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update

Equitable pulling out of small group health market

NEW YORK—Small employers are losing an important market for group health and life insurance.

Equitable Life Assurance Society of the United States says it will phase out its Equi-Group program that provides health and life plans for companies with fewer than 100 employees.

Although Equitable wouldn't reveal how much money it lost on the program, the company acknowledges

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Basketball player's punch now felt by reinsurers

By DOUGLAS McLEOD

LOS ANGELES—Three liability reinsurers are smarting from the latest blow in a coverage battle with a ceding company over claims stemming from a player fight at a 1977 Los Angeles Lakers basketball game.

Photo: Wide World

Mr. Tomjanovich wore a mask after returning to action.

A Los Angeles County Superior Court jury earlier this month ruled the reinsurers must contribute $1.4 million to the ceding company's settlement of two lawsuits filed after a Lakers player punched Rudy Tomjanovich of the Houston Rockets in the face.

The jury verdict came despite protests from the reinsurers that they weren't notified of the lawsuits until after a Texas jury had awarded $3.3 million to Mr. Tomjanovich.

The three reinsurers haven't yet decided whether to appeal the verdict, their attorney says. But an attorney for the ceding company, Central National Insurance Co. of Omaha, Neb., suggested that the reinsurers may settle the case rather than appeal it.

The insurers' brawl began after the Dec. 9, 1977, skirmish involving the Lakers' Kermit Washington and Mr. Tomjanovich, both 6-foot-8-inch forwards.

Early in the third period of a game played at the Los Angeles Forum, Mr. Washington and Houston center Kevin Kunnert began

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Bill would stick employers with new pension liabilities

By JERRY GEISEL

WASHINGTON—Key members of Congress want to pass legislation that would dramatically increase employers' pension liabilities.

Legislation introduced by Reps. William Clay, D-Mo., and John Erlenborn, R-Ill., would stick employers with liabilities they never bargained for when they set up pension plans.

"This bill should make employers howl," says Frank Cummings, a partner with Cummings & Kershaw, a Washington law firm.

The Single-Employer Pension Plan Amendments Act of 1983, which already has cleared a House subcommittee, would:

- Give labor unions virtually total control in deciding whether an employer could terminate a pension plan.
- *Retroactively* increase the annual premium employers with pension plans pay the federal Pension Benefit Guaranty Corp. for termination insurance. Premiums would rise to $6 per plan participant from the current $2.60, retroactive to Jan. 1, 1983.

The retroactive increase would mean that employers that already paid their termination insurance premiums this year would have to fork over an additional payment beyond what they budgeted.

For example, a firm with 10,000 participants in its pension plan that already paid a $26,000 premium to the PBGC this year would have to make an additional $34,000 payment.

> 'Not a lot of people have been following this bill. People may think they understand the bill, but they don't,' warns attorney James P. Klein.

- Make employers that want to terminate their pension plans liable for participants' accrued but nonvested benefits. Now, when a plan terminates, employees are vested in accrued benefits but the employer pays only to the extent of available assets.
- Make a parent company liable for a subsidiary's pension benefits for up to five years after it sells a subsidiary to another firm.

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

Some pension experts already are labeling the Clay-Erlenborn bill, H.R. 3930, "dangerous and troublesome."

They say the bill has much in common with the Multiemployer Amendments Act, the 1980 law that imposes enormous pension liabilities on employers that leave multiemployer pension plans.

When the Multiemployer Amendments Act was being considered in Congress, few employers understood how the bill would increase their pension liabilities. It wasn't until it was too late—after the law was passed—that employers realized that they faced huge new pension liabilities.

Similarly, employers aren't following the Clay-Erlenborn bill, a major piece of legislation that cleared a House subcommittee after just one day of hearings.

"Not a lot of people have been following this bill.

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Plan would compensate future Manville claimants

By STEPHEN TARNOFF

NEW YORK—Under a plan proposed by a federal district court judge, payments to current asbestos claimants and other unsecured creditors of Manville Corp. would be stretched out over 20 years to guarantee that future claimants will be compensated.

U.S. District Judge David N. Edelstein suggested his plan at an Oct. 25 hearing to determine if the U.S. District Court for the Southern District of New York should take over Manville's reorganization from the U.S. Bankruptcy Court in New York.

At another hearing two days later, U.S. Bankruptcy Court Judge Burton Lifland gave Manville and asbestos claimants until Nov. 7 to negotiate a consensual reorganization plan to settle asbestos claims.

Technically, the district court has jurisdiction over the bankruptcy court and can move bankruptcy cases to its court.

While no final decision has been made, Judge Edelstein said he would not recommend the case be heard by the district court if he could be assured that future claimants will be adequately provided for.

"I am not going to be satisfied with any plan that does not give me some sense of confidence that we are not expunging and destroying the rights of future claimants," Judge Edelstein said.

"I think we have to be moral and I think we have to be concerned that we need some plan, some method of dealing with future claimants. . ."

He also warned plaintiffs' attorneys that if he were to preside over the case, he would insist that a system of arbitration for settling asbestos claims be considered in lieu of jury trials.

The plan for paying future asbestos claimants, as proposed by Judge Edelstein, calls for establishment of a 20-year sinking fund financed by 50% of the funds available to unsecured creditors at the time of reorganization. This fund would be tapped annually to pay new asbestos claimants.

In bankruptcy proceedings, the secured creditors are those who are paid 100% of what is owed them because they have a lien of some nature on the bankrupt company's assets, while the unsecured creditors, like the asbestos plaintiffs and those who supplied goods to Manville, split on a pro rata basis whatever money is left after the secured creditors are paid.

Judge Edelstein's plan, for which no details have been worked out, basically would work like this:

At the time Manville emerges from reorganization, all claims against Manville by unsecured creditors would be be pooled and paid off in cash and secured notes on a pro rata basis.

However, for every dollar that goes to pay off unsecured creditors' claims, Judge Edel-

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U.S. insurers still willing to cover Beirut risks Page 2

update

Small-group insurer pulls out

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that the business was not profitable. In 1981, Equitable estimated it lost $5 million on the Equi-Group plan (*BI*, Nov. 16, 1981).

Equitable says the Equi-Group program covers about 18,000 employers, down from 27,000 in 1981. Premium flow from small employers covered by the program totaled about $458 million last year.

Bendectin still off the market

WASHINGTON—Merrell Dow Pharmaceuticals Inc. of Cincinnati will not reconsider its decision to stop production of Bendectin, an anti-nausea drug for pregnant women, even though two jury verdicts against the firm have been set aside.

The company stopped Bendectin production in June, citing bad publicity, litigation costs and increasing insurance premiums after it lost several suits that alleged Bendectin caused birth defects.

A District of Columbia Superior Court judge last month set aside a $750,000 award against Merrell Dow to a deformed 12-year-old girl whose mother allegedly took Bendectin (*BI*, June 20). And in August, a federal appeals court in Atlanta rejected a $20,000 jury verdict rendered in an earlier Orlando, Fla., case.

State clear in Savitch case

NEW HOPE, Pa.—The state of Pennsylvania may well escape any liability in the deaths of TV newscaster Jessica Savitch and a companion whose car plunged into the Delaware Canal Oct. 23—even though it faces a $1.2 million verdict in a similar 1977 death.

Businessman Caron N. Ehehalt of York, Pa., died in 1977 when his car fell into the picturesque canal. A Court of Common Pleas jury found the state 70% liable for his death and Mr. Ehehalt himself 10% liable, blaming the state for failing to properly warn of the canal hazard. A canal-side restaurant where the businessman was last seen was found 20% liable but had settled the case for a nominal amount prior to trial. The state has appealed the judgment.

In Pennsylvania, the courts had struck down sovereign immunity for the state but the Legislature reinstated it by statute. The Ehehalt case was filed before the new statute took effect a few years ago.

Teachers help cut health costs

CHICAGO—Benefit dollars will be tapped to help cover the 5% pay raise the Chicago Board of Education negotiated last week with 27,000 teachers and 11,000 school workers to end a 15-day strike.

The Chicago Teachers Union and 18 other unions representing the striking workers agreed to help the school board shave $3.7 million from the $83.7 million currently budgeted for medical and dental coverage.

"But, the measures to keep expenditures down to $80 million have not been agreed upon yet," said Leroy R. Hansen, director of the school board's insurance department. "We will have a joint board-union committee to study and make the agreed-upon changes."

School employees currently receive first-dollar coverage through four health maintenance organizations or a self-funded plan.

Michigan comp insurers stymied

LANSING, Mich.—Insurance Commissioner Nancy A. Baerwaldt has denied a request for an administrative hearing on her decision to cut the workers compensation insurance rates charged by the State Accident Fund beginning Jan. 1. Ms. Baerwaldt said the request was premature since the rate order hasn't been filed yet.

Insurers are protesting the decision to cut state fund rates by as much as 17%, explaining that they will be unable to match the rate cut (*BI*, Oct. 17).

In another workers compensation development, Gov. James Blanchard has withdrawn the nomination of Clifford D. Allo as chairman of the Michigan Worker's Compensation Appeal Board. Employers had opposed the appointment of Mr. Allo, who has served as a consultant to the United Auto Workers.

Panel OKs pension equity bill

WASHINGTON—The Senate Finance Committee last week approved legislation making it easier for women to collect a pension. The Retirement Equity Act, introduced by Sen. Robert Dole, R-Kan., and backed by 30 co-sponsors would:

- Lower the minimum age at which employees must be allowed to participate in retirement plans to 21 from 25.
- Lower the minimum age for vesting credit to 18 from 22.
- Allow courts to divide a pension benefit in a divorce.

The measure was attached to legislation, H.R. 2769, that previously cleared the House.

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U.S. political risk insurers still write Lebanese risks

Photo: Wide World

Lebanese soldiers watch U.S. Marines sift through the rubble caused by last week's bombing.

By BILL DENSMORE and STACY SHAPIRO

U.S. insurers say they would probably still write political risk insurance for companies operating in Lebanon, despite the recent deaths of more than 200 U.S. soldiers in a terrorist attack.

But, the insurers say the price wouldn't be cheap, and they note that there seems to be almost no demand for such coverage.

Underwriters in London, on the other hand, say it would probably be impossible for a U.S. company with Lebanese exposures to purchase political risk coverage in that market. However, they agree with the U.S. insurers that few businesses have requested the coverage since fighting in Lebanon escalated several months ago.

Political risk insurance is a term used to describe a broad area of coverages. In most cases, it refers to coverage aimed at reducing the financial and/or commercial risks that a company faces in exporting products or locating operations in foreign nations.

If the policy covers exports, it may be termed credit risk insurance and may be arranged as part of an exporter's bank financing.

Common coverages under a political risk policy include: expropriation of assets, currency inconvertibility and export restrictions.

Coverage also may be available to handle losses resulting from non-governmental acts. For example, some underwriters will cover losses for a forced aban-

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Washington comp funds want 55% hike

By CAROL CAIN

OLYMPIA, Wash.—Most of the 112,000 employers in the state of Washington are just learning about a 55% rate increase proposed by the state's exclusive workers compensation fund.

The Department of Labor & Industries, which proposed the rate hike earlier this month, and large employer groups are getting the word out to employers and notifying them about a Nov. 9 public hearing on the increase.

The Department of Labor and Industries says the rate increase is necessary to return the workers compensation trust funds to actuarial solvency. The state fund actually includes three separate funds: the medical aid fund, supplemental pension fund and accident fund.

During the past two years, the department reduced proposed rate increases at the request of employers that said the area's poor econ-

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K mart learns lessons from warehouse disaster

By STEVE SHERWOOD

MORRISVILLE, Pa.—"We're sorry it had to be our loss, but it has provided a lesson. There's no question about that."

That is how Noel C. Powers, attorney in charge of risk management for K mart Corp. in Troy, Mich., reflects on the $100 million fire that destroyed a K mart warehouse in Morrisville, Pa., early in the summer of 1982.

Now as the winter of 1983 nears and K mart winds up the rebuilding of that facility, it and many others have learned a powerful lesson in storage of aerosol containers and the importance of adequate fire walls in warehouses.

Companies with similar risks are taking a hard look at their own fire protection systems and K mart is doing things differently as it rebuilds and expands the Morrisville facility. It also is revamping fire protection measures at nine other warehouses.

On June 21, 1982, sparks from an electric lift truck ignited aerosol cans of carburetor cleaner stored on pallets in the Morrisville distribution center, starting a fire that burned the 1.2 million-square-foot warehouse to the ground.

"The hazards of aerosol products and their protection needs were established prior to the fire, but when you get a fire of this magnitude it emphasizes them and makes people more aware of them," says William Marsh, vp and manager of the Standards Division of the Factory Mutual System. One of its member companies, Protection Mutual of Park Ridge, Ill., insured the K mart warehouse and its contents for $113 million.

Mr. Marsh also supervised Factory Mutual's investigation of the

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Illinois insurer, 2 officers face federal fraud charges

By LEN STRAZEWSKI

KANSAS CITY, Mo.—Federal prosecutors are taking over the investigation of Heritage Insurance Co. and two top officers previously indicted on state charges of bribing the state of Missouri's risk manager, the U.S. Attorney's Office says.

Vincent Giacinto, president of the Lincolnwood, Ill., insurer, and John Hancir, a Heritage vp, were indicted by a state grand jury last year for their alleged involvement in payoffs to Harvey F. McFerron, an insurance specialist with the Missouri Office of Administration's Division of Purchasing and Risk.

The alleged payoffs, which totaled more than $45,000, took place from March to July 1980, according to the state indictment (*BI*, Nov. 22, 1982).

Mr. McFerron pleaded guilty to charges of misconduct and conflict of interest and is awaiting sentencing, but prosecutors in Cole County, Mo., deemed the investigation of Messrs. Giacinto and Hancir "too complicated and involved for the county," says Assistant County Prosecutor Richard Callahan.

Mr. Callahan also requested that the state drop charges against a St. Louis insurance agent, Arthur A. Blumeyer III, who had been named in the state indictment.

Federal prosecutors in Kansas City, however, have picked up the investigation of Heritage and its officers at the request of the state and have received a new fraud indictment from a federal grand jury.

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errors & omissions

- The Washington, D.C., law firm representing Lockheed Corp. in litigation with Unigard Mutual Insurance Co. is Rogers & Wells, not Rogers & Clark as reported in a story in the Oct. 24 issue.

California Market

Is a takeover in Mission's future? 18

Regulator focuses on solvency issues 22

Brokers innovate to better compete 26

Employers slow to join PPOs 36

By RHONDA L. RUNDLE

Freedom and opportunity are the two advantages that come instantly to mind when marketers consider what distinguishes the California insurance environment from the rest of the country.

There is freedom from regulatory intervention that impedes the commerce of new ideas. There is freedom—except in workers compensation—from rate and form constraints that discourage or delay the introduction of new policies and competitive pricing.

Opportunities to succeed in the Golden State's insurance business are defined by the size of the market, the ease of entry for entrepreneurs and the widespread acceptance by established players of newcomers on the scene.

Californians boast that if the state were a separate nation its economic output would rank eighth in the world, ahead of such countries as Canada, Brazil and Spain. And, California is a world leader in enterprises as diverse as agriculture, entertainment and electronics.

Loyalty to an incumbent broker or insurer can be overpowered in California more often than in other markets by the lure of a lower price or a better idea, industry observers say. This phenomenon is especially apparent in the Southern California brokerage business (see story, page 26).

The sheer size of the California market has attracted nearly every major property/casualty and life/health insurance company, brokerage firm, third-party administrator and sundry service and consulting company to the state.

"Companies like to do business here because regulation is fair and adequate, but not excessive," observes a spokesman for the Assn. of California Insurance Cos. in Sacramento. "The environment encourages hard competition," he adds.

Insurers wrote $12.8 billion in California property/casualty premiums last year, about 13% of the total U.S. market, according to ACIC figures. Life and health insurers in the state wrote about $10.9 billion in premium last year, or 11% of the nationwide total, reports the California Insurance Department.

Because of its size and the variety of players in the market, California is virtually a microcosm of the vast U.S. market. The biggest names in the U.S. insurance and brokerage businesses also are the dominant forces here.

Major writers include Aetna Life & Casualty Co., CIGNA Corp. and Prudential Insurance Co. of America—to name three from the insurance company ranks. The New York-based national brokers, led by Marsh & McLennan Cos. Inc., Johnson & Higgins and Fred S. James & Co. Inc., maintain major presences in California.

The same elements that have made California a hospitable market for primary insurers and brokers have created a haven for excess/surplus lines brokers and insurers. Last year, $249 million in premium volume was placed with non-admitted markets, a decline from $274 million in 1981, but still tops in the nation.

"We've always been on the leading edge of new coverages in California," declares David Anderson, president of Anderson & Murison Inc., an E/S brokerage firm in Pasadena. "We don't have the difficulties other states have with regulation, and we have the freedom to draft forms and set rates."

Mr. Anderson recalls that the California E/S market introduced commercial block insurance 30 years ago—the forerunner to all-risk coverage for commercial accounts. Today, specialty markets are tailoring new directors and officers liability and errors and omissions coverages for businesses with unusual exposures, such as computer programmers.

Earthquake insurance is another specialty product in demand in California. But, how much is actually sold and who buys it are questions that regulators have been trying to answer for at least four years.

These are important questions since an insurer or reinsurer with exposures concentrated in the high-risk San Francisco Bay or Los Angeles basin areas could potentially be wiped out by a single, severe quake.

Continued on next page

Comp insurers find California profitable

Competition hurts service from claims administrators

By STEVE TARAVELLA

Many California workers compensation claims administrators are not retaining the quality of their services while they try to gobble up more of the market, administrators admit.

The claims administrators are constantly criticized—and criticize themselves—for allowing the fierce competition to tempt them to bite off more than they can handle or charge too little to support the competent staff needed do the job correctly.

"Proper claims management is so important today, but unfortunately, so many claims administrators low-bid to get the business, and they can't manage it properly," says J. Patrick Crow, vp-national division of Fred S. James & Co.'s claims management services in Los Angeles.

Who are California's largest workers compensation claims administrators? See chart, page 14.

However, some have realized this and have stopped to mend their ways, even at the risk of losing business. The cutthroat competition and poor quality of services it generates also will end when buyers demand quality services and the financially weaker administrators are weeded out of the market, administrators say.

But in the meantime, the competition has gotten stiffer in recent years as the number of claims administrators in the state has continued to grow while the number of companies self-insuring their workers compensation risks has leveled after a big surge in 1970s.

About 80 administrators now vie for the business of the more than 1,400 private employers and about 1,600 public entities that self-fund their workers compensation risks.

Based on the number of claims received last year, the largest administrators doing business in the state are Bierly & Associates Inc., headquartered in South Pasadena; R.L. Kautz & Co. in Irvine, a subsidiary of Emett & Chandler Cos. Inc.; Scott Wetzel Services Inc. in Bremerton, Wash., a subsidiary of The Home Group Inc.; Gates-McDonald & Co. of Marina del Rey; Fred S. James & Co. in Los Angeles, a subsidiary of Transamerica Corp.; and Keenan & Associates in Torrance (see chart, page 14).

Even though the movement toward self-funding has slowed, the self-insured employers served by the administrators annually take more than $1 billion in workers compensation premium volume

And, at companies that have not been willing to pay the price for

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By RHONDA L. RUNDLE

They may quibble over figures, but employers, insurers, regulators and investors do not dispute the main point: Workers compensation is enormously profitable for California insurers.

Although the state's minimum-rate law is designed to protect the injured worker's benefit dollars from erosion through irresponsible insurance company competition, it also serves a second, unintended purpose: It virtually guarantees profits to California workers compensation insurers.

That's because the minimum rate is set by a state agency at a level calculated to cover claims payments and the costs of doing business. Thus, apart from premium refunds, insurers are insulated from the cost-cutting mania that afflicts other lines of business in California and elsewhere.

During four of the five years from 1977 through 1981, the average return on net worth for California workers compensation insurers on their comp business exceeded 20%, according to estimates compiled by the state Workers Compensation Insurance Rating Bureau.

By contrast, the property/casualty insurance industry experienced an overall return on net worth of about 18% in 1977, which subsequently dropped to 11.7% in 1981, according to figures published by the National Assn. of Insurance Commissioners.

Indeed, a recent WCIRB report shows that until last year California work comp insurers' profits outstripped those of other U.S. businesses, including banks, diversified financial companies, utilities, transportation firms and smokestack industrials.

This performance hasn't escaped the notice of the stock market, as players have invested heavily in firms that own California work comp writers like Mission Insurance Co., a unit of the Mission Insurance Group; Fremont Indemnity Co., a unit of Fremont General Corp.; Industrial Indemnity Co., a unit of Crum & Forster; and Zenith Insurance Co., part of Zenith National Insurance Co.

"California has consistently offered the most profitable climate for comp," notes Fred Hill, vp-insurance stock research for Mosely, Hallgarten, Eastabrook & Frederick in New York. He credits the state's unique rating law for keeping rates and profits high.

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Top 10 California workers comp insurers in 1982

Insurer *(Parent company)*	Premium volume (000)	Market share
State Compensation Insurance Fund	**$420,229**	**14.7%**
Crum & Forster Inc. *(led by Industrial Indemnity Co.)*	**167,922**	**5.9**
CIGNA Corp. *(led by Pacific Employers Insurance Co. & INA)*	**155,376**	**5.4**
Fremont General Group *(Fremont Indemnity Co.)*	**154,281**	**5.4**
Mission Insurance Group. *(led by Mission Insurance Co.)*	**151,652**	**5.3**
Liberty Mutual Group *(led by Liberty Mutual Fire Insurance Co.)*	**144,976**	**5.1**
Fireman's Fund Insurance Cos. *(led by Associated Indemnity Corp.)*	**140,883**	**4.9**
Travelers Corp. *(led by Travelers Indemnity Co.)*	**102,925**	**3.6**
Zenith National Insurance Corp. *(Zenith Insurance Co.)*	**89,192**	**3.1**
American Financial Insurance Group *(led by Republic Indemnity Co. of America & Great American Insurance Co.)*	**89,167**	**3.1**

"Led by" indicates there is more than one insurer within the group that is active in California workers compensation insurance.

California offers freedom, opportunity

Continued from previous page

When it comes to issues involving earthquake insurance, however, there are no easy answers. Expert opinions even differ over current levels of demand for the coverage. Some say cheap rates in today's market have merely caused buyers to swap insurers rather than to buy more. Others report that purchase of earthquake coverage has accelerated dramatically during the past five years.

"There probably isn't much more earthquake liability being accumulated (by insurers) today than six years ago," observes Hermann P. Schlander, underwriting manager of Global Surplus Insurance Services Inc., a unit of Frank E. Hall & Co. Global Surplus places earthquake insurance for apartment and condominium owners.

"What we are witnessing is a game of musical chairs, the transfer of liability from one carrier to the other," he explains. New players, such as State Farm, have entered the excess/surplus lines market for earthquake insurance, but others have withdrawn or reduced their writings.

