will be drawn and the length of their staggered terms. In addition to Mr. Rupert, Robert B. Preston, vp of the Kentucky Central Life Insurance Co. is serving a one-year term as the insurance industry executive; Billy Joe Hall president of the Mt. Sterling National Bank is serving a two-year term as the commercial consumer

Continued on following page

Inside:

Broker's captive
Baldwin & Lyons discovers a captive is a way to insure consistent growth even during tight markets. **Page 32C.**

Looking at 1987
Fees for service arrangements and employe benefits will be much more important to the top brokers a decade from now. **Page 32F.**

Mass marketing
The exact outlines of new regulations for mass marketing are still under negotiation, a public hearing in Chicago discloses. **Page 32G.**

Agents' lobbyist
California agents and brokers are the first group in the nation to have a full time lobbyist working for them. **Page 32J.**

Kentucky board . . .

Continued from preceding page
representative, and Richard C. Horn, insurance professor at East Kentucky University is representing the academic community for a three-year term. Representing the buyers of non-commercial insurance are Jackye Wilkins, union president at Southern Bell for three years; farmer and realtor William K. Henry for four years and former Louisville alderman and minority group worker Lois Morris for four years.

The board's first job was to tackle the backlog of rate filings that has accumulated since December when Gov. Carroll put a freeze on all rates.

The backlog

Commissioner McGuffey estimates the board has reviewed between 150 and 200 filings to date and is now caught up. The board has approved increases as high as 39.3% and decreases as low as 18%. The average adjustment has been an 18.9% increase, covering all classifications. About 10% of the increase requests have been denied.

The reason for the freeze, according to the commissioner was that "I was accused to have granted excessive rates, primarily by labor and trial lawyers for workers comp. The governor and I and the staff knew we were right, but the governor created the board to share the flack. Also, if you have seven people deciding the rates, the public could swallow it better."

Commissioner McGuffey feels the board is working well so far. "Just how well the board responds will depend on the makeup of the people and with the present makeup I don't think we will have any trouble."

Rating authority is not new to Mr. Preston. He served as insurance commissioner from 1967 to 1971 and was appointed by both a Democratic governor and a Republican governor.

The parent company of his firm is Kentucky Central Insurance Co. which has a casualty division subject to the regulatory board. When filings for this division come up, Mr. Preston disqualifies himself from the voting.

About 400 companies file in Kentucky, about half of which are independent, he estimates.

"Every member of the board has the opportunity for a conflict of interest, as a policyholder if nothing else. There is no way we could have people who at one time would not have to disqualify themselves at one time or another."

The board meets regularly twice a month and members are reimbursed for travel plus a $50 per diem.

Presently the budget for the regulatory board is being drawn from contingency funds of Governor Carroll. Commissioner McGuffey estimated between $40,000 and $50,000 as the first year's budget.

In January Governor Carroll plans to increase the per day to $100. The insurance department has budgeted about $80,000 for board expenses in fiscal 1979, the commissioner said.

In addition to approving rates in Kentucky, a prior approval state, the board also has investigative authority.

The board will also be able to investigate the rate making process, probe current marketing practices by insurance companies, consider a system of monitoring insurers and establish minimum standards for automobile and homeowners insurance.

Mississippi

While Kentucky's citizen rating board may be the most extensive, it is not unique. Mississippi has given rating authority to a three-citizen panel since 1924.

One representative is appointed by the governor, the attorney general and the insurance commissioner. The attorney general's appointee may not be active in the insurance industry.

The panel presently has two insurance agents. Thomas L. Delashment of the Moss Point Insurance Agency in Moss Point has been the commissioner's appointee for the last one and a half years. A. Q. Greer of the Greer & White Insurance Agency in Holly Springs has been on the committee for 16 years and has chaired it for the last 14.

"I think it's important to have someone on the commission who knows about insurance. If you have three farmers or lawyers, I think you'd be in trouble," said Mr. Greer.

Mr. Greer believes Mississippi's pioneering role in this area "has worked. Over the years we have had a lot of people looking at our situation. We keep rates out of politics. I think it's very important. In years where markets were tight we have enjoyed a market situation better than many other states."

Being on the committee "has not made any difference in being an agent, although I understand more about the regulatory business. I have always tried to be fair with all companies. Over the years I have always felt I represented the consumer. We have granted increases when they were due and denied them when not. It has given me insight into insurance companies and how they operate."

Greer & White generates about $1 million in premiums about half of which are commercial.

Mississippi's panel has regulatory authority on fire, casualty and inland marine lines. The commissioner, who is elected, serves as the ex-officio chairman without a vote. Members are paid a flat $5,000 annual salary for their work.

"One person making the decisions is not enough," says Robert Gibson, director of the commission. "We don't think that one person should have the power. Too much goes into it."

Louisiana

Louisiana has had citizen rating authority in various forms since 1936. The present arrangement established in 1972 is a six-person board appointed by the governor with the elected commissioner acting as an ex-officio and a voting member.

The panel was created by the merger of three separate rating committees on casualty/surety, fire and allied lines and marine and inland marine.

Two of the six citizens are insurance agents. Bobby Dupre of the Dupre-Carrier-Callahan Insurance Agency in Opelousas has served since 1972. The experience has helped him combat questioning of premium rates by his clients, Mr. Dupre says. "I'm a local agent and it has given me insight into company problems which were extensive in 1974 and 1975 when surpluses were strained heavily. Today, the companies are still feeling the results of it."

Photo: Barbara Jean Gray

"I decided to take the position of the consumer advocate on the regulatory board," said George C. Rupert. Mr. Rupert, president of an Ashland insurance agency, is one of the members of the Kentucky regulatory board.

Conflicts of interest

If the company filing for an adjustment is a company he represents, "I will vote but I won't make the motion. I try to give what I know about my business to the commission. They have to lean on us for information."

Alymer Montgomery of the Montgomery Insurance Agency in Monroe has also served since the merger. "It keeps me in close contact with the business. I think it's necessary for an agent to be on the board because an independent agent usually has a better grasp of the business than the lay person and I believe that it gives a better balance to the board."

Mr. Montgomery said he has never felt a conflict of interest.

Other members of the Louisiana board include a building materials dealer, a jewelry salesman, a realtor and a housewife. Each is paid $50 per day.

South Carolina has had a citizen advisory panel since 1960 when the governor appointed a five-member commission to select an insurance commissioner and to advise him on administration and laws, including rating.

According to the provisions, no more than two of the members may hail from the insurance industry ranks. The commission's present chairman is insurance agent Claude McCain of the McCain Insurance Agency in Denmark who has been on the commission since 1967. The commission meets monthly and the members are paid $100 per year plus expenses under $25 plus mileage to each meeting.

The suggestion of a citizen's rating panel was brought before the rating bureau in North Carolina recently, but the idea got little support according to Charles M. Plaxico, staff attorney for the commission. ■

Links to Lloyd's . . .

Continued from preceding page
20%, Mr. Newhouse said. The remaining interests are held by other investors.

Fred S. James & Co. Inc. began a joint venture with London broker J. H. Minet & Co. Ltd. in 1974 when it purchased a 31.8% interest in Minet James International, an international holding company which has offices and brokerage operations around the world. Minet James International is headquartered in the U.K. and the managing director lives in Nairobi, Kenya. MJI operates everywhere except in the U.K., the U.S., Bermuda and Canada. In this arrangement, Minet purchased about 10% of James' stock.

"The advantages of such an agreement are that we obviously have an international operation that owns equity interest in offices throughout the world," said international operations director Alton Irby III of James' Atlanta office. Including those added this year, there are now 50 such offices, he said.

Similarly viewing the international entrees as the prime advantage is Corroon & Black Corp. which has held a 35% ownership of Glanvill Enthoven Ltd. since 1975. Directing the international operations from his Nashville headquarters, senior vp Hunter Armistead said, "The least important reason is the investment aspect. There are operational aspects necessary before we would consider investment.

"It gives us an immediate entree into the areas where it's located outside of London, like Nigeria, Spain, South Africa and New Zealand. We think that it enables us and Glanvill Enthoven to service accounts better not only in areas where we have offices but where we don't. We have arrangements in various countries to call on people. It gives us a worldwide source of new business. I think it gives us another London broker source. We do business with a number of them. We give each other leads back and forth.

Intimate links

"As an owner, we have a more intimate link in the London market. Having an ownership interest, we seem to be more current with the London market.

"We make a nice profit but the operational aspect is the prime necessity of the relationship."

The other 65% interest in Glanvill is owned by Charter House, a British holding company.

The investment was prompted because "we felt we needed to broaden our geographical service area to our customers to gain whatever expertise possible in ownership to foreign subsidiaries," Mr. Armistead said.

The smallest broker to have an official equity interest in a London broker is the Arthur J. Gallagher & Co.

That firm entered into a joint venture with Hinton Hill & Coles, Ltd. in 1973. The result was Gallagher Hinton & Verecker. The U.S. broker owns 57% of the operation, Hinton Hill & Coles 26% and the managing director of the firm owns 17%.

"The primary advantage of the set-up is the service we can relate to our clients," said president Robert E. Gallagher. "We're involved with our own people in the London market, both Lloyd's brokers and the rest of them. It's a very strong added service that we're providing our clients."

With the exception of a few specialty lines, Gallagher places all of its London book with Gallagher Hinton & Verecker which operates through Hinton Hill & Coles.

Regarding the return on investment, Mr. Gallagher said, "we're bullish. It's a small entity, but very growing and vital.

"The great advantage is the extra service to the client. Other operations might not have the same style, speed and efficiency. These are our own people, caught up with the same fire and professionalism as we are here."

Johnson & Higgins, the nation's largest privately held broker, has enjoyed an exclusive relationship with Willis, Faber & Dumas, Ltd. since the 19th century.

Enduring relationship

"We consider this relationship to be unique both in its breadth and longevity among all the relationships which exist between American and English brokers and we believe it has produced over the years many important and unduplicable advantages for our clients. With the continuing importance of the London insurance market in all areas, we are confident that this state of affairs will not change," a J&H executive reported.

This summer, J&H, together with Willis, Faber and another exclusive correspondent, Jauch & Hubener of Germany and Zand Insurance Offices, opened an insurance and reinsurance brokerage firm in Teheran, called United Iranian Insurance Services.

The managing director of UIIS is Mahmoud Zand, president of Zand and other senior employes are from J&H and Willis Faber.

Although the U.S. brokers have obviously been aggressive in pursuing ties, one of the earliest official link-ups between the North American continent and London was initiated by the Toronto-based Reed Shaw Osler Ltd. Through its European subsidiary, A. R. Stenhouse Reed Shaw & Partners Ltd., it acquired in 1971 the London brokerage firm of Sir William Garthwaite Ltd. Two years later, the subsidiary purchased another London broker, the Wright, Dean & Co. Ltd. Reed Shaw bought them both totally and "I don't think it would be possible today because the committee at Lloyd's does not like it," observed a spokesman for the firm.

Reed Shaw Osler places business with brokers other than those two firms on such lines as aviation, the executive said, and conversely the two brokers accept business from brokers other than Reed Shaw.

"We acquired them for having a presence in London. We had always had a portfolio, so it made good sense. The greatest advantage is that whatever profit is made, it goes to our own firm. We don't see any advantage for a competitive reason.

"Obviously, from this point of view one is also in a better position to influence operations over those businesses. With a minority position, you cannot do that. That would be true of any business." ■

Brokerage firm discovers its captive is the avenue to consistent growth

CHICAGO—For an insurance brokerage firm to have a captive insurance company during normal market conditions is convenient; in tight market conditions owning a captive is enviable.

Even with the underwriting losses suffered by insurers in recent years, Baldwin & Lyons in Indianapolis has reported increasing revenues for the last four years and steady or increasing net income. Baldwin & Lyons, a transportation specialty agency, is the sole owner of Protective Insurance Co.

Until 1972 greater growth was registered by the agency, even though the insurance company was the major contributor to earnings since its creation in the mid 1950s. Then the markets tightened and Protective Insurance Co. became the growth factor.

One of its best customers has been Baldwin & Lyons, which has placed 78% of its business so far this year with its wholly owned casualty insurer compared to 25% five years ago.

A built-in insurer is not an instant problem solver however because along with built-in capacity is built-in loss experience.

"With the shrinking of these excess markets and utilization of Protective we had to be sure it was good business because if it failed we partly felt the effect. Before, if it didn't perform for INA or someone else, that was their problem."

In estimating a risk " you can look at five years experience and say 'What can we anticipate because of past experience?' in coming up with a material figure. Over five years you should know all the good and bad that can happen and can project from that."

Last year, Protective contributed about two-thirds of the firm's $1.8 million in income. In the five-year period from 1972 to 1976, consolidated net income was relatively stable. Net income went from $1.6 million in 1972 to $1.6 million in 1973, $1.9 million in 1974, $1.8 million in 1975 and $1.8 million in 1976.

Income strictly from the brokerage operations during the same years dipped then rebounded. In 1972 income from the agency was reported at $530,000, $387,000 in 1973, $316,000 in 1974, $358,000 in 1975 and in 1976 at $637,000.

For the first nine months of this year, gross revenues of the brokerage operations were up 11% over the comparable period last year, rising to $2,959,986 from $2,672,230 in 1976. This equalled 11% of the firm's consolidated revenues and 24% of its net income.

The tail did not always wag the dog. Although the brokerage firm now is a marketing arm of the insurance company Baldwin & Lyons began strictly as an agency in 1930. In the late 40s a mutual company was formed to handle the hard to place transportation risks the broker specialized in. From this mutual company, a stock company was formed in 1954, Mr. Smith recalled.

This year about 30% of the risks of Protective Insurance will be placed by Baldwin & Lyons. The agency gets a 10% commission on this business, although any other broker placing business would have received between 15% and 20%.

Baldwin & Lyons went public in 1969. Mr. Smith joined the firm a few months later after a 15-year career in the banking business. He says he spent a lot of time at the beginning auditing the insurance industry and found that everyone was an "expert" and that he was an "outsider." After seven years in the industry he believes "the industry needs more outsiders."

With the experience of an agent and the breeding of a banker, Mr. Smith also has the perspective of an insurer. In viewing the capacity situation which has had major effects upon the overall business Mr. Smith notes that while insurers are beginning to make a comeback in the black, casualty insurers are not yet out of the woods.

"The nation's insurance needs are growing at an annual rate of 11%. Continuing at this rate there will be a need for $120 billion in writings by 1985 and a surplus of $40 billion," he said.

"With the $22 billion the industry has today, $18 billion must be attracted so the industry can provide coverage. Rather than making progress towards these goals the industry has less that it had at the end of 1972."

The reasons for this, he feels is that the "brainstomers thought that 110% loss ratios would be covered by the underwritings in

Continued on following page

Photo: Barbara Jean Gray

"With the shrinking of excess markets and utilization of Protective (our own insurance company), we had to be sure it was good business," said Merritt W. Smith, chairman and chief executive officer of Baldwin & Lyons Inc.

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Baldwin & Lyons . . .

Continued from preceding page

1973 and 1974. But they found that not to be true. They were faced with the diminishing opportunities due to the stock market and the value of their own portfolios and their subsequent underwriting losses. So they were being cut with a double-edged sword.

"Traditionally, the industry has looked at the ratio of two to one, writings to surplus. Beginning in 1973 through 1975, we saw ratios going up to 6 to 1.

"We retain a most conservative writings to surplus position, 1.7 to 1. Most companies have a 3 to 1 or better ratio.

"We're specialists in transportation. There were so many new companies coming into the field in 1971 and 1972 that had never been there before. They were scratching for new business.

"In the latter part of 1973 and into 1974 the money markets started a dramatic decrease and careless underwriting was done. The losses started coming home."

The industry lost some $9.2 billion between 1973 and 1975 and although there is some slight improvement in 1976, it has not still fully recovered, the executive believes. Furthermore, the gains being shown now are in personal lines and not casualty.

"Protective had projected some of these trends and in 1971 and 1972. We elected not to compete on what we considered unprofitable business. We put pressure on insureds for higher rates. For the most part, our accounts are experience rated, so when we put in for a rate increase we had to make sure it was salable. In some cases it was not. We were still being undercut by 20% or 30% in some cases.

"As this was happening, many of these insurers began abandoning commercial vehicle risks. That left us standing."

Protective took on new business in 1974 and especially 1975. "We were growing at a rate of 60% and it was too darn fast. We saw this happening and decided to get brakes on, but didn't get it accomplished until 1975."

One of the main purposes of the firm's second stock offering in 1972 was to build a base for Protective, the chairman recounted.

"We had utilized the London market so there were pressures there to control their writings on the excess. Where prior to these problems we placed excess over $100,000, we started to discover that these markets were not interested in anything less than $1 million. So Protective filled that vacancy for less than $1 million."

These risks were used for self-insurance retentions for its major commercial vehicle risks. Baldwin & Lyons handles its major transportation risks through its transportation underwriters division in which all clients are self-insured.

Regulated common carriers comprise 98% of the broker's business and they include such jumbos as Roadway Express Inc. and Yellow Freight System Inc. "It's our bread and butter and we will stay in that area" he claimed although it does look for diversification opportunities.

The agency has an office in San Francisco, but the firm's other nine domestic offices are primarily for Protective.

"We felt these offices for the most part either directly or indirectly generate business for Protective. We had hoped that we could ultimately develop these into general agencies so it would not only be motor transportation but other things. But with the problems of the last seven years, we have been adhering to the basic business."

Transportation companies may lend themselves to self-insurance more readily than other industries because claims handling is an extension of cargo claims transportation firms have always had, he continued. Compared to other types of insurance, self-insurance affords the clients both savings and the ability to control and utilize cash on a day-to-day basis.

Insurance costs are getting more attention than ever before now that it may equal 4% of the budget compared to 1% or 2% a few years ago. "There was a time when insurance was the collateral responsibility of some staff person. Today, at least the chief financial officer is aware of insurance," he observed.

"In the commercial vehicle area, one of the factors affecting premiums has been social inflation. If a truck is involved in an accident—from a social attitude viewpoint—they say 'look at this monster of the highway. It has to be his fault.' This is the social attitude.

"The thing that the public does not realize is that one out of every hundred is a regulated type of carrier. The independent operator is the person trying to make a living and carry freight whenever he can. That's when they start getting careless with long hours of driving, etc. That's not to say that regulated carriers don't from time to time make similar mistakes."

But loss prevention, which has been given a lot of lip service in the past is becoming much more important he said. —bjg ■

Texas agents find profits are up 5.5%

AUSTIN—Net profits increased 5.5% annually in the last six years for members of the Independent Insurance Agents of Texas, an agency cost survey revealed recently.

The survey was conducted by Agency Records Control and was compared to figures submitted by the agents group in 1970.

According to the association's newsletter, premiums for the agencies responding increased 67% while property/casualty commissions rose 60%. Selling expenses jumped 102% and operating expenses shot up 79% during the same period, resulting in an aggregate 38% net profit increase between 1970 and 1976.

The average commission rate decreased 13%, from an agency average of 18.2% in 1970 to 15.9% in 1976.

Twenty-two percent of all fire and casualty premiums were directly billed in 1976 compared to 5% in 1970.

Automobile was the largest classification of fire and casualty income in both surveys. In 1970 it accounted for 35% of income and in 1976, 31%.

The number of agencies incorporated quadrupled in the six-year period. In 1970 5% of the agencies were corporations, but 20% of the respondents were corporations in 1976. Sole proprietorships declined from 52% of the respondents to 48%. Partnerships decreased from 43% to 32%. ■

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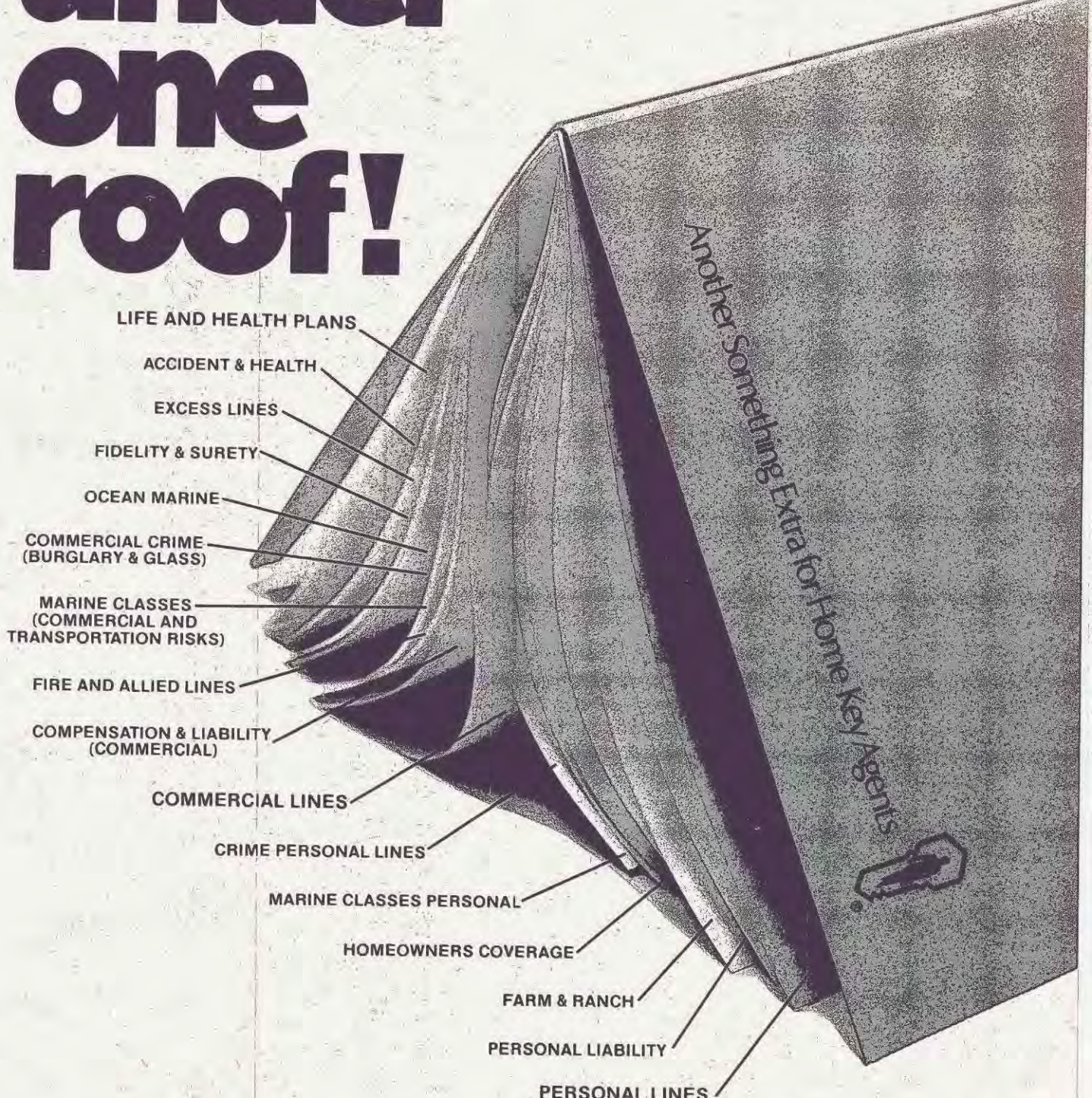

Where, oh where, is the elusive daily report?

A fictional account may be more truth than fantasy, from what we hear about your business. This lighthearted view of the broker's workaday world is designed to sprinkle a little oil on the daily grind (no pun intended, but read on to find out why).

By BARBARA JEAN GRAY

Running an insurance brokerage house is a snap. Right? . . . RIGHT? C'mon now, is it right or isn't it?

To substantiate this assumption, Agent/Broker Topics sent out its omniscient eye to survey the scene.

The omniscient eye decends upon a brokerage firm and focuses on commercial producer par excellence who is avidly reading a copy of *Business Insurance*. He is aborbed in a story on an expert's estimate that an average commercial insurance transaction should take 20 minutes.

As he scoffs at this efficiency standard, his telephone rings.

It is a client, making a claim under a commercial property policy. He duly notes the facts, hangs up, and proceeds to the file.

He observes the time, 9:02 a.m. and sets out to finish the transaction in less than 20 minutes. "Ha! Twenty minutes! That's nothing!"

He steps lightly to the files and begins scanning the C's. "MMMMMmmm . . . Client, Client, Client. After B and before D, right?" The daily is not there. Where is the daily?

Perhaps it's in the claims department being processed for a different claim. To the claims department he directs himself, noting that it is already 9:05 a.m.

"Client, Client, Client" he mumbles to himself as he thumbs through every pile of papers on every desk, still not finding the daily.

By now it's 9:07 a.m., according to his watch. His self-imposed schedule is already doing poorly.

Maybe in underwriting. Quickly, he turns on his heel and moves toward the underwriting department.

In the underwriting department, the search becomes frantic. "Where is the daily Client?" he accuses the workers there. "I mean, the Client daily?" By this time the frenzy is beginning to show on his face and in his voice.

Producer par excellence plows frantically through mountains of papers on desks, in typewriters and wastebaskets. "It must be here. It must be here."

Looking again to his co-workers, each in turn, he implores "Where is the daily? It's 9:13!" When they each shrug in ignorance, he asks the file cabinets, the walls, and finally the ceiling "Where is the daily?"

Accounting! That's it! Maybe it's in accounting, probably there for a correction. Toward accounting.

"OK you guys where is the client daily?" he charges into the room.

"Client?" the department members ask. "Daily?"

"Yes! The daily for Client. It's already 13 minutes past the start. I only have seven minutes left!

"Not in the file, not in claims, not in underwriting, not in accounting. Where is the daily? How can I complete a transaction in 20 minutes if I can't even find the daily. How?"

That's it! Maybe with producer Zilch for an endorsement!

Producer Zilch isn't at his desk. Producer par excellence rifles through the papers on his desk, then turns and leaves the office in frustration. Perhaps it's on producer Zilch's secretary's desk. She is not there, either.

"Where is she? Isn't she here?" Producer par excellence asks a fellow worker in the room. The fellow worker looks at the empty chair. "I don't see her there, do you? Do you?"

"Do you know if she has Client's daily?" our hero asks.

"Yes, she was working on it yesterday."

Producer par excellence's eyes widen with disbelief. His body tenses like an animal of prey on the scent, moving in for the kill. It's 9:15 a.m. Seven more minutes are left for him to show those efficiency experts!

"Where might she have put it?" he asks of the employe, but without waiting for a response he begins ferociously digging through the files. "Client, Client, Client. . ."

It is not there.

"Where did you say she might have filed it?"

