Week of November 3, 1975

business insurance

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

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GM execs urged to fight rising health fee

By RICHARD L. GORDON



GM employes' health benefits are becoming very costly.

DETROIT—General Motors Corp. called a special meeting of all its executives who hold public service jobs in the health care field last month after the company was socked with an increase of about 21% in the cost of its employe health insurance.

GM, largest industrial employer in the nation, expects to pay about $800 million for health insurance in 1975, a total that includes costs of a new dental health insurance program.

That compares to about $600 million in calendar 1974, when the dental program costs only began in the last quarter.

The recent rate increase, effective October 1, involved an added $108 million to cover increased costs and utilization of services under existing benefits, Victor Zink, General Motors' employe benefits manager, told *Business Insurance*. An additional $15 million of increase was for new benefits.

"There's really no end in sight," Mr. Zink complained.

Which is one reason for the unprecedented meeting of company executives last month to talk about health care costs.

"As far as we know, it's the first one of its kind," Mr. Zink said.

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Benefit trust put out of action for self-insuring pooled group plans

By PAUL R. MERRION

CHICAGO—ERISA's power to exempt certain benefit plans from state regulation remains undefined following a successful action by the Illinois Department of Insurance brought against a self-insured multiemployer trust.

Insurance Administration Unlimited (IAU) Inc., Oakbrook, Il., was put out of business September 11 under an order of liquidation. The state insurance commissioner said the firm's decision on June 6 to drop John Hancock Mutual Life Insurance Co. and go on a self-insured basis was illegal, in that the trust was operating as an insurance company.

This case is important because of the large number of multiemployer trusts (sometimes known as multiple employer trusts) springing up around the nation in the wake of federal pension reform. These trusts apparently are being used by all kinds of small and medium sized employers as alternate benefits funding vehicles. As employers have become more concerned about the rising costs of benefit insurance providing life and health coverage for employes, they have banded together in these trusts to buy insurance cooperatively, thereby generating savings on group programs.

IAU contended that section 514 of the Employe Retirement Income Security Act (ERISA), which exempts employe benefit plans from state supervision, applied to multiemployer trusts such as IAU. The legal question was never settled because IAU decided to default on its contest against the state's conservation of assets motion, without mention of the ERISA question.

The state solicited bids on the business and on Sept. 25, William M. Mercer Co., a division of Marsh & McLennan Inc., was approved by the court as the broker and Sentry Insurance was approved as the carrier, beginning Oct. 1.

Out of 377 letters sent to IAU's insureds to explain the liquidation order and Mercer's capabilities to assume the business, 271 replied to say they were not interested and would get coverage elsewhere, according to Richard Seligman, chief counsel in the Illinois Department of Insurance.

Indications are that most of IAU's clients suffered with the transition, according to companies and agents contacted by this magazine. Beside having to find coverage in a very short period of time, premium increases for the same or lesser coverage were common.

At the H. Bairstow Co. here, the new rate with Occidental Insurance Co. is about 10% higher for coverage that is "not as good," according to vp Bud Bairstow. "To get the same cover we'd have to pay 20% more," he said.

The Cass School District #63 in suburban Chicago put its business (50 lives) with Bankers Life Insurance Co. and got somewhat better benefits for about a 6% rate increase, according to superintendent Michael Donohue.

The same coverage as before, now insured by the Travelers Insurance Co., was available only with about a 20% rate hike, according to a spokesman for a small (10 lives), Chicago firm which had belonged to the trust.

The state's decision to fold the company came as a surprise to many of the insureds even though a warning letter was issued by the state last August after insurance commissioner Robert Wilcox was temporarily appointed conservator of IAU's assets on August 6.

"I didn't think much of the state's investigation—I let it pass," said one broker affiliated with IAU. "We had no formal communication until Sept. 26 when our clients received a letter from the state telling them what happened."

"Irrespective of the reasons for the state doing what they did,"

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Health insurance cost up 35% for U.S. govt.

WASHINGTON—The insurance managers who easily make the biggest health insurance buy in the nation—those in the federal government—have come away from the bargaining table with a 35% premium increase that will boost costs in calendar year 1976 to at least $2.54 billion.

The government's insurance contractors had initially sought renewal increases of from 38% to 54%.

By comparison, sources in private industry told *Business Insurance* that cost increases on recent health insurance renewals have been running in the 15% to 20% range.

But it's difficult, if not impossible, to make valid comparisons between the federal plans and private plans because of the wide variety of benefit packages and experience rates in private industry.

The federal package is, admittedly, a "rich" one, and the 1976 rate jump is provoking talk on Capitol Hill of taking a thorough look at the growing cost of the program.

A "hard look" at the program would be welcomed, says the government's top health insurance buyer, Thomas Tinsley, chief of the U.S. Civil Service Commission's Bureau of Retirement, Insurance, and Occupational Health.

Mr. Tinsley deals with dozens of health plans covering various groups of federal civilian employes—including some self-insured plans and numbers of local health maintenance organizations.

The two largest health insurance contractors for the federal government are Blue Cross-Blue Shield and Aetna Life & Casualty Co.

Both the Blues and Aetna offer plans for federal employes nationwide, and both said they are losing money on the business this year.

Of 3.1 million federal employes paying premiums as of November, 1974 (last figure available), 1.9 million were enrolled with Blue Cross-Blue Shield.

About 471,000 federal employes were enrolled under the Aetna plan, which Aetna administers largely on behalf of other private insurance underwriters. A total of 104 other companies reinsure 91.7% of the risk, with Aetna retaining the remaining 8.3%.

Under both of these plans, the federal government pays 60% of the cost, with 40% passed on to the employe.

For 1976, the premium for Blue Cross-Blue Shield's "high option" family coverage has been pegged at $43.14, up from $31.81 in 1975. That amount is payable every two weeks.

The Aetna "high option" family policy will cost a total of $38.46 every two weeks in 1976, up from $28.70 in 1975. The employe share of the bill will be $15.33 every two weeks, up $5.56 from 1975.

Some 2.7 million federal employe health insurance subscribers elected the "high option" type plans last November while 419,000 subscribers elected the "low option" plan.

Federal employe health insurance bills had actually dropped in 1975 over 1974 because the government began paying 60% of the cost last January 1. The govern-

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Third annual Wyatt study

'D&O loss ratio to be 100%'

By ELISABETH M. WECHSLER

CHICAGO—The Wyatt Co.'s third annual survey of directors' and officers' (D&O) liability insurance projects that "current loss frequency and severity will result in a 100% loss ratio at current premium levels."

"This is not our finding of an historical loss ratio (but) rather a projection as to what current loss ratios will be," emphasized Warren G. Brockmeier, director of risk management services for the actuarial consulting firm.

The projection is based on the pattern of D&O claims actually settled which was then used to make assumptions about outstanding claims. "We had no access to reserve figures."

Over 1,700 U.S. and Canadian firms, ranging in asset size from under $10 million to over $2 billion, participated in this year's survey, which for the first time included information about fiduciary liability coverage. Of those companies participating, 149 reported that claims had been made against their directors and officers between 1969 and 1974. Some 24% of the 7,178 corporations which received the questionnaire participated, said Mr. Brockmeier, who supervised the project.

The main reason Wyatt's projection of the D&O loss ratio is high, Mr. Brockmeier believes, is that premiums are "inadequate. Some of the companies which have been most aggressive at low rates are presently raising their rate levels," he said. "The ones that had not cut premiums drastically will probably hold the line at the point they're at."

The average D&O premium dropped by 17.2% between 1974 and 1975, Wyatt estimates in its projection. Other reasons for the high projection are an increase in claim frequency and a reduction in deductibles and retention percentages, the survey concluded.

The 1975 survey shows that 41% of the participants carried specific and separate fiduciary liability policies, while 32% had no coverage in this area. Some 6% had fiduciary coverage by endorsement to D&O policies and 5% obtained it by endorsement to CGL policies.

The most common limits for fiduciary liability coverage were $5 million and $1 million. The most commonly reported deductible was $1,000, for companies indicating a deductible other than that on the D&O policy.

The leading underwriters for the fiduciary liability coverage indicated in the survey are National Union (American International Group) and Aetna Casualty (Aetna Life & Casualty group). Together they have 70% of the market represented in the survey.

D&O results indicated, Mr. Brockmeier said, that the "largest companies which are not profitable have the most claims. If the economy turned around and the biggest companies were profitable, then there'd be fewer claims."

A comparison between the claim frequencies of publicly-held and non-publicly-held corporations found that publicly-held companies had 213 claims in 1975

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Wyatt D&O survey . . .

Continued from page 1

while non-public organizations had 12 claims. The report noted that an adjustment should be made to recognize the fact that non-publicly-held corporations "tend to be smaller in size."

Although stockholders headed the source-of-claims list by filing 39% of claims, employes or former employes ranked second by filing 15% of claims.

"Misleading representations" and "irregularity in securities issues" together constituted the largest single body of allegations of wrongful act on the part of directors and officers, the survey found.

For the 149 claims reported in this year's survey, 33% were not covered because insurance was not carried.

Corporations with assets of $800 million or more experienced more D&O claims. About one in six reported a claim in the 1969-75 period under study. Those companies indicating more than one type of business activity had greater than average D&O claim susceptibility and frequency.

Including both payment to the claimant and the cost of defense, the average D&O payment would be approximately $865,000, the report found. "Since 46% of the claims seem to involve no payment to the claimant, the average for all claims would be $468,000 in terms of award and $114,000 for defense costs, or a total claim cost of $582,000," the report said. Last year D&O survey found an average total claim cost of $566,500 (*Business Insurance*, Oct. 14, 1974.)

Adjusting for annual inflation of 10% over the six-year period, an average cost for present 1975 claim would be $740,000.

Directors' and officers' liability insurance is much more prevalent among large corporations than small ones. Of those with assets of $2 billion or more, 79.9% had the coverage. Of those with assets of $50 million to $100 million, 66% had coverage. However, of those corporations with assets under $10 million, 22.2% had coverage.

Coverage appears to be significantly more common among utilities and less prevalent among construction companies, professional service organizations and publishing companies, the report found.

"Utilities tend to be conservative," Mr. Brockmeier pointed out. "They are most interested in nonfluctuations in their earnings and costs. They don't care if (the coverage) costs a little more because they get it back through rate increases. Their investors are more interested in stable income.

"Utilities have lower premiums because they are by and large not involved in diversification," he continued. "Also because they're regulated, there is less chance of a claim because the government is looking over their shoulder on everything they're doing."

Of the Canadian companies participating in the survey, 39% carry D&O coverage, compared with 65% of the U.S. companies participating.

The highest D&O limit indicated is $50 million and the lowest is $1 million for Fortune-listed companies. Utilities have the highest limits while construction and real estate firms, merchandising, professional service organizations and insurance companies have the lowest D&O limits.

The most frequent limit reported is $5 million, while the average limit in the 1975 survey is slightly over $8 million, reflecting a 14% increase over 1974. The average limit for Canadian firms is $4 million, or about one-half that for U.S. companies participating in the survey.

Regarding retention above the basic deductible, "there are 41% who have the retention cease as to that portion of loss above $1 million as compared with 33% in 1974. There are 22% who have no retention," the report stated.

Wyatt noted the factors taken into official rating formulas for D&O coverage include: Company size and type, policy limits, number of directors and officers being insured, deductibles and retention arrangements.

Not included officially in rate filings but believed by Wyatt to be "certainly reflected in actual premium charges" are: Acquisition activity, diversification, losses, profitability, the number of subsidiaries and the degree of their control by the parent, the nature of distribution of stock in the corporation, special features such as elimination of the insurance exclusion and special circumstances such as antitrust possibilities.

The leading carriers of primary D&O policies indicated in the survey in descending order are: American International Group, Lloyd's of London, Harbor/Buffalo and the CNA group. ■

Corroon & Black, Synercon to merge

Synercon Corp., Nashville, and Corroon & Black Corp., New York, have reached an agreement in principle to merge the two corporations. Corroon & Black, the surviving corporation in the proposed merger, will issue two shares of its common stock for each three shares of Synercon common stock presently outstanding, Corroon & Black will issue approximately 1,028,219 shares of its common stock worth an estimated $20.3 million. Corroon & Black is an international insurance brokerage firm with 25 offices throughout the U.S. Synercon has 20 offices located principally in the southeastern U.S. Corroon & Black's 1974 gross revenues were $30,646,000, making it the seventh largest broker, the same position the firm will occupy after the merger with Synercon, which had 1974 gross revenues of $17,200,000. Synercon is the nation's tenth largest brokerage firm.

$1 million settlement

Firestone Tire & Rubber Co., Akron, announced a settlement of $1 million to Kenneth E. Porter, who suffered injuries in an automobile accident reportedly caused by a faulty Firestone tire. The action came shortly before a jury selection was to begin in a civil trial. Firestone declined all comment about settlement.

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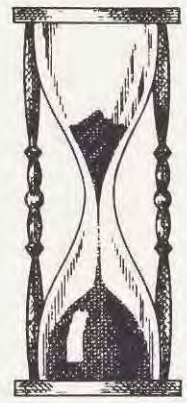
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Profit sharing plans stand to suffer significant lawsuits under ERISA

By JOANNE GAMLIN

SAN DIEGO—Profit sharing plans, far more than fixed benefit pension plans will confront the hazard of lawsuits under the 1974 Pension Reform Act or ERISA, predicted Harry C. Anderson, president, Corporate Policyholders Counsel Inc., Chicago.

Mr. Anderson, who presented an overvew of the subject of fiduciary liability insurance at the 28th annual conference of the Profit Sharing Council of Ameirca held here in mid-October, said he disagrees with corporate attorneys who maintain that ERISA does not expand the responsibilities of fiduciaries and of corporate directors and officers.

He told the conference that the concern over individual liability is justified. And he noted that most companies that research the question end up by buying fiduciary liability coverage.

Mr. Anderson offered the following major guidelines for firms that are contemplating the purchase of such coverage:

- Directors and officers (D&O) cannot be confidently regarded as a source of fiduciary liability coverage in the future because D&O carriers are writing exclusions of liability under ERISA in their new and renewal policies.
- Quotations must be obtained from various insurers. There is no such thing as a standard form and no fixed prices for fiduciary liability coverage. Three-year policies were not advocated by Mr. Anderson who cited the unsettled nature of the coverage.
- Indemnification agreements between fiduciaries and the plans are now void and unenforceable. Nevertheless, such agreements are permissible—and, perhaps, advisable—among different fiduciaries.

"Most of the liability of a fiduciary will arise from poor investment performance," Mr. Anderson continued, noting that this is the reason why he believes that profit-sharing plans, rather than pension plans, will be the targets of lawsuits in the fiduciary area.

Profit-sharing plans, that is, that experience a plunge in value.

"If you do not now use outside investment counsel, you should consider this approach," he advocated.

Indeed, he said, the more use that is made of outside professional services, "the less chance there should be of a successful suit against the primary fiduciaries."

At the same time, Mr. Anderson observed that "banks, of course, have their own problems. They can scarcely consider providing insurance covering their liability for the management of all their other trust assets. Since such insurance is hard to come by in adequate amounts and is very expensive, most of the largest banks do not insure the risk," he said, adding:

"However, we have seen some banks insuring their liability under ERISA in respect of their own employe benefit plans applying to their own employes."

Nevertheless, the use of outside investment or management firms does not push the primary fiduciary totally out of the way of a lawsuit threat.

"It is still necessary to make a prudent decision as to which firm to use," pointed out Mr. Anderson. And, he said, the output of this firm must be unrelentingly scrutinized.

Actuaries, life insurance pension experts as well as bank trust departments, share substantial liabilities under ERISA, continued Mr. Anderson.

He related that some of these persons or organizations have approached clients of Corporate Policyholders Counsel to ask to be included under their fidelity bond or fiduciary liability coverage.

The insurance consulting firm has responded with a forceful "no."

"The problem is that such an inclusion could dilute the limits of liability," explained Mr. Anderson. "We feel outside interests should insure separately on their own behalf."

As for the burning issue of using the D&O insurer for fiduciary coverage, the executive, as indicated earlier, was largely negative.

He said that the sole advantage of such an arrangement is that it abolishes any dispute about who will defend a lawsuit.

On the other hand, Mr. Anderson suggested that the blending of coverage and terms and conditions can result in watered-down protection.

"In addition, there is the possibility of dilution of limits when the two coverages are combined," he noted.

The consultant firm chief went on to point to a potential conflict of interest inherent in the combination of two coverages under a single policy.

The problem: A director or officer is required to act in the best interests of the stockholders while a fiduciary must think first of the interests of plan beneficiaries.

Another coverage related to fiduciary liability is employe benefit errors and omissions liability.

"This has usually been insured under public liability policies," Mr. Anderson elaborated. "This extension grew out of the Anheuser-Busch case some years ago where there was the allegation that the plan sponsors had not fully explained various options under the pension plan. The coverage under the extension related primarily to administrative acts and usually extends even to plans not covered by ERISA, notably worker's compensation and unemployment compensation plans.

Ultimately, his firm believes that this coverage will be incorporated under fiduciary liability policies, Mr. Anderson said.

Yet for the moment, he suggests that the cost of adding employe benefit errors and omissions liability to fiduciary liability be compared to the cost of including the former coverage under public liability insurance.

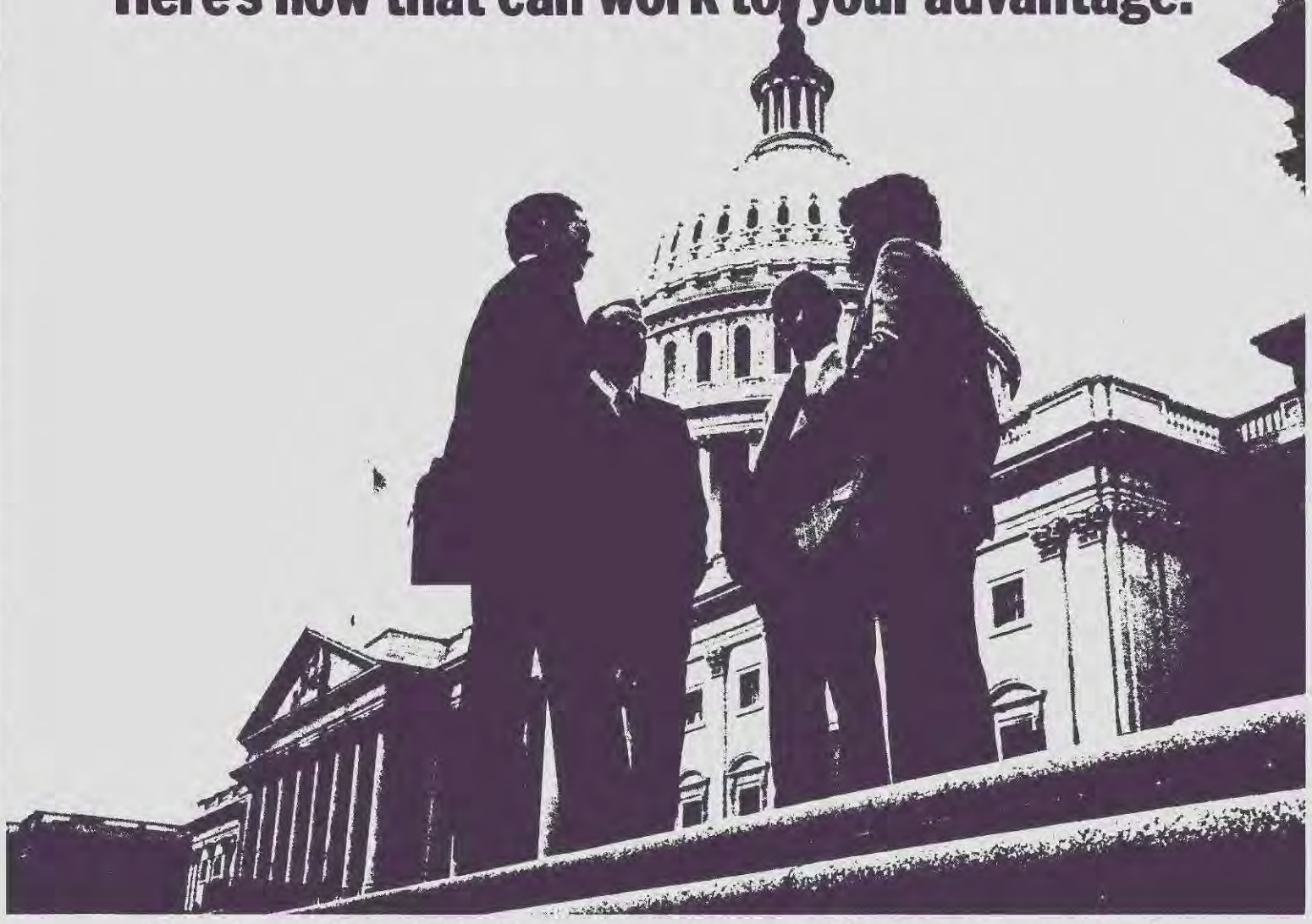
Noting that ERISA requires only that plans carry plan termination insurance provided by the Pension Benefit Insurance Corp. and that most fiduciaries be bonded, Mr. Anderson concluded his talk by pointing out the differences in the policies offered by the principal underwriters.

He noted, for example, that Corporate Policyholders Counsel prefers policies that cover "any wrongful acts" rather than those that limit their coverage to liability arising from ERISA.

Policies also vary as to whether they cover the plans themselves, he noted. "For example, the first Lloyd's form did not cover these interests but the latest form does.

Continued on page 4

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Only one big London D&O writer left

By MARGARET LeROUX

PHILADELPHIA—There's only one major source in London for directors' and officers' liability insurance as of the first of this month and the result will be "a significant impact" on the market, according to the major U. S. underwriter of D&O coverage.

John Huckstable of Lloyd's Sturge syndicate, the prime source for D&O insurance in London, retired Nov. 1. His book of business has been transferred to Leslie R. Dew, chairman of the Merrett Group at Lloyd's. Mr. Dew becomes the sole lead underwriter for D&O liability in the London market.

Joseph DeAlessandro, senior vp for American International Group, who spoke at the annual insurance conference sponsored by the Delaware Valley chapter of the Risk and Insurance Management Society (RIMS) here last month predicted, "You'll start to see the reduction of capacity as of Jan. 1, 1976."

Others, however, discounted the impact of the development on the U. S. D&O market when contacted by *Business Insurance*.

Specific limits of D&O liability coverage are something underwriters are loathe to discuss. However, one broker knowledgeable in the D&O liability market noted that "traditionally you can depend on $5 million to $10 million. From there on, it depends on the risk, loss experience and the marketing effort.

AIG's experience in the D&O liability market has been good, Mr. DeAlessandro claimed. "It is my understanding that the London experience has not been so good."

Reinsurance markets are starting to feel the pinch of D&O loss experience, the AIG executive told the RIMS group. He expects reinsurers to react by cutting back on limits of liability.

Other domestic D&O liability underwriters, however, are not so willing to speculate on the future of the market.

At Crum & Forster Insurance Co. which underwrites D&O liability through a subsidiary L. W. Bigler & Co., a spokesman said, "We're not prepared to make any comment on the London action."

A St. Paul Fire & Marine Insurance Co. spokesman said he doesn't think the transfer of the D&O liability business in London to the Merrett syndicate "would diminish the market."

