Court decision on rail disaster could change liability risks

By GREG DAVID

CHICAGO—A decision by an Illinois jury holding the Burlington Northern railroad responsible for a 1970 accident that destroyed part of a small town could have a major effect on railroad liability.

A Peoria jury awarded the Toledo, Peoria & Western railroad $1.7 million in damages, the amount it had paid out in connection with the June 21, 1970, accident in Crescent City, Ill., 80 miles south of Chicago.

The decision could force a major change in "interchange rule 1" under which a railroad is responsible for all cars on its lines whether it owns them or not. The rule could greatly broaden the product liability exposure of railroads and railroad car manufacturers and owners.

One observer of the railroad industry said the decision could create a chaotic situation and "pit one railroad against another instead of encouraging railroad cooperation."

Attrorneys for the TP&W as well as the insurance manager of one of the nation's largest railroads said the decision could force railroads to upgrade their maintenance programs.

Five tank cars exploded in Crescent City after a hopper car on a TP&W trail derailed. The town's business district and 25 homes were destroyed and 70 persons, mostly firemen, were injured. The TP&W had received the car in interchange from the Peoria & Pekin Union Railroad the day before the accident.

The TP&W sued the Burlington Northern under the strict product liability law now being used in Illinois, Cornelius P. Callahan, the railroad's attorney, said. It argued the Burlington Northern had become a manufacturer when it rebuilt the car in 1969.

Mr. Robert P. Schmidt, another TP&W attorney, said he believed that rule 1 was thus not applicable to the Burlington Northern's (manufacturer) relationship to the TP&W (consumer).

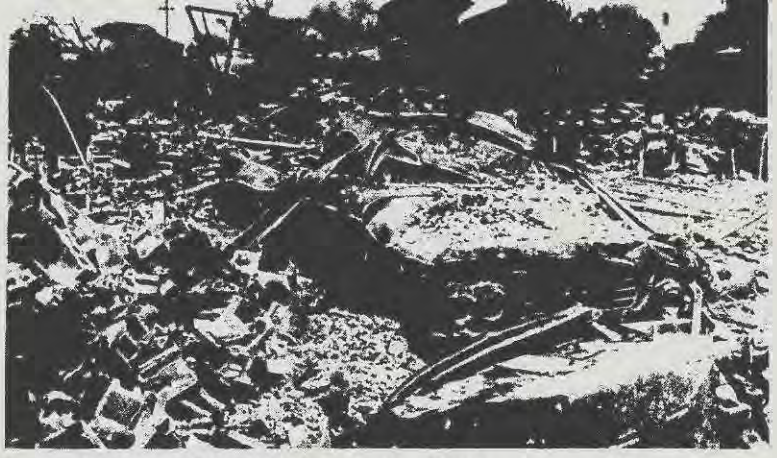
But Mr. Schmidt said it would be reasonable to expect a court to also hold a railroad liable if its maintenance program was responsible for an accident even if the car had been interchanged to another railroad.

The TP&W argued the Burlington Northern used defective friction bearings. Evidence at the trial showed a roller bearing could be expected to last for one million miles, Mr. Schmidt said. Three of the friction bearings on the hopper car had burned out after only 16,000 miles of use.

The American Assn. of Railroads requires roller bearings to be used on all new cars built after August 1968, but the association did not require roller bearings to be installed on all cars until January 1970, 11 months after the car was rebuilt. Nevertheless, the TP&W attorneys argued, the state of the art required the Burlington Northern to use the more advanced bearings when it rebuilt the car.

R.C. Skove, an attorney for the Burlington Northern, said Burlington contended that the TP&W was responsible for the car under rule 1 when it was interchanged from the Peoria & Pekin railroad. It also argued that the TP&W was also negligent since testimony at the trial indicated pedestrians had attempted to warn the train's crew that something was wrong with the

Continued on page 2



Scene at Crescent City, Ill. following the TP&W tank car explosion.

Liability reform

The product liability problems that many manufacturers say could drive them out of business have sparked a nationwide effort to push legislation through Congress and the the state legislatures. In the second of a two-part series, *Business Insurance* explores several of the proposals to provide relief. Story on pages 84 and 85.

Week of November 15, 1976

business insurance®

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Dock worker comp costs seen as critical problem

By HARRIET KING

SEATTLE—The high cost of federal longshoremen's and harbor worker's benefits is creating a problem for employers "that is every bit as critical as malpractice," say brokers.

Many Seattle area companies are not only laying off employes but are shutting down their dockside operations entirely. They say the problem is that insurance costs have soared so high that some employers either can't afford to buy insurance—or can't find carriers who'll cover the risk.

"What has happened is that the longshoring and harbor thing got out of hand. Men can get almost two times their base pay for staying home," says one observer. "Unfortunately, the situation is like a bad cold—it just gets worse."

Only two companies are writing this insurance for Seattle area firms now: Home Insurance Cos. and Providence-Washington Insurance Group. This is a far cry from the 25 companies that were writing it several years ago.

The insurance companies are running scared, especially when premiums are small, says a broker who lists possible disability compensation benefits: The actuarial figure on loss of a thumb is $25,690; an arm loss runs $106,872; a widow's benefits for a man, 28, can run up to $803,000.

The problem is particularly severe now in Seattle, as many yearly insurance contracts have come up for renewal.

For instance, in July one 60-year-old company, Rowe Machine Works, laid off 20 persons and shut down its marine repair and dry dock work, at a cost of about $100,000 a month in peak periods. The company is still in the throes of the shutdown. Those laid off include six outside machinists, four boilermakers, three scalers, two shipwrights and a supervisor.

"Our broker had been trying for months to find coverage. All he could get was one prohibitive quote and we couldn't live with that. We could not run our business and pay that price, so we closed down," says president Clarence Rowe.

"We've written letters to everyone we can think of, from insurance commissioners to legislators but haven't received any help," says Mr. Rowe. "I know of a shipyard which has had its insurance doubled—and they paid it just to stay in business."

Industrial insurance for landside workers is handled in Washington by the state. But the minute a man steps onto a dock or starts work on any marine project, he comes under the federal longshoremen's act, which specifies that only private underwriters are authorized to write the insurance unless the state elects to take over the coverage.

Another waterfront employer, Don Mulivrana of Northwest Tank Service, fears for the future of his company. When his contract ended, he was given a 15-day extension in order to give his broker time to canvass the market for a carrier willing to assume the risk.

"We started shopping around and found out that many small companies are being denied insurance, although bigger companies seem to have nothing to worry

Continued on page 81

Dental plan costs stabilize at Sybron

By MARGARET LeROUX

NEW YORK—An in-depth study of one company's 11-year-old dental benefit plan shows that costs "are not only predictable, but stabilize" after the first few years, according to the author.

A relationship between employe family size, utilization and cost is also shown in the study of the Sybron Corp. dental benefit plan.

Stephen D. Hooper, marketing director for Sybron Dental Administration Inc., a dental plan administrative services company which evolved from Sybron's self-insured dental plan, summarized the findings in an interview with *Business Insurance*.

Sybron's dental plan currently covers 11,000 employes and their families, or about 27,000 persons. Employes are eligible for the plan after one year of employment. To move from one benefit year to the next, (to qualify for higher maximum benefits) the employe must go to the dentist for an examination, paid in full by the plan.

For each eligible family member the plan pays 100% (up to $30 per year) for examination and diagnosis; 75% of the maximum for treatment benefits; 50% of the maximum for full denture replacement and 50% maximum for orthodontic benefits.

For the first year, $200 is the maximum amount per individual and $500 is the maximum amount per family. The second year maximums increase to $300 per individual and $750 per family; for the third year the figures are $400 and $1,000, respectively. The lifetime limit per person is $500.

Mr. Hooper said the time it takes for employes to move from the first to the second year utilization of the plan is in large part a function of the way an employer (or union) "sells" the plan.

Continued on page 3

Wyatt D&O study—p. 6

EXCESS/SURPLUS and special risks

As associate editor Margaret LeRoux found when gathering information on the excess and surplus markets, the buffer layer phenomenon is not a new aspirin but certainly is causing risk managers a lot of headaches.

Pages 11 through 35 contain stories spotlighting fast paced activity in the excess and surplus lines markets. The need for high limits of liability insurance coupled with shrinking availability of primary insurance means insurance buyers for even the smaller and medium sized companies are now having to approach the excess markets to obtain coverage. We've looked at how risk managers use the markets, how their agents and brokers use the markets, the role of excess and surplus lines intermediaries, and the capacity outlook for excess insurers themselves.

On pages 71 and 72 are two Perspective articles on usage of the excess/surplus lines markets.

Railroad liability . . .

Continued from page 1

hopper car. Finally, the Burlington said it had only performed routine maintenance, not rebuilt the car, in 1969.

Mr. Skove said Burlington is considering appealing the decision. but refused to discuss the grounds of the appeal. The TP&W attorneys, Mr. Callahan and Mr. Schmidt, said they believe the Burlington has no grounds on which to win an appeal.

The decision could force railroads to reconsider rebuilding cars for other railroads and could have an impact on the rates charged for the use of cars, said Mr. Skove.

Mr. Callahan suggested it is time for the railroads to reconsider rule 1 especially since nearly 20% of the freight cars and 30% of hopper cars are privately owned and are not sharing in the substantial risks assumed by railroads.

Carl Lyon, senior vp of the American Assn. of Railroads, said it was too early to assess the impact of the Illinois decision. Mr. Lyon said he hoped the rule could eventually he amended to allow railroads to conduct orderly business involving interchanges.

The decision could be beneficial for a railroad hauling many cars owned by other railroads for private companies, said an insurance manager for a large railroad. At the same time, however, large railroads would face a new product liability exposure offsetting any restriction of their general liability obligations, this manager said.

The decision might force underwriters to pay closer attention to the maintenance practices of railroads, the insurance manager added. That was also the view of Mr. Callahan, the TP&W attorney.

Don E. Cooke, insurance manager for the Union Pacific railroad in Omaha said he could not comment on the case. However, Mr. Cooke said he had long been concerned with the liability the Union Pacific assumed when it took cars from other railroads. Despite inspections, many defects remain hidden which can cause problems, he said.

All in all the overall affect would not be great, according to Mr. Cooke, "as long as you apply the rule equally."

Felix Kloman, whose Risk Planning Group Inc. was involved in a feasibility study for a railroad industry captive insurer, said the decision "cculd accentuate an already difficult liability problem" for the industry.

In general, Mr. Cooke said, "railroad insurance is tighter than hell and can't get much tighter."

Burlington Northern would not discuss what insurance it had to cover the loss. ■

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Develop loss control guide

ATLANTA—The International Loss Control Institute has developed a program to train middle level managers in loss control. The program highlights waste, personal injuries, health hazards, property damage, fire, drug abuse, alcoholism and high labor turnover.

A basic "Management Guide to Loss Control" book can be used by the middle manager or in conjunction with a supervisor home-study correspondent course package.

Further information may be obtained from the Institute, P. O. Box 3435, Loganville, Ga. 30249. ■

St. Paul president

St. Paul Hospital & Casualty Co., a wholly-owned Mutual of Omaha affiliate, has named Warren Whitted president, succeeding Frank J. Hogan. Mr. Whitted will be headquartered in Bloomington, Minn. he formerly was an associate administrator of policy control and coordination for the Social and coordination for HEWs Social and Rehabilitation Service.

Tighter fidelity bonds face mercantile firms

By MARGARET LeROUX

NEW YORK—Restrictions in the commercial policy form for fidelity bonds, including tightening the inventory exclusion and amending the dishonesty definition, are under study by the Surety Assn. of America (SAA), *Business Insurance* learned.

"It's just a matter of time until the changes will be made," Francis LeMunyon, secretary of the association said.

The changes will be similar to those put into the banker's blanket bond this year, Mr. LeMunyon indicated. The coverage restrictions will be included in the comprehensive dishonesty, disappearance and destruction policies written for large mercantile insureds.

The Insurance Services Office (ISO) "will pick up the same exclusions and changes" in its special multi-peril package policy written for small to medium size mercantile insureds, a spokesman for that organization said.

Fidelity bonds for financial institutions have resulted in big underwriting losses in recent years, according to SAA statistics. The average underwriting loss for companies writing fidelity business for financial institutions last year was 106%.

In comparison, the loss ratio for fidelity bonds written for the entire mercantile establishment in 1974, the most recent year statistics are available, was 57.3%, according to the SAA. This figure represents $27.5 million in losses on $48 million in premium volume.

"There's no question that mercentile establishment business is better than financial institutions," Mr. LeMunyon said. However, losses due to crimes against businesses show "staggering increases over the past five years," a study by the Bureau of Domestic Commerce states.

The bureau estimates retailers lost $6.5 billion in 1975 due to ordinary crime, a increase of 12% from 1974 and 60% above 1970. Another Department of Commerce study estimates that 15% to 20% of what was thought to be shoplifting losses in recent years was actually employe dishonesty.

The use of inventory computation in cases involving employe dishonesty, upheld by courts in several states, most recently Massachusetts (*BI*, Oct. 4) is another factor contributing to restrictive changes in the mercantile fidelity bond.

The Massachusetts case, Popeo versus Liberty Mutual Insurance Co., was "a landmark case," according to one underwriting source. The court upheld inventory computation as corroberative evidence in proving an insurable loss through dishonest acts by employes.

"The inventory exclusion clause has always been a bugaboo," a spokesman for a major fidelity bond underwriting company said. "Over the years we've struggled with the definition of it."

The SAA would not comment on details of the revised inventory exclusion, but Mr. LeMunyon said that the exclusion "had been causing problems for a couple of years now."

The amended definition of dishonesty is expected to parallel the definition put into the banker's blanket bond this past year. It defines dishonest acts as "acts committed by such employe with the manifest intent to cause the insured to sustain such loss."

The amended definition also states the underwriter will not be liable for "potential income, including, but not limited to interest and dividends, not realized by the insured because of a loss covered under the bond."

Another exclusion for "all damages of any type for which the insured is legally liable" intends to prohibit claims of punitive damages, a fidelity bond underwriter noted.

These broad changes in the fidelity bond "will make some businessmen holler," one risk manager in the retail field said. "I've always felt the bond was intended to cover only deliberate dishonesty, not losses due to mistakes in bookkeeping or sloppy auditing."

But if the SAA's changes "take away coverage or restrict coverage we now have, I'll be upset," the risk manager said. ■

Kemper sees little impact from Carter

CHICAGO—The election of Jimmy Carter will have little if any impact on the property/casualty insurance industry in the next four years, according to James S. Kemper Jr., president of Kemper Insurance Cos.

"We are not going to have the kinds of drastic changes in direction that would make a difference to the property/casualty business," he told a luncheon meeting with reporters.

Inflation will continue at a 6% to 8% rate in 1977 unless Mr. Carter implements all his promises immediately, an unlikely event, according to the Kemper president.

Passage of federal no-fault insurance next year instead of 1978 was the only significant difference Mr. Kemper said would result from the election.

Other major insurance questions such as product liability and general tort reform will have to be solved no matter who controls the government, he said.

Earlier in the year, Kemper asked the major candidates to explain their positions on seven major insurance questions. Mr. Carter said he believed no-fault decisions and general insurance regulation should be left to the states.

"There is no way he will keep those positions," Mr. Kemper said.

Maxwell D. Ruders, senior vp, told the luncheon Kemper was committed to remain in the workers' compensation area. He said it was prepared to accept only a 2% profit on workers' compensation businesses. ■

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Vol. 10 No. 23—Business Insurance is published every other Monday at 740 Rush St., Chicago, Il. 60611. Controlled circulation postage paid at Brookfield, Wisconsin. Copyright 1976 by Crain Communications Inc.

Dental study . . .

Continued from page 1

The Sybron study shows a steady increase in use according to the benefit year and the family size for the first three years. After that use levels off.

For example, 34% of two-member families in the first benefit year used the program in 1973. By 1973, 63% of two-member families in the first benefit year used the program. But, 70% of two-member families in the third year of eligibility used the program in 1973; by 1975 use among this group was 75%, an increase of only 5%.

Since the utilization of the dental benefit increases according to family size, it's important for an employer to keep records on the number of dependents in each employe family, Mr. Hooper said.

This is where self-administrating a dental plan is preferable to insuring it, he added, "We can look at statistics for any given quarter and know what the plan is costing us." Insurance companies are often reluctant to give out such information, Mr. Hooper said.

Sybron's dental plan costs from five cents to six cents per employe per hour, or a total $120 per employe per year, Mr. Hooper said.

He said one of the major unknowns in dental plans is why some members of the family take advantage of the benefit and others don't.

The Sybron study shows that 14% of families of four or more persons in the third year of eligibility sent only one family member to the dentist, while 29% of the families of that size all go to the dentist.

For families of three members, in the third year of eligibility, 26% sent one person to the dentist and 35% of the families all went to the dentist in 1975.

Mr. Hooper advised employers who are looking into a dental plan to carefully study cost projections and deductibles.

"If you make the deductibles so high that it's expensive for employes to take advantage of the benefit, you'll create ill will," he said. "It will become a negative benefit."

He warned that some cost projections put out by insurers of dental plans use tables that haven't been updated in several years.

Schedules of customary dental fees should be revised each year and should reflect the differences in high cost of living areas and small towns, he said.

Orthodontic care is a popular benefit that is "not too terribly expensive to add," Mr. Hooper said.

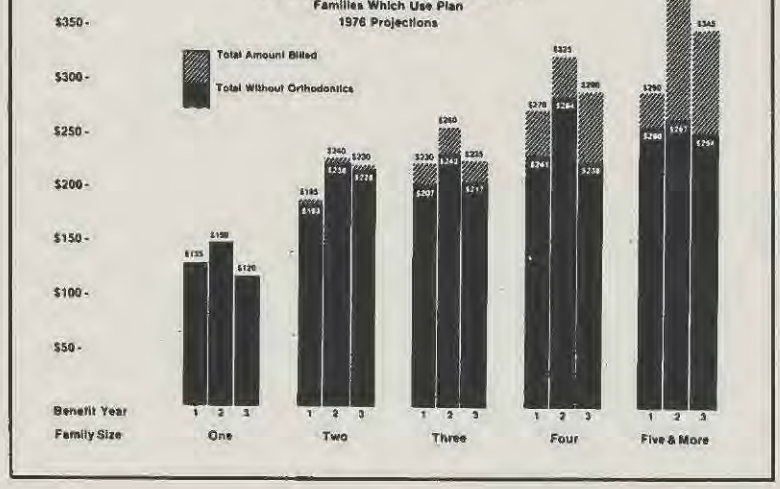
The Sybron study shows in 1975, 4.1% of three member families used the orthodonic benefit; 11.7% of four member families and 19.9% of families of five or more members.

The Sybron marketing director advised a common sense approach when a company establishes a dental plan.

"Look at how many people will benefit by it," he said. "A lot of this is common sense, if you include a good data base." ■

SYBRON DENTAL PLAN UTILIZATION
WITHIN FAMILIES IN WHICH
AT LEAST ONE MEMBER GOES
TO A DENTIST DURING THE YEAR

Family Size	Family Members Using Plan	Benefit Year: One			Two			Three		
		1973	1974	1975	1973	1974	1975	1973	1974	1975
1	One									
	All									
2	One	53%	37%	43%	56%	51%	42%	41%	40%	41%
	All	47%	63%	57%	44%	49%	58%	59%	60%	59%
3	One	41%	36%	30%	54%	33%	31%	27%	28%	26%
	All	26%	36%	34%	24%	32%	36%	37%	35%	35%
4	One	31%	28%	19%	33%	26%	18%	15%	15%	17%
	All	29%	30%	37%	15%	23%	32%	33%	36%	36%
4+	One	18%	27%	17%	19%	27%	22%	20%	13%	14%
	All	16%	18%	33%	20%	15%	18%	25%	28%	29%



OSHA visits in August down a bit

WASHINGTON—The federal Occupational Safety and Health Administration inspected 5,563 firms employing nearly 6 million workers during August 1976.

As a result of the inspections OSHA issued 4,258 citations alleging 20,600 violation of job safety and health standards. Proposed penalties for these violations totaled $872,659.

OSHA inspectors found 25% of the workplaces they visited to be in compliance.

From its inception on April 28 1971, OSHA has conducted 337,079 inspections resulting in the issuance of 245,138 citations alleging 1,270,212 violations, for which penalties of more than $34.6 million were proposed.

Total establishments inspected in August were substantially less than the figure for the same month a year ago, when 9,170 workplaces were visited. However last year's inspections covered only 1.3 million workers, almost 300 000 less than in August 1975.

Proposed penalties were also lower than the nearly $1.1 million reported for August 1975, and there was a dramatic decrease in the number of "non-serious" alleged violations. There were 38,517 such violations in August 1975.

The total figure for all alleged violations was also down, with this year's August figure at 20,600 compared to August 1975's 39,548 reflecting the drop in non-serious violations. ■

the benefit beat

Illinois utility taps CNA for ASO program

COMMONWEALTH EDISON CO. selected CNA Insurance to handle the administrative services for its self-funded medical benefit plan involving $9 million in claims annually. Robert L. Stauder, employe benefits manager, said the cost will be $1.13 per employe and that CNA promises to pay all claims within five days. Commonwealth previously processed the claims internally using Aetna Life & Casualty Co. for some administrative services. The cost and backlogs in claims convinced the company to move to entirely third-party administration. CNA solicited the account through a broker and Aetna countered with an offer "nickles below" the CNA proposal, Mr. Stauder said. But the company had decided on CNA before Aetna made its counter offer, he said, and Commonwealth stayed with that decision. Jan. 1 is the transition date.

RETIREMENT BENEFITS for President Ford will total about $100,000 annually, in addition to several perquisites afforded ex-presidents. The presidential pension is set at $63,000 per year under the Presidential Pension Act, according to White House deputy press secretary John Carlson. As an ex-congressman with 25 years of service, President Ford's congressional pension is $40,500 annually. However, if the President elects a survivor option for the first lady, that pension will be reduced to $36,932 per year. In addition to these direct cash benefits, the President and Mrs. Ford will have Secret Servcie protection for the rest of their lives, although surveillance of the Ford children ends on Inauguration Day, Jan. 20. After he leaves office, the President will also be able to draw federal funds for his transition expenses. Up to $1 million will be available in the first six months after retirement to finance office space and staff, communications gear, and travel. After that period, the Former President's Act provides money for an office anywhere in the United States and up to $96,000 per year for staff salaries. The President and his wife will also have franking privileges with the U.S. Postal Service so they will never have to worry about finding a stamp.

THE INTERNATIONAL ASSN. of Machinists (IAM) renewed its massive dental insurance plan with Delta Dental Plans Assn. of Chicago. The IAM program will eventually cover 800,000 members and dependents. Under the program which went into effect Nov. 1 the machinists dropped "incentive" coverage in favor of a constant 80% coverage by the insurance and 20% copayment by the employe for all basic and preventive care. Under the incentive provision, coverage was 70% of basic dental care in the first year, 80% in the second and 90% in the third. That provision was dropped because of its high cost. The monthly premium per employe was increased to $15.75 from $14.07 on Nov. 1. Delta Dental plans now cover 11 million persons across the country.

THE NEXT CONGRESS is likely to move toward making dividends paid on ESOP (employe stock ownership plans) tax free in 1977, said Claude L. Kordus, partner, Hewitt Associates, during a session of the 30th annual conference of the Council on Employe Benefits held in late October in San Francisco. If such legislation passes, Mr. Kordus said, "everyone in this audience will be in the business of running ESOPs or TRESOP." He said leveraged ESOPs could cost corporations more to finance in the long run than traditional pension or profit-sharing plans if they are placed on top of—not substituted for—conventional retirement programs. However, if the leveraged ESOP is substituted for traditional retirement plans, Mr. Kordus said they would not cost more to finance in the long run than standard pension or profit-sharing plans.

Questions which corporations must ponder when considering an ESOP include whether the company is willing to give up the flexibility in dispensing benefit dollars that may be necessary with a leveraged ESOP and how management will deal with employe attitudes in the advent of a falling stock market. Mr. Kordus said TRESOPs are, in effect, "free plans" because corporate contributions to them result in a tax credit rather than a deductible expense. Their disadvantages lie with how much stock you can buy for 1% to 2% of qualified capital expenditures, he said, citing one company which estimated that a TRESOP would yield only $39 of company stock for each participating employe.

THERE MAY BE BACKPEDALING on employe benefits in some foreign countries, according to Vincent Simone, vp and director of Kwasha Lipton's International division. Speaking at the 30th annual conference of the Council of Employe Benefits, Mr. Simone said Australia is talking about reducing its "means test" for benefits under its Social Security type program. Moreover, Australia's program of national health insurance has not succeeded, he said. In the United Kingdom, the national health program has resulted in a reduced number of physicians, Mr. Simone said, adding: "I think these countries are backpedaling. The future of employe benefits will have to be regarded as a joint responsibility of business.

FORD MOTOR CO'S Paul Ryder, assistant director of labor relations planning told the 30th annual conference of the Council on Employe Benefits in San Francisco that the company's recent settlement with the UAW settlement gave "full visibility to health care inflation." Pre-surgical screening, independent hospital review and dental auxiliary utilization are part of the agreement, he said. D. Bruce Sidebotham, director of employe services for General Tire & Rubber Co., said chiropractic benefits were part of the recent labor settlement in the rubber industry. Both men termed their respective settlements "very expensive."

CHRYSLER CORP.'S new contract with the United Auto Workers covering 109,000 production workers is almost identical to the pacesetting agreement the union negotiated earlier with the Ford Motor Co. Key benefit provisions of that contract included new programs for vision care, hearing aids and a company agreement to pay any future premiums or taxes in connection with a national health insurance program. Chrysler agreed to an added feature which will give hourly workers greater protection against layoffs. The company also agreed to contribute an additional $1.2 million into the company-paid fund to protect 9,000 salaried workers in the event of layoffs. In other respects the contract for salaried employes follows the one negotiated for the production workers.

ARMOUR & CO., a subsidiary of The Greyhound Corp., has chosen Delta Dental Plans to administer a new dental insurance program for its 14,000 employes. The program will provide 80% of the basic fees charged by participating dentists for examinations, cleaning, fillings, root canals, oral surgery, periodontics and prosthetic services such as bridges and dentures. There will be a $25 individual deductible, $75 maximum family deductible and a $750 annual maximum. The program will be operated on a cost-plus basis. Delta Dental Plans said the expected cost for Armour is $18 per month per employe.

Contributory payment demand could bring a strike by machinists

By JOANNE GAMLIN

SAN FRANCISCO—The International Assn. of Machinists (IAM) will regard as cause for a strike any demand by corporate management to return to a contributory basis for payment of employe benefits.

Reginald Newell, director of research for the IAM, told the 30th annual conference of the Council of Employe Benefits (CEB) that an era of heightened confrontation between labor and management over the issue of employe benefits is on the horizon.

Noting that in 1975 employe benefits amounted to 35% of total payroll hours, Mr. Newell said ballooning health care costs are forcing workers to exert increasing pressure on their unions for higher employe benefit coverage.

As a result of this pressure, he predicted that the IAM could well strike if employers should move to make workers pay for some of these rising costs.

Among the areas where labor/management battles over employe benefits will be fiercest, he forecast, are:

- Medical care and attendant costs. Unions want plans to pay for a host of new benefits such as out-of-hospital care, vision care, well-baby care and special treatments such as gynecological tests including Pap smears.
- Alcoholism, which must soon be included in the definition of illness, according to the union executive. Stating that about $15 billion a year is wasted due to this malady, Mr. Newell said the IAM wants a joint union/management program for rehabilitating afflicted employes.
- Higher pension benefits. In the future the IAM will demand the removal of the 'cap' on benefits under retirement plans that are integrated with Social Security.
- Higher benefits to retired workers. While unions have been barred from negotiating higher benefits for retirees, they will now seek a system to protect the income standard of these people.
- Employe Stock Ownership Plans (ESOPs). Any move to substitute ESOPs for traditional pension or profit-sharing plans will be resisted by unions.

Emphasizing that pension benefits will be a large part of the forthcoming conflict between labor and management over employe benefits, the IAM executive said workers are no longer willing to wait until age 60 or 65 to retire. Union members in their 20s are eager to picket in order to reap the benefits of retirement payouts at ages when they are young enough to enjoy life, he said, adding: "We think instances where an employe makes more money when retired than he did while employed will be small. Nevertheless, when they occur, our reaction will be 'so be it.'"

Mr. Newell said the IAM views the integration of retirement benefits with Social Security, as unfair to the economic security of its members.

The use of ESOPs in place of standard pension or profit-sharing plans will be opposed by unions because, among other things, they fear their members will be disturbed when the price of their company stock plummets during economic hard times. "The biggest danger in ESOPs is that they are 100% invested in company stock," he elaborated. "It is our position that workers, because of their jobs, already have a sufficient vested interest in the well-being of their employers."

It is the experience of the IAM that most companies turning to ESOPs do so as a means of replacing a traditional retirement program, he added.

There is, however, one trend in the employe benefit field which the union executive applauds. It is the cafeteria approach to benefits, adopted by TRW Inc., California. Arguing that every employe should have his or her own benefit design, Mr. Newell said that savings plans, additional life insurance and a choice of health maintenance organizations (HMOs) are among the options the IAM would like to see adopted by corporations in the future.

"The degree of flexibility in cafeteria benefits is a matter for negotiation," he added.

To control galloping employe benefit costs, Mr. Newell suggested a number of approaches be explored, including pre-surgical screening, an expanded use of HMOs and convalescence in the home.

However, the health care establishment has worked to thwart attempts to resign in skyrocketing costs, he said. Dentists oppose checks on their work, physicians resist peer review and hospitals put up obstacles to outside evaluation of their financial structures, he noted.

"Clearly, the major hurdles to controlling health care costs lie with the medical establishment," the IAM executive asserted. ■

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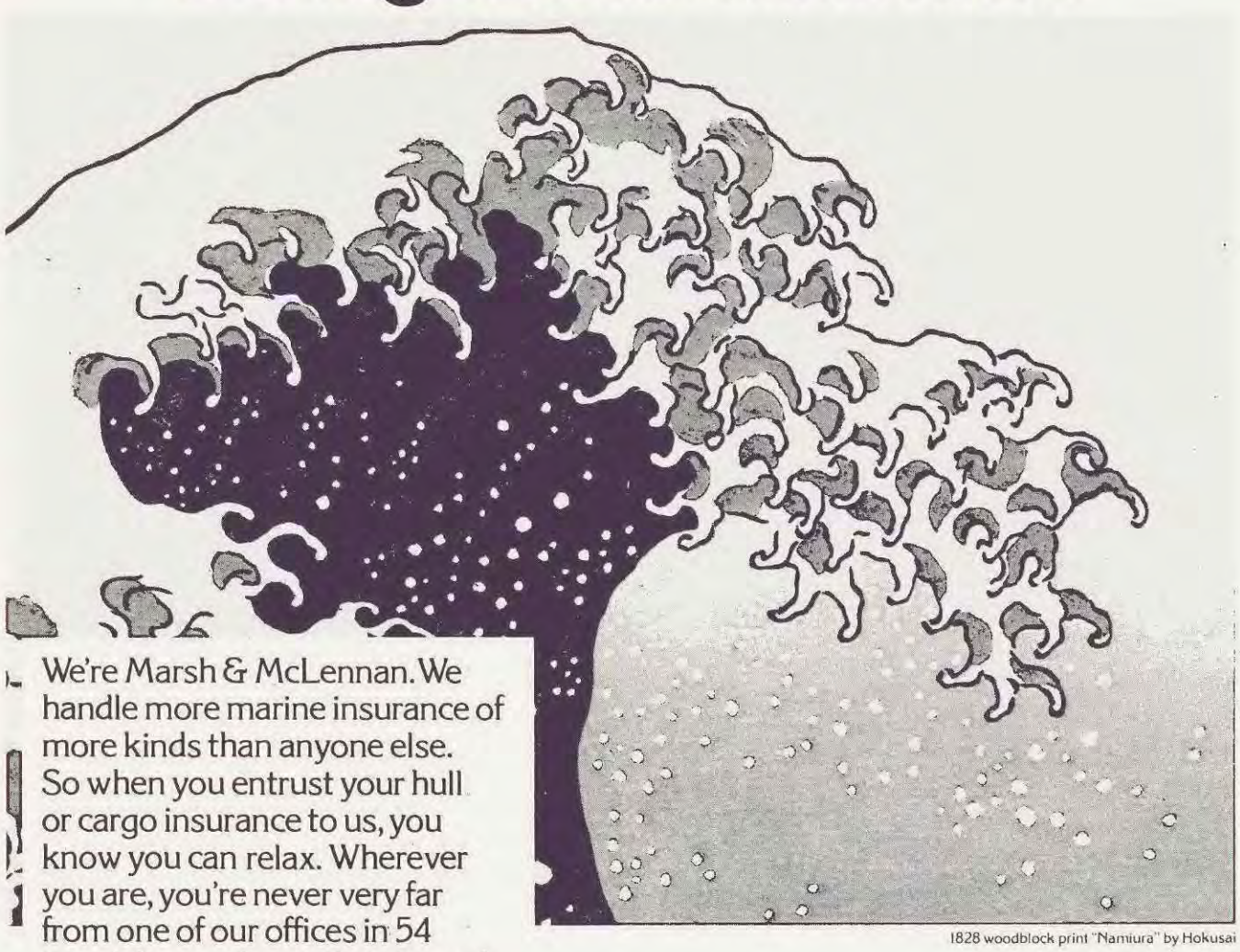

1828 woodblock print "Namiura" by Hokusai

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Kemper says it's not pulling out of field

CHICAGO—Kemper Insurance Co. divisional manager Palmer App has denied his company is pulling out of any workers' compensation underwriting in any states.

"In no state have we discontinued writing new business," Mr. App said.

Some persons had expressed concern that Kemper was pulling out of workers' compensation in Illinois and Michigan because of the increased liberalization of benefits in those states.

Mr. App said as long as reasonable Insurance Service Operations rates are available in Illinois and other states, Kemper Insurance will continue to underwrite. In Illinois, workers' compensation rates have increased three times since July 1975—up an estimated 88% according to Richard Seligman, chief counsel of the Illinois Department of Insurance.

Other producers who have restricted underwriting in Illinois are Fireman's Fund, Aetna Life & Casualty Co., and Hartford Insurance Co. (*Business Insurance*, April 5). Kemper spokesmen at that time said it was also restricting writing.

Mr. App said that the rate increases were not enough to offset losses in the workers' compensation area in Illinois but were enough to allow Kemper to continue writing in the state. He said that Kemper has no plans to pull out of Illinois or any other state in the immediate future. ■

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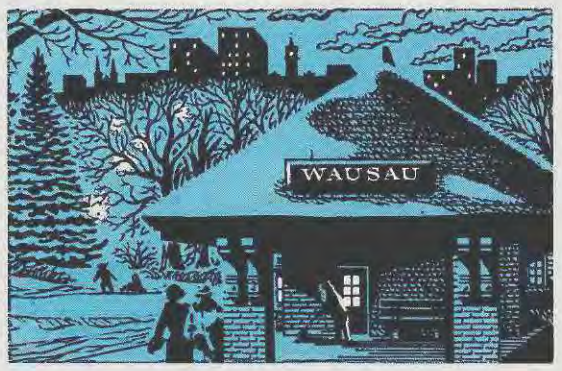

EMPLOYERS INSURANCE OF WAUSAU Wausau, Wisconsin

D&O markets highly competitive, study finds

CHICAGO—Wyatt Co.'s fourth annual survey of corporate experience purchasing directors and officers liability insurance found markets continuing to be highly competitive, with some companies able to increase their limits of D&O coverage and decrease their premiums at the same time.

"Basically, the D&O markets have not deteriorated," said Warren Brockmeier, director of risk management services for Wyatt Co. and initiator of the annual survey. "Competitive quotes can still be obtained from D&O underwriters unless the particular account has an apparent problem," he said, characterizing the availability of D&O insurance as "stable, with no cause for panic."

Of the 1,731 corporations participating in Wyatt's study this year, 71.4% purchase D&O insurance. Seventy-four percent of U.S. companies carry the coverage, while 28% of Canadian companies have the policies. This is an increase from the 65% found to purchase D&O policies in last year's survey.

Wyatt said 738 of the companies having D&O insurance and participating this year also responded last year. Some 70.2% of these reported no change in premiums from a year ago, most because they did not have to renew their policies.

One hundred three companies said premiums had risen and 75 said premiums fell. Eighty companies whose premiums rose within the year increased their policy limits in the course of the year. However, eight others increased their policy limits with no corresponding change in premium cost, while another 21 corporations were able to increase their D&O policy limits and still swing a premium reduction from a year ago.

"What that shows, is companies with no apparent D&O problems can hold down premiums," said Mr. Brockmeier. "Even well managed companies in tough industries can get competitive rates."

"Underwriters' impression of management" is the key factor in assessing D&O insurance premiums, and the rule in examining management is to look at the corporation's profitability, he added. Thus, rates do seem to be industry-sensitive, to a large degree, he told *Business Insurance*.

In fact, 25 corporations reporting to Wyatt this year said they've been unable to obtain D&O insurance coverage at any price. Among these uninsured firms which were denied coverage were a Fortune 1,000 listed company in the communications field, a mining company, and a forest products concern. Electronics companies have problems obtaining D&O insurance, Mr. Brockmeier said, as do real estate and construction firms involved with real estate investment trusts.

The biggest policy limits reported were $60 million, with 50% of the companies reporting that they have D&O policy limits of $10 million or more. This is significantly higher than earlier findings when the bulk of participants had limits of $5 million. Slightly more than one-third of participants having D&O insurance reported limits of $5 million, although the same percentage (32%) had limits of $10 million. Another 18% carried limits of $15 million or more. About 18% had policy limits under $5 million.

Among the 494 survey participants not having any D&O insurance, 161 saw no need for it, 146 said they were considering buying the coverage, 71 said costs were too high, 66 said they weren't carrying it on the advice of their attorneys and 44 said the coverage was too limited. Another 25, he noted, said they were unable to obtain the insurance.

The leading insurers of directors and officers liability, in order of size, were: American Home/AIG with about 28% of the responses; Lloyd's, with about 15%; Harbor Insurance/Buffalo with about 15%; CNA with about 10%; Crum & Forster/International Surplus Lines with about 8%; and The Home Insurance Co. with about 6%. Insurers receiving less than five responses each included GATX Insurance Co., Imperial Casualty Insurance Co. (affiliated with GATX), Kemper Insurance Co./Sequoia, MGIC, St. Paul and Liberty Mutual, said Mr. Brockmeier.

Last year, Aetna Casualty & Surety was listed as a leading D&O insurer.

In excess D&O insurance coverage, Northbrook Insurance Co., which is part of Allstate, is also a factor, Mr. Brockmeier added.

Typical premium cost findings in this year's study also showed falling premiums due to competition among insurers. For example, companies with sales of $250 million to $400 million buying policies with $5 million limits showed a range of premium costs from $1,333 to $65,000 with a median cost of $13,167. Last year the range went from $7,470 up to $38,614, with the median cost at $15,720.

Companies of that same size buying limits of $10 million paid between $1,467 and $38,333 this year, with the median cost at $18,500. Last year's range for $10 million coverage was $8,200 up to $51,000, with a median cost of $20,187.

The largest corporations with sales over $2 billion a year, and buying policies with $10 million limits this year reported premium costs ranging from $2,033 (which Mr. Brockmeier thinks is obviously out of line) to a high cost of $137,500. Last year the range was from $19,039 to $75,000. The median cost this year for these giant companies was at $37,750, while last year's median cost was $41,869.

Wyatt's study indicated that claims under D&O insurance policies may be up about 5% over last year, said Mr. Brockmeier. Last year, 149 companies out of the 1,721 participating reported filing a claim under their policies.

This year's Wyatt survey showed many more companies are purchasing separate fiduciary liability insurance policies. Of the U. S. firms participating in the study, 60% had separate fiduciary liability insurance, while 11% of the Canadian firms bought that coverage separately. Last year, 41% of the participants had separate fiduciary coverage, while 32% had no coverage at all. Only 20% of the firms this year said they had no fiduciary liability insurance policies at all.

Another 8% purchased fiduciary liability coverage as an endorsement to the D&O liability policy, up from 6% last year. Four percent had the coverage for fiduciaries as an endorsement to general liability policies, down from 5% last year. ■

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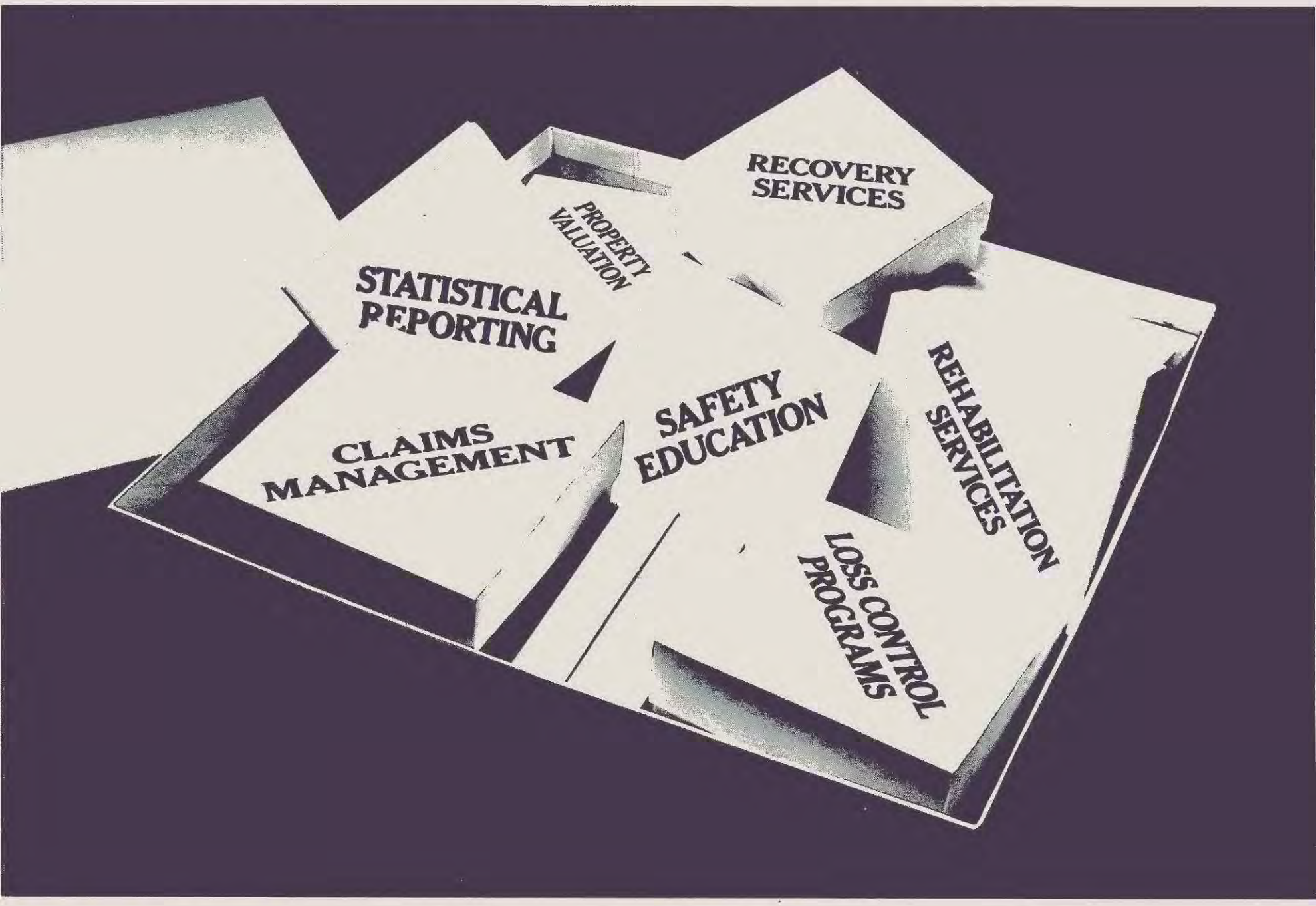
Inside most self insurance packages are a lot of outside services.



Most companies providing self insurance services really act just as general contractors. They have to go outside for things like claims handling, or loss control programs, or rehabilitation services.

There is nothing inherently wrong with that, except the people doing the work are often a long way down the line and there can be layers and layers of management between you and them.

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Info for buyers issue

If you have not yet submitted data or literature for publication in Jan. 10, 1977 Info for Buyers Issue, please return the coupon below for forms and instructions. All material for publication must be in the hands of the editors no later than Dec. 1, 1976.

Mail to: Info for Buyers
Business Insurance
740 Rush St.
Chicago, Il. 60611

Please rush me forms and instructions for submitting data for publication in your Jan. 10, 1977 Info for Buyers Issue. I understand that there is no obligation on your part to publish the items submitted, nor is there any cost or obligation to my firm if they are published.

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THE ANNUAL INFO for Buyers issue of *Business Insurance* is scheduled for Jan. 10, 1977. In this issue, the editors provide hundreds of informative items about publications and pamphlets available from insurance companies, brokerage firms and service suppliers about topics of interest to risk and insurance managers, and financial executives, planning for contingencies.

The 1976 Info for Buyers issue carried over 250 items of information, which pulled over 36,000 responses from readers requesting copies of the available brochures.

All material relating to planning, funding, controlling, monitoring or prevention of risks and losses must be in the hands of the magazine's editors no later than Dec. 1, 1976. Acceptable material for the Info issue includes a variety of commercial property and liability categories, as well as employe benefits classifications. ■

Chesebrough-Pond Inc. sets Bermuda captive

By MARIE KRAKOWIECKI

GREENWICH, CONN.—Chesebrough-Pond's Inc., which has branches and subsidiaries all over the world, is setting up a captive insurance company in Bermuda to handle its international risks.

The diversified consumer products company selected Reed Shaw Stenhouse & Partners Ltd., the Western Hemisphere operating division of broker Reed Shaw Osler Ltd., to manage the captive.

The broker will run Chesebrough-Pond's captive through a wholly-owned subsidiary, Insurance Managers Ltd., Bermuda, which specializes in managing captive insurance companies of large multinationals.

Insurance Managers Ltd. (IML) adds the new account to a current stable of 15 to 20 captives, some in Bermuda and others domiciled in jurisdictions such as Panama.

Many of these captives belong to Canadian or British parent companies. Reed Shaw's success in winning the Chesebrough account is seen as part of its aggressive effort to expand its share of the captive management business from U. S. companies.

Michael Waskom, risk manager for Chesebrough-Pond's, refused to comment either on the captive itself or on the selection of the captive manager.

It is understood, however, that Chesebrough considered a number of major firms before narrowing the competition to Reed Shaw and Johnson & Higgins. In September, the two finalists each made presentations to Chesebrough-Pond's.

The Boston office of Reed Shaw Stenhouse Inc., the U. S. arm of Reed Shaw Stenhouse & Partners, produced the business. Peter Stokes Godfrey, a vp at that office, will join Lynn Thomas, director of Reed Shaw Stenhouse & Partners, Toronto, in managing the account domestically.

Mr. Godfrey and Mr. Thomas are both officers in another Reed Shaw subsidiary which acted as a consultant in winning the Chesebrough-Pond's captive. Reed Risk Management International, an engineering and consulting firm which advises clients on funding techniques.

Reed Risk Management International's president, George P. McEvenue, confirmed that the parent broker has indeed stepped up its efforts to win more United States captive management business.

"Whereas Reed Shaw Osler has been very active in this field for many years, now with the company's much larger involvement in the U. S. market, and with a marked increase in interest in risk management approaches by large foreign corporations, there has been a substantial escalation in the number of projects undertaken and implemented by clients," he said.

He explained that since IML was established in 1969 to manage captives for Reed Shaw client firms, it has noted a definite increase in risk management sophistication and interest in captives on the part of European and Pacific countries.

Mr. McEvenue, who is a director of IML, said it has also picked up captives to manage for Australian and New Zealand firms.

Since Chesebrough-Pond's was reluctant to discuss any aspect of its new captive, details of premiums to be paid into the captive and of coverage to be provided were not available.

However, one knowledgeable source claimed that the Chesebrough-Pond's captive's property portions involve only non-HPR risks.

The $675 million company is known for its brand name products such as Vaseline, Cutex, Pond's Cold Cream, Ragu Spaghetti Sauce, and Adolph's Meat Tenderizer. ■

Appointed to board

Marsha Chapman, manager of group insurance for SCM Corp., has been appointed to the board of the National Assn. of Employers on Health Maintenance Organizations, Minneapolis. NAEHMO provides members with information services to aid HMOs in complying with state and federal laws.

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THE INSURANCE BUYER'S ERISA QUIZ

- ☐ Does your policy limit coverage to persons defined as fiduciaries?
- ☐ Does your policy limit coverage to wrongful acts of insureds only?
- ☐ Does your policy provide defense costs within the limits of liability?
- ☐ Does your policy limit loss to damages by definition, and exclude non-pecuniary claims?
- ☐ Does your policy by definition exclude employee benefits liability losses?
- ☐ Does your policy include outside persons as insured fiduciaries?
- ☐ Does your policy contain a limited retroactive acts exclusion?
- ☐ Has your policy been purchased without the advice of competent legal counsel who has rendered an opinion in writing as to which contract he felt offered the broadest coverage?

If the answer to *any* of the above questions is "Yes," the chances are you have probably purchased the wrong policy. And the real problem is that you will probably never know until you have an uninsured loss.

How do you know you have the right fiduciary liability policy? There's only one way—to *compare.* Remember—*all policies are not created equal.* While all contracts may appear to be similar, there can be substantial differences in their terms and conditions—differences which can be very significant—and costly. And, unfortunately, it's impossible to compare policies without a thorough understanding of the law. (ERISA)

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Clearing the canal

Pictured below are just two of the dozens of sunken ships which for nearly 8 years blockaded the Suez Canal during the Arab-Israeli conflict.

Removing these vessels was a massive undertaking—one which demanded both a skilled salvage company to head the project and a knowledgeable insurance broker to design a protection program against the unique and catastrophic hazards involved.

An American firm directed the salvage operation. The risk management plan was arranged by Corroon & Black. Working together, these professionals helped execute one of the most important salvage projects ever attempted.

From a risk management standpoint, the task was not easy. Liabilities transcended international boundaries and the assets and reputations of several clients were on the line. Any gap in coverage could have been disastrous.

Corroon & Black made sure there were none. Our team of international specialists arranged protection for every aspect of the project from bid bond to final bond and from workers' compensation to builder's risk coverage. In the process, they reinforced our reputation as one of the world's most respected insurance brokers.