"Well, if she was working on an endorsement, she probably filed it under 'E'."

"E?"

"Yes, E. Zilch always has her file them under E. E for endorsement."

The eyes of Producer par exlence roll back in his head, then quickly return so he can check the E's. Yes. There it is. Finally. The Client daily. At last!

Clutching it tightly in his hand, he trips over his feet hurrying back to his desk and fall exhaustedly into his chair. It is 9:22 a.m. precisely. A full twenty minutes from when the search began.

He glances at the *Business Insurance* story, muttering to himself. "Yes, but did they say what kind of a transaction?

"Maybe the other workers just didn't understand that the daily report is the abbreviated policy information sheet. Should I tell them? Let's see, for me to make the rounds and explain that would take about about 20 minutes. Or maybe 18 if I hurried. Or maybe. . . . "

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The broker of 1987

Fee for service to increase, brokers say

CHICAGO—Fee for services arrangements will be two-and-a-half times more important to the overall revenues of the brokerage firm of 1987 than they are today.

Employe benefits will contribute 50% more than they do today.

And mass marketing, although still only a fraction of total business, will be two and a half times larger than it is today.

They will, that is, if the predictions of 13 major U.S. brokers prove true. *Business Insurance* surveyed the top national brokers to profile the brokerage firm of 1987 and the responses were fairly uniform.

The biggest changes, the brokers believed, would be in the growth of technical services, greater geographical spread and more fee work.

By 1987, commercial lines will represent 95% of all revenues in the composite drawn up by the responses. This is a 5% increase over the 90% average today.

Personal lines will dwindle to 5% of all revenues, versus 10% now.

Fees will contribute 18% of all gross revenues by 1987. That's a whopping 157% increase over the 7% average today.

Employe benefits will be 17% of total revenues for the 1987 broker of 5% larger than the 11% average in 1977.

And mass marketing will mean 5% of the revenues for major U.S. brokers if predictions come true. That's 150% more than the 2% they now generate.

More fee work will result with the increase of self-insurance programs, employe benefit consulting and more captive management, the brokers believed.

The biggest difference for one firm was detailed as a "substantially larger organization with more expertise throughout individual differences in automation of records, files, coverages, etc.; increased professionalism and billing for fee services; growth of self-insurance; more worldwide pools due to capacity and desire of other nations to invest in U.S.; continued reduction in number of small independent agents; trend toward financial service centers—provide insurance, money management, investment advice, and growth of excess/surplus lines."

Another brokerage identified its five areas of change in the next decade as: greater mix of business, larger accounts, more foreign business, more captives and more employe benefit business.

"In 1987 our people will have to be even more technically competitive than they are today," elaborated a leading national broker. "Our business gets more complex each year and we will devote much attention to recruiting and training in the next 10 years in order to have properly qualified people in 1987. We will be doing much more risk management consolidating and providing more indepth loss control and claims analysis than we had in 1977. More of our clients will be retaining higher levels of self-insurance and for others we will be providing only self-insurance administration and high limit excess covages.

"It would appear that reinsurance will be an even greater part of our business than it is today. This would include reinsurance for captive (assuming changes in the recent IRS statement) and reinsurance intermediary services."

At least two firms singled out size as a major difference in their firms, with one of them projecting a 700% increase.

The 10 largest brokers in 1987 will not differ too much from the major firms today, the 13 surveys respondents predicted.

According to their rankings, the largest broker in 1987 will be Marsh & McLennan, followed by Alexander & Alexander, Johnson & Higgins, Frank B. Hall, Fred S. James, Corroon & Black, Rollins Burdick Hunter, Bayly, Martin & Fay, R.B. Jones and Nordstrom Larpenteur.

That differs only slightly from the ten largest brokers listed in the *Business Insurance* Agent/Broker Directory for 1977 which puts J&H in the number two slot, A&A in the number three slot and Penn Central Agencies as number 10. —bjg ■

Expert says expect more tax reforms

CHICAGO—While still digesting the Tax Reform Act of 1976, insurance agents can anticipate further tax reform next year.

Travel and expenses, for example, is one area where the Treasury is promising some changes, tax specialist Gerald I. Lenrow told a seminar of Professional Insurance Agents.

Another possible change is the elimination of the double taxation now imposed on corporate dividends which has been suggested by the Carter administration.

It's impossible to predict an outcome of such proposals, the Coopers & Lybrand principal told the group. And it may also be counterproductive to change tactics because of any such prediction since it's possible for a regulation to be issued in 1978 and have an impact on the firm's 1974 tax return.

Regardless of the potential changes, Mr. Lenrow and coworker Larry Friedman urged agents to give consideration to incorporating their businesses, if they had not already done so.

Of the more than 50 individual agents attending the seminar, about a dozen identified themselves as sole proprietors. About were partnerships, eight were corporations electing to be taxed as a partnership and the rest were corporations.

"There may be advantages to operating with corporate forms," Mr. Lenrow said. "Mainly, you have a corporate vehicle for sheltering yourself for limited liability."

The ability to accumulate funds at a low tax rate is another advantage.

Corporations may accumulate funds to meet the "reasonable needs" of the business. However, just what "reasonable needs" are falls into the "facts and circumstances" area of interpretation, the CPAs acknowledged.

Although there are some criteria, Mr. Lenrow urged agents to record and file supporting evidence on the "reasonable needs" of the business. As an example, the agent who believes he might be buying a building but later decides not to should have in his file letters of correspondence or other proof that it was a consideration. ■

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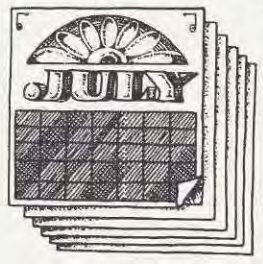

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Some regulation seems certain

Mass marketing rules controversy continues

CHICAGO—Mass marketed life or health insurance programs are destined for regulation, but the extent and terminology are still in the negotiable stages.

The second draft of a model bill to regulate mass marketing got a vigorous once over at a recent public hearing here held by the National Assn. of Insurance Commissioners task force.

Thirteen individuals including insurers and trade association officers voiced a gamut of opinions to the five-member NAIC panel.

The committee is shooting for a model bill in December. Task force committee chairman Herbert Anderson said another draft would be drawn up before then and another public hearing held if warranted.

In addition to the Iowa insurance commissioner, other panel members included Angele Khachadour, chief legal counsel for the California insurance department, Missouri insurance director Jerry Buxton and NAIC counsel David Brummond.

The draft seeks to regulate the distribution of life or health insurance programs in which the public pays most or all of the premium and deals with individuals other than an insurer or its representatives. This includes third parties, an association or an employer. Direct wirters are exempt, but some direct response firms will be put back into the next draft, commissioner Anderson said.

Although support was expressed by individual companies and jointly by the American Council on Life Insurance and the Health Insurance Assn. of America, the majority of individual speakers expressed reservations, if not objections.

Opposition to the bill was obviously not unexpected at the hearing. Ms. Khachadour summed up feedback by saying "the big life companies don't want things which would encroach on their group business and the other companies say 'Why are you making us the villians?'

"We don't have what regulators thought would be protection of employes where the employer does not pay or pays very little and they are no different from fictitious groups. Employers who don't pay don't give a damn. We're saying that kind of marketing requires protection."

Support from the ACLI and the HIAA was voiced jointly by John Meyerholz, although he acknowledged that the support was not uniform throughout the combined 582 insurer membership. Together, the two groups represent 90% of all life insurance premiums in the country.

Mr. Meyerholz noted that section one of the draft has been lightly referred to as the "club in the closet". This section empowers the commissioner to discontinue insurance if he finds "that the total charges to the persons insured are unreasonable in relation to the benefits provided."

The trade association counsel appeared to express some reservations about section one. "Unlike rate regulation which is unnecessary, hopefully competition will act to keep premiums at reasonable levels. Where there is abuse, regulators can choose to act.

"We feel regulatory authority is needed in the area of coverage definitions.

"Suggestions have been made to expand this to employe unions. This should be rejected. They are not comparable and there is no pattern of abuses which require regulation. No one wants regulation for the sake of regulation. ERISA (Employe Retirement Income Security Act) amply regulates employe benefits."

The Industry Advisory Committee has been working on these issues since 1972, he said, and "tampering with the basic thrust shouldn't be treated casually in view of its historic development."

Later however Ms. Khachadour noted that while the Industry Advisory Committee had remained unchanged in the five-year period, the task force committee had not and had changed views over that period.

Agent administrators were represented at the hearing by the Professional Independent Mass Marketing Administrators. Executive director Robert Finnegan told the committee that his three-year old organization of 100 administrators deal with "extremely sophisticated insurance buyers" and already feel ensnarled in red tape.

Mr. Finnegan said the associations with whom his members work generally have a committee for insurance selection or some other professional advisers in this area. Asked by commissioner Anderson if there was no opportunity for abuse in those quarters, Mr. Finnegan said it was taken care of by the competitive nature of the marketplace.

"There is a trend in trade associations to eliminate playing fast and loose. We don't feel the members of these associations will buy a bad product," he replied.

Although Mr. Finnegan said he had not had the opportunity to study the September draft, the association executive said that the regulations imposed by the administrator statute adopted last year are "onerous and cumbersome."

The administrator statute adopted by the NAIC last December has been enacted in three states—Nevada, Arizona, and most recently California where it will become effective Jan. 1.

One of the problems with the present regulatory system, Ms. Khachadour said, is that the individual states always have the right to amend the proposed model bill.

Opposition from one insurer was voiced by senior vp William M. Kruzan of All American Life & Casualty Co. Since there are "20 large insurance companies and several hundred agents selling this type of insurance a need for a bill to regulate plans for associations is not necessary," he

Continued on following page

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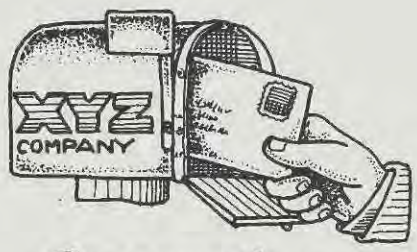

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Mass marketing . . .

Continued from preceding page
said.

"Insurance commissioners don't have to worry about charges being unreasonable in relation to benefits because plans are being constantly investigated by the companies themselves and the competition. 'Mass marketing' as used paints too broad a brush. Don't cause additional expense which will eventually be borne by the consumer."

Ms. Khachadour questioned the amount of concern within associations where the membership was based merely on a professional standing or where members may not have even sought membership.

"The point is that where I may seek membership because of having something in common with other members, I have difficulty in identifying with the association. It could be that the product is excellent but people may resent being solicited by the aegis of an organization. We have had many complaints about that type of business."

There are problems in this area, she said, "that's why we're here."

Mr. Kruzan said that national programs, such as the one his company administers in Washington, D.C., for the 700,000 member American Federation of Teachers would be faced with administrative work if the program had to be amended by the administrator at each individual state level.

Commissioner Buxton said that was "missing the boat. If we have standards and you comply, there is no problem. That's one of the reasons we're here today. Also, our presence says that we think mass marketing is here to stay and needs a set of guidelines."

Oppositions primarily on the grounds of ambiguity were outlined by Allstate legal counsel James Hodapp. In addition to the reservations Allstate had about the May draft, additional ambiguities are contained in the recent draft, he said.

He enumerated a lack of precise definitions for the terms "total charges," "mass marketing life or health" and "coverage," as well as ambiguity on the relation of total charges to benefits which would be "reasonable," whether this relationship would differ from state to state, whether national statistics or regulatory statistics would apply and whether the possibility of different rates for the same product could be allowed without being discriminatory.

Mr. Hodapp said he believed Allstate would fall within the purview of the regulation on its long term disability program for Sears employes, according to the present draft, and "we don't think we should have 50 state regulators telling us that Sears is the sponsor."

The draft is too vague, said John Ginetti for the Life Insurance Co. of North America, an affiliate of INA. "From the commissioner's point of view, he must initiate any regulatory monitoring. His test is subjective. Accordingly we suggest that it require that prior to an offering of group mass marketing, each insurer certify that rate have been achieved to attain a certain loss ratio, such as 65% for life insurance and 60% for health insurance."

Although acknowledging it's dangerous to suggest certifying loss ratios, he said it could give credibility to workable percentage for establishing what is reasonable in relation to benefits.

The subject of the exemption of some direct mass marketers, an area where there has been revision from the May to the September draft and which will be the subject of more revision in the next draft, was brought up by Bob Younger of the Prudential Ins. Co.

"I believe there is a severe problem with the September draft in that mass marketed mailing and Sunday supplements are exempt. To exempt direct mass marketers would be a distinct disservice which the May draft provides."

"The task force is interested in affording some degree of protection to persons in making a buying decision by establishing requirements upon recommendations and sponsorships apart from an insurance company, and that that person who has made a program in the interest of a group has made an adequate investigation and if so the requirements are well placed," said commissioner Anderson. "But it may also be that the person has act in self interest and there is no recommendation for placing. I don't think that the task force is ready to move to the place to say that one who is making a buying decision and one who is dealing with an insurance company or an insurance representative need to be afforded this protection." —bjg ■

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Nordstrom moves some offices back

MINNEAPOLIS — Nordstrom Larpenteur Agency Inc., a major commercial insurance brokerage firm here, has moved its sales and electronic processing operations back here after operating those functions in New York City for five years.

Nordstrom Larpenteur continues to maintain its national underwriting offices, eastern division headquarters and branch office in New York.

The decision to bring some operations back to the city where the firm was founded in 1919 was not reached through any extensive studies, according to executive vp Steve Nordstrom, but after analyzing the possibilities of headquarters in Los Angeles and New York. "Minneapolis won by default, although it's not necessarily a permanent decision," he said.

Mr. Nordstrom, who heads the firm's sales and underwriting departments, has just moved back here after headquartering in New York since 1974.

"It's our home town and it's centrally located" which is convenient for travel, he said.

Nordstrom Larpenteur generated gross revenues of $14 million in 1976 in 32 cities across the country. ■

Nevins to head CPCU society

SAN FRANCISCO—Robert C. Nevins, managing partner of Dinner-Levison Co. was named president of the Society of Chartered Property & Casualty Underwriters (CPCU) at the 33rd annual business meeting here last month.

Other elected officers include Edwin J. Sealy, president of Insurance Management Services Inc., Cleveland, Ohio, president-elect; Burt C. Proom, general manager of the Nuclear Energy Liability-Property Insurance Assn., Farmington, Conn., vp; Robert D. Bischoff, regional vp of State Farm Insurance Co., Greeley, Colo., secretary, and Louis P. Sigel, president, Louis P. Sigel & Son, Inc., Philadelphia, Pa., treasurer. ■

Hales & Associates survey

Payroll bite declines as an agency grows

CHICAGO—Executive and sales payroll decreases as a percentage of net revenue for privately held insurance brokers as the overall size of the firm grows. At the same time the percentage of net revenues paid for office payroll gradually increases.

That was one of the revelations made in a composite of operating ratios of 24 closely held firms, divided into four different revenue groups, according to a recent Hales Report, a monthly newsletter distributed by Hales & Associates Inc., a consulting firm here.

The average dollar amount spent for executive and sales compensation by six firms in the $300,000 to $450,000 revenue range was $132,203. This equaled 35.9% of the firm's total net revenue. For the six firms in the next higher bracket ($550,000 to $650,000 revenues) the executive and sales compensation was $196,654 or 31% of net revenues.

In the $1 million to $2 million revenue group, executives and sales people were paid an average of $406,924 per agency which equaled 28.5% of revenues. And in the group of brokers generating revenues of $2.75 million to $5.5 million the compensation totaled $969,369 or 23.2% of net revenues.

For these same groups, the office payroll as a percentage of net revenues progressively declined. For example, the smallest broker group spent $64,839 or 17.6% of its net revenues for its office people. The next largest group paid an average aggregate of $113,198 or 17.9% of its net revenues.

Firms in the next bracket committed an average aggregate of $153,471 or 22.1% for office payroll. And the group of largest brokers spent $964,355 or 23.1%.

"Perhaps this illustrates the principle of moving as much of the work to the lowest pay level to maximize profits and often times improve the level of service," the newsletter observed.

"Employe benefits cost the most in the $1 million to $2 million size category, followed closely by the larger firms. Overall, benefits averaged 12% of net revenues and 25% payroll.

"Total compensation as a percent of net revenues was less for the $500,000 to $650,000 revenue group at 55% and highest for the next largest group at 64%. Together, all 24 firms had 60% of net revenues going out for payroll and benefits compared with the public brokers (Marsh & McLennan, Alexander & Alexander, Fred S. James, Frank B. Hall, Corroon & Black and Rollins Burdick Hunter) which had a 49.3% ratio in 1976.

"In the aggregate, compensation per employe for the private firms was $23,065 compared with the publics at $20,123. Obviously, this is the principle place where adjustments are made in merger considerations." ■

letters

Corroon & Black

To the editor: Your Sept. 5 issue had a delightful article on the insurance brokerage business in San Francisco. In listing the larger firms with offices here, Corroon & Black somehow or other escaped detection. We would be delighted to show you our lovely office with over 75 employes and an unmatched view of the Bay. We really do have a presence in San Francisco—one that was established in the 1930s under the Miller & Ames name.

H. J. Trainor
Corroon & Black-Miller & Ames
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Corroon & Black's office did not escape the detection of our reporter, Margaret LeRoux. Ms. LeRoux phoned the office three times in an unsuccessful attempt to set up an interview while researching the story.

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California has first full time specialist

Agent lobbyist finds new field to work

By MARGARET LeROUX

SACRAMENTO—California agents and brokers are the first group in the nation to have a full time lobbyist working for them in the state legislature. Having completed his first full session, lobbyist John Norwood notes that nine bills he's supported have been signed into law.

"We've given the legislature a whole new view of the insurance industry," the lobbyist said, ticking off his accomplishments. "We've got a good start at some long range objectives. We've established a place where legislators and their staffs can call and get expertise on insurance matters. The legislature is realizing there's another voice in the industry, other than the underwriters."

His efforts have earned him praise from agents and brokers. "John is a bright, energetic young man," said Jerry Aparton, head of the Joint Producers Council, a group representing five different agent and broker organizations which hired the lobbyist. Energy is the key word in that description, for in addition to his lobbying duties, Mr. Norwood attends law school at night.

Recent California legislation strictly limits the amount of money lobbyists can spend on entertaining. "We can get by with our budget and John can pursue his studies in the evening," Mr. Aparton said. The budget of $40,000 covers the lobbyist's salary, cost of maintaining an office and printing costs.

"In the old days lobbying was buying lunch for the legislators," Mr. Aparton said, "now it's supplying them with information."

Mr. Norwood and his staff of one keep an active list of 200 bills supported or opposed by producers. He reports twice a month to the Insurance Agents and Brokers Legislative Council (ABL), a subcommittee of the producers council.

He is the former lead lobbyist for the California Manufacturers Assn. and was hired from a field of 50 applicants for the lobbyist position.

Reviewing proposed legislation and amendments occupies a great deal of time for the lobbyist. Between the senate and assembly, 3,500 bills were proposed during the first part of the legislature's two-year term which began in January 1977. "Since each bill is amended an average five times, this involves a lot of review," Mr. Norwood said.

"We get copies of each bill and check them to see if they have an effect on producers," he continued. "Copies of bills I select are sent to members of ABL so they can give me their organization's position."

During meetings with ABL, priority of support is determined. Then it's Mr. Norwood's job to carry that information to legislators and their staffs in discussions, through public appearances and testimony before committees.

ABL is composed of the legislative chairmen from five producers' groups: the California Insurance Assn., the Independent Insurance Agents of California, the Insur-Brokers Society of Southern California, the Society of Insurance Brokers and the Western Assn. of Insurance Brokers.

The presidents of these same groups form the Joint Producers Council, to which Mr. Aparton, a vp of Johnson & Higgins in San Francisco, reports.

A major success in the first legislative session, Mr. Norwood said, was passage of AB 133, aimed at correcting deficiencies in the domestic workers compensation law.

"The final version signed by Gov. Brown incorporated several of our suggestions," Mr. Norwood said. "Our objective was to clean up the law and change it so it wouldn't be dangerous to producers."

The original law, effective Jan. 1, 1977, extended coverage to domestic workers and incorporated the cost, an additional $5, into all homeowners policies.

A proposed change in the law would have made the coverage optional and homeowners without domestic help could reject the additional charge for it.

"This would have put producers in a bind," Mr. Norwood explained. "If a customer rejected the workers compensation charge, then later hired help and had a claim, it's conceivable the producer would be held liable for not making the importance of the coverage known to the customer."

"The whole idea behind the original law was to solve a social problem by sharing the cost among all homeowners policies," he said.

AB 133 subjected the coverage to the open rating law which removed it as a separate charge on homeowners policies. The law also extended coverage to employes of tenants and lowered the minimum length of employment before eligibility for workers compensation benefits.

Another successful lobbying effort added an amendment to AB 486 which prohibited lenders from giving out information contained in a borrower's insurance policy for purposes of solicitation.

The amendment also prohibited lenders from using this information internally.

The brokers' support of AB 155, which assigns liability in cumulative trauma cases, aided its passage according to their lobbyist.

During the recess of legislative session Mr. Norwood is preparing statements and testifying before the standing committees that meet.

For the future the producers council is looking at other projects for the lobbyist. "Someone has got to be a catalyst for the introduction of the findings of the Citizens Committee on Tort Reform to the legislature," Mr. Aparton said. "Something also has to be done on the subject of no-fault auto insurance." ■

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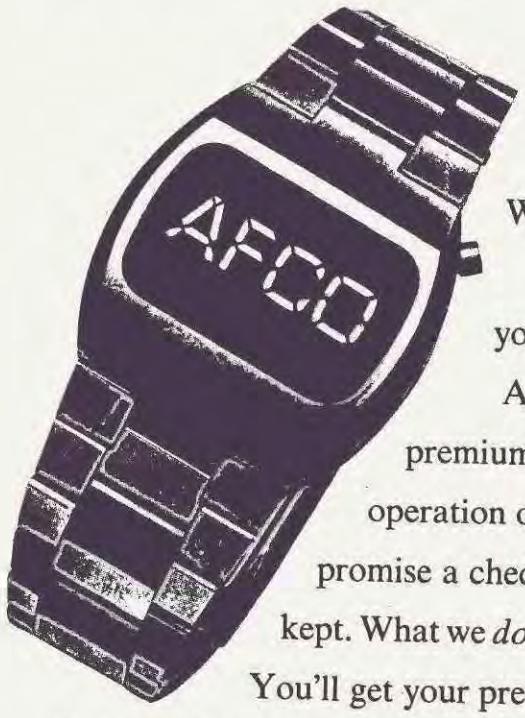

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For more facts circle 161 on reply card

Assurex moves executive offices

COLUMBUS, Ohio—Assurex International has moved its executive offices to the Busch Corporate Center here.

Robert P. Ashlock will be executive vp for the association of 67 international agents and brokers.

The organization formerly had been located in Wheeling, W.Va. David S. Butler, who has served the 23-year-old organization as its first and only other executive vp there since 1962, will retire early next year. ■

Supermarkets stock this broker's shelves as mass marketer expands

KANSAS CITY—Automatic sprinkler systems means automatically lower losses.

Not necessarily. At least not for supermarkets.

That's just one of the peculiar aspects of supermarkets identified by an insurance broker who knows supermarkets well since he administers insurance programs for about 5,000 of them across the country.

"There's a practical explanation for it," says Richard C. Fuchs, executive vp for the Strauss Fuchs Organization Inc. "One of the reasons is that automatic sprinkler systems give a credit between 60% and 75%. When you cut the premium, then when any losses do occur, you don't have as many premiums to pay small losses. So they may have less in premiums but the same losses. They may pay a $2,500 to $4,000 premium for having an automatic sprinkler system, but $10,000 on a non-sprinklered system."

The mass marketing administrator has been specializing in supermarket programs for the last 25 years and now writes programs for grocers in every state except Hawaii. But, it does not write in major metro areas.

The average premium for a store between 7,000 and 11,000 square feet is $3,000, he estimates. For a bigger store, between 18,000 and 40,000 square feet, which may have an adjacent soft goods store, the premium may range from $5,000 to $35,000.

SFO's supermarket program is a package policy. "In the past, agents have done a poor job on grocers," Mr. Fuchs believes. "They have written the bare minimum because they couldn't round out property coverages and sometimes didn't include business interruption. They thought they couldn't write a package policy for stores with $2 million values at risk," he says. Today, SFO writes coverages for stores with as much as $3.5 million values at risk.

The bulk of a supermarket's value, between 60% and 65%, is in equipment, not stock. "Grocers don't stock as much as they used to. They can get prompt deliveries from warehouses, which is particularly helpful with the growing cost of groceries." On the other hand, the cost has increased with sophisticated cash registers and other electronic equipment, as well as more expensive equipment such as freezers.

The SFO package includes building, contents and, optional business interruption insurance. It is written as if one carrier was involved, although actually there are four carriers now on the program.

SFO composes its own computerized proposal and rate sheet on its in-house computer, which it sends to the agent upon receiving his application. Agents are paid a commission of 14% on new and renewal business.

SFO devotes time to engineering and underwriting risks. It designs its own inspection reports to insure that it receives all of the necessary information and hires outside inspectors to conduct inspections on every risk annually.

Each risk is underwritten individually. An individual risk premium modification system, a 25% credit allowed in most states for "good housekeeping".

The Strauss Fuchs Organization Inc. was founded in 1906 by agents. When Mr. Fuchs joined the organization in 1951, the firm was writing supermarket coverages locally only. The program was expanded gradually and by 1970 it had programs in six or eight states, the executive estimates. By 1972 distribution was national.

Today, SFO handles between $50 and $60 million in annual premiums, with net revenues of about $10 million.

This summer the organization moved its 138 local employes into two floors of the plush Mercantile Bank Tower in Kansas City.

About 40% of the firm's volume is in property/casualty business and 60% in life and health.

SFO's method of soliciting business is to go directly to the prospective insured and get him to submit the name of his present agent to the mass marketer. It approaches the grocers through direct mailings using lists purchased from Dun & Bradstreet, Mr. Fuchs explains.

"Our first mailing to grocers using this method was in 1969. It went to 25,000 grocers in the U.S. We got 5,000 responses from grocers who sent us the name of their present agent. Then we sent those agents a list of our

Continued on following page

Photo: Barbara Jean Gray

"The concept of contacting the consumer works, not the concept of contacting the agent," says Richard C. Fuchs, executive vp of the Strauss Fuchs Organization.

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Supermarkets . . .