But Don Sherwood, president of Sherwood Insurance Services in San Francisco, disagrees. He thinks there are many more businesses buying earthquake insurance today because of the low cost. And longtime buyers, such as high-technology firms in the Silicon Valley, are seeking higher limits and lower deductibles.

Five years ago coverage on a $10 million plant with good construction might have cost $25,000 with a $500,000 deductible. The same coverage is available in today's market for $7,500 and a $100,000- to $250,000 deductible, he reports.

Many new markets have entered the earthquake arena to garner loss-free premium dollars, Mr. Sherwood points out. "This is a problem unique to California," he emphasizes. "Insurers are booking earthquake premium and using it to pay other fire, property and windstorm losses."

California Insurance Commissioner Bruce Bunner says he is extremely concerned about the earthquake problem. Since insurers are taxed for contingency reserves, no one is storing away funds to pay an earthquake calamity. He wants the industry to study the problem and propose some solutions (see related story, p. 22).

Workers compensation is the only insurance market in California in which rates are not set by open competition. The minimum rate law, unique to California, has maintained high levels of profitability for work comp writers in recent years (see related story, page 3).

Because of its profitability and the size of the market, California has attracted a number of small companies that specialize in writing the state's workers compensation business.

Zenith Insurance Co., California Casualty Indemnity Exchange and Employee Benefits Insurance Co., for example, are major forces in the market alongside the East Coast stock companies and such big California multiline insurers as Fireman's Fund Insurance Cos., Mission Insurance Group and Crum & Forster's Industrial Indemnity Co.

The regional specialist insurers say they provide better claims management and loss prevention services because they focus their energies on the workers compensation business.

Indeed, these specialists proclaim that their claims management services are vastly superior to those offered by the state's over-crowded claims administration market for self-insurers. There are at least 80 third-party administrators slugging it out for a share of the business from the state's more than 3,000 self-funded private and public entities.

"The quality of claims handling from fee administrators is far less than that from work comp insurers," declares Tom Brown, chairman of the California Casualty Group, which includes California Casualty Indemnity Exchange.

This assessment is based on firsthand observation of claims files taken over by Cal Casualty from various third-party administrators, he says. "Price competition in the fee business is so fierce it is forcing vendors into a check-writing mode," he explains.

Many California third-party administrators admit that quality is an issue in their business and are taking steps to mend their ways. At least one company has decided to trim its customer list in order to deliver better service to remaining clients (see related story, p. 3).

One reason for the high cost of workers compensation benefits in California is the astronomical cost of hospital, physician and other medical services. The average daily cost incurred by a hospital patient in California is $755, about 40% more than the national average, says the California Hospital Assn.

Nearly half of every workers compensation dollar goes to medical costs, compared with about one-third in the rest of the country, observes Alan Tebb, general manager of the California Workers Compensation Institute, a research organization that tracks trends for workers compensation insurers.

These costs hit California employers in the form of health insurance premiums or self-funded expenses for employee benefit programs. The skyrocketing cost of medical care has focused the attention of California employers on a wide variety of cost containment schemes.

Ten of the nation's approximately 100 health care employer coalitions are in California. They are active in collecting diagnostic information for utilization review programs, assessing the effectiveness of employee bonus incentive programs to reduce health care utilization and development of preferred provider organizations.

Indeed, the rest of the nation is watching California to see if PPOs will reduce the cost of health care. The idea is for health care providers to contract with employers, insurance companies and other third-party payers to deliver health care services to an employee group at a reduced fee (see related story, page 36).

Despite brisk formation of PPOs and an avalanche of marketing throughout the state, it seems that employers so far are reluctant to take the plunge. Only a handful of California employers have joined PPOs to date. Others have adopted a wait-and-see attitude. ■

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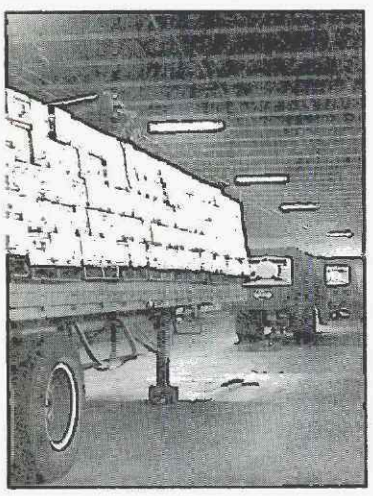

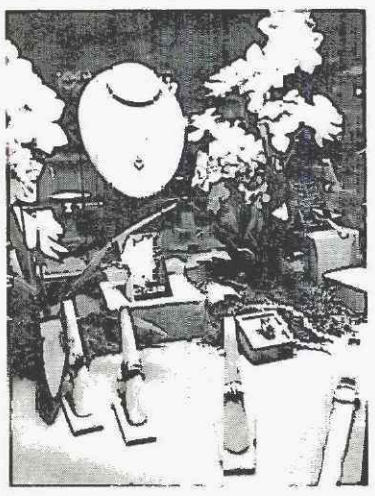

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Is Mission looking for a buyer?

Continued from page 18

The relationship between Mission and American Financial, whose president Carl H. Lindner is also on Mission's board of directors, dates back to the late 1970s when American Financial bought about 19.7% of Mission's stock in a move that prevented an unfriendly takeover by American International Group Inc.

At that time, American Financial agreed it would not acquire more than 20% of the company's stock. The agreement was amended last year, raising the limit to 25%.

"Technically, we didn't think we could uphold that," Mr. Marioni says, and the limit was removed altogether May 18.

In July, American Financial filed to increase its stake to 49.9% with the Securities and Exchange Commission and with the Texas Insurance Department. (Texas requires that such transactions be approved for insurers operating in that state; Mission has two insurers licensed in Texas.)

Mr. Marioni believes American Financial did not apply to acquire a greater portion "because he (Mr. Lindner) didn't want to make a tender offer to buy the company."

Among American Financial's holdings are Great American Surplus Lines Insurance Co. and Great American Insurance Co., whose president is Ronald F. Walker, also on Mission's board of directors.

If American Financial's filing is approved as expected, Mr. Lindner will have powerful input in choosing Mr. DeRosa's successor, analysts point out. However, they do not expect him to be the successor.

A search committee, whose members are all on the company's board, is looking for a successor from both within Mission's ranks and from outside. Analysts and others in-the-know are uncertain about the arena from which the leader will come but lean toward an outside candidate.

Some suggest Mr. DeRosa's successor may be named at the board's next meeting, set for the third week of November, but Mr. Marioni says, "They aren't in any hurry (to name a successor) because current management is in place."

Neither he nor Mission's chairman, Mr. Smith, would discuss candidates who have been considered.

Mr. Marioni, however, suggests that Mr. DeRosa's permanent successor may come from within the organization. "If I had to take a vote now (of committee members), I doubt if they'd go to the outside," he says.

But, he is quick to point out that he is not interested in the job. "I'm very comfortable doing what I'm doing. Some roles are just different from others." Until a successor is named, Mr. Marioni has temporarily assumed the CEO duties.

"If Marioni is not chosen as successor, I wouldn't be real surprised," says one securities analyst who wishes to remain anonymous. "That's not to say anything about his ability—as a chief operating officer, he's probably dynamite—but he doesn't present himself as one would expect a CEO to come across."

If the successor does come from within, a likely candidate is Executive Vp Westley M. Heyward.

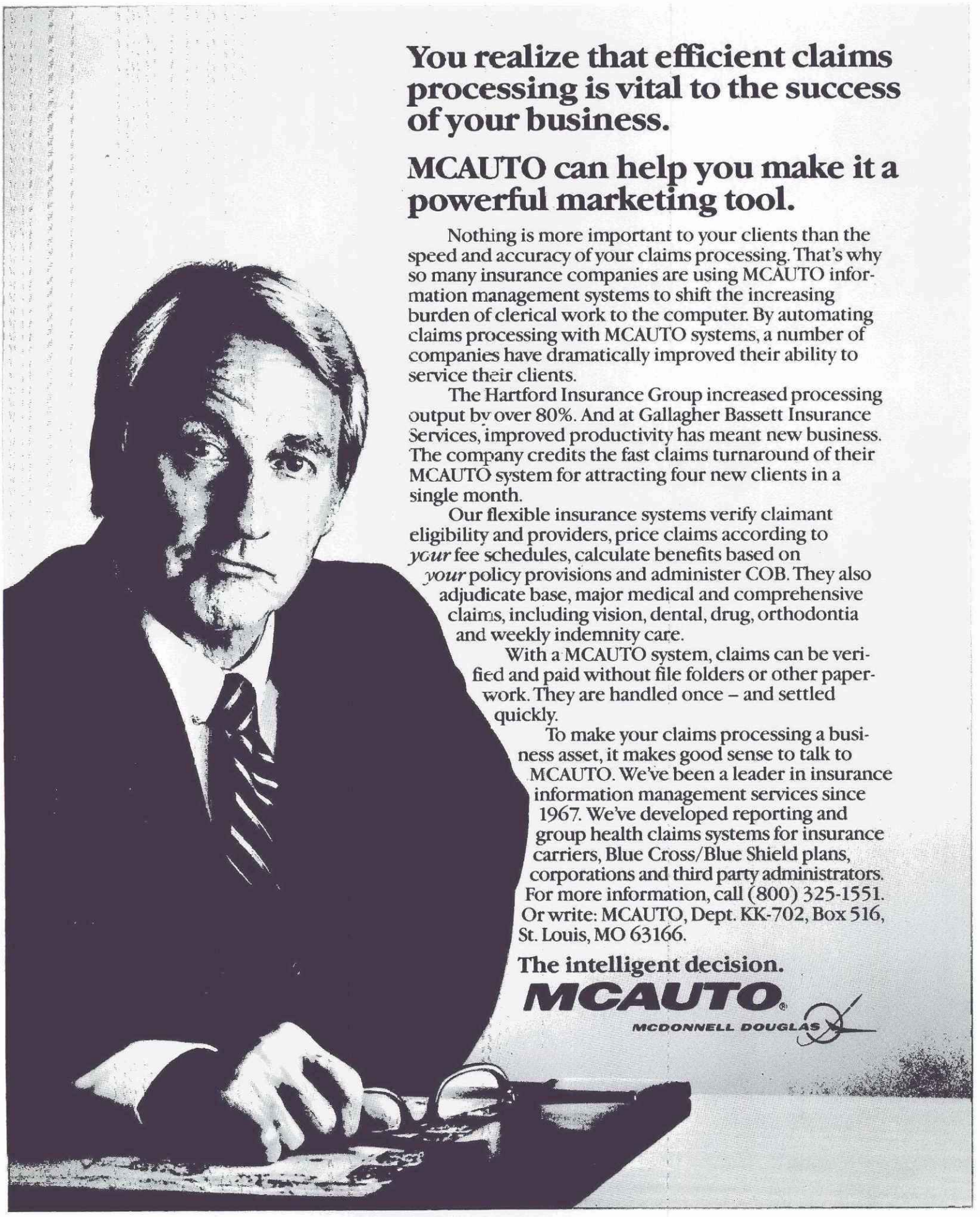
"Heyward is the logical heir apparent. He's been groomed for the job and probably is qualified to do it, but Dick (DeRosa) is a tough act to follow," notes Prudential Bache's Mr. Goodfriend.

Because it already has been five months since Mr. DeRosa announced his retirement, others are betting the replacement will be an outsider.

"One would assume his successor would come from the outside," says Joan Zief, vp-securities research in the capital markets division of Merrill Lynch, Pierce, Fenner & Smith. "If someone within the company were chosen, it would have been announced already."

Drexel Burnham Lambert's Mr. Jacobs also suspects that

Continued on facing page



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opinions

More congressional surprises

PLEASE, CONGRESS, no more surprises!

We have found too many already in H.R. 3930, introduced by Reps. William Clay, D-Mo., and John Erlenborn, R-Ill.

The bill, entitled the Single-Employer Pension Plan Amendments Act of 1983, is intended to shore up the Pension Benefit Guaranty Corp., the federal agency that guarantees workers' pension benefits. Because the PBGC has been incurring increasing liabilities, the premiums paid by employers to the PBGC need to be raised.

The bill proposes to increase premiums to $6 per plan participant from $2.60 and tighten loopholes that allow employers to dump unfunded pension plans on the PBGC, even when they are not going out of business.

But, while the bill is touted by its sponsors as necessary to protect the PBGC's single-employer pension insurance program, some of its provisions in no way will help the PBGC. Instead, they will saddle employers with pension liabilities they never bargained for when they set up their pension plans.

First, for example, the bill says that an employer with a collectively bargained plan could not terminate it unless it first received approval from its union. And, even after a collective bargaining agreement expired, a company would have to wait another two years before it could terminate the plan if the union objected.

Not only do we disagree with giving unions this unilateral control over a company's pension decisions, but what really concerns us is that we don't understand what this has to do with shoring up the PBGC. And, of course, employers never expected when they first set up those pension plans that they in no way could terminate one if the union said no.

In a similar vein, the bill would suddenly make employers that want to terminate plans liable for participants' accrued-but-non-vested benefits.

Employers could no longer terminate plans that lack sufficient assets to pay benefits, including those that are not vested. Instead, they would have to contribute to the plans until all accrued benefits were funded.

Yes, we admit this is a good way to assure that plan participants will get their fair share but, unfortunately, this will do nothing to help the PBGC.

The PBGC does not have to pay for accrued-but-non-vested benefits when a company shuts down an underfunded plan. The PBGC only pays guaranteed benefits, which on the average total about 85% of vested benefits.

And, on top of all of this, it appears that the PBGC premium increase to $6 per plan participant will be retroactive to Jan. 1, 1983.

Not only will this cost employers more, but such a retroactive provision is likely to spur legal challenges that will cost both employers and the PBGC money.

One encouraging sign, however, is that Rep. Erlenborn himself admits that some of the provisions—like union approval to terminate plans—are "overreaching."

His use of that word doesn't surprise us at all.

letters

Forgetting part of the cost-containment equation

To the editor: Dr. D. Kete Cockrell deserves praise for a well-researched, well-presented Perspective article (*BI*, Oct. 17). Unfortunately, both he and the majority of authors addressing cost-containment issues range far too wide of the problem.

Cost-containment efforts to date dwell on having the insurance industry (the supposed representative of the employer) work in concert with legislative bodies to curtail or eliminate (excessive) renumeration in the medical profession and the health care delivery system.

Left out of this equation are the two most important direct contributing factors: the employer—for workers compensation costs; and the employee—for personal health matters.

It should be obvious that the easiest way to minimize health care costs is to drain the "well" of patients. This can be accomplished by:

- Limiting commercial insurance coverage and benefits. Proprietary responsibility for both personal and occupational health and safety matters has, over the years, been handed over to a third-party—the insurance industry. We have groomed generations of corporate managers and their employees into the philosophy of "Don't worry, that's why we buy insurance."

Corporate and individual responsibility for one's own actions must be returned to its proper place. The availability of commercial insurance should be limited, with exceptions like pregnancy or preventive health examinations, to catastrophic coverage only. Making one personally financially responsible for how they protect their workers or how they eat, play, drive etc., will certainly provide the incentive to practice prevention or wellness.

- Correlating corporate income tax with the experience modification factor or incurred loss ratio of the employer. Corporate decision makers can more easily deal with the "black and white" of taxes than they can with the nebulous issues in health and insurance costs.

Sliding scales can be developed that reward employers who reduce their experience modification factor or loss ratio, and penalize employers whose EMF and loss ratio remain constant or increases.

- Requiring the medical profession, health care delivery systems and insurance industry to devote 10% of their annual gross earnings to the funding of the National Public Health Service or other public health education and information forums.

As long as the emphasis remains on treatments and cures rather than prevention and individual responsibility for one's actions is ignored or subrogated, we will not be able to even address the problem, let alone correct it.

True cost containment for employers will never be achieved by pitting one multibillion-dollar industry—insurance—against another multibillion-dollar industry—medicine.

As with most other factors involved in our daily lives, the laws of supply and demand govern the ultimate costs of the products we buy and the services we use.

Bruce A. Lepore
Hayward, Calif.

The future of Scor Reinsurance Co.

To the editor: One of your reinsurance articles (*BI*, Oct. 10) indicated that Scor Reinsurance Co. had made final plans regarding its future in the American market, including location of home office, staff size, marketing goals, etc. In fact, the article stated that definite steps are being taken to implement those alleged plans. Needless to say, this article does not reflect the position of the company.

In an effort to clarify all rumors, innuendos and misconceptions regarding the future marketing and organizational goals of Scor Reinsurance Co., we have prepared the following statement, which is the official position of the company.

Scor Reinsurance Co. has undergone a recent top management change as well as a subsequent reorganization. In the process, many rumors have circulated about Scor, particularly in the past few months, which do not tell an accurate story and reflect negatively on the company.

Scor Reinsurance Co., like most companies in our industry, has suffered through a period of depressed prices, increasing expenses and increasing losses. Therefore, in order to continue a high level of service to its treaty and facultative customers, both existing and potential, our company has undertaken strong corrective measures.

Scor Re has streamlined its facultative organization by closing its Atlanta branch office and reducing staff in the Irving, Texas, Chicago, and Hartford, Conn., branch offices. These moves were prompted by a desire to reduce corporate expenses, as well as a shift in underwriting policy. Scor Re plans to concentrate in the future on specialized, larger facultative risks where Scor's expertise can be put to the most effective use.

In order to be closer to major production sources and other reinsurers, Scor Re management is very seriously considering a move of its U.S. headquarters to New York. The final decision on this matter will be made prior to the end of November. Such a move would not involve Scor Re Life Insurance Co. nor the Irving, Texas, branch office of Scor Re.

Scor's results have been better than the recent industry average. We feel confident these changes will improve results and enable Scor to continue its commitment in the long term of serving the U.S. insurance industry as a professional reinsurer.

Malcolm S. Robinson
Vp, General Counsel
and Corporate Secretary
Scor Reinsurance Co.
Irving, Texas

■ *Business Insurance did contact Scor Re before the Oct. 10 article was published, but it said it was not prepared at that time to comment on its plans.*

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

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- **SERVICE**

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Extortionists and kidnappers are basically mentally unstable. An inexperienced response to such mentalities can lead to complications that create a life-threatening situation.

FACTS

According to the FBI statistics, in 1981 there were over 200 domestic kidnappings. This record may be incomplete because all kidnapping acts are not a violation of Federal law. There were in excess of 4,700 extortion attempts in the U.S. and over 235 violations of the Hobbs Act.

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Comp insurance market

Continued from page 6

Still pending, however, is the most critical issue. The industry agrees that some sort of uniform point-of-sale disclosure document should be prepared that will spell out how the dividend will be calculated. But, there is disagreement over whether the document should be based on insurers' historical dividend payment practices or should permit prospective quotations.

Mr. Sharp, a committee member who favors the historical approach, is concerned this controversy could derail the committee from its mission. The committee's original assignment was to develop a point-of-sale document that gives policyholders a basis for comparing quotes from different insurers..

"If we don't establish more discipline in the dividend area, open rating is a definite possibility not too far down the road," he warns.

Employers in California are pretty fed up with the high cost of workers compensation and are looking for ways to reduce it. So far, however, employers' efforts have focused on reform of the benefit delivery system.

Employers gripe that benefits are ending up in attorneys' pockets. And they believe the system lacks adequate incentives to get injured workers back on the job.

They are especially critical of the state's vocational rehabilitation law, which requires employers to provide job retraining and education for injured workers who cannot return to their old jobs. Too often, the injured employee never works in the new field.

Rehabilitation costs constitute 5% to 7% of the total incurred workers compensation losses in California, notes the CWCI's Mr. Tebb. And that figure could climb to 10% in the next year, he believes.

A legislative joint study committee has been formed to examine the California workers compensation system, with an emphasis on the wage replacement concept. Under the wage replacement system, benefits to injured workers are paid only for proven lost wages after a job loss (*BI*, Oct. 10).

A handful of insurance company proponents of open rating of workers compensation blame the minimum-rate law for chasing employers into self-funding their risks. Roughly 25% of the potential state workers compensation market has been lost to self-insurance (see related story, page 3).

Another criticism of the minimum-rate law is that it forces insurers to skirt the rules in order to be competitive.

Besides improper dividend practices, California cash-flow plans have been a focus of controversy in recent years.

Cash-flow plans allow policyholders to defer premium payment until the end of the policy period, at which time it can be reduced by the dividend refund. Under California law, insurers are required to charge interest on the deferred premium, which effectively converts the transaction into a loan.

"Since new rules were established last year to set a level playing surface, competition has shifted to other areas," says Marcus W. Ramsey, the Insurance Department's chief of rate regulation.

However, insurers say they are still writing the plans. But most insurers are playing by the rules, so the contracts are generating fewer complaints to the Insurance Department. ■

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Administrators say it's tough to turn profits

Continued from page 3

good staffers, employee turnover is high. Competent claims processers often find the only way to increase their salary is to leave the employment of one firm for that of another. And that can hurt services.

One or two key people leaving an administrator can affect that firm's ability to process claims quickly and properly, says Richard S. Anderson, manager of the state Office of Self-Insurance Plans.

"If you've got qualified people, they're often overworked, and can't provide the best service for the employer or the employee," he notes.

But, the fact is many of the administrators cannot afford more staffers.

Some like Fred S. James, Bierly & Associates and Scott Wetzel report they are now making money, but many are not.

"Most California work comp administrators are losing money. It's just not a very profitable area right now, principally because of the number of competitors out there," observes Thomas Leonard, president of Associated Claims Management Inc. in Walnut Creek, Calif.

"It's getting increasingly difficult to make a profit, and many are facing an interesting dilemma," notes Jack R. Powell, president of EBI Services Inc., the San Jose-based subsidiary of Orion Group. "They want to raise their prices to be profitable, but the quality of service they deliver doesn't allow it."

"Overall, we're awfully close to breaking even, but that's because we've had a lot of start-up costs penetrating California," he says.

EBI Services has only targeted its California comp claims-handling energies toward self-insureds since January. For about five years previously, the company's services for self-insureds were handled by the same operation that processes claims for insurance companies.

EBI Services broke away from Employee Benefit Insurance Co. to devote attention exclusively to self-funders to avoid any conflict of interests.

"There are some who are not making money, and some who are even losing it," says Scott Wetzel, president of Scott Wetzel Services Inc. "We admit our profits are depressed in California, but we're not in a losing position.

"We're doing all right. Our volume is up, and we're pretty confident about our ability to hold onto our business," he says.

Mr. Wetzel says his company has not engaged in the price war, but concedes that it has lost some business because of it.

In some cases, larger administrators have lost business to smaller ones who can attract clients with more personal service, but Mr. Wetzel believes the squeeze on administrators' profits is across-the-board because of the recent economic recession.

R.L. Kautz is one administrator that did not like the position it found itself in after cutting prices.

Kautz is in the middle of what Mr. Emett calls "a 180-degree change in philosophy" about its claims-handling operations, and has recently replaced relatively inexperienced claims handlers with people who've been in the business for 20 to 25 years.

The company has not shown a profit since 1978, Mr. Emett says, because it took on too many clients at rates too low to allow it to provide good service.