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EXCESS/SURPLUS
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Larger retentions key factor in rising cost of work comp

By MARIE KRAKOWIECKI

NEW YORK—It's becoming more expensive all over the country to buy excess insurance to supplement self-insured workers' compensation programs.

The expense is not necessarily restricted to premiums, although they are increasing. It seems to be more a function of the minimum levels of self-assumption which excess insurers are insisting upon before they will provide coverage.

Minimum retention levels have jumped so dramatically in the last few years, particularly in the Midwest, that only the largest and most financially secure companies find self-insured workers' compensation programs profitable.

There are a number of reasons why the excess markets have suddenly become 'as tight as a drum,' as one specialty broker put it. Inflation and bigger court awards in recent years play some part. But the main reason for the recent catapulting minimum retention levels seems to be excess insurers' jittery reaction to state efforts at bringing disability benefit schedules into the twentieth century.

In states where benefits have been extensively liberalized—Illinois, Michigan, and Alaska are frequently mentioned as extremes—the excess insurance markets won't even consider providing coverage unless the employer self-assumes between $250,000 and $300,000 of its own per occurrence losses.

But in states where a disabled worker is expected to live on as little as $41 a week, the excess markets offer self-insurers a better bargain.

In Alabama, which just passed the $41 minimum workers' compensation payment level in July, for example, a typical minimum retention level is only $75,000 per occurrence.

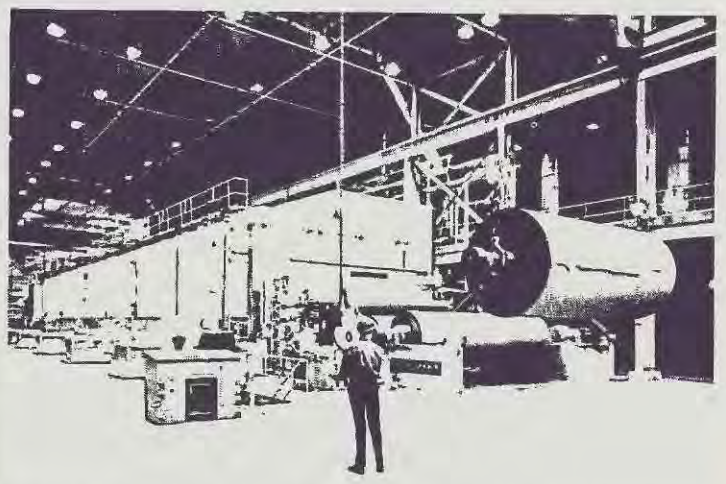
That is three times higher than self-insurers had to assume in the Deep South as little as five years ago, brokers say, but as retention levels go today, it is still among the lowest available anywhere.

The exception, one Southern broker explained, would be for firms in the South which have had low-retention programs for a long time with the same underwriter. Some of these older programs may still be able to use retentions in the $50,000 range because of existing relationships with the excess writer.

At the other extreme are the minimum retention levels required for certain groups of workers whose high benefit levels are federally legislated rather than set by the states. A firm with a longshoremen's or harbor workers' work comp exposure, for instance, would have to assume a minimum retention of about $500,000 no matter where it is located.

Some firms, particularly in the West and the Midwest, have already taken to assuming retentions in the $500,000 per occurrence range even if they do not have longshoremen's exposures.

Georgia Pacific Corp., the forest and paper product manufacturer in Portland, Ore., is one example. In the course of 10 years, Georgia Pacific has gone from a self-insurance program with a $25,000 retention and about five excess underwriters taking various high layers of upper limit coverage insurance to a program with a $500,000 retention and just a single excess insurance carrier.



Forest products firm Georgia Pacific upped its retention in the last 10 years from $25,000 to $500,000.

The firm, which uses broker Marsh & McLennan, analyzed its losses at lower retention levels and decided it could absorb a higher deductible and still save money on its program for 25,000 employes. Georgia Pacific does all its own administrative work.

One of the advantages of taking the large retention level, the company said, is that the premium on the excess insurance is lower.

Premium rates for excess coverage for self-insured workers' compensation plans are set at a percentage of the standard premium the company would pay if it went to the regular insurance market for its primary coverage.

Rates rise or fall depending on retention levels. But, in general, excess coverage will cost between 5% to 15% of a standard workers' compensation premium, and will be expressed in terms of cents per hundred dollars of payroll for specific excess coverage.

For the most part, it seems that insurance markets are willing to write specific excess policies for self-insured workers' compensation, but are generally reluctant to provide what is called aggregate excess insurance.

In specific excess coverage, the employer pays an agreed-upon amount (self-insured retention) for each individual occurrence of loss, and the insurer pays for amounts above that on a per-loss basis up to the policy limits.

Aggregate excess insurance differs in that it provides a ceiling on total losses over a contract period, usually one or two years, up to the limit of liability.

In some states, such as California, the only kind of excess coverage allowed by law is specific. But many companies with locations where aggregate coverage is legal, want it, and it is becoming much harder to obtain.

R.P. Hewitt, president of Greenville, S.C.-based Hewitt, Coleman & Associates, said aggregate excess is the most difficult line to buy now.

"The aggregate markets have diminished tremendously over the last few years, and I don't understand why, because the loss ratio in aggregate has been better than in specific," he complained.

His firm, which places just over $1 million a year in excess premiums for workers' compensation, tries to dissuade its clients from purchasing aggregate excess coverage.

"Because of the costs involved (between 10% and 15% of the normal standard premium for workers' compensation insurance) there is really no need for a company to rely on aggregate excess. Specific protection will do the trick if the firm is financially stable," he said.

Nevertheless, most of his firm's customers want to buy both specific and aggregate coverages. Mr. Hewitt said he knew of only about eight insurers offering it consistently, and several others which will offer it on an occasional basis.

One time aggregate excess coverage is absolutely necessary, he explained, is when a self-insured workers' compensation program of

Continued on page 12

Book rates 35 liability insurance forms

Is your umbrella leaking? Here's help

The Umbrella Book, by Warren, McVeigh, Griffin & Huntington, ($50) Publisher: WMGH Corp., 680 Beach St. Suit 307, San Francisco, Calif. 94109.

Reviewed by SUSAN ALT

THE MYSTIQUE of the insurance industry is built on things like bumbershoots and blankets.

As the terms may imply, the bumbershoots are meant to afford sweeping protection from, in this case, the perils of liability losses, while the blanket is associated with warmth and security.

At least that's what underwriters of insurance would have their policyholders believe. And, pray tell, how many warmly secure policyholders take the time to ferret out holes in the bumbershoot before a loss befalls them?

If the answer is "not many," then those lacking the time or patience to read the fine print are now saved.

The mysterious bumbershoot—also variously known as the umbrella, excess cover or the blanket—is laid bare at last. And in a fashion that's sure to raise the eyebrows of the entire insurance industry. "The Umbrella Book" is meant to help the unwary policy holder discover the blanket's lose weave of shrunken security which leaves the sleeping liability giant uncovered.

Warren, McVeigh, Griffin & Huntington, San Francisco-based risk management consultants, have doggedly analyzed 35 umbrella liability insurance forms, breaking several rules of the insurance industry along the way. Although expensive at $50, their volume accomplishes a valuable first for the insurance buyer: It contains three detailed charts which rank the breadth of insurance coverage provided by the 35 underwriters who are the leading suppliers of umbrella coverage.

CNA and INA will undoubtedly be pleased that they tied for first place as having the best coverage, on the basis of points assigned to various parts of the policies, but U. S. Fidelity & Guaranty and American Mutual Liability Insurance Co. aren't going to be happy that they ended up at the bottom of the list.

As the consulting firm points out in the book's overview, the umbrella liability policy could be characterized as the single most important one in an organization's entire insurance portfolio. It's meant to cover catastrophic losses while covering the broadest possible range of liability risks.

Although it assesses the strengths of policies sold by these 35 insurers, the book also unhesitatingly points out the weaknesses in umbrella policies. The authors

Continued on page 14

INSURANCE COMPANY RANKINGS

1. CNA
2. INA
3. Continental
4. Allstate
5. Chubb/PI
6. Royal Globe
7. American Home
8. United Pacific/Reliance
9. Industrial Indemnity (Crum & Forster)
10. Ohio Casualty
11. St. Paul
12. Transamerica
13. Travelers
14. Safeco
15. Liberty Mutual
16. Mission
17. Great American
18. Harbor
19. Home
20. Aetna Casualty & Surety
21. Centennial
22. Midland
23. Northwestern National
24. Central National
25. Commercial Union
26. Insurance Co. of State of Penn.
27. Stonewall
28. Lloyd's
29. Employers of Wausau
30. Fireman's Fund
31 Kemper
32. Highlands
33. Hartford
34. USF&G
35. American Mutual

Work comp costs . . .

Continued from page 11

a group or an association is involved. Then, in all cases, they must buy aggregate excess coverage.

One firm headquartered in the East which buys both specific excess and aggregate excess insurance to supplement its self-insured workers' compensation program is Sperry & Hutchinson Co., New York.

Donald W. Cherry, corporate insurance manager for S&H, said the firm has been buying both aggregate and specific excess since about 1972 through the Atlanta office of the firm's wholly-owned brokerage firm Bayly, Martin & Fay Inc. Its excess carrier is Employers Reinsurance Corp.

S&H has a concentration of manufacturing subsidiaries in the South that make furniture and carpets. What it did was to merge the programs of several of these subsidiaries into a self-insured workers' compensation plan covering about 8,000 workers, Mr. Cherry said.

Beech Clark, vp of the Atlanta office of Bayly, Martin & Fay, said a $100,000 minimum retention is usual for workers' compensation programs in the South, although he did not make specific reference to S&H's self-assumption level in Virginia, North Carolina, South Carolina, Tennessee and Georgia.

Mr. Clark primarily works in the South for clients trying to get excess covers for self-insured workers' compensation programs. Like brokers in other parts of the country, he has noticed a tightening in aggregate excess markets, and an insistence that self-insurance assume much larger retentions for specific excess. No more than five years ago, for instance, Mr. Clark said it was possible in the South to buy excess insurance with a minimum retention of only $25,000.

"It's just a rule of thumb and not absolute, but reinsurers don't want to be involved in a single claim. So as benefits increased, retentions also increased to keep the reinsurer out of single-employe claims in workers' compensation cases," he explained.

Mr. Clark said he prefers to use the term "reinsurance" rather than "excess" because a qualified self-insurer who buys high limit coverage is legally the same as an insurance company which purchases reinsurance.

But in almost all of the cases, the reinsurance market is the excess and surplus market for workers' compensation, he said.

Although this should not be considered a complete list, or even an applicable one for certain parts of the country since each state has different laws regarding workers' compensation, the markets brokers most frequently mentioned to *Business Insurance* in connection with excess coverage for self-insurance programs included:

Safety Mutual Casualty Corp., St. Louis; Employers Reinsurance Corp., Kansas City; Aetna Fire Underwriters; American Reinsurance Co.; General Reinsurance Co.; Employers of Wausau; Mission Insurance Co., and Lloyd's of London.

Other companies were: International Surplus Lines, Chicago; Zurich Insurance Co.; Drake Insurance Co.; Appalachian Insurance Co. (a subsidiary of Allendale Mutual); California Union Insurance Co.; American Home Assurance; The Home Insurance Co.; Continental Casualty Co.; and the U. S. Fire Division of Crum and Forster.

A word of caution: Some of these firms will only write excess for self-insured workers' comp for existing clients, and others don't want any new business. And in the case of Lloyd's, it appears that in areas such as the South, the London market is no longer competitive.

Business Insurance called General Reinsurance to confirm a report that in Illinois the minimum retention the company now requires is $300,000.

A spokesman for General Reinsurance prefaced his comments by emphasizing that excess coverage for self-insured workers' compensation programs comprises less than 1% of the business his firm writes, and that it did not want to give the impression that it is actively seeking such business.

If General Re should get involved in providing excess workers' compensation coverage for a client, it would probably insist that a self-insurer take a minimum retention of about $500,000, not $300,000, the spokesman explained.

It seems that the firm only writes direct excess workers' compensation for catastrophic losses (in excess of one employes' disability). General Re does not write the type of aggregate excess coverage which is similar to stop loss reinsurance because the insurer doesn't have claims handling capabilities.

How other reinsurers view the excess workers' compensation markets is not clear. Some of the ones most prominently mentioned as markets flatly refused to discuss either their pricing of the line or the areas of the country where they will provide coverage.

One firm which did provide information was American Reinsurance. Assistant vp Martin J. Cullen in the firm's New York headquarters consulted an in-house manual of pricing practices including minimum retention levels the firm requires of self-insurers before it will provide excess.

The states which have the highest retention levels are Illinois and Alaska, with minimums of $250,000, and the lowest is Alabama, with a minimum of $75,000.

Mr. Cullen said the manual which American Re uses is based only upon the benefit levels in each state; claims experience and the frequency of losses of a particular industry or company is not taken into consideration when minimum retention levels are set.

This does not necessarily mean a company in a given state will have to retain exactly the amount suggested in the reinsurers' manual. From what excess and surplus brokers have indicated, retentions on self-insured workers' compensation programs do vary by negotiation, although area guidelines are followed.

But it does add credence to the notion that where you are means more than what you do when you are shopping for excess insurance coverage. ■

Form new company

The formation of the Barrett Treaty Corp., Huntington, N.Y., was announced by William P. Barrett. The new company will function as a professional treaty reinsurance underwriting agency under the direction and leadership of Mr. Barrett. Other officers of the corporation are Bernard J. Bowden, secretary-treasurer and Arthur E. Torrington, vp. Barrett Treaty Corp. will operate principally under an underwriting binding authority provided by the American Centennial Insurance Co. of Morristown, N.J., a subsidiary of Beneficial Corp. In addition, the company will service the outstanding treaty accounts of Treaty Capacity Inc., which has elected to withdraw from the treaty underwriting business effective Oct. 1.

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The Umbrella Book . . .

Continued from page 11
see "a serious need" to provide a detailed analysis and comparison of the policies to enable corporate policyholders to eliminate important gaps in their liability coverage, to enable insurers to develop improved contracts, and to help agents and brokers select the correct policy forms for their clients.

About 75 insurers are writing umbrella liability insurance today, but Warren, McVeigh compare only the 35 companies and policy forms which represent the bulk of umbrella insurance written for U.S. companies.

Among the most frequent weaknesses Warren, McVeigh found are:

- Exclusion of property in care, custody or control.
- Lack of coverage for discrimination.
- Exclusion of fellow employe suits.
- Failure to be "following form" by matching the coverage of the primary and excess policies.
- Exclusion of sudden and accidental pollution.
- Exclusion of punitive damages.
- Failure to cover all associated entities.
- Coverage subject to a limited definition of occurrence, limiting insurance to accidents rather than a broader "events or happenings."
- Incomplete coverage of defense costs.

The authors evaluated each policy in five areas—coverage, exclusions, persons insured, definitions, and conditions—graded each policy numerically. The spread of points, reflecting considerable differences in coverage, covers a range from 26 at best down to minus-18 at worst. Much to its credit, the book doesn't stop with the ratings, which are interesting enough. It scrutinizes each insurer's policy, details unusual aspects of each different form, and offers advice on how to improve weak policy forms by broadening definitions or adding endorsements.

Despite its importance to most, if not all, organizations, the umbrella policy is rarely analyzed for aptness of coverage, the consultants contend, reasoning that this may be attributable to the policy's infrequent use to pay a loss.

Price is often the principal criterion for choice of umbrella carriers. But coverage is an equally important factor, especially considering that prices (rates) are rapidly changing with the underwriting environment. Because there are no so-called "standard" forms for umbrella liability insurance, rates are established largely by judgment.

Underwriters universally apply minimum premiums to each million dollars of umbrella coverage, with minimum figures most often about $500 per million coverage. Some insurers ask as much as $1,000 per million of coverage. This is a far cry from the early 1970s when some excess insurance could be found for only $100 per million of coverage. Rising prices make it even more economically sensible for buyers to consider coverage along with cost before purchasing.

The authors, citing a greater number of large court awards, suggest $10 million limits should be considered the norm for most small to medium sized commercial enterprises, with $5 the minimum for even a small organization.

Umbrella liability insurance apparently originated at Lloyd's of London in the 1940s, in the wake of excess liability insurance which was introduced in the 1930s. There's a technical difference between the two kinds of insurance, the excess policy intended to be "excess of" or following the form of specific liability policies. The true umbrella does both of these things and also provides broader coverage.

Lloyd's coined the term umbrella to facilitate sending overseas cables concerning their "blanket catastrophe liability insurance," the full name of what eventually came to be known lightly as the bumbershoot.

American insurers gradually became interested in writing this coverage, introducing in the 1950s their first forms. These, like London's, were very broad and resulted in heavy claims from types of losses underwriters had not anticipated. The forms used currently were introduced about 1961. ■

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Underwriters are acquiring brokers and subsidiaries

CHICAGO—Excess and surplus underwriters are acquiring independent brokerage firms or forming subsidiaries in an effort to move aggressively into the excess market.

Capacity Management Inc. is a recently formed subsidiary of Midland Insurance Co. Lee Orabano, vp in charge of casualty for CMI, said Midland was frustrated by its inability to grow as fast as it wanted and its lack of surplus.

To deal with the problem, Mr. Orabano said, Midland formed CMI and staffed it with a young and aggressive underwriting staff "ready to write all the business they could." CMI has been named managing general agent for Midland and will place most of its risks with its parent. But CMI will also broker to other underwriters risks or part of risks that Midland is unable to handle.

Sayre & Toso in California is a similar firm, president West Haywood said. Sayre & Toso is the managing general agent for Mission Equities Inc., part of the overall company, but also brokers some risks to other underwriters.

Another major trend in the excess markets is for the giant insurance brokerage firm of Charles, excess and surplus underwriting subsidiaries. Allstate Insurance Co. has established Northbrook Insurance Co. as its excess subsidiary, while CNA has formed Columbia Casualty Insurance Co.

Several excess brokers, worried over the lack of capacity in the marketplace, said such subsidiaries could help alleviate the problem. But one, Fred H. Pearson of Avreco in Chicago, said the subsidiaries would aid the excess markets only if they were allowed to pursue a different underwriting philosophy than the parent. ■

LA brokers acquired

Rollins Burdick Hunter Co., national insurance brokers in Chicago, have signed an agreement to acquire the Los Angeles-based insurance brokerage firm of Charles, Ryan & Rivers. The California firm serves industrial and commercial accounts with property, casualty, employe benefits and special risk management services, Adrian Palmer, RBH chairman, said the firm would be operated as a separate subsidiary under its present management.

New fronting maneuver used to involve Lloyd's

By MARIE KRAKOWIECKI

NEW YORK—U.S. insurance companies unable to write all the coverage that's desired by a client are helping the London markets garner new business.

Requesting anonymity during a phone interview, one excess and surplus lines broker described what he said was a new type of "fronting" maneuver to bring the London market into play in certain third party liability insurance coverages.

It works like this: Say an employer wants to buy excess insurance with limits of $10 million in excess of $5 million. For reasons of its own, or because of certain state legislation, the employer may want to get the entire policy from a single excess underwriter or at least give the appearance that one company is providing all the insurance.

But the firm's regular broker cannot find enough capacity among admitted carriers. At this point, the enterprising surplus lines broker enters the picture.

He goes to a primary insurance company that is willing to provide up to $1 million in capacity, but cannot afford to write more than that.

With a bit of wheeling, he convinces the primary company to use him to arrange another $9 million capacity through reinsurance with London. That gives the employer the full $10 million limits originally sought.

The catch is that although $9 million of the $10 million is actually coming from London, the policy issued indicates that the entire amount is being provided by the primary company. There is no hint of foreign participation.

In one stroke, this accomplishes a number of objectives. The employer gets the full amount of excess insurance coverage he needs. The London market gets a fat chunk of business in a state where it may be officially listed as a non-admitted carrier. The primary insurance company not only gets premium for the $1 million limit it is providing, but in the classical sense of fronting it can issue a policy without really participating in the risk it represents.

Finally, and certainly a significant consideration to the excess and surplus lines broker, the London reinsurer pays a healthy commission for arranging the deal.

Actually, according to the source, there are two fees he collects. For not only does the reinsurer pay handsomely for the arrangement, but the insured also pays the excess and surplus lines broker a fee for managing to get the full amount of coverage requested. The source said he had already participated in a number of deals like this with London, but most of the insurance market might not be aware such set-ups were being routinely arranged.

He said a more typical situation would involve a firm which might need $1 million in coverage, but was only able to get $300,000 of primary insurance. It would then be struck with a $700,000 gap in coverage between its primary coverage and the $1 million floor at which excess insurers would begin to write policies.

If the firm is one which needs an actual insurance policy in hand to comply with certain laws, what it might need to do is go to a primary insurer, pay the insurer a fee to issue a "policy" for that $700,000 gap.

But although the fronting company issues a policy for the record, in turn it is given an indemnification agreement from the "insured" stating that if a loss occurs, the fronting company will not be liable for it.

As a sweetener, in many cases the fronting company will assist the firm on claims administration and services.

Although there are subtle variations on the theme, he said, this kind of coverage is essentially a "buffer layer" of excess insurance, and some insurance companies get away with calling it a risk management program by offering the service only in conjunction with providing all the claims services. ■

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editorial opinions

Workplace safety is in for some change

THE GREATEST INCENTIVE for employers to operate safe and healthful workplaces is the liability now emerging in the spate of cases involving dangerous substances.

This is the view of Morton Corn, director of the federal Occupational Safety and Health Administration. He points to the vinyl chloride workplace hazards, the Kepone case, and several other notable hazards which have employes suing their employers and refusing to work because of danger to themselves. There is a point when risks become so big that no one will take them.

Perhaps that's what is happening in the field of occupational safety and health. "Enormous sums of money at stake" can be powerful safety and health motivators, Mr. Corn recently told this magazine.

Risk management is at a critical stage in its development. Moving beyond—far beyond—just insurance or the traditionally insurable risks, good, tough risk management is good business. And good risk management is cleaning up the workplace, and reducing exposures to the various "injuries" which can result from chemicals, noise, and machines.

It's reassuring to hear Mr. Corn say that he doesn't think most corporations are the "bad guys." Most employers, he submits, are startled to learn the facts about hazards in their operations.

That's where a good risk manager starts. By identifying and informing management about every hazard the company faces. OSHA's philosophy under Mr. Corn is that "reasonable awareness" by the employer of hazards involved in operations is necessary.

There's the challenge, risk managers. Are you "reasonably aware" of all the possible hazards of your operations?

Under Mr. Corn, OSHA's role is to inform, consult, investigate, set guidelines for safety and then enforce them. To date, Mr. Corn has never had a visit from a corporate risk manager. In fact, he said, no one has ever mentioned the relationship of safety, health, insurance and risk management to him.

"That would be a good type of discussion to get into," said the OSHA director. His only contact with insurance is through the president of Liberty Mutual who sits on the OSHA advisory board.

Perhaps a group of corporate risk managers should visit Mr. Corn in Washington and talk with him about the relationship between risk management and insurance, safety and loss prevention, accidents and premiums, hazard identification and risk control.

You'll be interested to know that Mr. Corn is on your side, as buyers of insurance. He believes strongly that "the guy who goes all out for health and safety should get lower premiums." And he says there's "no incentive in this area right now" for employers to engineer safe workplaces. He blasts the class rating system and the insurance industry's reluctance to provide premium incentives to companies which cut accidents to the bone and which are safety-responsible.

This is going to require "some imagination" on the part of insurers, he acknowledges. But the insurance industry has to provide the "sweeteners."

Right on, Mr. Corn.

Hypertension costs your company a fortune

EMPLOYERS WHO'VE not thought about how much they're paying for the ravages of high blood pressure among workers should take a look. As a recent one-day conference in Washington made ever so clear, high blood pressure in the workplace can cost a loss of efficiency among employes, a tendency to forego safety practices on the job, heart attacks at an early age, and life insurance and disability payments for those employes who've suffered the effects of sustained high blood pressure.

Peter Krist of Mobil Oil Corp. figures a short term disability cost of $5,500 for every worker who suffers a heart attack, not to mention the $20,000 in medical expenses under the health insurance plan and for the employe.

That, indeed, is enough reason for employers to consider the opportunity they have to control stress and high blood pressure in their workforces. Because workers spend so many of their waking hours at their jobs, the work setting is the logical place to conduct regular high blood pressure detection and treatment programs.

Some employers have already launched these efforts. But not nearly enough of them. As Mobil's Mr. Krist pointed out, the cost of initiating such programs is miniscule compared with the short and long term savings to be generated, both in occupational safety and health in the area of lower employe benefit plan payouts.

Clearly this is one of the very few loss control efforts that can cut across a wide range of corporate "exposures," ranging from workers' compensation and general liability to life, health, and disability benefits.

Representatives of labor unions showed particularly strong interest in hypertension detection and treatment in the work setting. Several union officials indicated this may be in line as the next bargainable benefit because of its importance in preserving the good health of workers. Labor unions also recognize that a high percentage of workers suffer from high blood pressure and are potential heart attack victims.

Hypertension screening and treatment is an essential step in the shift to preventive medicine, a concept advocated for many years as a potentially effective way to control illness and to cut health care costs. A company establishing such a preventive plan doesn't need to initiate a complicated health screening operation for all employes. Often the medical clinics already present in plants and offices can be used for regular high blood pressure screening, with industrial nurses or other technicians administering the tests.

Treatment can then involve drug medication, referral to a family physician for treatment, or a combination program using drugs, diet and exercises.

As Mobil has found, the effort pays off.

letters

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

Old golden days

To the Editor: Working in my files, I have just come across an item of poignant interest: a front page article from *Business Insurance* headlined, "Pay dividend on hospital malpractice." A couple of sentences from the story: "The Minnesota Hospital Association has been paid a 40% dividend on its malpractice coverage and 10% on the workmen's compensation coverage it offers its members."

"The Minnesota group has been with Argonaut since 1959, and although it has won rebates in several other years, [this] 1969 dividend was by far the largest."

Ah, for those old golden days—when they should have had better crystal balls. But some did: another article in the same issue (July 7, 1969) reports that C.A. Des Champs, a Fireman's Fund vice president, warned C.P.C.U.s about serious rises in medical and other malpractice exposures and in products liability. (That was back on page 15, not the front page.)

Bob Hedges

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

'Sue the Bastards'

To the Editor: I am presently Chairman of the Liability Subcommittee of the Edison Electric Institute Insurance Committee. This Insurance Committee is composed of about 85 representatives of the major electric utilities throughout the country. All of these utilities carry excess liability insurance and most, if not all, have been experiencing higher deductibles and substantial premium increases during the past year. Needless to say, there is considerable concern over the liability insurance situation and alternative ways of handling this risk are being looked into by the Committee.

On October 18, 1976 members of the EEI Insurance Committee will hold a three day meeting to discuss mutual problems. I would like very much to include with my report a copy of your August 9, 1976 editorial entitled "Sue the Bastards."

W. J. Dundas

Superintendent, Insurance and Claims Division, Wisconsin Electric Power Co., Milwaukee, Wi.

* * *

To the Editor: We recently distributed copies of your editorial entitled "Sue the bastards: A social malaise" to all our division managers for their use in commu-

Continued on page 18

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Published by Crain Communications Inc., Chicago, publisher of Advertising Age, Pensions & Investments, Industrial Marketing. KEITH E. CRAIN, *secretary-treasurer;* M. A. HARTENFELD, *executive vice president;* D. J. CLEARY JR., *senior vice president;* ALFRED MALECKI, J. J. GRAHAM, J. V. O'GARA, S. E. COHEN, LOUIS F. DEMARCO, WILLIAM STRONG, ROBERT W. KRAFT, *vice presidents;* MERRILEE P. CRAIN, *assistant secretary;* JAMES M. FRANKLIN, *director of finance and administration.*

Published biweekly at 740 Rush St., Chicago, Il. 60611 (312-649-5200). Offices at 708 Third Ave., New York, N.Y. 10017 (212-986-5050); Suite 1253 National Press Building, Washington, D.C. 20004 (202-638-5300); 6404 Wilshire Blvd., Los Angeles, Ca. 90048 (213-651-3710). 50 cents a copy. $12 a year in U.S. Elsewhere $4 a year additional. WILLIAM STRONG, circulation director. ROGER DiGREGORIO, subscription manager. Four weeks' notice required for change of address. Address all subscription correspondence to subscription manager, Business Insurance, 740 Rush St., Chicago, Il. 60611 Telex number: 25-4248; Cable address: CRAINCOM

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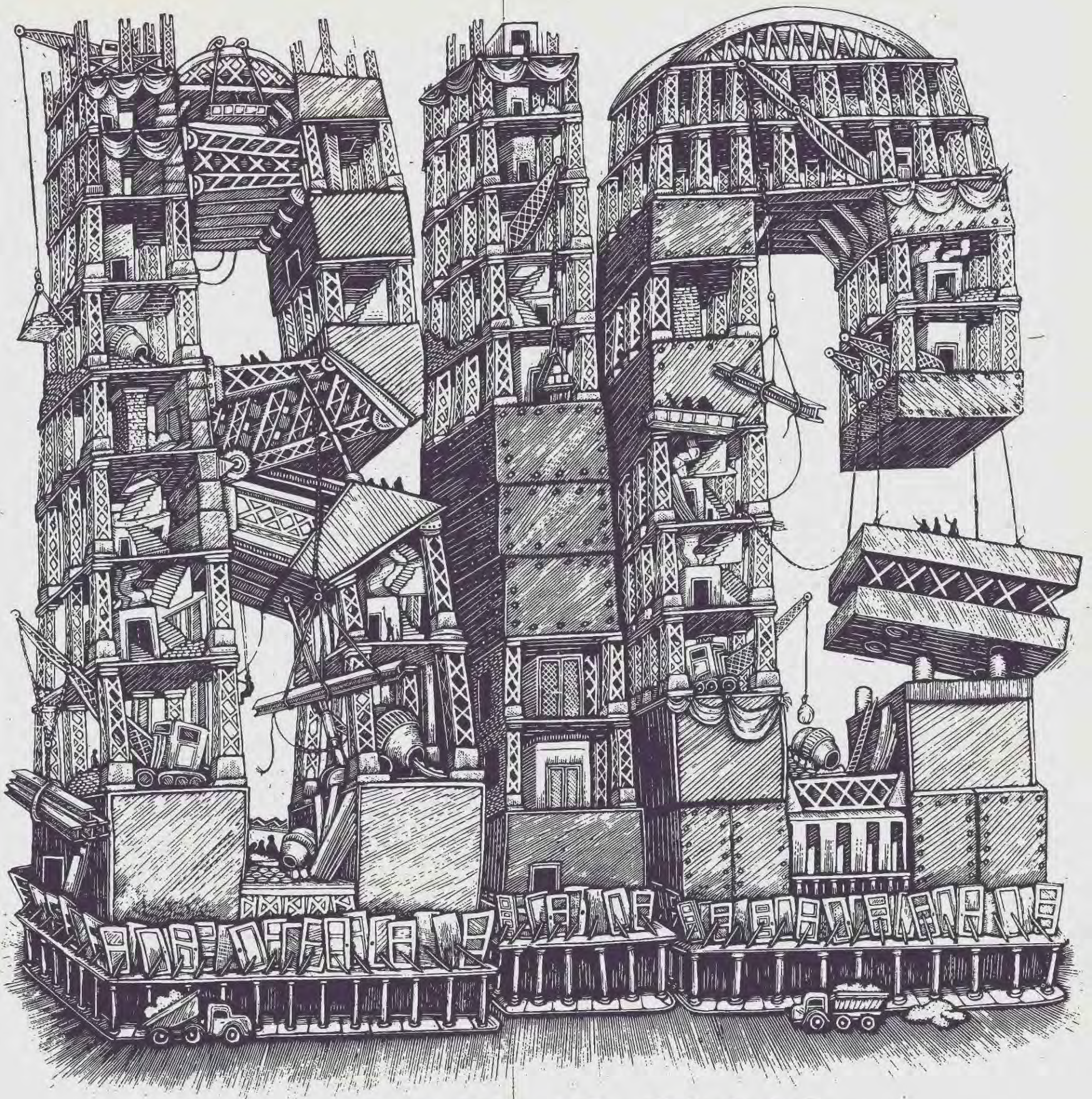

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letters

Continued from page 16

nicating the insurance problem to their employes.

We find *Business Insurance* magazine very interesting and the answers to many of our problems.

The text of the letter which we sent to our managers follows:

Each time you look at a new financial statement you must notice the increased cost of insurance. This expense has increased more rapidly than any other. Our experience has, however, been much better than the average in our industry. This, I believe, has been the result of the attitude of all company personnel and their effort to create and maintain safe working conditions and work habits.

Some elements involved in the increased costs are good. Increased benefits for injured employees losing time at work puts additional dollars where they are needed. Insuring our property at appreciated values provides better protection for the company should we suffer a loss. Other elements of the increased costs are the result of the economics of our times and the tendency of our system to reward injured parties instead of covering their losses. These may seem to be beyond our control and yet we should not assume a do-nothing attitude.

The enclosed reprint of an editorial appearing in *Business Insurance* August 9th suggests solutions which seem worthy of our support. If you agree, please have copies made available to everyone in your division.

Some of the things we have done and should continue to do and to expand on, have proven very effective.

Our safety meetings have eliminated many hazards and made personnel safety conscious. This is good, but we should not rest on our laurels. Encourage your safety committee to continue to search out and eliminate hazardous conditions. Ask them to improve investigation of accidents and injuries when they do occur. We need the information to help eliminate unsafe practices and conditions to control losses in the future.

Loss control pays off; more now than ever before. It begins with *YOU*.

I. E. Meacham
Assistant Treasurer and Director of Employe Benefits and Insurance, Western Consumers Industries Inc., Paramount, Ca.

Pursue topic

To the Editor: We read with great interest the article by Mr. Bernard M. Brown of Risk Planning Group Inc. on page 25 of your October 4th issue.

We would appreciate very much being advised of how we can can contact Mr. Brown in order to pursue the topic in more depth with him and/or his firm. We would also appreciate any direction you can give us with regard to further studies or details of articles regarding the mechanics, pros, cons, etc., of self-insurance with particular emphasis on contractors.

John D. Hoffman
Executive vp, Warren-Hoffman & Associates Inc., Niagara Falls, N. Y.

Editor's note: Mr. Brown can be reached at 24 Old King's Highway South, Darian, Conn., 06820.

Complicated area

To the Editor: Imagine you have just returned from lunch and find the director of administrative services busily drumming his fingers on your 18th century Chippendale desk accompanied by a small but impressive number of people, perhaps more at home on an episode of "Kojack" than in your office on a Friday afternoon. You extend your hand and start to say hello, but you are cut off in mid-sentence as the director gets immediately to the point. Several hundred thousand dollars are missing.

It seems that the company hired a black male in Computer Services 15 months ago. He seemed promising and nothing seemed wrong. Now, he goes on, it seems we have a systematic theft scheme facing the company involving accounts payable transactions. On the one hand it is terribly imaginative, but on the other it is rather costly. The internal audit service group is still trying to determine the full extent of the loss. Several things are clear. One is that we can't find the employe. Another is that we can't find the address he gave us at the time he was hired. In fact, we can't find the street.

One of the other gentlemen introduces himself as a police detective lieutenant. He has additional news. It seems, following a review of "mug-shots" the employe has been identified. Since his teens he has been in and out of institutions, associated with street gangs. And, as an adult, he has two arrests finally serving two years in state prison for mail fraud.

Very creative. High IQ. Took English and computer programming courses while he served time.

As the insurance manager, you express confidence as you inquire into how this could have happened. You were wise in purchasing a blanket crime insurance cover which should more than cover an employe dishonesty less of several hundred thousand dollars. The conversation turns toward participation by the company in government affirmative action employment goals; which, as you remember, the chairman personally expressed interest in around the time this fellow was hired. It seems that the employe was recruited through a store-front project run by one of the company executives, who was on a year leave of absence. As the story unfolds you can't help but think how dumb everybody appeared. You shake hands with the small group and the little incident fades to six weeks later as you are reading a letter from the bonding company. They have turned down the claim on the basiss that the company was negligent in failing to conduct a proper background investigation on a new employe.

Dramatic fiction or plausible fact?

Each company will have to examine its own problems in this area and come to a decision which properly treats the problem. One suggestion is to ask for an expres endorsement to the crime coverage as follows:

"Notwithstanding anything to the contrary, participation by the Named Insured in Affirmative Action goals will not, in and of itself, preclude recovery under the policy."

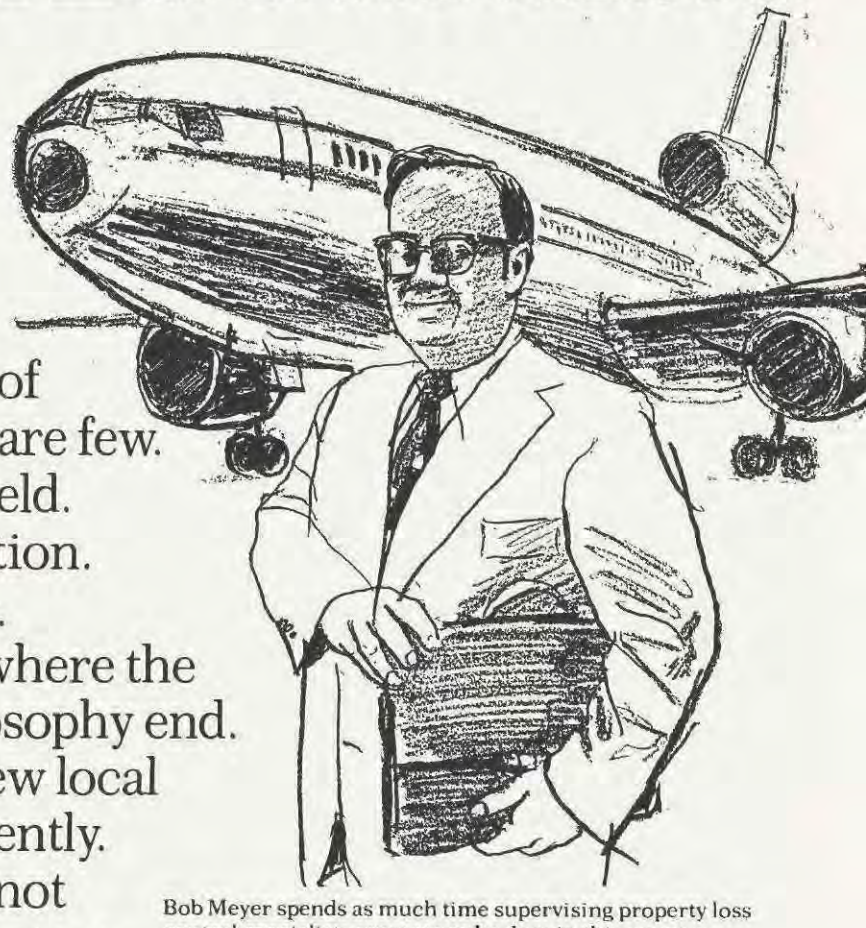
Discrimination is a very complicated area and should be examined closely. The remarks in the 10/04/76 *Business Insurance* article "Equal employment rules may cause problems with fidelity bond claims" on page 15 are not something to be dismissed casually.

E. Bernard McGlynn Jr.
Bloomfield, N. J.

Warns hospitals

To the Editor: *Business Insurance* is to be complimented on its October 18 editorial which warns hospitals of the "so-called risk management consulting firms . . . springing up everywhere." Those of us who have counselled hospitals over the years are amazed at the array of "solutions" and "most sophisticated programs yet developed" which are being proffered throughout the country. Not only the methods, but also the n,ames of these new firms are unique; a

If we didn't own ourselves, maybe our local offices would think like local offices.



Insurance brokers of our scope and size are few. Most are publicly-held. There is one exception. Johnson & Higgins.

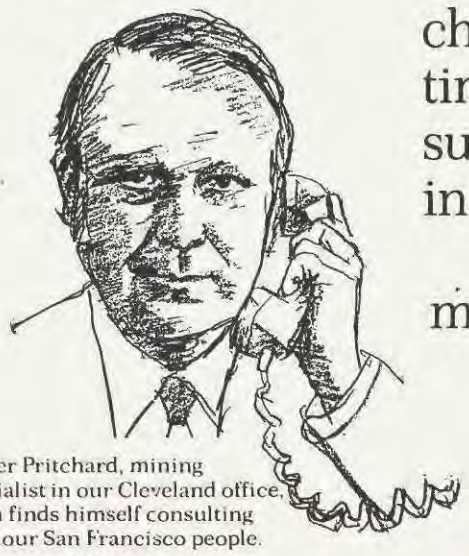
But that's not where the differences in philosophy end. For example, we view local offices much differently.

To us they are not individual profit centers.

Bob Meyer spends as much time supervising property loss control specialists overseas as he does in this country.

If we looked at them as profit centers, we'd have to charge a local office every time it asked for special support from somewhere else in the system.

Which could easily make an office hesitate to request



Walter Pritchard, mining specialist in our Cleveland office, often finds himself consulting with our San Francisco people.

midwestern hospital was recently approached by a firm which is in no way connected with the famed university for which it was named. In some cases services are sold to comply with federal regulations which have not yet been promulgated and which have been significantly changed since the early drafts that served as the basis for the development of the "required" services.

Unfortunately, the victims are little able to protect themselves against these "experts" as hospitals have not traditionally employed internal risk management functions. The gravity of the crisis palces them in the position similar to the terminal patient grasping at any straw.

In conducting their evaluations hospitals should contact other institutions which have engaged the services of these firms and should also ask very specifically what bottom-line effect the offered programs are to have on the hospital. In many cases, the hospitals will recognize that they already have internally what is being offered to them externally.

Klaus J. Gebhardt
Principal and senior consultant, RIMCO Risk Managers and Consultants, Dallas, Tex.

Design engineers

To the Editor: In a small piece on page 34 of your September 20 issue, you reported that the American Society of Safety Engineers has stated, "Producers of industrial equipment should take responsibility for assuring their devices are as safe as possible for worker use." Most of the members of ASSE are industrial safety engineers, i.e., responsible for on-the-job, not design, safety. It would be interesting to learn the view of the society to which the design engineers belong.

Bob A. Hedges
Professor of Insurance and Risk, Temple University, Philadelphia.

Soaring premiums, disappearing markets leave feelings of deja vu

By MARGARET LeROUX

NEW YORK—Premiums are skyrocketing. markets are disappearing and risk managers are experiencing a bitter sense of deja vu as they confront the excess and surplus lines market. The problems the primary liability market experienced in recent years are currently being re-run with the added attraction of inflation in the excess market today.

EXCESS/SURPLUS and special risks

The cost of excess coverage used to be figured as a percentage of the premium for lower layers. But in today's market excess liability coverage for some risks costs as much as lower layers of insurance.

"Nothing is common about prices in the excess market," a broker said. "What was true a week ago won't be true a week from today."

Brokers predict some improvement in the future—but not the immediate future.

"We won't see any improvement in rates in the next six months," Robert Clements, in charge of national services-casualty for Marsh & McLennan said. "But we may see a slow improvement over the next 18 months."

"I think we've seen the worst of the increases," according to Joseph Lombardo, vp of casualty at Schiff Terhune. "Risks that experienced a 10-fold increase in premiums won't see this kind of increase on their next renewal. But the ones whose premiums were doubled on the last renewal may be doubled again."

"There's definitely a capacity shortage for third party liability insurance in the primary market," an officer of an excess and surplus lines underwriting company said in a telephone interview.

Most of the large commercial risks are buying all the excess coverage that's available, "or at least what's available at prices they're willing to pay," an excess lines broker said.

Companies having problems with the excess market include those trying to cover professional and products liability and excess workers' compensation coverage for self insureds, according to brokers.

Pharmaceutical manufacturers have had to settle for less excess coverage than they want, another broker said. "So have chemical companies and auto manufacturers."

Emphasizing the limited market facing large commercial risks, said Mr. Lombardo, "only 24% to 40% of the markets that were available two years ago are available today."

Besides fewer markets for excess umbrella liability insurance, risk managers are finding those insurers which will write the coverage are requiring higher primary limits.

"It's now difficult to find an excess insurer who will cover anything less than a $1 million primary limit," Mr. Lombardo said. "In the last couple of years we were seeing primary limits from $100,000 to $300,000 with a $1 million excess umbrella. Now you're talking about a $1 million primary layer."

The problem is that the primary market hasn't responded by making higher limits available, said Mr. Clements. "They're not willing to commit their reserves."

The result has been a surge of growth in the buffer layer market: excess underwriters who will fill in the gaps between the primary limit and the excess minimum requirements.

Costs of excess umbrella coverage are being defined in "multiples of last year's premiums instead of percentage increases," Mr. Clements said.

"Prices are no longer competitive," according to a spokesman for a liability insurance company. "Today excess premiums for some risks such as products liability are higher than premiums at the primary level."

"In the last year we've seen premiums jump from $10,000 to $1 million for a risk that had incurred no losses," Mr. Lombardo said.

As recently as 1973 excess coverage was still cheap, another broker said. "You could still buy $1 million of coverage for $250." Today, however, there is no minimum premium, he said.

Each risk is rated on its own merits, the broker explained, "although $750 to $1,000 could buy $1 million excess coverage" in a no-risk situation, he added. ■

Stock firms seminar

Leading executives of the New York Stock Exchange and the Depository Trust Co. met with Lomdon insurance underwriters in late October to explain the methods they use to protect customers' assets.

Chuck Mathers, a J&H nuclear specialist at 95 Wall Street, is a regular visitor to our New Orleans office.

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Need is 'greater than ever' to assess excess insurers' financial stability

By GREG DAVID

CHICAGO—Assuring the financial stability of an excess and surplus underwriter is a crucial part of any excess insurance placement, risk managers, underwriters and excess brokers believe.

"You don't want to be involved with a company that is here today and gone tomorrow," T. R. Mitchell, director of insurance and assistant treasurer for White Motor Corp. in Cleveland, said.

Many of the excess and surplus companies are smaller and less well known than the large primary insurance companies. David M. Melton, vp of the Dallas excess brokerage firm of Dub Martin & Co. Inc., said there "is a growing concern" whether some of these companies have the expertise or surplus to write the large and difficult risks now in the market.

But the excess brokers contacted by *Business Insurance* feel they have an obligation to investi-

EXCESS/SURPLUS
and special risks

gate the financial security of the companies with whom they work. "There's more to it than just commissions," said Thomas S. Bloom, vp of McAlear Associates Inc. in Grand Rapids, Mich.

"In this day and age there is no way anybody is going to sell anything that he would not put in his own back pocket," said John Van Cleave, president of the Chicago excess brokerage firm of Excess Underwriters Inc.

The excess brokers said an insurance manager or risk manager could easly use their techniques to make their own evaluations.

Mr. Melton said Texas law requires excess brokers to exercise "due diligence" in placing risks. Mr. Melton said Dub Martin has moved excess insurance from one company to another, even if it cost the firm money, when the financial condition of the original insurer deteriorated significantly.

Mr. Van Cleave also said his firm had replaced insurers when it observed changes in financial conditions. This usually happened before the adverse information became public, he said.

The excess broker may be in the best position to evaluate a company's financial position because he is "in the trenches" and sees developments before insurance regulators, Mr. Bloom said.

A company should not use an insurer smaller or less financially stable than itself, suggested Lee Oraban, vp in charge of casualty for Capacity Management Inc., subsidiary of Midland Insurance Co.

But Fred H. Pearson, president of Avreco, a Chicago excess brokerage firm, said a company's ability to insure a risk is a function of the risk as well as the insurer's financial condition. For example, he said, a company might be qualified to handle a $100,000 of coverage over a $50,000 primary label but be unable to insure a $5 million policy over a $1 million primary label.

Avreco makes its own assessment of whether a company is qualified to handle a risk. It decides if the insurer has the technical expertise; it wants to know the reinsurance arrangements; and it determines how a company is creating its surplus, said Mr. Pearson. Avreco uses the company's financial statement as well as A. M. Best & Co. ratings and other personal sources in making its decisins.

Mr. Pearson said his firm had not been able to place risks with the less formidable excess and surplus companies because the large corporations he worked with required the best security available.

"So far we've been able to satisfy them," but he said the tightening excess market meant that companies Avreco previously would not have considered acceptable are now participating fully in the market.

Excess Underwriters' Mr. Van Cleave said he checks the Best rating for a general overview. Some companies, such as Northbrook Insurance Co. and Columbia Casualty Co. that are subsidiaries of the large insurance companies (Allstate and CNA in this case), do not need substantial research, he said. But Excess Underwriters examines the financial statements of other companies, determines the reinsurance arrangements, the volume of business a company is writing and the type of brokers it is working with.

Like most other excess brokers, Mr. Bloom said McAlear begins with Best ratings. But since that information is also several months old, he said, McAlear also subscribes to Conning & Co.'s investment service and considers information in stock brokers' reports. A third source of information is the business press, he said.

The insurance managers contacted by *Business Insurance* also do their own evaluations on the companies handling their excess risks. An insurance manager for a large West Coast consumer products company said he gives his broker minimum standards for the excess and surplus insurers. This manager said the tightening insurance market might force him to lower those standards. If that happens he said he would examine financial statements.

Jake Pascall, corporate insurance manager for Whirlpool Corp. in Benton Harbor, Mich., said unfavorable insurance trends can be determined by checking the Best rating in most cases.

White Motor Corp.'s Mr. Mitchell said he also does his own independent analysis of the excess insurer. As an assistant treasurer, he said, his analysis is done with a different perspective than Best, although he does use the Best rating as a factor in his buying decision.

One Texas excess broker said he believes "a high level of trust exists in the insurance industry" and a risk manager could rely on his broker to place his insurance with a secure company.

But John Murphy, insurance manager for Avis Inc. in Garden City, N. Y., said his 30 years in the insurance area had taught him "never to rely on anybody." Mr. Murphy said he uses Best ratings and conversations with other sources, but that he had not dealt with companies that required additional examination.

Mr. Murphy did say, however, that the tightening insurance market made the "challenge greater than ever these days."