Continued from preceding page
underwriting guidelines," he said.

"If we don't get an agent's response after two letters, we send a letter to the grocer telling him that the agent has not responded. We also send a carbon copy of that letter to the agent.

"The concept of contacting the consumer works, not the concept of contacting the agent." Why? "Because it's (the mass marketing concept) is something new."

Of the applications submitted by the agents contacted in this manner, SFO rejects about 20%, he says. Because of this, "we don't necessarily seek third-party endorsements because we can't necessarily write all members."

That in fact is the reason given by a grocer's large trade association for withdrawing is endorsement.

In 1973 the SFO supermarket policy was voluntarily given the endorsement of the National Assn. of Retail Grocers. However, this year, the 40,000 member NARGUS withdrew its endorsement.

At the association's headquarters in Reston, Va., Frank Register, executive director of the trade group said, "It was no reflection on SFO. The problem we had with the insurance market was that some of the retailers were applying for coverage and not being able to get it. We felt there were valid reasons why they couldn't, but felt as a trade association we couldn't endorse it if it wasn't available to everyone."

Supermarket's account for 70% of SFO's property/casualty revenues, Mr. Fuchs estimates. Much of the remaining p/c volume has been generated as a result of the supermarket programs. "The agents we wrote supermarket coverages for would come to us with bowling alleys, restaurants, and shopping centers, so we've diversified there for those reasons.

"We're starting now to broaden our base, with the Automotive Warehouse Distributors of America. We have the most sophisticated program in the U.S. today. We took it over three years ago and have quadrupled the premium and doubled the number of insureds, despite a competing MarketDyne program." The AWDA is the only program on which SFO pays dividends.

One of the major life and health programs of the firm is the United Employers Trust program, begun in 1967 and initially underwritten by the Hartford. SFO held 300 agents seminars during the first years of the program and had a network of 2,500 independent producers who signed compensation agreements. "In fact," he laughs, "the UET was so successful we almost went bankrupt because of its fast growth and high agent commissions.

"We thought we could get the UET off the ground for an investment of between $100,000 and $150,000. But by the end of the first two years, we had invested $500,000. The more we wrote, the more we lost. Our bonuses ran as high as $200,000 per year."

Because of the diversity of state regulations on mass marketing, SFO employs John McBain, a recent retiree from R. B. Jones, as a part-time consultant to keep track of all state licensing regualtions, filings and perform some risk management functions. ■

ARM gets first check from plan

CHICAGO—The Associated Risk Managers International received a $340 check in September, its first income generated from a national program.

James Sandner, chairman of ARM International's income producing committee which was formed one year ago, identified the earnings as a "means to becoming a self-supporting organization."

The money was a 2.5% override on a mass marketed business legal expense program of NAS Insurance Services Inc. of Santa Monica, Calif.

ARM agents have been selling the program since last March when it was explained at their semi-annual meeting in Atlanta.

Under the NAS business legal expense program, a 2.5% override goes to ARM International and a 2.5% ovrride goes to the state ARM affiliate. The remaining 15% goes to the agent of record.

NAS Insurance Services Inc. is a division of NAS Ltd., an excess/surplus broker headquartered here. Business legal expense is the only coverage the division handles. The project was in the research stages three years before being introduced three years ago, according to the division's head Sydney Aronson. The coverage is underwritten by Lloyd's.

Mr. Aronson conducted one of the several small seminar groups at ARM's semi-annual meeting.

About 100 ARM affiliates attended the meeting, according to Joseph Bow, treasurer of ARM International. He estimated that ARM affiliates generate about $1 billion in premiums of mass marketed programs.

The average premium for the business legal expense policy is $700, Mr. Aronson told the attendees. The maximum policy limits are $10,000; with all endorsements the highest possible premium is $890.

NAS Insurance Services Inc. writes a premium volume of close to $1 million on the coverage. It is available to firms with 50 or less employes. The majority of policyholders employ five to 15 persons. ■

errors & omissions

• In the October 3 issue of Agent/Broker Topics it was reported that James P. Metzler, chairman of the R. B. Jones Corp., is the great grandson of the firm's founder. Mr. Metzler is not a blood relative of the firm's founder. Another Jones executive, vp Cary W. Jones III, is the great grandson of the founder.

• In the same issue, an Agent/Broker Topics survey on the impact of a recent Securities & Exchange Commission ruling quoted Mr. William Burch, president of Fred S. James & Co. Inc. as saying his firm had no company-owned cars. Mr. Burch subsequently said that the firm "of course" has cars. Mr. Burch also said he believed the ruling didn't apply to cars. The SEC ruling, however, specifies that the personal use of corporation-owned autos must be reported in the firm's proxy statement for officers and directors whose remuneration is otherwise reported.

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For large and small risks

Fireman's Fund prints out new EDP policy

SAN FRANCISCO—A new all-risk electronic data processing policy is hot off the presses from Fireman's Fund Insurance Cos.

It offers business interruption and extra expense coverages as either part of the physical damage package or separately. Insuring accounts receivable and valuable papers is optional, with accounts receivable coverage available on a non-reporting form only, in amounts to $1 million.

A single occurrence deductible that applies to two or more subjects of insurance is available as well as the standard approach of single deductibles on each policy section.

Director of field operations Frank Early said the single occurrence deductible is the "biggest advantage" of the new Fireman's Fund policy. With a $5,000 deductible on each policy section an insured could suffer a $20,000 loss, Mr. Early said. But with the single occurrence deductible, the insured can limit his losses, for example to $10,000.

This policy is intended to be flexible enough to meet the insurance needs of those with only software or a few access terminals as well as those with elaborate computer installations, says the insurer.

Rates are based on the local fire, sprinkler leakage and earthquake rates with loading dependent upon the results of a physical inspection of the facility. There could be charges or deductions based on the inspectors report. Credits are given for safeguards and deductibles. Deductibles are usually written for $5,000 or more.

Fireman's Fund does not include an extended coverage rate or vandalism and malicious mischief rate when pricing the policy unless the exposure appears to be more than average, Mr. Early said.

EDP coverage, he explained, sports "high values on a very low premium" because in-house loss control is usually excellent. Generally a computer installation is "built like a fortress," Mr. Early noted.

Physical damage coverage under the Fireman's Fund policy can be purchased for actual cash value or replacement cost. It includes dishonest, fraudulent or criminal acts of employes and is extended to include tapes, cards and other forms of media, programs or instruction vehicles.

Extra expense coverage includes indemnification for use of outside data processing equipment, additional payroll, emergency supplies, temporary rental of outside quarters and extra office equipment if the EDP system or media are damaged or destroyed. The actual amount of loss is paid, less the chosen deductible, rather than a limited per-day or per-month recovery.

Business interruption protection continues customary profits when disaster forces reduction of business or a shut down of operations.

Fireman's Fund notes that it offers varying deductibles when deleting various coverage exclusions, such as those regarding mechanical failure, faulty construction, design errors, atmospheric conditions, corrosion, rust, short-circuit, blowout or other electrical disturbances. Other companies usually require a minimum deductible of $10,000 to $25,000 or more when removing these exclusions, Fireman's Fund said, but it will accept $5,000.

Other features of the new EDP policy, as outlined by Fireman's Fund, include automatic shipment and transit coverage without a notification requirement and debris removal coverage after a total loss payable to 5% of the limits set for equipment or media protection, or $50,000 each, whichever is less. ■

R.I. authority seeks funds to self-insure

PROVIDENCE—The Rhode Island Public Transit Authority (RIPTA), confronting soaring liability insurance rates, plans to seek money from the legislature to start a 10-year buildup of a $3-million, self-insurance fund for its more than 200 vehicles.

The authority's insurance consultant said the plan is the next logical step for the quasi-public bus company, which earlier this year rejected a renewal policy from its traditional insurer that would have boosted rates in fiscal 1978 to more than $745,000 from about $318,000.

Transit Casualty Co., which for the past 10 years has underwritten a $3-million policy for the authority, demanded a $745,224 premium last spring for the second year of a three-year insurance agreement.

The Transit Authority rejected the higher premium, which Transit Casualty maintained was prompted by a "deteriorated" accident and "severity" rate that was causing it to lose money.

Instead, the authority won legislative permission to opt for self-insurance, decided for the current fiscal year to pay any liability claims out of the $350,000 budgeted for premiums. According to Raymond E. Herbert, insurance consultant for the authority, claims paid over the last three years averaged $135,000.

Mr. Herbert outlined to the authority a self-insurance program that on an annual operational basis would cost only $290,000. This includes $135,000 for payment of projected claims, an estimated $100,000 for administration and $55,000 for workers compensation. ■

Consultant relocated

J. L. Greene Associates, a management consulting and executive search firm for insurance and financial services companies, has moved to 23958 Craftsman Road, Calabasas, Calif. Prior to forming the consulting firm last year, James L. Greene had been vp of Piedmont Management Co. of Los Angeles.

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Plan for terrorism, security chiefs told

NEW YORK—Top corporate officials must be made to realize that they are potential targets for kidnapings and terrorist attacks, according to two corporate security managers who spoke on executive protection at the 1977 International Security Conference.

However, measures taken by companies to protect their key personnel should not be so stringent that they interfere with individuals' lifestyles, they said.

"When an executive is in a high position, he must realize that he is a target," said Charles J. Diecidue, director of security for the American Stock Exchange Inc. "He has to accept that security will be part of his lifestyle."

Getting high-ranking officials to recognize this is the biggest obstacle for security planners to overcome," he added.

The success of an executive protection program depends to a large extent on how the executive responds, noted Richard L. Buonocore, corporate security manager with SCM Corp.

It is the job of the security managers to point out the dangers to an executive and show him the viable alternatives. However, the executive should be allowed to analyze the risks and make a decision like he would on any other business matter, he explained.

However, Mr. Diecidue added that if the executive agrees to participate in such a protection program, the security manager must follow up on it. "I can't tell him to get a alarm system, I have to get the alarm system for him," he explained.

An executive protection manual, describing steps a company and its executives can take to minimize executive exposure, is a must for a successful program, said Mr. Buonocore. In addition, a crisis management team should be set up to quickly respond to kidnaping and terrorist emergencies, he said.

However, an executive security program should not create an "Orwellian atmosphere," said Mr. Diecidue.

"You can't tell him (an executive) not to play tennis," added Mr. Buonocore.

Varying routes of travel and being aware of what types of people to look out for were suggested by Mr. Buonocore as steps an executive could take to protect himself. He also recommended that if the executive had a regular golf or tennis match at a certain location, that the company be given the phone number so they can contact him in the event of an emergency.

"The corporate executive is most vulnerable when he is alone," said Mr. Diecidue. Being alone includes traveling with a chauffeur or in a cab, he explained. Mr. Diecidue suggested that a security officer or the director accompany the executive when he attends business meetings or similar functions.

An executive protection program should take an executive's family into consideration, as well, the two security managers said. The executive should foster an awareness of the dangers to his family, added Mr. Diecidue.

The family protection program should cover an executive's children who may be away at college, he added. Corporate security managers should keep tabs on the individual and in some cases, a bodyguard might be advisable, he said.

It is also important to "build bridges" to local law enforcement units, the FBI and campus security forces, Mr. Diecidue noted.

Executive protection programs differ from company to company, since each firm has different exposures, said Mr. Buonocore. "ITT handles it one way, Bill's hardware store handles it another."

Kidnaping for profit is the biggest risk faced by executives and their families in the U.S. Politically oriented attacks have been relatively rare.

However, terrorism is a far greater danger overseas and U.S. corporate officials are often the target. In a foreign country, security precautions may dictate an executive's lifestyle, said Mr. Buonocore.

Mr. Diecidue suggested maintaining a low profile and blending in with the local populace as ways of reducing exposure. ■

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Polygraphs help? Expert replies yes

NEW YORK—Will the polygraph help in preventing internal theft? "There's no question about it," said Richard O. Arthur, director of the National Training Center of Polygraph Science in New York City.

But "any polygraph is only as good as the person operating it," Mr. Arthur said at the International Security Conference here.

Out of 12,000 to 13,000 employes Mr. Arthur has recommended to companies, only three have gone wrong, he said. "We don't claim to be 100% perfect," he added. "But I know it keeps the thief out of the workplace."

Two of the individuals he recommended got married after the exam and then had financial problems. The third had never handled finances before he took the job that Mr. Arthur recommended he take.

"They were truthful that they hadn't ever stolen anything before so I recommended them," said Mr. Arthur, who is also president of Scientific Lie Detection Inc., also in New York City.

Mr. Arthur questions a potential employe about any possible involvement with narcotics abuse, major crimes and also about his debts. The employe is also questioned about why he wants the job. A polygraph exam follows the interview.

By questioning applicants about why they want the job, Mr. Arthur said he is able to prevent such cases as a worker who takes the job just to become disabled in order to collect settlements from the companies.

The National Training Center of Polygraph Science also investigates employes who have already been hired and are suspected of wrongdoing.

Drug related industries are particularly vulnerable since narcotics addicts may want the job to have access to drugs.

Mr. Arther also noted the growth of polygraph operations. He said his firm started in 1953 was the first expert in the field. "But now there are 40-50 polygraph firms." ■

Continental pumps $20 million into Harbor

By ELLIS SIMON

NEW YORK—The Continental Corp. has pumped $20 million into Harbor Insurance Co. since acquiring the Los Angeles-based Swett & Crawford Group at the end of 1976 and more money is on the way.

Harbor Insurance Co. is Swett & Crawford's excess and surplus entity.

The acquisition of Swett & Crawford marks Continental's first direct participation in such special risk markets as excess and surplus, reinsurance and the London market.

In addition to Harbor, the group consists of Swett & Crawford, a wholesale broker; Buffalo Reinsurance; RFC Intermediaries, a reinsurance intermediary, and Unionamerica, a London market company. The group is part owner of Guest Spencer & Co. Ltd., a Lloyd's broker.

Acquisition of the firms should help stabilize Continental's financial picture, which has for the most part been tied to the ups and downs of the primary insurance market, explained Continental executive vp Lee Barnes.

So far, Continental has stressed development of Harbor, which Mr. Barnes said plays a special role in the Swett & Crawford group. Swett & Crawford president William Fellows called Harbor the group's captive insurer since brokers can only gain access to Harbor through Swett & Crawford.

Having its own underwriting organization puts Swett & Crawford's wholesale brokerage operations at a competitive advantage. The internal underwriter can structure the layers of coverage for a large risk and the fact that part of the risk is retained makes it more attractive to outside markets, Mr. Barnes explained.

So far, Continental has put $10 million towards building up Harbor's surplus to its current level of about $38 million. As a result, Harbor, which was previously undercapitalized, has had its Best's rating raised from B+ to A, he noted.

Plans for Harbor go beyond improving its premiums to surplus ratio, however. An additional $10 million has been put towards expanding the company's underwriting activities and Mr. Barnes said plans have been made for an additional contribution.

Part of this push for new business will involve advertising for the first time in Swett & Crawford's history. About $250,000 has been budgeted for this, with the campaign geared towards attracting more profitable medium-size accounts rather than large, prestige accounts.

Much of the effort will be directed towards lowering Harbor's ratio of casualty to property risks from 70%/30% to 60%/40%, Mr. Fellows said. In addition, the carrier is seeking to have the proportion of its risks written in California, its home base, reduced from the current 50% to about 30%.

At one time, California risks accounted for 85% of Harbor's exposure. However, the state's liberal liability laws have led the carrier to shift its underwriting emphasis eastward, explained Swett & Crawford's Mr. Fellows.

Harbor's marketing efforts are being concentrated in the Sunbelt states, particularly Georgia, Texas and surrounding states, Mr. Fellows noted. The influx of capital and new plants in the South has resulted in more attractive risks, he added.

While much of Harbor's growth is being geared towards these new geographic markets, it also plans to continue to push its relatively new directors and officers liability coverage. Harbor is, at present, one of two American markets writing D&O coverage and, according to Mr. Fellows, it has about 15% of the $100 million worldwide D&O market.

Mr. Fellows explained that Harbor is able to compete in this risky yet profitable area because it has brought into its organization underwriters with the expertise not only to determine what a premium should be, but whether the D&O risk is insurable at all.

Harbor's future plans include underwriting in the cast insurance market, which covers talent participating in film making and stage shows, Mr. Fellows said. For Swett & Crawford, it will mark a return to a market which it pioneered about 20 years ago.

Swett & Crawford originally placed cast coverage for small brokers on the London surplus market and later placed reinsurance on the London market when Firemen's Fund began marketing cast insurance as a primary line. The wholesale broker dropped out of the cast market when Firemen's Fund began placing reinsurance directly in London, he explained. ■

Colorado court backs 2-year limit

DENVER—The Colorado supreme court has ruled that a claim for damages under the state's wrongful death statute must be filed within two years of the negligent act.

Even if an injustice results, the two-year statute of limitations can't be counted from the date of the victim's death, the court said.

Its 4-1 ruling may bring an unfair result, the court acknowledged, but the remedy for the problem lies with the legislature.

Ernest Crownover lost an attempt to sue a Denver physician for alleged failure to discover his wife's cancer during the reading of X-rays.

Large areas of cancerous tissue were found in the chest of Ardyce Crownover during surgery in April 1972, eight months after the physician examined her chest X-rays and found no growths.

Crownover sued a second Denver doctor in September 1973, but didn't discover the possible involvement of the first doctor until October 1974. The plaintiff asked the court to add the physician as a co-defendant and filed an amended lawsuit in November 1974, the high court said.

The amended complaint was filed within two years of the date of Mrs. Crownover's death but more than two years after discovery of the cancer, the supreme court said.

The doctor won dismissal on grounds that the lawsuit was barred by the statute of limitations and the Colorado court of appeals agreed. The Supreme Court affirmed the appellate court ruling. ■

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In Britain

MDs shun insurers despite rising awards

LONDON—Payouts to doctors for malpractice claims are rising in Britain, but they still refuse to turn to the commercial insurance market for insurance.

Damages are so low compared with U.S. awards that it is easily possible to cover all medical risks within their existing mutual pool, except for a degree of reinsurance in case of catastrophe liabilities, which have so far not occurred.

Dr. F. Harwood Stevenson, chairman of the 66,000-member Medical Protection Society, has warned his members: "The U.S. scene with its inflated costs, damages, ever increasing premiums and the loading of individual premiums in response to claims would be disastrous if it was imported into Britain."

Damages in the U.K. are still less than $200,000, even for serious malpractice liabilities, as they are assessed either by individual High Court judges on the basis of need or by negotiated out-of-court settlements.

So the total losses of the two U.K. medical defense societies rose from only $2.5 million in 1975 to nearly $4 million last year, enabling them to cover 150,000 doctors and dentists at the uniquely low figure of $70 a year.

For this they get full protection against any malpractice claims, as well as legal costs and advice on problems of medical etiquette and disciplinary rules.

The two societies make no profit out of their activities and have been in existence for more than 80 years. They differ in this respect from lawyers, who have turned to U.K. insurers for indemnity cover and will have to pay heavy charges this year because of rising claims, which can lead to premium rates of nearly $1,000 for each of the 20,000 attorneys involved.

But while lawyers can be involved in international or commercial malpractice judgments running into hundreds of thousands of dollars, the average doctor in the U.K. is rarely caught by major negligence claims.

Typical incidents this year have involved a $300 award to a 36-year-old salesman who failed to get proper attention to his hands after an auto crash and a $850 settlement to a hospital patient who stayed awake during an operation because she was not properly anaesthetized.

Both cases caused no lasting damage, so the awards were meager, as British law does not consider emotional effects. The largest award in Britain, therefore, last year was made against an anaesthetist who had to pay $140,000 for causing harm to an unborn child by maltreatment of its mother during birth. ■

Drug bill: A dose of consumer action

SOUTHFIELD, Mich.—Wouldn't you like to have Mrs. Constance Feola on your health plan roll?

Mrs. Feola was looking over an $896.26 bill for her son's tonsilectomy last May and spotted a $139.46 charge from the pharmacy. It included $26.86 for one teaspoon of cough syrup and $50.88 for other medicine her 19-year-old son Brett said he never received.

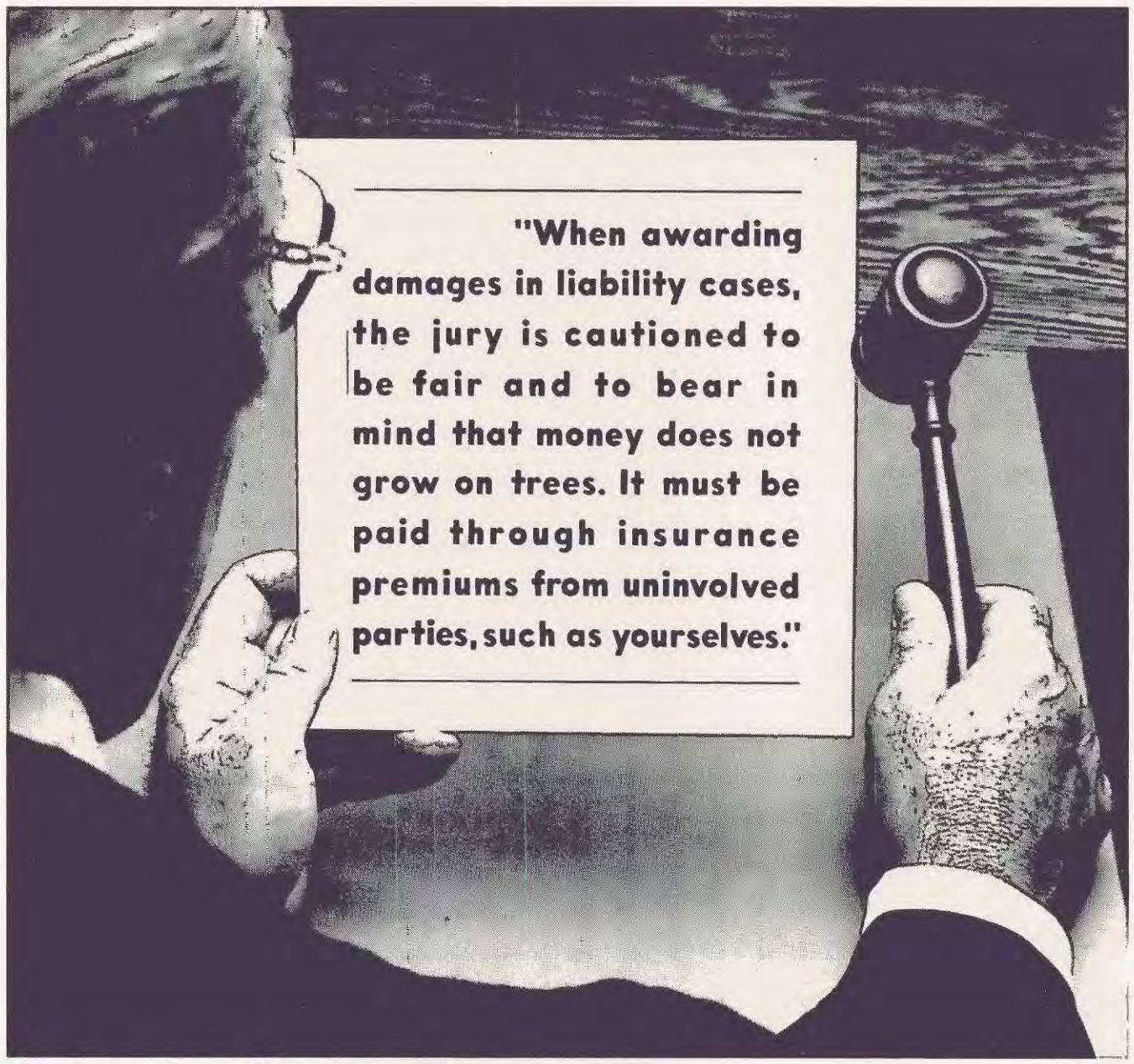
When she checked the costs she discovered that Beaumont Hospital in Royal Oak, Mich., had charged as much as 130 times more for certain medications than did local drugstores or other hospitals, according to an Associated Press report.

It took the hospital five months to get a breakdown on the charges, the report continued, because thousands of bills had to be checked by hand.

But finally, the administrator of Beaumont Hospital called Mrs. Feola to apologize and announce that her insurer would get a $69.07 refund. AP also quoted administrator Ted Wasson as saying, "This is the first time we have found ourselves to be in error on prescriptions and we handle 350,000 a month. But as a result of Mrs. Feola's complaints, we are making sure that this won't happen again."

Mrs. Feola, who said she'd "never done anything like this before in my life," pursued the overcharges because "people may think the overcharges and padded hospital bills are just an insurance company's problem, but the cost is passed along to us in premium increases."

The word is out.



Too bad judges can't read this to a jury.

In a small Florida town, a decorative boulder rests on the median of a road. A man with three drinks in him and no sleep for 18 hours smashes his car headlong into it. *A jury orders the town to pay him $4.7 million in damages.*[1]

A truck without brake lights is hit from behind. For

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around the states

Kentucky panel OKs $22 million work comp hike

FRANKFORT—The Kentucky insurance regulatory board has granted a $22 million rate increase for workers compensation in Kentucky.

The new workers compensation rates, retroactive to Aug. 1, affect about 650 categories of employers, who pay the premiums to provide benefits to workers injured on the job.

The largest increase for an employer is 39% and the biggest decrease is 18%—depending on the actuarial risk of the business.

The National Council on Compensation Insurance had sought a 20% overall increase. It received 18.9%. The new rates do not apply to underground coal and surface mining. Increased rates also are sought for those industries and are pending before the board.

Prepaid plans

SACRAMENTO—Gov. Edmund Brown of California has signed legislation giving the state tighter controls over prepaid health plans.

The plans receive a flat monthly fee from the state for providing whatever health care their enrollees may need. The new law, effective Jan. 1, bans door-to-door solicitations for enrollments, one of the major causes of abuses in the program. Instead plan operators will get information about potential enrollees from county welfare offices.

The bill also prohibits doctors and other health care providers from serving on managing boards, permits limiting state money used for administrative purposes, allows the state to audit plan subcontractors and authorize fines of up to $5,000 for any violation of a contract.

Pregnancy law

LANSING—Michigan State Rep. Barbara Rose-Collins has introduced legislation that would prohibit Michigan employers from firing pregnant women or denying them insurance and pension benefits.

"This bill will stop employers from discrimination against pregnant women as far as pregnancy benefits are related," Mrs. Collins said.

"Some companies charge men and women the same for insurance premiums, but when it comes time to provide the benefits, they pay the women less under the nebulous notion that women are 'longer-livers' than men. This amounts to horrendous discrimination," she said.

