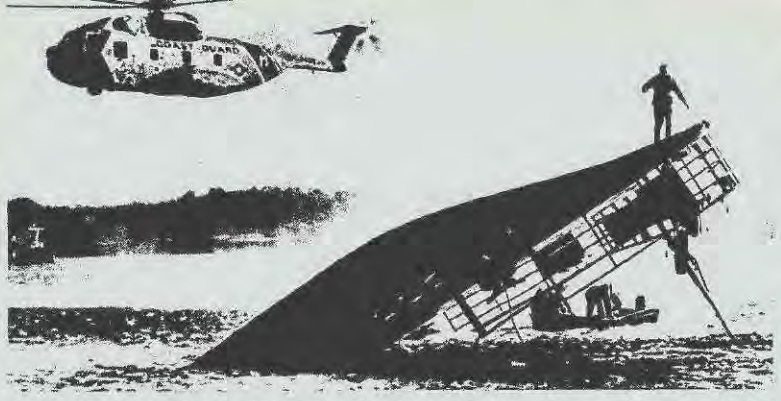

A Coast Guard helicopter circles the ferry George Prince after it collided with the Norwegian tanker Frosta. Early reports said the ferry's captain was in the engine room at the time. The Louisiana Department of Highways, which owned the ferry, said it had a $300,000 liability policy with Southern American Insurance Co. The death toll is expected to reach 100.

Insurers pay most of damages paid to Michigan utility

By SUSAN ALT

CHICAGO—Insurance is paying the lion's share of a $13.5 million product liability settlement of several suits filed by Consumers Power Co. of Jackson, Mi., although the utility is still seeking damages of some $300 million from two other suppliers of nuclear power equipment which has failed.

Ingersoll-Rand Corp., producer of valves and the steam condenser at the ill-fated Palisades nuclear power plant owned by Consumers Power, paid $11 million out of court to settle the charges against it.

After paying its own $100,000 deductible, Ingersoll-Rand said, four insurance companies which underwrote various layers of liability insurance paid the remaining loss.

UOP Corp., whose Wolverine tube division supplied tubing used in the steam condenser, contributed $2.5 million to the settlement, most of which was also covered by insurance underwritten by six different companies. Although company officials wouldn't comment on UOP's deductible under the policies, it's understood that the firm's out of pocket costs were $400,000 because UOP's liability policies excluded damage to the steam condenser itself, a standard provision of liability policies.

UOP's coverage is with Employers Mutual of Wausau on the primary layer and the first excess layer of liability.

Consumers Power is still pursuing its lawsuits against two other companies, Combustion Engineering Corp., and Bechtel Corp. Neither would make any comment on insurance or the adequacy of coverage for losses which Consumers Power says will run to at least $300 million and possibly much higher.

Combustion Engineering produced the plant's steam generator, which failed in 1974 during the early life of the Palisades power plant. Papers filed with the federal court in Grand Rapids, Mi. show that direct damage replacement cost is an estimated $65 million. In addition, replacement power supplies are costing Consumers Power Co. $100 million a year. And a source at the utility said that if the steam generator has to be totally replaced, the electric power company will incur substantially more damages than have been estimated so far.

The $300 million alleged damages are past, present and prospective losses which the utility expects to generate. Consumers Power figures it has lost $140 million to date, of which $110 million to $120 million is consequential loss resulting from shutdown of the plant.

Bechtel Corp.'s subsidiary, Benchel Co., designed and built the Palisades plant.

Consumers Power hasn't determined what portion of the losses should be covered by each of the two remaining defendants.

Consumers Power filed one claim against its own insurer, Nuclear Mutual Ltd., for $250,000 to cover

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Plan terminations up 75%

Profit sharing benefits decline

By JANE WINEBRENNER

CHICAGO—Changes in the status of employers caused the majority of all terminations of profit sharing plans in 1975, with the poor stock market and ERISA reporting requirements adding to the rise in terminations.

Plan terminations in 1975 were 75% higher than in 1974, the Profits Sharing Research Foundation revealed at the 29th annual conference of the Profit Sharing Council of America. Plan approvals from the Internal Revenue Service fell to 55% of the 1974 rate of approvals.

The foundation, a research arm of the Profit Sharing Council, said changes in the employer's status, such as liquidations, dissolutions and corporate mergers, accounted for 50% of the 1975 terminations. This also includes cases where a corporate merger resulted in a profit sharing fund being taken over by a pension plan.

Bert Metzger, president of the research foundation, said the complex reporting and disclosure requirements of ERISA have prompted some plan administrators to wait until clear guidelines are issued by the Department of Labor.

The bear market of 1974 and the recession in 1975 resulted in more layoffs and lower company earnings, meaning less employe and corporate contributions to plan funds, he added.

Termination figures for 1976 show that the trend is accelerating; from January through March of this year, 1,572 profit sharing plans were terminated and 2,167 pension or annuity plans also were ended, Mr. Metzger said.

He does not see a reversal in the trend until the end of 1977 when final guidelines for the Employe Retirement Income Security Act

Continued on page 4

Week of November 1, 1976

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Efforts intensify nationally in push for liability reform

By GREG DAVID

CHICAGO—A broad national effort has developed to push product liability legislation through the next Congress and the state legislatures convening in 1977.

This effort involves most segments of the insurance industry as well as manufacturing firms. It has resulted in the creation of two national ad hoc groups, the Multiple Assn. Action Committee (MAAC) and the National Product Liability Council, as well as a number of state organizations. In addition most state organizations of independent insurance agents are at least studying the problem and some have moved into the forefront of pushing legislation.

But any drive to enact legislation to deal with what is being characterized as a crisis in product liability may be hampered by differences among the groups.

- Manufacturers, the two national organizations and some insurance groups regard the situation as "extremely urgent." But others worry that a hasty solution could create more problems than it solves.
- A federal solution is favored by a large number of those involved. But a significant number of those contacted by *Business Insurance* said they preferred a state-by-state approach and some argued a federal approach might not be constitutional.
- The wide variety of proposals now being developed could dilute the impact of the reform effort.

The Multiple Assn. Action Committee has been spearheaded by the Sporting Goods Manufacturers Assn. and is working out of the group's Chicago office. MAAC has formed 22 state action committees, according to Jon Gehbauer, and is supporting a model Kansas proposal because it fears too many different suggestions will divide the various groups.

The National Product Liability Council consists mostly of capital goods manufacturers, Herb Goetz, chairman of the group and product safety manager for Cincinnati Corp. said. The council, which has 24 members, hopes to have its model bill ready by mid-November.

The American Mutual Insurance Assn. in Chicago has developed a bill that it hopes to have introduced in the various state legislatures next year, Richard Goodman, assistant general counsel said. But two other national insurance organizations, the American Insurance Assn. and the Independent Insurance Agents of America, are still working towards specific proposals though both emphasized they are spending a great deal of time on the subject.

Furthest along the road to legislation is Kansas, where a special legislative committee has proposed a bill to be considered by the 1977 legislature, said Alvin Herrington, an attorney and leader with the state's MAAC group. Many groups across the country consider the Kansas bill a model and are using it in their drafting sessions.

Continued on page 12

PRODUCT LIABILITY: The problem with product liability that many manufacturers say may drive them out of business has sparked a nationwide effort to push product liability reforms through Congress and the state legislatures. In a two-part series Business Insurance explores the progress and problems of the groups working on product liability. In the next issue, we'll compare in detail the many proposals that have been drafted around the country.

Lloyd's pays in Ampex case

SAN FRANCISCO—A $9 million settlement of a class action damage suit filed against Ampex Corp. by its shareholders includes $5.5 million to be paid by Lloyd's of London as insurers of the corporation's directors.

Federal District Judge Spencer Williams approved the settlement of the suit that was filed five years ago by shareholders who claimed that they were induced to purchase shares of Ampex common stock at excessive costs by officials who filed false reports with the Securities & Exchange Commission, and overstated Ampex earnings in the annual and interim reports and in press releases.

David Berger of Philadelphia, chief attorney for the plaintiffs in the case, said that 70,000 notices were sent out to individuals who purchased Ampex securities between May 2, 1970 and August 3, 1972.

Twenty thousand claims have been received so far, making the "percentage of recovery by plaintiffs probably one of the largest in such actions," he said. Deadline for filing claims is November 15.

Ampex, a producer of video and audio recording equipment, will provide $2.25 million of the settlement fund in addition to the $5.5 million to be contributed by Lloyd's. Touche Ross & Co., Ampex's former independent auditor, settled for $1.25 million.

Lloyd's has not cancelled Ampex's policy, *Business Insurance* learned. The Redwood City, Cal., corporation will continue to purchase Lloyd's D&O insurance, said W. Kenneth Sinn Sr., director of risk management at Ampex. Marsh & McLennan Inc., San Francisco, has been Ampex's insurance broker since the company was founded.

Helen Johnson, the insurance administrator at Ampex, said that Lloyd's updated its policy with Ampex after the litigation started, by increasing the number of exclusions. She said that the limits of the D&O insurance were "about the same as those for most corporations" of Ampex's size, but declined to specify the limits of the insurance or the cost of the policy. However, it is known that the limits were $20 million and the cost was between $82,000 and $100,000.

Lloyd's did not try to deny the claim, according to plaintiff's attorney W. Robert Morgan of San Jose, Cal. Lloyd's was represented by Alfred Morgan of New York, who is with the Bank of England. ■

Pillsbury eyes financial incentive to cut losses

By GREG DAVID

CHICAGO—Beginning in January, The Pillsbury Co. will attempt to reduce workers' compensation losses by employing financial incentives for its location managers. Howard Helberg, director of corporate insurance, told a National Safety Council seminar here.

Mr. Helberg called the plan "kind of unique" and said it was implemented because 'financial incentive really talks."

Pillsbury, the billion-dollar food processing company headquartered in Minneapolis, uses profit and loss statements for each location and a management by objective plan for its managers. Now, Mr. Helberg said, good loss experience will be reflected in the manager's financial compensation. Pillsbury has over 200 locations under its corporate umbrella.

For the last 10 years, he said, Pillsbury has allocated insurance costs to each location on the basis of a three year average. But this failed to reward a plant manager or other supervisor who had an exceptionally good year, free of accidents. The new plan will reward such a year almost immediately.

Under the new plan, Mr. Helberg will continue to negotiate one workers' compensation insurance program for the entire company. Last year Pillsbury's premiums for coverage amounted to $3.5 million. Mr. Helberg will figure each location's standard premium and will determine a maximum and a minimum premium charge for each location ranging from 60% to 140% of the standard premium. The program involves excess insurance to pay for large losses that cannot be absorbed by a small location.

Mr. Helberg said the plan resulted from complaints by his location managers that they were not being rewarded for good performance under the three year averaging system. In putting the plan together, he said he surveyed risk managers and brokers to find out what other companies were doing and incorporated suggestions from within the company.

Mr. Helberg hopes to hold workers' compensation premiums to $3.5 million in the next year, and then either reduce the figure or hold cost increases to a minimum.

He warned the seminar that any program like the one at Pillsbury must be equitable, treating all operating divisions fairly. Charges to locations must be reasonable and must be loss responsive, he said.

Property and casualty premiums are also allocated to locations but on the basis of risk rather than loss experience. This provides an immediate financial incentive for a location manager to improve his performance if his premiums are going up, Mr. Helberg said.

Pillsbury had to implement a computer program to make the new system work, Mr. Helberg said, but that cost of $20,000 was small compared to the $3.5 million annual premiums. ■

Caribbean earthquake problems reviewed

LONDON—Earthquake problems in the Caribbean area, including those that may affect Puerto Rico, Jamaica and Trinidad, have been reviewed by the Reinsurance Offices' Assn. with a view to guiding underwriters.

Its conclusions are contained in a series of reports covering these three countries where there has been important business development in recent years.

Dealing with Puerto Rico, where there was a disastrous earthquake in 1918 with the loss of 116 lives, the report says: "Effectiveness of its earthquake resistive design and construction workmanship are probably superior to many Latin American standards, but may well fall short of the best U.S. practices.

"Although it is an island of low seismicity, it is bounded by areas which are much more active, and developments of high-rise buildings would be at risk from larger incidents as the effect on such buildings is selective.

"The vast majority of higher magnitude earthquakes which occur some distance off the coasts of Puerto Rico and the Dominican Republic have been felt on those islands with little or no damage, but another incident like 1918, with a magnitude of 7.5, would cause an extensive amount of damage today.

"The threat of fire, with San Francisco, Tokyo and more recently Managua in mind, is only too apparent, and according to one report the local fire departments may not have studied the island's water supply and distribution systems with regard to such 'quake damage."

Concerning both Jamaica and Trinidad, the report points out that in some cases builders work to the SEAOC (California) code, but this choice might be open to question as conditions in the Caribbean are different, and many designers fail to follow the code in any case. Risks of earthquake in these two places are comparable to California in being more than moderate, but seem unlikely to reach the excessive levels of western South America or Japan. ■

N.Y. Blues ask 25.9% rate hike

NEW YORK—Blue Cross and Blue Shield of Greater New York are seeking an average 25.9% increase on rates for group hospital and surgical medical service plans.

If approved by the state insurance department, the increases would affect 3.3 million enrollees under basic hospital coverage, 3.3 million under basic surgical-medical coverage and 1.2 million under Medicare.

The insurance department will hold public herings Nov. 12 on the Blues' rate increase request.

The application for an increase contains the following rate changes:

- Subscription charges to non-Medicare community-rated basic hospital coverage subscribers under the age of 65 would increase an average 25.9%;
- Subscription charges to community-rated subscribers of the same age group for basic surgical-medical coverage would increase an average 10.1%;
- Subscription charges to community-rated Medicare supplementary coverage subscribers would increase an average 29.3%;
- Rates in the experimental prepaid group practice program sponsored by the plan would increase a weighted average 20.2%.

The new rates would increase the monthly cost of basic family group coverage to $38.20 from the current rate of $29.52 for basic hospital coverage. ■

GUIDE TO FEATURES

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the benefit beat

MMI considers suit in St. Paul trust cancellation

MARKETING MANAGEMENT Inc. in Birmingham, Al., is considering legal action against St. Paul Hospital & Casualty Co. in connection with the midterm cancellation of a multiple employer benefit trust plan. Ken Williams, one of the leading brokers for mass marketed commercial programs, said the cancellation was being studied by the firm's general counsel. "We had a guarantee that the rates effective January 1975 were guaranteed for one year," Mr. Williams said. The termination violated that guarantee, he said.

The trust included 1850 smaller employers and involved $4.5 million in premiums annually. Mr. Williams said notice of the Aug. 1 cancellation came only 30 days after St. Paul had complimented MMI on the program's profitability. The program has been converted into a self-funded employe health benefit plan under ERISA and a life insurance policy with Boston Mutual Life Insurance Co. Mr. Williams wouldn't give details on how the new plan operates, but said costs to employers have not changed under the new arrangement. If the new plan had not gone into effect, Mr. Williams said, many of the employers would have been unable to get insurance.

THE GREAT ATLANTIC & Pacific Tea Co. started a long term disability benefit program for about 20,000 non-contract employes on Oct. 1. Reliance Insurance Cos. was the winning underwriter for the new two-year LTD contract according to Richard V. Porrett, A&P's director of insurance and pensions. He said Reliance submitted the winning competitive bid from among four finalists after the Montvale, N. J.-based retailer looked at "all the major" life and health carriers for the business. Johnson & Higgins is the broker on the account. The new benefit is non-contributory and will supply eligible participants with 50% of salary, offset by Social Security. A six-month waiting period applies. Mr. Porrett said the total cost to A&P for for the LTD benefit had not yet been computed in October, but that the premium would be a function of payroll.

SAN FRANCISCO's Unified School District consolidated its benefit program for teachers with Aetna Life & Casualty Co. Previously the program was divided among four insurance companies. Now Aetna will provide dental, life, drug and accident and dismemberment insurance while Phoenix Mutual Life Insurance Co. will continue to provide long term disability coverage. The district made the move to consolidate its program and Aetna was the low bidder. Dental coverage costs $15.68 per employe per month; life, $4.77; drug, $2.77. Phoenix provides long term disability for $13.42 per employe per month. All premiums are paid by the school district.

WANTING TO UPGRADE benefits and hoping to eventually save money, Northern Trust Co. of Chicago has switched to a 501(c)(9) plan for disability. Harry Riddell, second vp, said the plan provides a worker with the bank for two years 60% of final salary (minus Social Security) as opposed to only 35% under Northern's old plan. The bank's pension plan previously provided for disability for workers with the company for more than 15 years, but that provision was dropped in meeting ERISA guidelines and benefits for workers with less time with the company improve. A 501(c)(9) account has advantages when you are a bank, Mr. Riddell admitted, since the account is handled "just as another trust account" within Northern. Riddell said he hasn't had to add any more people to his staff ("yet") but he's a lot busier these days. And the plan seems to be more popular with Northern's employes. There have been 12 requests for disability since the plan went into effect Jan. 1., Mr. Riddell said, compared with a total of only six requests under the old plan.