Consumers Power Co. of Michigan uses a consultant to place its insurance, Jim Cooper, insurance supervisor said. The consultant checks the excess insurer, he said. ■

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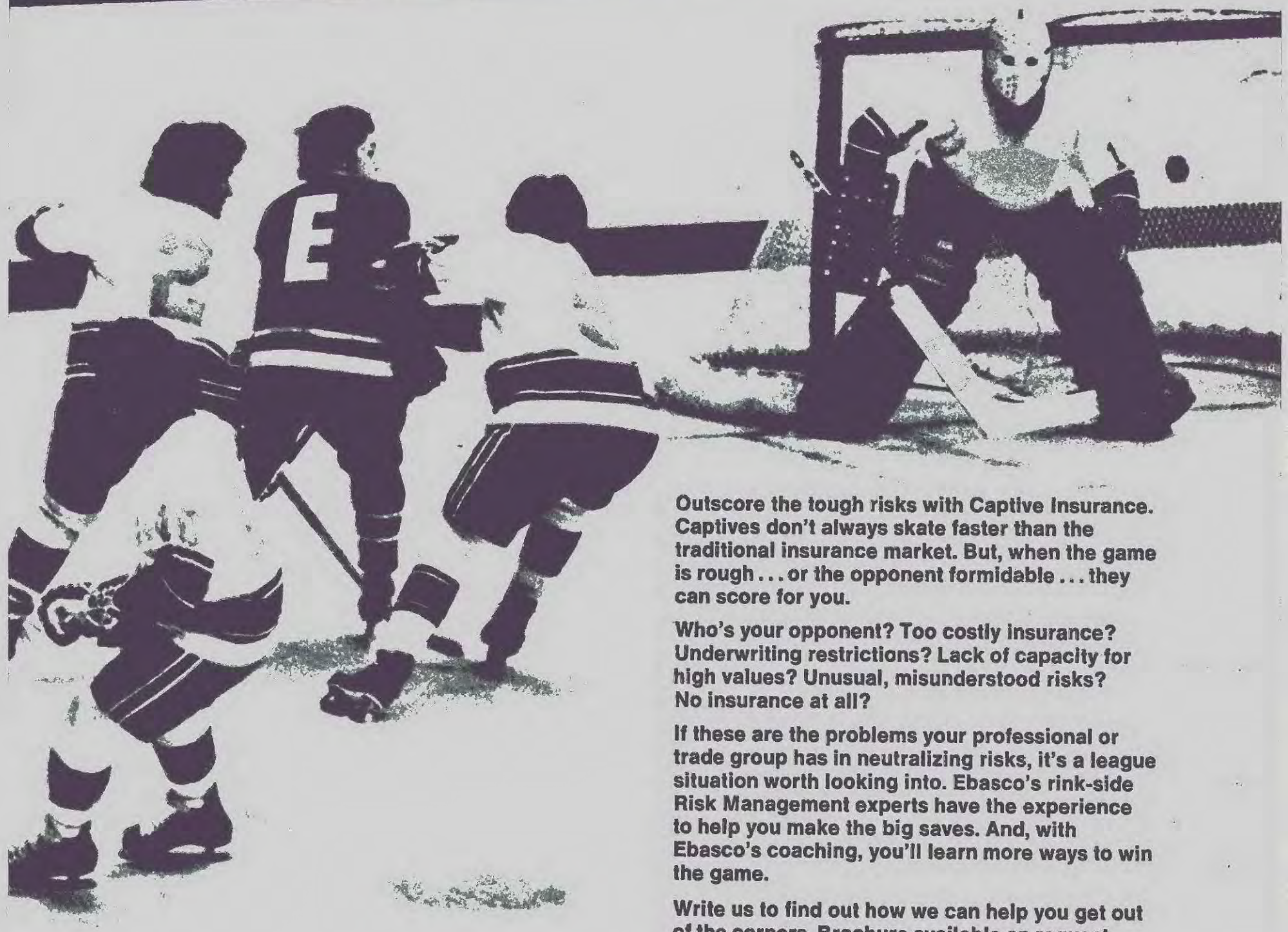

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This broker finds a way to insure the uninsurable

By GREG DAVID

CHICAGO—There are four characteristics that make a risk difficult to insure, explained Fred H. Pearson, a 44-year-old excess broker here with a reputation for placing the tough ones.

When an account has all these characteristics—broad coverage requirements, pricing problems, large limits and previous claims—the excess and surplus broker faces a difficult task.

Last year Mr. Pearson conducted a worldwide search and approached 100 companies in an effort to place a $50 million hospital malpractice policy. In the end, over 40 companies participated.

"It's as large a task as we've had to do," said the president of the Chicago excess brokerage firm Avreco, "and one we wouldn't want to have to do every year."

Working with the large national brokerage houses, Mr. Pearson has placed the large excess insurance programs for some of the nation's largest corporations. Avreco, working as the intermediary between the retail brokers and the

EXCESS/SURPLUS
and special risks

underwriting markets, took in $25 million in premiums last year working with less than 50 sources and about 30 underwriters.

"He finds a way to insure what on the surface appears to be uninsurable," said Glenn Isiminger, assistant underwriting manager for Columbia Casualty Insurance Co. "He is one of the most imaginative and professional surplus lines brokers."

The excess and surplus lines markets have lost their image as a fringe area, Mr. Pearson began an interview in his conservative and uncluttered office in a new Chicago office building, as primary insurance companies rejected more and more risks that did not fit their computer programs.

But at the same time, some underwriters and brokers have moved to combine the two functions, possibly threatening the existence of the independent excess broker.

"Our philosophy is to remain independent because we feel a broker who is also doing underwriting has a horrendous confict," Mr. Pearson said. "The future of the independent broker is good as long as there is an independent market."

He made it clear he feels an excess broker's responsibility is to the companies he represents and to protect the excess marketplace. At times, he said, he has raised a premium quotation if he felt it did not reflect the market.

Mr. Pearson doesn't think excess brokers are able to achieve something by using their personality rather than relying on the logic of their approach or their grasp of the market.

That style characterizes many of the excess brokers on the West Coast, he said, where there seems to be an emphasis on "flair and prsonality." The East Coast represents the other extreme, where the agency situation has resulted in excess brokers without the imagination to work effectively in the excess markets.

Chicago represents a compromise, he contended. He also said the encouragement by the state of Illinois for Lloyd's representatives to locate in Chicago had resulted in the high standards of the many excess brokers in the city.

(Some other insurance industry observers agreed with his comments. One individual said the California situation is sometimes referred to as "the zoo." But others, including executives with Columbia Casualty and Northbrook Insurance Co. said there were good brokers and not-so-good brokers, but they doubted geography had much to do with quality.)

The excess insurance business is very competitive both in Chicago and around the nation, Mr. Pearson said. Brokers have very little communication with each other although they are able to tell what the competition is doing by actions on specific accounts.

Mr. Pearson began working in a small Lloyd's marine insurance firm in New York after his graduation from Northwestern University in 1954. He then joined Stewart Smith & Co. before moving on to Avreco (then Aviation and Reinsurance Corp.) 14 years ago.

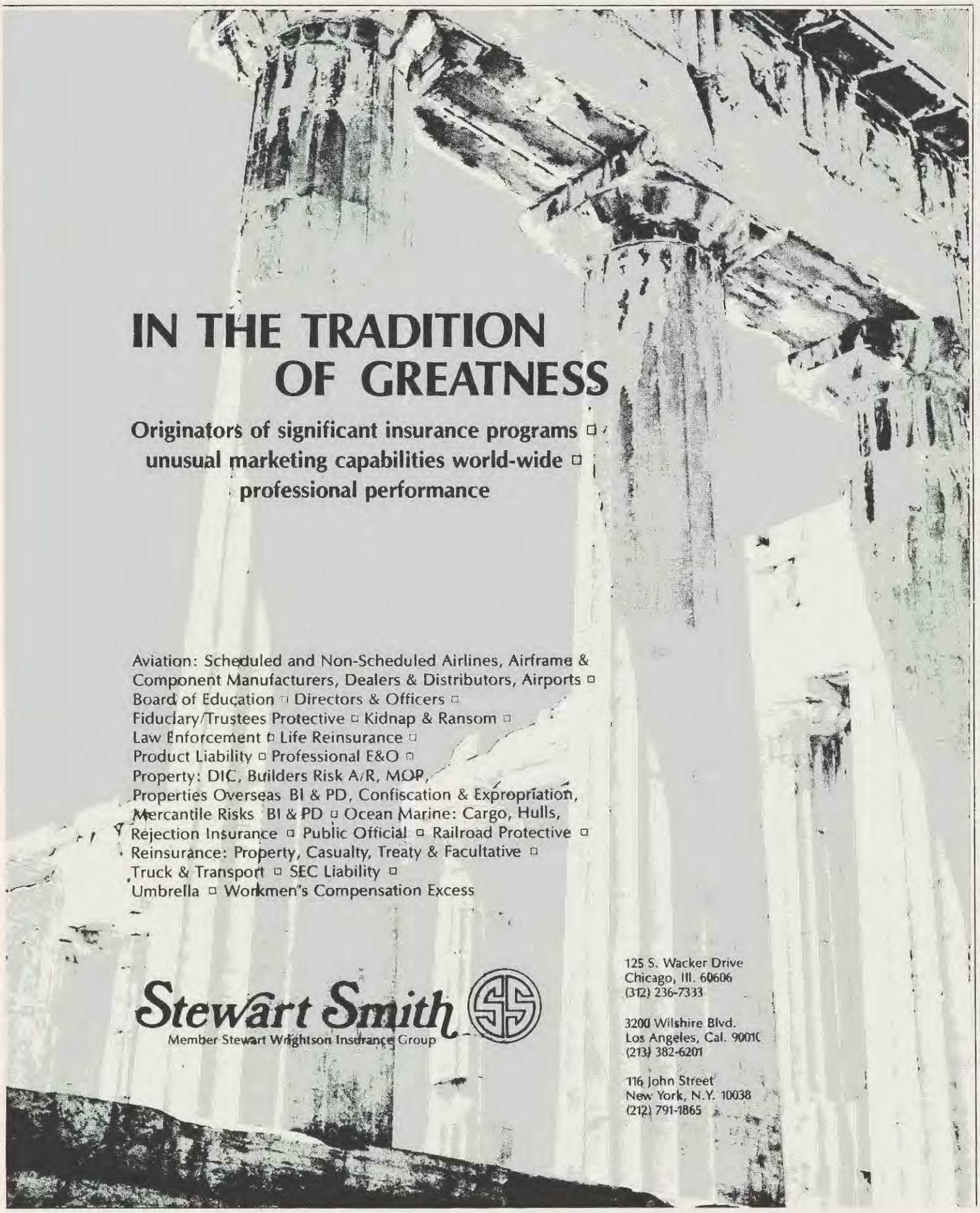
His background with Lloyd's and his ability to surround himself with talented people has been the key to Mr. Pearson's success, according to Warren Richey, a property underwriter with California Union Insurance Co.

For the long range Mr. Pearson is worried about the outlook for the insurance industry as a whole. Following the example of the oil industry the insurance industry decided to get around antitrust regulations and the pricing competition of the marketplace by creating a shortage, he believes. This allowed the companies to raise prices, he said, "even though the product has not improved. If anything it has deteriorated."

The result has been more companies moving to some form of self-insurance. This will siphon off money which the insurance companies have traditionally used to create income to pay for claims and processing, while the self-insured companies will begin producing their own income to pay their expenses, he predicted.

The insurance industry will then have less cash while expenses remain high, he said, which will result in a cash flow crises.

The insurance companies recognize the problem, he concluded, but they aren't doing anything about it. ■



Acquire risk consultants

SAN FRANCISCO—Design Professionals Financial Corp., a holding company for Design Professional Insurance Co., acquired Risk Analysis & Research Corp. (RAR), effective Oct. 7.

A spokesman said that RAR was an outside manager for Design Professionals Insurance Co. (DPIC), which underwrites insurance coverage for engineers and architects.

RAR will continue to act as outside manager for its existing clients and is expected to contribute approximately $150,000 in income before taxes to Design Professionals Financial Corp. during its first year of operation.

Among RAR's clients is the Society of Soil & Foundation Engineers.

Design Professional Financial Corp. owns 100% of Design Professionals Insurance Corp. ■

Brokers report large increases in business

By LINDA MOSKOWITZ

NEW YORK—Excess and surplus brokers in the U.S. are reporting substantial increases in business this year, with some brokers noting a rise in volume of at least 50% since last year.

EXCESS/SURPLUS
and special risks

Capacity problems in the primary insurance market are in part responsible for the increased use of excess line coverage to insure risks.

Despite the increases in business now channeled through the London markets, it appears that the same brokers are handling the growing accounts.

"Maybe the volume has grown," a broker commented about the current excess and surplus market, "but there hasn't been any change in the percentage of business going one way or another."

"We're having the biggest year we ever had," said the president of one large excess lines brokerage house which acts as an intermediary. "The bulk of our business is from the largest agents in the country."

"People have always tried to go direct" to the London market to place excess and surplus coverage. "But there are some horrible examples of mistakes made by people who didn't know what they were doing," this excess lines broker said.

Those brokers without the necessary contacts in London or a large volume of business may be turned away from the overseas marketplace, when they attempt to place coverages.

"Anyone who goes directly to London has to have a substantial volume of business, at least a couple of million dollars worth, or else they're wasting their time," said Bernard J. Daenzer, president of the Howden Swann Group in Cranford, N.J.

Familiarity with the excess and surplus insurance field is an equally important prerequisite for transacting business in the London market.

"People doing business in London haven't got the time to go through an educational process with new orders," said Sidney A. Stewart Jr., president of E. H. Crump & Co., in Memphis.

"Brokers are tending to go through an excess and surplus line broker, because they have more expertise and can place coverage more effectively," he continued.

"In the difficult market climate that we have now," Mr. Stewart said, "people need all the expertise they can get."

E. H. Crump, which has several regional divisions devoted exclusively to placing excess and surplus coverages, has experienced a 50% increase in business since last year in these specialized areas.

"Volume is up because the markets are tight and people are asking us to place special coverage for them," Mr. Stewart said.

Another broker who recently returned from London agrees that "you can't go to London unless you've got a good book of business."

"Americans are coming over in droves to establish London contacts, but many are being referred back to U. S. intermediaries," said David M. Melton, vp at Dub Martin & Co. Inc. in Dallas, a brokerage firm represented at Lloyd's. ■

Champion negotiations

The United Auto Workers opened contract negotiations with Champion Spark Plug Co. on Nov. 8, according to the director of the UAW Champion department, Emil Mazey. Champion workers in the United States and Canada are covered by an international agreement that expires Feb. 1, 1977. The plants, with over 5,000 workers, are located in Detroit; Toldedo; Cambridge, Ohio; Hellertown, Penn.; Burlington, Iowa and Windsor, Ontario, Canada. Champion, with headquarters in Toledo, manufactures more than 450 types of spark plugs and supplies over 200 companies with original equipment.

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WHAT BERNARD DAENZER SAID ABOUT RISK MANAGEMENT.

"There is nothing more embarrassing to a risk manager than to build a whole program of insurance and then to discover that it went all wrong because it was built on an improper assumption of facts or on inadequate information. If he really wants to break down this whole idea of the 'insurance survey' or 'financial management of a risk,' or whatever term he uses for his approach to the problem of risk, he must start with an analysis of the three basic functions: (1) risk detection, (2) analysis and evaluation, and (3) decision making.

"The biggest problem is definitely in risk detection, the basic fact-finding procedure."

(Bernard John Daenzer. From his book "Fact-Finding Techniques in Risk Analysis." ©1970 by American Management Association, Inc.)

WHAT HARTFORD STEAM BOILER SAID ABOUT BERNARD DAENZER.

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Excess intermediaries are thrust into spotlight as 'specialist' help is sought

By GREG DAVID

CHICAGO—The tightening of the primary insurance markets and the movement of more risks into the excess and surplus area has brought increased importance to the role of the excess and surplus broker.

This person, called by some a wholesaler or by others an intermediary, plays an often indispensable role in the placement of excess and surplus risks. But many insurance managers contacted by *Business Insurance* did not understand the complex relationship between the buyer, agent or broker, excess broker and underwriter.

Yet the independent excess brokers said they wanted their activities to be conducted as openly as possible. "It's time for bringing all this voodoo from behind the curtain and laying all the cards on the table," said David M. Melton, vp of the Dallas brokerage firm of Dub Martin & Co. Inc.

Excess brokers are the "intermediaries between the agents and the proper insurance markets," according to Thomas S. Bloom, vp of McAlear Associates Inc. in Grand Rapids, Mich. "We act among American excess and surplus companies as a Lloyd's broker acts among the Lloyd's syndicates."

Independent brokers, underwriters and some brokers at large national brokerage houses said the excess brokers bring expertise and rapport with various markets to the placement of difficult risks. Many excess underwriters said they preferred to work with independent excess brokers rather than directly with the excess and surplus specialists at the large retail brokerage firms.

Frank Fischer, an executive vp with Northbrook Insurance Co., said 85% of that company's business came through wholesalers. He said the intermediaries (the term Northbrook prefers) know the markets better than retail brokers, and are helpful in developing approaches to pricing.

Mr. Fischer also said excess brokers are careful to comply with the complicated filing and tax laws in the various states. Retail brokers often don't want to be bothered with the details necessary to "keep a risk legal," he said.

Northbrook also finds excess brokers provide the underwriter with the information he needs to evaluate a particular risk.

Warren Richey, a property underwriter with California Union Insurance Co., said his company has only 28 employes to process the $43 million in business it wrote last year. The excess brokers are able to screen submissions so California Union receives only those it would be able to underwrite and the brokers handle much of the paperwork involved in each transaction. If the company worked directly with the retail brokers, Mr. Richey said, the staff would be overwhelmed with proposals and be unable to evaluate them properly.

Glenn Isiminger, assistant underwriting manager for Columbia Casualty Insurance Co., said the excess broker "saves time for the retailer and the underwriter" by screening proposals and getting all the information an insurer needs to make a decision. An excess broker often finds a way to insure a risk that appears to be uninsurable by suggesting alternatives such as large self-retentions to make the risk more attractive, he said.

An excess broker must be certain a submission from an agent or company is complete and accurate, according to Thomas Bloom of McAlear. He then must submit the proposal to the right underwriter.

EXCESS/SURPLUS
and special risks

Fred H. Pearson, president of the Chicago brokerage firm Avreco, said an excess broker must make his own appraisal of an account. Avreco "preprograms" an account and approaches the underwriters it believes are best able to handle the submission.

"To a large extent we understand the appetites of our companies," he said, "although we have made mistakes."

An excess brokers' primary responsibility is to the underwriters he works with, Mr. Pearson believes. "We must develop favorable loss ratios for our companies."

As part of that responsibility, Avreco has increased a premium quotation from an underwriter if it felt it did not accurately reflect the market. Risk managers and agents are too often only concerned with the pressures of the moment and the placement of a risk rather than the overall condition of the market, Mr. Pearson said.

Retail agents and brokers bring most of their excess and surplus risks to wholesalers. Wes Haywood, president of the California firm of Sayre & Toso, said his company receives most of its business from agents in medium sized communities.

The large wholesale brokerage firms receive most of their business from the large retail brokerage firms. Avreco did more than $25 million in premiums last year working with 50 sources, Mr. Pearson said.

Harold O'Hanlon, a vp with Fred S. James Inc. in Philadelphia, said the best results in the excess and surplus market are obtained by working through an independent broker. Underwriters prefer to work with the intermediaries because they get a more professional submission since the excess broker has often worked previously in both a retail brokerage firm and as an excess underwriter, he said.

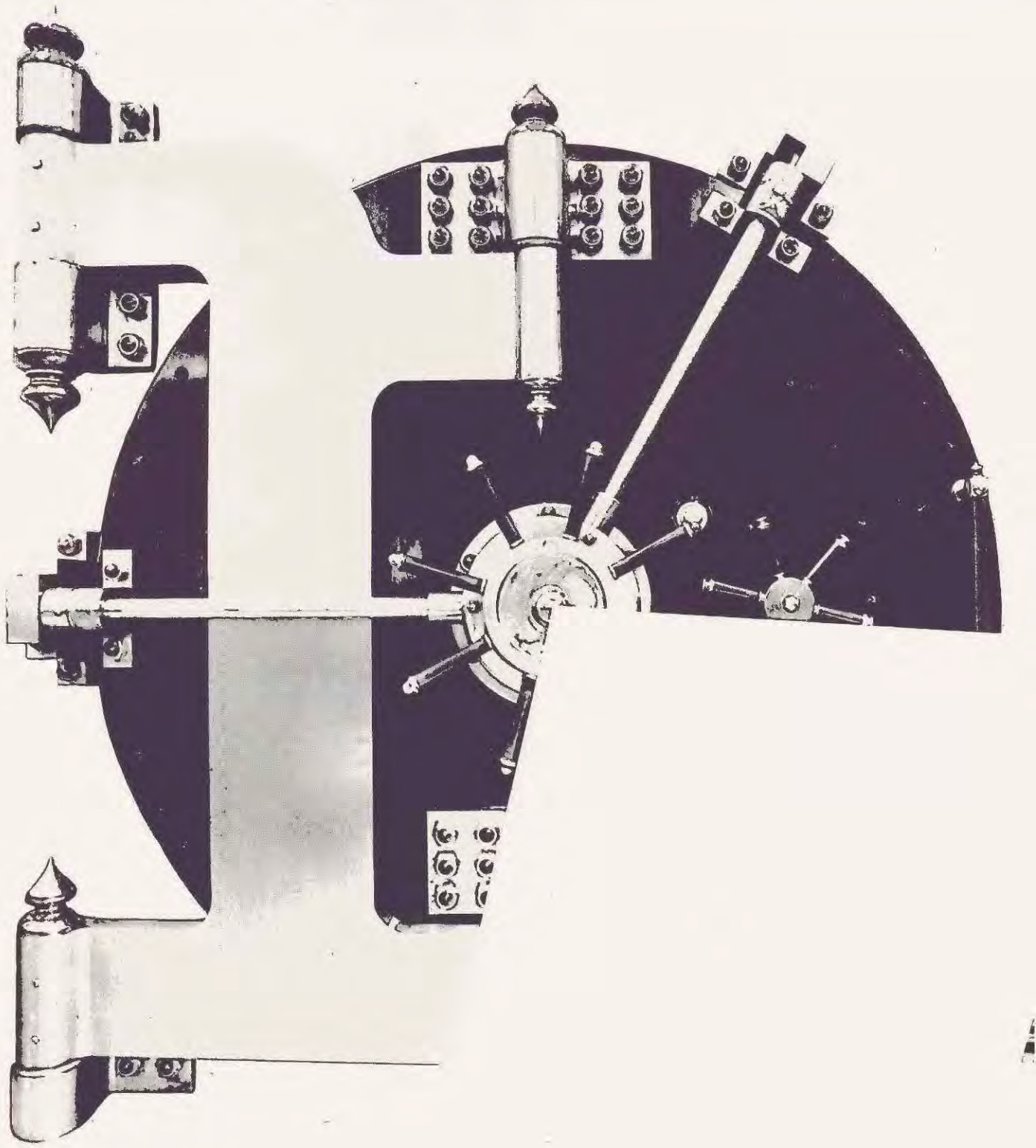
In-house excess and surplus divisions of large national retail brokerage firms have the technical ability to place difficult risks themselves, said a major broker at one of the largest national brokerage houses, but have not been able to develop the necessary rapport with the markets.

"Although the excess underwriters may not admit it, they seem to prefer to work through excess brokers," he said.

But several excess underwriters contacted by *Business Insurance* had no reluctance to state they prefer to work through wholesalers.

Retail brokers have the necessary technical knowledge, agreed Mr. Fischer at Northbrook, but they often prefer to move on to the next account and avoid a time consuming search of the excess and surplus markets.

The brokers in the excess and surplus divisions of retail brokerage companies are often transferred from other areas without the specialized knowledge and ex-



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IS YOUR AGENT using an excess broker when placing your risk?

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Some retail brokers and insurance managers contacted by *Business Insurance* said buyers did not want to know the details of an insurance placement. But the excess brokers said they wanted complete disclosure of their activities.

Thomas S. Bloom, vp of McAlear Associates Inc., said a major problem in the excess market is capacity. When a risk manager uses two or more brokers without informing the other, he said, a tight market is divided still further, adding to the already difficult problems in placing risks.

Finally, Mr. Bloom said, an insurance manager has right to know what's going on because "it's his money."

perience of the independent wholesaler, according to Warren Richey.

Excess brokers are the only ones "with the contacts, knowledge and acceptance of the markets to place difficult risks," contended Mr. Bloom, an excess broker.

Some of the large national retail brokerage firms are apparently able to work directly with the excess markets in some cases. Mr. O'Hanlon with Fred S. James said he does a large amount of business with National Union Insurance Co. In placing a large risk involving both primary and excess insurance, he said he can work directly with the Lexington Insurance Co. (that group's excess subsidiary).

One underwriter, Northwestern National Life Insurance Co. in Minneapolis, works directly with the retail insurance firms when placing excess insurance for employe benefit plans, said Al Benson, manager of group sales promotion and advertising.

Excess brokers are usually paid by the underwriter. Mr. O'Hanlon said a retail broker often receives the same commission whether it places the risk directly in the excess market or works through an excess broker. One company pays the wholesaler 5% and the retailer 10% commission, he said, but would pay the retailer the same 10% if the risk were placed directly with the underwriter.

None of the excess brokers contacted by *Business Insurance* work directly with the risk managers. Mr. Melton and others said they did not want to compete with the source of their business, the retail brokers. If approached directly by a risk manager, Mr. Melton said, Dub Martin would place an agent between the client and themselves "as gently as possible." ■

Excedrin headache #11: the buffered layer pain

NEW YORK—"The buffer layer phenomenon" is not a new brand of aspirin but certainly is causing risk managers a lot of headaches.

Buffer layers are levels of insurance for the gaps between primary limits and excess minimum amounts of coverage. Many primary underwriters are reducing their limits for risks such as product liability and malpractice at the same time that unbrella insurers are demanding higher minimum levels of coverage. What results is a gap.

In turn, the market for the gap coverage has seen a lot of activity in recent months.

"It's confusing, difficult and expensive," one broker said, referring to the buffer layer market.

"Brokers really have to manipulate" to fill in the gaps, Joseph Lombard, vp-casualty at Schiff Terhune, said. For example, a large commercial casualty risk with a primary policy of $300,000 to $500,000 covered by an excess umbrella policy extending up to $30 million or $50 million is hard put to find an excess umbrella insurer to go under a $1 million limit, he said.

"That's what caused the buffer phenomenon, according to Robert Clements, national services-casualty at Marsh & McLennan, said. Primary insurers aren't willing to commit their reserves to make higher limits available, he said.

Risks that are heavily self-insured are also finding the buffer market a necessary stop before obtaining excess coverage.

"There is a role for the buffer layer underwriter in this instance," Mr. Clements said.

A number of excess and surplus lines underwriters are involved in buffer layering. Drake Insurance Co. of New York and Lexington Insurance Co. were named by one underwriter as "heavily involved in buffer layers."

"Lots of companies are dabbling in buffer layers," the underwriter said, "but not all of them are serious about it."

Nevertheless the underwriting practices of buffer layer companies were criticized by some risk and insurance managers.

"A lot of companies writing buffer layers don't know what they're getting into," said a risk manager for a large Eastern manufacturing company. "They're burying themselves in paperwork so deeply that they don't understand the risks they're writing."

The risk manager noted he had 32 insurers involved in a $80 million casualty program.

"The buffer layer policies are written for one year," he complained. "By the time I've barely completed this year's program, it's time to start on next year's."

Another insurance manager objected to the lack of government control over companies writing buffer layers. Many of these companies are non-admitted and therefore do not fall under the jurisdiction of state insurance departments.

"Since buffer layer companies control the market," the insurance manager said, "you can't argue with them."

"You pay what they ask because it's better than going to your board of directors and telling them 'We can't get the insurance at the price we're willing to pay,' " he added.

Insureds are paying a high price for buffer layers.

"Buffer layer premiums are often higher than primary liability coverage," a spokesman for an insurer in the buffer market said. Because of inflation and the potential size of liability claims, we find many of them falling in that area between the primary limit and the excess minimum, he said.

Some insureds object to using the buffer layer market to meet the excess market's primary coverage requirements, another broker explained. "They prefer that the primary underwriter go to the market."

"It's best not to ask the underwriter to get involved in reinsurance treaties to do this," the broker advised. "To maintain the integrity of the primary layer, it should be done in-house by the primary underwriter." ■

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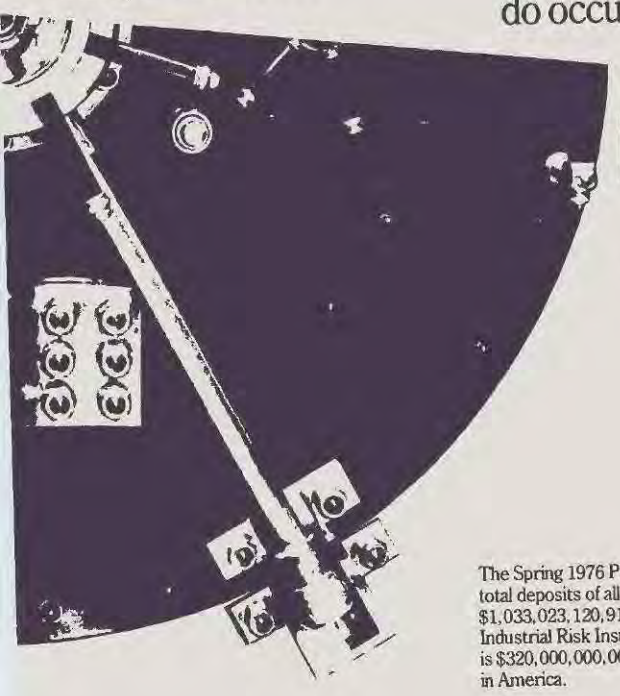

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Like grocery shoppers, buyers find prices a pain

By JANE WINEBRENNER

CHICAGO—Like harried consumers moaning over meat prices at the supermarket, corporate risk and insurance managers are complaining about rising costs and increased comparison shopping in the excess and surplus lines insurance marketplace.

Nineteen of the 20 risk managers of large, medium and small firms surveyed at random now use excess or surplus lines insurance for at least part of their insurance coverage. Comprehensive general liability (CGL) umbrella coverage comprises the bulk of excess insurance, with aviation, workers' compensation and, to a lesser extent, fiduciary insurance also placed in the excess and surplus market.

Risk managers seem split between whether the excess market is a temporary stop-gap measure or a permanent part of the insurance market. Several insurance buyers who've been picking up their umbrella coverage in the excess market for as long as 15 years say the excess market is cyclical and has tightened up in the past and will in the future.

EXCESS/SURPLUS
and special risks

Howard Weber, risk manager for 3M Co. found the only difference between the excess market today and that of 14 years ago is in the big increase in expected losses which in turn creates a bigger demand on the excess market to cover the losses.

"Before if you were buying excess coverage, you went to Lloyd's. Today you go to Lloyd's and 50 other companies.

"The price may be the same, but your method of getting there is different," Mr. Weber said. 'This is an art, not a science. The business of trying to put together a package is done a lot of different ways."

Other risk managers, however, believe the excess market is a temporary phenomenon. At Joslyn Manufacturing & Supply Co., risk manager Philip B. Gehrke said he used the route as "temporary coverage." A rubber industry risk manager who preferred not to be identified called the excess insurers more flexible and more inclined to take risks. But he said he "would like to see conventional markets handling risks."

Specialty carriers sometimes can do a better underwriting job, he said, noting that the "cycles seem to come and go." The company currently has some property, product liability and some comprehensive liability in the surplus lines market, "using it more than we like to."

B.H. Shaver, manager of insurance and assistant treasurer at Goodyear Tire & Rubber Co. said, "The entire excess market is going through agonies because of losses; this has happened in the past."

One risk manager found the excess market different today in the high amount of retentions which corporations are expected to assume. In 1970, Ryder Truck Lines Inc. of Jacksonville, Fla. had a deductible of $25,000 for workers' compensation; it will probably be $100,000 to $150,000 when Ryder renews its coverage in the future, according to Harold Flax, director of insurance.

Not only are retentions higher, but it is not uncommon for corporations to have to use four or five carriers in the excess market. One medium-sized mold and steel company has 10 different layers of $5 million to $10 million in each CGL layer. Not surprisingly, the risk manager complained of the extra administrative work when dealing with a large number of companies.

At National Industries, a Louisville-based holding company with $800 million in sales last year, the number of policies for its $25 million excess umbrella coverage was kept down to one mainly because of a "good mix of companies" sharing the risk with a fronting insurer. Alan Goldberg, director of insurance, said a joint venture between a local Louisville broker, Nahn, Turner, Vaughn & Landrum Inc. and Alexander & Alexander, was able to find enough carriers to rewrite the coverage. The only surplus contract was for fiduciary insurance with Lloyd's.

The kicker to that happy story, however, is that National's premiums in 1976 for excess umbrella liability insurance rose 600% over 1975. As Mr. Goldberg said, "we ate the 600% increase."

At Joslyn Manufacturing & Supply, CGL umbrella (including product liability) premiums in the excess market increased "several times," said risk manager Mr. Gehrke. Although he was unable to get quotes on primary coverage in some areas, the same companies were interested in the excess policy, which is $25 million in two layers at Joslyn.

Not all risk managers share this experience with inflated premiums. Mr. Weber of 3M believes the cost increases are not as outrageous as they appear at first glance, when coverage of expected loss levels is also considered.

"It's more difficult to find adequate markets now than 10 years ago, but in terms of cost, it hasn't significantly changed.

"In our own situation, the relative cost of excess coverage has not changed in the last 10 years as a ratio to sales and inflation," Mr. Weber said.

One risk manager found his premium up 48% and limits decreased 60% when his excess umbrella liability policy was renewed this year. Another manufacturing company found its umbrella liability premium had been increased 75% and amount of coverage reduced by 20%.

Exclusions such as one for punitive damages, are being added to umbrella liability policies, another risk manager told *Business Insurance,* "and we're all ending up with gaps in coverage," he added.

Another holding company insurance director found that not only had his prices increased for $40 million of umbrella liability insurance, but found his umbrella was leaking. His excess liability insurance excluded errors and omissions, fidelity and captive insurance agency insurance which had to be covered in the surplus lines market.

Risk managers who have been to hell and back—otherwise known as the insurance market—offer some cautious advice to those renegotiating their excess or surplus lines policies this year. David Otto, manager of insurance for Eaton Corp. said, "We plan to start earlier, and gvie ourselves and our underwriters more time."

Mr. Otto also said when seeking quotes in the London market, a company can penalize itself if cov-

Continued on page 30

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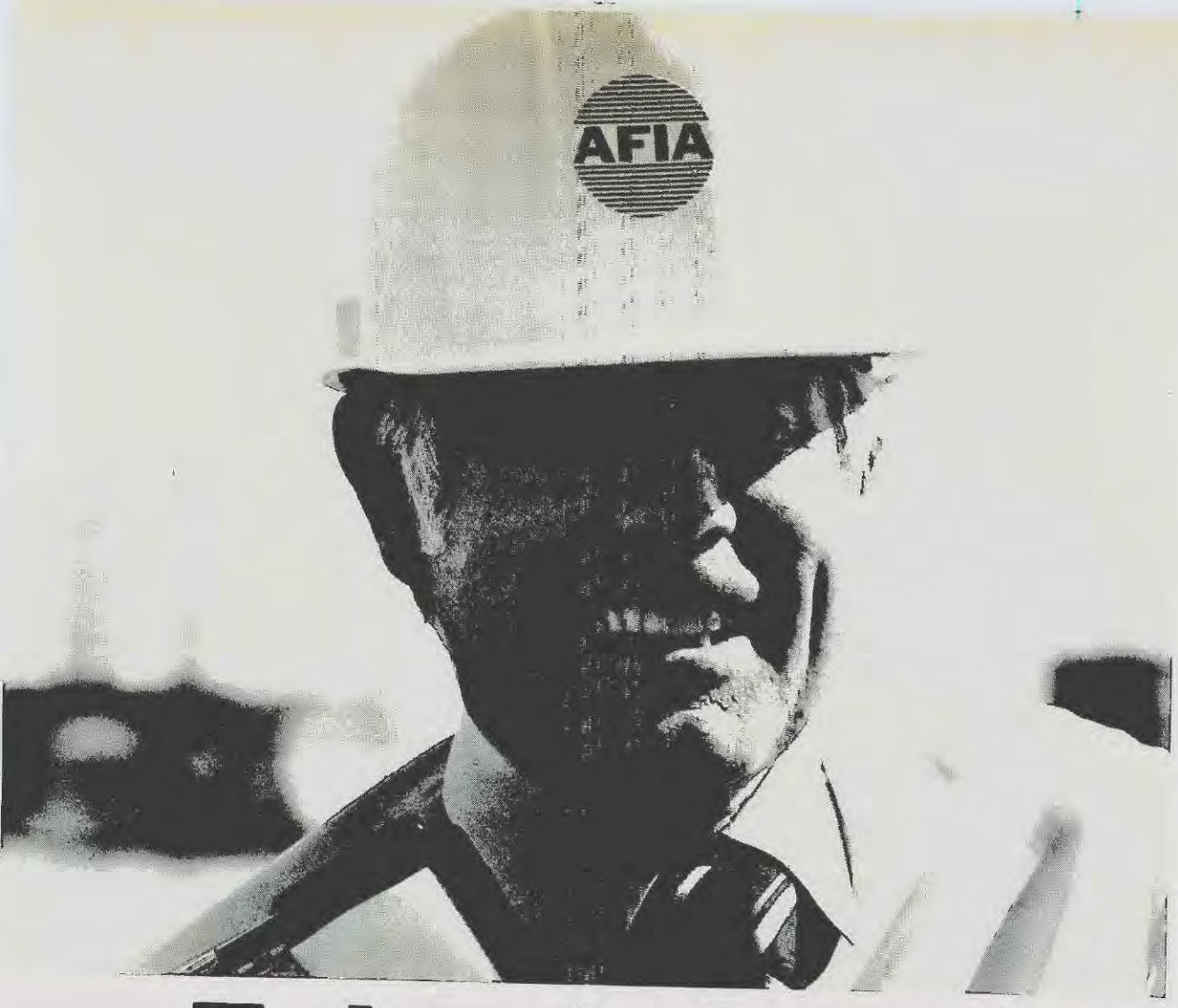

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Hospital group is about to sponsor excess liability plan for members

CHICAGO—The American Hospital Assn. is on the verge of sponsoring an excess general liability insurance program for its hospital members put together by the Chicago office of Alexander & Alexander.

The program would provide $5 million worth of insurance coverage for third party injuries not caused by professional malpractice, at much lower costs and using broader policy forms than the excess insurance generally available to hospitals at present, said James Groves, risk manager for the AHA.

Hospitals have recently been faced, he said, with a growing inability to obtain umbrella liability coverage which includes insurance for losses arising out of injuries caused by nonprofessional acts and premises injuries.

Within the last year, said Kay Hartlieb, A&A account executive responsible for putting the plan together, more insurers which formerly underwrote very broad hospital umbrella liability insurance changed to a policy form which insures only named perils such as fire, explosion and windstorm. Thus, hospitals are left uninsured for premises liability, an area which can create significant losses.

In the event a patient fell out of bed or down stairs, the hospital would be left with an uninsured third party liability loss under the types of umbrella policies now being written, she told *Business Insurance*. Ms. Hartlieb has generally been successful in obtaining for her 20 hospital clients umbrella liability policies written with only the traditional exclusion for malpractice liability claims.

The problem for hospitals has been aggravated, said Mr. Groves, since the passage in some states of laws creating pools to cover high malpractice losses. These pools generally do not cover any other liability losses except malpractice injuries.

"Hospitals looking for comprehensive general liability umbrella policies, if they can find an insurer at all, will encounter insurers who then routinely exclude all claims arising out of injuries to patients" figuring the pools cover that area, he said.

The hitch comes when the hospital's malpractice policy or the state pool picks up losses attributable to professional acts, and the CGL policy, which formerly picked up losses from all injuries from nonprofessional acts, only covers events such as injuries from fire.

The Alexander & Alexander program is reported to be underwritten by First State Insurance Co., although neither Mr. Groves nor Ms. Hartlieb would confirm this. It's designed to take a $1 million deductible, although Mr. Groves said the AHA is working to "get that down to whatever levels the hospitals need."

Mr. Grves said a second layer of excess umbrella insurance is all ready to be implemented, for $5 million excess of $6 million. But Ms. Hartlieb says she's still working to find an insurer which will commit itself to take the second excess layer. She's willing to say at this point only that the insurer she has in mind is "also a 5A company" in terms of its Best rating.

Premiums on the program are "so good that nothing else ever comes close," said Mr. Groves. A flat charge of $4,400 is made for $5 million coverage excess of the $1 million primary layer for hospitals with up to 100 beds. Hospitals with 100 to 300 beds pay $5,500 for the same coverage and hospitals with 300 to 700 beds pay $6,600. Above that, the risks are individually rated.

"Because it was difficult to underwrite premises liability for hospitals, insurers have been charging exorbitant rates," said Ms. Hartlieb. "I've seen some premium bills for $25,000—five times what our coverage would cost—for the same $5 million coverage."

The A&A excess umbrella coverage contains only two major exclusions, one being for helicopter pads and the other for hospital-owned ambulances. This coverage can be bought by endorsement at extra cost. The umbrella policies would exclude malpractice losses and claims, by using the insuring agreement for the hospital's own malpractice policy, so that the forms agree and the coverage dovetails correctly. ■

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Continued from page 28

erage comes in from three or four markets, and that prices are generally locked in. Eaton has $1.8 billion in sales projected for 1976 and manufactures truck equipment. The company currently has $100 million worth of coverage in the excess markets, including the liability umbrella, some property and workers' compensation insurance.

At Boise Cascade, insurance director C. E. Carlson, said he prefers to deal directly with the insurance market but uses brokers on occasion when he needs a special line of coverage such as for aviation. Mr. Carlson said when he deals directly with the excess market, "I don't have to go through an intermediary and I can get quotes more rapidly."

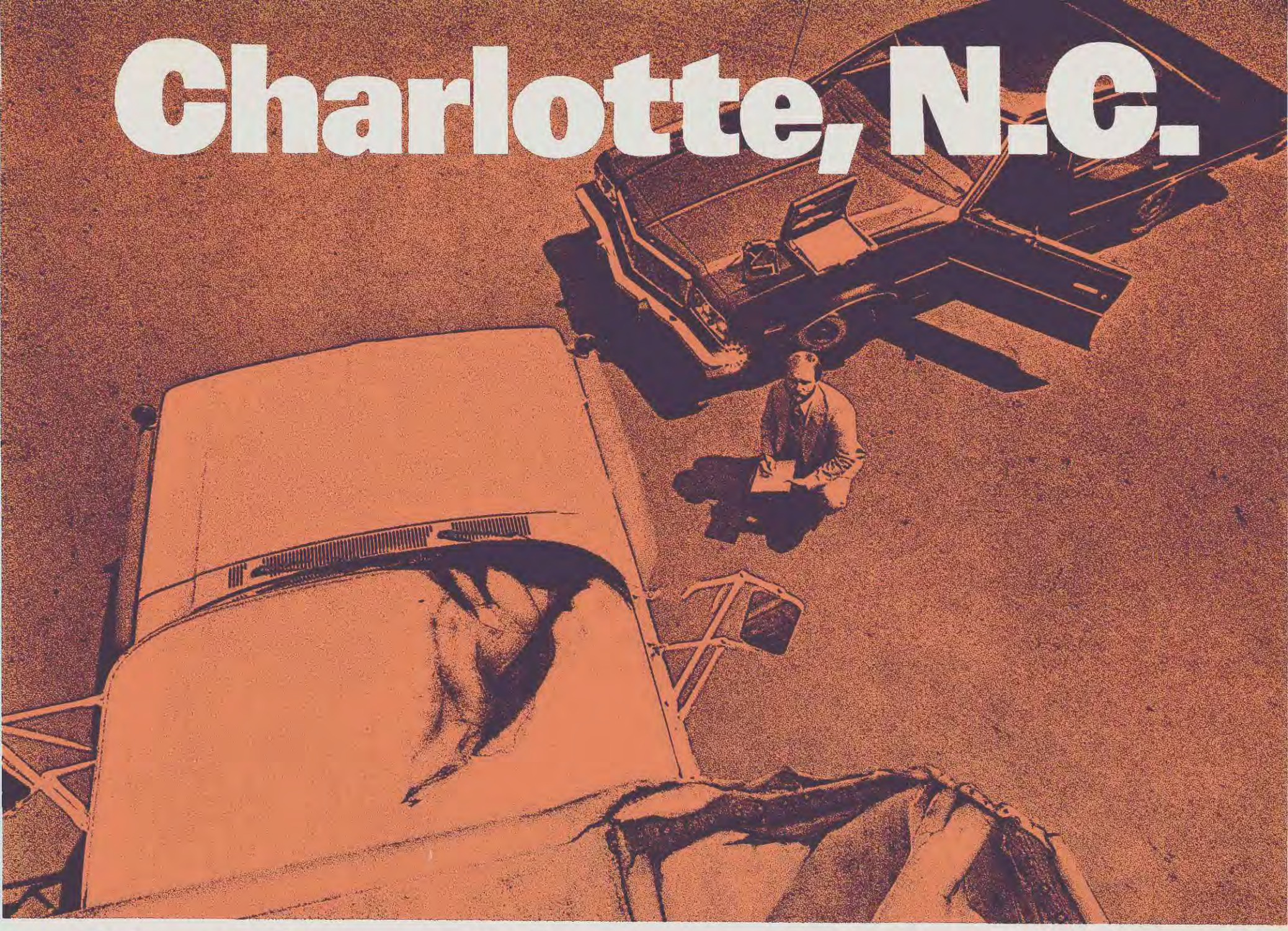
Other advice is to know your risk. "Have a real good feel for actual claims over five to 10 years; know if your risk is good, bad or lousy," Mr. Gehrke of Joslyn said.

Many risk managers agreed that the excess and surplus carriers should be checked out for financial stability—either through checking the American Mutual Insurance Alliance, state insurance departments or "word of mouth." One risk manager advised that if the buyer doesn't know anything about the market, find out what insurers other similar type sof risks are using.

On the brighter side, some risk managers said they have not found any difference between dealing with excess and surplus lines brokers and with the standard insurance market. As Thomas Conroy, risk manager for Pullman Inc., maker of railroad equipment, said, "I don't think there's any more problem in the excess market over the standard one. We're getting a lot more experience in the excess market."

Views on whether excess and surplus lines markets are here to stay reflect sheer pragmatism. One risk manager said simply, "You don't have any choice," while Mr. Weber said, "You have to use all markets available.

"Large carriers are not going to assume more risk; they are assuming less. They are assuming more of a service role. I think this is a permanent situation of carriers cutting back," Mr. Weber added. ■



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Extraordinary growth attracting wary eye of insurance regulators

By JOANNE GAMLIN

LOS ANGELES—There can be no question that the excess and surplus lines area of insurance, although a stepchild in most state insurance departments, is beginning to take on new luster. The reason: Extraordinary growth.

In California, it is estimated that this year about $150 million in excess/surplus lines business will be written in 'filed' business (excluding ocean/marine, railroad and aircraft hull) compared with about $77 million written in 1975.

In Texas, the surplus lines business is up a notable 50% to approximately $100 million this year from $67 million in 1975.

In New York, which has figures only for 1975, excess/surplus lines writing came to $72 million.

Illinois had $28 million in 1975 written on risks in the state.

Despite the impressive increases, officials in insurance departments of the largest states told *Business*

EXCESS/SURPLUS
and special risks

Insurance they know of no commanding problems stemming from this growth. Not yet, anyway. But Texas Insurance Commissioner Joe Hawkins isn't alone when he indicates he cannot rule out new regulations if excess/surplus lines business in his state continues to escalate.

For now, however, Commissioner Hawkins said no headaches exist that demand changes in insurance regulations.

Illinois boasts a regulation of recent vintage that requires excess/surplus lines carriers to state on their policies that they are not licensed carriers in the state and that the policy is not protected by the state's insurance guarantee fund.

"One could have assumed that this assertion would have dented the excess/surplus lines business in this state," said Ken Smith, assistant deputy director in the property/liability regulatory division. "But it hasn't."

One of the few state insurance department officials to openly question the effectiveness of his state's regulations regarding the licensing of surplus lines brokers, Mr. Smith acknowledged he harbors doubts about the department's ability to control the excess/surplus lines business written in the state.

"We don't know if what is being reported to us by the 120 brokers in the state who are qualified to write surplus lines business is what is actually being written," he explained, noting that Illinois has slightly less than 100,000 agents and brokers within its boundaries, of whom only 120 have sought qualification as surplus lines brokers. Illinois, at the same time, has only 27 surplus lines underwriters on its qualified list.

Like many other states, Illinois demands that its surplus lines brokers make sincere attempts to place a given risk with two licensed carriers or advertise the risk with the Chicago Board of Underwriters before entering the excess/surplus market.

"In reality, the surplus market is often less expensive," he continued, pointing out he is acquainted with several surplus lines brokers who regularly place certain lines with surplus lines carriers.

"The reason is that these carriers really do charge less," he emphasized. Thus, whether this practice is detrimental or not to the insurance buying public is a question which the assistant deputy director has not yet resolved.

In any case, policing powers possessed by the insurance department are inadequate to the job, he said.

"We examine surplus lines brokers at the same time we examine regular brokers and agents and we do this with five examiners who must deal with 100,000 agents and brokers.

"The odds of a given surplus lines broker actually being examined, hence, are remote. Right now, we don't know if this is a problem or not."

He added that most of the brokers qualified in Illinois to write surplus lines business are big, letter-name firms.

To James Flanagan of the New Jersey department of insurance, the most grinding headache at present is the fact that for the last three years no new excess/surplus lines carriers have been approved to operate in the state.

Pointing out he knows of three men who were forced out of business because they could not acquire needed product liability coverage, Mr. Flanagan said the plunge in the number of excess/surplus lines underwriters is exacerbating a dire insurance marketability problem in the state.

"New Jersey is 50th in insurance marketability in the United States," he declared, recalling the experience of a general contractor of a snow plowing operation who told him that he had contacted 33 insurance companies only to be told that 17 of them were no longer writing coverage in the state.

"Surplus lines brokers are not our problem," he repeated. "Rather, it is the ton of business to be placed that has nowhere to go."

Massachusetts deputy commissioner, Keith Rodney, also pointed to a halt in the growth in his state of new excess/surplus lines underwriters. A year ago, the Bay state began to require excess/surplus lines insurers to meet the same standards demanded of licensed carriers. Since that time, the state has not gained a single new excess/surplus line underwriter, Mr. Rodney revealed adding:

"I think our standards are pretty liberal. Besides showing a profit, the prospective insurer must only have a surplus of $300,000 for a single line of business, such as livestock or accident/health, or $3 million for all lines of coverage. We regard these requirements as modest."