The intent of the bill is to provide that pregnancy be considered a legitimate leave of absence. Pension benefits that have accrued could not be denied due to such absence under the bill.

Maryland Blues

ANNAPOLIS—Blue Cross of Maryland, the state's largest provider of health and accident insurance, is seeking state permission to offer life and disability policies.

Whether it does depends on actions by the attorney general and state insurance commissioner.

A couple of major uncertainties must be resolved before the plan can go forward. Blue Cross is a non-profit organization, but the new coverages would be sold on a profit-making basis. If the plan would be legal, should Blue Cross continue to be accorded benefits it receives because of its nonprofit status, including an exemption from taxes on premiums?

The questions have been asked of attorney general Francis B. Burch by insurance commissioner Edward J. Birrance Jr.

About 30 Blue Cross plans in other states already sell life and disability coverage. "We've been working on the concept for about two years," said Nicholas G. Greaves, the Blue Cross public information director.

State power

HARRISBURG—Gov. Milton J. Shapp has signed legislation empowering the state to intervene in disputes between employers and workers over fringe benefits.

The Pennsylvania bill requires employers to keep payroll records available for inspection by the state labor and industry department and permit workers to be questioned on the job with respect to payment of wages and fringe benefits.

Florida bias law

TALLAHASSEE—Florida insurance commissioner Bill Gunter has approved broad-based new regulations to ban unfair discrimination in insurance matters based solely on sex or marital status.

"This," he said, "should finally give us the teeth we need to effectively police the problem of unfair discrimination in this area."

Mr. Gunter filed the rule with the Joint Administrative Procedures Committee for review. The rule is scheduled to become effective Jan. 1, giving companies time to voluntarily eliminate any unfairly discriminatory practices or policies.

He said that while the rule was prompted primarily because of unfair discrimination against women, it will apply equally to both men and women.

Specific practices outlawed by the rule are offering lower maximum monthly benefits to women than to men who are in the same classification under a disability income contract; treating complications of pregnancy differently from any other illness or sickness under the contract; denying disability income contracts to employed women when coverage is offered to men similarly employed, and limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's marital status. ■

"psychic damages" to the driver, because his pride was hurt when his wife had to work, *a jury awards $480,000 above and beyond his medical bills and wage losses.*

Then there's the one...but *you* can probably provide the next example. Most of us know hair-raising stories of windfall awards won in court.[2] Justified claims should be compensated, of course. Ætna's point is that it is time to look hard at what windfall awards are costing.[3]

What can we do? Several things:

We can stop assessing "liability" where there really *was* no fault—and express our sympathy for victims through other means.

We can ask juries to take into account a victim's *own* responsibility for his losses. And we can urge that awards realistically reflect the actual loss suffered—that they be a fair *compensation*, but not a reward.[4]

Insurers, lawyers, judges—each of us shares some blame for this mess. But it is you, the public, who can best begin to clean it up. Don't underestimate your own influence. Use it, as we are trying to use ours.

Ætna wants insurance to be affordable.

[1] This case is being appealed by the town. In addition to the court-awarded damages, two other defendants (the contractor and the county) settled out of court for an additional $1.15 million. This illustrates how extravagant jury-awarded damages set a standard for extravagant *out-of-court* settlements—the real problem, since most liability cases *are* settled out of court.

[2] A by-product of such awards has been a quantum leap in the number of personal injury and property damage suits filed. A 1976 study in California shows such suits increasing at *five times the rate of population growth.*

[3] Most awards are paid by insurance, and insurance companies spend millions more defending policyholders against lawsuits. The direct result is rising premiums for automobile and other liability coverages. The *indirect* result is higher prices for goods and services—prices which are boosted to cover the skyrocketing insurance premiums of manufacturers, doctors, hospitals, and others who are targets for windfall awards.

[4] For example, it would help if juries were simply required to take into account payments the claimant has already received for medical bills and lost wages. Under the present system, these bills may be paid all over again.

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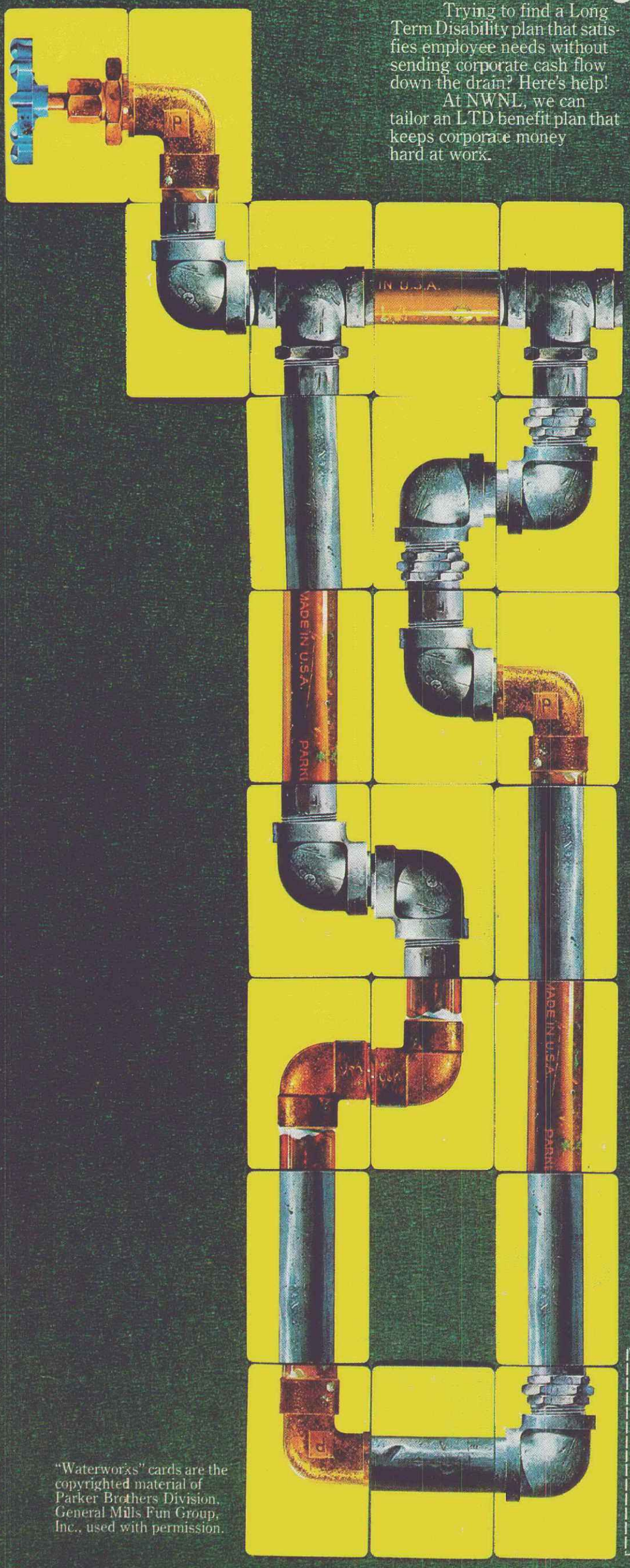

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We make claim payments from the employer's account and generate all necessary cash flow and disclosure reports.

We'll also assist in setting up a 501(c)(9) Trust to gain the maximum tax advantage.

In short, with NWNL you get all the pluses and none of the hassles of 'do-it-yourself' insurance.

For most companies, a good insurance policy is still the best policy.

But that doesn't mean good LTD coverage has to be expensive.

We've got the expertise to provide insured LTD benefits for companies both large and small. Our rates are competitive and our contract guarantees are as good as any you'll find.

LTD should help your employees get back to work, too.

NWNL specializes in implementing personal rehabilitation programs to help the disabled employee get back on the road toward a productive and fulfilling life.

Good LTD plans don't happen by accident.

They take plenty of preparation and planning to control costs and claims. They take extensive experience and stable rates. That's why we think the first step to a successful LTD plan—whether self-insured or not—is to hire a good insurance company: NWNL.

Find out how you can get our LTD benefits flowing.

For more information and a copy of our "501(c)(9) Trust Primer," just clip and attach your business card or letterhead. Or call Al Benson, Northwestern National Life, Box 20, Minneapolis, MN 55440, (612) 372-5350.

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PERSPECTIVE

Despite ERISA's rules, don't forget spoken word is a way to communicate

By Russell J. Alberding
Senior Consultant
A. S. Hansen Inc.
New York

Illustration courtesy GAB

Personal communication in small groups is often more effective than written benefit statements, says Russell Alberding, a senior consultant for A. S. Hansen.

IN THE AGE of ERISA, written reporting and disclosure is making an endangered species of one of the most effective means of winning favorable response to employe benefit programs: the spoken word.

ERISA's requirements have so dominated benefits communication budgets and planning that the most effective of all techniques—the small group meeting—is in temporary eclipse. ERISA requires information in writing because it is tangible and lasting, not because it is effective. In the minds of legislators and lawyers seeking to pin responsibility on trustees and administrators, printed matter is proof that an *attempt* at communication has been made and evidence of *what* information has been made available. So much faith is placed in the written word that employes who exercise ERISA rights by making requests for information in writing have direct access to federal courts and can be rewarded with handsome daily fines imposed on administrators who do not reply on a timely basis. But the poor guy who asks for something verbally has no recourse at all—until he creates a piece of paper which evidences his request.

The printed booklet—the summary plan description—will always be a central part of benefits communication. It gives the diligent and inquiring reader a starting point in understanding his or her plan. It can be read and reread, kept for future reference, shared with a spouse. It has permanence. Printed literature demonstrates that information has been made available and that's all the law requires—an *opportunity* for communication. If plan members read and react, communication takes place.

However, written language has its limitations. Here's a newsworthy example from a lawsuit between two professional basketball teams over the meaning of a single sentence in an agreement prepared and revised by two major law firms. The subject is no more complicated than a pension plan's vesting provisions. At stake is the multimillion dollar New York market. The sentence reads:

> The Nets shall have the right without further approval of the Center (Madison Square Garden Center, the Knicks' owner) to play their home games in any location within the Nets' home territory in New York other than the Counties of New York, Bronx, Queens, Kings and Westchester or at any location in the State of New Jersey.

Does that sentence mean the Nets can, or cannot, play in New Jersey without the consent of the Knicks? The Knicks say "other than" includes everything which follows; the Nets say "other than" stops at Westchester. A federal judge will decide.

Keeping in mind that the Nets paid $4 million to the Knicks for the sentence—that is, for the privilege of entering the Knicks' New York territory in the National Basketball Assn.—you can be sure that lengthy verbal discussions preceded the drafting of the agreement and that on the basis of those discussions—the spoken word—there was no doubt that New Jersey was out of bounds to the Nets. But when they put it in writing . . .

If something as carefully prepared as that agreement might be nullified by unclear writing, what fate awaits the thousands of pension plans at the hands of booklet drafters conscious of ERISA's legalistic and ambiguous requirement that booklets be written "in a manner calculated to be understood by the average plan participant"? Two of the key terms in that statement—"calculated" and "average"—have precise meanings if used in a mathematical context, but are fuzzy and imprecise if used as everyday words. Does "calculated" mean the same as "intended"? If so, why not use this clearer word? Does "average" mean that the booklet writer can forget about the half of the people who, by definition, are below average? Would it not have been clearer to say that booklets "should be written so that they are understandable to most plan participants"? That would be a tougher standard, but at least the challenge would be clear.

As things stand, the temptation to use legalese will still be strong. That's the kind of writing which takes a simple thought and makes it into something like this:

> We respectively petition request and entreat that due and adequate provision be made, this day and the date hereinafter subscribed, for the satisfying of these petitioners' nutritional requirements and for the organizing of such methods of allocation and distribution as may be deemed necessary and proper to assure the reception by and for said petitioners of such quantities of baked cereal products as shall, in the judgment of the aforesaid petitioners, constitute a sufficient supply thereof.

That is how "Give us this day our daily bread" will end up if we are not careful.

Because they concentrate on written and printed material, the reporting and disclosure requirements of ERISA will not result in effective communications, which requires a transaction or an exchange. When one party can be passive, reaction or response is limited. That's why trustees and plan administrators who want favorable employe response and understanding are turning to the spoken word—in meetings, counseling, visual presentations, interviews, telephone hot lines and other techniques of verbal communications.

The spoken word is fundamental to any form of organized life and activity. It is a partner or collaborator in any communications program intended not only to comply with ERISA requirements but also to win participant support. Since the purpose of benefits is to meet employe needs and thus to build goodwill for the employers and unions involved, favorable response is a vote of approval and confidence.

The potency of the spoken word can be demonstrated by a few examples. Virtually everyone over age 50 can bring to mind the voices of Franklin D. Roosevelt—"the only thing we have to fear is fear itself . . ."—and Winston Churchill—"we shall fight on the beaches and in the villages . . . but we shall never surrender. . . ."

The most memorable communications have always been spoken and to this day they are known because they have been *heard* and *spoken*. The Our Father, the Ten Commandments and Sh'ma, the central prayer of Judaism, were all originally spoken. North of the Mason-Dixon line, most Americans instantly recognize Lincoln's Gettysburg Address, not because they have read it, but because they have *heard* it and *spoken* it. Americans everywhere can recite the Pledge of Allegiance, or sing "Dixie," without being able to recall ever having seen the words in print.

If verbal communication, therefore, has a potency and force which should be put to work in benefits communication, does it fit into ERISA and how can it be used? Although ERISA's reporting and disclosure requirements resemble somewhat the disclosure requirements of the Securites & Exchange Commission for stock offerings, there is one important difference. Whereas *all* communications by a corporation to its stockholders and the public are subject to SEC rules, ERISA only specifies the minimum which must be communicated about benefit plans. It places no limit on what additional voluntary information can be

Continued on following page

Improving profits won't mean a soft market

By J. Bransford Wallace
Senior vp
Corroon & Black
Nashville

DURING THE FIRST six months of 1977, the results of the U. S. property and casualty insurers were very interesting indeed:

- Earned premiums were up 21% to $27,150,890,000;
- Incurred losses up 11.5% to $17,125,-853,000;
- Underwriting gain of $128,631,000 as opposed to better than a $1.4 billion loss, and
- Net income up 460% to $2,046,111,000.

The all-important policyholders' surplus was also up 18.6% to better than $24 billion. These are salutary results of the first order when you consider they are developed in a very conservative atmosphere. Certainly you can be sure that they are profits couched in an extremely careful reserving climate. Already the national press and TV networks are rumbling about obscene profits and giant ripoffs in premiums and rates. (I suspect that sentiment has also occurred to more than a few of you!)

Not only has the American market returned to profitability but it is a fact that there are close to 5,000 new names making application to Lloyd's for Jan. 1, 1978, which is nearly 50% of the total names currently engaged in underwriting.

With these two optimistic developments, it is therefore obvious that there is so much new capacity that once again the market will soften dramatically and we will have that competitive heyday of the early '70s all over again. Right?

Wrong! Or at least wrong as far as most of the risks that you people have responsibility to manage.

There are a variety of quantitative tools we have and are developing to assist in evaluating the alternatives to pure insurance, with an eye to using these alternatives within the framework of your company's ability to retain risk.

We are spending a great deal of time and energy on these projects because we are convinced that there will be no material softening of the large risk casualty market in the foreseeable future.

I say this because I am convinced that the present top management of the U.S. property/casualty companies will see to it that the lid is kept tightly, especially for the business that has any significant tail associated with it. They now recognize the problem coverages and will not waiver on their caution for the foreseeable future.

There are a number of reasons for my having this opinion: Too many insurance companies came within a whisker of financial collapse in late '74 and early '75 as a direct result of known marginal underwriting practices coupled with runaway inflation, a recession in the stock and bond market and serious under-reserving.

Part of the problem was brought about because the carriers did not keep statistics in a manner that could be of value when various forms of liability cover started going wild. Medical malpractice and product liability, to mention a couple, had their results included in with all other forms of liability and there was no way to isolate them to allow a credible actuarial workup.

The results of this have obviously been either abandonment of the class by carriers or enormous premium increases which indicate a "rather-be-safe-than-sorry" attitude.

And a somewhat more subjective evaluation is the impact I see as a result of the change in ownership of a large number of property/casualty companies as well as the background of the top management teams: Fireman's Fund—American Express; CNA—Loew's; Hartford—ITT; Home—City Investing. INA's CEO has a total financial background.

They seek and demand acceptable financial results, and that philosophy has now been passed throughout the ranks. It is inconceivable to me that they will be anything but ultra-cautious in rating their liability policies with which a tail is associated until their actuaries have accumulated credible data. That will take several more years. If I am correct, then this newfound profitability will result in softening of rates only in the most visible areas where there has clearly been an overreaction in rating; i.e., personal auto, OL&T associated with small commercial enterprises and homeowners.

On the other hand, classes such as workers compensation where every state seems to broaden the benefits annually, product liability where we are still unsure of the depth of the crisis, all forms of professional liability and even commercial auto liability will continue to be viewed with great conservatism by the underwriters. Thus, charged with the responsibility of doing the most effective job for your company, you must carefully examine the alternatives. ■

PERSPECTIVE

Loss control is a remedy to many of today's ills

By Fred C. Maltman, CLA
Insurance Adjuster
F. C. Maltman & Co. Ltd.
Toronto, Ontario

THAT THE PROFESSIONS are being attacked from every quarter is plain enough to see. You can not pick up a journal without an article on this subject: "Lawyers Who Sue Lawyers," "Are Lawyers An Insurance Risk?" and "Protect Yourself" were three concerning the legal profession encountered while writing this piece.

Colorado's "sunset legislation" requiring corporations to prove their usefulness or be dissolved is an example of what is to be expected from the politicians, as is the "Office des Professions" in the province of Québec. In Ontario the Health Disciplines Act now applies to five professions and provides for public representation on their governing bodies. In the United States medical and legal societies have lost their powers of discipline to the courts. An index of all this is the state of malpractice or E & O insurance, an equally popular subject in the papers and ultimately one of primary importance to us all, since the cost of regulation and the professions' experience is reflected in taxes and fees.

A real remedy is loss control, although any of the advertisements about it are artificial and clearly refer to old-fashioned ideas of accident prevention. After the Pill, such assertions are merely nostalgic.

Is there such a thing, then, as loss control and if so, what is it? Fortunately there is and its techniques are effective. You will find its exponents among risk managers, adjusters and even some consultants. The interest of risk and insurance managers is self-evident, as is the attention given the subject by consultants whose clientele have noticeable exposures. But adjusters . . . ?

It seems they have a natural interest as doctors do in preventive medicine.

The current movement to loss control did not originate with insurance companies and this is why some of their advertisements miss the mark. The insurance business by and large lost interest in claims feedback when competition encouraged the marketing force to ignore the worry-warts back in the office. Only the claimsmen hung on, perhaps because they saw so much crumpled metal and spilled brains that they couldn't let go.

In any event, their cynical interest ultimately spilled over to risk managers, who, as an arm of the private sector, were the first group to become really active in loss control. They started with simple prevention, especially in industrial plants and large retail establishments, but even here a philosophic broadening of negative concepts could be seen. For example, one countrywide department store put its partly insured liability program under the care of a corporate secretary while the rest left it with their insurance buyers.

Loss control through public relations was thus becoming a management function. On the professional liability scene, Canadian engineers and architects began to show concern about 1960 over the claims trend then developing in the United States. A course of action not unlike the Schinnerer program was inaugurated by Continental Casualty, then the principal carrier in Canada. That program employed independent adjusters and counsel as a team and soon demonstrated that money spent in the investigation of every potential claim facilitated the deflection or defense of alleged losses and threw up valuable data which could be employed to avoid recurrences. This program was successful and when their book of business was finally wound down because of the company having withdrawn from the professional indemnity field, it had made—in Canada at least—a handsome profit.

The insurance market for engineers and architects in Canada is now largely restricted to two elective programs, one of which was sponsored by the professional societies and which currently retains about 60% of the business. The other plan is underwritten by L. W. Biegler Inc. and fronted by Crum & Forster. Both carriers conduct vigorous loss control programs and both accounts are in the black after seven years of competitive operation. The Biegler plan utilizes the team concept with adjusters and lawyers working together at all stages. The best evidence of the efficacy of this approach lies in the fact that they have not suffered one defeat in the courts and have maintained a satisfactory loss ratio throughout.

A similar plan was developed for the Salvation Army in Canada and Bermuda. The high loss potential here lay in hospitals which are located from coast to coast. Our program involves tight control over the reporting of all incidents, investigation of every item showing claims potential and a continuous feed-back of information on causes, trends and administrative bottlenecks that interfere with smooth public contact. We lecture to graduating classes at the Officers' Training College to indoctrinate future administrators in the importance of claims, both to their image and their finances. We maintain a consulting service for these administrators and their staffs all across the country.

There are similar programs for the dentists and lawyers of Ontario. Both of these are compulsory plans and partially self-insured, thus producing true statistics and ensuring that when something has to be said about control it will be heard. The adjusters report to both insurer and insured, since the burning cost in such programs is largely the latter's.

Underwriters have been impressed with the efficiency of this approach and the resultant minimizing of loss payments. More is spent on investigation, adjustment and counsel than on losses, but the total remains within contemplated ratios, with the result that premiums are favorable compared with other jurisdictions.

The most important effect is slowing down the claims incidence curve, a factor that recently attracted the attention of the Canadian Institute of Chartered Accountants and their brokers, resulting in the underwriters of their sponsored group program naming us the control adjusters in a nation-wide program.

In the case of the Royal College of Dental Surgeons, the $500,000 primary coverage with $25,000 self-retention per claim costs $50 per practitioner per annum. The Law Society of Upper Canada's annual premium levy is $375 for $100,000 primary with $35,000 deductible and self-retention combined. This figure is less than the average premium per individual lawyer revealed in a survey made in 1970! Lloyd's underwrote both these schemes from 1972 through 1976. The present underwriters are a consortium managed by Gestas Corp. Ltd., a setup roughly analagous to the Giebler/U.S. Fire arrangement in the case of the architects and engineers.

Last but not least, these are insurance programs and we are insurance adjusters. The insurance companies have at their doorstep the expertise necessary for control to succeed. Instead of advertising "we hate claims" they should see them as their raison d'être and rediscover the Cinderella claimsmen in their midst.

•

Fred Maltman, born and educated in Toronto, Ontario, formed his own company in 1949 to adjust errors and omissions, malpractice and other liability claims. Maltman & Co. handles this kind of work for engineers and architects, accountants, adjusters, dentists and lawyers, believing that it is no more expensive to investigate and repair claims with or without the use of lawyers.

The spoken word . . .

Continued from preceding page

communicated, provides no standards for such voluntary reports and thus opens the door for supplementary printed literature and for a variety of verbal communications.

Among the many faces of the spoken word in benefits communication is the individual or face-to-face discussion initiated by a participant who brings a question or individual inquiry to the plan administrator. These individual problems and concerns are the building blocks of effective communication, since they involve the participant telling the administrator what concerns him —not the other way around.

Most professionals who are skilled in face-to-face communication, such as therapists, counselors, job interviewers, market researchers and the like, agree that the most important aspect of individual communication is not responding or talking, but listening and interpreting what the participant is saying. That's because every communications activity has two reciprocal activities—sending and receiving, or output and input. They should be kept in balance.

Many programs skip or minimize the input part of communications, which every experienced communicator knows is the foundation for putting a good message together. Many administrators assume they know what their participants think about their benefits, or what they want to know. They thereby miss the positive effects that listening to participants can yield.

The ways to listen are many—surveys, interviews, informal opinion round-ups, reply postcards included in booklets or computer statements or publications. They can be thorough and complete, such as computer-scored surveys with answers correlated by age, pay, sex and location, or they can be quick and informal. Either way, they improve your ability to aim communications at the expressed interest and needs of the audience. They will help you avoid the classic excuse after the program that falls flat: "I communicated good, but boy, are they stupid!"

It is not realistic for any but the largest benefit funds to provide sophisticated training for handling individual inquiries, but merely calling attention to the need for active listening and careful questioning before responding can improve performance. In addition to developing listening skills, larger funds will also want to prepare standard responses to the inquiries which are most frequently made.

Of course, individual inquiries can be stimulated by a variety of techniques, such as identifying the availability of hot line telephone services or by informing participants on a regular basis of their right to make inquiries and indicating the kinds of inquiries and questions that are frequently encountered. Such matters as pre-retirement options and elections, their effect on benefits, the designation of beneficiaries, the meaning of vesting and accrued benefits and similar matters are common areas of difficulty or confusion.

Keeping logs and records of all inquiries is obviously desirable, both to identify the most common inquiries and to see how booklets and other literature can be altered to more effectively explain them. Keeping logs also permits follow-up with participants, to be sure they have been satisfied with the adequacy of the response.

Since answering inquiries on a case-by-case basis is time-consuming, some funds arrange clinics or seminars for the groups which generate most questions, such as participants approaching early retirement, or participants and spouses who want information on options or more general pre-retirement counseling. While many funds will not find it practical to train personnel in handling inquiries, or even to consider this as a major part of communications, almost every plan admnistrator can improve the kinds of responses made to participants who bring questions to the fund.

Another category of verbal communication is the group meeting and visual presentation, both as a supplement to printed literature and as primary communication in itself. Small group meetings, supported by a visual presentation made by a well-trained meeting leader, are unquestionably the most effective way of improving understanding and acceptance of benefit programs by a group of participants.

Live meetings create interest and awareness, raise understanding in the employe group as a whole, answer questions and uncover areas of misunderstanding or apprehension, clear the air and indicate future opportunities for communications by identifying what participants want to know and need to know. Sound slidefilms, motion pictures and videotapes are an alternative, assuring consistency of message but reducing the spontaneity and impact of a live presentation.

Planning and conducting successful meetings requires the application of skills in many areas, such as creating appropriate physical arrangements, obtaining the active cooperation of persons with leadership responsibility, the ability to run meetings and question-handling ability. At bedrock, however, they mean *talking with people* and dollar for dollar that's a better investment than *writing at people*.

For the busy fund administrator or trustee, developing the skills which make for effective verbal communications is at best a spare time activity. But there are some fundamentals that, if observed, will pay off. Remember that effective communicators are made, not born. Speaking well is not a gift but a skill learned through practice. The most common weakness is not in the sending part of the process—the speaking —but in the receiving, in listening to what people are saying, so that you speak to their needs and interest instead of yours.

There is no lack of opportunity to practice verbal communications, since it's what most of us spend a good portion of each day doing. Speaking to large groups, of course, is not an everyday occurrence. However, the most effective speakers to large groups are those who create the impression they are talking to each person singly and directly.