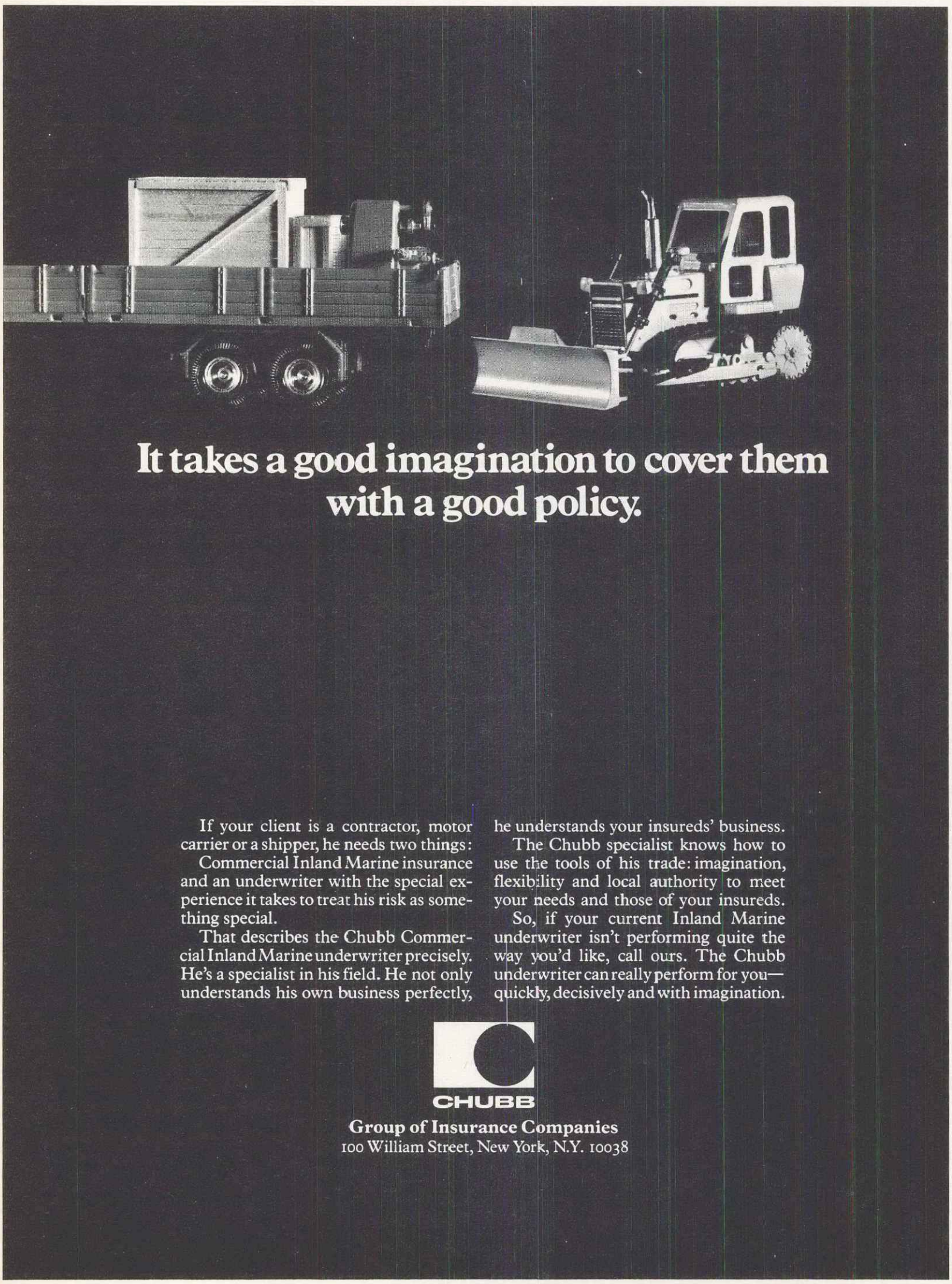
A spokesman for Home Insurance Co., also involved in the D&O market, agreed that London's action will not have significant reverberations in the U.S. market.

Another source for D&O liability coverage observed that the problem is not so much capacity as loss experience. The London action "is not a bad omen for the market," a spokesman for the D&O insurer said. "There is little difference in the underwriting philosophy of Jack Huckstable and Leslie Dew regarding D&O liability. They were of a common mind."

Nevertheless, this spokesman predicted a price increase for D&O liability premiums. "There's been one U. S. company that's been sort of a maverick and underpricing other D&O underwriters," he continued. "Up to now they've had pretty good experience, but we're waiting for losses to catch up with them."

A D&O broker told this magazine he's "dubious about a shrinking capacity in the market. It was never really true that Jack Huckstable and Leslie Dew were in competition with each other," he said, noting that the Sturge syndicate may still participate in the D&O market, while letting Mr. Dew have the lead.

"In theory the market may look different," the broker concluded, "but in practice it won't be any different." ■



ERISA . . .

Continued from page 3

The change was doubtless due to competitive pressure.

He advised that protection buyers should look carefully to see whether defense costs are part of the limits of liability.

Moreover, the question of whether "the negligence of wrongful acts of some fiduciaries can be imputed to the other fiduciaries to deny them coverage under the fiduciary liability insurance" is another area that insurance buyers should investigate, he said.

The question of whether the policy will defend the insured for non-pecuniary relief—that is, when the plaintiff is demanding actions which the fiduciaries do not wish to take—also should be examined, he said.

"Competition has compelled them (the liability carriers) to be somewhat flexible," he pointed out. But "you will find them much more willing to negotiate before they get the order than midway through the policy term."

Another speaker at the conference, Michael I. Lew, a partner in a Chicago law firm, said that ESOPs or employe stock ownership plans, must be regarded as an employe benefit and not as another means of financing. ■

Where is Wausau?



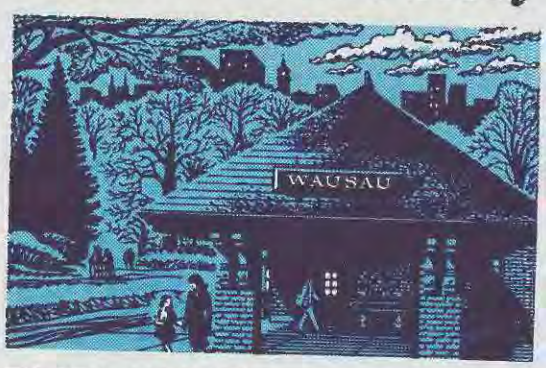
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EMPLOYERS INSURANCE OF WAUSAU, Wausau, Wis.

Big Aetna offers dental to civilians' children

WASHINGTON—Aetna Life & Casualty Co. is offering a comprehensive dental insurance plan for children of federal civilian employes, with coverage effective next January 1.

It is the first time that one of the government's major health insurance contractors has included a dental policy in its benefit package. Aetna's package, heavily reinsured by 104 other private health insurers, is second in size behind Blue Cross-Blue Shield.

Dental plans have been offered or are being added in 1976 by three insurance plans sponsored by federal employe organizations and six comprehensive (health maintenance type) medical plans.

Aggregate cost increases by all of the government health insurance providers will hit 35% in 1976 over 1975, however. In this situation, the U. S. Civil Service Commission, health insurance buyer for the government, insisted that all benefit increases be offset by other cost reduction within the plan.

In Aetna's case, the dental benefits cost was offset by increasing the deductible of the "high option" benefit package to $75 from $50. The maximum family deductible was raised to $225 from $150.

Earlier this year, it was revealed that Blue Cross-Blue Shield had proposed a dental package priced at $19.71 a month for an employe and his dependents, with the government paying $11.83 and the employe paying $7.88. That proposal was apparently dropped in the course of negotiations this fall.

Two postal union plans—the National Assn. of Letter Carriers and the American Postal Workers Union—will also offer a dental plan in 1976. To offset the cost, the plans will combine their "high" and "low" option alternatives into one plan.

The Aetna dental program will offer to dependent children under age 22 semi-annual examinations, fluoride treatments, x-rays, extractions, fillings, anesthetics, bridgework, root canal therapy, treatment of gum diseases, and other services.

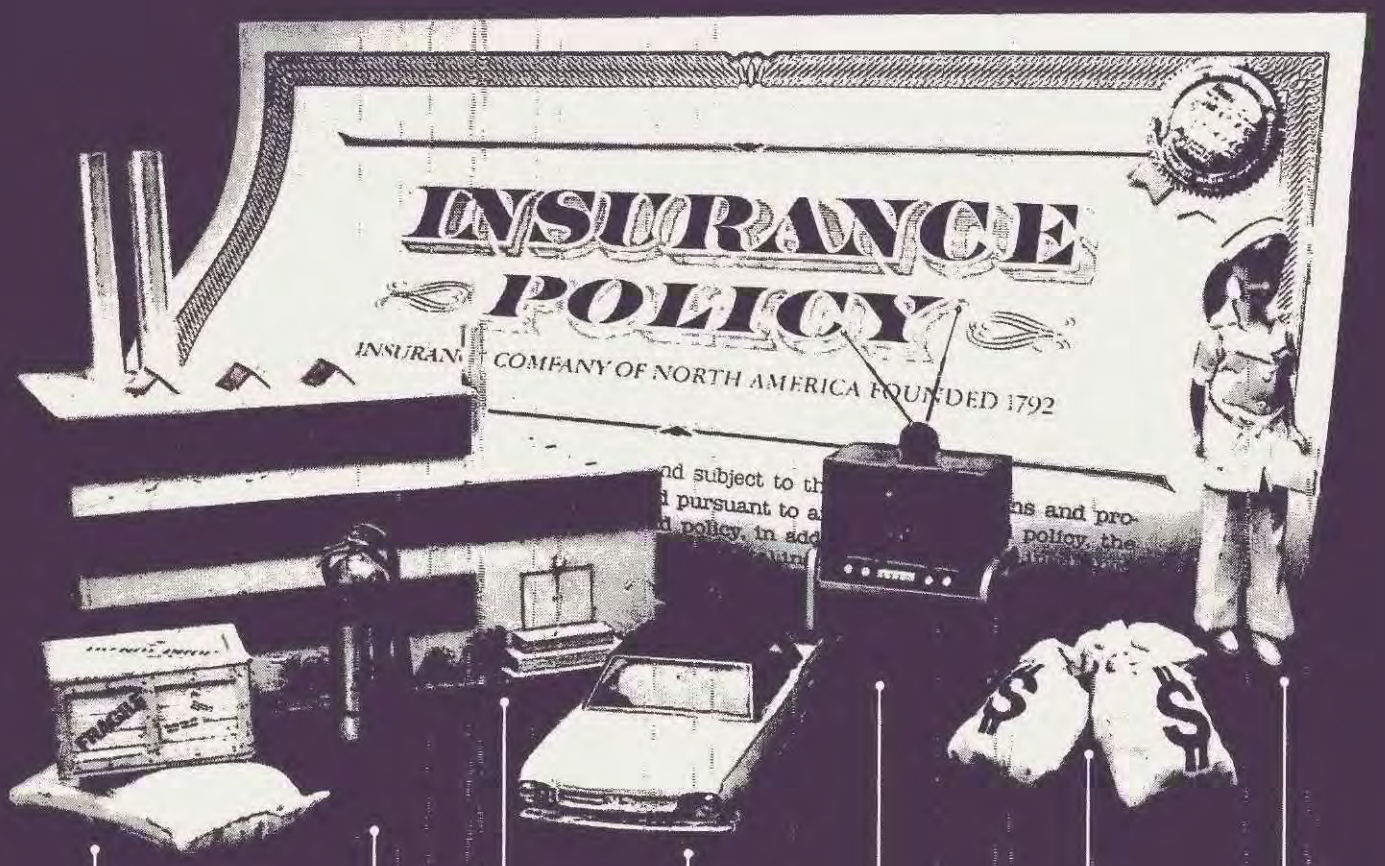
In other benefit changes for 1976, Aetna increased its lifetime maximum benefits for both its high and low option plans and eliminated the deductible from its benefit for inpatient hospital expenses (the full deductible will apply to hospital outpatient and other covered expenses).

The lifetime maximum benefit will be $1 million under Aetna's high option program, up from $250,000. The new low option life time maximum will be $250,000, up from $100,000.

Blue Cross-Blue Shield added benefits for home health care and inpatient newborn care and included what amounted to one benefit reduction. That move eliminated supplemental benefits coverage for the difference between the total charge of a non-member hospital and the 80% paid under Basic Hospital Benefits coverage.

The Civil Service Commission said these moves by Blue Cross-Blue Shield had minimal effect on the rate increases. ■

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Health . . .

Continued from page 1

ment share had been 50% in 1974. (For postal workers who bargain for their pay and benefits, the government now pays 75% of the insurance bill.)

While the 1976 cost projections are already grim, the Civil Service Commission warned they could be even worse if Congress fails to amend the Social Security Act.

Section 1862(c) of the law states that, as of next January 1, the Civil Service Commission's private insurance contractors will be the primary provider of benefits for retired employes with Medicare the secondary provider.

"If no action is taken by Congress, FEHB (Federal Employe Health Benefits) contractors will pay additional benefits of about $250 million in 1976, which otherwise would have been paid by Medicare," the Civil Service Commission said. That would mean higher premiums.

And, the Commission said, it would make the FEHB program "the only group health program in the nation in which Medicare does not pay benefits before the incumbent concerned receives the benefits of his group insurance."

Without the change in the law, the Civil Service Commission said "high option" premiums for a Blue Cross-Blue Shield policy would be $47.46 in 1976 instead of $43.14.

The Aetna "high option" family policy would cost $43.08 every two weeks without the change instead of $38.46 with the change. ■

Gulf refinery fire

Lloyd's of London had substantial participation in coverage on the Gulf Oil Co. refinery blaze in Philadelphia, either by reinsurance or by other lines. Lloyd's has reinsurance interests in the property damage risks understood to be carried by oil risk groups in the U.S. Liability cover is understood to be borne by Lloyd's, so that compensation costs for the victims can hit the London market.



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Blues, Aetna asked to explain 35% rate hike

WASHINGTON—Within hours of the announcement of a 35% increase in federal employe health insurance premiums last month, officials of the two largest insurers in the program were called before Congress.

With a deficit-swollen federal budget already facing them, the Congressmen found themselves confronted with a $620 million increase in health insurance costs.

Blue Cross-Blue Shield, which insured 1.9 million federal civilian employes, told the House Subcommittee on Retirement and Employe Benefits that they expected to lose about $100 million on the federal account this year.

Making up that deficit accounts for 14.3% of the Blues' 35.3% rate increase, according to Robert J. Laur, vp of the Blue Cross Assn. and the National Assn. of Blue Shield Plans. Mr. Laur is also director of the federal employe program.

He said the Blues failed to predict the double digit inflation rampant in the health care industry once federal price controls were removed in 1974. "In addition, there was an unanticipated increase in the use of health care services by federal subscribers," he said. "The number of claims paid for the first six months of 1975 was up more than 21% over the same period in 1974."

Aetna Life & Casualty, the second largest insurer of federal employes with about 471,000 enrollees, anticipates losing $31 million on federal business this year.

That will force a 17% rate increase in 1976 to recover the loss, according to Malcolm McIntyre, manager of government relations for Aetna's group division.

Together with higher utilization rates and costs, Aetna said it really wanted a 42.5% increase, but agreed to a 35% increase in an attempt to be optimistic.

Blue Cross-Blue Shield said the remainder of their price increase was due to projected cost and use trends for 1976, 18.3%; benefit changes, 0.7%; and other factors, 2%.

The Blues' Mr. Laur gave the subcommittee these rather gloomy predictions on cost trends:

- average hospital charge per in-patient admission (non-maternity)—from $821 in 1974 to a projected $1,116 in 1976;
- average charge per hospital day (non-maternity)—$108 in 1974 to a projected $149 in 1976;
- average inpatient surgical cost procedure—from $245 in 1974 to a projected $291 in 1976;
- average amount of benefit per subscriber receiving benefits—from $371 in 1974 to a projected $495 in 1976.

Faced with these trends, Mr. Laur admitted that one solution "would be to adjust the benefit level downward, thus shifting more of the cost to the employe who is sick or injured.

"This, however, is a shortsighted response and one which we do not believe to be in the best interest of federal employes," he said. ■


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Merge for reinsurance

W. R. Berkley Corp., New York, and Reinsurance Underwriters Corp., Omaha, Ne., announced an agreement to merge the latter company with Berkley. The acquired company would underwrite for a new reinsurance subsidiary to be formed by Berkley with initial capital of $4 million.

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- **Construction Contract Bond Indemnity Agreement Provisions** are analyzed in a monograph from the Defense Research Institute. Research was based on the indemnity agreement forms of General Insurance Corp. of America, Globe Indemnity Co. and the National Surety Corp. In addition to a detailed study of 28 provisions of an indemnity agreement by a surety on a construction contract bond, a section of comments on a model general agreement of indemnity is included. The publication is available to DRI members for $2.50 and to non-members for $5, prepaid through the Defense Research Institute, 1100 West Wells St., Milwaukee, Wi. 53233.

- The International Safety Academy, a division of ESIS Inc., an INA subsidiary, is offering a **Catalog of Safety & Training Films.** The films in the 28-page catalog cover safety management and supervision, safety training, material handling, fire and plant protection, hospital safety, construction, chemicals, first aid and many other subjects. To obtain a free copy, write to the International Safety Academy, P.O. Box 4365, 1021 Georgia Ave., Macon, Ga. 31201.

- A brochure on **How Personnel Research Associates Can Help You** explains the firm's experience in researching and preparing reports on personnel related subjects. Examples of past topics include health maintenance organizations, pre-retirement counseling, employe communications and employe benefits. For a free copy write to Personnel Research Associates, 49 Oakridge Road, Verona, N.J. 07044.

- **HMO's Make Economic Sense,** by Joseph N. Rosenfield, is available for $4 from Protech Publications. There is a 25% discount for *Business Insurance* subscribers. Write to Protech, 2181 Dupont Dr., Irvine, CA. 92664.

- **Contractors' Additional Interest Expense** describes the protection now being offered by Wohlreich & Anderson Ltd. for insuring contractors. Written by Bernard J. Daenzer, president of the Howden Swann Group, the article explains the coverage afforded for the additional interest charged on loans which have to be renegotiated due to reconstruction, and tells how this new policy provides assurance to lenders for interest payments in the event of a delay caused by physical damage. For a free copy, write to Mike Lauro, Wohlreich & Anderson, 55 John St., New York, N.Y,. 10038.

- **Closing in on GAAP,** from Washington National Insurance Co., describes the principles used by them to develop their financial statements. The booklet is designed to show how one company derived its reported earnings on a GAAP (generally accepted accounting practices) basis. For a free copy write R. N. Whiteside, Public Relations Dept., Washington National Insurance Co., 1630 Chicago Ave., Evanston, Il. 60201.

- Commercial quotes can be faster and more accurate, says Zurich-American Insurance Cos. in a brochure which describes **ZIP,** Zurich's instant price computer quote system. How ZIP operates on providing quotes on top security, the Z-A commercial package policy and actual agents' experiences are summarized. For a free copy of the brochure write Pamela Janousek, Communications Dept., Zurich-American Insurance Cos., 111 W. Jackson Blvd., Chicago, Il. 60604.

- A revised **Basic Drug Program** brochure is available from PAID Prescriptions. This 12-page brochure explains how easy it is for a employe to use the PAID card throughout the nation. Example of client computer cost control reports is included. For a free copy write to: PAID Prescriptions Information Center, 1633 Bayshore Highway, Burlingame, Ca. 94010.

- **Your Employes. Do They Know All You're Doing for Them?** This brochure from Synerconsultants discusses current problems and solutions in communicating employe benefits. It focusses on a cafeteria approach to benefits communications, including computerized benefits booklets, statements, audio-visual presentations and monthly benefit reminders. For a free copy write to J. F. Swygert Jr., president, Synerconsultants Corp., 95 White Bridge Road, Nashville, Tn. 37205.

- **Incentive Dental Plan,** published in October by American Way Group Insurance Trust, describes a dental plan that pays increasing amounts of an individual's dental bills, provided the insured has diagnostic and preventative services performed annually. The plan is available to companies with three or more employes. For a free copy of the brochure, write American Way Group Insurance Trust, 2530 Crawford Ave., Evanston, Il. 60201.

- Glass Door Hardware is a brochure which describes a full range of maximum security locks and latches for glass doors that swing or slide, published by Adams Rite Mfg. Co. For a free copy, write Russ Hawe, Adams Rite Mfg. Co., 4040 S. Capitol Ave., City of Industry, Ca. 91749.

- Prepared by Wohlreich & Anderson, an article entitled **FIPP** (financial institution protection policy) describes in depth the new comprehensive chattel mortgage policy now available for financial institutions. This article, by Bernard J. Daenzer, president of the Howden Swann Group, discusses the three sections of the new chattel mortgage wording, which covers filing and non-filing of chattel mortgages, lenders single interest in respect of automobiles and other chattel mortgages, as well as physical damage to chattels repossessed by the assured. This article can be obtained by writing to Arther Fullan, manager-financial institutions, Wohlreich & Anderson Ltd., 55 John St., New York, N.Y. 10038.

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Nuclear suppliers need contracts, not insurance

PHILADELPHIA—How suppliers of goods and services to a nuclear facility can adequately cover their exposures was described by Charles Mathers, vp and coordinator of the nuclear advisory group for Johnson & Higgins insurance brokers, speaking at the Delaware Valley chapter of the Risk and Insurance Managers Society (RIMS) annual insurance Managers Society (RIMS) annual insurance conference late last month.

Specific areas of concern for suppliers, Mr. Mathers said, are physical damage to the facility itself due to the nuclear energy hazard, physical damage to property away from the facility, and bodily injury to third parties at or away from the nuclear facility where jobs are being performed.

Suppliers to nuclear facilities cannot buy insurance to cover on-site property damage, Mr. Mathers noted, "The only one who can buy such coverage is the owner of the nuclear facility."

Suppliers can minimize these exposures contractually, Mr. Mathers noted, through property damage waivers, hold harmless and indemnification agreements, limitations of liability and requirements to carry insurance.

These contractual devices are necessary, for several reasons, according to Mr. Mathers:

- The maximum limit of available insurance under the nuclear property policies is $175 million, while values at a nuclear site can be $1.5 billion or more.
- The nuclear property policy for an operating reactor contains a deductible which ranges from a minimum $50,000 to a maximum $1 million. Furthermore, a condition of the Nuclear Energy Liability-Property Insurance Assn. (NELPIA), the nuclear property insurance pool, forbids the insured to insure the deductible.
- If a loss occurred, there is a possibility that the owner would sue the supplier rather than submit a claim to his insurers.
- If the facility is insured, there is no reasonable way for a supplier to know if the insurance is carried on a continuing basis.
- Nuclear property policies cover only direct physical damage to the insured's property and do not provide coverage for loss-of-use or loss of income.

Although there are no laws requring a nuclear facility to buy property insurance, most of them, especially commercial nuclear power electric generating stations buy property insurance from either NELPIA or the utility captive Nuclear Mutual Ltd. (NML).

The major exception, he added, is the Tennessee Valley Authority which does not buy property insurance for its plants.

The NEL-PIA and NML policies are "all risk" and contain an automatic waiver of the right of subrogation against suppliers for direct physical damage caused by the nuclear energy hazard.

Suppliers to commercial nuclear power plants are covered for on-site bodily injury and off-site property damage and bodily injury, because all commercial nuclear power plants are required by the Atomic Energy Act of 1934, as amended, to furnish financial protection.

Utilities get their liability insurance from NELPIA and Mutual Atomic Energy Liability Underwriters (MAELU). The maximum amount available is currently $125 million, Mr. Mathers said. The U. S. government will issue an indemnity agreement above this amount up to $560 million, the maximum statutory limit of liability.

Other types of nuclear facilities, however, are not indemnified nor are they required to buy insurance, Mr. Mather noted. These facilities include: fuel fabricators, chemical conversion facilities, private waste burial grounds and "hot" laboratories.

A supplier can cover his exposures in these situations by purchasing a nuclear energy liability policy, supplier's and transporter's form, available for limits up to $125 million, he said.

