

business insurance

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update

Former P.C.W. officials face disciplinary action at Lloyd's

LONDON—A former chairman of P.C.W. Underwriting Agencies Ltd. faces expulsion from Lloyd's of London and three other men face disciplinary action for the alleged misappropriation of funds belonging to syndicates managed by P.C.W.

Lloyd's sources confirm a disciplinary committee recommended:

- Peter Dixon, former Lloyd's underwriter and P.C.W. chairman, be

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Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$52 a year

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Citicorp loan cover killed by reinsurance disputes

By DOUGLAS McLEOD

NEW YORK—CIGNA Corp.'s plan to write a \$900 million policy to insure some of Citicorp's foreign loan exposures finally collapsed this month because of disagreements between CIGNA and its political risk treaty reinsurers over how the treaty could be used, sources say.

The Citicorp contract, bound in May 1984, called for CIGNA to insure Citicorp's risk that borrowers in five financially troubled developing nations would not be able to repay loans because they were unable to convert local currency.

CIGNA had originally planned to use its political risk reinsurance treaty—which provided capacity of \$20 million per risk—to reinsure a portion of the Citicorp program, while reinsuring the bulk of the program on a facultative basis, one source said.

After failing to line up the required facultative capacity, however, CIGNA tried to redefine the Citicorp risk so it could reinsure the entire \$900 million program on its \$20 million treaty, sources say.

CIGNA had planned to divide the program into multiple policies, each of which would carry a limit of \$20 million backed by CIGNA's treaty, sources say.

Treaty underwriters—some of whom did not find out about the Citicorp coverage until it was reported in newspapers last September—disputed CIGNA's interpretation of the treaty, and the deal subsequently fell through, sources say.

"They were absolutely furious," said one New York reinsurance broker of Kemper Reinsurance Co., lead reinsurer on CIGNA's political risk treaty.

Largely because of its problems with the Citicorp program, CIGNA has so far been unable to complete the Jan. 1 renewal of its political risk treaty, sources say.

The Citicorp deal also has added to the reinsurance renewal problems of other political risk insurers, experts agree. Renewals had

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Manville gets \$112 million to cover asbestos claims

By STEPHEN TARNOFF

SAN FRANCISCO—Manville Corp.'s recent \$111.8 million settlement with three excess insurers provides the asbestos producer with broad coverage for asbestos bodily injury claims and brings Manville's available insurance for these claims to \$426 million.

In agreeing to provide Manville with \$111.8 million in coverage to settle the insurance litigation, the excess insurers agreed to pay bodily injury claims filed against their policies under the broadest interpretation of coverage for asbestos claims.

The settlement is based on a "comprehensive coverage" theory, said Robin Neuman, an attorney for Manville with the San Francisco firm of Heller Ehrman White & McAuliffe.

"I would call it similar to a Keene trigger," she said, referring to the landmark *Keene Corp. vs. Insurance Co. of America* decision handed down by the U.S. Court of Appeals for the District of Columbia in 1981.

That decision said all insurers on the risk from the time of inhalation through manifestation of an asbestos-related disease are liable for defense and indemnification costs.

This means the excess insurers will pay all claims filed as long as the claimant was either exposed to as-

bestos during the policy periods, had previously been exposed to asbestos and the disease was latent or the asbestos-related disease manifested itself during the policy periods, up to \$111.8 million.

This is the broad coverage that Manville had sought and the insurers had tried to limit.

An earlier settlement with primary insurers did not require the primary insurers to submit to any coverage theory since they merely agreed to pay \$314.4 million in cash to Manville to be used to pay claims as Manville wanted.

The settlement with the excess insurers, however, provides Manville with future "coverage in place." The excess insurers will pay claims as presented.

While the settlement with the excess insurers provides Manville with broad coverage for asbestos claims, it caps the settling insurers' liability for asbestos claims and saves them the cost of continuing litigation with Manville over the coverage provided by their policies.

Some of the policies involved may not have contained aggregates. In addition, the \$111.8 million does not appear to represent the full policy limits for all the policies provided.

Based on a chart of Manville's insurance coverage filed in bankruptcy court, it appears that the settling

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What Manville will receive from excess insurers

Midland Insurance Co.	\$46.75 million
Insurance Co. of North America	\$37.00 million
Northbrook Excess & Surplus Insurance Co.	\$28.05 million

Aviation insurance costs taking off

Manufacturers' product liability rates climb | Airlines may see more hikes

By STACY SHAPIRO

LONDON—Aircraft manufacturers are fastening their seat belts in anticipation of turbulence during product liability coverage renewals this year.

A tightening market, in part caused by increasing aviation liability awards against manufacturers, is causing rates to rise by as much as 200% over last year while the size of deductibles is sometimes tripling, manufacturers and aviation underwriters say.

And, one major light aircraft manufacturer—Beech Aircraft Corp. of Wichita, Kan.—has still not filled out the high excess layers of its product liability coverage, which renewed on Jan. 1.

Aviation product liability insurance is usually written by specialized aviation underwriters rather than other liability insurance markets because of the unique nature of the risk.

The coverage typically responds to losses stemming from air disasters that are ruled to have occurred because of manufacturing defects.

Although many of the rising number of aviation product liability claims now being paid by insurers stem from recent aviation accidents, some of the claims date back almost 30 years and underwriters say that often they had not reserved for these losses.

Because of this increased claims activity, some European and London aviation markets are shunning U.S. aviation product liability risks, and that's making it tough for buyers to find adequate capacity at reasonable rates.

"There is a shortage of capacity because a lot of people have pulled out or are cutting down," said Wally Corbett, aviation underwriter at Minister Insurance Co. Ltd. in London.

"There has been a swath of late (notification) on claims...we are not set up to handle long-tail business where we don't know about the losses," Mr. Corbett said.

Beech knows about the capacity problems firsthand.

More than a month after Beech was scheduled to complete its renewal, "the lines are not fully completed. (The layers) still need to be filled out," confirmed John Stokdyk, president of Travelair Insurance Co. Ltd., Beech's insurance subsidiary in Bermuda. Travelair writes Beech's primary aviation product lia-

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By STACY SHAPIRO

LONDON—Airlines can probably expect rate increases and stricter coverage terms when they renew their aviation insurance this year.

But aviation underwriters and brokers say that airlines may not face the steep climb in rates—ranging up to 150% for some airlines—that they encountered during 1984 renewals.

"It is difficult to make forecasts," said Richard Maylem, Lloyd's aviation underwriter for syndicates managed by Alexander Howden Underwriting Ltd. "But on the airline front, because underwriting results have been poor...rates will continue to escalate. Rates will rise, but not to such an extent as 1984."

Rates for hull insurance will probably rise only slightly to match the increase in insured hull values, brokers and underwriters agree.

However, aviation liability insurance rates may balloon and liability coverage restrictions may increase further, depending on an airline's loss experience.

"Liability rates are all over the place," said John Palmer-Brown, managing director of Stewart Wrightson (Aviation) Ltd. in London. "So, rates boil down to the relevance of the liability exposure, such as in the U.S., where awards are liable to be high."

Brokers and underwriters note that 1985 rate hikes cannot be accurately

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barred from Lloyd's for life and be fined 1 million pounds (\$1.12 million) plus 200,000 pounds in costs.

- Adrian Hardman, another former P.C.W. chairman and marine underwriter, be suspended for two years from Lloyd's membership and pay an undetermined amount of costs. Mr. Hardman is now a consultant with Willis Faber P.L.C.

- Colin Davies, a former P.C.W. director, be suspended from Lloyd's membership for one year and pay 40,000 pounds in costs. But, the committee ruled he should be free to work in the Lloyd's market. He works at broker Benfield, Lovick & Rees & Co. Ltd.

- David Hill, a P.C.W. underwriter, be reprimanded and pay an undetermined amount. He works at broker Thos. R. Miller & Son Ltd.

The four men have 14 days in which to file an appeal and an additional 14 days to produce evidence for the appeal.

Mr. Dixon, who is living in Spain, and Mr. Davies and Mr. Hill were unavailable for comment. Mr. Hardman would say only that he may appeal the amount of the costs he has been assessed.

After any appeals, the Council of Lloyd's will vote on whether to accept the committee's recommendations, a Lloyd's spokesman said.

The committee's findings come after a two-year investigation into the P.C.W. affair. In 1982, it was discovered that about 39 million pounds (\$43.7 million) of syndicate assets allegedly had been misappropriated for the personal benefit of former P.C.W. directors.

In addition to these four men, two others were alleged to have personally benefited from the money. They are former Minet Holdings P.L.C. Chairman John Wallrock and former P.C.W. Chairman Peter Cameron-Webb, who now is an underwriter at the Insurance Exchange of the Americas in Miami (BI, July 23, 1984).

Mr. Wallrock has asked for a public hearing on the charges against him. It will be held in the spring, a Lloyd's spokesman said.

Mr. Cameron-Webb resigned from Lloyd's in 1982, and therefore is not under Lloyd's jurisdiction, the spokesman said.

Also, the newspaper Lloyd's List confirmed a Lloyd's disciplinary committee recommended the expulsion from Lloyd's membership of Kenneth Grob, former chairman of Alexander Howden Group P.L.C. He is being disciplined in connection with the alleged misappropriation of \$55 million in Howden syndicate funds.

Six Flags must stand trial

TOMS RIVER, N.J.—Six Flags Great Adventure amusement park and its parent company, Six Flags Corp. of Los Angeles, must stand trial next month on charges of aggravated manslaughter in connection with the May 11, 1984, fire at the park in which eight teen-agers died (BI, Sept. 24, 1984).

New Jersey Superior Court Judge Arthur J. Blake ruled last week that corporations were not eligible for a pre-trial program that permits first-time offenders to avoid trial without admitting guilt by doing community service and paying restitution to the victims' families, said a spokeswoman for the judge.

The spokeswoman said the judge noted that the language of the statute makes it clear the pre-trial program is intended to apply only to individuals, not corporations. Judge Blake had ruled in December that David L. Paltzik, the park's current general manager, and Larry B. Cochran, executive vp of Six Flags Corp. and the park's former general manager, could enter the program. Both had been charged with manslaughter in the deaths.

In addition to the criminal charges, civil lawsuits have been filed on behalf of the families of all eight teens killed and on behalf of a teen-age girl who was injured. Attorney Morris J. Eisen of New York, who is representing the families of four of the teen-agers killed, said those suits are expected to be heard after the criminal trial.

Carbide suits to be heard in N.Y.

NEW YORK—Lawsuits filed on behalf of victims of the toxic gas leak at Union Carbide Corp.'s plant in Bhopal, India, will be consolidated and heard in U.S. District Court for the Southern District of New York, a panel of judges has decided.

The Judicial Panel on Multidistrict Litigation decided in Washington last week the suits would be heard in the Manhattan court if they are heard in the United States. About two dozen suits seek billions of dollars as a result of the Dec. 3 accident in which leaking methyl isocyanate from the Bhopal plant killed about 2,500 people and injured at least 150,000 more.

Union Carbide's more than \$200 million in liability insurance may not include coverage for defense costs (BI, Dec. 24-31, 1984).

Compass pays \$198,500 fine

NEW YORK—Compass Insurance Co. has paid a \$198,500 fine to the New York Insurance Department for violations of the state's Holding Companies Law, a department spokesman said.

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FASB reports it will soften proposed pension rules

By JERRY GEISEL

STAMFORD, Conn.—The amount of pension liabilities that some employers would have to report on their balance sheets under the Financial Accounting Standards Board's controversial pension accounting proposal may be reduced.

FASB no longer will require employers who base pension benefits on employees' salaries to estimate future salary increases when they calculate their pension liabilities, confirms Timothy B. Lucas, the manager of the FASB project.

Including an estimate of future salary increases in the calculation of corporate pension liabilities would dramatically increase those liabilities (BI, May 30, 1983; Jan. 24, 1984).

However, employers still would have to move their unfunded pension liabilities onto their balance sheets under the new FASB proposal.

In its decision to drop future salary increases from the pension accounting proposal, FASB concluded "that a defined benefit plan gives rise to obligations of the sponsor and that those obligations qualify as recognizable liabilities. (But) because there are different views about the measurement of that liability, and for practical reasons, the board concluded that only a minimum liability—unfunded accumulated benefits—

should be recognized at this time."

FASB's first comments on a wide variety of pension and benefit accounting issues were first published in November 1982 in a report called "Preliminary Views on Employers' Accounting for Pensions and other Post-employment Benefits."



Since then, FASB—the rule-making body of the accounting profession—has sought public comments on its preliminary views before publishing its final proposals, possibly as soon as late this year.

FASB's proposal that employers include future salary increases when they calculate their pension obligations would have been a radical departure from current accounting practices, experts say.

Companies now list in footnotes to their financial statements the market value of pension assets, the accumulated present value of vested benefits and the accumulated value of non-vested benefits.

For example, the footnotes to a small company's financial statement might list \$1 million in pension plan assets, \$500,000 in accumulated vested pension benefits and \$150,000 in accumulated non-vested benefits.

However, some members of the accounting profession believe that listing only pension assets and accumulated vested and non-vested benefits does not ac-

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Chicken farmers may recoup losses despite lack of coverage

By DIANE LYNN KASTIEL

BIRMINGHAM, Ala.—The owners of many of the chicken houses in Alabama and Mississippi that collapsed last week under the weight of ice and snow do not have collapse coverage, although the farmers' insurers say they may pay some claims anyway.

And, one of the principal owners of the chickens killed in the collapse says it self-insures its animal mortality risks.

Total losses in northeast Mississippi and northwest Alabama, including property damage to the chicken houses and the loss of as many as 4 million chickens, are estimated at \$10 million, according to officials at the Alabama and Mississippi poultry associations.

Dave Carter, president of the Alabama Poultry & Egg Assn., said 75 of the state's 150 chicken houses collapsed, killing about 2.25 million chickens.

Joe Shipp, president and executive director of the Mississippi Poultry Assn., said 100 of the estimated 150 to 200 chicken houses in the state collapsed, killing between 1.5 million and 2 million chickens.

Although the chickens that were killed were largely owned by large poultry marketers, individual farmers owned most of the houses that were destroyed.

Most of the Alabama farmers who buy property coverage from Alabama Farm Bureau Mutual Casualty Insurance Co. Inc., which insures about 70% of the state's farmers, did not purchase optional col-

lapse coverage for their chicken houses, said Gary Daniel, vp of farm owner underwriting for the insurer in Montgomery, Ala.

Mr. Daniel explained that coverage for chicken houses is excluded from farmers' basic property policies because many of the houses are in bad condition.

New chicken houses cost between \$50,000 and \$100,000, he said, adding that the actual value of some of the houses is much less.

Jim Jenkins, administrative assistant for Mississippi Farm Bureau Mutual Insurance Co. in Jackson, which writes coverage for Mississippi farmers, noted that few farmers in the state buy collapse coverage.

Only 20 to 30 of the some 100 chicken houses in Mississippi that are known to have collapsed were covered according to Mr. Jenkins.

"Unfortunately, this is like earthquake coverage," he said. "People don't buy it because 'The earthquake's not gonna come. It's not gonna happen to me.'"

However, the Mississippi insurance company, which is owned by the Mississippi Farm Bureau, may pay some claims to uninsured farmers, Mr. Jenkins said.

"If the owners decide (to provide restitution), that's what they're going to do," he said.

Alabama Farm Bureau Mutual is also considering paying some claims to uninsured farmers.

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New York judge approves Ideal Mutual's liquidation

By JUDY GREENWALD

NEW YORK—The New York Insurance Department is proceeding with the liquidation of Ideal Mutual Insurance Co. after a judge last week approved the department's liquidation request.

State Supreme Court Justice Stanley Parness gave the department the go-ahead to liquidate Ideal after no one objected to the liquidation at a hearing held Thursday.

Now that the order has been approved, the New York department can actually begin liquidating Ideal Mutual, a process that some observers have said could take as long as 10 years.

Meanwhile, the first shareholder suit stemming from Ideal Mutual's demise has been filed.

A shareholder of Optimum Holding Corp., a downstream company that is 51% owned by Ideal and 49% publicly held, is suing Optimum, Ideal Mutual, Optimum's directors, the companies' current and former officers and their auditor, Arthur Andersen & Co., for compensatory and punitive damages caused by the decline in the value of Optimum's stock.

Among those named in the suit are B. Frederick Becker, Optimum's and Ideal's former president and chief executive officer, and Edward P. Lalley, who preceded Mr. Becker as president and chief executive officer of Ideal and Optimum and later served as chairman of both companies.

The New York Insurance Department placed Ideal Mutual into rehabilitation Dec. 26, after a triennial examination of the company by the department as of Dec. 31, 1983, found the insurer was \$155.3 million short of meeting its \$310.6 million of liabilities (BI, Jan. 14).

The New York department noted in court papers recently filed in connection with the liquidation request that Ideal Mutual's financial condition did not improve during 1984.

New York Insurance Superintendent James P. Corcoran said in the papers that Ideal had a net loss of \$6.1 million for the first 11 months of 1984, and he noted the company did not have the financial resources to continue operation this year.

Mr. Corcoran said in the court papers that Ideal's financial results since December 1983 "points out the fu-

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Savings for employers, employees

By ALISON KITTRELL

LINCOLNSHIRE, Ill.—Salaried workers are now more likely to be able to contribute to a 401(k) salary reduction plan but are less likely to have first-dollar medical coverage, according to a new survey.

The number of companies offering 401(k) plans to salaried employees has mushroomed, according to an ongoing survey of 250 major U.S. employers by Hewitt Associates of Lincolnshire.

Nearly three-quarters of the surveyed de-

Salaried workers get 401(k) plans but must pay more for health care

defined contribution plans offered to salaried employees had a 401(k) feature in 1984, up from less than half in 1983 and virtually none in 1982.

"That was just so dramatic," said Jamie Roberts, a consultant with Hewitt in Lincolnshire. "For (401(k) plans) to jump that much in three years means it's a hot benefit... and people are still looking at it. It's still a hot benefit."