As one consciously attempts to speak better by listening better, the importance of trust becomes more apparent. Communication brings you into relationship with others, and relationships are based on trust and mutual respect. This ethical/moral dimension is an often overlooked but central concept in planning and executing communications.

While it is relatively easy for written communications to be ambiguous, incomplete, confused and, perchance, misleading, it's a lot harder for this to happen in verbal communications. And that's why the fund which wants to go beyond ERISA's reporting and disclosure requirements will turn to verbal communications.

•

Mr. Alberding is responsible for a range of consulting services for pension and welfare plans. He is a specialist in communications. Prior to joining A.S. Hansen in 1969, he served six years as benefits administrator for Servomation Corp.

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• A new **International Insurance Directory**, published by Royal-Globe Insurance Cos., contains current insurance information for more than 100 countries. Topics include legislation, property, casualty and marine insurance and general information about each country. The directory is arranged in a three-ring, loose-leaf binder. An optional reprint service will periodically supply updated information as regulations change. Cost $5; one-time charge for reprint service, $2.50. Write John D. Ormerod, Assistant Secretary, International Dept., Royal-Globe Insurance Cos., 150 William St., New York, N.Y. 10038.

• **Professional liability insurance** for management consultants and executive search consultants, available from the National Union Fire Insurance Co. of Pittsburgh, is outlined in the brochure: Here's the Answer to a problem that must be faced. For a free copy write the American International Group, 102 Maiden Lane, New York, N.Y. 10005.

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• **Insurance on Building and Contents Is All I Need!** Right? Wrong? The answers are contained in a booklet from Improved Risk Mutuals explaining the need for business interruption insurance. For a free copy write W. Scholz, Director of Advertising, Improved Risk Mutuals, 15 N. Broadway, White Plains, N.Y. 10601.

• **The Tent** is a promotional brochure describing a supplemental multi-peril policy offered by the Kemper Insurance Cos. to protect businesses against catastrophic losses to property of million dollar lawsuits. For a free copy write Communications & Public Affairs, Kemper Insurance Cos., Long Grove, Ill. 60049.

• The results of a recent study on the performance of residential fire detectors are available in a 400-page, illustrated book titled **Detector Sensitivity and Siting Requirements for Dwellings.** More than 20 detectors of various types and sensitivities were exposed to 40 residential fires in the testing. Copies are $10 each. Write the National Fire Protection Assn., Publications Sales Dept., 470 Atlantic Ave., Boston, Mass. 02210.

• How do insurers explain the rising cost of insurance to the public? Nationwide Insurance is offering a brochure, **The Problems of Insuring Our Changing Society,** which defends the industry against attacks on its rising premiums using automobile insurance as an example. For a free copy write Public Relations Dept., Nationwide Insurance, 246 N. High, Columbus, Ohio 43216, Attention: corporate literature manager.

• **How an Insurance Consultant Pays Big Dividends** in the case of one trucking firm is reprinted by RIMCO Inc. How costs were reduced, the kind of assistance provided and previous experiences are described in the article. For a free copy write Robert N. Hughes, RIMCO Inc., 10300 North Central Expressway, Suite 180, Dallas, Tex. 75231.

• RIMCO Inc. has recently published its **Insurance Buyer's Checklist for Truckmen** which includes guidelines to help insurance buyers for truckmen. The booklet helps insureds request agents to schedule coverages presently carried as well as outlining recommendations on modifications. Copies are $5. Write William McIntyre, RIMCO Inc., 10300 North Central Expressway, Suite 180, Dallas, Tex. 75231.

• The **Employe Benefit Programs** and consulting services of Reed Shaw Stenhouse Inc. are described in a brief, promotional brochure. For a free copy write Reed Shaw Stenhouse Inc., 230 W. Monroe St., Chicago, Ill. 60606.

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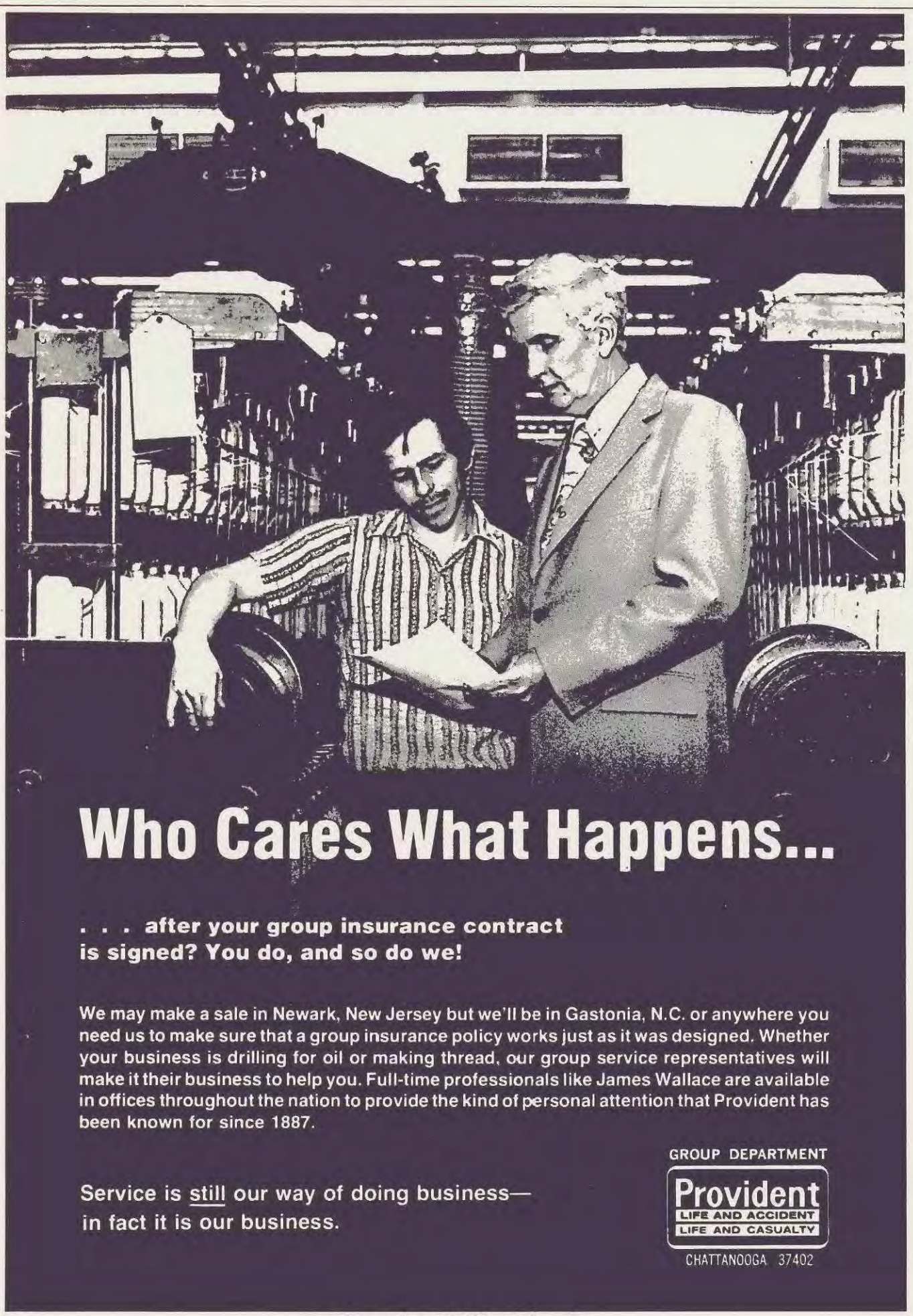

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We'd like Info for Buyers items for our new format

Business Insurance needs items to include in our regular Info for Buyers column which will appear in each issue of *Business Insurance* during 1978.

Though we won't have our regular Info for Buyers issue next year, *BI* will carry expanded Info sections in each of its special issues in 1978, starting with the Jan. 9 Captives and Self-Insurance Review. We're also accepting information on other topics for the Jan. 9 section.

WARNING: None of the info items used during 1977 will be automatically repeated in 1978. If the materials are up-to-date and still available, please submit them again.

Send us a copy of the material or brochure including the price and the person to write. Deadline for the Jan. 9 issue is Dec. 15.

Remember, informational materials can deal with the entire spectrum of subjects we cover: property and liability insurance, employe benefits, safety, loss control claims administration, self-insurance, international risk management, security, fire protection, excess and surplus lines, agent and broker services, etc.

Send all correspondence to Merrill Saltzman, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

munications & Public Affairs, Kemper Insurance Cos., Long Grove, Ill. 60049.

• Many insurance companies and self-insured employers are becoming very interested in rehabilitation of workers drawing benefits under workers compensation, casualty or liability coverage. A 15-page folder from Homemakers Upjohn discusses **Rehabilitation Case Histories** of the company. For a free copy write James L. Bischoff, National Insurance Director, Homemakers Upjohn, 3651 Van Rock Drive, Kalamazoo, Mich. 49002..

• An easy-to-read chart listing legislative changes proposed by major insurance, manufacturing and legal organizations to help solve the product liability problem is contained in the pamphlet **The Product Liability Problem:** Proposals for Solutions Through Tort Reform. For a free copy write The Insurance Information Institute, 110 Williams St., New York, N.Y. 10038.

• **Insurance Consultants' Society** brochure includes information on risk management services provided by members of the society. Included is a mimeographed list of the members. For a free copy write William S. McIntyre, Suite 180, RIMCO Inc., 10300 N. Central Expressway, Dallas, Tex. 75231.

• A quick **True or False** quiz on employe benefits is published in pamphlet form by Johnson & Higgins. Service, costs, pension plans, cash flow arrangements and other benefit topics are covered. For a free copy write Judith Cromwell, Assistant Manager, Production & Coordination Dept., Johnson & Higgins, 95 Wall St., New York, N.Y. 10005.

• A newsletter entitled **The United Kingdom Social Security Pensions Act 1975,** subtitled "The perplexing question of contracting in or contracting out," is available from Kwasha Lipton Inc. The title refers to the fact that in the U.K. Social Security benefits, although mandatory, need not be wholly provided by the state. Part of the benefit may be provided by an employer through a private plan. If this is the case, the employer is said to have "contracted out." For a free copy write Dept. M, Kwasha Lipton Inc., 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

• **The Tax Reform Act of 1976:** What It Means to the Corporate Executive, a six-page newsletter from Kwasha Lipton Inc., offers a brief summary of the changes in the law affecting executive compensation and provides a dollar and cents comparison of how the new tax rules affect stock options and "phantom" stock plans. For a free copy write Dept. M, Kwasha Lipton, 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

• Attention brokers: Statistics on operating expenses, pre-tax profits, revenue growth and commissions per employe for California brokerage firms are the highlights of a study by the Russell R. Miller Co. The report also includes a series of charts and is broken down by premium volume and geographic location within California. The title is **Survey-Financial Operating Experience of a Cross Section of California Insurance Brokers.** Copies cost $7.50 each. Write Russell R. Miller & Co. Inc., 300 Montgomery St., San Francisco, Calif. 94104.

• **Smoke and Other Products of Combustion** is a 98-page, illustrated compilation of 11 articles discussing the reasons smoke kills and what can be done about the smoke problem. Cost is $5 a copy and a schedule of discounts begins with purchase of 25 copies. Write the National Fire Protection Assn., Publications Sales Dept., 470 Atlantic Ave., Boston, Mass. 02210.

• **There is a difference in security . . .** is an eight-page brochure from Pinkerton's detailing its operation and services. For a free copy write Pinkerton's Inc., 100 Church St., New York, N.Y. 10007.

• RIMCO Inc. has prepared a **Government Insurance Buyer's Checklist** for those engaged in arranging insurance for municipalities. The booklet contains guidelines to aid in determining the best insurance program and a working section for the insured and his agent. The price of the booklet is $5. Write Keith Kakaceck, RIMCO Inc., 10300 North Central Expressway, Suite 180, Dallas, Tex. 75231.

• **The Claims Administration System** of System Development Corp. is detailed in a brochure by that name. For a free copy write System Development Corp., Benefits Administration Services Division, 2500 Colorado Ave., Santa Monica, Calif. 90406.

• If you are **Looking for the Best Dental Care for Your Group,** Delta Dental Plans Assn. explains why they think their services, state and national programs, preventive benefits, professional supervision and subscriber services are the best. For a free copy write Delta Dental Plans Assn., 211 E. Chicago Ave., Chicago, Ill. 60611.

• **Disaster Restoration Estimator,** a four-page booklet developed by the Easton Corp. for insurance adjusters, describes how to estimate restoration costs based on product effectiveness and manufacturers' recommended coverage. For a free copy write Jean Mateson, president, Easton Corp., 4907 Farragut Road, Brooklyn, N.Y. 11203.

dates for buyers

Nov. 13-16. Regional Bank Security Seminar to be held by the American Bankers Assn. in Washington, D.C. This is the first such seminar and is designed to develop an awareness within banking of potential internal and external security threats. The program will cover robbery, check swindles, embezzlement and other acts of employe dishonesty. There will be a presentation on crisis-management planning techniques regarding extortion, kidnaping and bomb threats. Cost: $245. Contact Linda Estep, Registrar, Insurance and Protection Division, American Bankers Assn., 1120 Connecticut, Ave. N.W., Washington, D.C. 20036; phone 202-467-4047.

Nov. 16. Greater Detroit Chapter of CPCU to hold its 27th annual "All Industry Day" in the Detroit Renaissance Center. The title of the program is "Marketing of Insurance Coverages: Three Points of View." Cost: $18 per person. Contact Richard Heskin, Greater Detroit Chapter of CPCU; phone 313-553-2121.

Nov. 28-29. Crisis in obtaining legal malpractice coverage seminar, sponsored by New York Law School, to be held in New York City. The program will center on transferring, controlling and preventing the malpractice risk. The seminar is designed for members of the bar, legislators, state insurance commissioners, insurance professionals and law school faculty. Cost: advance registration, $225. Contact: Laurie Hutzler, Legal Management Services Inc., 145 W. 58th St., New York, N.Y. 10019; phone 212-581-4909.

Nov. 29-30. Risk control seminars, sponsored by Commercial Union Risk Management Inc., to be held in Williamsburg, Va. The first seminar (in Nov.) will cover principles of risk control for operating management; the second seminar, **Dec. 1-2,** will cover property risk control for operating management. Cost: $295 per participant. Contact: Mr. Jack Kennedy, Commercial Union Risk Management Inc., 1 Beacon St., Boston, Mass. 02108; phone 617-725-6022.

Nov. 30-Dec. 2. Third annual World Congress of Crime Prevention to be held in New Orleans. Topics include academic and technical countermeasures to American and European white collar crime, industrial espionage and protection of trade secrets, fraudulent document identification, the actuary function, psychological characteristics of the white collar criminal, photo-electronic art identification, economic crime displacement, industrial involvement toward the prevention of crime, executive protection and terrorism. Cost: $250. Contact Crime Prevention International Inc., Suite 200, 2100 Gardiner Lane, Louisville, Ky. 40205; phone 502-458-5992.

Dec. 12-13. Corporate insurance management seminar, sponsored by New York University to be held in Los Angeles. The program will be repeated in Houston, **Feb. 6-7;** New York City, **March 13-14,** and Chicago, **April 20-21.** Topics will include risk management, property and business interruption coverage, minimizing claims problems, controlling fringe benefit costs, workers' compensation and liability insurance, loss costs and product liability. Cost: $60 registration; $425 tuition. Contact: Heidi E. Kaplan, Dept. 14NR, New York Management Co., 360 Lexington Ave., New York, N.Y. 10017; phone 212-953-7262.

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benefit tax slants

IRS reexamines exec deferred plans

By JOSEPH S. ROBINSON
Attorney-at-Law

COMPANIES OFTEN use deferred compensation arrangements as bait to catch the "big fish" on the executive level. This program assures the executive that in addition to current salary he can look forward to a sizable paycheck upon retirement or to his family in the event of his death. While the agreed upon commitment is made in specified dollars, more and more executives insist that the money be invested at a specified rate of interest to partially offset inflation's impact on the funds.

Other types of retirement plans provide for shadow or phantom stock that use hypothetical investments as a measurement of the amount of money to which the executive will be entitled to when reaching the conclusion of the deferral period.

Now the IRS is reconsidering its position on these plans. Pending completion of its review, it will not issue any more letter rulings on plans that "permit the employe to individually elect to defer a portion of his or her salary. The deferred amounts may be invested by the employer in annuity contracts, regulated investment company stock, or other funding mechanisms.

"The investment is designated either by the terms of the plan or by the employe's individual election. The employe's rights are in the form of an unsecured promise from the employer. The amount of the payments is generally determined by the specific type of investment, whether or not the employer actually invests in the funding media."

In announcing the suspension, IRS said in substance that the employe in these situations receives the compensation and deposits it with the employer to be held for the employe's benefit. Thus, it would be taxable immediately. *(IR-1881, 9/7/77).*

Stock bonus plan

The deduction for contributions by a corporation to a trust under a stock bonus plan was disallowed under the following circumstances. The company's two top officers borrowed money from the trust. The other employes of the firm were not given the same privilege. The tax court threw out the plan because it was patently operated for the benefit of the two top men—a "no-no" to any qualified plan. *(Jobusch, 68 T. C. No. 62).*

Group term life

While the Treasury may be pushing for a cut from $50,000 to a $25,000 ceiling on the tax-free portion of employer-paid group term life insurance, it will still be a good deal should the proposed reduction come to pass. The amount taxed to the employe on the excess will be far less than the premium he'd pay were he to purchase similar coverage himself.

Here are examples of the taxable amounts from the Treasury table and the actual tax cost to employes per $1,000 of excess coverage. For age 42, employe is taxed on $2.76; for age 47, employe is taxed on $4.80; for age 52, employe is taxed on $8.16.

EXAMPLE: Suppose Jones, a 52-year-old department head is in the 50% tax bracket. His company provides him with $50,000 coverage above the Treasury ceiling at an actual cost of $747. If Jones had to purchase the $50,000 policy on his own, it would cost him about $875. He would need an extra $1,750 in pre-tax income to pay the $875 premium. Thus, providing the $50,000 additional coverage through group term insurance only costs Jones $408 in added taxable compensation, or $467 cheaper than increasing his salary to cover his outlay if he had to buy term insurance on his own.

Employe travel expenses

We previously reported new IRS rules concerning auto and other one-day local transportation expenses between an employe's residence and his first and last customer or client. (*Business Insurance,* March 4). The effective date of the rule change was re-scheduled for Oct. 1 after several prior postponements. Now there's another switch in plans.

IRS will propose regulations on travel costs and reimbursements between an employe's home and office when he visits a client or a customer en route. While the proposals are expected soon, any adverse rules eventually adopted will not be made retroactive. IRS has promised Congress to delay any change to May 1978, at least.

Here's another change in employe auto travel costs: IRS will shortly increase the standard mileage rate deduction to 17 cents—up from 15 cents—on the first 15,000 miles, effective Jan. 1, 1977. Thus, employes who are not reimbursed for car expenses will be able to deduct 17 cents per mile for business driving without having to keep detailed records on their actual car expenses. As to those employes who are reimbursed, they won't be required to report either the reimbursement or their actual expenses on their individual tax return where the standard mileage allowance is used.

Here's what the company should do to qualify the mileage allowance for non-reporting:

The Treasury says that if an employer sets up a "fixed mileage allowance not exceeding 17 cents per mile in payment of an employe's ordinary and neecessary expenses of transportation and the elements of time, place and business purpose of the travel are substantiated," then the substantiation and adequate accounting requirements will be treated as satisfied. Satisfying these requirements is what makes it unnecessary for the employe to report the reimbursement and expense.

Tax hike

Employes who earn over $17,700 next year can look forward to a $105.60 drop in take-home pay when the wage base for social security goes from $16,500 (for 1977) to $17,700 (for 1978). That will bring the tab to $1,070.85—a far cry from the $30 employes paid when it all began in 1937. ■

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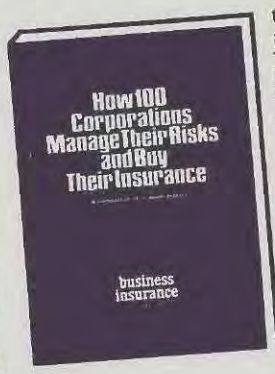

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legal brief

Defective cement can cause tangible damage

DOES A COMPENSABLE injury to or destruction of tangible property occur within the meaning of a manufacturers general liability insurance policy, when defective cement destroys the structural integrity of a partially concrete building? The Supreme Court of Nevada has ruled that it did.

Nevada Cement Co. (NC) manufactured and sold cement to concrete manufacturers. In 1969 a production error resulted in the manufacture of a quantity of cement with an insufficient amount of a chemical compound needed to give it strength. Subsequently, some of the deficient cement was sold to a concrete company which supplied it to a construction company. The construction company used the defective cement in erecting additional floors to a hotel.

The deficiency was revealed during construction, requiring additional supportive shoring to strengthen the building's structural integrity. The cost of the additional work was nearly $170,000. The construction company sought reimbursement from NC who submitted a claim to its insurer, U.S. Fidelity & Guaranty Co. (USFG).

USFG denied the claim claiming that there was no property damage. NC settled with the construction company for $129,000. NC recovered $100,000 in its suit against USFG.

On this appeal, USFG's main contention was that because the additional shoring avoided the consequences of a structural collapse, there was no injury to or destruction of tangible property under the coverage afforded by the general liability policy. The appellate court was not persuaded that structural damage may be recognized only if collapse or removal ensued. The court concluded that an injury to tangible property had occurred here within the meaning of the policy. *U.S. Fid. & Guaranty* v. *Nevada Cement Co.*, Supreme Court of Nevada, March 30, 1977 (BI/01/N.-$3).

Malpractice insurer

Is a malpractice insurer obligated to take an appeal from a judgment which was substantially above the policy limits? A Michigan appellate court has held that an insurance company will be expected to proceed with an appeal, if requested by an insured, if it writes a broad "duty to defend" clause into its insurance contracts.

Benjamin E. Palmer, an osteopath, had $10,000 in malpractice insurance coverage with Pacific Indemnity Co. (Pacific). The policy was purchased through Nettleship Co., which was the sponsored insurance representative of the National Osteopathic Assn. An $82,000 judgment was entered against Mr. Palmer in a malpractice suit.

Palmer sued Pacific and Nettleship to have them held liable for the amount of the judgment in excess of his coverage, as well as for damages incurred, because Pacific refused to appeal from the original judgment. The trial court returned a verdict in favor of Mr. Palmer against Nettleship, as agent, but released Pacific from liability.

The principal issue on appeal was the interpretation and applicability of a clause in the policy which provided that Pacific would defend any suit brought against the insured. Pacific argued that the duty to defend on appeal was conditioned upon whether the insurer reasonably believed that there were grounds for an appeal. However, the appellate court concluded that such an interpretation "places a harsh burden upon the insured, particularly in a case such as this, where the limits of the policy are substantially below the amount of the judgment."

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

Consequently, the court held that since Pacific did not limit its duty to defend, the insured could reasonably expect the company to take an appeal from an adverse judgment. Furthermore, the court agreed that the mental distress Mr. Palmer experienced from the failure to appeal a severe malpractice judgment would be considered foreseeable and could be considered by the jury. *Palmer* v. *Pacific Indem. Co.*, Court of Appeals of Michigan, March 28, 1977, *rehearing denied* April 27, 1977, Campbell J., 254 N.W.2d 52 (BI/01/O.-$3).

Professional liability

Here suit was brought against an insurer seeking damages for failing to defend under a lawyers professional liability policy. A New Jersey court ruled that the six year statute of limitations begins to run from the date of the termination of the underlying suit against the insured. According to the court, a "no action" clause in the policy requiring the insured to hold off suit against the insurer until a final determination of his obligation to pay delayed the accrual of the right of suit against the insurer.

A lawyer was covered under lawyers professional liability policy issued by St. Paul Fire & Marine Insurance Co. (St. Paul). The lawyer was sued by a client in late 1967 for fraud. St. Paul was notified of the suit and refused a demand to defend. By letter dated April 18, 1968, St. Paul informed

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the lawyer that its reason for refusing to defend was because the action was not within the policy coverage.

The policy did contain a clause precluding action against the insurer by the insured until there was a final determination that the insured had an obligation to pay. In July 1974 the litigation against the lawyer was concluded. In August 1974 the lawyer sued St. Paul to recover the fees and costs incurred in the professional liability suit. St. Paul argued that this suit was brought too late because it was more than six years after they had declined the defense and thus was barred by the state statute of limitations.

The appellate court noted that the issue raised here had not previously been resolved in New Jersey. Relying on decisions from other jurisdictions, the court concluded that the statute of limitations begins to run as of the date of the termination of the litigation involving the insured rather than from the date the insurer refused to defend.

Any other result, the court believed, would have allowed "piecemeal litigation and a multiplicity of suits, both of which are looked upon with disfavor in the law." *Kielb* v. *Couch*, Superior Court of New Jersey, Law Division, April 27, 1977, Gaynor, J., 374 A.2d 79 (BI/02/O.-$3).

Ambiguity unconscionable

In a suit to recover under a group credit life policy, a Florida appellate court has held that where the master policy provided that the aggregate amount of insurance in force on the debtor's life would in no case exceed a maximum of $35,000, but where the certificate could be interpreted to mean that the limit would apply to each certificate purchased, the insurer could not deny coverage under the second and distinct certificate of credit life insurance.

This suit involved two separate credit life insurance certificates issued to the Rucks by Old Republic Life Insurance Co. (Republic), each in connection with a substantial bank loan. The first certificate for $117,000 issued by Republic included a statement that the "amount of insurance may not at any time exceed $35,000" and that the certificate was issued "under and subject to the terms and conditions of the Creditors Group Policy." The second policy was issued for $40,000.

The group policy, which was never seen by the Rucks, specifically limited coverage to $35,000 should the life of the debtor be insured in connection with more than one indebtedness. Upon Rucks' death, Republic paid the bank $35,000 under the first certificate. The bank did not attempt to collect on the second. Republic advised Mrs. Rucks that the group policy precluded recovery beyond $35,000. The trial court ruled that Republic was not liable on the second certificate.

The appellate court pointed out that, as a practical matter, the certificate is the only document an insured ever sees under a group life insurance policy. The court agreed with the majority view that both the certificate and the master policy construed together make up the contract between an insurer and an insured. Thus, the court emphasized that ambiguities or conflicts between the two must be resolved so as to provide the broadest coverage.