If an incident occurred at a non-indemnified facility the operator's nuclear energy liability policy (facility form) would provide coverage on a primary basis and the supplier's policy would provide excess coverage.

The supplier's and transporter's policy, in contrast to liability policies written for the nuclear facilities, covers only those specifically named in the policy. The nuclear facilities policies, however, contain an omnibus insuring definition so that anyone legally liable, except the U.S. government or any of its agencies, is included as insured.

There is an aggregate limit of $125 million liability, when more than one policy is involved, he explained. The $125 million limit is the capacity of the nuclear liability pools.

Some 67%-75% of premiums for suppliers and transporter's policies are placed in reserve, used to pay claims or claim expense and remains the property of the insured. Credit refunds are made to insureds after a 10 year period based on the industry's experience, Mr. Mathers added. ■



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Multiemployer trust. . .

Continued from page 1

said another broker, "communications were horrible."

Besides having to scramble for coverage elsewhere in the few days between notification and Oct. 1, when the policies expired, all of the companies and agents contacted were quick to express their satisfaction with the previous arrangement.

"Their benefit package was the best in Chicago," said a broker who had worked with IAU for about four years.

"They were a great company," said Mr. Bairstow. "I liked the way they handled claims. We always got more than we expected."

Charles Yessick, a Penn Mutual agent who worked with IAU for five years, said, "I felt that they had the best group insurance program in Chicago. The state screwed up the whole thing.

"I'd get one call a year regarding the coverage from one of my 10 groups. And when I did get a call, it would be for a question, not a complaint. It was one of the most beautiful things I've seen."

"If anything they should have preserved it as a model for other insurance companies."

Problems began for the multiemployer trust last June 1 when Ray Elenteny, president and founder of Insurance Administration Unlimited, decided to drop John Hancock and self-insure the health and life insurance benefits programs designed specifically for small employe groups.

The state began to receive a few letters from IAU's clients after the firm sent out a letter notifying its insureds of the change, according to Mr. Seligman. "The letters were asking, 'Is this a correct way of doing business?' "

IAU's contention was that section 514 of ERISA exempted multiemployer trusts from state regulation, thus allowing them to self-insure. The decision to self-insure was in the works for about two years, according to a source close to the company.

The state argued that multiemployer trusts must, for one thing, be the result of collectively barbained plans, and neither did they meet other requirements of ERISA, said Mr. Seligman.

The state held that IAU was operating as an insurance company in that it was collecting premiums, paying claims and writing and selling insurance contracts. Since it did not have the reserves or capacity requirements that insurance companies must have, insurance director Robert Wilcox filed a cease and desist order on July 8, 1975.

IAU's clients and producers were not as concerned as the state regarding the self-insurance decision. "I knew he (Mr. Elenteny) had been thinking about it for about two years," said Mr. Yessick. "When he made the decision, I said hurrah."

"It didn't bother me," said one client. "I had no basis for doubt."

"It was fine with me," said Mr. Bairstow regarding the June 1 move. "It made other insurance companies look bad."

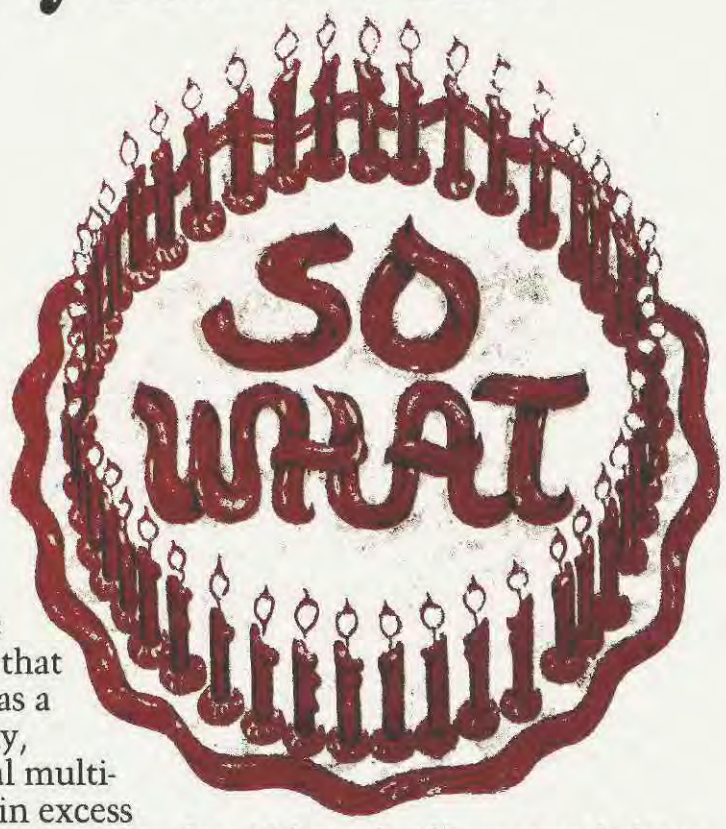
On top of the avoidance of state regulation, the court records indicate that IAU was not making a profit, with a $4 million premium volume and more than $350,000 monthly in claims.

A source close to the company, however, told this magazine that premium volume in 1974 was $4.7 million, with $3.6 million in claims. Also, Lloyd's of London was providing excess insurance for the self-insured program. After studying three years of claims, Lloyd's agreed to insure 90% of claims over 125% of the average, up to $1 million, according to the source.

Mr. Elenteny's ERISA-based challenge to the cease and desist order was met with the state's filing of an order of conservation of assets which was temporarily granted on August 6. Under that injunction, insurance director Wilcox was able to seize the assets of the corporation as well as Mr. Elenteny's personal assets.

On behalf of IAU, Mr. Elenteny filed a counter-motion to this suit, once again presenting the ERISA argument. The question never came before the court, however, as Mr. Elenteny decided to withdraw his motion and not contest the matter. ■

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Incentives emphasize people over machines

CHICAGO—Labor-intensive hospital operations are less expensive than machine-intensive operations, according to a hospital cost control consultant.

"With the reimbursement cost system with the Blues and insurers, services are reimbursed 100% while capital investments are only depreciated," said Richard L. Johnson, president of Tribrook Group Inc., Oakbrook, Il., a hospital consulting firm. "Therefore, less automation means more reimbursement," he told employe benefit managers meeting at the Council on Employe Benefits (CEB) here.

"Because of this method, if a hospital decreases its personnel expenses, it also decreases its reimbursed revenues substantially," he explained. He addressed himself to the economic "tarradiddles" (or petty falsehoods) of hospitals in order "to set the record straight."

Employe benefit managers should be interested in this topic, the CEB membership believes, because premiums for group health insurance premiums are reflecting substantial increases in hospital costs. Companies which self-insure these benefits are feeling the pinch of rising hospital costs even more directly.

"I could probably go into a hospital with a consulting team and cut costs 10% to 15%," Mr. Johnson admitted. "But I could also probably walk into any corporation and do the same thing."

Among the myths that Mr. Johnson said should be dispelled are that hospitals "are inefficient and mismanaged" and that "hospitals are highly profitable."

In fact, Mr. Johnson said, "the larger the total volume of units, the higher the average cost per day. In a larger hospital, he said, the range and comprehensiveness of the services are broadened. "You don't have a nuclear therapist in a small or medium size hospitals," he added.

Also, the more competition between hospitals on service and convenience, the more expensive it is to run a hospital, he said. "Patients and doctors don't select a hospital based on price."

Mr. Johnson pointed out that cost reimbursement formulas don't pay for the treatment at hospitals. "If a hospital had all Medicare patients, it would go broke."

Many corporate critics charge that hospitals should be run more like factories, Mr. Johnson said. "Although factories have high standardization and repetition, such characteristics of materials management don't apply to hospitals. They have instead a low volume and a highly varied range of services."

The better managed the hospital, the more it was adversely affected by wage/price controls, he claims. "Managerial acumen had little to do with deficits in, for example, ghetto hospitals. They had already trimmed the fat in their budget. The only way for these hospitals to get by was to defer expenditures," Mr. Johnson said.

"A patient isn't asked which services he wants in a hospital. He's expected to pay for them or have an insurer pay for them," he said. "The user and the payer is the captive of his physician. It's not clear who the customer is in a hospital."

Another tarradiddle, he believes, is that it would "seem better for hospitals to maximize the use of their services but this isn't true," he said. "Hospitals are encouraged to share cost data and rate structures," he added.

There are "losing profit centers in hospitals," he explained, pointing out that they "are needed to provide training. As long as hospitals break even overall, it's okay."

The relationship of quality of service, comprehensiveness of care and introduction of new technology is "not likely to be appreciated as the financial noose is tightened around hospitals' necks," Mr. Johnson said.

"The sharing of expensive technology, equipment and specialty physicians between hospitals is "not effective," he believes. ■

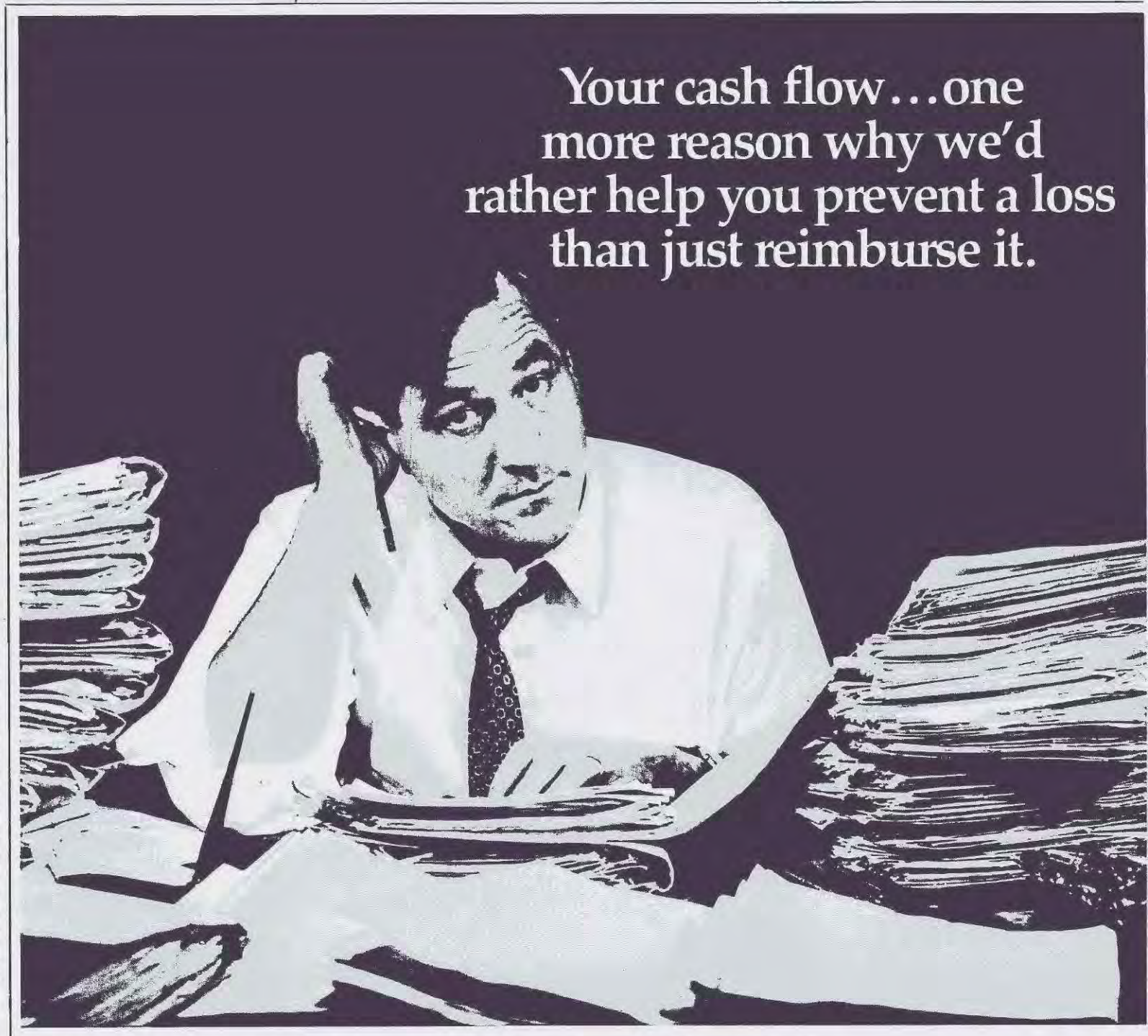
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Alcoholism identified can save company 25% in productivity

CHICAGO—"It takes an average of 14 years of being an alcoholic and performing a job poorly to be fired by an employer," said Jack W. Campbell, director of employe assistance programs for Reynolds Metals Co., Richmond, Va.

Because alcoholism affects job performance and because it is difficult to detect the disease at an early stage, Mr. Campbell believes more corporations "would find it worth their while to offer assistance programs" to their workforce and dependents.

Alchoholism causes "absenteism, reduced productivity, accidents in the workplace and bad morale for co-workers who are asked to cover up for alcoholics," Mr. Campbell said.

Take the average company salary, multiply that by 8% or the average percentage of alcoholics in the workforce, and then multiply that by 25%—or the approximate rate for the drop in efficiency due to alcoholism to calculate the disease's cost impact on a company, he explained.

Reynolds' cost for the employe assistance program is Mr. Campbell's salary and travel costs to other company locations plus a secretary, he said. He pointed out however, that the company's health insurance already covers the treatment costs of alcoholism and that Reynolds has staff doctors. "Technically, it doesn't cost any more to use them for our program," he said.

The cost of supervisor training to identify and refer employes whose job performance is affected has not been calculated, Mr. Campbell explained. Problems other than alcoholism are also covered by Reynolds' program.

"Alcoholism is treatable but it's not as clearcut as treating diabetes," Mr. Campbell noted. He is a former Reynolds sales manager who became interested in the treatment of alcoholism because his wife is "a recovering alcoholic." Reynolds approved the idea of an employe assistance program and put Mr. Campbell in charge of it in October, 1974.

Other companies which reportedly have similar programs are: Bechtel, Caterpillar Tractor, Control Data, Eastman Kodak, Firestone Tire & Rubber, General Motors, Hughes Aircraft, ITT, 3M, Metropolitan Life Insurance, Standard Oil of California, Travelers Insurance, and Western Electric.

Mr. Campbell emphasized that alcoholism usually "hits in the middle years when workers should be at the peak of their productivity.

"We have supervisors concentrate on factors such as job performance and attendance and don't attempt to train them to be diagnostic physicians or counselors," he said.

An employe with a drinking problem wants to keep his or her job and this factor provides the motivation to accept Reynolds' referral for treatment, Mr. Campbell emphasized. "It's easier for the alcoholic to rationalize help from family or friends."

The assistance from Reynolds does not become part of the employe's official record, he said, "and the former alcoholic must perform satisfactorily in the supervisor's opinion at his or her job for two years before being pronounced cured." The industry average for the effectiveness of cure is 65% to 80%, Mr. Campbell said.

"Early identification of a drinking problem is the key," Mr. Campbell said. "Community resources are then used for the treatment."

With five more assistants around the country and more money for travel and brochure printing costs, Mr. Campbell believes the employe assistance program can save Reynolds $9 million a year projected over 15 years if 15% of the alcoholics statistically present in the workforce can be found and referred for treatment. ■

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Focus on Social Security as primary retirement benefit, says union official

By ELISABETH M. WECHSLER

CHICAGO—A union official recommended that corporations make their pensions supplemental and instead emphasize improvements in Social Security benefits.

The advantages to employers are lower administrative costs, no funding of reserves and no worries about compliance with ERISA, according to Melvin A. Glasser, director of Social Security for the International Union of United Auto Workers (UAW), Detroit. He addressed his remarks to employe benefits managers from major corporations attending the Council on Employe Benefits meeting here.

The median monthly pension benefit is $200 for those who work until age 65 and $224 for those who retire early because of disability, he said. "Most employed people do not have private pensions to supplement Social Security benefits. An estimated 4.8 million people age 65 or over are living in poverty," he alleged.

"Yet we have a pension program which has universal coverage, provision for survivor and disability benefits, complete portability, very low administrative costs (1.9%) and no need for huge reserve funds or elaborate pension reform regulations," Mr. Glasser said.

"It would be interesting to consider how much easier, more equitable and less expensive it would be for employes to bring about major improvements in Social Security, rather than retain the piecemeal approach implicit in private pension plans," he said.

Mr. Glasser would like to see corporate pension funds "freed up for supplemental programs like early retirement," which he believes "reflects the view of younger people and also the limitations of job satisfaction."

"Last year, 44% of all male insured workers receiving Social Security benefits were under the age of 65," he said. "Compare this with just nine years earlier when the comparable figure was 32%," he pointed out.

He sees several "serious drawbacks in relying on the collective bargaining process to obtain benefits. "First, it reduces the amount of the economic settlement which can be devoted to wages or to time away from the job. Secondly, benefit protection has developed quite unevenly," Mr. Glasser believes.

He pointed to a discrepancy in figures supposedly representing the percentage of payroll which fringe benefits comprise. The U.S. Chamber of Commerce surveyed 742 companies in 1973 and reported that fringe benefits came to 32.7% of payroll, he said.

The Bureau of Labor Statistics surveyed 5,100 companies in 1972 and reported that fringe benefit expenditures represented 19.5% of payroll, he continued.

In another stand, Mr. Glasser criticized the commercial insurance companies for ignoring "our efforts to interest them in standards of quality. Neither they nor the Blues have been able to do much about cost containment."

"Many observers recognize that the time is past due to take personal health services from the private sector. . .and put them. . . in a comprehensive national health insurance program," Mr. Glasser said.

"Unless the right kind of a program is adopted. . . the costs to employers and workers will continue to be among the most expensive now in the benefit package," he added.

"The union movement is unanimous in believing that a health security program such as is proposed in the Kennedy-Corman bill is the right approach to solving the cost problem for employers as well as the problems of access, delivery and quality controls for all Americans," he said.

"We're the only industrial nation without a national health insurance program," Mr. Glasser emphasized.

He thinks the costs would be substantially less for a government-sponsored health program because 45,000 government employes could replace the 300,000 employes now in the private health insurance industry in order to deliver the public program. "Canada's national health program administrative costs are about 5%," he said.

Mr. Glasser believes that co-insurance and deductibles on health care and other benefits "solve nothing. They simply transfer costs to workers and continue to disregard the causes of the problem."

Co-insurance and deductibles "only deter poor people or those with low incomes from using health care in the first year and cause expenses in the second year to be much higher," he charged. A study completed on the use of small deductibles in California's Medicaid program found that the total cost of the program was higher if hospital costs were added in.

Mr. Glasser called for improvements in unemployment benefits from 52 to 104 weeks at 90% to 100% of pay "such as exists in a number of industrialized countries of Europe."

Another problem related to unemployment compensation is yet unresolved is the continuation of health insurance coverage during periods of layoffs, he believes.

"We must do a better job of integrating insurance, pensions and publicly-funded disability benefits," Mr. Glasser said. He pointed to the UAW's program of paying monthly installments of insurance benefits to surviving spouses and children in order to supplement death benefits and survivor's benefits available under Social Security.

Unions are interested in prepaid legal services, automobile insurance coverage and the four-day work week, Mr. Glasser reported. He said he is not as enthusiastic about HMOs at this point and he labeled Employe Stock Option Plans (ESOPs) as "poor."

"If we merely bargained for what was available from the insurance industry, we would have done a very poor job of protecting our members," Mr. Glasser said.

"The pressing problems of compensation and benefits does not mean that job satisfaction goals should be ignored," he emphasized. Employe benefits constitute trade-offs with wages and must be discussed in the same context, he added.

As if anticipating the corporate audience's reaction to his remarks, Mr. Glasser asked, "Where will it all end? It won't. If it should end, America as we know it will be at an end." ■

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Individual serves as a better fiduciary shield

CHICAGO—A consulting actuary advised corporations to "use individuals more" in focusing fiduciary responsibility rather than appointing committees.

"The individual allocator or fiduciary representative of the company is a more complete legal shield than naming the company itself as fiduciary," said Blackburn Hazelhurst, principal actuary with the firm of Hazelhurst & Assoc., based in Atlanta.

"If the courts interpret the plans the way they seem to be written, it could bring an end to private pensions," Mr. Hazelhurst told participants at the Council on Employe Benefits here. What he finds particularly worrisome is the ERISA requirement that "a fiduciary should act only for the benefit of the plan participants" because it is nebulous.

"We could go back to fully guaranteed benefits," he predicted, adding that he hopes "it's a different kind of insurance policy than that which is available today."

Mr. Hazelhurst pointed out the difference in security between a private corporate pension fund "which is a trust and which sets aside reserves" and a government "pay-as-you-go approach which requires the taxpayer to keep shelling out.

"The taxpayer may decide he doesn't want to pay any more," he added.

He advised corporations in preparing booklets about their pension plans "to begin each section with the principals, followed by examples, discussion and explanation.

"Talk about what's in the booklet because the booklet probably helps the administrator of the plan as much as the employe," Mr. Hazelhurst said.

"In preparing the pension plan text, consider whether it can be made any less dreary or more understandable," he said.

"Disclaimer language in the plan booklet indicating that all legal responsibility is based on the full text of the plan could lead to a more expensive, more worrisome proposition," Mr. Hazelhurst believes. ■

We won't know cost until program enacted

CHICAGO—"Whether or not we can afford national health insurance, we won't know until it's enacted," said Rep. Dan Rostenkowski (D-Il.).

"A phased in program with an increase in taxes is probably the logical way to approach it," Rep. Rostenkowski told employe benefit managers meeting here at the Council on Employe Benefits.

He said he knows that employers are "not enthusiastic" about national health insurance but added that he hasn't seen "any sign on the part of employers to participate" in the legislative process.

"What concerns me is that we're in a mood today that people want national health insurance to feel secure," Rep. Rostenkowski said.

"Many people who are in your employ today take for granted your contribution to their health insurance," he continued. For this reason, it is important for employers to communicate their benefits to employes "not by pamphlets but by sitting down and explaining what benefits they have.

"This is a visual society rather than a reading society," Rep. Rostenkowski emphasized. "If your company is in export, tell your employes that their job is directly involved," implying that an employe's attitudes towards political issues can be related to their specific jobs and earning power. "You must educate your employes," he said. ■

Retirement at age 50, 75 coming

CHICAGO—A consultant predicted that "flexible retirement from age 50 to 75" is one benefit change to come, along with "full survivor rights for an employe's family" and no penalty for "breaks in service" in computing vesting rights or pension eligibility.

"My idea of a good balance in a pension is two-thirds' pay counting full primary Social Security benefits—more or less depending on the case," said Paul J. Jackson, a consultant with the Wyatt Co.

Corporations "almost never consider that the wife's pay stops at an employe's retirement when they're looking at the replacement income provided by a pension," Mr. Jackson told employe benefit managers meeting at the Council on Employe Benefits here.

Mr. Jackson advised benefit managers to look at their employes' needs rather than "superimpose their own needs and perceptions on the entire workforce.

"Corporations are promising less but delivering 100%," he said, adding that the tendency to add and upgrade the pension plan every year is "leveling off."

He believes that most companies that have pension plans wouldn't drop them if they had the choice. "If you have a pension plan, you have one. You can't go back." ■

Utilize issue of 'electivity' in dental plan

CHICAGO—An underwriter of dental coverage told corporate employers to utilize the element of "electivity" in setting up new dental plans but warned against cutting out "fundamental dental procedures.