G. D. SEARLE & CO., headquartered in Skokie, Il., worked with a consulting firm to produce a new benefits communication package for its 5,000 employes. The presentation folio designed by Source/Inc. of Riverside, Il. was put together primarily to meet reporting requirements of Employe Retirement Income Security Act of 1974, according to Searle's manager of special communications projects, William Wilson Jr., Mr. Wilson said the new portfolio, distributed in October, was the company's first effort at putting all benefit information into a single package. It replaces Searle's old program in which a number of descriptive booklets on various benefits were distributed at different times. Bill Lloyd, design director of Source/Inc. developed the concept for Searle. It features a 9½" x 12" portfolio designed to hold actual policies and has a side pocket with color-coded file folders. A total of nine new booklets were prepared for the project, Mr. Wilson said. Five were done for the corporate headquarters and Searle Laboratories and four for the Searle Medical Instrumentation Group: the copy was written by the Searle Human Resource Division. ■

Exec: HMOs key to cost

WASHINGTON—Health maintenance organizations (HMOs) probably provide the best hope of controlling the nation's escalating medical care costs, a leading life insurance industry spokesman says.

Abram T. Collier, chairman of New England Mutual Life Insurance Co. told the Assn. of Life Insurance Medical Directors of America's annual meeting that present system of "reimbursement insurance" is responsible for the sprialing costs.

"We have a payment system that gives people excessive encouragement to seek medical advice and gives doctors and hospital excessive encouragement to charge whatever they think their services are worth," he said. "As a result, the recent inflation in the costs of health care has been greater than the inflation in any other part of the economy."

Collier said the HMO system encourages early use of medical services by patients. ■

Profit sharing changes...

Continued from page 1
are finally issued and should be in effect.

Fiduciary responsibility for plan administrators, conflicting requirements for the Department of Labor and the Internal Revenue Service, and eroded plan account balances also were mentioned as causes for terminations.

Plan administrators and employe benefit managers "should not panic" during this "shakeout" period, Mr. Metzger said. While the number of terminations is increasing, the mortality rate is still only 1.9% of all profit sharing plans.

In 1974 the erosion of account balances and the federal pension law forced many corporations to either "scrap or improve" their plans. Not all of the profit sharing plans that terminated were weak or belonged to small companies, Mr. Metzger said. "Some of the plans were very good but they just did not want to bother with all the ERISA paperwork and administration."

To avoid termination of plans, a company committed to its profit sharing program can strengthen its present plans. Mr. Metzger recommended creating built-in contribution guarantees of 5% or 6% yearly of company profits. He cited Bell & Howell Co.'s increased contributions to its profit sharing fund from a flat $2 million presently, up to $3 million in 1977 and $3.5 million in 1978.

Other ways to strengthen plans are to institute investment performance guarantees and invest more conservatively such as in fixed income securities. Employes close to retirement age can be given the option of transferring their money into these more conservative funds. Also installments could be used on paid-out money, letting the principal remain in the fund to recover any losses.

Mr. Metzger says profit sharing plans should be able to survive the present environment and adjust to future changes.

"After the shakedown period is over and the dust settles, terminations will increase but we'll see more approvals coming down the pike. Corporations will adjust to the reporting, adjust to the disclosing and private enterprise will not let those plans die. And in the future there'll be more commitment from top management to these plans," he told the profit sharing conference.

Some plans, he said, could allow themselves to be terminated with the intention of starting up another profit sharing plan when the ERISA rules are clarified. ■

Wood blames govt. in fund terminations

CHICAGO—Social Security taxes, government intervention and low profits are some reasons for the large increase in profit sharing fund terminations according to Arthur M. Wood, chairman of Sears, Roebuck and Co.

Mr. Wood told the Profit Sharing Council of America in October that private retirement plans should complement Social Security payments to avoid threatening the future of profit sharing.

"We cannot assume an employer can forever maintain a viable private retirement program and, at the same time, pay ever-escalating Social Security taxes," he said. "Moreover, we cannot assume employes can continue to pay their share of Social Security taxes without consequences for the private plan."

The Employe Retirement Income Security Act of 1974 (ERISA) is to blame in part for the more than 3,000 profit sharing plans which have terminated in the first six months of 1976 Mr. Wood said.

Sears, Roebuck and Co.'s profit-sharing plan is now 60 years old. Mr. Wood said simply that good profits are necessary for good profit sharing.

"And I am sorry to report, the performance of profits in the 1970's has not been nearly what it should be or even what it once was as recently as the 1950s and 1960s," Mr. Wood said.

Profits in the 1970s should match the 1960s figure of 9.8% of Gross Naitonal Product. ■

Thalidomide settlements favor Lloyd's

LONDON—Settlements which are largely in favor of Lloyd's underwriters have been reached in the $40 million thalidomide insurance lawsuit lodged in the U.K. High Court (*Business Insurance*, Oct. 4).

Members of the Lloyd's syndicate involved in the action have consented to pay Distillers Co. (Biochemicals) $5 million in order to dispose of the claim.

This amount has been accepted by the company, which in turn has agreed to release the underwriters from any further claims for product liability damage caused by the drug more than fourteen years ago. Legal costs will be met by the Lloyd's syndicate, which had an expert team of lawyers headed by Robert Gatehouse and William Teggin at their disposal in order to ascertain their responsibility under insurance policies taken out by the Distillers group in 1958-1962.

The Syndicate contended at all times that they were only liable for $2,000,000 under the terms of the policies, which were taken out over four years to protect the company against any damage caused by its pharmaceutical products, but were intended to have a limit of $500,000 for any one incident in each year they operated.

It seems that a suitable compromise has been established on this issue, for the company has now withdrawn its approach that each individual case of a "thalidomide baby" should be treated as a separate incident, for this would have meant a far larger pay-out, up to a potential $40 million, by the Lloyd's underwriters involved.

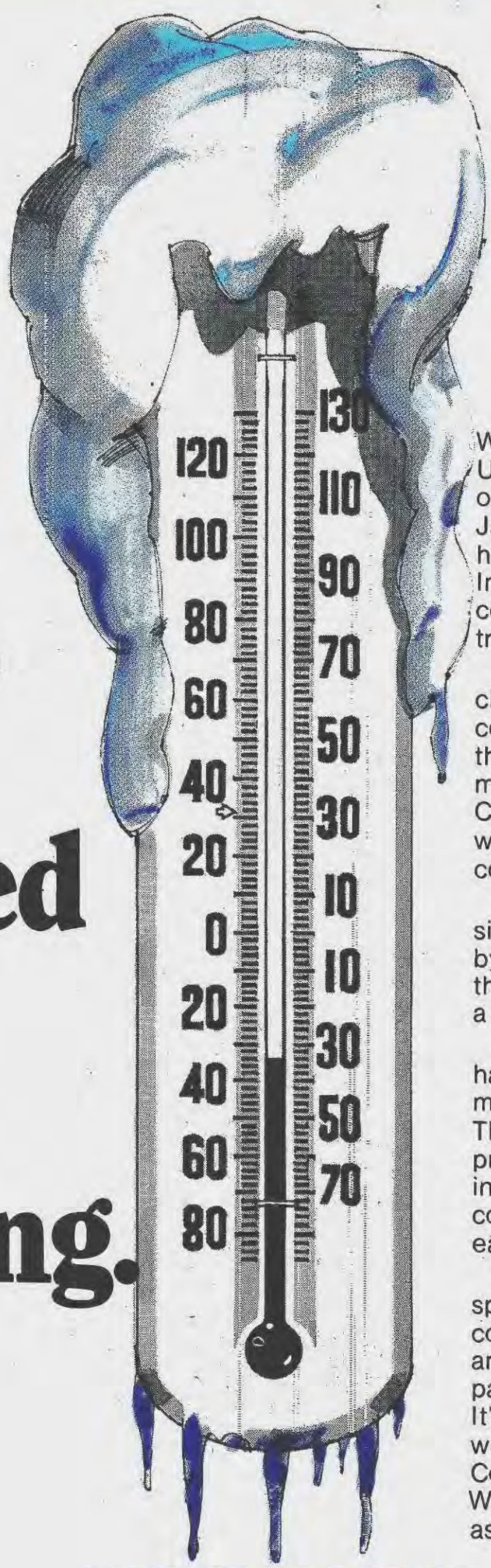
The matter has not been fully tested in the courts in Britain, as this was an out-of-court settlement reached before the trial was set to open, and the precise terms have not been disclosed.

So the legal riddle of just what constitutes "one single incident" may still have to be resolved in some future case if ever a similar tragic dispute arises. ■

AIG in Hong Kong

American International Group, Inc., will establish a regional reinsurance office in Hong Kong to underwrite and service reinsurance business throughout the Far East. Robb Peglar has been transfered from New York to Hong Kong to direct the office.

How a warm partner-ship developed from a frigid beginning.



Warroad, Minnesota, is located on the U.S./Canadian border on the west shore of the Lake of the Woods. And in early January, it's an icebox. (You've often heard its neighbor to the east, International Falls, mentioned as the coldest spot in the nation.) So wintertime travel can be tough sledding.

We were aware of that when we were chosen to provide business insurance coverage by Marvin Windows—one of the nation's leading wood window manufacturers—located in Warroad. Consequently, our immediate concern was to assure fast, effective service and communications... fair weather or foul.

Two working days after the policy was signed, we were "winging it" to Warroad by chartered plane... despite the thermometers shivering at 34° below and a paralyzing minus 84° chill factor.

Regardless, six of our intrepid claims-handling and service people flew in to meet the intrepid folks at Marvin. They spent the day establishing the best procedures for claim reporting, investigation, follow-up and unit report conferences. And everyone got to know each other personally. It's paid off.

Communications have been smooth in spite of the distance or weather conditions. Questions from either end are answered accurately and promptly, and paperwork snarls are nonexistent. It's typical of the kind of partnership we—and our policyholders—enjoy. Cooperative, productive... *warm*. Which is as welcome in Wausau as it is in Warroad.

COME TO THE SOURCE
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EMPLOYERS INSURANCE OF WAUSAU Wausau, Wisconsin

Allied Chemical's $13.4 million fine uninsured

By MARIE KRAKOWIECKI

NEW YORK—Allied Chemical Corp. is uninsured for the $13.4 million fine it received for polluting the James River in Virginia with the deadly pesticide Kepone.

Travelers Insurance Cos. is the lead underwriter for Allied Chemical on a comprehensive general liability policy which runs until March 1977.

However, the insurance does not apply to the Kepone pollution fine, believed to be the largest ever levied against a corporation for polluting the nation's waterways, because the case was a criminal action.

An Allied plant in Hopewell, Va. manufactured Kepone until 1974, when production was taken over by Life Science Products Co. Inc. Life Science was run by former Allied Chemical employes and it manufactured Kepone for the sole use of Allied Chemical for 16 months.

About 80 former employes of Life Science were stricken with neurological disorders, sterility, liver damage, and possible cancer due to Kepone poisoning. They and fishermen from the James River filed civil damage suits against Allied Chemical for nearly $200 million.

Travelers was triply involved with the Kepone poisoning scandal. In addition to being the lead underwriter for Allied Chemical's general liability, it was also the workers' compensation insurer for Life Science and the insurer for workers' compensation for the city of Hopewell. (*Business Insurance*, April 19).

Allied Chemical claimed it was not responsible for what happened to the injured workers because Life Science was "absolutely independent of Allied Chemical."

Yet, at the same time, it tried to invoke the limitation of liability under Virginia's workers' compensation law by arguing it was the "statutory employer" for those same Life Science workers.

By mid-October, Allied Chemical was meeting with representatives of Travelers and many other participating liability underwriters on a weekly basis, even though no Kepone-related insurance matters have been tried in court yet, *Business Insurance* learned.

Edward DeKoskie, manager of insurance, explained that there were "myriad problems" to be worked out because of the unusual nature of the case, and some questions as to whether the policy language of the coverage included certain claims against Allied.

He said one key point had been resolved: The court had established that the relationship between Allied Chemical and Life Science was simply that of a buyer which had a "tolling contract."

This, he said, put the situation on a third party basis. As lead underwriter for Allied Chemical's liability coverage, Travelers provides the legal defense for the company in all third party cases. It seems likely, then, that the insurer will be fielding some of the $200 million in civil damage suits still pending in the Kepone poisonings—if they come to trial.

There have been suggestions that the corporation will seek out of court settlements to avoid another drawn out trial and because testimony given by the disabled Kepone victims, many of whom tremble and shake uncontrollably, might damage the company's reputation more than the criminal actions.

If the civil suits do come to trial, they will be heard by Judge Robert R. Merhige Jr., who presided over the criminal aspect of the case and who levied the $13,375,000 fine against Allied Chemical in a Richmond Federal district court on Oct. 5.

Judge Merhige also fined Life Science Products $3.6 million, but acknowledged "that is one fine that will never be collected." The now-defunct company, which operated out of a reconverted gas station, had assets of only $32.

A Richmond attorney involved in the Kepone case said in April that Life Science had a group medical policy with Blue Cross/Blue Shield, but that the coverage was dropped October 2, 1975 making the Kepone victims dependent on the Travelers' work comp policy.

However, workers' compensation does not extend to dependents. Some of the families of the men who worked at the Life Science plant also developed Kepone poisoning.

In mid-October, Travelers said it could not comment on the Kepone liability suits because of pending litigation, but a spokesman did say the company was still making medical payments to workers from Life Science afflicted by the pesticide. In Virginia, there is a 10-year limit on payments made to disabled worekrs under the current workers' compensation legislation.

Judge Merhige said he had considered giving some of the $3.4 million fine against Allied to the Kepone victims, but found out it couldn't be done. The entire amount, he said, would be paid to the U.S. Treasury. He also said the fine could be reduced.

Some observers interpreted the judge's remarks as an indirect suggestion to Allied Chemical that it should be generous in any out of court settlements to the Kepone victims and their families.

William Moore and Virgil Hundtofte, the two former Allied Chemical officials who ran Life Science, pleaded guilty to reduced misdemeanor charges in pre-trial

bargaining, and cooperated with the government's prosecuting attorneys.

They could have been fined millions of dollars and sentenced to long prison terms (153 years and 81 years respectively) but Judge Merhige suspended all but $25,000 of their fines and gave them five years under court probation to pay them, with no prison terms.

Allied Chemical was acquitted of charges that it had conspired to withhold from the Federal Environmental Agency information about toxic discharges.

However, Allied Chemical entered a plea of "no contest" to the 940 charges that it knowingly dumped Kepone and other toxic chemicals into the James River and thence into the Chesapeake Bay from its Hopewell, Va. plant between 1966 and 1974. Judge Merhige said the no contest plea had the same effect as a guilty plea.

Allied Chemical's Mr. DeKoskie said he did not think the Kepone case would prompt Travelers to drop Allied Chemical as an insured.

The insurance manager said it would be realistic to expect that the Kepone incident might result in some changes of conditions or changes in wordings of the coverage when Allied Chemical renews its liability insurance with Travelers, since the incident was the kind which is not easily accounted for in typical liability insurance policies.

However, by mid-October he had not received any notice of non-renewal from the company concerning the policy which expires in March, nor did he expect to.

Travelers has been Allied Chemical's only primary insurance carrier, and has had a relationship with the firm for about 60 years, he explained. ■

Benefit heads caught in ERISA rule dispute

LOS ANGELES—Employe benefit plan administrators may be caught in a dispute between actuaries and accountants as a result of Employe Retirement Income Security Act (ERISA) requirements, a consulting actuary said here last month.

The dispute is over two provisions of the 1974 Pension Reform Act that call for an annual audit of a pension's plan financial statement by an accountant and an annual actuarial statement.

The American Institute of Certified Public Accountants (AICPA) has proposed several principles under which accountants can render opinions on the financial statements of pension and other employe benefit plans.

Daniel F. McGinn, president of Dan McGinn & Associates, consulting actuaries, said one of the proposals "actuaries consider. . . an invasion of the actuarial field for which accountants are neither trained nor qualified."

That proposal says that "the measure of a plan's progress toward its objective of financing plan benefits is the relationship of existing resources to the value of earned benefits" on the date of the financial statement, Mr. McGinn said.

"**If the FASB** (Financial Accounting Standards Board) were to adopt such a posture, the accountants will have expanded their audit responsibilities far beyond any intentions of Congress when it passed ERISA," he said. The best interests of the participants would not be served by having actuarial decisions made by someone other than the person best qualifie dto make these decisions."

Traditionally, Mr. McGinn said, "accountants have been trained to examine 'what has been' and 'what is' in the financial statements, while, on the other hand, actuaries are trained and skilled in determining 'what might be.' "

"In examining the financial statement of a corporation which is the subject of numerous lawsuits, would the accountant propose to establish the guidelines by which the attorney would judge whether the lawsuits involved a high or low probability of being successful against the corporation?" he wondered.

Actuarial determinations and guidelines must be established by actuaries who have been trained to understand the many factors that affect the selection of actuarial assumptions and cost methods, Mr. McGinn said.

"The value of earned benefits at a given financial statement date, when compared with the value of assets, has no necessarily useful meaning to a plan participant," he said.

"It's very possible for the actuarial liability for pensioners alone to exceed the value of the assets when the assets were also 50% of the total value of accrued benefits."

"In such a case, an active participant could be misled, since his benefits would be completely unfunded," Mr. McGinn said. ■

Rate hike bid denied in Pa.

HARRISBURG, PA.—Argonaut Insurance Co. has been denied a request to increase malpractice premiums 42.4% by the Pennsylvania Insurance Department. Pennsylvania Insurance Commissioner William J. Sheppard termed the proposed rate hike "excessive."