And, more employers are including health plan deductibles and dropping 100% reimbursement of hospital and surgical coverages for their salaried employees, a trend that has been growing in the five years covered by the survey.

Don Hasbargen, a partner with Hewitt in Minneapolis, said the changes in medical plans and the growth of 401(k) plans are both part of a trend to give employees more options in and control of their benefits.

"The benefits business is going through an evolution—not so much giving more, but giving it better," he said. "We have recognized that we can no longer create an average employee" and design benefit plans around the needs of that average employee, he added.

The most dramatic trend noted by the survey is the growth of 401(k) plans. In 1984, 74% of the surveyed defined contribution plans had a 401(k) feature. Only 41% offered a

401(k) feature in 1983, while virtually no plans had 401(k) features before then.

In both 1984 and 1983, 5% of those companies offered the 401(k) feature as part of a savings plan without a company match.

Ms. Roberts attributed the popularity of 401(k) plans to the fact that they "encourage people to save... to put their own dollars away for retirement."

"It's one of those benefits where everyone wins," she said. The employee is able to save money on a pretax basis, and the employer is able to ease some of the pressure on company-sponsored pension plans.

Mr. Hasbargen adds 401(k) plans have "re-established the three-legged stool," a traditional concept that retirement income should be based on company pension benefits, Social Security and personal savings.

For some time, he said, personal savings has been the weak leg of the stool. But, "401(k) gives us a way of intensifying an employee's willingness to save."

However, the Treasury Department has proposed eliminating 401(k) plans and some Washington observers expect Congress will pass laws that would curb the plans' growth (BI, Jan. 28).

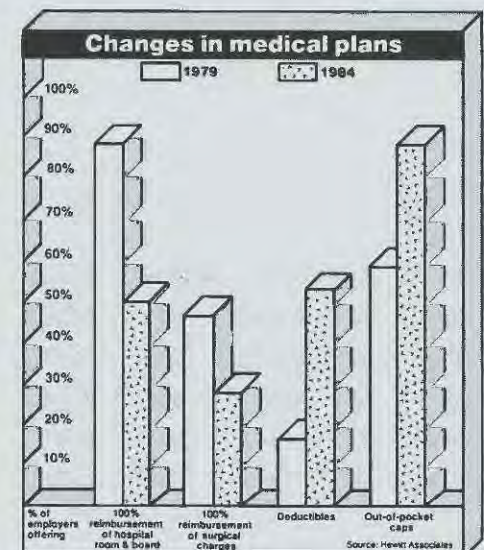
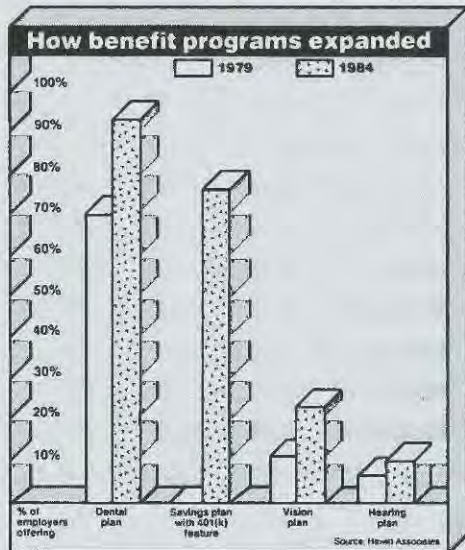
Employers are more likely to offer defined contribution plans in general to their salaried workers, the survey shows.

For instance, 79% of the surveyed companies offered some kind of matching thrift or savings plan in 1984, up from 67% in 1979.

Forty-six percent of the employers offered either Employee Stock Ownership Plans and Payroll-Based Stock Ownership Plans in 1984, compared with 24% in 1979. And, the number of companies offering profit-sharing plans rose to 23% in 1984 from 19% in 1979.

In addition, companies with matching plans are matching their employees' contributions at a higher rate, according to the survey.

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Budget proposes shifting costs from Medicare to employers

By JERRY GEISEL

WASHINGTON—The Reagan administration wants to shift more health care costs to employers from the federal Medicare program.

In the proposed fiscal 1986 budget submitted to Congress last week, the administration said employers should be forced to give workers and spouses over age 70 the choice of enrolling in the corporate health care plan to provide their primary coverage, or using Medicare as their primary insurer.

Currently, only workers under age 70 and their spouses must be given the option of enrolling in the employer plan.

Under the administration's plan, employers would have to offer all older workers the same health care benefits provided to the rest of their employees.

Carolyn K. Davis, administrator of the Health Care Financing Administration, said the administration doesn't believe it is fair that the Medicare program should subsidize the health care costs of older workers.

"The proposal has philosophical appeal," said Rick Lee, vp-policy for the Washington Business Group on Health, a group that represents large employers on health issues. The administration believes that if people are working—even if they are past normal retirement age—their health care needs should be taken care of by their employer, he said.

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Equity and philosophy aside, the administration proposal also would save the Medicare program \$296 million in fiscal 1986 and presumably add that much to employers' health care costs.

Given the choice between employer-provided plans, and Medicare with its high deductibles and coinsurance requirements, older workers and spouses would be much more likely to select corporate health plans for their primary health care coverage.

If Congress accepts the proposal, it would mark the third time since 1982 that health care costs formerly paid by Medicare have been shifted to employers.

The Tax Equity and Fiscal Responsibility Act of 1982 required companies with more than 20 employees to offer workers between ages 65 and 69 the choice of enrolling in the corporate health care plan or sticking with the federal Medicare program for their primary health care cover-

age.

If these older workers had spouses who also were between 65 and 69, employers also had to offer the corporate health coverage to the spouses.

Then, in the Deficit Reduction Act of 1984, employers were required to offer health care coverage to employees' spouses who are between 65 and 69—even if the employee is under 65.

Under the latest proposal, even if a worker or a spouse

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PBGC again asks Congress for premium hike

By JERRY GEISEL

WASHINGTON—The Reagan administration will again try this year to strengthen the financial base of the Pension Benefit Guaranty Corp.

In its proposed federal budget for fiscal 1986 (see related story), the administration says it will ask Congress to raise the annual termination insurance premium employers pay to the PBGC to \$7.50 per plan participant from \$2.60.

The legislative package the administration will send to Congress also will propose changes to make it more difficult for employers to shift pension liabilities to the PBGC, a factor in the agency's financial problems.

This isn't the first time that Congress has been asked to consider a premium hike for the PBGC, the federal agency that guarantees workers' and retirees' basic pension benefits.

During the last session of Congress, the PBGC sought to increase termination insurance premiums to \$7 per plan participant, as well as enact reforms in the agency's insurance program.

But, that effort collapsed because the agency could not win broad-based support—either within or outside the business community—for its legislative package.

But this year, things could be different, according to PBGC Executive Director Charles Tharp.

"We think the time is ripe" for Congress to approve PBGC legislation, Mr. Tharp said.

The agency has learned from its unsuccessful legislative efforts, Mr. Tharp says, and he and his staff are talking to many different business and labor groups to gather their views before a PBGC reform bill is introduced.

In 1983, for example, some business lobbyists accused the PBGC of only consulting the ERISA Industry Committee, a benefits lobbying group better known as ERIC that represents large employers, and union organizations when the agency was drafting and refining its proposals.

For instance, in 1983 an agreement between ERIC and organized labor that would have given unions virtual "veto power" to prevent employers from terminating

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Michigan committee to devise changes in work comp law

By CAROL CAIN

LANSING, Mich.—A bipartisan team of senators, representatives and Cabinet members is expected to meet this week to begin negotiating reforms to Michigan's workers compensation law.

The expiring definition of disability and streamlining administrative procedures to speed disposition of a five-year backlog of cases at the Workers' Compensation Appeal Board are the major issues before the team.

Other issues include erosion of the exclusive remedy rule and apportionment of disability when non-work related factors are involved.

Employer groups, meanwhile, are meeting to develop their own reform proposals in hopes of influencing the legislative team and to ready themselves for lobbying when the team's reform proposals are introduced.

Labor groups, however, support the status quo and would prefer no changes to the current law.

Democratic Gov. James Blanchard supports the Senate Republican initiative to tackle work comp law reforms with a legislative team.

Just last month, two identical packages of nine bills addressing these and other concerns were introduced in the state Senate and House.

But, instead of offering these bills up for debate, the Republicans proposed a summit approach to avoid "all the bloodshed" that accompanied the 1981 reforms of the workers compensation law, said Lou Glazer, deputy director of the Michigan Department of Commerce.

Mr. Glazer is one of two Cabinet members on the team, which is still being organized.

Michigan's workers compensation system was overhauled in 1980 and 1981. Benefits were increased to injured workers and open rating was adopted, a system under which each individual insurer must file its rates, rather than allowing insurers to file rates en masse.

The reforms, however, were reached only after business and labor leaders formed coalitions and fought for their special needs.

The current team approach to developing reforms hopefully will be "a calmer, more rational way than what has been done in the past," said David S. Zurvalec, director of industrial relations for the Michigan Manufacturers Assn. in Lansing.

But, the special team has only until April to agree on reforms before the Senate Republicans will go to the floor with their package.

S.B. 7 through S.B. 15 and H.B. 4050 through H.B. 4058 offer amendments to the workers compensation statute and other laws that would change the hearings and appeals practices of disputed claims. One of the bills (S.B. 11/H.B. 4055) would strengthen the exclusive remedy standard in the law and another (S.B. 14/H.B. 4057) would toughen standards for proving that a disability is work-related.

On the private front, a dozen or more business associations, like the state Chamber of Commerce and the Michigan Manufacturers Assn., already are meeting and preparing to act together if the legislative summit breaks down.

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FASB changes proposed pension rules

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curately reflect the company's pension obligations when it sponsors a pension plan that bases benefits on future salary, such as a final-average-pay pension plan.

In a final-average-pay-plan, employees' pension benefits are based on their highest salaries over a period of several years—usually the workers' final years of employment.

According to Bob Byrne, a partner with Fort Lee, N.J., benefit consultant Kwasha Lipton, FASB was saying in its original proposal that "some recognition had to be given to future salary increases because employees' ultimate benefits—based on service rendered—will, in fact, be higher than their current vested benefits."

Thus, under FASB's initial pro-

posal, companies with pay-related pension plans would have had to list pension benefit liabilities that resulted from estimated future salary increases.

For example, the small company with \$1 million in pension assets, \$900,000 in vested benefits and \$150,000 in non-vested benefits would also have had to estimate plan participants' future salary increases. If, in this example, the company estimated future salary increases at 7% a year, projected pension obligations would be increased by \$300,000.

Under the initial FASB proposal, the company would have been required to list \$350,000 in pension liabilities on its balance sheet. Of that \$350,000, \$50,000 would have represented the difference between the company's pension assets and

'This (proposal) is a step in the right direction,' says Douglas C. Borton of Buck Consultants.

current accumulated vested and non-vested benefits, while the other \$300,000 would have represented benefit liabilities resulting from future salary increases.

The new FASB exposure draft probably will propose that a company list as pension liabilities only the difference between the market value of its pension assets and its accumulated vested and non-vested benefits, consultants say.

Under such a proposal, the small company would only have to list the \$50,000 obligation on its balance sheet.

Pension experts last week applauded FASB for no longer insisting that future salary increases be recognized when a company calculates its pension liabilities.

"This is a step in the right direction," said Douglas C. Borton, chief actuary for Buck Consultants Inc. in New York.

The requirement that employers estimate future salary increases discriminated against pay-related plans, Mr. Borton said. For example, the FASB proposal would not have affected plans in which benefits are based exclusively on length of service.

In such plans, which are often offered to union workers, monthly

pension benefits are based on an employee's years of service rather than his or her salary.

"We thought it was very important that pay-related plans not be discriminated against. Accounting should not encourage one plan or another," Mr. Borton said.

Others objected to the FASB proposal because pension liabilities that result from future salary increases do not meet the standard definition of a liability.

"Liabilities are based on something that has already happened," said Don Fuerst, a principal in the Los Angeles office of benefit consultant William M. Mercer-Meindinger Inc.

"Future salary increases obviously have not happened yet and don't meet the definition of a liability. The FASB has accepted that view," Mr. Fuerst said.

Kwasha Lipton's Mr. Byrne notes it would be difficult for employers to accurately estimate the size of future salary increases. "It would be difficult to put a meaningful number on something that hasn't happened yet," he said.

And, depending upon the assumption used for future salary increases, the results could differ widely. Assuming future salary increases of 7% a year would produce a much different pension liability than assuming annual salary increases of 3%.

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Chicken farmers lacking coverage

Continued from page 2

"Our company is having some meetings to decide exactly what we will do on this," said Mr. Daniel. "There are other considerations other than if they have (coverage). This will have a huge economic impact in the poultry industry."

Marshall Durbin Cos. in Birmingham, which owns most of the chickens destroyed in Mississippi, many of the animals killed in Alabama and a few of the chicken houses that were destroyed, did purchase collapse coverage on its chicken houses, according to Irby Sellers, the company's assistant secretary and risk manager.

The coverage, underwritten by Millers Mutual Insurance Co. in Harrisburg, Pa., was placed by Miller-Harris-Breland Insurance, Inc., an Albertville, Ala.-based agency specializing in poultry insurance.

Mr. Sellers could not estimate Marshall Durbin's losses. "We're still in the process now of determining what the losses might be," he said.

According to Dick Miller, president of Miller-Harris-Breland, preliminary figures show that Marshall Durbin suffered damage to "three or four of the houses out of the eight or so they own in the area," adding that the houses are worth between \$45,000 and \$50,000 each.

Although it bought coverage for its chicken houses, Marshall Durbin self-insures its animal mortality exposures. As of late last week, the company could not estimate how many chickens it lost.

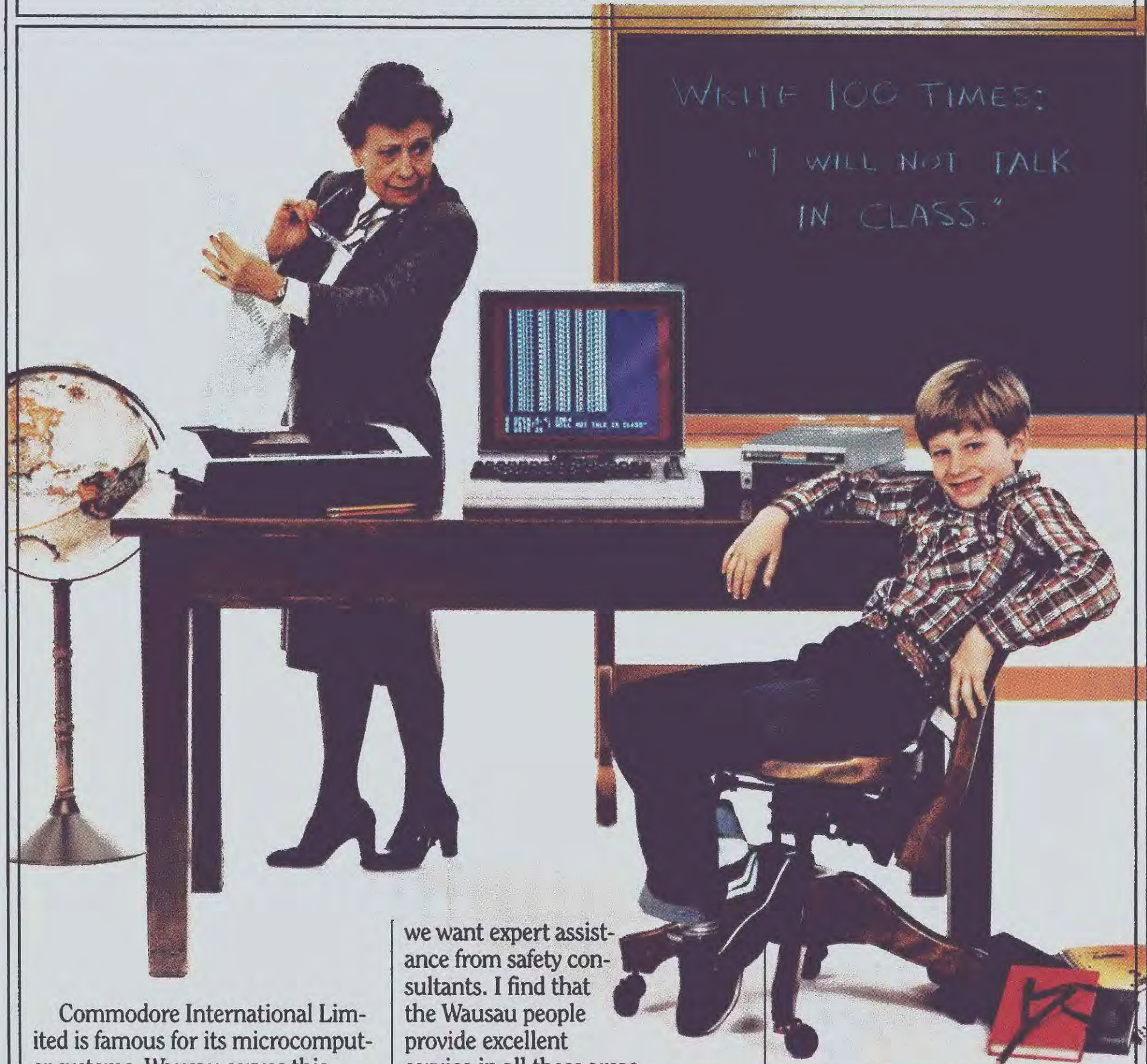
Mr. Sellers said the chickens that were killed would be destroyed and could not be sold.

The average chicken is worth \$2.50 to \$3, estimates Mr. Daniel.

Although the farmers and corporations may recoup their losses, it looks like a no-win situation for many of the chickens—even the ones that survived the collapse but were left homeless.

"The chickens that were not killed in the collapse of the houses and were old enough were slaughtered," Mr. Carter noted.

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opinions

No time for division

INSURANCE BUYERS and sellers alike should support the creation of a government-backed reinsurance facility for earthquake risks—now.

Such a facility would guarantee that U.S. insurers could pay claims following a major earthquake and survive to write more insurance.