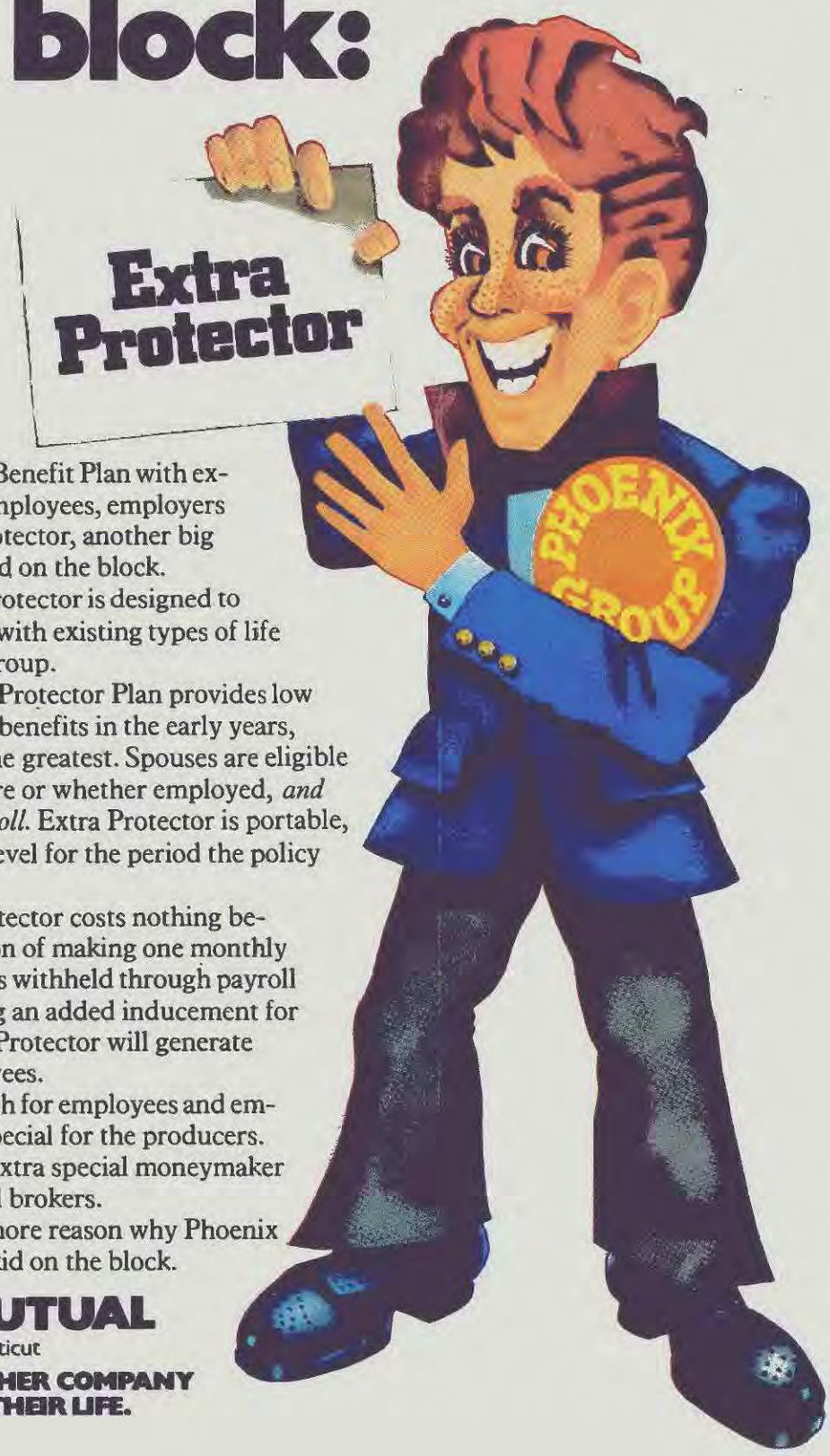
"If fundamental dental procedures are not performed, subsequent dental work is virtually worthless," said Robert Hall, assistant vp-group division, Aetna Life Insurance Co.

"The adequacy or sufficiency of dental care provided (under an insured plant) is not a life or death matter because it doesn't usually affect a person's overall physical condition," Mr. Hall said.

He urged corporations to investigate the option of determining which types of dental treatment should be covered in the plan based on how much a corporation wants to spend for this benefit.

"Aetna found that the issue of electivity was either overlooked or ignored," Mr. Hall told participants at the Council on Employe Benefits, which met here. ■

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Debate heats up as Price-Anderson goes before Congress

By RICHARD L. GORDON

WASHINGTON—The nuclear industry is pushing for another 10-year extension of the Price-Anderson Act, which sets rules for liability in the event of a doomsday-type atomic power plant accident.

But nuclear power foe Ralph Nader has challenged the whole Price-Anderson system as being both inequitable, by subsidizing the nuclear industry, and a poor guarantee for compensation of victims.

Hearings last month before the Joint Committee on Atomic Energy marked the second year in a row that Price-Anderson has been before the Congress. Like last year, the debate is going to be lively.

Congress, in the energy crunched 1970s, is unlikely to kill off the program, despite the efforts of Mr. Nader and other critics, however.

Jitters about just how safe nuclear plants really are were largely responsible for the failure of a five year extension of Price-Anderson last year. The law is due to expire in August, 1977.

Both the Senate and the House approved the extension last year, but with the important condition that it could be cancelled if Congress didn't like the findings of a final report on nuclear accident probabilities.

The Ford administration, which backed the bill, nevertheless found the cancellation clause objectionable and vetoed the measure.

The final version of the accident probability study—known as the Rasmussen report—would go to Congress late this fall before any vote on the current extension proposal.

Its findings are expected to be about the same as the draft report released last year—favorable to the nuclear industry by holding that the probability of a major accident is small and the damages would be less than previously expected.

The damage estimate is important because the $560 million liability limit per plant that is imposed by Price-Anderson has been unchanged since the law was first passed in 1957.

The law currently requires nuclear plant operators to purchase as much private liability insurance as is available. That amount is now $125 million per plant, up from the $60 million per plant that was available in 1957.

The average premium charged to a power reactor for $125 million of liability insurance is about $250,000 subject to the possibility of retrospective premium refunds.

Coverage for the remainder of the liability imposed upon an atomic plant—the $435 million difference between the $125 million of private coverage and the $560 million limit—is provided by a federal indemnity guarantee.

This indemnity arrangement, charged Mr. Nader in testimony before the Joint Committee, amounts to an artifical subsidy for the atomic power industry.

The fee the plant operator pays the federal Nuclear Regulatory Commission for this indemnity is only a small fraction of what private insurance for a similar amount of coverage would be, he said. The fee is based on an assumption that private coverage in that amount would be available.

The NRC, he said, charges an administrative fee of $30 per year for each 1,000 kilowats of thermal energy capacity at a plant.

"Thus, the annual indemnity fee for a 1,000 megawatt reactor would be $90,000," according to Mr. Nader. "The best estimate of costs of the same insurance coverage in the private market would be $258,000 or over $10 million over the lifetime of the reactor."

Part of Mr. Nader's complaint concerning the indemnity portion of Price-Anderson would be solved over time by modifications proposed in the law.

These modifications would impose a retroactive premium on atomic plant operators in the event of a serious accident. The premiums would range from $2 million to $5 million per plant, and would form an extra layer of private insurance on top of the $125 million now offered.

The industry argues that as more plants become operational, the federal indemnity would diminish and eventually disappear. Over time, the $560 million liability limit would float upwards, also thanks to the retroactive premium arrangement.

Mr. Nader's contention that the nuclear industry refuses to take full financial responsibility for its acts is not completely borne out, however.

Hubert H. Nexon, senior vp for Commonwealth Edison, Chicago,



told the joint committee that "a number of major utilities have stated their willingness to build additional nuclear plants even if Price-Anderson were not extended.

Expiration of Price-Anderson would not affect already operating plants or plants for which construction permits are issued by August, 1977. The Price-Anderson liability limits and indemnity arrangement accompany the permit and are generally based on a 40-year period.

Major reactor suppliers may also be willing to stay in the nuclear business without Price-Anderson's protections, according to John W. Simpson, director-officer at Westinghouse Corp.

Mr. Simpson warned, however, that "suppliers of nuclear system components like pumps or valves who have a small economic stake in the nuclear business will probably remain unwilling or reluctant to undertake new projects if their risks are not constrained."

Congress has previously stated that in the event damages exceeded $560 million, it would consider special relief. A massive 1947 blast in Texas City, Tx., is usually cited as the precedent.

Mr. Nader argued that, in the Texas City case, Congress did not vote compensation until 1955. "Although the damages were estimated to be between $80 million and $300 million (in 1947 dollars)," he said, "total government compensation was $21 million (in 1955 dollars)."

Mr. Nader distrusts the risk assessment of the federal government, but strongly backs the role of the private insurance industry in this function.

"Through its premium setting mechanisms or through its refusal to offer insurance for certain enterprises or individuals, the insurance industry signals to society whether or not or at what risk (translated in economic terms into premiums) an enterprise can be conducted," Mr. Nader said.

"It is especially questionable whether government should distort the professional risk assessment function of private industry in an area of as great controversy and hazard as atomic power," he said.

"It is especially questionable whether government should distort the professional risk assessment function of private industry in an area of as great controversy and hazard as atomic power," he said.

Mr. Nader said any nuclear insurance plan should impose:

- full responsibility on those who profit from use of the technology.
- strict liability, with compensation payable first by the federal government, which would then sue those it determined were responsible.
- no statute of limitations on filing of claims (the law now has a 10 year statute of liability) to accommodate latent illnesses. ■

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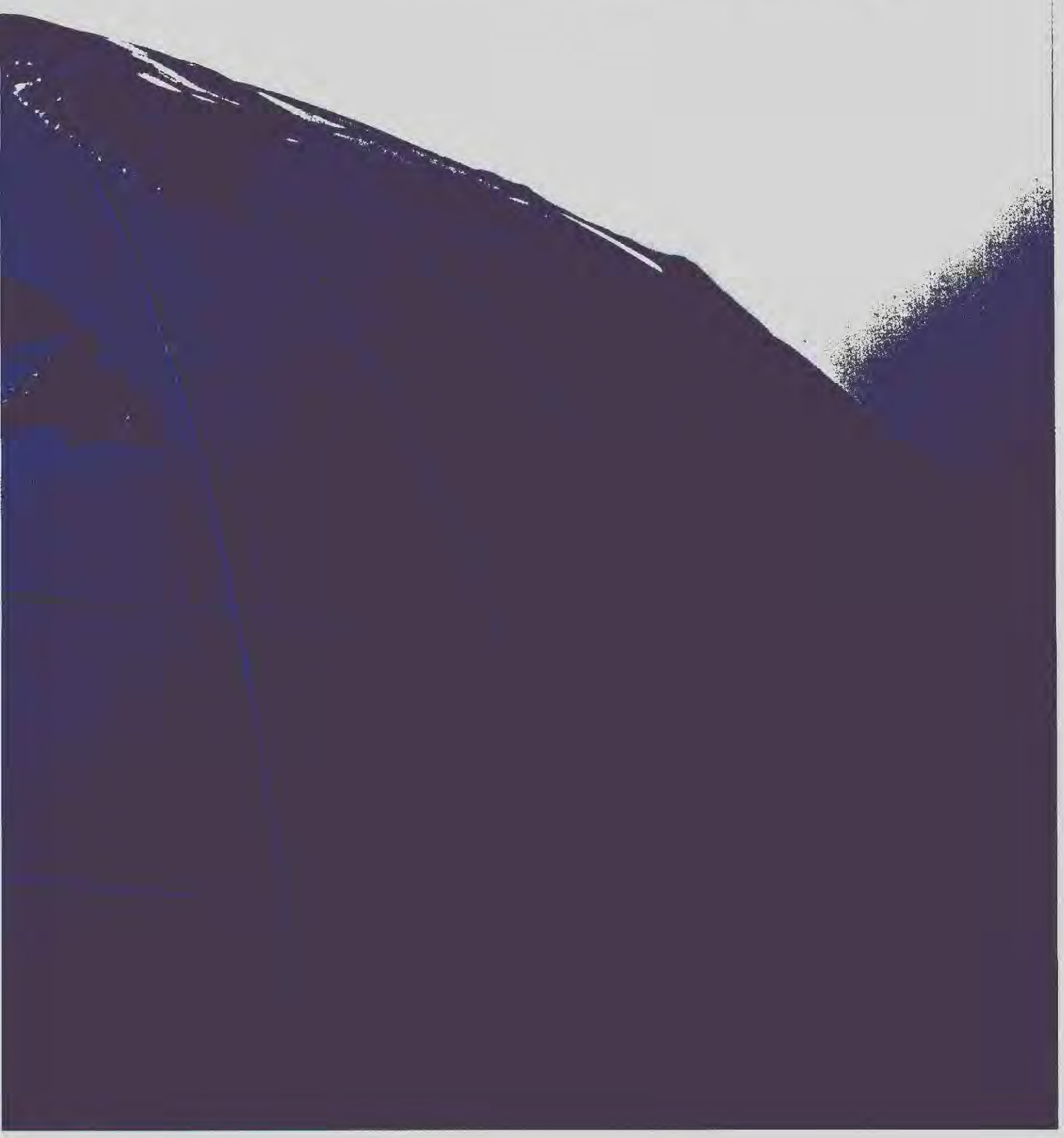
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New benefits go into effect at Caterpillar

PEORIA, IL.—Improved medical benefits, negotiated by the United Auto Workers (UAW) in 1973, went into effect at Caterpillar Tractor Co. as scheduled on October 1, according to Jack Ziegler, manager of employe benefits.

The improvements affected hourly and weekly salaried workers only, but Mr. Ziegler noted that benefits gained for this segment of the workforce through collective bargaining "cannot be ignored" as for their effect on medical benefits for managerial personnel.

Highlights of the expanded benefit program, based on reasonable and customary charges, include:

- Outpatient physical therapy benefits for 60 days of treatment in a hospital, approved nursing home or physical therapy rehabilitation center. One consultation service benefit during a course of treatment is also allowed. The 60-day limit is renewable after 12 months for an unrelated condition or after surgery if physical therapy is needed.
- Durable medical equipment rental for home use if prescribed by a physician. Purchase reimbursment is covered if this cost is anticipated to be equal to or less than rental charges.
- Elective sterilization and abortion for either sex.
- The maximum annual limit for outpatient psychiatric benefits was raised from $400 to $1,000 per person covered. The co-insurance payment was increased from the 55%—85% scale to 90%.
- The maintenance prescription drug list was expanded.
- Routine laboratory services relating to maternity care, excluding tests for pregnancy, are provided. ■

Blues' increase okay

A $27.4 million rate hike was approved for Blue Cross of Greater Philadelphia, effective Oct. 15. Approximately 1.5 million group and non-group subscribers are affected. "Rapidly deteriorating financial condition" was the reason given for the first general increase in three and one half years, according to Pennsylvania's Insurance Commissioner William J. Sheppard.

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'30 and out' is out for federal employes

WASHINGTON—A $3 billion dollar proposal to allow federal and postal employes to retire at any age after 30 years of service was dropped last month after being sharply criticized in debate before the House of Representatives.

While some private and public employe pension plans provide for "30 and out" retirement "this is where those companies or municipal governments cease to be able to compare favorably with the federal government regarding annuity adjustment benefits, disability and vesting requirements," said Rep. Robin L. Beard (R-Tn.) arguing against the proposal.

Rep. Beard said the Republican staff of the House Civil Service Committee surveyed the retirement systems of Baton Rouge, La.; San Diego County, Ca.; Detroit; Los Angeles; Miami, Fl.; the state of Hawaii; Western Electric; and John Deere Tractor Works.

The survey revealed, he said, "that on the question of disability, five of eight employers required 10 to 15 years of service to qualify for disability retirement. The other three employers had no service or one day service requirement for service connected disability and five to 10 years for non-service connected disability.

"The Civil Service system," he said, "requires five years of service."

He said only the Hawaii state plan had a five year vesting rule identical to the Civil Service system and only the city of Los Angeles provided for an annuity adjustment in recognition of the rise in the cost of living.

The cost of the 30 and out proposal would have added $3.4 billion to the unfunded liability of the Civil Service retirement system. That liability is already in the $90 billion range.

The new debt would have been amortized over 30 years in annual payments of $209 million. "However," said Rep. Beard, "the real cost to the government is the amount of money—principal and interest paid over thirty years—which is $6.2 billion."

The 30 and out plan, as proposed, would have required a two percent annuity reduction for each year the employe is under age 55 at the time of retirement.

Proponents argued that, by encouraging early retirements, the 30 and our proposal would create 104,000 new jobs. ■



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Profit sharing council elects

SAN DIEGO—The Profit Sharing Council of America re-elected incumbent officers for a one-year term at the Council's 28th annual conference here.

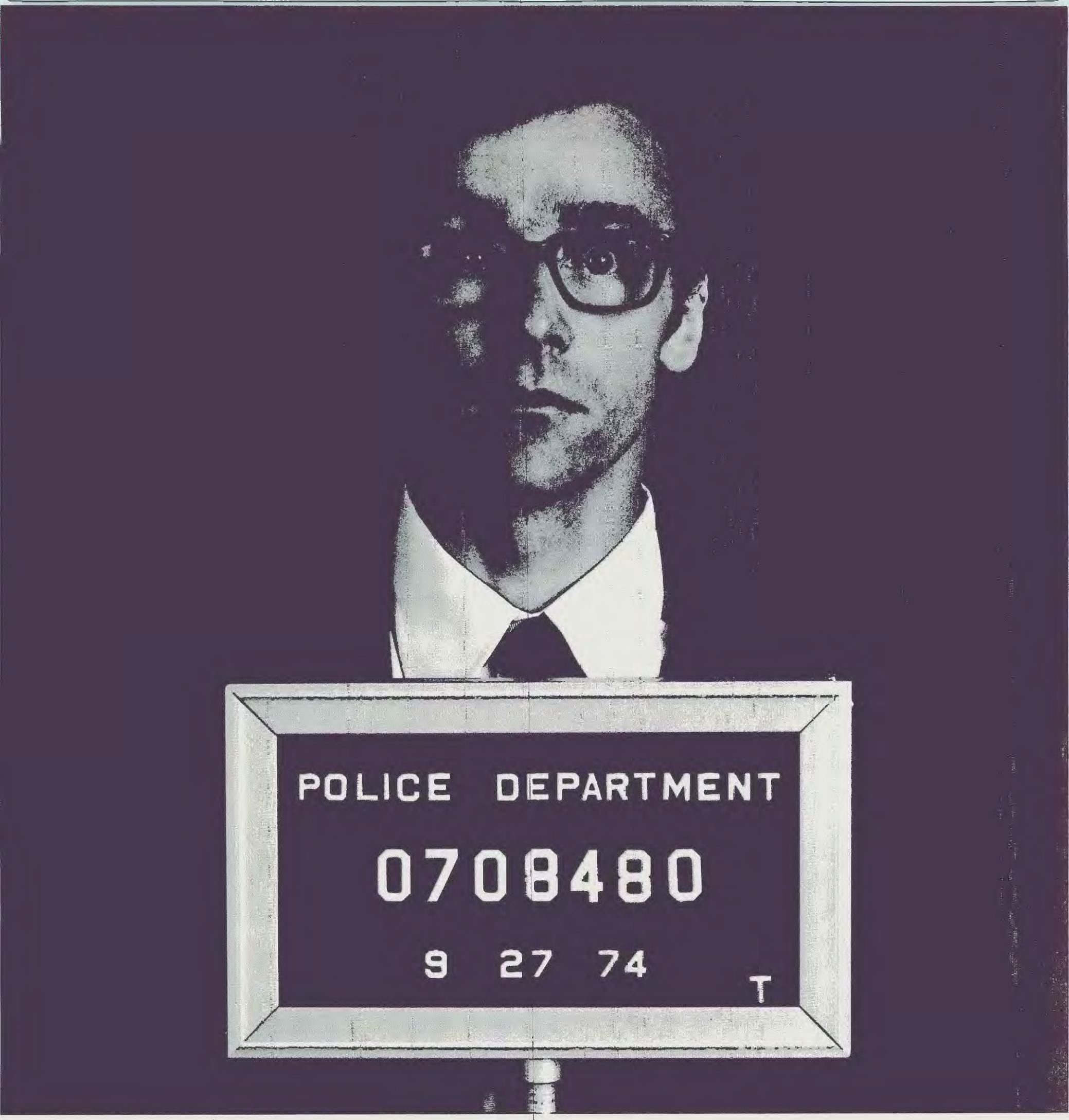
Elected were: chairman, Roger H. Cushman, executive director, profit sharing trust fund, Signode Corp., Glenview, Il.; first vice chairman, William D. Meyer, corporate secretary and profit sharing administrator, Carter Hawley Hale Stores Inc., Los Angeles, Ca.; second vice chairman, Park R. Davidson, assistant vp, Burlington Industries Inc., Greensboro, N.C.; and treasurer, Richard A. Andersen, vp, the First National Bank of Chicago.

The council also elected three new directors and two incumbents to three year terms. They are: Bee McCormack, vp, Bobs Candies Inc., Albany, Georgia; Robert R. Midkiff, president, American Trust Co. of Hawaii Inc., Honolulu; and Roger D. Mulhollen, vp, corporate personnel, S.C. Johnson & Son Inc., Racine, Wis.

Richard F. Fernstrum, president of M. P. Pumps Inc., Detroit and Albon P. Man, vp, Prentice-Hall Inc., Englewood Cliffs, N.J., are the incumbents.

W. O. Strawn, administrator, employes' savings and profit sharing fund, DeKalb AgResearch Inc., DeKalb, Il., was also elected a director.

The Profit Sharing Council of America is a non-profit association with more than 1400 member companies. ■



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editorial opinions

The real reason?

GULF OIL CO.'s decision to withdraw its participation in Oil Insurance Ltd. (OIL), the petroleum industry's mutual insurance company, could hurt the industry's attempts to solve its insurance problems by setting up the Bermuda-based mutual insurer.

One cannot be sure at this point, of course, but the viability of OIL will depend largely on whether Gulf's move will inspire other defections from the pool, or lead nonmember that may have been considering OIL to reconsider.

Gulf, with assets of $12.3 billion, is the mutual's largest participant, and one of the founding companies. It has been participating in the mutual at a much higher level than most OIL members (absorbing a $10 million deductible, while other members have deductibles of either $1 million or $5 million), and kicking premiums of about $1 million into the pool.

While the official word from Gulf on the withdrawal is that the decision was based on "a re-examination of our insurance practices," industry sources say another reason for the Gulf move was that the large oil company was being asked to pull an unfair amount of the weight in the mutual. Premiums paid into OIL are based on losses of all members, then are prorated on the basis of each member's gross assets. The smaller in size a company is the greater the chances its loss proceeds will exceed its premiums, says a source familiar with the operation.

If this is true, then, it would appear that a company like Gulf is being penalized for its size. One would have to assume, too, that a company like Gulf has a far more sophisticated risk management program than some of the smaller participants who pay a lesser share to the risk pie.

OIL, it seems to us, should not slough off the Gulf withdrawal if it wants to continue being a viable alternative to the traditional insurance markets for oil companies. It should probe for the real reasons for the withdrawal and, if discrimination of the sort suggested above exists, take appropriate action.

Purchasing power

IT'S REFRESHING TO SEE a retailer take a firm stand on product safety and quality by reaffirming that responsibility to its customers and by leaning on manufacturers with its purchasing power. As reported in the Oct. 20 issue, Target Stores division of Dayton Hudson Corp. in Minneapolis gave its suppliers an ultimatum: Either sell us merchandise which is safe and has a reasonable life span, or we'll buy elsewhere.