The insurer is the second largest writer of malpractice insurance in the state, providing coverage to approximately 4,200 doctors. Among the groups which objected to the rate hike were the Pennsylvania Medical Society and the Bucks County Medical Society.

Argonaut is currently involved in a court dispute with the Pennsylvania Medical Society. The insurance company has sued the medical group for $25 million in damages, charging that the group contract was violated. ■

info for buyers

To receive literature listed in Info for Buyers write directly to the name and address accompanying each item, mentioning that you saw the offering in *Business Insurance*. Readers are welcome to submit items for possible inclusion in the column. All items that are free and have informational value to readers are eligible. The column will also consider items for which there is a modest handling change. A sample of your literature should be sent to Info for Buyers, *Business Insurance*, 740 Rush St., Chicago, Il. 60611.

• The 1976 edition of the **Life Insurance Fact Book** is now available with information on amounts of insurance protection purchased, averages, and statistical information compiled from insurance companies and the American Council of Life Insurance. Information on pension programs, benefit payments and insurance company assets is also included. Single copies are free; additional copies are $1 each. Write American Council of Life Insurance, 277 Park Ave., New York, N.Y. 10017.

• Among the **Accident Facts** found in the 1976 edition of the National Safety Council's new booklet is the reduction in work-related deaths throughout industry. The 96-page booklet reports on accidents and accident factors. Cost is $3.35 a copy; write the National Safety Council, 444 N. Michigan Ave., Chicago, Il. 60611.

• R. B. Jones explains their services and **Why we do it better** in a promotional pamphlet available free by writing R. B. Jones Corp., Commerce Tower, Kansas City, Mo. 64199.

• A critical look at the insurance industry and its future is presented in Papers in Risk Management series: **Insurance 1985.** The papers on multinationals, consumerism, self-insurance, the European Economic Community among others were presented before The Geneva Assn. (The International Assn. for the Study of Insurance Economics) in late 1975. Cost is $6.00 in the U.S.A. and Canada. Write G.N. Crockford, Keith Shipton Developments Ltd., Adelaide House, London Bridge, London EC3R, 9DS. England.

• Environmental Labs' **Total Environmental Analytical Services** are described in a booklet. Their monitoring equipment for OSHA status and field services are outlined. For a free copy write Diamond Shamrock Corp., P.O. Box 348, Painesville, Oh. 44077.

• A comprehensive evaluation of proposals for national health insurance has been compiled by the Institute for Contemporary Studies. **New Directions in Public Health Care** contains articles by economists on medical care, the medical health market, health insurance and long run effects of national health insurance on medical care prices. Copies are $3.95 for the 278-page book plus 50¢ postage. Write the Institute for Contemporary Studies, 260 California St., Suite 811, San Francisco, Ca. 94111.

• The ABCs of hearing conservation are presented in an employe-directed booklet, **Noise and You,** published by the David Clark Co. Inc., makers of noise protective devices. For a free copy, write to: David Clark Co. Inc., 360 Franklin St., Worcester, Ma. 01604.

• **I.N.S.I.D.E. is an Economical Risk Management Alternative** describing American International Group's services to corporate self-insured programs. For a free copy of the folio, write to Info for Buyers, American International Group, 102 Maiden Lane, New York, N.Y. 10005.

• **How Not to Cook Your Corporate Goose,** from Marshall & Stevens Inc., Los Angeles, cuts through commercial insurance contract language to explain key areas of coverage. Included are how to be sure assets are really covered, how to be ready with the facts in case of loss, how to double check coinsurance. For a free copy of the pamphlet, write to John Heath Jr., vp, Marshall & Stevens Inc., 1645 Beverly Blvd., Los Angeles, Ca. 90026.

• **Practical Risk Management Application: A Guide for the Part-Time Risk Manager or Insurance Buyer,** by Edward W. Silver, is a compilation of 12 articles originally appearing in Risk Management magazine. Particular emphasis is given to loss prevention and corporate insurance programs for modest-size corporations. Sections on risk retention, catastrophe planning, insurance management and asset preservation are included. Single copies are $2 each. For 10-99 copies, the charge is $1.50 each. Write to Dept. RM, Risk and Insurance Management Society (RIMS), 205 E. 42nd St., New York, N.Y. 10017.

• Advantages and benefits of analysis of the workplace environment are discussed in **Industrial Hygiene Consulting Services.** The booklet, published by National Loss Control Service Corp., points out the ways a company can benefit by reducing or eliminating industrial hygiene problems in the workplace. For a free copy write to: A. D. Odom, National Loss Control Service Corp., Long Grove, Il. 60049.

• **Massive Service Interruptions** are possible when a fire occurs in telecommunications equipment, according to a brochure by Fenwal Inc. Information is provided on possible ignition and the resulting damage to equipment and building caused by heat, smoke and fire. The booklet describes the advantages of automatic Halon 1301 fire suppression systems for telecommunication installations. To obtain a free copy write George Crosby Jr., manager, Advertising & Public Relations Dept., Fenwal Inc., 400 Main St., Ashland, Ma. 01721.

• From Zurich-American Insurance Cos. is a booklet entitled **Honesty is the Best Policy** which discusses surety bonds. For a free copy, write to Ms. Diane Albrecht, Communications Dept., Zurich-American Insurance Cos., 111 W. Jackson Blvd., Chicago, Il. 60604.

• **If,** available free of charge from American Credit Indemnity Co., briefly describes the type of credit insurance the insurer provides. For a free copy of this colorful, short brochure, write to Miss L. Wright, American Credit Indemnity Co., 300 St. Paul Pl., Baltimore, Md. 21202.

Consumers Power . . .

Continued from page 1

damage to the turbine blading caused by failure of feedwater heaters which allowed water to back up an extraction steam line. The total claim was for $1 million, but Consumers Power's self-insured retention level was $750,000.

The utility also tried to recover more of its loss from its own insurer, NML. "We did discuss with them the various product liability losses, analyzing whether they'd be covered under our insurance. The insurance company denied liability under the exclusions of our policy," said R. Larry Drake, an attorney with Consumers Power. "We made claim also for the property damage to the turbine. NML denied liability on everything but the turbine damage, and that is being submitted as a $250,000 claim," Mr. Drake said.

The NML policy isn't meant to cover consequential losses. Also clearly excluded from coverage are corrosion-type problems and warranty losses.

Mr. Drake declined to comment on reports that Consumers Power disagreed with NML's denial of claims, and also demurred on the subject of possible legal action against NML to recover some part of losses which it believes might be covered under the policy. One source close to the utility said "The question is still open."

Damages from the Palisades failure could possibly go as high as $1 billion, said Mr. Drake, if the consequential damages are allowed to run and if it takes several more years to replace the faulty generator. But he added that he doesn't believe this is a realistic possibility.

Ingersoll-Rand's John P. Olsen, director of insurance and safety and a New York attorney, would not say who that company's insurers or brokers are. "We consider this loss completely isolated and expect that it can never occur again," he told *Business Insurance*. "We now limit our liability under the terms of our contracts, with full limitations of liability as to consequential loss and relayed damages." The Palisades project was covered by a 1966 contract, and at that time, Ingersoll-Rand was not using such a limitation clause in contracts.

There were "some severe questions of coverage" for Ingersoll-Rand under its policies, said Mr. Olsen, "which were resolved in our favor by our insurers." Limits were well in excess of the final $11 million loss, he said.

"When the facts alleged by the plaintiffs were presented in sufficient detail to our insurers, they agreed with our position that the events constituted those covered under our policies." The question was whether an "occurrence" had taken place to cause the loss, said Mr. Olsen.

Ingersoll-Rand still has its liability insurance with three of the four product liability insurers involved in this settlement. Out of pocket costs for the company were limited to the $100,000 deductible because Mr. Olsen had eliminated an exclusion within the comprehensive general liability policy for damage to the product itself, which is normally excluded from this type of insurance coverage.

Although negotiations to determine whether there was actual liability by Ingersoll-Rand to Consumer Power for damages, the out of court settlement was the result of a "remote, but distinct" possibility of an adverse jury verdict, said Mr. Olsen.

UOP Corp. said its insurance was more than adequate "for any reasonably foreseeable type of recovery." John G. Woods, vp and general counsel for the corporation, said UOP "rigidly denied liability, and was confident that UOP had a good case." The company decided to settle "because we wanted to avoid an expensive litigation process," he said. UOP's insurance policies included coverage of defense costs.

Insurance and legal experts close to the Consumers Power case believe that all four defendants are "very worried about their ability to purchase liability insurance in the future." This is particularly true of the two companies—Combustion Engineering and Bechtel—which are still in litigation, the sources said. It's known that both companies have insurance for these liabilities, but neither limits nor carriers have been revealed. ■

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Product liability effort...

Continued from page 1

The Kansas bill would set a statute of limitations on claims over the "useful life of the product"; prohibit claims against a manufacturer if modifications were the primary cause of the accident; change the burden of evidence for awarding punitive damages from weight of the evidence to beyond a reasonable doubt; absolve a manufacturer if the user should have known a product should not be used in a certain way and absolve a manufacturer if his product was equal to the "state of the art" at the time of manufacturer.

In Wisconsin, the independent insurance agents have taken the lead in supporting legislation. Paul Mast, executive secretary, said his group had circulated a tentative proposal to candidates running for the state legislature. The group has attempted to get commitments from those legislators and has formed a political action committee to make contributions after the Nov. 2 election to those favoring product liability legislation.

Indiana's state Chamber of Commerce is preparing legislation for the next session of its legislature and is mobilizing wide support for the effort, said Robert L. Craft, vp of the Independent Insurance Agents of Indiana. Mr. Craft said he expected his group to support the chamber's proposal.

An Ohio Product Liability Council has been formed, according to Thomas Johnson of the Ohio Manufacturers Assn. Mr. Johnson, who is affiliated with both MAAC and the National Product Liability Council, said the Ohio group hopes to have model legislation ready by Dec. 1.

Groups in Illinois are in the process of organizing an ad hoc committee to study the problem, Orville Bergren, president of the state's manufacturer association, said.

But some agent groups, deeply involved in a variety of insurance problems, haven't been able to turn their full attention to the product liability issue. Frank Mancini, government affairs director for the Independent Insurance Agents of Massachusetts, said his organization has a tentative proposal but has been too involved in the state's auto insurance problems to pursue it actively. The Illinois independent agents feel that state's major problem is workers' compensation, Roy Robinson, executive manager, said.

Not all the groups working on the problem agree on how fast to push action. Herb Goetz, chairman of the National Product Liability Council called the situation "extremely urgent." James Easton, president of the California sporting manufacturer bearing his name and the state MAAC representative, said he might not be able to stay in business without legislation. "I'll take what I can get," Mr. Easton said.

But Dennis Connolly, counsel for the American Insurance Assn., said he is concerned by the prospect of hasty legislation. "To use a cliche, we don't want to throw out the baby with the bath water," he said.

The ALA is working to develop a coherent philosophy about the program, Mr. Connolly said. It sees the need for reforms in the product liability system.

Fred Dupuis, executive vp of the Independent Insurance Agents of California, said his group is trying to approach the product liability problem with a "look before you leap" philsophy. He said no meaningful solution could be found in one year and that any solution would need wide public support.

The California legislature has created a special committee to study the state's liability laws. That commission is required to report by Jan. 1, 1978.

A majority of those contracted by *BI* favor federal action to solve the problem. Paul Kipp, vp of government and industry relations for the Risk & Insurance Management Society and manager of insurance for U.S. Gypsum, said a majority of RIMS members favor federal action.

An attorney working with the National Product Liability Council said a state-by-state solution would not work because the jurisdictions with the most liberal laws would not be effected. Manufacturers, he argued, would have to gear their products, insurance and prices to those states, in effect imposing those standards on citizens of other states.

Mr. Johnson in Ohio and others argue that national action is needed since most companies sell their products across the nation and should not have to meet different laws in different states.

But, a significant number argue that a state-by-state solution would allow experimentation that would eventually result in the best law. Jeff Yates, assistant general counsel for the Independent Insurance Agents of America, said he was personally "reluctant to get the federal government involved in anything." The American Mutual Insurance Assn., is also "firmly committed" to a state approach.

In Kansas, Alvin Herrington said many of the proposed reforms involve the rules of admissible evidence ,which can only be altered state-by-state. The constitutionality of a federal solution was also questioned by Orville Bergren in Illinois.

MAAC is concentrating on state action, Jon Gehbauer said, because it believes a Democratic victory Nov. 2 will disrupt the Inter-Agency Task Force studying the problem. Others, including the National Product Liability Council's Herb Goetz, said a Republican victory would aid federal action.

Several groups, including Mr. Bergren in Illinois and Mr. Johnson in Ohio, fear that Democrats in Congress will link action on product liability to the federalization of workers' compensation. Mr. Johnson said he would oppose any product liability legislation tied to federal workers' compensation.

There appears to be little coordination between the various groups working on the problem. Mr. Yates with the Independent Insurance Agents of America, said his group is exploring an umbrella organization but he is not sure that approach is going to work.

Both the Multiple Assn. Action Committee and the National Product Liability Council also said they fear too many proposals would dilute the impact of the organizations. ■

Insurance services can help cut losses

CHICAGO—Question: How can companies and insurance managers use their insurance carriers to cut losses?

One answer is to use all the services an insurance company can provide its clients, according to William Grahams, safety and health manager for Employers Insurance of Wausau.

Mr. Grahams told a National Safety Council seminar in Chicago to explore:

- Annual loss reports. Some companies can provide monthly or bi-monthly reports on request.
- Safety consultants. Don't regard these inspections as harassment. Identify your problem areas for the consultants and ask them for their recommendations.
- Occupational health consultants.
- Rehabilitation nurses. These individuals can coordinate medical care and rehabilitation, motivate workers to return to their jobs and cut costs in the long run.
- Specialists. Such individuals might be able, for example, to check microwave ovens for leakage or work with a company's fleet manager to cut losses.
- Educational programs. Some might be as small as posters but others might involve films and training.
- Technical information on casualty causes. Ask your insurer if it is conducting technical studies. Use their research to design a prevention program. ■

Cal. right-to-die law limits hospital liability

SACRAMENTO—California's Governor Edmond G. Brown Jr., signed into a law a right-to-die bill that relieves hospitals and nursing homes from civil liability if they honor a terminal patient's request to withhold or withdraw extraordinary life-sustaining measures.

The natural death act, authored by state assemblyman Barry Keene, allows an adult patient to make a written statement or "living will' instructing his physician not to prolong life by mechanical means. Two physicians must certify that the patient's condition is terminal.

The act is an effort to clear up the medicolegal uncertainty about the medical profession's responsibility to make use of advanced technology to prolong life beyond its natural limits, according to a consultant in the assembly health committee.

A patient's request is recognized as valid if he is conscious and mentally competent at the time that he signed the "living will" even if he later becomes unconscious or mentally incompetent. The statement must be signed in the presence of two witnesses who may not be related to the patient by blood or marriage. This directive goes into effect 72 hours after the patient has signed it, and can be revoked at any time by a written or oral statement from the patient.

Hospitals are often caught in the crossfire between the patient who does not want artificial life-sustaining procedures and the family who wants to keep the patient alive as long as possible, the consultant, Steve Lipton, said.

The hospital administration is often an interested party in the decision, and it is often included in litigation if the family charges the attending physician with negligence or malpractice in failing to prolong the patient's life.

The patient's written statement does not compel the hospital administration to take action, because it is directed to the physician rather than to the hospital, said Paul Hoffman, director of the hospital and clinics at Stanford University Medical Center, Stanford, Ca. Mr. Hoffman, a strong advocate of the right-to-die legislation, testified in its favor at senate health committee hearings.

The hospital administration and medical staff need to consult together to establish a protocol to accomplish the intentions of the legislation, Mr. Hoffman said in an interview.

A key element of this protocol would be the accessibility of the "living will" when the patient is admitted in an unconscious condition. The state could maintain a central file for these documents, Mr. Hoffman said.

Several hospital administrators in the state concurred that the act will have a minimal impact on their activities. They have not printed up the written directive that is prescribed in the act. Few patients are expected to take advantage of the act, they said.

It will not affect hospitals' insurance rates.

The California Hospital Assn. took a neutral position on the bill, and to date, no hospitals are planning to contest it.

A. Dale Morgan, administrator of Marshall Hale Memorial Hospital in San Francisco said that, because the procedure is so new, he would consult an attorney for the hospital the first time a patient requests to file a "living will." ■

Seattle branch set

Scott Wetzel Services Inc., has opened a new claims office in Seattle to serve the workers' compensation needs of the risk management service agency's 35 Washington corporate clients. The office is the company's 13th in the nation. The company said the move resulted from the dramatic growth in local service work since the state authorized self-insurance operations in January 1972. "At that time there were 52 corporations ready to assume risks," the company said. "Today there are at least three times that number with fully operational self-insured (or partially) self-insured) risk management programs. "

editorial opinions

No federal solution

THE WORD IS BEING spread in some quarters in Washington that regardless of who's elected President this month, the Federal Insurance Administration may soon move —or be drawn—into the business of providing product liability insurance.

Concern for small businesses particularly, which are unable to purchase this insurance, and therefore are threatened with extinction, is spurring investigation into the causes and the solutions to the problem.

We applaud these moves, for they're encouraging valuable fact-finding and documentation of product liability claims, losses, and lawsuits which heretofore have been mostly hearsay.