More immediately, such a facility should make earthquake insurance more available to corporations that are now finding it difficult to buy enough earthquake insurance to protect their big property values.

A government-backed catastrophe reinsurance facility is not a new idea, but the movement to develop one is gaining some momentum now that the Reinsurance Assn. of America and American International Group Inc. have compromised their differing positions and agree on a proposal to create a reinsurance facility strictly for earthquake losses (*BI*, Feb. 4).

Under the proposal, insurers and reinsurers would pay premiums to the facility for earthquake reinsurance. The coverage would be triggered only when the insurer or reinsurer's net loss from an earthquake exceeded 25% of its surplus or the limit of its catastrophe coverage, whichever is greater. If the facility ran out of funds to pay earthquake losses, the Treasury would pay claims on behalf of the corporation up to \$50 billion. Any advance would be repaid so taxpayers would cover only the cost of lending the money.

While we believe that ideally the reinsurance facility should respond to losses stemming from other natural catastrophes, we nonetheless support the RAA and AIG in their joint effort to form this facility.

Unfortunately, some insurance industry leaders and regulators oppose any federal government involve-



ment in such a facility, due to paranoia about federal intervention in the insurance business.

Surely state regulation of insurance won't crumble with the creation of an earthquake reinsurance facility.

Others in the industry suggest that the industry should wait until after a catastrophic earthquake to take a loan proposal to Congress.

That approach is contrary to the sound risk management principle of securing needed risk financing before, not after, the loss.

letters

Buyers must battle regulators' 'capricious' actions

To the editor: I want to congratulate *Business Insurance* on its fine reporting of the Ideal Mutual story (*BI*, Jan. 14, Jan. 21, Jan. 28, Feb. 4). Your reporter developed enough facts to make it completely obvious that the New York Insurance Department deliberately set out at the start to put Ideal out of business. Their actions to cancel all policies in 30 days, rule good security invalid, speed up their takeover action from February 1985 to December 1984 so that several of the policyholders would not have time to raise \$25 to \$30 million additional surplus, made their self-serving prophecy that Ideal would fail a certainty.

Very few insurance companies would have been able to survive such action by the department. The New York department made sure that Ideal could not be rehabilitated, which they did not want anyway.

Your list of the differences of opinion between Ideal and the department (*BI*, Jan. 21), made it quite clear that nothing Ideal or its actuary, Tillinghast, Nelson & Warren, said would have been accepted by the department. I am sure that they would have disputed the number of paper clips available if Ideal had counted them.

The department, by its arbitrary actions, put approximately 204 people out of a job, canceled insurance for about 1,000 individual policyholders without proper notice and disrupted a number of perfectly proper risk financing programs for a number of larger risks.

There is no question that the department deliberately put Ideal out of business. The real question is why. Again, the answer is quite clear. Ideal Mutual was closed down as an example and a warning to all insurance companies that they are not to provide fronting and offer cost-effective insurance programs to large risks. This is an effort by the New York department to force the large risks to go back to the past when large risks lost large sums of money, dollar swapping with the insurance companies and received little or no benefit from investment income.

One of the Ideal policyholders, when asked about the situation, said, "You can't fight city hall." Risk managers cannot afford to buy that approach. Risk managers owe it to their employers and their profession to try to make sure that the New York Insurance Department is unable to ever again take retaliatory action against other insurance companies for providing cost-effective risk financing programs for large risks. If risk managers do not fight, they will lose other gains made over many years through their hard work.

The New York department can be beat by coordinated action. The department's first battle to stop fronting took place in 1982, under the misguidance of former Superintendent Albert Lewis. He was totally shot down by the efforts of the Risk & Insurance Management Society and of the insurance industry. The move against Ideal is but another phase of that 1982 battle. Here they used the divide and conquer approach. The department struck quickly at Ideal, which they figured was a weak link, and destroyed Ideal before anybody could take defensive action. The fact that Ideal was a mutual company made it even easier, since there were no stockholders available to take concerted action to stop the courts.

Risk managers must gather forces to fight the department. They must make sure that no insurance company is ever again put out of business for providing fronting, cost-effective risk financing plans and services to large risks. In addition, they must show the insurance companies that this will not happen. To do this, it will be necessary to force the department to accept fronting as a reasonable and effective means of good risk financing.

In order to stop such capricious action by the department in the future, it will be necessary for a new law to be enacted by the State of New York. A law should be written to allow fronting and other alternative risk financing plans as long as the admitted insurance company has adequate security, such as a letter of credit,

etc. The risk managers for New York corporations should lead in this effort. They should be backed by all of RIMS' resources. RIMS should also use all of its contacts with the insurance industry, companies and brokers to push for such legislation.

William S. Mortimer
Risk Management Consultants Inc.
Newport Beach, Calif.

Experience rating not always available

To the editor: Richard C. Phillips of Keenan & Associates points out in his letter that cost-containment measures can be equally beneficial... "to the 50-life employer as to the 5,000-life employer." (*BI*, Jan. 28). I respect Mr. Phillips' opinion, but I feel he may be dealing with primarily larger groups.

I know of very few insurers that will experience-rate a 50-life group. Those that do are either "fly-by-night" or uncompetitive. Consequently, if this size group institutes a second opinion surgery program, pre-admission and concurrent review program, etc., the benefits obtained by such programs are experienced primarily by the respective insurer.

The health benefits field is drastically changing, so Mr. Phillips' statements could very well become true in the not so distant future. For the employer's sake, I truly hope so.

Richard C. Mattingley
Regional Manager
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Panel formed to study Michigan comp reform

Continued from page 3

It was expected that employers would draft their agenda this week.

Efforts to reach a summit agreement aside, the stage is set for another standoff between employers and labor over the definition of disability. The definition is set to expire June 30.

Employers would like to see the current definition tightened, to say the "state of being disabled from earning full wages at the work in which the employee was last subject to the conditions resulting in disability."

This definition means "disability is said to exist in Michigan... if an employee is unable to earn full wages in the same area of work,"

explains Charles Dawson, who is an attorney with Consumers Power Co. in Jackson, Mich., as well as chairman of the Michigan Self-Insurers Assn.

As a result, the courts and workers compensation hearing judges are declaring more and more injuries as compensable under this definition, Mr. Dawson and other employers say.

Labor leaders, and a law professor who recently submitted a year-long study of Michigan's workers compensation law, contend that the current definition of disability should stand.

Before the 1981 amendments, the benefits section of the statute contained no definition of disability specifically applicable to traumatic injuries, though a definition was contained in the occupational disease portion of the law, notes Theodore J. St. Antoine, the law professor from the University of Michigan who submitted the report.

Some observers warn, however, that if the definition of disability is allowed to expire June 30, the entire section of the act in which it is contained will expire, since the entire section had to be considered as the amendment.

This would leave a gaping hole in the workers compensation law governing benefits for disabilities, they add.

Others, like Mr. St. Antoine, contend that if the definition were allowed to expire, only that sentence would expire.

Employers and labor groups believe that the backlog of some 7,000 cases at the Workers' Compensation Appeal Board needs to be addressed through administrative changes.

Mr. St. Antoine agrees. "Fundamental procedural changes are necessary," he said, recommending that short-form findings of fact and conclusions of law should be made at the trial stage and that duplicative "de novo" (new) review of the facts should be eliminated at the appeal level.

He also recommends that the 15-member Appeal Board be reduced to five or seven members.

Mr. St. Antoine, however, does not advocate any other changes to the Michigan workers compensation laws suggested by employers, and adds that more time is needed to determine the effects of the 1980 and 1981 amendments.

"The 1980 and 1981 amendments to the workers compensation law dealing with the definition of disability, liability for occupational diseases (and) the eligibility of retired persons for benefits... have not yet been definitively interpreted.

"But a dramatic drop in claims filings, especially by retirees, attests to the likely impact of the recent changes. It is premature to consider further major substantive revisions in the statute at this time," Mr. St. Antoine said.

And, these changes, notably open rating and the tightening up of benefit eligibility, appear to have saved the business community well over \$500,000 in the past two years. At the same time, the the maximum weekly benefits for many disabled workers have been increased substantially, Mr. St. Antoine's report says.

The professor does recommend the creation of a permanent workers compensation labor-management advisory council to monitor and review the system and recommend any needed changes.

Many business leaders believe the St. Antoine report doesn't go far enough and overstates the amount of money saved in the past two years.

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Salaried workers receive new benefits

Continued from page 3

vey. The majority of the plans—61%—matched at a rate of 50 cents per \$1 of employee contributions in 1984, compared with 65% that matched at that rate in 1979. However, the percentage of plans that matched at a rate greater than 50 cents per \$1 of employee contributions increased to 30% in 1984 from 19% in 1979.

Mr. Hasbargen said employers are moving away from traditional defined benefit plans and toward defined contribution plans.

"What you're seeing is that companies, when they want to improve retirement, make that improvement on the defined contribution side," he said.

The percentage of companies that did not offer any kind of capital accumulation plan declined to 3% in 1984 from 10% in 1979.

All 250 employers surveyed provide medical coverage to their salaried employees. However, those employers are opting to pass more of their health plan costs onto employees in order to cope with the rapidly increasing cost of health care.

For example, the percentage of employers that did not require employee co-payments for hospital room-and-board charges declined to 50% in 1984 from 89% in 1979. And, the percent of plans requiring no co-payments for surgery declined to 27% in 1984 from 45% in 1979.

In addition, deductibles have become the norm rather than the exception. Some 52% of the employers surveyed had medical plan deductibles in 1984, up dramatically from 17% in 1982 and 14% in 1979. And, in 1984, an additional 6% of the employers said a deductible is sometimes required, depending on the coverage option chosen by the employee.

And, average deductibles have increased, especially in the last two years. In 1984, 51% of the plans with deductibles had a per-person deductible of \$100 or less, down from 82% of the plans in 1982 and 85% in 1979.

Mr. Hasbargen said that increased deductibles are "part of a great attempt by organizations to change (employee) behavior... making people more aware of what they are spending."

The idea, Mr. Hasbargen said, is to "affect the way employees use medical services, not just who pays for them."

Although more employers are requiring deductibles and employee co-payments, the number of employers that require premium contributions from salaried employees is staying stable.

Fifty-seven percent of the employers in 1984 required employee contributions for either individual or family coverage, compared with 61% in 1979. However, an additional 7% of the employers in 1984 said that employee contributions may be required depending upon the coverage option chosen by the employee.

In 1984, 18% allowed employees to make premium contributions on a pretax basis. And, 12% of the plans offered flexible spending accounts for medical and dental expenses not covered by the regular plan. The questions about FSAs and making contributions on a pretax basis were not asked prior to the 1984 survey.

More employers are also capping the amount of medical expenses for which an employee is liable during one year.

Some 87% of plans included an out-of-pocket cap in 1984, up from 59% in 1979.

Mr. Hasbargen said the increase in the number of employers instituting out-of-pocket caps indicates

that employers understand that benefit changes "have to be tempered with a concern for the really serious health care needs."

He noted a trend toward "letting the employee see to those things that are budgetable and plannable and letting the organization help for those things that are catastrophic in nature."

This emphasis on protecting employees from catastrophic expenses also is in the fact that lifetime coverage maximums are being increased. In 1984, 59% of the sur-

veyed employers offered lifetime medical plan maximums exceeding \$250,000, up dramatically from 13% in 1979.

Employees had many options for medical coverage in 1984, with 11% of companies offering a choice of medical plans, not including health maintenance organization and preferred provider organization options. This question was asked for the first time in the 1984 survey.

And, many employers offered incentives for their employees to use health care more efficiently. In

1984, 39% of the surveyed companies offered higher coverage for outpatient surgery than for inpatient surgery, and 36% increased coverage for specific surgical procedures if a second opinion was obtained.

These statistics were not collected prior to 1984.

And, 94% of the surveyed companies provided post-retirement medical coverage for employees over 65. This percentage is unchanged since 1982, but is up from 88% in 1979.

Other highlights of the survey include:

- **Pensions.** The survey found that an increasing number of employers are basing benefits paid under defined benefit plans on the average of a retiree's three highest-paid years rather than the five highest-paid years. Basing the benefit on the three highest-paid years usually means a higher benefit.

In 1984, 76% of the employers based benefits on the average of the five highest-paid years, down from

Continued on facing page



Continued from page 11

81% in 1979. But, 10% based pension benefits on the three highest-paid years in 1984, up from 7% in 1979.

Some 12% of employers base pension benefits on career average pay, unchanged from 1979. Basing pension benefits on career average pay tends to result in lower benefits because it includes an employee's early years with a company, when pay tends to be lower.

• Group life insurance. Employers are more likely to offer group life programs, the survey notes.

In 1984, 92% of the employers surveyed offered group life insurance benefits that were at least partially employer-paid, compared with 85% in 1979.

In 1984, 10% of the surveyed employers paid all group life insurance premiums, while 82% paid part of the plan cost. In 1979, 11% of the employers paid the full cost of the group life plan, while 74% paid part of the premium.

Group life insurance plans also are offering salaried employees higher benefit levels. In 1984, 65% of the companies offered a benefit level of three times pay or more. This benefit level was offered by only 48% in 1979.

More employers are offering dependent life insurance coverage, according to the survey. In 1984, some 41% of the employers offered dependent coverage—5% company-paid and 36% on a contributory

basis. In 1979, 29% offered dependent coverage—4% company-paid and 25% contributory.

• Long-term disability. The percentage of companies offering group LTD plans increased to 80% in 1984 from 74% in 1979, according to the survey.

The maximum LTD benefits have increased significantly since 1979, mirroring the general increase in salaries and inflation. In 1984, 70% of the plans had a monthly maximum of more than \$4,000, including 41% that had no dollar maximum. This is up from 41% with a monthly maximum of more than \$4,000 in 1979, when only 29% had no dollar maximum.

The percentage of LTD plans

that required employee contributions dropped to 42% in 1984 from 47% in 1979.

• Dental coverage. The percentage of companies offering dental coverage has grown steadily during the period. In 1984, 93% offered a dental plan, up from 70% in 1979.

And, the degree of coverage offered has continued to expand as well. Although 75% of the plans included a deductible in both 1984 and in 1979, 47% of the 1984 respondents said they waive the deductible for preventive services, compared with 28% in 1979.

And, more plans are covering orthodontia: Some 87% of the respondents in 1984 said their plans offered benefits for orthodontia,

compared with 75% in 1979.

In 1984, some 52% of the dental plans surveyed required employee contributions, either for individual or family coverage, which is basically unchanged from 49% in 1979.

• Vision and hearing plans. These plans also have grown steadily in popularity. In 1984, 24% of the respondents said they had a vision care plan, up from 11% in 1979. And, in 1984, an additional 7% provided vision care benefits as part of an FSA.

And, 10% of the respondents in 1984 said they had a hearing care plan, double the percentage of respondents that had a plan in 1979. And, an additional 8% provided hearing benefits as part of an FSA.

• Vacation and days off. The survey shows a continued increase in the amount of paid time off. For example, 73% of the companies offered employees three or more weeks of paid vacation after five years of service, compared with 59% in 1979.

And, 55% of the surveyed companies provided employees with 11 or more paid holidays a year in 1984, compared with 48% in 1979.

Copies of "Salaried Employee Benefits Provided by Major U.S. Employers, 1979 through 1984" are available for \$25 from Lori Cuda, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015.

Houston workers to share more costs

HOUSTON—The city of Houston is requiring city employees to pay more for their health care because claims currently are running about \$400,000 a month ahead of employee contributions to the self-funded health plan.

According to Tom Cody, the city's risk and insurance manager, the plan "is not in the red" because the city has been paying its claims with money held in a reserve fund.

"The urgency was that we did not want to eat up all the reserves," he explained.

On Dec. 27, the City Council approved the new insurance program. Under the new program, employees must choose between making larger premium contributions for dependent coverage or paying higher deductibles.

Employees who pick the first option will pay more for dependent coverage; the city will continue to pay the total cost of health insurance for employees. Under this option, the cost of dependent coverage will increase to \$57.97 a month from \$30.10 a month for one dependent and to \$78.70 a month from \$51.66 a month for more than one dependent.

Employees who pick this option will see no increase in their deductibles, which currently are \$250 for individual coverage and \$500 for family coverage.

Employees who choose the other option and choose to pay an increased deductible will have to meet a \$1,250 family deductible beginning Feb. 1. However, the individual deductible of \$250 will not increase.

Employees who choose the higher-deductible option also will have to pay more for dependent coverage, but not as much more as employees who do not choose this option will be required to pay. Employees who choose to pay higher deductibles will pay \$48.56 a month for health care coverage for one dependent and \$51.96 for more than one dependent.

Also, the city will appoint a panel of health care professionals to administer pre-certification and concurrent review programs that also go into effect Feb. 1.

Employees had until Jan. 31 to make their choices. Mr. Cody said he expects that most employees will opt to pay the higher cost for dependent coverage.