Thus, the court ordered Republic to pay off the second certificate of insurance. *Rucks* v. *Old Republic Life Ins. Co.*, District Court of Appeals of Florida, Fourth District, April 15, 1977 (BI/03/O.-$3).

Horseplay victim

May an innocent victim of horseplay injured during the course of his employment recover workers compensation benefits for such injury? The Supreme Court of Appeals of West Virginia has ruled that he could.

While waiting with other employes to leave the employer's premises at the conclusion of his work shift, Elmer E. Sizemore received a cervical injury when he was hit on his hard hat by a fellow employe. It was not disputed that the act was not motivated by any ill feeling. Sizemore was unaware of the prank until hit and his assailant, a fellow employe, had no intention to injure him.

The Workmens Compensation Appeal Board (Board) denied Sizemore compensation benefits on the ground that his injury was a result of an "assault" and therefore was not compensable.

The appellate court believed that the Board erred in characterizing the facts here as an assault. Sizemore did nothing to provoke the occurrence, according to the court, and was merely an innocent victim of it.

"Even if the assault label were correct," the court said, "we have held that if an assault has its origin in the work context and the claimant is not the aggressor, an injury resulting therefrom is compensable." *Sizemore* v. *State Workmens Comp. Com'r.*, Supreme Court of Appeals of W. Va., June 14, 1977 (BI/02/N.-$3)

Arson coverage

The U.S. Court of Appeals for the Fifth Circuit has ruled in a suit on a fire insurance policy that a criminal act of a manager of a corporation's business enterprise, who was allowed to make executive decisions, was not attributable to the corporation.

This suit was brought by Owl & Turtle Inc., owner of the Yum Yum Tree nightclub, against Travelers Indemnity Co. (Travelers) seeking indemnification under a fire insurance policy. Travelers acknowledged liability under the policy for arson; however, it refused payment in the belief that the son of the sole shareholder of the corporation had procured the fire.

Travelers presented evidence in an attempt to prove that the son, although not the legal owner of the club, was actually the dominant force directing the club's business activities. A jury awarded a verdict absolving Travelers from liability.

The appellate court acknowledged that it was settled that public policy denies the right of recovery to an insured who fraudulently sets on fire the property covered by the contract of insurance. But, the court emphasized that there was insufficient evidence here to establish that the owner's son had acted as the insured. According to the court, the jury should have been directed to the question of whether the corporation or its shareholder had consented to the incendiarism rather than to the mental attitude of the son.

Because no evidence was presented of any fraudulent intent on the part of the corporation's sole owner, the court concluded that the decision should be reversed and sent back for another trial. *Owl & Turtle Inc.* v. *Travelers Indem. Co.*, U.S. Court of Appeals for the Fifth Circuit, June 17, 1977 (BI/03/N.-$3).

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(Copies of the entire decision of cases described may be obtained by sending a check for $3 made out to Cases Unlimited to Legal Briefs, Business Insurance, *740 N. Rush St., Chicago, Ill. 60611. Please list the number for each opinion requested, which is at the end of the brief.)*

for a Federal law to keep wrong hands.

"Don't touch that!" is one way to keep a child's curiosity from leading to serious injury.

But The Hartford's loss prevention service suggested a safer way for one manufacturer of a common household product. Almost two years before those hard-to-open bottle tops became Federal law, The Hartford recommended that they be placed on the manufacturer's product. As an extra safeguard, we also suggested that the product be reformulated, but in a way that wouldn't change its effectiveness.

The results of this loss prevention counseling are history. The manufacturer hasn't encountered any more injuries to children, or product liability lawsuits, from this product.

When losses go down, rates don't have to go up.

Nowadays, the competition isn't all that can hurt manufacturers of consumer, medical, and industrial products. Or their retailers and wholesalers. Because now there's an increasing chance of their products landing in court as evidence. Last year, hundreds of thousands of product liability claims did end up in front of a judge—with more and more plaintiffs winning their cases. And winning bigger and bigger settlements.

This alarming trend has caused product liability premiums to soar because insurance companies, like any business, have to raise their rates when costs increase.

However, many claims and losses—and their effect on rates—can be avoided by using a product loss control program designed with The Hartford's help.

Our program may recommend changes in design, quality control, production techniques, labeling, record-keeping. Whatever is necessary.

It may also help you avoid costly product recalls. And the effects on your product's reputation—and profitability.

Product inspection is only part of prevention.

Since we've inspected more than 100,000 products, ranging from toys to giant power shovels, our product safety knowledge is virtually unmatched in the industry.

It's knowledge other manufacturers can use to help build better, safer products. It also keeps retailers and wholesalers aware of special problems. And as an information clearinghouse, we can also keep manufacturers of new products informed of recent government rulings. We do all we can to help keep your product or service out of trouble.

The Hartford is able to provide all this counseling because there are more than 450 loss prevention experts on our staff, located throughout the nation. Chemists, engineers, and experts in fire protection, construction, health care—and product liability.

It's the kind of preventive help a wide variety of businesses urgently need, but can't always afford on their own. Which is why more of them are asking for The Hartford's help—and getting results.

Loss prevention is part of our policy.

When you buy a commercial policy from The Hartford, you also get our loss prevention counseling. You get advice on how to prevent serious injuries, which can help avoid lawsuits and lost profits. And your business, regardless of size, gets this help when necessary.

Find out how it can be an asset to your business by contacting your independent Hartford agent.

Do it today. It could keep your product on the shelf—and off the bench.

The best protection is prevention.

THE HARTFORD

The Hartford Insurance Group, Hartford, Connecticut 06115

For more facts circle 113 on reply card

Wholesale and Retail Clerks Industry

Dangerous Health Hazard	Industry workers exposed regularly on the job
Isopropanol (causes kidney disorders)	20%
Detergent	20%
Butoxyethanol, 2 (a toxic pesicide and possibly carinogenic agent)	15%
Cleaning Compound	15%
Naphtha (a leukemogenic agent)	10%
Ammonia	10%

Food & Kindred Products Industry

Continuous Noise	33%
General Products of Combustion (contains carbon monoxide and lead)	10%
Cleaning Compound	10%

Union official blasts food industry inaction on occupational safety

NEW YORK—Union leaders charge there is a "startling lack of occupatiocnal safety precautions in the food and beverage industry."

Robert F. Harbrant, secretary-treasurer of the food and beverage trades department of the AFL-CIO, cited a National Institute for Occupational Safety & Health study in calling for additional research to "fully reveal the extent of existing occupational hazards and to develop necessary safety measures."

Five years ago 20 chemical engineers set out to record health hazards in industrial plants around the nation.

During the two years of the survey, 7,143 hazards were found in 4,700 plants. Since then, the National Institute for Occupational Safety and Health, has been busy compiling the results and comparing the list of hazards to a list of toxic agents prepared by NIOSH.

The comparison has found that 3,000 of the hazards the engineers spotted were listed in NIOSH's hazardous chemical registry. And Dave Sundin, chief of hazards at NIOSH, says he's "confident that 5,000 of the 7,143 spotted dangers will be valid safety hazards.

Mr. Sundin agreed with the union official, saying, "It's disappointing that there's a very low percentage of industrial hygienists, medical services, medical exams or safety committees" existing in industry.

"They should be monitoring people's health not just out of maternalistic or altruistic concerns," Mr. Sundin said. "It's an economic issue also. Workers compensation and insurance rates ought to force them to do this (monitor workers health)."

He admitted, however, that industry's concern "has changed a little bit since the study was undertaken" from 1972 to 1974. He said OSHA regulations have required industries to pay more attention to health hazards.

Mr. Sundin blamed NIOSH's delays in identifying hazards and OSHA's slowness in developing regulations after NIOSH has determined a chemical exposure harmful.

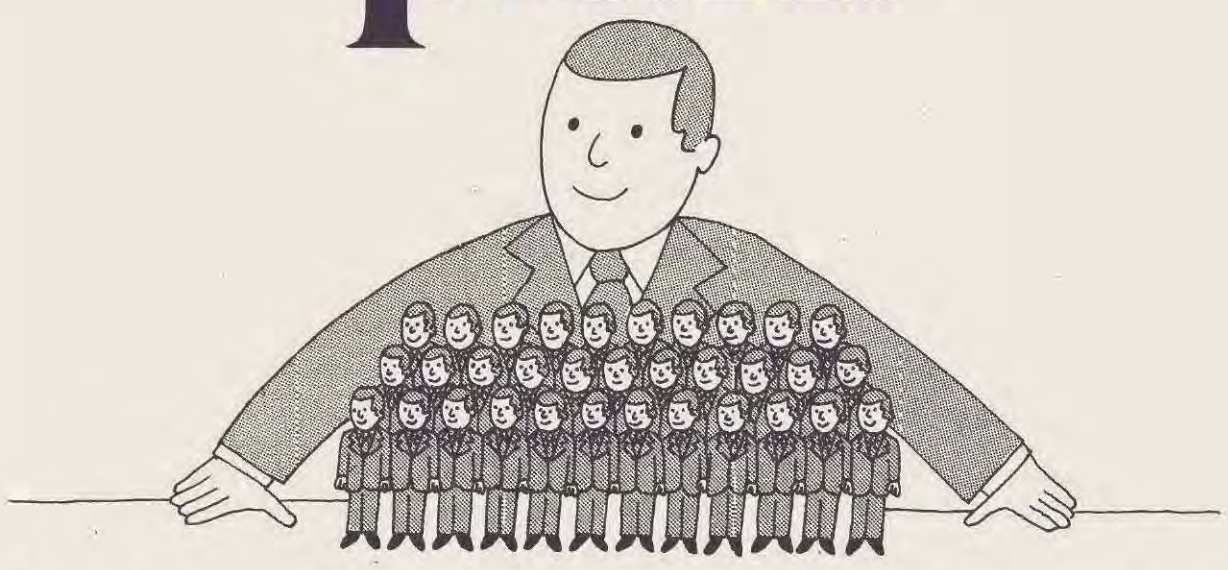
"There are plenty of dangerous substances that do not have standards," he said. "But it's not a simple exercise."

The labeling of chemical products by brand name only, which fail to mention ingredient in chemical mixtures, have delayed NIOSH's identification of all chemical product hazards, according to Mr. Sundin. He said there may be a substance in the mixture that may be harmful yet no one but the producer is aware of the hazardous ingredient.

Also slowing the process of regulating chemicals is that OSHA identifies hazards on a trade name basis instead of by classes of chemicals, he added. OSHA, however, is proposing that identification be made by classes of chemicals, he said.

Mr. Sundin suggested that safety directors could help if they would only buy products that labeled chemical ingredients. ■

The ROYAL plan.



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For more facts circle 124 on reply card

AIG plans major reinsurance plan

NEW YORK—A worldwide reinsurance program has been formed by American International Group Inc. to offer Third World insurers an opportunity to take a selected account of the company's ceded reinsurance.

The program, American International Reinsurance Account (AIRA), will help insurance companies in developing countries broaden business beyond national boundaries to give them better-balanced insurance risks, according to AIG.

The company's commitment to strengthening the insurance industry in Third World nations has motivated AIG to set aside a share in the program for these nations.

The American International Companies maintain reinsurance and business relationships with most other nations.

AIG intends to continue to develop its relationships that have already been established with insurers in developing countries. ■

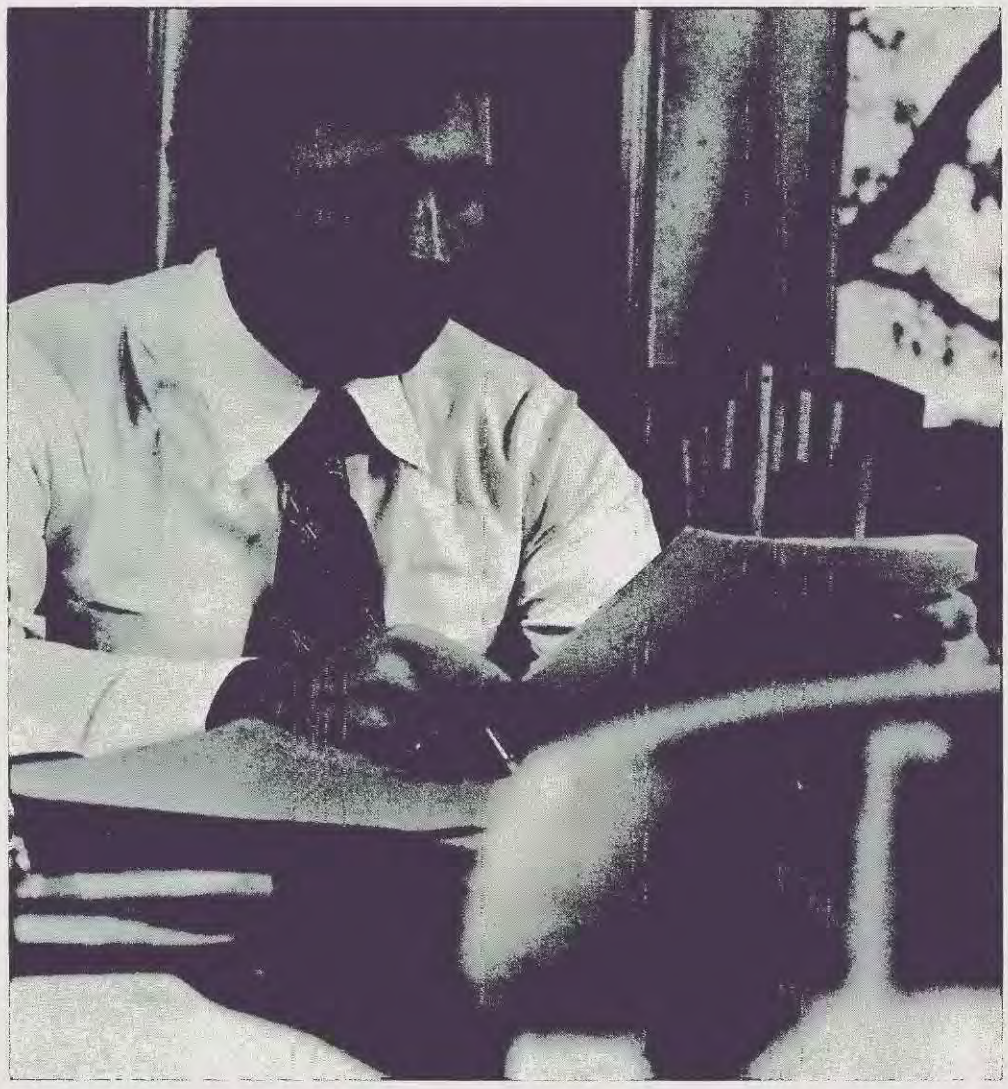
Mayhew to head James in Bermuda

NEW YORK—Stanley Mayhew has been named president and managing director of James (Bermuda) Ltd., the Bermuda-based subsidiary of Fred S. James & Co. Inc.

Prior to joining James, Mr. Mayhew was president and managing director of London Weavers Reinsurance Agency (Bermuda) Ltd., London United Management Co. (Bermuda) Ltd. and London United Reinsurance Co. (Bermuda) Ltd.

James chairman James H. Vaughn said Mr. Mayhew's appoint reflects his company's commitment to the Bermuda insurance market. James is now fully staffed to handle captive insurance problems, he said. ■

Sometimes Arkwright-Boston reps don't call home for months.



That's because they're the best in the business.

Since we're a decentralized company, they have to be. They've got to be good enough and professional enough to make decisions and come up with answers without calling the home office every five minutes. In effect, they're Arkwright-Boston wherever they are.

That means that if you have a company in Des Moines, it will get the same attention as a company in Atlanta or one in Stuttgart, Germany. And the attention you'll get is the best. In fact, you'll probably have a better loss prevention record when you insure with us than you'll have when you insure with anyone else.

After we sell you insurance, we want to make sure you'll never need it.

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letters

Continued from page 8
traditional ways hospitals have been doing things wrongly to offer really fresh viewpoints. Second, risk management (or anything else) by committee is a ponderously tangled process usually giving forth with a mouse when a lion is needed. Third, a well-experienced "claims person" from a multi-line casualty carrier is probably the best source of a risk manager, for that person is the most well-versed in the whole insurance process from production, underwriting, loss engineering to claims management and suit preparation.

And, after all, one of the most important thrusts of modern risk management is finding new fiscal alternatives to buying insurance to manage risk. That usually translates to self-insurance.

Finding a risk manager in a health care administrator is about as far-fetched as finding one in a CPCU, or even worse than that, agents.

Robert G. Walters
Risk manager, the city of San Diego, Security Pacific Bank, San Diego, Ca.

National health

To the editor: I read with interest Peter Downes' article "A national health plan: What will it really mean?" (Oct. 17). I share some of Mr. Downes' concern in regard to a national health plan, for I believe that without proper restraints and regulation that it will be another boon for physicians. But what disturbs me is that Mr. Downes, like all opponents of national health care, holds up the English system as an example of the failure of any national health plan.

What he fails to mention is that practically all developed nations have some form of national health insurance. Why doesn't Mr. Downes, or the AMA, ever mention this fact or compare our system with that of New Zealand or the Scandinavian countries or other nations such as Germany?

The City of Denver's employes next year will have to pay $121.99 per month out-of-pocket, with an employer contribution of $34.02, a total of $156.01, for family health insurance. And whereas I would hasten to point out that the City of Denver's problems are unique in some respects, I suggest that a national health plan with restraints and proper rules is the only ultimate viable solution to the ridiculous cost of medical care confronting our employes and all other citizens of this country.

Jack Love
Director, Risk Management Office, City and County of Denver, Denver, Colo.

Polygraphs

To the editor: Though overdosing on mood, Mr. Harvey Yaffe's letter to the editor (Oct. 17) defending polygraph tests accurately creates the right apprehensiveness for a police episode depicting a highway accident involving children. His "polygraph technique" totally ignores fundamental 1st and 14th Amendment questions, making the test(s) above cross-examination and, accordingly, sacrosanct.

The recognition of the polygraph ". . . as a valuable tool in sound business operation . . ." is a matter of opinion and in many cases inadmissable as evidence in criminal proceedings. The depiction is one of a scientific instrument. The reality is less than an expert witness.

E. Bernard McGlynn Jr.
Bloomfield, N. J.

Punitive damages III

To the editor: There are a few major holes in your editorial on punitive damages.

First, if we are discussing conduct which is at its base unlawful, then state laws should be uniform in making it illegal to insure against such conduct. This isn't a matter for the ISO; it's the province of the respective state supreme courts.

Second, if the conduct is "willful and wanton," i.e., meant to harm, then why should insurers be willing to buy back the exclusion? Granted, they should be excluded. Let them stay excluded, not make a marketing scheme out of the discussion.

Third, there is a tremendous cloud over the entire subject, because no one has come up with a clear definition of what conduct should be punished. Should gross neglect be punished, or not? What are the parameters?

Before an exclusion is written, legal precedent should be set and it should be uniform, particularly if the ISO is going to publish a form for use. The attack on the problem to this date is haphazard and premature. What should be punished are acts meant to injure, not neglect. The distinction, if indeed there is to be one, between exemplary and punitive damages should be set clearly and carefully.

This is too important a subject. Let's get it right the first time, please!

Robert Field
Insurance administrator, Rapistan Inc., Grand Rapids, Mich.

. . . Reconsider

To the editor: In this day and age of higher and higher premiums for less and less coverage, it seems ironic that a publication such as yours would advocate excluding another coverage heretofore included. Your position will open another door to the "buy back" game being played by underwriters.

The place to fight puntive damages is in the legislatures where admittedly reforms are needed.

W. M. Schmitt
Insurance manager, Coats & Clark Inc., Stamford, Conn.

. . . Tort reform

To the editor: With all the difficulties experienced by buyers of casualty insurance over the past several years and the demands for reform of our judicial system, I frankly cannot agree with your unqualified approval of ISO's recent action regarding punitive damages exclusion in liability contracts.

This is not to say that punitive damages awards are not, in certain instances, justified. They certainly are in those instances involving gross and wanton misconduct on the part of the defendant. Unfortunately, most juries have little or no understanding of exactly what constitutes "wanton misconduct." Judging by today's awards no one is taking the time to educate them.

I believe *Business Insurance* should take another look at the issue and consider adjusting their priorities. Let's first direct our efforts towards bringing about judicial reform that discourages indiscriminent awards for so called punitive damages. Once this objective is realized, we can then address the question of coverage.

G. F. Whelan
Manager, Corporate Risk and Insurance, Inmont Corp., New York, N. Y.

Payments

Life insurance companies paid $9.6 billion in the United States during 1976 to the beneficiaries of policyholders, reports the American Council of Life Insurance.

The Multi-Assumption Projection System.

If we didn't own ourselves, maybe we wouldn't have created it.

This new Johnson & Higgins system is an advanced pension plan cost forecasting tool that "maps" where your pension costs might be five, ten or even more years down the road. Frankly, it's an eye-popper for many corporations.

The system works via complex computer techniques using a variety of possible scenarios. It's like watching a movie instead of looking at the static snapshot the usual actuarial valuation represents.

Consulting Actuaries George Budd [left] and Bob Bein of J&H New York and Russ Millman [center] of J&H Cleveland, review a Multi-Assumption Projection System print-out.

One corporation employed the system to help decide investment policy for pension funding. But after the future costs of benefit improvements already scheduled were revealed, the company's original thinking was immediately modified. A re-evaluation of basic pricing policies followed.

For still another firm, the system became the key to illustrating the long-term effects of inflation on pension cost and investment return.

Forecasting today requires more precision than "Guesstimating" or using rules of thumb.

The actuarial specialists who created this system are part of a technical team noted for cracking complicated problems for clients.

The fact that we are a privately held firm has helped gain this distinction. Because it made it easier for us to invest in the human and technical resources that can produce key consulting advances.

The Multi-Assumption Projection System. The newest example of 50 years of J&H benefit consulting leadership.

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EMPLOYEE BENEFIT AND ACTUARIAL CONSULTING; RISK AND INSURANCE MANAGEMENT SERVICES THROUGHOUT THE WORLD.

Mattel lawsuit . . .

Continued from page 1

from its Mattel account ranged from $82,000 in 1971 to $179,000 (including three-year surety bonds) in 1974 to none in 1976.

The toy manufacturer first became a M&M account in the mid-1960s and was an exclusive account for the broker until 1970.

Mattel attorney Gregory Smith said in his opening statement that his client acquired its first $5 million D&O policy in 1967. That policy expired at midnight March 13, 1970. A $5 million renewal policy was then purchased which expired at midnight March 13, 1973.

For its next one-year renewal policy, Mattel wanted $10 million of coverage, he said.

Mattel, however, alleged that Marsh & McLennan was more interested in excluding another broker, Booth & Simpson, from obtaining the policy than it was in serving Mattel's interests.

Elaborating on Mattel's charges, Mr. Smith said in his opening statement that the plaintiff would show that M&M, in an effort to lock in the D&O market and exclude Booth & Simpson, "contacted insurers before Mattel authorized it to do so . . . and continued to contact insurers after it had received quotes for the insurance which it did not pass on to Mattel."

"Marsh & McLennan as early . . . as February 26, 1973, had a quote on this insurance, but Marsh & McLennan did not tell this quote to Mattel," he said. "They didn't tell it to Mattel because they were afraid that Mattel would in turn tell the quote to Booth & Simpson and that Booth & Simpson would then go out and find an insurer who would undercut them."

One way in which M&M prevented Mattel from discovering the quote, which initially was $49,500 for 94.392% of the first $2 million layer of the renewal coverage, he said, was by placing only $2 million of coverage in the London market. Mr. Smith said Marsh & McLennan feared that if Lloyd's broker Bland-Welch asked Rodney Wace, a leading D&O underwriter, to place $5 million of coverage, the latter would have to approach Leslie Dew, revealing the premium in the process. He said the brokerage house was worried that Mr. Dew would disclose the premium to his London broker, Stewart Smith, who, would then reveal it to Booth & Simpson.

Another central charge by Mattel against M&M concerns a class action suit (the Greenfield complaint) filed on March 12, 1973. Although the March 12 complaint would not have been covered by the renewal policies effective March 14, it would have aroused alarm in the prospective insurers who knew that class action lawsuits tend to come in groups, Mr. Smith said.

However, he told the jury that ISLIC and Unigard never had an opportunity to evaluate the Greenfield complaint because "Marsh & McLennan . . . didn't bother to tell the insurers about the existence of the Greenfield case."

At a March 12 meeting at Mattel between Messrs. Tily and Fox and two Mattel executives—assistant treasurer John Pinner and general counsel Raymond Ferris—Mr. Ferris handed a copy of the Greenfield case filed March 12 to the M&M executives, Mr. Smith said. Later in the afternoon at M&M's Los Angeles headquarters, he said a Telex was sent to Bland-Welch notifying them of the existence of the complaint.

Because Lloyd's was involved in the D&O policy covering 1970-1973, the brokerage firm felt compelled to report the existence of the claim to Lloyd's, he asserted. But no similar steps were taken in regard to ISLIC or Allen-Miller, the managing agent for Unigard, he charged.

"Throughout this period the evidence will show that they hide and conceal the existence of the Greenfield case for fear it will upset their ability to place coverage, coverage . . . they should have been able to place at least by March 7 . . ." he said.

He said it wasn't until 10:30 a.m. on March 12, the last day of the old policy, that John Pinner of Mattel learned from M&M that a renewal quotation existed. Mr. Smith said that at 3 p.m. on March 13 Mattel gave M&M authority to bind the coverage, not knowing that the coverage had been bound the previous day.

It wasn't until March 12 that M&M began negotiations with Allen-Miller, Unigard's agent, for coverage of the additional $5 million third layer, according to the Mattel opening statement.

Lloyd's, ISLIC and Unigard all canceled their policies effective June 30, 1973, Mr. Smith continued, stating that Mattel would show that the reason for Lloyd's cancellation was fear of "the domino effect" of class action suits like the Greenfield complaint filed March 12.

Marsh & McLennan in its opening statement said that it will prove that the decision by the excess insurers originally not to honor their D&O policies had nothing to do with the Greenfield case.

"I am going to prove that whether or not Greenfield was disclosed . . . the disclosure or nondisclosure of that fact had absolutely no bearing on whether or not these two insurance companies paid or would not pay," said Maurice C. Inman Jr., M&M's chief attorney.

Mr. Inman said that 94% of the first $2 million of coverage on the D&O policy was held by Lloyd's underwriter Rodney Wace. ISLIC took 6% of that coverage under a longstanding agreement with Mr. Wace, eventually increasing its share to 15% of the primary layer.