Unlike Mr. Flanagan of New Jersey, the Massachusetts insurance department official pointed to no pounding on the doors for insurance protection. Medical malpractice was a problem until a year ago, but the formation of a joint underwriting association wiped out that difficulty, he believes.

California has laws governing the surplus lines business that reach back to the late 1930s and have not been amended much since that time, according to John Faber, assistant chief, legal division of the insurance department.

One of the few recent amendments, he said, was a 1972 regulation stating that every policy or

Continued on page 35

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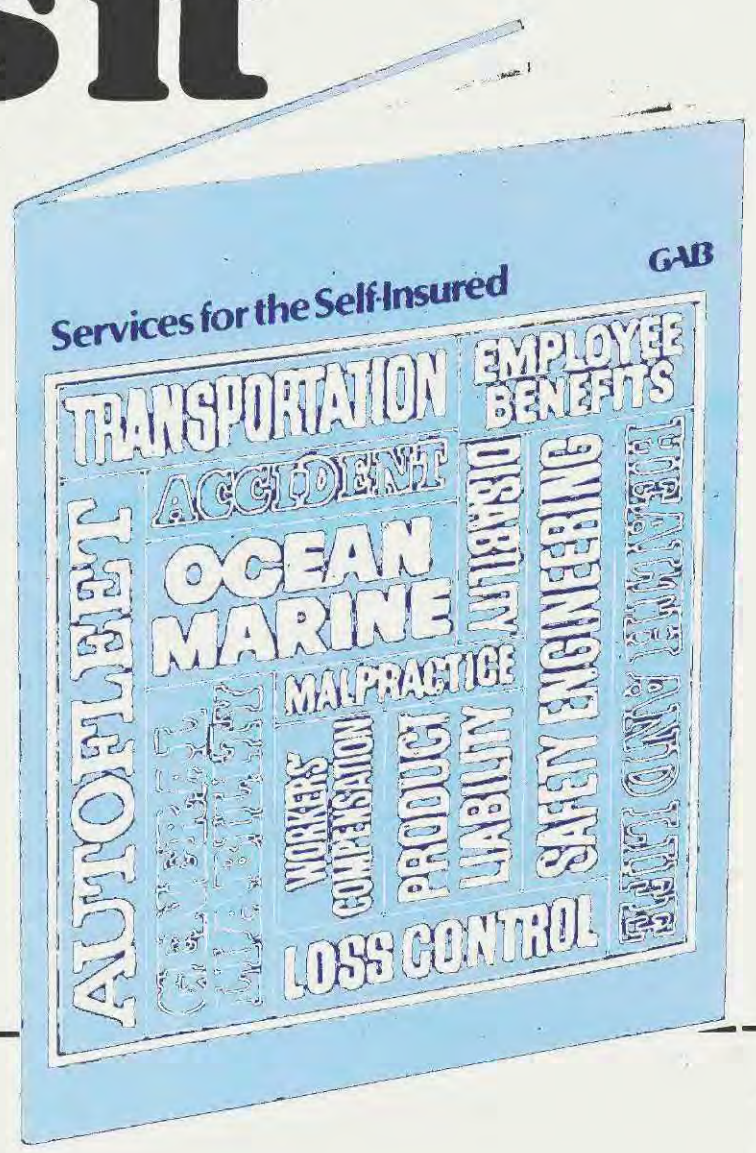

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Benefit manager told to expand job outlooks

LAS VEGAS—Benefits professionals must be prepared to have their job functions overlap into more areas of management than ever before if they expect to control the significant amount of money that their companies contribute to employe benefits.

Joseph Duva, director of employe benefits and compensation for the SCM Corp., New York, told an annual benefit conference sponsored by the American Management Assn. here that management is the most significant area facing employe benefits administration.

He outlined a five-point program that touched on most of the benefits functions which have become more complex in the last few years. Benefits managers, he said, must be ready to deal with compliance with legislation on pensions, health maintenance organizations and equal employment opportunity; cost control programs to minimize benefits expenditures; adoption of better and more efficient cash flow vehicles; design and update of employe benefits programs, and the professional administration of those programs.

Mr. Duva pinpointed two benefits policy provisions as examples showing how employe benefits managers could be making mistakes for their companies if they don't review provisions.

The first would be extending maternity, benefits for nine months following the termination of a group insurance plan. The second would be continuing to pay life insurance premiums on disabled employes rather than taking advantage of a premium waiver under which the employer would stop paying premiums, and the insurer would set up a reserve like a paid claim for each case.

"Both provisions demand a build-up of sizeable reserves that are held by the insurance companies for the duration of the contract and both could be eliminated without cutting benefits," Mr. Duva explained.

He suggested that benefits managers make a careful review of their companies' group insurance programs to spot any troublesome provisions.

"Perhaps the most important challenge facing employe benefits managers is to maximize the value of the employe benefit dollar. In other words, you have to reduce the cost of providing benefits, and once reduced, keep them that way as far as possible," he said.

One of the cost control methods Mr. Duva outlined was the appropriate relationship a benefit manager should maintain with outside insurance consultants and service organizations.

"A manager who does not request the highest quality of service at a competitive price is costing his company a considerable amount of money over a period of years.

"Never get too comfortable with a service company; always seek competitive quotes," Mr. Duva said.

He told the group that over the years SCM has saved significant amounts of money by selecting, on a competitive basis, a new service company to replace an existing company that "began to fall asleep at the switch, but at the same time, increased the cost of their services."

He said he has not found it to be true that the hidden costs of transferring a service company will eat up more than the savings involved with such a tactic. He advised meeting with the service company periodically to review the quality and costs of their services.

"Don't hesitate to ask the tough questions, such as an itemization of services and costs rendered by dates. Remember, you are responsible for making sure that your company does not overpay for these services,." Mr. Duva said

Mr. Duva used SCM as an example of the vast amounts of money corporations are spending on benefits. In calendar year 1975 SCM spent approximately $83 million to provide benefits for its employes, representing 36% of payroll.

The SCM employe benefit manager made the point that with such large contributions going into benefits, the various methods of funding can affect a company's income and the cash flow.

The professional, Mr. Duva said, must be prepared to operate as a profit center manager in order to manage and control the significant amounts of money new spent. ■

Excess insurance regulation . . .

Continued from page 32

certificate of insurance delivered by a surplus lines broker must have a sticker which says: "This insurance is issued pursuant to the California insurance code sections 1760-1780 and is placed in an insurer or insurers not holding a certificate of authority from or regulated by the California Insurance Commissioner."

Mr. Faber noted there is another regulation which says the commissioner may request from any surplus lines broker full and complete information regarding the financial stability, reputation and integrity of any non-admitted insurer.

The same regulation says that the commissioner can order the broker not to place any more insurance with a non-admitted underwriter. If the licensed broker then puts more business into this non-admitted carrier he is in violation of surplus lines laws, said Mr. Faber. This section of the insurance code is little used.

"With the stamping program, we know the carriers used by the surplus lines brokers and this gives us a measure of control," he said.

Les Lathrop, manager of the Surplus Lines Assn. of California, an organization embracing all brokers in the state who have surplus lines licenses, pointed out that his group works with the state insurance department in its role of monitoring the state's surplus lines brokers.

"To be sure that all surplus lines policies and certificates are written in accordance with California law, we receive a full copy of such documents," he said.

Should the insurer involved be "alien" to California, that is a foreign carrieir with no conventional policy forms, the association undertakes to review the alien's financial statements and to place the findings in a book published by the group.

If, on the other hand, the insurer involved is a domestic company not licensed in California, the association taps a special relationship it has with the state insurance department for data.

"We have an informal program of assistance with the insurance department for obtaining information on domestic insurers not licensed in the state," explained Mr. Lathrop.

Responding to a question about the need for changes in state regulation of the surplus lines insurance industry, he said that "self-regulation has done such a good job that there is no need for substantial change." ■

Hall acquires HPA

Frank B. Hall & Co. Inc., for an undisclosed sum, has acquired Los Angeles based John W. Maxwell Inc. and Health Plan Administrators, specialists in payment of self-insured and insured health and disability claims. The Maxwell agency is the brokerage arm of HPA and provides employe benefit services on insured coverages. Health Plan Administrators moved to 3200 Wilshire Blvd. with the Hall office, but will also retain an office in Santa Barbara. John Maxwell will become a vp of Hll.

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Limitations on health insurance upheld by Georgia appeals court

IN A CLASS action suit, a Georgia appellate court has upheld the validity of a provision in a group health insurance contract limiting an insurer's liability to the excess of expenses covered by any other insurance.

This suit was brought buy Rosa Barker against Coastal States Life Insurance Co. (Coastal) after it declined a claim filed by her for medical expenses incurred in the treatment of her deceased husband. As an employe of Lummus Industries, Mr. Barker had been covered under that company's Blue Cross-Blue Shield policy. Blue Cross-Blue Shield paid the bulk of the claim. However, Mrs. Barker then filed a claim against Coastal, her own group health insurer, because her husband had also been covered as a dependent under the family protection provisions.

Coastal denied the claim in part asserting that the standard "co-ordination of benefits" provision limited its liability to the excess of those expenses covered by any other insurance. The trial court held that the provision was valid and enforceable.

On appeal, Barker argued that the clause was invalid because it intended to defeat and lessen competition among insurance companies and encouraged monopoly. Barker also contended that it constituted an unfair method of competition in the insurance business and interfered with her personal property (insurance premiums). The appellate court rejected all of these arguments.

Initially, the court pointed out that insurance, including group insurance, is a matter of contract and the parties are bound by the terms of the contract. Noting that the specific clause under consideration here had not been reviewed by Georgia's appellate courts previously, the court relied upon decisions from other jurisdictions.

The court concluded that from the standpoint of public policy there was "nothing unjust or wrong in the clause. . . ." The court cited the following reasons for upholding the validity of the clause: 1) to prevent an insured from recovering more than is necessary to make him whole; 2) to keep premium rates as low as possible while assuring full compensation to the group policy holder; and 3) to reimburse employes for their medical expenses and not to enable them to make a profit out of being ill by obtaining multiple benefits for the same expenses, thereby encouraging malingering. *Barker* v. *Coastal States Life Ins. Co.*, Court of Appeals of Georgia, Division No. 2, March 18, 1976, Marshall, J., 225 S.E.2d 924 (BI/01/N.-$3)

Banker's blanket bond

This suit was brought by a bank against its insurer under a banker's blanket bond. The bank sought to recover $40,000 that it lost when its president paid that amount to an extortionist who kidnaped his wife. A Texas appellate court ruled that the loss occurred on the premises within the meaning of the insuring bond. Furthermore, the court decided that the extortion activity was directed at the bank rather than the president personally and, therefore, there was coverage for the action taken by the president in meeting the extortionist's demands.

Kenneth C. Dean, president of the First State Bank of El Paso (First State), turned over $40,000 to an unknown assailant who had kidnapped Mrs. Dean in August 1972. The money, to be paid in small bills, was demanded by telephone under threat of killing Mrs.

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

Dean. Faced with a 10 minute time limit imposed by the extortionist, Dean followed instructions resulting in his leaving the money in his car at a shopping center. The money was removed from his car, Mrs. Dean was subsequently released but the money was never recovered.

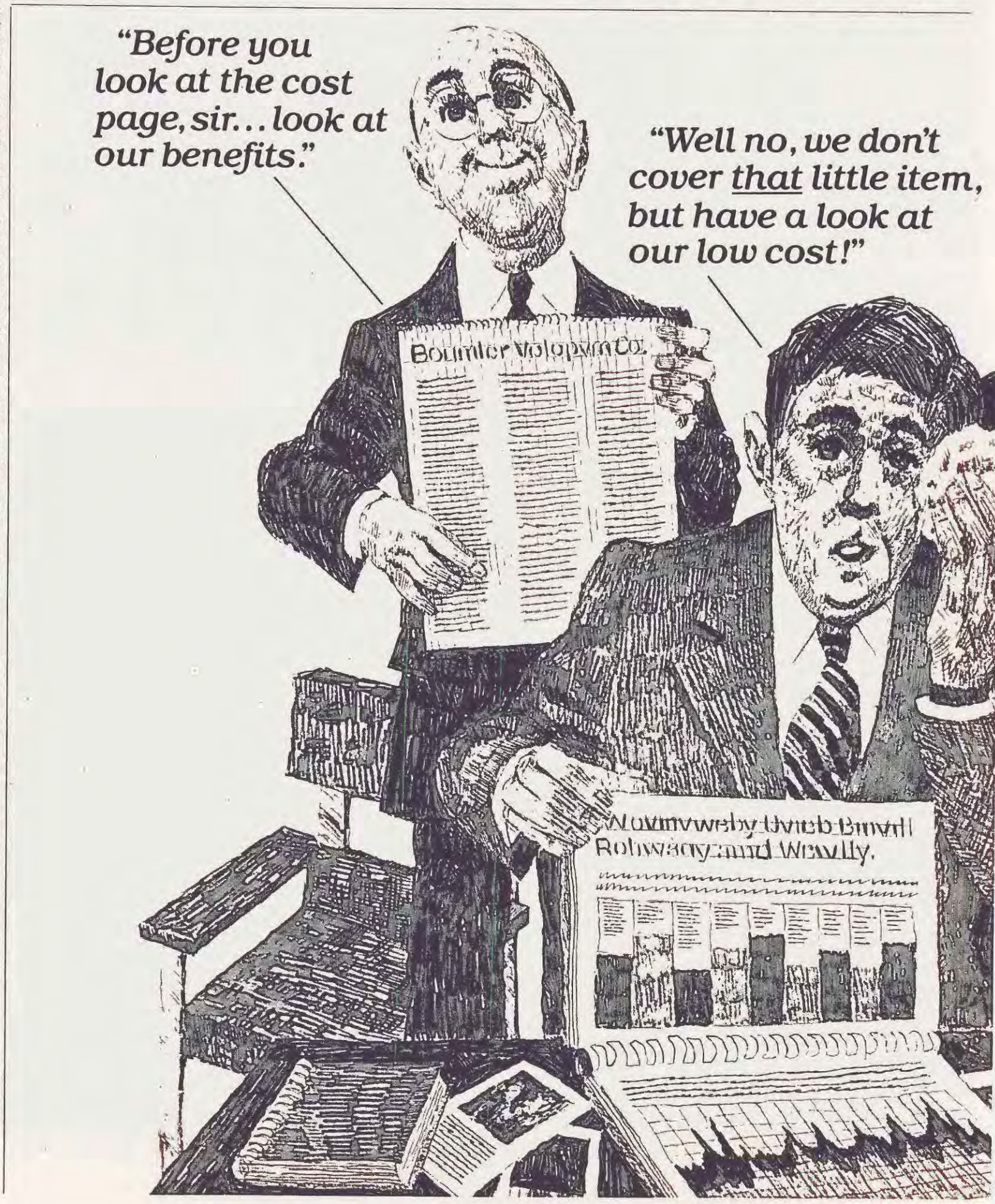
First State's board of directors later absolved Dean of any liability or wrongdoing. At all material times First State was insured under a banker's blanket bond issued by the United States Fire Insurance Co. The policy indemnified First State for a number of losses including those through robbery, burglary, common law or statutory larceny, and theft while the property "is lodged or deposited within any offices or premises located anywhere. . ." The insurance company denied coverage although it agreed that even though extortion was not specifically named the criminal activity which occurred here was covered under this paragraph. The trial court awarded judgment to First State.

On appeal the insurance company argued that there was no coverage because 1) the crime insured against had to occur "on premises," meaning within the offices of the bank, and 2) that the criminal activity was directed at the president personally and not the bank. The court rejected both contentions pointing out that with regard to the first claim the bank president was an unwilling agent of the extortionist in effectuating the actual removal. As a consequence the loss occurred at the moment he took possession of the money with the purpose of depriving the bank of it.

The court also believed that the coverage should not be denied because of the manner of taking from the premises if, in fact, it would be established that there was a covered taking. In concluding that the criminal activity was directed at First State rather than the president, the court pointed out that "the bank is the entity covered by the bond; it is a corporation, bloodless, without emotion, incapable of fear from bodily harm or criminal violence; even as a corporation can act only through its officers and employes." *U.S. Fire Ins. Co.* v. *First St. Bk. of El Paso*, Court of Civil Appeals of Texas, June 2, 1976, *rehearing denied* June 30, 1976, Preslar, C. J., 538 S. W. 2d 209 (BI/02/N.-$3)

Group major medical coverage

In a suit under a group major medical policy, the Supreme Court of South Carolina ruled that a certificate of insurance given to an employe that had a sticker attached to it containing information on coverage, was not a rider or a part of the policy itself. The court believed that absent any contention of ambiguity within the policy in



itself, the certificate and sticker could not be referred to in construing the policy.

Joyce S. Yarborough, one of thousands of employes of Raylass' Department Stores, became a participant in a group major medical offered by Phoenix Mutual Life Insurance Co. (Phoenix). Yarborough managed the company's Rock Hill store. The company was headquartered in New York. Yarborough was issued a certificate of insurance to which was attached a sticker containing relative information. The master policy was retained by the employer in its New York office.

The information on the sticker listed $100 as the deductible amount and also stated that the "individual certificate is not a contract." In 1972 Yarborough incurred medical and hospital expense of $3177.85. She filed a claim for $2877.85 under the policy. However, Phoenix offered only $30.92. The trial court held in favor of the employe.

On appeal Phoenix contended that the master policy was not ambiguous with regard to the deductible features, and thus the language on the sticker was not controlling. The appellate court agreed stating that the general rule is that the employe's contract of insurance under a group plan consists of the policy issued to the employer and that the individual certificate delivered by the employer to the employe is not a part of the contract.

The court noted that it is appropriate "to consider both the sticker and the certificate in construing a policy, but only if an ambiguity exists within the policy itself." Reading the insurance contract as a whole, the court concluded that there was no ambiguity because the words "deductible amount $100" appearing on the sticker conveyed no meaning until the coverage provided by the whole policy was ascertained. Consequently, the court ordered that the decision be reversed and a judgment entered in favor of Phoenix. *Yarborough v. Phoenix Mut. Life Ins. Co.*, Supreme Court of South Carolina, June 1, 1976, Littlejohn, J., 225 S. E. 2d 344 (BI/03/N.-$3)

Malpractice insurance

A Louisiana appellate court has ruled that an insurance company was not liable for claims arising out of the alleged malpractice of an architect, even though the alleged malpractice occurred during the effective period of the insurance policy. The court based its decision on the fact that the policy was a "discovery" rather than an "occurrence" type policy.

The Stuyvesant Insurance Co. had issued a professional liability insurance policy to the architect covering the period January 31, 1973 to January 31, 1974. When the policy was not renewed, the architect obtained similar coverage with the Northbrook Insurance Co. The actual occurrence giving rise to the malpractice claims took place during or before Stuyvesant's policy period.

After settling the claims, Northbrook sued Stuyvesant for recovery under the Stuyvesant policy. The grounds were that although the occurrences took place during or before the Stuyvesant policy period, no notice or report of the incident which gave rise to the malpractice claim was made during Stuyvesant's policy period. Thus Stuyvesant asserted that it was not liable, because coverage under its policy was limited to those claims which were asserted against the insured and reported to the company during the policy.

The Court of Appeal of Louisiana agreed with Stuyvesant. The court concluded that the policy was a "discovery" rather than an "occurrence" policy and emphasized that the plain intent of the Stuyvesant policy was to restrict Stuyvesant's liability to those claims reported and discoverd during the policy period. *Breaux v. St. Paul & Marine Insurance Co.*, Court of Appeal of Louisiana, Third Circuit, February 18, 1976 (BI/04/Au.-$3)

Banker's fidelity bond

According to the Supreme Court of Minnesota an insurer under a banker's fidelity bond is not obligated to indemnify an insured bank for legal expenses incurred by the bank in defense and settlement of a customer's suit for damages alleging fraudulent acts on the part of the bank and three of its directors.

The court held that the bond "did not cover losses suffered by reason of fraud, dishonesty or breach of fiduciary duty when a bank, through its board of directors, had knowledge of the acts complained of, appreciated their fraudulent nature, and condoned, acquiesced, or participated in them."

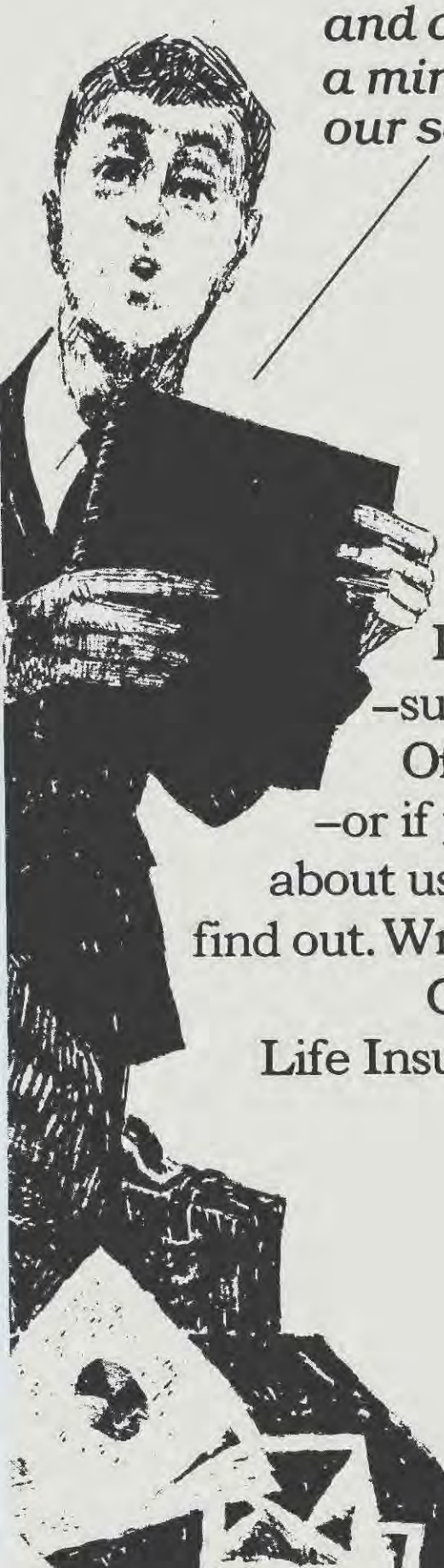
The Farmers and Merchants State Bank of Pierz (Farmers Bank) incurred legal fees of $5730.14 in settling a lawsuit brought against it by customers. The customers were interested in purchasing a piece of property owned by the Catholic parish. The customers conferred with Farmers Bank's cashier and a vice president, both of whom served on the bank's board of directors, concerning a real estate loan for the transaction. Three of the bank's board of directors, including the cashier and vice president, also served on the church senate responsible for deciding on the sale.

After the customers presented their plan to the church senate, Farmers Bank became interested in purchasing the same property. Through its board of directors, it confirmed an offer of $10,000 for the property knowing that the customers proposed to bid $3,000. Although cognizant of their conflict of interest, Farmers Bank did not inform the customers of their plan until 25 minutes before bids were received. The church senate accepted the bank's bid. St. Paul Fire and Marine Insurance Co. (St. Paul) had issued Farmers Bank a banker's fidelity bond but declined to defend the bank when the customers brought suit for alleged breach of fiduciary responsibility.

In the present action Farmers Bank sought recovery of the legal fees it incurred in defending the customer's suit. The trial court ruled in favor of the bank.

While recognizing that if any part of a suit against an insured arguably falls within the scope of coverage the insurer must defend, the supreme court emphasized that if the insurer has knowledge from facts without the complaint that the acts giving rise to the suit are outside the policy coverage, there is no duty to defend. The court concluded that it was undisputed that the bank, through its officers and directors, were aware of the customer's proposal and thus the fraudulent acts in this case were acts of the bank. Consequently, the court concluded that coverage did not exist here "otherwise the bank would be insured against its own dishonesty." *F. & M. State Bank v. St. Paul Fire & Marine*, Supreme Court of Minnesota, May 28, 1976, Rogosheske, J., 242 N. W. 2d 840 (BI/03/0.-$3)

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



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Product liability hikes threaten some firms' existence: Researchers

NEW YORK—So many people are suing companies over allegedly defective products that product liability insurance premium increases are threatening the very existence of some small businesses.

For some industries with extensive product liability exposures, the increase in insurance premium rates is more than tenfold over the past year or two, according to The Conference Board, a private, non-profit business research organization.

In an analysis released late last month, The Conference Board cited predictions that the costs of product liability insurance will continue to rise nearly 50% a year and that costs of non-auto liability insurance by 1980 could climb as high as $30 billion, compared with only $3 billion in 1974.

The burden of the resulting product liability crisis may be most heavily felt by small businesses which decide to go self-insured, but which are actually uninsured, with no reserve funds set aside to pay injury claims, The Conference Board said.

This lack of product liability insurance could put some manufacturers out of business within months, or would produce consequences of equal seriousness, it said.

It cited the case of the Havir Manufacturing Co., St. Paul, which was forced to liquidate because it couldn't buy product liability insurance. But it said a more typical consequence would be that manufacturers would be forced to pass increased insurance costs to their customers through higher prices.

It cited the experience of Koehring Co., a Milwaukee-based maker of construction machinery. Koehring's product liability insurance premiums have increased nearly 200 times in 12 years.

"To put it another way, this year it may well take $30 million of our sales merely to earn a profit sufficient to pay the premiums for our product liability and property damage insurance," said Orville R. Mertz, Koehring's chief executive officer.

Koehring's experience is not unique, according to the analysis. Among woodworking machinery manufacturers, product liability insurance premiums soared from an average of $2,100 per company in 1970 to $29,000 in 1976, the study revealed.

More Americans than ever before are filing suits and the large increases in the size of awards is encouraging the filing of more claims—even when the consumer uses the product negligently.

Awards have been made even in such cases as when a man lifted a rotary power mower to waist height and attempted to use it to trim a hedge, the study said. Manufacturers are not allowed to use the consumer's negligence as a defense in many cases.

During the last 15 years, more than 50 product liability awards have topped the $1 million mark, The Conference Board said.

A manufacturer's experience is not even a guide in its ability to purchase product liability insurance. In some instances, manufacturers reported that, although they have never had a product liability claim, they have lost their insurance or faced staggering increases in premium costs.

Another Conference Board finding was that on-the-job accidents are the cause for many of the product liability lawsuits today even though U. S. industry has been providing a safer working environment than in previous years.

Almost one-third of all product liability cases currently in the courts involve industrial accidents. and many injured parties have come to regard workers' compensation awards as only partial payment.

The analysis recognized that some recent suggestions include increasing workers' compensation benefits in order to remove some of the need for litigation in jurisdictions where compensation benefits have been inadequate in covering injured workers.

The report noted that some action in this direction has already taken place. Thirty-two states have increased workers' compensation benefits during 1975, while proposed legislation would tend to increase and standardize benefits throughout the states.

Nevertheless, the product liability suits continue, and manufacturers need to make their products as nearly "idiot proof" as possible, the report suggested.

E. Patrick McGuire, project director of The Conference Board, wrote the analysis which appears in the November issue of the organization's publication.

Mr. McGuire's analysis likened the product liability situation to "manufacturer's malpractice" but warned that the potential economic impact of product liability costs on the American economy far outstrip that of costs relating to medical malpractice. ■

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Deadline for SRP reports is extended

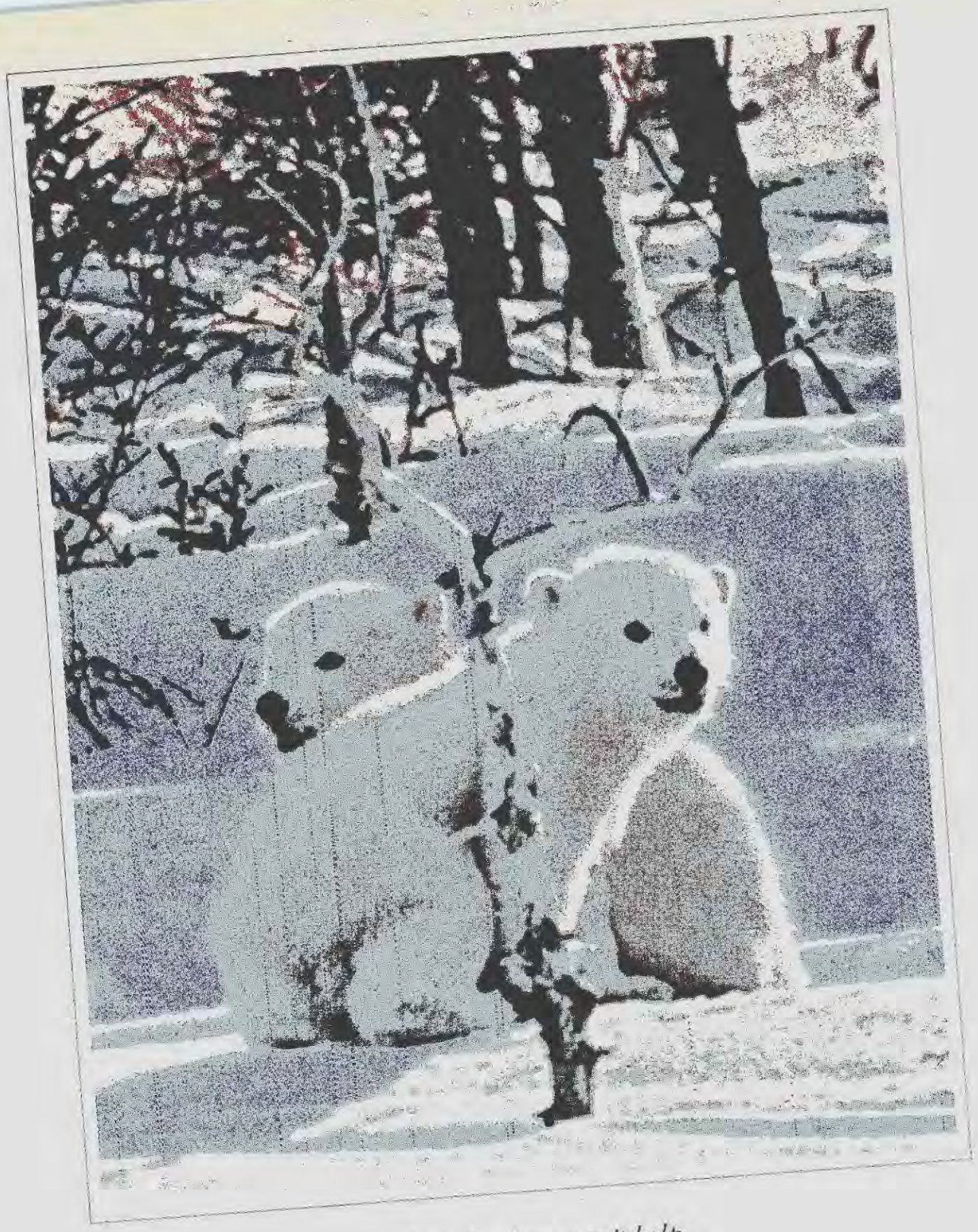
WASHINGTON—The Internal Revenue Service extended to Dec. 31 the deadline for adopting benefit plans or plan amendments under the special reliance procedure (SRP), a set of temporary regulations that the IRS has "frozen" to allow compliance with ERISA while the regulations are being finished.

The two-month extension of the deadline was offered because "we want more people to take advantage of the SRP," an IRS spokesman said. Employers have not used the SRP out of fear that final regulations will be less strict, he said, and they would then be unable to cut back to less stringent plan provisions.

The IRS also announced that it will soon liberalize the "cutback" rule, which will regulate reduction of benefits if final guidelines turn out to be more permissive, the IRS said. "It will provide a greater opportunity for employers to take advantage of the SRP," the spokesman added.

As of Sept. 30, only 27,151 new plans had been filed using the SRP, the IRS said, while there were 34,186 amendments based on the temporary regulations.

The deadline for filing for IRS approval on master, prototype and pattern plans based onn the SRP has also been extended to Dec. 31. The previous deadline was Oct. 31. ■



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U.K. markets pay serious attention to capacity

LONDON—Serious attention is being paid in the U.K. market to a major appraisal of capacity problems which Leslie R. Dew, of Lloyd's, has outlined to U.S. buyers of big-time casualty and property cover.

He predicts that there has to be a positive injection of monetary support, combined with realistic premium rates, if the industry is to survive. But the growth of property/casualty premiums in the next two years will mean that U.S. corporations will have to make increasing use of overseas markets, he believes.

Naming the U.K., Japan, West Germany and Switzerland as in the forefront of providing this extra coverage, he warned: "Insurers' funds are a plum which politicians find almost irrestible, and to solve the capacity problem in the U.S. will take time, but I believe it will be solved."

Looking at the scene from the standpoint of an experienced Lloyd's underwriter, Mr. Dew, who has often visited the U.S. and is a former deputy chairman of Lloyd's, discussed to *Business Insurance* the views he expressed at the Greenbrier convention of major U.S. brokers and agents.

In a special address to the National Assn. of Casualty and Surety Executives and the National Assn. of Casualty and Surety Agents, he said: "The capacity problem is the worst we've seen in 25 years. It has been suggested that property/casualty premiums will increase by $15 billion over the next two years. The conclusion must be either more capital, or more federal and state intervention.

"It is difficult to foresee adequate private capital backing unless the insurance industry can demonstrate a firm resolve to return to its primary function, which is to produce regular profits from underwriting.

"There are signs that casualty underwriters are recognizing this and the list of increases in filed rates in some lines is impressive.

"However, unless you can sweep away all prior approval rate laws and replace them with a truly competitive rating system, you are not going to have enough flexibility to operate private insurance for the maximum benefit of the policyholders.

Mr. Dew said: "I must make it clear that I do not advocate federal regulation. That would be a clear invitation to rape. But it seems to me that many state regulators realize that their primary duty is to ensure that the public has access to an adequate and secure market and to accept that there is no such article as 'cheap' insurance.

"If there are signs of a return to realism in the casualty field, the same cannot be said of property. In general terms underwriting experience has been somewhat better. But to a Lloyd's underwriter, who by the nature of things sees more of the larger risks than the smaller ones, it often appears that the increasing catastrophe element is totally ignored for rating purposes, or perhaps even discounted.

"Regrettably, in the private sector political motives still play a part in depressing rates.

"To encourage private capital into the business will require a very urgent, positive and compelling approach. The enemies are many, such as consumerists, ecologists, bureaucrats, anarchists and self-servers generally. Other objectionable alternatives exist in the shape of Fair Plans, self-insurers, captives, retrospective rating plans and the like. All the time the public image of insurance sinks lower."

Mr. Dew criticized the recent history of casualty/property underwriting as being a "veritable rake's progress", with the worst loss experience in history in 1974 and 1975.

To gain maximum capacity support in London, U.S. brokers and agents will now have to be willing to provide a fuller underwriting presentation than has been customary, and credible rates and terms will be needed, he said.

The Lloyd's non-marine market is adopting tougher underwriting standards, and without adequate information, the Lloyd's broker cannot get a prompt and effective response from his underwriters, Mr. Dew said.

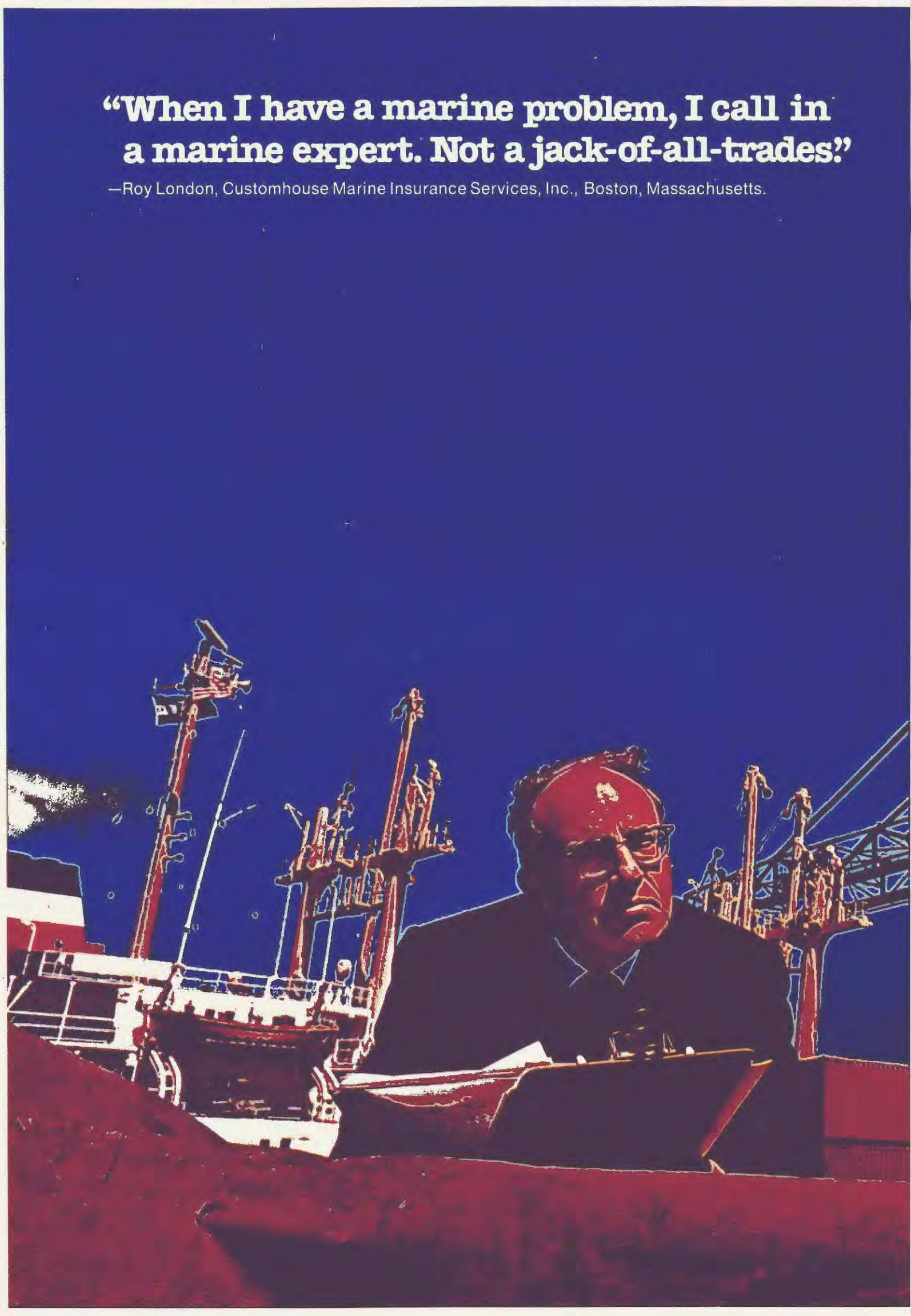
Explaining the Lloyd's attitude to future insurance requirements, he added: "Our U.S. friends are making heavy demands on us for additional support. We're deeply concerned to respond constructively.

"Traditionally we've always written well within our permitted premium limits, believing as we do that underwriting profit is the goal, and that only profitable premium is worth writing.

"But the margin between premium limits and writrings has shrunk

"When I have a marine problem, I call in a marine expert. Not a jack-of-all-trades."

—Roy London, Customhouse Marine Insurance Services, Inc., Boston, Massachusetts.



and in some markets a serious shortage is indicated. However, after a record intake of names in 1975 and 1976, and the prospect of a substantial intake in 1977, barring runaway inflation, I feel we'll be able to keep pace with increased demands in the short term.

"We are hopeful that many existing members of Lloyd's will be willing to increase their stake in the business. Looking beyond the short term, it seems probable that overseas' members applications will accelerate. Seventy-five percent of our business is international, and some 40 countries are represented in our membership; 300 of them are from the U.S., together with a further 250 on the lists for 1977. There will be another big rise in membership that will bring Lloyd's overall premium capacity to an estimated sterling value of 1.25 billion pounds. That figure is net of permitted reinsurance, and of brokerage and commission, and in company terms is probably equivalent to 2 billion pounds. All dollar business is written through the U.S. Trust Fund which at present holds $1.5 billion.

"Our basic function is to fill out surplus line requirements, and I don't think you'll be disappointed. Property offerings may prove unattractive because of rate inadequacies, and certain casualty lines will scare off underwriters because of the startling increase in the premium base. But by and large I believe we'll set a good example for the London market."

Mr. Dew blamed Labor Party moves in the U.K. to nationalize seven leading insurance companies on extremist politicians whose schemes would be defeated by moderating influences. Socialist control of insurance in British Columbia and other places had clearly shown the defects of such a system, he said.

But there are other threats to the insurance industry, such as legislative changes which might affect the doctrines of tort liability that are being studied in the European Economic Community and that have to be watched, Mr. Dew commented.

Product manufacturers, importers and distributors are now facing unreasonable and indefensible liabilities, he said, which result in almost a complete "hold harmless" agreement to every product user.

Asked whether the trend towards more government intervention, more no-fault, more compulsory risk pools, and more strict liability can be reversed, he replied: "I think not, for society's belief that someone has to pay for any personal injury or damage sustained is too deeply rooted to be changed radically.

"But it might be contained if insurers can persuade themselves, the public and regulators that the private market can meet most foreseeable demands if it is allowed to work on a competitive rating basis.

"This will require a vocal, aggressive and determined offensive by the insurance industry which has shown an unwillingness to go over to the attack. You really cannot afford to ignore, for example, the vicious attacks of some congressmen and senators on insurers who had been pressed into a one-off deal in the swine flu vaccine program." ■

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Flood rules issued by FIA chief

WASHINGTON—New regulations for communities participating in the national flood insurance program were issued last month by the Federal Insurance Administration (FIA).

"These are the first comprehesnive changes ever made to the flood insurance program's regulations," said J. Robert Hunter, FIA administrator. "They have been designed to improve the effectiveness and efficiency of the program and to help local governments more effectively enforce and more clearly understand flood plain management requirements."

Among the changes in the regulations, which are effective Dec. 1, are requirements that all participating communities keep records of the elevation of floodproofed structures, anchor mobile homes in flood hazard areas and specify the coordination necessary with nearby communities prior to the alteration of a waterway.

The revised regulations were developed after a series of public hearings held by the FIA last year in seven major cities.

More than 15,000 communities are currently participating in the national flood insurance program, according to the FIA. Those communities must take steps to assure safer development of known flood prone areas to enable residence to take advanatage of federally subsidized rates for flood insurance.

The FIA is giving those communities that must amend their existing flood plain management ordinances until June 1 to comply with the revised regulations. ■

Maher selected

Guy Carpenter & Co. (Canada) Ltd., provider of reinsurance and related services, has named Edward G. Maher president at a board of directors meeting in October. A division of Marsh & McLennan Cos., Guy Carpenter is headquartered in Toronto. Mr. Maher, 49, previously was a vice president and director of the company.

Offshore oil risks get closer attention in U.K.

By JOHN H. MILLER

LONDON—Risk problems in the offshore oil industry are being given close attention in Britain and Norway where the ever-expanding developments of the various North Sea fields are presenting insurers with significant demands on their resources.

Minimizing losses is now becoming an essential part of drilling operations. Many international corporations are facing renewed pressures for safety on both their construction and personnel commitments.

Aspects of these developments were reviewed at a seminar for more than 100 experts from Scandinavia, the U.K. and the U.S. The seminar was sponsored by the U.K. Institute of Petroleum, and organized by Oyez IBC consultants in London.

Speakers at the two-day seminar included several who explored the risk management requirements of the North Sea fields, where energy resources are now being exploited as vigorously as anywhere else in the world, with many U.S. multinational corporates involved in costly operations.

J. William Sherar, president of Corroon & Black of Louisiana Inc., New Orleans, explained: "Insurers are fortunate today in having available a worldwide capacity for offshore construction risks of quite substantial levels.

"But even this is not enough to cover fully some of the projects being completed. Property damage insurance above $400 million is difficult to obtain for a single risk. Coverage for business interruption or failure to start up during the course of construction above $400 million is difficult at any price.

"Cover for oil or chemical pollution on the water from a shore terminal is difficult and generally available in only limited amounts. So if the project can't be fully insured because of its size, coverages need to be structured so as to use available capacity to maximum advantage," Mr. Sherar said.

Risk managers must use their experience to identify loss exposures which can be reduced or eliminated by modifying procedures or in other ways.

After paring loss exposures down to the minimum, it might still happen that commercial insurance would not be fully available, he said.

It is then that various risk retention after natives must be examined, said Mr. Sherar, adding: "In the dollar trading area of losses, say below $100,000, it would appear that paying losses from current expenses or from an unfunded reserve would be most appropriate since the size of the losses in relation to the project itself are not meaningful.

"Larger losses, in the $100,000 to $2 million range, would appear to be best spread through methods such as a funded reserve or a chronological stabilization plan."

Owners must control the insurance program for major capacity risks so as to ensure they are adequately insured.

In that connection, risk managers must make the right choice of broker, for in significant terms a risk manager needed a broker who could "interface" properly with him, his engineers and top management. ■

Britain faces hundreds of big disasters at factories

LONDON—Disasters like the Flixborough blast, which cost insurers $80 million in 1974, could occur at more than 300 plants in Britain.

This warning is expressed in a U.K. government survey of major hazards in industry.

Greater effort in risk management is called for in the report. "Chances that a plant failure will involve many deaths have greatly increased, and it is essential to get both design and operating procedures right the first time," it said.

The government's Health & Safety Commission wants greater control over the siting and operation of hazardous plants, especially in chemical processes, because their size can cause great public risks.

The commission proposes to issue licenses to plants where "high degrees of risk" are concerned and will try to analyze their potential failure rate.

Pointing out that, NASA as well as the aircraft and nuclear industries in the U.S. are consistently trying to improve their reliability analysis processes, the report adds: "If it is found that in a particular plant a serious accident is unlikely to occur more than once in 10,000 years—or to put it another way, there is a one in 10,000 chance in any one year—this might be regarded as being just on the borderline of acceptability."

Safety representatives are being appointed to major hazard installations with instructions that their rules must be accepted every day the plant is in operation.

The Nypro plant at Flixborough, where 28 people were killed in 1974, is being rebuilt at a cost of $70 million. Special steps will be taken to ensure that it can operate without harm to the people living in the vicinity. ■

3 problems confronting self-insureds

CHICAGO—Hospitals looking to self-insure their medical and professional malpractice liability risks and those considering going bare by ignoring the funding of these exposures, face three main problems, said a leading hospital insurance broker here who handles some 20 major hospital programs.

The three problems are:

- Hospital bond indenture requirements that say hospitals must insure certain risks in order to assure creditors that they are financially sound.
- Hospital staffs—nurses, other semi-professional employes and sometimes staff doctors who may refuse to work without insurance coverage because of their concern that a hospital must be able to defend them and cover loss for cases that arise in the future.
- The hospital's directors' and officers' liability insurance (D&O) which may be voided if there is no hospital and professional liability insurance purchased by the institution. D&O insurance policies purchased by hospitals having members of the public on their boards commonly require adequate underlying liability insurance. ■

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Exec tabs inadequate rates as the capacity culprit

SAN FRANCISCO—The present premium to surplus ratio is not the reason the insurance industry is being stopped from writing additional business, Edward J. Noha, chairman of CNA Insurance, says.

Despite the talk of lack of capacity, the insurance industry could write billions of dollars more in annual premiums immediately if the prices were adequate, he said.

Mr. Noha outlined the tactics property/casualty insurers should take in what he called their "struggle to survive" during a seminar with a group of Chartered Property & Casualty Underwriters in San Francisco.

Mr. Noha pointed out that the present premium to surplus ratio for the industry as a whole is 2.5 to 1, while the accepted norm is a 3 to 1 radio. This means an insurer will operate with $3 premium written for every one dollar in reserves.

"Translated into dollars, we could write $10 billion more in annual premium today, immediately," Mr. Noha said.

"So what does lack of capacity mean. It means that the property/casualty companies in general are refusing to write business at inadequate prices," Mr. Noha continued. He referred to that as "hope for the sanity of the property/casualty management."

The CNA chief said insurance companies should aim for underwriting profits of 3% in most lines to remain solvent. To get that percentage, the insurance industry needs to increase its premiums to restore surplus and maintain market capacity, he said.

"But, in some areas, premium costs already exceed what people are willing to pay. And to further compound the problem, increasingly capricious (jury) awards under certain coverages are making costs unpredictable. Thus, these risks become uninsurable at any reasonable premium," Mr. Noha said.

He then urged open rating of insurance policies, in which insurance companies would be free to set their own rates on a competitive basis with one another rather than waiting for "prior approval" from insurance regulators.

The Risk & Insurance Management society has endorsed that proposal nationally for a number of years, but it has not achieved widespread popularity.

"With respect to price, we must have open rating," Mr. Noha said. "We must use adequate trend factors. Data must be available much earlier than it is presently. We should put in indexing on those coverages where appropriate.

"In setting the rates we should target for at least a 3% underwriting profit and include as an expense those residual market mechanisms which are costing us hundreds of millions of dollars each year. Company management must establish controls to spot unusual claim amounts and high credits for rated risks. Further company management must commit to more frequent claim and rating audit."

Citing what he referred to as a change in "market distribution," Mr. Noha claimed that direct writers of insurance have "chopped off half the personal lines market" and are now moving into the commercial lines market.

He predicted large life insurance companies which are moving into the property/casualty area could capture between 20% and 30% of the commercial market within a 10 to 15 year period.

In addition to open rating, Mr. Noha said the insurance industry should improve its service to the public, push for legislative solutions to problems of excessive court awards, improve its relationship with agents, and agree not to "withdraw impulsively from lines of business."

Speaking of traditional property/casualty underwriters, Mr. Noha said: "My sector of the industry has been carrying the bulk of the burden in areas that got worst earliest—workers' compensation, medical malpractice and product liability. But the inflation of expectations will sooner or later involve us all. The industry as we know it will not survive unless we somehow alter the public's attitudes about insurance and revise public policy toward the insurance industry." ■

Ambulatory surgery can cost less

CHICAGO—Outpatient surgery can cost between 42% and 53% less at an ambulatory surgical facility than in a hospital, according to Joseph L. Clune, mananger of group health claims for Metropolitan Life Insurance Co., New York.

"The question to us is: Can you accept ambulatory surgical centers in the same way as hospitals?" Mr. Clune said. "If I can equate what the centers are doing with a hospital, we cover them (the policyholders) the same way." He explained that if outpatient surgery in a center is covered in the same manner as hospital care, the entire bill is paid. Otherwise, there is a $100 deductible with the insurance paying 80% of the balance.

Mr. Clune has spent the last five years visiting freestanding surgery centers to see whether they provide across-the-board services. Clinics which provide only one type of services such as abortion clinics or tooth extraction clinics, are immediately disqualified. If he determines that the surgery center provides a wide range of services, a Metropolitan policyholder is then covered for hospital-type health benefits obtained there. Mr. Clune has to date visited about 80 facilities and accepted half as eligible for full payment.