A conversation two weeks ago with J. Robert Hunter, Federal Insurance Administrator, indicated to the editors of this magazine that rumors about FIA offering product liability coverage just may not be too far-fetched.

As a story in this issue indicates, Mr. Hunter is confident that his department could nicely handle any solution at the federal level that involves insurance. He is quick to note, though, that he doesn't want to handle a federal product liability insurance program, just because he says he "could" do it.

That's a relief to hear. We've not been uniformly impressed with government programs in the insurance field or any other. Federal entry into the realm of product liability insurance would certainly be the forerunner of severe regulation of both industry and insurance.

Even Mr. Hunter concedes that if the Federal Insurance Administration were to function as, say, a reinsurer for product liability risks, there would have to be "rules" governing mandatory state tort reforms, minimum and maximum premium charges, and necessary loss control measures to be fulfilled by each and every insured party.

Can you imagine the size of the bureaucracy needed to set up federal product liability loss control standards and enforcement?

As Mr. Hunter rightly states, what's best is loss prevention for product liability risks. He says that any federal program in this area must have a quid pro quo so that taxpayer dollars go into a required loss prevention effort.

Sounds good, in theory. But how would such a program of standard-setting and enforcement impinge on the Consumer Product Safety Act and its commission? That's only one question, and one sector of the government, where there is clearly a possibility of "dual regulation" and infighting which could hurt business in the long run. Look at what's happening to federal pension reform law enforcement: Dual regulation by the Treasury and Labor Departments is forcing problems in Washington as well as shoving employers right out of the private pension benefit business.

Other product liability dual regulation conflicts could arise with federal agencies including the Food and Drug Administration, the Occupational Safety and Health Administration and even the Federal Trade Commission, to name a few.

Thus, we conclude that concern in the nation's capitol over businesses' product liability problems is good. Studies being done will act as catalysts for change within the insurance industry as well as in the corporate world. This will happen as new information that's never been summarized is pulled together forming a picture of a commercial risk that has to be managed carefully and differently.

But we urge caution on federal legislation to "solve" the product liability crisis. Management by crisis is seldom effective, especially when you ask the federal government to intervene.

More room for abuse

CONTINGENT FEES WIN again. It's beginning to look as if there's no end to them. We recently read of a case in which the American Bar Assn., which has actually opposed for many years contingent fees paid to expert witnesses based on winning a case, was sued by a New York lawyer charging that the Bar Assn.'s rule was discriminatory because it prevented poor plaintiffs from calling expert witnesses in complex cases.

Lo and behold, a federal court said the rule can't be enforced. Thus at a time when we're questioning whether lawyer's contingent fees are good or bad, and whether they aggravate a tendency in our society to sue everyone in sight, we have still another broadening of the contingent fee theory.

The American Bar had maintained that contingent fees were unethical for expert witnesses because they would have an incentive to give untruthful testimony. The bar maintained that witnesses should be paid a reasonable fee regardless of the outcome of the case.

But the federal court judge didn't buy that reasoning. He decided witnesses can be paid fees contingent on winning a case, and that such an arrangement won't induce witnesses to lie or stretch the truth when they testify.

Instead of working to correct a litigation problem that's at least partially caused by lawyers' abuse of the contingent fee system, this federal judge is miring the country even more deeply in legal problems.

"That was our insurance man—They're recalling our policies—the exclusions aren't working."

letters

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

Blue Shield defended

To the Editor: The lead editorial in the Oct. 4 issue of *Business Insurance* was "Are the Blues instruments of price fixers?" While I applaud your sincere concern that the price of medical care remains governed by the free forces of the marketplace, I am deeply disappointed in the distortions of fact through which you chose to pursue it.

The editorial dwelt at length on a Federal District Court case brought by the Ohio attorney general against Ohio Medical Indemnity Inc., a Blue Shield Plan, and the Ohio State Medical Assn. You failed to mention that the court had dismissed the action against Blue Shield almost three weeks before the date of your editorial.

The editorial also was misleading in its statement that before the emergence of "provider-sponsored" Blue Shield Plans in the 1930s "private health insurers aggressively sought to reduce the costs of insured medical care. . . . But they no longer have this power." The simple and incontrovertible fact is that before the emergence of Blue Shield Plans, health insurance was, for all practical purpose, not even available in this country. Blue Shield Plans were formed because the commercial insurance companies refused to enter the marketplace realistically. Only after Blue Shield Plans demonstrated that prepaid health plans could be viable did the commercial companies seriously enter the field.

Blue Shield Plan throughout the country have aggressively sought to hold down costs. This has sometimes been a difficult and frustrating experience because of general economic inflation and other social forces—all factors over which they have very little control. Still, those efforts have saved subscribers considerable sums. Your statement that the commercial insurance companies do not have similar power does not recognize the efforts of some commercial companies—the major ones—who have attempted cost containment efforts.

Your reference to those early Blue Shield Plans as being "physician-dominated," is a pejorative implication that the motives of those physicians were merely self-serving. In fact, those plans were also "physician-subsidized." They operated with infinitesimal reserves by today's standards, and Blue Shield participating physicians sometimes provided their services without assurance of payment. The subscriber took no risk;

Continued on page 18

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letters

Continued from page 16
only the physician stood to lose if reserves proved insufficient.

Today, any prepaid health care plan using the Blue Shield name and symbol must include adequate representation on its board for spokesmen for public interests. In addition, adequate reserves are essential.

Finally, your statement attributed to the Ohio attorney general that ". . . Blue Shield Plans are under attack for price fixing" is not entirely accurate. That may have been his allegation against one Ohio Plan, but it isn't true of all Blue Shield Plans. The Federal Trade Commission is making formal inquiries into the composition and operations of Blue Shield Plans as part of a wider investigation of competition in delivering and financing health care services. They have not been accused of anything, including price-fixing.

I sincerely hope *Business Insurance* continues an active editorial interest in the high cost of health care in this country and the role the private sector has in accomplishing overall social objectives. But I hope it will resist the temptation to chase scapegoats, and avoid giving allegations the status of fact.

William E. Ryan
President, Natl. Assn. of Blue Shield Plans, Chicago

Editor's note: The Blues have often been accused of restraint of trade. Conviction, however, is another question. We believe the Ohio attorney general raised some good points.

New ISO form

To the Editor: The elimination of the broad form vendors interest endorsement by most of the insurance companies is causing serious problems for the small manufacturer. Three of the largest retail organizations are refusing to accept the new ISO form known as the limited form. Granted the form is extremely restrictive to the vendor who changed the condition of the products or fails to maintain the product in merchantable condition, the form would still protect the vendor against the negligent acts of the manufacturer.

Further, the purchase order agreements hold the purchaser harmless.

I prefer not to blame the retailers because there are probably many more who are threatening to withhold orders from the small manufacturer who is unable to supply them with the broad form endorsement.

I believe that the retailer should take a second look at the requirement in view of the highly restrictive liability market today. Any refusal to do so would be extremely prejudical to the small manufacturer.

Arthur Ostrow
VP, Brokerage Resources, Inc., New York, N.Y.

Guaranteed return

To the Editor: On all sides, we hear the cry for freedom of rates —no regulation. The assumption is, of course, that the insurance industry will then be able to charge proper rates and make a profit.

Fat Chance!

The track record, from my observation, doesn't bear out these forecasts. In the areas that have been "open" (large accounts), the margins have been thin, from all reports. Open competition, it seems, (as well as bad regulation) breeds inadequate rates. This is only to be expected because, unlike any other product, the cost is not known 'til the transaction is completed—but the rates must be stated in advance. This feature attracts good business to the underwriter with the most inadequate rate—creating a snowball effect and a decline in quality of the general book of business written by others.

The only answer is *informed* (as opposed to political) regulation which, in the interest of market availability, requires that underwriters charge credible rates based on realistic forecasts.

In fact, we are convinced (as I am) that insurance is vital to our society, it should be handled as a public utility, with a reasonable return on capital guaranteed. Is there any other method left?

James R. Taylor
Springfield, Pa.

'Sue the bastards'

To the Editor: Your article "Sue The Bastards" appearing in the August 9 issue is well-written and "tells it like it is."

Stanley T. Shaw
Manager—Commercial Lines, The Travelers Insurance Cos., Orlando, Fl.

* * *

To the Editor: Congratulations on the excellent editorial which appeared August 9th.

There is no question but the tendency to sue is hurting not only the insurance business but society as well.

D. S. Butler
Executive vp, Assurex International, Wheeling, W.V.

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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.

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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. ■

Insurance mandated for Canada nuclear plants

OTTAWA—Canadian nuclear power plant operators must now carry up to $75 million in no-fault liability insurance for victims of a nuclear accident.

After six years of negotiations to work out details, the Canadian federal government enacted the Nuclear Liability Act here on October 11. It became effective immediately.

Operators of nuclear facilities previously have been covered by free protection from an indemnity plan written by Ottawa.

But under the new law, they will be paying insurance premiums typically between $650,000 to $750,000 a year, according to a spokesman for the Atomic Energy Control Board, a government agency.

The law also provides for the establishment of a nuclear damage claims commission to handle claims and payments to victims of a nuclear accident which exceed the $75 million liability limit, the AECB said.

Under the law, payments of up to $75 million would be made to nuclear accident victims for injury or property damage even if the facility operator is not at fault.

The law places full responsibility on the operator for any damages caused by radioactive materials used in the plant processes. This releases suppliers from liability.

At this writing, it is not clear whether the $75 million limit of liability will cover reactors in adjacent complexes

Operators which have a number of reactors all on the same location may have to purchase separate coverages for some of them.

According to a report in the The Montreal Star, for instance, the Pickering nuclear complex near Toronto which has four 500-megawatt reactors will be covered by a single $75 million policy. But a second stage, four-reactor complex planned for the same site in the 1980s might be covered separately.

The Nuclear Liability Act was first approved by the Canadian Parliament back in June of 1970, but met with opposition from private insurers and others who questioned whether the $75 million limit of liability was high enough in the event of a nuclear accident.

One way the federal government helped clear the way for the law to be enacted was to agree to reinsure participating insurance companies for coverages which are normally excluded in commercial nuclear liability insurance policies.

As one AECB official pointed out, the $75 million limit of liability is much lower than the United States' nuclear insurance scheme under the Price-Anderson Act. In the U.S. there is a limit of liability of $560 million, with $125 million coming from private insurers.

However, the Canadian bill, with its special damage commission, gives homeowners and others redress for payments in excess of the $75 million, and it is considerably more liberal than two European nuclear insurance schemes which set liability limits at $5 million and $15 million respectively. ■

Take Advantage of Us. Our Engineers Will Love It.

Engineering services abroad is a lot more than having an engineer on staff who is on the run all the time. It takes back-up, plenty of experience, and an organization that knows the local markets in depth to provide a multi-national company with the kind of engineering services it should have.

Fire protection and loss prevention techniques demand an intimate knowledge of not only what can be done but what should be done. Uniform worldwide codes and standards are decades away and those that do exist are more often far below the standards that are taken for granted in the United States.

AFIA, the largest U.S. underwriter of foreign insurance with more branches overseas than any other, knows what the differences can mean. It has been the leader in fire protection and loss prevention services abroad and pioneered the HPR concept in Europe.

Like we said, it takes a lot more than an engineer to provide engineering services. AFIA, has over 4,OOO employees abroad and with almost 6O years of on-the-spot experience, we know the markets, the codes, the ins-and-outs like it was our own backyard.

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legal brief

Ambiguous policy language nets damages for insured's fire loss

IN THIS ACTION the insured sued Merchants Property Insurance Co. of Indiana to recover for construction materials destroyed by fire. The Supreme Court of Appeals of West Virginia ruled that the language of the multi-peril policies was ambiguous and would be interpreted to include the insured's loss within the coverage of the policies.

The multi-peril insurance policies with builder's risk provisions from the insurers covered the apartment structure under construction and any construction materials and supplies while stored within the specific areas designated by the policies. While stored in the basement of a building locatd across the street from the construction project, but within 82 feet of the insured premises, certain materials and supplies intended for use in the insured premises were destroyed by fire. The plaintiffs were denied recovery upon their two insurance policies by the trial court's conclusion that the destroyed materials were not on premises described in the policy when the fire occurred.

The following policy provision was the focal point of the dispute:

"Coverage A—Building(s): . . .

"This policy also covers temporary structures, materials, equipment and supplies of all kinds incident to the construction of said building or structure and, when not otherwise covered by insurance, builders' machinery, tools and equipment owned by the insured or similar property of others for not exceeding the amount for which the insured is liable; *all while in or on the described buildings, structures or temporary structures, or in the open (including within vehicles) on the described premises or within 100 feet thereof.*" (emphasis added)

The defendants-insurers argued that construction materials were covered only when they were stored in a building on the 'described premises" or in the open within 100 feet of the premises. The insured maintained that all construction materials were insured under the policy wherever they were stored, providing the storage area was within 100 feet of the "described premises.' The court agreed with the insured.

Ruling that the above provision was ambiguous, the court stated that ambiguous and irreconcilable provisions should be construed strictly against the insurer and liberally in favor of the insured. But the court emphasized that such construction should not be unreasonably applied to contravene the object and intent of the parties. *Prete* v. *Merchants Property Ins. Co. of Ind.*, Supreme Court of Appeals of West Virginia, April 6, 1976, Flowers, J. 223 S.E.2d 441 (BI/05/S.-$3)

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

Banker's blanket bond

The question before the United States Court of Appeals for the Fifth Circuit in this action was whether banks could recover under provisions of their banker's blanket bonds for money advanced to a customer.

The court found that money had been advanced by the banks to the customer upon his deposit of drafts. Interest was to be charged and if the banks did not realize a profit from the interest, they would do so, in the court's opinion, from nurturing the customer's business. In one case the banks took promissory notes with the drafts. In another case the transactions were similar to previous ones in which notes had been taken.

The court believed that these transactions were de facto "loans." Consequently, since the banks could have had no reasonable expectation that the drafts would be paid in the normal course of business, the court believed these transactions fell within the banker's blanket bond provision excluding coverage for losses due to bank loans.

According to the court the banks' expectation that the banker's blanket bond would afford coverage for money advanced to the customer upon deposit of drafts and that such advances would not be considered loans under the bond provisions were not objectively reasonable in view of the fact that the term "any loan" as used in the exclusion was broad and not restricted by any narrowing modifier. Also, the court pointed out that the banks here were in effect asking for credit insurance, which under Louisiana law is not provided by a banker's blanket bond. *Calcasieu-Marine Nat. Bank, Etc.* v. *Am. Emp. Ins.*, United States Court of Appeals for the Fifth Circuit, June 14, 1976, Wisdom, J. (BI/01/0.-$3)

Workers' compensation

The Supreme Court of Wisconsin has upheld a 25% permanent partial disability award to an employe for mental disability arising out of unusual work stress to which she was subjected. In reaching its decision, the court pointed out that in workers' compensation proceedings the exact same standards should not be applied to cases of mental and physical disability.

This claim for compensation was filed by Etha Schillinger for mental injury arising out of her employment by The Swiss Colony Inc. (Colony), a mail-order cheese company. Schillinger started to work for Colony in 1955 and became the purchasing agent in 1961. In 1971 she began to feel "rattled" and 'disorganized" and was hospitalized and treated for schizophrenia. It was established that from 1961 to 1971 Colony's gross mail-order sales rose from $2 million to $13 million annually.

In addition retail stores were added to the business in the 1960's. Schillinger served as purchasing agent for both the retail and the mail-order business. In 1970 Schillinger acquired an immediate supervisor who was characterized as "negative, brusque, and belittling, especially to women . . ." It was further established that Schillinger worked unusually long hours in 1971 and had to forgo her vacations because of work related problems.

The appellate court was satisfied that there was abundant evidence in the record that Schillinger was subject to stresses and strains which were out of the ordinary from the day-to-day stresses and strains which all employes must experience. Under such circumstances, the court concluded, nontraumatically caused mental injury was compensable in workers' compensation cases. *Swiss Colony* v. *Dept. of Ind., L. & H. Re.*, Supreme Court of Wisconsin, April 7, 1976, Wilkie, C. J., 240 N. W. 2nd 128 (BI/03/S.-$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, Il. 60611. Please enclose a $3 check made out to Cases Unlimited Inc., for each case, and specify the code number of the opinion, which is at the end of each brief.)*

Ford Motor will pay all national health costs, dental premium hikes

DETROIT—The Ford Motor Co. has agreed to pay any direct premiums, taxes or contributions which may be required of its workers under a national health insurance program as part of the company's settlement with the United Auto Workers.

The new contract, which one report estimates will increase the company's total compensation cost 34% from the current $11 per hour per worker, is expected to be the basic agreement for the entire auto industry. In addition, UAW contracts often set patterns for other industries in the nation.

Other major changes in the benefit package for Ford workers include new programs for vision care and hearing aids and improvements in the dental and health programs.

Ford has agreed to pay all future increases in premiums for the UAW-Ford dental care program. Other changes, effective Jan. 1, 1977, increased from 85% to 90% the payment for dental x-rays, extractions, oral surgery, fillings and other services and increase from $500 to $650 the lifetime maximum for orthodontic treatment.