On top of its participation in the primary layer, ISLIC provided a $3 million excess layer, Mr. Inman said, in an effort to indicate that M&M's notification to Lloyd's of the Greenfield suit should have been the same as informing ISLIC.

"Now, the evidence will show . . . that there were constant communications between Marsh & McLennan and Mr. Cleland, the representative of ISLIC who handled this particular matter," Mr. Inman said.

He said that William Spargur, formerly in M&M's marketing department, would testify that he met with Lou Biegler, president of ISLIC and of L. W. Biegler Inc. on Feb. 7. Mr. Spargur was told that ISLIC would rely on London with respect to terms, conditions and rates.

The M&M attorney said Mr. Spargur would also testify that to his best recollection he advised Mr. Cleland of the existence of the Greenfield case.

"And Mr. Cleland took the position that so long as Lloyd's of London was going on the primary, that was okay," said Mr. Inman in his opening statement. Mr. Inman said Marsh & McLennan could not put the insurance package together until March 13, 1973, the day it communicated the quotations to Mattel.

"There were quotes that were communicated to Marsh & McLennan before that; but these quotations were partial quotations," he said. "They did not cover what Mattel was seeking because they

Continued on following page

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The nation's leading group company. For the third year in a row.

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EQUITABLE

The Equitable Life Assurance Society of the United States, New York, N.Y.

Mattel lawsuit . . .

Continued from preceding page
did not cover the full $5 million.

Until March 13, he said Mr. Spargur was attempting to knock out exclusions on the coverage.

In addition, he said that a representative of Allen-Miller would testify that he went along with the decision made in London to insure Mattel. Mr. Inman said that once Allen-Miller was assured that Greenfield was a claim on the prior policy, "everything was okay" with him.

The attorney further said in his opening statement that Rodney Wace knew of the existence of the Greenfield suit because it involved his prior coverage. Although Mr. Wace was upset about the claim, Mr. Inman said he nevertheless went ahead on the new policy.

The decision by Mr. Wace to cancel the $2 million primary layer on June 30, 1973, had nothing to do with the Greenfield suit, Mr. Inman continued. He said that a representative of Mr. Wace would testify that Mattel's bad earnings reports were responsible for the cancellation.

However, after the June 30 cancellation, the M&M attorney said his clients "nearly knocked themselves out to replace this coverage."

John Pinner, assistant treasurer of Mattel and the company's first witness, testified that as far back as 1970 he talked to John Fox and other M&M executives about problems in the service Mattel was receiving from M&M. By January 1973, he said he had moved general and auto liability and out-of-state workers compensation as well as lines of coverage for a subsidiary from M&M to Booth & Simpson.

In February 1973, he said he asked Booth & Simpson to look for a domestic D&O underwriter.

Booth & Simpson, however, was unable to place the coverage, testified Raymond Ferris, a following witness.

None of the Mattel witnesses said they would have accepted the February 26 quote for 94.392% of the $2 million primary layer with its exclusions and without the remainder of the primary layer ($3 million) and the $3 million excess.

Marsh & McLennan vp John Fox, who was on the stand for nearly an entire week, said he got involved with D&O insurance discussions with Mattel in about 1967.

However, he said that from July 1972 to January 1973, his major involvement with Mattel involved negotiations regarding a Mexican fire loss. Under later examination by M&M attorney Inman, Mr. Fox testified that M&M attempted to persuade insurance adjusters to agree with Mattel's figure on the amount of the loss.

Under direct examination, he agreed that the possibility of Mattel's asking Booth & Simpson to participate in D&O renewal seemed "very real" in early 1973.

On March 1 and 2, he said he phoned Mr. Pinner and his assistant, Elve Wilson, from New York to tell them that it was not a good idea to have two brokers in the limited D&O market and that Lloyd's people would not compete against each other. Under further direct examination, he said he was "mad as hell" during the March 1 conversation and that he told Ms. Wilson that Booth & Simpson was "messing up the London market."

London's initial quote of $49,500 on the 94% portion of the $2 million layer was upped to $59,500 after Mattel's second press release warning of a loss on February 23. Mr. Fox said he never told Mattel of the first quote.

A 19-year employe of M&M, Mr. Fox said he informs clients of final quotes when the total package, including terms, conditions, exclusions and prices, are "the best we can do." He said one of the problems with the Mattel renewal is that the company did not want any exclusions at all.

He said that to the best of his recollection the final quotes were given to Mattel on March 13, 1973. He said no quotes were discussed at the March 12 meeting at Mattel because they were not yet firm.

Mr. Fox said he gave the Greenfield complaint to William Higgins on March 12. Mr. Higgins was responsible for claims reporting, he said, and would give it to London. He also said he thought he talked to Mr. Spargur on March 12, mentioning the Greenfield case while discussing other matters.

Under questioning by an ISLIC attorney, Mr. Fox said "it did not enter my mind at all" to ask Mr. Spargar to advise ISLIC of the case.

Mr. Tily, a 25-year M&M employe, testified he did not meet anyone from the toy company until the March 12 meeting, although he dictated a memo on March 7 that laid out some of the prices and conditions of the first two layers of renewal coverage.

Under direct examination by a Mattel attorney, Mr. Tily said he could not recall any quotes being discussed at the March 12 meeting. He also testified that he does not remember whether he knew in early 1973 Booth & Simpson had part of the Mattel account.

Mr. Tily, CPCU, also was asked if past claims constitute essential underwriting information.

Initially, Mr. Tily responded that the question should be directed to the underwriting department. But when pressed he replied, "I don't know."

Examined about his procedures for disclosing claims to underwriters about to accept coverage, William Spargur, who was formerly assistant vp in the Los Angeles office marketing department, and a subsequent Mattel witness, said that as a marketing official he had no obligation to disclose any information concerning an insured to an insurer. If an underwriter wants new information after an application is filled out and signed, the underwriter must request a new application, he testified.

He further said that the responsibility lies with an insured, and not his broker, to inform underwriters of unfavorable claims developments.

Mr. Spargur testified that the first he knows he was informed of the claim was on March 13 when he received a phone call from Bland-Welch. But even at that date, he said he had no knowledge of what the suit was about or its degree of seriousness. It was not until a few weeks later, testified Mr. Spargur, that he obtained more complete knowledge of the Greenfield suit.

However, he also said that although he does not remember doing so, he is confident that had he had known of Greenfield on March 12 he would have told both ISLIC and Unigard of the case.

On other issues of the lawsuit, Mr. Spargur testified that brokers never pass on partial quotes to their clients two weeks before the effective date. Because he made a last ditch effort to eliminate the exclusions, he said he did not have the Mattel D&O package put together until the morning of March 13.

Mr. Spargur said that the so-called strategy to keep Booth & Simpson out of the renewal process by not approaching Leslie Dew was never put into effect. ■

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Involving bankrupt GAC Corp.

Lloyd's may not cover $135 million D&O suit

By REBECCA A. FANNIN

NEW YORK—Lloyd's of London hasn't yet decided whether it will cover a $135 million damage suit filed by two trustees of GAC Corp. against four former officers of what was once the largest land sales company in Florida.

A directors and officers liability policy with limits of $10 million and a $500,000 deductible may not respond because notification of the suit came after Lloyd's declined to renew the policy, said Martin Hartung, a former outside general counsel to GAC. The Lloyd's policy lapsed after GAC went bankrupt.

A clause in the policy, however, states that damage suits filed after the policy expiration will be covered if the suit relates to others filed during the policy's term, said Mr. Hartung, a lawyer at the New York law firm of Conboy, Hewitt, O'Brien & Boardman.

"I think the policy will respond since the suit appears to be related to other suits filed when the policy was in effect," Mr. Hartung added.

The two corporate trustees sued the former officers for mismanaging the funds of a GAC subsidiary causing the subsidiary, and eventually the parent company, to become bankrupt.

Victor Gleser, a Lloyd's attorney at Mendes & Mount, a New York law firm, said that the $500,000 deductible only applys to corporate reimbursement of directors and officers. Under the second type of directors and officers coverage for personal obligations of directors and officers, a $250,000 deductible will apply.

It is unclear which type of coverage will be involved in this case since the corporation is bankrupt, Mr. Gleser said.

Suits are usually filed claiming damages that are within policy limits because the plaintiff knows the limits. Co-counsel for the trustees John Camp said the amount sought is more than the policy limits because the trustees are seeking to recover both from the carrier and from the former officers.

Lloyd's attorney Mr. Gleser said the amount of a suit is "usually a figure pulled out of the air and this one is also pulled out of the air."

A motion to dismiss the case on behalf of Lloyd's has been filed with the court, stating that the suit failed to cite a "cause of action," said trustee lawyer Mr. Camp, who is employed by the law firm, Blackwell, Walker, Gray, Powers, Flick & Hoehl in Miami.

The plaintiffs will file a reply and the court will then decide whether it will hear the case, Mr. Camp said. He added that it will be "many, many months before the case reaches trial."

The suit, by trustees Frank J. Callahan and Herbert S. Freehling, charge the parent company GAC Corp. manipulated funds to conceal the poor financial condition of two of its subsidiaries, GAC Credit Inc. and GAC Properties Inc. The alleged manipulation constituted "gross neglect, willful abuse and misapplication of funds," they allege.

Defendants include S. Hayward Wills, former GAC president and board chairman, and former board members Russell E. Kemmerer, Paul R. Stuken and John F. Ring.

According to the suit, the maneuvering began in 1970 when the defendants instructed the firm's banks to deposit all cash from GAC Credit in the GAC Properties accounts, which drained cash from GAC Credit.

When GAC issued $50 million in bonds at 12% interest in 1970 and issued another $50 million in bonds at 11% bonds in 1971 to generate cash for sales contracts, it later had no funds to pay off the $100 million debt.

In 1974, two officers and the state land sales division agreed that GAC Credit could assume GAC Properties obligations. This action violated the operating agreement of GAC, the trustees contend.

The suit claims that GAC Credit could not have guaranteed the funds in excess of $100 million because it was unable to pay its own debts.

GAC Credit's collateral for the obligation decreased in value during 1975 when the firm's cash flow was impaired following a slump in the land sales program. The four defendants tried to correct this, the suit alleges, by having GAC Credit purchase $21 million of its own shares from GAC Properties.

The result, according to the suit, was that GAC received paper stock of little value six months before it would have to redeem the first $50 million in bonds.

The trustees also charge that the re-purchase of stock violated Florida law, where GAC is headquartered, and Delaware, where it is chartered.

When the defendants next tried to create fixed assets of $12.1 million by buying real estate and equipment of GAC Properties, the firm was forced into bankruptcy and was followed by GAC Properties and the parent company, GAC Corp., later in 1976. ■

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Michigan boycott . . .

Continued from page 1
to accept fee schedules.

"Our primary concern is for the patient; he should have the right to choose his doctor. Our concern is the interjection of finances into the doctor/patient relationship and what services will be received. We have to fight for our patients," said Dr. Vernon V. Bass, president of the Michigan medical society.

What can happen

Whether Michigan's 8,700 participating doctors will answer the call to stop participating with the Blues is still unknown, but what could happen has been considered.

"Elimination of doctors' service contracts with the Blues would cause untold confusion and grave financial hardship," charges UAW vp Ken Bannon. "It would require those who can least afford it to try to pay out of their pockets the amounts needed to treat illnesses which have struck their families, with doctors free to callously charge not only what the traffic will bear but even more . . ."

By refusing to participate as full service doctors with the Michigan Blues, doctors will no longer bill the Blues directly for their services. Patients will have to pay the doctors themselves and file claims for reimbursement. Doctors aren't saying if they will ask for payment up-front or wait for the patient to receive a check from the Blues.

If doctors are charging other patients more than the Blues' schedules, ending participation agreements with the Blues will allow them to bill the patient at the higher fees. Michigan medical society president Dr. Bass doubts this will happen often because "BC/BS payments pretty much set the fees."

Dr. Bass believes the Blues will have to call a moratorium on the programs the doctors object to, as the doctors had asked before voting last month to recommend a participation boycott.

"If they don't, Blue Shield will end up not having enough physicians to service their needs. And I don't know what happens then," he said.

Michigan Blue Cross/Blue Shield is concerned about the vote to boycott participation agreements. President John C. McCabe said, "It's regrettable that a well-conceived program that corrects past inequities and provides for physician responsibility for restraining utilization and volume of medical services has met such obstinance.

"There are times when it appears that the medical profession is intent on self-destruction; quite simply, professional genocide. Not only will this behavior do violence to their legitimate aspirations, it can seriously hurt their patients whom they have vowed to care for and protect. It is incredible behavior of an otherwise thoughtful profession. It is irresponsible."

In Indiana, the state medical association is also opposing the payment provisions for hearing and vision care in the UAW contracts. Doctors there do not have any participating agreements with the Blues to renege on, but they are petitioning the insurance commissioner and intend to lobby the legislature to outlaw any differences in reimbursement for services provided by participating and non-participating physicians.

The UAW contracts, effective Oct. 1, require that a worker be treated for a hearing problem by a participating physician if he is to have full coverage. Treatment by a non-participating physician is not covered.

UAW contract

Vision care by a participating physician is subject only to a 20% copayment by the patient. If the doctor is non-participating, the patient must pick up 40% of the bill.

"They should not pay differently," argues Dr. Bass, president of the Michigan medical society.

Indiana's medical association, in opposing all arrangements under which there is a discriminatory feature for participating and non-participating physicians, said, "It is in the interest of the preservation of the covered patient's rights to free choice of physicians that there be no differential on the amount paid for the provision of the same service by a participating physician and a non-participating physician."

The UAW disagrees citing the cost control and quality service offered by such arrangements.

Arthur Hughes of the UAW, responsible for the administration of benefit contracts at Chrysler Corp., said the different payment schedules "came from collective bargaining." He explained, "We set a cost level as to what we had to spend. Based on the profile of charges, we said it would provide for certain levels of payment."

Chrysler critical

In addition to keeping a lid on what participating doctors can charge, Mr. Hughes said requiring services be rendered by participating physicians for full reimbursement "maintains quality providers."

Not allowing a UAW worker to just pick up the difference in charges between a participating and non-participating physician steers him away from higher priced doctors, Mr. Hughes agreed, shielding the worker from higher charges.

Chrysler Corp. released an official statement endorsing "the cost containment features inherent in the BC/BS participating agreements under attack by MSMS (Michigan State Medical Society). Participating agreements provide both protection to our employes and their families from additional physician charges and a guaranteed source of renumeration for the physician.

"Escalating health care costs are something everyone must be vitally concerned about and therefore, in view of the great benefits such health care programs provide, we regret that the medical society has found it necessary to take the position it has," the company said.

The Blues argue the UAW contracts do not say a worker "must" see a participating physician for treatment so he is free to visit whom he chooses. The Blues also note they had no control over the contract provisions but have merely agreed to service them.

"The doctors are saying maybe they should disagree to service the contracts," Dr. Bass of the Michigan medical society said.

The Blues don't have the market on the UAW contracts everywhere, but they appear to be meeting the most resistance.

General Motors has its vision program with Metropolitan Life Insurance Co. A spokesman for General Motors said, "We haven't had any problems that I know of, but it did just go into effect."

John Hancock Mutual Life Insurance Co. is carrying hearing and vision contracts for Ford outside Michigan. John Hancock vp Henry McArdle said, "We've had some doctors and optometrists complain, but they are signing." No one has complained about the hearing service contracts, he said, "but we have hearing in only certain areas."

Michigan doctors fear the payment differentials for hearing and vision care are just the beginning. "It looks like there might be a pattern here," Dr. Bass said.

In addition to recommending doctors dissolve participation agreements with the Blues, the Michigan medical society has authorized its governing board to sue the Blues, charging restraint of trade by servicing the UAW contract provisions for hearing and vision care payments.

The doctors were warned their own actions could bring them a suit charging them with an illegal boycott.

On top of the new UAW contract provisions that the doctors abhor, the Blues announced new reimbursement and cost control programs.

"They're a carrot on a stick," a Michigan medical society spokesman said, because some features of the new reimbursement program have been clamored for by the doctors but would drag them into a cost control program they don't like.

Beginning in January, the Blues will apply one schedule of maximum payments statewide regardless of specialty. Currently doctors' fees are subject to varying screens depending on their location in the state and their specialty.

In addition, participating doctors will automatically receive an update of their profiles. A doctor's profile is the Blue's calculation of his reasonable and customary fees.

But the new statewide screen and automatic update of profiles, which the doctors have asked for before, will apply only to participating doctors. The medical society charges the program discriminates against non-participating doctors and is intended to "get more doctors on the participating line."

Blues' defense

Joseph Velky, manager of professional reimbursement policy development for the Michigan Blues, readily admits the new program is intended to "correct deterioration in the formal participation rate." In 1968, 70% of the state's physicians were participating as full service Blues doctors; today only 62% of the physicians are participating.

Applying the new screen only to participating doctors will guarantee that doctors who don't participate won't get more reimbursement from the Blues than those who do, Mr. Velky said.

The Blues want to reward doctors who support the system, he said.

The doctors also strenuously object to a new "target limitation on expenditures" program by the Michigan Blues "to deal with utilization," due to begin in January.

Next year the Blues will set targets for spending in anesthesiology, psychiatry, surgery, X-ray and laboratory and pathology. The targets will be to reduce in half next year the rate of increased spending last year in these areas.

If doctors spend below the target, half of the savings will be given to the doctors and the other half of the savings will be built up in Blues' reserves. But this is a one-time return on savings for doctors.

Starting in 1979, the Blues propose to calculate one target for physician spending based on 1978 spending and taking into account infation, new members and new benefits. In each following year a "reasonable" target will be set and the doctors will be asked to meet it.

If doctors spend over the target in one year, the calculated target for the next year will be reduced by half of what the doctors over spent. But if they spend under the

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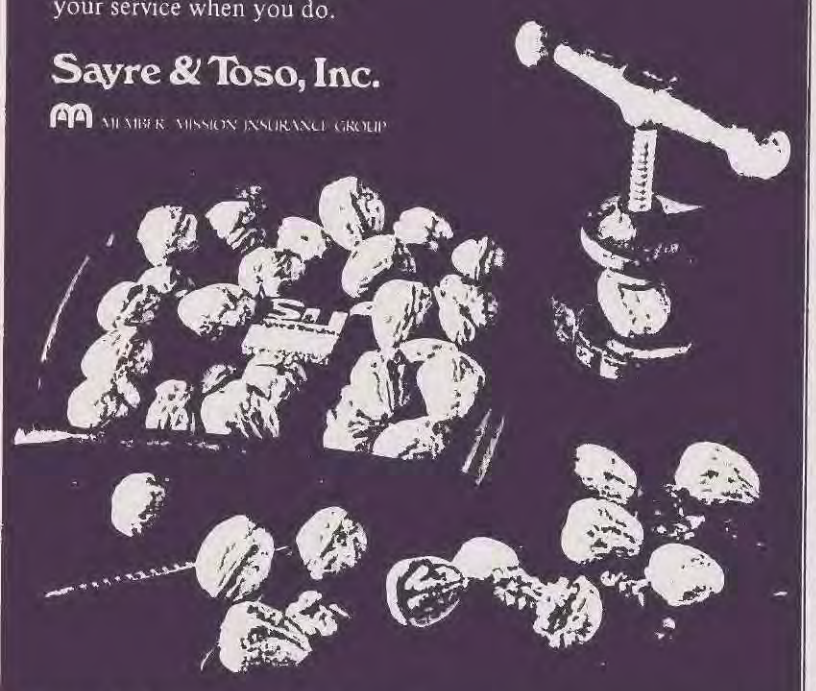

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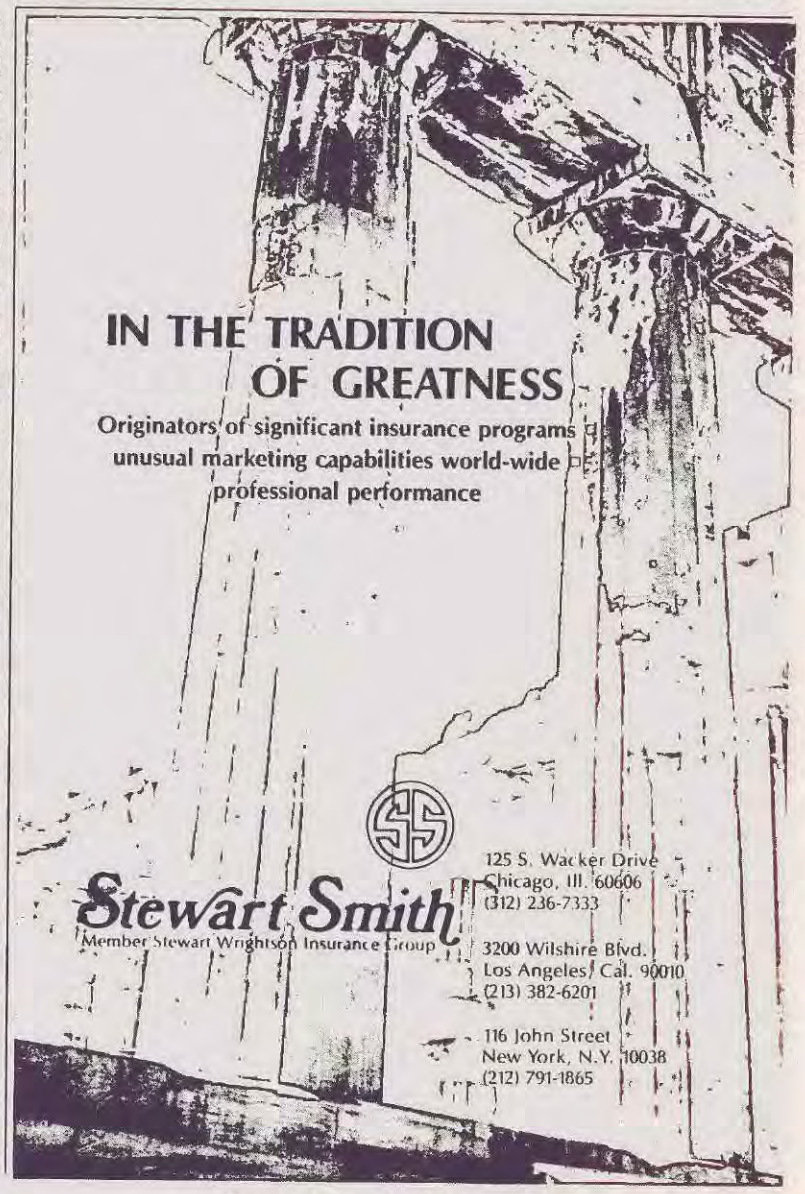

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Product liability . . .

Continued from page 1

troversy is mentioned, Mr. Schwartz stops smiling and becomes defensive.

He criticizes the reporters who broke the story of the task force's findings without waiting for the "official" interpretation of the conclusions given by top Commerce Department staffers at a brief, cramped press conference.

But he doesnt give an inch. Nor is it considered likely that this law professor will change his position that conclusions are not recommendations, no matter how much pressure he is likely to face when he testifies later before Congressional committees on the report's findings.

He's been described as rather cocky, a tough cookie who appeared unruffled despite constant badgering from an angry Sen. John Culver (D-Iowa), no softie himself, during a Senate hearing.

When asked about administration attempts to influence him while he prepared the report, Mr. Schwartz said there was no pressure of any kind, paused a minute and said: "Well, they wouldn't try that kind of stuff with me."

Coming out with specific recommendations never was in the cards. Back in January 1976, the Commerce Department, acting on the instructions of former presidential assistant for economic affairs L. William Seidman, began a crash, two-month study of the product liability problems faced by businnesses.

The report that came out in March 1976 concluded tentatively that there might be a widespread problem with regard to availability and affordability of product liability insurance.

That initial report prompted the Ford administration to form an interagency task force to study the product liability problem in more depth.

Briefing report

The task force—headed by Mr. Schwartz who took a leave of absence from the University of Cincinnati College of Law—produced a briefing report in December 1976. The briefing report, in one of its conclusions, noted that there was no nationwide crisis in product liability.

At the same time, a decision was made to prepare special studies of legal, insurance and industry problems. These studies were incorporated in the final report.

At no point was the task force given authority to make recommendations, Mr. Schwartz said. A major shift in policy occurred in April 1977, when under secretary of commerce Sidney Harman directed the task force to come to "conclusions" in its final report, with respect to the mass of remedies that had been proposed.

In the last chapter, the task force suggested consideration be given to:

- A modified 10-year statute of limitations, after which time a manufacturer would assume liability for economic damages only if the injury was caused by a defect at the time the product was sold, but not discovered until the time of he injury.
- A defense against liability if a product was made in conformity with objective and up-to-date government safety standards.
- Reducing a plaintiff's award to the extent that his or her own negligence contributed to the accident.
- Allowing judges, not juries, to determine the amount of punitive damages.
- Force lawyers who bring frivolous lawsuits to the docket to pay for defense costs.
- Permit companies to receive tax deductions for setting aside reserves to pay for product liability losses.
- Encourage the expansion of captives by changing the tax rules regarding the deduction of premiums paid by a parent.

Those conclusions will aid legislators when they consider possible changes in the tort system, Mr. Schwartz said.

Immediate effect

The most immediate effect of the final report is that states no longer will have to form interim study committees to examine product liability.

"With this report as a base, they (the states) shouldn't be engaging in expenditures of large amounts of money to restudy product liability."

The report should serve as a "sourcebook" in which legislators can turn for a discussion of all the benefits and shortcomings of changing the law.

Mr. Schwartz and other Commerce Department staffers will be working next on developing "options" for the Carter administration to consider on whether any further federal action is necessary.

He also plans to testify before Congressional committees that are considering a variety of proposals, all of which are now stalled.

When asked for his reaction on what will happen if action is not taken on the report's conclusions, Mr. Schwartz said simply: "The problem will not go away."

"The initial reaction from the advisory committee is that it is a very balanced report," Mr. Schwartz said. "There seems to be a consensus that this is a much better report than the briefing report (issued in January 1977)."

That balance has been achieved because of the points of view and arguments of rival interest groups —manufacturers, the legal profession, the insurance industry—all were considered carefully.

Three factors

Not too surprisingly, the task force came to the conclusion that product liability problems are the results of three factors that have converged simultaneously: inadequate rate-making procedures by the insurance industry, manufacturers producing unsafe products and uncertainties in the tort-litigation system.

The task force did not come to a conclusion as to which factor contributed most to the product liability problem, with Mr. Schwartz saying simply that the system would be improved if all three causes were corrected.

It isn't so important to know who is the tallest person in the class as much as knowing how many persons are in the class, Mr. Schwartz said, in reflecting why it wasn't necessary to rank causes.