Savings to Metropolitan policyholders over the five-year period are estimated to be about $3 million. Mr. Clune said that savings like these are of great interest to companies like General Motors Corp. which pay substantial health premiums for their employes.

In states where licensing laws applicable to ambulatory surgical centers exist, Metropolitan rewords contracts for those states so that licensed centers' patients can be covered at the hospital rate, he said. ■

Kidnap insurance

Insurance of German business executives by Lloyd's of London against kidnap risks now is being frowned on by the Federal German insurance control agency which has just ruled that such policies may not be advertised in Germany.

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• **Arson: America's Malignant Crime,** the fastest growing crime is discussed in a report released by the U. S. Department of Commerce's National Fire Prevention and Control Administration. The report represents the views of 36 arson experts and explores the development of programs and reporting to combat the crime. For free copies, contact the Office of Information Services, NFPCA, Department of Commerce, Washington, D.C. 20230.

• A pre-paid, outpatient mental health program, California Psychological Health Plan, is described in **Evidence of Coverage.** What types of services are covered, termination of beneefits, eligibility and benefits are described. For free copies write John E. Armer Associates Inc., 4401 Wilshire Blvd., Los Angeles, Calif. 90010.

• **Directors' and Officers' Liability Insurance: Selecting the Insurer,** and factors to be weighed, are discussed in a free booklet from MGIC. The booklet also shows MGIC's services, such as claims services, reinsurance and coverage options. For a copy write MGIC Indemnity Corp., MGIC Plaza, Milwaukee, Wis. 53201.

• Trends in **The Insurance Market Place** in 1975 are described in a free copy of the 128-page magazine put out by Rough Notes Co. Coverage listings, a company home office directory and sections on aviation, international, marine and regional insurance are included. For a copy write Wallace Clapp Jr., The Rough Notes Co. Inc., 1200 N. Meridian St., Indianapolis, Ind. 46204.

• Nuclear Insurance Consultants Service tells **About Nuclear Power Plants,** a general overview of costs, methods, safety systems in nuclear plants and nuclear insurance. Copies are 20¢ each plus shipping. For additional copies, write the Nuclear Insurance Consultants, Marsh & McLennan Inc., 1221 Avenue of the Americas, New York, N. Y. 10020.

• An assessment of related problems and issues on **Product Liability Insurance** is now available in the Bureau of Domestic Commerce study. The findings of the Department of Commerce study include the scope of the problem, trends and potential remedies. Copies of the entire staff study are available for $5.00 Write the Bureau of Domestic Commerce, Domestic & International Business Administration, U. S. Department of Commerce, Washington, D. C.

• The latest court decisions regarding Premises Liability: **What Is Your Liability** have been compiled in layman's language. Insurance information on injuries occurring on roads, streets, paths and tracks are included. Cost is $5.00. Write Institutional Research Consultants, 5725 Fremont Pike, Box 181, Stony Ridge, Ohio. 43463.

• Matt Jaffe Associates Ltd. offers a brochure entitled **A Short and Simple Introduction to Insurance Specialists,** providing a description of insurance and insurance-related services offered to commercial clients. For a free copy of the booklet write to: G. Rosner, CLU, Jaffe Associates Ltd., 27 East 39th St., New York, N.Y. 10016.

• The advantages of coating plastic safety lenses with TEMA II, made by American Cyanamid, are explained in a question and answer booklet from Glendale Optical Co., **Glass or Plastic?** For a free copy, write to: Glendale Optical Co., 130 Crossways Park Dr., Woodbury, N.Y. 11797.

• Tap to the beat of **The New Nashville Sound,** a cleverly written and illustrated brochure which describes data processing packages offered by Data Service Corp., Nashville. Emphasis is on time/cost accounting and payroll/accounting programs for lawyers, printers, beverage distributors, retailers, wholesalers and bankers plus OSHA recordkeeping. For a free copy, write to Bill Cox, Data Service Corp., P.O. Box 1371, Nashville, Tenn. 37202.

• Stewart Smith is now offering a question-and-answer brochure which describes their **School Board Liability Program.** The coverage is designed for Boards of Education and Boards of Governors, Regents or Trustees for colleges and universities. For a free copy, write to Stewart Smith, Attn: School Board Liability, Dept. 125 S. Wacker Drive, Chicago, Ill. 60606.

• **OSHA Recordkeeping Service** describes an accident information program that analyses employe accidents in terms of cause and effect. Monthly employe profiles, incidence rate reports, analysis by department, occupations, etc. are generated. OSHA compliance (recordkeeping) is guaranteed as an addition or separate service for clients who do not need analysis. For a free copy of the Data Service Corp. brochure, write James Levine, Manager, Accident Information Services, Data Service Corp., P.O. Box 1371, Nashville, Tenn. 37202.

• Werbel's **Variable Annuities Booklet** provides explanations of variable annuities by defining them and describing their functions. The company has now come out with its third edition, first printing, and follows a format of detailing the operation of fixed annuities and the workings of separate accounts. The booklet includes a self-quiz and is suitable for preparation for state examinations. It is available for $1.50 from Werbel Publishing Co., Mrs. V. Merkel, Manager, Circulation Department, 595 Old Willets Path, Smithtown, N.Y. 11787.

• **Excess of Policy Limits,** published by Underwriters Adjusting Co., discusses the principles as to what an insurer must do or not do to avoid excess judgments. "Since the insurance company bears the burden of judgment and the cost of defense it must have the right

control the defense carries with it the legal obligation to use due care or good faith respecting the interests of the insured." For a free copy, write to Underwriters Adjusting Co., Sylvia J. Jurkevich, director of communications, 224 S. Wacker Dr., Chicago, Ill. 60606.

• Mine Safety Appliances Co. is offering its **Industrial Safety Equipment** catalog. Listed are personal protection products, environmental surveillance products, hazard control products, and emergency care products. For a free copy, write to F. C. Ferguson, advertising manager, Mine Safety Appliances Co., 400 Penn Center Blvd., Pittsburgh, Pa. 15235.

• A kit which includes worksheets and instructions for development and implementation of affirmative action programs is available from Entelekia Associates at a cost of $5.95. **The Quick Analysis Worksheet** is designed to assist in the required analyses and goal setting procedures for affirmative action. To obtain the booklet and worksheets write to James M. McHugh, President, Entelekia Associates, R.D. #1, Box 264, Vincetown, N.J. 08088.

• An updated version of **Approach to Property and Casualty Insurance,** written by Harold F. Gee, has been published by The Rough Notes Co. The revised contents of the text reflect changes in wording of policies discussed, and, in a few instances, changes in coverages which have been made during the past three years. Cost is $3, less in quantity. Write to the firm at 1200 North Meridian St., Indianapolis, Ind. 46204.

• **Scope of Burns Services** describes the security services available from Burns International Security Services Inc. Included in this brochure is information on guard protection, electronic security, crime prevention and detection, investigations, airport security and management consulting. For a free copy, write to Mr. Ashley W. Burner, Burns Intl. Security Services, Briarcliff Manor, N.Y. 10510.

• A brochure describing the **Insurance Institute of America's Program in Risk Management** is available. The program's main aim is to teach the use of a logical process when making risk management decision; the program ties risk management decisions; the program ties risk management to the mainstream of general management principles. For a free copy write: Director of Risk Management Education, Insurance Institue of American, Providence and Sugartown Roads, Malvern, Pa. 19355.

• **Occupational Health Consulting Services,** published by National Loss Control Service Corp., explains how consulting services can help lower health insurance and worker's compensation costs. It also discusses how improved employe health programs, medical program analysis and "tailored" first aid training programs can reduce employe health and injury cost. For a free copy, write to G. J. Krafcisin, National Loss Control Services Corp., Long Grove, Ill. 60049.

• Two checklists for OSHA compliance—one for general industry and one for construction—are available from the Atlantic Cos. They cover the most commonly inspected areas of inspection and about 90% of all OSHA-listed standards. Single copies are available free by writing to Engineering Administration, the Atlantic Cos., 45 Wall St., New York, N.Y. 10005.

• A description of the consulting, recordkeeping and communication services available from George B. Buck Consulting Actuaries Inc. is provided in **Thrift Plan Administration Services.** The brochure explains design and administration of a defined contribution plan for thrift, savings, or profit sharing plans in compliance with ERISA. For a free copy, write Terrance T. Toth, Manager Plan Administration, Dept., George B. Buck Consulting Actuaries Inc., 2 Pennsylvania Plaza, New York, N.Y. 10001.

• **Mark V Central Surveillance and Monitor Panel** explains a product from Continental Instruments Corp. which monitors other security systems and devices, temperature and medical equipment. Illustrations and diagrams are included in this free brochure. For a copy, write to Michael Morgenstern, Continental Instruments Corp., 170 Lauman Lane, Hicksville, N.Y. 11801.

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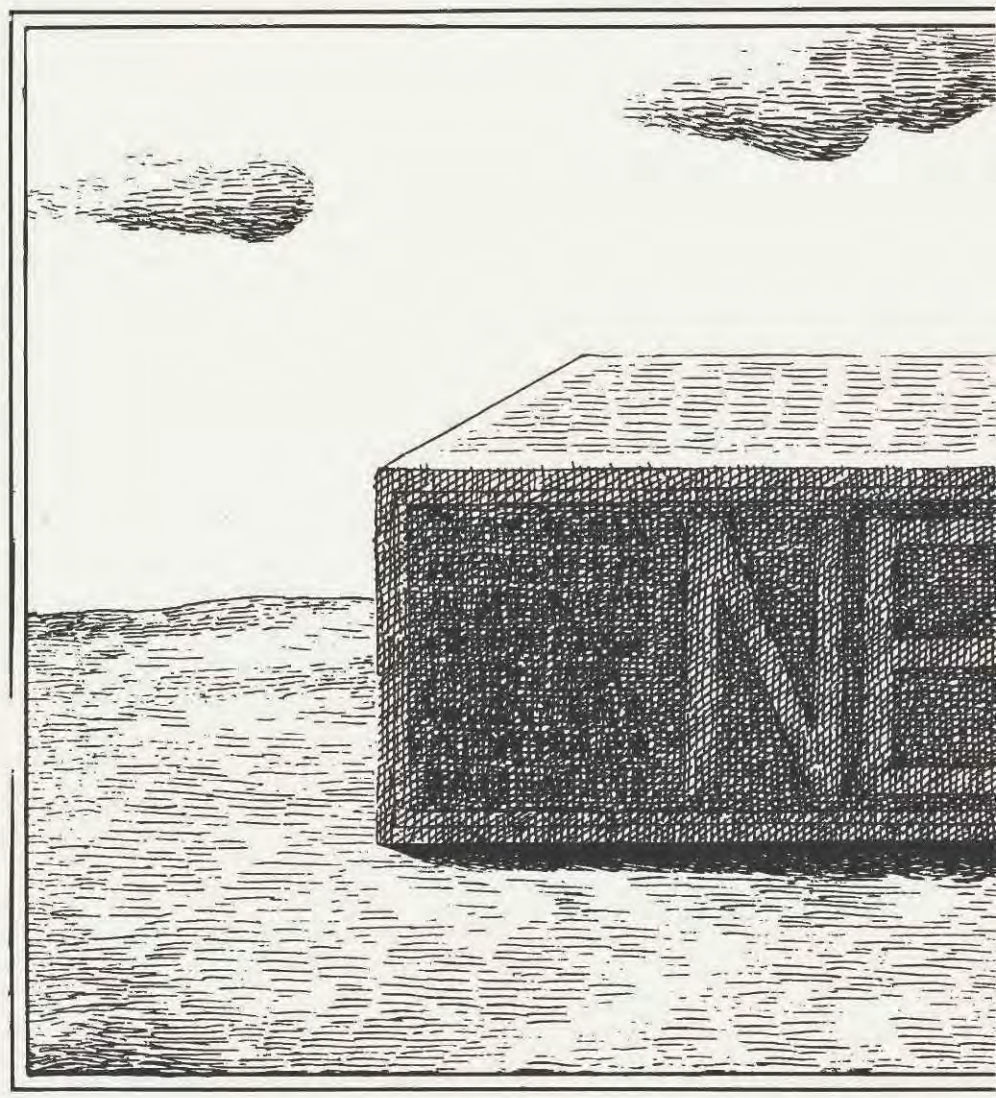
Product

A surge of claims and lawsuits, greatly increased jury awards and broadened interpretations of product liability, have created severe problems for today's manufacturers.

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



Americans' concerns about the products they use, both at work and away from it, have increased rapidly in recent years. There is a growing expectation that goods will not be offered for sale unless surrounded by every possible safeguard against misuse and injury, and a greater inclination to seek legal redress when product related losses or accidents occur.

These attitudes are accompanied by heightened expectations of compensation for injuries connected with product use. As the number of insurance claims and lawsuits has soared, so has the size of awards in product liability cases.

At the same time, the concept of product liability has widened to take in situations where liability was formerly thought not to exist.

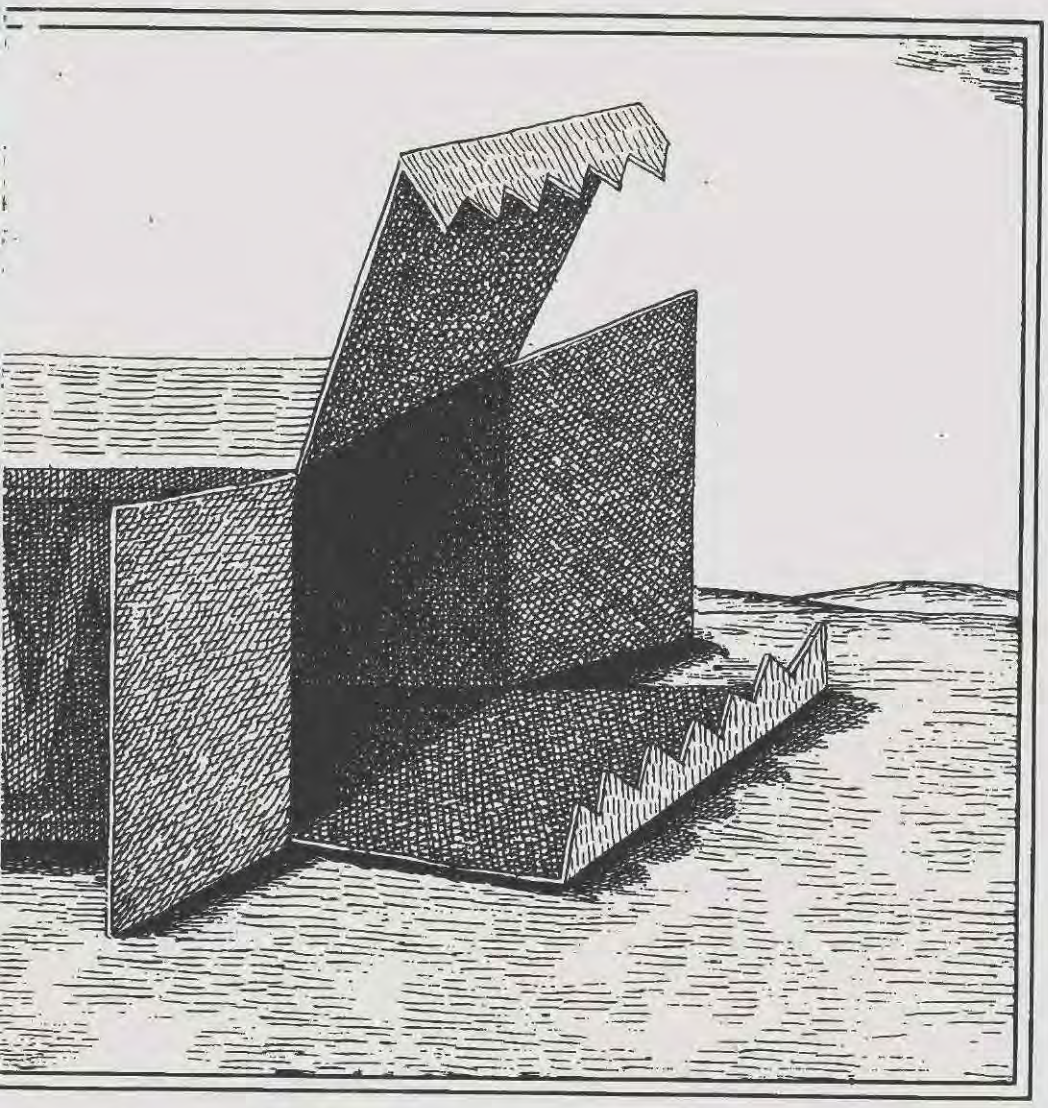
For example, claims have been made against manufacturers for products built and sold as long as 15 or more years ago, even though the products may have changed hands, gone through several modifications, or even been misused by their owners.

Before the upsurge of product liability cases, there would have been little likelihood of such claims being made, and even less likelihood that they would have succeeded. Manufacturers and suppliers, in short, today are more accountable and face greater financial exposure for everything they make and sell.

The cumulative effect of these trends on the costs of providing product liability insurance has been predictable. In 1975, insurers incurred $116 of losses and expenses for every $100 they earned in premiums on miscellaneous liability coverages, much of which was product liability. Premiums have risen, resulting in higher business costs for manufacturers and suppliers. However, it is doubtful that the effect of future claims can be predicted either by insurers or insureds.

In some industries where product liability exposures and expenses are particularly high, such as the machine tool industry, several companies

Liability



have said they may be forced out of business entirely, because potential product liability claims could exceed their total assets.

What can be done?

The current trend of product liability awards threatens to outstrip all efforts to finance them, leading to a possible breakdown of the compensation mechanism itself. This has led to an urgent search for remedies by manufacturers, consumer groups, the legal profession and the insurance industry.

Proposals have been made for modifications in the existing legal system under which negligence, liability and subsequent awards for damage are determined, so that the financial burden on manufacturers, and indirectly on their customers in the form of price increases, may be lightened.

At the same time, many executives of manufacturing firms are focusing ever-increasing attention on tighter safety programs—both for established products and for new product development activities. Integral parts of such programs include extensive product research and testing before production, painstaking safeguards during manufacture, and thorough quality testing afterward.

Better quality control.

Many insurance companies provide professional product safety and quality control reviews as part of their underwriting service. By holding down insurance premiums, such reviews can be very much in the manufacturer's interest. In some cases, they have even resulted in substantial savings in production costs.

As a fuller discussion of product liability from an objective standpoint, INA has prepared a booklet entitled, "Product Liability: Some Professional Considerations." Copies may be requested by writing INA Corporation, 1600 Arch Street, Philadelphia, Pa. 19101.

* * *

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Classic example of problems

Hospital captive effort collapses in Chicago area

CHICAGO—A year-long effort to form a captive insurance company to write malpractice insurance for hospitals in the North Suburban Assn. for Health Resources has collapsed.

Eight large suburban hospitals in the shared services organization were ready to sign up with the captive. But now, after a series of problems obtaining the necessary reinsurance, only three remain interested.

The hospital's interest in the captive was sparked by fears of difficulty in renewing malpractice coverage. But one of the hospitals was recently able to renew its policy with Argonaut Insurance Co. at the same rate as last year and dropped out of the plan.

The association's problems are a classic case of the difficulties in starting a captive insurance company even when the potential annual premiums, $7 million in this case, are very large.

Two brokers worked diligently to find reinsurance for the captive. Arthur J. Gallagher worked from early 1976 to find $10 million per occurrence coverage. When that failed, it attempted to find $4 million coverage, over the captive's retention level of $500,000 per occurrence. This would have been Gallagher's first hospital captive management.

The London markets agreed to take 50% of the coverage if the domestic markets would also take 50%. But the deal fell through in August when one of Gallagher's reinsurance brokers was unable to fill a commitment in the name of domestic insurer. Lou Metzger at Gallagher declined to disclose the name of the reinsurance intermediary.

At that point Alexander & Alexander arrived to fill the gap, establishing a so-called "straight excess plan" instead of the reinsurance deal Gallagher had worked on. A&A arranged for American International Group to write excess insurance for $2 million of loss over a layer retained in the captive amounting to $1 million per occurrence and $3 million aggregate. A&A was also hunting for another high layer of excess coverage to provide the needed limits.

The A&A plan didn't provide any stop loss coverage for hospital or professional liability, but would have provided a stop loss for premises liability losses, said Kay Hartlieb, Chicago account manager.

Gallagher, on the other hand, had worked to find coverage with stop loss provisions, and with $10 million limits, at that.

The A&A plan was called "not quite as favorable," by Phil Haas, assistant director of the North Suburban Assn.

"The plan has pretty much fallen apart at this point," says Dick Huntington, a risk management consultant with Warren, McVeigh, Griffin & Huntington in Newport Beach, Ca. In early 1976 Mr. Huntington compiled a feasibility study for the group, recommending a Colorado captive be established as one risk funding alternative.

The North Suburban Assn. figured that in the first year, the direct cost of the captive to the eight participating hospitals would be just a bit over $7 million, including $2,750,000 reinsurance cost, said Mr. Haas.

"Initially, we were going to have minimum capitalization and surplus of $750,000 ($400,000 required capital and $300,000 surplus). But the Colorado insurance commissioner wanted a two-to-one surplus, which would have required funding the surplus at $3 million," Mr. Haas said.

When the group gave the account to A&A, participation was already down to six hospitals. "We felt four was the bare minimum, and that five was better," he added. Now, with only three hospitals eager to use such a vehicle for insurance, the plan is all but dead.

One of those hospitals pulled out because renewal was coming up and new insurance is being purchased. Another said there was no real problem obtaining adequate insurance at affordable prices and a third decided the group was too small.

Lutheran General, the largest hospital in the group, recently joined Multihospital Mutual Insurance Co. (MMI) based in California. Lutheran General had its insurance previously with Argonaut, at a $1.3 million annual premium. Argonaut told the hospital its premium would double to $2.6 million on renewal July 1.

The North Suburban Assn. hadn't ever purchased insurance centrally for its hospital participants. Most, if not all, had their insurance with Argonaut, and most are back with Argonaut now that the deal's fallen through.

As one administrator says, "Argonaut is still the Number One writer of malpractice insurance in Illinois. And their loss ratio isn't bad at all—about 55%—and that looks like profit to me. They insure probably 75% to 80% of all the hospitals in the state, and they're even being competitive on some new accounts."

Argonaut was partly at fault for the crumbling of the captive plan, said several people close to the North Suburban Assn. program. "As Gallagher seemed to be getting closer to putting the group plan together, Argonaut came in with some low premiums. Take Holy Family Hospital, for example. . ."

Holy Family was fortunate with its renewal. Alberto Heller, vp of finance for Holy Family, based in Des Plaines, believes he was successful because he dealt with the president of Argonaut directly, and was effective in showing Argonaut that it had to compete for the business, or else.

The 247-bed Holy Family Hospital previously had its insurance with Continental Assurance (part of CNA), but went with Argonaut for medical malpractice as well as workers' compensation. Premiums for the first dollar malpractice coverage are extremely competitive, at about $1,500 per bed, said Mr. Heller.

(A very low cost per bed is $1,400, say insurance observers, while an upper range would be $3,250 per bed.)

Mr. Heller was able to obtain an occurrence type of policy, as well as a one-year non-cancellable provision from Argonaut "in writing,"

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Five alternatives were open to Holy Family for malpractice risks, said Mr. Heller: The captive, CNA, a self-insurance fund, Argonaut, or the European markets which had already been lined up for the hospital by its broker, Maine Insurance Agency, also in Des Plaines.

"The premium in the captive would have been higher, for us," recalled Mr. Heller. "And we've only paid about $160,000 in losses over the last 10 years. Continental quoted premiums at 120% of the coverage. We decided Argonaut was the best coverage because the premiums for much higher coverage are lower than the premiums would have been with Continental for less coverage."

Northwest Community Hospital was not as lucky. Its renewal was Nov. 1 and it was within days of completing placement of its first-dollar insurance for $1 million/$3 million with Argonaut, insurer of the hospital's malpractice risks for some years. But premiums are rising 49%.

Bayly Martin & Fay, Northwest Community Hospital's broker, has been working frantically to complete the placement of an excess umbrella liability policy with limits of $10 million which the hospital feels confident it will obtain. "It looks as though we'll be able to get that coverage again also," said hospital president Malcolm MacCoun, "although I anticipate that there will be substantial premium increases for this coverage too." He expects that the excess coverage will be in the form of two or three layers. It's previously been written by Crum & Forster.

Unlike some other administrators, Mr. MacCoun hasn't given up on the idea of a captive. Wyatt Co. is currently working on actuarial studies for Northwest Community Hospital in order to define the feasibility of various alternatives.

But several individuals involved with the North Suburban Assn. have complaints about a group captive like the one attempted. "A captive can work," says Mr. Heller of Holy Family Hospital. "But I think you need more than eight hospitals with a lot of experience and a wide range of experience. Some of the hospitals in our group didn't have any loss experience to speak of."

To broker Lou Metzger of Arthur J. Gallagher, "the trouble with associations is that there isn't one person who can make the decision" on the captive.

Kay Hartlieb of A&A concurs that at least part of the problem stemmed from lack of agreement by the hospitals.

Mr. Metzger says, with a trace of bitterness, that Gallagher worked to come up with three completely different alternative plans for the captive operation.

They included one which "was immediately turned down," because it involved a modified occurrence basis coverage, which required an incident report to be filed by the hospital with the insurer within four years after the expiration of the policy.

The second proposal was a full occurrence type reinsurance plan, initially starting out with a $100,000 retention and the captive's 20% participation in the reinsured losses. "This was the one that couldn't be completed, though," said Mr. Metzger. The third plan incorporated a higher per loss retention of $10 million.

"But by that time several hospitals had already pulled out," Mr. Metzger said. ■

Outpatient care urged

CHICAGO—Extended care facilities that cost up to 50% less than general hospitals can help contain rising hospital costs without reducing the quality of care, according to the Chicago-based Blue Cross and Blue Shield plan.

"Often the extensive services of a general hospital are not necessary for a successful recovery from surgery, a serious illness or injury," said Charles R. Goulet, executive vp of the group.

In addition to lower direct costs, use of extended care facilities reduces hospital crowdings and lessens the pressure for additional expensive hospitals. Patients who must also pay part of the medical costs also save money by using extended care facilities.

Mr. Goulet said Blue Cross and Blue Shield members receive two days of care in an extended care facility for every unused day of in-patient hospital care. ■

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Broader continuations urged by Prudential

CHICAGO—Robert A. Beck, president of The Prudential, said health insurers should provide "broader continuation of group coverage" including temporary continuation of coverage at termination of employment and liberalized conversion provision and benefits.

"I recognize that this may place an additional financial burden on the group policyholder, but our experience indicates that this is a need which is difficult for traditional individual health insurance to fill," Mr. Beck told an October meeting of the Health Insurance Assn.

The Prudential president said the insurance industry must demonstrate its commitment to coverage for all peple to avoid having blame placed upon it by the government.

"Additionally, I believe there is more at stake here than the health insurance business. A Federal takeover . . . could well be the stepping stone to similar takeovers in the life and property and casualty areas," Mr. Beck said.

He also recommended that carriers provide a "low-load" individual health insurance policy to provide interim temporary coverage on a single-premium basis.

Mr. Beck described the present market for individual health insurance as made up of those who are permanently without access to group coverage, such as the self-employed, and those who are temporarily without coverage, such as students and unemployed.

"I recognize that this may place an additional financial burden on the group policyholder," Mr. Beck said, "but our experience indicates that this is a need which is difficult for traditional health insurance to fill."

He also recommended a solution he said was already in use by some companies; providing a low-load individual health insurance policy designed to provide interim temporary coverage on a single-premium basis.

Mr. Beck told the group that health insurers have "an obligation to provide solutions to the insurance needs of all segments of the market." If they fail to meet the public's needs, he warned, a federal takeover could occur that could possibly lead to other steps involving a similar takeover in the life and property and casualty insurance areas. ■

Chadwick takes over Labor pension post

WASHINGTON—The new administrator of pension and welfare benefit programs at the Department of Labor, William Jordan Chadwick, took over on Oct. 26.

He succeeds James D. Hutchinson, who resigned effective October 1 to bring attention to the problems of joint jurisdiction among the three federal agencies that administer ERISA and the "pressing" need for greater flexibility in hiring benefits experts.

Mr. Chadwick was appointed in mid-September by Labor Secretary W. J. Usery after the field of candidates was narrowed to Mr. Chadwick and Matthew Lind, who heads the office of Program and Policy Development at the Pension Benefit Guaranty Corp.

Mr. Lind, 34, was seen as a more seasoned administrator with greater experience in government work, but Mr. Chadwick who served as Mr. Hutchinson's special assistant since May 1975, was considered more in tune with the current issues and problems facing the Labor Department, according to government sources. Also, Mr. Hutchinson pushed hard to have his special assistant succeed him at Labor's top ERISA post, a source close to the Labor Department said.

The administrator of pension and welfare benefit programs is responsible for enforcing ERISA and he reports directly to the Secretary of Labor.

Prior to working at the Labor Department, Mr. Chadwick was attorney-advisor in the Office of Tax Legislative Counsel in the Treasury Department, from April 1974 to May 1975. Before going into the government, he was in private law practice with Paul, Hastings and Janofsky (formerly Paul, Hastings, Janofsky and Walker), a Los Angeles tax law firm.

While at the Treasury Department, Mr. Chadwick represented that agency on the Congressional conference committee that drafted the final version of ERISA.

He is a graduate of Vanderbilt University School of Law, Nashville, Tenn., and St. Lawrence University, Canton, N. Y. Mr. Chadwick has authored many articles on taxation and the pension law as well as lecturing frequently on the subject. ■

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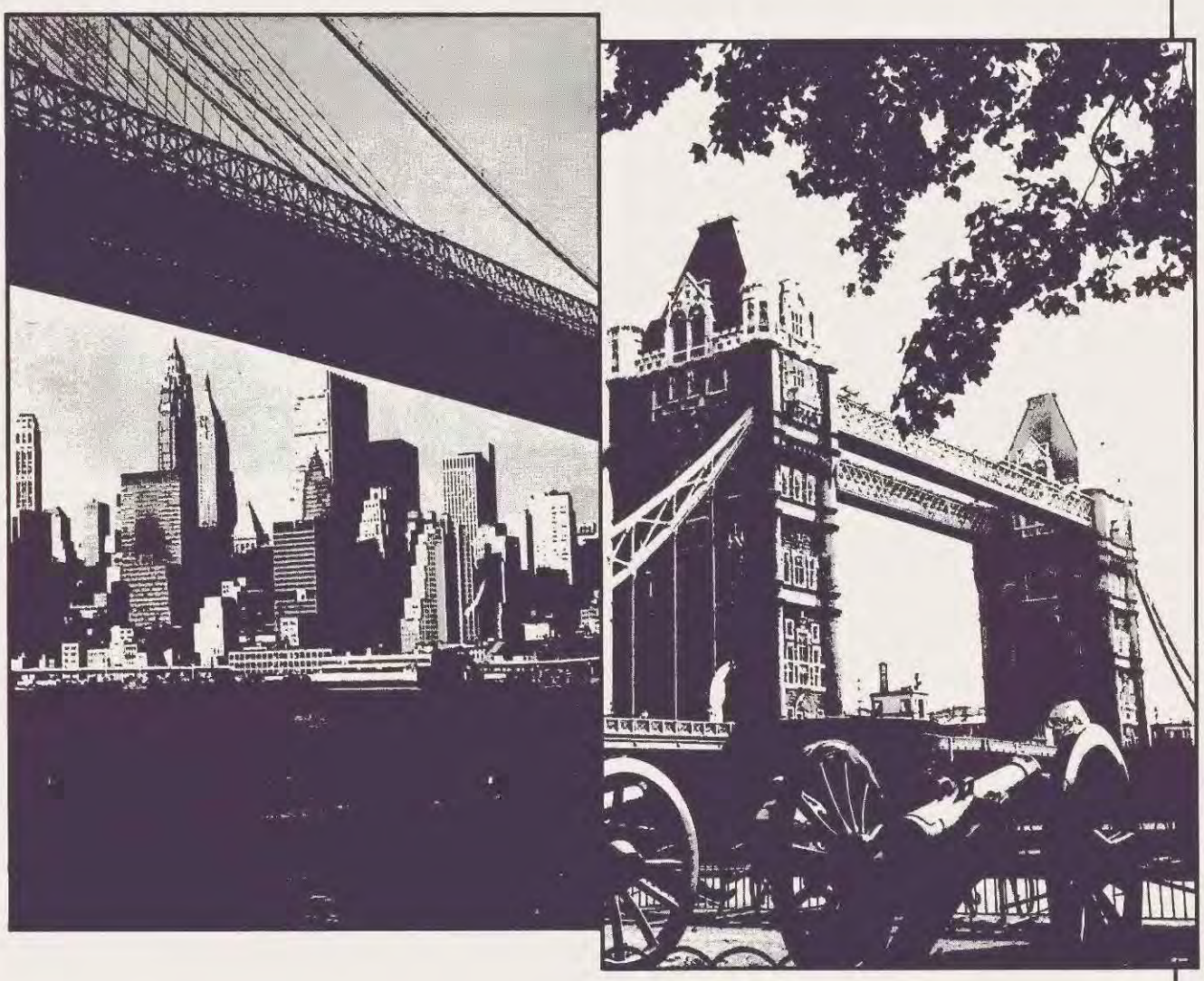

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A 'flexible' hospital plan is discussed

CHICAGO—Hospital indemnity coverage supplementing basic medical coverage purchased on an individual or group basis offers a lower incidence of claims than any other health insurance product, according to the president of Bankers Life and Casualty.

Robert P. Ewing said indemnity policies are flexible, are easily understood and offer lower processing costs. Because of this, they are becoming more popular with the public.

"Sold in higher amounts it is most useful in offsetting the catastrophic hospital expenses of a lengthy hospital confinement. With a convalescent benefit included, it further assists with nursing home or convalescent expenses," Mr. Ewing said.

Speaking at the Health Insurance Assn. of America forum in October, Mr. Ewing said the hospital indemnity coverage would be useful "if and when a national health care bill is passed, assuming that national health care leaves the opportunity for supplemental coverage."

The indemnity coverage can also serve as a "wrap-around or assist" to senior citizens presently covered by Medicare.

"This a period for us to retrench, streamline our operations for efficiency and service and discard wasteful practices and products so that we will be lean enough and strong enough to take advantage of the opportunities which are sure to be ours as we emerge from this stressful, upsetting period," Mr. Ewing said. ■

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National health could hike costs by $25 billion

By ANNE MYERSON AYERS

WASHINGTON — National health insurance will raise total annual health spending $10 billion to $25 billion by 1980, depending on which of six major proposals is enacted, according to a comparison of the plans by Gordon R. Trapnell Consulting Actuaries.

The study was done for the Department of Health, Education and Welfare using government figures and is the most detailed information to date on how much the plans will cost.

Even if no national health insurance program exists, the U.S. will spend $223 billion on healthcare in 1980, the study found. The federal government would pay $59 billion for its military, veterans, public health, Medicare and Medicaid programs, while private and public health insurance would cover $127 billion.

Congressional hearings, department papers, industry discussion and the health press, however, have largely assumed national health insurance is inevitable in some form in the future. Democratic presidential candidate Jimmy Carter endorsed a plan similar to the labor-backed Health Security Bill sponsored by Sen. Edward Kennedy (D-Ma.) and Rep. James Corman (D-Ca.), while President Ford was expected to unveil a catastrophic coverage plan before the election.

The study assumes national health insurance would take effect in July 1977, and estimates cost increases by fiscal 1980 in 1976 dollars. All six plans, it concludes, "would add several billions to the federal health care budget primarily to provide improved health services for the poor." Any national health insurance plan would also encourage greater use of health services, the study said, because health insurance coverage would be increased.

The issue is certain to be debated in Congress next year. Most observers say cost containment will be the most important factor in efforts to pass a bill. The Health Security bill, labeled a budget breaker by its opponents, is not the most expensive plan, according to the Trapnell study: The Kennedy plan would increase annual healthcare spending by $24.8 billion in 1980. But the report also notes this plan would provide more complete and more general coverage than the less costly bills.

The most expensive of the six plans is the one proposed by the American Hospital Assn., (AHA) sponsored by Rep. Al Ullman (D-Or.), chairman of the House Ways and Means Committee. That bill would cost taxpayers an additional $25.1 billion.

The Long-Ribicoff catastrophic bill was found to be the least expensive of the six, but also would not provide as many services as the others. The bill would federalize Medicaid and would add $9.8 billion annually to health costs by 1980.

In addition to the AHA and Health Security bills, expensive plans include one put forth by the American Medical Assn., which would increase health costs $20.3 billion a year. That bill, the study found, would also raise physicians' fees due to lack of a control mechanism.

Among the less expensive proposals are the Comprehensive Health Insurance Plan proposed in 1973 by former President Nixon and now advocated by President Ford.

The measure would add $11.3 billion to yearly health spending by 1980. Slightly less expensive than that plan, but more costly than the Long-Ribicoff measure, is the bill backed by the health insurance industry, which would raise annual health spending by $11 billion. The Health Insurance Assn. of America's plan would extend more coverage than the other two proposals and would limit hospital charges more severely through state rate setting. ■

Rate hikes for Norway

NEW YORK—Insurance premiums will rise at least 40% for Norwegian chemical plants which use flammable substances, as insurance companies in Norway react to an unusually high number of serious industrial fire losses this year.

Spokesman for Norwegian insurance companies told the Financial Times of London that the premium hike might be even higher unless the firms can spread the bill for 1976 over several years.

The spokesman said a particularly bad example of the kind of loss which sparked the rate increase was an explosive fire at a Sandefjord paint factory in September.

Combined damages and loss of production expenses are expected to reach about $300,000 from the paint factory fire. ■

Cafeteria-style plans can cope with diversity

CHICAGO—New social values emphasizing the individual have reached the employe benefits field, an industrial psychologist said, recommending cafeteria-style benefits as one way corporations can deal with the change.

Stephen Zimney, vp of Yankelovich, Skelly & White research firm, said employes have returned to the "psychology of entitlement" as the 1974-75 recession becomes a memory. Employes now feel pensions, profit-sharing plans, a good work environment, communications with employer and other employe benefits are a right, not just "nice to have."

Despite the increased individualism, which is partly a result of better education and more affluence, employers still tend to treat employes as if they were all alike.

"Communications and benefit packages are usually unitary—apply to all people at all times. But employes are pluralistic and methods of dealing with them are varied," Mr. Zimney told the annual conference of the Profit Sharing Council of America.

Mr. Zimney said the "major misconception among employers is that they can get to core of workers' attitudes." This, he said, is holding back organizations from implementing methods of answering their employe problems.

To communicate with employes, one corporate communications specialist recommended "keep it simple and direct." Richard Coffin, a principal with Towers, Perrin, Forster & Crosby, said too many employe communications devices "get bogged down in analogies and technicalities."

Profit sharing plan presentations should focus on the most important question. "What do I have to do to get it?" Employes should be told, Mr. Coffin said, that to increase their profits it is necessary to increase company profits.

To do this, one large department store told its sales people that it takes $100 in sales to create $5.00 in profits—for every $5.00 wasted, $100 in sales is lost. Texas Instruments Inc., according to Mr. Coffin, issued comic books explaining the profit sharing idea to its unskilled workers.

Mr. Coffin also warned against employe benefit managers becoming too involved in "ERISA minutiae" and losing sight of simple communication of benefits.

He said some ERISA requirements still need clarification, including fiduciary liabilities, the "prudent" man rule, summary plan descriptions, and filing dates for Labor Dept. and Internal Revenue Service requirements.

Deborah Fishman, a consultant with Kwasha Lipton Inc., told the Profit Sharing conference to keep reporting procedures as simple as possible to save administration costs. For example, using elapsed time rather than counting hours when figuring vesting schedules, is cheaper according to Ms. Fishman.

However, R. Michael Sanchez, an employe benefits lawyer, said that hours rather than elapsed time methods should be used until final regulations are passed because of the too-liberal interpretation that may be given to vesting rules. ■

Changes are predicted for LTD plans

CHICAGO—Disability income providers need more complete actuarial guidelines reflecting the risk inherent in guaranteed premiums and benefits. They must also have the know-how to professionally manage and administer costs and claims, according to two life insurance officers.

John C. Angle, senior vp of Guardian Life Co., and Colin C. Hampton, president of Union Mutual Life told the Society of Actuaries insurance forum in October that disability income providers will have to change their operations in the future.

Mr. Hampton said some providers "will simply be unable to reverse the deteriorating trend in profitability and will of necessity lose interest in, or completely abandon the (disability insurance) business." The companies that will succeed, he said, are those that have substantial surplus, professional cost administration and are well managed.

More actuarial guidelines are needed, according to Mr. Angle, to clarify disability issues: how to distinguish risk in issuing guaranteed premium from adjustable premium disability insurance; the magnitude of risk in the various definitions of disability; and the need for supplemental reserves when premium income falls below claims and expenses.

"No one has had any desire to abandon the present market distribution system nor to disturb competition," Mr. Angle said. "What we can ask is that all players be properly informed about the consequences of their decisions. ■

Some joining self-insurance move but most are waiting, study finds

WASHINGTON—There is a trend toward self-insurance of employe benefits, but by no means a rush in that direction, concluded the Washington Business Group on Health after conducting a survey on self-insurance practices among 96 of its corporate members.

Three companies do not provide basic medical benefits. Of the 93 companies providing basic medical benefits for employes, eight said they fully self-insure those benefits, while 19 others said they have some form of self-insurance in combination with an underwriter's program. Seventy-nine respondents said they use the Blues for basic medical benefits, either alone or with commercial carriers or self-insurance.

All 96 companies provide major medical benefits.

Major medical plans are fully self-insured by nine companies, the survey found. Fifty-one companies use commercial carriers alone, while 17 use Blues and commercial insurers. Only three use the Blues alone. But a total of 22% of the companies participating said they use the Blues in some combination with other insurers or with self-insurance.

Of the firms with fully self-insured major medical plans, 16 said they began self-insuring in the period 1970 to 1975, while 10 began in the period 1960 to 1969. Only six began self-funding these benefits before 1960.

Cost savings were overwhelmingly the reason for implementing self-insurance on medical benefit plans, with 33 companies citing this as the major reason. Another three said they obtained greater benefits per dollar spent. Twelve said easier administration was the reason for self-funding, while one noted that employe requests resulted in the self-insured plan.

Of 27 companies self-insuring medical benefits, 16 told the Washington Business Group on Health that they had no difficulties with their plans. Among the 11 saying they had some difficulties, nine concerned administrative burdens, one referred to cash flow uncertainty, and one spoke of the disadvantage of losing the third party payer as a buffer between the employe-patient and the employer.

Some 30 companies who said they don't self-insure noted they'd previously rejected the idea, for four main reasons. Ten said they could not foresee any financial savings; seven avoided the start-up administrative difficulties; six didn't want to lose the third party buffer and two bypassed self-insurance because of union objections.

Of 61 companies that disclosed future plans, 43 or 70% said they don't plan to switch to self-insurance for medical benefits. However of the 18 companies which do plan to self-insure, 16 predict that this will occur within the next two to five years.

Half will make the change to save premium dollars, and another five want to improve cash flow by reducing retention funds. Three believe they will improve benefit administration by doing servicing themselves.

Most of the companies which self-insured their medical plans use an insurance company for administrative purposes, the survey reported.

One reason for self-insurance not found in the survey data, but frequently cited in conversations with employers, is access to greater direct involvement with the health care providers, such as hospitals, said the Washington Business Group on Health. ■

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Allstate exec sees problems by 2000

TOTONTO—The U. S. Social Security system will not last until the year 2000 unless its coverages and mechanics of compensation are overhauled, an insurance company executive said here.

Addressing the annual meeting of the Society of Actuaries, Roy R. Anderson, vp for strategic planning at Allstate Insurance Co., accused the Social Security system of being based on an invalid concept, "the idea of a contract between generations."

"We seem to have convinced ourselves that it is possible for one generation to contract with a later generation such that the latter must continue to perform. Children now unborn are supposed to be willing to provide the benefits that today's politicians see fit to promise to today's voters," Mr. Anderson said.

"And we seem to want to induce the workers of today to believe that the contributions they are now making are in effect buying them their own identifiable annuity plan. They evidently feel they have to believe this fiction if they are going to be willing to continue to support the system with their contributions."

Mr. Anderson suggested the system be reconstructed under the concept that the goods and services that are being produced by those who can work should be made available to those who can't, with Congress re-examining the generosity of that support every few years.

The single factor which may prove to be the "fatal flaw" of the Social Security System is its disability income feature, because it is too liberal in its benefit structure and overlaps with too many other systems of income disability, Mr. Anderson said. ■

Product claim increases detailed by ISO study

NEW YORK—The Insurance Services Office has released information detailing the increases in product liability claims between 1969 and 1973, the last year for which figures are available.

The numbers represent product liability policies written separately, known as monoline policies, not included under other general liability coverage.

Underwriters said the number of product liability claims increased to 34,321 from 27,298, or 26%. The average loss rose to $8,519 from $2,830, or 202%.

The total incurred losses rose 279%. Basic losses (those below $25,000) rose to $167,838,505 from $50,214,763, while excess losses went to $135,540,896 from $27-039,402.

Premiums increased 154% to $216,704,433 from $85,039,402. The combined loss ratio rose to 135%, meaning the companies paid out $1.35 for losses and related expenses for every $1 collected.

Figures are also available for composite-rated general liability coverages, estimated to include another third of product liability volume.

Earned premiums increased 148% while incurred losses increased 198%. These figures are divided into bodily injury and property damage. Bodily injury premiums rose to $252,134,903 from $97,-425,291 while property damage premiums rose to $93,797,082 from $41,855,901. Losses on bodily injury liability rose to $538,038,877 from $164,162,146 while property losses rose to $105,230,929 from $51,664,130.

The loss ratio rose to 1.86 in 1973 from 1.55 in 1969 meaning the companies paid out $1.86 in 1973 for losses and expenses for every $1 taken in premiums. The bodily injury ratio rose to 2.13 from 1.69 while property fell to 1.12 from 1.23.

Mike McManus, the ISO staff member who developed the figures, said a "major problem is getting a handle on the scope of the problem." He said ISO is considering requiring all losses be identified by the type of loss and encouraging underwriters to isolate products coverage. Most of the insurance companies are.

Mr. McManus said the figure for 1974 will be available in late December. ■

JUA called 'euphemism' for pay-outs

BOSTON—An insurance industry spokesman has called suggestions insurers form joint underwriting mechanisms to absorb large product liability losses a "sanctimonious euphemism for picking up the tab."

Richard J. Underwood, New England regional vp of the American Insurance Assn., said any proposals to have the insurance industry bear a greater burden of the cost should be delayed until current studies measuring the impact of large claims are completed in mid-December.

The insurance industry is not responsible for conditions that brought on the medical malpractice or product liability problems, Underwood argued.

"And yet, whenever some segment of the business or professional community finds itself distressed by these manifestations of society's weaknesses and failures, there is a march to legislative halls and a demand that insurance companies meet their corporate responsibilities," he said.

Mr. Underwood also dismissed recent statements by the American Trial Lawyers Assn. that the property and casualty insurance industry was attempting to deprive consumers of their "human rights" in the product liability field.

"This spokesman chose to ignore the carefully contrived but well-organized efforts of his own organization to sidetrack federal and state legislation to protect consumers by curbing the excesses of our legal system." ■

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benefit tax slants

Here's a guide to benefit changes in this year's major tax reform act

By JOSEPH S. ROBINSON
Attorney-at-Law

THE ANNUAL meeting of the National Assn. of Estate Planning Councils featured an all day session on the Tax Reform Act of 1976. We've singled out the major areas of discussion by the speakers—attorneys, accountants and insurance consultants (all specialists in their field)—and summarize their observations on how the tax law has changed in ways that will affect employe benefit plans.

Qualified plans: Until the tax rules were revised, an interest left by a deceased employe in a qualified employe pension or profit-sharing plan was exempt from the estate—a big break to the heirs of an executive. The tax act has partially eliminated this tax shelter.

Commencing in 1977, any lump-sum distribution from such company sponsored plans will be taxed to the recipient as ordinary income, subject however, to a separately computed ten year averaging tax. The panel pointed out that the switch in the tax law does not alter the estate tax exclusion of payouts made in the form of an annuity (defined as equal payments over at least 36 months.) So it's now important to compare the estate tax saving that spring fro mannuities with the net income tax savings from the special averaging formula applicable to single-sum distribution of pension benefits.

ESOPs: For raising cash, the conference focused on another device that enjoyed continued congressional approval—the Employe Stock Ownership Plan. Though generally advocated as a boon for employes, the arrangement can be useful to a corporation in seeking capital by going public. A corporation can get an infusion of cash by converting an existing retirement plan to an ESOP, selling off the plan's holdings and purchasing the company's own shares. Thus, the corporation funds its retirement plan by buying its own stock and the payments are deductible.

Deferred compensation and the "max" tax: In the past the enactment of the 50% maximum tax on earned income greatly reduced the benefits of a nonqualified deferred pay plan. That's because such arrangements usually did not fit the definition of earned income and so would be subject to the minimum tax on preference income.

The old earned income definition has been changed under the new law to include personal service income. This is another way of saying that deferred compensation now comes within the 50% ceiling. Thus in the opinion of the panel, is the time to take another look at this method of compensating executives.

But keep in mind that there are estate tax consequences to be considered in connection with a deferred compensation arrangement. Since it is an agreement to provide future income, if payments are made to the executive's beneficiary in the event of his untimely death, the payout will be treated as income with respect to a decedent.

Stock options: One of the most talked about new developments relating to executive compensation is the elimination of the tax break built into qualified stock options. The revised rule in effect treats qualified options the same as nonqualified options if they were granted after May 20, 1976. Nevertheless, the panel feels that the nonqualified option is a valuable benefit because of the guaranty to the employe that he can purchase the shares at a stated price.

An alternative includes phantom shares which have the basic advantage of requiring no cash outlay by the individual. With phantom shares, a simple bookkeeping entry credits the executive with a block of company shares, as of a future date, with the stipulation that the executive must be employed there at that time. For high-income executives, phantom shares have the advantage of being subject to the revised 50% maximum tax or earned income, and create no minimum-tax problems.

Performances shares are similar to phantom shares but with the payoff for the executive based on the future price movement of the company stock. They have a parallel tax result.

Prepaid group legal plans: A new provision of the tax law deals entirely with the qualified group legal services plan. A written plan may be established by any employer for the exclusive benefit of his employes, their spouses and dependents. The plan must provide specified legal services paid for in advance wholly or in part by the employer. Neither contributions nor benefits may discriminate in favor of officers, shareholders, self-employed persons or highly paid employes.