"We'd gone through a transition period of about 1½ to two years of

Continued on page 12

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"The Annuity Settlement Experts"

Administrators answer critics

Continued from page 10

trying to bring on whatever revenues we could at whatever rates," he admits. "But we realized that, sooner or later, that impacts the service you give all your clients."

Six or eight months ago, Kautz changed course.

"We've tried to eliminate some of the business we weren't making money on and do a good job in the remaining book we have," he says. "We've had a fair portion of business leave, but most of it has been underpriced, so it's a favorable change."

"It's tricky to improve quality and profitability at the same time," he admits. "But within the past 10 months, we've not only significantly improved the quality of our services, but we're seeing right now about $100,000 per month improvement in profitability (just in California)."

The company had not recorded a profit through March of this year, Mr. Emett says. "But I'd say at this point, we'll probably be profitable the last three months of the year."

Kautz is not actively soliciting business now, as are other administrators. "There are just too many people out there offering to do the world for peanuts—it's hard to compete against that," Mr. Emett said.

"We'd rather bring in a half to a third of the business we did before, and do a good job on our client base. If somebody wants to hop around, they can talk to somebody else."

The company is, however, interested in strengthening its position on the West Coast. "We're focusing our attention now on improving our California operations," he says, adding that Kautz has increased its claims staff in California by 10% to 15% this year.

Administrators are quick to point out that employers that shop for price only and do not acknowledge the long-term benefits of proper claims management are cutting their own throats.

"The administrative fee is a nickel compared to what's at stake," says Tom Malooly, vp-administration at Fred S. James. "My main concern is when the client is shopping strictly on administrative costs and not looking at the total program."

Paying 10% more for a claims administrator with a larger staff or additional facilities might mean that the administrator could save the employer 20% to 30% on claims, administrators point out.

"If somebody's doing it for price, they're doing a trade-off for service. That's not practical, but that's the game being played throughout the marketplace," observes Ray McCarthy, manager of ESIS, the claims administration subsidiary of CIGNA Corp.

ESIS, once a leader in California workers compenstation administration, lost a good portion of its business three or four years ago. Mr. McCarthy isn't sure how much, but says, "Our business is growing right now."

ESIS lost business when it became known that the company's methods of collecting and reporting certain data were being questioned by the state Office of Self-Insurance Plans, although Mr. Anderson declined to discuss the situation further (*BI*, Jan. 25, 1982).

"When your reputation gets tarnished, it takes a lot to turn it around. Word just travels like lightening," he says. He adds that although the company has done well retaining business over the past 12 to 13 months, he doesn't think its client base will ever return to what it was several years ago because of all the competition.

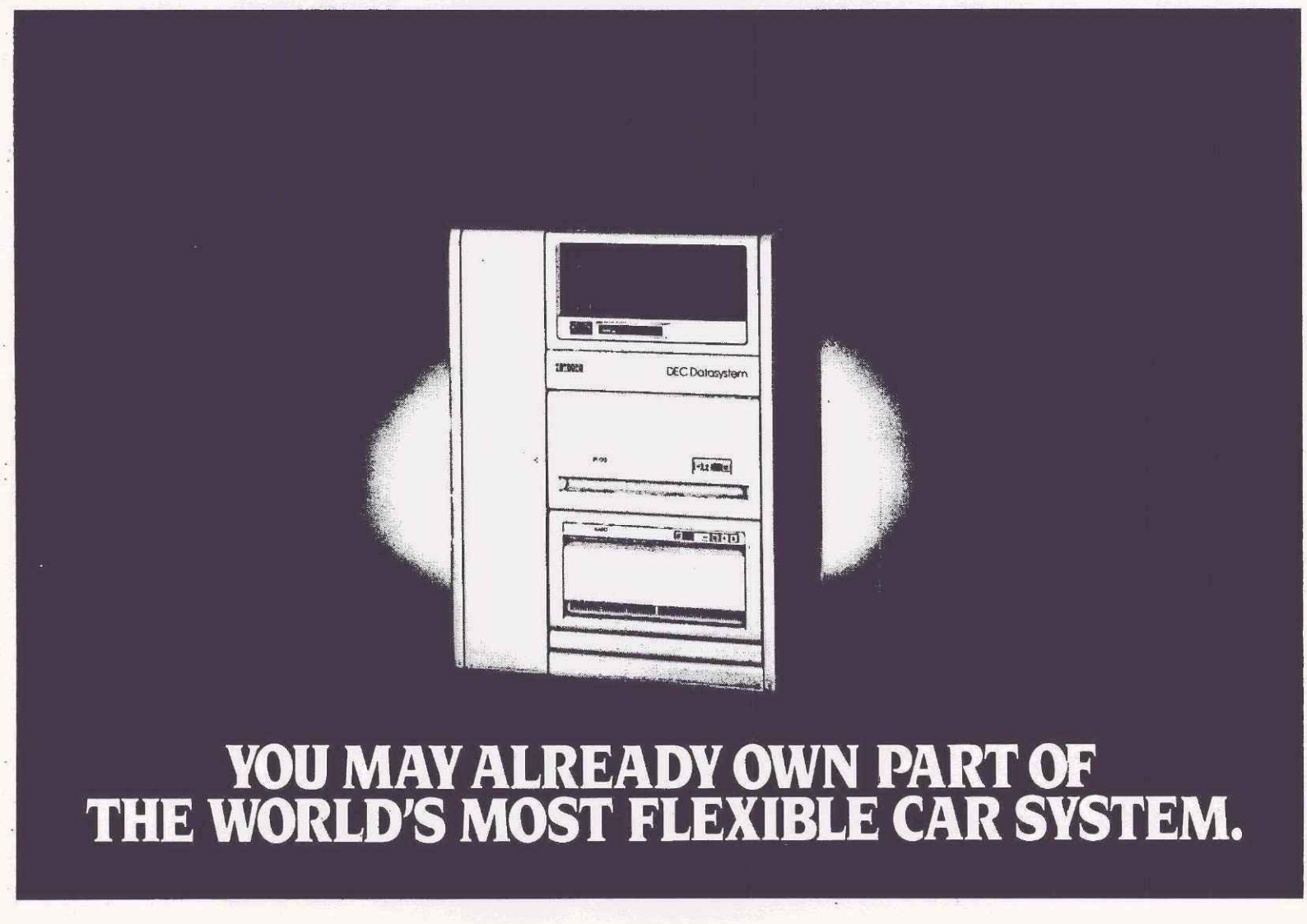
Workers compensation administrators do see a movement toward clients becoming increasingly aware of the importance of quality service, and suggest that the market may see more reasonable pricing soon because of it.

"I believe we can see a trend where there is some stability coming back, where pricing won't be as essential as it has been," suggests Mr. Wetzel. "People are dissatisfied with some of the service they've bought."

Administrators also point out that the private sector is adopting wiser shopping policies faster than the public sector, whose members include municipalities, school districts, and joint power authorities.

"Public entities are strapped for funds, and often choose the TPA more on price than on services rendered," notes David Guyer, senior vp-self-funding division of Keenan

Continued on page 14



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Leading California work comp claims administrators

Claims administrator *(Parent company)*	New claims reported in 1982	Staff	Number of clients	Client employees	Major clients
Bierly & Associates Inc.	35,000	180	150	350,000	Hospitals, cities, counties, manufacturers
R.L. Kautz & Co. *(Emett & Chandler Cos. Inc.)*	28,000	78	115	50,000-100,000	Private business, school districts, city & county governments
Scott Wetzel Services Inc. *(The Home Group Inc.)*	20,000	60	60	200,000	Private industry, retailers, manufacturers
Gates-McDonald & Co.	16,000-17,000	66	72	50,000-100,000	Municipalities, diversified private industry
Fred S. James & Co. *(Transamerica Corp.)*	14,000-15,000	80	60	226,000	Large private industry
Keenan & Associates	10,680	60	420	200,000	Joint power authorities, public school districts

All figures represented are approximations.

Public sector looks for price

Continued from page 12

& Associates, whose major clients are public entities.

"But the private sector is not that way," he says, adding that employers in private industry generally shop because of non-economic reasons, such as a dissatisfaction with the quality of service the administrator is providing.

"Assuming the claims service is satisfactory, there is automatically more shopping in the public sector than in the private sector. The public sector has to shop the market—almost statutorily—more frequently because of their own economic reasons," Mr. Guyer says.

Mr. Wetzel agrees that public entities, as a whole, shop with more regularity than private employers. "That's one reason we're not big in that sector; we feel it's essential to establish a relationship that's ongoing."

But, he observes, "The public sector is educating itself as well. They are coming to view the importance of service rather than pricing more now than they ever have."

"The quality of servicing claims will improve dramatically," predicts Michael Bierly, president of Bierly & Associates, the largest administrator of workers compensation claims in the state. "Many will go out of business because they take no responsibility for fee structure. Fees are being quoted with almost no responsibility whatever."

Bierly & Associates is operating at a profit, Mr. Bierly says, although he declined to discuss gross revenues. He reports that the company's client base has grown 10% since last year, and that the company's staff now sits at 180, up from just 12 in 1976.

"One of the reasons for our growth—which has been fantastic—is that we're specialists," he says. The company only processes self-insured's claims for workers compensation. He expects that the company's growth will continue, as will the number of employers who self-insure their work comp exposures.

But others agree with Mr. Bierly that many adminstrators are not so lucky.

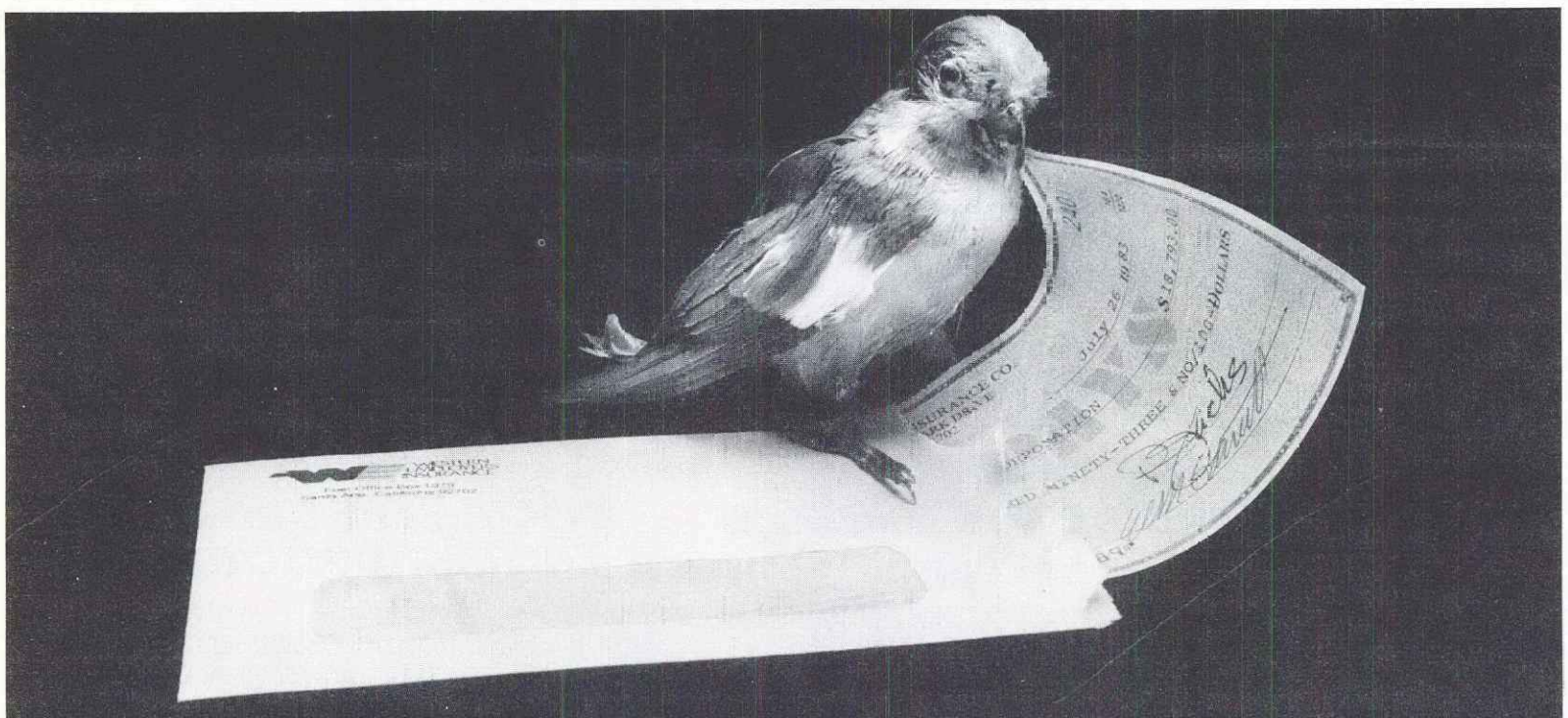
"I think we've already evidenced some of that (administrators leaving the market). Some small ones are having it very difficult, and some of the bigger brokerage houses aren't capable of providing the service big clients are desirous of and are suffering from it," observes Keenan's Mr. Guyer.

"Some of them will undoubtedly close, or will no longer be a competing force in the California market," notes James Hooker, general sales manager of the Western region for Gates-McDonald & Co. in Oakland. "I've seen indications of that happening—companies who've lost a significant number of clients."

EBI's Mr. Powell characterizes market conditions as "a process of elimination for some of the administrators. A lot will go through financial strains and some will be weeded out."

Mr. Emett says that some of the companies who would be forced out of the business in other areas of the country are being kept in business only because their losses are being funded by parent companies.

"I've been surprised at the number of (these broker-affiliated companies) that have been able to stay in the business today," Mr. Emett explains. "They've been able to fund their losses longer than they would have if they'd been in other markets." ■



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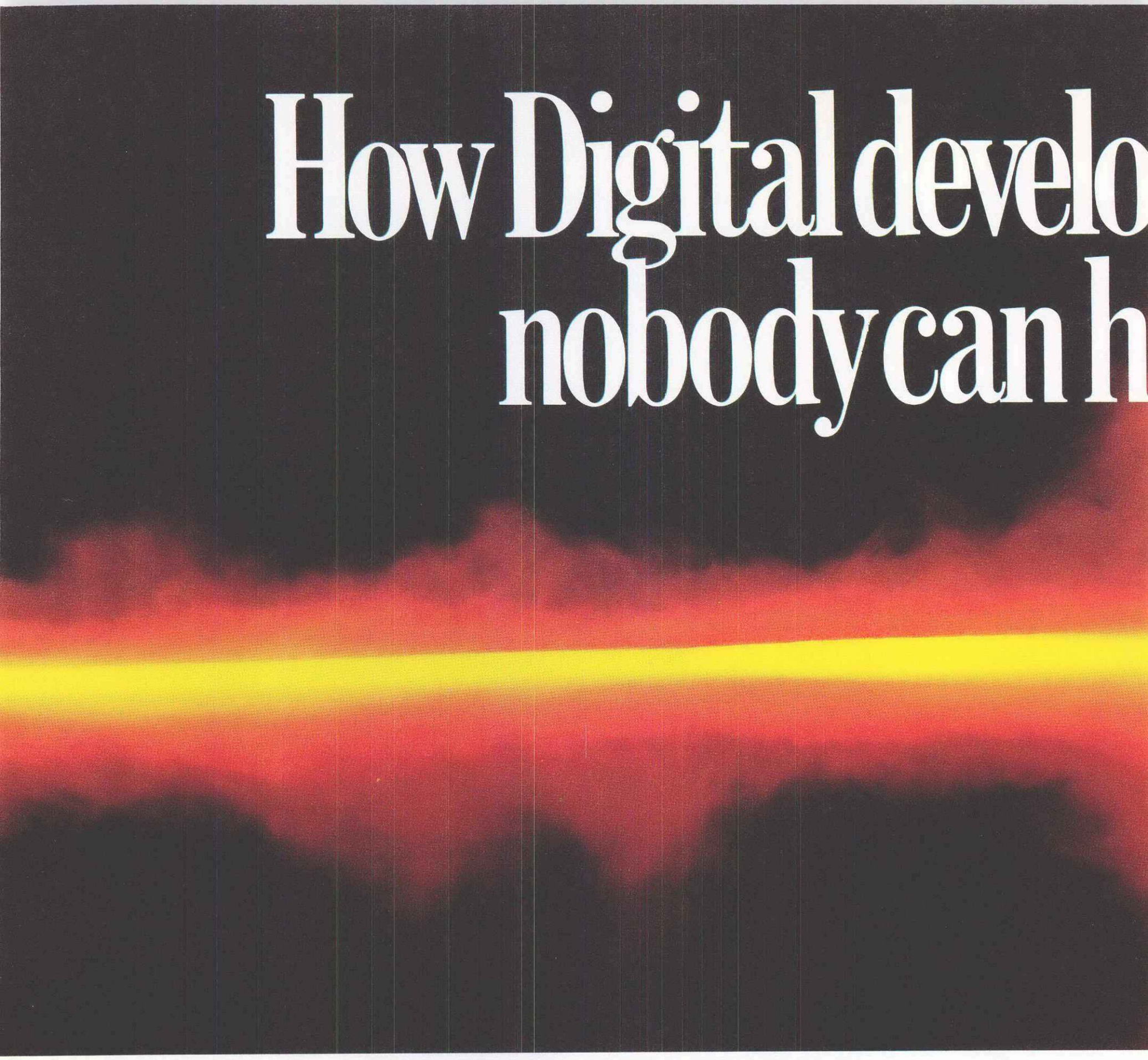

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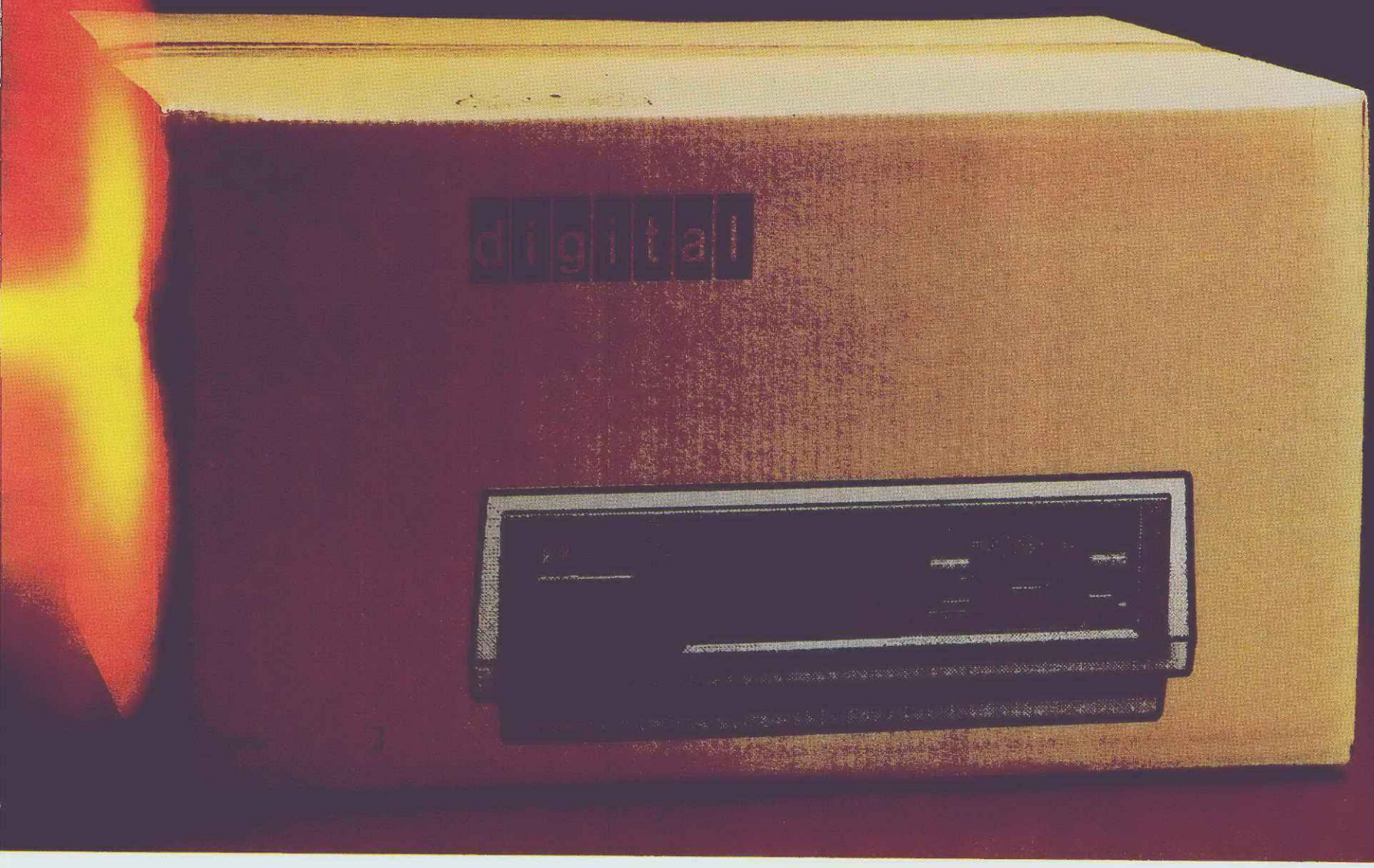

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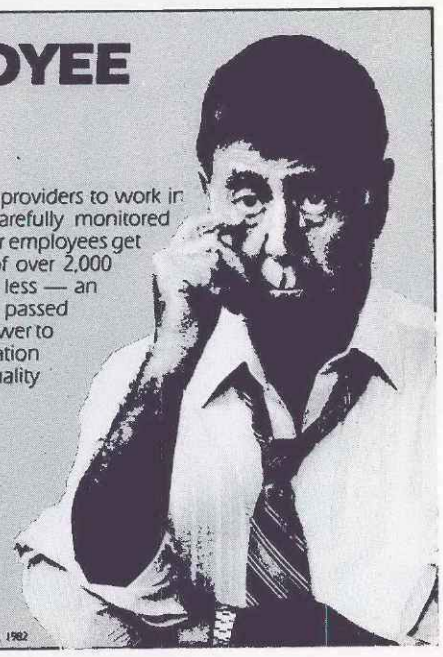

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Will Mission be sold after DeRosa leaves?

By STEVE TARAVELLA

LOS ANGELES—Speculations abound about the future leadership of Los Angeles-based Mission Insurance Group, one of the state's leading commercial insurance companies, whose presence is felt nationwide.

It has been five months since E. Richard DeRosa, the company's president and chief executive officer, announced his retirement, effective Jan. 1, and in the words of Louis F. Marioni, executive vp and chief operating officer, "They don't have a single candidate yet."

Mr. DeRosa's announcement has placed the company in an awkward transitional period—"probably its toughest period in 10 years," according to one securities analyst. But the bigger question on the minds of many is whether Mission's change of leadership will be followed by a change of ownership.

The search for the new executive has led to increased speculation about the possibility of a takeover, particularly since Mr. DeRosa's announcement came within days of the company's decision to lift a purchase limitation agreement that has prevented American Financial Corp. from obtaining more than 25% of Mission stock.

