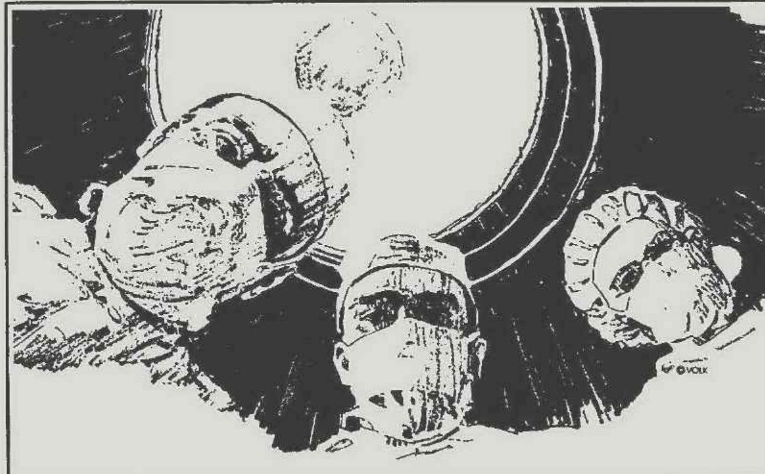
Doctor's antitrust suit claims insurance bias



Week of September 8, 1975

business insurance

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

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By JOANNE GAMLIN

LOS ANGELES—A $120 million antitrust, class action lawsuit has been filed against the Los Angeles County Medical Assn., Hartford Fire Insurance Co. and Phoenix Insurance Co. by a Los Angeles area anesthesiologist who alleges that doctors could not buy malpractice insurance from the companies unless they were dues-paying members of the association.

The lawsuit, filed in U.S. District Court here, charges that local and state medical associations formed agreements first with Hartford Fire Insurance Co. and currently with Phoenix Insurance Co. to restrain trade in violation of federal antitrust legislation.

The plaintiff is Dr. Morton H. Pastor, an anesthesiologist who resides in suburban Granada Hills. He is represented by attorney Lawrence John Appel of the San Francisco firm of Joseph L. Alioto (the San Francisco mayor).

What Dr. Pastor seeks in his lawsuit is a declaratory judgment in regard to the rights of each of the parties in the alleged agreement and a determination whether the alleged agreement is in violation of the antitrust laws.

A spokesman for the Los Angeles County Medical Assn. (LACMA) told *Business Insurance* that the association believes that the suit is without merit. He also refused to discuss LACMA's insurance coverage. There is a question, however, whether insurance protection exists to cover antitrust violations.

The LACMA spokesman did verify, however, that Dr. Pastor has been an association member since 1968.

At presstime, all three defendants had nearly two weeks in which to file a first response to the lawsuit.

The suit alleges that the Hartford Fire Insurance Co. and various medical associations in California agreed, beginning July 1, 1970, that the carrier would not sell malpractice insurance to California physicians unless they were dues-paying members of one of the county medical associations.

After Hartford was dropped by LACMA at the end of 1973, an identical agreement allegedly was drawn up with Phoenix Insurance, according to the suit. It has been in effect since Jan. 1, 1974.

The lawsuit further states that LACMA would meet to fix the average premium rate to be charged physicians and that the insurance carrier would pay the association 1% of the malpractice insurance premiums contributed by local dues-paying physicians.

If a doctor failed to come up with his dues, the suit says that the insurance carrier would use that fact to cancel his policy or to refuse to re-issue the policy at the time of renewal.

In addition, the lawsuit says that when a doctor opposed settling a malpractice claim, the matter was turned over to the medical association and that the insurance company would follow its recommendations.

"Along with the antitrust violations charges, we are saying that the county medical associations entered into agreements with the various medical malpractice insurance companies and, because they did, the number of insurance companies willing to come into California to write malpractice was reduced," said a spokesman for the Alioto law firm. ■

Partial termination denied for anthracite miners' fund

WASHINGTON—Partial termination of the Anthracite (Coal) Health and Welfare Fund will not be backed up by the Pension Benefit Guaranty Corp. (PBGC), although full termination would be considered.

A strict legal interpretation of the Employe Retirement Income Security Act (ERISA) led the PBGC to determine that it could not legally cover a partial termination as proposed by the anthracite fund last January. Pertinent sections of the pension reform act referred to full terminations only, in contrast to other sections which distinguish between partial and full, the PBGC said in a letter to the fund.

The anthracite proposal would have shifted some $6.4 million in pension obligations to the government agency to cover about 6,300 retired coal workers.

Besides the legal justification, the PBGC said it was a matter of discretion not to approve the proposal. "Even if we had broad legal authority such as this at this time, it would seem inappropriate to insure more broadly during a discretionary period than we can after," said Chester Salkind, deputy director, PBGC Office of Communications.

Under ERISA, the PBGC will insure terminated multi-employer plans at its discretion until Jan. 1, 1978, after which it becomes mandatory. After the discretionary period, it is apparently clear that the agency's powers will extend only to full terminations.

The anthracite fund proposal sought coverage until the end of the discretionary period for its miners with less then 14 years of covered service since June 1, 1946, or who retired from a company that ceased contributing to the fund prior to January 1, 1975.

PBGC also refused another request from the fund—that its contributing employers be granted a blanket waiver of liability to PBGC for the debts of the fund.

This had been a key element for the coal mine operators since there are now only about a dozen employers contributing to the fund where once there had been more than 200.

"The corporation has determined not to grant such blanket waivers," PBGC said in a letter to the fund's Washington law firm, Arnold & Porter. "Rather, it will consider each contributing employer's situation separately and grant a waiver or reduce liability where the facts warrant relief."

The anthracite proposal is the first one from a multi-employer fund to be turned down by PBGC.

Similar requests for partial termination for two multi-employer funds—a millinery workers fund and a dairy workers fund—will most likely meet the same fate because the PBGC's refusal was based on legal grounds.

"I think this position will certainly have great weight (on the other two proposals)" said Mr. Salkind. Rulings are expected soon, he said.

PBGC's decision "comes as a tragedy to us," said William Savitsky, chairman of the fund's board.

Much hard lobbying was done at the time of the pension reform law's passage to make coverage for the anthracite fund possible.

"To have your hopes built up and then dashed at such a critical time is tragic," said Mr. Savitsky, an officer of the United Mine Workers of America.

Subsidies from the miners' union—amounting to $10 million or more over the past several years—have been the only thing keeping the fund afloat.

Mr. Savitsky said the subsidy currently soaks up about one-third of all dues collected by the mine workers union.

"It's quite evident that this subsidy cannot be carried on indefinitely.

"We're going to explore every

Continued on page 12

Environment law breeds insurer woes

By ELISABETH M. WECHSLER

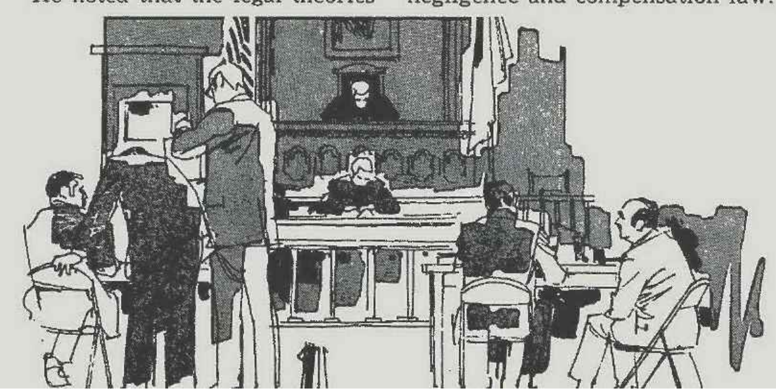
MONTREAL — "Environmental litigation, like civil rights litigation, will continue to increase," an attorney predicted here. Furthermore, when the actions are filed, they probably will end up in the claims department of a liability carrier, he said.

Coverage of the ABA's conference on insurance, negligence and compensation law continues on pages 40-45 with speakers' remarks on aircraft and breach of contract liability; arson defense; state workers' compensation; and banker's bond.

Insurance coverage problems under the present environmental liability policy provisions, definitions, exclusions and endorsements are "clearly caused by the very nature of environmental litigation," said Robert S. Soderstrom, who is a member of the Chicago law firm of McKenna, Storer, Rowe, White & Farrug.

"Since the environmental exclusions have not yet been tested in the courts, the applicability of all these provisions remains somewhat unclear. There can be little doubt that this is a ripe field of coverage questions," he said.

He noted that the legal theories presented in environmental cases under present policy provisions are "as diverse as lawyers' imaginations are fertile." They range from "grandiose constitutional claims of a right to a decent environment to simple assertions of nuisance, trespass and negligence," he told participants at the American Bar Assn.'s conference on insurance, negligence and compensation law.



Traditionally, the insurance industry's answer to the question of coverage for environmental losses has been to honor only those claims that were the result of a sudden and accidental cause, Mr. Soderstrom explained.

The standard policy form forces the carrier to defend any lawsuits against the insured "even if the allegations of the suit are groundless, false or fraudulent," Mr. Soderstrom said. "Another real concern is the duty of the insurance company to defend its policyholder where coverage is in doubt or even absent."

He went on to say that a carrier refusing a defense does so "at its peril." If the court finds that it owed a defense, even though the carrier was not obligated to pay the judgment, it becomes responsible for the "full judgment" regardless of the policy's limits.

Continued on page 44

Suit charges Gulf Oil with manipulation of stock plan

NEW YORK—Gulf Oil Corp.'s directors and officers were named in a $2.8 million lawsuit charging manipulation of the company stock option plan. But neither the oil company nor Crum & Forster Insurance Co., the underwriter for Gulf's $25 million directors' and officers' liability policy, are commenting on whether the action is covered under the policy.

The policy includes "a small deductible, either $50,000 or $100,000," Joseph Edwards, assistant treasurer for Gulf, said.

Another Gulf spokesman, referring to the lawsuit noted, "The matter is so complex at this point we are not in a position to comment on it."

The lawsuit follows a $68 million fiduciary liability suit filed by a local of the Oil, Chemical and Atomic Workers International Union in June (*Business Insurance*, July 28).

The New York action was a two-part lawsuit; in the second part the plaintiff, identified as Abraham Wechsler, a stockholder, asked that Gulf's directors be forced to pay back $10 million in political contributions Gulf acknowledged making between 1960 and 1973

New business ban put on Argonaut Insurance by British authorities

By MARGARET LeROUX

NEW YORK—British authorities have stopped the Argonaut Insurance Co. from doing business in England, *Business Insurance* learned.

The Board of Trade in London placed an order barring the company from doing any further business in the United Kingdom. However the order does not exempt Argonaut from its liabilities under existing policies.

Agonaut, which writes insurance and reinsurance in England through the H.S. Weaver Agencies Ltd., was ordered not to vary existing contracts.

The company cannot amend, renew, modify or increase premiums for existing policies, the order states.

Argonaut's 1974 premium income for British business was 363,000 pounds sterling, mainly in reinsurance, sources in London said.

A spokesman for the underwriter, when contacted by *Business Insurance*, said that he could not comment on the action because it was the first he had heard of it.

The 1974 figures from the Argonaut Insurance Group, which includes Argonaut Insurance Co., Argonaut Insurance-Southwest, Financial Indemnity Insurance Co., Security National Insurance Co. and Trinity Universal Insurance Co., showed a net operating loss of $87,369,000.

The Argonaut Insurance Co. had net earned premiums totalling $69 million for 1974, according to California Insurance Commissioner Wesley J. Winder.

The company's net incurred losses totalled $47 million and Argonaut suffered an underwriting loss in excess of $90 million.

First quarter figures for 1975 show net earned premiums totalling $74 million and net incurred losses of $69 million with underwriting losses at $22 million.

The California insurance department is conducting a tri-annual examination of the Argonaut Insurance Co.

Commenting on the action of the British trade authorities, Commissioner Kinder noted that "I can't believe that it would have an effect on the company's business in the U.S."

The underwriter was in the malpractice market in more than 30 states. Late last year, however, Argonaut began a state by state withdrawal from the market, precipitating malpractice crises in many of those states.

In California, Argonaut was involved in 10 malpractice settlements of more than $1 million each.

The underwriter has also withdrawn from the reinsurance market, Argonaut officials announced this past spring. ■

Northwest Air contract revises benefit formula

By PAUL R. MERRION

ST. PAUL—The new Northwest Airlines pilots contract, successfully negotiated August 6 after pension and disability squabbles caused a three-day strike, contains a company proposal made two days before the strike began which will completely restructure the retirement benefit formula, according to a union negotiator.

The pilots' pension plan will be converted to a single-fund, fixed benefit plan. Like several other major airlines, Northwest's previous pension plan for pilots used two funds and two benefit formulas: fixed and variable.

Under the new contract, pilots will receive 60% of their average salary during the last five consecutive calendar years of their careers, according to Roger Bruggemeyer, a Northwestern pilot and a member of the Air Lines Pilots Assn. (ALPA) retirement board.

The old plan gave pilots a fixed benefit of ¾ of 1% of their average career salary for every year of service, he said, while the variable benefit depended on the size of the pilot's account in the variable fund at the time of retirement.

Both funds will be consolidated into a $90 million fund for fixed benefits, Mr. Bruggemeyer said, and variable benefits will be eliminated.

The company offer "came as a distinct surprise" to the union negotiator. "I originally wanted a final average plan for the A plan (fixed benefits), instead of career average as it was. But I could see we wouldn't get it," Mr. Bruggemeyer said.

Contract talks broke down July 23 over pension and disability pay provisions, when the company and the union met to put the finishing touches on a tentative agreement reached July 19, which gave the pilots a 34.4% increase in wages and benefits through June 1977 and retroactive to July 1974, when the previous pact expired.

Northwest's 1,550 pilots walked out on Monday, August 3, and the contract was settled in the early morning hours of August 6, after an all-night bargaining session under the auspices of William J. Usery, director of the Federal Mediation and Conciliation Service.

On the Saturday before the strike, the company offered the single-fund, single-benefit plan. "They were saying no to our proposal all along, and then ba-boom, there it was," said Mr. Bruggemeyer.

The union proposal would not have equalled the company's offer, he added. Northwest refused to comment on its reasons for changing the dual-benefit system.

Basing the new pension formula on the final five years of service instead of the pilot's whole career will have little effect on a long-term employe who starts to work for Northwest now, but it is a "dramatic improvement for a pilot retiring soon," the union negotiator said. Figuring the benefit from more recent salary levels gives more weight to the impact of increased inflation over the last few years, he went on to say.

Beside the pension formula change, the new contract alters the formula for disability pay provisions. Under the old plan, disability benefits were based on the pilot's age only, according to Mr. Bruggemeyer.

The new disability plan incorporates years of service into a sliding benefit formula, he said. With a minimum of five years of service, a 35-year-old pilot will receive 30% of his pay if he becomes disabled, while a 45-year-old pilot would get 50%, he continued.

Minor changes in the group health insurance plan are also in the new pact. The major medical expense limit was lifted to $250,000 from $25,000, and a $10,000 stop-loss provision was installed, Mr. Bruggemeyer said. Connecticut General Insurance Co. will continue to be the group health carrier for the nation's seventh largest airline. ■

Old plant checks out

Some 200 lucky former employes of the old Fisher Body Co., Memphis, received the news that they are eligible for pension benefits that will total about $700,000. Monthly checks will range from $25 to $200, a spokesman said. Retroactive checks already have been distributed. The plant, which made wooden parts for cars, airplanes and boats from the 1920s through World War II, was shut down in 1946.

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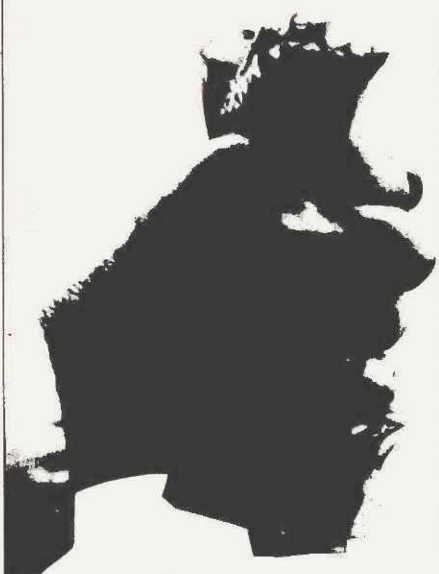

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Correspondents in All Other States

Binding arbitration seen as the only alternative

By MARGARET LeROUX

NEW YORK—A variety of solutions, ranging from legal reforms to coordinated action by liability underwriters were the results of three recent studies of the malpractice crisis.

The studies include a court docket survey by Michigan physicians, a study done by members of the House of Representatives and a presentation to the American Bar Assn. convention by an insurance company executive.

The court docket survey, done by the Physicians Crisis Committee (PCC) maintains that the present court-jury system "just doesn't work," and binding contractual arbitration is the only fair alternative to the existing system of deciding medical malpractice disputes.

The PCC survey, based on circuit court records of malpractice cases filed in three Michigan counties from 1970-1974 found that of 1,910 cases, four out of five never went to trial, that law firms filing malpractice lawsuits were "successful" 80% to 91% of the time and that the risk of loss to the plaintiff's attorney is minimal.

The Michigan survey also claims "clear evidence of a relationship between the advent of no-fault auto insurance and the growth of the malpractice crisis" in that state.

The number of malpractice suits increased by 61% after no-fault auto insurance went into effect in October of 1973, the survey noted.

Average settlement of malpractice cases was $78,148, according to the PCC survey and 55 hospitals in the Detroit metropolitan area has an average of one malpractice suit for every 2,581 admissions.

The PCC survey noted a discrepency in the number of malpractice claims filed against two classes of physicians and the risk class assigned the two physician groups.

Anesthesiologists, who averaged one claim per 10.7 doctors during the time period of the survey were assigned to class five (high risk) by insurance companies, while the number of claims against pediatricians averaged one for every 9.6 doctors.

Pediatricians, however were assigned class one, (low risk) ratings.

A study by the House Wednesday Group said that in the past 10 years the average national cost of malpractice liability insurance has increased 950% for surgeons and 540% for other physicians.

The total premium value for malpractice insurance for doctors and hospitals increased from $61 million in 1960 to $371 million in 1970 and to approximately $500 million in 1975, according to the House study.

The contingency fee system for legal services is cited as a cause of the malpractice crisis by the House study.

The study compared the situation in Canada, where most provinces allow no contingency fee, to the U.S.

Doctors in Canada pay only $50 for $100,000-$300,000 liability coverage, while in the U.S. physicians pay on the average, $1,500 for the same amount of coverage, the study said.

The real problem underlying the malpractice crisis, is the increase in claims frequency according to Thomas F. Sheehan, president of GATX Insurance Co., who addressed the American Bar Assn. section of insurance, negligence and compensation law at the annual convention in Montreal last month.

Mr. Sheehan highlighted aspects of St. Paul Fire & Marine Insurance Co.'s experience in the malpractice field and a program established by the Florida Medical Assn. and concluded that "a single source of statistics in the U.S. is needed to give us workable data compiled from all companies writing malpractice insurance in all states."

Proposed legislative remedies which favor the doctor at the expense of the patient-victim should not be enacted in a time of crisis, Mr. Sheehan said, "since the prescription to cure the malady is too costly a price for the patient to pay."

However, the no-fault approach to the malpractice problem is not a viable solution, according to Mr. Sheehan.

"No-fault medical insurance would require the federal government to subsidize its excess costs under a Social Security program," Mr. Sheehan said.

"This would plunge Social Security into bankruptcy, requiring the use of general revenue to bail out the financial insolvent Social Security system," he continued. "Federally insured no-fault medical malpractice insurance is socialized medical malpractice insurance."

What is needed, Mr. Sheehan concluded, is the leadership to bring into a single body the unselfish efforts of all groups affected by the problem in order to provide the necessary solutions. ■

Engineers charge daily rate of $218

PARK RIDGE, ILL.—A mail survey of members of the American Society of Safety Engineers (ASSE) found that the national average daily fee charged clients is $218 for safety consulting services.

The rates varied from $184 to $239 per day, depending on the geographical residence of the consultant, a spokesman for the organization said. Respondents totaled 134—a majority of the membership—for this first ASSE survey on average daily rates, he said.

"On a nationwide basis, half the consultants charge less than $200 a day and half charge more," the ASSE spokesman said. "One consultant charges as little as $50 and one charges as much as $500 a day," adding the rate does not include reimbursement for expenses.

Survey results are "not intended to be used as a minimum fee schedule nor do they suggest what a reasonable fee in a particular area might be," the spokesman said, adding that the fee varies according to the "qualifications and skills of the consultant, the complexity and character of the work to be performed, the novelty and risks involved and the length and urgency of an assignment." ■

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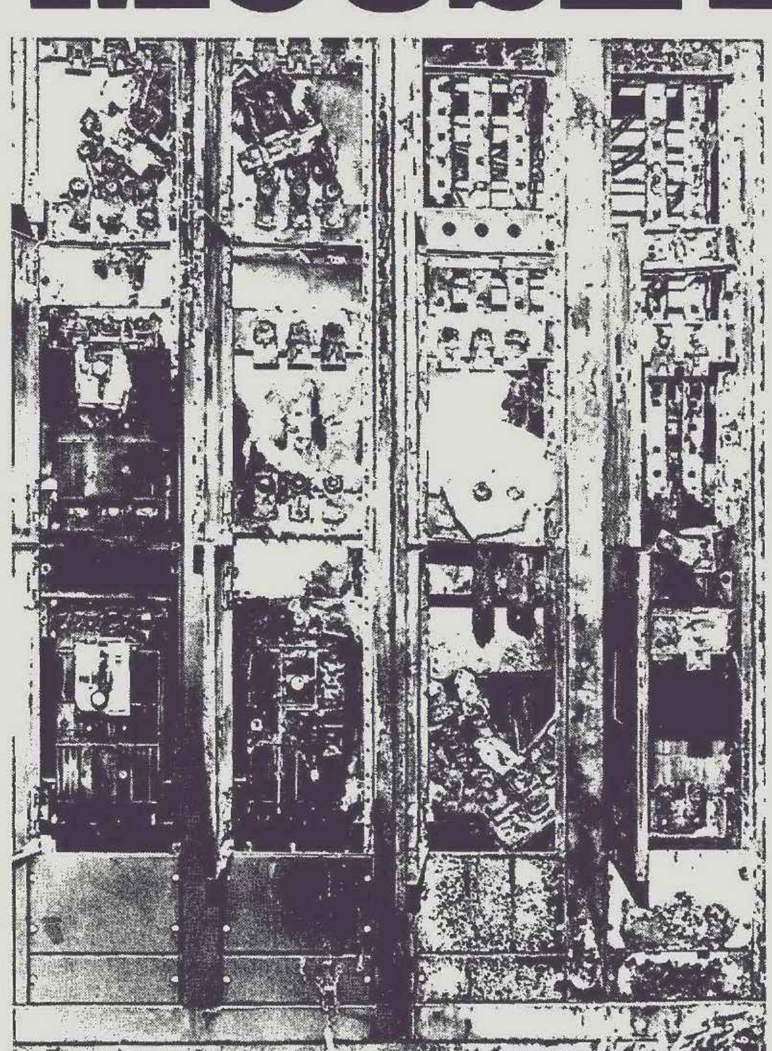

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Levi Strauss charges its cost centers a premium share plus 15% for fund

By JOANNE GAMLIN

SAN FRANCISCO—Richard H. Soper, director of the risk and insurance management department, Levi Strauss & Co., hopes that one day he will be able to pick up a punch card or a magnetic tape and say: "This is Levi's insurance program."

Mr. Soper, whose job embraces accounting, claims handling and loss control, is not indulging in idle daydreams. On the contrary, his futuristic vision is firmly rooted in an existing, yet highly sophisticated, risk and insurance funding program at Levi Strauss, a program which has been under development for two years and went into effect last November.

In essence, the program views the $1 billion apparel manufacturer as a cluster of 500 cost centers, generally, physical locations both in this country and overseas. Under the program each center is charged its applicable portion of the premiums paid to Levi's insurers each month, along with an additional increment, usually 15%, which goes to build up a new corporate self-insurance fund.

What we have developed is a cost center loss participation formula," pointed out Mr. Soper during an interview with *Business Insurance*.

He elaborated: "It relies on new, high deductibles across the spectrum of corporate insurance coverage and a new self-insurance fund which is used to pay for losses within the deductible area."

The beauty of the arrangement, he continued, is that it ties the level of the deductibles to the ability of the cost centers to bear losses and to the level of losses which the whole corporation believes it can assume in a pre-tax situation. At the same time, the loss participation formula stands as a powerful incentive to the cost centers to restrain their expenses, first of all by beefing up their loss control efforts.

"A cost center can now boast of tangible control over insurance expenses," he said.

And apparently, Levi's cost center heads leapt at the chance to take concrete cost action. Total premium costs have plunged 20% to 25%, Mr. Soper estimated, due to the larger deductibles and the stronger loss control program inherent in the formula.