The new vision care plan provides 80% of costs for eye examination and glasses once every two years. The plan will also pay the entire cost of contact lenses if they are needed to correct severe visual problems. Glasses must be bought from participating optometrists and opticians and workers must pay for any extras such as oversized lenses or prescription sunglasses. Glasses obtained by nonparticipating providers will be at a lower rate than for those participating in the program.

The union said the hearing aid provision is the first such benefit negotiated in a national contract. The plan will cover the entire cost of an examination by a participating audiologist and hearing aid from a participating dealer.

The union agreed to an increase from $2 to $3 for the patient copayment for each drug prescription and to moving health insurance coverage for new workers from the first day of the second month to the first day of the third month.

Increases were negotiated in the annual maximum for psychiatric care (from $800 to $1,000) and the number of ambulatory visits in drug abuse and alcoholism programs (from 70 to 140). Other changes made the emergency care benefits payable on the basis of symptoms rather than the final diagnosis; made nursing services and physical therapy available without a hospital visit and allowed more outpatient psychiatric coverage.

The health benefit coverage for laid off workers will now be continued for 12 months for those with six years seniority. Previously 10 years were required to extend coverage for 12 months.

Retired UAW workers will now be covered under the company's dental, vision and hearing aid programs. The company also agreed to increase Medicare Part B payments from $6.30 to $7.20.

Retirees will also receive a one-time bonus of up to $600 to help offset inflation. Other elements of the pension plan were not open to negotiation this year.

The wage increases in the contract will result in increases in life insurance, accident and sickness insurance and extended disability insurance which are tied to salary.

For example, the UAW said a major assembler at Ford will have his life insurance increased from $13,000 to $17,000; accident and sickness benefits from $130 to $180 and extended disability coverage from $480 to $710 for a worker with 10 years experience. ■

Ever wonder who pays for all those lawsuits you've been reading about?

The right to sue is basic to the American legal system. But lately there's been an enormous increase in the number of liability claims. For example, medical malpractice claims have been soaring, and a similar trend is now appearing in products liability.

And not only has the number of claims been escalating, but the amount of money involved has been increasing dramatically, too.

These are some of the reasons why you and everyone who buys liability insurance must pay higher premiums.

Insurance, after all, is simply a means of spreading risk. Insurance companies collect premiums from many people and compensate those who have losses.

The price of insurance must reflect the rising cost of paying for those losses and the expense of handling them. That's why your insurance premiums have been going up.

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PERSPECTIVE

EMPLOYE BENEFITS:

Budgets, controls for administrative costs required post-ERISA

By GRANT H. MORRIS
Consultant, Morris Associates
New York, N. Y.

EVERYONE IN THE employe benefits field knows that ERISA is going to cost plan sponsors more money than they've been accustomed to paying in the past. If you're on the company side of this field, you know it is going to cost more in service fees and charges, more for internal work to prepare the necessary records and reports, and more in amounts set aside for benefits. Of course, the people on the service side of benefits, employed by actuaries, accountants, lawyers, and so on, all know that it is going to generate more income for their firms. But how much more?

The answer to that question obviously, varies from company to company, depending on many factors, such as: nature of the employe benefit plans before ERISA, attitudes of the employer toward ERISA compliance and toward using outside expertise to draft new plans, prepare employe booklets, perform special pension cost studies, etc. In the end, the true costs of this beginning phase of ERISA will not be known until the lawyers, accountants, actuaries, employe communications firms, and others present their bills.

Let's leave aside these more spectacular one time charges which many companies are now in the process of paying, and concentrate on an area which may prove far more costly in the long run. This area can be described generally as the overhead cost of ongoing administration of the records required by ERISA. Included within it are all internal costs of administration of employe benefits, and all fees paid to outside firms for specialized services related to benefits, such as actuarial valuations, auditing by a public accountant, benefit statement production, thrift plan processing, and other outside data processing services.

While it is easy enough for most companies to find out how much they have paid in any year for outside employe benefits services, it often appears quite difficult for them to separate their internal costs in a meaningful way, because these are shared between several staff functions and are usually not the full time responsibility of the individuals involved. This is not a valid reason for giving up on the attempt to find out how much it costs to administer pension and welfare plans.

If you are concerned about it, and you, or someone in your organization should be, you can arrive at an acceptable ballpark estimate of the overall costs in this area. And that should be sufficient to indicate whether you ought to invest some time and money in doing this kind of administration more efficiently, or whether you should decide to tolerate the amounts being spent.

How to go about this? The chart on this page is a generalized guideline to the process of figuring out how much benefit plan administration is costing your company. Since it is generalized, it may cover some items not applicable to your situation, or it may have left out items peculiar to your company or industry. With a little alteration on your part, you can easily develop your own check list from this one and apply it to your company.

A few notes of explanation may help you to use this list more effectively:

1. Multiplying annual salary by the factor 1.7 may seem a little high to some people, but it is by now a common yardstick for measuring the actual cost in fringe benefits and other expenses for having an employe on the company payroll.

2. It is assumed that the employe benefits department is the only place where you will find people who spend their full time on employe benefits work. In this case, the salary of the department manager (if he or she is full time) should be included with the employes on line 1, and part of the salaries of the mythical "management" persons above the department level who spend part of their time on benefits administration problems should be entered on line 2.

3. After you calculate the cost of benefits for these employes, which should be relatively easy, you will be venturing into uncharted waters. Most of us have an aversion to putting a dollar figure down on paper if it doesn't come from some accounting record. This tendency is particularly noticeable in accountants, but all of us share it to some degree. Dollars and cents are somehow sacred numbers, and if not enshrined in some journal or ledger, are highly suspect. You can overcome your reluctance to put fictitious numbers down when you realize that estimates are better than nothing, and that unless you do it, no one else will. Instead, everyone will continue moaning about the high, and increasing, costs of benefits administration, without ever being able to specify what it is they complain about.

4. A note of caution here. Since you *are* estimating at many points in this check list, be sure to note in your work papers the basis of your estimates. If someone guesses that she spends 30% of her time on benefits, note who said it and when.

5. If you are "lucky" enough to have a complete chargeback system in the data processing center, so that computer time, systems work, and programming are all itemized on monthly bills, here at last is your chance to lay it all back at their doorstep, showing the horrendous contribution to overhead they are making.

6. Under Internal Costs, item E2 may be one you prefer to skip. Nevertheless, it is one example, out of many in this area, of something called opportunity cost. What would all those clerks, supervisors, and managers be doing with their time if they were not spending hours and hours trying to reconcile the company's profit sharing records with the bank's? Or, trying to figure out why 100 employe thrift plan statements at random appear to be wrong in their acumulations, or, any of the endless list of things which can go wrong and cause people to drop whatever they're doing and help put out the brush fire.

It will not really take very long to get some preliminary estimates filled in on this list, perhaps two or three working days. After review with the managers responsible for the areas touched on by this study, and redefinition of exactly what is to be included, the estimates can be refined to a reasonably firm set of numbers, agreed to by all those affected.

Now, what should you do with your shiny new page of figures? First, divide the grand total of internal and external costs by the total number of employes to get an approximation of the per head cost of benefits administration. Does it look reasonable? Remember, there are few, if any, standards for this kind of cost, so you have to use your own judgment. An amount per employe which seems reasonable to one company, may be extremely painful to another company in the same industry.

If the per capita cost, and the individual items which go toward creating it, seem reasonable, then you have at least reassured yourself on that point, and also in the process you've established a basis for comparative studies of these costs at later dates, and done it at very little cost. File the study away; call it back six months or a year from now for updating and comparison. In the meanwhile, you can spend your time on other matters with some reassurance that these costs are not out of control.

If the results of this study upset you, if you get the feeling that costs are out of line for one or more of the items covered, then you've got to spend some time to dig deeper .First, pick the most flagrant case and go back to the source. If it was a figure taken from an accounting record, say the general ledger, you may find that the ledger account name is misleading, and that more is accumulated there than just what you were looking for. It may be necessary to go back to original journal entries to track down the numbers you want. If it was an estimated figure, it will be necessary to go back over the estimating process again, asking more detailed questions on the second interview, and pinning things down more precisely.

The steps described above should be repeated for all items on the check list which indicate excessive costs. At the end of this process, if you still have a cost picture which troubles you, then you can prepare yourself for some really grinding work, especially when the problem lies with internal costs. Somebody has got to go through the departments involved and do a thorough investigation of how people spend their time.

Frankly, the author's 20 years of experience in dealing with in-house administrative problems have taught him that, unless you can eliminate a job completely so that no one ever has to do it again, you are probably better off looking elsewhere to save money. It is actually rather rare to find people in the administrative cadres of most companies who do one thing and one thing only. It is far more common to find that they perform several different tasks, and as long as one of them has not been eliminated, Parkinson's Law plus the natural tendency of the department manager to keep his body count up, will keep that employe on the payroll. A lot of time and effort may have gone into eliminating nearly all of the clerical function, but it won't result in the saving of much over-

Continued on following page

Check List for ERISA Administration Costs

I. Internal Costs

A. Employe Benefits Department
1. Total employes annual salaries × 1.7 = $_____
2. Management-part annual salary(s) × 1.7 = _____

B. Payroll Department
1. Partial employes annual salaries × 1.7 = _____
2. Management-part annual salary(s) × 1.7 = _____

C. Personnel Department
1. Partial employes annual salaries × 1.7 = _____
2. Management-part annual salary(s) × 1.7 = _____

D. Data Processing Department
1. Amounts charged back for: computer time= _____
systems work= _____
programming= _____
2. Management-part annual salaries × 1.7 = _____

E. Other Factors
1. Cost of forms, records, tapes; etc; = _____
2. Value of time lost in reconciliations, error corrections, etc; = _____
Total Internal Cost = _____

II. External Costs

A. Consulting Actuary
1. Bill for normal valuation = _____
2. Bill for special cost estimates = _____
3. Consulting fee for ERISA record keeping system design = _____

B. Public Accountant
1. Portion of fee attributable to ERISA records audit = _____
2. Consulting fee for ERISA record keeping system design = _____

C. Thrift/Savings Plan Processor
1. Basic annual charge, or set up charges = _____
2. Per head charge for periodic processing = _____
3. Extra charges for systems, programming, special runs, etc; = _____

D. Benefit Statement Processor
1. Set up charge = _____
2. Per head charge for processing = _____
3. Extra charges for graphics, systems, programming, etc; = _____

E. Other External Costs
1. _____
2. _____
Total External Cost = _____
Grand Total of Internal & External Costs = $_____

Benefits . . .

Continued from preceding page
head as long as the personnel count remains the same.

So, unless you have a lot of clerical staff somewhere in the employe benefits administration picture who all do the same thing, and you can figure out a way to completely eliminate their job function, you'll probably be much happier, and strike paydirt much sooner, if you concentrate your efforts on the external costs.

As far as outside fees are concerned, perhaps it is too easy to look at the general ledger and write down a figure without thinking about it or analyzing it. All too often, a careful review of the fee, breaking it down into its parts to see what the company received for its money, is simply not done. In too many companies, outside fees are dealt with from the seat of the pants. The responsible person reviews them briefly, and if the total isn't above some intuitive maximum that person carries in his or her head, they need no comment.

We have dwelt on this point, not because there is any underlying assumption that fees are inaccurate or padded, but because it is easy to foresee that they are going to rise in coming years. ERISA has given every kind of employe benefit servicer more functions to perform, and therefore more to charge for. Inflation will also tend to drive up their fees. If the company paying for the service doesn't exercise sound business practice in reviewing the charges, doesn't know what it has contracted for, nor what it is worth, it will almost certainly end up paying out a good deal more than necessary for benefits services.

Let's stress the fact that, although it often seems so, the review of fees charged you by any outside servicer is not of necessity an adversary proceeding, any more than the review of your own work by superiors within the company. More often than not, managers reviewing the work of subordinates, the details of which they cannot possibly know as well as the subordinates do, ask questions primarily to elicit enough information to make a decision. It is an attempt to clarify and understand the material, not to pick it apart. Or at least it begins that way.

Just as your superiors have the right to question how you arrived at the conclusions in a report, so do various people in the company have a right, indeed a duty, to review charges by outside suppliers. While some professional consultants do act somewhat huffy when their fees are questioned, if you make it clear that you are seeking clarification, it should be possible to develop a working relationship. In the process, you will begin to learn why his fees are high (if they are), and he will be kept on his toes, which is generally the best posture for anyone supplying services. The first thing you will learn is that the actuaries, accountants, and data processing services try to keep accurate time records so that they can bill you for everything they do on your behalf. Then, you may discover that some of the work they perform for you is necessary only because of poor procedures in your own shop, or a misunderstanding of what you want done.

For example, if your company submits sloppy, inaccurate data to the actuary for the annual valuation, he usually bills about $50 per hour to have an actuarial clerk clean it up. (I once saw actuarial data submitted on the backs of laundry slips, written with a dull soft pencil, which is the worst I've encountered, but there are continual less spectacular examples of this sort in most actuarial offices). If you demand that your thrift plan reports be delivered on time, but your payroll output tape never gets to the processor on schedule, he is going to bill you some way or other for the overtime he puts in.

If the public accountant has to look in three files instead of one to perform his audit, that means extra time for him and extra billing for you. If your company hires a communications firm to prepare a comprehensive statement of benefits for each employe, and then finds, after the statements are printed, that some of the data sent to them was wrong, it costs them time and money to rerun and it is going to cost you, too.

Analyzing fees begins to sound as tedious, time consuming and unrewarding as analyzing internal costs, but it isn't, and for a number of reasons. First, the consultant has no choice but to cooperate with your review. He needs you more than you need him; there are always others who can replace him. Second, in reviewing the consultant's work, you need not be concerned with internal company politics (unless he has political connections in the company). You won't be stepping on any of your co-worker's toes, curbing their empires, or battling Parkinson's Law. Third, it is rewarding because any fee which is cut back or reduced for the future, represents demonstrable cash outlay saved by the company. It is not always as easy to convince management of the savings when internal costs are reduced.

When you've completed this entire review, you may not have directly saved one cent for the company, but you will have established a firm basis for tracking ERISA administration costs, you will have learned in greater detail about administrative overhead and how it grows, and you will have put your outside servicers on their toes. These steps constitute the beginning of cost control, and are fundamental for making further improvements in this area. ■

Grant Morris began his own consulting operation this year after spending five years with Johnson & Higgins as manager of data processing. At J&H, Mr. Morris helped develop the firm's system for processing valuations, cost estimates, benefit statements and pension forecasts. Between 1958 and 1970, Mr. Morris was manager of systems and programming for the Teachers Insurance and Annuity Assn.-College Retirement Equities Fund, one of the largest pension funds in the world. He has a BA from Yale University.

Disadvantages seen in underground siting of nuclear generators

By EUGENE F. JOHNSON,
vice president
Clifton & Co., Los Angeles

Recently the California Legislature enacted a package of three restrictive nuclear bills. Two pieces of this legislation prohibits permits for new nuclear power plant construction until the State Energy Commission: (1) determines that the federal government has approved a technology for reprocessing spent fuel, and (2) determines that the federal government has approved a demonstrated technology, not necessarily operating, for disposal of high level wastes.

The third law requires the State Energy Commission to undertake a study of the feasibility and economic viability of underground containment. If the commission determines that undergrounding is not necessary, effective or economically feasible, the legislature could prohibit the issuance of new land use permits for nuclear plants for an additional year to evaluate the study. Alternatively, if the commission finds a need for undergrounding, the legislature could suspend the ruling for one year to consider legislation.

Currently, underground siting of nuclear power plants has been undertaken only in Europe on a limited basis. Original projected benefits of this containment technique were: improved protection from natural and man-made hazards; improved safety and the possibility of urban siting; possibilities of utilizing urban sited reactors for the production of process heat; reduction of environmental impact.

The Swedish Urban Siting Study, in 1974, stated; "Installations in rock caverns provide added protection against external missiles and also provide certain other safeguards. It thus appears that the use of rock containments is the easiest way to improve protection against damage to the containment in connection with major ruptures in the pressure vessel and in the primary circulation system. However, location in rock also entails certain disadvantages".

As a member of the American Society of Civil Engineers Committee on Nuclear Power Plant Siting this writer was given an opportunity to visit European underground nuclear plants. From this firsthand experience insight was gained into the disadvantages of underground containment referred to in the Swedish Urban Siting Study; and of benefits projected by European planners.

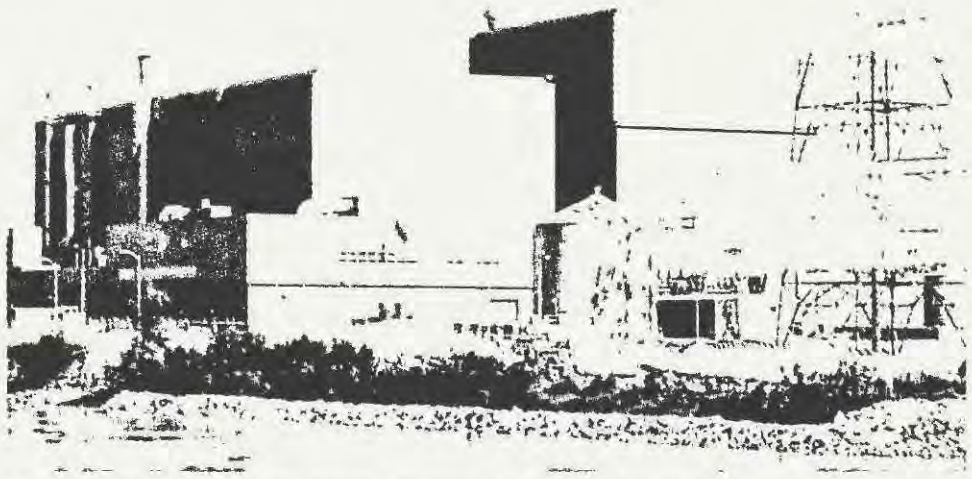
Prime consideration for underground siting in Europe was based on a belief that rock containment substantially improved protection against external missiles. This goal failed to materialize in all instances because the reactor alone was placed underground leaving key components aboveground vulnerable to missile attack. To provide a war protected electrical generation capability requires relocation underground of cooling towers, ventilation, water intakes, generators, switchyards, etc. Even with these additional measures undertaken (with resulting substantially higher project costs) questionable protection from attack upon main power cable and reactor tunnel openings would still remain.