Cincinnati-based American Financial, the financial holding company that is Mission's major shareholder with 20% of its outstanding stock, has since filed to increase its holdings to 49.9%.

The industry is following developments at Mission so closely because of the company's position in the market. The group's 15 member companies are active in all areas of the property/casualty business and produced a gross premium volume in 1982 of $626.4 million.

Mission was the fifth-largest workers compensation underwriter in California last year and is a large work comp insurer in the western and southeastern United States as well.

And Mission's managing general agency arm, Sayre & Toso Inc., produced more business last year than any other MGA nationwide, racking up $245.4 million in premium volume.

"The company (Mission) is for sale and everyone knows it. It's just a matter of time," says Herbert E. Goodfriend, insurance analyst at Prudential Bache Securities in New York. "Keep your eye on Cincinnati."

"Is Mission going to remain a free-standing company, or will it be bought up by somebody? That's the big question now," says Michael Lewis, vp-insurance stocks analysis at E.F. Hutton Group Inc. in New York.

Mr. Lewis notes that well-run regional companies are sought-after investments and suggests that any company looking to broaden its operations or financial services scope would consider Mission a wise acquisition.

"Without a successor, the possibility of the company selling out has increased," says Ernest G. Jacob, vp-research at Drexel Burnham Lambert Inc. in New York.

However, Edward A. Smith, Mission's chairman of the board, maintains that the likelihood of a takeover and the search for Mr. DeRosa's successor "are two completely different issues."

Mr. Smith dismisses the possibility of the company changing hands in the near future. "It's an independent company and it's functioning well as such," he says.

But other members of the Mission board appear less certain. Harold J. Toso, director emeritus and honorary chairman, says a purchase of Mission "is always possible. You just never know. We're a good company and a growing company."

And board member Maarten van Hengel says Mission's name would certainly be on a roster of investment possibilities compiled by major corporations looking to expand.

Mr. Marioni says Mission recently warded off approaches by two industrial companies that wanted to purchase the insurance giant, but he would not reveal their names.

Continued on page 20

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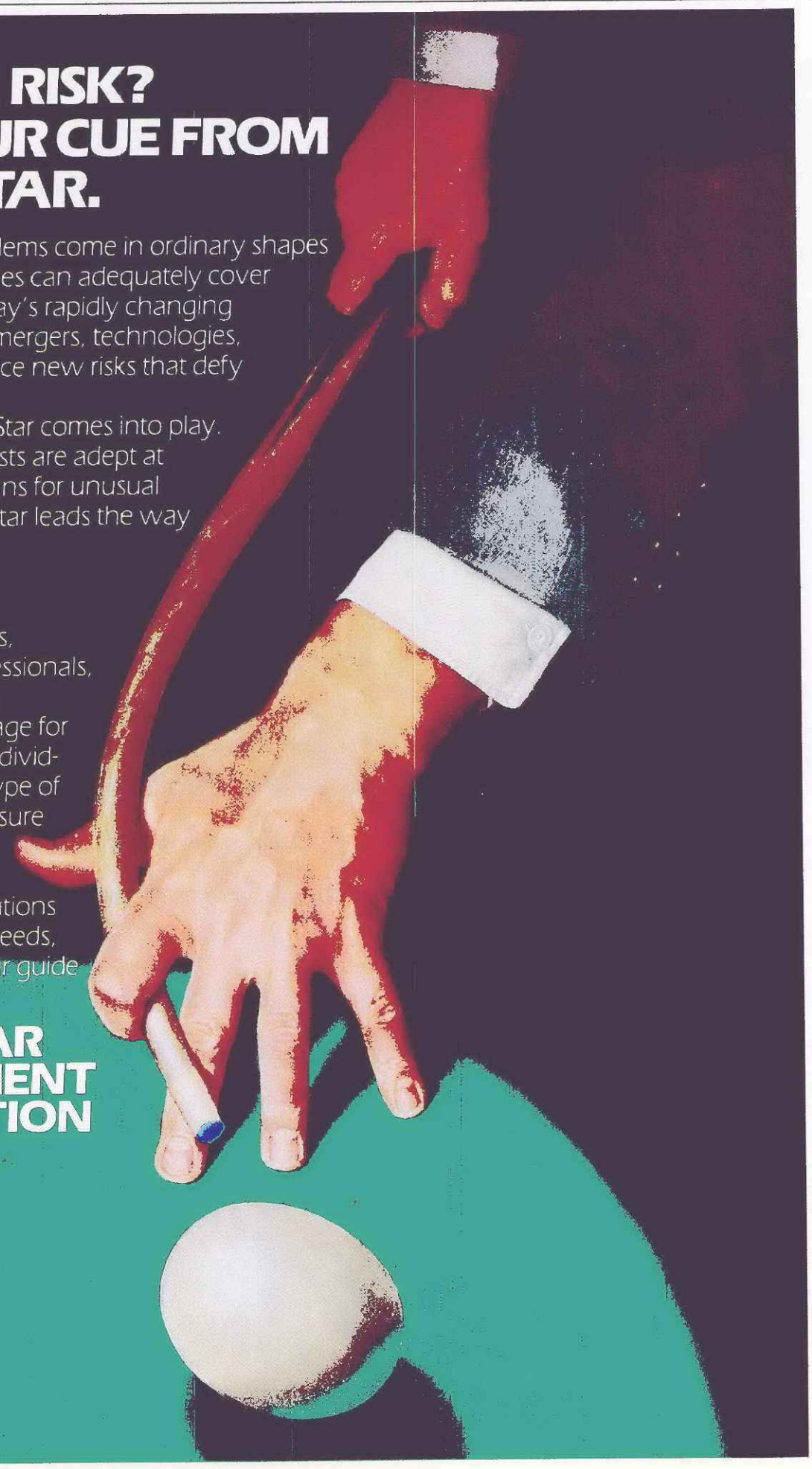

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Continued from facing page
Mission's new leader will come from outside the company.

John R. Cox, former executive vp-property/casualty at CIGNA Corp., says a member of the search committee asked him if he would consider taking the position, "although I never had a formal meeting with the people."

Mr. Cox just recently accepted a position as deputy chairman at Associated Madison Cos. Inc., a financial services division of American Can Co. in New York.

Whether the successor is chosen from within or from the outside, replacing Mr. DeRosa will not be easy. The man has earned a stellar reputation during his 25 years with Mission and is largely credited with transforming the company from an underwriter of substandard auto insurance—"We were really broke then, were facing a cease-and-desist order, and couldn't even make payroll," Mr. Marioni remembers—into a major commercial insurance company.

The imposing Mr. DeRosa is known for his dedication and 50-hour workweeks, colleagues say. After his retirement, he will serve Mission in an advisory capacity as a director and chairman of the board's executive committee.

Mr. DeRosa's reasons for leaving are left to speculation. A spokesman for the company said Mr. DeRosa is traveling and, therefore, unavailable for comment.

But sources say 60-year-old Mr. DeRosa, who has held his current position for 20 years, wants to leave for personal reasons while the business is good.

"I wonder if it's just the fact that it's just not going to be fun anymore," suggests Ms. Zief. "It's a difficult year and competition is fierce."

Mr. Goodfriend agrees. "He just doesn't see the workers comp business nearly so fruitful in the next five years as its been."

"I don't think he left with any dissension. He just got tired and worn out, and wants to take it easy," says Mr. Toso.

Many say that Mr. DeRosa had been wanting to cut back his day-to-day involvement for quite some time.

"I would suspect that if the opportunity were presented to him where he could assume a less active role—such as chairman of the board—it would have been an area he'd consider," says Michael A. Mulholland, vp and chief financial officer.

Mr. Smith explains, "Mr. DeRosa has been a dynamic president for a number of years, but the company has reached the point where the job is bigger than one person. The company will go on to do an excellent job (after he retires)."

Mr. Marioni agrees. He explains that 10 or 15 years ago, the company might have suffered significantly if someone in Mr. DeRosa's position retired. "But today, we're a billion-dollar business and Mr. DeRosa is just one person."

Industry insiders say that any change in direction that Mission may experience because of its new leader will depend on who the successor turns out to be.

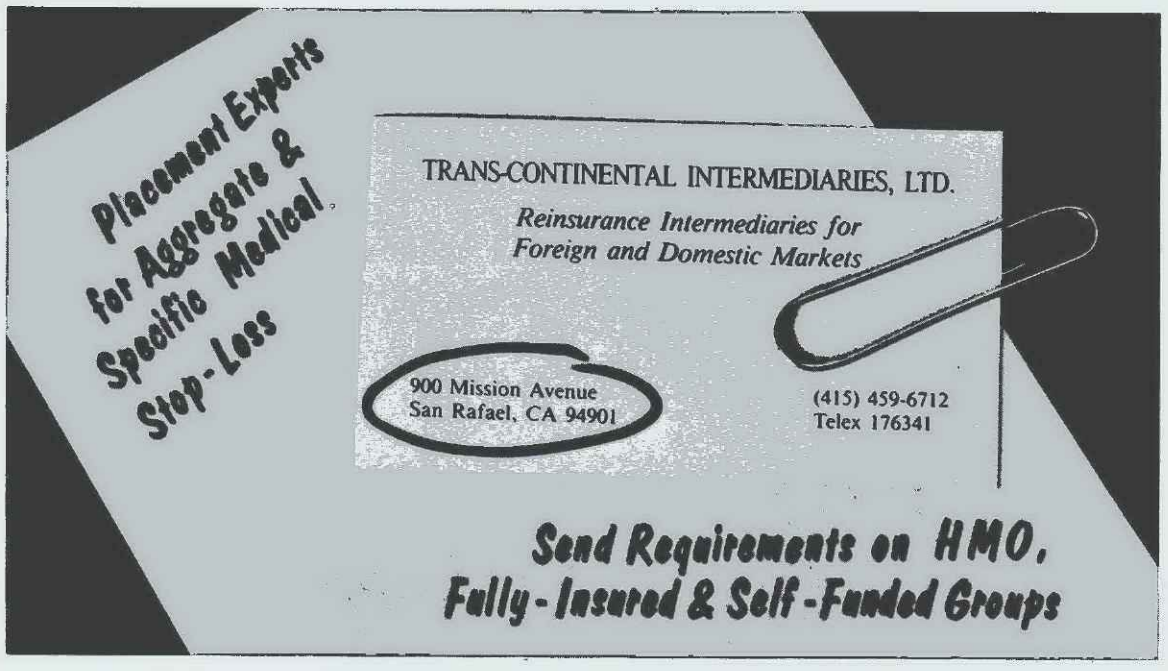
"It's very hard to make any quantifiable statement, since we don't know who will take over. Every CEO tends to give a company a personality and thrust," observes Ms. Zief.

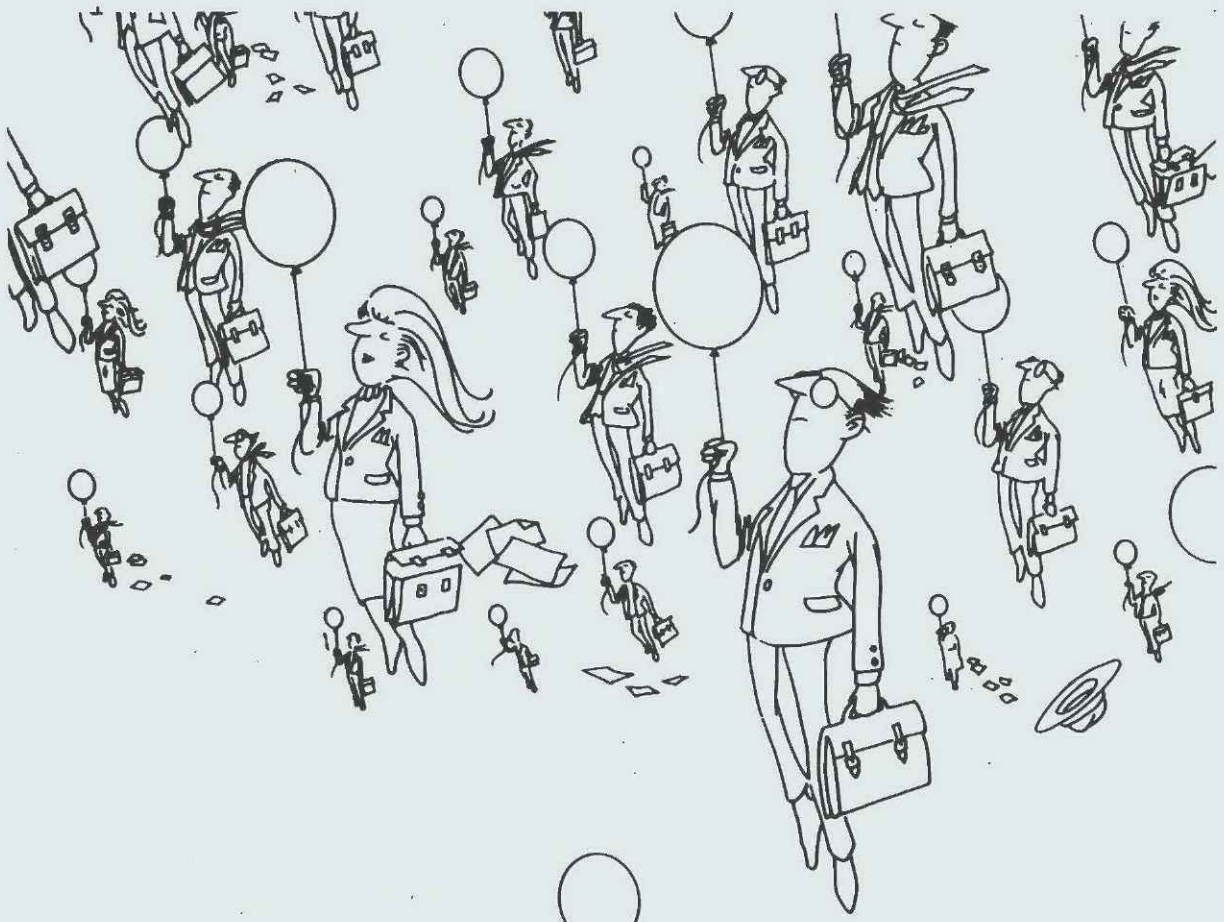
"Dick DeRosa is a very strong chief executive. He called many of the shots there," notes Mr. Jacobs. "Whenever a figure as influential as he leaves a company, it's reasonable to expect changes." But he says the changes are difficult to predict until the successor is named.

"I can't see any major changes happening (after Mr. DeRosa leaves)," Mr. Marioni says, because Mr. DeRosa's activities in recent years have been somewhat removed from the day-to-day operations of the company. He has focused his energies chiefly on investments, working with securities analysts, and in the public relations arena, he explains.

"To change our style at this point would be idiotic. We have a very strong management group."

"The company will be constantly seeking new avenues of profitability, but I don't expect its direction to change at all," resounds Mr. Smith. ■





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New regulator focuses on solvency issues

By RHONDA L. RUNDLE

SACRAMENTO, Calif.—State insurance regulators are charged with the difficult assignment of preventing insurer insolvency.

And, the task is becoming even more difficult as insurance companies use more sophisticated financial techniques and tools to conduct their businesses.

But, after only seven months on the job, California Insurance Commissioner Bruce Bunner is earning respect within the state and among his regulatory peers for his handling of financial stability issues.

In his short tenure, Mr. Bunner has adopted new regulations concerning insurance company financial reporting that the National Assn. of Insurance Commissioners has batted about for years. And he is clamping down on credits for insurers that place reinsurance with non-admitted underwriters.

Mr. Bunner's actions relate to a concept called "regulatory drift," to which he often refers.

Mr. Bunner

If regulators are remiss as enforcers and fail to exercise leadership, their problems just grow thornier, he believes. Even though industry dislikes regulators who impede change, it welcomes strong regulatory leadership, he adds.

Mr. Bunner is not a boastful man, but after some pressing he admits that California is moving ahead of the NAIC on the financial disclosure issue.

"It's one of those things that's been discussed for years," he notes. "We know what the issues are—for and against. I just didn't see the point of discussing it any further. Somebody had to make a decision."

The decision Mr. Bunner made was to require insurance companies doing business in California to disclose the market value of their bond portfolios.

Regulators have long worried that the cash value of insurance company investments may be materially less than their stated value on the balance sheet. In the event of insolvency, claims and other obligations might exceed overvalued assets.

Although the bull market of the past year has restored substantial value to insurers' investment portfolios, the valuation problem persists.

But, beginning with the filing of 1983 annual statements, due on March 1, insurers in California must disclose both the aggregate stated value and the market value of their bond portfolios, the difference between the two values and an explanation of how the market value was derived.

California thus becomes the first state to impose this requirement, which has been the subject of regulatory discussion for years (*BI*, June 27).

To Mr. Bunner, the issue is clearly one of good, sensible accounting and disclosure. His perspective is that of a public accountant with more than 25 years of professional experience, much of it spent working with the insurance industry.

Before being appointed to the insurance commissioner's post by Gov. George Deukmejian in March, Mr. Bunner was a partner in the Los Angeles offices of Peat, Marwick, Mitchell & Co., the international accounting and consulting firm. He succeeded former Commissioner Robert C. Quinn, who has since formed an independent consulting company in Sacramento.

"I don't think the insurance industry should be in the dark ages on the disclosure issue," says Mr. Bunner. Publicly owned companies are already required to make market-value disclosure to the Securities and Exchange Commission, he points out.

Since insurers occupy a position of fiduciary trust for their policyholders, Mr. Bunner believes they should be at least equal to, if not in front of, the rest of the financial world with respect to disclosure of assets.

"I feel very strongly during my tenure that financial strength and stability are paramount issues and I intend to get there," he stresses. "I have the support of the consumer and the industry. . .because I think that down deep that is what everybody really wants."

Mr. Bunner says his recent order that requires California insurers that purchase reinsurance from non-admitted underwriters to supply letters of credit is motivated by the same concern.

In the event of a major loss, a letter of credit, naming the ceding company as beneficiary, assures the prompt payment of funds to that insurer. This security, in turn, strengthens the insurer's ability to pay an avalanche of claims that might follow in the wake of a devastating storm or earthquake.

Mr. Bunner is also scrutinizing other aspects of the reinsurance business.

"I don't want to interfere in the insurer-reinsurer relationship," he emphasizes. However, he says he feels strongly that some reinsurance transactions—and the financial reporting that accompanies them—violate the spirit, if not the substance, of the statutory accounting framework.

"When you get down to the economic essence of some of these transactions, you find back-end arrangements and millions of dollars in losses that just fell through the crack," he complains.

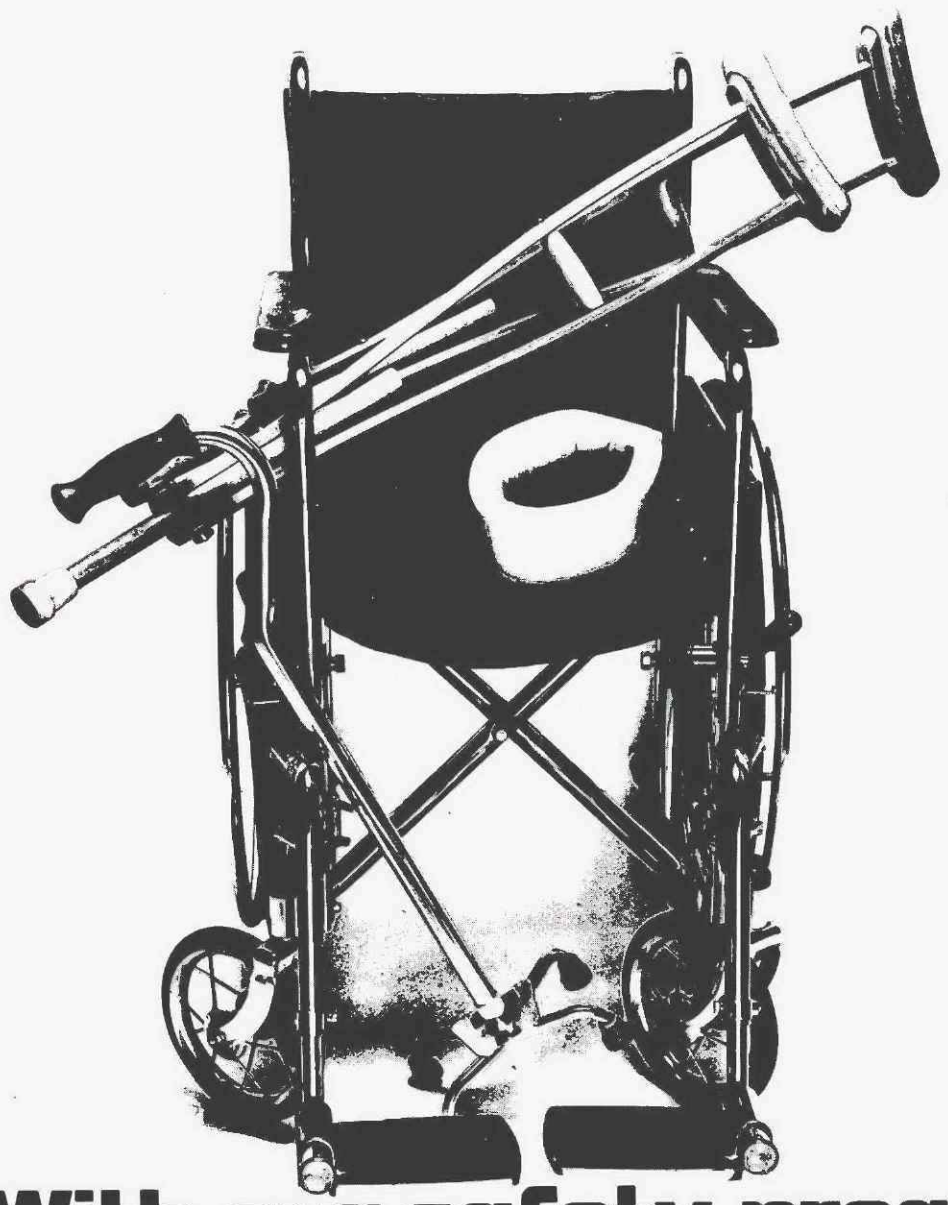
Although he does not believe there is a "superabundance" of examples, he notes that the Insurance Department knows of cases in which insurance companies have sold off loss reserves, but the assuming company has reported that it picked up a different amount.

These loss-portfolio transactions raise many questions, says Mr. Bunner. Is there a genuine transfer of risk? What assumptions are used in discounting the present value of unpaid claims? And how does the use of contracts that discount reserves square with the industry's opposition to the same practice for federal taxation purposes?

Each transaction needs to be looked at to see if it passes certain tests for risk transfer and proper reporting, notes Mr. Bunner.

Disclosure is also at issue in the California workers compensation arena where employers feel they have been misled by brokers and insurers over the size of the dividend check they receive at the end of a policy term.