Economies that flow from computerization also may have influenced the premium cost reduction. For the fact is that Levi's large workers' compensation program along with its property insurance program for this country, Canada and overseas have been under the command of banks of computers for some time.

Indeed, the loss participation formula, which requires automation to be workable, appears to be running smoothly enough to allow Mr. Soper time to delve into new projects.

A Levi Strauss offshore captive, for instance. It is at present nearly on-line, he said.

Beyond that, he said he is close to completing a battery of insurance manuals to be used by Levi employes. They deal with five topics: administration, claims, recovery, loss control, expense allocation and emergency procedures.

In addition, Mr. Soper said Levi Strauss' international exposures are being put under new scrutiny by the firm.

The loss participation program which is now opening up time for the risk manager got its first breath of life during a free-flying think tank session, he recalled. He said that besides top financial executives from Levi Strauss other members of the think tank were consultants from Warren, McVeigh, Griffin & Huntington, the Risk Planning Group, Inc. and Robert C. Goshay, professor and associate dean of academic affairs, School of Business Administration, University of California, Berkeley.

Mr. Soper, who has taught risk management at the University of California at Los Angeles' extension school, noted that the use of high deductibles extends the breadth of the corporate insurance program, from property/-liability to difference in conditions and boiler/machinery.

In general, Levi's deductibles are in the area of $100,000 for controllable operations, and in the area of $25,000 for risks such as transit exposures or manufacturing contractors operations which are not regarded as controllable.

He explained that losses involving high deductibles are handled as if there were a full insurance policy in force. The major portion of the large deductible is charged to the corporate self-insurance fund, while a smaller but equitable amount is assumed by the cost center where the loss occurred.

Mr. Soper, who formerly worked in Southern California in the insurance management departments of Hughes Aircraft Corp. and Federated Department Stores, went on to point out that the allocation of risk funding expense is based either upon a cost center's previous loss experience or its ability to control losses.

Naturally, the apparel manufacturer's giant workers' compensation program—the company operates in 26 countries—is calculated on a cost center's previous years' loss experience.

To provide a deeper analysis of this experience, Mr. Soper said a five-category experience modification formula was devised using the payroll in relation to prior losses. The five rating categories, he said, range from 'excellent' to 'deficient.' Significantly, the cost centers in the latter group claims an expense factor of nearly 15 times those in the first group, he pointed out.

For property coverage for facilities in this country and in Canada the expense allocation factor, of course, is an ascertainable ability to control losses. Thus he noted a plus with a fully approved sprinkler system will normally carry a property insurance premium that has a 90% credit or reduction over a similar non-sprinklered property.

"We figure that the premium savings for fully sprinklered facilities are frequently sufficient to amortize the cost of the sprinkler system in less than seven years," Mr. Soper observed.

In a similar vein, cost centers abroad are rated in terms of loss control features geared to all risk coverage, including fire and burglary protection.

Mr. Soper said that the resulting rating schedule produces either a credit or a debit to the existing blanket insurance rate which is provided by the American Foreign Insurance Assn., through Marsh &

Continued on page 6

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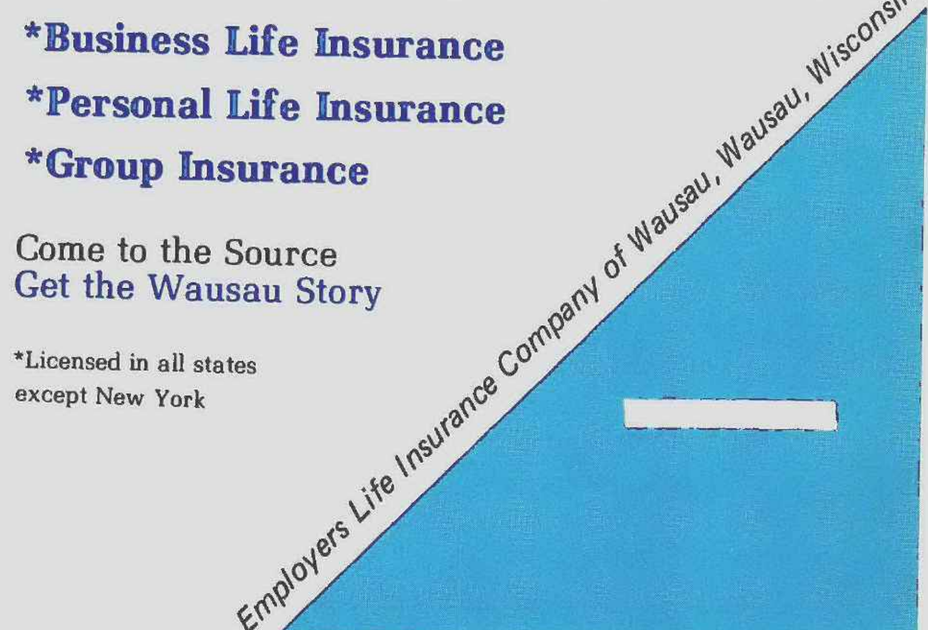

Ford Motor named in suit by ex-alcoholic

DEARBORN, MI.—Lack of an alcoholic rehabilitation program at Ford Motor Co. in the late 1960s has caused a former senior executive to file a $1.3 million civil suit, charging that the automaker should have offered him that option before giving him what he calls a "forced early retirement" at age 50 because of his drinking problem.

John R. Brennan, chairman and managing director of Ford Motor Co. (Switzerland) S.A. from 1966 to March 1969, told *Business Insurance* that he was not claiming that the job caused him to become an alcoholic, as inferred by other reports, but that the option of treatment should have come before his alleged forced retirement.

"In today's society, an employe has the right to be offered treatment as an alternative to retirement or dismissal," Mr. Brennan said. He further claimed that "at the time this happened to me, there were other people there who were allowed to go for alcoholism treatment."

A Ford spokesman said the company started a drug rehabilitation program in the early 1970s, which shortly afterward was expanded to include alcoholism. He characterized it as a "referral service mainly," with no rehabilitation programs taking place on the company's premises. No other suits similar to Mr. Brennan's have been filed, he said.

Mr. Brennan confirmed that Ford now has a written policy on alcoholism giving employes the option for treatment.

Mr. Brennan emphasized that he was "not blaming Ford" for his alcoholism, although he said that the job made the problem more acute.

Mr. Brennan, who was with Ford for 30 years, was also the executive vp of the American Chamber of Commerce in Switzerland at the time he left the company. Prior to his service in Switzerland, he was general manager of Ford Motor Co. (Austria) for five years.

Mr. Brennan's suit, filed in Detroit in early July, asks for $1.3 million in damages for back pay and bonuses, full pension compensation through his scheduled retirement date of 1992, punitive damages and costs of rehabilitation, plus loss of all personal property and real property resulting from his termination.

Mr. Brennan said his retirement benefits did not start coming until he reached the early retirement age of 55, five years after he left the company.

Now cured of alcoholism, Mr. Brennan works as the business manager of an alcoholic treatment center in Brighton, Mi. In the interim he served as administrator of Brighton Hospital, another alcoholic treatment center in Brighton, Mi.

He has no plans to ask for reinstatement at Ford, and, he said, "I wouldn't go back to working in any industry. I plan on staying and doing work in the field of alcoholism.

"I've found a new career," Mr. Brennan said. "I'm planning to make a headlong attack against the stigma society places on alcoholism.

"I think my story gave the conscience of society an enormous boot in the ass," he said. ■

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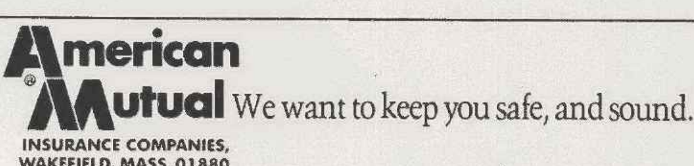

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Levi . . .

Continued from page 4

McLennan, one of Levi Strauss' three brokers.

The other two are Fred S. James & Co. and Richard N. Goldman & Co. of San Francisco.

The brokers split the Levi Strauss insurance program almost in thirds. Fred S. James, for example, handles the domestic workers' compensation program through the Insurance Company of North America (INA). Workers' compensation, incidentally, is self-insured in the states of Arkansas, California, Georgia, New Mexico and Tennessee through the offices of the Employer's Self-Insurance Services (ESIS), a unit of INA. In all other states where the corporation maintains a workforce, INA provides a cash flow program.

Marsh & McLennan Inc., handles three different programs. It has the domestic property program, including boiler and machinery, the whole program being written by Allendale Coverage Mutual Insurance Co. Similarly, domestic comprehensive general liability, through Fireman's Fund American, is in Marsh & McLennan's hands.

In addition, M&M handles Levi Strauss' international property and casualty program.

Richard N. Goldman & Co., is in charge of five different coverages. They are: ocean and inland marine, written by Fireman's Fund American; difference in conditions, from Swett & Crawford, the Unionamerica Insurance Group; directors and officers, from Lloyd's; fidelity coverage, from Aetna; and excess umbrella liability, from various carriers.

It is to the brokers, Marsh & McLennan and Fred S. James, that Mr. Soper looks for the computers that churn out the loss, claim and cost data which he needs to make the loss participation formula work like a Swiss watch.

"The computer program is in their hands, entirely," asserted Mr. Soper, noting that the two programs are compatible and can interface.

"Ultimately, I would like printouts providing all insurance and self-insurance expenses for each cost center for the purpose of budgeting and allocation of expenses. I envision a media form which would interface with Levi Strauss' corporate accounting and data systems."

When that day comes, it will seem natural for Mr. Soper to go to his boss, Robert B. Kern, v.p., secretary and treasurer, with a magnetic tape and say: "Here's the Levi Strauss insurance program." ■

Teledyne takes J&H

BEVERLY HILLS, CA.—Teledyne Inc. has moved its aircraft liability, general liability and workers' compensation coverage from Marsh & McLennan to Johnson & Higgins, both of Los Angeles, *Business Insurance* learned.

The transfer was confirmed by a spokesman inside Teledyne, although the company officially said it had "no comment" on the move.

Johnson & Higgins is known to have been the broker for the company's fire and property coverage.

Workers' compensation and aircraft products liability are said to be the two largest policies, the latter due to the fact that one of the corporation's units, Teledyne Continental Motors, is in the aircraft product business. ■

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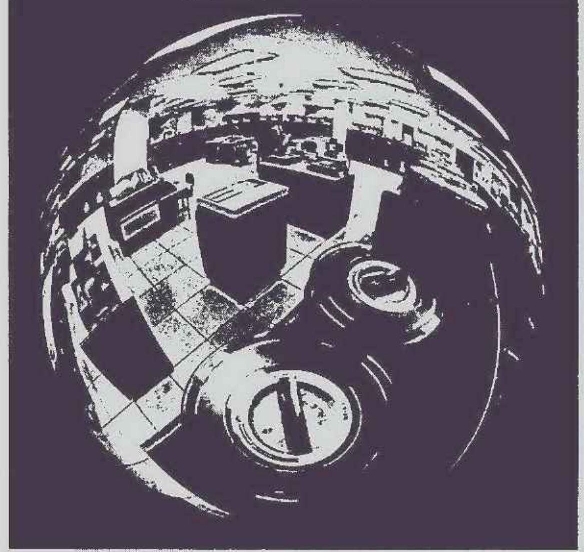

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N.Y. teachers sue fiduciary over stock sale

NEW YORK—A $13.3 million lawsuit filed here by the New York Teachers' Retirement System against U.S. Trust Co., one of the fund's 10 investment managers, is being watched closely as one of the first major actions to confront the issue of fiduciary responsibility and the prudent man rule since the passage of the Employe Retirement Income Security Act of 1974 (ERISA).

The suit claims negligence contributed to losses incurred in Pennsylvania Life Co. and Singer Co. common stock, which were purchased by the bank for the pension fund.

U. S. Trust does not have errors and omissions insurance which might respond to a possible loss, *Business Insurance* learned.

"Most, if not all the New York clearing house banks don't carry the coverage," a U.S. Trust spokesman said. "It's prohibitively expensive and most banks self-insure this exposure."

The bank does not have fiduciary liability insurance either. The U.S. Trust spokesman said the bank is looking into the coverage for its trust departments "but we haven't obtained a quote on it yet."

Although the New York Teachers' Fund does not fall under the jurisdiction of ERISA because it is a public fund, industry experts believe the lawsuit will have far-reaching ramifications in setting important precedents as similar cases are brought to the courts in the future.

Fiduciary liability and insurance for the risk is one of the hottest subjects confronting bank risk managers these days. Corporate risk managers, too, are scurrying for coverage to protect fiduciaries of their pension funds for potential judgments rendered in similar actions.

Although U.S. Trust has not yet filed its reply to the complaint by the Teachers' Fund (tentative filing date is Oct. 2), the bank has said it intends to refute the allegations "vigorously." The suit, said the bank, "has no sound basis."

Specifically, the complaint alleges that about 200,000 shares of Penn Life stock was purchased by the bank for the Teachers' account for almost $6.87 million between Aug. 27, 1971 and Feb. 7, 1972.

Further, the complaint alleges that the bank held the stock in the Teachers' account for about two years, incurring losses of about $7.8 million (assuming the stock had been sold at its high) despite the bank's own internal coding system which, if followed, would have meant sale of the stock in March of 1972 or shortly thereafter when the stock ranged around a high of $39 per share.

In addition, the complaint alleges that about 300,000 shares of Penn Life common stock were sold for other bank clients between late 1972 and February 1974, but not for the Teachers' account.

U.S. Trust, however, said that the 300,000 share figure quoted in the complaint is "substantially overstated."

Also, the bank said that the Teachers' Fund was not the last account to hold Penn Life stock. In addition, the shares sold for other clients, according to the bank, were traded after November 1972 when the price had already declined to less than $10 per share.

Apparently, according to one source, U.S. Trust operates less on an across-the-board system than some other banks do.

In other words, once the decision is made to sell a stock, a key question in many bank trust departments is which accounts get sold out first. This can be a particular problem if the float on the stock is thin and all of the shares cannot be sold evenly from account to account.

At U.S. Trust, according to one official, every account is handled by the account manager, subject to "instant" review from the bank's investment committee. And, he added, accounts may differ in terms of objectives and overall asset mix.

"An investment advisor is not a guarantor of the performance of stocks held in a fund which it manages in a competent manner," the bank said.

And, according to the bank, during the time that these stocks were retained and their market value was decreasing, their retention was reviewed regularly with the Teachers' System through its retirement board, which was kept informed as to why retention was deemed advisable.

The bank sold the Singer common stock in February this year, incurring losses of almost $6 million due to a decline in the price of the stock, the complaint said.

Charges of negligence for handling investments of Singer were far less specific than those for Penn Life. According to one source, the bank's coding system for Singer was not shown to Teachers' fund officials.

Indeed, a key issue for the plaintiff hangs on the claim that the bank disregarded its own coding system regarding its various stock lists.

"Throughout the period, U.S. Trust was purchasing Penn Life stock for the retirement system" according to the complaint, "the stock was designated on U.S. Trust's recommended list as a stock to be purchased.

"About early March 1972, without the knowledge of the retirement system, U.S. Trust removed the stock from the recommended list," it continued.

And in early March, 1972, Penn Life was moved to a list coded HS, defined to apply to "those stocks whose long term growth prospects are relatively unattractive, but whose prices are overly depressed, making their immediate sale inadvisable."

The definition of this list, the complaint alleges, was changed in April 1972 to apply to long term growth prospects which are such "that the stock should not have a continuing place among our long-term holdings, but where current circumstances make prompt sale inadvisable."

"We are suing for negligence," said a lawyer for the Teachers' fund, who declined to comment beyond what was contained in the fund's legal complaint.

Trustees of the Teachers' Retirement System have reportedly been contemplating taking action against U.S. Trust for "quite some time," due to dissatisfaction with the bank's performance generally in recent years.

It will probably be more than three years before the case reaches trial. "It should be an interesting case," said one source. ■

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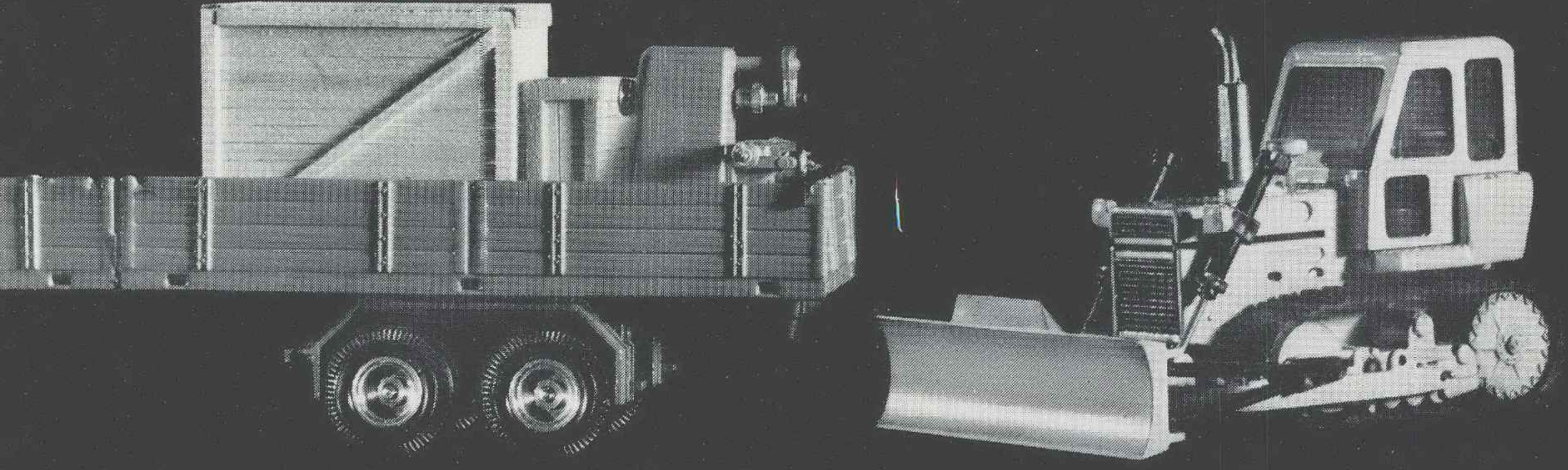

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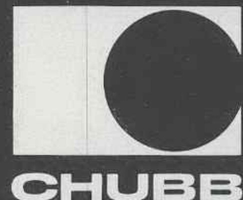

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Illinois malpractice arbitration plan stalled; hospitals wait for legal aid

By PAUL R. MERRION

CHICAGO—A pilot program to substitute arbitration for court action in malpractice suits at Illinois hospitals is still awaiting implementation, as only one health-care facility has signed up while others wait to see what kind of malpractice relief will be passed by the state legislature this fall.

The proposed arbitration plan, which would ask for the patient's approval upon admittance, has already come under fire from the Chicago Bar Assn. and the Illinois State Bar Assn.

Under the experimental plan, the patient would voluntarily sign an agreement upon admittance to submit malpractice claims in excess of $20,000 to a three-person panel set up by the American Arbitration Assn., rather than the usual route through the courts. Admittance cannot be denied for failing to sign the agreement.

The Illinois Hospital Assn., which is sponsoring the plan along with the Chicago Hospital Council and the Illinois State Medical Society, expects the plan to have benefits for patients as well as hospitals and doctors.

Beside reducing the number and size of awards, which would presumably lower the cost of health care, the arbitration process under a panel of experts would benefit patients by resolving claims faster than the court system, by providing a more convenient means of seeking relief, and by avoiding the publicity that usually attends malpractice suits, according to James Ahrens, assistant director of the Illinois Hospital Assn.

But John Hayes, a personal injury lawyer and a leader of the Chicago Bar Assn.'s movement against the plan, said, "I don't think justice would be served by arbitration."

Faster decisions on claims would not be very important, Mr. Hayes said. "The backlog in the courts has been reduced from seven years not too long ago to two to three years. Arbitration will take less than two to three years, but the time involved is not a persuasive factor against the rights that are given up."

Fewer awards of lower value would mean a reduction in contingency fees, but Mr. Hayes said his objections are not motivated by that: "If I thought that the plan would result in equitable compensation, I would be in favor of it. Arbitration hearings would require less time which would require a lesser fee."

Under the experimental plan, a claimant would be represented by an attorney before a three-person arbitration panel composed of a representative of the health care industry, the general public and malpractice lawyers. The American Arbitration Assn. would draw up the lists of possible arbitrators, and the parties involved would agree on a name from each list.

A similar plan has been in existence for five years in the Los Angeles area, with only one $1,-500 award on a $20,000 claim out of about 12 cases that have been settled by the arbitration method so far, according to Tom Stevens, regional director for the Los Angeles office of the American Arbitration Assn. Slightly more than 20 other claims have been filed, he said, and they should be "getting more now" that the program has been functioning for awhile.

An almost identical plan began in San Diego at the first of this year, and another is expected to start in Monterey County soon, Mr. Stevens said.

More than 750,000 incoming patients have signed the Los Angeles area agreement, Mr. Stevens said, with only an "infinitesimal number" refusing to sign since the plan went into operation on July 1, 1970. Twelve hospitals are now participating in the plan, including the Good Samaritan, St. Vincent's, Holy Cross, California and Daniel Freeman hospitals.

Mr. Stevens said there is "quite a movement out here for the expansion of the program," even though it has had no effect so far on malpractice insurance rates for hospitals or doctors.

The California program definitely influenced the Illinois Hospital Assn.'s decision to try a similar program. "We decided to do it in 1972, before the malpractice thing heated up," said Mr. Ahrens of the association. "The thought to do something different was there, and then we heard of the southern California approach."

The main difference between the California plan and the Illinois experiment is that the Illinois plan allows a patient 60 days to back out of the agreement after leaving the hospital, while the Los Angeles program offers only 30 days. However, that provision may be changed soon to 60 days, according to Mr. Stevens.

In the five years of the California plan's existence, only a "very small percentage" of patients have taken their 30-day option, he said.

Mr. Hayes of the Chicago Bar Assn. said, "We don't believe the opting out feature affords much protection to the patient. It's uncommon for malpractice evidence to show within 60 days. After that period, the patient won't be making an informed, knowledgeable waiver decision."

Although there are 12 to 15 Illinois hospitals "really interested" in the pilot program, only one, the Carle Foundation in Urbana, has signed up, Mr. Ahrens said. "We would like to get a larger sample," he said, "and we're trying for a mix of geographical locations.

"With malpractice premiums high now, a lot more people are interested in it," Mr. Ahrens said. He is basically looking for 12 to 20 hospitals with 250,000 to 300,-000 admissions per year to allow the experimental program to show what kind of savings could be realized in the whole state.

While arbitration may result in a lower award, the day-to-day costs are not low. The American Arbitration Assn. charges $150 per party represented by separate counsel for the first day of hearings, after which the fee is reduced to $25, according to Charles H. Bridge, regional director of the Chicago office of the AAA.

In addition, all parties share the cost of compensating the arbitrators for their time. Although they typically serve without charge for one or two days (which may be taken up in pre-hearing preparation), arbitrators are usually paid at the rate of $150 to $200 a day after that, according to Mr. Bridge. In California, Mr. Stevens said the rate for arbitrators is $200 to $300 a day. ▪

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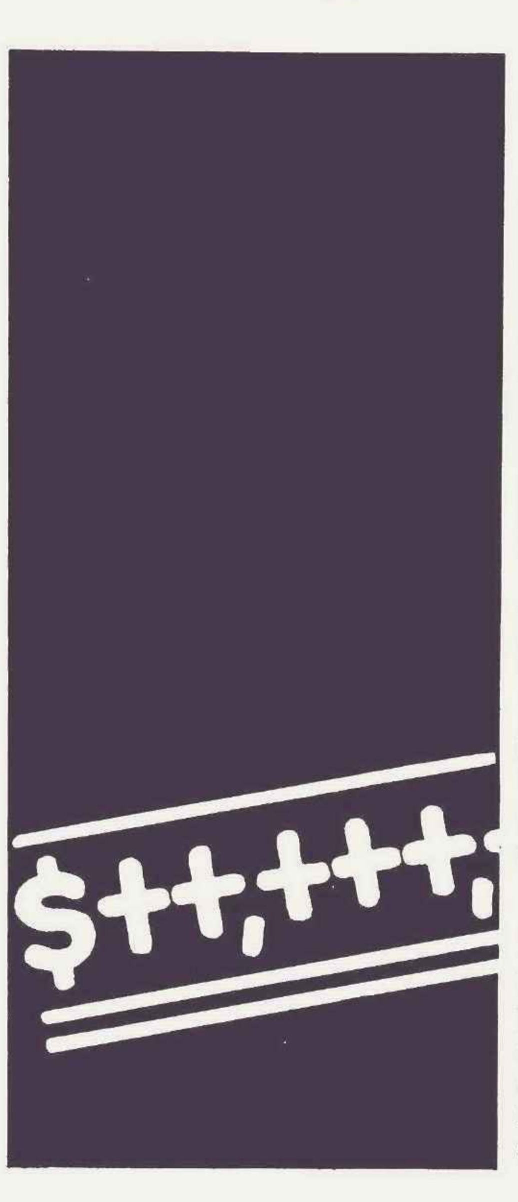

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Fireman's Fund cited for sex discrimination

SAN FRANCISCO—A group of six individual women and a group called Women Organized for Employment has filed a $10 million sex discrimination lawsuit against Fireman's Fund American Insurance Co. in U.S. District Court here.