Improved safety aspects of underground siting was given as another prime advantage by European planners. However results of their experiences indicate disadvantages previously not encountered with aboveground nuclear power plant siting.

Initial design of underground cavities provides a fixed plant seldom envisioning future needs or expansion requirements. This lack of flexibility eventually results in congested equipment placement and creation of inaccessible work areas. Expansion of a rock cavity, after the reactor has been placed in service, could require a prolonged shutdown or continued plant operations under less than optimum conditions.

The size of a nuclear power plant has a direct influence upon the cost per unit of electricty: the larger the plant, the cheaper the power. The Diablo Canyon containment structure has an inside diameter of 140 feet to allow for a 1,060 MWe reactor. Underground spans, for reactor containment such as this, have not been publicly announced. Technical solutions to this construction difficulty could be found if good rock formations were available. For California the supply of favorable geological sites will be a serious detriment to long term nuclear energy growth.

The quality of underground rock, as to providing a leaktight containment, requires either concrete, concrete and steel or steel liner walls. At one underground facility, pencil size holes formed, due to electrolysis, penetrating the steel containment liner. Leakage through these openings into groundwater necessitated plant shutdown. Locating and repairing of these small inaccessible openings proved to be a long and arduous task.



Recently enacted California legislation provides impetus for studies of underground containment for nuclear installations such as this.

Construction of containment walls creates a void area between the rock cavity and liner material. Water saturated rock, common to many subterranean cavities, introduces the risk of hydrologic forces. To reduce water pressure on containment walls, drainage is supplied in the void area. Over a period of time these drains tend to clog shut as cavity rock grdually deteriorates from wetting. Failure to maintain adequate drainage can produce structural stress or corrosion effects upon containment walls and equipment.

Protection of access and ventilation shafts to an underground nuclear power plant site must also be assured against flood conditions. With vital parts of an underground nuclear power plant often below recipient level of cooling water, a risk of internal flooding exists. To provide adequate safeguards in this event will require reliance upon auxiliary pumping systems.

Pressure relief inside an underground cavity must also be taken into careful consideration. The Lucens, Switzerland underground reactor experienced a major accident Jan. 21, 1969. Thirteen hours after startup, following shutdown for corrective work, a pressure tube ruptured. Although the reactor cavern ventilation isolated valves closed, the overpressure caused greater than expected leakage into the next cavern. Following this incident the Lucens Reactor was never returned to service.

Limited access to underground nuclear power plants introduces various disadvantages. During construction, inability of cranes to operate from above and with limited access from around impedes construction. Swedish authorities reported that construction time for underground plants was about one year longer than for aboveground plants. In Norway it was stated that total construction costs, including interest (1974), increased project expense by 12%.

On an operational basis this limited access to an underground cavity could hamper entry of emergency personnel. Inability to vent fumes and smoke may delay entry with resultant increase in danger. The rock containment will further impair or make impractical introduction of large mobile emergency apparatus.

From the practical experience accumulated in Europe, with construction of underground nuclear power plants, it becomes evident that this siting technique is not without disadvantage. As with aboveground and floating nuclear power plant siting certain advantages and disadvantages accrue to each specfic concept. Total reliance upon underground nuclear power plant construction would not provide any greater degree of safety than at present.

The California State Energy Commission must recognize, in its investigation, that siting flexibility provides "engineered" safeguards to best meet individual site conditions. Through analysis and flexibility, with regulatory review, the engineer develops optimum safeguards. Restrictive legislation will only serve to limit engineering options and provide mediocrity. Final Commission findings, in the public interest, should be that legislation is not required to restrict future construction, to underground sites, of nuclear power plants. ■

$6 million suit filed in high school football injury

By GREG DAVID

CHICAGO—A $6 million damage suit has been filed against Riddell Inc., the sporting goods manufacturer, an Illinois school district and a sporting goods distributor in connection with an injury suffered by a high school football player.

Riddell is also facing $5.3 million in damages awarded a Miami, Fl., high school football player in connection with injuries he suffered while wearing a Riddell helmet. That case is being appealed.

Several officials in Illinois said the suit could cripple high school football in the state.

William Galindo Jr., 18, of Chillicothe, Il., suffered a spinal cord injury in a varsity football game on Oct. 11, 1974, and has been paralyzed from the neck down.

According to the youth's attorney, Robert G. Day Jr. of Peoria, the suit seeks $5 million in compensatory damages against Riddell, Illinois Valley Central Unit School District 321 and Bailey & Himes Inc., a Champaign, Il., sporting goods distributor. An additional $1 million in punitive damages is being sought against the two firms.

The suit claims the youth was given a defective face mask and helmet and that the school failed to provide either proper coaching or a doctor at the game. It also alleges Mr. Galindo was playing a dangerous position because of his age, physique, inexperience and poor eyesight.

The suit says the padding used in the suspension system in the helmet was inadequate, the rear edge of the helmet was too low on the youth's neck and the face mask could be used as a lever.

Neither the school district nor the two companies would comment on their liability insurance. However, *Business Insurance* reported (April 19) that Riddell is insured up to $250,000 with no deductible through Insurance Co. of North America. American Home Assurance Co. provides the umbrella policy with a limit of $10 million. Defense costs are covered by the insurance which comes up for renewal in 1977.

An insurance source who has worked with school districts said many districts in less claims-conscious areas outside large metropolitan centers often don't carry more than a $1 million umbrella policy.

Don Himes, president of Bailey & Himes, said he had not been served with the papers in the case and could not comment until he had conferred with his attorney.

Al Weiss, a spokesman for Riddell, said the publicity from the suits had not hurt Riddell's helmet sales. Last year was the best ever for the company's helmets, Mr. Riddell said, and this year is expected to be even better.

Mr. Weiss would not discuss specifics but did say "any manufacturer worth anything has seen his insurance go up."

The Illinois High School Assn., the controlling body for inter-school activities in the state, carries a $100,000 catastrophe medical policy for all students in their activities.

Kenneth W. Freeto, a broker with the Freeto Insurance Agency in Chicago, said the policy provides $100,000 in coverage for a wide range of medical bills for up to four years after an accident with a $5,000 deductible. The benefits are pro-rated with the parents' insurance policy.

Mr. Freeto would not disclose the amount of premiums paid by the high school association. Loss experience under the policy written by Century Life Insurance Co. of Stevens Point, Wi., "has not been favorable," he said.

Mr. Galindo began receiving payments under the policy 18 months ago, Mr. Freeto said.

Thomas Kehr, attorney for the school district, saw the youth's injury take place. Mr. Kehr said Galindo, a cornerback, was hurt when he made a routine tackle against a pass receiver. The opposing team's coach immediately noticed something was wrong, Mr. Kehr said, and called for assistance.

Mr. Kehr said he did not know how a school could decide a given position was dangerous to a youth on the basis of physique or inexperience.

"Once a parent gives his consent," the attorney said, "injury is a risk youngsters take when they play."

Ralph Metcalf, executive director of the Illinois Coaches Assn., said once a doctor gives his approval "that's it." Mr. Metcalf said the courts would have a difficult time telling a coach a baseball player could only be a pitcher because of his physique or inexperience.

Liz Astroth, assistant executive secretary of the Illinois High School Assn., said he "did not know a coach who would continue to coach" if the courts told him where and how a youngster could play.

Mr. Day, the youth's attorney, said a decision in favor of his client would have an effect on high school football but he didn't know "if that effect would be harmful."

Mr. Day would not discuss the youth's physique or inexperience.

The school district's Mr. Kehr said he thought the Miami damage suit "had something to do" with the filing of the Galindo lawsuit.

But Mr. Day said he was working on the suit before the Miami verdict.

The Miami case involved a $5.3 million award to a high school football player paralyzed after suffering a broken neck in a game while wearing a Riddell helmet. A spokesman for the Fifth Circuit Court of Appeals in New Orleans said the case had been scheduled for arguments. ■

Court of appeals bans forced early retirement

RICHMOND, VA.—In a decision with implications for millions of workers and their employers, a U.S. Circuit Court of Appeals has ruled a United Airlines pension plan requiring retirement before age 65 is illegal under the 1967 Age Discrimination in Employment Act.

Earl Dolan, attorney for United said the company would appeal the case to the Supreme Court.

The U.S. Labor Department said millions of workers are covered by mandatory retirement clauses similar to United's and called the decision "a major victory." If the Supreme Court upholds the appeals court, millions of workers would be able to work until age 65.

The Labor Department brought the case on behalf of Harris S. McMann, a United employe for 29 years who was forced to retire at age 60 under a provision of United's pension plan. The Labor Department said the plan violated the 1967 set which prohibits any employer for discharging an employe between 45 and 65 because of age.

United, the nation's largest airline, said a provision of the 1967 law allowed plans then in effect to continue their mandatory retirement before 65 clauses as long as the rules were not a subterfuge to avoid the law. United's position was upheld by a district court.

But the Fourth Circuit Court of Appeals said the provision could not exempt plans that violated the purpose of the 1967 law. The court said a ruling in favor of United would create an absurd situation: The law would allow Mr. McMann to be forced to retire at age 60 and at the same time prohibit United from not rehiring Mr. McMann the next day if their only reason was age.

The decision would not affect employes who are forced to retire for reasons having to do with their jobs, such as flight officers who are required to retire at 60 by federal regulations.

Mr. Dolan said United was pursuing the case because "we want to know where we stand" and because the district court and previous rulings supported the company's position.

The mandatory retirement clauses had been requested by the unions and were a part of the company's contracts, Mr. Dolan said.

The appeals court noted the ruling might actually result in a small decrease in pension costs. ■

A new liability market open to N.Y. hospitals

ALBANY, N. Y.—New York hospitals will have a new market for professional and general liability insurance with the incorportation of Hospital Underwriters Mutual (HUM) organized by the state's hospital association.

HUM's charter has been approved by the state insurance department and the mutual is now in the process of acquiring members.

"We hope to be licensed and be issuing binders by the first of the year," John Duncan, interim president of the mutual said in an interview.

The mutual must have at least 40 members and a 3 to 1 premium to surplus ratio before it can issue policies, Mr. Duncan said. But HUM doesn't currently have any hospitals committed to join the plan.

"We propose to offer $1 million per occurrence, $3 million aggregate, but this will be at the discretion of the superintendent of insurance," he said.

HUM is negotiating with the insurance department over use of Insurance Services Office (ISO) base rates, to be applied to calculate premiums before any modifications are figured in, Mr. Duncan said.

"We won't propose to start with a unique rating situation," he said. One of the first projects for the new mutual, however, Mr. Duncan added, would be develop a difference insurance rating structure.

One of the reasons HUM was set up, Mr. Duncan said, was that the hospitals' experience with the state's joint underwriting association "left them with a bad taste."

He criticized the JUA for the manner of calculating premiums "which left the insured up in the air," and for adminstrative difficulties. "It took 10 to 11 months for hospitals to get policies and that long for them to find out how much the policies would cost."

HUM hired AIG Risk Management to handle the day-to-day administrative activities for its members, Mr. Duncan said.

"It is our intent to operate in a not-for-profit basis," HUM's president said. "We will have strong emphasis on loss prevention and tight control on claims settlement."

A malpractice insurance captive with a similar acronym, Hospital Underwriting Group (HUG) was established earlier this year for proprietary hospitals (*Business Insurance* Aug. 23).

"HUM will be licensed by the state insurance department, while HUG is a Bermuda operation," Mr. Duncan said. "There is an advantage to the fact that our operation will be overseen by the superintendent of insurance."

Although HUG offers different levels of insurance and its premiums include a deductible, HUM "doesn't propose to have a deductible for the first year," Mr. Duncan said. "This could be subject to change later on." ■

SEE OUR AD ON PAGE 3

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Special Emphasis Issue December 13

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Annuities urged to pay product liabiliry claims

WOODBURY, CT.—Insurance companies should be allowed to purchase annuities to pay off plaintiffs in product liability claims, a manufacturing representative suggested in testimony here.

This would give more money to the plaintiff, would ease the insurance companies' reserve problems and would help to alleviate the capacity crunch now facing small businesses which need product liability insurance coverage, he said.

Elbridge D. Joel, assistant to the president of Safeguard Manufacturing Inc., told a hearing of the Connecticut Joint Insurance and Real Estate Committee last month that annuities with a 40-year amortization period could mean an immediate 76% savings for insurance based on a $2.6 million judgment.

According to his figures, based on an average product liability premium of $40,000, the number of corporations which would be "paying" for such a claim would be only 72, compared to 195 which would be paying under the current claim settlement arrangements.

Mr. Joel also proposed that insurance companies be required to inform their client companies on a special form every time there is a product liability claim settlement. In addition, insurers should also report claims to the insurance commissioner by industry and classification codes, and to the insurance committee of the state legislature.

Mr. Joel predicted that next year will be the peak of a five year product liability insurance cost crunch now in its second year.

He said, based on discussions with business people and the insurance industry, that there could be a gradual tapering off of costs through 1979, provided the states and the federal government pass legislation to relieve the product liability problem.

For the short term, he said insurance commissioners should set up by an executive order an insurance pool format for manufacturers with a $500,000 basic coverage and a premium equal to a maximum of 5% of sales.

For the medium term solution to product liability insurance shortages, he urged that workers' compensation limits be raised four times, that workers be allowed to name employers in a negligence suit and that compensation carriers not be given subrogation rights against third parties. ■

Tanker deductibles up; casualty losses down

NEW YORK—Deductibles ranging from $10,000 to $60,000 in tanker hull and machinery insurance policies are causing a decline in the number of reported tanker casualties worldwide this year, the Tanker Advisory Center here said.

In its report for the first six months of 1976, the center noted a drop off in reported tanker casualties for all categories except fire and explosions, which remained at the same level as last year in the same period.

Using casualty data from Lloyd's List (published by Lloyd's of London) for vessels of 6,000 deadweight tons or more, the report cited 419 partial and total losses for the first two quarters this yeary compared to 520 for the same period last year.

Besides the higher deductibles shipowners appear to be assuming, another contributing factor in the decline of reported casualities is the slowdown of nearly all tankers and tie-up of about 500 surplus tankers, the report said.

Arthur McKenzie, the Tanker Advisory Center's director, urged that existing tankers be equipped with segregated ballast as a control measure to reduce oil discharges into the seas.

He pointed out that about five to 10 million tons of petroleum enter the oceans each year from all sources, and that based on an analysis by Exxon Corp. scientists, there are approximately 250 to 500 tons of potentially cancer-causing compounds spilled.

Mr. McKenzie agreed with a National Academy of Sciences' statement that the whole area of possible human effect from such environmental chemical compounds is one of "very considerable ignorance," but he said the capability of reducing the input of oil to the seas already exists and can be accomplished with minimum disruption to the marketplace. ■

Prudent rule is explained

CHICAGO—A specialist in employe benefits law says there is "only a relative degree of insulation in compartmentalizing" fiduciary responsibilities in defined contribution plans. George Pantos, of the law firm of Vedeer, Price, Kaufman, Kammholz & Day in Washington D.C., told the 29th annual conference of the Profit Sharing Council of America in October, "To avoid liability, one must act 'prudently' in selecting investment advisors and in periodic reviews."

The so-called "prudent man" rule of fiduciary liability under the Employe Retirement Income Security Act is currently being modified by the Labor Department according to Mr. Pantos, and is evolving into whether similar action would be taken by a similar fund of a similar size.

Mr. Pantos said fiduciaries are "never totally free of responsibility." ■

SEE OUR AD ON PAGE 3

New tax bill eases HMO requirements

By ANNE MYERSON AYERS

WASHINGTON—Requirements for federal qualification of health maintenance organizations (HMOs) were eased under amendments to the 1973 HMO Act and signed into law by President Ford in October. There are currently 21 federally qualified HMOs, and 61 others have applied.

The amendments delay controversial open enrollment and community rating requirements, and change the dual choice section. The original law required any employer with more than 25 employes to offer membership in a federally qualified HMO, if one is available, as a health benefits option. But now, the employer must do so only if 25 employes reside in an HMO service area. In other words, if an employer has 15 employes in one state and 10 in another, he need not offer an HMO. But if all 25 live in one area that contains a qualified HMO, it must be offered.

The original law was interpreted to require offering the HMO option to individual employes even if a collective bargaining representative turned it down. But the amendments require the employer to offer the option to the union representative first, where it can be rejected.