Continued on page 24



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New regulator acts quickly

Continued from page 22

Everybody favors disclosure in principle, notes Mr. Bunner, but there is disagreement about how to go about it.

Dividends are especially important to California employers because they can be a substantial percentage of the policy premium. Last year, for example, the average dividend was about 24% of the premium. Since the state's minimum rate law establishes a price floor for insurers, competition focuses on the size of the dividend returned.

Employers complain that insurers promise huge dividends to win their business, then fail to deliver them at the end of the policy term. Although it is illegal to promise dividends—intended to reward good loss experience and insurer efficiency—the distinction between a "promise" and an "indication" is a fine line indeed.

The California Insurance Department has asked insurer and brokerage representatives to meet and discuss the drafting of uniform disclosure documents for dividend presentations. These documents would be used by the agent or broker at the point of sale and by the insurer to accompany a dividend check to explain how the amount was calculated.

So far, the committee has agreed on the format for the dividend payment document. And all committee members agree that dividend penalties for policyholders that fail to renew coverage with an insurer should be prohibited.

These proposals will be incorporated into regulations governing dividend payments before the end of the year, Mr. Bunner says.

However, there is fundamental disagreement among segments of the industry over the point-of-sale document. Most insurers believe that the document should permit insurers to indicate prospectively what they expect the future dividend to be. Others argue that the document should follow existing law, which permits an indication based on historical experience only.

Mr. Bunner has not taken a position, but he is clearly leaning toward preservation of the historical approach to dividend quotations. He believes that tinkering too much with the dividend rules jeopardizes the minimum rate law. And he says the minimum rate law has brought about a workers compensation system "that has worked better than any state in the union."

He says he will reconvene the dividend disclosure committee soon to resolve the point-of-sale issue.

Another critical issue in California is the ability of insurers and reinsurers to pay claims in the aftermath of a severe earthquake. The first step to measure the total liability of the industry based on outstanding policies was taken several years ago.

The report, initiated in 1979 and completed two years later, found that the industrywide probable maximum insured loss for a severe earthquake would be $1.2 billion in the Los Angeles/Orange County areas and about $844 million in the San Francisco Bay area.

"Based on a gut feeling from the first report, it looks like capacity is adequate with respect to the exposure of the industry," he notes.

However, the report did not include losses from fire and casualty claims following an earthquake, nor from workers compensation, boiler and machinery and other types of policies that might be also triggered in the event of a major catastrophe.

Some observers criticize the report as meaningless because it fails to include the earthquake coverages provided by blanket insurance programs written out-of-state.

Laying aside the issue of whether insurers could meet their current exposures, Mr. Bunner believes that California still has not attacked the real problem. Insurers need to establish a mechanism that will provide for an accumulation of contingency reserves, he argues.

"We're wasting time. We really need to be getting a solution," he urges.

Premiums collected for earthquake insurance today are not "stored away" but are dissipated through taxation, dividend payments to stockholders and other purposes, he points out.

Mr. Bunner says setting up an industry pool is a possible solution to the problem, but he says he wants insurers to come up with their own solution. And, he doesn't want to see federal encroachment in the problem. ■

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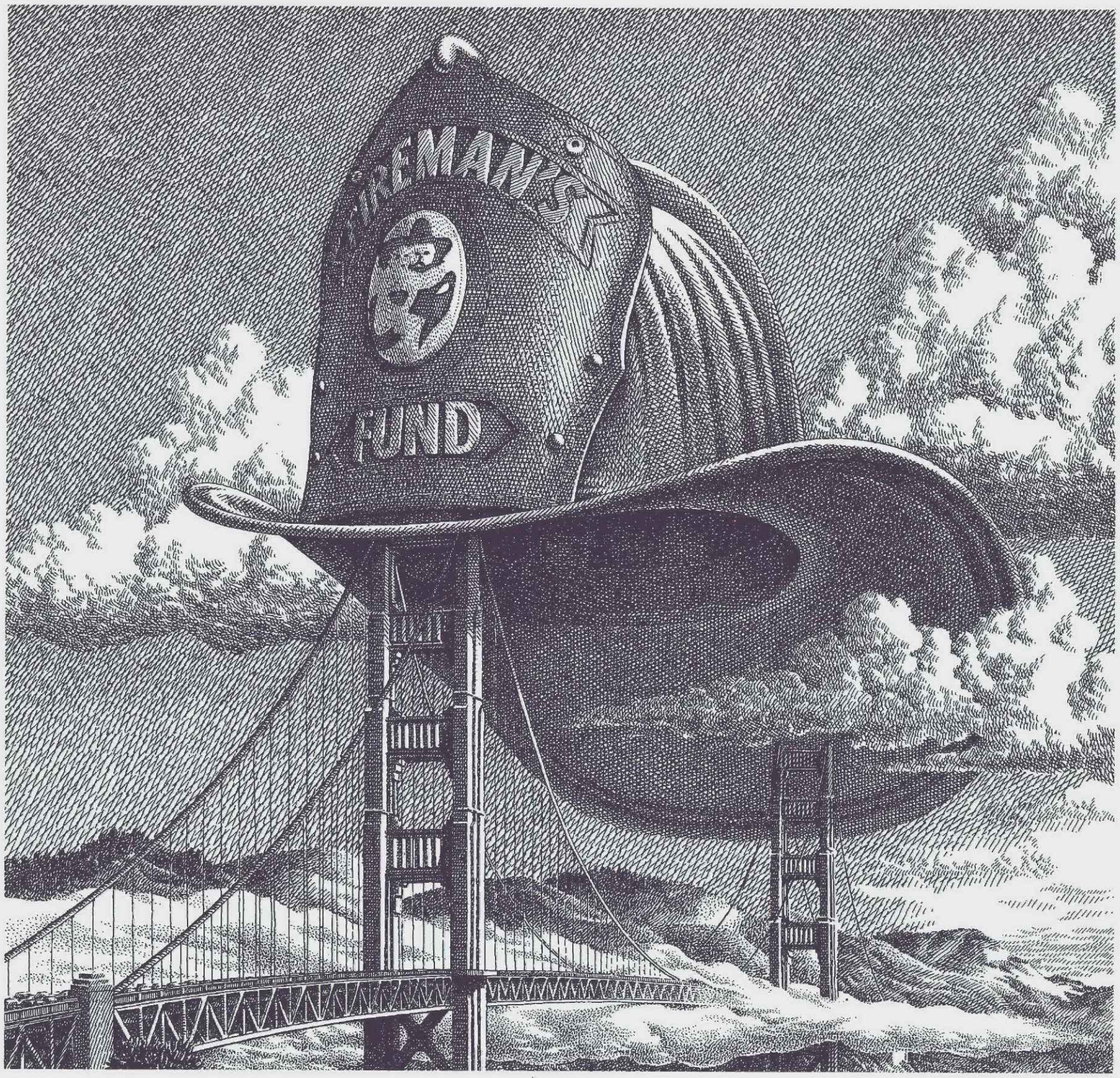

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FIREMAN'S FUND

Insuring the future.

State's brokers must innovate to compete

By STEVE SHERWOOD

PALO ALTO, Calif.—In many ways, California's Silicon Valley is to technology what California itself is to insurance brokerage: a fast-paced center of innovation and competition.

"All you can be certain of here is change," says David Svendsen, senior vp of Rollins Burdick Hunter Co.'s Palo Alto office. "Clients are always looking for creativity, flexibility and good pricing. You have to give them those three ingredients."

Mr. Svendsen refers specifically to the insurance needs of his company's Silicon Valley clients, which generate about $20 million in premium a year and include two of the three largest silicon chip manufacturers in the United States.

But his words could as easily apply to California's insurance brokerage marketplace as a whole. Brokers say it is full of sophisticated buyers with ever-changing needs, who know what they want and are willing to shop for it.

Top five California brokers

Broker	Estimated gross revenues	Number employees
Marsh & McLennan Cos. Inc.	$50 million	850
Johnson & Higgins	$45 million	700
Fred S. James & Co. Inc.	$40 million*	550
Frank B. Hall & Co. Inc.	$34 million	580
Alexander & Alexander Services Inc.	$32 million	470

* Includes gross revenues of Dinner Levison Co., acquired recently by Fred S. James.

And, they apparently pick their brokers a little differently from the rest of the nation. While the top brokers nationwide are the key players in California too, the top five are ranked differently on the West Coast.

Based on *Business Insurance* estimates, Marsh & McLennan Cos. Inc. clearly holds the No. 1 spot in California, as it does nationwide, with an estimated $50 million in gross revenues statewide in 1982.

Following Marsh & McLennan are Johnson & Higgins, Fred S. James & Co. Inc., Frank B. Hall & Co. Inc. and Alexander & Alexander Services Inc., with estimated gross revenues ranging from $45 million to $32 million (see chart).

However, nationwide the rank would be M&M, A&A, Hall, J&H and James.

James, which would not rank as one of the five-largest in California brokers based on its 1982 gross revenues statewide, has secured the No. 3 spot due to its recent acquisition of San Francisco-based Dinner Levison Co.

Ranked behind the top five, but also key figures in the California insurance market are Corroon & Black Corp. with $31 million in statewide gross revenues in 1982; Bayly, Martin & Fay International Inc., $25.4 million; Emett & Chandler Cos. Inc., $16.5 million; Jardine Insurance Brokers Inc., $14.8 million; and Rollins Burdick Hunter, $14 million.

Regardless of their ranking, the brokers all compete hard for their business, noting that they find competition the keenest in Southern California.

"Insurers have traditionally found California to be profitable, so there has always been a battle for the market," says John Kabaker, vp and national director of marketing for San Francisco-based Jardine. "California is a large market but not staid or traditional."

"Business here is open to competitive bidding," agrees John Peretti, head of M&M's Los Angeles operations, which specialize particularly in coverage for the petrochemical, aviation and aerospace industries. It also is becoming more active with mid-sized clients in a wide variety of industries.

Client loyalty runs strong in Northern California, while competition runs rampant in the southern part of the state, the brokers say.

"Bloodlines run deeper in the Bay Area and clients don't shift around as much there," notes one broker at an alphabet house in Los Angeles. In contrast, in his home city where droves of new businesses with no long-term insurance relationship start up every year, competition is "murderous," he says.

The Los Angeles area is a fast-money environment where people have a different view of the world, says Jardine's Mr. Kabaker, who has worked in both Southern and Northern California.

"The ability to break down the barrier of client trust and loyalty in Northern California is difficult for a salesman to do. But in Southern California, you're almost guaranteed to have three or four bidders on a contract," he says.

He adds, however, that Northern California is becoming more like the Los Angeles area every day.

"You can get business easier and lose it easier in Southern California than you can in places like Boston and New York," notes Joseph Nally, Los Angeles profit center manager for Frank B. Hall, which employs about 580 people in California.

To survive in Southern California, a broker needs to have a strong service department and strong technical ability, Mr. Nally says. "Those two things have to team up for a broker to be good for the long pull. Sophisticated clients expect it."

Others agree with his summation that California is a market of sophisticated buyers who know what they want and expect their brokers and insurers to be innovative enough to provide it.

"California tends to be a more active market than anywhere else, receptive to change and willing to try something new," says Samuel Alcorn, senior vp-operations for Bayly, Martin & Fay International Inc., based in Newport Beach.

Continued on page 34

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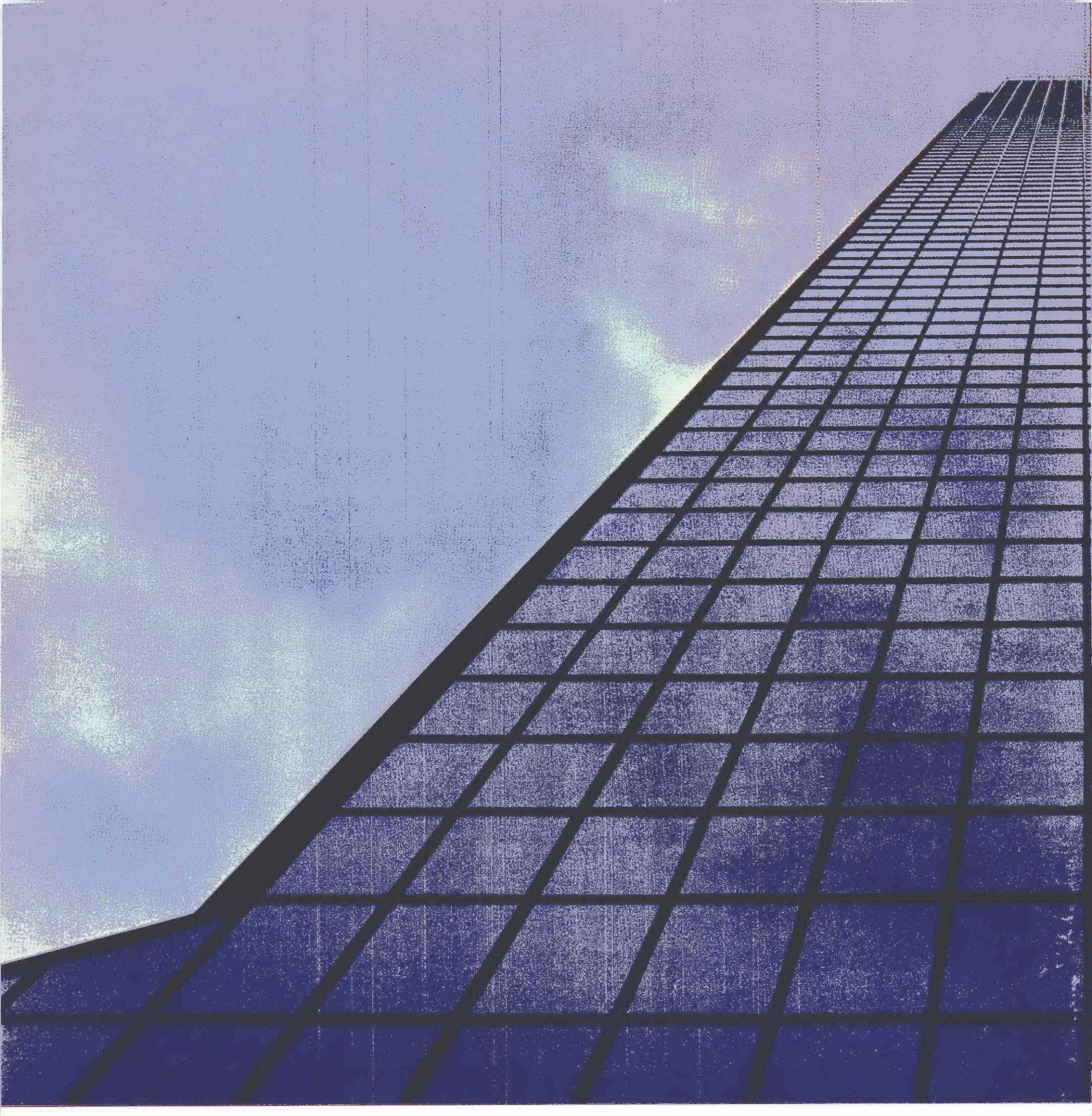

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perspective

Can industry afford to let older, skilled employees go?

books & ideas

By Horace C. Mayo

"Adjusting to an Older Work Force"
By Lois F. Copperman and Frederick D. Keast
Van Nostrand Reinhold Co. Inc.
135 W. 50th St., New York, N.Y. 10020
192 pages; $22.50

EMPLOYERS IN THE forefront of reappraising personnel policies affecting retirement, including those contemplating the employment of retirement-age workers, will find this book most stimulating.

Older workers worrying that they might someday be pushed into retirement will find an encouraging message from authors Copperman and Keast: Hold on.

'While planning on early retirement, most individuals expected to have inadequate income, with many favoring part-time work or flexible work hours. Older workers most interested in such work options are likely to be the same workers employers would prefer to keep on the job.'

This also could be the motto of the manager of older workers, too. Even though older workers may wish to work reduced hours or demand more flexible work schedules, they are valuable employees on any timetable. When the future shortage of skilled workers is upon the market, a manager will be happy to accommodate those skilled, mature employees.

"Both government and businesses are capable of influencing workers within their spheres. . .to alter retirement behavior. What's more, the results of policy changes in each setting can be materially affected by policies in the other." This is the objective the book puts before governmental and private sectors.

Exploring these issues, the authors work from the premise that retaining older employees in the labor force is in the interest of management and corporations—if not now, then in the near future.

They begin with a broad overview of shifts in the country's population that are expected to affect the labor force over the next 20 years. Specific emphasis is placed on the roles of older workers now and in the future.

There follows a detailed treatment of personnel practices and remunerative issues that can be used to alter existing retirement patterns. Finally, the book concludes with a general discussion of the issues involved in older workers' employment and recommendations.

In the 1980s, the authors assert that the demographic trends that underlie labor statistics will force many employers to review past personnel practices. Because of labor shortages in the next two decades, employers will be obliged to search for new sources of labor supply.

The prime source for a supplementary labor force, as pointed out, will be older workers. However, there are at least two obstacles to be faced in rehiring or permitting workers to stay beyond retirement age:

- Retirement plans generally do not permit a worker to receive both a pension and regular wages. Thus, a person wanting to retire but wishing to work either part-time or full-time must seek new employment.
- There are limits to the earnings of anyone who receives Social Security benefits. In 1983, for example, a person 65 or older may only earn $6,600 without losing benefits, while a worker under age 65 is limited to $5,000 a year.

A study reported by the authors found that while planning on early retirement, most individuals expected to have inadequate income, with many favoring part-time work or flexible work hours. This same study found that older workers most interested in such work options are likely to be the same workers employers would prefer to keep on the job.

Ms. Copperman and Mr. Keast admit that there are myths concerning the older worker, and these may be among the primary barriers influencing employers' policies toward this category of worker. They point out, however, that recent research has found that problem-solving, number facility and verbal comprehension were unaffected by age and concluded that managers should reassess training programs that limit opportunities for older workers.

To the extent that older workers are arbitrarily eliminated from such programs, an employer is missing opportunities to utilize their skills. One of the conclusions in the chapter titled Personnel Policies is that few employers currently understand the need or even the existence of a need of many older employees to work full-time on a flexible schedule or on a part-time basis, rather than change the actual nature of their employment.

The book is easy reading with excellent summaries at the end of its six chapters. In addition to Personnel Policies, the chapter titles are: Background Issues; Markets for Older Labor: the Next Twenty Years; Compensation: Examining Remuneration; Models for Change: Innovative Employer Policies; and Discussion and Policy Implications.

The authors find increasing reasons to question whether this nation can afford to either lose the skills of older workers or support them in comfortable, and longer, retirement.

They claim there are indications that current patterns of labor market behavior will lead to labor shortages during the next 20 years. One indication is that the trend toward early retirement that has accelerated during the past two decades.

The authors indicate that unless employers and the government change personnel policies, continued work may not be an economically viable alternative for most American workers eligible for retirement. Older workers could well be one of the few groups in the nation's population required to lose income in order to work.

As noted, one chapter is devoted to identifying common characteristics of retirement programs. It also presents a number of examples of what can be done as well as what has been done to adapt employer policies to correct the penalties assessed against those who work beyond retirement.

The reader should be aware that the authors do not address the high unemployment that has existed during the current recession. Nor did they mention the numerous employers that have offered "golden-handshake" plans that provide incentives such as severance pay, elimination of early retirement pension penalties and other benefits to accept early retirement.

Such plans have been offered to employees by Polaroid Corp., Eastman Kodak Co. and several insurance companies, one of which was Travelers Corp. (*BI*, Sept. 19), which are seeking to reduce their workforces rather than to lay off employees.

The reader may also want to contemplate on whether the authors intentionally omitted a definition of the term older worker.

Does the term apply to those over age 55 or does it mean only employees over age 65? The government study committee proposing methods to bail out the Social Security system from its financial dilemma suggests that unreduced benefits will not be payable until a worker attains age 68. If this is adopted, will the phrase older worker be applied only to those age employees 68 and over?

As pointed out on the dust jacket, "For business executives, human resource planners, government administrators, legislators, educators and all those concerned with the 'graying' of America's labor forces, this book will prove provocative and useful." Readers of this book will conclude this is a valid statement. ■

Horace C. Mayo, a recent retiree, was benefits manager at The Kendall Co. in Boston. He is active in benefits issues and resides in Wellesley Hills, Mass.

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

Resolving multiparty suits in 'good faith'

Continued from previous page

They should next determine what claims are actually barred by a particular jurisdiction's contribution statute to be sure that a settlement would close the file on the defendant.

For example, claims for indemnity based on a written indemnity contract or claims arising from a special relationship between the defendants, such as manufacturer-distributor or a principal-agent, may not be barred in some instances.

Even if the law in the jurisdiction is not certain, as a practical matter, some security can be obtained from an order of dismissal against all co-defendants.

By this device, the defendants can only upset the finality of settlement by prosecuting a successful appeal.

Even if they prevail, there could still be a second attempt at a good-faith settlement or relitigation of the liability issues at a later date against an opponent who does not share the plaintiff's enthusiasm or have the same emotional appeal to the jury.

Finally, to protect against an adverse result on appeal, assuming the defendant has adequate leverage, the settlement with the plaintiff can be conditioned upon a final judgment, like a successful result on appeal. One possibility in this regard is to place settlement funds in an escrow account pending the final outcome.

In sum, good-faith settlements provide a vehicle for early file closings in jurisdictions that allow them. Nonetheless, there are dangers inherent in the good-faith process. The vital element is the skill and judgment of claims personnel and their counsel who apply these skills to ensure that the risks taken are reasonable.

Some suggested guidelines for applying this judgment are as follows:

- Check the contribution statute, if any, that has been adopted in your jurisdiction.
- Examine the types of claims that decisional law has interpreted will be barred by the good-faith settlement.
- Condition the settlement, if possible, with the plaintiff on a good-faith finding and an order dismissing non-settling defendants' actions.
- Evaluate the chances of obtaining a dismissal of all claims in the trial court.
- Determine costs of procedures necessary to obtain dismissal of all claims (i.e., summary judgment, minitrial).
- Determine the cost and chances of prevailing if good-faith dismissal is appealed. Bargain for payment conditional upon a *final* judgment.