Their attorney, Guy Saperstein of Oakland, told *Business Insurance* that the suit seeks a permanent injunction against further "discrimination" and job reprisals and a "specific plan for the inclusion of women at the board of directors and top evecutive level." He said the lawsuit also requests a jury trial.

Mr. Saperstein explained that the lawsuit is being brought under Title 7 of the Civil Rights Act of 1964 and amendments thereunder as well as under the Equal Pay Act of 1963.

"The Equal Pay Act states that women should be paid the same as men for performing the same work," he said.

Two of the six women plaintiffs are employes of Fireman's Fund, he said. Another plaintiff is a Phi Beta Kappa graduate in mathematics of the University of California at Berkeley who states that she was rejected twice in an application for an actuarial position at Fireman's Fund.

The other three are former employes.

A spokesman for the company's chief attorney said that all requests for information are being directed to the company's public relations department.

Edward O. Scharteg, vp, in charge of public relations, is known to have stated earlier that Fireman's Fund has "an affirmative action program approved by the San Francisco Human Rights Commission.

"We feel that we have made good progress in implementing our affirmative program, and we are willing to stand on our record in this area." ■

Texas hailstorm

A 20 minute hailstorm with heavy winds in the city of Austin, Tx. has cost American insurance carriers nearly $15 million, with 950 claims against Fireman's Fund American alone, which sent ten adjusters from offices as far east as Pittsburgh and as far west as Anaheim, Ca. to process the huge claims load.

Anthracite miners . . .

Continued from page 1

avenue of appeal of review whether to the corporation itself or outside the agency," he said. "I hope that Sen. Schweiker (Richard Schweiker, R-Pa.) and Sen. Randolph (Jennings Randolph, D-W.V.) will take up the cudgel on our behalf."

The cost of the takeover was estimated at $6.4 million. In exchange for assuming the pension responsibility, the fund would have assigned to PBGC all of its current claims to delinquent contributions.

Pensions of the miners, once about $150 a month, have been gradually reduced to $30 a month.

Mr. Savitsky, who took over the fund in 1973, said they had been successful in cutting administrative costs. The union this year also negotiated a contract calling for higher contributions to the fund.

The PBGC, in its letter to the fund's attorneys, said that insuring a partial termination would not be correct, as a matter of discretion, because such a course "might prompt a spate of applications from plans which, rather than revise their benefit structures or increase contributions, as the (Anthracite) fund has, will terminate a group of retirees, and apply for insurance on their behalf."

The anthracite fund is a separate entity than the much larger United Mine Workers Health and Retirement Funds. Those funds, once in critical financial condition also, are now on a sounder footing due to sharply increased revenues negotiated in the last bituminous coal industry labor contract. ■

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Miners not eligible for auto discount

HARRISBURG, PA.—Pennsylvania coal miners who thought the United Mine Workers Health & Retirement Fund qualifies as a primary program for health insurance and disability benefits may have mistakenly selected optional discounts on their no-fault auto insurance.

The UMW fund does not qualify as an acceptable plan under the state's regulations on no-fault auto discounts, Insurance Commissioner William J. Sheppard reported.

Miners having some other qualified health or disability plan could legally claim a no-fault discount. But the UMW fund will not pay health or disability benefits if auto insurance is available to cover the loss.

The only way a miner could be eligible for a no-fault discount with just the UMW fund as a benefit backup would be to absorb a $100 deductible on medical or funeral expenses and a one-week waiting period for wage loss. ■

A short term disability plan hits market

NEW YORK—American International Life Assurance Co. of New York (AILife) and the Life Insurance Co. of New Hampshire are marketing group short term disability coverage on a nation-wide basis.

The program offers coverage on a 24-hour basis to groups of at least 10 employes. Plans can be either contributory or non-contributory; the former requires 75% of all eligible employes to be enrolled, while the latter requires 100% enrollment.

Cost of the program "depends on the size of the employe group," a spokesman for AILife said, with an average cost of $5 per employe a month for a benefit of 50% of salary up to a maximum of $125 per week.

The maximum benefit schedule for less than 50 employes is 66⅔% of wages to a maximum of $100 per week. For 1,000 or more employes the ceiling is 75% of wages to a maximum of $250 in weekly benefits. ■

Bank of America covers its loan customers for life/health/disability

SAN FRANCISCO—Norman S. Wintemute, assistant vp and general manager of the Bank of America insurance department, isn't kidding when he tells you that as part of his job he functions as the head of an insurance company and an insurance agency.

Appropriately enough, the insurance company is known as the BA Insurance Co. Equally unblinkingly, the other entity goes by the title of the BA Insurance Agency. The latest edition of Best's says the fledgling company has admitted assets and liabilities of $4,355,890.

Mr. Wintemute, in an interview with *Business Insurance*, explained that the insurance company was licensed by the state of California in September, 1974, and offers coverage for life/health/disability for loan customers of the bank.

"We are limited by the Federal Reserve Board to doing business with bank loan customers," he observed.

The BA Agency administers a life/disability insurance plan, underwritten by Occidental Life Insurance Co., that covers home loan borrowers during the life of the loan.

"These enterprises leave me with about 40% of my time that can be spent on traditional risk management activities," acknowledged Mr. Wintemute, explaining that when he wears his risk management hat he abides by the principle that "insurance should act as a security blanket.

"We believe in high deductibles—high even for banks—that walk hand-in-hand with high limits," he said. "Our primary objective is to provide deductibles on major policies which will result in self-insurance on many claims.

"What we want are much higher deductibles than are average for the banking industry which will, at the same time, leave corporate earnings materially unaffected.

"A $1 million loss would not substantially injure earnings, for example, but a $10 million loss would," he said.

The parent company, Bank America Corp., reported earnings of $136,248,000 or $1.97 a share—for a hefty increase of 22.4%—for the first six months of its fiscal year, ended June 30, on total operating income of $2,356,614,000.

Bankers' blanket bond, D&O, and third party liability all have high limits, he added.

The three coverages are brokered by Marsh & Melennan, which is the bank's casualty broker. Johnson & Higgins, on the other hand, is the corporation's property broker.

"I am heavily dependent on my broker; they do the marketing," admitted Mr. Wintemute, indicating that his variety of responsibilities means that he must be able to finesse his time with the skill of a champion bridge player.

Fortunately, loss experience for the world's largest bank and its parent company has been satisfactory, he went on, noting that the bank's biggest headache, fidelity losses, is checked by a strong auditing program.

If the executive, who at one time served as the president of the organization now known as Risk and Insurance Management Society (RIMS), has any insurance concerns on his mind at present it might be the cancellation of his giant property policy by its underwriter, the Unigard Insurance Group. The policy was put together by Allen, Miller & Assoc., San Francisco.

The letter containing the cancellation came as something of a jolt to Mr. Wintemute due to the fact, he said, that "we have not had a loss."

"I assume we got a good deal," he said, in reference to the fact that the premium on the policy was moderate.

"But our exposure was low," he pointed out, "because we had a study made of the value per location of each piece of our property and we found out that we have a good spread of risk of between $200,000 and $500,000."

One problem which may haunt others but not him is the question of fiduciary liability insurance.

"As I read our D&O policy I believe that it covers fiduciary liability exposure," he stated.

Still he added: "There's no question that such exposure will be excluded at renewal time."

Lloyd's underwrites D&O coverage for BankAmerica Corp. ■

Will process drug claims for Louisiana

SAN FRANCISCO—Effective October 1, Pharmaceutical Card System Inc., a subsidiary of Foremost-McKesson Inc., based here, will process claims for the State of Louisiana's Medicaid prescription drug reimbursement program.

The contract covers reimbursement of more than 1,000 Louisiana pharmacies on a twice-monthly basis and will include the processing of some 400,000 prescription claims a month, according to a spokesman for Pharmaceutical Card System. Computer and administrative facilities are being established in Baton Rouge.

Lincoln National Life Insurance Co. is the underwriter for the state program, which is called the Louisiana Medical Assistance Program. The program provides eligible recipients with prescribed legend drugs and a limited number of prescribed over-the-counter drugs and reimburses the dispensing pharmacies for their costs directly.

Pharmaceutical Card System currently administers over 500 prescription drug plans for employe groups in the U.S., Puerto Rico and Canada, covering over 2 million families, a spokesman said.

These various drug reimbursement programs are insured by 32 insurance companies as well as self-insurance, the spokesman said.

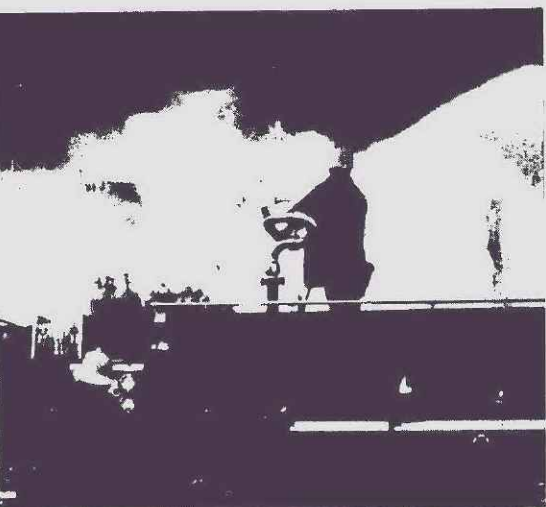
The company claims to have an unbroken six-year record of paying all valid pharmaceutical claims within two weeks of submission. ■

Arizona storm damage

Seventy-mile-per-hour winds caused an estimated $1,009,000 damage in Tucson, Az. on July 24, according to the American Insurance Assn. Most of the damage involved residences and apartment buildings, but several retail stores were hard hit.

"LIGHT WATER" AFFF controls 48-hour tanker fire in 30 minutes.

JANUARY 18, 1974. Sixteen crewmen dead when a freighter collides with a tankership loaded with 143,000 barrels of gasoline, jet fuel and diesel oil. Fire rages out of control for two days despite application of conventional foam. Emergency supplies of "LIGHT WATER" Agent are rushed in. 30 minutes after application, fire is under control. Over 90% of valuable cargo saved.



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editorial opinions

Profit or claims?

IT HAS OFT BEEN SAID that Lloyd's is in the business of making money. More recently, Lloyd's members have made it perfectly clear that they underwrite for profit, not for investment income.

Would it also be possible that Lloyd's underwriters are assuring their profitability by denying a lot of claims lately? Perhaps it is only a sign of the times that the atmosphere of increased litigation would carry over to the relationship between Lloyd's and its happy (or unhappy) clients.

Two out of the last four issues of this magazine have contained stories about major suits being filed against Lloyd's to force payment of claims summarily denied by underwriters in that venerable London institution. In one case, Flintkote Co. was attempting to recover some $474,458 which it believed should have been paid by Lloyd's under coverage afforded by a directors' and officers' liability policy. The second involved a suit by Madison Square Garden Corp. against Lloyd's to recover expenses of nearly $850,000 incurred when basketball star Willis Reed injured his knee and couldn't play for the New York Knicks, a team owned by the Garden. The Garden contends that these costs should be covered by an insurance policy issued by Lloyd's.

A popular saying in the industry is that insurers are in business to pay claims. Looks as if insurers are taking care to protect their flanks by denying quite a few, too.

Flaunting it

WE NEVER CEASE to be amazed to learn that many insurance/risk managers and their junior assistants are being forced to view their jobs as dead-end positions within their companies. This doesn't necessarily say anything bad about the individuals themselves, but it does say something about a de facto situation that's been evident in corporations for many years.

It may not be intended by top management, insurance managers have told us, but it's a fact of life. Or, as one insurance administrator with an MBA in finance told us recently, "The insurance department should be viewed as a great place to get experience and training, and then move on. But that's just not the way things have worked.

Ever since the days of "insurance clerks," there's been a tendency of top management to shuffle people off into insurance departments and forget them. And despite the increased recognition of good risk management's importance to the corporation, it appears that all too seldom are good risk managers rewarded with new authority, or by means of promotions into other departments. There's been a sad lack of movement of "staff" managers in insurance departments into line management or operations departments.

It is a rare occasion indeed to learn of a former risk manager moving into the ranks of senior executives within major corporations. There are some, yes. Their names and accomplishments have appeared in these pages on occasion. But we think there should be more, based on what we believe to be a valid premise, that the insurance department affords one of the best financial management training grounds in a company. Furthermore, insurance department personnel often have a grasp of all operations—an overview—that few other departmental managers have an opportunity to assimilate.

Risk managers, like any other managers, however, need to know there is a chance for them to be mobile within their own companies. If they don't, how can companies expect to attract the best of the fresh young managers into risk management. They can't, of course.

At the moment, the fact persists that many bright young business people who've somehow gotten into corporate insurance departments of big companies see themselves as having very few options: They can find new challenges by leaving their companies and going into the insurance departments at other companies. Or they can move into consulting or insurance brokerage firms, make better money and find new challenges (which is not the worst that could happen, of course, but for every such move corporate risk management is the loser, and in the end corporate risk management could become the "captive" of outside suppliers and consultants).

In any event, corporate risk managers are in dire need of some promotion at the top management level. In far too many cases we continue to find bright and articulate corporate risk managers unwilling to speak out actively on behalf of risk management within their own companies or risk management in general.

In short: If you've got it, why not flaunt it?

Stepping back

AS HAS BEEN noted in this space earlier, the editors of *Business Insurance* will release a special report on the property/casualty insurance industry in the next issue of this magazine, Sept. 22.

The insurance industry today is faced with some very crucial problems, and some of them not of its own making (one could hardly say that the malpractice situation has been brought on by insurers).

In our Sept. 22 issue we'll be taking a look at those problems and how the industry is facing them as it steps into the last 25 years of this century.

In researching for the issue our reporters and editors have sought to step back from the trees to view the entire forest. Communicating the view from that perspective, we feel, is something the insurance industry has done poorly.

A major portion of our industry report will be devoted to publishing the transcript of a roundtable session the editors of *Business Insurance* had late last month with the chief executives of six major insurance companies. Over coffee in our New York offices, the industry executives had a free-wheeling discussion about the problems of the present and the challenges to come. One thing is certain: These executives know what the problems are. The discussion, we think, produced some possible solutions and we look forward to presenting them in the next issue.

letters

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

Extensively involved

To the Editor: Our company was particularly distressed with the error appearing in the July 28 issue of *Business Insurance* which stated that Synercon "bowed out of the employe benefits consulting business", when, in fact, we are extensively involved in this area.

Group Management Services, a division of our Blair, Follin, Allen & Walker affiliate, is totally involved in the employe benefit consulting area. The firm devotes 100% of its time to the analysis, design, implementation and operation of employe benefit programs across the nation, within the scope of client goals and aspirations.

Several of our Group Management Services' customers were quite concerned with this segment of your article, and have, understandably, asked for a full explanation. I sincerely hope that you will take the opportunity to rectify this matter immediately through a retraction and correction statement.

Synercon Corporation has followed with great interest the in-depth reporting of *Business Insurance*. We appreciate your overall treatment of our company in the past, and, for this reason, are confident that this unfortunate error will be resolved with the utmost expediency.

Robert J. Jennings
Marketing manager, Synercon, Nashville, Tn.

Merit in retro plans

To the Editor: Before reading far enough to find out from his letter in your July 14th issue, it was evident that Justin S. Lencke was an insurance agent or a "dyed-in-the-wool" company man.

At first, my impression was that this bias against both self-insured and retro workers' compensation plans was just self-serving; but, later, I came to the conclusion that he must be limited to serving the local corner drug store or the village machine shop—certainly not firms large enough to employ a full time risk manager.

While not for everybody, Mr. Lencke must realize that there has to be merit in both self-insurance and retro plans for their use to be so widespread. I question his cost figures: we are paying substantially less for administration of our self-insured industrial injuries, including na-

Continued on page 18

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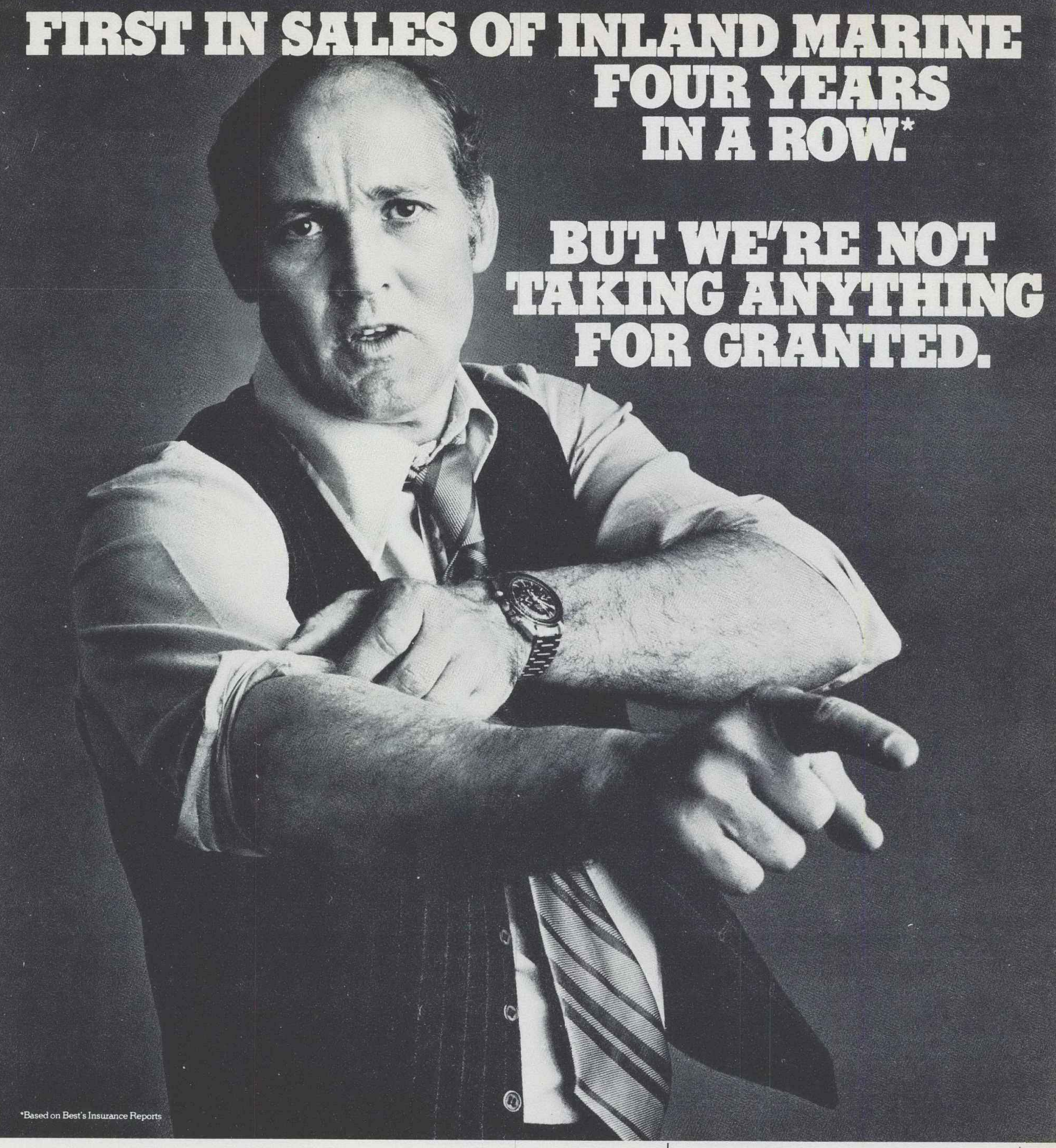

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Pensions not exempt from UK wage freeze

LONDON—Pension managers warned the U.K. government that the plan to ban pay hikes of more than $13 a week as a counter-inflation measure will force them to delay any pension improvements.

The government refuses to exempt pension funds from the rule that pay raises and associated benefits improvements must be limited by law if the nation is to recover economic stability and cut inflation to 10% from 20%.

Effective from Aug. 1 the government has banned any pay raises of more than $13 a week as an emergency step towards reducing inflation. It has also frozen any changes in other benefits which might have enabled employers to get round the pay ban by "back-door" incentive schemes.

This means that it is reversing previous hopes to improve pension rights for many workers by 1978, which Labor Ministers were until now pressing industry to adopt.

Laurie Cottrell, general manager of Sun Life Assurance group, which supervises many large pension plans, commented: "The ruling will slow down the momentum towards better pensions, and means that many people will get lower pensions than they would otherwise be entitled to receive, if wages had risen normally.

"Pensions have long been recognized as a method of saving, as well as supplying investment for industry through the use of their funds, and surely this should be encouraged at the present time," Mr. Cottrell said.

But the Labor government has insisted that for the next 12 months new benefits can only be allowed if the cost comes within the $13 a week limit allowed for wage improvements. ■

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letters

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tionwide claim service, excellent engineering, excess coverage, and attorney representation.

Mr. Lencke should look at some of the plusses, notably the cash flow value (worth over 10% to us)—look how long insurance companys have the use of that reserve money they dole out over the years on serious cases. And, more important, the psychological impact self-insurance or retro rating has on profit-conscious local management.

In addition to the firm's adequate size and spread of risk, the successful self-insurer probably has a risk manager with the expertise and management backing to use the program to improve safety. Neither self-insurance nor retro rating are worth the effort if the objective is only a new way to handle the same losses. Mr. Lencke should not be condemning these plans, rather he should be condemning their use by firms not qualified to take proper advantage of them.

Larry Bell
Risk manager, Kaiser Aetna, Oakland, Ca.

Citation

To the Editor: I am interested in obtaining further information regarding an article by Margaret LeRoux in a back issue of *Business Insurance*, entitled "Use of Trusts for Self-insured Benefits Gets Double Boost."

Ms. LeRoux referred to a Missouri Supreme Court decision in her article. I have searched through our Tax Library and cannot find the decision which she referred to. I would appreciate it if you could send me the citation for the case.

Roberta Axelrod
Corporate Tax Dept., First National City Bank, New York, N.Y.

Editor's note: The case in point involved the Superintendent of Missouri v. Monsanto Co., 58-310 Superior Court of Mo., division #2, 1974.

Marsh Mac announces new name in Bermuda

Marsh & McLennan Inc., New York, reorganized its Bermuda-based subsidiary responsible for captive insurance company management, renaming it Marsh & McLennan (Bermuda) Ltd. The company, formerly called Marsh & McLennan Management Ltd., provides management or consulting services for 23 captive insurance companies. David Vaughan, managing director, will continue to head Marsh & McLennan (Bermuda) Ltd.

info for buyers

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

• **Practical Risk Management: a Guide for the Part-time Risk Manager or Insurance Buyer** compiles 12 articles by Edward W. Siver that originally appeared in Risk Management magazine. Topics include insurance management, loss prevention, risk retention and catastrophe planning. Copies are $2.00, available from the American Society of Insurance Management, Dept. RM, 205 East 42d St., New York, N.Y. 10017. Bulk prices are available.

• The **1973-1974 List of ASTM Publications**, issued by the American Society for Testing and Materials, lists more than 600 ASTM publications dealing with standardization test methods and specifications for materials, the knowledge of materials and materials evaluation. For a free copy write ASTM, 1916 Race St., Philadelphia, Pa. 19103.

• **Seedman Errors and Omissions**, underwritten by Lloyd's of London, discusses a specially developed insurance program exclusively for members of the American Seed Trade Assn. For a free copy of the brochure write Richard Rune, Il. R. B. Jones, 175 W. Jackson Blvd., Chicago, Il. 60604.

• **Social Security Benefits & Taxes—Their Impact on the Economy & on Future Private Pensions,** published by Alexander & Alexander Inc., is based on a speech by Geoffrey N. Calvert given at the American Pension Conference in December, 1973. It raises questions regarding the future of the Social Security system and its likely future impact on private benefit plans. For a free copy, write R. Scott Taylor, Director of Communications, Alexander & Alexander Inc., 1185 Avenue of the Americas, N.Y., N.Y. 10036.

• **Leased Fire Protection Systems** explores the alternatives to outright purchase of sprinkler systems. The booklet covers the effects of leasing on insurance premiums, capitalization and taxes. For a free copy write to Manager of Marketing Services, "Automatic" Sprinkler Corp., 1000 E. Edgerton Rd., Cleveland, Oh. 44147.

• **Money Moves—But Sometimes It's Better Staying Put** is a booklet available from All Risk Management Services Inc. The booklet describes ARMS's services available to risk managers. For a free copy write Joseph Tapfar, ARMS Inc., 160 Water St., New York, N.Y. 10038.

• **Real Estate Investment Counseling for Corporate Executives: One Part of a Compensation Program** is offered by American Realty Consultants Inc. It discusses assistance available to corporations in providing real estate investment counseling for key employes. For a copy write American Realty Consultants Inc., Norb Wall, 222 South Riverside Dr., Chicago, Il. 60602.