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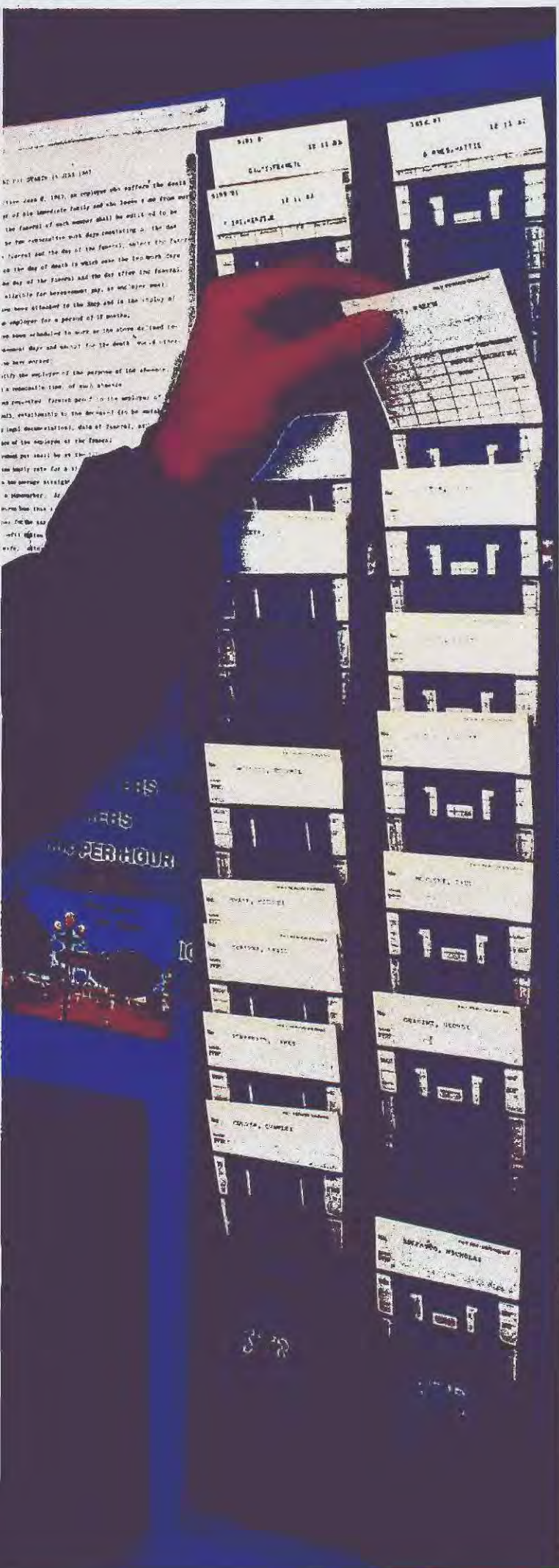
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Donaldson, Lufkin & Jenrette

January 29, 1985

Harvester pact stresses containing medical costs

benefit beat

The 12,000 United Auto Workers employed by Chicago-based International Harvester Co. have a new contract aimed at containing health care costs through the use of second surgical opinions, outpatient surgery and utilization review.

The three-year agreement, ratified Jan. 24, also calls for slight increases in some health care benefits, such as vision care and prescription drugs. Harvester's health care benefits are self-insured.

According to Raymond H. Stevenson, director of employee insurance and pensions for Harvester, participation in the second surgical opinion and ambulatory surgery programs will be voluntary in the first year of the contract; employees who do not participate will not be penalized.

But, after the first year, these programs will be made mandatory if studies show that not enough employees are using the programs.

If these programs become mandatory, Mr. Stevenson said, employees who do not use them will have to pay 20% of the cost of surgery itself, not including hospital costs, up to \$500. Normally, employees do not pay any surgery costs, he added.

The new contract also calls for the establishment of a company-funded, joint labor-management committee to study health care utilization and cost.

Mr. Stevenson said the committee will consider a wellness program, hospice care and a substance abuse program.

It also will study the "Informed Choice" health care program, re-

cently made available to UAW members at General Motors Corp. and the Ford Motor Co., which offers employees a choice between a health maintenance organization, a preferred provider organization and a traditional health care plan.

The new contract increases health care benefits in some areas. It raises ambulance expense reimbursement to \$100 from \$50 and increases the reimbursement schedule for vision care by \$5 per item.

Also, beginning July 1, a new prescription drug program will be available to all employees and retirees not enrolled in a health maintenance organization. Under this program employees can receive up to a 90-day supply of prescription drugs after paying a \$2 per-prescription deductible for generic drugs and a \$3 deductible for brand-name drugs.

The contract also increases the reimbursement for Part B Medicare, a voluntary Medicare program under which covered persons pay a nominal premium.

The \$13 a month reimbursement to the employee under the old contract will increase to \$15.50 the first year of the new contract, \$17.60 the second year and \$19.60 the third year.

The contract also promises the installation of a prepaid legal plan by January 1986. Mr. Stevenson said the company will finance the plan, which will be designed this year.

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Aviation product liability rates taking off

Continued from page 1

bility coverage and participates on some excess layers.

"Some of the people on the coverage last year cut back on their retentions. Others have not renewed. And one of the particular insurers (European) is not writing U.S. product liability, period," said Mr. Stokdyk, who would not comment on the limits or layers that Beech is trying to complete.

Other aircraft manufacturers, which will renew their product liability coverage later in the year, are fearful that the worst is yet to come.

"It's anybody's guess come July when we renew," said Robert E. Butler, corporate director of insurance/risk management at Lockheed Corp. in Los Angeles. "I am sure you have heard the horror stories."

Last July, Lockheed received a 40% rate increase for its \$1 billion aviation product liability program, Mr. Butler said (BI, Jan. 21). About 80% of Lockheed's coverage is placed in the London market with Lloyd's of London underwriters, Orion Insurance Co. P.L.C., British Aviation Insurance Co. Ltd. and other insurers. The coverage is brokered by Marsh & McLennan Inc. in the United States and M&M affiliate C.T. Bowring & Co. Ltd. in Britain.

"We are hoping for a leveling off (of rates) this year, but chances are slim. There probably will be increases, but I don't know what the size of the increases will be, Mr. Butler says.

"We are hoping for the same capacity as last year, too. But, there is a big question mark on that," he adds.

Lockheed already has been named in at least two lawsuits, totaling more than \$10 million, over last month's crash of a Lockheed Electra operated by Galaxy Airlines of Fort Lauderdale, Fla. (BI, Jan. 28).

A Lloyd's broker noted last week that aviation underwriters are reserving \$50 million on behalf of various policyholders for anticipated liability claims from the Jan. 21 crash, in which 68 people were killed.

Another manufacturer, Cessna Aircraft Co., based in Wichita, also is wondering how its August renewal will be affected by rate increases and capacity shortages.

Ronald J. Graybill, manager of risk/insurance at Cessna, noted the cost of Cessna's product liability program doubled at renewal time last year. Although he would not disclose the limits of Cessna's program or the underwriter, he did say that aircraft manufacturers generally purchase between \$500 million and \$1 billion of product liability coverage.

"In our case, there have not been drastic increases (in deductibles), but we've heard that some companies with \$4 million retentions last year have \$15 million retentions this year."

The tightening of the aviation product liability market is the result of several factors, brokers and underwriters say.

In 1984, underwriters were hit with between \$300 million and \$400 million in aviation product liability losses, compared with about \$150 million in losses in 1983. Underwriters could not estimate the total premium written by the market during those years.

Many of these losses are the result of awards and settlements in the United States against manufacturers of light aircraft.

For example, Cessna is appealing a \$29.3 million jury award stemming from a June 1980 private plane crash that killed three people (BI, June 18, 1984).

And, Piper Aircraft Corp., a subsidiary of Bangor Punta Corp. of Greenwich, Conn., last April agreed to pay \$10 million to the families of those killed in a 1976 crash of a Piper Cheyenne airplane (BI, April 16, 1984).

The unexpected long tail of some of the aviation product liability claims is especially worrying aviation underwriters.

For example, the Aircraft Builders Council's product liability insurance program—a program written by London underwriters for some 60 U.S. aviation equipment manufacturers—is still reporting about \$2 million of claims annually on policies written between 1955 and 1968.

These claims include not only lawsuits stemming from plane crashes but claims from pilots who

allege they contracted cancer from exposure to radium used on aircraft cockpit dials, notes James Bowden, executive director of the aviation division of J.H. Minet & Co. Ltd. in London.

"This business has proved to be very long tail and aviation underwriters did not anticipate the long tail," adds Peter O'Grady, president of Aviation Office of America in Dallas, a unit of Crum & Forster. "American courts have given substantial court awards...causing reserve deterioration."

"I have pulled my horns in substantially," said Mr. Corbett, at Minister Insurance Co. Ltd. "I am seeking to come out of product liability with small airplanes and small helicopters and such."

A good example of the contrac-

tion of the market can be seen through the changes in the Aircraft Builders' Council program.

The ABC program, formed in 1955 by Minet and Stewart Smith & Co. Ltd. in London, is designed to provide up to \$500 million in product and grounding liability coverage to aviation product suppliers, generally small to medium-size manufacturers of aviation components.

The program is led by three London insurers: the Ariel Syndicate at Lloyd's, the British Aviation Insurance Co. and Orion.

When the ABC program renewed on Dec. 1, Minet, the program administrator, found a "shortage of capacity" and had to layer the program for the first time in several years, said Mr. Bowden, adding that layering increased the

costs to the buyers.

"In the end we managed to place it," said Mr. Bowden. "But the European market pulled out of underwriting American aviation products liability. And, in London there was a certain amount of contraction because reinsurers are worried about U.S. awards," Mr. Bowden said.

Manufacturers covered under the program now have to purchase a primary \$100 million layer and a \$400 million excess layer instead of one \$500 million layer, he said. In the past, Minet has been able to find enough capacity to write one \$500 million later, Mr. Bowden added.

Rates are "considerably" higher, Mr. Bowden said. "The average premium rate increase is not less than 50%," he said. ■

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Airlines hope for lower rate hikes in 1985

Continued from page 1

predicted until April, when several large trunk airlines like British Airways and Qantas Airways Ltd. of Australia renew their coverages.

Last year, the April renewals signaled the beginning of the stiff rate hikes for most major airlines. The rate hikes continued throughout the year as underwriters attempted to make up for the disastrous losses they suffered during 1983 (BI, March 26, 1984; May 28, 1984).

Although some airlines—like Lufthansa German Airlines—received hefty rate increases when they renewed their aviation coverage on Jan. 1, underwriters note these policyholders were only coming into line with the rate increases that began last year. The underwriters say the Jan. 1 rate hikes may not be indicative of rate in-

creases that will be imposed later this year.

Commercial airlines may not be exposed to big rate hikes and further coverage restriction in 1985 for two reasons, sources in the aviation market say.

First, the 1984 loss record for Western-built commercial aircraft was one of the lowest since 1959, the year commercial airlines first began flying jetliners.

Only two commercial airline passengers were killed in accidents last year, while eight jetliners were declared total losses, according to Aviation Information Services Ltd. in London, an aviation statistical organization. Hull losses totaled only \$60 million for the year, of which \$21 million were classified as aviation war risk claims.

With such a good record, un-

derwriters may have trouble convincing airlines to accept substantial rate increases, some observers suggest.

Aviation underwriters, though, maintain that 1984 was a "freak" year. Over the last 10 years, the average annual hull loss has been \$173 million, according to Aviation Information Services. And, an average of 740 people are killed in airline accidents annually, according to statistics gathered by AIS over the last 10 years.

In 1983, insurers point out, underwriters paid a record \$302 million in commercial aviation losses, and more than 1,000 people died as a result of aviation accidents.

And, 1985 is already shaping up to be a bad year for aviation underwriters. In just one month there have been five significant losses

around the world, including:

- The crash in early January of an Eastern Airlines Boeing 727 in a mountainous area of Bolivia, killing all 19 people on board. The aircraft was insured for \$20.5 million (BI, Jan. 7).

- The Jan. 21 crash of a Galaxy Airlines Lockheed Electra in Reno Nev., killing 68 people (BI, Jan. 28). While the hull was insured for only \$1.8 million, aviation underwriters have already reserved \$50 million for liability claims stemming from the crash, sources say (see story, page 1).

Some observers also suggest that rate increases may be relatively mild during 1985 because of the rugged renewals airlines encountered last year.

Last year, airlines' hull and liability insurance rates increased an

average of 40%. Some airlines were hit with only a 25% increase, while others saw their rates rise as much as 150%.

In addition, underwriters in July began imposing increased deductibles for partial hull losses.

And, two U.S. airlines negotiated separate \$10 million aggregate deductibles for hull and liability losses on top of standard per-occurrence deductibles for partial hull losses. Airlines traditionally have not paid deductibles for liability losses (BI, July 28, 1984).

Pan American World Airways Inc. was the first to accept this aggregate deductible last summer. And, in November, American Airlines Inc. put together an unusual program in which some underwriters, including London insurers and some U.S. markets, wrote the airlines' hull and liability coverage over a \$10 million aggregate deductible while others wrote first-dollar coverage for the airline at a higher rate.

American Airlines and its broker Alexander & Alexander Services Inc. in Dallas were unavailable for comment on the unique coverage.

As a result of the tough aviation market during 1984, the International Air Transport Assn. based in Geneva, Switzerland, last year considered reopening two dormant captives in Bermuda to insure the hull and liability risks of the 126 international airlines belonging to the organization.

But, the IATA may not reopen the captives if the aviation market calms this year, says Tony Kelly, the IATA's assistant director of industry monetary affairs, who adds that the IATA is still studying the idea (BI, May 28, 1984).

"If the market was very firm and rates increased 15% to 30%, then I can see it happening quickly," said Mr. Kelly. "Otherwise, a few members might (consider a captive)." ■

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as reserves for retirement pensions, widows' and orphans' pensions, disability claims, unpaid local dividend reserves, and all other types of reserves.

If outgo exceeds income Winterthur carries the loss according to the experience rating system chosen by the corporation. On the other hand, if the overall result shows a positive balance, this will be paid to the customer.

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Tort awards decline in California courts

SAN FRANCISCO—The average product liability award handed down in 1984 by California Superior Court juries dropped substantially from the 1983 average, according to an ongoing study by the Insurance Information Institute.

In 1984, the average award was \$776,312, compared with an average award of \$939,709 in 1983. The total amount of awards in 1984 was slightly more than \$48 million, compared with a 1983 total of nearly \$53 million.

In 1983, three multimillion-dollar awards accounted for more than \$20 million of the total.

The total number of verdicts reached in California also declined to 136 in 1984 from 166 in 1983. Of the 1984 verdicts, 74 were for the defendant and 62 were for the plaintiff.

Five of the 1984 awards were for \$3 million or more each, and the largest verdict was slightly more than \$4.4 million.

Of these five large verdicts, three involved vehicles or their components, one involved X-ray equipment and one involved ski bindings.

The IIA's study is a tabulation of verdict data reported during the calendar year by two California jury reporting services. Only Superior Court cases are included in the study.

Single copies of the one-page summary of the IIA verdict data from 1974 through 1984 are available by sending a prepaid, self-addressed envelope to the Insurance Information Institute, 400 Montgomery St. San Francisco, Calif. 94104.

Metropolitan's increase in individual life premium sales exceeds \$100 million.

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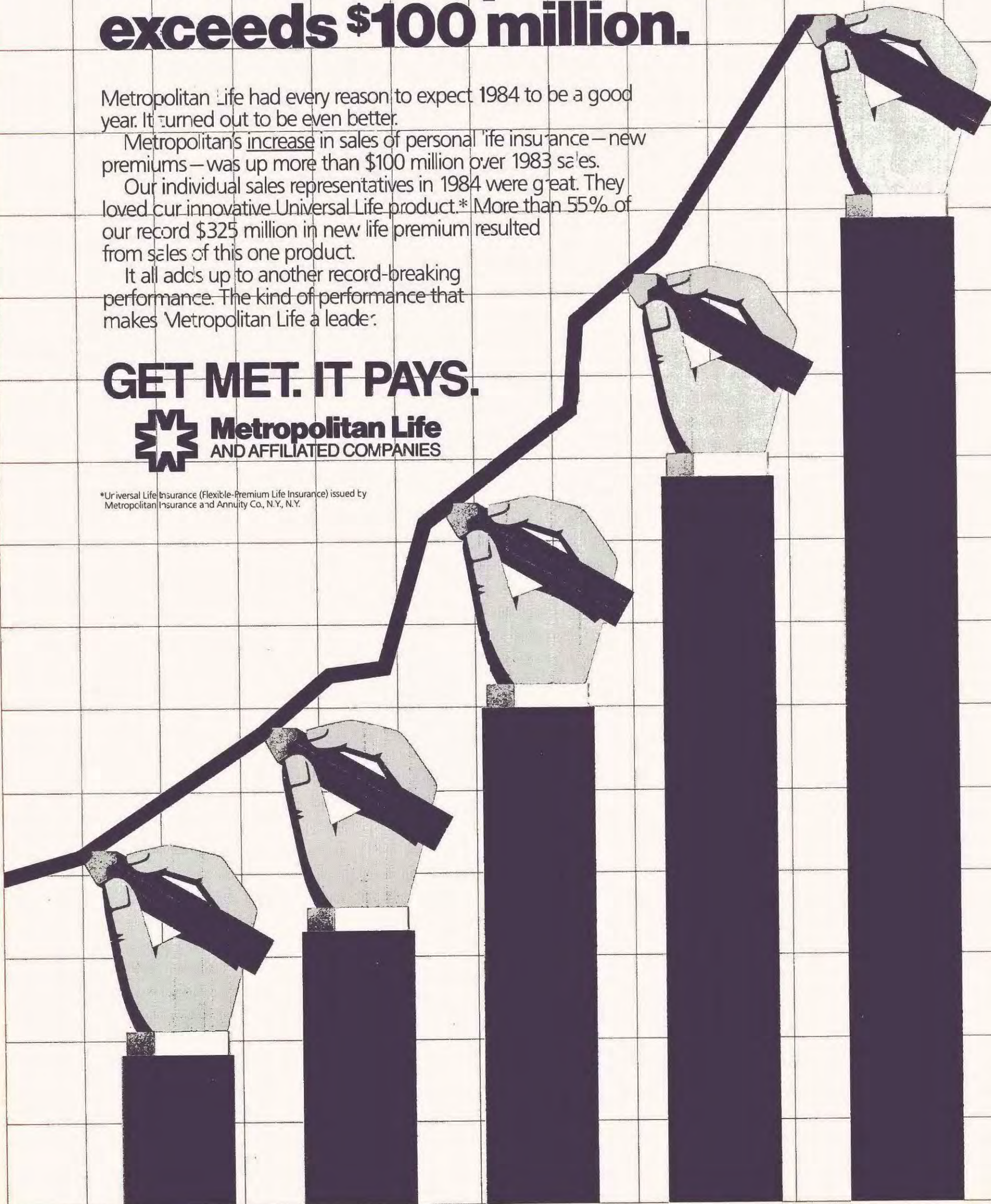
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Rx FOR DRUG PLANS

Halting the runaway cost of prescription coverage

By Michael J. Barberi

PRESCRIPTION DRUG PLANS are programs that reimburse employees and their dependents for the cost of prescribed drugs after an initial deductible or co-payment. Co-payments generally average \$2 per prescription, but they may vary from \$1 to \$4, depending on the labor agreement or the budget constraints of the employer.