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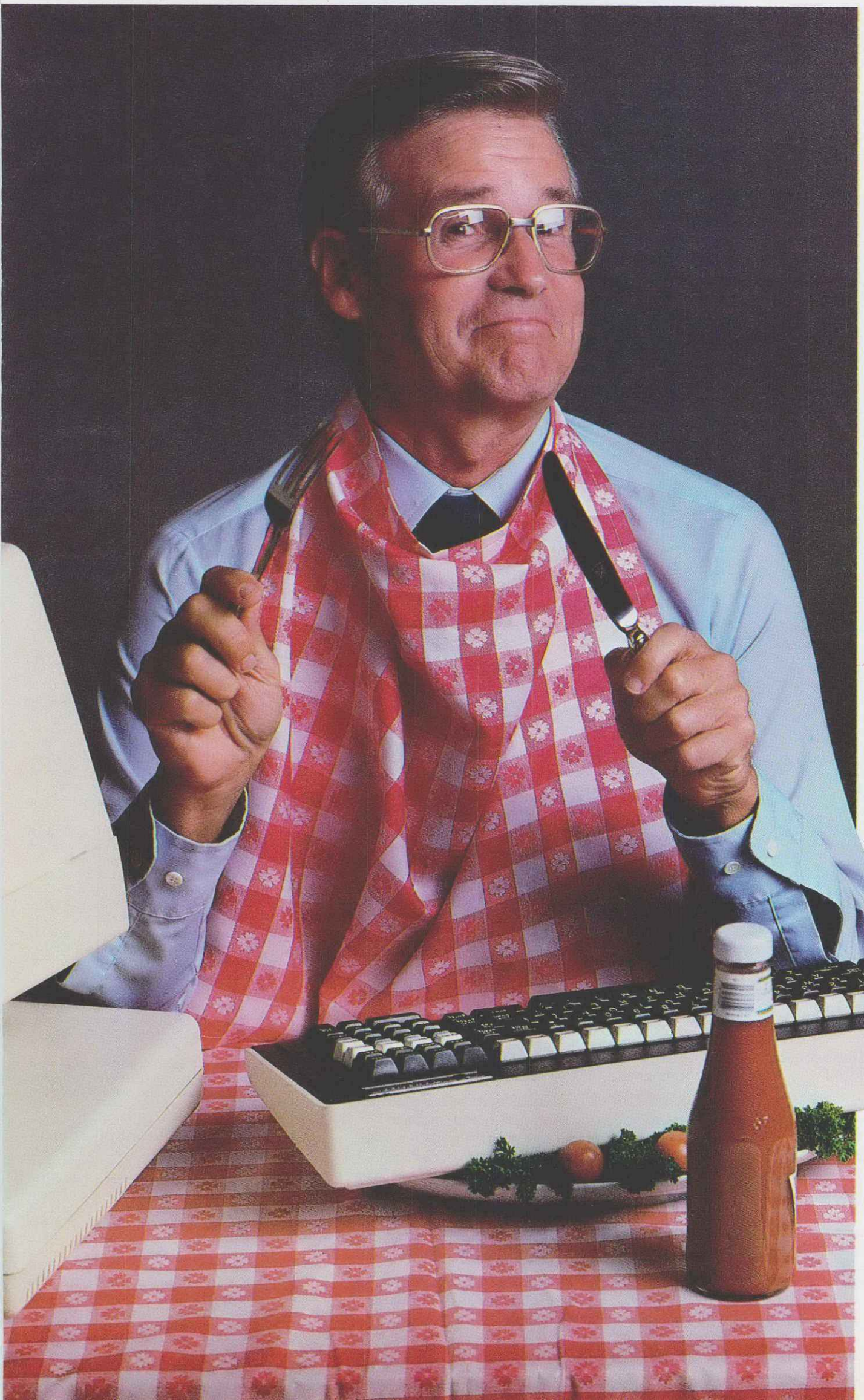

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Acquisitions abound for California brokers

Continued from page 26

This holds true in the Silicon Valley for Rollins Burdick Hunter. Its 80-person office there is successfully marketing a property policy that covers both foreign and domestic risks under one contract, says Executive Vp Ron Massa. The policy is aimed primarily at mid-sized, high-tech firms.

"California tends to be a leader in product design," says Leonard Lawrence, chairman of Emett & Chandler International of Los Angeles.

"California always makes Eastern-based insurers pull their hair out since it contaminates classic insurance thinking," Mr. Leonard adds.

The tremendous diversity of risk in California tends to generate more need for innovative products. California corporations are involved in agriculture, aeronautics, maritime business, oil and energy, to name just a few of the state's industries.

California also has a file-and-use system for rates, which allows insurers to set non-discriminatory rates and write manuscript policies without prior approval of the state insurance commissioner, expect for workers compensation coverage. This system also facilitates innovations.

California, however, could be losing its long-standing tradition of regional insurance brokerage as national brokers acquire California-based brokers and other California-based brokers seek a national marketplace.

> 'Insurers have traditionally found California to be profitable, so there has always been a battle for the market. California is a large market, but not staid or traditional,' says Jardine Insurance Brokers Inc.'s John Kabaker.

The most recent acquisition was just earlier this month when Dinner Levison was acquired by Fred S. James. The transaction added $12.5 million in gross revenues to James' operations, nearly doubling the brokerage's Bay Area operation and giving it estimated statewide revenues of $40 million, James officials say.

Including Dinner Levison's employees, James now employs about 550 people in California. Its clients include financial institutions, heavy construction contractors, manufacturers, transport companies and professional associations.

The Dinner Levison merger, says one James official, "brings to us some of the most prestigious accounts in the Bay Area."

During 1982, A&A merged with San Francisco-based Clifton & Co., which brought added revenues of about $10 million into A&A.

"The merger enabled us (Clifton) to bring extended services to clients, including risk management techniques and international capabilities," says Ed Flinn, A&A's regional director in San Francisco and former chief executive officer of Clifton.

Such mergers also give the national brokers expanded presence in the area and a ready-made client roster.

"There is a tendency for regional brokers that book national or international business and whose size hampers them to hook up with national brokers," says Craig Clements, managing vp of A&A's Los Angeles office.

"It is our tendency to acquire any broker we feel can benefit from the acquisition and can benefit us," he explains.

A&A has about 560 employees in California with clients in all lines. Its estimated 1982 statewide gross revenue was $36 million.

With its 1982 acquisition of Rowan-Wilson Inc. of Pasadena, Corroon & Black became a leader in animal mortality insurance for West Coast thoroughbred owners, says John Lamberson, director of C&B's Pacific Northwest region in San Francisco. The acquisition brought a "substantial premium base" to the broker, which employs about 475 people in California and is particularly strong in construction-related coverages.

C&B's 1982 statewide revenues were about $31 million, including $23 million on the retail side and $8 million generated by underwriting manager Baccala & Shoop Insurance Services in Newport Beach, officials say.

In January 1982, Hong Kong-based Jardine Matheson & Co. Ltd. acquired Bache Insurance Services (formerly Albert M. Bender Co. of San Francisco) for its Jardine Insurance Brokers unit. And, in June 1981, Penn General Agencies Inc. in Los Angeles was acquired by Republic Hogg Robinson Inc., a joint venture of Republic Steel Corp. of Cleveland and Lloyd's broker Hogg Robinson P.L.C.

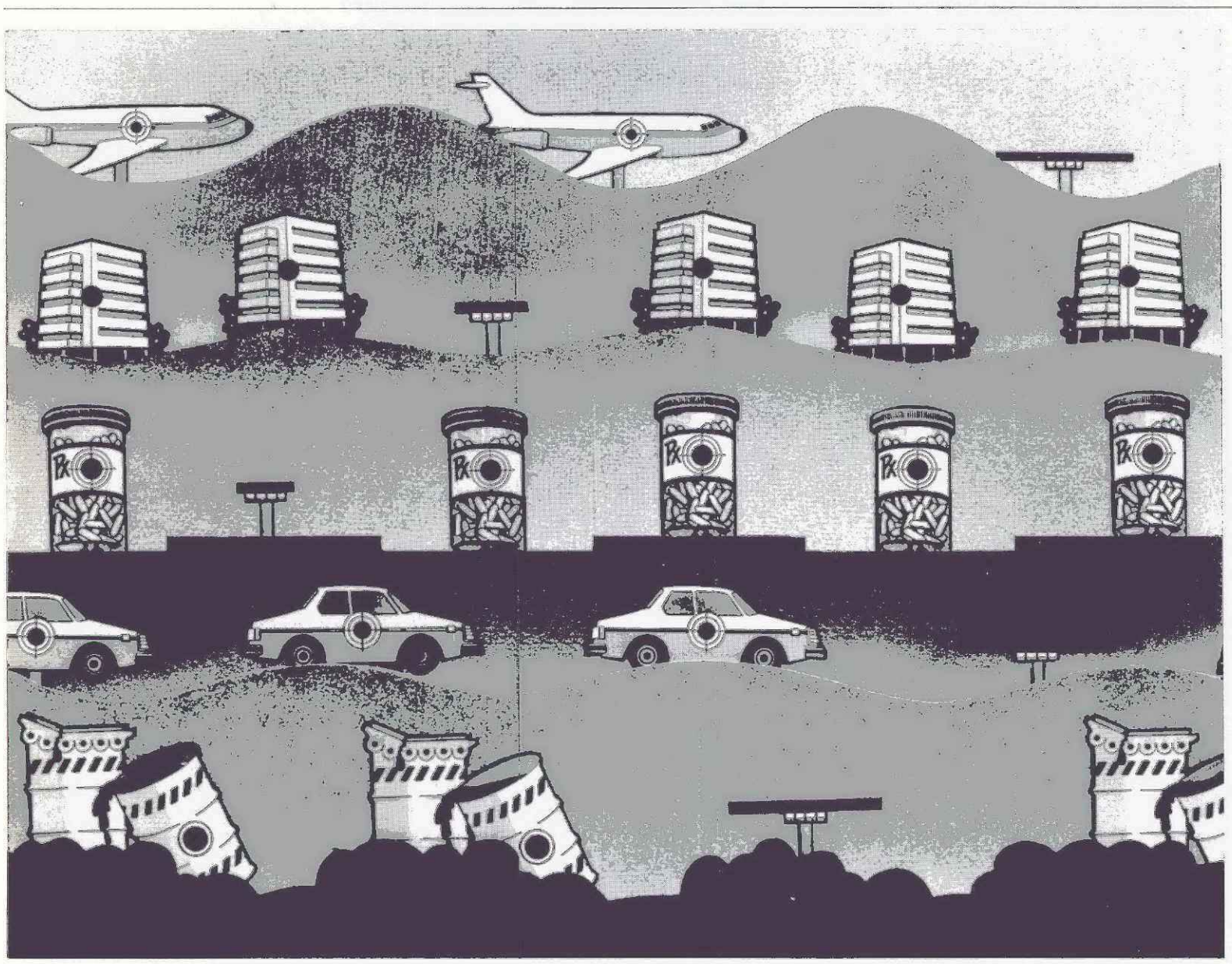
"A lot of it is survival," Ray Prince, vp and general manager of the San Francisco office of Kindler & Laucci Insurance Brokers, says of the mergers. "I think much of the market's thrust here in Northern California will be toward continued consolidation of regional and national brokers, since together they can reduce expenses, and operate a litle leaner."

Kindler & Laucci, which has 120 employees and estimated statewide revenues for 1982 of $8 million, was itself acquired by E.H. Crump in 1981.

The state's second-largest and perhaps its oldest broker, Johnson & Higgins, has not been involved in mergers.

"We're not really an acquisition firm," says Dickinson Ross, director and chairman of Johnson & Higgins California Corp. "We work on the theory of internal growth, adding a certain amount of new business every year. We didn't need to make acquisitions to grow in this state because we were here early and grew with it."

The brokerage started a San Francisco office in 1883 with three employees and now employs some 700 throughout California. In 1982, it generated an estimated $45 million in gross revenues in California. ■



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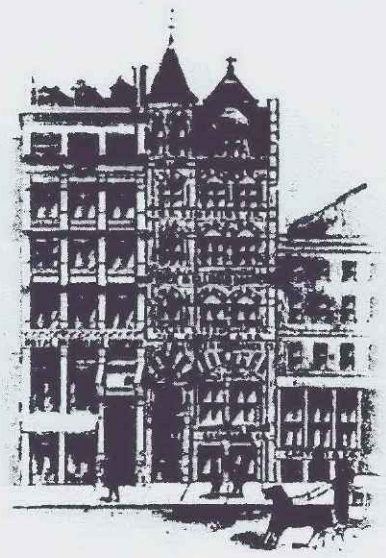

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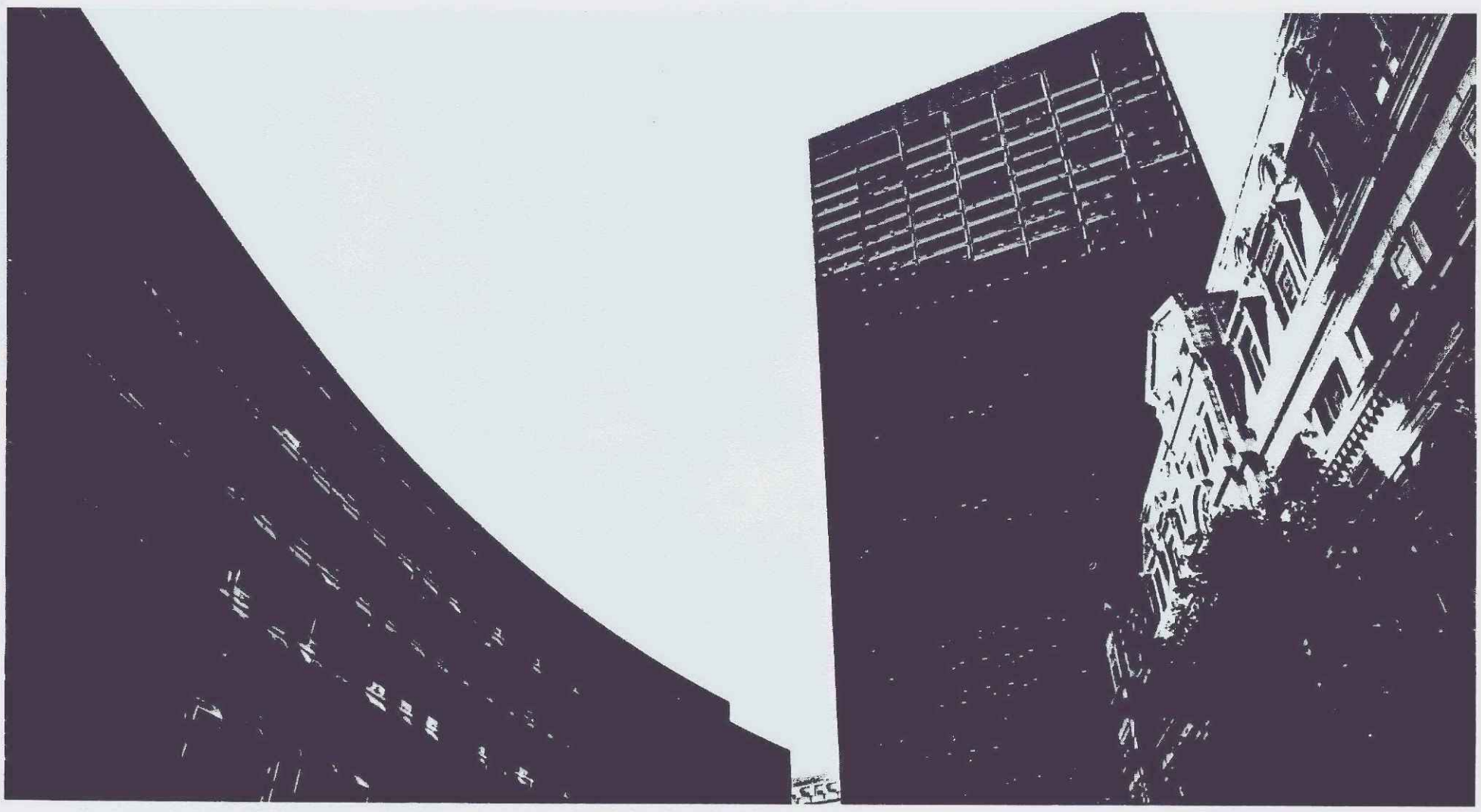

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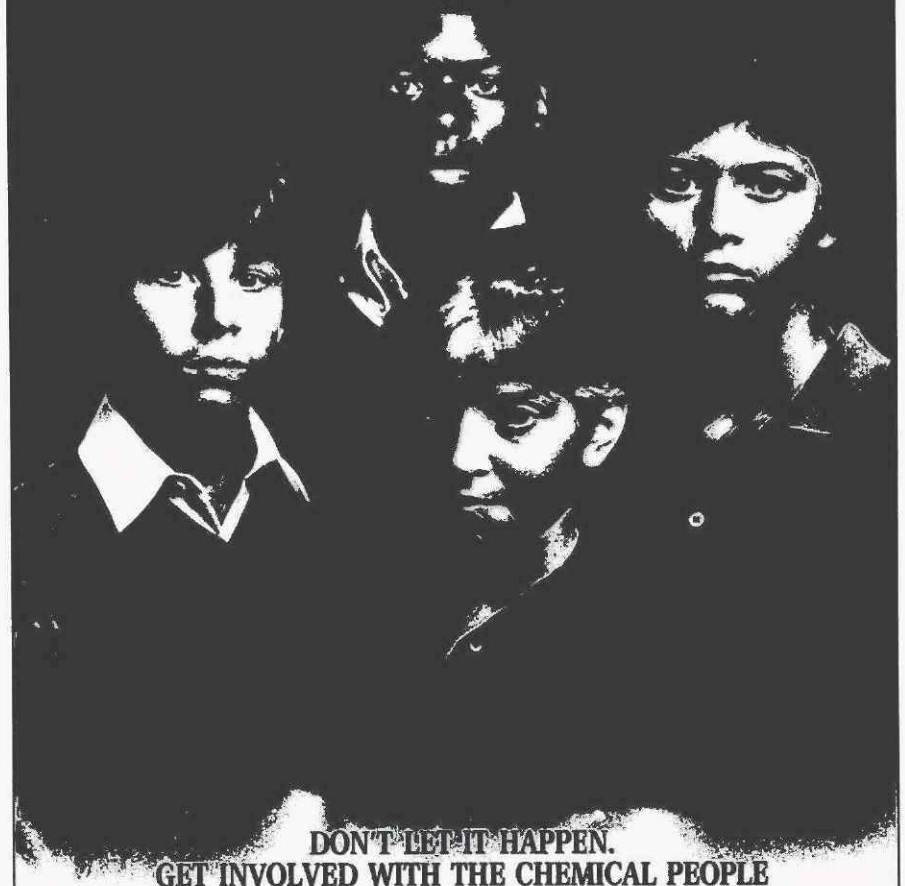

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Employers ambivalent about big PPO push

By MARGARET LeROUX

A host of preferred provider organizations say they're ready and waiting to cut health care costs for California companies, but employers are still largely taking a wait-and-see attitude.

More than 150 PPOs are being marketed by hospitals, physicians and other health care providers; third-party administrators; insurance companies; and even employers themselves (see stories, pages 38 and 42).

"Wherever two hospital administrators, two doctors or two health insurance executives have lunch, there's the beginning of a PPO," quipped Jerry T. Payne, vp-marketing for Preferred Health Network, a PPO owned and operated by physicians and hospitals in Southern California.

Although they come with different names, different owners and different marketing pitches, all of the PPOs are offering basically the same thing: the chance for employers to save on their health care costs by contracting with a group of health care providers to provide services for a reduced fee.

Almost all of the California PPOs also boast elaborate utilization review procedures, to ensure that employees are in the hospital no longer than medically necessary.

In return for the reduced rates, the providers hope to increase—or at least preserve—their share of the ever-competitive health care market (*BI*, May 30).

Although the PPOs guarantee employers health care cost savings of 10% to 25%, remarkably few employer groups have jumped on the PPO bandwagon.

For instance, a survey of 130 Southern California employers conducted this summer by the Los Angeles office of benefit consultant William M. Mercer Inc. noted that only 3.9% had contracted with a PPO.

However, more than half of the respondents said they believed PPOs are "the direction of the future" of health care.

In addition, a vast majority of the California PPOs either in operation or about to start services admit they have not yet signed a contract with an employer.

A notable exception to the employers still making their mind up about PPOs is Security Pacific Corp. of Los Angeles, the parent of California's second-largest bank, which has contracted with Med Network, a PPO run by Admar Corp., a Santa Ana third-party administrator.

Alan M. Jeffrey, Security Pacific's vp of employee benefits for the 27,000-employee company, estimates between 12% and 15% of the health care claims the bank has received since the banks joined Med Network Sept. 1 have been submitted by physicians and hospitals affiliated with the PPO.

"It's been one of the most positively received features of our benefit plan," Mr. Jeffrey said. "Normally, I don't get positive feedback, but this time I am."

Security Pacific wants to accumulate "at least nine to 12 months of experience with the PPO before attempting a statistical analysis," he notes. However, he expects that many employees could switch from health maintenance organizations to the Med Network plans when Security Pacific holds open enrollment in November.

Perhaps Security Pacific's favorable relationship with a PPO will persuade other employers to sign up, though so far few have take any action.

For instance, San Francisco-based Levi Strauss & Co., a bellwether for benefit advances, "is still studying the PPO concept," said Robert Corbett, Levi's director for employee benefits.

"We certainly see PPOs as a vehicle for attempting to contain health care costs," he added, "but we haven't signed any contracts."

At DiGiorgio Corp., a San Francisco-based conglomerate with 5,000 employees nationwide, John Wilson, manager of employee benefits, said he "still gets worried when I hear about offers of discounts such as 35% off physician and hospital services. Are they overcharging by that much?

"I just can't believe doctors and hospitals operate on that kind of margin."

Mr. Wilson also questioned who will eventually pay for the discounts large employers are negotiating with physicians and hospitals. "Are they going to be shifting the costs to smaller groups?"

Others in the benefit industry question the PPOs' effect on the cost of medical malpractice insurance.

Peter N. Grant, a San Francisco attorney representing the Hospital Council of Northern California, cited a recent $500,000 judgment against the state of California as an example of the exposures that an overzealous PPO utilization review could trigger.

The plaintiff, a Medicaid recipient, was forced to undergo a leg amputation following complication after he was released from a hospital too early as the result of a utilization review recommendation.