• Fire protection for electric generating plants is described in a brochure from "Automatic" Sprinkler Corp. **Special Hazard Fire Protection-Electric Generating Plants** covers both ordinary and special hazards associated with the turbine/generator, boiler, fuel supply, transformers and other vital plant systems. For a free copy write: Manager of Marketing Services, "Automatic" Sprinkler Corp. of America, P.O. Box 180, Cleveland, Oh. 44147.

• **Washington Information: National Health Insurance** is a complete information service on the subject of national health insurance which includes monthly newsletters, special bulletins to keep subscribers informed on fast-breaking activities, summaries of House ways and means committee NHI testimony, etc. Subscribers are provided with a loose leaf binder including summaries of the major proposals and other basic resource documents. For subscription information write Washington Information: National Health Insurance, 399 Howard Blvd., Mt. Arlington, N.J. 07856.

• Western Drinking Fountain has a 40-page catalog describing **Western Safety Equipment.** The catalog describes more than 150 eyewashes, deluge showers, and eye/face wash units. There is a complete section on excessories and dimensional drawings are included. For a free copy write Western Drinking Fountain, P.M. Lindley, Director of Advertising, Box 47, Glen Riddle, Pa. 19037.

• The Wyatt Co. is offering a descriptive brochure—**Earthquake—a Manageable Risk**—on a technique for determining earthquake probability. In addition to describing the company's data bank and computer program, the brochure explains various magnitude and intensity ratings. A comprehensive bibliography on earthquakes is also included. For a free copy write to Michael W. Cetera, The Wyatt Co., One First National Plaza, Chicago, Il. 60603.

• The new pension reform law has defined the fiduciary liability of trustees, eliminated exculpatory provisions in trust documents and has cleared the way for the purchase of liability insurance for trustees and others they hire. An article entitled **The Latest Developments in Pension Trust Liability,** by Bernard J. Daenzer, president of Howden Swann Group for Wohlreich & Anderson Ltd., is available free to interested parties. Write Anthony C. Bova, CPCU, senior vp, Wohlreich & Anderson Ltd, 55 John St., N.Y., N.Y. 10038.

• **A Circular on Aldon Glide-Slide** offers *Business Insurance* readers illustrations and information on electric machines for opening sliding doors of railroad hopper cars. These can be used to ereplace hand bars. For a free copy write R. V. Switzer, Aldon Co., 3338 Ravenswood Ave., Chicago, Il. 60657.

• Anchor Corp's **An Investor's Handbook,** describes the types of financial services it offers. The brochure explains free services

available to Anchor Group shareholders as well as the financial counseling, products and services which the firm and its affiliates provide. For a free copy of the brochure, write B. West, Anchor Corp., 40 Parker Rd., Elizabeth, N.J. 07207.

• This booklet discusses how Arthur D. Little Inc. can provide technical backup and expert witness to attornies and insurance companies involved in **Product Liability Litigation.** Some case histories are included. For a free copy write Irving J. Arons, ADL Inc., 15 Acorn Park, Cambridge, Ma. 02140.

• **A Custom Service for Banks** describes the uni-group approach to property management and control and the diverse record needs for bank owned, managed or leased property. Bankers may obtain this free booklet by writing E. J. Francione Jr., The American Appraisal Co. Inc., 525 E. Michigan St., Milwaukee, Wi. 53201.

• **PacFacs** (programmed appropriation commitments—fixed asset control system) is a complete system used for the control of appropriations and construction-in-progress information. Designed by American Valuation Consultants Inc., it provides reporting of all cost, capital and expense, and the time commitments—from the authorization of an expenditure to the beginning of fixed asset depreciation. For a descriptive brochure write Davis R. Blaine, vp, American Valuation Consultants Inc., One North Broadway, Des Plaines, Il. 60016.

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

• Kwasha Lipton has released a booklet entitled **Summary of Impact on Savings Plans of Employe Retirement Income Security Act of 1974.** It presents a summary of the major provisions of ERISA that affect savings plans. For a free copy of the 23-page booklet, write to Henry F. Magnusen, Kwasha Lipton Inc., 429 Sylvan Ave., Englewood Cliffs, N.J. 07632.

• The Profit Sharing Research Foundation's latest study, **Pension, Profit Sharing, or Both?**, is now available. The booklet points up for managements with only pension plans the merits of supplementing these plans with profit sharing, thrift, or stock plans. Cost of the 56-page booklet is $4, postage pre-paid. To order, write to Bert L. Metzger, Profit Sharing Research Foundation, 1718 Sherman Ave., Evanston, Il. 60201.

• Proceedings of regional seminars conducted earlier this year on **ERISA Rules and Regulations Affecting Joint Trusts** have been published by the International Foundation of Employe Benefit Plans. The 95-page booklet is a composite of discussions during the one-day programs held May 28-30 in New York, Chicago and San Francisco. The booklet focuses on the issues facing joint labor-management employe benefit trust funds as they strive to comply with ERISA. Cost is $5 to members, $7.50 to nonmembers. To order, write: International Foundation of Employe Benefit Plans, P.O. Box 69, Brookfield, Wi. 53005.

• American Insurance Assn. has released an employe-oriented pamphlet with on-the-job fire prevention tips, titled **No Work Till Further Notice Because of Fire.** It contains a number of dos and don'ts that includes the proper way to handle overheated machinery and oil-soaked rags. The pamphlet is available in quantities of 100 for $2 or 1,000 for $15 from the American Insurance Assn., 85 John St., New York, N.Y. 10038.

• Allstate Insurance Co.'s **Automotive Air Bags—Questions and Answers** provides research, developments and current experiences drivers have had when an air bag is deployed during a crash. This booklet also answers many consumer questions about air bag technology and operation in crashes. For your free copy write Safety Director-F3, Allstate Insurance Cos., Allstate Plaza, Northbrook, Il. 60062.

Blues seek substantial increase in premiums

NEW YORK—Blue Cross and Blue Shield of Greater New York filed requests for an increase of 23% in hospitalization premiums, 11.1% for surgical-medical coverage and 22% for Medicare supplementary benefits coverage.

This is the fifth consecutive year that the Blues have asked for premium increases. The last increase granted by the New York Insurance Department was 16.8% last March.

A spokesman for Blue Cross said that if the current increase is granted no further increases would be needed "until well into 1977." The increases will affect approximately four million plan subscribers.

The state insurance department will hold hearings on the Blues request in late September or early October.

Rate hikes in two other Eastern states will commence this fall.

Increases for the Blues are also being considered in Pennsylvania where Blue Cross of Greater Philadelphia and Pennsylvania Blue Shield both requested 27% increases in premiums.

Blue Cross of Western Pennsylvania was granted a 27.5% increase, effective Sept. 1, for general health plan premiums affecting 405,000 group and non-group subscribers.

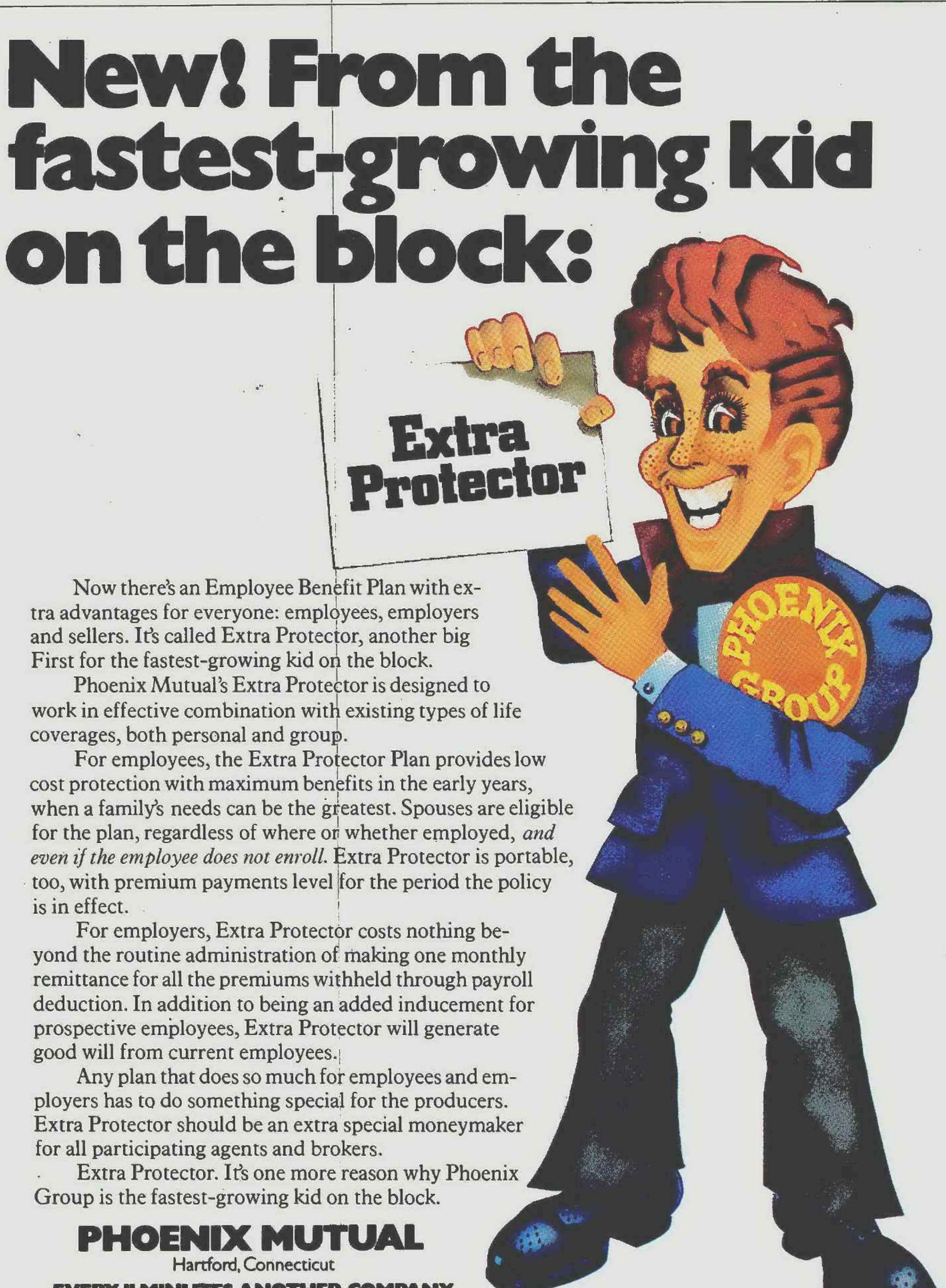
A 25% increase for 245,000 members of the Plan's "65-Special" program that provides supplementary Medicare benefits was also granted.

Hearings will be held Oct. 1 on the Pennsylvania Blues latest requests for increases which will affect 1.5 million policyholders in the greater Philadelphia area and 6.5 million Blue Shield subscribers.

In New Jersey, small group or community rated subscribers to that state's Blue Cross and Blue Shield plans will pay 29.8% more in premiums beginning this month.

In approving the increase, James Sheenan, state insurance commissioner, said that he was calling on both plans to slow down the rate of increase of their operating expenses in the interest of economy.

Commissioner Sheehan said he would issue another order within the next several weeks in which he would comment on the Plans' operations and make recommendations for improvement. ■



Nuclear insurers favor continued government role

By TIMM HERDT

NEW YORK—Preliminary hearings on a bill to renew the Price-Anderson Act, an unprecedented 1957 statute which provides for government indemnification of nuclear reactors, are slated to begin soon.

When the act was passed there was a great deal of uncertainty about the safety of reactors and a reluctance on the part of the private sector to insure nuclear risks. The continued development of peaceful uses of the atom was contingent upon government indemnification.

In 1975 the uncertainty, or at least the controversy, still lingers. Ralph Nader calls for a moratorium on the construction of new nuclear power plants. A group called the Union of Concerned Scientists last month presented a petition to the White House and Congress calling for "a drastic reduction" in the construction of new reactors.

But other signs indicate both a growing acceptance of nuclear power among the public at large and a consistantly good safety record for existing power plants. A recent public opinion poll conducted by Louis Harris and Assoc. found 63% of the public in favor of construction of new nuclear plants.

A more important indicator of the maturity and acceptance of nuclear power, however, comes from the insurance industry.

As Congress considers an Administration proposal to extend the expiration date of Price-Anderson from August 1, 1977 to August 1, 1987, the private sector —in the form of the Nuclear Energy Liability-Property Assn. —will testify in favor of the bill which will signal what NEL-PIA calls "the gradual phasing out of the government indemnification" program.

The act originally established a $560 million liability limit, of which only $60 million was provided by the insurance industry. Now, although the limit remains the same, the private sector provides $125 million of the coverage.

The reason for the industry's increased commitment is simple: Good experience. The nuclear liability pools—NEL-PIA, the association of stock companies, and its counterpart of the mutual companies, the Mutual Atomic Energy Liability Underwriters—have paid only $567,000 in liability losses from 1957 through June 30, 1975. "The experience we've had in the last 20 years has been just incredible," boasts Joseph Marrone, general counsel fo NEL-PIA.

Mr. Marrone can point to some impressive developments to document his claim. In addition to doubling their capacity, the pools have been able to refund some $8 million of premiums to nuclear insureds since 1967.

Combined capacity of the liability and property pools climbed to $300 million in January—a 25% increase from 1974. Over 100 stock companies now participate in NEL-PIA. Combined with mutual companies and foreign reinsurance companies, the pools now claim 145 participants.

One reason, of course, for the growing participation is the expanding premium base of the pools. From a single policy in 1957, the liability and property pools now write 450 policies—346 liability and 104 property.

There are now 55 operating nuclear power plants nationwide, with an additional 63 under construction and 103 awaiting construction licenses from the Atomic Energy Commission. The plants now in operation provide approximately 8.5% of the nation's electricity.

Premiums for the pools totaled $29 million in 1974. While this indicates a sizeable premium growth, one NEL-PIA official indicated this is a pretty small premium base for the $300 million risks it insures.

Of the 346 liability policies, only 161 cover an existing reactor. These include not only the power generators of the utility plants, but also reactors used by various research institutions and universities. The rest of the policies cover nuclear suppliers and transporters.

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The number of property policies is considerably less. This is due to competition from Nuclear Mutual Limited, a Bermuda-based captive of several utilities including Commonwealth Edison and Consolidated Edison.

The growth in both participating insurers and insureds would not have been possible without good claims' experience. The safety record reads like this: 27 incidents in 20 years, net loss of $570,000.

None of those incidents have arisen from a reactor accident and there have been no accidents involving the general public; claims have been made only to workers directly involved in the handling of nuclear materials.

The bulk of the total paid losses have gone for the settlement of two incidents which resulted in combined settlements of $400,000. The first of those, made in 1963, went to a worker who contracted cancer as a result of exposure to nuclear materials. The settlement in that case was $325,000. The other major incident involved a Rhode Island worker who died in 1964. His settlement was $76,000.

Despite a 1965 no-fault amendment to Price-Anderson, there have been no major claims since 1964. The remainder of the losses have gone to settle 25 minor incidents, mostly involving contamination of property resulting from leakage of nuclear material during shipment.

The relative safety of the nuclear industry will soon receive further documentation with the release of the latest AEC reactor safety study.

A draft of the study, prepared under the direction of MIT professor Norman C. Rasmussen, shows reactors to be dramatically safer than previous reports had indicated.

Previous studies had calculated the outer limits of a reactor disaster. The 1957 WASH 740 report, using this method, predicted up to $7 billion in damages and 3,400 deaths would result from such a disaster. While nuclear critics often cite this report as evidence of the danger of nuclear reactors, proponents claim the study calculated the effects of a disaster that, realistically, could never happen.

The Rasmussen report, on the other hand, takes into account the various safety measures implemented by the nuclear industry and the history of the industry, which has shown 200 reactor years without a fuel melting—the incident which would trigger the most potential damage.

The preliminary report shows the likelihood of one core melt as one in 17,000 per reactor per year. This means that if, as anticipated by 1980, there are 100 reactors in operation that one such accident would occur once in 175 years.

Interestingly, the chance of a major disaster—one which would cause 1,000 or more fatalities—is listed in the draft report as once every one million years—the same as the probability of a meteor striking a major population center causing 1,000 or more deaths.

Yet even with the developments on the liability side, the nuclear experience in property hasn't been as encouraging.

Total property losses from 1957 through May 31 of this year have been $21 million. The pool writes an all-risk property policy and most of the property losses have resulted from "conventional fires," according to Mr. Proom.

Despite the loss of property clients to utility captives—and self-insurance in the case of TVA—and the $21 million in losses, NEL-PIA has been able to reduce property premium rates yearly since 1972 by giving credit to its insureds. The initial credit in March of 1972 was 7.7%. The credit rate has increased each subsequent year to its current level of 21.4%.

The cost of insuring a nuclear power plant remains, however, higher than insurance costs for fossil fuel plants. Mr. Proom says NEL-PIA is in the process of making a study of the comparative costs of the two, but for now would only say the comparison is "very difficult to make." ■

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When shipping plays accounting who pays for Joe's broken leg?

By LINDA MOSKOWITZ

NEW YORK—While company-sponsored recreational programs can sometimes lead to better employe relations, they can also result in some sticky legal questions when injuries are sustained during such activities.

Whether the subsequent medical care should be paid for from the employe's health plan or from workers' compensation is contingent upon many factors, and laws governing the issue of employe compensability vary from state to state.

It's "specifically a legal question, not a corporate policy," explains Howard Weber, risk manager at 3M Corp. in St. Paul.

He describes the Minnesota workers' compensation law as "quite broad and liberal in considering what activities are in the course of employment."

While there are many variables in deciding a case, Mr. Weber believes his state's laws favor workers' compensation payment in the case of activities or sports played between different companies.

Intra-mural games, or games between employe teams at the same firm, however, are generally non-compensable and are paid by the employe's medical plan.

3M offers its employes a fairly extensive recreation program, especially in the St. Paul area.

The employe club in St. Paul provides a golf course and club house, picnic grounds, tennis courts, ski and tobogganing hills, archery ranges, skeet shooting and snow-mobile trails among its facilities. A pool is also being planned, and the club has its own restaurant.

To handle the sizable risk posed by this enterprise, a separate non-profit corporation was formed by 3M called the 3M Club of St. Paul Inc., according to Mr. Weber.

The 3M Club, while working closely with Mr. Weber's office, purchases its own insurance.

Described as a "good-sized corporation" by Mr. Weber, the insured value of the club's property is over $1 million, Mr. Weber said.

The liability and workmen's compensation carriers are the same for 3M and the 3M Club, "so there will be no argument as to which insurance company is involved," in the event of a suit, Mr. Weber said.

Other carriers used, though, are not necessarily the same as those used by 3M. The club, according to Mr. Weber, does have "all the normal coverage" a corporation would have.

Not all companies provide their employes with such a wide scope of activities.

The Pillsbury Co. in Minneapolis has no recreational facilities, but many employes participate in inter-office teams for bowling, golf, softball and tennis, according to Douglas L. Hail, director of corporate insurance at the company.

However, Mr. Hail explained that Pillsbury has "no real organized recreational programs," and in the case of employe injuries occurring during these events, the state workers' compensation board decides who pays for medical benefits.

The few instances Mr. Hail recalled where employe accidents occurred, the injuries were always held to be compensable. But, he said, these have been "pretty few and far between," citing only three or four cases in the 25 years he's been with the company.

Degree of company sponsorship and support given to employe recreational events is an important point considered by workers' compensation boards when debating whether a case is compensable or not.

Two landmark cases in New York State helped set precedents for this state's workers' compensation board on this issue. These are Wilson vs. General Motors, 1949, and Tedesco vs. General Electric in 1953.

The major points involved in these cases, as outlined in a talk given earlier this year by Chet Feldman, a Liberty Mutual loss prevention representative, are degree of support and sponsorship of the company, amount of benefit derived by the company, and injury out of and in the course of employment.

The Wilson vs. General Motors (GM) suit arose from an injury during a baseball game where the employes had organized their own league and the game was played on their own time and not on company premises.

"Mr. Wilson's claim for compensation against General Motors was denied," explained Mr. Feldman.

"The games were not advertised and no outside publicity attended their playing. The league was not connected with the employer nor subject to the employer's control in any way," continued Mr. Feldman. "In short, the employer gained no business advantage from the league activities."

In the case against General Electric (GE), the firm was found to be highly involved with the recreational program as it was highly influential in the activities of a separate organization, the General Electric Athletic Assn. (GEAA).

The injury in question was sustained during a GEAA softball game. The board ruled against GE because, as Mr. Feldman pointed out, "In addition to all GEAA activities being at the employer's premises, the activities were in a large degree dominated by and supported by the employer."

These cases represent two extreme situations, Mr. Feldman believes. "Most often the degree of a company's support, sponsorship, and derived benefit fall somewhere in the gray area between the GM and GE extremes," he said.

"In the end," he continued, "the individual facts developed in any given case must be weighed and considered by the workers' compensation board, which must decide how much support, sponsorship, control and benefit was exercised by, or derived for, the company." ■

Speir buys 11th agency

Atlanta-based Speir Insurance Agency Inc. acquired its 11th agency in that metropolitan area —American Underwriters Insurance Agency Inc., Tucker, Ga. Speir, which handles both commercial and personal insurance, began its expansion program in mid-1974.

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legal brief

Ambiguity in accident and health policy makes court favor employe

THE SUPREME COURT of Louisiana has ruled that a group health and accident insurance policy that provided coverage during an insured's travel on the business of his employer-policyholder was ambiguous as to whether it provided coverage from the minute the insured left his home until the moment of his return.

Consequently, the court construed the policy in favor of the employe by holding that the policy covered the employe's death in an air crash. The crash occurred after the employe had attended a business meeting for his employer but while he was on a flight with a friend for reasons completely unrelated to the employer's business.

This action was brought by the widow of W. K. Lea (Lea) to recover $100,000 in accidental death benefits under a health and accident group insurance policy issued by St. Paul Fire and Marine Insurance Co. (St. Paul) to the Louisiana Hospital Assn. (Assn.). Lea was a member and chairman of the Hospital Credit Union Committee and was, by virtue of this membership, insured under the policy. Lea had left his home in Winnsboro, Louisiana to attend a Credit Union Committee meeting in New Orleans. After the meeting, and while enroute back to his home, he stopped in Baton Rouge. Lea flew as a passenger in a private plane piloted by a friend from Baton Rouge to White Castle, Louisiana, where he was killed in an airplane crash. This flight was personal and unrelated to association business.

The group policy provided coverage for committee members for "24-hour business travel and sojourn outside city limits. . ." while "on the business of the policyholder." The policy also provided that coverage began at the actual start of the business trip and terminated "upon the insured person's return to his place of regular employment or home . . ." Both the trial court and the court of appeals denied recovery to the plaintiff.

St. Paul contended it was contemplated that only "business travel" and "sojourn" while on the "business of the policy holder" would be covered by the policy and that Lea's death when he "deviated" for personal reasons occurred outside the policy coverage.

Although inclined to believe that the language of the policy was unambiguous in providing 24-hour coverage, the supreme court deferred to the lower courts' findings that the policy language was ambiguous. Thus, the court held that because of the ambiguity, particularly with respect to the words "business of the policy holder" in the "description of hazards," Lea's death was covered and his widow was entitled to recover $100,000 from St. Paul. *Lea v. St. Paul Fire and Marine Insurance Co.*, Supreme Court of Louisiana, January 20, 1974 (BI/01/Au.-$2)

Bee stings

Can a bee sting constitute a hazard incident to employment under a state's Workmen's Compensation Act? Yes, according to the Supreme Court of Tennessee. The court concluded that, in this case, the bees in the plant were part of the environment of working on the assembly line, and, consequently, were a risk or hazard of employment.

The employe, Gladys O'Dell,

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

worked on an assembly line assembling radio chassis. While performing the task assigned her by her employer, O'Dell felt something moving in her hair. On reaching to her head to determine what it was, she was stung on the middle finger of her right hand by a honey bee. O'Dell suffered a violent allergic reaction to the bee sting, evidenced by "swelling all over her body." She did not respond to treatment as expected and was hospitalized for a week for treatment with the drugs, dramamine and cortisone. Although the swelling subsided, O'Dell continued to complain of stiffness, swelling and numbness.

In ruling that the bee sting was a hazard incident to O'Dell's employment, the court cited testimony at trial that bees often entered walls of buildings in the warm summer months and came out later in the year. There was evidence that the plant here had been treated to kill bees.

In addition, O'Dell testified that she and other employes had seen bees in the plant on several occasions before she was actually stung. Finally, the court noted that after O'Dell was stung, the company again hired exterminators to kill bees in the plant.

Thus, having sustained an accidental injury in the course and scope of her employment, the court believed that O'Dell was entitled to benefits commensurate with the disability resulting from the accidental injury as provided in the Workmen's Compensation Act. *Electro-Voice, Inc.* v. *O'Dell*, Supreme Court of Tennessee, January 6, 1975, Cooper, J. 519 S.W. 2d 395 (BI/04/Au.-$2)

Automatic sprinkler warranty

A rubber company brought an action against American Star Insurance Co. and its agent for money damages under two policies of fire insurance for the loss of stock due to fire. At issue was whether the policy covered stock which was stored in a building prior to completion of construction and installation of a sprinkler system, which was lying outside the building awaiting installation at the time of the fire.