Criticisms of the report, though, already have cropped up. There were unconfirmed reports, for example, that the Insurance Services Office was preparing a rebuttal of the task force's analysis of rate making procedures.

Mr. Schwartz conceded that there are bound to be errors in the report, just as one would expect some errors in any report of this size (about 600 pages).

But Mr. Schwartz vehemently defends the report noting it is the most definitive attempt to pinpoint the causes of product liability problems. One example of the of the thoroughness of research effort: the insurance contractor examined 3,000 underwriting files before reaching conclusions about rate making procedures. ■

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Self-funded trusts . . .

Continued from page 1

could open up new legal problems. Mr. Dorais told the trusts they could either continue to pay commissions and contest the Labor Department action or could stop paying commissions, the source added.

The self-funded multiple employer trusts provide medical and death benefits. They file with the U.S. Department of Labor as employe benefit plans under ERISA and argue they are exempt from state insurance regulation under ERISA's preemption of state insurance laws.

Self-funded trusts could not exist under state law as presently organized. The trusts would either have to find a licensed insurer to underwrite their coverage or would have to meet state requirements for becoming a licensed insurer.

Opinion letters

The Labor Department has issued several advisory opinion letters and intervened in one court case to argue that trusts that solicit employes as well as employers are not employe benefit plans under ERISA but are schemes to escape state insurance regulation.

Federal courts have also ruled that two trusts—Employe Security Benefit Assn. (ESBA) of Bellevue, Wash., and VIP Insurance Trust of Phoenix—are not employe benefit plans and are subject to state insurance regulation.

The federal court in Arizona focused on the lack of control by members of VIP Insurance Trust in ruling that VIP was not an employe benefit plan. A Kansas federal court dealt with ESBA's solicitation of individuals in ruling the trust was a scheme to escape state insurance regulation.

The Kansas court also set up a test for what constitutes a legitimate employe benefit plan and what is merely a scheme to escape state insurance regulation, focusing on a trust's origin, solicitation procedures and method of operation.

State insurance officials and many within the Labor Department believe the Kansas test should be applied to all self-funded multiple employer trusts, a move that would exclude most of them from ERISA. But the trust administrators argue the Kansas decision dealt only with trusts that solicited individuals as well as employers, leaving unresolved the issue of trusts dealing only with employers.

"Congress has declared in ERISA that plan assets must be used exclusively for providing benefits to participants and defraying necessary administrative expenses," Mr. Lanoff said in the Labor Department announcement. "In our view solicitation of employers or employes not covered by a plan does not fall into either of these categories."

Mr. Lanoff distinguished the payment of commissions to solicit new members for a plan from an insurance company's payment of commissions to an agent involved in providing coverage to a plan. The insurance company commissions are acceptable, he said.

The department also said that persons selling self-funded multiple employer trusts are not exempt from state regulation.

Officials within the Labor Department and others in Washington involved in the issue say the Labor Department has been considering the issue of commissions for some time.

Sources indicate that Labor Department officials were frustrated in recent weeks by continuing efforts of trusts to escape state regulation. As reported in *Business Insurance* Oct. 17, many trust administrators have made changes in their operations after each court decision or Labor Department announcement in an effort to comply with ERISA.

That frustration is reflected in the Labor Department announcement. "Despite the (Kansas) court decision and others like it," Mr. Lanoff said, "some multiple employer trusts continue to litigate over whether they are ERISA plans and the reason is that they apparently believe that regulation will be lighter under ERISA than under state insurance law."

The announcement was designed to discourage "false hopes" among trust administrators, he said.

Trusts respond

John Rigby, a vp of the trusts' association, said, "Mr. Lanoff's pronouncement was made with little consideration of the issues but to aid and abet the (states) in regulating a federal program."

Mr. Lanoff has been unwilling to meet with representatives of the trust, Mr. Rigby said.

Self-funded trust attorney Claude Dorais was critical both of the announcement and that it was made without consulting the trusts. "Even if the Department of Labor had ended up taking the same position, at least the people affected most by (the announcement) would have had an opportunity to present their case and clarify the situation," he said.

"It is not at all correct to imply that self-funded multiple employer trusts generally desire to avoid legitimate regulation," Mr. Dorais added, challenging the department's view that the trusts are seeking the easiest regulatory authority.

Mr. Dorais argued that the payment of commissions by a self-funded trust is not that different from the payment of commissions by an insurance company.

"The department of Labor seems to be saying that it is all right for a portion of the money an employer pays for coverage on behalf of plan participants to go to a plan, and from the plan to an insurance company, which uses part of the funds to pay commissions," he said.

"But it is not okay if part of the employer contribution is to be paid for commissions if the employer payment is made to a self-funded plan," he added. "In both cases a portion of the money will be paid into the plan and assets end up being used to pay commissions."

Other structures

Mr. Dorais argued that many trusts contesting state insurance regulation are not similar to Employe Security Benefit Assn. and may not be affected by the Kansas decision.

The Labor Department announcement on commissions ducked the real issue, he argued, which is "whether the trusts are plans under ERISA."

That view is shared by some officials within the Labor Department, who believe the trusts are not employe benefit plans under ERISA regardless of their commission structure.

But a Labor Department ruling on trusts that solicit only employers has been blocked by disagreements between the pension and welfare section and the solicitor's office. The solicitor's office appears reluctant to act for fear it would unintentionally exclude from ERISA a group that should be covered by ERISA. ■

Key trust officials' licenses suspended

SAN FRANCISCO — The California insurance department last month suspended for six months the insurance licenses of two key figures—Gerald E. Webb and Nicholas J. Dollwet—in the bankrupt National Multiple Employers Foundation.

In addition, the Arizona insurance department suspended the licenses of two insurance companies owned by the two men for a questionable reinsurance contract involving the Foundation.

The National Multiple Employers Foundation was a self-funded multiple employer trust that filed for bankruptcy in February 1977. The trust was founded by Mr. Webb, who turned control over to his business associate, Mr. Dollwet, in June 1975, shortly after Mr. Webb was indicted on criminal charges in Los Angeles.

Mr. Webb remained a vp of the firm that administered the Foundation, N.D. & Associates, and received 2% of all money collected by the Foundation, according to insurance department records.

The Foundation claimed to be an employe benefit plan under the Employe Retirement Income Security Act (ERISA) and therefore exempt from state insurance regulation. But the hearing officer ruled that the Foundation was not covered by ERISA, was an unauthorized insurer and that Mr. Webb and Mr. Dollwet acted in violation of California law.

Mr. Webb and Mr. Dollwet may appeal the order, which could delay its effective date of Nov. 14.

The Arizona department suspended the license of Contract Life Insurance Co. and revoked the license of Valor Life Insurance Co.

According to the Arizona insurance department and documents obtained by *Business Insurance*, Mr. Webb is the owner of Contract Life and Mr. Webb and Mr. Dollwet share ownership of Valor Life.

The Foundation was originally reinsured with Safety Mutual Casualty Corp. of St. Louis. That contract was cancelled in late 1976, effective Aug. 28, 1976, for failure to pay premiums, according to Safety Mutual officials.

Mr. Webb and Mr. Dollwet signed an agreement on Jan. 6, 1977, for Contract Life to provide reinsurance coverage effective Aug. 28, 1976, for losses over $12,500 per individual to a maximum of $275,000. However, the company was a "mini-capitalization" insurer, allowed to accept only $3,000 of risk per individual, the Arizona department argued, making the contract illegal.

Half the risk and half of the $195,000 premium were ceded by Contract to Valor, owned jointly by Mr. Webb and Mr. Dollwet, according to an interview Mr. Dollwet gave to California insurance investigators.

The reinsurance contract was cancelled Jan. 6, 1977, the same day the original agreement was signed, with coverage to end Jan. 1, 1977.

Terrence Stinnett, the attorney for the Foundation's trustee, said Mr. Dollwet and Mr. Webb returned $155,000 of the reinsurance premium to the Foundation.

Claims filed in the bankruptcy are still being processed, according to the attorney. The latest estimate of the California insurance department is that the total of unpaid medical claims may hit $3.5 million.

Mr. Webb and the Foundation were among the subjects of the first three *Business Insurance* articles on the self-funded multiple employer trust controversy published in February and March. ■

Michigan boycott . . .

Continued from page 56

target, half the savings will be added to the new target as a cushion or bonus. The other half of the money saved will be built up in reserves and will reduce rate increases, Mr. Velky said.

Contrary to what some members of the medical society understand, all bills will be paid even if doctors overshoot the target, Mr. Velky said.

There's really nothing to prevent the doctors from just ignoring the targets, he admitted. But if the doctors continually spend over target, and the Blues don't find reasonable reasons for it, then it will mean "the doctors didn't try," Mr. Velky said.

"This is a first attempt at controlling costs," he noted. "We're at a point that we have to make some changes. There are only so many dollars to be spent."

Doctors, however, fear such targets for spending could "compromise someone's health," a medical society spokesman said. "It's based on the theory there are unnecessary treatments, but what if all the services were absolutely necessary?"

Mr. Velky believes it was "bad timing" for the Blues to introduce new reimbursement and cost control programs on top of servicing the new UAW benefits.

"If the doctors will sit back and see what we're proposing, they'll see it's a reasonable approach," he said. "We intend to do a lot of work on the target limitation on expenditures program. We're interested in their ideas."

The doctors want a moratorium on the programs before they sit down to talk. Dr. Bass warns that if there isn't some discussion soon, there will be "further deterioration of our relationship with an outfit we started."

That could include finding another insurer to replace the Blues for the doctors' health plan if the conflict is not resolved. "Financially it won't make a big difference to the Blues. But it would be an embarrassment if even the doctors won't insure with the Blues," a medical society spokesman said.

The relationship between Massachusetts doctors and their Blue Shield plan has also deteriorated to the point of a lawsuit. The state medical society is suing Blue Shield, challenging the "equity" of the plan's participating physician agreement.

Massachusetts Blue Shield subscribers must be treated by a Blue Shield participating physician or lose coverage. It's the only Blue Shield plan in the country with such a restriction. But as elsewhere, participating physicians must accept the Blue Shield schedule for reimbursement as payment-in-full for services. The doctors charge the reimbursement levels are inadequate. They want the schedules updated and they want coverage, according to the schedules, for treatment rendered by a non-participating physician with the right to bill for the balance of the fee. ■

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Congress considers ousting insurers from OPIC

WASHINGTON—Congress is on the verge of approving legislation that will require the Overseas Private Investment Corp. (OPIC) to terminate its joint direct underwriting arrangements with 21 private insurers.

The Senate already has passed a bill (S. 1771) that would end the joint direct underwriting arrangements. A similar measure (H.R. 9179) now is pending on the House floor.

The impact of this pending change is unclear though it appears that rates will remain stable while coverage in more developed countries will become more difficult to obtain.

Several factors are behind the move toward eliminating the private insurance companies' role at OPIC, the government agency that encourages investment abroad by providing insurance against losses caused by war, insurrection or revolution.

In 1974 Congress directed OPIC to shift 100% of its direct underwriting risks to a pool of insurance companies.

That hasn't happened. The 21 private insurance companies working with OPIC provide only 26% (excluding reinsurance) of the "first loss pool" for expropriation and inconvertibility risks.

By limiting its losses to about $10 million per country, "the private insurers were getting off easy," one House committee staffer charged. "They (insurance companies) were not having to take a large amount of the risk, but they were getting a sizable amount of the profit.

One former insider at OPIC concedes that the insurance companies "got a fat deal." But those companies were willing to negotiate a new treaty, he said.

Even if a new treaty were negotiated, the insurance companies still would be unwilling to provide coverage in less developed countries where OPIC is required to encourage investment, a house committee staffer said.

That charge is hotly denied by a source close to OPIC's operations who says flatly, "The insurance companies have never turned down one risk that OPIC brought to them."

Still, Congress appears sufficiently impressed with the charge that "private insurers more immediate interest is minimizing risks and maximizing profits" that it is prepared to eliminate the private insurance companies from direct coverage operations.

In addition, OPIC is preparing to sharply restrict coverage in countries with a per capita income of more than $1,000 and will give special consideration to small firms in providing coverage.

This move is seen as a response to charges by Rep. Tim L. Carter (R-K.Y.) and other congressmen that OPIC is providing the bulk of its coverage to large companies at the expense of firms with sales of less than $2.5 million.

How OPIC will encourage investment in the poorest countries is not exactly clear, though consideration has been given to establishing a sliding rate scale in which lower premiums would be charged in the least developed countries than in more advanced nations.

But OPIC critics maintain that the availability or rates charged for political risk insurance is not the "sine qua non" that will stimulate U.S. firms to invest in the less developed countries.

"The basic economics of the deal must be there," says one source. "A company doesn't decide to invest in Haiti instead of Brazil solely because of the availability of insurance. It is just one factor of many."

So, while it may be good public policy to encourage investment in less developed countries, it is questionable whether OPIC's coverage shift from more developed to less developed countries will be the right vehicle to stimulate that shift, critics charge. ■

A divorce looms for flood plan

WASHINGTON—That "family squabble" between the federal government and the insurance industry over the operation of the national flood insurance program has resulted in a divorce between the two quarreling parties.

The Department of Housing and Urban Development (HUD) is terminating its relationship with the National Flood Insurers Assn. (NFIA), a consortium of 132 insurance companies.

Under that relationship, NFIA had been administering the program, writing policies as well as putting up about $48 million in risk capital. For operating the program, which was known as Part A, NFIA reportedly earned about $2.7 million annually in profits.

That relationship is about to end. HUD is expected to award a contract to operate and administer the eight-year-old program to EDS Federal Corp., a Texas firm controlled by millionaire H. Ross Perot.

EDS won the contract for one simple reason, according to insiders at HUD: Its bid of $11 million was $15 million less than the bid placed by NFIA. "That's money in the bank," said one staffer.

The reason EDS was able to make such a dramatically lower bid is due primarily to NFIA's hefty overhead in maintaining 46 regional processing centers.

"There is a lot of waste and duplication with NFIA's decentralized system," said a senior HUD official. By contrast, EDS will run a centralized processing system, employing about 100 fewer staffers than NFIA.

Some insurance industry executives, however, question whether EDS's centralized operations can respond adequately in case of a major flood.

"It remains to be seen how an insurance program that involves 15,000 communities across the country and more than 1 million policyholders can be operated out of a single office," said Leslie Cheek, vp-federal affairs for the American Insurance Assn.

Mr. Cheek also questioned whether EDS has the experience in property insurance field to adequately supervise the measurement as to what constitutes a reasonable payment for a loss.

HUD Secretary Patricia Roberts Harris, however said: "It is hard to ascribe any dollar value, either to the consumer or to the government, for NFIA's decentralized operation plus its risk sharing." EDS will act only as a fiscal agent and not put up risk capital; losses not covered by premiums will come out of U.S. funds. ■

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- a review of smaller firms using self-insurance and the impact of such programs on their companies;
- a thorough review of workers' compensation self-insurance...how many companies are now self-insured for comp in the states that allow it;
- a look at self-insured health plans and the use of 501 (c) (9) trusts;
- an examination of the reinsurance market for captive insurance companies and the rates being charged;
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Salesman is key figure in N.Y. case

By ELLIS SIMON

RIVERHEAD, N. Y.—A surgical products salesman who claims to have assisted in the implantation of an artificial hip to a patient at a Suffolk County hospital may be the central figure in a multimillion dollar malpractice suit brought by the patient against two surgeons and Smithtown General Hospital.

William MacKay of Garden City, N.Y., a salesman for the A. E. Johnston Co. of Southampton, N. Y., claims to have assisted in the implantation operation performed July 3, 1975, on Franklin Mirando of Central Islip, N. Y.

Mr. Mirando filed a medical malpractice action six months ago charging that Drs. David Lipton and Harold Massoff, both of Smithtown, left him crippled as the result of two operations to implant the prosthetic device into his pelvic region. The hospital was also named in the suit.

However, Mr. MacKay was not named in the suit. In fact, Mr. Mirando has called the salesman's presence a positive rather than a negative factor, noted Howard F. Davis, the hospital's attorney.

Mr. MacKay has said that he was called from a golf game to assist the two doctors after they fractured Mr. Mirando's femur during a second attempt to implant the artificial hip. A previous attempt the day before was unsuccessful and the second operation was required.

Mr. Mirando has since been confined to a wheelchair.

Attorneys for Mr. Mirando would not reveal the amount sought in the suit since these figures are not permitted to be included in papers presented to the courts in New York malpractice cases. However, The New York Times reported the figure to be $2 million.

The hospital, the two doctors, a nurse and an anesthesiologist have been charged with assault in the case for having rendered Mr. Mirando unconscious to allow an unqualified person to practice medicine on him.

Additional allegations charge Dr. Lipton, the nurse and the hospital with falsifying records to conceal the unauthorized practice.

Mr. Davis declined to reveal the identity of Smithtown General's malpractice carrier, explaining that New York law prevents this from being released during a case. Officials of Medical Malpractice Insurance Associates and Hospital Underwriters Mutual Liability, the state's two principal hospital malpractice underwriters said they were not involved in the case.

Medical Malpractice, which is one of two firms underwriting doctors malpractice in the state said it did not have the policies on either of the physicians. *Business Insurance* was unable to confirm whether the policies were placed with the other principal underwriter, Medical Liability Mutual Insurance.

Presence of salesmen and other non-medical personnel in operating rooms is relatively common, Mr. Davis said. The most familiar example, he noted, is the father who joins his wife in the delivery room during childbirth.

Walter Shakespeare, associate program director of the Joint Commission on Accreditation of Hospitals, agreed that it is quite acceptable for a salesman to provide surgeons with technical advice. However, he said that in his 30 years in the business he never heard of a salesman giving patient care. ■

people

Continued from page 62

safety supervisor at Harmon Colors Corp. in Haledon, N.J., where **Charles Macri** replaces him. Mr. Macri previously was a production foreman for 13 years at Harmon Colors and has been with the company since 1947.

* * *

A. Grant Whitney, executive vp of Belk Stores Insurance Reciprocal in Charlotte, N.C., has been elected vice chairman of the National Assn. of Independent Insurers. Mr. Whitney functions as risk manager of Belk Stores.

* * *

Leland J. Gorevin, 51, has been named insurance manager at Matson Navigation Co. in San Francisco. He was promoted from assistant manager, a position he had held since 1966, upon the retirement of insurance manager **John V. Beahrs.** Mr. Beahrs joined Matson in 1965 after serving with major western insurance and marine insurance firms. Mr. Gorevin joined Matson in 1951 in the financial department. Matson, a wholly owned subsidiary of Honolulu-based Alexander & Baldwin Inc., operates 12 cargo vessels running between Hawaii and the West Coast and three cargo vessels between the West Coast and Guam.

* * *

Gerald P. Yates, 41, has been appointed Dow Corning Corp.'s manager of benefits and manager of international personnel coordination. Mr. Yates is responsible for corporate employe benefits such as retirement, insurance for life, medical and dental coverage and vacation and holiday policies. Mr. Yates also serves as the focal point for all overseas personnel transfers and is responsible for developing and administering a personnel data system. Previously, he was supervisor in the resins and chemicals business of technical service and development at Dow Corning. He replaces **Leon Ostrowski,** who has been transferred to Brussels, European headquarters of Dow Corning, as manager of compensation and benefits. Mr. Ostrowski worked as manager of compensation and benefits at the company's Midland, Mich., headquarters for three years.

* * *

Russell A. Putney, 50, has been named assistant director of safety and security for White Consolidated Industries Inc. in Cleveland, a new position. He reports to Charles J. Conlin, vp of industrial relations. Mr. Putney was with Nationwide Insurance Co. for the past 17 years, most recently as staff loss control consultant. He previously served as a regional loss prevention manager. White Consolidated Industries, with annual sales in excess of $1.2 billion, is a widely diversified manufacturer of home products and industrial machinery and equipment.

* * *

Donald M. Cooper, 44, has been named liability program manager at Weyerhaeuser Co. in Tacoma, Wash. In this new position, he is responsible for liability claims investigation and supervision, including product liability and loss prevention for the general liability program. He reports to J. L. Christenson, director of insurance. Mr. Cooper was previously home office claims supervisor for Fireman's Fund for 15 years.

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people

Aetna unit taps Kooi in Chicago

Duane T. Kooi, 34, has been named risk manager for Urban Investment and Development Co. in Chicago. This is a new position, reporting to treasurer Jeffrey Rhodes. Urban is a subsidiary of Aetna Life & Casualty of Hartford. Previously, Mr. Kooi was insurance manager for Chamberlain Manufacturing Corp. for more than 4 years where he was responsible for casualty, property, and benefits programs encompassing self-insurance of workers compensation and product liability retention. He hasn't been replaced at Chamberlain.

* * *

Patricia McGlynn Nazemetz, 27, has joined W.R. Grace & Co. as benefits adviser—administration, systems and procedures. She previously worked for three years as assistant to the director of insurance for Macmillian Inc. in New York, where she hasn't been replaced. At W. R. Grace, Mrs. Nazemetz replaces **Norman N. Kushin,** 26, who has been transferred to benefit planning, development and consulting after working as benefits adviser for 1½ years. Mr. Kushin replaces **J. Pat Gibson,** 42, who has joined Becker Co., an employe benefits consulting firm located in East Orange, N.J., after working for W.R. Grace for 1½ years.

* * *

Douglas M. Bartlett has joined NCR in Dayton as director of employe benefits-U.S. He provides leadership at the corporate level for development, design and control of all U.S. employe benefit plans. The firm has more than 32,000 employes and 80 employe benefit plans that Mr. Bartlett helps manage with a staff of nine employes. Mr. Bartlett reports to James McElwian, assistant vp. Previously, Mr. Bartlett worked for Coopers & Librand, a consulting firm in Chicago.

* * *

Barry Busch, 31, has joined American Home Products Corp. in New York as a benefits specialist in charge of managing group insurance planning and development. His duties include maintaining liason with the group insurance underwriter concerning renewal procedures, benefit charges and cost analyses for all benefits except pensions. He also updates benefits communication and handles ERISA reports and filings. Mr. Busch reports to Dave Pegg, assistant director of employe benefits, and helps manage benefits for the company's 25,000 domestic and 45,000 international employes. Mr. Busch previously was an account coordinator for Metropolitan Life Insurance Co. in New York. At American Home Products, Mr. Busch replaces **Jim Fitzmaurice,** who joined Merrill Lynch & Co. Inc. in New York as a benefit planner.

* * *

Anthony J. Piniat, 30, has joined Schering-Plough Corp. in Union, N.J., as an assistant safety manager, a new position. Reporting to corporate safety manager, Charles W. Ross, he coordinates the industrial hygiene program and develops safety policies, guidelines and programs and methods of identifying hazards. Mr. Piniat formerly worked as a

Continued on page 61

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The Missouri Municipal League is seeking from qualified insurance management consulting firms proposals to determine the feasibility of creating a joint workers' compensation insurance fund for 400+ member cities. Proposals to include the methods to be employed in analyzing costs, positive and negative aspects of a joint fund, implementation and control, claims administration, loss control, investment, and such other aspects as the firm may recommend. In addition, each proposal should include detailed information on the firm's experience, size, location of main and branch offices, availability of legal staff, projected time to complete the study, and an estimate of cost and resumes of principle staff in charge of the project. Interested firms should submit their proposals to the Director, MML, 1913 William Street, Jefferson City, Missouri 65101 no later than December 31, 1977.

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City Utilities of Springfield, Missouri is currently seeking a Risk Manager to be responsible for developing and implementing a comprehensive municipal utility risk management program. A degree from an accredited university with specific concentration in insurance, law, business administration or closely related fields, and approximately five (5) years of progressively responsible experience in the field of risk management required. A comprehensive benefit package is provided.

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A major corporation located in Minneapolis is looking for an individual to provide "in house" consulting on the benefit plans of subsidiaries and divisions throughout the United States. The candidates should be fully knowledgeable and have experience in both group insurance and pension plans.

The successful candidate should demonstrate a strong ability to communicate with top level operating company management and provide sound technical staff support on all benefit matters. Position involves direct contact with insurers, actuaries and outside consultants.

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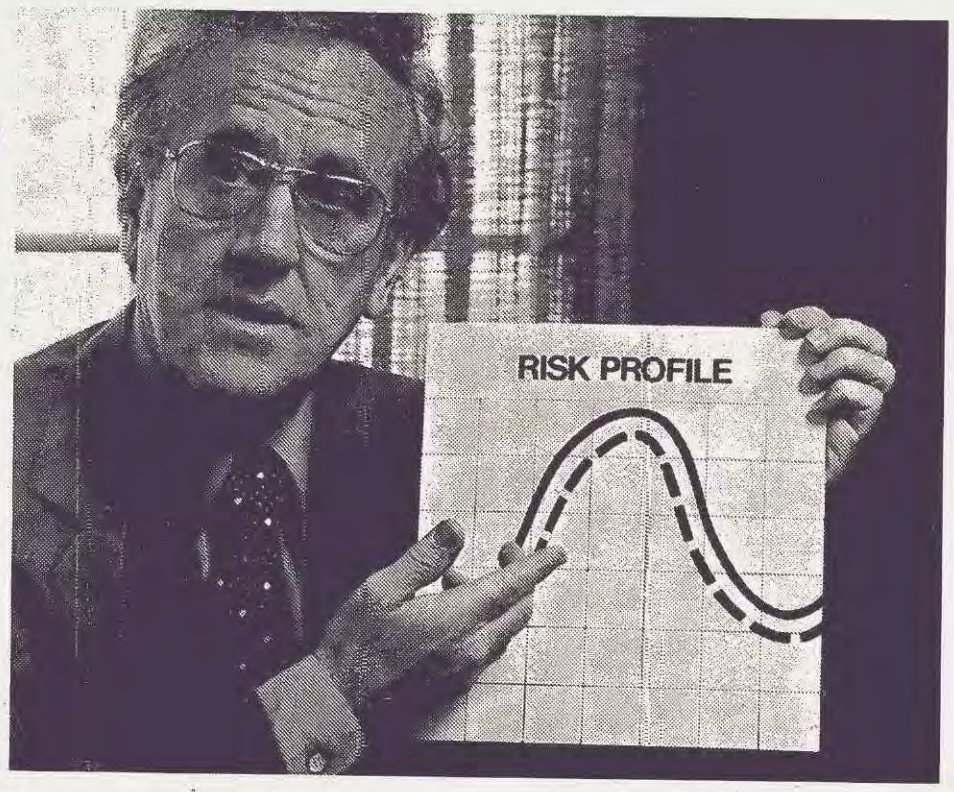

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