Not only is it good for the consumer but apparently the approach has boosted Target's bottom line in the last three years. Consumers have shown renewed confidence that someone continues to take responsibility after their sale is rung up. Target's president Stephen L. Pistner says that most manufacturers have cooperated by redesigning products reported to be unsafe. Consumers appreciate the chain's policy of giving an immediate refund for a product that isn't up to snuff even though it costs Target $5 or $10 in handling fees. Local media are impressed by the retailer's willingness to stick its neck out for the products it sells, even when this means recalling those it thinks may be unsafe.

What a sharp contrast to the cautious, deliberate, time-consuming approach Sears Roebuck & Co. seems to prefer in investigating "allegedly" inferior products. In several instances brought out at the National Safety Congress meeting in Chicago, Sears cited misuse of its products rather than the quality of the products themselves. Even if the analysis was correct in these cases, it indicates a reluctance on Sears' part to investigate its products. At least that's the impression given by Sears' corporate product safety coordinator George F. Zelazney, who also spoke at the meeting.

The difference is that once is not enough for Sears to act. Once is more than enough for Target.

Encouraging sign

THE FEDERAL investigation into the $1.3 billion Teamsters Union Central States Pension Fund is long overdue, but it's begun nonetheless and that's encouraging.

According to Labor Secretary John Dunlop, the new investigation is being conducted by the Labor Department in coordination with the Justice Department and the Internal Revenue Service. In its preliminary stages, it's reported the investigation will focus on possible violations of the 1974 federal pension act, which restricts the way pension assets may be handled.

There had been some speculation that the enforcement unit of the Labor Department was going soft on the urgency of challenging the pension operations of the fund under provisions of the Employe Retirement Income Security Act because it was reluctant to take on the biggest fish in the pond.

Why take on the toughest case first, it was suggested, if you can establish credibility by going after a smaller plan in the first vigorous attempt to enforce provisions of ERISA? It would be very embarrassing if the department took on the Teamsters and failed to come up with anything.

It would be embarrassing, true, but the likelihood of that occurring seems remote based on the evidence already available to investigators without turning over even one leaf.

Employe benefits

IN THE 14 MONTHS since the passage of ERISA, known to laymen as federal pension reform, employe benefits planners and managers have had to adapt to new forces, including legal pressures, inflation pressures, and the pressure of a cash squeeze in most corporations. Our annual employe benefits issue on December 15 will investigate the impact of these compelling influences on benefits. Topics covered will include disability protection, dental plans, educational benefits, recordkeeping and communications, employe fitness, medical care cost controls, and early retirement incentive plans. And we'll take a special look at multi-employer trusts for benefit funding through insurance via pooled purchase.

letters

Letters are welcome. Address letters to the Editor of Business Insurance, 708 Third Ave., New York, N.Y. 10017.

Fully informed

To the Editor: Thank you for the copy of the September 22 issue of *Business Insurance* on the property and casualty insurance industry.

I feel it is important that those of us in public service remain fully informed in regard to business in general and particularly the area which your publication highlights.

Sen. Howard H. Baker Jr.
Washington, D.C.

Justify presence

To the Editor: If the areas of responsibility outlined in *Business Insurance*, Oct. 6, for corporate insurance management by two Marsh & McLennan employes are accurately depicted, and the premium volume thereunder ("the insurance coverage involving some $3 million in property/casualty premiums, and $5 million in employe benefit premiums") properly delineated, then the 2.5% commission level earned by Marsh & McLennan based on $200,000 payment is money well-spent.

The cost avoidance action eliminating in-house risk management employes is, conversely, money well-unspent.

Given the professionalism of, and services rendered by, a few international brokerages, every insurance and risk manager had best justify his own presence, examine his own credentials and pinpoint his own contributions to his employer before downgrading the Fairchild Camera and Instrument Corp. action.

I could justify my replacement with a competent, full-service insurance brokerage (whether or not personnel from that firm operated from within or without Reliance Electric's corporate headquarters) without hesitation.

Having written this, and painted myself into a corner, I leave the readers to their thoughts.

Robert C. Wellman, Jr.
Corporate manager—General Insurance, Reliance Electric Co., Cleveland, Oh.

Cargo delays

To the Editor: Because of the enormous buying power which the Middle East and other oil-producing nations have acquired in the last several years, they are buying tremendous quantities of industrial, commercial, and consumer goods from the United States.

However, as their ports are usually well behind their aspira-

Continued on page 26

business insurance

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

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And nowadays, the damages of flood are worse than ever. It is estimated that, because of the ravages of inflation, a loss occurring today would cost twice as much as a similar loss of only a few years ago.

That's why more and more business executives are depending on us for protection, through specialty insurance coverages: Difference in Conditions policies, Manufacturers Output policies, Installation floaters, Transportation floaters, or other All-Risk policies under which flood coverage may be purchased.

When Hurricane Eloise roared out of the Caribbean recently, across the gulf coast up into the northeast, it flooded countless U.S. warehouses, offices, and plants.

In the past, flood coverages of this kind have often served to minimize such losses. And, in some cases, they have actually helped companies to survive.

So, if you have financial responsibility for a company, think about it: *Are you ready for next time?*

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Info for Buyers issue

If you have not yet submitted data or literature for publication in Jan. 12, 1976 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, 1975.

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

Please rush me forms and instructions for submitting data for publication in your Jan. 12, 1976 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. 12, 1976. 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 1974 Info for Buyers issue carried over 200 items of information, which pulled an impressive 25,414 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, 1975. Acceptable material for the Info issue include a variety of commercial property and liability categories, as well as employe benefits classifications. ■

letters

Continued from page 24

tions with respect to modern development, a situation of long delays while cargo sits on the ocean vessel has come to the fore. There are certain requirements and restrictions in an ocean marine policy which many risk managers, as well as brokers, do not understand or in many instances do not even know exist.

It is incumbent upon an underwriter to be given written notification when the goods are delayed so that the proper coverages can be arranged and the necessary extensions put into effect. However, I have found that on several occasions when I spoke with an insured and then called an underwriter, I had to explain the coverage to the underwriter, as he had never run into the problem before.

We must remember that on shipments to Lagos, Nigeria, there could be as much as an eight to 10 week delay before the goods are landed.

David J. Bernstein
Assistant vp, and cargo specialist, Bleichroeder, Bing & Co. (Illinois) Inc., Chicago.

Certificates

To the Editor: I have to agree wholeheartedly with Ford Bell's letter in the September issue. Insurance certificates have gotten completely out of hand. There is a definite need for certificates and even copies of policies but these needs should be perfectly obvious even to a novice. Routinely requiring certificates of insurance for vehicle coverage or for workers' compensation, which is a compulsory coverage, seems a little asinine. Even requiring evidence of liability coverage on a routine basis is an insult to a reputable company.

The insurance industry has brought a lot of this on itself by advising their insureds to require such evidences in order to protect loss experience and premium.

B. R. Scott
Insurance manager, The Manitowoc Co., Manitowoc, Wi.

'Light water'

To the Editor: We noted with interest the article by E. Stanford Bell in the August 25 issue of *Business Insurance* magazine in which reference was made to 3M's "Light Water" Aqueous Film Forming Foam (AFFF).

We are delighted that you're aware of our product, and appreciate the reference in the article. However, we would like to point out that "Light Water" is a trademark of 3M Co. and not a generic term. The proper generic reference for products of this type is aqueous film forming foam.

Henry G. Owen
Division Public Relations Service manager, 3M Co.

FAA to get safety help from NASA

WASHINGTON—The Federal Aviation Administration has hired another federal agency—the National Aeronautics and Space Administration—to help improve the reporting of unsafe flight conditions or practices.

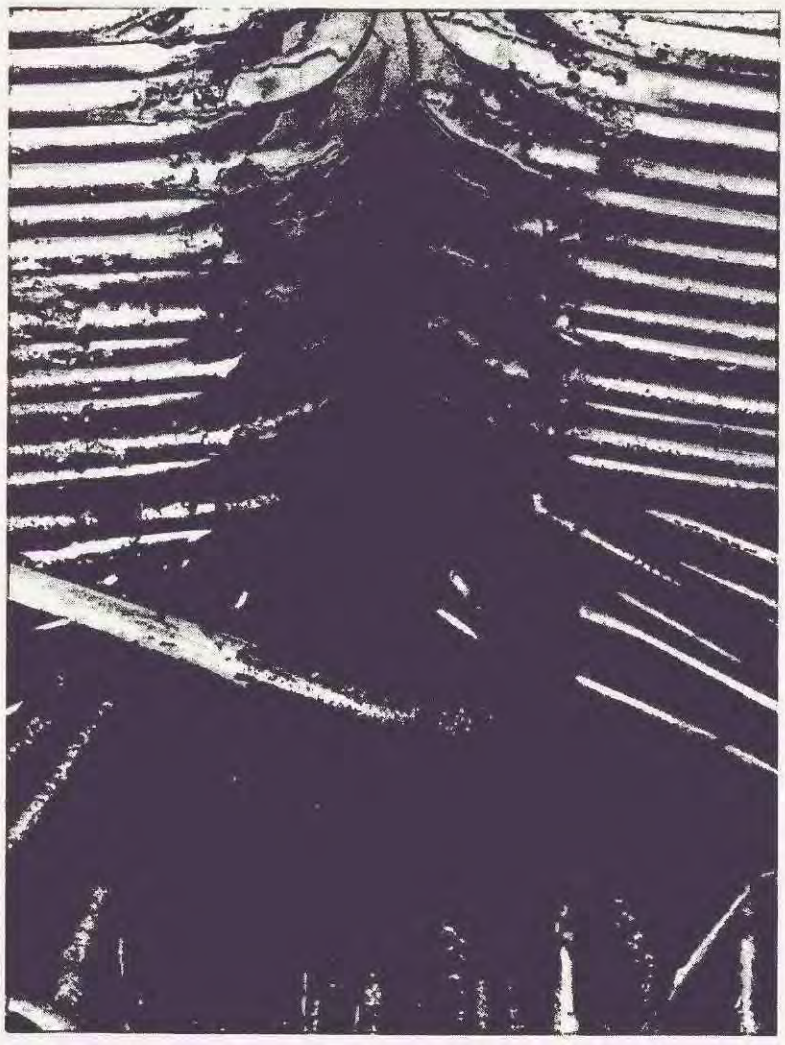
NASA will act as a "third party" for the purpose of receiving, processing and analyzing reports of unsafe conditions or practices.

FAA administrator James E. Dow said the "third party arrangement should assure everyone that the FAA's only objective in this program is to provide the safest possible aviation system by identifying and correcting unsafe conditions before they lead to accidents. It should therefore further stimulate the free and unrestricted flow of information."

The agreement contains specific procedures to provide for the protection of the identity of persons involved in reports submitted to NASA, except in those cases involving alleged criminal conduct or accidents.

A NASA Advisory Council on safety matters will include aviation and consumer groups and others involved in the operational aspects of the national avaiation system. The FAA did not specify if airline risk managers or aviation hull insurance underwriters would participate on the NASA council. ■

$70,000 DOWN THE TUBES.



When a simple, unobtrusive, water control valve on a plant boiler fails to function, a lot of money can go down the tubes. If you're a risk manager or other executive responsible for loss prevention and asset conservation, you should be aware of how seemingly minor accidents like this can cause major losses.

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WHEN THE WATER LEVEL DROPPED, THE COMPANY DROPPED $70,000. The control operated valve in the make-up water line serving this boiler stuck in the closed position, and the water level immediately began to drop. Two low-water fuel cutoffs failed to function, and the boiler was destroyed by overheating. Many of the boiler tubes actually melted down into the water wall headers. Regular testing of controls could have prevented this loss.

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Five-year-old firm sees 'important need' for risk management dept.

By LINDA MOSKOWITZ

GREENWICH, CT.—After three years of "explosive growth," as one vp terms the development of Beker Industries Corp., a sophisticated risk management program is now being coordinated through Beker's newly-created risk management department.

Alex E. Carrozelli, the company's risk and insurance manager, reports that before his appointment in May, the insurance program was handled primarily through the treasurer's department. The company was formed in 1971.

"It became apparent that there was an important and serious need for development of a risk manager program," he said.

The goals of this department, as Mr. Carrozelli defines them, are to develop adequate loss prevention safety programs, to take a close, hard look at the exposures to risk, and to plan a long range program of risk management.

For the past several months, Mr. Carrozelli and those working with him have been conducting an in-depth study of the total operations of the firm "in conjunction with various insurance representatives and markets."

On a separate basis, another study was begun several months ago to determine "how to direct the program," he said. The study should be finished by yearend.

In order to gain an appreciation of the risks he is responsible for, Mr. Carrozelli spent a good deal of his first months at Beker touring the companies domestic plants and facilities.

The manufacturer of chemical fertilizers, based here, has plants in Louisiana, Illinois, Idaho and New Mexico. Another is located in Ontario, Canada.

A new phosphate mining operation is under construction in Florida and several overseas plants, in Brazil, Italy and West Germany are in the early stages of planning and construction. A sales office is located in Singapore.

Beker's products, which include di-ammonia phosphate (DAP), triple sulfuric phosphate (TSP), and anhydrous ammonia, are sold to domestic and international wholesalers and distributors.

The most recent coverage purchased by Mr. Carrozelli for Beker is a $5 million fiduciary liability policy from National Union Insurance Co. With the importance of obtaining fiduciary liability insurance still a matter of debate in some risk management circles, Mr. Carrozelli agrees it is "a gray area." He compares questions surrounding the need for the coverage to these surrounding directors' and officers' liability coverage several years ago.

"Based on what is recommended by counsel, actuaries and public accountants, I would say right now it is certainly best to buy it," he said, "until we have a better interpretation of what the federal government intends."

The firm, in addition, is "actively obtaining proposals" on directors' an dofficers' liability coverage, according to Mr. Carrozelli.

Property is insured by Beker with Arkwright-Boston Manufacturers Mutual Insurance Co. The $378 million policy includes a difference-in-conditions clauses, business interruption insurance, all-risk builders coverage for the construction sites and a tentative arrangement for boiler and machinery coverage.

Casualty coverage is under study, according to Mr. Carrozelli, and will most likely be changing soon. Presently there are several contracts with different insurers.

"The most esential area where emphasis has to be placed right now is our property/casualty loss prevention program" said Mr. Carrozelli, "in spite of the fact that we are currently developing a revised coverage/cost program."

Two brokers are "essentially used," Mr. Carrozelli said. These are Johnson & Higgins, which also handles the international accounts, and Franco & Son Inc. of New York.

The risk management program is actually a three-faceted operation at Beker. Along with Mr. Carrozelli's department, there are the director of employe relations and a director of safety.

The insured group benefits at the company include primary and major medical, travel/accident, short and long term disability, group life, and accidental death and dismemberment.

Metropolitan Life is the carrier for the medical and life insurance. Connecticut General handles other benefits.

The safety program at Beker is precently in the process of being consolidated and expanded.

Ed Drill, the new director of safety is, according to Mr. Carrozelli, "actively developing and administering a safety and environmental program within the overall concepts of risk management and safety.

"Plant industrial managers are also actively developing programs along the same lines," Mr. Carrozelli continued.

Further centralization of procedures and claims reporting among the various plants is one of the chief aims of all the risk management programs at Beker. ■

No settlement in Anaconda OPIC dispute

NEW YORK—A stalemate was reached in attempts to settle Anaconda Co.'s $154 million claim against the Overseas Private Investment Corp. (OPIC) for mining properties expropriated by the Chilean government in 1972 (*Business Insurance* Aug. 19, 1974).

Both Anaconda and OPIC asked the American Arbitration Assn. to set aside a decision reached in July which held OPIC liable for the claims but did not award a monetary amount.

OPIC charges Anaconda with impropriety in the affiliation of a member of the three-man arbitration team who six weeks after the decision was announced joined a law firm retained by Anaconda last winter to help prepare its case.

The negotiator maintains that he had no knowledge of the law firm's association with Anaconda until after he became counsel to it. Anaconda stated that the law firm in question was retained to prepare an affidavit about foreign law, not ultimately used in presentaton of the case. ■

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legal brief

Loss not covered by banker's bond because moral turpitude not involved

THE COURT OF APPEALS of Maryland has ruled that a bank officer's acts done in actual good faith and without intentional fault were neither dishonest, fraudulent or criminal within the meaning of banker's blanket bond. The court arrived at this conclusion even though it found that the acts in question constituted a breach of obligation by the officer whose fidelity was insured under the bond.

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

The First National Bank of Southern Maryland (First) brought this action against United States Fidelity and Guaranty Co. (USF & G) on a banker's bond issued by USF & G. The bond provided for coverage against any loss through any "dishonest, fraudulent or criminal act of any of the employes. . ." First sought to recover approximately $44,000 representing losses and attorney's fees it incurred allegedly as the result of the acts of G. Robert Sellner, an assistant vp and general manager of a First branch. The losses arose out of Sellner's handling of an account of a borrower from First, Continental Electronics Inc.

Sellner had been assigned to manage the loan account under the direct supervision of First's president and board chairman who was also a close friend of Continental's president. Sellner was instructed to adhere to certain specific mandates with respect to the loans of Continental and complied with all of them. Sellner was also placed on Continental's board of directors in order to obtain the "scrutiny clearance" which was necessary for the government contract in which Continental was engaged.

Continental's first loan from First was reduced to a "zero balance." However, additional capital was needed and this led to a series of additional loans from First without any further approbation from First's board. These notes were not discharged. The national bank examiners directed First to "charge off" the line of credit totalling nearly $100,000 as a bad debt. This amount was reduced to a total of $28,587 plus attorney's fees after First sold Continental's inventory and recovered judgments against principals and endorsers of the notes. The trial court found in favor of USF & G.

On appeal First's primary contention was that Sellner concealed and misrepresented the poor financial status of Continental and that such action constituted a "dishonest and fraudulent" act under the bond. The court noted that the discount committee of First's board was apprised weekly of Continental's financial status and that Sellner also submitted monthly reports concerning all loan accounts at the branch.

In addition, the court pointed out that other auditing procedures were undertaken, all of which disproved Sellner's alleged concealment and misrepresentation. The court concluded that Sellner's acts did not fall within the coverage of the bond because under its terms the insurer was not liable for a loss occasioned by "mere negligence, carelessness, inattention to business, mistake, errors in judgment, incompetency, or other acts and omissions not denoting conscous wrongdoing or involving moral turpitude." *First Nat. Bk. of So. Md.* v. *United States Fid. & G. Co.*, Court of Appeals of Maryland, June 30, 1975, O'Donnell, J. 340 A.2d 275 (BI/01/0.-$3)

All risk policy

A New York appellate court has upheld an insurance company's liability under an all risk insurance policy for damages to an apartment building incurred when water entered the basement of the building after a break in a water main. The court ruled that the water damage did not fall within the policy's exclusions for floods, sewer back-up or water below the surface of the ground.

The owners of the building sought to recover $54,000 from Security Mutual Insurance Co. of New York (Security) under an all risk policy, when water from a broken water main entered their rear yard and basement. Security refused to pay, contending that the loss fell within policy exclusions for loss resulting from flood, sewer back-up or below surface waters. The owners brought this action alleging breach of contract.

In holding that the water damage did not fall within the policy exclusions, the court pointed out that "given its ordinary meaning, the term 'flood' in the context of the insurance agreement, does not encompass water damage sustained as a result of a broken water main. It connotes an innundation; a deluge."

Furthermore, the court believed that the word "flood" as used in the exclusionary clause related to "natural phenomena." The court concluded that the evidence also demonstrated that the water damage did not occur because of water back-up through the sewer or drains "independent" of the water main break.

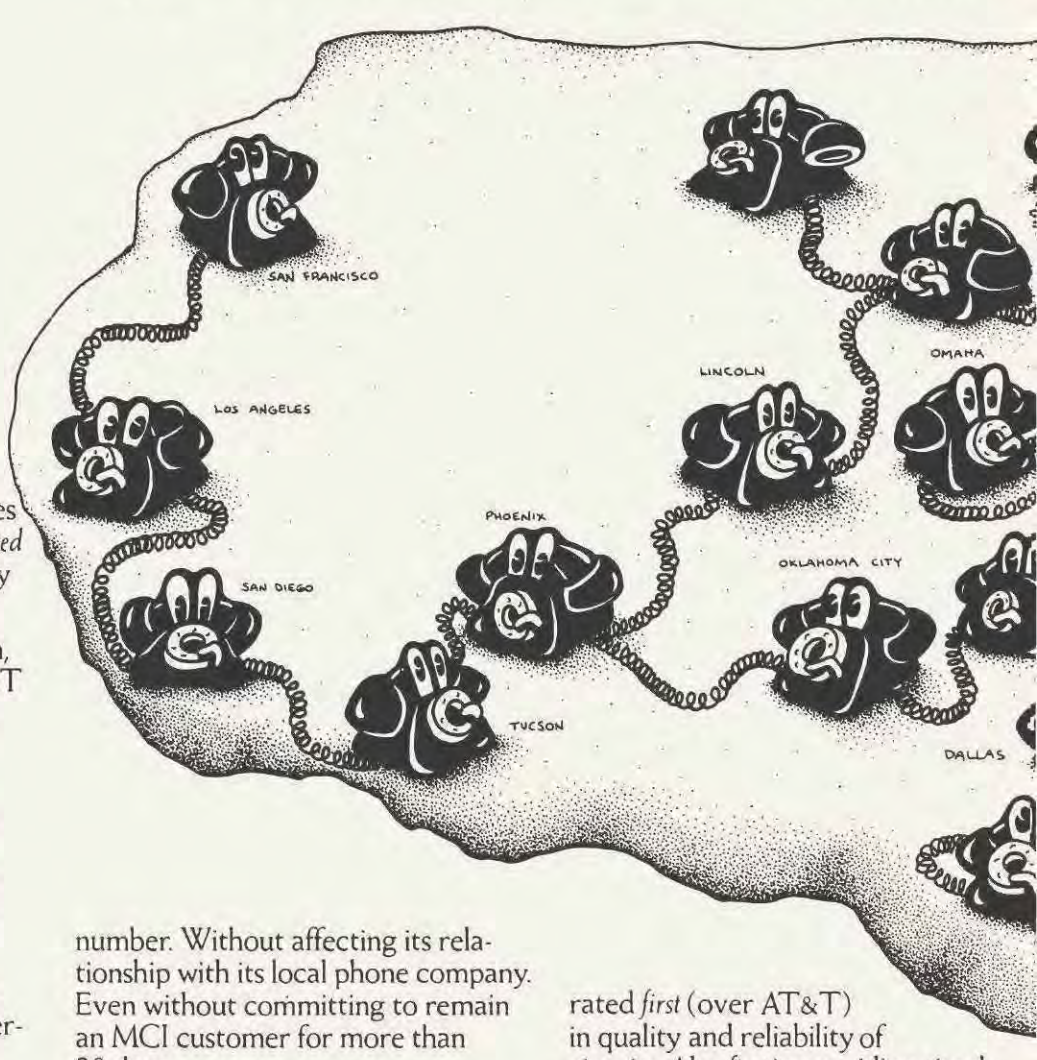
Finally, the court decided that Security had not established that the bulding owners had willfully and grossly exaggerated the amount of damages so as to vitiate the insurance contract. Thus, the court held that Security was liable under the policy. However, it returned the case to the trial court for an assessment of the actual damages. *Popkin* v. *Security Mut. Ins. Co. of New York*, Supreme Court of New York, Appellate Division, May 13, 1975, 367 N.Y.S.2d 492 (BI/01/0.-$2)

Workers' compensation

Is an employe entitled to re-

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An East Coast shipping company making more and more long-distance calls to five major port cities discovers a new way to make *unlimited* calls to those cities for a flat monthly fee. Their savings: $10,000 a year.

A "Fortune 500" retailing firm, using an interstate network of AT&T tie-lines replaces 171 of those lines, saving $190,000 a year.