These plans grew in popularity among employers and employee groups during the 1960s and 1970s because of two attractive features: the immediate expense reimbursement at point of purchase and the relatively small deductible. The plans are particularly popular in many public employee plans, private industry union plans and in some salaried plans.

However, the high cost and lack of cost-containment features of these plans frighten many employers. The cost of these programs has increased dramatically over the past decade and is expected to continue to do so. There are many reasons for this increase, including:

- A shift in demographic trends as more people enter the 65-and-over age group.
- The increased development of more expensive "wonder drugs," as a result of the highly competitive pharmaceutical industry.
- Price inflation reflecting the amortization of high costs of research, development and production.
- Increased demand for the latest brand-name drugs among health care providers.
- The lack of employee or provider incentives to use generic drugs.

However, there are ways to reduce the cost of a prescription drug plan. Some of these ways follow.

Generic incentive plans

One way to contain costs is to encourage the use of less-costly generic drugs instead of brand-name drugs, if the patient's doctor approves. There are several approaches to generic incentive plans.

One alternative gives the pharmacist an incentive to dispense generic prescriptions by returning to the pharmacist 25% of the difference in cost between the generic and the brand-name drug. In those states where a pharmacist is prohibited by law from altering a prescription, the pharmacist may call the physician for approval to substitute a generic alternative, if the incentive is attractive enough.

A second approach encourages the employee to use generic drugs by imposing a higher out-of-pocket charge if he or she does not. For example, in a \$3.50/\$7 generic incentive plan, employees would pay \$7 for any brand-name drug purchased when a less-expensive generic alternative was available, and \$3.50 if a generic drug was purchased or if no generic alternative was available.

Some employers go one step further and share part of the savings between the brand-name drug and the generic alternative by paying employees who use the generic alternative a bonus at year-end.

The generic incentive plan's objective is to encourage employees to explore generic alternatives with the prescribing physician so that the employee may save on the cost of prescriptions, because of a lower co-payment. These programs also provide the patient with greater freedom of choice in drug selection and increased awareness of and involvement in the cost-containment process.

These programs also use a "formulary," a listing put

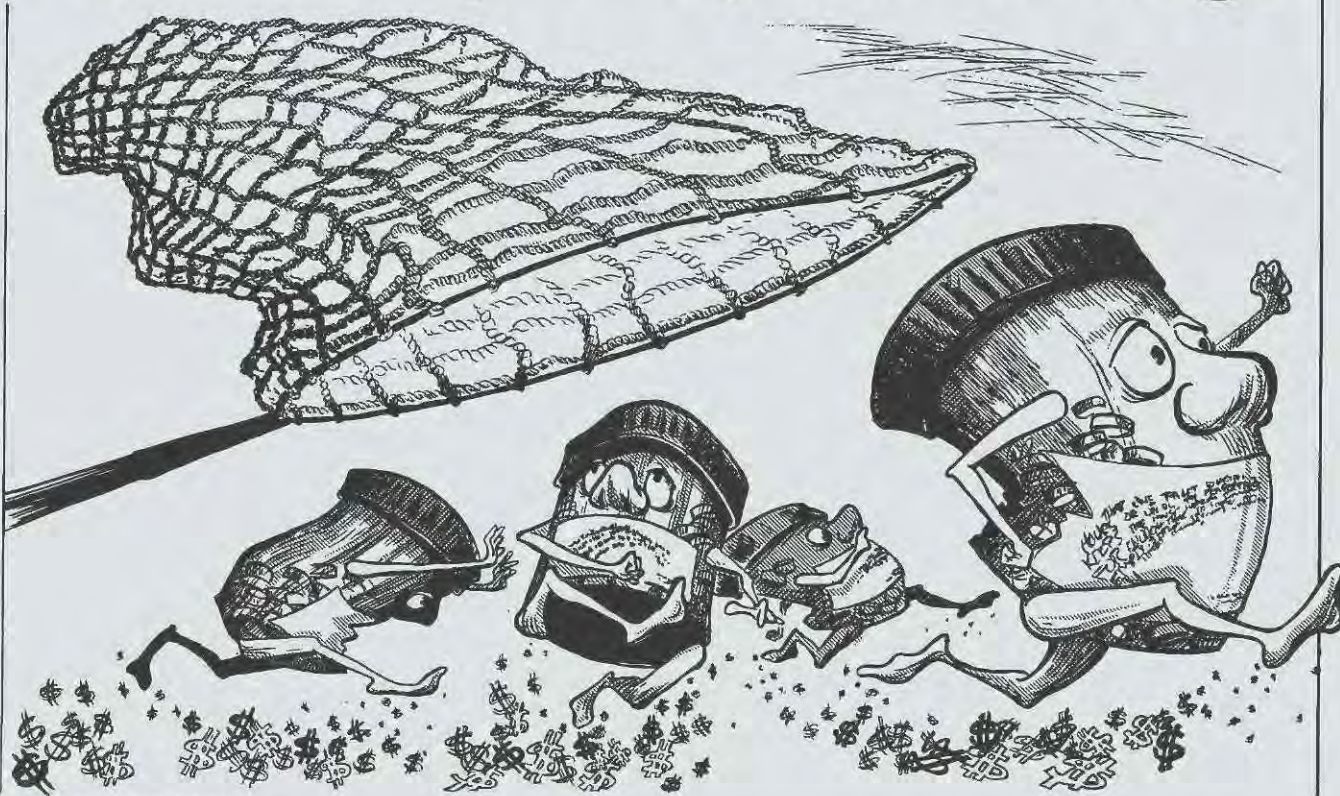


Illustration by Roger Schillerstrom

out by each state of generic substitutes for a number of more expensive brand-name drugs. The impact of the program can be substantial, since the average cost of a generic drug can be as much as 40% to 50% less than the average cost of a corresponding brand-name drug.

An analysis of the drug-utilization patterns of your plan will help determine what percentage of all drug purchases have a generic substitute. For one large employer, 35% of all drug purchases had generic alternatives available, but only 2% of the purchases were the generic alternative. By switching to a plan that involves a lower co-payment for generic drug purchases, projected savings for this employer were more than \$1 million a year.

It is estimated the number of generic drugs will substantially increase because of the Drug Price/Patent Term Extension Act signed by President Reagan in September 1984. This law was designed to promote the use of generic alternatives by easing federal testing requirements for generic drugs if the equivalent brand-name drug has been approved. It is good news for employers seeking to control their health care costs and implement generic incentive plans.

Mail-order programs

A second way to cut the cost of prescription drug plans is through mail-order programs. A mail-order program, which involves only prescriptions for maintenance drugs, usually can save employees two or more co-payments because a 90- to 180-day supply of the drug is purchased through a mail-order program, compared with the traditional plan, through which only a 30-day supply is purchased.

Employers are able to reduce their prescription drug costs by saving on their share of the dispensing fee and receiving the mail-order discount.

Pricing method

The pricing method used also can affect the cost of prescription drugs. Typically, most plans reimburse pharmacists for prescription drugs at or below the average wholesale price, or AWP, listed in the Drug Topics Red Book. However, there are other price lists for prescription drugs. And, some plans consider several price source books and then choose either the lowest or the average price as a basis for reimbursing the pharmacist.

Another pricing method is to reimburse the pharmacist at the lower of the AWP or the pharmacist's actual cost.

Before setting up the program, select a statistically reliable sample of the most-frequently used drugs and compare the differences in reimbursement of several providers. If your plan's reimbursement formula averages 90% to 94% of AWP, you have an efficient pricing method.

Dispensing fees

Controlling dispensing fees also can hold down an employer's costs. Claims paid under a prescription drug program are made up of drug cost reimbursement plus a dispensing fee. Dispensing fees are usually less than the pharmacist's reasonable and customary charge.

Since the dispensing costs of many pharmacists vary, some plans have a low initial fee but provide for additional increments for dispensing high-cost drugs, providing patient consultations and a 24-hour emergency service. And, in some plans the fee is compounded rather than being a flat fee for each dispensed prescription.

Dispensing fees are based on specific agreements with the pharmacist. Ask your insurer or claims administrator for the range of fees established for its largest customers and compare them with the Medicare dispensing fee. Keeping the fee at the lower end of the acceptable range adds another dimension to your cost-containment program.

Administrative fees

Administrative fees of the large, independent third-party administrator generally are less than what an insurance company charges. Many of the largest insurers use third parties to administer the prescription drug programs the insurers themselves sponsor. One large employer in the Northeast found the administrative fees of a third-party prescription drug processor to be 30% less than the fees of its insurance company.

Further cost savings may result from comparing fees of several insurance companies and third-party claims administrators when selecting a company to administer a prescription drug program.

Claims processing

Ask your current insurer and a reputable outside vendor to prepare a detailed explanation of the cost-containment procedures they use when processing claims. Also ask for an in-person presentation. You may find out that your claim-paying system is not as

Continued on next page



Michael J. Barberi is a manager in the actuarial and benefits consulting division of the New York office of Touche Ross & Co.

ASK A RISK MANAGER

Use care in explaining increases in premiums

Q

As the insurance marketplace continues to tighten, how are you communicating anticipated increased insured premium expense to your profit centers?

A

We have found there are two necessary ingredients to this exercise. One involves getting your senior management's support and understanding as to the reasons for the increased expense. The second is the method used to communicate the

best cost estimate you have to your profit centers.

To begin our planning process, we analyzed our entire insured budget expense, estimating percentage changes and the total dollar effect. This gave us a good overview and showed senior management the big picture.

At this point, it was easy to identify two insurance contracts that have the largest premium dollar increases, and, consequently, the most visibility. We limited our subsequent discussion to these two policies.

There are two lesser activities, which are equally important, that take place as you go through the process. One involves communicating the insurance market changes via new articles in *Business Insurance* along with those in *The Wall Street Journal*. We never assume these articles are read by others with as much interest as by ourselves.

Don't overdo this, since it is a negative activity.

Second, a point should be made in verbal communications that insured premium expense, during this sharp market change, can be out of your control. Point out that your self-insured program, which in our case makes up 70% of our total budget, continues under profit center control through effective risk-control programs. The net effect of total risk management and insurance expense increases should not, therefore, be as great as they would otherwise be with a totally insured program.

We used one article, which appeared in *The Wall Street Journal* on Dec. 31, to back up our notice to profit centers that increased insured expense was on its way. We opened our memo to the senior management and profit centers' controllers with the statement: "Several of you have asked about the effect this news will have on our purchased insurance costs."

Get the message out early, and good luck!

Better data can ease surprise adjustments

Q

Our profit center budgets were hit last year with a sizable adjustment to their self-insured workers compensation expense. How can you avoid these expense adjustment surprises?

A

These adjustments are unfortunate and cause many problems, particularly if they come too late in the year, and they may suggest the lack of control you have over the proper funding of this expense.

While we know from news articles that major insurance companies also suffered from under-reserving, this support gave our company's

controllers little comfort and no sympathy for us when they were asked to increase their expense more than 45%.

Our problem developed from an actuarial study of workers compensation reserves in 1981, 1982 and 1983. Not only were retrospective adjustments necessary to properly fund these claims, but also the actuary saw an unfavorable trend in the growth of these claims that required an additional adjustment.

These adjustments came at an unfortunate time of year and under unfavorable circumstances.

Here is what we have decided to do to eliminate surprises and keep profit centers informed about claim cost trends, particularly in the workers compensation area, but also for general and automobile liability claims.

In the past, we have provided profit centers with quarterly retrospective rating calculations that showed trends for these three lines of self-insurance for each of the past four years. This apparently has not provided a complete answer, so we now intend to add to this report a loss-development analysis and visual graph.

Collectively, the reports will show how much money they have paid in premiums to fund their self-insured losses and whether this premium is sufficient to pay for claims as they develop.

The graph will provide a visual picture. The quarterly retro trend, loss development and premium report will provide the numbers.

Hopefully, in a future column, we may tell you if it works.

A good broker provides important advantages

Q

What are the advantages of buying insurance "direct" rather than through a broker. What are the disadvantages?

A

Part of the answer to this question is understanding the interest the broker represents in a "buying" transaction.

Brokers hold themselves out as representatives of the insured. While this may be true as they conduct business on behalf of the insured, it is

also true that they are concerned with the health of their insurance company markets. These markets, which accepting and paying for risks presented to them by the broker, represent the broker's livelihood.

I know a very successful Lloyd's of London broker who said, "When I am on the floor at Lloyd's, I'm representing my client, the insured. When I'm traveling and visiting clients, I am the eyes and ears of the underwriter."

A simple answer to the question is that buying "direct" should save you between 15% and 20% of the premium expense you might otherwise pay by going through a

broker. Let's call that an advantage.

A more complex question is what could you lose, or what are the disadvantages? I can only answer this from my current environment.

We self-fund and self-insure 66% of our total cost of risk, insure 23% and set aside 11% for expenses, including department expense.

The insured portion of our program covers catastrophe-type coverages with high limits and broad terms. The self-insured area can be best described as funding for loss dollars that occur year after year and are true expense items.

There are many advantages to having a broker do your insured coverage marketing. At a minimum, the broker should:

- Know the general insurance market.
- Know the specialty markets and costs.
- Be able to set up underwriting specifications to better broker the business.

- Know how to develop manuscript policies.
- Know how to market a risk that needs several insurers.

• Use their book of business with insurers to assist in marketing your cover. (This can also work to your advantage after a loss.)

- Help you avoid gaps in coverage.

If you have concern about the dollar value of their service, ask for quarterly time reports with the names and hours spent by the brokerage staff on your account. Apply their fee schedule to this time report and then compare this to the commission income report that we assume you receive.

As you analyze the value of a good marketing and consulting service, remember that brokers hold themselves out as insurance professionals. This is an asset to you and covers a professional liability exposure, shared by both you and the broker. I consider this a very valuable advantage in buying insurance through a broker. ■

Would you like advice from an experienced colleague on a risk management or benefit management problem? Two features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues.



Mr. Perry

This month's column on risk management issues was written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Next month, Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York, answers benefit management questions.

Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Perry's next column will appear in March.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Cutting the cost of prescription drug plans

Continued from preceding page
efficient as you think.

You should also look for a series of systemwide audits to detect abusive use of drugs. Look for such things as prescriptions for more than a 30-day supply, large-dollar prescriptions, use of drugs for more than four weeks, etc.

In addition, a series of informative statistical and management reports should be provided so that your company can analyze and manage its program effectively. This is usually a good indication of how sophisticated your administrator/insurer is in processing and controlling claims costs. Useful reports include claims analysis reports, detailed claims listings, drug popularity reports, patient profile reports and reports that detect claims submitted by terminated employees.

Funding

For large plans, some form of self-insurance should be

considered, as well as minimum premium plans. Positive aspects of these arrangements include the elimination of reserves, lower retention charges and other cash-flow advantages.

For plans that are fully insured, make sure that competitive interest is being credited each month on positive cash-flow—the difference between premiums paid and the cash claims plus retention.

Also, make certain that the margin for claims fluctuation is part of a retrospective premium agreement rather than being built into the rate structure and paid during the year.

Another funding arrangement worth exploring is deferred premium payments.

Finally, if the plan is self-insured, any stop-loss coverage you maintain should be reviewed to ensure that it provides an appropriate degree of protection for the premium charged.

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Copy Editor Alison Kittrell. She can be reached at 312-649-5262.

Budget proposes shifting Medicare costs to employers

Continued from page 3

is 70 or older, those individuals will have to be offered the opportunity to enroll in an employer-provided group health care program.

While such individuals constitute a small percentage of the total workforce, benefit experts warn that extending eligibility of employer-provided health care programs to more older workers sets the stage for shifting even more health care costs from Medicare to the private sector.

"This is another inch in the cost-shifting route," said William J. Arnone, a benefit consultant with Buck Consultants Inc. in New York.

Down the road, the administration could propose that retirees be offered the opportunity of opting for employer-provided group health care plans rather than being covered by Medicare, Mr. Arnone warned.

If that happens, employers would face tens of billions of dollars in added health care costs.

Such experts question the administration's timing in proposing that companies offer workers and their spouses 70 and older the option of enrolling in group health care plans.

"Isn't this a situation where the cart is being put in front of the horse?" asked John Hickey, a partner with Kwasha Lipton, a Fort Lee, N.J., benefit consultant.

Mr. Hickey notes that under the Age Discrimination in Employment Act, employers generally can force workers to retire when they reach age 70.

Unless ADEA were amended, an unusual situation would exist in which companies still could impose mandatory retirement at age 70, but employers that lack forced retirement rules would have to extend group health coverage to older workers and their spouses.

To remedy this apparent inconsistency, one consultant suggests that Congress also will wipe out mandatory retirement as part of a legislative package that will require companies to extend health benefits to these older workers and spouses.

In addition, the Reagan administration's proposed budget calls for more cost shifting from Medicare to employer plans: Medicare coverage for retirees would not begin until the first full month in which the beneficiary is 65.

Under current law, retirees are eligible for Medicare on the first day of the month in which they turn 65.

For example, a retiree who turns 65 on Feb. 15 now is covered under Medicare starting on Feb. 1. Under the administration proposal, Medicare coverage for such a retiree would not begin until March 1.

The administration says this delay would not hurt many individuals since most employer-provided plans automatically extend benefits until Medicare coverage begins.

Although some of the entries in the budget proposal are regarded as unfavorable to employers, the Reagan administration's proposed tax on employer-paid health care premiums is missing from the budget.

That proposal—which says employees should be taxed on employer contributions toward group health plans that exceed \$70 a month for individual coverage and \$175 a month for family coverage—was included in last year's budget proposal (BI, Feb. 6, 1984).

But, while the health care tax isn't in the proposed 1986 federal budget, that doesn't mean the administration is dropping its support. The administration simply decided not to include proposals,

like the health care tax, that are in the Treasury Department's tax reform and simplification plan.