Contributions can be paid only to:

1. Providers of legal services under the plan, as prepayments.
2. Insurance companies, organizations or persons providing personal legal services, or which indemnify against the cost of legal services in exchange for a prepayment or a premium.
3. An organization or trust authorized under the new law to receive employer contributions which are then channelled to another organization or trust established to provide group legal service.
4. Organizations or trusts organized exclusively to provide qualified group legal services.

The establishment of a group legal plan is clearly an intricate matter. The experience of the panel indicates many basic questions should be considered when a group legal plan is contemplated. Some are:

- What legal services are appropriate for the group?
- How broad or extensive should coverabe be?
- What forms of coverage should be excluded?
- Should the plan be insured or self-insured?

Group-term life insurance: Ordinarily, when an employe dies, the group-term policy proceeds paid to his beneficiary are subject to estate tax. As a result, many executives have adopted the practice of assigning all ownership rights to

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U.K. risk man urges outspoken stance on liability

LONDON—British businessmen were urged to express their fears over product liability insurance in the U.S. when they met at a London seminar to study international marketing problems.

Prominent among the speakers was John Havers, U. K. insurance manager for the Dunlop tire and rubber group, who said there were signs of influential efforts to get the situation under control.

He praised *Business Insurance* for its enterprise in putting forward seven steps to stop the "orgy of litigation" in its editorial "Sue the Bastards" on Aug. 9, and said:

"Risk managers in the U.S. are concerned that in today's social climate juries are basing awards not on the principles of liability, but on the manufacturer's ability to compensate the injured party.

"I was much taken by the headline in that excellent magazine, *Business Insurance*—good value at $12 a year. The headline on 'A Social Malaise' persuaded me to read what turned out to be a most excellent editorial, and one that summarises the problems succintly.

"The subject of products liability is an emotive one in the U.S.A., and the point was made in that article that the whole scene is becoming unreal.

"Selling of goods is going to become more onerous with the growth of consumerism, and underwriters' accounts in Britain would have been in a reasonably happy position if the results from the U.S. had not been so appalling.

"We can help by pressing on our own connections in the U.S. our fears about the deteriorating position, and the need to improve on the existing system."

Segments of the *B.I.* editorial, which has already received wide publicity in the U. K., were read to leading executives in the U. K. export field at a Junior Chamber of Commerce for London seminar by Mr. Havers.

He said: "They are strong words. But unlike a number of other articles, speeches and reports coming from the U.S., *Business Insurance* magazine does attempt to offer some solution to the problem.

"It urges risk managers, corporate financial executives and the insurance industry to coordinate their activities in an effort to bring about an improvement.

"I find it difficult to improve on its seven recommendations, and make no apology for using an influential U. K. audience to start the ball rolling here.

"Clearly all these points will be discussed by the interested parties in the U.S., and there are encouraging signs that other influential groups in the U.S. are also aware of the seriousness of the problem.

"But we must get the problem into perspective, and I suggest that before approaching your broker or insurer you should discover as much as you can about your company's products. Examine the selling and purchasing conditions with care in the case of products for the U.S. market, and ask what quality controls and safety checks are used in their manufacture.

"Obtain the claims statistics over the last five years, and find out if adequate records are kept on your company's research and development side. Records are vital, for courts in the U.S. are impressed if a full range of tests on any given product can be supplied to them. So will your defense attorney.

"Only when you are in full possession of all the facts do you approach the market. But go to it in a mood of optimism! For the products liability market in the U. K. is not in the turmoil of its U.S. counterpart."

Advising exporters on the best way to get cover for their products, Mr. Havers said: "If you are in a business that has a recognizable product risk, such as pharmaceuticals, autos or machine tools, it may be prudent to examine the possibility of eliminating that part of the risk which pertains to the U.S.

"I say this in the full knowledge that the advice flies in the face of one of insurance's most sacred principles, namely that selection of risks is disliked and that you should always put to the underwriter the good, bad and indifferent.

"I am only recently a somewhat unwilling convert to this other way of thinking, but the advice from brokers and insurers from both sides of the Atlantic is unshakable in the view that this is the way to deal with the problem.

"What levels of indemnity are required? My view is that it should never be shorter than $2 million and that is an absolute minimum. Some of you will require $20 million and even $50 million. In the aviation and pharmaceutical industries you may well be governed by the extent of the market available.

"Take a pragmatic view of the potential hazards facing your company. You may be tempted to arrange high levels of cover, and then find the premiums become a crippling financial burden.

"If you make a potentially hazardous product, and the turnover is relatively small in the U.S., there may be a strong ease to withdraw it. Risk avoidance it's called in our jargon, and it's the surest way of sleeping easy at night.

"But most of us find this easy solution is unobtainable. Then we must make the best of the bad job and ensure that all those directly concerned with selling to the U.S. are aware of the problems." ■

Tax . . .

Continued from page 56

the policy in an effort to avoid this tax. Some executives have varied the pattern by transferring all incidents of ownership to an irrevocable life insurance trust with the hope of avoiding estate tax in the trust beneficiary's estate as well as their own.

Under the revised tax law, the panel suggested that the practice of assigning group-term life insurance is more dubious than before. *Reason*: From now on, all transfers made within three years of death will automatically throw the entire proceeds back into the insured-employes estate as a gift "in contemplation of death."

Sick pay: The elimination of the $100 per week exclusion allowance for disability payments may cause executives to apply for disability income insurance on their own. In this way, all benefits which they receive from the policy will be tax-free to them. It has been suggested that companies can "bonus out" the premium cost to the executives. ■

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Group has substantial insurance for Italian disaster

By JOHN H. MILLER

LONDON—Developments in the "poison cloud" disaster at Seveso, in Northern Italy, indicate that the vast international pharmaceutical group F. Hoffman-La Roche & Co. has substantial liability insurance in London and other world markets, including the U.S. and West Germany.

But there is no sign so far at Lloyd's that any specific claim for product liability loss has been lodged.

It's thought the Givaudan chemical plant near Milan where the pollution leak occurred, however, may not be fully covered by the terms of the policies.

Sums ranging up to more than $100 million are being named as the likely compensation which the firm may have to pay the Italian government or other authorities if it is found liable.

This is far more than a property loss such as Flixborough, which cost about $60 million and is already causing other multinational corporations to review their policy limits in relevant insurance markets.

It is suggested in London, for example, that the Imperial Chemical Industries group is trying to raise its third-party liability coverage substantially.

Clearly this is feedback following the incident at Seveso, where clouds of noxious gas were released after an industrial breakdown at the plant.

But the insurance angle is being played down until compensation has been clarified, for it would not be in the interests of either the firm or the underwriters to provoke vociferous demands by the Italian victims of the leakage at this stage, say spokesmen. It's likely that Hoffman-La Roche will keep the insurance market out of its talks with the Italian authorities at this stage, and then have recourse to its liability cover once compensation has been settled.

Extensive inquiries by *Business Insurance* in the U.K. and western Europe suggest the insurance position over the Seveso disaster is complicated.

As an international group based in Basle, Hoffman-La Roche has basic product liability coverage in its Swiss domestic market for up to $500,000 or so for any loss that might stem from the distribution of its products.

But this is just a preliminary amount which it has chosen to place in its own national market for obvious reasons of convenience.

The actual limits of all liability insurance in the Swiss market is not known for certain, but on top of that Hoffman-La Roche is known to have at least four or five layers of excess liability insurance placed at Lloyd's, with U.K. companies, and in other international centers.

These would probably bring its actual coverage to an amount variously estimated at anywhere from $50 million to $100 million, with probably extra coverage for the individual operations of its subsidiaries such as the Givaudan plant in northern Italy.

Traditionally Hoffman-La Roche is very reticent about its administrative activities, in keeping with the tight-lipped attitude of many Swiss businessmen and banks, so that it is virtually impossible to determine the actual extent of its policies.

Many of them are reinsured back into the Swiss and other markets, so that no major loss is going to affect any particular underwriter.

Latest reports in London, however, suggest that the northern Italian plant may not have been insured for the emission of vapors and noxious gases under the policy in force. Sources also said that this peril could be excluded for other reasons.

This would explain the veil of secrecy which exists in the affair, as various brokers in London who handle some of the widespread Hoffman-La Roche business insist that no claim has yet been lodged in the U.K. arising from the Seveso disaster.

There is still plenty of time available, of course, for claims to be lodged, as the process of clearing the contaminated area around the affected plant is still going on and may take months to complete. The long-term effects on individuals could last for years.

Alex P. Rice, senior partner in the U.K. chemical firm of Cremer & Warner, which has been called in to advise on the problems, is expressing "guarded optimism" about the outcome.

But the catastrophe is a reminder of the perils that can pollute industrial communities if highly sophisticated processes get out of hand.

It is believed that a breakdown in temperature control led to the emission of gases containing large quantities of TCDD from the plant at Seveso. This is a highly toxic substance, known sometimes as tetrachlora-benzo-dioxine.

Farming and residential areas were evacuated, and crops were destroyed by government order to prevent them from being eaten after the the pollution. Warnings that babies might be born deformed if their parents had sexual intercourse during the height of the contamination were broadcast over Italian networks. Tourists returning to Britain, for example, have been calling at the London offices of Hoffman-La Roche to get advice, and have been told that it would be a reasonable precaution to keep in close in touch with their doctors if they are pregnant, until it is clear they are out of danger.

There are also clear consumer memories of the thalidomide tragedy in Britain, which cost Distillers Co. about $40 million and was only partly covered by insurance.

Underwriters at Lloyd's are still watching for the outcome of the northern Italian situation, as its full dimensions could take a decade to evaluate. ■

Change vesting?

The U.S. Department of Labor reportedly is considering changing its vesting regulations for defined contribution plans, permitting employers to record hours for the first 1,000 hours of service for employes and then switch to the more easily-administered elapsed time method. A Labor Department spokesman would not confirm the change. Under the elapsed time method, calendar years, or valuation year dates are used.

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Chicago hospitals move away from full coverage

CHICAGO—One-third of the hospitals in a survey by the Chicago Hospital Council have decided to meet the rising costs of malpractice coverage by opting for self-insurance or only partially insuring their liability exposures.

The survey of 63 members of the council also found the average cost per patient day had increased more than 1,000% between 1971 and 1976. Malpractice insurance now costs an average of $8.79 per patient day compared with $.81 in 1971. The cost per admission, based on average hospital stay, has risen to $65 per admission from $6.50.

Howard F. Cook, president of the council, estimated the total cost to the Chicago hospitals for malpractice coverage is now $54 million a year.

"As recently as 1971 professional liability insurance costs were a minor item of hospital expense. Now it has turned into a budgetary threat of foreboding consequences," he said.

The Chicago Hospital Council study was released shortly after the American Medical Assn. said malpractice coverage for doctors now costs each patient $1.24 for every visit.

The AMA said the average doctor paid $4,533 for malpractice insurance in 1975, up from $610 in 1968 and $1,905 in 1973. Malpractice insurance now represents 8.1% of the total charge for a visit compared with 2.4% in 1973.

In Chicago, the hospital council said 41 of the hospitals in the survey (65%) carry both primary and excess professional insurance with commercial companies. The one-third of the hospitals who have opted for self-insurance or to go partially uninsured include 15 hospitals (24%) that carry only primary professional liability insurance and have no excess insurance; one hospital that has both primary and excess coverage with a hospital captive; two hospitals (3%) that self-insure all or part of their coverage and purchase excess coverage from commercial companies; three hospitals (5%) that self-insure all their professional liability risks; and one hospital that carries no professional liability insurance.

Mr. Cook said no single alternative to commercial insurance had yet emerged as less expensive.

The 41 hospitals purchasing commercial primary and excess insurance paid a total premium of $39.7 million. The average cost per patient day for this group was $9.23 with the range among hospitals from $1.48 to $31. The increase in total cost between 1971 and 1975 was 1,282%.

Total premiums for the 15 hospitals that purchased only primary coverage from commercial companies was $6 million. The average cost per patient day was $6.87 with a range from $1.89 to $23.24. The five-year increase in total cost was 223%.

The hospital that purchased both primary and excess coverage from a hospital captive paid $1.5 million in premiums. The cost per patient day was $7.25. Comparisons are inaccurate since that hospital's 1971 rate was exceptionally low and it has expanded greatly during the five-year period.

The study did not provide information on the costs for the two hospitals that self-insure some risks, the three that self-insure all their professional liability exposures or the hospital that carries no coverage. ■

ASIS in show biz

The American Society for Industrial Security (ASIS) has broken into show business. The Defense Department's Defense Civil Preparedness Agency has awarded ASIS a contract to produce a motion picture on industrial and business organizations development of nuclear or man-made disaster programs. The 30-minute film will emphasize the basic elements of disaster preparedness, including surveys, emergency plans, protection of vital records, continuity of management and emergency operating capabilities. ASIS is composed of professional security managers in industry, government, business and public institutions.

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Coverage for alcoholism treatment is cutting employer disability cost

NEWPORT BEACH, CALIF.—Providing adequate coverage for alcoholism for employes may be able to save employers, unions, or insurers money in the long run, according to studies of an alcoholic treatment hospital and the National Institute of Alcohol Abuse and Alcoholism.

Alcoholism in the United States in 1971 affected ten million people and costs an estimated $25 billion to society, through lost production, health and medical costs, accidents and justice system costs. Treatment for alcoholism accounted for 12% of the $68.3 billion health costs for adult Americans in 1971.

According to National Institute on Alcohol studies, an employer can estimate that problem-drinking employes are responsible for 15% of claims paid annually. Another five-year mortality study shows that the drinker's overall accident rate is 3.6 times that of other employes. In total, alcoholics cost employers three times the sickness benefits of other employes.

Because of this, Enos L. Cook, CLU, believes "all other factors being equal, adequate health insurance coverage for alcoholism should result in a decrease in the total health insurance premiums when combined with an effective employe alcoholism control program.

Raleigh Hills Hospital in Newport Beach conducted the study of health insurance benefits and alcoholism treatment. It has been treating alcoholism since 1942 and is the largest private provider of alcoholism treatment.

The Raleigh Hills study found that "although some insurance policies continue to exclude or limit the benefits for the treatment of alcoholism, there are as many reasons to doubt that exclusion of alcoholism achieves any savings for either the policyholders or carriers. Physicians and hospitals often treat alcoholism under other diagnoses either from ignorance of the primary diagnosis or intentionally to protect reputations and to obtain insurance benefits despite exclusions."

A Florida alcoholic rehabilitation program study in 1975, cited by the Raleigh Hills Hospital, shows that Kennecott Copper Co. in Salt Lake City, Utah cut hospital, medical and surgical costs by 55.35% after a year's involvement in an alcoholism program.

The same Florida study showed that sickness disability decreased 45% to 46% at Illinois Bell Telephone Co. Job rehabilitation was 72% effective. The 402 employes studied had 602 cases of sickness disability before rehabilitation and 356 cases after.

Equally important, corporate experience indicates that insurance carriers are not raising their premiums significantly for the coverage of alcoholic treatment, both in-patient and outpatient.

At Hughes Aircraft Co. in Los Angeles, Jack Guest, manager of employe counseling-corporate industrial relations, said "since establishing the benefit for alcoholism there hasn't been an increase in their major medical premium rates." He added: "Hospitals specifically organized to treat alcoholics are much better—they are better staffed, have meaningful programs, and get results at less cost."

A 1973 report under a joint project conducted by the National Institute on Alcohol Abuse and Alcoholism and the National Council on Alcoholism, showed that among 21 major corporations responding to their study (representing an employe population of one million), only one firm did not provide coverage for the treatment of alcoholism in its benefits package.

To assure that alcoholism treatment program costs and procedures are responsibly managed, and benefits are actuarily sound, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) charetered the Joint Commission on Accreditation of Hospitals (JCAH) to develop standards for the accreditation of alcoholism treatment programs.

Among other employers who've instituted alcoholism treatment programs, Scovill Manufacturing Co., Waterbury, Conn., realized savings of $186,555 by referring 78% of its alcoholic employes to treatment, which resulted in full rehabilitation. The firm has a total of 6,500 employes.

Economic Laboratory Inc. in St. Paul, Minn, said it had a rehabilitation success rate of 80% among the alcoholics in its 3,500 person workforce.

The DePaul Industrial Alcoholism Project of Milwaukee chalked up a success rate of 71% initially, and significantly improved on that after nine months.

Kennecott Copper's experience was that sickness and accident costs among the alcoholics it employed were more than five to one when compared with costs for the average employe. Those same alcoholic employes generated hospital, medical and surgical costs of more than three to one compared with the average employe.

Historically, discriminatory clauses in many health insurance policies have generally denied access to treatment for alcoholism except under subterfuge diagnosis, noted the Raleigh Hills Hospital report. "New attitudes, legislation, regulations, personnel policies, payment sources and a variety of government fostered actions are expected to stimulate new health insurance practices which will enable most alcoholic people to obtain treatment and rehabilitation services openly and earlier," said Mr. Whiton of Raleigh Hills.

Thirteen states have now passed legislation which mandates that insurance carriers provide or at least offer coverage for the treatment of alcoholism. Furthermore, the Health Maintenance Organization Act of 1973 required that all HMOs receiving federal assistance include alcoholism in their services package.

Health insurers are expected to further expand their benefits to meet the needs of alcoholics, Mr. Whiton predicted. "Although alcoholism is not a fully accepted benefit in all health insurance policies today, the prospects are improving greatly," he said. Dr. James G. Westbay, associate medical director of the Metropolitan Life Insurance Co. has said that "treatment of alcoholism belongs in every health insurance contract written."

Kemper Insurance Co. and Blue Cross are two carriers which have extended health coverage for alcoholism to their benefit policies. Capital Blue Cross began its program in 1975, providing the added coverage at no rate increase because of the expectation that first year utilization of the benefit would be low. ■

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New York's Harnett holds down auto rates

NEW YORK—No insurer in New York will be granted a rate increase for automobile insurance uness it makes a commitment to maintain an open market in the state, Superintendent Thomas A. Harnett said in testimony here.

He said if he had to he was also prepared to tell the legislature to authorize a government insurance facility on a stand-by basis to underwrite essential coverages if administrative remedies are not enough to care the "availability problem" in the estate.

The superintendent made his comments late last month before New York's assembly committee on insurance. He said the insurance companies would be expected to keep an open market only to the extent that their own solvency is not genuinely endangered.

The government insurance facility he proposed as a possible solution to capacity problems could be accomplished by expanding the powers of the state insurance fund, according to his testimony.

Superintendent Harnett also commented that it was still too early for a final judgment on New York's no-fault law, with only two-and-a-half years of experience.

"However, it is reasonably clear that on balance the major objectives to the law are being fulfilled," he said. He did, however, express dissatisfaction with the experience to date on personal injury claims filed since the law was passed.

"We are particularly disturbed that about twice as many people appear to be meeting the $500 medical threshold requirement for serious injury as had been projected from data available prior to the no-fault law," he told the committee.

The superintendent also said hospital and medical costs appear to be consuming at least 70% of total first-party benefits. They had been expected to constitute only 50%. The insurance regulator said his department did not believe it was merely coincidental that the medical costs are proportionately so much higher than anticipated at the same time that more people are meeting the medical threshold. It suspects victims of auto accidents are cooperating with lawyers and health providers to deliberately inflate medical costs in order to reach the $500 medical threshold for recovery of damages for pain and suffering, he said.

Superintendent Harnett suggested that automobile insurance, as another form of social insurance, would appropriately be subject to the same fee schedule as workers' compensation.

"Preliminary results of an insurance department survey now in progress show that insurers appear to be paying health providers some 40% more than they would have paid for identical services for the same type of injury had it been a workers' compensation claim," he said.

Commenting on assembly bill 12616-C which was proposed to the state legislature to amend the no-fault law, Superintendent Harnet told the committee that one of the bill's provisions would raise the mandatory liability limits for automobiles in the state.

"The present required auto liability insurance limits of $10,000/$20,000/$5,000 have not been revised in the 20 years since enactment of the compulsory automobile insurance law. The assembly bill proposes that mandatory minimum liability limits be raised to $25,000/$50,000/$10,000," he testified.

The assembly bill recommends an extension of the no-fault law's excess profits provisions for an additional three years, Superintendent Harnett said. The provision prohibits an insurance company from making excess profits which might result from current or future rate levels originally approved because of poor loss ratio experience in the state..

Since July 1975, automobile insurance rates in New York rose sharply, averaging a 55% increase statewide. The insurance superintendent said he approved the rate increases because to do otherwise "would have been runious for the public and the insurance industry" both in the long and short run. ■

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OSHA's emissions rules for steel makers signals tough safety stance

By PAUL R. MERRION

WASHINGTON—After three and a half years of controversy, the Occupational Safety and Health Administration has issued a final regulation on coke oven emission standards that may signal a more stringent stance on future workplace rules.

For the first time, the coke oven emissions standard specifies numerous engineering controls and work practices that must be met to limit worker exposure to 150 micrograms of benzene-soluble fraction of total particulate matter BSFTPM per cubic meter of air averaged over an eight-hour period.

In the past, OSHA regulations have set a standard of exposure and left the changes needed to comply up to the employer. In announcing the coke oven standard, the Assistant Secretary of Labor for OSHA, Dr. Morton Corn, said the new approach is "promising" because it bypasses arguments over what is "feasible."

An OSHA spokesman said it is "not fair or correct" to say that all future regulations will require specific engineering controls, but said "we have to suit the controls to the substance."

An upcoming final regulation on exposure to noise says in proposed form that engineering controls—rather than ear protectors—must be used. It does not specify what kind of controls. Whether the final rule will specify what physical changes must be made in noisy machines "remains to be seen," the OSHA spokesman said.

The new coke oven emissions regulation becomes effective Jan. 20, 1977. The specified engineering and work practice controls will have to implement as soon as possible but not later than Jan. 20, 1980.

Legal action to block the new regulation was instituted by the steel industry shortly after the new rule was issued. The American Iron and Steel Institute here and six leading steel makers petitioned the U.S. Third Circuit Court of Appeals in Philadelphia to review the Labor Department's latest OSHA regulation. A spokesman for the steel industry trade association said the industry objects to the new rule because "there is no technology currently available" to meet the standard.

At the same time, the United Steel Workers union was dissatisfied with the final form of the regulation because it eliminated a provision that would have required employers to reassign coke oven workers who are found to have medical problems.

The steelworkers wanted assurance that reassigned coke oven workers would continue at the same rate of pay even if placed in a lower paying job. The question of pay protection caused the entire provision to be dropped, Dr. Corn said because it is a matter for the collective bargaining process. He said, because it is a matter for the dertaking a study of the issue.

New emission standards for coke ovens will require the steel industry to make engineering changes for the first time.

OSHA based its decision to issue a coke oven standard on evidence that coke oven emissions "play a causal role in the induction of cancer of the lung and genito-urinary tract" among exposed workers.

OSHA started work on the problem of coke oven emissions when the National Institute for Occupational Safety and Health issued a recommended standard in February 1973.

In August 1974, OSHA formed a coke oven standard advisory committee to assist in the writing of a proposed standard. The panel first met on Nov. 6, 1974 and issued its final recommendations to OSHA on May 24, 1975.

A proposed standard was published on July 31, 1975. That proposed regulation would have set a maximum exposure of 300 micrograms of respirable particulate matter per cubic meter of air, plus other provisions.

A public hearing on the proposal began Nov. 4, 1975, and recessed Jan. 8, 1976. In addition, a hearing on the economic and technological aspects of the proposed regulation were held this year from May 4 to May 14.

OSHA concluded the standard is economically and technically feasible after the second round of hearings.

OSHA found the cost to the steel indsutry of complying with the standard to be $200 million per year. Other estimates said the total cost for the industry would range from $139 million to $1.28 billion.

Based on a steel price of $291 per ton, the per-ton cost of complying with the standard was estimated to range from $1.50 per ton to $13.29 per ton.

The inflationary impact of meeting the new regulation is estimated by OSHA to range between 0.01% and 0.07% of the Consumer Price Index.

"In any event, it is clear, and we find, that the inflationary impact is small and therefore will not disrupt substantially the income and consumption patterns of the economy," OSHA said.

OSHA has calculated that only 1% or 2% of the steel industry's capital requirements over the next few years will go toward meeting job safety and health standards.

Approximately 61 million tons of coke are produced annually in the United States, with 90% coming from the steel industry. Foundries produce another 8%, according to OSHA.

Coke is produced by burning coal and is used as a fuel and reducing agent in blast furnaces for making steel and in foundries. A variety of by-products are released during the coking process, many of which are potentially harmful, according to OSHA. The new coke oven emissions regulation uses the benzene soluble fraction of total particulate matter as an indicator of these emissions.

About 22,000 workers will come under the scope of the new regulation, according to OSHA.

The new regulation requires specific changes in coke ovens to reduce worker exposure to the prescribed maximum of 150 micrograms of BSFTPM. Those controls must be used regardless of whether the standard is met or exceeded.

If the standard can't be met, further engineering controls must be used. Employers are also required to supply respirators to reduce exposure of workers as an interim measure until the engineering changes are made.

The standard also requires employers to provide voluntary medical examinations on an annual basis for younger workers and on a semi-annual basis for workers over 45 years old or those with more than five years of working near coke ovens. Procedures for examinations are specified in the regulation.

Provisions of the new coke oven emissions standard include:

A "regulated area" must be established with access limited to authorized persons. Regulated areas are the coke oven battery including topsides, push-sides, coke sides and their machinery, the battery ends, the wharf, and the screening station.

Monitoring and measuring requirements must be repeated every three months or whenever there have been production, process or control changes. Measurements will be made by monitoring the air to which coke oven workers are exposed without regard to protection by respirators. Employes must be notified within five days of the results of the tests.

Detailed engineering controls must be applied during charging operations (the loading of coal into the ovens), including: specified methods of charging, drafting, and aspirating the ovens: volume controls to charge sufficient coal to permit gases to effectively move from the oven into collectors. Services for rapid movement of coal into ovens; drop sleeves and slide gates for carry cars permitting gases to be moved from ovens into collectors; mechanized cleaners for goosenecks and standpipes; air seals on pusher machine leveler bars; and roof carbon cutters and/or a compressed air system on the pusher machine rams.

Engineering controls during coking operations will be required, including: a pressure control system on each coke oven battery to maintain uniform collector main pressure; ready access to one or more door repair facilities capable of repair of doors, door sealing edges and all door parts, as soon

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as possible; an adequate number of spare doors available for replacement purposes; chuck door gaskets to control emissions until defective doors are repaired or replaced; and heat shields on door machines.

Work practice controls will be required that include preparation of written inspection and cleaning procedures, and charging, coking and punching procedures. However, one onerous paperwork provision was dropped in the final form of the regulation, after employers complained. The proposal would have required a log to be kept of all persons entering the regulated areas around the ovens.

Provisions will be required that new and rehabilitated coke oven batteries incorporate the best available engineering and work practice controls to achieve compliance with the BSTFPM.

A detailed written compliance program will be required specifying dates for installation of engineering and work practice controls, monitoring dates, technology considered in meeting the permissible exposure limit, and any other relevant information. If, at the end of the compliance period, the permissible exposure limit is still exceeded, the employer must develop a detailed schedule for any other enginering or work practice controls.

Respirators must be furnished wherever controls do not reduce exposures sufficiently. The wearing of respirators by employes is voluntary for one year, under certain conditions. After one year, respirators will be required to be furnished and used whenever the permissible exposure limit is exceeded. Employes will have the option of wearing particulate filter respirators or power air purifying respirators. Until January 1979, respirators must be NIOSH-approved for dust, fume and mist. After that date, NIOSH-approved coke oven respirators will be required.

Protective clothing and equipment other than respirators where the possibility exists of repeated skin contact or of exposures will be required to heat and/or generated by the coking process.

Initial and annual refresher training will be provided to all employes in a regulated area. Training is to be conducted four times a year during the first year due to the voluntary respirator program. Training program content must include a review of the coke oven standard, information on engineering and work practices used in the employe's area, and the purpose for and a detailed description of the medical surveillance program.

After Jan. 20, 1979, regulated areas will be posted with warning signs alerting employes to hazards and, where required, to the need for using a respirator.

Recordkeeping is required that includes medical examination results, and results of employe exposure measurements.

Sanitation and hygiene requirements for a change room, showers, lavatories, lunchrooms free from coke oven emissions, and prohibitions against eating and smoking in the regulated areas. Water is permitted in regulated areas, under certain conditions, to help employes avoid damage to their health from excessive heat. ■

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Pension termination on way to being processed in wake of rules' issuance

By PAUL R. MERRION

WASHINGTON—The Pension Benefit Guaranty Corp. has issued two important regulations that are needed to begin processing the thousands of defunct pension plans that have terminated since ERISA was enacted two year ago.

The majority of the plans that have terminated so far have been in limbo because PBGC has not fully defined how to divide the remaining assets of a dying plan with its participants.

As of Oct. 30, 1976, PBGC had received 12,040 notices of intent to terminate, according to a PBGC spokesman. Of these, 5,467 have been declared clearly sufficient to purchase annuities for the benefits they had promised to participants, he said, while 51 have been put into trusteeship by PBGC. Another 21 cases have received notice that the pension corporation is unable to determine sufficiency, the spokesman added.

But for the majority of plans, PBGC has not been able to act without deciding how to value plan assets, how to value benefits, how to allocate the assets among several priorities of benefits established by ERISA and what tests to use in deciding plan was sufficient assets to buy annuities.

The PBGC issued on Nov. 3 two "interim" regulations on allocation of plan assets and valuation of plan benefits and a proposed regulation on determination of plan sufficiency. (a final valuation of assets regulation was issued last May.)

The regulations are not final because the proposed form of the regulation did not differentiate between sufficient and insufficient plans, PBGC said. The pension corporation has addressed this issue in its proposed rule on determination of plan sufficiency, but for now the interim regulations will not apply to plans that have enough assets to guarantee benefits through the purchase of annuities.

The one-year gap between publication of the proposed regulations and the interim regulation is an indication of the complexity surrounding the methods PBGC must use in winding up the affairs of a termination plan. PBGC said comments on the proposed allocation at assets regulation came from six organizations, including Kwasha Lipton, the American Life Insurance Assn. and the National Marine Engineers Beneficial Assn.

At one time this year, PBGC hoped to have a package of final regulations finished by spring so the 4,800 plans that terminated last year could be processed. Steven Schanes, former executive director of the PBGC, said in an interview with *Business Insurance* in January that completion of the regulations package was a top priority before leaving office Feb. 14.

The two interim regulations issued this month are among the most crucial rules in the package. Besides the valuation of assets rule that was finished in May, the PBGC also issued regulations on a definition of basic benefits in September 1975 and determination of coverage limitations in February 1976.

Still to come is a determination of employer's net worth which is necessary information when a plan's assets do not meet its obligations. Under the pension reform law, an employer can be liable for up to 30% of the net worth of the company if a plan folds with insufficient assets. However, a PBGC spokesman said the processing of termination notices will increase following the recently released interim rules, despite the lack of a net worth definition.

Besides the interim regulations on allocation of assets and valuation of benefits, supplemental proposals on each of the rules have been issued to take care of minor problems in the interim regulations.

The allocation of assets regulation substantially follows its proposed form in establishing six categories of benefits according to the priority in which they must be paid. The first category is voluntary employe contributions, which means payments an employe makes voluntarily must be repaid before the plan pays any benefits.

The second category contains accumulated mandatory contributions and interest, followed by any annuities that have been paying pension benefits for at least three years on the date of plan termination.

The fourth category is other basic benefits not in the second or third category, and the fifth category is nonforfeitable benefits not contained in the previous categories. The sixth category is all other benefits.

The proposed supplement to the allocation of assets regulation deals with the date for distribution of assets by sufficient plans. These plans, according to the PBGC, "pose a special problem in allocating plan assets because in most cases some period of time will elapse between the date a plan's Notice of Intent to terminate is filed and the date plan assets are finally liquidated and distributed.

"An allocation of plan assets which does not take into account the possibility that assets and benefits value will fluctuate during that period is not only unrealistic but it also may create rights to benefits, not guarangeed by PBGC, which the plan is unable to provide."

To solve this problem, PBGC has proposed that a specific date be set on which assets are to be allocated. That date will be the date on which the assets are distributed, which in most cases will mean the date on which annuities are purchased.

The proposed supplemental regulation also allows employers to set up several subclasses within each of the six categories of minorities, as long as the subclasses do not discriminate in favor of highly-paid employes or otherwise violate the tax laws.

The interim regulation on valuation of benefits is largely technical and contains the actuarial equations, mortality tables and other information the PBGC will use to figure the value on the date of plan termination of various benefits, including immediate annuities, deferred annuities, early retirement benefits, death benefits and other.

Under the PBGC assumptions, the current value of a $10 per month life annuity payable to a health male participant at age 65 is $959.87.

In its proposed supplemental valuation of benefits regulation, the PBGC said sufficient plans can figure the value of their annuity benefits to be the cost of purchasing those benefits from an insurance company.

Continued on page 67

Continued from page 66

In its completely new proposed regulation on determination of plan sufficiency, the PBGC set down the procedures under which terminating plans will be processed.

Among its provisions, the proposed rule states that annuity benefits must be paid in that form unless another form of distribution, provided by the plan, is elected by the participant..

Upon receipt of a Notice of Intent to Terminate, PBGC will decide if a plan is clearly insufficient, in which case it goes into trusteeship, or clearly sufficient, in which case the pension corporation will issue a Notice of Sufficiency and the administrators of the plan will proceed with termination.

The gray area that comes up when a plan is neither clearly sufficient nor insufficient is also handled by the proposed rule. Two alternatives are provided. One method requires plan administrators to seek bids from an insurance company for annuity benefits. The other method does not require that bids be bought but puts the plan in trusteeship and makes PBGC responsible for either paying benefits or purchasing annuities.

In either event, PBGC said, a Notice of Sufficiency will be issued only if plan assets are sufficient, on the basis of a bid, to provide all benefits in categories one through four. Plans not receiving a Notice of Sufficiency will be placed in trusteeship.

PBGC said allowing plans to seek bids for annuities when a plan terminates will "avoid PBGC's becoming trustee of sufficient plans and minimize intrusion in the private sector."

However, PBGC said since it "is in a unique position to pool plan assets and liabilities, its rates should reflect economies of scale and fewer other costs. Thus, it is expected that PBGC rates generally will be more favorable than rates currently available from insurers." ■

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High pension benefits hurt public plans

TORONTO—The higher benefits in public pension plans are the main reasons many of the plans are encountering problems, a consulting actuary said here.

James S. Rubie, vp and consulting actuary with Nelson and Warren Inc. of St. Louis, said public pension plans often provide double the benefits of a comparable private pension plan.

According to a House subcommittee study there are over 11 million employes and recipients covered by 6,000 state and local retirement systems with over $90 billion in assets.

In addition to higher benefits, public plans often allow retirement at age 60 compared with the normal retirement age of 65 in the private sector. Some public plans covering policemen, firemen and other uniformed employes provide retirement after 20 or 25 years of service regardless of age, Mr. Rubie said.

One major cause of the higher benefits is the shorter period used by most public plans in determining benefits. Private plans usually use a five-year period in determining benefits while many public plans use a three-year period and some even key benefits to the last year of salary, he said. The situation is compounded in plans where lump sum sick pay settlements and overtime are added in computing benefits.

A large proportion of public plans regularly provide a post-retirement adjustment compared to very few private plans that provide for such an adjustment he said. Public plans also allow employes to purchase credit for other public military service.

While public pension plans are more expensive, they are administered by policy makers who respond to political pressure which often keep plans from being adequately funded. The lack of regulation, Mr. Rubie said, allows many public plans to go partially unfunded.

Mr. Rubie singled out smaller public pension plans as a major source of future problems. The taxing authority of the agencies running these plans is often limited, he said, while benefits continue to rise.

The prospect of federal legislation to regulate pension plans is likely as a result of the publicity of pension plan difficulties. ■

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Employe benefits cost Canadian firms 35%

TORONTO—Employe benefits cost Canadian businesses an average $3,849 per employe in fiscal year 1973-76, or 31% of annual payroll, a recently published study revealed.

In contrast, U.S. businesses paid an average $3,984 per employe; 35.4% of gross annual payroll, a study by the U.S. Chamber of Commerce found.

The Canadian benefit study by Thorne Riddell Associates Ltd., management consultants, says benefit costs increased 10.5% from 28.1% of gross annual payroll in 1973-74 to 31.1% of gross annual payroll in 1975-76.

In the U.S., according to the Thorne Riddell study, benefit costs increased 8.3%, from 32.7% of gross annual payroll in 1973-74 to 35.4% in 1975-76.

Benefits as a percentage of gross payroll in Canada are higher in the manufacturing sector at 32.1% than the non-manufacturing sector where they total 30.1%, the study found.

They are highest in the mining industry at 37.7% of gross payroll and lowest in the construction industry, at 21.1%.

Thorne Riddell surveyed 155 companies which included 587,858 employes. The consultants have published studies of employe benefits since 1953. This year the study's title was changed from "Fringe Benefit Costs in Canada" to "Employe Benefit Costs in Canad," because the costs which account for almost one-third of total compensation costs, can't be considered "fringe," Neil Milroy, president of the firm said.

Paid time off was the most expensive category of employe benefits at 14.7% of gross payroll, the Thorne Riddell study said, followed by pension and welfare plans at 9.2% of gross annual pay.

Vacations were the most costly single employe benefit at 5.9% of gross annual payroll, followed by welfare benefits at 5%, organization pensions at 4.2%, coffee breaks and rest periods at 4% and holidays at 3.7%.

Ten years ago employes paid about 8 cents for every dollar that companies paid toward pension plans, the study found. Last year employes paid 52 cents for every employer dollar.

The survey showed that companies are absorbing a rising share of pension and welfare plan costs, while employe contributions are decreasing proportionately.

Ten years ago employes paid about 8 cents for every dollar that companies paid towards pension plans, the Thorne Riddell study found. Last year employes paid 52 cents for every employer dollar.

A decade ago, employes paid 52 cents for every employer dollar toward welfare plans, the study stated, while last year the amount had dropped to 21%. ■

New A&A vps

Two vice presidents were elected in Alexander & Alexander Inc.'s premium finance division located in Baltimore. Alfred E. Bittner and Charlotte S. Pflaum were elected in October. Bufco Inc. and Tico are the two major subsidiaries.

Four Nebraska hospitals form new mutual insurer

By JANE WINEBRENNER

OMAHA—Four Nebraska hospitals have banded together and formed a mutual insurance company to underwrite their malpractice liability insurance, under the enabling legislation passed here early in 1976.

The Nebraska Hospital & Physicians Mutual Insurance Assn. Act passed in March permits three or more hospitals to organize a mutual insurer with $500,000 capitalization or a letter of credit from a banking institution. The new Nebraska mutual, named Hospital Mutual Insurance Co., used a letter of credit from a Lincoln, Nebraska bank.

President of the Nebraska mutual, James Ensign, said the four hospitals are St. Joseph's-Creighton Hospital in Omaha; St. Elizabeth's Hospital in Lincoln; St. Frances Hospital in Grand Island; and Good Samaritan, in Kearney. Also scheduled to join the hospital in about one year is the famous Father Flannagan's Boys Town Clinic in Omaha. The four hospitals have a total of 2,000 beds.

Other Nebraska institutions have expressed interest in joining the captive insurance company, said Mr. Ensign. The hospital mutual said it will begin taking applications for admission after November. Under the Nebraska law, out of state hospitals are not eligible to join until one year after the start of operations, or July 1, 1977.

The hospital mutual is insuring the hospitals for $10 million aggregate and $3 million per occurrence. Mr. Ensign said the mutual was "still working on premium rates" but said they would be a percentage below the Insurance Service Office rates.

Multi-Hospital Mutual in Bermuda is handling the reinsurance and will coordinate the risk management programs for all the hospitals. Multi-Hospital Mutual and its manager, Ebasco, is also under contract to handle some of the administrative duties, such as claims handling.

Work on the Hospital Mutual Insurance Co. captive program began even before the end of 1975, when lobbying was initiated to have the law passed so the hospitals could go ahead with their plan.

The four affiliated Catholic hospitals, operated by the Sisters of St. Frances, previously bought malpractice coverage from Hartford Fire Insurance Co. through the Sisters of St. Frances Share Services organization. Premiums soared to a whopping $600,000 in 1976 from the $70,000 paid in 1975 for far more coverage. At the same time Hartford raised the premiums it cut the $3 million per loss and $10 million aggregate coverage to only $1 million per loss and $1 million aggregate.

The captive mutual is reinsuring the first $1 million layer of risk with with MMI, while the next $3 million layer of coverage, along with the third layer of $6 million are reinsured in the London and Lloyd's markets.

Reinsurance costs have not been determined yet, said Mr. Ensign who noted that "they're still being calculated." He's banking on any malpractice lawsuits taking several years to settle while the captive gets on its feet. The four hospitals figure they'll be paying premiums, in any case, "substantially below what we were paying," said Mr. Ensign.

In the event of a catastrophic loss, the hospital mutual has made provisions for the collections of more premiums, but Mr. Ensign declined to disclose any details.

The mutual was a risk funding alternative which Mr. Ensign said he had hoped wouldn't be necessary. His organization, The Creighton-Omaha Regional Health Care Corp., had explored a number of alternative funding methods, including the possibility of joining other captives being established in states such as Michigan, New Jersey, Massachusetts (the Harvard Group captive in the Cayman Islands), and Pennsylvania. Also considered was a pooling of hospital risks in several midwestern states to form a captive. ■

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Major Labor Dept. reorganization consolidates pension law division

By PAUL R. MERRION

WASHINGTON—Major organizational changes are underway at the branch of the Labor Department that is responsible for administering the pension reform law, as the deadline nears for finishing and issuing several crucial regulations.

Besides the appointment last month of a new administrator, 28-year-old William J. Chadwick, to replace James D. Hutchinson who resigned October 1, the Office of Employe Benefits has been scrapped and replaced with two new entities, the Office of Regulatory Standards and Exceptions and the Office of Policy Planning and Research.

The restructuring will concentrate all ERISA administration under one roof called Pension and Welfare Benefit Programs. Previously, the Office of Employe Benefits Security drew on resources from elsewhere in the Labor Department, such as the Office of Labor-Management Policy Development and the Bureau of Labor Statistics. Also, the ERISA administrator will now report directly to the Secretary of Labor, rather than the Assistant Secretary for Labor-Management Services Administration.

Many of the bureaucratic changes, and a current hiring program designed to attract employe benefit experts into the department, are a result of Mr. Hutchinson's departure. He resigned partially to draw attention to the need for a strong, well-organized program for administering ERISA, a plan that was hindered, he said at the time, by Civil Service hiring policies that discouraged hiring people outside of government. Those policies have since been relaxed and hiring was begun, according to sources in the Labor Department. Mr. Chadwick said he expects to fill 50 must positions by the end of the year.

The reorganization should speed the issuance of vitally needed rules and class exemptions to ERISA's prohibited transactions rules, Mr. Chadwick said at his first press conference.

Top priority is being placed in finishing by the end of the year a package of minimum standards for determining eligibility in a benefit plan, he said, which is needed so that plans can be amended to comply with ERISA.

Also, broad exemptions for insurance brokers, mutual fund salesmen and pension fund consultants should be finished in the next few months, Mr. Chadwick said. These will avoid upsetting some common practices that technically fall under the party-in-interest rules.

"With the regulations and the exemptions we should create a better climate" for compliance with ERISA, the newly appointed administrator said.

"For the last one-and-a-half years we have made a lot of promises and commitments but we have not produced enough substantial guidance for the public," he said. "We are going to focus our energies on producing substantial guidance," especially for plan sponsors, Mr. Chadwick added.

Another large task facing the new administrator is completion of rules that will determine what employes must be told about their plans through summary plan description booklets, which must be in the hands of employes by March 31, 1977.

In the Office of Regulatory Standards and Exceptions, four divisions have also been set up: Regulatory Standards, Interpretations and Opinions, Plan Standards and Exceptions, and Exemptions.

"These four divisions will do work along functional lines that was handled before by one office," Mr. Chadwick said.

The agency will also be divided along functional lines. The two divisions will be Research and Evaluation, and Policy Planning, with Dallas L. Salisbury, former executive assistant to Mr. Hutchinson, as acting director of the latter.

Other top priorities for the Office of Regulatory Standards and Exceptions include class exemptions for party-in-interest transactions for service providers and banks providing ancillary services, Mr. Chadwick said.

These priorities will not be affected by the election of Jimmy Carter, he said, because the regulations and exemptions must be issued in the next few months, and it will take longer than that before the new administration gets around to changing personnel at that level of the Labor Department. "There's a hell of a lot to do by the end of January even," Mr. Chadwick said.

Turning to other facets of ERISA administration, the new administrator said he feels he has a "strong suit" in providing good relations with the Internal Revenue Service, which has equal jurisdiction over some sections of the law. Much of the delay in processing exemptions to the prohibited transactions rules has been blamed on the dual jurisdiction problems, for example, and the revocation of the tax exempt status of the Teamsters Central States pension fund last June without first informing the Labor Department is often cited as an example of the lack of cooperation between the two agencies.

Mr. Chadwick said he can build good relations with the IRS because he served as attorney-advisor in the Treasury Department's Office of Tax Counsel from April 1974 to May 1975. While there, he represented Treasury on the congressional conference committee that hammered out ERISA in the summer of 1974, and he was respnsible for many of the early ERISA regulations issued by the Treasury Department.

Moreover, he said he is optimistic about the dual jurisdiction of ERISA because there is a "greater blending of viewpoints" among staff people at both agencies since the law was enacted.

When the law was signed on Sept. 2, 1974, there was a definite difference in the way each agency interpreted its duties, with IRS taking a tax-economics view and Labor taking a labor-management relations view, Mr. Chadwick said.

Today, "it's not only the Department of Labor that says, 'What about the participants and beneficiaries?,' people at IRS are doing it now too," he said.

The problems of dual jurisdiction can be more accurately called the "problems of cooperative administration," he said. "In the past, people wrestled with problems at the staff level instead of going to the policymakers," Mr. Chadwick said, adding that the two agencies sat down recently to plan what they will do over the next six months.

A "memo of understanding" with the IRS has been prepared, handling individual prohibited transaction exemptions more quickly.

The new agreement splits equally the number of exemption requests that come in between the two agencies, and either agency has authority to issue a tenative denial on its own. The other agency is notified and has a chance to intervene if it wishes. If the other agency does not intervene, the tentative denial will then become effective.

Although Mr. Chadwick said relations with the IRS are improving, he said during a discussion of possible upcoming Congressional activity that the best resolution of the dual jurisdiction problem would be to give the authority for the whole exemption process to one agency. "I would like Congress to give it all to the Labor Department," he said, adding it is "difficult if not impossible to carve up jurisdiction." ■

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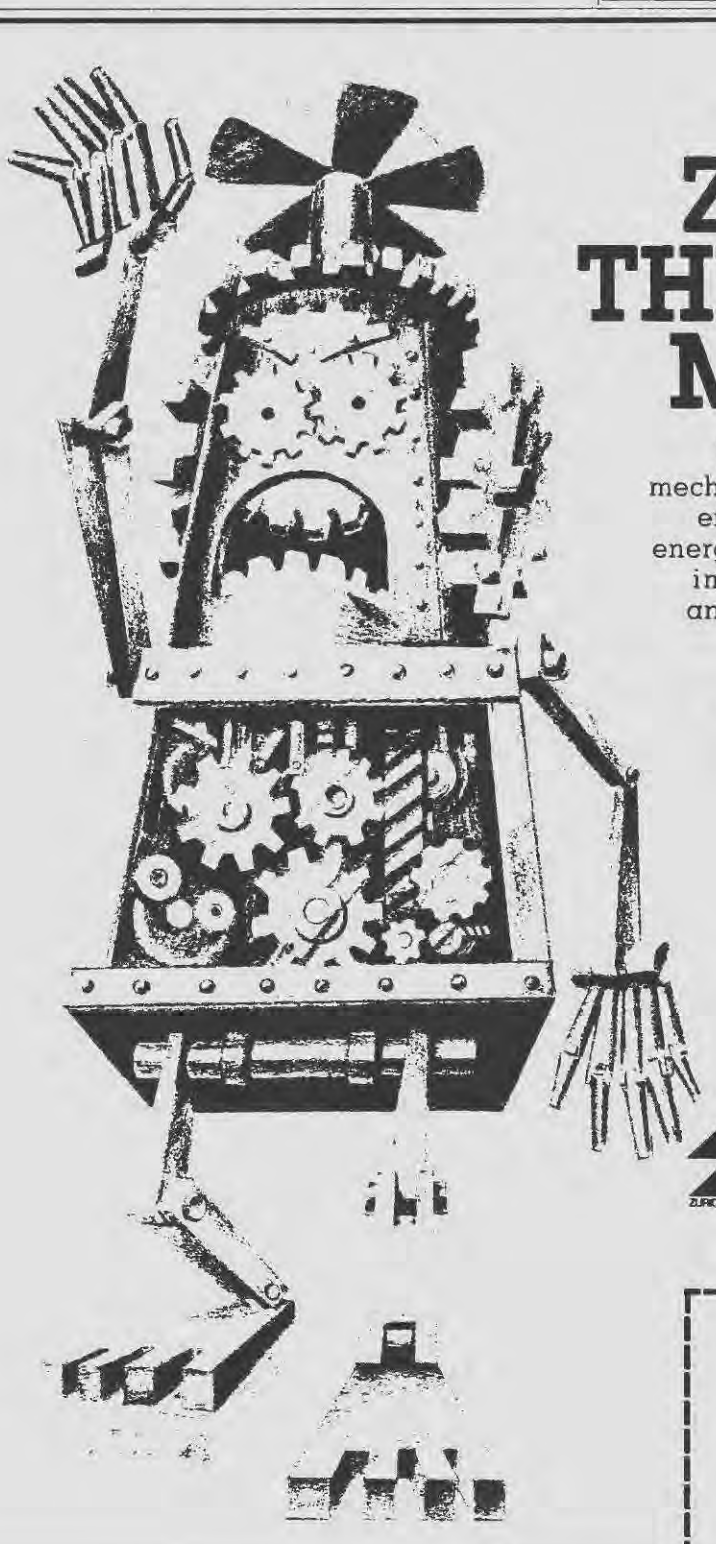

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PERSPECTIVE

Here are the steps to undertake in placing your excess insurance

By Robert P. Quinn
President, J. H. Blade & Co., Houston

Editor's note: Mr. Quinn's remarks were delivered to a group of casualty insurance agents and brokers. Thus, his advice to this group about using excess and surplus markets is not oriented to insurance buyers, but is, nonetheless, appropriate if buyers are to use the markets effectively.