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These companies (actual case histories) have all discovered a lower-priced alternative to AT&T long-distance phone service—MCI.

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cover workers' compensation benefits for injuries sustained while enroute to an appointment for medical treatment for an industrial injury previously incurred? In a case of first impression, a California appellate court ruled in favor of the employe even though the journey had not started at the employe's place of employment.

Oscar Laines received injuries to his left knee in two separate accidents occurring in June 1973, while in the course of his employment with Mack Truck Inc. His employer directed him to seek medical treatment at the Levine Medical Center. On July 20, 1973, while enroute from his attorney's office to the medical center to keep an appointment for a medical examination in connection with his earlier injury, Laines was injured again when his motorcycle was hit by a truck.

Laines sought workers' compensation for all three injuries. A referee decided that Laines' July injury did not arise out of and in the course of his employment but was a "compensable consequence" of his earlier injuries and thus awarded him temporary disability. However, a Workers' Compensation Appeals Board reversed this ruling and denied Laines any recovery for the July injuries.

Laines contended that his July injuries were compensable under workers' compensation because he was required to visit the examining physician under the labor code. The court believed that where, as in California, a visit to a doctor is based on a statutory obligation of the employer to furnish medical treatment and of the employe to submit to medical examination and nondangerous treatment, then "an injury sustained in the course of such visit should be held to be an injury arising out of and in the course of employment" within the meaning of the workers' compensation code.

Consequently the court held that the June industrial injury suffered by Laines was a proximate cause of his July accident injury and was compensable under the law. *Laines* v. *Workmen's Appeals Board,* California Court of Appeal, First District, June 5, 1975, 122 Cal.Rptr. 139 (BI/02/0.-$2).

Loss of goods

Here an action was brought against a trucking company's insurer to recover the full amount of a judgment rendered against the trucking company for the loss of goods in transit. The policy issued by Liberty Mutual Insurance Co. to the trucking company provided that "all shipments for which the insured's legal liability is insured hereunder are by agreement valued at the amount of invoice or if not under invoice then at cash market value on date and place of shipment."

A New York appellate court ruled that the policy was unambiguous and that Liberty Mutual was not required to pay the full amount of the judgment obtained by the plaintiff, Bache & Co. Inc., against the trucking company for the loss of goods in transit. Rather, the court concluded that Liberty Mutual was only required to pay such amount as was attributable to the invoice value of the merchandise, plus costs and interest.

Thus the court affirmed a modification of a trial court's judgment of $50,055 in favor of Bache & Co., against the trucking company to $24,171, the damages reflecting the amount of invoiced merchandise less $1,000 deductible. The court emphasized that under the terms of the policy here, the amount of the invoice less the $1,000 deductible, set the limit of Liberty Mutual's liability. *Bache & Co. Inc.* v. *Liberty Mut. Ins. Co.,* Supreme Court of New York, Appellate Division, April 22, 1975, 367 N.Y.S.2d 11 (BI/04/0.-$2)

Burglary loss

In this action an operator of a fertilizer plant brought suit to recover for a burglary loss under two separate insurance policies. The insurance policies' definition of "burglary" required the exterior of the premises to bear visible marks of force and violence. Here only an interior door of the insured's warehouse was damaged during the burglary.

Nevertheless, the Supreme court of Iowa ruled that the insured could recover for its loss (1) under the doctrine of reasonable expectations, (2) on a theory of breach of implied warranty, and (3) because the liability-avoiding provision in the definition was, in the circumstances of the case, unconscionable.

The court pointed out that under the doctrine of reasonable expectations the insured could have recovered for the burglary loss since the most the insured might have legally anticipated was a policy requirement of visual evidence indicating the burglary was an "outside" rather than an "inside" job.

Also the court emphasized that the insured could recover for its loss on the theory that the insurer breached an implied warranty that the policy, delivered subsequent to negotiations, would be reasonably fit for its intended purpose: to set out in writing the obligation of the parties without altering or impairing the fair meaning of the protection bargained for when read alone.

In striking the liability-avoiding provision as unconscionable, the court pointed out that the policies here contained "a classic example of that proverbial fine print" (six point type as compared with the twenty-four point type appearing on the face of the policies: "BROAD FORM STOREKEEPERS POLICY" and "MERCANTILE BURGLARY AND ROBBERY POLICY") which "becomes visible only after the event." Such print, the court observed, is additionally suspect when, instead of appearing logically in the "exclusions" of the policies, it "poses as a part of an esoteric definition of burglary." *C & J Fert. Inc.* v. *Allied Mut. Ins. Co.,* Suprem Court of Iowa, March 19, 1975, 227 N.W.2d 169 (BI/05/0.-$2) ■

(Copies of the entire decisions described in this column may be obtained by writing to* Business Insurance, *attn. Managing Editor, 740 N. Rush St., Chicago, Il. 60611. Please enclose a $2 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.)

Termination notices

The Pension Benefit Guaranty Corp. (PBGC) has received 4,999 notices of terminations for defined benefit pension plans as of Oct. 22, according to an official. The agency, set up to reinsure private pension benefits, has accepted such notices from plans which terminated on or after July 1, 1974.

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Safety and good management go hand in hand

CHICAGO—A good safety performance reflects good overall management and a poor accident record is indicative of poor or slipping management, declared M. H. Collett, president of Olinkraft Co., at the National Safety Congress here.

Mr. Collett says this was his conclusion when managers at the forest-products company were implementing tough safety programs to reduce the rising accident rate. Safety programs were initiated in several plants in 1958 and after two or three years managers at Olinkraft began to see that the projects "paid substantial dividends in reduced compensation payments and workers' compensation insurance premiums."

The programs also resulted in increased productivity and a reduction in wasted materials, as accident rates declined, said Mr. Collett. Olinkraft has an award-winning safety record, having won the Arthur Hoyt Scott trophy four times in eight years and seven Paper Industry Management Assn. awards in eight years.

The company has sustained a stunning accident record of a low 1.30 frequency rate over 10 years.

Olinkraft, said Mr. Collett, has better bargaining relationships with its unions because of the emphasis on a goal of zero accidents. Mr. Collett acknowledges that the company knows it can't eliminate all accidents in its hazardous fields (logging being one), but believes "only in striving toward a goal of preventing the first accident can we make our woods, plants and transport safe places of work."

A key problem which Olinkraft is alerted to is the multiple occurrence phenomenon of industrial accidents. "We have found a high incidence of second and third accidents following hard on the heels of the first accident that occurs following a long period of no lost-time accidents," said Mr. Collett.

All safety activities are intensified once an accident has occurred, he said in an attempt to prevent the multiple-accidents "that ruined our safety performance in the 1950s, and occasionally does so even today," said Mr. Collett.

Several years ago, Olinkraft "realized the value of self-insurance in workers' compensation, as opposed to an insurance carrier," he told his audience. "This has provided an effective tool as we can more readily use accident costs in detecting trends within a department and highlighting the supervisors' operating costs relating to industrial expenses in a positive manner," he said.

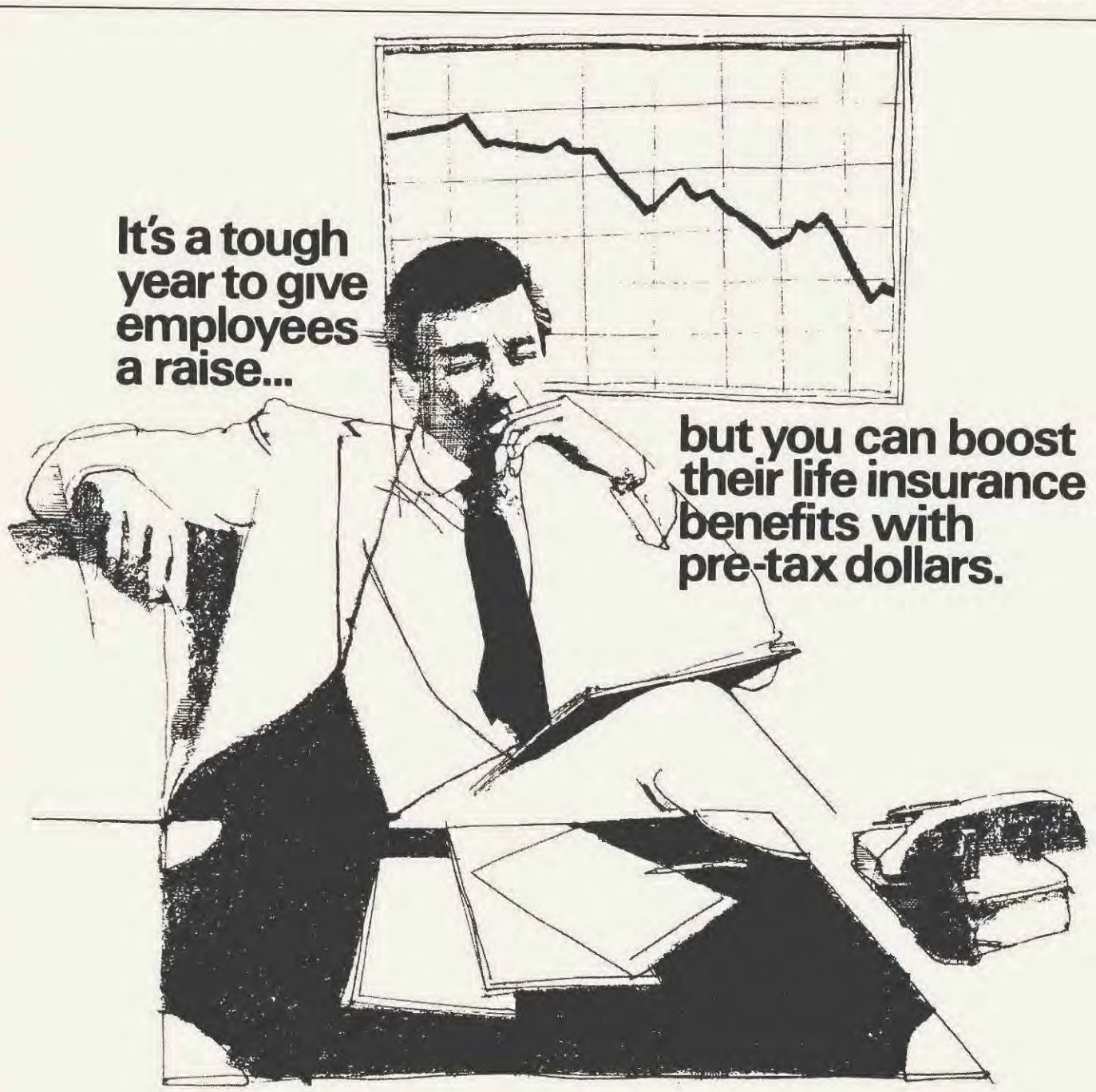
The company also uses safety promotional programs that keep employes working safely, and provides safety scholarships to sustain employe interest. The scholarship plan provides $2,000 for one million man-hours worked without an accident, to children of employes. In 10 years, Olinkraft has awarded 65 grants for a total cost of $75,000, Mr. Collett noted.

He illustrated the effectiveness of Olinkraft's efforts by citing the case of Wood-Mosaic Corp. of Louisville, acquired in 1969 by Olinkraft. Wood-Mosaic then had an accident frequency rate of 44.1, in two sawmills, three veneer plants and a flooring plant with 444 employes in three locations. The annual frequency has dropped below 1%, said Mr. Collett, since installing a self-insurance program at Wood-Mosaic along with other safety plans.

"Not until last year (1974) did we consider that we had full personal commitment from all Wood-Mosaic managers to our safety programs," so that it was operating effectively, said Mr. Collett.

The installation of a self-insurance program at Wood-Mosaic in the last quarter of 1973 has been a major contributing factor to the dramatic improvement in accident frequency in that division," he declared. "Prior to our self-insurance program our annual accident frequency averaged 20% for a three year period, and since we have been self-insured the annual frequncy has dropped below 1%," he said.

Particularly valuable about self-insurance, said Mr. Collett, is the ability to provide cost figures on industrial accidents on a current basis to each of the company's managers and supervisors. ■



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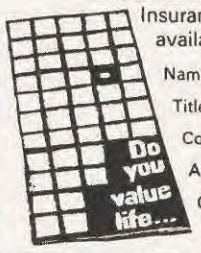
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Need outside loss services for hospitals

OTTAWA, ON.—A Canadian broker said there is a need for an "outside" loss prevention service for hospitals and physicians "whose activities receive strong disciplinary support" to avoid a malpractice insurance crisis in Canada.

Noting that Canada has relatively few malpractice suits in comparison with the U.S., F. Peter Kendrick, senior vp and head of the Toronto office of Marsh & McLennan Ltd., said that techniques of patient handling and safety have lagged behind medical and surgical practices.

"As a result many malpractice actions are the direct result of carelessness and are not directly based on alleged medical errors," Mr. Kendrick pointed out to a symposium called by the Canadian Hospital Assn. here.

He criticized the insurance industry in the U.S. and Canada for an "unrealistic" approach to medical malpractice insurance. "The industry has made altogether too many assumptions about loss prevention and safe practices . . . and has not initiated steps to minimize claims and counter claims, nor has it actively sought the cooperation of hospitals, doctors and lawyers" said Mr. Kendrick.

Mr. Kendrick also blamed contingency fees for lawyers as giving rise to needless and costly litigation and threats thereof.

He expressed serious doubts about proposals for no-fault malpractice insurance "after seeing the principle at work in automobile insurance." ■

CPCU seminar, Chicago

The Chicago chapter of CPCU will hold a two-part seminar in conjunction with its 1975 annual conferment luncheon Nov. 18, discussing in depth the latest revisions in the Illinois Workers' Compensation Act. Subjects to be discussed include administration, claims handling, litigation and self-insured workers' compensation programs.

Medical malpractice to remain "hot" as long as premiums stay high

CHICAGO—An anesthesiologist predicted the medical malpractice crisis will stay "hot" as long as premiums for certain medical specialists remain high. He also predicted the U.S. would have national health insurance by 1980.

"Work stoppage and union action" among physicians could intensify if premiums for malpractice coverage remain excessive, according to J. Gerard Converse, M.D., of Florida. He spoke at a press conference following a session on medical malpractice sponsored by the American Society of Anesthesiologists, (ASA) at their annual meeting here.

"It may take three years of watching and waiting but I hope it won't take that long to solve the problem," Dr. Converse said. He is chairman of the ASA's committee on professional liability.

On the subject of national health insurance, Dr. Converse said he would like to see the demand for it subside but noted that "you can't turn around social change."

"The problem of availability of malpractice insurance isn't as bad as it used to be," said Warren P. Cooper, vp and actuary for Chubb & Son Inc., another panelist.

"The dollars that are needed by insurance companies must be there to settle for injuries. If there is a change in the amount of dollars, there must be a change in the mechanism (of rate computation)," he added.

Mr. Cooper said that malpractice underwriters view corporate staff physicians as having the "same amount of risk" as their colleagues in comparable specialties in private practice. "The loyalty question—is the doctor loyal to the patient or to the corporation—has producted some cases," he added, indicating there are risks unique to this side of medicine.

Anesthesiologists are "frequently" brought in as co-defendants in malpractice suits because they're involved in the entire surgery procedure, Dr. Converse explained. "Instant death in the operating room is, regretably, often blamed on the anesthesiologist."

The doctor/patient relationship is a "very important aspect of the malpractice problem," Dr. Converse continued. "The nature of an anesthesiologist's practice—having patients referred to them by other doctors—means they don't have time to get to know their patients well," Dr. Converse pointed out.

It's important for hospitals to give patients "a greater opportunity to air their grievances even while they're in the hospital,' observed Michael Scott, an attorney with the Washington firm of Cox, Langford & Brown, and the ASA's counsel there.

Dr. Converse believes that there are "accomplishments rather than solutions" in the malpractice problem. "We need the passage of time to see whether they are in fact solutions."

"Contingency fees for lawyers are a red herring," Dr. Converse believes. He thinks that physician's insurance trusts will provide a subtle form of peer review among doctors. "When you're buying coverage for someone else, you're more careful about who you let in," he said.

Arbitration which is "compulsory and binding saves in defense costs," Mr. Cooper noted. "Without a jury present, general damages would be cut down." He explained that juries often award punitive damages implicitly although technically they may have been instructed to award only general damages.

"Every group has its facile way of blaming someone else," Mr. Scott said.

"I expect to see the Constitutionality of some provisions of some laws limiting malpractice claims tested," said Geoffrey Segar, an attorney with the Indianapolis firm of Ice, Miller, Donadio & Ryan.

Mr. Segar played an integral role in shaping the Indiana law to limit malpractice claims to $500,000 (*Business Insurance*, May 19).

He does not believe the Idaho law, which was ruled unconstitutional in September (*Business Insurance*, Oct. 20), will be a precedent for other states.

"The way it was found unconstitutional may be a hint to other states to insure that their laws will be upheld," he said, explaining that he interprets the Idaho law as limiting only certain types of damages rather than general damages.

"This may be a technicality on which the law eventually is upheld," Mr. Segar suggested. ■

Saves co-worker's life

The National Safety Council awarded its President's Medal to a Nebraska utility employe who saved a fellow worker's life after he received a severe electric shock and burns when a high voltage electrical arc snapped. Rollie S. Gibson, a lineman for Howard Greeley Rural Power District, St. Paul, Nb., acted quickly to give external cardiopulmonary heart massage until John L. Kowalski, also of St. Paul, began breathing again. The award, presented at the 63rd National Safety Congress, Chicago, is given for the "successful resuscitation by approved manual methods from (various) accidental causes that may result in prolonged suspension of natural breathing."



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IRA OFFERS MORE FLEXIBILITY

But watch for some inherent pitfalls

By EDWARD C. KATZ
Employe Benefits Department
Johnson & Higgins, N.Y.

A TOTALLY NEW concept in retirement planning—the individual retirement account—was introduced with the passage of the Employe Retirement Income Security Act of 1974 (ERISA). Although essentially geared to non-participants in the typical tax-favored retirement plan, the implications of IRAs to management are significant. IRAs offer opportunities for flexibility, but it is also important to be aware of the various pitfalls inherent in this new concept. Consider the following situations:

Stan Holloway, an officer of a major industrial corporation, received a firm offer a year ago to join another company. Stan would have moved except that he was vested in over $100,000 of his company's profit sharing plan. This plan requires employes to take a lump sum distribution in cash at termination. Stan felt that his tax bite on the "cash out" would be too great, so he regretfully declined the offer.

Art Williams, vp of industrial relations for a large holding company, has an unusual problem. A number of key technicians are transferred at frequent intervals among various subsidiaries which the company has acquired over the years. Some of the subsidiaries have retirement plans —either pension or profit sharing—but eligibility rules, benefit formulas and rates of contribution vary widely among the plans. For internal reasons, these technicians are on the payroll of the respective subsidiaries and have been concerned for some time about a lack of pension benefits. Art Williams would like to provide uniform retirement benefits for these key technicians.

Karl Dormeyer has been transferred from West Germany to his company's subsidiary in the U.S. Although he has requested the move, Karl finds it a mixed blessing. Since he remains on the foreign company's payroll, he is ineligible to participate in the subsidiary's pension plan, but is nevertheles subject to U.S. income tax on resident earnings.

Paul Jones recently went to another company at age 61. His new employer's pension plan has a maximum eligibility age of 60. Paul accepted the job offer after knowing that he would be unable to participate in his new firm's pension plan.

Joe Green mentioned to his personnel manager that his wife's part-time employment to bolster family income has had a less than desirable effect on their finances. The Greens now find themselves in a higher joint tax bracket. The anticipated saving has not been accomplished.

Beginnng January 1, 1975, all five of these "problems" may be resolved through a device known as an Individual Retirement Account (IRA). A concept developed under recent pension reform legislation, the central objective of IRA is to provide employes with a tax favored means of saving for retirement where they do not participate in an employer-sponsored retirement plan. In creating IRAs, Congress also addressed itself to pension portability, long an issue of interest and debate among retirement planners. As will be seen, IRAs have definite advantages but some disasvantages for both management and employes. The pros and cons will be apparent when the mechanics of IRAs are explored in some detail.

IRAs have been designed basically to give a non-participant in an employer-sponsored retirement plan the opportunity to contribute up to 15% of annual compensation, subject to a current $1,500 yearly maximum contribution. This can then be applied toward personal retirement savings. The contribution is deductible from the individual's gross income for federal income tax purposes, whether or not the taxpayer itemizes deductions. States and municipalities which generally follow federal tax policy may also recognize IRA savings as a deduction from taxable income.

The savings medium may be any domestic trust or custodial account (individual trustees are not generally to be used) which provides for investment in such categories as time deposits, mutual funds, special government retirement bonds, insurance company retirement annuity or

Continued on following page

Several factors slow HMO growth

EMPLOYERS PREFER TO WAIT

By RUTH H. STACK
Director
Twin City Health Care
Development Project

THE FEDERAL HEALTH Maintenance Organization Act, enacted in December of 1973, was heralded by most HMO proponents as a major step forward. It provided formal national recognition to prepaid health care delivery, funds to assist planning, formational and operational HMOs plus a significant marketing advantage in the mandatory dual choice requirements for employers.

However, enthusasm for the act has waned substantially in the last 18 months. Some of the requirements placed on federally qualified HMOs will make it difficult for them to compete with traditional indemnity plans even with federal grants and loans. In addition, delays in drafting administrative regulations have postponed the marketing advantage afforded qualified HMOs—mandatory dual choice requirements for employers.

The effect on HMO enrollments has been particularly disturbing. The depressed state of the economy has received some blame for the slow enrollment growth of the past several months, but many of the enrollment problems have been attributed to the Federal HMO Act. Many companies that were considering an HMO option curtailed further action until the HMO Act took effect. This "wait and see" attitude was illustrated in the results of a survey of the Fortune 500 companes conducted by the Twin City Health Care Development Project. About 73% of the respondents indicated that their company will take no further action on HMOs until final regulations are published. This is unfortunate since the record of HMOs has been good and should motivate increased interest in prepaid health care delivery

Twenty large companies in metropolitan Minneapolis/St. Paul displayed an early interest in HMOs and jointly funded efforts to stimulate the development of prepaid health care delivery. Their continued support is based on the apparent ability of HMOs to provide comprehensive care at a bargin rate. Like these businesses, HMOs are concerned about keeping production costs down while trying to make their products more attractive to their customers.

Several of the companies that sponsored the Twin City Health Care Development Project have offered the HMO option and rate it highly. In all of the companies the employes express satisfaction, and in two companies over 40% of eligible employes have selected the HMO option. Further, employe surveys emphasize the acceptance of prepaid plans. Over 94% of the employes of one company rated the plan good or excellent with 97% electing to continue with the plan. At another company, only three employes out of the 844 that chose the HMO option elected to leave after a year of enrollment—and only one did so because of dissatisfaction with the plan.

Besides a high level of employe satisfaction, all of the companies report that their administrative problems have been limited, and well below their expectations. In fact, one company that planned to hire an individual to process indemnity claims found it unnecessary because of the sharp drop in claims that followed offering the HMO option. More importantly, increases in the costs of HMOs last year averaged between 10% and 15%—well below the 20% to 30% average increase in indemnity plan costs. Therefore, the companies that offered the HMO option see the short-run cost savings of HMOs exerting downward pressures on overall health costs in the long-run.

The recent reluctance of employers to offer an HMO option may reflect apprehension beyond the confusion spawned by pending federal requirements. Offering an option requires not only a review of a reimbursement mechanism as is required for indemnity insurance, but also involves an appraisal of a healthy delivery organiztion—the place where employes and their families will receive health care services.

Continued on following page

business insurance PERSPECTIVE

IRAs . . .