The Supreme Court of California held that the stock was covered and American Star was liable for damages.

The court pointed out that the automatic sprinkler warranty of the two policies covered stock of the insured while located anywhere on the insured's premises. Also, the warranty expressly granted permission for buildings containing covered property to be in the course of construction. Most important, the court noted that the warranty failed to specify the insured's obligation with

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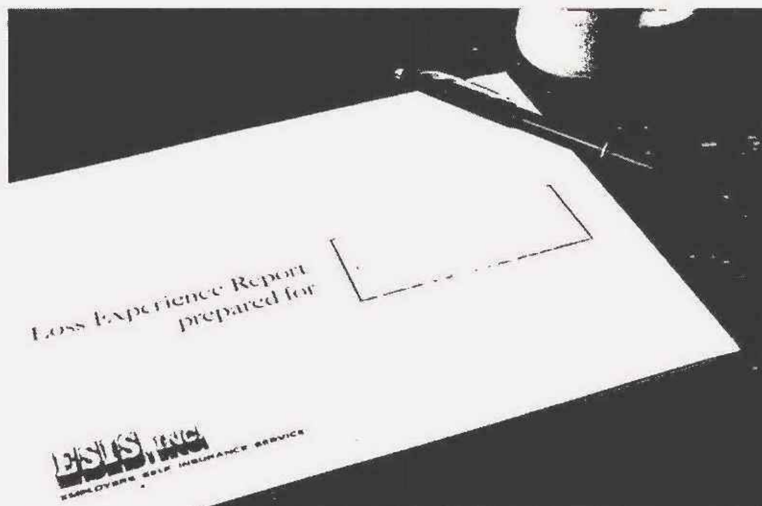

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respect to sprinklering of newly-constructed buildings.

Accordingly, the court ruled that the warranty required only that the insured use "due diligence" in installing a sprinkler system in a new building whose construction was commenced after the issuance of the policies. The warranty did not prohibit, the court stated, use of the building for storage of stock pending installation of the sprinkler system.

An insurer who wishes to condition its contractual liability upon the insured's conformance with certain conduct must do so in clear, unambiguous language, the court stated. *Holz Rubber Co., Inc.* v. *American Star Insurance Co.*, Supreme Court of California, April 18, 1975, Sullivan, J. 533 P.2d 1055 (BI/05/Au.-$2)

Group accident insurance

In this action an insured under a group accident insurance policy sought to recover benefits against the Travelers Insurance Co. for the accidental loss of the sight of one eye. The trial court entered a judgment in favor of the insured against Travelers for the principal sum of $50,000. The only issue on this appeal concerned the time from which interest accrues on the principle sum of the policy.

The Court of Appeals of Kentucky ruled that interest accrues on amounts payable under an insurance policy only from the time that the payment is due under the terms of the policy unless the insurance company denies liability before the filing of a proof of loss or other prerequisite to payment.

The trial court had held that the insured was entitled to interest on the principal amount from the date of the accident, December 12, 1967. Travelers contended that the insured was not entitled to any interest prior to the date he filed his proof of loss, March 1, 1971. Travelers had paid the principal sum, and all interest accruing after March 1, 1971. In reversing the trial court's judgment, the court noted that as a general rule, interest on the amount payable under an insurance policy commences to run from the time when the loss is payable by the terms of the policy.

Under the terms of this policy, the $50,000 payable to the insured was not due until he filed the proof of loss on March 1, 1971. Had the insured made demand for payment under the policy prior to that time, Travelers would have been under no duty, according to the court, to make payment under the terms of the policy.

The court rejected the insured's contention that Travelers lost the right to avoid the payment of preclaim interest by its denial of liability. The court pointed out that Travelers did not deny the insured's claim until after he had filed the proof of loss.

"The fact that Travelers ultimately denied liability did not warrant an inference that it waived its right under the policy to require filing of a proof of loss as a condition to payment," the court stated. "Travelers cannot be said to have elected to pay interest from December 12, 1967," the court concluded, "when there is no evidence that it had any knowledge of the claim before the insured filed his proof of claim on March 1, 1971." *Travelers Insurance Co.* v. *Hawks*, Court of Appeals of Kentucky, December 13, 1974, *rehearing denied*, February 7, 1975, Park, C., 517 S.W.2nd 740 (BI/-

Workers' Compensation

May a nurse's aide recover workers' compensation benefits for injuries arising out of an accident to which there were no eyewitnesses and which occurred during the course of her employment at a hospital? The Supreme Court of Nebraska ruled she could recover and affirmed an award to her based on temporary total disability.

In this case Kathleen H. Chester (Chester), a nurse's aide at the Douglas County Hospital slipped and fell while leaving the dining area of the hospital where she had gone to get some fruit juice for one of her patients. While there were no eyewitnesses to the actual fall, another employe walking ahead of Chester heard her call out and turned to observe her lying on the floor. Chester was taken to the emergency room and examined. The doctor found no fractures and prescribed aspirin and rest.

After staying home one day, Chester returned to work but after experiencing back pains she sought medical care. She was subsequently hospitalized in pelvic traction for more than two weeks. Upon release and after intermittent employment, interrupted by reoccurring pain, Chester was terminated by the hospital for absenteeism. No evidence of permanent physicial disability had been disclosed, nor was there any objective evidence of any physical injury of a permanent nature.

A workers' compensation court awarded Chester compensation for 13 weeks and four days in addition to the payment of certain hospital and medical bills. The hospital appealed this decision, contending that there was no evidence to prove that Chester had sustained personal injury from an accident arising out of and in the course of her employment. They also argued she should not be allowed to recover for subjective symptoms apparent only to her—the injured person.

In affirming the award of compensation the supreme court pointed out that the Workmen's Compensation Act does not require that the "objective symptoms of an injury produced at the time of the accident be observed by others or that their existence be proved by independnet testimony." Consequently, the court concluded that Chester had submitted sufficient evidence of her work-related injury to support the disability award. *Chester* v. *Douglas County*, Supreme Court of Nebraska, December 4, 1974, McCown, J. 223 N.W. 2d 491 (BI/02/My.—$2) ■

(Copies of the entire decisions described in this column may be obtained by writing to Business Insurance, *att. Managing Editor, 740 N. Rush St., Chicago, Il. 60511. 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.)*

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Lloyd's adds in defense costs, wins Lever Bros. on its fiduciary policy

By MARIE KRAKOWIECKI

NEW YORK—Lever Brothers Co., wholly-owned American subsidiary of the European giant Unilever, has picked Lloyd's of London to write a one-year fiduciary liability insurance policy.

Fred S. James was broker on the business. Lever examined a number of forms before going with Lloyd's, and seriously considered the National Union Fire Insurance Co., which provided a competitively priced bid for the business.

The main reason Lloyd's was selected, according to Lever risk and insurance manager John F. Dorgan, was that the London firm included defense costs in addition to basic limits.

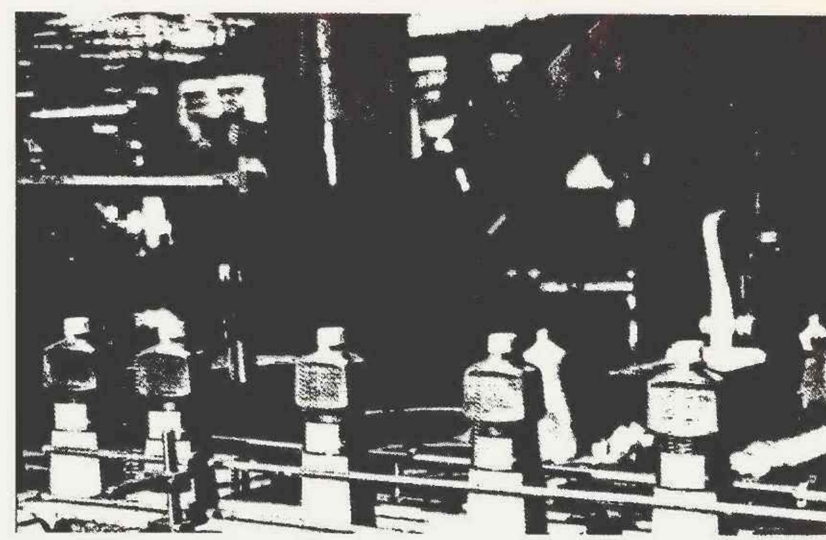
While the bidding for the fiduciary cover was going on, the Kemper Insurance Group, Lever's liability underwriter, sent Mr. Dorgan a clarification in wording on an employe benefits liability endorsement, specifying that the terminology "administration" did not include coverage for fiduciary liability.

Kemper, particularly through its subsidiary Sequoia Insurance had issued such exclusions to a number of group insureds since ERISA was passed (*Business Insurance*, May 5), particularly on directors' and officers' liability policies, but Mr. Dorgan was not as perturbed about it as some other risk managers.

"We anticipated this," Mr. Dorgan said of the Kemper fiduciary exclusion, "but I was hanging my hat on the endorsement." He said Lloyd's inclusion of naming the employer/sponsor as a fiduciary was not instrumental in his decision to pick the London underwriter, because the National Union form had the same inclusion. Lloyd's expansion in this area has been cited as a reason for its picking up more fiduciary policies lately.

Mr. Dorgan and the four-person department he heads have nothing directly to do with the Lever Bros.' $47 million pension fund, aside from the selection of Lloyd's to cover exposures under the 1974 Employes Retirement Income Security Act. Of the fiduciary cover Mr. Dorgan remarked:

"This is a type of insurance I didn't expect to be buying." He feels it is an unnecessary obligation placed on corporations and administrators of various benefits plans, but he made the recommendation to buy the coverage until such time as the government modifies ERISA regulations.



One of Lever's 7,000 employes who can expect to profit from an extra

Mr. Dorgan won't release dollar figures on his property/casualty insurance program for Lever Bros. (one reason is that the firm has suits pending against it which ask for the limits of liability; and the company is trying not to let those limits into print).

However, the firm is known to be pumping an extra $3.5 million into improved benefits for its 7,000 workers this year. A new, entirely company-paid dental plan written by the Travelers Insurance Cos. became effective April 1 as a supplement to the Travelers group health package.

Since employes knew a year ahead of time that the plan was coming, claims are pouring in at a lively clip so far, according to Mr. Dorgan. Estimates are that the company will pick up a $1 million dental bill this year.

Travelers' successful bid for the dental contract may have hinged on the insurer's 50-year-plus relationship with Lever Bros., but Mr. Dorgan insists Travelers was not handed the account carte blanche. Although he usually deals directly with Travelers, Marsh & McLennan was utilized as a consultant.

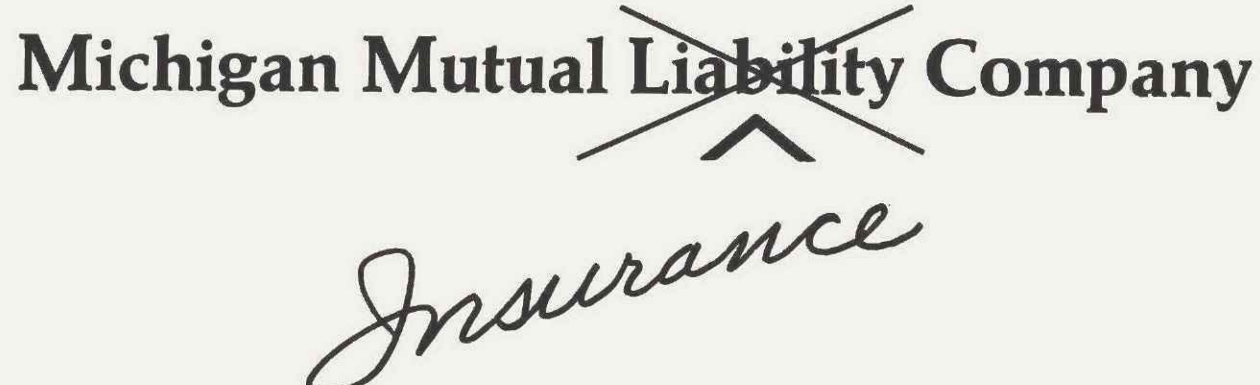
M&M studied bids from four underwriters, including the Blues, before it was decided Travelers' offer was most viable, partly because of cost-saving overlaps in areas like oral surgery, which is already featured on the health plan.

Two major international unions comprise about half of Lever Bros.' national work force, and were instrumental in nudging the foods and consumer products manufacturer to provide a dental plan when their 1972 contracts expired last year.

Lever has six manufacturing plants across the country in addition to a corporate research center in Edgewater, N.J. and its corporate headquarters here in Manhattan.

To make sure the insurance division (part of Lever Bros.' fiscal division) gets the proper input to labor negotiations for these locations, Mr. Dorgan works very closely with A. John Lamantia, benefits administrator from the company's personnel division. The personnel division is in charge of contract negotiations with the unions, the Oil, Chemical and Atomic Workers (OCAW) and the International Chemical Workers Union (ICWU).

Mr. Lamantia sat in on some of the bargaining sessions with both groups when they were hammering out terms for their 1974-1976 contract. He kept in close touch with Mr. Dorgan, who



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$3.5 million in improved benefits.

in turn bounced ideas to insurers for cost estimates. At one point, Travelers was even brought into the labor talks to make a direct presentation to the unions.

Last year the union was eyeing a paid-prescription plan, and it brought in a special carrier to make a presentation. That carrier was not ultimately selected, but its introduction by the union, rather than by the insurance department was a link in a current trend a number of industrial firms have noted: union pre-emption of management selection of underwriters. Mr. Dorgan says this has not been a strong issue yet with Lever Bros., but he is watching it closely.

When final terms of the Travelers-written dental plan were out (see box), Mr. Lamantia and members of the insurance division, aided by consultant Hewitt Associates, revamped the employe benefits communication program by designing an audio-visual program. Lever also prepared a separate booklet on the dental plan, and other booklets that describe benefits on a per-occurence basis.

The audio-visual program supplementing the written descriptions finished the job, and won Lever a second prize in this magazine's employe benefits communications contest in April.

Kemper Insurance Group, the Factory Insurance Assn., Commercial Union Insurance Co., and First State Insurance Co., as well as the recent addition of Lloyd's for fiduciary liability, and a number of assorted carriers for excess liability layers, currently make up the list of Lever's underwriters.

Kemper writes a liability package covering workers' compensation, comprehensive general liability and auto liability. Excess cover is provided in layers by a group of carriers.

FIA writes property plant coverage with a $10,000 deductible. Commercial Union writes an all-risk inland marine policy with a $2,500 deductible, flood and earthquake coverage with a special limit of liability, and a comprehensive blanket boiler and machinery policy including business interruption, with a $10,000 deductible.

First State Insurance Co. provides an excess policy on a difference in conditions basis, to back up the Commercial Union all-risk inland marine cover and the FIA plant property coverage. The deductible is $25,000.

Mr. Dorgan buys no directors' and officers' liability because Lever Bros., as a Unilever subsidiary, is not subject to shareholder suits, which is a primary reason for purchasing such coverage.

No deductibles apply to the casualty portion of the program. However, it is written on a retrospective basis.

Mr. Dorgan uses a special reserving practice analysis on workers' compensation claims in excess of $2500, which he says has contributed to increased cash flow.

Marsh & McLennan acts as broker for most of the property/casualty program. At present Mr. Dorgan does no business with property/casualty direct writers.

Aetna Casualty and Surety held the liability account for Lever Bros. for some 17 years before it was replaced by the Kemper Group in 1970. The Kemper policy, which follows retrospective rating, was renewed in 1973.

Lever Bros. self-assumes casualty exposures such as auto collisions, and takes the money from operating expenses, so the new Financial Accounting Standards Board rules on contingency reserving do not adversely affect Mr. Dorgan's program. He is, however, opposed to the rules.

"I'm not happy about the FASB rules because they could hurt other risk managers, and it could be conceivable they could affect us sometime in the future."

On the Travelers' employe benefits plans Mr. Dorgan uses an retroactive rating plan as well as an administrative services only (ASO) approach.

He does not have a formal premium financing plan in the Lever Bros.' property/casualty program. However, with Kemper, a cash flow arrangement provides for premiums to be paid on a monthly basis. And on workers' compensation premiums, Lever gains time with its cash by using discounted premiums for deposit and paying up the difference when audit adjustment time rolls around.

Mr. Dorgan, who joined Lever in 1948, has been with the insurance department for 24 years. Last October, the company formerly recognized the risk management function he serves, and incorporated "risk manager" into his official title. ■

Lever health benefits

Lever Brother's latest addition to its group health package is a fully-paid dental plan that features a maximum per-person yearly benefit of $1,000 on a schedule of preventative, diagnostic, therapeutic, restorative and prosthetic services.

Lever's largest labor unions were instrumental in bargaining for the dental plan, and they went after it because it was one of the few major health benefits not already available to them, according to benefits administrator, A. John Lamantia.

A quick scan of the Lever benefits package does indeed turn up some liberal coverages. In addition to a $30,000 major medical plan and a hospital-surgical medical plan and company-paid life insurance, the company offers alcoholic treatment and psychiatric care. Maternity hospital-surgical medical benefits are handled the same as any other sickness or accident.

For those who leave the work force due to injury, disability payments are provided for non-occupational as well as on-the-job injuries (under the retirement and life insurance plans).

And for those ready to leave for other reasons, Lever offers early retirement benefits after 30 years' service, or after reaching age 55 with five years service, as well as a plan to retire at age 60 with no reduction in accrued benefits.

london line

$15 million fire at U.K. Chrysler plant blamed on visiting workmen

LONDON—Prevention techniques operated on risk management principles like those in the U.S. are in regular and effective use throughout the big Chrysler auto plants in Britain.

But $15 million damage was suddenly caused at a packaging unit at Coventry, Warwickshire County, when the system broke down through "human error" at a peak moment in a major fire.

The defect is blamed on visiting workmen and not on any corporate employes. It is expected to be covered by insurance, according to a Chrysler U.K. spokesman who surveyed the problem for *Business Insurance*.

Lessons from the fire, one of the largest recorded recently in any British industrial plant, are now being studied by safety experts to ensure there is no repetition of the accident.

The blaze broke out on a site used by Chrysler U.K. for storing and packing many different kinds of components required by associated corporate auto plants overseas, notably in Iran, Malaysia and New Zealand.

It spread within seven minutes from a small section of the plant and burned out the whole building as well as destroyed millions of dollars' worth of auto parts.

Losses are estimated at $6.5 million for the building which was rented from Coventry Trading Estate and $8.5 million for the components. The main insurance carrier was Commercial Union Insurance Co.

Consequential losses may also be incurred, although Chrysler executives were able to reshape packaging operations so quickly that little delay was anticipated for delivery to their overseas plants.

According to a company spokesman, the fire broke out in a unit where tires, foam rubber, paint and other highly flammable goods used in production lines were stored.

"It is a company rule that if any hazardous work is being carried out in any part of our plants where there are flammable materials or where there is a high fire risk, then a fire safety and security officer must be present to ensure that danger is kept to a minimum," he said.

"It seems, however, that welding operations were being carried out by a sub-contracting firm from outside, who sent two of their own welders along to do the work. The two welders were reminded when they arrived at the Chrysler works that one of our fire officers must be present when they started their operations," he continued.

"Now it appears they broke this rule, for they began work on their own and when sparks from their apparatus set some foam rubber sheets on fire, they were not able to use the fire extinguishers properly. We are investigating what happened, because the fire got out of hand too quickly for our own fire safety officers to stop it, even though they went there immediately. The position of outside contractors will doubtless be reviewed when it comes to insurance claims," the spokesman said.

* * *

The London insurance market expects to pay out nearly $5 million on the hull value of the Boeing 707 which crashed in Morocco on August 3 with the loss of 188 lives.

It was the fourth worst air disaster on record in terms of victims, but passengers' claims are expected to be comparatively small. Most of the passengers were locally-born workers who were returning home from France for vacation.

John Peters, chairman of the Aviation Insurance Offices Assn., told *Business Insurance:* "Though jet losses so far this year have been fairly moderate in scale, we are prepared for any adjustment to occur in the statistics before the year is ended."

The plane was owned by the Jordanian state airline and was on charter to Air Maroc.

* * *

Demands for a completely new type of world currency for major insurance business are being made by reinsurers here after studying the adverse effects of inflation on their long-term claims.

It would be like the "paper gold" system already in use for more than six years by expert financiers to handle international deals.

This system was devised at a summit meeting by the highly-respected International Monetary Fund, which created a massive pool of so-called Special Drawing Rights (SDRs) in order to stabilize transactions between nations.

These SDRs smooth out any sudden fluctuations in exchange rates and are called paper gold because they take over the traditional custom of arranging contracts on a dollar or sterling basis.

Because there is growing anxiety that firm moves are needed to combat inflation in insurance payouts, John C. S. Lepine, chairman of the U.K.'s Reinsurance Offices Assn. called for a similar monetary system for worldwide insurance.

Reaction is being sought on the "Lepine Unit" theory. The Reinsurance Offices Assn. represents nearly 270 reinsurers, including many under foreign control, and is a vital meeting place for the London market.

Disclosing his project to *Business Insurance*, Mr. Lepine said, "There's obviously need for a stable and mutually acceptable form of currency for international trading because of the continuing instability. I feel that now is the time for insurers to look at the concept which the IMF devised for SDRs and see if something similar can be done for our own business," he added.

"Nothing can be lost if those concerned with the international insurance and reinsurance business and their financial advisers started to think about this whole theme," Mr. Lepine continued.

"Indexation may be one hedge against inflation in some types of cover, but I think there's a need for something else as well. Why we shouldn't adopt the concept of

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SDRs, or something like them, to fix indemnities, underwriting limits, premiums and claims settlements on certain ranges of international business or the risk needs of multinational corporates?" he queried.

"Marine business and worldwide accounts may well form the basis for such an idea if we are to avoid economic and monetary uncertainties in reinsurance," Mr. Lepine said.

Inflation naturally hits many world insurers if they receive premiums in one type of national currency, and then must pay out claims in the same currency years later after exchange rates have moved unfavorably, he said.

Declining rates for the pound sterling obviously compelled Mr. Lepine to advance his theme in favor of the London market, where both Lloyd's underwriters and domestic insurance companies can suffer if currency rates swing too rapidly.

Lloyd's certainly has its own American trust fund to enable it to deal directly in dollars in its widespread U.S. operations. U.K. companies also operate in North America on a dollar basis.

But if premiums come into the London market from other countries, such as Germany or France, they are held by British tax laws in sterling until claims are settled. So any major drop in the pound's exchange rate can have an adverse effect on underwriting profits.

World interest in SDRs is being revived as various oil-producing countries in the Middle East are now considering contracts in this type of currency instead of on a dollar or pound basis.

The long term benefit is based on the fact that under the control of the IMF the value of such units is calculated from a so-called "cocktail basket" of exchange rates operating in sixteen nations, including the U.S., Japan, Canada and Britain, but also covering at least nine European centers as well.

The ups and downs of exchange rates are thus smoothed out in the interests of international financial deals, in the same way that reinsurers hope they can smooth out the trends in their own world business where heavy losses can be incurred if they are tied to individual currencies.

* * *

Perils from earthquake losses are being probed by the Reinsurance Offices Assn., which is seeking more information on their impact on insurers in different parts of the world.

The survey is being undertaken with the guidance of T. Robin Monteath of the Royal Insurance Co., who believes that this is necessary to protect the rating structure adopted by underwriters in various markets.

He explained, "Without a basic control system to monitor acceptances of earthquake risks, we may well find that we are committed to a much greater extent than we expect when a catastrophe occurs.

"In areas which are subject to constant quakes, such as Chile, companies are generally aware of the risk and have taken steps to ensure their commitments are contained," Mr. Monteath said.

"The problem arises in other areas not subject to frequent tremors. The sheer force of earthquakes is hard to comprehend and I believe it is the obligation of reinsurers to build up their own technical expertise."

Mr. Monteath, who is chairman of the association's earthquake committee, pointed out that in the Caribbean, Kingston, Jamaica, had been destroyed twice in history. On a recent earthquake map locating epicenters of earthquakes in the period 1960-1970, Jamaica appeared to be completely stable.

He praised California as an area where an effective building code was enforced, but noted that in many other places this was not done.

* * *

Britain is introducing state-run inflation-proof pensions for men over 65 and women over 60 beginning in mid-1978. But the plan will take 20 years to come into full force, as that is the period during which contributions from employers and employes will accumulate.

Corporate management will be compelled to join the plan, recently introduced by the Labor Government, unless they can produce a better pension program of their own.