Out-of-the-ordinary

Surplus lines casualty coverages are more oriented to policies tailor-made for out-of-the-ordinary exposures, such as public official liability or kidnap-ransom risks. These are considered non-standard and aren't usually underwritten in the standard markets.

I CONSIDER EXCESS casualty coverages to be as the name implies—additional limits or layers over either an underlying program of primary insurance coverages written in a conventional manner or alternately a primary program of a self-insurance program or even a modified self-insurance program where some insurance is included with some self-assumption of risk.

I consider surplus lines casualty coverages as being more oriented to insurance coverages that are specifically designed for specific exposures such as S.E.C. liability, public official liability, kidnap-ransom, the various professional liability coverages, errors and omissions, specialty lines, nonstandard and coverages not usually written in the usual licensed or admitted company markets.

The reason the excess and surplus markets exist is almost naive in the answer. They exist to provide additional capacity (excess) and to provide insurance coverages not written by the conventional market (suprlus lines) due to their not wanting to do so, or being incapable of doing so, either by lack of expertise or inability to perform due to regulation.

In a tight insurance marketing climate which we are now experiencing, there is much more encroachment on the licensed or admitted side of the fence (with visible signs of relief by the licensed companies). Two years ago the reverse was true—the licensed companies were complaining vociferously about the surplus lines companies poaching on their preserve.

Factually, however, over a period of many, many years, the surplus lines markets created new coverages such as umbrellas, installation floater, animal mortality, package policies, various errors and omissions, etc., all of which are now being freely written by the so-called licensed admitted insurance companies. Possibly, this is the proper role of the surplus lines people, but I must say the veneer wears thin at times when some admitted company people and insurance regulators attack our segment of the industry in "loose" periods, then push for aid and assistance during "lean" times, such as we are now experiencing.

With the aforementioned explanatory comments, I proceed to briefly outline the basic steps that should be considered when contemplating placing either an excess casualty coverage or surplus lines coverage in the state of Texas.

1. Determine first whether the subject coverage is readily available in the admitted market, and if so, is there sufficient limit available and is the available type and form satisfactory? (In Texas, the rates and forms, of course, are controlled for many classes. Unfortunately, also in many cases the limits required are not adequate, nor are the necessary broad features of coverage required for the client).

2. Once the agent determines he must go the excess or surplus lines route, then he must make a decision to either place the necessary coverage through a Texas surplus lines licensee or secure such a license himself. (If the coverage required includes exposure in states other than Texas, then a check on surplus lines requirements in other states should be made).

3. Don't overlook the requirement in this state if you are the surplus lines licensee that an affidavit must be signed by the surplus lines agent which states that "diligent effort was made to secure the limits or coverage involved." If the premium is in excess of $25,000 annually, the insured may sign the affidavit.

4. A state surplus lines tax of 3.85% applied to the approximate amount of exposure within the state is levied. (The basis of exposure in the state can be payroll, gross receipts, or any other reasonable basis). The tax, by law, must be paid by the insured and is paid monthly by the surplus lines agent placing the coverage.

In Texas, a client may report and pay the state tax directly to the insurance department. Each year a franchise tax report form must be completed showing the details of non-admitted insurance purchased, from where, and from whom. If it is purchased through a Texas surplus line agency, there are few problems; if not, it becomes somewhat unwieldy.

5. A federal tax of 4% is levied on any placement with an alien or foreign insurer. Lloyd's and some British carriers have made specific arrangements with the federal government and pay an income tax directly to the government and we do not show the 4% tax figure for that portion of the premium. For the balance of the security, the surplus lines agent must remit the proper tax to the federal government. Tax is ordinarily absorbed by the underwriter on an offset basis.

6. The policy cover note or certificate that is issued must clearly show that the coverage was issued under the provisions of Article 1.14-2 of the Texas insurance code, and also clearly show the name and address of the surplus lines broker and a person or firm designated for "Service of Suit" so that the appropriate court has immediate jurisdiction. In any event, the acts of the surplus lines broker will usually legally constitute the appointment of the secretary of state as the agent for service of process.

Once the legal and mechanical considerations are well in hand, the *most important consideration* must be analyzed. You have already made the decision to utilize the non-admitted marketplace for the client's needs. Unless your firm is experienced and well staffed enough to approach the surplus lines markets directly (and you are licensed as a Texas surplus lines agent), pick a reputable surplus lines firm to market your coverage. In Texas we have a very viable Surplus Lines Assn. with some

Continued on following page

Characterized by change

Surplus is imperfect mechanism

By Charles A. McAlear, CPCU
McAlear Associates Inc.,
Grand Rapids, Mich.

THE FUNCTIONS AND characteristics of the surplus line marketplace are many and varied. It is in this market that many of the coverages we view as standard were born, it is this market where many such coverages return in difficult times. It is in this market that many coverages die and fade away. In some geographical areas we can trace this entire cycle of birth, life and death in a single coverage—individual medical malpractice, which was created as a surplus lines cover, adopted and promoted by the so-called standard market, only to return to the surplus lines market and then disappear as a commercially available insurance.

The surplus lines market is creative, innovative, volatile, dangerous, aggressive, flexible, adaptable and somewhat disappointing. It can be unique, unusual and exciting, it can also be dumb, boring and deadly dull. All these things are true because the market does not consist of managements marching in lock step to new horizons or flocking like lemmings to the sea. It consists of underwriters, brokers and agents of every persuasion of every nation and style. It includes companies, syndicates, captives, pools, reinsurers and brokers all trying to respond intelligently and responsibly to insurance problems arising from our physical world or created by our societies. It also includes a few fast buck artists.

It is a mechanism, and not always a perfect one, where by the risks of Milwaukee or Calcutta are distributed among underwriters in New York and London, Zurich and Tokyo, Moscow and Peking. It spans oceans, vaults mountains and even, somehow, insinuates through political barriers. But it's function never changes, it must respond to insurance needs.

But it has its limitations. Although it consists of some domestic companies, the majority of the actual surplus is overseas. And this is important when it comes to responding to problems that are peculiar to our society. A fire or an earthquake or any exposure that relates to our physical world can be universally understood. A fire in Oshkosh differs little from one in London or Zurich, so surplus lines capacity in property coverages, excepting earthquake and flood where local knowledge is again essential, while not unlimited, is certainly adequate.

But those things which are unique to our society can only be successfully insured if our own domestic companies take a leading position. What must an underwriter in London or Tokyo think when he sees our large standard carriers marching grandly and uniformly away from the problems of malpractice and product liability? How can he risk the assets of his backers when our carriers won't risk theirs?

What about the domestic surplus lines carriers? Why can't they take the leap? They have and they are but they have a major limitation. The dollar surplus of all our domestic surplus lines carriers is less than 5% of the total surplus available in the United States. There is simply not enough to permit them to absorb the kind of volume being generated by malpractice and product liability premiums at their present levels. Nor can they expand their capacity with reinsurance from overseas. Each domestic is admitted in at least one state and must produce a convention statement just like any other domestic carrier. Non-admitted reinsurance is not recognized; it offers no surplus relief.

The surplus lines market has grown up responding to the needs of the insureds and supplementing the standard market. It can't replace it, at least not overnight.

We must abandon concepts that have seen their day. For example, "the balanced book of business", that marvelous idea that suggests that each dollar of casualty premiums must be balanced by a dollar in property premium. Some companies persist in trying to "balance" their book despite the fact that casualty premiums for the same risks are expanding dramatically while the property premiums are increasing little. In a time of a real scarcity of surplus we are treated to the sight of good casualty insureds going begging for coverage at any price while on the property side the same insured may be buying its coverage for 60%, 50% or even 40% of the filed rate; and having companies stand in line to do the deed. Based upon this information alone we can clearly predict a future major crisis in property insurance.

We must put surplus where it is needed, to support existing books of good casualty

Continued on following page

PERSPECTIVE

Placing excess lines . . .

Continued from preceding page
business, not to compete for property at depressed rate levels. To put surplus where it is needed is a function of the surplus lines market in normal times. Now it must be a function of all carriers.

How can it be done?

By supporting, to the extent possible, casualty risks now on the books.

By abandoning outmoded ideas such as "balancing the book," to seek out new casualty business at adequate rates.

By supporting the surplus lines carriers who have proven their capacity to underwrite tough casualty business at a profit. This can be accomplished in many ways. By reinsuring such carriers, of course. Also, many standard companies have subsidiaries in the surplus lines market, these must be furnished adequate surplus, staffed with the best available underwriters and encouraged to act aggressively and independently with intelligence and skill in the marketplace.

For those who choose not to reinsure and who do not have a subsidiary operating in the surplus lines market, I would suggest, under the right circumstances, establishing such a carrier. The spate of mergers a few years ago has left many holding companies and conglomerates with charters which are inactive or not used efficiently, their entrance into the arena as surplus lines carriers could strengthen the market as well as add to the profits and sophistication of the parent.

I said "under the right circumstances," because there are dangers. First, and most likely, is that of over-control. An insurer can't use a surplus lines carrier as merely a vehicle for the company's underwriting department to administer. A surplus lines company is, by definition, independent. Able to swiftly move to respond to insurance needs and underwriting climate.

A second danger is people. Surplus lines underwriters with skill and experience are not, these days, waiting around the union hall for a job call. Even among the currently employed at their craft, there are more poor ones than otherwise. Today, assembling a competent staff would be virtually impossible.

It is undoubtedly true that more good underwriters are on the staffs of managing underwriters and surplus lines brokers than work for the carriers. But the "managing underwriter" route to the marketplace is also full of pitfalls. There are those who have burnt a succession of companies and always are looking for another, by promising lots of "profitable" volume. There are also those with an enviable record. The same is true of surplus lines brokers. Fortunately for any carrier who wishes to enter the surplus lines field, our world is small and information is freely traded. With responsible research, a careful look before the leap, the pitfalls can be avoided.

I see the surplus lines business growing in size and stature as it responds to the needs of our society. As its surplus grows I see it underwriting a larger portion of the property and casualty business.

It may well be that certain tough classes of casualty business may be underwritten exclusively in our marketplace. There are two reasons for this. First, by coping, or attempting to cope, with the difficulties our society has created, it has developed an underwriting sophistication that cannot be matched in large individual companies where the problems of management cutweigh the problems of underwriting. Our market is dedicated in a very large sense to individual risk underwriting without reliance on published rates, and this demands experience, judgment, imagination and initative that is simply not being developed on this scale outside of our market.

Secondly the market itself is a mechanism for spreading risk with individual underwriters only to the extent and at the level which they wish to participate. This allows insureds a more stable, responsive market. As examples I might describe what I see as happening in some problem lines.

Individual medical malpractice—the future looks glum. This class could, I am certain, be underwritten on a businesslike basis using a "claims made" form with the thoughtful and commendable assurances provided in the St. Paul form. But in many juristictions it has become a political football. Specialists want to have their way paid by family practitioners who resent subsidizing specialists. All use the political forum.

Hospital professional, on the other hand, can, I believe, be underwritten profitably. Individual malpractice requires an underwriter to provide separate limits to many practitioners.

For each hospital, usually producing much higher premiums, one limit is sufficient. The maximum limit for which the hospital underwriter might become liable is substantially less than that of the underwriter who has a book of individual practioners. Also, though the underwriting of this class is difficult and specialized it does lend itself to variations of traditional risk management techniques.

The principle reason that we have seen this class in difficulty is the scarcity of surplus in sufficient concentration to support a creditable book and the lack of knowledgeable, confident underwriters. Both may exist but not often enough together.

Product liability is what the surplus lines market is seeing a lot of these days. The market is responding but within its limitations. Each risk is underwritten individually and this represents a problem. It is expensive; minimum premiums have to be set at a relatively high level. While there may be theoretical reasons why a man making birth control pills in his basement or manufacturing automobile brakes in this garage should be able to transfer his product liability risk, there are practical reasons why this can't be done through our market. Receipts just don't support the minimum premiums. Unfortunately this applies also to many less hazardous classes.

For moderate sized risks our office has pioneered the use of modest retentions. This makes it more attractive to underwriters and conserves surplus. A retention of $10,000 to $25,000 can usually be supported by the insured with claim handling and engineering handled by independents approved by the carrier but paid for by the insured.

For larger insureds, retention of $100,000 and above are indicated. First, to conserve company surplus but secondly because the new products rates and increased limit factors often make the premiums in this area redundant, an insured is paying more in premiums than he can receive in protection.

There is some talk of a "claims made" form as a partial answer in the products liability area. If this is adopted unilaterally by some companies I would foresee some problems. If it were universally adopted with some guarantees relative to extending the discovery period and common procedures for handling the retroactive date, maybe it would help.

The insurance business seems to be trying to kill itself in its workers' compensation subrogation efforts. It seems to insist on taking money from one of its smaller pockets to give to a big one. We would like to see subrogation severely restricted, perhaps to cases of gross negligence.

In the surplus lines market, the three year excess liability policy has been dead for some time. The $300 umbrella is a thing of the past. Umbrella underwriters now view any level less than $500,000 in the primary, not their cup of tea on any risk.

Many carriers, standard as well as surplus line, have difficulty writing the primary at the required level. However, there is a fairly vigorous market for the so called "buffer layer", used to bring limits up to the umbrella carrier's requirements excess of whatever primary is available. There are also so called "buffer umbrella", some restricted umbrella forms written over limits as low as $10,000/$300,000 but priced as if it were a "buffer" or "working" layer.

Certainly, total excess capacity is lower and pricing indicates this. Minimum premiums for umbrellas and "buffer" layers in the surplus lines market are about $5,000. Above that figure surplus lines pricing seems as good as anything available. ■

Mr. McAlear was born in Bay City, Mich. Upon graduating from high school he promptly flunked out of junior college. Unemployed, he joined the Army and served in Korea. He subsequently received a BA from the University of Michigan in Chinese language, and an MA in English composition. He began working in the insurance business in 1957 with Travelers, where he was a casualty underwriter, for nine years. Eighteen months with Employers Re as a special risk underwriter led to the surplus lines business where he's been ever since. He founded his own firm in late 1970.

Surplus . . .

Continued from preceding page
300 members. By law in this state, they must evaluate the soundness of the carriers they utilize.

Once you have selected a firm to work with on the specific subject involved, please do not approach any other competing firm on the same subject, unless or until you are dissatisfied with the result. The worst procedure you can follow is to submit the same risk to several surplus lines brokers at the same time, and in today's marketplace, discover one or more completing brokers going to the same markets. This can create confusion, distrust and trauma to not only the surplus lines brokers involved, but also to yourself, and unfortunately to the poor client. Anticipate that you must explain to the client the "inability to perform" due to this action and discretion will be your byword!

Establish a rapport with that surplus lines firm. The individuals that make up that firm can provide you with ideas as to coverage—different ways of doing it, etc., because, simply, they have seen many, many similar type risks. Use their expertise, "pluck their brains." If they are honest, trustworthy and experienced, you have added additional staff to your own firm's and their commission retention on that piece of business is a tremendous investment on your part.

I suggest the best way to submit a risk to the surplus lines brokers is this:

If an application is asked for, fill it out completely. If the application isn't sufficient, add *all* the pertinent information that you know is relevant. Loss information for three or more past years is mandatory. Names of current or prior carriers are vital.

If you are asking for excess coverage, provide copies of the underlying coverages. If it is to be a specially designed coverage, detail *all* the operations of the client. If it is an excess umbrella line, list all of the underlying carriers plus their premium charges. If you can find out the reinsurers who are involved, list them. This will save time for the surplus lines broker and result ultimately in less wasted time before the quotation becomes available.

If engineering reports or inspection reports are available, provide them at submission time. If you are familiar enough with the client's operations to write a short report, do so.

Consult with the surplus lines broker as to any reaction you have had from the admitted market. For example, if you can get primary coverage of even basic limits, then an excess quotation will usually be lower in price and possibly broader in coverage than if you tried to place the same coverage from "ground up" in the surplus lines marketplace.

When you do get your quotation, be extremely careful about the form itself. The admitted market in most areas of coverage has somewhat standardized wordings The exact reverse is true in the excess and surplus lines field. For example, to the best of my knowledge, there are no two exactly similar umbrella forms in the world today. The London market usually uses a standard London basic form, but, with endorsements rarely are two alike. When we move to the United States, no two company forms are the same. The coverage sections must be studied.

Insist on knowing the financial stability details of the insurance carrier or carriers being quoted. Who holds their reinsurance treaties? The surplus lines laws of Texas, and of most other states, have put the burden of proof as to financial stability, claims practices, etc. on the backs of the surplus lines broker—period. This is one of many very good reasons for funneling your excess and surplus lines business through a surplus lines broker. If the quotation is from an alien insurer, does it have a trust fund in the United States?

Insist on being given written evidence of binding, including rates, coverage, etc. as soon as possible. Do not either submit a risk or accept a binder by telephone unless followed up immediately with a written submission or a written binder. Oversights in these two areas probably contribute in excess of 50% of all errors and omissions claims presented by agents and brokers, including surplus lines brokers.

There usually seems to be a general interest in statistics relating to the excess and surplus lines fields. In 1971 the total reported surplus lines premiums reported by state insurance departments was $298,216,333. In 1974 the total was $405,404,724. In 1975 there will probably be at least a 50% increase to $600 million.

In 1971, United States domiciled insurers wrote $219,829,334 of the total of some $298 million in excess and surplus insurance. In 1974, they wrote $278,040,879 of the total of some $405 million.

Approximately one-third of the gross premium of approximately $400 million written in the surplus lines area during 1974 was written by seven United States domiciled insurers which, in fact, are wholly owned subsidiaries of major American admitted insurance groups. These insurers are listed below, followed by their parent:

Appalachian, Allendale Group; California Union Insurance, Insurance Co. of North America; Employers Surplus Lines, Employers Group; First State Insurance, Hartford; International Surplus Lines, Crum & Forster; Lexington Insurance Co., American International Group; Northbrook Insurance Co., Allstate Insurance Co.

Another interesting trend was revealed. The gross premiums written versus net preiums retained by the United States companies is shifting. In other words, the ratio of retained versus written premiums is definitely increasing, which we feel shows a retrenching action by reinsurers. This is very much reinforced in today's reinsurance marketplace by lack of capacity.

More and larger deductibles will be imposed. Quota sharing of risks by the insured with the insurer will increase. Self-insurance concepts are rapidly increasing in use.

Retrospective concepts on buffer layers and even excess layers will become more prevalent.

For the foreseeable future, tremendous limits on umbrellas for large risks are no longer available. The potential capacity in the London non-marine market is now probably $25 million (a couple of years ago it was probably double that). The American market capacity in the same area is reduced. Very few insurance companies are willing to front limits in excess of $10 million.

A somewhat new item is the emergence of the "captive" insurance company marketplace for excess and surplus lines casualty coverages. In Bermuda alone there are over 300 offshore captive insurance companies operating. Many of them are, in fact, insurance companies in name only. Many of these are also viable insurance markets which are financially stable and staffed by people who are experts. These companies have been founded for various reasons, ranging from some major client funding self-insured retentions or deductibles, to professional risk assuming firms.

The capitive will also be used in the excess area as a fronting vehicle to reach the reinsurance market. ■

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PERSPECTIVE

Insurance service is hidden element in the cost of risk

By Peter Armour
President
Peter Armour Insurance Counseling Ltd., Toronto, Canada

INSURANCE SERVICE is the big hidden cost in cost of risk.

Let's look for a moment at the four components of cost of risk, as defined by Douglas Barlow and now accepted as standard in every risk management glossary in the western world:

- Insurance premiums
- Uninsured losses
- Administrative costs
- Risk control costs

Three of the four components of cost of risk are adversely affected when you receive inferior service from your insurers and brokers, or when you are guilty of less than top notch insurance management.

Insurance premium cost—when you just let renewals happen—is more and more the product of last-minute marketing, which gives neither you nor your broker time to seek competitive alternatives.

Uninsured losses—generally those which are uninsured by your conscious and deliberate choice. But increasingly we are witnessing restrictions in cover imposed at renewal by underwriters, without your knowledge and consent and, incredibly in some cases, with no comment from the broker.

Administrative cost is the incredible workload which rests on your shoulders because you can't put files to bed for months —even periods in excess of a year, from what some of you have told me. In terms of grey areas of coverage, this has to be a serious worry for the conscientious risk manager, and in terms of job satisfaction none of us enjoy our work when we have a lot of loose ends which we cannot clean up.

Those who remember me a few years ago as a broker must detect an element of hypocrisy in my talking about insurance service. Let me say, however, that because of the quality of my service or the lack thereof as a broker, I have a growing concern on this subject, and feel well qualified to state some opinions.

By way of definition, I want to clarify that my comments on service are directed not only at brokers, agents and insurers—both agency and direct writers—but also, and perhaps primarily, at you the insurance managers and at consultants such as myself. This is not an exercise in finger pointing, but hopefully an honest look by all of us engaged in the insurance transaction at the present state of affairs and at the role we can play collectively in improving it.

Is the service problem in the property and casualty insurance business widespread, or just a few isolated cases?

It appears to be all over the business community. If I may cite a few examples of incidents involving clients of my office —there would appear to be a general problem.

Case 1): Direct writer insures an auto fleet of 1,200 units. March renewal. Binding letter from insurer arrives May 21. As of Sept. 14 no policies have been received.

Case 2): Broker A—Aviation underwriter requested cancellation May 12—broker remarketed program at 2½ times premium with no advice to insured of any problem until Aug. 16.

Case 3): Broker B bound Lloyd's umbrella liability policy with worldwide products coverage in April 1974. Wording received in Dec. '74 restricted products coverage to Canada and was returned for correction. Policy finally received in May 1975 still contained restriction to Canada, and the underwriter demanded and got $15,000 minimum additional premium to remove the restriction.

Case 4): Broker C processed endorsement #11 incorrectly, and after five subsequent endorsements attempting to correct the error, issued endorsement #17 which cancelled all the previous attempts and started over again. Broker kept correcting the wrong parts of the endorsement or introducing new errors.

If these are cases experienced by my clients, how many more of you in this room are having similar problems, and possibly presuming that the condition is peculiar only to your company and one or two others?

In our discussions with brokers on the matter, they usually cite two causes: The current market distruption and the heavy work load this imposes on them in buying your insurance, and, secondly, the very slow and poor quality of service they are receiving from insurance companies.

On the first point—the market disruption —I acknowledge the added time demand. But I would note that the service problem was serious long before the market deteriorated, and will continue that way long after the market improves unless we move together to solve it. Furthermore, brokers' earnings—because of the steep rise in rates and premiums—have also inflated. I believe that brokers generally could direct a higher percentage of their income into greater in-depth service for the client without watering down the bottom line too seriously.

On the second point—insurance company service—my experience is that this shoe fits, and that insurers generally should address themselves to this problem in a collective discussion with brokers—agents and yourselves, the insurance managers of industry.

So far all my comments have been directed at the insurance community. But now if I may gently bite the hand that feeds me, let's take a look at you, and cite a few examples of how the quality of your insurance management has a direct effect on the quality of performance either good or poor by your brokers and insurers.

Three or four months prior to renewal, you should take the initiative and talk out the scheduling of renewal marketing with your broker or direct writers. In that way they will be well aware that you have retained the option of testing other markets, particularly when you specify receipt of their terms four to six weeks before policy expiration.

The all-too-normal alternative we see today is a lack of initiative by you—presuming that your broker is busting some part of his anatomy on your behalf. When you get a binder at the eleventh, twelfth or even thirteenth hour, with no firm quotation, or premiums and coverage that are quite unpalatable, you have no time for alternatives to the coverage and premium offered.

On the day-to-day changes that go on in mid-term, it is a basic management technique to dictate to oneself—and maybe to the broker or the insurer—the substance of points discussed and commitments made by them and you. Not more than one week later, touch base with them, even if by phone, and confirm that wheels have been set in motion. Although this is a basic technique, how often do any of us do it?

It's axiomatic that if your accounts manager thinks you have a handle on the situation, and that your system will keep regurgitating this item until it has been finalized, he is going to get the habit of promptly initiating and riding herd on your requisitions.

Don't lose momentum. So often, both you and your brokers or insurers come away from a meeting all fired up to resolve a situation with diligence, but the first step is the development by you of underwriting data. Give this a high priority, and get it out as early as possible so that you can keep a not-too-subtle pressure on your insurers to give the matter an equal priority. Otherwise by the time you have your data in their hands, they are preoccupied with another three clients who are just a little more organized and effective in keeping the ball rolling.

In-depth communications with brokers or direct writing insurers are essential. Incredibly, we run into insurance managers whose only line of communication is the account manager, and when he isn't performing, they are lost. Frequently they then turn to us for assistance. You must have a director of your broker/insurer totem pole. As a very minimum you should not only know the identify of, but should schedule once or twice a year a no-agenda bull session with these broker personnel:

a) the account manager
b) his group manager
c) his marketing personnel for the major classes of insurance
d) his claims manager.

Quite apart from the benefits to you, senior management of brokers and insurers welcome the establishment of these strong lines of communication, since it gives them a finger on your pulse and the state of your adrenalin before a problem becomes a crisis.

While we are talking about communications, let's also look at your own pipeline to and from your senior management. Because insurance and risk management are cost rather than profit sources, officers and directors tend to focus on this area only when something has gone seriously awry. I don't need to tell you the importance of a good two-way pipeline between you and senior management, but it is worth restating if only to emphasize the key—albeit defensive—role which a sophisticated risk management program plays in the makeup of the corporate tapestry. ■

SPEAKING OUT

What does the government really want with its outrageous rules?

By Waller B. Smith
Vice President
Rollins Burdick Hunter Co., Chicago

THE EXISTENCE OF anomalies in official pronouncements from Washington is more to be expected than a source of surprise. But it does cause the citizenry to wonder what our government wants of us.

I continue to be one of the few who are outraged by FASB-5. As the insurance markets show decreasing enthusiasm for certain risks, the need for workable self-insurance grows. We appear to be facing an increasing tide of businesses facing closing because insurance is either not available or prohibitive in cost. More and more essential products or services become unavailable because the risk of supplying them in today's insurance-frame-of-reference, becomes too high. We came within an eyelash of losing the swine-flu vaccine because the risk, in today's marketplace, was prohibitive.

In this climate, the SEC delegated and prodded the FASB into promulgating rules that flatly prohibit real self-insurance, no matter how reasonably it may be expensed from an actuarial standpoint, or how well financed it was. If reserving for unincurred losses or undetermined losses is involved, it is a "no-no"—No spreading of risk over a period of time! And it was this ability to achieve chronological stabilization that was the very essence of self-insurance.

Consequently, the new regulations on reimbursement to health providers for self-insurance would be a welcome breath of fresh air, if the end result weren't too puzzling. I feel like a guy who has just received detailed instruction on how to conserve fuel by operating a truck at 70 m.p.h., while the 55 mandatory speed limit stands. One agency has told me flatly, "No self-insurance reserving"! while another publishes rules on how to maintain a sound self-insurance program with reserves.

The background for the "regs" is the fact that HEW reimburses hospitals for services to Medicare patients as a group, based on hospital costs. Many hospitals have been forced into self-insurance on their malpractice risk—an area which obviously can't be expensed in a single accounting period.

Recognizing this, HEW tells hospitals it will reimburse them for self-insurance *reserves*, provided they observe certain rules. The cardinal ones are:

1. Funds must be paid into an outside trust.
2. The trust must be exclusively for the payment of losses.
3. The reasonableness of the contributions must be certified by an independent actuary on a recurring basis.
4. There must be a provision for claims management.
5. There must be a risk management program to abate risk.

There's no question that this is a tough set of rules. Viewed from a 1974 angle, they were unduly onerous. But viewed from the parched viewpoint of the risk manager for whom all self-insurance is taboo, they look like a pretty reasonable deal. So you have to fund! This will protect shareholders of the future, as less expense and cash loss to today's shareholders than insurance premiums. So you need actuarial support! Isn't this better than going into a trance, and having the current financial exigencies concoct your contributions?

Importantly, it puts your comptroller and public accountant in the posture of determining the fairness and reasonableness of self-insurance programs, rather than banning them all, good, bad or indifferent.

But, in the face of implacable FASB-5, how does a hospital implement such a plan if its financial statement must be certified? How can it publish a financial statement and get by SEC? How can it utilize this intelligent self-insurance program in the face of the intransigence of the FASB?

One of the advantages of Washington's ambivalence is that one of its positions must be right. ■

Cutting prevention is the shortcut to higher costs

By SUSAN ALT

WASHINGTON—If companies attempting to cut costs or limit benefit programs eliminate preventive medical programs, the long term costs would greatly outweigh the short term savings, said Mobil Oil Corp.'s director of employe benefits.

Peter Krist, vp of employe relations for Mobil, told a conference held here to discuss high blood pressure in the workplace that he fears "preventive medicine may be the first to go" in the benefit cost cutting process.

Mr. Krist cited Modil's experience with hypertensive detection and treatment programs and advocated that more companies establish such plans.

"In the context of the cost containment pressures which we all face these days, I believe it is terribly important that high blood pressure detection and control programs not be axed," Mr. Krist said. "We must therefore, be in a position to argue that both from cost and humanitarian standpoints, it's good business to have a high blood pressure program."

Mobil has found that some heart attacks can be eliminated or reduced in severity through the program it has operated for several years. "We figure that our average employe will be out 12 weeks if he or she has a heart attack. That represents a cost of $5,500 to our short term disability plan, not to mention $20,000 in medical expenses to the insurance plan and the employe," Mr. Krist said.

This line of reasoning motivates Mobil's Mr. Krist to argue that such preventive plans reduce costs overall. "Another is that through the use of computers and nurse practitioners we can treat patients in our clinics, get them back on the job efficiently and at less cost than by always having them see a doctor," the benefits manager said.

The one-day session at which Mr. Krist delivered his remarks was sponsored by the Secretary of Health, Education and Welfare. Several hundred people from around the nation, including corporate medical directors, researchers, industrial safety personnel, labor union representatives and health insurers convened at the first conference ever held to discuss high blood pressure in the work place. A dozen speakers presented many views on the detection and treatment of hypertension, also touching on the workers' compensation aspects of high blood pressure. Along with discussions of hypertension as an occupational disease were presentations tracing the costs of hypertension to health and medical insurance bills and disability benefit payouts.

Representing the employer viewpoint were a number of corporate medical directors, employe benefit experts such as Mr. Krist, and on a reaction panel, Willis B. Goldbeck, staff director of the Washington Group on Health.

The conference, judged very valuable by most who attended, was unusual because it pulled together safety, occupational health, workers' compensation laws, health insurance, and employe benefits, areas usually separated within corporations, particularly in terms of managerial responsibility.

Mr. Krist, who has responsibility for employe benefits as well as Mobil's industrial medical department as part of his employe relations duties, said Mobil does practically all of its hypertension testing and treatment in-house. "The added cost is very low; so low, you can hardly see it. But the savings are enormous."

Mobil's health insurance premiums, under a plan with Metropolitan Life Insurance Co., have been rising like everyone else's, he said The firm shares the cost of premiums with employes, but nontheless medical premiums paid by Mobil have risen to $15 million in 1975, more than double the 1971 cost of $7 million, Mr. Krist said. "Similarly, our annual short and long term disability costs have risen from $6 million in 1971 to $10 million in 1975."

At the same time Mr. Krist blasted fully-employer-paid benefit plans as discouraging cost control. "Too many companies have agreed to company-pay-all medical insurance programs," he charged. "This is bad because if employes are not concerned about costs, they tend to overuse medical services and not to question the doctors prescribing drugs, tests, surgery, etc. As their premiums are skyrocketing, such companies are regretting their pay-all decisions and are looking for ways to cut costs."

Medical costs due to legislation involving industrial hygiene, toxicology, testing of products and mandatory physicals have also increased for Mobil, Mr. Krist said, to $2 million in 1975 from a much lower $128,000 in 1973.

During 1970, Mobil converted one-quarter of one floor of its New York City headquarters into "a NASA-type fitness unit," recounted Mr. Krist. Mobil created a voluntary blood pressure control program directed by graduate physical education majors, coordinated it with the company doctors, and encouraged upper-level executives to use it.

"Some 45% or 325 of the 722 employes who are eligible have taken advantage of it on a regular basis," he said. "Those who have done so over a two-year period have, on average, lowered their pulse rate by nine beats per minute and their diastolic pressure from 86.5 to 83.4 millimeters of mercury. Also, for those with elevated cholesterol levels, they have reduced their levels by 514 milligrams 'per cent', from an elevated range of 240 to 300 milligrams 'per cent'."

The Mobil fitness program for selected executives has been such a success, Mr. Krist said, that the company is now developing a personalized home exercise program for the headquarters employes they can serve. This will include the same physical exams including stress EKGs, individual exercise programs, and follow-up as the initial program contained.

"By these steps, we will have made available a program by which our people can, if they choose, handle stress . . . and reduce their chances of developing high blood pressure. If this pilot program is a similar success, we will extend it to other locations," said Mr. Krist.

As part of its programs to fight high blood pressure caused by continuous stress, Mobil insists that employes take two weeks of vacation at a time, and gives executives who travel through several time zones 24 hours to adjust to jet lag.

To prevent an underlying source of stress for Mobil families living outside the U.S., the company spends $1,200 per person per year to "offer adequate medical care and health services on the spot" in remote places, said Mr. Krist.

In order to keep continuous tabs on high blood pressure among employes, Mobil's medical clinics, which are part of most facilities, check blood pressure during employes' regular physicals and during many types of clinic visits. Mobil requires all employes to have physicals every three years up to age 50, and every two years between 50 and 65. Employes in stressful and hazardous occupations, such as top executives and employes exposed to lead, asbestos, radiation, etc., must have physicals every year.

"This gives us a good chance to discover trends pointing toward high blood pressure as well as the disease itself. It also gives us a chance to give a patient with high blood pressure the continuous, long term attention its treatment requires," said Mr. Krist.

Mobil plans to use its computerized medical data storage system in combination with its recently expanded use of nurse-practitioner in several clinics to improve the blood pressure control programs.

"The computer can also be used to activate a special program of planned follow up of those on blood pressure control programs," said Mr. Krist.

The key to Mobil's success with preventive medicine programs, said Mr. Krist, is guaranteed confidentiality of employes' medical histories. Written consent of the employe is required before any supervisor can obtain any medical information about that employe, he said, which "leads employes to trust and use our medical facilities." ■

Attorney hits 'overselling' of insurance

NASSAU, Bahamas—Underwriters must adopt more realistic practices and salesmen must stop overselling disability insurance, a leading Los Angeles attorney told the annual meeting of the International Claim Assn.

James S. Cline, a partner in the firm of Adams, Deque & Hazeltine said many of the distinctions in current policies are meaningless and unenforceable in the courts.

"Similarly, the actuaries, salesmen and underwriters should stop overselling disability insurance. Selling disability insurance with limits based on gross earnings rather than after tax earnings, not providing for offsets if additional insurance is purchased and selling for the sake of selling have recently been identified as key factors in the recent increase in disability income experience," he said.

"When people can live as good or better a life unemployed as they can working, many will not work. Claim representatives can't be expected to solve these problems without running the risk of a bad faith suit every time they deny a claim." ■

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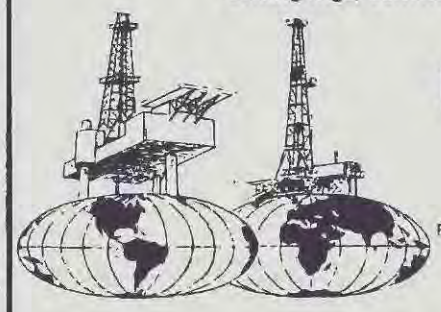

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BI benefit communication contest underway; deadline is Feb. 28

NEW YORK—The fifth annual *Business Insurance* Employe Benefits Communications Awards Competition is now underway. Last year, 110 entries, submitted by 83 corporations were judged in the contest.

Categories to be judged include booklets, personalized correspondence, audio-visual presentation, and total communications program. A panel of six judges will be chosen in December.

The awards will be presented at the annual Risk and Insurance Management Society (RIMS) conference, to be held this year at the Americana Hotel in New York.

Last year's winners for total communications program included Owens-Corning Fiberglas Corp., Toledo, Oh., first place; Continental Can Co. Inc., New York, second place; and Chemetron Corp., Chicago, third place.

Chemetron Corp. won top honors in the booklets category last year. The second place award went to Continental Can Co., New York. Birminghma News, a division of the Newhouse Group, which worked with Employe Communications Services Co. in Birmingham as a consultant, won third place.

First place award for personalized correspondence went to Medtronic Inc., Minneapolis, during last year's competition. Xerox Corp., Stamford, Ct. took the second place award. Third place honors were given to Pfizer Inc., New York.

Hewitt Associates acted as consultant for both Medtronic Inc. and Xerox Corp. Xerox also used Benefacts Inc., a division of Alexander and Alexander, as a consultant.

Winners in the audio-visual category in last year's competition were American Can Co., Greenwich, Ct., first place; Dow Chemical Co. U.S.A., Midland, Mi., second place; and Richardson-Merrell Co., Wilton, Ct., third place.

American Can Co. used Hewitt Associates as consultant. William Charmatz of New York was the consultant to Richardson-Merrell.

Entry forms, contest rules and further information can be obtained by contacting Ms. Ronnie Drachman, Awards Coordinator, *Business Insurance*, 708 Third Ave., New York, N. Y. 10017; or call her at 212-985-5050.

All entries will be accepted at the above address between Jan. 1, 1977 and Feb. 28. ■

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IMA says Illinois workers' comp changes will have little impact

By JANE WINEBRENNER

CHICAGO—Recent amendments to the Illinois workers' compensation laws have reduced the average weekly survivors benefits from a maximum of 50% of wages with no cap to a maximum $231.

But some Illinois manufacturers feel the impact of the amendments will be minimal.

The amendments, passed in late July, went into effect Oct. 1. The Illinois Manufacturer's Assn. Workmen's Compensation Committee said the amendments would make less than 0.5% difference in premiums paid. They said very few injured had weekly wages of more than twice the $231 figure, the Illinois average weekly wage for all manufacturers.

Among the other amendments passed in July are those imposing maximum penalties of $2,500 for late payment of temporary total compensation; and one redefining occupational disease "aggravation" so that to be compensable, "aggravation must arise out of a risk peculiar or increased by the employment, and not common to the general public."

Under the previous act passed in July 1975 occupational diseases could be defined to include colds and bad backs if they were aggravated in the workplace.

Also, the amendments deferred coverage of household and domestic employes until July 1980. They also exempt businesses with an annual payroll of less than $1,000. Farmers employing less than 500 man-days of agricultural labor per quarter were also excluded from the act.

In an IMA legislative report in July, the new act was called "cosmetic." The IMA said of the reduction of maximum survivor's benefits: "Because of the relatively few claims involving high paid employes, this change will have virtually no effect on insurance costs to employers."

Douglas Stevenson, IMA's workers' compensation chairman, said the major reason for the 88% overall increase in Illinois rates was the liberalized schedule of benefits paid for injuries. According to him, 70% of workers' compensation payments are for the payment of temporary disability benefits.

To reduce the premiums paid in Illinois for workers' compensation, Mr. Stevenson said the payment of permanent partial disability benefits for "loss of use" should be reduced. Presently, a worker may be paid two-thirds of his wages, up to the $231 figure, after he returns to work.

"In Illinois a worker with an injured leg receives 200 weeks of compensation," Mr. Stevenson said. "Where before he was paid $80 a week, now he can get $231. However, we don't object to payments of temporary disability or death benefits."

The recent amendments fall far short of Illinois' manufacturers all-out efforts to alter the liberalized workers' compensation laws. A stream of insurance company representatives and manufacturers' organizations testified in Springfield in hearings held in March by the Illinois legislature.

In June, the Joint Employers Council, which includes the IMA, the Illinois Chamber of Commerce, the Chicago Assn. of Commerce & Industry and the Illinois Coal Producers, pushed 13 changes in the Illinois house and senate.

Expectations among business officials were high that the original 13 amendments could pass and bring down the workers' compensation rates, but the Democratic-controlled legislature has been accused of watering down the bills.

Among the original 13 amendments only two were passed unchanged—revision of unlimited death benefits and the Occupational Diseases Act.

Because of the higher insurance rates, manufacturers must pay higher premiums—a possible 100% increase in one year in the case of Joslyn Manufacturing & Supply Co. according to its risk manager Philip B. Gehrke.

Underwriting of workers' compensation coverage in Illinois has been restricted, and some smaller companies have pulled out altogether, according to the insurance commissioner's office. Aetna Life & Casualty Co., Kemper Insuranance Co., and Fireman's Fund Insurance Co. all said last April they were becoming more restrictive in their Illinois writings.

Recent increases in rates may have allayed insurance company fears somewhat. Palmer App, division manager of Kemper Insurance Co. of Long Grove, Il., said the 88% increases have permitted Kemper to continue writing some new business.

Insurance Services Office rates were increased 48% in July, 3% in December and another 24.3% in June. The IMA claims, however, that because benefits in the compensation schedule for employment classifications were increased by 125%, the actual increase in insurance premiums on the average is 199%.

The state's assigned risk pool for workers' compensation insurance also underwent some changes when the recent amendments were passed. Risk pool applicants now must be turned down by two insurance companies instead of three in order to qualify, and the pool must make available installment plans for premiums in excess of $1,000.

The state's assigned risk pool has also increased—in 1974 there were 544 pool applications; in 1975 there were 1,483 and in the first six months of 1976 the figure is about 2,145. ■

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Bellevue's Social Security rejection still attractive

By HARRIET KING

BELLEVUE, WASH.—To the dismay of Social Security administrators, nearly 140 city and county governments nationally have opted to withdraw their employes from the Social Security system in the last four years. Another 200 have declared their intent to do so.

And queries on how the alternative system works still pour into Bellevue, the city that pioneered the withdrawal concept.

"It has created a lot of interest among many cities," says Cabot Dow, the young assistant city manager who fathered Bellevue's Employe Benefit Trust System. "But many are afraid to do it because of the potential unknowns.

"For instance, the majority of employes in the governmental unit must elect to withdraw. So some cities are afraid it might cause dissention among employes, or they're afraid unions will get upset. Some are afraid they might be too small to be able to buy privately the same amount of benefits that Social Security offers."

But Mr. Dow smiles. "At first, Social Security people couldn't believe we wanted to withdraw. They figured we were an upstart young city that was going about it half-cocked. They were later surprised that we had researched the matter as thoroughly as we did. We even had a local Social Security person come and speak to our employes on the benefits of Social Security and why we should stay in.

"But our employes weren't convinced that Social Security was the answer for them. So 87% of our 400 employes voted to get out. That scared the Social Security administration, especially since the vote came after one of their own people talked to our employes," says Mr. Dow.

He warns cities contemplating similar action "must provide clear and adequate information to employes. Few employes will consider withdrawal unless they have a liberally-funded substitute.

"Then the Social Security people said 'you can't go out in the private market and provide the type of coverage Social Security provides,' and they gave dramatic examples of how Social Security benefits people. They said benefits are going up and we can't keep up with it in a private plan, that we couldn't plug all the holes. They said we had a moral obligation to pay for the benefits of the older generation.

"But we've been able to prove they're wrong. We'll increase the city's contributions just as if we had stayed in Social Security. And we said it was not a moral issue, but an economic issue, a matter of dollars and cents to us.

"We take the same dollars and invest them. We aren't planning on balancing the city's budget with the money as New York planned to do before their alternative proposal was discarded," says Mr. Dow.

Social Security has three core components: retirement, survivor and disability benefits, and medicare, says Mr. Dow. "We purchased our mandatory survivor and disability benefits from a private insurance company, Standard Insurance Co. of Oregon. For the same amount of money we put into Social Security—5.85%—we were able to buy substantially more coverage.

"We placed 2% in survivor and disability and that left 3.85% to go into the optional retirement portion of the plan. We're not buying hot stocks, land or volatile issues with the money. It is invested conservatively in funds with People's National Bank (Seattle)."

Initially Mr. Dow got bids from 30 to 40 insurance companies and 20 different banks. "We based our choice on performance they've displayed and the costs for the benefits received," he noted.

The alternative plan is in effect in a number of states. California has 92 cities under the plan, including San Jose where city workers now contribute 3% less than they did under Social Security and enjoy benefits that average 25% higher. Louisiana has 50 governmental units, including Baton Rouge, under the plan. Other states include Indiana (11 units), Colorado, Kentucky, Maine, Maryland, Michigan, Mississippi, and Texas.

Mr. Dow credits the success of Bellevue's plan to the open mindedness of city manager Joe Miller. "He's flexible, feels cities must change with the times if they're to be responsive to the needs of employes and its people. When someone suggests that we try something new, Mr. Miller says 'lets look at it,' and if there are no substantial reasons not to do it, 'let's do it.'

"We don't go around breaking the law, but if the law doesn't prevent it, then why not do it," says Mr. Dow. "We knew of no one else in the country who had a similar plan when we drew ours up—but our plan soon got national attention."

Bellevue managers got the idea of providing an alternative system in 1969. "The first seeds of discontent with Social Security were sown by the police department. They had a strong, aggressive leader who took it upon himself to analyze what they were paying for retirement, survivor, midical, disability and then how it was duplicated by their Law Enforcement and Firefighters Retirement System. The police discovered that there were substantial overlapping coverages, yet they couldn't pyramid their benefits. So they were paying twice for the same thing," Mr. Dow says.

"I got involved in the legwork and retained an attorney to review the legality of setting out of Social Security," says Mr. Dow.

He also retained a pension consultant. "Actuaries and pension consultants are important resources in reviewing the alternatives of maintaining the status quo or withdrawing and developing an alternative plan. The third party consultant, too, is helpful in matters of plan design, filing the plan with the Internal Revenue Service for tax deferred status, administration of the plan, evaluating proposals of money managers on the business of investing funds and employee communications."

Bellevue gave the Social Security administration termination notice in 1972 and implemented the plan in October 1974. The law required that a governmental entity belong to Social Security for five years and also required an additional two year interlude between notice and withdrawal.

Basically, Bellevue contributes the same amount each payday as would have been paid for Social Security coverage. The individual employe has the option of joining the savings (retirement) portion of the plan by contributing at the Social Security rates currently in effect. The individual also has the alternative of not joining the savings portion of the plan. The city buys the survivor and disability regardless of participation in the savings plan.

The savings plan consists of an individual account for each participant. Each is credited with 100% of the employe's contribution and a matching payment obtained from the city's contributions to the plan. In 1973, the city's match was 60%; today, the rate is 75%. Income from investments has exceeded 9% yearly and is credited quarterly to each account.

Accumulated balances are paid to a participant upon death, disability, retirement, termination of employment or voluntary plan withdrawal. In the latter two cases, a vesting schedule is applied to the city's matching portion, at a rate of 10% per year of participation in the plan, resulting in 100% vesting after 10 years.

So far, the majority—77% of Bellevue employes—participate in the savings plan. Total value in all savings accounts presently is

Continued on page 78

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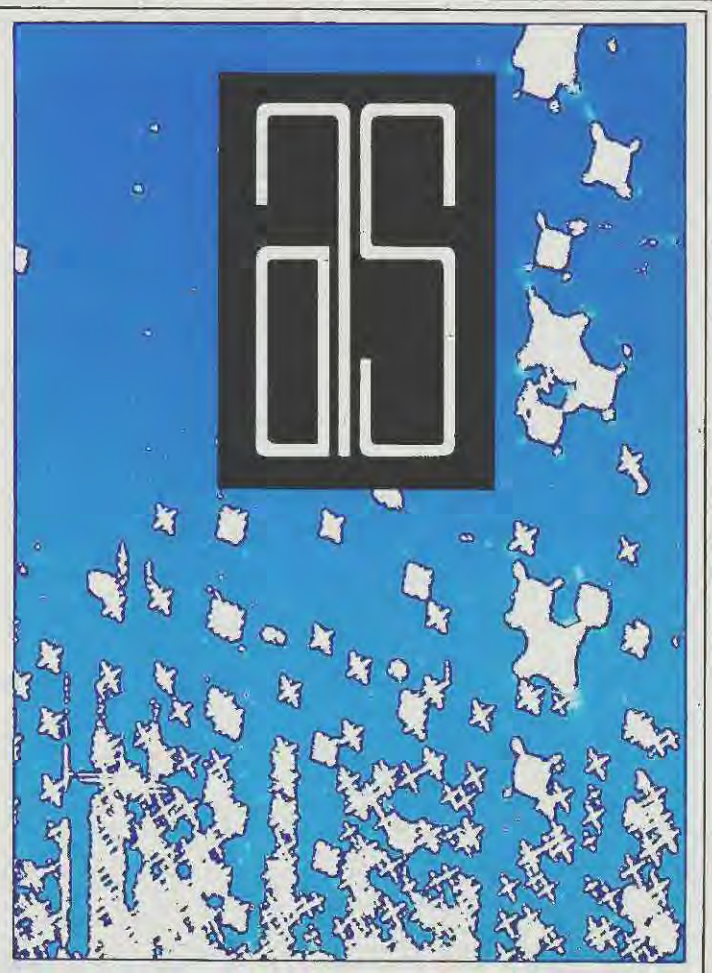

Asbestos co. faces $1 billion in suits without a cent of liability insurance

By JANE WINEBRENNER

VANCOUVER, B.C.—Cassiar Asbestos Corp. sells $100 million yearly—but it has over $1 billion filed against it in class action suits for alleged asbestos damage and it doesn't have a dollar of product liability coverage to pay them.

Cassiar is hoping that by the skin of its teeth and some legal delays, it will be able to sit tight and hope for product liability reform or relief from the courts to bail them out.

"Right now the amount is so huge it's gone past the imagination of anyone," Cassiar's insurance manager Gerald Valgardson said. "We can't comprehend it. It's so large it comes down to 'will the government allow this to thing to happen.' "

The problem stems from 15 class action suits filed in 1973 naming Cassiar and all asbestos companies in North America. The first was filed in Texas. In Cassiar's case, the actions included one case with 500 plaintiffs and 250 in another, Mr. Valgardson said. Each lawsuit asks different amount in damages on different counts, so the $1 billion figure may be a low estimate, Cassiar's lawyer, Ron Campbell, said. He said lawsuits involving other asbestos companies in other courts may number 100 which don't affect Cassiar directly, "but the public thinks it will," Mr. Campbell said.

American employes who cannot sue their employers under the workers' compensation act are suing Cassiar as a supplier of asbestos fiber to U.S. companies. It has two mines in British Columbia and one in the Yukon but none in the United States. It has been in operation since 1953.