"Because tax reform legislation will be revenue neutral, it is not essential that it be reflected in the budget at this time," the administration said in the budget proposal.

Other benefit provisions contained in the Treasury Department's proposal include the elimination of 401(k) salary reduction plans and tax-free cafeteria plans. Also, employers' contributions toward group term life insurance, dependent child care benefits, tuition reimbursement, van pooling and group legal benefits would become taxable income to employees (BI, Dec. 3, 1984).

The proposed budget also calls for a major overhaul of the Civil Service Retirement System, which covers federal workers and retirees.

Pension benefits for future retirees would be based on a worker's highest five years of salary, instead of the highest three years of salary.

In addition, the next cost-of-living adjustment to federal retirees' pension checks would be delayed until January 1987.

The January 1986 COLA for military retirees also would be skipped, the only change sought for that program.

Beginning in 1987, the COLA for retirees would be limited to the increase in federal white-collar pay or the Consumer Price Index, whichever is less. Also, cost-of-living adjustments to annual benefits exceeding \$10,000 would be capped at 55% of the COLA adjustment.

The administration sought similar changes last year, but Congress did not act.

The proposed budget also affects several federal agencies that are involved in risk management and employee benefit issues. These agencies include:

OSHA

The Occupational Safety and Health Administration says it will issue more regulations but conduct the same number of worksite inspections next year.

In the administration's proposed budget, OSHA says it will issue 13 health and safety rules in fiscal 1986, compared with 11 during the current fiscal year.

OSHA inspectors will make 71,400 worksite inspections in 1986, the same number as in fiscal 1985, which ends on Sept. 30, 1985.

The administration has asked Congress to appropriate \$213.1 million for OSHA, down from \$220.8 million in 1985.

Pension office

The Office of Pension and Welfare Benefit Plans, which helps administer the Employee Retirement Income Security Act, will conduct 2,897 employee benefit plan reviews and investigations, up from 2,822 in fiscal 1985, according to the proposed budget.

The pension office estimates that it will process some 657,000 ERISA-related reports filed by employers in fiscal 1986, up slightly from 656,000 in 1985.

Due to last-minute computation errors, a proposed budget for the pension office was not available late last week.

OPIC

The Overseas Private Investment Corp., which provides political risk insurance to U.S. companies investing in less-developed countries, estimates its revenues will increase to \$36 million in fiscal 1986, up from \$34.5 million.

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PBGC to ask Congress for premium increase

Continued from page 3

pension plans was attached to PBGC legislation. That enraged other business groups (BI, Oct. 31, 1983).

Under that provision, an employer with a collectively bargained pension plan could not terminate the plan unless it received approval from its union. Even after a collective bargaining agreement expired, a company would have had to wait an additional two years before it could terminate the plan.

Opposition by other employer groups over the union veto provision led to the collapse of business support for the 1983 legislation, PBGC observers agree.



Mr. Tharp

Mr. Tharp acknowledged that the PBGC legislation is too important to be considered by only big business and big labor.

Now, the agency has broadened its legislative discussions to include, among others, the U.S. Chamber of Commerce, which has many small employers among its 237,000 members, and the Assn. of Private Pension & Welfare Plans, a Washington-based group whose 500 members include benefit managers, consultants, attorneys and actuaries.

"We've had a number of discussions with the PBGC," said Stuart Brahs, executive director of the APPWP. "We think we now have a good working relationship with them."

And, Mr. Tharp said, the controversial union veto provision will not be in the PBGC bill this year—at least not if the Reagan administration can help it.

"It won't be in our bill," he said simply.

Previous PBGC legislative efforts also failed because the proposals were too complex and often confusing, observers say.

Under a provision in the bill Congress considered during its last session, a parent company would have been liable for a subsidiary's pension benefits for up to five years after the subsidiary was sold to another company.

For example, if the company that purchased the subsidiary failed within five years after the sale, the original parent would be stuck with the subsidiary's pension liabilities.

But, experts said this "contingent liability" or "transfer liability" provision was so broadly written that it unintentionally made those acquiring another company's subsidiaries liable for the parent's pension liabilities.

For instance, some pension experts said that a small corporation

that bought a subsidiary from a Fortune 500 company could be liable for the giant company's pension benefits if the big company later shut down and folded its pension plan.

While the ambiguous contingent liability section later was rewritten to make clear that the buyer had no liability for the pension plan of the company from which it purchased the subsidiary, it was difficult for the PBGC to end employer confusion about the contingency liability provision (BI, Nov. 14, 1983).

Now, Mr. Tharp pledges that the contingency liability section will be much simpler and not interfere with regular business transactions, though he declined to provide a detailed explanation until legislation is ready for introduction later this month.

"It will be a much more streamlined bill," Mr. Tharp said.

Employers objected to the provision because, they said, it had nothing to do with the main purpose of the PBGC legislation: to strengthen the agency's financial condition.

A different legislative strategy also will be pursued this session. The PBGC wants Congress to consider the increase in the termination insurance premium and the PBGC reform legislation as part of its work on the federal budget.

If the PBGC proposals are linked to legislation designed to keep federal agencies running, the proposals should receive a higher priority from legislators, said Kevin Putt, the PBGC's assistant executive director.

If that strategy fails, it is always possible that the PBGC proposals will be considered separately, as they have been in previous years.

Mr. Tharp said Congress will pass the premium hike and reform legislation because it has to.

"Our (financial) situation is becoming desperate," Mr. Tharp says. The agency now has approximately \$1 billion in assets while its liabilities now exceed \$1.4 billion.

The PBGC is also in a negative cash-flow situation in which the agency is paying out more in benefits than it is collecting in termination insurance premiums. That means the agency is tapping on reserves to pay benefits, said Mr. Putt.

Without a premium increase, the agency's financial condition will continue to deteriorate and confidence in the PBGC insurance program—which will pay about \$182 million in benefits to 62,000 people this year—will erode, Mr. Tharp said.

By increasing the termination insurance premium to \$7.50 per plan participant from the current \$2.60, the PBGC's revenues would increase by \$140 million to \$150 million per year.

Court broadens tavern liability

SALEM, Ore.—Taverns in Oregon may now be assessed punitive damages for serving alcohol to intoxicated patrons who later injure someone, the state Court of Appeals has ruled.

In the Jan. 9 decision, the court affirmed an earlier verdict by the Washington County Circuit Court, which held The Outrigger Tavern in Hillsboro liable for \$100,000 in punitive damages.

Anthony Pfeifer, who was 12 years old, died when a car driven by an intoxicated tavern customer collided with the car in which he was riding Sept. 19, 1981, according to David G. Frost of Frost & Kohl in Hillsboro, the plaintiff's lawyer.

State law permits the recovery of actual damages caused by intoxicated customers. However, the ap-

peals court's ruling represents the first time in which punitive damages have been allowed in such cases in Oregon, he added.

The only states where dramshop statutes allow for punitive damage recovery are Alabama, New York and Wyoming, said Ron S. Beitman of Kistin, Babitsky, Latimer, Kalnins and Beitman in Falmouth, Mass., who specializes in representing victims of drunken drivers.

The appeals court also upheld a \$10,000 punitive damage award against the tavern's bartender.

Lawyers for the tavern challenged the ruling, saying sanctions by the Oregon Liquor Control Commission, the state's licensing body, would be sufficient punishment, Mr. Frost said.

N.Y. judge signs order for liquidation of Ideal

Continued from page 2

tility of any attempted rehabilitation" and a continued attempt to rehabilitate "will increase the perils and hazards to policyholders, creditors and others."

He said liquidation also will trigger the guaranty funds of the remaining 22 states whose funds were not triggered by Ideal's rehabilitation order.

One of the reasons cited by Mr. Corcoran for Ideal Mutual's liquidation was that Ideal was no longer generating any significant premium volume.

According to a report prepared by independent Certified Public Accountant Richard Pluschau of Dix Hills, N.Y., Ideal Mutual canceled or did not renew policies that had generated written premiums of \$167.7 million for the year ending December 1984, or 75% of its total 1984 written premium volume.

Many major policyholders had moved their policies from Ideal prior to its rehabilitation (BI, Jan. 14).

Policies generating an additional \$57 million in written premium were replaced or canceled prior to Jan. 27, under terms of the rehabilitation order.

According to Mr. Pluschau's report, between Jan. 1, 1984, and Nov. 30, 1984, Ideal had cash receipts of \$212.8 million and cash disbursements of \$246.4 million, or a \$33.5 million operating loss. Non-recurring cash receipts, including an income tax refund and the sale of investments, reduced this deficit to \$6.1 million.

Ideal had \$1.9 million in cash as of Nov. 30. It also had investments valued at \$44.2 million, according to the court papers. However, \$29.5 million of those investments are unavailable to the New York department because most of those funds are tied up in special security deposits with other state regulatory bodies.

This leaves the Insurance Department, according to the court papers, with \$16.5 million available from cash and investments as of Nov. 30. While December 1984 figures are not yet available for incorporation into the report, "indications are that the situation would not in all probability improve, but could in fact become worse."

Meanwhile, management has estimated that Ideal's expenses will total \$12.4 million during 1985, according to the court papers. With only \$16.5 million in cash and investments available, "It can be readily ascertained that the cash flow of this company is barely able to pay continuing operational expenses."

The court papers note that this amount does not take into account "the payment of losses on claims which the company cannot pay, which makes up a major portion of the \$155.3 million deficit."

The Insurance Department's assertion that Ideal had a \$155.3 million deficit is cited in the shareholder suit brought by Optimum Holding Corp. shareholder Meyer Kimmel.

Mr. Kimmel, who is seeking to have his suit designated as a class action, bought 1,000 shares of Optimum stock on Jan. 24, 1984 at \$5 a share.

According to court papers, Optimum stock was worth about 25 cents a share in late January 1985. The stock was trading at \$1 a share on Feb. 6.

The suit says the defendants engaged in "deceptive and manipulative devices and contrivances" to artificially inflate the price of Optimum common stock.

Among other accusations, the suit alleges that Optimum's 10K

form for the year ending December 1983, which was submitted to the Securities and Exchange Commission, was "materially false and misleading" because it concealed the serious financial difficulties of Ideal and of Optimum Holding's wholly owned subsidiary, Optimum Insurance Co. of Illinois.

Optimum Insurance is now in rehabilitation in Illinois.

Mr. Lalley said last week that he believes an "effective defense can be mounted" against the charges in the lawsuit.

Mr. Lalley said Ideal has \$25 million in directors and officers liability coverage underwritten by National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. affiliate. ■

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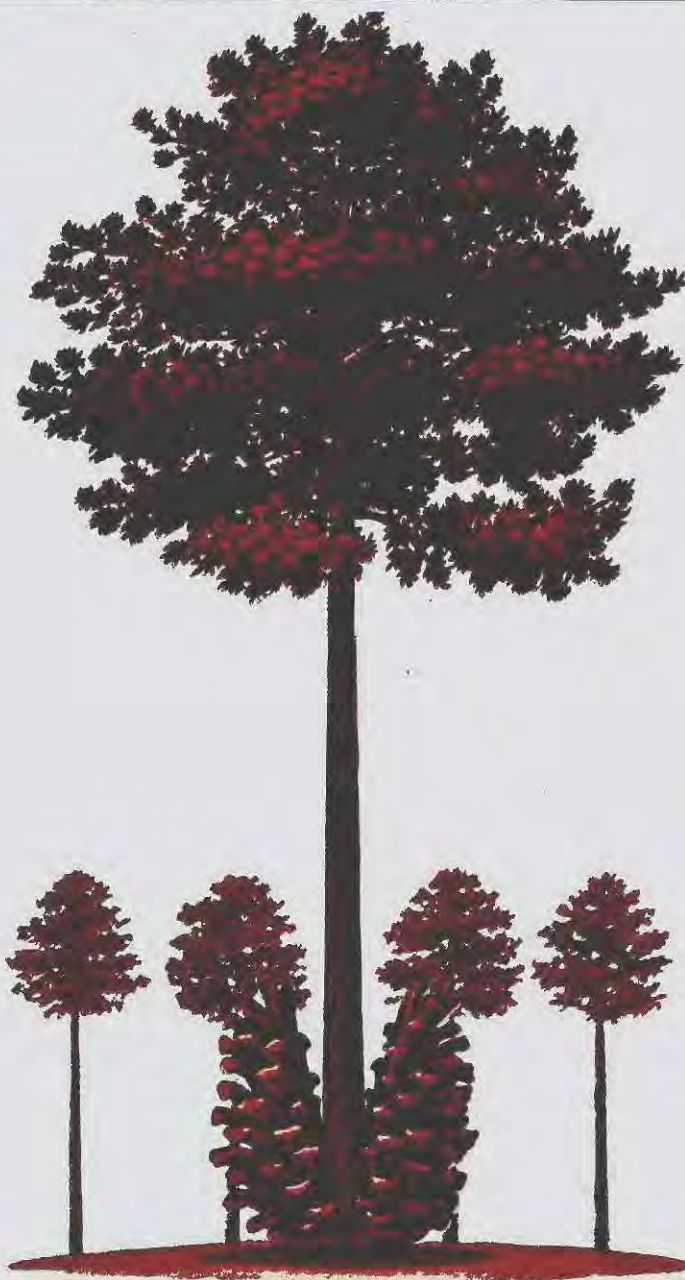
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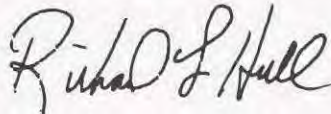
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comings & goings: industry

Larry C. Ballard appointed Sentry Insurance president

Larry C. Ballard has been named president and chief executive officer of Sentry Insurance, a Mutual Co. in Stevens Point, Wis.

Mr. Ballard, 49, who joined Sentry earlier this month, will eventually succeed Sentry Chairman John W. Joanis who will retire later this year.

Mr. Ballard, 49, had been senior vp at CNA Insurance Cos.

In other insurer changes:

Donald H. McComber elected vice chairman and chief insurance officer at Crum & Forster Inc., Morristown, N.J. Mr. McComber currently is senior executive vp and chief insurance officer.

In recent changes at CIGNA Corp. in Philadelphia **G. Robert O'Brien** and **Thomas H. Dooley** appointed executive vps. Mr. O'Brien will head the newly formed Employee Benefits and Health Care Group, and Mr. Dooley will head the new Individual Financial Group. Both had been senior vps in the Employee Benefits and Financial Services Group.

Also at CIGNA, **Marvin A. Levins** named president of the group insurance division. He had been senior vp of the Employee Benefits and Health Care Group. **George R. Trumbull III** named president of the group pension division. He had been an executive vp. And, **Donald M. Levinson** named senior vp-human resources. He had been a vp.

Richard D. Coleman Sr. named regional vp of the Western Region of Maryland Casualty Co. in Sacramento, Calif. Mr. Coleman joined the company in January 1984. He succeeds **Lucien L. Lucas**, who is retiring.

Excess/surplus

Era Eugene Horner Jr. promoted to executive vp and general manager of Crump London Underwriters. He previously served as vp of The Crump Cos. Inc., as senior vp of E.H. Crump & Co., and in a variety of technical and marketing positions.

At Shand, Morahan & Co. Inc. in Evanston, Ill., **Richard P. Kropp** named senior vp-underwriting. He joined the company in 1976. Also, **Thomas G. Bottum** named vp-architects and engineers claims. He joined the company in 1978 and had been an assistant vp.

Kevin P. Brooks appointed president of Genstar Management Co. and Genstar Indemnity Co., subsidiaries of General Reinsurance Corp in Stamford, Conn.

Agents/brokers

Keith A. Pierce named president of McElroy-Minister, a Columbus, Ohio-based insurance brokerage. He replaces **John C. Glandon**, who will become vice chairman of McElroy-Minister.

Wayne S. Mountz promoted to executive vp and office manager at Fred S. James & Co. Inc. of Pennsylvania. Mr. Mountz had been senior vp in the Harrisburg office. Also, **John Folsom** named executive vp of Fred S. James & Co. of California and president of the San Francisco office. He replaces **John Jacobs**, who will take another management post.

Jacqueline Klager promoted to vp-commercial lines production at Meeker-Magner Co. in Des Plaines, Ill.

Lawrence A. Berg appointed vp-commercial operations at Insurance Management Services Inc. in Cleveland. He had been underwriting manager of the Home Insurance Cos.

R. David Turner named president of Rollins Burdick Hunter Management Inc. in Chicago, the captive insurance services subsidiary of Rollins Burdick Hunter Co. He had been manager of risk management services at Rollins Burdick Hunter. Also, **Frank B. Thompson** named president and chief executive officer of Rollins Burdick Hunter of Alaska in Anchorage. Also, **Philip E. Fowler** named executive vp and chief operations officer. Mr. Thompson joined Rollins Burdick Hunter in 1977, and Mr. Fowler joined the brokerage firm in 1970. ■



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Circulation Breakdown*

Commercial Consumers

Administrative Management: owners, presidents, vps, etc. 5,357

Financial Management: chief financial officers, vps of finance, secretaries, treasurers, etc. 9,876

Insurance Management: vps, directors, managers of insurance, risk, benefits compensation, safety, security, etc. 7,254

Associations 1,069

Government, Unions

Educational Institutions 860

Commercial Consumers

Sub-Total 24,416

Insurance Agents & Brokers 9443

Insurance Cos. 5636

Financial Institutions 403

Actuaries, Attorneys, Adjusters, Appraisers & Consultants 3220

Others allied to the field 1127

TOTAL 44,245

*Source: Business/Occupational breakdown of qualified circulation, May 7, 1984 issue, as submitted to BPA for June 1984, BPA Publisher's Statement.

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Manville coverage

Continued from page 1

insurers wrote about \$125 million of insurance for Manville.

The three excess insurers that settled with Manville are Midland Insurance Co., Insurance Co. of North America and Allstate Insurance Co., acting on behalf of its subsidiary Northbrook Excess & Surplus Insurance Co., which stopped new and renewal business as of Jan. 1. (BI, Nov. 19).