In that event, they must only be involved in partial acceptance of the plan which is intended to ensure complete welfare facilities in retirement for every working person. ■

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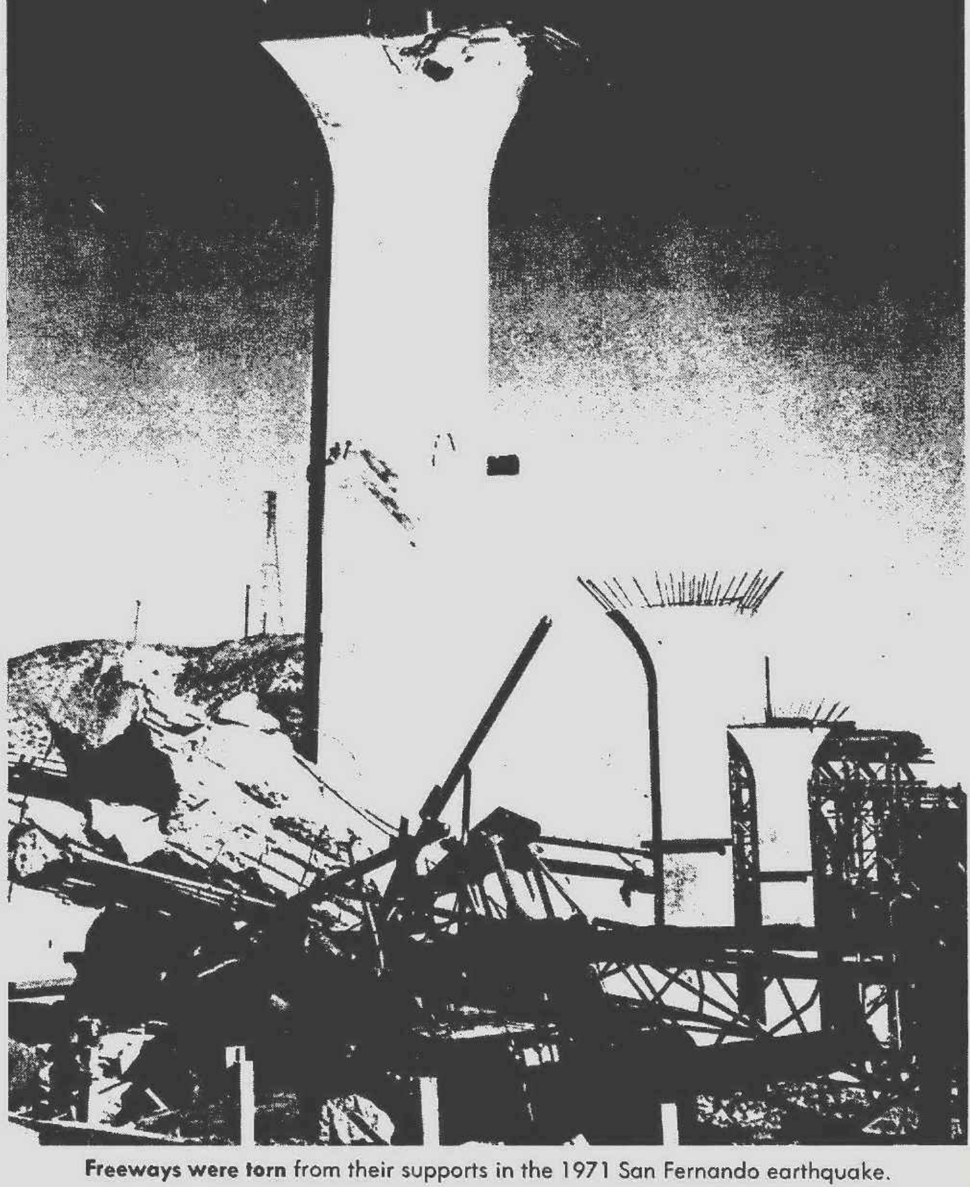
business insurance

PERSPECTIVE

Carriers can afford to write earthquake coverage because few people buy it

"A repetition of the San Francisco earthquake or its equivalent in another area could result in billions of dollars in fire losses. There is a serious question whether insurance companies could withstand the impact. . . ."



Freeways were torn from their supports in the 1971 San Fernando earthquake.

By WILLIAM H. RODDA
President, Marine Insurance Handbook Inc.

EARTHQUAKES HAVE occurred in every part of the United States except for a limited area along the Gulf of Mexico. The severest earthquake ever to hit the continental United States in historic times was a series of quakes in southeastern Missouri in 1811 and 1812. If they were to be repeated today, St. Louis, Memphis, and other nearby cities would be in a shambles. Almost no earthquake insurance is written in this area but fire loss from the resulting conflagrations would be covered by fire insurance policies.

There are seven areas within the 48 contiguous states that are considered to have a high earthquake potential. Conflagrations following a severe earthquake are probable in the cities within these regions. They are:

- California and parts of adjacent Nevada.
- A ridge extending from Montana southward through Idaho into Utah.
- A portion of northwestern Washington.
- A ridge along the Mississippi River including portions of southern Illinois, southern Indiana, western Tennessee, southeastern Missouri, and into Arkansas.
- The area surrounding Charleston, South Carolina.
- The St. Lawrence River valley.
- A coastal area of eastern Massachusetts.

The cities that could be hit by a destructive earthquake would include most of the cities in California and western Nevada; Salt Lake City, Utah: Butte and Helena, Montana; Boston and the Cape Cod area; Charleston, South Carolina; Savannah, Geoergia; St. Louis, Missouri; and Memphis, Tennessee.

However, there has not yet been developed any way of predicting when such a destructive earthquake might occur. The areas named are those under which faults in the earth's crust are known to exist.

Should a businessman buy earthquake insurance? It is interesting to note that earthquake insurance is available, which is contrary to the situation with flood, earth movement such as landslides, and some other natural catastrophes. Why have insurance companies considered it feasible to write earthquake insurance when they will not cover other natural catastrophes without government backing?

An important reason why insurance companies can write earthquake insurance is because few people buy it. Estimates are that only five percent of the people living in earthquake prone areas of California bother to secure earthquake insurance. It is almost unknown elsewhere in the United States.

It is contended by knowledgeable underwriters that the purchase of earthquake insurance by a large proportion of the property owners in an area such as California would increase the exposure to a point where insurance companies would be forced to cease writing the coverage.

Part of the lack of interest in earthquake insurance results from habit. People see and hear about fires every day and they have become accustomed to buying fire insurance. Earthquake damage, though potentially severe, is infrequent. There is a flurry of new earthquake policies following a bad quake, but most of the policies are dropped at renewal time.

It is interesting to note the parallel with flood insurance. The government-supported flood insurance program has met with only lukewarm success in spite of vigorous promotion and rates that are far below any actuarially sound rates. People just don't worry about protecting themselves from an infrequent, uncertain hazard.

A justifiable reason for the indifferent interest in earthquake insurance is the fact that damage from fire following earthquake is covered by fire insurance in the United States. (This is contrary to the practice in some other countries). Fire following earthquake is an important exposure to insurance companies and may be the principal threat to property owners.

For example, the damage from the San Francisco earthquake of 1906 was reported to be $24 million from the quake and $350 million from the resulting fire. The fire loss was about 15 times the earthquake loss. Some insurance companies had difficulty in meeting their obligations under their fire insurance policies.

Some California cities have paid attention to the importance of protecting their water supplies from earthquake damage. There has been an attempt to keep water mains from crossing above known faults in the earth's crust. However, recent California earthquakes have caused major

Continued on following page

Growth of nuclear power industry impeded

Price-Anderson soon to expire

By EUGENE F. JOHNSON
Vice President
Clifton & Co., Los Angeles, California

IT IS BECOMING MORE apparent that we will not see passage of a Price-Anderson "extension bill" by Congress during 1975. Failure on the part of our legislators to take action on this important bill impedes the growth of our vital nuclear power industry.

The Price-Anderson Act, designed to provide financial protection for the public against accidents resulting from the generation and use of nuclear energy, expires August 1, 1977. This at first glance would seem to give ample time for Congressional action. Unfortunately the present act's provisions apply only to facilitaties for which construction permits are issued prior to the expiration date. With a required three to four year lead time for nuclear power plant design, uncertainty as to the ultimate status of the act can only inhibit future commitments by utility planners.

Basic to utility expansion programs is investor participation for needed capital and without a specific commitment to Price-Anderson investors will view the assets of utilities as a greater risk. The increased financial risk will be reflected in higher costs for capital requirements, and utilities will have no incentive to proceed with needed nuclear facilities.

Another important consideration for utility applicants seeking a license to build and operate nuclear power plants is their ability to demonstrate financial capability before the NRC. At present, a portion of this capability is represented by the existence of the Price-Anderson Act. Utilities holding construction permits issued before August 1, 1977 will be covered during their operating lifetimes by existing legislation. Those failing to receive such permits by that date face an unpredictable future.

If required, utilities probably could provide a financial protection plan for the public, but nuclear component suppliers and contractors, with limited assets, would most likely not have this capability. The outcome, would be a narrowing of markets and disruption of the competitive pricing system.

Why has Congress not acted? In 1974, Congress passed H.R. 15323 extending the Price-Anderson Act for five years. This was subsequently vetoed by President Ford due to a constitutional defect. The Joint Committee on Atomic Energy then decided to postpone action until the 94th Congress convened in 1975. During this current session, three major issues have detained further action. Primary was introduction of the Ribicoff Amendment in 1974 to the Price-Anderson Act. For the first time, the diversion question, was introduced as an issue.

As written, the Price-Anderson Act, does not cover injuries or damages occurring after unauthorized removal of nuclear material from an insured facility or associated transportation. Senator Ribicoff, from statements made when he proposed this amendment, was concerned mainly with safety procedures. It is his feeling that by imposition of liability upon the industry, intensified efforts in design and implementation of security would occur.

Nuclear diversion, as pointed to by Senator Ribicoff, is a threat. What the unprecedented level of care proposed by this Act has lost sight of, is that utility plants do not provide a likely target for diversion. Military sources, which stock bomb grade material in quantity, present a more appealing target. Safeguards in the areas of military, foreign sources, transportation and reprocessing should be the recipients of Senator Ribicoff's attention.

Price-Anderson currently excludes acts of war and non-domestic sources of nuclear material. If a nuclear diversion incident were to take place under the pro-

Continued on following page

business insurance PERSPECTIVE

Earthquake insurance . . .

Continued from preceding page

disruption of emergency facilities of all kinds.

A conflagration of great proportions can be anticipated in the wake of any serious earthquake. Almost no attention has been paid to the protection of water supplies from earthquake damage outside of California.

The nature of the earthquake insurance that is written is another reason for the lack of interest in the coverage. A substantial deductible is customary, and it is almost unheard of to write first dollar earthquake insurance. The usual deductible is five percent in the western part of the United States and two percent elsewhere. The five percent deductible would amount to $800 on a $40,000 dwelling.

The use of this high deductible has been considered necessary by insurance underwriters. Insurance against earthquake loss has been viewed as a strictly catastrophe coverage.

Deductible insurance is not popular with Americans. The popularity of first dollar coverage is one reason for the fantastic success of accident and health insurance. Such policies are geared to pay the first dollar of loss even if the ultimate amount payable is limited. Major medical expense insurance which is comparable to earthquake insurance in that it covers only the catastrophe does not enjoy the popularity of the hospitalization policy that steps in with the first dollar of expense.

Rates for earthquake insurance are not inconsequential. They may range from 15 cents to 25 cents for $100 of coverage on buildings of ordinary construction. This means an annual premium of $60 to $100 for a $40,000 structure. It is impossible to develop an actuarially based rate because of the low frequency of occurrences even in the so-called earthquake prone areas.

What is the frequency of damaging earthquakes? A United States Department of Commerce publication, "United States Earthquakes 1971", lists 50 "prominent" earthquakes in the United States from 1663 through 1971. Of these 50 earthquakes that did substantial damage, 23 centered in California. Nevada had five; Montana four; Utah and Missouri had two each.

Californians have to consider frequency as well as severity in their estimate of exposure to damage, particularly if their property is located near a known fault. Complete collapse of certain types of structures has occurred in recent earthquakes.

The property owner must ask what are the reasonable chances that his property will sustain damage in excess of the deductible. Reinforced concrete and steel frame structures have performed well, especially if some attention has been paid to the location of faults in the earth and to earthquake resistant features in the construction. Such an owner may well decide that the premium on a million dollar building is unwarranted when the five percent ($50,000) deductible is considered.

The fact that fire insurance policies cover fire damage following earthquake is another consideration in deciding whether to buy earthquake insurance. Damage by the quake may be limited in any individual case but the possibility of complete loss by fire is very real. An insurance loss adjustment in such a case would involve a determination of how much damage was from fire and how much from earthquake.

Past experience indicates that the major damage may be from fire. Why buy earthquake insurance which would limit its recovery by the deductible when all of the remaining fire damage would be covered? This is a question that must be examined by the property owner in view of his location, the construction of his property, the premium for the insurance, and the deductible that would apply to the earthquake coverage. It is not a simple problem.

Earthquake insurance is seldom purchased outside of the West Coast areas of the United States even though it is available. The infrequent occurrence of quakes, plus the two percent deductible, are deterrents to the purchase of the coverage. The deductible is essential even in these parts of the country because of the potential severity should an earthquake occur. At least, that is the view of insurance underwriters.

Earthquake insurance lacks the economic feasibility of a coverage applying to everyday occurrences. Coverage that is written to cover earthquakes in St. Louis or Memphis must take into account the fact that 160 years ago there was an earthquake of devastating proportions. Yet this insurance has to be written today on the basis of covering expenses year after year without paying a single loss. The property owner would save this expense if he decides to take a chance that such devastation will not happen for another 160 years.

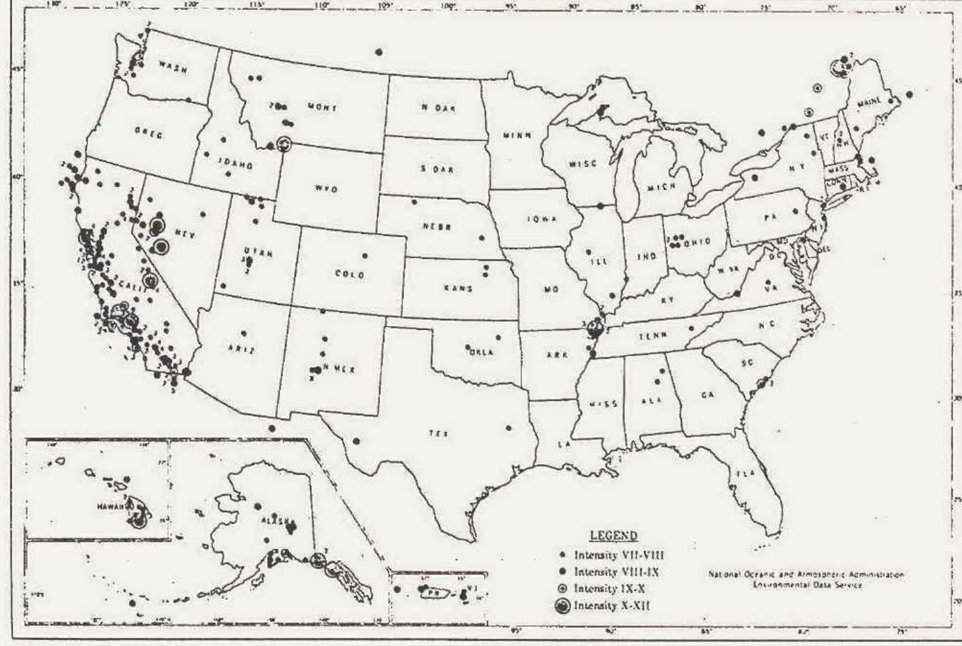
The purchase of fire insurance in an earthquake prone area requires special attention to the strength and stability of the insurance company. A repetition of the San Francisco earthquake or its equivalent in another area could result in billions of dollars in fire losses. There is a serious question whether all insurance companies that operate in any section of the country could withstand the impact of fire losses following a serious earthquake.

The stronger companies, and particularly those with reinsurance that takes into account the earthquake-fire potential, probably could weather the emergency. There could be trouble such as that which followed the San Francisco earthquake for those companies with high concentrations of business in the affected sections of those cities.

Conflagrations have been well contained in large American cities during the past 25 years. This has been due largely to good water supplies, the massive fire department response that is available by means of mutual aid between communities, and rapid communication systems. Earthquake experience shows that water supplies, electrical power, and communications are quickly disrupted by a serious earthquake. The biggest threat from earthquake in the United States in the terms of probable damage and the threat to the stability of insurance companies is from the conflagration that is likely to follow any major earthquake.

Insurance buyer precautions should include self-contained fire protection as far as posible without dependence upon municipal water and electrical supplies, plus the purchase of fire insurance from the strongest available insurance companies. ■

William H. Rodda, a CPCU and a member of Phi Beta Kappa, graduated with honors from Rutgers University. He is the president of Marine Insurance Handbook Inc., which publishes the standard inland marine insurance rate book for agents, and he is a consultant to numerous companies in the multiple line insurance field. Mr. Rodda has written numerous books and articles, and several of his books are considered definitive textbooks on important insurance subjects.



Damaging earthquakes in the U.S. from earliest history through 1971.

Nuclear power industry . . .

Continued from preceding page

posed Ribicoff amendment, the proof of specific source could provide a monumental task. Public invokement of the amendment would most likely constitute a prolonged legal confrontation or outright private insurance and governmental indemnity grant.

A second issue, impeding Congressional action, has been final release of the Rasmussen Report (WASH-1400). This study to assess potential risks to the public from reactor accidents was published in draft form in the latter part of 1974. It is now expected that the final report, for Congressional review of Price-Anderson limits, will be ready in late 1975 or early 1976.

The Rasmussen draft report has met with a predictable mixed reception. Proponents of nuclear power contend that the study provides added confidence in reactor safety. The report found that the consequences of potential nuclear accidents are no larger, and in most cases are much smaller, than people have been led to believe by previous studies.

For the purpose of evaluating adequacy of Price-Anderson limits, conversion to a dollar amount of potential nuclear power plant accidents and their consequences will be provided from Rasmussen report data. According to the draft report, the probability of a core-melt accident resulting in excess of Price-Anderson limits ($560,000,000) is 12%.

Opponents of nuclear power have criticized the Rasmussen report asserting that the study is defective in evaluation. Principal among their objections are:

- Sabotage was not considered.
- Omission of multi-unit sites.
- Report dealt only with water reactors.
- Adequacy of the calculations of reactor consequences.
- Use of the fault tree approach for the analysis of a very complex system permits the outcome to be influenced by the assumptions made by analysts.

Two major facts are often overlooked in this controversy over report reliability. First, that in 19 years of operation no member of the public has ever been injured as a result of operation of a licensed reactor. Secondly, resulting from this record, Price-Anderson has experienced a net cash flow to the taxpayers. The industry having paid in nearly $9 million of indemnity fees to the federal treasury with no payments out.

A final obstacle to early passage of a Price-Anderson extension bill is the vocal anti-nuclear lobby. By use of fear tactics these critics have created the greatest barrier to the growth of nuclear power in the United States.

No individual, knowing the facts of this issue, can deny that nuclear power is encompassed by risk. This was recognized in the passage of the Price-Anderson Act, which singled out nuclear energy, alone among our technologies, for special government indemnity. The question that the American public must resolve in its own mind is the true degree of this risk and is it "acceptable"?

The alternatives to nuclear energy are limited and encompass their own specific risks. Dependence upon oil-diplomacy leaves the United States vulnerable to foreign fuel embargo. Coal in ready supply is a chief air pollutant with emissions of oxide of sulfur. Use of solar energy as a viable energy source awaits many years of development before major commercial application. Nuclear technology which is now available can produce electricity at a kilowatt hour cost which ranges from 20% to 50% less than that of fossil fuel generated power.

The United States was not born out of a "negative" attitude toward risk assumption. We as a nation have prided ourselves on the ability to overcome risk with a "can do" philosophy. To meet the present fuel crises requires constructive application of that philosophy to attain energy independence and in so doing make certain nuclear power remains an acceptable risk.

If the utility industry is to make intelligent long range plans for meeting the nation's electrical needs the Price-Anderson Act must be resolved. To this end Congress must at this time proceed towards swift conclusion of extension legislation. In light of nuclear power plant experience and the Rasmussen draft report, Price-Anderson limits should be increased with greater participation by insurance industry pools. These essential actions can provide the yeast for making the utility industries long range growth plans a reality. ■

Mr. Johnson is a vp and account executive in the Los Angeles office of Clifton & Co. He is a CPCU and associate in risk management, Insurance Institute of America, member of the American Society of Civil Engineers nuclear structures and materials manual section committee dealing with general structural aspects of nuclear plant site-selection.

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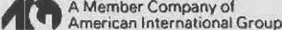

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British OSHA alters management policies

LONDON—Just as their counterparts in the U.S. are striving to meet safety standards imposed by OSHA, employe health and safety on the job have become major concerns to Britain's labor market since the passage of the Health and Safety Act early this year.

How the Act is changing management's attitude is the subject of a report on health and safety on the job written by David Farmer, group safety advisor for British Petroleum, and published last month.

Management should be looking at matters of procedure and organization first, with specific health dangers second on the list, the report states.

The new law imposes wider responsibilities on management than ever before. Employers are obliged to have policy statements listing attitudes to and procedures for improved standards.

"A checklist is not always the answer," Mr. Farmer says. "Managers now need to concentrate on the software rather than the hardware."

Since the Act came into force, Mr. Farmer has given teach-ins to more than 2,000 managers, briefing them on the history of the Act and how it could affect them.

"Most managers want to know what their liability would be if they made a mistake which led to injuries or death," he said.

Safety inspectors have new power in Great Britain since the passage of the Act. Until this year an inspector had to bring a violator to the courts to enforce better safety standards. Now he can issue a prohibition which immediately prohibits the violater from using machinery if there is a threat to the safety of employes or the public involved.

A violator can appeal to an industrial tribunal and the safety inspector will have to justify his action. But until judgment is passed, the machinery in question cannot be used.

In the first six months of the Act's life there have been 647 prohibitive notices issued and 263 deferred prohibitive notices. In addition there have been 1,743 improvement notices given, requiring some action to premises within a fixed time period.

The Health and Safety Executive, the administrative arm established by the Act, employs approximately 700 inspectors. ■

$20 billion damage in event earthquake hit the San Francisco area

MENLO PARK, CA.—Property damage of as much as $20 billion may face insurance carriers in the event of a San Francisco Bay Area earthquake of 8.25 on the Richter scale, with loss of as many as 20,000 lives if the quake occurs during business hours.

This is the estimate currently being offered by San Francisco consulting engineer John A. Blume and U.S. Geological Surveyor geo-physicists Robert A. Page and William B. Joyner, both of the Office of Earthquake Studies here. The three are authors of a new earthquake report in the current issue of the Journal of Science.

The 1906 earthquake at San Francisco measured 8.25 and killed 400. "Should an earthquake of that magnitude occur now, during non-business hours," Mr. Blume predicts, "the death toll could range between 3,000 and 5,000 killed, with at least $10 billion in property damage, if there are no major fires or dam failures."

Mr. Joyner adds: "New earthquake evidence now available to scientists indicate that maximum lateral acceleration at the ground is the most important factor to be considered in building design and construction.

"In the earlier days of earthquake investigation," Mr. Joyner explained, "it was believed that acceleration or the initial shock felt by a building did not exceed about one third of the force of gravity and this meant buildings were designed to withstand a momentary sideways force equal to about a third of the structure's weight.

"Now, however," Mr. Joyner insists, "we know that even an earthquake of lesser magnitude, such as a Richter scale of 5.5, produces a momentary sideways acceleration of the ground equal to half the force of gravity.

"In the 1971 San Fernando earthquake that caused $500 million of damage and killed 58 Southern California residents, a lateral acceleration 1.25 times the force of gravity was measured and today we would have to assume that even higher acceleration rates are possible.

"As a result," Mr. Joyner said, "the resistance of buildings to damage from earthquakes requires design consideration far in excess of those stated in the most modern seismic building code."

Mr. Blume said that in the instance of such comparatively new San Francisco high rise structures as the Transamerica Pyramid or the Bank of America building "these may be required by an earthquake to bend considerably more than we previously thought."

The current report strongly urges "substantial improvement of modern building codes, to allow for the previously unrecognized high degree of shaking that occurs during an earthquake."

Other recommendations call for gradual replacement of older structures not expected to adequately resist a major earthquake as well as "a complete re-evaluation of other structures such as freeways and overpasses." ■

NIOSH funds program

The University of Arizona will offer a master's degree program in safety management funded by a $300,000 three-year grant from the National Institute for Occupational Safety and Health (NIOSH). Ten stipends will be provided for students enrolled in the program at the U of A's College of Business and Public Administration. Curriculum will include safety law, safety management, risk management and research techniques in safety. For more information, write to Dr. Nestor R. Roos, professor of insurance, Business and Public Administration College, University of Arizona, Tucson, Az. 85721.

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Corporate social responsibility is an issue risk managers must face

NEW YORK—Corporate social responsibility is almost unheard of in relation to risk management, yet a risk manager who ignores the issue of corporate social responsibility is leaving his company exposed to serious and expensive liabilities, according to Barbara Cox, executive director, NOW Legal Defense and Education Fund. Ms. Cox has written an article on corporate social responsibility for the current issue of Risk Management Reports.