Since November, 1975 Cassiar has been without product liability coverage and their brokerage firm, McCauley, Nichols & Matland of Vancouver, says none is available.

According to Cassiar's broker, Michael Smith, bodily injury cannot be covered in the general liability policy. Inhalation is included in bodily injury and all of the claims against Cassiar fall under this classification.

In all, the brokers went "all around the world," including to Lloyd's and 25 other carriers, but could not place the product liability insurance. Mr. Smith said he does not see any solution to the problem.

It was a year ago that Royal Insurance Corp. cancelled Cassiar's general comprehensive liability policy, including the bodily injury, with 30 days notice. Mr. Valgardson now says, "I don't think there is an insurance company in the world who will take us."

At that time, Cassiar was paying an $8,000 premium for $10 million comprehensive liability primary insurance and umbrella liability premiums of about $20,000, Mr. Valgardson said.

Because of the complexity and scope of the lawsuits, Mr. Campbell says it will be several years before any of the lawsuits are settled. Michael Smith said one area that may consume much time is the question of who has jurisdiction over Americans suing a Canadian firm.

Also, Mr. Valgardson said, in Canadian courts a person must sue individually. But if the claims are successful, "Cassiar wouldn't be in existence for very long."

Other legal factors that may work in Cassiar's favor if the cases are heard in Canadian courts are: There is no contingency fee system; judges decide award amounts and the burden of proof in on the plaintiff, the Financial Post reports.

In the meantime, Cassiar is conducting business as usual. "We're not doing anything," Mr. Valgardson said. "There's nothing we can do. We don't have the money to set aside funds."

Mr. Valgardson is hoping if events reach a "crucial point" the Canadian or American government will not "let that happen" because asbestos is a necessary product and required in the transportation industry.

Mr. Valgardson said the workers who have contracted the asbestosis disease (scarring of lung tissue) represent "a clear compensation case," and suggested a workers' compensation board for those who have the disease.

Earlier this year, eight law suits seeking $10 million from Johns-Manville Corp. were filed in a California court charging that the company "permitted its workers to face unnecessary exposure to the risks of asbestos without ever properly informing their victims of their developing lung problems or of making any effort to eliminate the risk," (*Business Insurance*, April 19). Asbestos fibers have been directly linked to lung cancer. ■

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Bellevue . . .

Continued from page 77

over $1 million, plus accumulated reserves of nearly $200,000.

Twenty to 25% of the employes have elected not to go into the retirement portion of Bellevue's program. "Of course, the Social Security administration objects to that and says you have to have that benefit. We don't think that's necessarily so. We have a vesting schedule and our employes are guaranteed eventually to get out more than they put in. They get no such guarantee under Social Security."

Under Social Security, he notes that the average wage earner who enters the workforce at age 21 and retires at age 65 contributes $41,184 under the current level of $936 contributed annually for the entire period. The earnable interest, less operating expenses, etc., comes to $79,226 compounded annually at 5%, for a total contribution of $120,410.

"With this, you could purchase a monthly annuity of about $845 a month," says Mr. Dow.

But the maximum monthly benefits allowed under current Social Security by a man and his wife are $386, assuming the wage earner and his wife live to ages 70 and 72 respectively, says Mr. Dow.

"The one part we couldn't match was the medicare part that's available under Social Security," says Mr. Dow. "That's the one weakness with our plan. We can duplicate the doctor's portion, but we can't duplicate the hospital portion.

"But it doesn't worry us. Over 90% of our employes have at least 40 quarters in to Social Security, the minimum requirement to qualify for these benefits. And there are many indications that a national health insurance plan may be in effect before many more years pass, so that the medicare portion probably won't matter." ■

Hypertension screening could bring big savings

WASHINGTON—"If hypertensive screening and treatment programs were initiated by companies, savings could be realized in their group life, group health, major medical and especially in their long term disability benefit plans."

This was the view of Richard B. Singer, second vp and director of medical research for New England Life Insurance Co., speaking at a conference on high blood pressure control in the work place held here last month.

Dr. Singer said that it's his personal feeling "that an in-house treatment program" is more successful for detecting and treating hypertension as a cause of accidents, disability and heart disease than external program. In-house screening programs should be considered by all companies with inside health facilities or clinics for their workers, he urged.

Blue Cross Assn. is in the process of asking the National Heart, Lung and Blood Institute to join them in developing and implementing comprehensive hypertension benefits, according to Howard Berman, vp, a speaker at the same meeting. Blue Cross is "very interested" in speeding up the attempts by employers around the country to provide high blood pressure detection and treatment programs and benefits, said Mr. Berman.

Mr. Berman told the audience Blue Cross wants to implement comprehensive hypertension benefits through its more than 60,000 group customers, which cover 83 million employes..

As part of Blue Cross' role as health care catalyst, the organization is most interested in hypertension treatment as a significant shift to preventive services. "Recognizing hypertension as a major health problem, though overdue, is only a first step," said Mr. Berman.

In the next year, over $500 million will be spent in the U.S. for coronary by-pass operations, "a surgical procedure whose efficacy is still being proven," he pointed out. "Through benign neglect, we will incur economic costs of over $20 billion for cardiovascular disease," he added.

"Hypertension is not only a major contributing factor to cardiovascular disease, but more importantly is a factor which we know we can control in terms of both prolonging and saving lives," he said.

Hypertension must be considered and approached as a major health problem in the U. S., Mr. Berman stated. "Hypertension is our silent epidemic—a leading, and in too many instances, uncontrolled cause of morbidity and mortality."

Blue Cross accepts its share of the blame for over-emphasizing hospital acute care benefits in the past, Mr. Berman said. However, hospital acute care is the most expensive component of overall health care, and the component for which there's been the biggest demand for insurance coverage, he said.

Blue Cross recognizes its responsibility to provide leadership in this area of preventive health care, shifting to an emphasis on rational and efficient utilization of health resources and services.

"It is apparent after even a little investigation, that a key element in a cost/effective solution to the hypertension problem is the recognition of the usefulness of some non-traditional health services delivery sites," said Mr. Berman. Part of this recognition of alternative sites focuses on the notion of the work setting as a health service delivery place other than employment physicals and traditional occupational health concerns, Mr. Berman added. He called hypertension tests and treatment in the workplace as "an important innovation in the concept of health care delivery."

Statistics show that about half of all adults can be reached in the work setting on a regular basis for this kind of tests and treatment. "Further, there is a cohesive and stable community in the work setting allowing for effective follow up and peer reinforcement influences," said Mr. Berman.

He suggested that Blue Cross could establish the mechanics of a broad health screening effort, joining industry to accomplish the screening aspect of the program. But Mr. Berman believes the "more appropriate role" for Blue Cross is that of catalyst and "a broker for making the benefit happen." Blue Cross would do this, he said, by providing an incremental health services benefit which would finance screening and detection programs and would cover treatment, health education and follow up.

Mr. Berman noted the difficulty in designing and rating such a benefit. "With respect to cost effectiveness, the direct economics of the benefit to Blue Cross are at the moment a moot, as well as secondary, point. However, from an employer's, and the community's perspective, the economics are likely to be attractive," he said.

It is likely that a high blood pressure benefit would add to the costs of a group insurance program, Mr. Berman told his audience, rather than being a substitute for another kind of benefit in the premium formula. But, he added somewhat confusingly, "the employer's and the community's total cost can be expected to be less" even though premium costs may rise.

While Blue Cross is willing to be "the facilitator" for such programs, Mr. Berman called for federal funding to help with the plan. He wants another organization to contribute its technical capabilities "as well as the risk capital" to the effort.

"We will all need the resources of the National Heart, Lung and Blood Institute to develop and field test prototype alternative benefits," according to the Blue Cross Assn. official. ■

Family changes could affect life insurance

TORONTO—Changes in the American family structure and a reorientation in society towards the individual could affect life insurance, health insurance, and pension plans of corporations, according to Dr. Mathew Greenwald, research associate of the American Council of Life Insurance.

Using American Council attitude surveys and government data, Dr. Greenwald said the changing role of women, childless marriages and high divorce rates are the major changes evolving.

The implications of these trends are less willingness to purchase life insurance, which is oriented to the needs of others, and an increased interest in pension plans, which are oriented to the individual.

Also, the greater "focus on self" may lead to a centering on the present rather than the future—with an obvious impact on life insurance business, he said. There is also a question of whether personal security products (life insurance) meets the needs of the public in these unstable times.

Dr. Greenwald made his remarks before the Society of Actuaries annual meeting in October. He said surveys by the council show less emphasis on happy family life as a goal and increasing desire for the opportunity to develop as an individual. He also cited figures showing the participation of wives in the labor force has nearly doubled in the last 25 years.

It may be significant for pension plans that increases in life expectancy have meant older people have living parents.

"There is evidence that people over 65 with surviving parents or parents-in-law are less likely to retire than those of that age with no surviving parents or in-laws," he said. "What degree of responsibility will future generations feel toward very elderly parents?" he wondered. ■

Mich. leads in inspections

WASHINGTON—A total of 38,482 workplace inspections were conducted by 21 states and one territory with federally approved state safety and health programs from April 1 to June 30, the U.S. Department of Labor announced.

Michigan conducted the greatest number of inspections (8,524), followed by California (5,236), Oregon (4,982) and Washington (4,946).

Proposed penalties were highest in California, however, at $403,947 based on 14,298 alleged violations found in the second quarter of the year. Michigan was second with $175,231 in proposed penalties for 18,234 alleged violations.

As each of the 21 states and the Virgin Islands conducted inspections under state Occupational Safety and Health Acts in lieu of federal OSHA jurisdiction, a total of 101,083 alleged violations were found resulting in proposed penalties totaling $1.5 million. ■

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Study shows product rates cripple small firms

FRANKLIN, MASS.—A product liability survey was conducted by RETORT Inc. here to determine the extent of the problems faced by small businesses needing insurance but complaining that it's either too high priced or that they can't obtain any coverage.

In addition to being one of the first nationwide data-gathering efforts by the non-profit group, the survey is meant to give added clout to RETORT's call for tort reform as a solution to the product liability crisis.

Although RETORT kept the names of the partcipating companies confidential, *Business Insurance* obtained the actual responses of 71 firms, which ran the gamut from manufacturers of foot warmers and fire protection devices to suppliers of specialty animal feed additives and acetylene compressors.

Because of the varying rate classifications of the different industries represented and the different rating methods used by insurers to determine premiums. RETORT said it was impossible to arrive at an average profile. It instead lists the separate answers provided by each firm to questions about insurance markets, availability and prices.

What emerges is a composit picture of small business crippled by rising insurance rates, stung by lawsuits for products sometimes not even of their own manufacture but for which the companies nevertheless have to bear defense costs, and puzzled by what is happening to them.

Of the 71 respondents, 19 said they were uninsured, either because they could not get coverage at any price or because they couldn't afford what was available.

Product liability premium increases of as much as 1,350% in one year's time were reported, with the high figure coming from a commercial and industrial clothes dryer producer. A number of the respondents indicated they were having trouble not only with primary insurance coverages, but also with excess and surplus lines.

"We recently marketed our liability coverage and found the primary as well as the excess markets to be extremely tight," an automatic fire sprinkler company said, adding:

"Our primary costs are based on a retrospective rating program; therefore, we are facing a drastic increase in our excess premium. The increase will be approximately 1,300, going from $23,000 to $300,-000. The previous policy was a three-year policy and the limits have remained the same."

A wire and plastics machinery company with a $15 million sales volume and five different layers of excess product liability insurance commented:

"The difficulty is in securing primary coverage because most carriers look at past records and see some claims, and feel defense costs will be too high. They say defense costs range between $5,000 and $25,000 per claim, even with no settlement, and thy want a guarantee to recover full legal costs, plus premium, to cover potential settlement costs. Without a primary carrier, no one will offer excess coverages."

In one case which underscored the vast discrepancy in product liability premium prices, a truck-equipment firm with a $1 million annual sales volume said that shortly after it received a quoted premium rate of $5,000 from a non-admitted (excess) carrier, it received a verbal quote from a primary carrier for the same risk that was ten times more, $50,000.

The trucking firm had approached the non-admitted carrier for product liability coverage and accepted its quote even though it was approximately 600% of the amount the firm paid the previous year because the firm's required carrier cancelled product liability from it overall comprehensive general liability policy.

The firm also said that the same carrier which cancelled its product liability coverages advised that it was reducing its blanket excess liability policy from $4 million to $1 million.

In certain instances, companies which had a diversified product line indicated that their insurance difficulties were coming mainly from one or two "problem" products. One $300 million consumer manufacturing firm which last year paid $250,000 for product liabillity premiums and reserved another $100,000 to handle problem cases, said that one of its products "in the recreational field" has been almost impossible to adequately insure.

The firm was able to buy only one-tenth of the basic coverage which it needed for the recreational product. Along with only the first layer of necessary excess coverage.

A wire and cable stripping machinery company with only $250,-000 in annual sales said that after its four insurance agents were unable to come up with a primary carrier for product liability, they went to the specialty market. The minimum premium they could get was $20,000, and that was with a $100, 000 deductible on judgment, but including first dollar legal expense coverage.

The same company offered its own version of another interesting twist to its product liability woes: It thinks the zeal of its agents may have been partly to blame for the carriers' reluctance to write any coverage. "Basically we believe that the concerted effort mounted through several agents to replace (our) Travelers coverage under binder, which was terminated with only 72 hours' notice, triggered a red flag on our account among the shrinking number of insurance carriers offering product liability coverage in May and June of 1975," the firm told RETORT.

After its analytical services division became uninsured when no carrier would quote on its coverage, a producer of feed tracers and specialty animal feed additives went to the Insurance Services Office (ISO) for help.

It sought guidelines for recommended product liability rates from the ISO, which refused to provide any, the firm told RETORT.

Eventually, the firm obtained access to ISO rating books from its state insurance department, only to find that the rates suggested were irrelevant because under the open-rating policies of the state, the insurance companies could charge what the market will bear, not what might be a recommended rate.

Some of the firms which filled out RETORT's questionnaire indicated that as many as 23 insurance carriers had either declined to write their product liability coverage, or refused to quote on it at all.

A few firms addressed their comments to the very problem RETORT was formed earlier this year to fight: inequities in the tort liability system which bear directly upon a business's product liability insurance costs. One problem which seemed to gnaw at a number of the respondents was the question of false suits brought against them, for which they were forced to pay legal defense costs.

A Massachusetts manufacturer of staging equipment recounted an instance when a suit was filed against it for one of its products about four years ago. The firm had its insurance company lawyer investigate.

It turned out that the defective product which sparked the suit was not even made by the firm. The suit was dropped. But the insurance company lawyer's fees for working on the case amounted to $1,755. Since the company's product liability policy had a $1,000 deductible, it wound up paying the full amount for legal work in a false suit.

When the insurance company lawyer asked the prosecuting lawyer why he had sued the Massachusetts firm, he is said to have answered that he "had to sue someone."

Many of the firms responding to RETORT's survey said they were outraged at the situation, or they asked for help.

"It seems we are at their mercy," one company wrote of insurance companies. Another respondent, from a used machinery company, was not as melodramatic, but was blunt about what the product liability situation means to his company.

After noting brief comments like "No insurance coverage. Coverage refused by original company. Refused by new company with excuse that they are not insuring product liability," he simply switched to all capital letters and wrote: "I'M CLOSING DOWN MY BUSINESS." ■

Injury rates same despite OSHA: Exec

WICHITA, KAN.—There has been no substantial reduction in job-related injuries since the Occupational Safety and Health Act (OSHA) was passed in 1970, a loss control executive for the Hartford Insurance Group said.

John L. Pickens called OSHA "one of the most significant pieces of labor legislation in recent years," but he said it was ineffective. He blamed that on a combination of ambiguous regulations, inexperienced and inadequately trained regulators, and an overemphasis on elimination of physical hazards.

OSHA also was guilty of trying to duplicate consulting services that were already available from private insurers. The duplication was an enormous cost to the government agency and taxpayers, he charged.

"We are constantly amazed that members of Congress, their staffs, and even the consulting firms under contract to them are so poorly informed on the insurance industry's contributions to employe safety," Mr. Pickens said.

He noted although most recent job safety initiatives had been undertaken by the federal government, the government hasn't been as effective as the private sector, even though it has enforcement power.

"Society is no longer willing to tolerate a high rate of accidental death and injury as the price it must pay for industrial progress," Mr. Pickens said. He made his remarks at the 27th annual Governor's Industrial Safety and Health Conference in late October. ■

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Continued from page 1

about," says Mr. Mulivrana. "But since we are small, our broker Marsh & McLennan can't get anyone to take it. And I can't run my business without it because the government says that we must have it.

"But if I can't get a renewal, I'm out of business on the waterfront. Our employes will be hardship cases. When employed, they make decent wage. But our broker says that companies like Aetna and Continental say they'll only insure companies with big payrolls.

"Part of the problem is the election. Candidates are hollering urban renewal and wanting votes and they triple harborworker benefits," says Mr. Mulivrana.

And there are built in problems with the federal law, observers note. Industrial insurance under state control is carefully monitored by the state, which checks to make sure those claiming benefits are really sick. But under the federal act, nobody is watching, they say. "Some guy in Boston or wherever can't run out here every time someone is injured," said an employer.

"One company in Seattle had a man who says he wrenched his back and has received $380 a week for three months—and then the company found out that he is bowling in three leagues every week.

"I've been in business for seven years and have never had an accident—we're careful and we're particular about who we hire. And now I hear that labor unions will fight any legislative changes in our state law that could rectify this," said Mr. Mulivrana.

Mr. Mulivrana says he has had nearly $300,000 invested in his tank cleaning equipment and trucks. Since the equipment is specialized, he doesn't know if he could sell them if he goes out of business. "I work in rain and at night on this job trying to repay the banks and this is the reward," he says bitterly.

Seattle as a community is also going to suffer from the business loss, he says. "I like to think we've helped the community. Several people have put themselves through college working for me summers. And the port will lose business. Right now, companies bring big ships down from Canada as there is no tank cleaning expertise in Vancouver. So they use our port facilities. But if they can't get their ships cleaned here, they'll go down to California, because California has state insurance that covers longshore and harbor workers."

Hal Cooke of Stanley Scott Co. here says "the problem is that the benefits are so great that if a fellow gets hurt, he's better off not to go back to work, so a lot of people who get injured are malingering.

"The average number of days off is twice as high now as five years ago for the same injury. As an insurance broker, our problem is that the property and casualty insurance industry has lost $5 billion in recent years. Insurance companies can't afford not to discriminate between good and bad risks.

"For instance, a man married with a couple of kids, making $15,000 to $18,000, if he is killed or permanently injured, his wife gets $1.75 million. There just isn't enough money generated by the average workers' compensation program to cover this type of expense.

"Consequently," says Mr. Cooke, "many clients aren't able to get insurance at any price. This covers people all over the state, too, wherever we have navigable waters such as the Columbia River.

"Of course, unions go for the federal laws, not state coverage, as federal benefits are better. While some movements are underway to get the state fund to provide offshore benefits, our legislature is slow to act. Especially since they're not meeting now, it will be January or February before we can get a bill before the legislature.

"I don't like to see the government doing this," says Mr. Cooke. "But faced with a government (state) market or no market, I'd rather at least have a market.

"Unfortunately, the problem is worse today because the underwriting results of insurance companies are so poor. Major insurers in the East, too, don't care about Washington state—there's no business reason for them to accept the dirty end of the stick when they are losing money all over the country," Mr. Cooke adds.

"The federal government is basically at fault for enacting benefits that the industry can't afford," he believes.

Meanwhile, Seattle area insurance brokers are attempting to put together a pool of carriers to provide this coverage.

Some union business agents claim the "insurance mess" drives legitimate contractors out of business and encourages "cutthroats" to take over contracts with non union employes.

And Governor Dan Evans outlined the problem in a letter to the Maritime Employers Mutual Assn., which is trying to arrange some joint coverage: "Federal legislation has created a situation which has made insurance for small maritime employers unobtainable. . . I believe we must find some way for our employers to comply with federal law. We cannot now do this on the state level, as our state industrial insurance law prohibits the state fund from providing coverage under the federal act." ■

Marine group forms

An Ocean Marine Assn. was formed in Chicago Oct. 21 to foster better understanding among area ocean marine underwriters. The new group will hold regular meetings and encourage discussion of topics interesting to ocean marine insurers. Officers elected at the charter meeting include president Francis J. Murphy, marine manager of INA; vp-treasurer Victor P. Simone, regional manager-ocean marine for St. Paul Fire & Marine Co.; and secretary Mike Jesic, marine manager for AUI/AIMA.

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Canadian pension study refutes private critics of indexed public plan

OTTAWA—Responding to criticism from the private pension sector, the Canadian government recently published a study stating the Public Service Pension Plan is financially sound. The document refutes the charge that full inflation indexing will cause the government financial difficulty in the future, according to Robert Anders, president of the provincial treasury board.

The study claims that some major private employers provide pensions that are better than those provided by the Public Service Pension Plan which covers some 270,000 federal public servants.

Federal servants can retire at age 55 with a minimum of 20 years of service and receive 60%-70% of average salary for the preceding six years. The pension is increased every year by the same percentage as the consumer price index.

Shell Oil Ltd. of Canada provides a pension as early as age 50, the government study says, as long as the employe's age and years of service add up to 75. The plan also provides automatic cost of living indexing of up to 10% per year.

While federal employes pay 7% of their salary to the pension plan, the Shell pension plan is noncontributory.

The Treasury Board document states that the total cost of federal public pension contributions has been the same as private sector costs, approximately 14.2% of pay in 1974, although employes contribute a larger share under the public service plan.

Civil servant contributions to the pension plan will increase to 7.5% in 1977. The treasury board notes that 43% of private sector employes covered by pension plans contribute nothing towards the financing of these plans and contributions of virtually all others amount to less than 5.9%.

The Public Service Pension Plan's total receipts in 1975-76 fiscal year were $1.1 billion; there were $211 million in expenditures leaving a net gain of $891 million for the year and bringing the total accumulated level of the fund to $7.3 billion.

A supplementary fund to finance indexing payments was established in 1973 and federal employes' contributions to this fund were .3%. This amount will increase to 1% Jan. 1, 1977.

Civil servants' pension benefits "are not extravagant," the government study said. In fiscal year 1975-76, approximately 59% of retiring civil servants were entitled to pensions of less than $5,000 and 90% of them received less than $10,000.

During the same period the average value of all pensions paid to former public servants was $5,100. ■

Life insurer to rewrite its policies

TORONTO—The Massachusetts Mutual Life Insurance Co. has formed a task force to rewrite its policy forms to comply with a readability law now pending in that state, its chief actuary said here.

C. Norman Peacor, executive vp, told a seminar at the Society of Actuaries annual meeting that the law would require every company doing business in the state to rewrite all policy forms by Jan. 1, 1979. The policies would have to be comprehensible to the average high school graduate using an unspecified readability test.

Other states that have adopted readability standards, Mr. Peacor said, have set different standards for comprehension. Thus insurance companies face the unenviable task of rewriting policies to a minimum level of comprehension and hoping they will be acceptable to other states.

Mr. Peacor predicted a series of court tests of the new policy language in some areas.

The administrative problems to be faced by the Massachusetts insurance regulators when they are confronted by hundreds of new policies boggle the mind, he said.

Massachusetts Mutual Life would have preferred a two-tiered approach under which new policies would have been rewritten first. Existing forms would then have been rewritten during a much longer period, Mr. Peacor said. ■

Dental plans should require second opinion

TORONTO—A well-designed dental insurance program requires a second opinion for major treatments and only pays for the least expensive alternative that will solve the problem, consulting actuary John P. Cookson said here.

Such a program, the Milliman & Robertson Inc. official told the Society of Actuaries annual meeting, would only pay the cost of an amalgam if a second opinion said that would restore a tooth even if the original dentist and patient wanted to use a crown.

That provision, called "alternative courses of treatment," as well as rating, benefit design and underwriting are the key elements in any well-designed dental plan, he said.

Mr. Cookson, said the health insurance industry should make sure the recent problems in medical insurance do not spread to the rapidly expanding area of dental insurance.

"We cannot afford to be timid any longer," he told the Society of Actuaries annual meeting. "We know more about this business than anyone and we have the responsibility to fully express our opinions even to the extent of legal action, if necessary."

Important factors in proper ratings highlighted by Mr. Cookson are employe class (professional groups use dental plans much more frequently than unskilled workers), advance notification of benefits which usually increases costs, sex (females have significantly higher use), coinsurance, deductible and annual maximum benefit payout regulations.

Other rating factors are location (since fees and care vary greatly by area), whether long rate guarantees are provided and age (since retirees may cause difficulties).

Several elements, he urged his audience, avoid in benefits are high coinsurance levels on expensive treatments such as periodontics, high or unlimited maximums, large deductibles that discourage the use of preventive services and incentive plans that encourage the postponement of major services until maximum coverage is available.

Possible underwriting problems to be monitored carefully are strikes and layoffs that reduce income while claims remain unaffected for the long run, turnover that results in a constant addition of new patients with unmet needs and contributory plans that eliminate those who would not use the services, lowering income without significantly lowering claims. ■

IRS develops 'model' profit sharing plan

LOS ANGELES—A model profit-sharing plan that carries instant approval by the Internal Revenue Service has been developed for use by individual corporate employers.

The IRS is making the plan available as a trouble-free way to get a profit-sharing plan's tax exempt status approved by the tax agency.

The model plan will automatically meet the requirements for qualification under the Internal Revenue Code as amended by the pension reform law, said IRS Commissioner Donald C. Alexander, speaking at the Western semiannual meeting of the Assn. of Private Pension and Welfare Plans.

To gain tax-exempt status, the plan must be adopted in its entirety and without modification, the commissioner said. A "simple" certification procedure will be substituted for the time-consuming determination letter procedure.

"Use of the model plan is expected to result in significant time and cost savings to small business that find it suitable for their purpose," he said.

Commissioner Alexander said the model plan will be accompanied by instructions for its use, and the IRS will announce soon the procedures and limitations on the use of the plan.

Those limitations, he said, will not allow use of the model plan if the employer has another plan in existence, or if the plan covers seasonal workers, employes in a maritime industry, shareholder-employes or employes on whose behalf contributions are made to an annuity set up under section 403(B) of the Internal Revenue Code.

Copies of the model plan will be available shortly for inspection at the IRS national office, and it will also be available to the public at IRS district offices as soon as it is printed and distributed, Mr. Alexander said. ■

Optimistic about future

James S. Kemper Jr., president of Kemper Insurance Cos., told the Wisconsin chapter of CPCU that he believes the private insurance industry will remain viable and potentially profitable from now until 1990. His belief that the insurance industry will remain private was tempered by the observation that liability insurance coverages could not continue to remain in the private sector without massive reform of the tort liability system.

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Population trends will affect pension plans

TORONTO, CANADA—The declining birth rate which has followed the post-World War II baby boom is now creating problems for the Canadian pension fund system. A future imbalance between retirees and workers is expected to occur in Canada by the early part of the next century.

In addition, unfunded pension liabilities may have to be supported by higher tax rates and the whole concept of early retirement may be called into question.

This forecast was made in a recent study of the Canadian retirement system for the Canadian Pen sion Conference. The study was authored by Geoffrey Calvert, an actuary who founded Alexander and Alexander Ltd., now known as Tomenson-Alexander Ltd. in Toronto.

"The source of concern stems not only from the swollen population now entering the work force, but equally from the shrunken population that will follow them up through the age groups and the imbalance between them," Mr. Calvert said.

There will be approximately one person over the age of 65 for every three working people in the year 2031, compared with six workers for every retiree over 65 presently, Mr. Calvert predicts.

This growth in the retirement population will make it more difficult for private firms and government to pay out adequate benefits, he said. And "to lower the retirement age would create monstrous and unacceptable burdens."

Mr. Calvert warned against commitments to expanded pension programs without setting aside reserves to back these assets. Taxation alone cannot be depended upon to finance future pension benefits.

"To plan in such a way as to weaken or over-burden the economic base is to plan the collapse of the entire system," he said.

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IRS extends deadline for Form 5500

WASHINGTON—The Internal Revenue Service has extended to Dec. 15 the deadline for filing annual financial returns on pension and profit sharing plans (the Form 5500 series)—for "hardship cases" only.

An unknown, but "significant" number of complaints from employers who could not gather the needed information needed to meet the Oct. 31 deadline—which was a previous extension of the normal July 31 due date for calendar year plans—convinced the IRS to push back the date two months, an IRS spokesman said.

The IRS action follows a previous move by the Labor Department, which also requires some of the information on the 5500 forms, to extend its deadline to December 15 because of delays in the getting the forms printed and distributed to pension and profit sharing plan sponsors.

The Dec. 15 deadline for the IRS will be limited to those plans that can prove they have exhausted "all reasonable efforts" to gather the information needed on the annual report, according to an IRS spokesman. ■

Solutions to product liability problems are contained in varied bills

The product liability problems that many manufacturers say could drive them out of business has sparked a nationwide effort to push legislation through Congress and the state legislatures. In the second of a two-part series, Business Insurance *explores several of the proposals to provide relief.*

By GREG DAVID

CHICAGO—A statute of limitations to restrict the time during which a product injury suit could be filed is the key provision of a series of proposals to deal with the product liability crisis.

A nationwide effort has developed in recent months to push product liability legislation through Congress and the state legislatures next year. Most segments of the insurance industry as well as manufacturers are involved.

Many of the groups are still drafting their proposals. But others—including a Kansas legislative committee, the Risk & Insurance Management Society, the Independent Insurance Agents of Wisconsin, the Independent Insurance Agents of Massachusetts and the American Mutual Insurance Alliance—have already unveiled their model legislation.

Prohibiting damages against a manufacturer when subsequent alteration of a product was the primary cause of an accident is another element in most of the proposals. Others include modifying or eliminating punitive damages, allowing "a state of the art" defense and prohibiting damages if the product met state or federal safety standards at the time of manufacture.

The bill drafted by a special commission of the Kansas legislature is being used as a model by many groups in the nation. Alvin Herrington, a lawyer with the Wichita firm of McDonald, Tinker, Skaer, Quinn & Herrington, said the bill will be introduced in one of the houses of the legislature when it reconvenes in January. The Kansas proposal involves 11 changes in present product liability law, more than any other model legislation.

The Kansas bill would limit product liability awards to the "useful life of the product." Mr. Herrington said his ad hoc group, which is affiliated with the national Multiple Assn. Action Committee, would attempt to amend that section to set a specific number of years during which claims could be filed.

All the proposals also contain a statute of limitations restriction. The Independent Insurance Agents of Wisconsin, the Independent Insurance Agents of Massachusetts and the American Mutual Insurance Alliance (AMIA) call for a six year statute of limitations, beginning when a product is first sold or delivered into commerce. The RIMS proposal calls for a shorter statute of limitations without citing a specific figure.

Except for RIMS, all of the proposals would absolve a manufacturer from responsibility if a subsequent alteration in the product was a primary cause of the accident. All, except for RIMS, would prohibit claims if a product met federal or state safety standards in effect at the time of manufacture.

The Kansas, Massachusetts and AMIA proposals would impose a "state of the art" rule under which a product would merely have to comply with the accepted practice at the time of manufacture. Evidence of subsequent improvements in technology could not be introduced into evidence.

All the proposals except Massa-

Continued on page 85

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Alliance study shows reforms will cut losses

CHICAGO—A number of the proposed reforms to deal with the product liability crisis could result in a major reduction in losses, according to a study by the American Mutual Insurance Alliance.

The AMIA study, based on 79 losses over $100,000 closed in 1975 by eight insurance companies, said four of the reforms now being suggested could result in a 50% reduction in payment for bodily injury claims. The four reforms are a six-year statute of limitations, eliminating claims when a product had been altered or misused, allowing a "state of the art" defense and prohibiting plaintiffs from specifying a dollar amount of damages when filing suits.

However, prohibiting contingency fees would have only a slight effect on the total award, the study said, although plaintiffs would receive more of the money they had been awarded. Other reforms not likely to have a major impact are the limination of punitive damages or prohibiting claims when a product met the state or federal safety standards at the time of manufacture. The study found 23% of the products in the study which caused injuries or claims failed to meet applicable safety standards.

The eight insurance companies had a total loss of $22.7 million in the 79 incidents, for an average loss of $287,964. Seven of the cases involved only damage to property. The other 72, including 13 that involved more than one person, resulted in injuries to 104 persons.

Other conclusions of the study are:

- Product liability problems result primarily from bodily injuries rather than property damage.
- Industrial products, rather than consumer products, are involved in most large losses.
- Most of the injured received generous payments. On average injury victims received $9.02 in tax-free cash payments for every $1 in economic loss sustained up to the time of the accident. When future economic losses are included in the total projected damages, victims received $1.47 for every $1 in losses.
- Workers' compensation subrogation involved 35% of the large claims, but was directly responsible for the filing of only 3% of the claims. ■

PROPOSED REFORMS IN PRODUCT LIABILITY LEGISLATION

	Statute of Limitations	Collateral Source	Alteration	Installment Payments	Punitive Damages	Duty to Warn	State of Art	Federal Standards	Guarantee Agreements	Pain and Suffering	Attorney's Fees	Court Costs
Kansas	X	X	X	X	M	X	X	X	X	M	X	
RIMS	X				E					E	X	X
Wisconsin	X		X					X			X	X
Massachusetts	X	X	X		E		X	X				X
AMIA	X		X		X		X	X		M	X	

E = Eliminate M = Modify

Products legislation . . .

Continued from page 84

chusetts call for some regulation of the contingent fee system. Wisconsin agents do not provide specifics while RIMS would allow a graduated scale of fees based only on the part of the award that exceeded the highest offer made by the defendant. Kansas would make all fees public and allow the court to reduce excessive ones. AMIA suggests a graduated scale allowing an attorney to charge up to 33% of any award to $25,000, 25% of the next $25,000, 20% of amounts between $50,000 and $100,000 and 10% of any damages over $100,000.

RIMS and the independent agents in Wisconsin and Massachusetts would require court costs and attorney's fees be paid by the loser in an effort to discourage frivolous suits.

RIMS, the independent agents in Massachusetts and AMIA would eliminate punitive damages. The Kansas law would change the burden of proof before punitive damages could be awarded from the weight of the evidence (now used in civil cases) to the "beyond a reasonable doubt" (now used in criminal cases).

RIMS would eliminate pain and suffering damages. AMIA proposes restricting those damages to twice the amount awarded for other damages. The Kansas bill would allow a judge to reduce a pain and suffering award if it "shocked the conscience" of the judge. Mr. Herrington said his group will attempt to change that to allow the reduction of awards merely if the judge feels they too large.

The Kansas and Massachusetts bill would allow the jury to be told of payments the plaintiff had received for medical and other expenses. The Kansas bill would, however, prohibit the introduction of payments made by insurance companies.

The Kansas bill would also allow the judge to order damages be paid in installments to insure that an award would not be squandered. It would absolve a manufacturer from liability if a user knew or should have known that a product should not be used in a certain way, even if there was no specific warning. Finally, the Kansas legislation would prohibit agreements between insurance companies and injured workers where the insurer paid awards with the understanding that the worker would then sue the manufacturer.

RIMS also urged that workers' compensation laws be improved to lessen the need to sue manufacturers and urged the tax laws be changed to allow companies to maintain reserves to pay claims.

The Wisconsin proposal would require a plaintiff to prove a product was defective or harmful, that the product caused the injury, that the defendant could have foreseen the problem and that the manufacturer failed to provide reasonable precautions. It would also require claims normally under the jurisdiction of small claims courts to be settled by arbitration.

AMIA would prohibit the naming of specific dollar amounts in suits and require separate trials before the same jury to decide liability and then damages. ■

U.K. analysts like U.S. companies

LONDON—Better prospects for insurance business in the U.S. next year are forecast by leading London stockbrokers Rowe & Pitman, Hurst-Brown, after surveying the underwriting situation.

They have advised their clients: "We have emphasised on several occasions this year our confidence that the recovery in the underwriting cycle in the U.S. will be a feature of the insurance market in 1977. Our forecasts have suggested that reductions in loss and expense ratios will bring them down from 108% in 1975 to 103-104% in 1976 and 100% in 1977.

"We believe that prospects for 1977, and also for 1978, are better than this forecast and suggest the strong possibility of the industry moving well into underwriting profit in both years.

"This conclusion is based primarily on the extent of action taken by the industry to put matters after the disastrous years of 1974 and 1975.

"In commercial classes there have been rate increases in 1975 and 1976, and in the automobile classes there has been a surge in rates this year. The process of rate adjustment will have been largely completed by the end of 1976, and we estimate that in the two years 1975-76 there will have been an overall rise in premium rates of around 45%.

"The impetus of these increases will largely be seen in the results for 1977-78, and there is a strong possibility that the scale of recovery now in the pipeline for those two years may be under estimated." ■

Terminations to continue

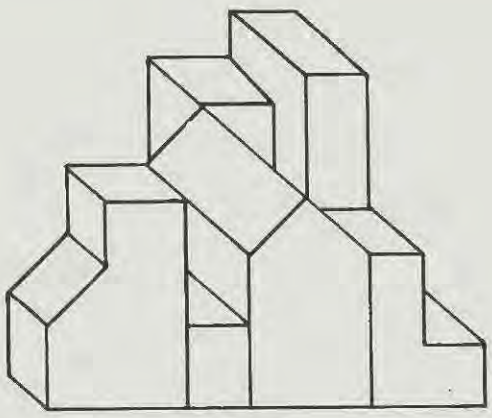
WASHINGTON—Continuing the high rate of pension and profit-sharing plan terminations that was seen last year following the passage of the pension reform law, termination notices are still coming in to the Pension Benefit Guaranty Corp. at a rate of about 600 per month, a PBGC official said.

The total number of Notices of Intent to Terminate that have been filed so far this year exceeds 6,500, he said.

Slightly more than 12,000 termination notices have been received by PBGC since ERISA was enacted 26 months ago.

The PBGC official noted that of the 5,035 termination notices filed last year, about 20% were found to be duplicates or otherwise in error, a trend that he said he expects to continue.

In a study PBGC made last March, economic reasons were given as the biggest factor in plan terminations, but the PBGC official noted that the passage this year of tax-free rollover provisions for converting disbursements from a defunct plan into individual retirement accounts now makes it "easy to terminate." ■



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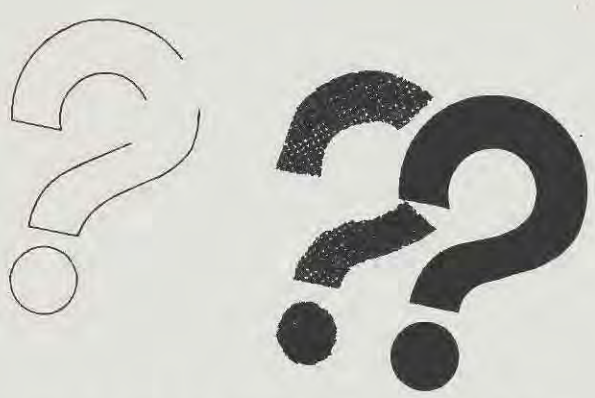

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Crowley taps Allan to direct insurance

James O. Allan, 38, was promoted to director of insurance at Crowley Maritime Corp., San Francisco, replacing **Steven M. Wilson,** who was named vp in charge of contract administration for the company's offshore division. Mr. Allan, formerly assistant insurance manager, was put in charge of Crowley's Bermuda captive, Beacon Insurance Co. Ltd. The company's property, hull, ocean marine property and indemnity (P&I) and mobile equipment coverage is handled through the captive. Mr. Allan reports to the executive vp of finance.

* * *

Norman Naughton, 33, was named corporate benefits administrator for Miller Brewing Co., Milwaukee. His responsibilities in the newly created position include daily administration of the company's 15 employe benefit programs. He will also assist in the design and implementation of new benefit programs. Mr. Naughton, former manager of personnel services at Bunge Corp., New York, reports to the manager of corporate benefits. No replacement for Mr. Naughton at Bunge has yet been named.

* * *

George Remmert, 52, special counsel for H. P. Hood Co. a Boston dairy, was named risk manager, replacing **Larry Sullivan** who joined Corroon & Black's Boston staff. Mr. Remmert supervises the corporate insurance program and is also responsible for the company's self-insurance program including comprehensive general liability, product liability, auto liability and workers' compensation. Fourteen years ago Mr. Remmert joined the company as insurance manager and for the last three years has been with the legal department as special counsel. He retains that title and responsibility. As risk manager he reports to the treasurer of H. P. Hood.

* * *

Bob Penzkover, 35, was promoted to manager of employe benefits at Quaker Oats Co., Chicago, replacing **Lee Kern** who left the company to join Saga Corp. in Menlo Park, Calif. Mr. Penzkover joined the company six months ago as manager, employe benefits administration. He was formerly corporate manager, benefits and compensation for ESB Corp., Philadelphia. In his new position he is responsible for all corporate benefit programs, including profit sharing, dental, medical and hospitalization, and short and long term disability, heading a department of 11 persons. He reports to the vp, employe relations.

* * *

At Saga Corp., **Lee Kern,** 37, is director of compensation and benefits, a new position. His responsibilities include designing, testing, implementing and communicating employe benefit programs, corporate recruitment for non-exempt employes and Equal Employment Opportunity and other personnel services. He reports to the vp, human resources. Saga Corp. is a food services company supplying business, hospitals and colleges. Another division operates a chain of restaurants including the Velvet Turtle, Straw Hat Pizza Palace and Refectory.

* * *

At ESB Corp., Philadelphia, **Stephen T. Brennan,** 28, was promoted to corporate-manager of benefits, replacing Bob Penzkover. Mr. Brennan was a benefits analyst reporting to Mr. Penzkover, and was also a former assistant to the company's insurance manager. In his new position he is responsible for 24 welfare plans and 38 pension plans. He is also involved in the design of new benefit plans and communication of benefits as well as ERISA compliance. He reports to the vp, employe relations.

* * *

John C. McKinley, 55, is the new director of safety and security for Neville Chemical Co., Pittsburgh. Responsible for the safety, fire protection, accident prevention, and security programs for the company, he reports directly to the president. Mr. McKinley was corporate safety manager at New Jersey Zinc Co., Bethlehem, Pa. A spokesman for New Jersey Zinc said the position was restructured and responsibilities divided between two people: corporate manager of safety and corporate manager of environmental health for Gulf & Western Natural Resources Group, of which New Jersey Zinc is a division.

Warner Communications Inc., New York, named **Peter M. Clark,** 34, corporate safety director, replacing **Dennis Garda** who joined the brokerage firm of Frank B. Hall & Co. in Boston. Besides safety, fire prevention and security programs for Warner's 40,000 employes, Mr. Clark is responsible for negotiations with state and federal Occupational Safety & Health Administration (OSHA) programs. He was formerly safety director at Cosco Industries, a division of Consolidated Foods Corp., Spring Valley, N. Y.

* * *

At Cosco Industries, **Edward J. Fitzgerald,** 50, former associate safety consultant with the New York Department of Labor was named safety director to replace Mr. Clark. He is responsible for coordination of all phases of safety programs and heads a staff of 25 persons. He reports to the director of personnel.

* * *

John A. Mancuso, 30, was named assistant risk manager at Merrill, Lynch Co. Inc., New York. Mr. Mancuso handles property and casualty coverage, claims and in-house loss prevention. He reports to Charles M. Mulle, the firm's risk manager. Mr. Mancuso was with Home Insurance Co.

* * *

Craig L. Ames, 32, will take over as assistant treasurer and insurance manager for Walgreen Co. in Chicago at the end of the year. Mr. Ames, an attorney, has spent the last seven years in the company's employe relations division. He succeeds **N. E. "Ed" Nilsson,** 63, who is retiring after 48½ years with Walgreen. Mr. Nilsson spent 29 years in the financial and insurance division and was named assistant treasurer in 1970.

* * *

David Haight, 43, joined C. F. Industries Inc., Chicago, as risk manager, replacing Leo Milota, who is now with Beatrice Foods Corp., as reported. Mr. Haight, who reports to the vp of finance, is responsible for all corporate insurance except employe benefits. He was with Ceco Corp. ■

dates for buyers

Dec. 3-8: International Foundation of Employe Benefit Plans—Plan administrators, advisors and trustees of joint labor-management employe benefit plans who are members of the Foundation are eligible to attend the conference held in Miami Beach. Among the 45 topics covered are trustee responsibility, health care cost control, plan termination insurance and insured welfare fund alternatives. Sessions will be held at the Fontainebleau, Doral Beach, Eden Roc and Konover hotels. Cost is $180. Contact James Neitzel, International Foundation of Employe Benefit Plans, P.O. Box 69, Brookfield, Wi. 53005 (414) 786-6700.

Dec. 8-10: American Management Assn. —self-insurance and risk retention—when and how it should be used—will be analyzed at the AMA meeting in Dallas. Risk retention, claims handling, funding of self-insurance programs are among the topics. Cost is $360 for AMA members; $415 for nonmembers. Contact Sal Nicosia, AMA program director, The American Management Assn. Building, 135 W. 50th St., New York, N.Y. 10020. (212) 586-8100.

Dec. 9-10: National Fire Protection Assn.—Seminars on the life safety code in fires, determining hazards and code requirements will be held in Washington D.C. Cost is $125 before Nov. 9 and $150 after. Application of the code to public assembly, educational, institutional industrial, storage and business occupancies are covered. Registration is limited to 125 persons. Contact the NFPA Seminar Registrar, 470 Atlantic Ave., Boston, Ma. 02210.

Dec. 14-16: Dept. of Transportation—A seminar on the problems in intermodal transportation of hazardous materials will be held at the Holiday Inn—Rivermont, Memphis, Tenn. The seminars are free and open to the public on a first come, first served basis. Contact Sandra Cureton, Office of Hazardous Material Operations, MTH-30, U.S. Department of Transportation, 2100 2nd St., S.W., Washington, D.C. 20590.

Feb. 1-3: University of Dallas—Financial costing in risk management, risk reduction transfers and budgeting, FASB #5 and SEC requirements for replacement cost disclosures will be discussed. Accounting decisions in self-insuring, and cost allocations also will be topics. Among the session instructors are corporate risk managers and accountants. Tuition is $325; cost for RIMS deputy members is $290. Contact the University of Dallas, Management Laboratories of America Inc., Irving, Tex. 75061. Attn: Bruce Evans, executive director, the Risk Management Institute. (214) 438-1123, ext. 360.

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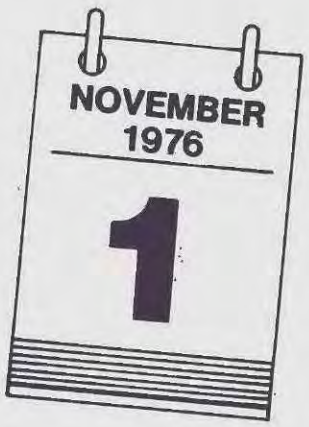

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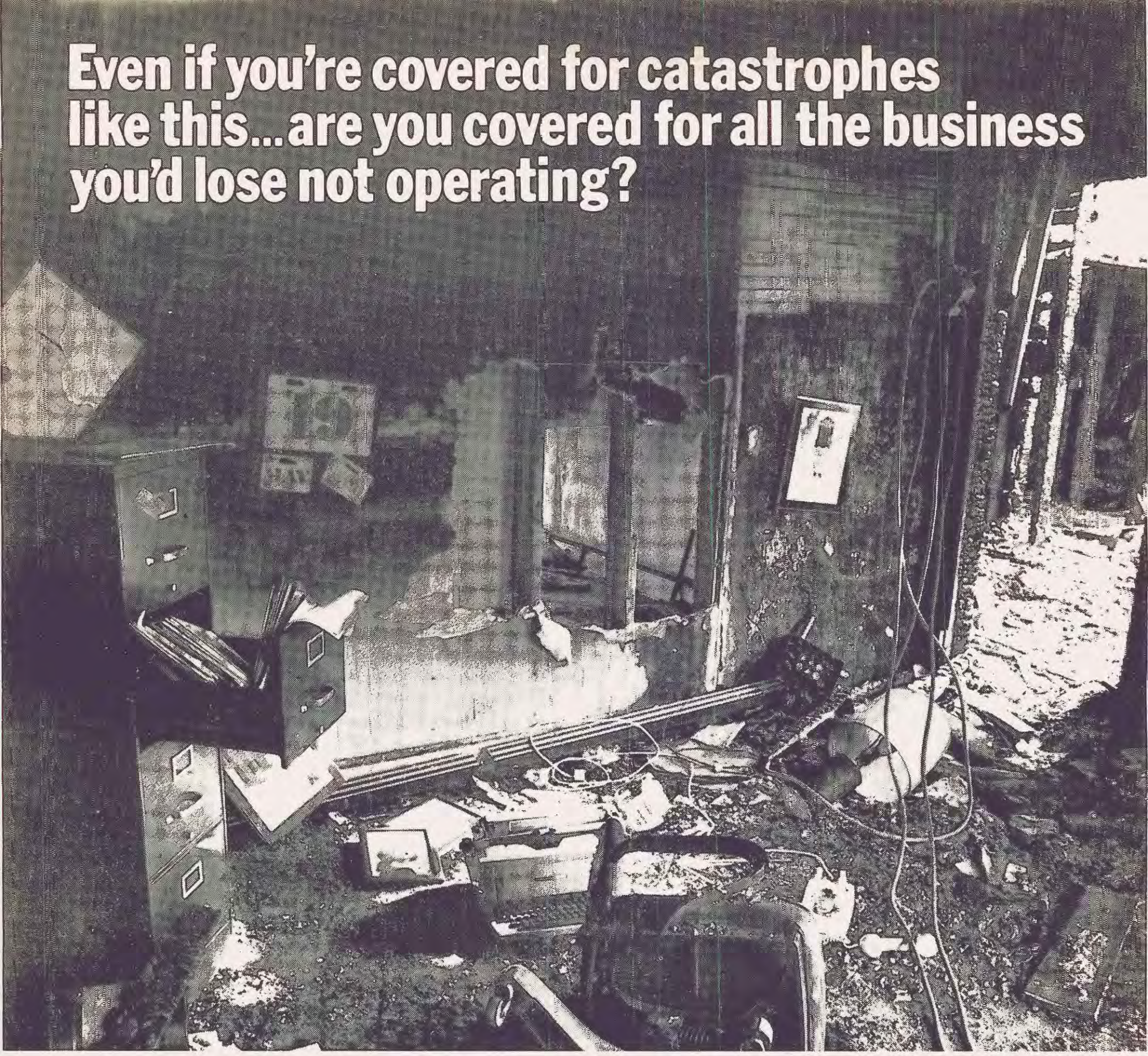

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