Continued from preceding page

retirement endowment policies (except that no portion of the premium attributable to life insurance protection is deductible), and common trust funds. However, IRA assets may not be commingled with non-IRA assets. As in a corporate or Keogh retirement plan, investment income, including interest, dividends and realized captal gains, is sheltered from income tax during the accumulation period.

Until IRA evolved, receipt of a lump sum distribution from a tax qualified retirement plan would always create a taxable event. Up to 1970 this could well have been regarded as a "blessed event"—since lump sum distributions within a single taxable year were then treated as long-term capital gains and were taxable at the lesser of one-half the distributee's regular bracket or 25%. With the substantial stock market appreciation during the 1960's, this was truly the era of the "profit-sharing millionaire".

The Tax Reform Act of 1969 limited long-term capital gains tax to that portion of the lump sum distribution attributable to employer contributions made prior to 1970 plus all investment earnings without regard to the year earned. That portion of the distribution attributable to employer contributions after 1969 was taxed at ordinary income rates, subject to a seven-year forward averaging device. Despite two sets of proposed regulations under the 1969 Act, the technical aspects of determining the proper tax liability resulting from a lump sum distribution were highly complicated.

In 1974, ERISA completely overhauled the lump sum distribution tax picture. Briefly, under ERISA, long term capital gains treatment is accorded that portion of a distribution based on pre-1974 plan participation. The remainder receives ordinary income tax treatment subject to a ten-year forward averaging device, if the distributee was a participant for at least five years.

The important distinction is that the investment element of the distribution no longer enjoys favored capital gains status as it did under the 1969 Act. Under ERISA, as time passes, an increasingly larger portion of the proceeds will be denied capital gains tax treatment; and this favored tax treatment will be entirely phased out for future generations of retirees. It will be offset to an extent by the 10 year forward averaging rule.

Here is where the IRA's second raison d'être applies. Earlier, Stan Holloway was mentioned as the key executive reluctant to leave his company because he would receive a substantial profit sharing plan distribution with attendant tax consequences. Now, Holloway may postpone "making peace" with the tax collector by transferring his distribution into an IRA within 60 days after receipt. This "rollover" from a qualified plan into an IRA may not occur more frequently than once every three years.

Except for the less than familiar tax deferred annuities for employes of charitable organizations and public school systems, IRAs now represent the sole vehicle which permits a typical employer to discriminate in his funding of tax favored pension benefits. This may seem a ninsignificant advantage considering the limited deduction available and the severe restrictions on form and time of distribution, which will be discussed later.

This de minimis benefit is further underscored since ERISA did not sweep IRAs under the automatic cost-of-living escalator provision which allows increases in the limitations on contributions and benefits under Title II and insured benefits under Title IV for other tax qualified plans. However, a glance back at pension benefits for self-employed individuals (Keogh plans) will show that a little over ten years ago the maximum annual deduction was a paltry $1,250, or half of the allowable contribution. For tax years after 1973, self-employed individuals may make deductible contributions up to six times as much. If history repeats itself in this area, IRAs may become more than incidental.

But IRAs do have some disadvantages for the participant. Contributions in excess of the statutory limits (15% of compensation subject to a yearly maximum of $1,500) are subject to a six per cent non-deductible excise tax, unless they are "backed-out" before the due date of the participant's tax return. This means for example, that where an individual has made a contribution to an IRA during a particular year, and is later covered under an employer-sponsored retirement plan in the same year, the contribution plus any earnings must be withdrawn. Where these excess contributions remain in the Individual Retirement Account and are not carried over and applied against the maximum permissible limit in future years, the penalty tax continues to apply.

Distributions from an IRA may not be made until the participant is at least age 59½, dies, or becomes totally disabled. A premature distribution results in ordinary income tax on the amount received, plus a 10% penalty.

Besides the proscription against receiving a premature distribution from an IRA, specific problems attach to the making of a loan or the pledging of account assets for the security of a creditor. This will trigger a constructive distribution of such portion of the account resulting in ordinary income tax in the year the loan or pledge was made, plus a 10% penalty on the entire amount.

Like self-employed retirement plans, which also prohibit premature distributions except for death or disability, the IRA requires that distributions must begin by 70½. Unless a participant who has reached that age receives the proceeds of his account or begins to receive benefits in the form of an individual or joint and survivor annuity, there is a penalty tax of 50% of the minimum distribution reduced by any actual distributions received.

Regardless of the form of distribution, a participant is always taxed at ordinary income rates without the advantages of the ten-year forward averaging provision available under corporate plans. (However, the five-year averaging provisions of IRC 1301 are available.) This aspect is particularly important when considering the "rollover" of a lump distribution from a qualified corporate plan to an IRA. The capital gains tax treatment which might otherwise have been available because of pre-1974 participation is lost forever. This consideration should not be taken lightly by a corporate plan participant who contemplates tax deferral. It should also be noted that where the "rollover" of a distribution into an IRA will preserve a death benefit from the former plan which would ordinarily not be accorded a terminated participant, there is no estate tax exclusion under IRC 2039(c).

Perhaps the single greatest disadvantage of IRAs to the employer is the effect they have on participation in the corporate retirement plan, where employe contributions are mandatory. To the extent that a 15% tax deduction is more meaningful to a younger employe than the promise of a future benefit or a minimal contribution under an employer's plan, IRAs may become a great stimulus for non-contributory pension plans.

Since Individual Retirement Accounts have so far had a short history, many questions remain to be clarified through regulations and interpretive rulings. For example, may employes withdraw from a non-contributory employer-sponsored plan, possibly jeopardizing its tax qualification? Could that portion of a lump sum distribution which would have enjoyed capital gains tax treatment regain this favored status when passed through an IRA into a second corporate plan? Answers to these and other questions may be resolved in time. Meanwhile, management should not dismiss the existence of IRAs as irrelevant to corporate retirement planning. ■

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HMOs . . .

Continued from preceding page

This is an important responsibility and should not be taken lightly by employe benefits managers. However, the experience of companies that have successfully offered an HMO option should be helpful to companies considering one. There is no specific set of criteria that an employer can use to select the correct HMO. However, there are several considerations that appear to be particularly important in determining which HMO best meets the needs of a company and its employes. The most important of these can be summarized in five words: accessibility, availabilty, appropriateness, acceptablity and accountability.

ACCESSIBILITY of an HMO should include such convenience considerations as the distance to the health care center and hospital. Travel time of 15 minutes to the medical center and 30 minutes to the hospital utilized is generally acceptable in metropolitan areas, depending upon the locality. Access is enhanced also by the availability of public transportation and the proximity of the health center to main highways and freeways.

Emergency care is also very important. In most HMOs, plan physicians are on call 24 hours to respond to enrollees' emergencies. In addition, HMOs usually purchase supplemental insurance coverage to reimburse plan members for emergencies that occur outside the service area.

AVAILABILITY relates to the HMO's health services and the necessary staff and facilities to provide them. HMOs provide fairly comprehensive services, although they will vary, and those services will usually exceed those of a company's indemnity or service plan. However, a popular benefit, such as prescription drugs, may not be available in the basic benefits of a particular HMO. If a company's employes have become accustomed to the benefit in the indemnity plan, it may be important to arrange for this service from the HMO on a supplemental basis if it's not included in the basic services.

Employe benefits managers will want reasonable assurances that an HMO has the necessary capacity to adequately provide health services. The standard formula for prepaid group practices is to employ one primary care physician for every 1000-1500 members. (Primary care physicians include family practice physicians, obstetrician/gynecologists, pediatricians and internists.) A smaller number is required if nurse practitioners and physician assistants are utilized.

APPROPRIATENESS of care is difficult to evaluate directly, but there are some proxy measures that can be used. Hospital utilization, for example, has averaged about 1000 days per year per 1000 indemnity plan subscribers. HMOs utilize about half that number by emphasizing ambulatory care.

The referral patterns of primary care physicians to specialists also reflects appropriate care. Although smaller HMOs may not have sufficient enrollees to require a wide range of specialists, they should have referral arrangements to assure enrollees access to specialty care.

Finally, several HMOs have adopted measures to assure appropriate health care delivery. Health education programs and protocols for allied health personnel providing care to members are two good examples.

ACCEPTABILITY of care is a fourth area to consider. If the HMO is an established group, its acceptance within the community should be examined. If it is a newly developing HMO, the acceptance of the planning group by the community and the status of any organizations that are promoting the development of the HMO should be considered.

The reactions of provider groups/organized medicine are important, and should be considered carefully. In some parts of the country, organized medicine is opposed to prepaid health care in principal regardless of the care provided. It may also be of value to interview members of other companies that have offered a particular HMO and obtain their reactions to the plan. Re-enrollment figures of companies that have offered HMOs for some time can also provide some information about the level of satisfaction among current enrollees.

A free choice among the plan's primary care physicians is important to many employes. Although most plans allow free selection among those physicians, plans can assign physicians based on their availability.

ACCOUNTABILITY mechanisms should also be evaluated in an HMO. Physicians remain the best judge of the care provided by themselves. A formal physician peer review system is some assurance that poor health care delivery modes will be noted and avoided. Other factors reflecting on the competence of the medical staff are the number of board certified physicians and those who are board eligible, and also any type of continuing education program for the health professional staff.

One important form of member accountability that has been implemented in many HMOs is a formal procedure for addressing member grievances. This is an important feedback mechanism that HMOs can utilize effectively to improve member satisfaction and potentially reduce the number of malpractice suits. In addition, an effective grievance procedure is likely to reduce the number of complaints directed at a company's employe benefits staff by dissatisfied employes.

Financial accountability, the ability to deliver quality care for the agreed upon price, is also important. Most HMOs assume some of the financial risks of providing care—sharing in any surplus or losses. The greater the risk assumed by HMO physicians, the larger the incentive to deliver care cost-effectively. HMOs should have procedures to protect enrollees should the plan become insolvent. Few HMOs maintain reserves similar to insurance companies, but many offer enrollees conversion rights to an indemnity plan in the event of insolvency. Others write contracts with health providers that prevent them from seeking reimbursement for individual enrollees should the plan default.

The brief discussion above of the HMO evaluation process highlights several important factors in selecting an HMO. However, if companies have a serious interest in HMOs as a potential health benefit option, there doesn't appear to be any advantage to waiting until the federal law takes effect. Federal qualification of HMOs may assure companies of some minimum standard but not necessarily the appropriate minimum for an employer. That has to be determined by the company's needs and expectations as reflected in the five areas outlined.

By selecting and offering an HMO option now, an employer can still exercise control over the selection process and best meet the employes' needs. Prepaid health care delivery has demonstrated a number of advantages as a health delivery alternative and has proven to be a valuable addition to an employe benefits program. ■

GM's premium hike . . .

Continued from page 1

General Motors executives who hold public service positions on hospital boards, Blue Cross-Blue Shield boards, and hospital planning agencies across the country were called together to talk about health costs.

The message of the meeting, Mr. Zink said, was to encourage these executives to become even more active in trying to keep a lid on the health care price spiral.

"In the cost area, we've reached an area of crisis proportions," he said.

The move to call in the executives was an attempt to counter the traditional "frustration" that confronts businessmen, said Mr. Zink, who feel they "have no control over these costs."

"I have never seen the people who are paying the bills as concerned, and with such strong feeling, about what's happening in the health care cost field," he said.

"It's going to take one hell of a lot of attention and sacrifice on everyone's part to turn this thing around," he argued, including "some sacrifices on the part of the users" of health insurance.

First dollar health insurance coverage, which pays all medical costs without any deductible amount, may be increasingly suspect at many companies, Mr. Zink indicated.

"I have to say I have basically changed my mind (about first dollar coverage)," he said. "There has got to be more of a cost consciousness on the part of the user.

"Right now, what we've done is create a system where the only limit on demand is supply," he said.

General Motors still appeared to come out of its renewal talks in better shape than the federal government, which faces a 35% increase in health insurance costs for its civilian employes in 1976. The boost brings the federal employe health insurance bill to $2.54 billion.

Mr. Zink pointed out that the two health insurance buys are only roughly similar, however. "It's apples and oranges," he noted.

The dollar increase per insured was about the same for the high option, or best, policy, he said, but GM's rate of increase was lower because their costs per insured started out higher than that of the federal government.

A "high option" family policy with Blue Cross-Blue Shield jumped $1.33 per two week payment for a federal employe in 1976. The provisions of the GM and federal benefit plans are different, however.

There is one thing General Motors and the federal government have in common, however. The principal carriers for both organizations say they are losing money in 1975.

General Motors' major health insurers are Blue Cross-Blue Shield and Metropolitan Life Insurance Co. The federal government uses the Blues and Aetna Life & Casualty Co.

American Telephone & Telegraph Corp. (AT&T) is also being stung by sharp health insurance increases. The company is expecting about a 27% increase, to $21.2 million, for basic medical expense coverage of its 35,500 long lines division employes.

A barometer of the seriousness of the situation comes from an actuary for the U.S. Civil Service Commission—which buys health insurance for federal employes.

Even had the federal government's health insurers broken even on 1975 costs, he said the commission still expected to see rate increases in the magnitude of 20% just to cover increased costs and higher utilization rates in 1976. ■

Florida comp up 14%

A workers' compensation filing in Florida requesting an overall 14.2% increase, which was on public inspection since Oct. 7, was allowed to become effective late last month. Insurance Commissioner-Treasurer Phil Ashler disapproved of a September filing which included a change in payroll base. The current filing does not contain a change in the present payroll base which is $100 per week.

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Machine tool companies demand mandatory product liability cover

By MARIE KRAKOWIECKI

BOSTON—More machinery manufacturers are on the verge of going out of business because they can't get products liability insurance, *Business Insurance* learned in the wake of news about the Havir Manufacturing Co. liquidation for the same reason (*BI*, Oct. 20).

Representatives from these firms and from machine tool industry groups confronted the Massachusetts legislature Oct. 21 to request passage of a law which would make products liability insurance mandatory, in much the same way that auto insurance is mandatory for all drivers.

At the meeting, the insurance committee of the state legislature was told of the desperate situation facing small machine suppliers being sued in accident cases and forced to pay the bulk of large awards, while employers have limited liability under workers' compensation laws.

Two such firms are Safeguard Manufacturing Co. in Woodbury, Ct. and the Rigby Manufacturing Co. in South Portland, Me.

Safeguard has been dropped by its products liability insurers five times. The last cancellation was in April from the Canadian Universal Insurance Co., according to Safeguard president Edwin W. Plumb. About two weeks after he lost that policy, there was an accident involving one of the company's safety devices for power presses. Last month, uninsured, Safeguard was named as a defendant in a $4 million lawsuit.

"It seems obvious that if the judgment goes against us on this one, we could go under," Mr. Plumb said. His firm expects to report only $600,000 in sales this year.

Rigby Manufacturing Co. has been without products liability insurance since May, when American Mutual Insurance Co. dropped the coverage from Rigby's package after two injuries were reported. According to Rigby president and treasurer Emery Manning, the insurer didn't even wait to pay any claims before it cancelled the policy.

Subsequently, Travelers Insurance Co. gave Mr. Emery a binder agreeing to provide products liability coverage if it could get the firm's entire package of insurance. But a month after issuing the binder, Travelers told Rigby the deal was off.

Mr. Emery then went to seven or eight insurance agencies that had access to eight or 10 products liability markets. But nothing came of it. The only coverage available was set up through a "specialty market" by John C. Paige Co.'s Portland office.

For $300,000 coverage, Mr. Emery would have had to pay a $20,000 minimum premium a year, regardless of sales volume. There would be a $10,000 deductible, and on top of everything else, Rigby would have been required to pay a commission of 8% of sales in addition to the premium.

Mr. Emery turned it down. It would have meant he would have had to increase the price of his product 10%, and the probable decrease in sales because of the higher price would have made it impossible for him to meet the premium anyway, he figured.

Mr. Emery has been operating since June without products liability coverage, and says he faces 12 to 15 suits. His firm has already paid about $25,000 in settlement costs. He maintains only about one-third of this money went to injured plaintiffs after the workers' compensation carriers and lawyers collected their fees.

"The real crux of the matter is that compensation court awards have lagged behind inflation. My sympathies are with the injured worker who is seldom compensated enough for what has happened to him. But the employers have a limit of liability. They don't have to pay anything beyond the low compensation amounts set up state by state," Mr. Emery said.

"That means the equipment manufacturer is forced to pay, even if it is the employer who has been grossly negligent. And at high payments like $6,000 to $10,000, only about $1,000 or $3,500 is actually fed to the plaintiff. It is very inefficient. The rest is going to insurance companies and the legal profession.

"I've been advised by my lawyers to pay and shut up. This is offensive in the extreme to my sense of ethics. I'm just too small to play that kind of game. A bunch of drones in the insurance companies and the legal profession are sucking out our lifeblood.

"So I made up my mind as a matter of principle to go under rather than to continue this way. Our net value at liquidation would be so small we wouldn't be attractive bait to sue any more, I hope," Mr. Emery said.

Mr. Emery and Mr. Plumb of Safeguard both traveled to Boston for the preliminary meeting with the Massachusetts legislature even though they are from out of state. At the meeting. E. H. (Peter) Rosenberg, chairman of the Small Business Assn. of New England, presented the idea to get products liability placed on a mandatory basis.

Part of the argument that insurers should be required to offer products liability coverage follows this line: That compensation carriers who subrogate in suits against small manufacturers, and who derive the greatest dollar profit from big settlements, are the same ones who are refusing to write products liability coverages.

The tool makers feel that if the insurance companies are making money from products liability suits against them, the least the carriers could do is offer products liability coverage.

Mr. Rosenberg, the SBANE chairman, was one of the few businessmen at the meeting lucky enough to presently have coverage for his firm. He runs Thomson National Press Co. in Franklin, Ma. His company has never lost a products liability case, but has had its coverage cancelled in the past, anyway.

Mr. Rosenberg asked that his present carrier not be named because of the difficulty in getting the insurance.

Mr. Rosenberg said he came away from the meeting with the feeling that if SBANE could organize enough support for its cause, the legislature would probably be most responsive to the idea of an assigned-risk pool which would provide the needed products liability insurance coverage in the state.

On a national level, there are

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Shift liability from supplier to employer

WOODBURY, CT.—Edwin Plumb has been doing a lot of writing and traveling since his firm, Safeguard Manufacturing Co., lost its products liability insurance for the fifth time in April.

He is trying to persuade legislators on both the national and state level to do something about workers' compensation laws which make equipment suppliers the targets of products liability suits rather than employers of the injured plaintiffs—employers who he says are almost always at fault in accidents, but who have limited liability under state compensation arrangements.

Mr. Plumb was part of a delegation that asked the Massachusetts legislature to enact a law making products liability coverage mandatory for small suppliers. He has good reason: Safeguard has about 20 suits pending against it, including a $4 million Minnesota action that was filed in October—and for which the 25 employe metal-stamping firm is uninsured.

In an 11-page letter Mr. Plumb sent to the Select House Labor Committee in Washington he described his problem and some possible solutions:

"I have been dropped by five carriers," he wrote. "The first cancelled before even one suit was filed against us because of subrogation notices from compensation carriers. The others all cancelled before paying a single award . . .

"The premium paid to our last carrier (which Mr. Plumb identified for this magazine as Canadian Universal Insurance Co.) amounted to over 10% of our gross sales. We were dropped after six months of coverage."

"If product liability insurance for press builders and safety device manufacturers were available to them on the same basis as is their compensation insurance, their most severe problem would be solved," Mr. Plumb suggested.

"Such a system should require that their product be built to Occupational Safety and Health Act standards and its design be certified by the National Institute for Occupational Safety and Health.

"Having met these qualifications, it would be only fair to assign their product liability insurance to the compensation carriers according to the amount of compensation business written. This would be particularly appropriate as at least some of the burden would then be returned to where it belonged in the first place," he suggested.

In a phone interview, Mr. Plumb gave high grades to brokers who tried to help him obtain coverage, even though they were unsuccessful in keeping or getting for him the products liability insurance he needed at a price he could afford.

The Woodbury Insurance Co. helped him obtain the $300,000 limit policy he had for six months with Canadian Universal. Its premium was $50,000 and it carried a $5,000 deductible.

After Canadian Universal cancelled the policy, Mr. Plumb said Alexander & Alexander worked very actively on Safeguard's behalf to try to place the firm's coverage with Fireman's Fund Insurance Co., underwriter for a special machine builders' package program, endorsed by the National Machine Tool Builders Assn. in Washington.

"A&A made a good effort, but the best premium quote they could come up with was $70,000. With our sales this year expected to be $600,000, that was just too substantial," Mr. Plumb said. ■

No willfulness needed

An employer who knows of an OSHA regulation is acting "willfully" if he intentionally disregards it or is indifferent to OSHA requirements, a federal court ruled. OSHA willfulness does not require an evil purpose or motive. The tenth circuit court upheld a conviction in U.S. vs. Dye Construction Co. that the employer showed willful failure to shore a trench which caved in and killed an employe, according to the Defense Research Institute.

Machine tool firms . . .

Continued from page 38

lobbying efforts by the National Machine Tool Builders Assn. (NMTBA) to introduce an amendment to S. 2018, the federal workers' compensation bill now pending before a Senate Labor Subcommittee.

James Mack, lobbyist and public affairs director for the NMTBA, said the amendment would affect employers subject to safety standards.

It would first make such an employer liable to be sued by a third party like an equipment manufacturer in a products liability case. Under present workers' compensation laws, employers may not be sued by third parties even if the employer has been found negligent.

The amendment would also allow a third party to raise employer negligence as a defense in cases where the compensation insurer is subrogating to collect damages. Manufacturers presently are not allowed to cite employer negligence in their own defense.

Mr. Mack thinks S. 2018 is likely to pass this year, but he's not so sure about the amendment. If the bill passes and the amendment doesn't, the NMTBA man thinks the products liability situation could worsen for manufacturers. "Our problem will be exacerbated by a trend to instant subrogation if that happens," he said. ■

Ruled unconstitutional

The New York Supreme Court ruled that the state's no-fault automobile law was unconstitutional because it eliminated the right to sue in tort and the righ tto recover for noneconomic loss, including pain and suffering. The court found that the state failed to show why a person injured in other than an auto accident could have access to the courts, while some one injured in an auto accident was barred from seeking tort recovery. The decision is being appealed, according to the Defense Research Institute, based in Milwaukee.

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Pennsylvania sets up JUA for malpractice

HARRISBURG, PA.—Pennsylvania joined the ranks of states with omnibus malpractice legislation on the books last month with passage of a bill establishing a modified form of a joint underwriting association (JUA) and a $15 million catastrophic loss fund.

The JUA was set up to provide malpractice coverage only for doctors unable to obtain it in the commercial market. Limits on primary coverage available either from the JUA or the commercial market are $100,000 per incident and $300,000 per policy year.

Coverage for claims in excess of these amounts will be provided by the catastrophic loss fund, financed by a 10% surcharge on physicians' malpractice insurance premiums.

Medical Protective Insurance Co. and the Argonaut Insurance Co. are the two major insurers of the members of the State Medical Society of Pennsylvania. Argonaut was granted a 206.9% increase in malpractice premiums by the state insurance commissioner.

Other features of the Pennsylvania legislation include a remedy for the "long tail" problems of malpractice claims. The law assigns claims made more than four years after the occurrence of the malpractice incident to the catastrophe fund, thus limiting underwriters' exposure to four years.

However, the law places a two-year statute of limitation from the time of discovery on filing malpractice claims, an interpretation considered too liberal by the State Medical Society.

Though supporting the law in general, the society finds fault with some of its particulars and its omissions.

"The law failed to address the problem of pain and suffering," a spokesman for the society told *Business Insurance*. "We feel since you cannot measure pain and suffering by money, they should not be considered in compensation."

Economic losses should be the losses compensated for in a malpractice claim, the spokesman added.