Under the settlement, INA says it will provide \$37 million in coverage. Midland will provide coverage of \$46.7 million, and Allstate \$28.05 million, industry sources say.

According to the chart of Manville's insurance, it appears that Northbrook negotiated the biggest discount on its liability limits. While it's impossible to tell if INA's \$37 million represents its full policy limits since the coverage was written on an undisclosed quota share basis, Midland's \$46.7 million appears to represent the full limits it wrote. However, from the chart it appears that Northbrook wrote \$33 million in limits.

All three insurers provided lower-layer excess insurance purchased by Manville from 1966 to 1978, a period of 12 years.

With this latest settlement, the Denver-based company has secured approximately \$426 million out of an estimated total of about \$600 million in liability insurance available to cover claims filed by asbestos victims.

Attorneys say that as Manville is able to obtain more money through settlements with insurers, it will probably make it easier to negotiate a reorganization plan that will enable it to emerge from bankruptcy.

Manville filed for reorganization more than two years ago, citing the burden of asbestos liability claims.

However, Manville must still overcome objections by creditors representing asbestos victims and Manville co-defendants to the previous \$314.4 million agreement reached last year with primary insurers Travelers Indemnity Co., The Home Insurance Co. and underwriters at Lloyd's of London.

Plaintiffs and co-defendants fear that Manville will use the proceeds of the settlement to pay thousands of property damage claims against Manville and other co-defendants brought by school districts and local governments that have asbestos in their buildings, thus depleting money for claimants with health problems.

The plaintiffs and co-defendants also object to the proviso that Manville will pay defense and indemnification costs incurred by the primary insurers if direct actions are brought against them by asbestos claimants.

The agreement with the excess insurers does not include this proviso, although, like the settlement with the primary insurers, it does provide for requesting an injunction from the bankruptcy court prohibiting other suits against the settling insurers.

If direct actions are permitted against the excess insurers, "We will eat the costs ourselves," said an

insurance industry source who asked not to be identified.

The settlement with the excess insurers is contingent upon Manville receiving the cash from the primary insurers and exhausting that money, plus interest, before the excess insurers will pay claims.

The settlement with the excess insurers also is contingent upon entry of a final order approving a reorganization plan for Manville.

While Manville can use the money from its settlement with the primary insurers as it wants, under the agreement with its excess insurers, asbestos health claims will be paid first.

For the first two years that the agreement is in effect, Midland, INA and Northbrook will pay only indemnification costs of asbestos health claims, Ms. Neuman explained.

After that time, the insurers will continue to pay health claims but Manville can then also submit defense expenses to the insurers.

While the \$111.8 million settlement calls for dismissal of the coverage litigation over asbestos bodily injury claims, it leaves open for negotiation and litigation the coverage for third-party property damage claims and excess workers compensation claims that could be covered by the policies.

However, if the \$111.8 million settlement is exhausted by asbestos bodily injury claims, there will be nothing to negotiate.

But, if there are funds available from the settlement and Manville and the excess insurers can't reach an agreement on coverage for property damage and excess workers compensation claims, Manville can choose a jurisdiction other than the bankruptcy court in New York to litigate the issue.

Because the settling excess insurers agreed to a broad interpretation of their policies, the agreement is compatible with the so-called Wellington agreement, which attempts to create an asbestos claims facility, according to one attorney.

The Wellington agreement, worked out between major insurers and defendants in asbestos litigation, attempts to resolve all coverage disputes and set up a facility to handle asbestos claims in a fairer, more efficient and less costly manner.

If Manville or any of the settling insurers decides to join the Wellington plan, this settlement with Manville can be brought into the facility. "It's completely compatible," the attorney said.

The Wellington agreement, however, currently prohibits insurance agreements between members worked out after Oct. 24, 1984 to be brought into the facility.

Manville, which conditionally signed onto Wellington late last year, has said that any agreement it works out must be integrated into the Wellington pact.

Manville Vp and Corporate Counsel Richard V. Von Wald, says the company has had no discussions yet with Wellington about its recent settlement, but a source close to the facility said that "it is certainly within the realm of reason that the (Oct. 24) date will be re-

viewed."

Midland, Northbrook and INA were on varying layers for varying years above Travelers, Home and self-insured retentions. "As a general rule, they are the next excess layer above Home," Mr. Von Wald said.

INA participated excess of \$10 million on about a \$15 million layer between 1966 and 1972 as part of a quota share arrangement with CNA and Employers Liability Assurance Corp., a predecessor company of Commercial Union Insurance Co.

Midland also wrote a \$15 million layer excess of \$10 million, between 1972 and 1975 and it also wrote a portion of insurance excess of \$30 million in 1972.

Northbrook wrote varying layers of insurance excess of about \$6 million between 1975 and 1978. In the 1975-76 policy year, Northbrook wrote about a \$16 million layer excess of about \$6 million. In 1976-77, Northbrook's layer was about \$5 million excess of \$6 million but in 1977-78 it increased to about \$12 million excess of \$6 million.

Underlying Midland's coverage in 1975-76 was insurance with The Home, but underlying Northbrook were an unidentified insurer in 1976-77, Manville's captive insurer Rocky Mountain International Insurance Ltd. in 1977-1978 and various self-insured retentions.

For the periods that Manville had self-insured some risk underlying the Northbrook coverage, including insurance with its captive insurer, the agreement provides that Manville must pay only 85% of its retained risk.

A spokesman for CIGNA said the agreement would have no impact on the insurer's earnings or require additional reserves.

"It is an agreement to fund up to \$37 million of future claims as they are presented and these are subject to reinsurance," the spokesman added.

Neither Midland nor Allstate would comment on the settlement.

Another 21 excess insurers of Manville have yet to settle the coverage dispute that is pending in state court in San Francisco. A trial in the California litigation is set for March 4 and as of last week Manville was not close to additional settlements, said Mr. Von Wald.

Ms. Neuman also would not say how much Manville anticipates it will receive if it settles with its remaining insurers.

She pointed out that there are still insurers it is litigating against that issued policies without aggregates or an unlimited duty to defend.

"Clearly, our claims in the litigation against the 21 left are worth way more than that," she said. "And it certainly wouldn't be short of \$600 million in the best case scenario."

update

Compass fined by New York

Continued from page 2

The spokesman said the Dallas-based insurer violated several holding company regulations including, failing to maintain proper records on transactions with affiliated companies and failing to obtain approval for a specific transaction.

The fine against Compass, a unit of Armco Inc., is among the largest ever issued by the department, the spokesman said.

Continental Bank suit amended

CHICAGO—The head of Continental Illinois Bank's real estate services is expected to be dropped this week from a shareholder suit alleging the bank and officers failed to disclose the extent of its problem loans and financial troubles (BI, July 16, 1984).

Lawyers for both the shareholders and James D. Harper have agreed to drop the charges against him. However, at a hearing last week, U.S. District Judge John F. Grady postponed the dismissal because of "technical questions," according to Mr. Harper's attorney Richard F. Levy of the Chicago firm Levy & Erens.

The action clears Mr. Harper of charges he did not disclose the extent of problem real estate loans to superiors. Charges against Mr. Harper of negligence and trading Continental Illinois Corp. stock on insider information were dropped previously.

Also at the hearing, Judge Grady set an Oct. 31 deadline for most of the discovery and depositions in the shareholder suit.

Toxic-waste bills introduced

WASHINGTON—Rep. James Florio, D-N.J., has introduced a packet of bills to impose new reporting and liability requirements on manufacturers and distributors of hazardous substances.

The bills, introduced last week, would require companies that handle at least 1,000 kilograms of a hazardous substance a month to file information with local police, fire and health departments.

That information would detail possible routes the chemical might follow if it were released and emergency procedures to follow in the event of a spill, fire or explosion.

The bills also would make clear that new underground storage tanks must prevent releases of hazardous substances.

And, the legislation would create a federal cause of action for those injured through the release of a hazardous substance into air.

Punitive damages denied

SAN FRANCISCO—A state court judge has ruled that asbestos defendant Nicolet Inc. cannot recover punitive damages for alleged bad-faith dealing on the part of Insurance Co. of North America in litigation over coverage of asbestos claims.

The Nicolet suit is part of litigation that includes suits against many insurers by several asbestos defendants. The ruling by San Francisco Superior Court Judge Ira Brown was the first ruling in the California case to say that punitive damages cannot be recovered, attorneys said. Judge Brown based his decision on the fact that the law in Pennsylvania—where INA, now part of CIGNA Corp., is based—does not permit punitive damages against insurers.

The decision is similar to a ruling by a U.S. District Court Judge June L. Green in Washington in litigation between Keene Corp. and its liability insurers last October (BI, Oct. 15, 1984).

INA wrote primary insurance for Nicolet, which is based in Ambler, Pa., from 1959 until 1970.

Lloyd's life subsidiary for sale

LONDON—Lloyd's of London wants to sell its life insurance subsidiary for 100 million pounds (\$112 million), Lloyd's Chairman Peter Miller announced last week.

Lloyd's Life Assurance Ltd., currently owned by 84 underwriting member agencies with a controlling share owned by the Council of Lloyd's, is for sale to outside buyers, a Lloyd's spokesman said.

Lloyd's Life was formed in 1971 to let Lloyd's members participate as shareholders in long-term life and pension funds. The Lloyd's market is barred from participating directly in these lines.

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Freeze damage reaches \$300 million

NEW YORK—Insured losses caused by wind, snow and freezing temperatures that affected parts of 29 states Jan. 19-22 are estimated at \$300 million by C.E. Hermanson, vp of the Property Claims Services division of American Insurance Services Group Inc.

The extreme cold air from Canada, called the "Alberta Clipper," swept across much of the nation.

Florida orange growers, however, were largely uninsured for their losses. Their losses were expected to exceed those suffered following a freeze in December 1983, when growers lost \$280 million in fruit and \$840 million in trees (BI,

Jan. 28).

Most of the insured damage resulted from frozen plumbing systems and water damage.

Damage occurred in Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia and Wisconsin.

The storm was assigned Catastrophe Number 56 by the Insurance Services Office.

Citicorp foreign loan insurance fizzles

Continued from page 1

already been made tougher by the Dec. 31 withdrawal of Allstate Insurance Co. from the political risk reinsurance market. Allstate had been a significant U.S. political risk reinsurance market.

Allstate was a participant on the CIGNA treaty, sources say, but its decision to withdraw was apparently unconnected to the Citicorp deal.

Political risk insurance experts generally expressed relief over the collapse of the Citicorp program, which was regarded with "shock and embarrassment" by the London market and with worry in U.S. markets, brokers say.

CIGNA executives declined to comment on the Citicorp contract.

The company announced the contract's cancellation in a Feb. 1 press release that cited changing market conditions as the reason for the cancellation.

Business Insurance learned details of the program's collapse in interviews with political risk brokers, insurers and reinsurers in the United States and London, some of whom participated on the CIGNA treaty. Most of these sources requested anonymity.

Existence of the Citicorp contract was first made public in a footnote to the New York-based bank holding company's 1984 second quarter 10-Q report filed with the Securities and Exchange Commission (SEC, Sept. 17, 1984).

The footnote described the insurance as covering "the risk of major losses from prolonged delays in receiving funds from a country because of a government's inability or refusal to make the foreign exchange available."

The policy, which was brokered by Corroon & Black Corp., covered only currency inconvertibility and wasn't intended to cover the risk of default by borrowers.

About 10% of the borrowers to be

covered by the policy were foreign government entities, a Citicorp executive said at the time the contract became known.

CIGNA had agreed to divide the total limit of \$900 million among five countries. Limits of \$200 million were to be provided on loans in Argentina, Venezuela, Mexico and the Philippines. A \$100 million limit was to be provided for Brazil.

The insurance was to carry a deductible equal to 25% of Citicorp's total loan exposure in each country. For example, the bank's exposure in Brazil as of last June 30 was \$4.8 billion, so its deductible at the time would have been \$1.2 billion.

Total premium for the three-year policy, which apparently contained a non-cancellation clause, was to be \$5 million per year. CIGNA has returned the first year's premium to Citicorp along with a penalty that one source said was probably connected to the non-cancellation agreement.

Observers noted last September that the Citicorp program was unusual, since currency inconvertibility coverage is typically written for commodity exports rather than for bank loans.

CIGNA had originally planned to use its treaty to provide capacity of \$20 million for each of the five countries covered by the Citicorp program, and to make up the difference in the limits for each country with facultative reinsurance, according to David D. Avasthi, president of UIC Ltd., a political risk wholesale broker and underwriting manager based in New York.

Mr. Avasthi, who said he has seen two or three versions of the proposed Citicorp contract, says he spoke last summer to reinsurers in the United States and Europe who had been approached by CIGNA to participate on a facultative basis but had rejected the risk.

One of the problems that would have faced reinsurers in the Citicorp program was that they would have had no idea what underlying commodities were the subject of the Citicorp loans, and thus would not know what priority a government might give in granting foreign exchange to keep these loan payments current.

In addition, Mr. Avasthi noted, foreign governments sometimes nationalize the debt of private borrowers. Such actions would increase a reinsurer's exposure to currency inconvertibility risks of sovereign entities.

When news stories about the policy appeared in September, Mr. Avasthi said he assumed that CIGNA had found the facultative capacity it needed from Lloyd's of London underwriters. But Mr. Avasthi said he later learned that Lloyd's syndicates also had refused the risk.

Lloyd's brokers specializing in political risk confirm that the London market was not interested in the Citicorp business.

"It is obvious to anyone who works in the market that the gist of the whole transaction was out of line with the thinking of the market," said one broker who asked not to be named. "This is not a market for bank risks; it is a market for export risks."

Having failed to find the facultative capacity it needed, CIGNA then restructured the program to put the entire \$900 million risk—less its own retention—on its political risk treaty, according to Mr. Avasthi and several other sources in the political risk market.

In order to do this, CIGNA planned to split the Citicorp program into several separate "risks" in each of the five covered countries. It would then issue a policy for each of these risks. Each policy would then carry a limit of \$20 million, to be backed by CIGNA's treaty, sources say.

For example, instead of using the treaty to provide a total limit of \$20 million in Brazil, CIGNA may have planned to issue five separate policies to Citicorp in Brazil, each with a limit of \$20 million, sources say.

CIGNA may have planned to divide the "risks" in each country by business segment, issuing one policy to cover currency inconvertibility on loans to borrowers in the banking business, another for those in the mining business, and others for the electronics, petroleum and agriculture segments, according to one political risk underwriter.

This practice would not normally violate any specific provision of a

reinsurance treaty, says one political risk reinsurance intermediary. Political risk treaties typically allow the ceding company to define a "risk," he noted.

But several sources said that CIGNA's action violated the "spirit" of the treaty, both in the size of the risk it hoped to cede and in ceding currency inconvertibility on loans to sovereign entities, a risk that reinsurers try to avoid.

CIGNA had to be foolish "to think that would go by the treaty underwriters," the New York intermediary said. "It is just so clearly a blatant misuse of the treaty, and very uncharacteristic of the parties."

Some of CIGNA's treaty reinsurers apparently had similar feelings.

"The treaty reinsurers, as I am told, went right through the roof," one political risk underwriter said.

Kemper, which led the treaty with a 7.5% quota share, was especially upset, sources say.

"It put them in the position of having other reinsurers come back to them and say, 'My God, how could you have let this happen?'" one source said.

Other domestic markets participating were Allstate, Prudential Reinsurance Co. and Resolute Reinsurance Co. of New York, a unit of GEICO Corp.

Executives at these companies would not comment for the record or could not be reached.

But, sources say many of the treaty underwriters didn't know anything about the Citicorp program until they read about it in news accounts.

After the story became public, though, the treaty reinsurers were "coming through the windows and the air-conditioning ducts" at CIGNA to find out what had happened, one of CIGNA's treaty underwriters said.

Some brokers expressed surprise that CIGNA would have proceeded with a program of Citicorp's size without first giving some notice to its treaty reinsurers.

"It's certainly not the sort of thing I would do if I did not have the approval of treaty underwriters," one London broker said. "It would rebound on you the next year when you come to renew your treaty."

One of CIGNA's reinsurers, however, says he was not disturbed that CIGNA didn't inform him of its intended use of the treaty. Such advance notice isn't normally required under treaties, he noted.

This reinsurer also says that CIGNA had originally planned to put the entire risk on its treaty, contrary to what others say. He says CIGNA went into the faculta-

tive market only after the Citicorp policy had become public.

This reinsurer, while noting that CIGNA may not have acted in the spirit of the treaty, suggested that the controversy over the Citicorp program was overblown.

"What we are dealing with here is fear," he said, explaining that some in the insurance marketplace had incorrectly construed the policy to cover bad debts.

"Insurance companies were not the patsies of the banking industry," he said. But "the banking industry had everyone thinking they were patsies, including government bodies."

"We might have got away with it in another market," he added. "We might have got away with it if managements weren't so jumpy."

One result of the Citicorp policy fiasco is that CIGNA has had problems with renewal of its political risk treaty, which expired Dec. 31 along with the treaty of its recently acquired subsidiary AFIA. Reinsurance purchased this year will incorporate AFIA risks.

CIGNA is still negotiating with Kemper, which is demanding changes in the treaty's conditions to limit its exposure to situations like Citicorp, sources say.

But few observers expect CIGNA to come out of the renewal with the same \$20 million capacity it had previously. This is due in part to the Citicorp policy, but also is the result of a general tightening in the political risk market exemplified by Allstate's withdrawal.

In the meantime, CIGNA is still writing political risk business, reinsuring it on a facultative basis.

The Citicorp deal has created problems for other political risk insurers trying to renew treaties.

"There's still a market, but this Citicorp thing really shook the political risk market," one reinsurance intermediary said.

"It really came as a splash of cold water in the face of a lot of reinsurers," said Robert S. Frank, manager of political risk for Chubb & Son Inc.

Chubb recently renewed its treaty with a decline in capacity per risk to \$10 million from \$10.5 million, but with an increase in the sublimit for civil war risks to \$7.5 million from \$5 million, he added.