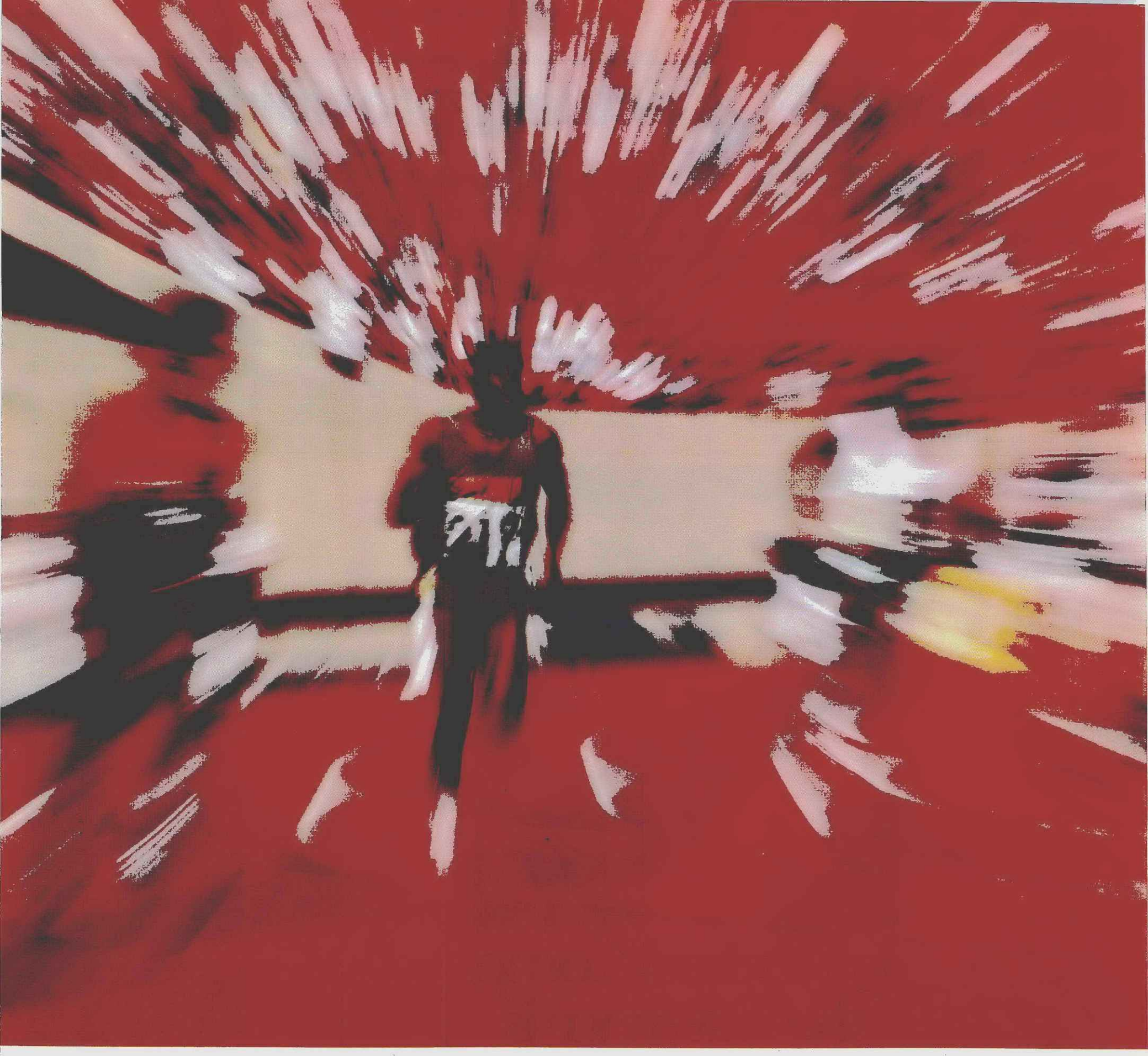
In addition, Mr. Grant says, physicians attending a meeting of the California Medical Assn. last month expressed concern that any savings from PPO or utilization review programs would be lost through an increase in malpractice awards.

But this contention is strongly disputed by Dr. Edward Zalta, chairman of the board of trustees of the Los Angeles County Medical Assn. and head of California Preferred Professionals Inc., a physician-based PPO.

"The threat of malpractice has led to the overutilization phenomena," he says. "There's far too much defensive medicine being practiced."

Mr. Grant, though, points out that the utilization review process, which supposedly will identify physicians who are undermining cost-containment efforts by ordering unnecessary treatment, doesn't necessarily guarantee they will be weeded out.

"If a physician on a preferred panel shows continuing inappropriate utilization, can you kick him off the panel?" The California Medical Assn. has proposed creation of a statewide peer-review organization to oversee all PPOs in the state, says Joan B. Trauner, a research associate with the Institute of Policy Studies at the University of California School of Medicine in San Francisco and the author of a recently published monograph on PPOs. However, she adds, this approach hasn't been endorsed by anyone outside the medical profession. ■



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Not many PPOs actually providing care

By MARGARET LeROUX

California employers thinking about joining a preferred provider organization have plenty of choices: More than 160 PPOs have registered with the state since laws authorizing PPOs took effect earlier this year.

However, fewer than 10 PPOs are now open for business, and many of these have not yet signed a contract with an employer, though spokesmen for several other plans say they expect to begin operations and start signing up employers on or shortly after the first of the year.

The PPOs are also taking a variety of different sales strategies. Some promise specific costs savings, while others plug their ability to contain costs through utilization reviews and other means.

> '(Employees) in our plan won't have to choose the (PPO) option, but their out-of-pocket expenses could be 20% to 30% higher for using non-panel services,' says Blue Cross of California's Mr. Leibson.

The current leader of the PPO pack is Med Network, a PPO operated by Admar Corp., a third-party administrator based in Santa Ana.

Med Network has approximately 60,000 member employees and dependents, according to Linda D. May, director of corporate marketing, including employees of Security Pacific Corp., the Auto Club of Southern California and the Southern California Drug Benefit Fund.

Among the health insurers offering employers the option of joining Med Network are Lincoln National Life Insurance Co., Transamerica Occidental Life Insurance Co., Washington National Insurance Co. and BEST Life Assurance Co. of California.

"We're the only PPO operating on a statewide basis at this time," Ms. May proclaims.

More than 3,000 physicians of all specialties and 10% of the hospitals in Southern California have joined Med Network so far.

With the addition on Sept. 1 of Security Pacific, the Los Angeles bank holding company with branches throughout the state, Med Network is adding physicians and hospitals in most California cities, Ms. May says.

The plan's cost-containment features include prior mandatory authorization for elective hospitalization, mandatory use of generic drugs and fee schedules that are less than 80% of reasonable and customary fees in urban areas. Employers can elect to receive monthly, bimonthly, semiannual or annual reports on claims and utilization, notes Ms. May.

"We can save an employer $4 to $5 for every $1 spent on program (fees)," she says, adding that Med Network charges employers between 1% and 2% of paid claims to join the PPO.

Competing for Med Network's share of the market is a PPO sponsored by a third-party administrator headed by a former Admar principal. Terry Worthylake left Admar earlier this year to head Benefit Panel Services in Los Angeles, which introduced its Health Plus PPO in August.

BPS is working primarily with Fireman's Fund Insurance Cos., which is marketing the program primarily to small employers.

"We're fulfilling a brokering role between insurers and providers of health care services," explains Mr. Worthylake. He adds that BPS is negotiating with six other insurance companies to offer Health Plus.

Six companies have signed up for the program since Sept. 1, according to Brenda Roberts, assistant vp of product development and director of the Health Plus program for Fireman's Fund in Novato.

"The Health Plus option is designed as a wraparound to an existing benefit plan," explained Ms. Roberts. "It reduces the employees' out-of-pocket expenses by eliminating or reducing the copayment or deductible for using physicians or hospitals on the panel."

BPS is "shooting for savings on health costs between 10% and 20%," Mr. Worthylake said.

One PPO that nearly everyone expects to capture a significant share of the California marketplace is the Prudent Buyer Plan, marketed by Blue Cross of California.

Blue Cross signed its first Prudent contract with a 100-employee stereo equipment company in San Diego on Oct. 11, and the insurer says it expects hundreds more to follow in the next few months as it mounts an aggressive marketing campaign to cover the entire state.

Currently, Blue Cross has contracted with 110 hospitals and 7,000 physicians, which have the ability to cover 72% of the state's population, says Ed Leibson, contracts manager for Blue Cross of California.

"And it's our intent to have 100% availability of the Prudent Buyer Plan in California by Jan. 1."

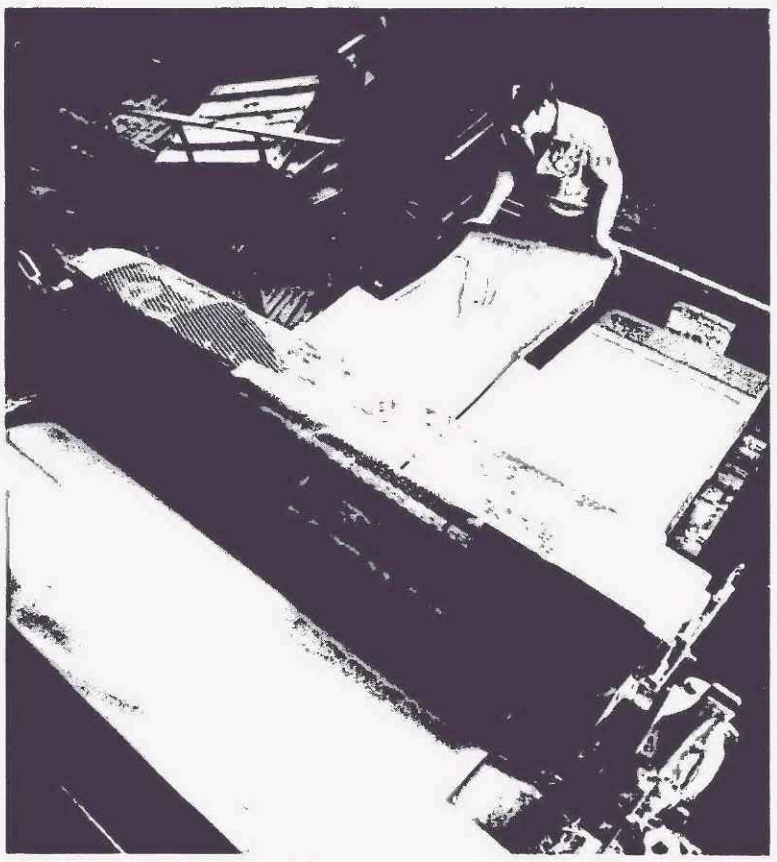
The insurer says premiums for employees using the Prudent Buyer Plan costs employers 15% less than the premium for comparable Blue Cross coverage. Employers have their choice of four different plan options, ranging from total first-dollar coverage to large deductible and coinsurance requirements, Mr. Leibson says.

"(Employees) in our plan won't have to choose the Prudent Buyer option," he added, "but their out-of-pocket expenses could be 20% to 30% higher for using non-panel services."

The key cost-saving feature is the per-diem rates Blue Cross has negotiated with hospitals for Prudent Buyer patients, he explains, adding that the program will be backed by a thorough utilization review program to be handled by four vendors in different sections of the state.

Although the California PPOs that are doing the most business thus far are sponsored by insurers or third-party administrators, plans sponsored by physicians' associations or hospitals are waiting in the wings.

Continued on page 40



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Providers behind many California PPOs

Continued from page 38

For instance, Los Angeles-based National Medical Enterprises Inc., the largest private hospital corporation in Southern California, has formed two separate PPOs.

Preferred Medical Systems, an NME subsidiary, plans to soon unveil an as-yet-unnamed PPO that will be marketed throughout the region by broker Corroon & Black Corp.

The new PPO follows the successful testing of Healthchoice, a dual-option plan formed by PMS in Modesto, and insured by Hartford Life Insurance Co. Healthchoice has already enrolled 7,800 participants, among them 2,300 local NME employees.

Since it started operating in February, Healthchoice has averaged 291 hospital days per 1,000 enrollees, compared with the national average of 700, according to Stuart Bruck, PMS' vp of health care cost containment. In addition, the average length of hospital stay for Healthchoice patients is 3.5 days, compared with 5.5 days elsewhere, he says.

"We have a comprehensive utilization review system with computerized reporting by employee, facility, plan or disease—however an employer would want it broken down," Mr. Bruck says. Preadmission, concurrent and retrospective reviews of hospitalization are included, he added.

FMS also offers audiovisual and printed materials to introduce the procedures, benefits and participating providers in its plan, Mr. Bruck added.

Preferred Health Network of Los Angeles, an association that includes 18 hospitals and 19 professional practice groups representing 2,500 physicians, has its PPO in operation, though it has not yet signed up an employer, according to Marketing Vp Jerry T. Payne.

The "track record of its members in cost control" gives PHN its advantage in the market, Mr. Payne boasts.

According to statistics from the California Health Facilities Commission cited by Mr. Payne, the average revenue per patient per day of the 18 hospitals in the PHN network was 18% less than its area competitors.

While the provider-based PPO realizes that submitting 'our claims to a strict utilization review raises the specter of the fox guarding the chicken coop, we are working diligently to prove we can perform," Mr. Payne said.

Another Los Angeles-area PPO, Universal Health Network in Cypress will be in business by the end of this month, says Vp Nicholas Moss.

Universal is a hospital-based PPO consisting of nine institutions, five of which are members of the Lutheran Hospital Society. All but one of the hospitals are in Southern California.

The PPO will charge a currently unspecified percentage of an employer's health insurance premium for administration and utilization review.

"Our utilization review is the backbone of the program," Mr. Moss explains.

The utilization review includes pre-admission and admission certification, continuing stay review, discharge planning and "a retrospective rating of hospital bills against our records," Mr. Moss notes.

California Preferred Professionals Inc. in Glendora, a Los Angeles suburb, will begin operation of its CaPP Care plan, a physician-based PPO marketed through Pacific Mutual Insurance Co., on Jan. 1.

"Though our agreement is non-exclusive, we're in discussions with five other insurers, several major unions and employers on a statewide basis," said Dr. Edward Zalta, the president of the PPO.

The CaPP Plan already has contracted with 1,200 physicians in Southern California to provide health services that will save an employer "22% of last year's expenditure on health care," claims Dr. Zalta.

Although the plan ordinarily would charge "a minimum amount per employee per month" for administration of the PPO, "we'll go at risk and share in the cost savings if that's what the employer wants," Dr. Zalta says.

The plan's utilization review "tracks a patient all through the health care delivery system," he continued. The checkpoints include frequency of procedures such as X-rays, lab work, injections, length of time under anesthesia—"all costs incurred on behalf of a patient," Dr. Zalta said.

"We also check a physician's referral rate to make sure he's not acting as a booking agent for specialists."

The plan includes a list of 1,300 procedures that will be done on an outpatient basis, saving what CaPP Plan claims is between 60% and 70% of the cost if the procedures had been done on an inpatient basis.

Preauthorization will be required for another 1,700 elective surgical procedures, he adds.

"We also check for underutilization of services," Dr. Zalta says, explaining that in some cases if a patient is discharged too early, there is the risk of readmission with complications.

Another Southern California physician-based PPO soon to be operational is Unified Preferred Providers Inc. of Signal Hill, formed by 23 physician groups that have been providing care to health maintenance organization members for the past five years.

"We're unique in that our members are experienced with practicing cost-control medicine," said President Mark Moser. He noted that in 1982 UPP's member groups cared for 200,000 HMO patients at a rate of 330 days of hospitalization per 1,000 people, compared with the national average of 700 days per 1,000.

Although Southern California appears to be the hotbed of PPO activity, providers in Northern California are getting into the act, too.

For instance, the Northern California Health Cooperative, a group composed of seven hospitals and several physicians' groups, is putting the finishing touches on its PPO, called the SELECT Health Plan.

The PPO currently has contracts with hospitals in San Francisco, Berkeley, San Mateo, San Jose, Sacramento and Walnut Creek, though other details have not yet been released. ■

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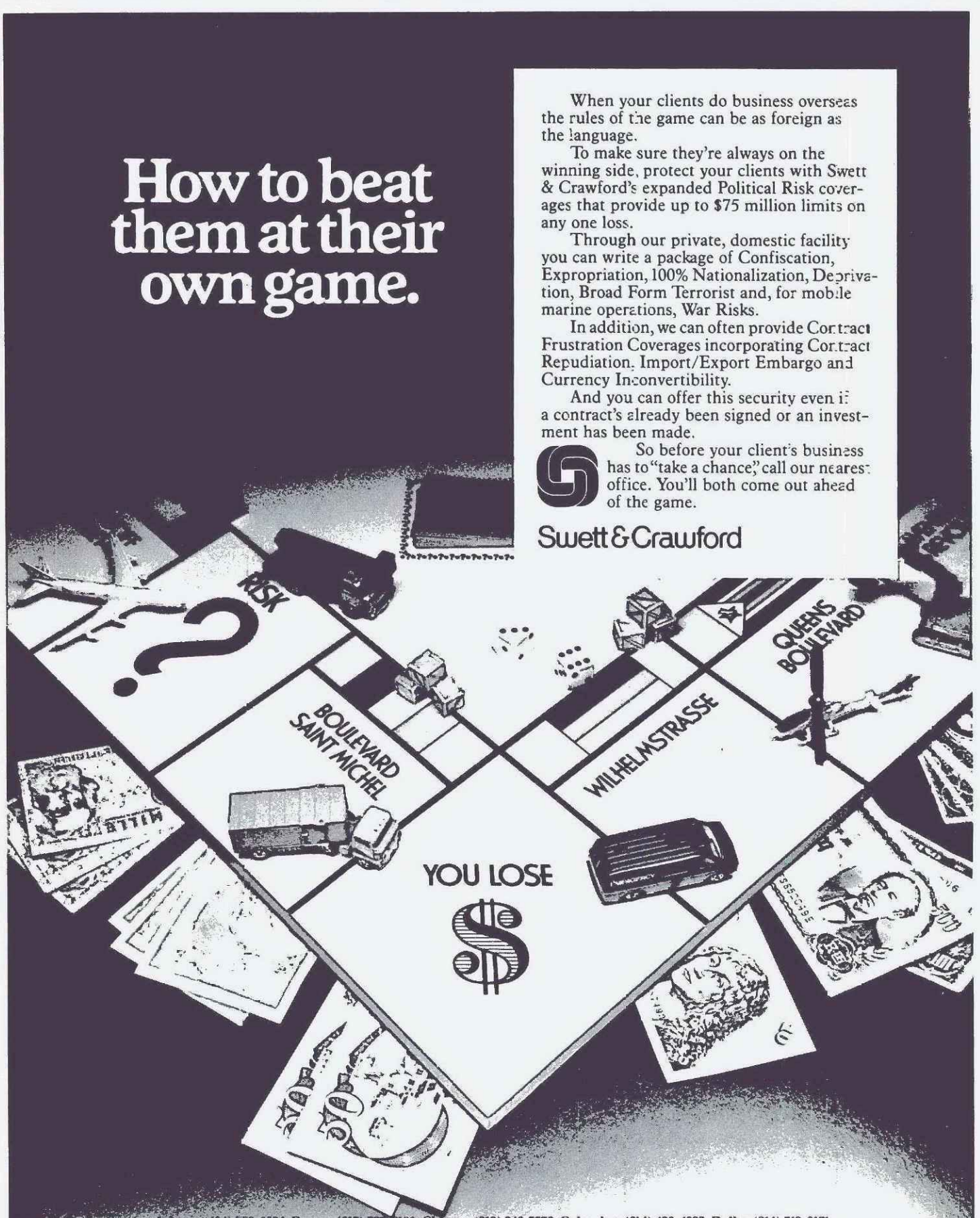

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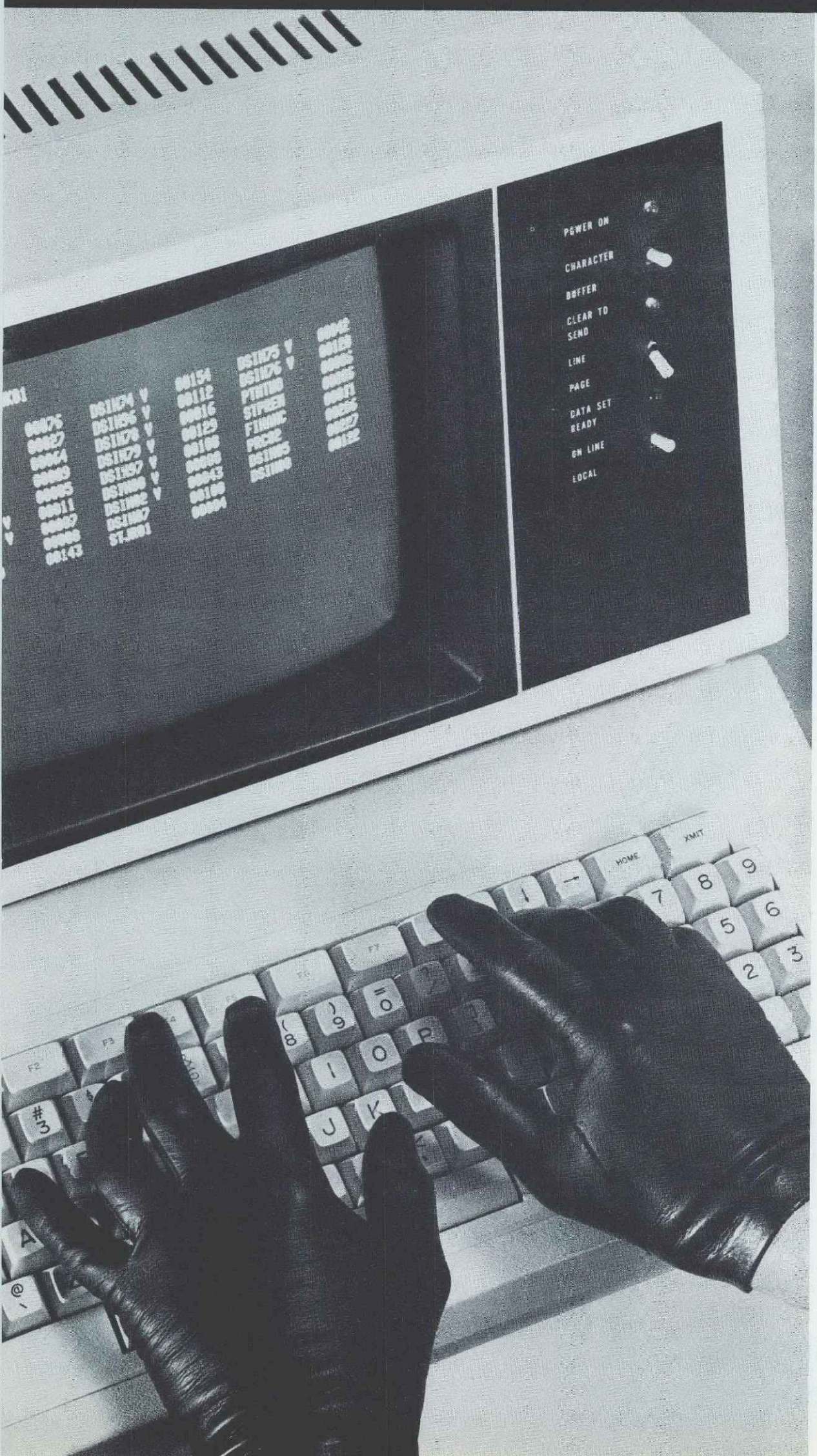

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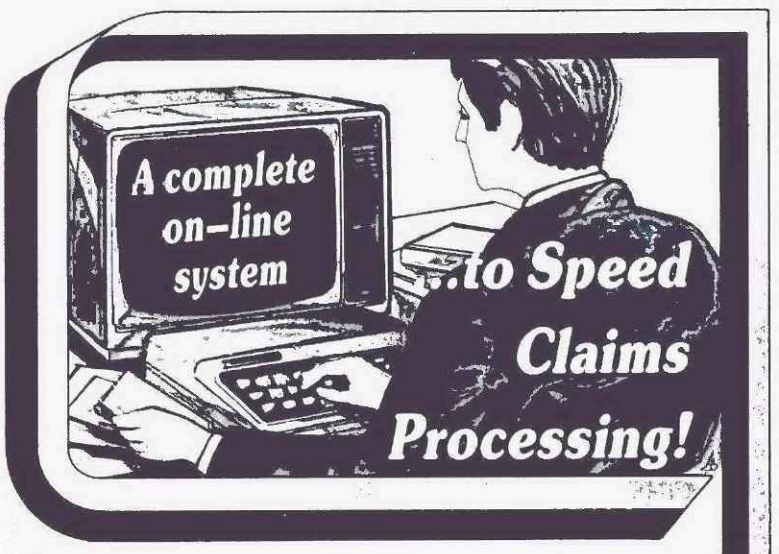

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San Diego-area employers doing it all by themselves

SAN DIEGO—Employers in the San Diego area aren't waiting for insurance companies or hospitals hawking preferred provider organizations to knock on their doors.