"The Pennsylvania law, is among the best in the country, even with its weaknesses," the medical society spokesman said, "but it's still a long way from what we need." ■

Chubb officer says JUAs 'here to stay'

WHITE SULPHUR SPRINGS, W.V.—Medical mutual insurance companies and joint underwriting associations, many legislated as temporary aids to the malpractice crisis, are here to stay, said the president of Chubb & Son.

Henry U. Harder told the joint meeting of the National Assn. of Casualty & Surety Agents and Executives meeting here: "As the ultimate guarantors of the success and solvency of both entities, our companies really must put time, talent and money into the loss handling and accounting of the JUAs."

Mr. Harder warned that "for three to five years JUAs and medical mutuals can look very healthy on a cash accounting basis." But where accounting, auditing and actuarial responsibility is missing, trouble can easily follow, he added.

"There is no camparison between a FAIR Plan, wind pool or auto assigned risk plan and medical malpractice," Mr. Harder noted. "JUAs are a completely no win situation."

Earlier at the conference another insurance company executive chided insurers for not speaking out forcefully enough in defense of their right to an underwriting make profit.

B. P. Russell, chairman of Crum & Forster Insurance Co. said rate increases obtained in the last 12 months "are too few and far between and not likely to produce much improvement for all of 1975, and 1976 is at least a question mark." ■

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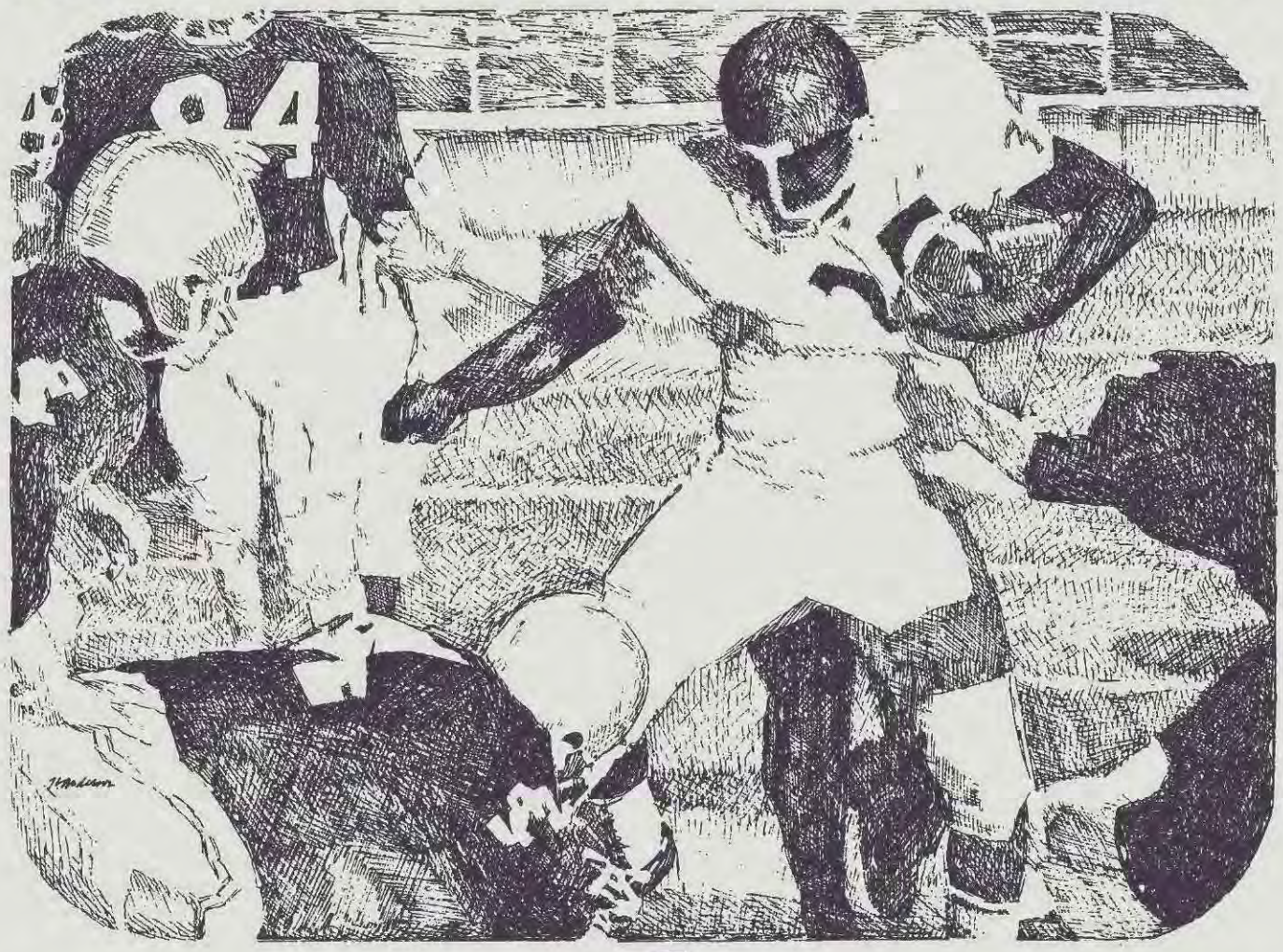
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Benefits communications contest entries will be accepted on Jan. 1

NEW YORK—The fourth annual *Business Insurance* Employe Benefits Communications Awards Competition will open Jan. 1, 1976 when entries will be accepted for the contest.

Presentation of the awards will be made during a luncheon on April 27 at the annual risk management and employe benefits conference sponsored by the Risk and Insurance Management Society (RIMS). The conference will be held in Los Angeles.

Top honors in last year's contest were given to Dow-Chemical, Ciba-Geigy Corp., Marsh & McLennan and the Maremont Corp.

Those invited to participate in the competition include employers and consultants involved in the benefits communication process. Consultants will receive recognition of their work on behalf of their clients.

The four categories to be judged are booklets, personal communications such as letters and computerized benefits statements, audio-visual materials and total communications program. The latter may be a combination of any or all of the other categories, as well as other elements in an effective employe benefits communication program.

Awards will be made on the basis of graphic appeal, effectiveness of copy, the amount of information provided, continuity of communications and use of novel techniques in communicating benefits.

Dow-Chemical and its consultant Scott Miller Inc. won first place last year in the total communications category.

The first place award for the audio-visual category went to Ciba-Geigy Corp. last year. Hewitt Assoc. was the consultant.

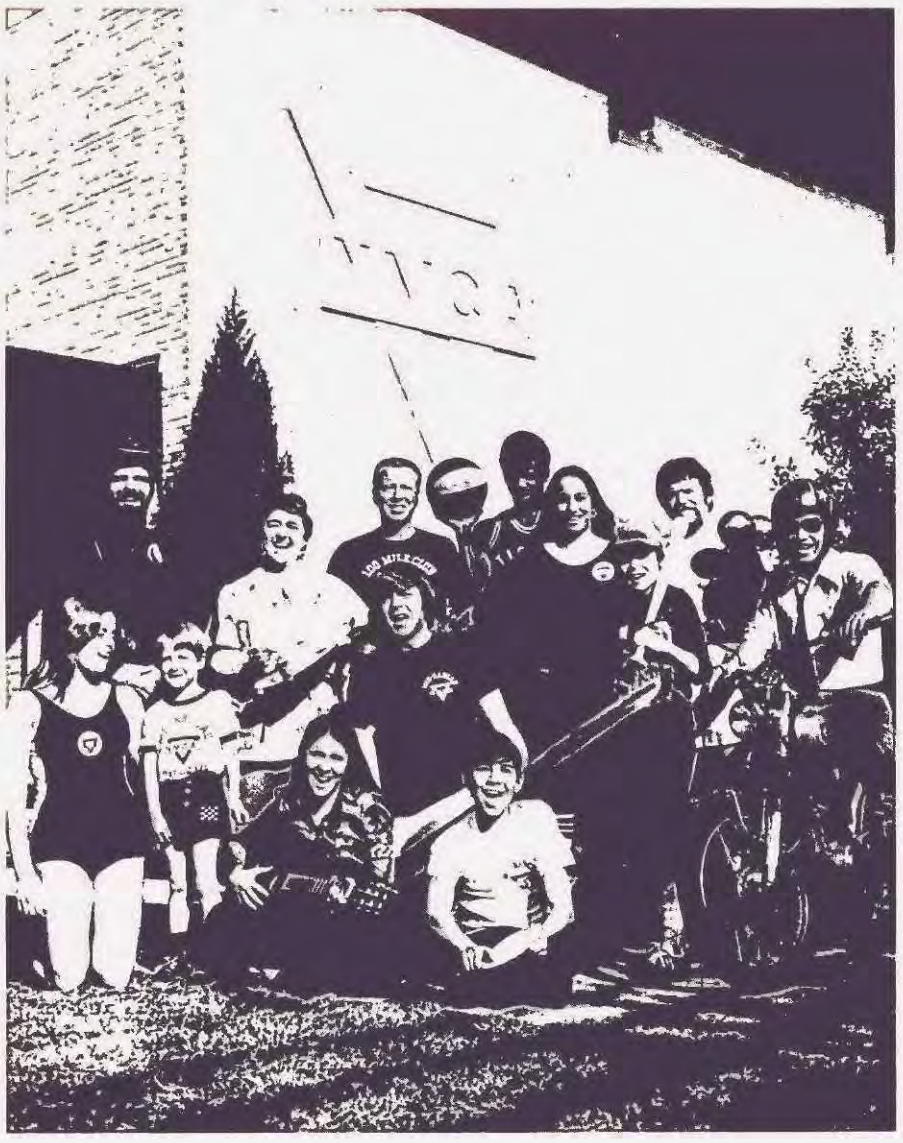
Top honors in the booklets category was given to Marsh & McLennan Communication Service.

A special award was given to Sun Oil International for a booklet dealing with special problems encountered by employes transferred overseas.

Maremont Corp. and its consultant, A. S. Hansen Inc., were named winners in the personalized correspondence category during last year's awards ceremony in Dallas.

The deadline for entries to be accepted for this year's competition is Feb. 23, 1976. Last year over 300 entry forms were sent out and 105 entries were judged. Entry blanks, rules and other material relating to the competition may be obtained by filling out the coupon. ■

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Home Insurance Companies

$52 million covered by flood policies

WASHINGTON—About half of an estimated $100 million in property damage from Hurricane Eloise was covered by national flood insurance, according to federal officials.

"These figures are early estimates only and are subject to change, of course, but we're now estimating damage to property covered by federal flood insurance policies at $52 million," said Acting Federal Insurance Administrator J. Robert Hunter.

"If these figures are anywhere near accurate," he said, "they show that that a lot of people bought flood insurance policies during the years between Hurricanes Agnes and Eloise. In 1972, when Agnes hit, only about two percent of the damage was covered by flood insurance."

Total flood insurance claims paid as a result of Agnes amounted to about only $5 million.

Mr. Hunter said that increased flood insurance coverage means many persons have been spared paying off a loan to rebuild their home or business.

Insured losses in the hardest hit states from Eloise were estimated to be: Pennsylvania, $32.5 million; Florida, $8 million; Virginia, $4.2 million; Maryland, $2.9 million; New York and New Jersey, $3 million; Puerto Rico, $900,000; and Connecticut, $500,000. ■

Restraints required

A Colorado court ruled for the defendant in a products liability case because the plaintiff failed to establish a defect in the rented forklift "as a matter of fact" which caused a construction industry trainee severe injury. In addition, the court found that the plaintiff could not establish a defect as a matter of law since no state statute required installation of human restraints in industrial equipment, reported the Defense Research Institute, based in Milwaukee.

USI, a Kaiser-owned broker, names Henning head to replace Barrett

SAN FRANCISCO—Donald W. Henning was named president of Underwriters Service Inc. (USI), a brokerage firm owned by the four Kaiser companies of Oakland.

Kaiser Industries and Kaiser Steel are the two major owners of USI, holding 38% and 29% of that business, respectively. Kaiser Aluminum has a 20% share of USI and Kaiser Cement & Gypsum comes in with a 13% share.

Mr. Henning, a CPCU, is a nearly 20-year employe of the Kaiser organization. While his last job was that of vp and general manager, international operations, Kaiser Cement & Gypsum Corp., he previously served as insurance manager for that company and as insurance director for Kaiser Industries and Kaiser Cement & Gypsum.

He replaces Joseph W. Barrett who was terminated as president and as a member of the USI board of directors on August 1 over what both he and the Kaiser organization describe as "major philosophical differences."

Mr. Barrett, said in a telephone interview with *Business Insurance* he was brought in to head USI in 1970 to turn the firm into a strong brokerage concern, largely independent of the Kaiser company insurance business. "My job was to bring Underwriters Service Inc. into the real world," he asserted.

And in line with that assignment, Mr. Barrett said USI was able to dramatically reduce its percentage of Kaiser company insurance business from a high of approximately 75% in 1970 to about 40% this year. Mr. Barrett also said he made it one of his objectives to attract new young people, including women, into USI.

"My idea was to accelerate their climb in USI by giving them more responsibility at an earlier stage than they would have gotten in other brokerage firms at the same point," he said.

Mr. Barrett, who is currently undecided about his future, declined to comment further. Knowledgeable sources, however, told this magazine that USI has drawn a number of impressive clients to its roster, including Western Union based in New York, Sedco based in Houston, and Bechtel Corp., San Francisco.

They said interference from the Kaiser organization was the central problem for the brokerage firm when it was headed by Mr. Barrett.

Mr. Henning could not be reached for comment on his future plans for USI. According to a statement made by the Kaiser organization, however, the firm will look to expanding its international and marine business. The statement said that the marine business, in particular, is enhanced by Kaiser Industries' "new organizational structure which combines the operations of shipping, ship building, and international business development with the insurance business.

"We see a number of new opportunities developing from this synergism," the statement concludes.

A San Francisco-based insurance director who is acquainted with the situation told *BI* that he does not regard the four Kaiser companies as a unit but as four totally independent concerns.

"Underwriters Service Inc. is a brokerage firm owned by four independent companies," he said. "Consequently, it should be regarded as an investment for the four Kaiser firms, and not as a captive," he maintained. "What happens at USI should have no impact whatsoever on the captive movement."

He added that the change at the USI helm is "an effort by shareholders to improve management." ■

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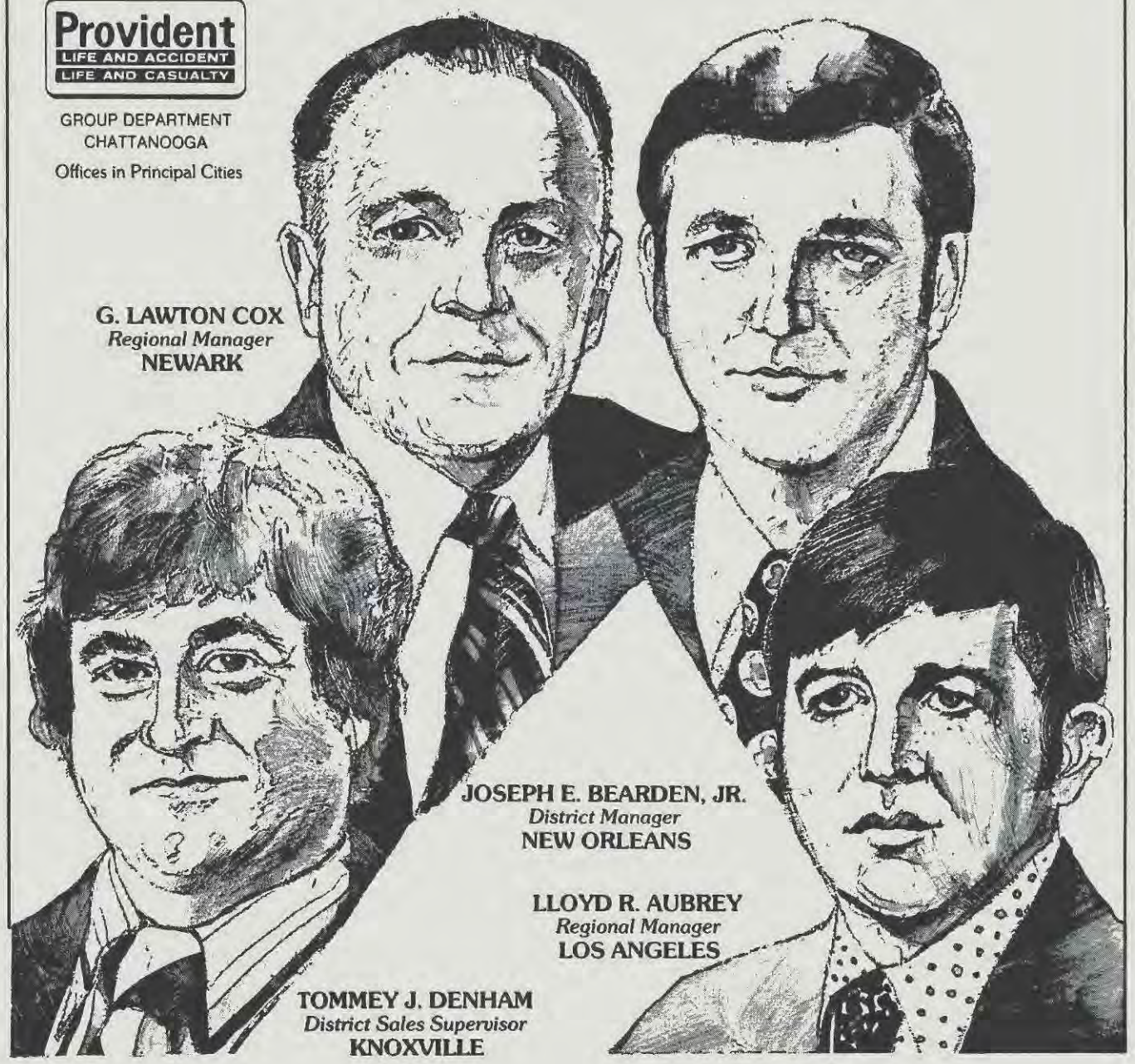
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Rapid American replaces its risk manager with broker

RAPID AMERICAN Corp., a diversified holding company based in New York whose subsidiaries include a retail chain store, replaced its risk manager with an account executive of the company's insurance broker, *Business Insurance* learned. **Martin E. Sutter,** formerly a broker with M. Y. Assoc., is the company's new risk manager and is responsible for administering its entire insurance program which previously existed as two separate entities. **Randy Shields,** the former risk manager, left Rapid American. He managed insurance for the retail division. For a period before the retail and manufacturing divisions' insurance programs were consolidated, Mr. Sutter served as insurance manager for the manufacturing divisions. Prior to his departure, Mr. Shields was named risk manager for both divisions and Mr. Sutter returned to the brokerage firm. Mr. Sutter said he is no longer in the employ of M. Y. Assoc., although the firm still handles Rapid American's insurance. The holding company includes among its subsidiaries Schenley Distillers, International Playtex Co. and McCrory, a retail chain store.

* * *

Fred Molineux, 38, was named manager of corporate insurance at Johnson & Johnson, New Brunswick, N.J. and came on board there Oct. 6. He replaces **Edward Clement,** who joined Johnson & Higgins in New York. Mr. Molineux reports to the assistant treasurer and is responsible for the property/casualty insurance program at Johnson & Johnson. He formerly was corporate insurance manager at Foster Wheeler, Livingston, N.J. Mr. Molineux's replacement there is Jesse Pagonis.

* * *

Foster Wheeler hired **Jesse Pagonis,** 42, as corporate insurance manager, effective this month, to replace Fred Molineux, who left as reported. Mr. Pagonis will be responsible for property/casualty coverage at Foster Wheeler and reports to the treasurer. He formerly was director of corporate insurance at Otis Elevator Co., New York. That position was not filled at press time.

* * *

Al Fathman, 42, was named risk manager for Weatherford International Inc., Houston. It is a newly created position. Mr. Fathman is responsible for all property, casualty and employe benefit programs and reports to the treasurer and chief financial officer. He was formerly a broker with McGriff & Siebel Inc., Birmingham, Al., as well as risk manager for Anderson Clayton & Co., Houston, and Southern Natural Gas Co., Birmingham.

* * *

First City Bancorporation of Texas Inc., Houston, gave **Vincent Williams,** 56, the broader title of insurance manager for the 23-member bank holding company in recognition of the expanded function he now has. Since January, Mr. Williams has been insurance manager for First City National Bank of Houston, the lead bank. He will continue to supervise property, casualty and bond coverage for that bank while serving as coordinator of risk and insurance for other Bancorporation subsidiaries. Mr. Williams is the first person to hold this position for the recently centralized insurance program. Before joining the bank, Mr. Williams was manager, general services, for the Port of Houston Authority, which involved insurance management responsibility. ■

NY musician strike is over

NEW YORK—The Broadway beat goes on. But if any of it is recorded instead of live, it will mean extra contributions for the musicians' pension fund.

After a 25-day strike that crippled the nation's most famous theater district, Local 802 of the American Federation of Musicians reached an agreement with the League of New York Theaters and Producers, and signed a new three-year contract.

The biggest issues in the labor dispute were wages and the minimum size of orchestras to be used in various theaters. However, one contract provision, which is expected to save the theaters about $1,400 a week, will also pump more money into the $72 million national pension fund in which Local 802 participates.

Under the old contract, theaters could not use any recorded music or mechanically reproduced music unless they also hired at least four musicians. The musicians wouldn't have to play a note, but they would be paid by the theaters anyway.

Under the new contract, a show can use recorded music for four minutes or less without hiring a musician, provided it makes a contribution to the pension fund.

The contract gives performing musicans an immediate pay increase of $60 a week the first year, bringing the minimum from $290 to $350. It also puts a six-year freeze on a minimum orchestra size of 26 musicians including the conductor, on most theaters. ■

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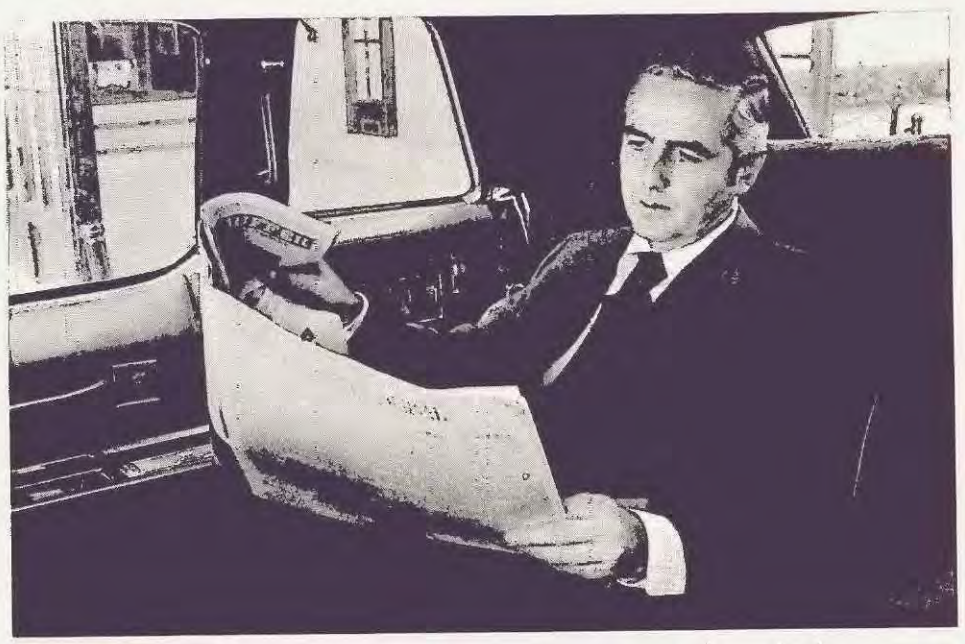
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