Corporate social responsibility (or CSR as Ms. Cox refers to it) offers an opportunity for risk managers to show what risk management is all about; it's one thing you can't buy insurance for.

There are those who argue that the only responsibility of a corporation is to make a profit. But Ms. Cox points out that CSR is but an extension of the scope of risk management's responsibility to protect assets and earnings from fortuitous loss.

Charitable contributions used to be the extent of a business's social responsibility, but today CSR includes "not only charitable contributions but also equal employment opportunity, conditions of work, environmental issues, product safety, use of resources and so on," Ms. Cox says.

To put it more basically, a corporation exists in a society and can hardly afford to ignore conditions in that society.

The good news in what may seem like extra work, expense and confusion, Ms. Cox says, "is that CSR is consistent with the basic corporate objective of return on investment. CSR can be enlightened self-interest."

More than enlightened self-interest, CSR can be a means of saving corporate assets from expensive lawsuits.

As any company which has been hit with an affirmative action judgment from an Equal Employment Opportunity lawsuit, lost profitable production time replacing or remodeling machinery to meet OSHA standards or has lost money and reputation because of a product recall can attest to, a little planning goes a long way.

What happens when planning ahead isn't done can be seen in the example of the National Organization for Women's campaign challenging employment and credit practices of Sears.

"It would be interesting to calculate the amount of expense in legal fees, lost business, ill will, etc., this has meant," Ms. Cox notes.

"A risk manager with a broad mandate to consider potential losses of this nature might have been able to devise an alternative to the hard line response that was followed," she adds.

Ms. Cox criticizes the adversary attitude with which business views groups such as Nader's Public Citizen.

When one considers the impact of the introduction of the seat belt alone, not to mention emissions control systems have had on America's automakers, the financial foolishness of such an attitude towards consumer groups is evident.

In contrast to Sear's attitude towards CSR, Ms. Cox points to Xerox. ("In many executive suites, CSR and Xerox are mentioned in the same breath.")

Xerox, Ms. Cox says, "at least comes closer than most in attempting to fill the lofty goals to which we all give voice."

Explaining Xerox's social service leave program, a company executive is quoted crediting the program with attracting and holding a "superior type of employe."

But more than reaching lofty goals and maintaining superior employes, businesses would do well to consider CSR in light of recent action by the Securities and Exchange Commission (SEC).

The SEC is considering requiring detailed disclosure on such things as environmental damage, pending or threatened judicial or agency proceedings, employment practices including litigation and equal employment statistics, illegal political contributions and "other topics of social nature," Ms. Cox says.

Rather than react to another set of government regulations, Ms. Cox urges the risk manager as well as others on the management team to "treat CSR like any other element of business."

It's difficult to estimate the loss potential of a company's ignoring CSR, especially in today's economic environment where costs in all areas are being cut to the bone. However, risk managers have the unique experience of dealing with disaster in the abstract. Can justifying the cost of CSR, then, be any more difficult than justifying the cost of insurance premiums for a fiduciary liability policy? ■

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Ct. doctor group extends Aetna malpractice cover

HARTFORD, CT.—There will be no malpractice insurance crisis in Connecticut. At least not for six years.

The Connecticut State Medical Society was granted a five-year extension on a malpractice insurance agreement it has with Aetna Life & Casualty, which underwrites malpractice coverage for 91% of the Society's members.

Along with the extension, however, there will be a 40.7% increase in premiums, effective Oct. 1.

General practitioners, the lowest risk group will pay yearly premiums of $913, an increase from $678 and neurosurgeons, the highest risk group will pay $7,511 annually, up from $5,258.

The premiums cover physicians for a limit of $100,000 liability per occurrence to $300,000 aggregate. Surgeons' liability limits are $250,000 per occurrence and $500,000 aggregate.

The umbrella layer covers physicians to an excess limit of $1 million, although doctors may purchase additional excess limits to $3 million and $5 million.

Loss control and active physician participation in policymaking and peer review were major factors in Aetna's decision to extend the coverage, a spokesman for Society told *Business Insurance*.

Four review panels with 15-25 physician members meet once a month to review malpractice cases, the Society spokesman said.

Since the panels' establishment, the incidence of reported malpractice cases has actually gone up, the spokesman continued, "because now doctors who think they might be involved in a malpractice case report it right away."

The Society's three-part insurance package, which includes premises liability with the basic malpractice and excess coverage, was negotiated with Aetna four years ago.

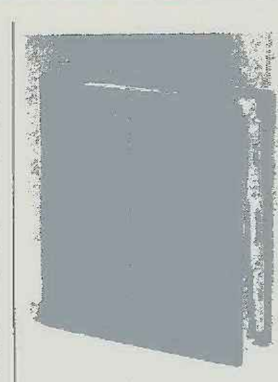
"At the time, the doctors wanted to be actively involved in the insurance program; they wanted the advantages of a set premium schedule and renewal date that a policy for the entire Society could offer," the Society spokesman explained.

The resulting policy has those advantages, though it is written for individual doctors or physician groups.

Connecticut was the first malpractice program of its type underwritten by Aetna, the Society spokesman said. "Since then Aetna has underwritten similar programs for medical societies in seven other states."

The states are: Vermont, Delaware, West Virginia, Utah, Wyoming, Montana and Washington.

"We're encouraged by the results of our experience in Connecticut," an Aetna spokesman said, "but you can't say that this is the answer to all malpractice problems." ■



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Insurers aim for wider use of EDP tools

CHICAGO—Heightened flexibility and productivity are key objectives for large, multi-line insurance companies, trying to catch up to other industries in applying advanced technology, according to a recent survey compiled by Booz, Allen & Hamilton Inc., international management consultants, based here.

The eight firms surveyed indicate that they want their computer systems geared to respond quickly to changing conditions such as national health insurance, no fault auto and ERISA. The companies plan "increased top management and user involvement and more comprehensive management control processes," a spokesman said.

For property/casualty lines, policy rating, premium accounting, statistical reporting, coverage verification and claims processing are computerized.

Staffing levels ranged between .17 and .47 employes per million dollars of 1973 premium income, accounting for $2,200 and $8,300 per million dollars of 1973 premium income, the survey said. ■

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Carrier needs other legal hooks besides arson charge to woo jury

MONTREAL—Because of a juror's understandable reluctance to brand someone an arsonist, particularly where the evidence is only circumstantial, the insurance company must provide the jury "with some additional legal hooks other than arson on which the jury can hang a defendant's verdict," advised Marvin L. Karp, an attorney with the Cleveland firm of Ulmer, Berne, Laronge, Glickman & Curtis.

Speaking at an American Bar Assn. conference on insurance, negligence and compensation law, Mr. Karp emphasized early preparation for the trial of an arson case and some tactical elements to keep in mind.

Several preparatory steps should be taken by the insurance company before any decision to deny the claim is made, Mr. Karp suggested. This legal framework, distilled over many years of court rulings on arson, allows the insurance company to establish the defense of incendiarism by providing circumstantial evidence that tends to demonstrate:

- that the fire was intentionally set,
- that the insured had the opportunity to set the fire or have it set, and
- that the insured had a motive for doing so.

Mr. Karp advised the audience to keep this legal framework "firmly" in mind when, for example, interviewing the firemen who first arrived on the scene in order to determine how they gained access. "If the doors and windows were locked and there was no evidence of a break-in, the only logical conclusion that can be drawn is that the arsonist had, or had been given, a key," he concluded.

If the insured property was a bar or tavern, the firemen should be queried about the quantities of liquor they found—"a small stock of liquor suggests that the owner was expecting the fire," Mr. Karp said.

He also suggested that insurance company representatives or counsel check on the existence and status of pending lawsuits and judgment liens for the insured at the local municipal, county or federal courthouses.

"If after taking the preceding steps, you and your client conclude that there is sufficient evidence to warrant a denial of liability—don't," Mr. Karp said.

Instead, he recommended, insist that the insured file a sworn proof of loss and then take the statement under oath. "These two elements will provide the cornerstone of the tactical framework within which your case should be tried," he said.

"It is imperative that both of these procedures . . . be completed before liability is denied,' Mr. Karp continued, "since the view of the majority of cases is that a misstatement or concealment of a material fact operates as a bar to recovery only if the misstatement or concealment occurred prior to the filing of the suit."

Statements under oath should also cover areas on which the attorney has already obtained "a great deal of information," Mr. Karp said. "If the insured testifies in a manner that is contrary to this information, the foundation has been laid for the successful establishment of the wilful misstatement defense."

The insured should be asked, for example, whether they have any knowledge as to how the fire started or whether they ever discussed with anybody the possible burning of their residence, according to Mr. Karp.

As far as the trial itself is concerned, he suggested filing the suit in federal court rather than in the state system. "The decisions of the various U.S. Courts of Appeal have given rise to a fully developed body of case law supporting the three principal affirmative defenses that should be asserted in (a circumstantial arson case)," he explained.

These defenses are: Incendiarism, violation of the policy provision with respect to increase of hazard and violation of the policy by wilful concealment or misrepresentation of material facts, Mr. Karp said.

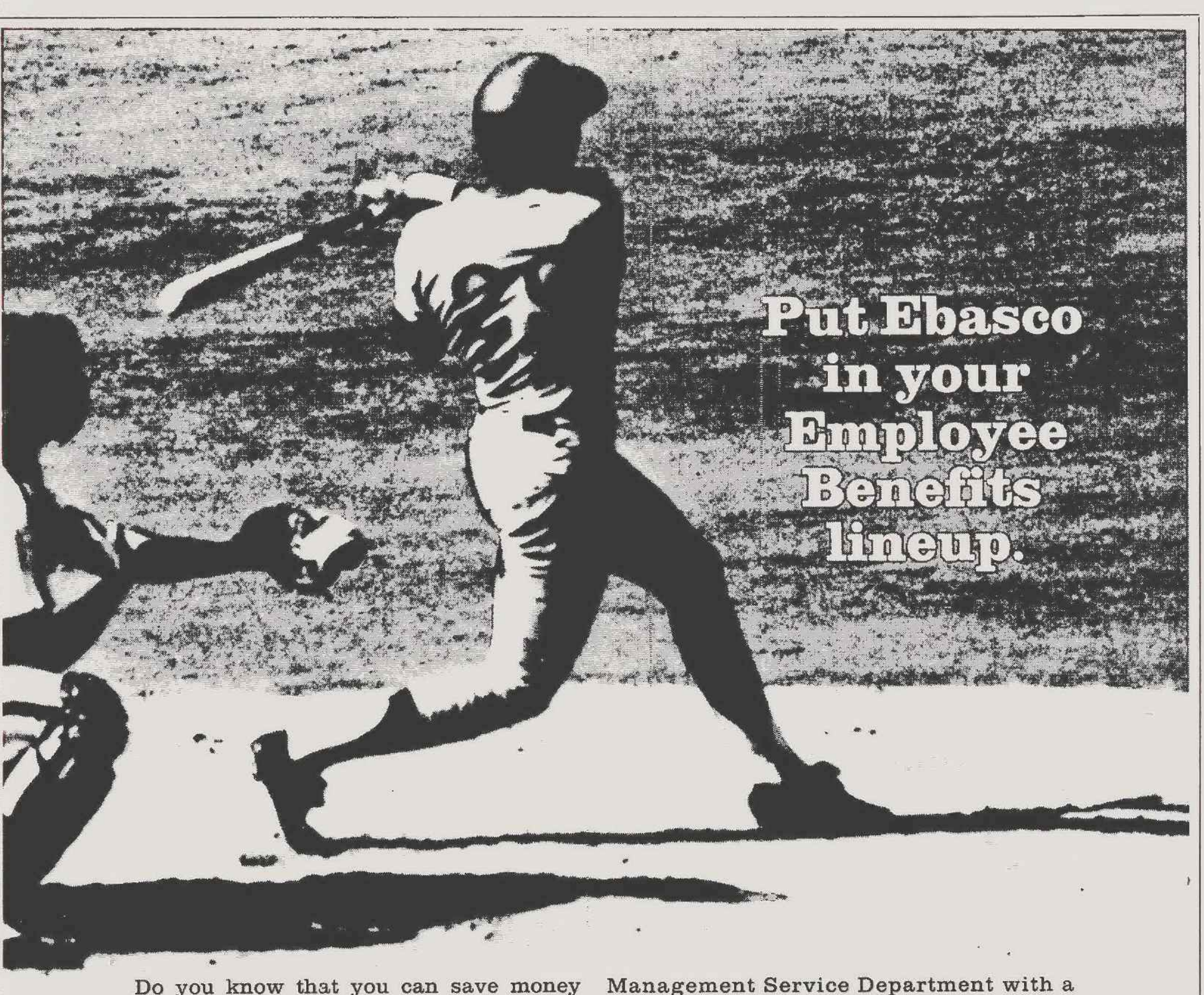
As the time of the trial approaches, Mr. Karp suggested that all potential witnesses be re-interviewed and courthouse records again be checked "on the chance that a newly filed lawsuit or lien may disclose a (new) significant financial obligation."

He also recommended preparing photographs and diagrams to assist the jury in following the testimony and "to enhance the drama and impact of the presentation."

"In a circumstantial evidence case," Mr. Karp continued, "having the last word can be a very definite advantage." For this reason, he advises using affirmative defenses in which the defendant has the burden of proof, as the "sole issue of fact in the case." This way, he said, you obtain the right to both open and close final argument.

Another defense is the increase of hazard defense, he said. The objective is "to set forth a number of analogous arson cases in which the courts have held that there was an increase of hazard in violation of the policy provision," he explained.

"The final defense is (the intentional) setting of the fire, or arson, although the use of the latter term should be avoided lest the court and jury begin thinking in criminal law terms," Mr. Karp said. ■



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Research on chemical is announced

WASHINGTON, D.C.—Six chemical companies will sponsor research on occupational health trichloroethylene, a substance used in dry cleaning, degreasing, printing inks, coatings and adhesives, the Manufacturing Chemists Assn. announced.

The association will administer the research program and has invited the National Cancer Institute to participate on a cooperative basis.

Though details are not yet final, the testing is expected to focus on long-term inhalation studies.

The companies sponsoring the research are: Canadian Industries Ltd., Diamond Shamrock Corp., Dow Chemical U.S.A., Ethyl Corp., Hooker Chemicals & Plastics Corp. and PPG Industries Inc. ■

Criminal penalties are few for aircraft liability

MONTREAL—Criminal penalties for violations of aircraft manufacturing safety regulations, in the few cases where they are detected, are totally inadequate as an enforcement mechanism, according to an attorney speaking at the American Bar Assn. (ABA) conference here.

"Seldom are corporate officers personally fined or imprisoned, and the corporate entity cannot be jailed," said Albert R. Abramson, a San Francisco attorney with the firm of Abramson & Bianco. "The only sensitive spot in the corporate body is the pocketbook and only large monetary sanctions can stimulate a change in the manufacturer's indifference to the welfare of its consumers."

Mr. Abramson recommends that liability insurance policies be revised specifically to include coverage for punitive damages. He said that damages are generally covered by the policies now but that the language is broad and open to interpretation.

Taking the opposite view, Lamberth S. Carsey, a Houston attorney, with the firm of Fulbright, Crooker & Jaworski, told the ABA's meeting on insurance, negligence and compensation law that punitive damage awards are no deterrent when they are covered by insurance.

"If insurance coverage is permitted against punitive damages, then punitive damages themselves should not be permitted," Mr. Carsey said. "If the threat of loss of liberty by engaging in criminal conduct is no deterrent, then the possibility of being required to pay a punitive damage award will not enhance the criminal law's deterrent effect," he added.

Mr. Carsey believes that "insurance against punitive damages is no different from insuring against traffic fines or other 'criminal' penalties." He continued by saying that "no sound justification exists for shifting to the public (through increased premiums, fares or product costs) the cost of punishing a wrongdoing defendant."

In advocating his position that punitive damages should not be protected by insurance, Mr. Carsey said that a first step toward eliminating damages altogether could be accomplished by denying any insurance coverage.

Mr. Abramson countered Mr. Carsey's argument by saying that actions seeking punitive damages are a form of civil enforcement of safety regulations. He believes that lawsuits such as these "augment the regulatory function of government agencies," particularly the Federal Aviation Administration, which he described as "underfinanced and understaffed."

"The purpose of punitive damages is not only to punish the manufacturing malefactor," Mr. Abramson continued, "but to deter it and others from future reckless disregard for the safety of the flying public."

Mr. Abramson believes that damage awards are "especially appropriate where the manufacturer stands to profit by his misconduct even after compensating the injured and the heirs. Corporate policy to risk lives for profit has occurred," he added.

He continued by pointing out that "manufacturers should be able to bargain and pay for "punitive demage insurance coverage.

In Mr. Abramson's opinion this action would "not frustrate the underlying policy of deterrence and example (because) the exemplary effect of an award of punitive damages would still remain in the adverse publicity received by a defendant." ■

Look at strategy first before suing the FAA

MONTREAL—Strategy is more important than legal theories of liability in determining whether it is "worthwhile" for a plaintiff to sue the Federal Aviation Administration (FAA) for negligence in the certification of aircraft, said attorney Tom H. Davis of the Austin, Tx. firm of Byrd, Davis, Eisenberg & Clark.

"For instance, in the crash of a major airline it might not be to the plaintiff's advantage to bring in the government since in all probability a good case of liability against the airline would exist," Mr. Davis said.

"The same considerations would exist where the manufacturer of a general aviation aircraft or its component parts was financially responsible," he continued.

Mr. Davis emphasized in his speech to the American Bar Assn.'s meeting on insurance, negligence and compensation law here, that "if there was negligence on the part of the government in certifying the aircraft, this would almost presuppose a defect which would subject the manufacturer to strict liability without the necessity of growing negligence. Of course, if the manufacturer was bankrupt or out of business, different considerations would appear," he added.

Only four reported court decisions are available, Mr. Davis said, that deal with the FAA's responsibility for negligence in the certification of aircraft in which there is "proximate cause of injury."

Other areas of possible negligence on the part of government are left open for discussion, in Mr. Davis' opinion. He raised the question of whether the FAA can delegate its duty to determine the airworthiness of an aircraft to a non-employe authorized inspector without being responsible for his negligence. "Liability has been imposed upon the United States under situations constituting a non-delegable duty," Mr. Davis said.

"Other interesting questions could arise where the FAA has allowed production of aircraft under a type of certificate issued many years ago which today does not conform to the state of the art or our present concept and knowledge of safety," he said.

Mr. Davis believes that "the area of supplemental type certificates and the issuance of airworthiness certificates following an annual" would provide the best basis for a suit against the government for negligent certification because "there is less likelihood that another financially wound defendant would be more readily available."

A disadvantage of joining a manufacturer with a suit against the government for negligent certification would be the "natural cooperation between both defendants in establishing that there was no defect or anything else wrong with the airplane or that

Continued on page 42

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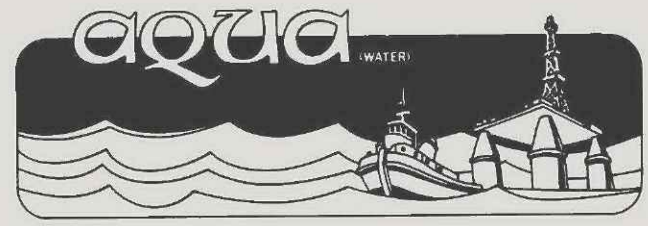

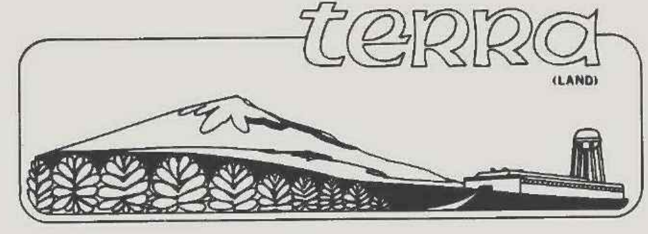

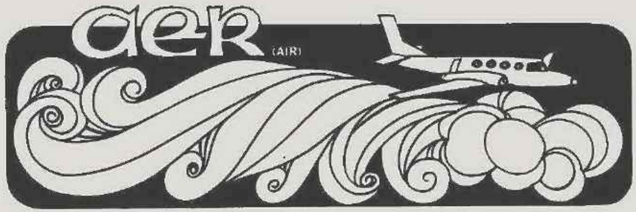

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Timely fire inspection is key to establishing carrier's arson defense

MONTREAL—Arson defense requires "great tenacity and persistence" on the part of insurance company counsel, according to William B. McGuire, an attorney with the Newark firm of Lum, Biunno & Tompkins.

Since it is assumed that fires are of accidental origin, "it must be shown that a fire was started by the insured in order to establish the arson defense in a suit under an insurance policy," Mr. McGuire said.

He strongly emphasized that "the very foundation of the defense lies in investigation immediately after the fire. All possible technological instrumentalities must be utilized."

He acknowledged that an initial determination as to whether a fire is incendiary or accidental is not "an easy one" especially where there has been total destruction or where the fire appears to be of accidental origin.

"One of the critical areas is in establishing the whereabouts of the insured or his representatives at the time of the fire," Mr. McGuire advised. "By discovering the asserted alibis early in the proceedings, the facts surrounding them and the people involved in them may be quickly confronted in order to ascertain their veracity."

He added that the jury is "prone" to favor the insured prior to the presentation of evidence that supports the arson defense at which point "their sympathies may change very quickly to resentment of the plaintiff."

Use of discovery tools available under the policy itself is advised, he told participants of the American Bar Assn. conference here on insurance, negligence and compensation law.

"Standard policies include a provision stating that a policy is void if the insured has willfully concealed or misrepresented any material fact or circumstance before or after a loss," he said. This could be accomplished, he added, by unravelling alibis or closely examining the proof of loss.

Another significant provision of typical standard insurance policies provides for the insured to submit to examination under oath. "One must be very careful in ascertaining the law of a given jurisdiction of this particular aspect,' Mr. McGuire advised. Sometimes a refusal to submit to examination "may result in forfeiture of his right to recover under the policy," though he added that these court holdings have been criticized.

One advantage of an examination, he said, is that it provides an opportunity for "discovery" before the suit is instituted. "The carrier has the advantage to obtain significant information under oath before being forced to take a position which may ultimately result in litigation.'

Such questions as to how the policy was obtained, who determined the amount of coverage, whether the business was for sale at the time of the fire, whether the building was vacant or unoccupied, should be asked the insured, he advised.

"The next step is to ascertain a motive for the insured,' he said. "Without a motive for arson to present to the jury, asserting the defense is practically frivolous."

Two examples of motives would be if the property is considered a "veritable white elephant" or if there was a large discrepancy between the amount paid for the property and the amount of insurance procured, Mr. McGuire explained, adding that "any factor which could possibly reflect a motive should be investigated."

Another area for discovery, Mr. McGuire said, includes "an attempt to delimit claimed damages." Living expenses after the fire should be questioned as to reasonableness, he said.

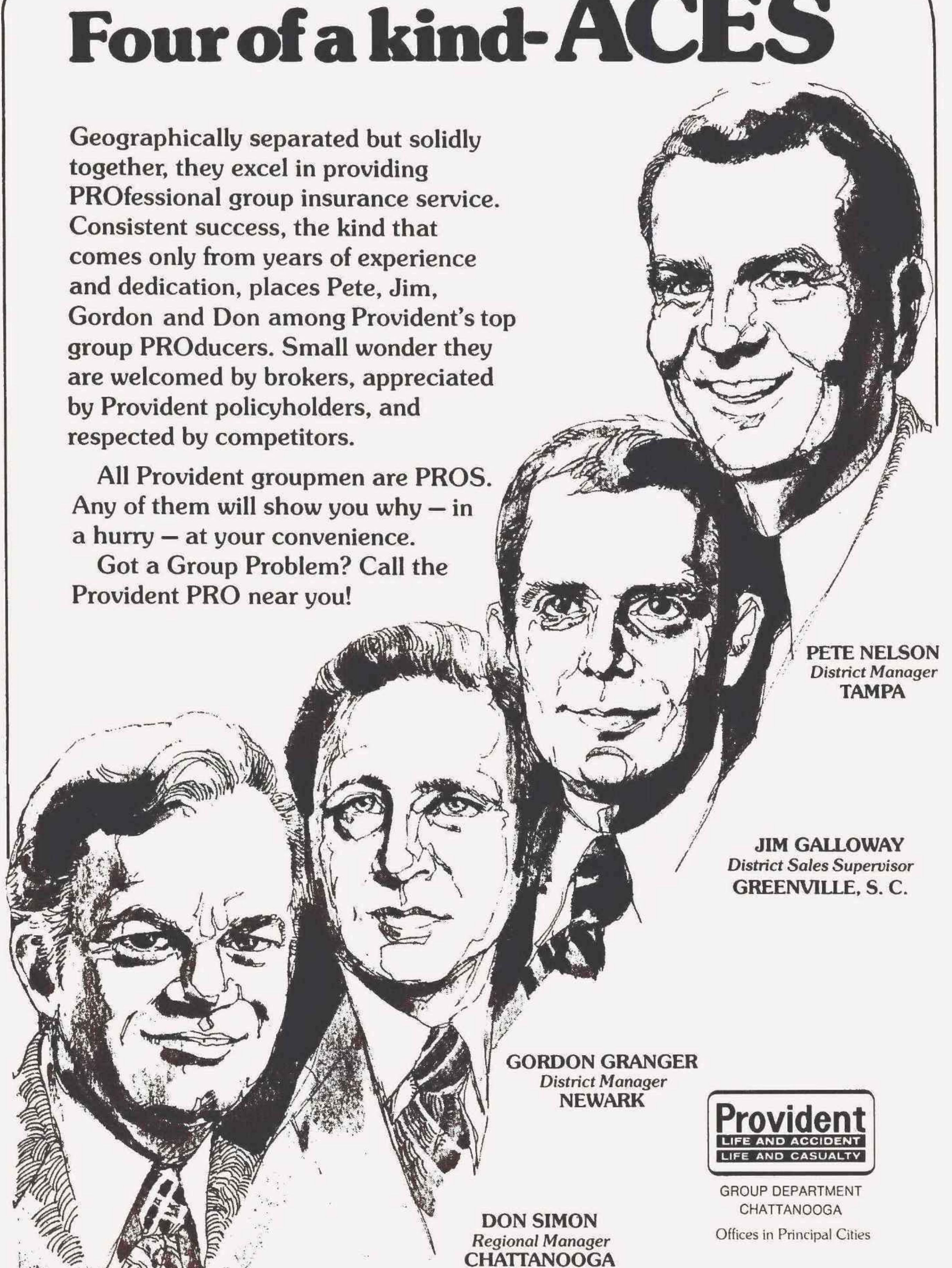
"Allegations of mental anguish, ridicule by friends, psychological damages . . . should be critically examined," he said. "Speculative claims such as the 'high probability of a miscarriage' should be confronted and eliminated if at all possible," he added.