An employer who knowingly does not comply with the dual choice requirements is subject to a $10,000 fine plus separate civil penalties for each 30 days of noncompliance.

Open enrollment is now required only for those HMOs that have been operating for five years or those with 50,000 members and no financial deficit in the previous year. Those HMOs need only open enroll a number of individuals equal to 3% of the total enrollment increase (not total enrollment) for the previous year. Open enrollment does not have to include people institutionalized with chronic illness or permanent injury if that would economically impair the HMO. A 90-day waiting period is allowed before benefits apply to new enrollees. Open enrollment can be waived entirely if it would jeopardize the HMO's economic viability.

Existing HMOs will not have to enroll under community rating, but new HMOs seeking federal qualification will.

HMOs will no longer have to offer the "rich" benefit package required by the original act; instead, they have the option to offer "supplemental" services. Preventive dental services for children were dropped from the list of required basic services; alcoholism and drug abuse treatment were retained.

Federal funding maximums were raised by the amendments: An HMO can receive $75,000 for feasibility studies instead of $50,000. Planning grant limits are now $200,000 instead of $125,000. An HMO that has already received $1 million for development can receive up to $1.6 million more.

No increases were authorized for initial operating loans, but those loans can be provided for a five year period, instead of three years as under the 1973 Act.

Funding for all HMO support programs (excluding feasibility studies) was stretched out to fiscal 1979 (the original law provided funding through fiscal 1977), and the total was increased by $10 million. Funding for fiscal 1976 is $40 million; for fiscal 1977 and 1978, $45 million; and $50 million for fiscal 1979.

The amendments stipulate that no HMO can have more than half its enrollees covered by Medicare or Medicaid, but this requirement can be waived for three years. ■

Employe Benefits Communications Awards Competition

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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.

Categcries 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. Birmingham 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. ■

Britain eyes reinsurance

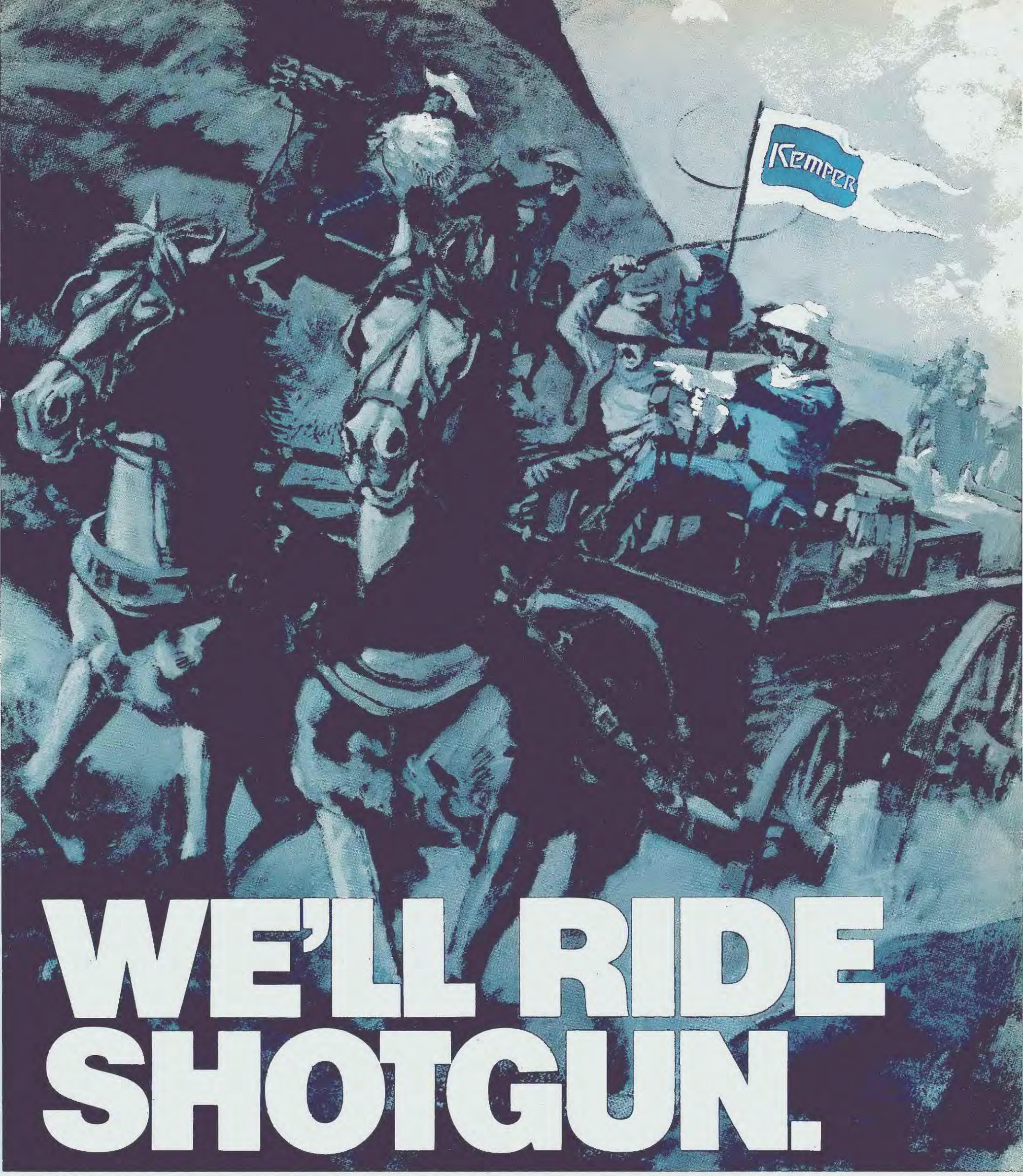
LONDON—Reinsurance is the principal growth area of overseas business for the U.K. market, Julius Neave, general manager, Mercantile and General Co., told the London Insurance Institute when he was installed as president for 1977.

"The day is in sight when more reinsurance than direct business will be flowing into London from abroad," he predicted.

Worldwide reinsurance business now produces premium revenue of $17 billion a year, and though $11 billion of this stays in its countries of origin, the remaining $6 billion is available for investment elsewhere in the world.

The U.K. reinsurance market, comprising Lloyd's and various insurance companies, probably handles about $3 million worth of reinsurance premiums annually.

Risk management would benefit if there was a "classification system" for major industrial and technological risks comparable with the traditional assessment of marine risks operated by Lloyd's Register of Shipping, Mr. Neave commented. ■



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FIA chief prefers others handle product problem, but if not . . .

WASHINGTON—The private sector and the individual states should work to solve the growing problem of product liability lawsuits, awards, and lack of availability of insurance, said the head of the Federal Insurance Administration.

J. Robert Hunter, however, told *Business Insurance* during an interview here that lacking corrective action by the private sector and the states, the solution to these problems might well fall on the federal doorstep.

"Regardless of who's president next year, the Federal Insurance Administration may move into product liability insurance," Mr. Hunter says. Although he firmly believes in the free markets, there "is a point at which the market breaks down," he said.

And that's what appears to have happened in the case of product liability insurance, particularly for small businesses. "Thus, the Small Business Committees (of Congress and in the Small Business Administration) are looking very closely at this problem. I think the committee is going to push for some kind of solution to the product liability problem. The Commerce Department is not going to stand by and allow machine tool manufacturers to be put out of business," Mr. Hunter said.

He pointed to the Congressional Record as an indicator of how much interest there is in this problem, and how many different people are making suggestions for its solution.

"I look for a very, very strong push" for some kind of federal solution to the problem, Mr. Hunter predicted. Some suggestions have been made which would involve the Federal Insurance Administration, although others would not. But if the solution involves a reinsurance program, "that's more like the things we do here already," so FIA involvement would be logical, Mr. Hunter said.

If the solution, on the other hand, is to involve a pool of machine tool or other industrial equipment producers for the purpose of self-insuring, that would probably involve not the FIA but the Justice Department, he added.

"What's best, obviously, is loss prevention. So anything that the FIA is involved in must have a quid pro quo so that we can assure that taxpayer dollars go into a required loss prevention effort," the Federal Insurance Administrator said.

There would also "probably have to be some tort reforms," he believes, if a federal solution to the problem is sought.

Mr. Hunter indicated he has considered the possibility that the FIA would be involved in underwriting product liability insurance. He feels the department could handle it. "If we have the staff, we can handle anything," he said, noting that FIA presently operates two reinsurance programs and could surely handle another. "And there's no tougher loss control program and problem than with the flood insurance program," he said, indicating that experience with the flood program could be translated into managing an effective product liability loss control plan.

"This doesn't mean I want to do it, just because I think I can do it," Mr. Hunter quickly noted. "The private sector and the states should handle the product liability problems."

Asked to consider how he would set up rules for such a federal product liability insurance program, however, he said: "If we were a reinsurer, we would definitely have to have rules, state tort reforms, definite changes in premium rates, and mandatory loss control measures. We can't simply hand somebody free federal money."

Summing up his assessment of proposals so far, Mr. Hunter said "if it's an answer that involves product liability insurance availability, then the FIA will probably be involved. But Justice, Commerce or HEW might be involved depending on whose committee wants to keep jurisdiction."

Without any fear of being wrong, Mr. Hunter said, he knows that the FIA will be involved in testifying about the problem and insurance solutions, as well as in other initial phases of determining answers, and then also in drawing up the final regulations.

Turning to problems in other lines of insurance, where availability of coverage is very scarce, Mr. Hunter predicted that "if there was a big earthquake tomorrow, (the FIA would) be in the earthquake insurance business." Earthquake insurance, he believes, is still available to individuals and homeowners at reasonably affordable rates. "But given a mandate to buy the insurance, there would have to be a federal program" because insurers wouldn't have the capacity to underwrite earthquake coverage on a broad scale.

"The commercial earthquake insurance market, I agree, is very limited. But I worry more about personal lines availability, figuring the commercial types can take care of themselves."

Earthquake risks, like product liability problems, is another area "which I consider a likely candidate" for federal action. In the earthquake category, Mr. Hunter included landslide risks, an area the FIA is currently surveying.

"We're initiating a feasibility study" on writing landslide coverage, he said, noting that this study grew out of a special request by Rep. Aucoin and Sen. Packwood from Oregon, who are concerned about growing losses from landslides in their state. The study is to start in October 1977, with completion and a final report sent to Congress within 1978.

"In the earthquake area, we are doing a capacity study requested by Daniel Flood of Pa., who wanted us to write an all-risk earthquake policy. We're also waiting for the report being done on this by the National Assn. of Insurance Commissioners before we make a report to Congress."

Mr. Hunter expressed concern about "initial indications that some big insurance companies don't realize the extent of their risks along earthquake faults. Some fairly large companies have 50% and more of their total fire insurance books in a geographical area where everything could go all at once.

"The indications to me were that there might not even be the kind of risk management by insurance companies that's necessary to assure the spread of risk within their books of business. I'm talking about fire insurance which covers fire following an earthquake. That's where the problem is," said Mr. Hunter. ■

Continental acquires Unionamerica group

LOS ANGELES—Unionamerica Inc. and Continental Corp., New York, have reached agreement to sell the principal assets of Unionamerica Insurance Group to Continental.

The purchase price will be approximately $29 million in cash, less an adjustment for the excess of the book value of the bond portfolio of the companies being acquired over their market value as of Oct. 15, 1976, which is expected to be in the range of $4 million to $5 million.

The Harbor Insurance Co., Swett & Crawford, Unionamerica Reinsurance Co., Reinsurance Facilities Corp., Unionamerica Insurance Co. Ltd. (London), Leslie H. Cook Inc., and Unionamerica International Inc. are the chief assets acquired by Continental.

Not included in the acquisition is Cypress Insurance Co., Cypress Management Co., Unionamerican Investment Mangement Co. and L. & B. H. Co., with an approximate book value of $7.8 million.

A spokesman for the insurance group being acquired by Continental told *Business Insurance* that Cypress Insurance Co., a workers' compensation firm writing only in California, was not part of the acquisition due to the fact that this is an area which Continental did not wish to enter.

Nevertheless, Cypress will be sold, the spokesman added.

The insurance group, which does not expect to change its name immediately, will be part of Continental's international and reinsurance sector.

No near-term personnel changes are foreseen among the corporate officials who operate the insurance group. W. F. W. Fellows is president of Unionamerica Insurance Group.

The proceeds of the sale will be used by the parent company to reduce its bank debt. ■

Group life contracts up

Group life insurance set up under new or revised group contracts totaled $9.45 billion in August, compared with $6.26 billion a year earlier, according to the Life Insurance Marketing and Research Assn. Industrial life insurance purchases in that month were $523 million, compared to $603 million in August of 1975.

British Airways spends $20 million on premiums; most stays in U.K.

LONDON—Premium income of nearly $20 million a year is being generated by British Airways in the U.K. aviation market for its domestic and international operations.

This is apportioned at the rate of about 50% for hull risks, 30% for passenger liability, and 20% for cargo risks and miscellaneous other liabilities.

Carrying fleet values of more than $1.2 billion, the state-owned airline believes it is second in size of overall operations only to the Soviet Union's Aeroflot, and handles more than 13 million passengers annually.

Most of its insurance is held in London, shared between Lloyd's and aviation insurance companies, but insurance is always a worldwide field and a proportion of the risks are taken up in the U.S. and other overseas markets.

Until the recent tragic mid-air collision due to ground control error between a Yugoslav DC9 and a British Airways Trident, the airline had had a relatively lossfree year.

Group insurance adviser, Raymond D. Binney, told *Business Insurance*: "This has had a helpful bearing on the rates we have been able to achieve, though the insurance market is always ready for the unexpected loss, like the Zagreb collision, which will put risk factors out of balance. We have our underwriters close at hand so that we can discuss coverage with them rapidly when neessary. The U.K. market certainly provides competitive rates, and has first class claims' handling service. So for many years our lead underwriters have traditionally been in London."

At one time the domestic U.K. risks of British Airways were partly self-insured, while its overseas division went by preference for full commercial insurance. But now all its operations are amalgamated and its risks are wholly under cover placed in the U.K. aviation market.

"But if rates harden, and it seems better to self-insurer, we'll certainly look at this possibility," Mr. Binney admitted. "Just now they're competitive enough to meet our requirements adequately."

Brokers C. T. Bowring and Co. have been used for many years for placing the required cover in the market. The amount to be allotted in respect to hull values is decided in effect by the financial division of British Airways, bearing in mind such factors as depreciation and other investment aspects.

The Concorde is, naturally enough, gaining world importance as efforts continue to improve its position on U.S. and other overseas routes. Five Concordes are coming into service with British Airways, which has insured them on an agreed value basis of £21 million sterling ($33.6 million) each for hull damage.

They are included in the overall fleet operations of the airline, which now has nearly 200 aircraft of various sizes, under an all risks policy without any geographical restrictions.

But like the jumbo jets several years ago, all new aircraft are specially rated until proven in service, and the Concorde is no exception.

Its supersonic qualities lead inevitably to the question: "What about sonic boom damage?"

British Airways takes the view that this is unlikely to occur, because the aircraft does not go through the sound barrier until well out to sea or away from populated areas.

"Crew training is designed to cover any contingencies that can occur in faster-than-sound flight," Mr. Binney explains. "Boom damage is so unlikely to occur, in our view, that we can carry the risk out of our own financial resources without trying for insurance coverage.

"In any case, this is not a phenomenon which is normally included in aviation policies, and we would have to take out special cover if we needed it. But we feel happy that we don't need it, for there's no cause in our experience for feeling that it's necessary. We're very satisfied with the way Concorde is being handled in the insurance market and in its operational use." ■

INA setting up captive

PHILADELPHIA—Insurance Co. of North America (INA) is in the process of activating a reinsurance facility in Bermuda, *Business Insurance* learned.

The company, formerly titled Winchester International Assurance Co. Ltd., will be called INA International Insurance Co. Ltd. It has a capitalization of $2 million and a surplus of $13 million.

Guy Patterson, president of INA Reinsurance Co., will head the Bermuda company.

Arrangements are still in the formative stage, a spokesman for INA said. The company is seeking administrative, claims and underwriting personnel for the reinsurance facility. ■

Safety council head

John E. Angle, former executive vp of U.S. Steel Corp., has been elected chairman of the board of directors of the National Safety Council. Mr. Angle replaces Dr. Dewey F. Barich who will remain a member of the board. The council also reelected Vincent L. Tofany at the group's annual meeting in Chicago in late October.

Esmark, GSI connection to remain despite sale

By JANE WINEBRENNER

CHICAGO—Esmark Inc.'s proposed divestiture of its insurance and financial services subsidiary, GSI Inc., apparently will not change the present operating relationship between the two companies—at least for now.

GSI presently performs insurance brokerage services for Esmark through a GSI company, Youngberg-Carlson Co. Inc. Youngberg-Carlson chairman John C. Brogan said, "To my knowledge the relationship is not going to change."

The president of another GSI company, Scarborough & Co., said his insurance agency has no plans to change its operations under new ownership.

"Esmark has committed itself to keep the services of GSI for a number of years at least," president Norman Clark said.

Esmark's chairman and chief executive officer Robert W. Reneker said in October that holding company has "reached an agreement in principle" to sell GSI to an investment group headed by GSI president Jerrold M. Roe. Esmark's financial vp Roger Briggs said negotiations are underway, although the completion date is unknown. Persons involved in the sale did say, however, divestiture is expected to be completed by the end of this year.