Most political risk brokers and underwriters viewed the failure of the Citicorp program as good news.

After the program became public, increasing numbers of banks inquired about arranging similar coverage, and complained when they were told it couldn't be done, Mr. Avasthi said.

"At least we are safe from being thought of as incompetent," he observed.

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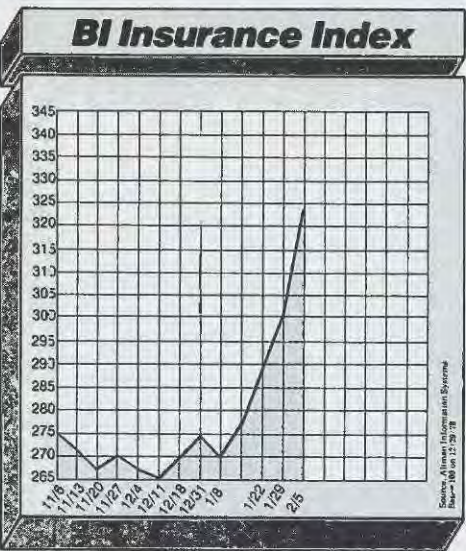
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Insurance industry stocks enjoyed their strongest week in recent years during the trading period ending Feb. 5 as the **Business Insurance** stock index surged 23.6 points to a record 325.0, compared with a close of 301.4 on Jan. 29. Forty-eight stocks posted gains during the period, only eight issues reported losses and two were unchanged. The largest gains were posted by Optimum Holding Corp., up 166.7%; Arthur J. Gallagher & Co., up 24.2%; Great Western Life Assurance Corp., up 15.4%; Mission Insurance Group Inc., up 15.3%; and American Indemnity Financial Corp., up 14.8%. The largest declines were reported by: Aneco Reinsurance Co. Ltd., down 7.7%; Tokio Fire & Marine Insurance Co., down 4.9%; Crown Life Insurance Co., down 2.9%; Northwestern National Life Insurance Co., down 2.5%; and US-LIFE Corp., down 2.0%. The **Business Insurance** index rose a whopping 5.5% during the trading period, easily outpacing the New York Insurance Exchange Composite, which rose slightly less than 1%, and the Dow Jones 30 Industrial average, which fell 0.6%.

British Issues						1 Week
5 Feb Companies	Price pence	P/E	Div. pence	Yield %	High—Low pence pence	
Comml Union	193	N/M	16.9	8.7	195—193	
Genl Accident	533	53.3	27.1	5.1	535—525	
Gdn Royal Exch	657	17.8	32.9	5.0	668—653	
Royal	575	95.8	32.6	5.7	578—570	
Sun Alliance	423	40.3	20.0	4.7	432—420	
Brokers						
CE Heath	635	10.9	24.3	3.8	635—623	
Hogg Robinson	250	14.3	9.7	3.9	250—244	
JH Minet	270	18.6	7.4	2.8	270—252	
Sedg Grp	377	17.5	11.5	3.0	377—368	
Stew Wrightson	607	17.3	21.4	3.5	619—603	
Willis Faber	667	23.8	15.0	2.2	667—658	
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kiteat & Aitken Stockbrokers, London						

'Happy Days Are Here Again' may be brokers' tune for '85

By **LEONARD M. WILSON**
Special to Business Insurance

"LET THE GOOD TIMES roll" might be an appropriate theme for insurance brokerages in 1985.

The publicly owned insurance brokers have seen the price of their shares increase sharply in anticipation of strong earnings gains this year. Price-to-earnings ratios are at levels not seen since the mid-1970s.

The explanation, in a word, is rate increases for commercial insurance lines.

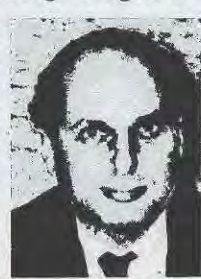
In the meantime, brokerage budgets for 1985 are being put to bed. Last year, we observed that budgets are inevitably conditioned by trends that occurred during the prior year. But not this year. Last year's benchmarks are obsolete.

Forecasts in insurance brokerage are never easy, and today's improved environment has not facilitated the process. What may be different is the possibility of actual results surpassing the forecasts in 1985 unlike the past few years when budgets almost always seemed too ambitious.

We are not privy to the closely guarded budgets of the publicly held brokers. But, as in the past, if we could look over the shoulder of the financial officer of ABC Risk Associates, a fictional entity, we might find the substance of a representative profit plan as detailed in the following paragraphs.

Looking at the renewal book of business, the economy is clearly going to help the broker. Even the most depressed sectors of the U.S. economy, with only a few exceptions, have recovered. Inventories, payrolls and capital spending should all be up smartly. Gains from the economy might amount to 4% to 5% for 1985.

Turnover of clients has tended to accelerate in the soft markets, but client wanderlust will be tempted by the current tightness in



Mr. Wilson

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

capacity. Existing relationships count for something, so lost business will likely decline in 1985, another plus for renewals.

The biggest variable, premium rate increases, also is the hardest call for the prognosticator. Premium rates are up 10% to 50%, depending upon the contract and the line of insurance. But not all lines are moving up dramatically. Moreover, higher deductibles, lower limits and lack of capacity for some risks are tradeoffs that restrain the dollar rise in premium.

As a reasonable figure for the budget, premium rates are calculated to contribute an increase of 10% to 12% to the commission stream.

New business was a mainstay for the public brokers in years of soft markets and rescued operating results from potential disaster. Tight markets should be especially favorable to new business owing to ABC's clout, worldwide access to markets, entree to reinsurers and general sophistication. New business should be strong in 1985.

Investment income, though, may be flat in 1985. The average 90-day certificate of deposit rate was about 10.5% in 1984. For forecasting, 8% might be a suitable estimate of 1985's average level. Even with a large upswing in premium volume, investment income figures to be about on a par with 1984.

Putting the top-line variables together, it looks like revenues could advance 20% to 25% in 1985. Interestingly, we suspect that some public brokers were running at that pace in the fourth quarter of 1984.

What about expenses? After three years of austerity, restraint and discipline are still watchwords. On the other hand, holes need to be filled, and business is increasing. Thus, the number of employees will likely rise 2% to 3% for the year on average, but may be advancing as much as 5% annually in the second half. Moderate inflation and steep increases in bonuses and incentives might lift employment costs 10% to 13% above 1984's costs.

Other operating expenses, we expect, could increase a little faster than employment costs. We are already seeing supporting evidence in recent reported results for the public brokers.

Using these elements of the budget, ABC Risk Associates finds itself with an enviable earnings increase of 50% to 60%. This is the positive operating leverage we have dis-

cussed in the past.

The actual earnings gains for the public brokers will not necessarily track our hypothetical broker. But the advances should be gratifying if costs are held in reasonable check.

We have long maintained that the profitability of insurance brokerage would approach the levels recorded in the 1970s, once premium rates entered a protracted cycle of increase. Contacts within the industry grouse about chaotic markets, difficulty in placing business and outright absence of capacity for some risks. Hectic and difficult might be an apt description, but given two or three years of similar markets, the insurance brokers—public and private—are almost certain to achieve scintillating profit gains.

St. Paul

The St. Paul Cos. Inc. reported a consolidated unaudited 1984 operating loss of \$196.7 million, compared with an operating gain of \$116 million in 1983. Revenues in 1984 totaled \$2.36 billion, compared with \$2.08 billion in 1983.

The company posted a net loss of \$210.9 million last year, compared with net income of almost \$136 million during the previous year.

"Clearly 1984 was a terrible year," said Chairman and Chief Executive Officer Robert J. Haugh. "Throughout the year, we continued to incur the effects of severe underwriting losses, primarily in the commercial insurance business of our property/liability operation."

St. Paul reported a \$217.8 million loss on its property/casualty insurance operations in 1984, compared with earnings of \$99.2 million in 1983. Underwriting losses for property/casualty business totaled \$572.6 million last year, compared with an underwriting loss of \$231.1 million in 1983. Property casualty investment income totaled \$319.4 million, up from \$274 million in 1983.

St. Paul's 1984 combined ratio was 130.3%, compared with 113.1% in 1983.

St. Paul last week also declared a regular quarterly dividend of 75 cents per share, payable April 17 to shareholders of record March 29.

Lincoln National

Lincoln National Corp. says it has agreed to buy The Western Casualty & Surety Co., a Fort Scott, Kan.-based property/casualty insurer, in a transaction valued at about \$270 million.

But a spokesman for Reliance Group Holdings Inc., which owns 9.9% of Western Casualty through a subsidiary, said it is considering making its own offer for the insurer.

Edwin Goss, president of Lincoln National's property/casualty affiliate, American States Insurance Co., says that as far as Lincoln National is concerned, the agreement is definitive. It is now proceeding with obtaining the approval of Western shareholders and regulators, he said.

Lincoln National will acquire 58.2% of Western Casualty for the \$270 million. As part of the transaction, Lincoln National has also agreed to acquire Western Insurance Securities Co., a holding company that owns the remaining 41.8% of Western Casualty, in a transaction valued at \$112.8 million.

Mr. Goss said Lincoln National's decision to acquire Western is part of its strategy to become more heavily involved in the property/casualty business.

Frank B. Hall

Frank B. Hall & Co. Inc. has declared a quarterly dividend of 25 cents a share on the company's common stock, payable May 12 to shareholders of record April 19.

American Family

American Family Corp., the parent company of American Family Life Assurance Co., has declared a quarterly dividend of 16 cents a share, payable March 1 to shareholders of record Feb. 15.

BI Industry Stock Report

Feb. 5, 19851/30/85 thru 2/5/85

Brokers										Price % Chg. P/E \$ Div. % Yld. High Low Vol.(000)									
Alexander & Alexander Svcs	NYSE	27.88	8.8	309.7	1.00	3.6	27.88*	26.25	987.0	Business Mens Assurn Co Amer	OTC	49.75	1.0	8.7	1.94	3.9	50.50*	49.50	39.1
Baldwin & Lyons Inc	OTC	48.00	2.1	20.7	0.80	1.7	48.00*	47.00	1.2	Carolina Gas Ins Co	OTC	3.00	-7.7	0.0	0.00	0.0	3.00	3.00	0.0
Corroon & Black Corp	NYSE	41.50	8.1	24.9	1.00	2.4	42.50*	39.00	1,005.7	Chubb Corp	NYSE	61.75	17.5	21.7	2.20	3.6	61.75*	56.00	560.7
Crumph & Co Inc	OTC	24.38	12.1	21.8	0.44	1.8	24.38*	22.75	193.9	Combinac Intl Corp	NYSE	43.00	6.8	10.9	2.08	4.8	43.00	40.38	314.0
Ewert & Chandler Cos Inc	OTC	11.75	6.8	0.0	0.00	0.0	11.75	11.00	3.6	Continental Corp	NYSE	41.63	8.5	118.9	2.60	6.2	41.63*	39.13	1,108.0
Gallagher Arthur J & Co	OTC	38.50	24.2	24.2	0.22	0.0	38.50*	32.50	104.4	Crown Life Ins Co	OTC	118.50	-2.9	7.7	4.00	3.4	122.00	118.00	1.6
Hall Frank B & Co Inc	NYSE	27.00	8.0	225.0	1.00	3.7	27.88*	26.00	1,012.3	Durham Corp	OTC	37.00	0.3	11.4	1.16	3.1	37.00	36.88	8.0
Marsh & McLennan Cos Inc	NYSE	64.25	6.2	39.7	2.40	3.7	64.25*	61.13	675.1	Farmers Group Inc	OTC	58.88	3.3	12.7	1.76	3.0	58.88*	57.63	491.3
Poe & Assoc Inc	OTC	7.75	10.7	0.0	0.00	0.0	7.75*	7.50	13.7	Fremont Gen Corp	OTC	21.88	4.2	0.0	0.48	2.2	21.88*	20.75	225.7
Reed Stenhouse Cos Ltd	OTC	21.38	6.9	30.5	0.60	2.8	21.38*	20.25	477.9	Great West Life Assurn Co	OTC	375.00	15.4	10.1	14.00	3.7	375.00*	325.00	0.0
AGENTS/BROKERS	AVERAGE			38.3		2.3				Hanover Ins Co	OTC	35.25	7.6	16.8	0.56	1.6	35.25*	33.50	70.1
										Hartford Steam Boiler Insptn	OTC	64.00	5.8	28.6	3.00	4.7	64.00*	61.00	10.8
Conglomerates & Holding Cos.										Kans City Life Ins	OTC	82.50	7.1	13.4	2.88	3.5	82.50*	79.00	8.8
American Express/Fireman's Fd	NYSE	43.00	2.4	15.4	1.28	3.0	43.00*	41.25	4,685.8	Kemper Corp	OTC	50.00	6.7	29.1	1.80	3.6	50.00*	48.00	143.8
Anderson Clayton/Ranger/PanAm	NYSE	36.13	0.7	17.0	1.32	3.7	36.13	35.25	90.4	Liberty Corp S C	NYSE	29.50	1.7	14.1	0.72	2.4	30.25*	29.13	32.9
Araco Inc	NYSE	10.88	-1.1	0.0	0.00	0.0	10.88	10.50	924.3	Lincoln Natl Corp Ind	NYSE	42.25	4.3	9.8	1.84	4.4	42.25*	40.75	415.2
CIGNA Corp	NYSE	47.50	0.8	39.3	2.60	5.5	47.50	45.75	1,684.6	Mission Ins Group Inc	NYSE	8.50	15.3	0.0	0.50	5.9	8.50	7.75	164.1
City Investing Co. (Home Ins.)	NYSE	40.25	1.3	9.7	0.00	0.0	40.25	39.50	697.9	Monumental Corp	OTC	30.00	2.1	13.5	1.30	4.3	30.00*	29.13	72.8
CNA Finl Corp (CNA)	NYSE	37.50	-1.3	18.3	0.00	0.0	37.75	37.50	181.9	Northwestern Natl Life Ins	OTC	34.00	-2.5	13.2	0.80	2.4	34.50	34.00	324.3
General Re Corp	NYSE	73.00	6.2	25.4	1.44	2.0	73.00*	68.25	646.8	Ohio Cas Corp	OTC	48.63	1.6	18.3	2.68	5.5	48.63	47.25	493.0
ITT (Hartford Group)	NYSE	30.88	-0.8	8.4	1.00	3.2	31.00	30.25	2,608.4	Old Rep Intl Corp	OTC	33.63	8.5	6.8	0.88	2.6	33.63	31.13	142.8
Optimum Hldg Corp	OTC	1.00	166.7	0.0	0.00	0.0	1.00	0.38	18.9	Orion Cap Corp	NYSE	24.50	7.7	27.2	0.76	3.1	24.50	23.38	34.5
Sears Roebuck & Co. (Allstate)	NYSE	35.25	-3.1	8.6	1.76	5.0	36.13	35.25	4,158.9	Protective Corp	OTC	21.50	3.6	10.2	0.62	2.9	21.50*	20.25	102.4
Teledyne Inc (Argonaut)	NYSE	261.50	-1.6	14.3	0.00	0.0	269.38	261.50	222.9	Provident Life & Acc Ins Co	OTC	88.00	4.1	6.3	2.88	3.3	88.00*	85.50	63.4
Transamerica Corp	NYSE	29.13	4.0	12.6	1.64	5.6	29.50	28.50	791.5	St Paul Cos Inc	OTC	58.13	11.5	0.0	3.00	5.2	58.88	51.88	762.4
(Occidental & Fred S. James)	NYSE	29.13	4.0	12.6	1.64	5.6	29.50	28.50	791.5	SAFECO Corp	OTC	34.50	-1.1	11.3	1.50	4.3	34.63	34.50	1,652.7
CONGLOMERATES/HOLDING COS.	AVERAGE			17.3		1.7				Sri Corp	OTC	18.75	-1.3	31.8	0.68	3.6	19.25	18.50	211.8
Insurers										Seibels Bruce Group Inc	OTC	23.75	4.4	0.0	0.80	3.4	23.75	22.50	124.6
Aetna Life & Gas Co	NYSE	41.13	3.5	21.1	2.64	6.4	41.13*	39.75	1,634.1	Statesman Group Inc	OTC	6.63	1.9	9.9	0.15	2.3	7.00	6.63	88.4
American General Corp	NYSE	30.00	7.6	11.1	0.90	3.0	30.00*	28.63	2,160.8	Tokio Marine & Fire Ins Co	OTC	135.25	-4.9	23.4	1.05	0.8	143.25	135.25	2.3
Ameron Heritage Life Invnt Co	NYSE	31.63	1.2	12.6	1.08	3.4	31.88*	31.25	3.3	Torchmark Corp	NYSE	38.13	5.3	9.1	1.00	2.6	38.13*	35.25	259.5
American Indty Finl Corp	OTC	17.50	14.8	0.0	1.12	6.4	17.50	15.25	32.2	Travelers Corp	NYSE	42.00	1.5	10.6	2.04	4.9	42.00*	40.50	1,452.0
American Intl Group Inc	NYSE	76.63	6.4	15.0	0.44	0.6	76.63*	74.00	1,096.4	United Fire & Cas Co	OTC	22.50	7.1	0.0	0.80	3.6	22.50	21.50	0.6
Aneco Reins Ltd	OTC	1.50	-7.7	0.0	0.00	0.0	1.63	1.50	12.0	United States Fid & Gty Co	NYSE	31.25	1.1	18.2	2.08	6.7	32.00*	28.38	1,390.7
Avanco Corp	ANEX	22.75	7.1	11.0	0.60	2.6	22.75	21.50	10.8	Uslife Corp	NYSE	37.13	-2.0	10.3	1.04	2.8	38.63*	37.13	265.4
Bitco Corp	OTC	12.25	4.3	2.2	0.40	3.3	12.25	11.63	48.6	Washington Natl Corp	NYSE	26.00	5.1	14.4	1.08	4.2	26.25	25.00	168.3
										Zenith Natl Ins Corp	OTC	14.75	1.7	26.8	0.68	4.6	15.00	14.25	138.4
INSURANCE COMPANIES										AVERAGE			15.6		3.5				

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