The insurer's liability should be considered where property jointly owned and insured is destroyed by the deliberate act of one of the co-owners and where corporate property is intentionally destroyed by a corporate officer, employe or stockholder, he advised.

"While the nominal beneficiary of the policy would be the corporation, the actual beneficiary would be the arsonist," Mr. McGuire said.

Arson is claimed to be the fastest growing crime in the U.S. with national annual losses at $1.5 billion and a yearly increase of 10% to 15%, according to Mr. McGuire.

"In addition, one must consider the large number of fires not investigated or those to which no cause or origin may be attributed after investigation," he said. "The statistics only represent a portion of the true number of arsonous fires committed." ■



FAA . . .

Continued from page 41

it was not a cause of the crash," he said.

"Sound strategy dictates against the joining two defendants with a mutuality of interest in defeating the plaintiff's claim when not required by other consideration," Mr. Davis said.

"While the pairing of defendants against one another on the issue of which one is liable to the plaintiff has definite advantages, it is unlikely that this advantage could be realized in a negligent certification case which also involved the manufacturer," he said.

"However, where the manufacturer seeks refuge behind FAA approval in certification and is going to emphasize this face in defense, there could be an advantage in joining the FAA for negligent certification. In justification of its position the FAA may present evidence that the manufacturer was less than candid, or did not supply all necessary factual information and test data upon which a thorough approval in certification could be made," he said.

"The advantages to the plaintiff in this conflict between the manufacturer and the FAA must be weighed against the disadvantage of their joining together in asserting that no defect or no proximate cause existed."

Another approach Mr. Davis suggested is to join the FAA for negligent certification so as to subject it to discovery under federal rules of procedure.

Breach of contract liability ruled broader now

MONTREAL—The day may come when a businessman who enters into a contract either with "reckless disregard" about continuing it or an "outright intention to breach" it, will find his exposure to damages is no longer limited to so-called forseeability tests but rather will be vulnerable to a "full broadside of consequential damage claims," an attorney predicted here.

Douglas G. Houser, with the law firm of Bullivant, Wright, Leedy, Johnson, Pendergrass & Hoffman, Portland, Or., told participants at the American Bar Assn. conference on insurance, negligence and compensation law that "it will be interesting to see if the insurance industry is singled out as the only target for exposure to extra-contract damage claims or whether an implied duty of good faith to perform every commercial contract will be found.

"When a contract is breached, the courts have previously held that the breaching party is only responsible for damages that a reasonable man could have foreseen at the time," explained Peter R. Mersereau, an attorney with the same firm.

"A responsibility for consequential damages—that is, broad liability resulting from the breached contract—could be much greater," Mr. Mersereau continued. Two examples of the trend of court rulings toward consequential damage liability are medical malpractice and product liability awards, he said.

Another point which Mr. Houser raised in his speech concerns good faith standards. Should an insurer's decision to deny a claim be based on admissible evidence or is a moral conviction justifying a denial sufficient? he queried.

Mr. Houser said he believes it would be "unreasonable" for the courts to impose an admissibility standard on insurance companies to justify a denial of claims. "Sometimes arson cases are defended as a matter of principle even when the chances of winning are slight in order to let a community know that arson is said, adding that he thought the not the path to easy money," he insurance company still should be prepared to justify the reasonableness of its action.

He observed that insurance companies would want to "play it safe and give the insured the benefit of doubt in claims handling procedures" to fend off charges of bad faith.

In cases where the independent adjuster or investigator is also named a defendent, Mr. Houser said he thinks that the insurnce company, "except in cases of clearly improper behavior, will probably choose to defend the (individual) rather than create the appearance that something was done improperly."

A threatened suit for bad faith practice on the part of the insurance company can be "eliminated where denial or other treatment of the claim is based upon relevant supporting facts contained in a 'clean' file," said Mr. Houser.

"If the insurance company reviews the claims file and decides the matter was handled poorly, it may be important to effect immediate remedial administrative reforms to prevent the mishandling from occurring again," he explained. "Such reforms should take most of the wind out of the plaintiff's sails as far as punitive damages are concerned (because) it would be obvious that the insurance company had learned its lesson."

Mr. Houser advised insurance companies to consider filing a declaratory judgment action to determine "if you owe anything," as soon as a charge of bad faith on a claim is imminent.

"This has some procedural advantage in jury argument and also shows the insurance company's good faith effort to get an early determination of the dispute," he said.

"If the only question is now much rather than coverage, the carrier should consider exercising its right to an appraisal or arbitration," Mr. Houser continued. Aside from obtaining an early determination of the dispute, it also "has the advantage of taking the decision out of the insurance company's hands," he added. Also, he advised carriers to be willing to make partial payments in these types of cases.

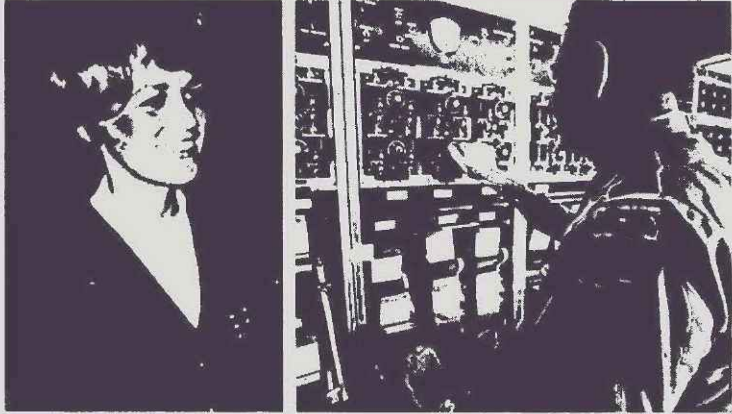
"Don't whiplash the insured if the real dispute is between two concurrent insurance carriers," Mr. Houser cautioned.

"Keep a clean file. Avoid inflammatory and derogatory remarks such as 'there's no doubt this gay, one-legged, white trash S.O.B. burned it down,' " he advised. Instead try, "the authorities advise that our insured is the probable arsonist."

Last but not least, Mr. Houser recommends keeping an open mind until the investigation is complete. "An early denial (of the claim) will destroy the right to insist that the insured fully comply with policy requirements such as proof of loss and examinations under oath," he said. ■

Acquisition

Marsh & McLennan Companies Inc., New York, has acquired a 15% interest in the business of Gradmann & Holler, Germany, with a provision for acquiring an additional 15% interest in the future. Gradmann & Holler serves as insurance, reinsurance and employe benefits broker and consultant for major West German industrial concerns.



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Environmental cover . . .

Continued from page 1

"The practical results may be a tendency to defend or settle when the slightest question exists in potentially high exposure cases," Mr. Soderstrom said.

Insurers should review their present policies as they relate to environmental or pollution hazards, he recommended. "A change to specific pollution coverage is not only necessary but also desirable," he said, adding that the process has already begun. (*Business Insurance*, June 16.)

"With the advent of the environmental impairment liability policy (EIL), the carriers' position may change considerably," he predicted. "It heralds (their) participation in environmental improvement, a welcome change."

Mr. Soderstrom pointed out that a special premium—up to 5% of the total premium—is charged as a "risk improvement contribution." This way, the insurance industry can offer specific environmental coverage to industries while "indirectly participating in the struggle against those forces that degrade our land and quality of life," he said.

He observed that the new EIL policy was more attractive to small- or medium-sized companies than to corporate giants for the primary reason that the latter are largely self-insured for this risk.

Another reason is that the biggest corporations find it less expensive to follow state and federal compliance with pollution control, for example, than to buy environmental liability coverage, Mr. Soderstrom said.

At least one large oil company debated buying the coverage because the director of insurance there found the application form "too onerous," according to Mr. Soderstrom. He added that a preliminary estimate of the premium can be based on limited information.

"If the premium terms are then agreed to, the insured will be required to complete the proposal form," he said.

Business Insurance learned that among the underwriters offering EIL coverage are Lloyd's of London, Swiss Reinsurance Co. and Mercantile & General Reinsurance Co. Mr. Soderstrom declined to identify which sample policy he based his discussion on, saying only that it is offered by "international underwriters."

The exclusion of coverage for "grossly negligent environmental impairment is perhaps the policy's biggest question mark," he said, acknowledging that an insured would regard this exclusion as a drawback because it narrows the coverage provided.

While some exclusions in the policy are regarded as "absolute," several others are considered "negotiable," he explained. "Insurers seem prepared to delete (certain exclusions) subject to supplementary information and additional premium.

"An insured's initial response may be that his company does not knowingly violate any appropriate regulation," Mr. Soderstrom said. "This may well be. On the other hand, the insured may admit that he has problems with the interpretation of some regulation (or conclude) that the enforcement agency is not presently demanding strict compliance.

"If he does nothing and the regulation is subsequently strictly construed and enforced, there may be no coverage until he undertakes appropriate control remedies," Mr. Soderstrom continued.

"If he had undertaken these measures earlier in even the most limited manner, coverage would most probably have been afforded under the new EIL policy."

Coverage is provided for residual pollution, caused by the emission of "quantities of pollutants which even the strictest compliance with control and prevention standards cannot eliminate entirely," he said. "It was to this end that the new EIL policy was formulated."

Other policy provisions include coverage for the costs of litigation and for expenses incurred in removing nullifying or cleaning up harmful substances, Mr. Soderstrom continued.

The insured usually can select reasonable limits for any one claim but the policy will contain a further aggregate limit of liability for any one year, Mr. Soderstrom said. Deductibles are negotiated on a case by case basis in accordance with the size of the insured's operations, he added.

The rating approach is complex, he said. It involves "a rather sophisticated rating system" by type of industry, production process and individual risk factors. ■

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OSHA inspections

The Occupational Safety and Health Administration (OSHA) conducted 7,370 workplace inspections during June, 1975 compared to 6,308 in June of 1974. The figures were announced by the Labor Department last month. The June, 1975 inspections resulted in the insurance of 5,803 citations alleging 30,616 violations of job safety and health standards. Proposed penalties totaled $894,36.

State workers' comp needs better delivery

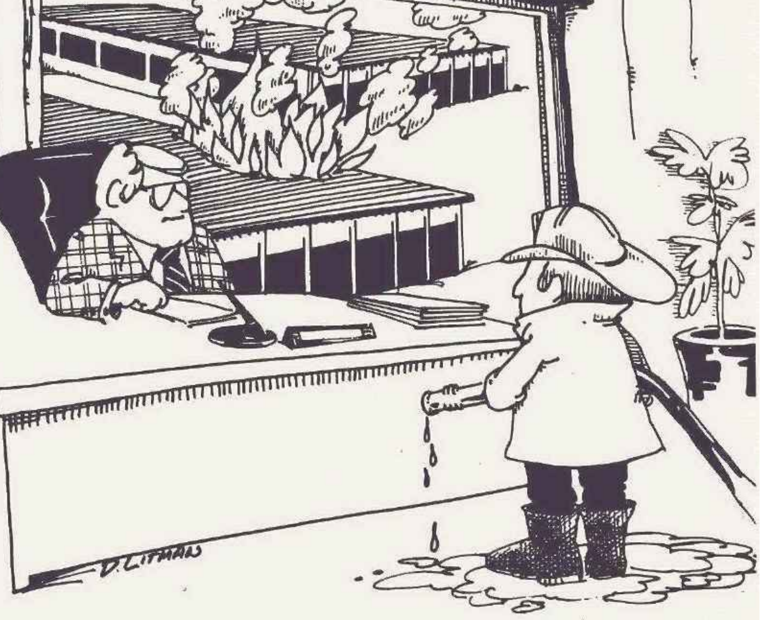
MONTREAL—An effective state workers' compensation delivery system "must be considered at the top of the essential recommendation list" of the National Study Commission on State Workmen's Compensation Laws, said Stephen M. Hadley, Industrial Commission of Utah, Salt Lake City.

Praising state compensation laws as demonstrating "a history of continuous progress," Mr. Hadley told participants at the American Bar Assn. conference on insurange, negligence and compensation law here that "a successful delivery system requires accessibility to a person needing help."

"Such accessible centers must be staffed with personnel who can give directions and answers without unreasonable delay," Mr. Hadley continued.

He recounted an experience involving a railroad worker who called his office seeking benefits under the Federal Employers Liability Act. "Desiring to help and wanting to know how the federal procedure operating," Mr. Hadley said he was eventually referred to the Sacramento, Ca., office. Not wanting to call that far away, Mr. Hadley said he was told that a representative from that office would be in his area "in about a month and could talk to the injured worker then."

Mr. Hadley believes "the most effective delivery system is a local or state-administered one, directly responsive to the needs of those aggrieved by the system." ■



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Insurers can demand affirmative proof of loss in bankers' bond claim

MONTREAL—Underwriters for both primary and excess bankers' blanket bond can demand "affirmative proof of loss with full particulars" as a precondition to honoring a claim, according to an attorney speaking here.

The only exception to this requirement in standard policies is the element of "impossibility of performance" which involves issues like national security, said Clyde J. Watts, an attorney with the Oklahoma City firm of Watts, Looney, Nichols, Johnson & Hayes.

What objectives, in the absence of fraud, could an insured bank possibly have to deny such proof permitting a routine claim rather than the basis for a lawsuit? Mr. Watts queried. "It could happen," he emphasized.

He gave an example of a bank customer who was a member of the Central Intelligence Agency (CIA) and whose safety deposit box was rifled of $1 million and various classified documents that would endanger national security if their loss were publicized.

The general rule applicable to contractual construction would apply, Mr. Watts said. The underwriter would be required to cover the loss suffered by the bank including the obligation to replace the contents of the rifled safe deposit box, he told the American Bar Assn. conference.

Mr. Watts distinguished between the varied responsibilities of surety bonds and insurance. In either case, he emphasized, a refusal to offer proof of loss "would preclude recovery under the bond whether it be considered insurance or a surety bond."

"In recent years, the courts have increasingly construed the liability of a fidelity bond surety as an insurer," Mr. Watts said. The effect of these rulings is that it is more difficult to collect a claim for a surety bond because the liability is interpreted more conservatively, he explained.

"An insurance policy, regardless of how many interests may be involved, is essentially a two-party instrument. It is an agreement on the part of the insuror to reimburse the insured in case of loss caused by a designated contingency," Mr. Watts said.

"A true bond, on the other hand, is always a three-party instrument. Fundamentally, it is a guaranty that one party (surety) will meet an obligation due the second party (obligee) from a third party (principal) if the third party does not," Mr. Watts said. "In every bond there is an expressed or implied obligation on the principal to reimburse the surety for a loss which the surety is compelled to pay because of the principal's default."

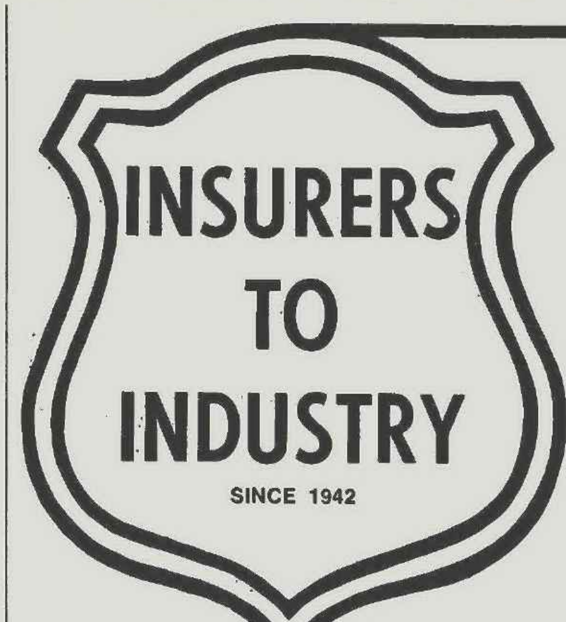
"The judicial identification as a fidelity bond or dishonesty insurance is not necessarily controlling as to whether an insuror or a surety is released from obligation," Mr. Watts continued.

"The decisive factor is whether the obligee (insured) has breached the terms of an enforcible condition precedent to the liability of the surety such as a fair and honest disclosure by the obligee (insuror) of knowledge of previous defalcations upon the part of the prospective principal."

If the surety could "prove prejudice" by the insured's delay past the prescribed 60 days to make a full disclosure, "it would appear that the surety would be relieved of liability," he said. ■

Omitted from its profile

Four officers' names were inadvertently omitted from *Business Insurance*'s profile on Mack & Parker Inc., Chicago, which appeared in the July 28 Agent/Broker issue. The following principal officers of the firm should be added to the list: Lance R. Sanberg, vp; William J. O'Keefe, vp; Kenneth T. Krispin, assistant treasurer; and C. Jean Underhill, assistant secretary.



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people

Reid replaces Griffin at Hughes Aircraft Co.

Hughes Aircraft Co., Los Angeles, named **D. F. Reid** risk manager to replace **Berry L. Griffin,** effective September 15. Mr. Reid formerly was assistant director of insurance for Santa Fe International Corp., Orange, Ca. No one has been named yet to replace him there. Before joining Santa Fe, Mr. Reid worked at Continental Can Co. for 15 years, five of them as risk manager. At Hughes, Mr. Reid will report to the company's treasurer. Mr. Griffin is national vp of RIMS and was slated for the organization's presidency. He also is an active member of the Los Angeles chapter of RIMS. At press time, Mr. Griffin had not disclosed his future plans to *Business Insurance*.

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Albert E. Dischinger was named insurance manager at Holly Sugar Corp., Colorado Springs, Co., following a division of the company's insurance responsibilities into two sections. Mr. Dischinger is in charge of property/casulaty risks which include safety management, insurance analysis and claims management. Workers' compensation and employe benefits administraton is being handled by **Vernon D. Hoff,** who previously was doing both jobs. Holly Sugar said the split in responsibilities was necessitated by "increasingly burdensome government regulations" along with increased values at risk due to inflation and the company's "expanded investment in inventories and property." Mr. Dischinger reports to the treasurer. He comes to Holly Sugar from Del Monte Corp., San Francisco, where he served as manager of corporate insurance for eight years.

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Del Monte Corp., San Francisco, named **Jerry G. Sullivan** to the position of manager-insurance division to replace Mr. Dischinger. Mr. Sullivan reports to the assistant treasurer—insurance and risk managemet. His responsibilities include property/casualty, marine and workers' compensation coverage plus self-insured risks. Before this appointment, Mr. Sullivan was manager of safety for Del Monte. **William Larson** was named to fill that position. Prior to that job, Mr. Sullivan was manager of the insurance claims section. Mr. Larson previously was administrative assistant, industrial relations, U.S. production at Del Monte before his promotion to manager of safety.

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LTV Corp., Dallas, lected **Walter E. Meyer, 43,** to vp-personnel, a newly-created position. Mr. Meyer formerly was director of corporate personnel operations at Xerox Corp., Stamford, Ct. In his new job, Mr. Meyer will focus on incentive builders such as benefits, management succession, career path planning, equal employment opportunity, compensation and "overall people development," according to an LTV spokesman. Mr. Meyer will report to the president and chief operating officer. No one has been named to replace him at Xerox. Mr. Meyer's prior experience includes serving as director of industrial relations for a division of Litton Industries Inc. He also was in personnel management at Lockheed Aircraft Corp. and Douglas Aircraft Co.

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Brown & Williamson Tobacco Corp., Louisville, promoted **Joseph T. Burkhardt** to manager of the insurance department. He replaces **William P. Koehler Sr.,** who retired Sept. 1. In his new position, Mr. Burkhardt is responsible for formulating and administering the corporate insurance program which covers subsidiaries, Export Leaf Tobacco Co. and Vita Food Products Inc., as well as five associated companies in Central America. Mr. Burkhardt joined Brown & Williamson in 1967. Since 1970 he has served as systems project manager. No one has been named to fill that position yet.

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G. D. Searle & Co., Skokie, Il., hired **Jim Morgan** for the newly created position of assistant insurance manager. He formerly was a senior underwriter for Aetna Life & Casualty Co. Mr. Morgan reports to the corporate risk manager and initially will assist in overseeing daily operations and loss adjustments for the pharmaceutical company. Part of his responsibilities include recommending improvements, standardizing procedures, training supportive personnel and updating G. D. Searle's corporate risk manuals.

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A chain of promotions in the employe benefits department at Parke-Davis & Co., Detroit, paved the road for the hiring of **Susan Way** as employe benefits supervisor. She formerly was assistant industrial relations manager at a B.F. Goodrich plant in Ohio. No one has been named to replace hr there yet. Beginning Sept. 8, she reports to **Larry Rappaport,** who was promoted from benefits supervisor to employe benefits manager. He, in turn, replaced Eve Adams, who was promoted to manager of compensation, a position which remained "open for months," according to Mr. Rappaport. **Dan Mertus,** who formerly held that position, was transferred to another division of the company.

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Edward O. Randy was named assistant vp and head of the employe benefits department for Textron Inc., Providence, R.I. He formerly was assistant secretary and assistant general counsel for the company. **Ronald van Brocklin,** who had held the position of head of the employe benefits department, was named controller of the company. ■

dates for buyers

Sept. 16-18: The International Foundation of Employe Benefit Plans' Washington Legislative Educational Conference will be held in Washington, D.C., to give a briefing on government interest in the labor-management employe benefit trust fund field. Senators and congressmen who sponsor or support key legislative proposals, staff aides and agency spokesman responsible for formulating and administering regulations will be on hand to present their views. For more details, write to the foundation at P.O. Box 69, Brookfield, Wi. 53005.

Sept. 17-19: Group Dental Benefit Plans will be the subject of an American Management Assn. workshop in Chicago. A team of knowledgeable speakers—including employe benefit managers and insurance company representatives—will explain the complexities of various plans: scheduled, comprehensive, major medical and others. For more information, write to the AMA, 135 W. 50th St., New York, N.Y. 10020.

Sept. 25-26: Hay Associates and Huggins & Co. Inc. will co-sponsor a seminar on Communicating Compensation and Benefit Programs, to be held in Philadelphia. Attendance cost is $225. For further information, contact Joseph A. Banik, Huggins & Co. Inc. 1401 Walnut St., Philadelphia, Pa. 19102.

Sept. 27-Oct. 1: Employe Benefits: The Challenge—Private or Public Domain? will be the theme of the Eighth Annual Conference of the International Foundation of Employe Benefit Plans, to be held in Vancouver, British Columbia. Workshops will be offered on legislation relating to employe benefits, union/management negotiation of contributions, union/management negotiation of benefits and the future of dental benefits. Additional information can be obtained from Edward D. Zacharko, president, Funds Administrative Services, 2204 Imperial Oil Building, 10025 Jasper Ave., Edmonton, Alberta, T5J 1W2.

Oct. 9-11: The 29th Annual Conference on Employe Benefits, sponsored by the Council on Employe Benefits, will be held in Chicago. National health insurance, Social Security, union views of employe benefits and retirement planning will be among the topics.

Nov. 3-5: The National Insurance Conference, sponsored by the American Management Assn., will be held in New Orleans. It will be divided into two sections: general insurance and employe benefits. For further information, contact John Devitt, group program manager, AMA, 135 W. 50th St., New York, N.Y. 10020.

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