Mr. Reneker said GSI's slow growth rate is the reason for the divetiture. "While GSI has achieved an attractive return on investment, we have not been able to grow (expand) them as hoped. This, coupled with changing economic priorities in Esmark brought us to the conclusion that divestiture is appropriate," he said.

A spokesman for Esmark confirmed that GSI's pre-tax earnings from operations more than doubled from 1974 to 1975. In 1975, GSI's pre-tax earnings from operations were $3.2 million and its revenue was $73.6 million. In 1974, their pre-tax earnings were $1.4 million and its revenue $56 million.

GSI accounts for only .2% of Esmark's total revenues of $4.7 billion according to Standard & Poor's 1975 figures.

Among the companies owned by GSI are Globe Insurance Co., which underwrites mainly life, accident and health insurance; Scarborough & Co.; American Benefit Corp.; Longwood Insurance Agency Inc.; Cogna Systems Corp. and Penmark Investments Inc.

Risk management at Esmark will remain unchanged, according to Jay Proops, Esmark's treasurer. Mr. Proops said he "will continue to have the final decision for insurance at Esmark and its subsidiaries" after the divestiture, and that "Youngberg-Carlson will still be playing an important part in our insurance program."

Day-to-day risk management at Esmark, including Swift & Co., is divided between two administrators. George Quandee handles property insurance and Robert Beranich handles liability insurance, both reporting to Mr. Proops.

Jerrold Roe, who heads the investment group planning to purchase GSI, was unavailable for comment on whether GSI would still perform financial and insurance services for Esmark which is headquartered in Chicago.

Donald Grahn, who handles general duties at Youngberg-Carlson, defined the agency's relationship with Esmark as an "unusual situation." Mr. Grahan said his duties change from week to week but at one time he had performed some of the risk management services for Esmark.

Mr. Grahn, who called Esmark "one big family," said of the pending spinoff of GSI, "It's not that fragmented. All of the services of Esmark are in one corporation (GSI)." The Esmark Inc. holding company was formed in 1973 with most of the revenue coming from Swift & Co. Other wholly-owned subsidiaries besides Swift and GSI are Estech Inc. (chemicals) and Vickers Energy Corp. ■

Even finicky Morris likes his health plan

SAN FRANCISCO—The nations estimated 100 million dogs and cats may now have a health and maintenace medical plan of their own. The plan is called Medi-Pet and will be offered through National Pet Care Inc., Los Altos, Ca.

National Pet Care Inc., is headed by Paul Murray Jr., 50, prior marketing vp for cash substitutes for the Bank of America.

According to literature on the plan, Medi-Pet is not an insurance plan, but "a plan where the professional fees paid are returned in services rendered—to keep your pet in top physical form." No figures on the cost of the services are available, however. ■

Hospital group picks A&A to handle risks

CHICAGO—While hospitals' risk management remains largely a part-time function of several middle managers and top executives, a county hospital group in Ohio has contracted with an insurance brokerage firm to handle its entire risk management program.

The county commission, which oversees operation of the over 1000-bed hospital group, contracted with Alexander & Alexander, Inc., a large national insurance brokerage firm, and paid $51,000 to the firm to mange the hospital group's entire insurance needs, including malpractice insurance coverage.

Faced with skyrocketing premiums but a favorable malpractice claims experience, the commission opted to self-insure the risk and rely on the broker for legal and technical aid.

"Why should we spend $800,000 for malpractice insurance when there are hardly any claims against us?" asked the group's chief administrator.

Instead, the hospital has been salting away $100,000 each month to fund its malpractice risks.

"The (broker) provides lawyers to talk to doctors, a loss control officer, a claims adjuster and consultation services," the chief administrator said.

The chief administrator reviews all malpractice claims and major safety and compensation reports before turning them over to an insurance broker for processing.

At other hospitals, however, risk management remains piecemeal, a survey found.

The administrator of a 300-bed Nebraska hospital handles the health, life and long-term disability insurance programs while the hospital's finance director spends up to 10% of his time administering malpractice insurance claims and servicing insurance for the hospital's physical plant.

The associate director of a 200-bed Chicago hospital spends about 20% of his time handling medical malpractice and workers' compensation claims as well as reviewing accident reports. The hospital's safety and personnel committees also share in maintaining safety standards and processing claims.

A $40,000-a-year financial vp spends up to 10% of his time servicing the insurance needs for a 400-bed Los Angeles area hospital. A $20,000-a-year manager of security and safety spends about 10% of his time maintaining safety standards.

A $20,000-a-year assistant administrator for a 425-bed Washington D.C. hospital works on malpractice claims.

The insurance and personnel committees of a hospital board handle the risk management function of a 550-bed Arizona Hospital while the administrator and personnel director handle insurance paperwork ■

Contingency accounting rules issued

STAMFORD, CT.—The Financial Accounting Standards Board issued another interpretation of its rules on accounting for contingencies, better known as FASB 5.

The latest notice said a company must accrue for a future loss if there is a cost range within which the loss is reasonably expected to fall, between a maximum and minimum amount. The presence of these maximum and minimum amounts, in other words, fulfills the second required condition for accruing future losses, the FASB said.

The FASB's rule No. 5 specifies two conditions, both of which must be met before an estimated loss from a contingency can be charged against income. First, it must be probable that an asset has been impaired or a liability incurred at the reporting date. Second, the amount of the loss must be reasonably estimatable.

The FASB was asked whether the second condtion is met if the estimated loss is a range of loss between a maximum and minimum amount. The range of amounts of loss does fulfill the second condition and the loss should be accrued, the FASB said.

"If some amount in the range is a better estimate of the loss than any other amount, that amount is accrued. If no one amount is a better estimate of the loss than any other amount, the minimum amount is accrued, the Board ruled. Provisions of the interpretation are effective for financial statements for periods beginning after Oct. 15, 1976. ■

people

United names Walker director of benefits

David Bruce Walker, 33 was promoted to director of employe benefits for United Airlines Inc. in Chicago, as the airline continues to realign its benefits and insurance department following the retirement in May of Waller B. Smith, director of corporate insurance. Mr. Walker will be responsible for the management of almost $1 billion in assets of United's pension plan fund, administration of the pension plan's benefits and portions of the group insurance program that deal with people. Gerald R. Howland, who formerly managed group insurance along with Mr. Walker, now reports to Mr. Walker. The promotion will consolidate the company's finance and planning functions for retirement and other benefits and separates the group insurance from the personnel department.

United's property and casualty responsibilities have been given to **Don H. Hansen,** director of corporate insurance. Both Mr. Walker and Mr. Hansen report to **Ralph Robertson,** vp-insurance. **Virginia Grady,** 27, was named supervisor of medical and dental claims and reports to Mr. Walker. She will have responsibility for processing the medical and dental claims for the Chicago and San Francisco units. She worked as a benefit specialist for Bordon Inc. in Columbus, Oh., before joining United.

* * *

Marsha B. Chapman, 31, was named manager of group insurance for SCM Corp., New York. Ms. Chapman was formerly SCM's employe benefits administrator. In her new job, she has complete responsibility for financial and planning aspects of the firm's group life, medical, and disability benefits for some 27,000 employes, and for the coordination of benefit administration companywide. She also oversees the group insurance budget for those benefit areas. Ms. Chapman reports to **Joseph Duva,** director of employe benefits and compensation. Her promotion was effective September 1, was part of a job realignment. Her responsibilities had broadened some months before the title change, and with the promotion, she also took over some responsibilities from SCM's former manager of group insurance and pensions, **Brendan McHugh,** who is now manager of pensions and thrift plans for the company. Before joining SCM four years ago, Ms. Chapman was employment and benefits administrator at the New York Times Media Co.

* * *

Ernest A. Liebre, 30, will become assistant treasurer and insurance manager at FMC Corp. in Chicago in mid-November. Mr. Liebre is presently assistant manager of insurance at W. R. Grace & Co. in New York and will report to the treasurer of FMC.

* * *

Rita P. Garcia was promoted to risk manager at Castle & Cooke Inc. in San Francisco. Mrs. Garcia was also elected president of Castle & Cooke's Bermuda-based captive insurance company, Ashford Co. Ltd. Formerly the assistant insurance manager, Mrs. Garcia replaces **Glen A. Wille,** who retired from the company. Other corporate insurance department changes at Castle & Cooke include promotion of **Joe Remedios,** formerly insurance administrator, to assistant insurance manager and the addition of **Sylvia Gunderson** to the staff as senior insurance clerk.

* * *

Charles W. Murray, 47, is the new assistant risk manager at Chicago-based Brunswick Corp., reporting to **Edward C. Sigler,** risk manager. Mr. Murray's responsibilities will involve claims adjustment and general risk management duties. Mr. Murray was assistant risk manager at City Products Corp. in Des Plaines, Il.

* * *

Richard J. Gribbins, 32, was named vp and treasurer of Service Envelope & Paper Co., a division of Service Envelope Manufacturing Co., Detroit. He reports to the president of the company and is responsible for all property/casualty insurance programs and employe benefits. He was formerly secretary-treasurer of Rockford Safety Equipment Co., Rockford, Il.

* * *

At Rockford Safety Equipment Co., **Dennis Potter,** 38, was promoted to secretary-treasurer, replacing Richard L. Gribbins. He was formerly comptroller of the company and now reports to the president of the firm. Besides property/casualty insurance and employe benefits, Mr. Potter is responsible for all financial functions of the company.

* * *

Glenn Pfundheller, 49, has assumed the duties of insurance administrator for Vapor Corp. in Niles, Ill. He retains his position as wage and salary administrator and adds insurance duties as part of a company reorganization of plant and corporate assignments. Mr. Pfundheller said he has no insurance background. ■

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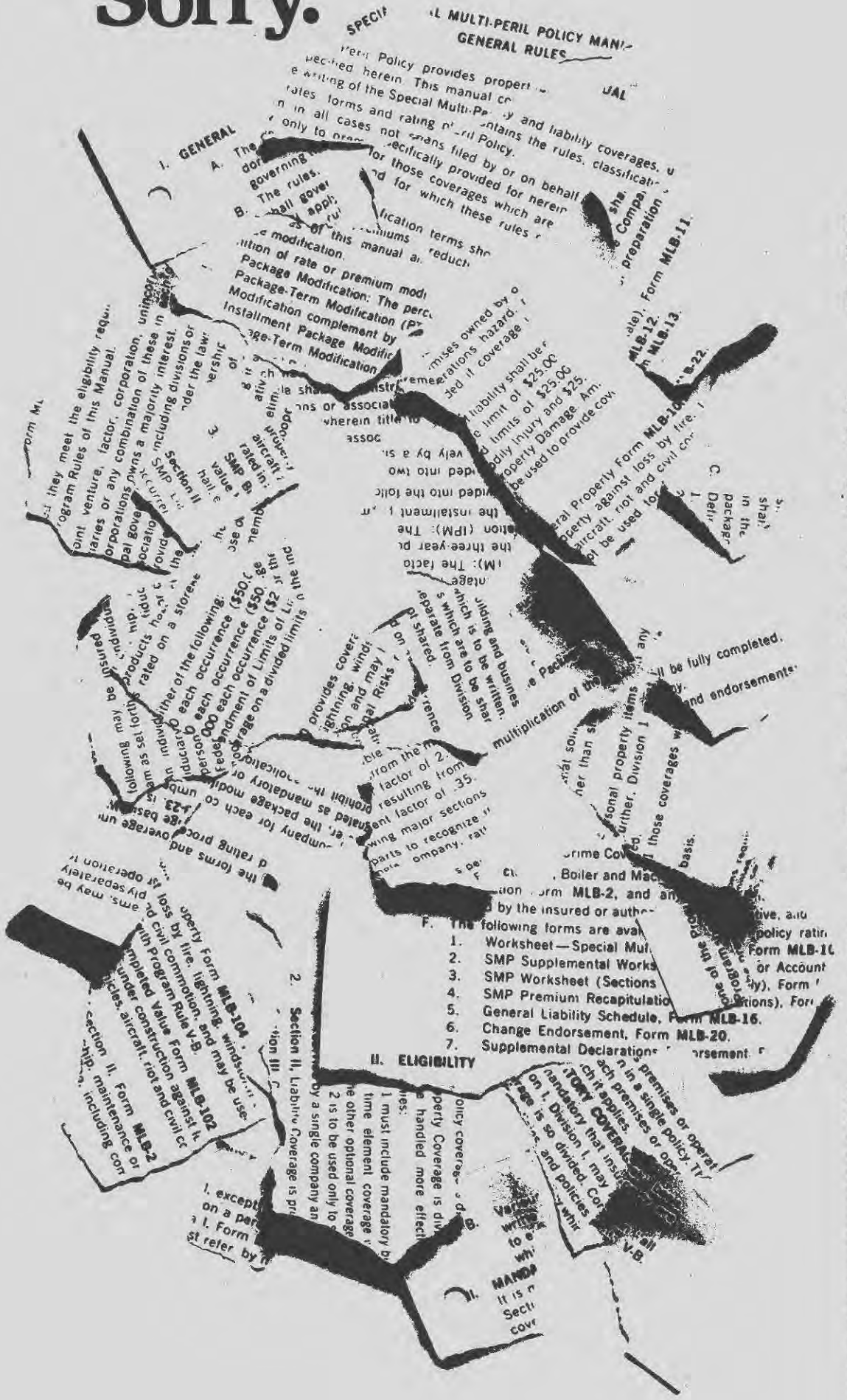

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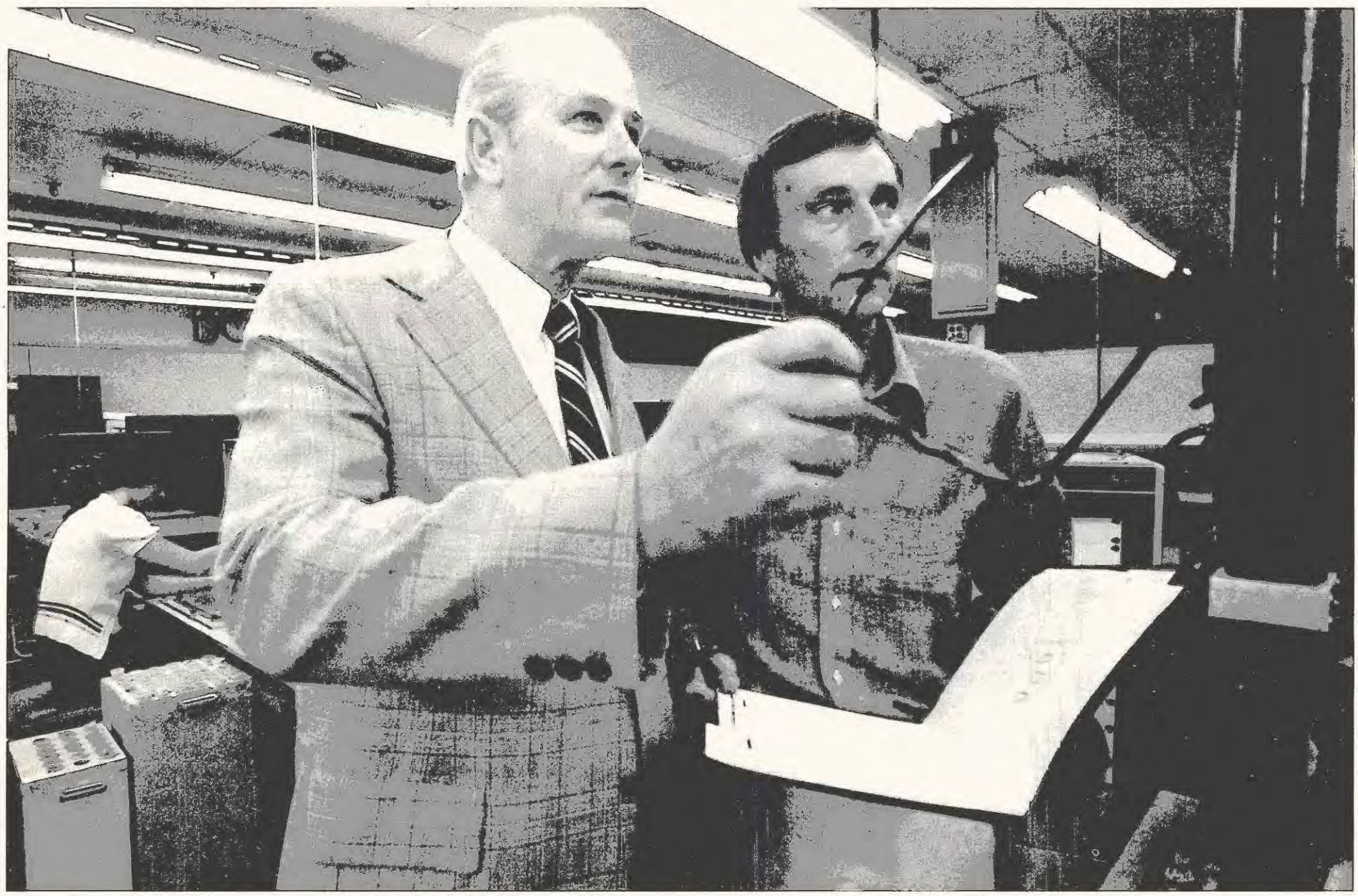

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