A group of employers is busy forming its own "second- or third-generation PPO," says George Murphy, corporate director of employee relations for Cubic Corp., a major San Diego employer.

The Community Care Network, the PPO being formed by a year-old employer coalition, the Committee of Affordable Health Care, represents a "unique approach," adds Robert M. Colasanto, director of insurance and benefits for Pacific Southwest Airlines.

"We're a marketplace looking for a product instead of a product looking for a marketplace," he explains, noting the difference between the San Diego PPO situation and employers in most California cities.

In San Diego, the employers themselves are the motivating force behind the formation of a PPO, while PPOs in most other areas of the state are being developed by providers, insurers or third-party administrators.

The Committee for Affordable Health Care, however, did have some outside help in the formation of the Community Care Network. Earlier this year, it won a $100,000 grant from the Robert Wood Johnson Foundation, the world's largest philanthropic health care foundation (*BI*, May 30).

CCN will file for another $1.5 million implementation grant from the Wood Foundation in December and, hopefully, begin contract negotiations with providers and insurance companies in January and February, says Mr. Murphy. Discussions with employers will then begin in March, he adds.

CCN hopes to reduce health costs by granting financial incentives to providers whose fees do not exceed target figures. If a provider's total cost per employee meets a complicated CCN formula, it will receive a portion of the savings the PPO generates.

"We'll be looking at high-quality, cost-conscious providers," said Mr. Murphy, who is spokesman for CCN. "There will be a rigorous utilization review and quality assurance system and a comprehensive data system to support it."

The San Diego PPO can be added as a separate option or can be offered in conjunction with an existing health insurance plan.

Although many details of the PPO have not yet been finalized, benefit plans that affiliate with CCN will be required to fulfill a list of provisions geared toward containment of health costs, including:

- The employer plan must specify that employees must be treated by a primary care physician contracting with CCN or a CCN staff doctor to participate in the PPO.
- The CCN-affiliated physician must provide, authorize or prescribe all services to be covered by the PPO, with several exceptions. For instance, employees will be able to use CCN chiropractors and podiatrists without referral.
- The employer plan must cover "subacute care," which is described as a level of care exceeding that normally provided in a skilled nursing facility, yet not involving the intensity of service normally provided in an acute-care hospital.
- Home health care services must be covered.
- Hospice care must be included.
- Services at skilled nursing facilities must be covered if they are prescribed in lieu of acute-care or subacute-care confinement.
- Urgent care services must be covered if they're used outside the primary physician's office hours.
- Services at ambulatory surgical centers must be covered.
- Financial incentives—like deductibles, coinsurance and stop-loss services—must favor the use of CCN providers. These incentives must be structured so that the projected annual cost per employee is at least 20% higher if non-CCN providers are used.

Although CCN is sponsored by employers themselves, Mr. Murphy admits that the PPO faces stiff competition in luring buyers, especially from the Prudent Buyer Plan, a PPO operated by Blue Cross of California that is up and running.

"The philosophy of the Committee for Affordable Health Costs is to encourage competition," he said. "We certainly don't expect to be the only game in town."

—By Margaret LeRoux

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Utility's health care plan predated today's PPOs

LOS ANGELES—Although preferred provider organizations are the hottest trend in the California benefit marketplace, PPO-type arrangements aren't anything new for Edison Co. of Southern California.

The Los Angeles-based utility has offered a PPO option in its self-insured medical plan for more than 80 years.

Since 1902, the utility has offered employees the option of using company doctors, clinics and a panel of outside providers at no cost after an annual $120 deductible. Employees who choose health care providers that are not affiliated with the Edison plan must pay 20% coinsurance.

Today, Edison's Employee Medical Plan includes 105 primary care physicians, nine clinics, 50 specialists and 105 pharmacies. And, the company is negotiating with a major Southern California hospital to add to the participants in its preferred provider program.

More than 80% of Edison's 19,000 employees choose the PPO option and about 6% chose one of the five health maintenance organization options the company offers, while the remainder "swing back and forth between the PPO and the 80% coverage option," said Kenneth W. Aaron, Edison's manager of health cost containment.

The PPO program has given Edison an enviable record of cost containment, Mr. Aaron points out.

"A survey of Los Angeles employers by Hewitt Associates showed our average (health care) cost per employee was $1,000 while others in the study averaged $1,365," he says. "And the others didn't include industrial care in their figures; we did."

Besides spending less per employee than the average employer, Edison's plan is designed to keep employees out of the hospital.

The utility spent 52% of its health care expenditures last year on physician services and 35% on hospital care, according to Mr. Aaron. This compares favorably with industry as a whole, where 41% of health care dollars is spent on hospital care while only 19% goes toward physicians' services, according to a survey by Industry Week magazine.

Mr. Aaron credits a thorough utilization review program for Edison's success in keeping employees out of the hospital.

Edison itself pre-certifies all non-emergency hospital stays. Once an employee checks into the hospital, the company turns the utilization review task over to Beech Street Healthcare Services of Santa Ana, Calif., a consulting firm whose nurses monitor the patient's progress throughout his or her hospital stay.

"They've been very tactful in their encounters with physicians and hospital staff," noted Mr. Aaron.

Edison hopes to make its "good thing" into something even better soon.

Currently, the Employee Medical Plan is just that: for employees only. Dependents are covered by another self-insured plan that is administered by Aetna Life & Casualty Co. However, that plan does not include the PPO features.

"Plans are to merge the dependent plan into the Employee Medical Plan in the next three to five years to create a family plan that we will administer ourselves," Mr. Aaron said. ■

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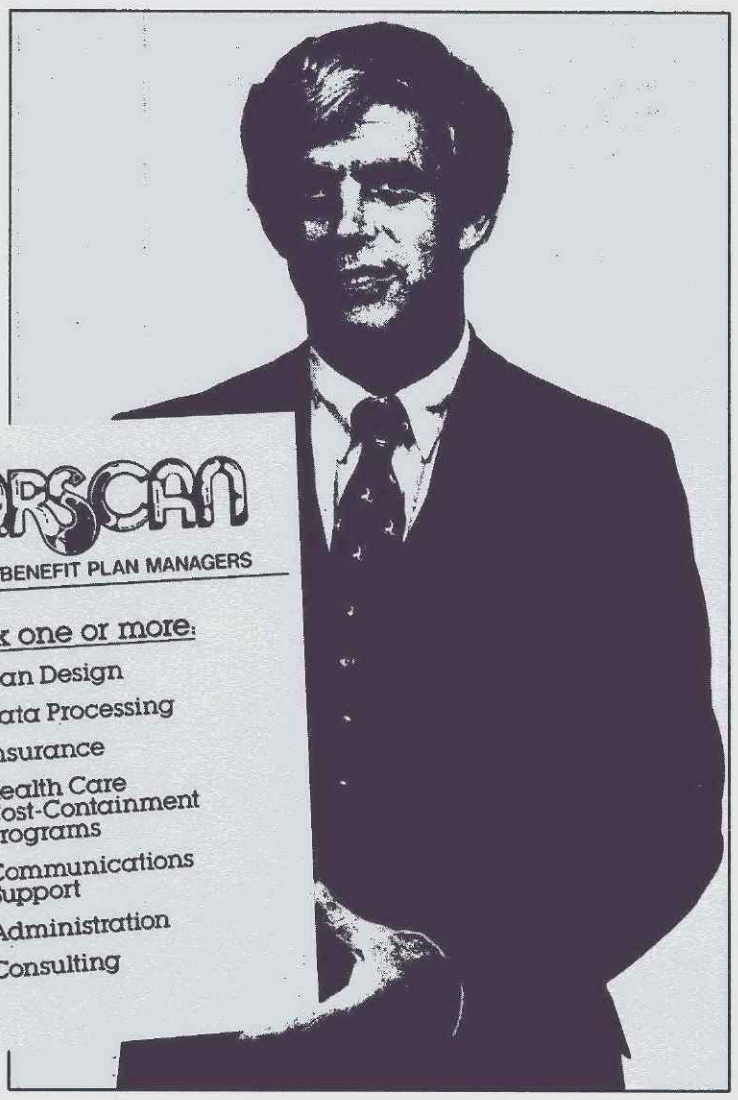

Q. What advantages does the Starscan approach have over traditional group benefit plans?

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Other advantages include more effective and efficient use of employer contributions, the opportunity to contain escalating benefit costs, greater employee appreciation of benefits, reduced pressure for across-the-board increases in benefits, and a progressive employer image. Not least, Starscan helps employers recruit and retain employees.

Q. How does the Starscan flexible benefit approach work?

A. In the way best suited to meet the needs of you and your employees. For example, existing benefits might be kept as they are, or reduced to a standard core for all employees. In either case, employees would be given credits to purchase additional benefits to fit their needs. Benefits beyond those the credits would buy could be purchased through payroll deductions.

Or, set benefits might be offered with different levels of coverage. By choosing a higher level of one benefit and a lower level of another, employees could match benefits more closely to their needs.

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Q. What about cost?

A. Obviously, changing a traditional benefit program to a tailored flexible plan involves initital costs. But selecting only those items you need from the Starscan menu can make those costs much lower than you might expect. And the kind of synergy involved in this approach has a real impact on bottom-line results, and can lead to significant cost savings over traditional group benefit plans.

Q. How can I get a brochure describing Starscan?

A. Just write to Starscan, Special Markets Department B, 8 Griffin Road North, Griffin Office Center, Windsor, CT 06095. Or call David Washburn, Director of New Products, at (203) 683-8435.

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NOV. 1-2. Communicating Employee Benefits conference in Chicago, sponsored by Business Insurance; $495; 10% discount for additional participants from the same company. Ann Vazquez, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

NOV. 27-30. Benefits Processing institute in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road Box 69, Brookfield, Wis. 53005; 414-786-6700.

NOV. 28-DEC. 1. Hemispheric Insurance 19th biennial conference in San Francisco, sponsored by the International Insurance Advisory Council; $400 for delegates; $100 for observers. Gordon Cloney, International Insurance Advisory Council, U.S. Chamber of Commerce, 1615 H St. N.W., Washington, D.C. 20062; 202-463-5480

NOV. 28-DEC. 2. Recognition of Occupational Health Hazards course in Los Angeles, sponsored by the University of Southern California; $650. Office of Extension & In-Service Programs, Institute of Safety & Systems Management, University of Southern California, Los Angeles, Calif. 90089; 213-743-6523/6524.

NOV. 29. Home Care: Acute, Long-Term and Hospice conference in New York, sponsored by the New York Business Group on Health Inc. and the National HomeCaring Council; $75 for members; $150 for non-members; discounts available for subsequent registrants. The New York Business Group on Health Inc., 1633 Broadway, 46th Floor, New York, N.Y. 10019; 212-397-1260; or the National HomeCaring Council, 235 Park Avenue S., New York, N.Y. 10003; 212-674-4990.

NOV. 30. Code 401(k): The Final Regulations seminar in Washington, D.C., sponsored by the Employers Council on Flexible Compensation; $250. Karin Gess or Margaret Shemo, Employers Council on Flexible Compensation, 1700 Pennsylvania Ave., Suite 600, Washington, D.C. 20006; 202-393-1728.

DEC. 1-2. Nuclear Litigation seminar in New York, sponsored by the Practising Law Institute; $390. Practising Law Institute, Department IFC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

DEC. 4-7. Corporate Benefits Management conference in Orlando, Fla., sponsored by the International Foundation of Employee Benefit Plans; $470 for members; $545 for non-members. IFEBP, Box 69, 18700 W. Bluemound Road, Brookfield, Wis. 53005; 414-786-6700.

DEC. 5-7. Techniques of Risk Management conference in San Francisco, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

DEC. 6. Directors and Officers Liability workshop in Houston, sponsored by the Society of Chartered Property & Casualty Underwriters; $80 for members; $90 for non-members. Coleen Mulhern, CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-648-0440.

DEC. 6-7. Health Planning and the Law seminar in Washington, sponsored by the American Health Planning Assn. and the National Health Lawyers Assn.; $360 for members; $395 for non-members. National Health Lawyers Assn., 522 21st St. N.W., Suite 120, Washington, D.C. 20006; 202-833-1100.

DEC. 7-9. Computer Programs for Occupational Health Systems course in Los Angeles, sponsored by the University of Southern California; $400. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

DEC. 8-9. Corporate Involvement in Developing Country Health Sectors conference in Newport Beach, Calif., sponsored by the National Council for International Health; $175 for members; $250 for non-members. Graeme Frelick, National Council for International Health, 2100 Pennsylvania Ave. N.W., Suite 740, Washington, D.C. 20037; 202-466-4740.

DEC. 8-9. Unjust Dismissal: Litigating, Settling and Avoiding Claims seminar in New York, sponsored by the Practising Law Institute; $350. Also **Jan. 26-27** in San Francisco. Practising Law Institute, Department ITC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

DEC. 12-13. Ergonomics course in Los Angeles, sponsored by the University of Southern California; $375. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

DEC. 12-14. Basic Security Management seminar in Houston, sponsored by the International Safety Academy; $395. ISA, 1600 Arch St., P.O. Box 8527, Philadelphia, Pa. 19101; 215-241-3176.

DEC. 13. Joint Venture Captives briefing in Miami, sponsored by Risk Planning Group Inc.; $200. Micki Briskin, Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

DEC. 14-15. Captive Insurer: Focus on Political Risk seminar in Miami, sponsored by Risk Planning Group Inc.; $600; discounts for subsequent registrants. Micki Briskin, Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

DEC. 14-16. Fundamentals of Insurance conference in Atlanta, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292. ■

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Trucking company names Howze to head risk management, benefits

comings & goings: buyers

Alvin D. Howze, 34, is the new director of human resources and risk management at Riss International, a trucking company in Kansas City, Mo. As the result of a reorganization and consolidation of responsibilities, Mr. Howze will oversee property/casualty insurance, workers compensation and employee benefit programs, as well as compensation administration, recruiting and other personnel functions. Prior to joining the company, Mr. Howze was manager of insurance for Time-DC Inc. in Lubbock, Texas. He also served for 11 years in various positions in the insurance industry. He received a bachelor of science degree in personnel management from Louisiana State University in Baton Rouge, is pursuing the Associate in Risk Management designation and is a deputy member of the Kansas City Chapter of the Risk & Insurance Management Society. Mr. Howze reports to President E.S. Riss.

* * *

E. John Yates is the new assistant insurance manager for Tetra Pak Insurance Services Ltd. in Saffron Walden, Essex, England. In this new position, Mr. Yates will handle property conservation and insurance, loss control and other risk management functions. Prior to joining the company, he served as insurance manager—Europe & Africa for Borg Warner Ltd. in Hitchin, Hertfordshire, England. Mr. Yates is a member of the Assn. of Insurance & Risk Managers in Industry & Commerce and an associate of the Chartered Insurance Institute. He reports to Hugh R. Loader, Tetra Pak's group insurance manager.

* * *

Donna M. Pecorino, 26, is general services manager, a new position, for Capital Preservation Fund in Palo Alto, Calif. She assumes risk, safety and security management duties. Ms. Pecorino joined the company in 1980 as a statistical analyst. She received a bachelor of arts degree from Loyola Marymount University in Los Angeles and a master of arts degree in industrial sociology from San Diego State University. Ms. Pecorino reports to Orin R. Olden, chief financial officer.

•

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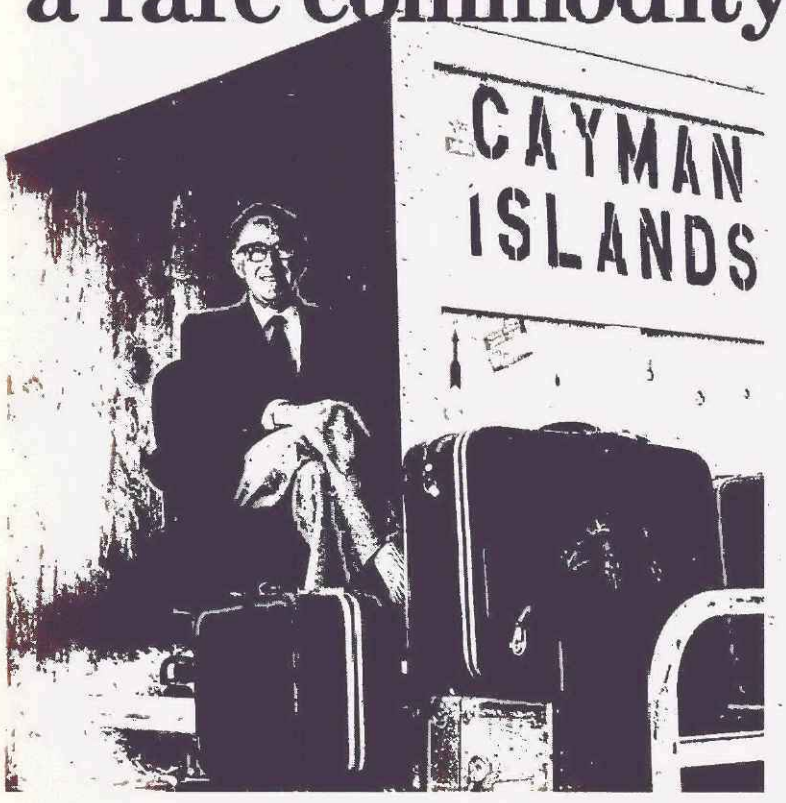

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More product liability suits being filed in federal courts

By JERRY GEISEL

washington

WASHINGTON—The number of product liability cases filed in federal courts around the country continues to increase.

Product liability complaints filed in U.S. District Courts increased 3.1% in fiscal 1983 compared with fiscal 1982, according to a report by the Administrative Office of the U.S. Courts.

The report shows 9,221 product liability suits filed in fiscal 1983, which ended June 30 for the courts, compared with 8,944 cases in fiscal 1982.

The 9,221 cases filed in 1983 are more than double the 4,372 cases filed in 1978.

States with the most product liability cases filed in federal courts in fiscal 1983 include:

- Texas, 906, down 12.8% from 1,039 cases in fiscal 1982.
- Pennsylvania, 815 cases, up 24.6% from 654.
- Massachusetts, 724 cases, up 64.5% from 440.
- Michigan, 460 cases, down 1% from 465.
- New York, 457 cases, down 3.7% from 474.
- Ohio, 443 cases, down 7% from 474.
- California, 425 cases, up 19% from 357.

Wyoming had the fewest number of product liability cases filed in federal court. It recorded nine cases in 1983, compared with 25 cases in 1982.

PPO legislation

Congress should pass legislation that would allow insurance companies to negotiate fees with physicians and hospitals, an insurance company executive says.

The Preferred Provider Health Care Act of 1983, proposed by Rep. Ron Wyden, D-Ore., would "free the marketplace of some regulatory impediments to competition," says Dennis Pedini, assistant vp at Aetna Life & Casualty Co.

Speaking before a House Energy and Commerce subcommittee, Mr. Pedini said the measure, H.R. 2956, would override anti-competitive laws in some 40 states that prevent insurers from establishing preferred provider organizations. PPOs are groups of selected hospitals and other health care providers that agree to provide services to an insurer or employer at predetermined, discounted rates (see story, page 36).

Many state laws prevent the formation of PPOs because they forbid insurers from selecting providers or reimbursing them at different levels.

"We support H.R. 2956 because we think there is a real need to free the marketplace of some regulatory impediments to competition that are no longer appropriate," Mr. Pedini said.

Oil industry injuries

Young and inexperienced workers in the oil and gas drilling industry are the most likely to suffer on-the-job injuries, the Bureau of Labor Statistics says.

In a 12-state survey of 1,000 oil and gas workers who were injured last year, the BLS found that 75% of the injured workers were under 35 years old and about 70% had been working in the industry for less than a year.

The BLS survey confirmed that injuries in the oil and gas drilling industry tend to be severe. On average, an injury forced a worker to miss 26 days of work, or 10 days more than the national average for a workplace injury.

In addition, some 20% of the injured workers had to be hospitalized with stays averaging seven nights.

About 40% of surveyed workers cited conditions at the worksite such as slippery surfaces, limited work areas and poor weather as contributing to their accidents.

Meanwhile, the Occupational Safety and Health Administration reports that the injury rate in the oil and gas field industry in 1981 was 19.4 per 100 workers—more than triple the nationwide average rate of 8.1 workplace injuries per 100 workers.

Asbestos inspections

The Occupational Safety and Health Administration says it will conduct 700 health inspections in the construction and manufacturing industries to check if employers are complying with the agency's rule on worker exposure to asbestos.

"Asbestos is a known carcinogen and OSHA is in the process of developing a more stringent standard to protect workers exposed to it. Apart from that effort, however, we intend to ensure that violations of our current standard are addressed and abated," said OSHA chief Thorne Auchter.

OSHA's asbestos standard prohibits worker exposure in excess of two fibers of asbestos longer than five micrometers per cubic centimeter of air over an eight-hour period.

501(c)(9) trusts

The Internal Revenue Service has made it official: Trade associations with members in the same state can set up 501(c)(9) tax-exempt health care trusts.

In transmittal 7751-61, the IRS redefined a 1981 rule that had severely limited 501(c)(9) trust operations.

Under that 1981 rule, trade associations could offer the trusts only if members were located in the same geographic area. The IRS had limited the same geographic area to a single city and its surrounding counties.

But in its transmittal to field agents, the IRS now says the same geographic locale can include employers located in the same state.

As a result, a state trade association would be free to set up a 501(c)(9) trust, although national trade associations still could not.

Advantages of a 501(c)(9) trust, named for the section of the tax code authorizing it, include:

- A tax deduction for the employer for its contribution to the trust.
- Tax-free accumulation of interest earned by assets in the trust.

Employers and trade associations have set up between 8,000 and 10,000 of the trusts, which usually provide health care and disability benefits.

Fiduciary violations

Officials of two Brooklyn, N.Y., employee benefit plans will pay more than $160,000 to the plans under a consent order.

The consent order, issued by the U.S. District Court for the Eastern District of New York, settles aLabor Department suit against four officials of the Teamsters Local 918 pension and welfare plans.

The department had charged that the officials violated their fiduciary duties when purchasing insurance and deposit administration contracts from the Foundation Life Insurance Co. of America.

The suit said the officials funded the plans' death benefits by purchasing excessively costly whole life insurance and investing plan funds in deposit administration contracts on terms less favorable than comparable investments available through other insurers. As a result of these actions, the plans lost money, the department said.

Aside from requiring the officials to pay $160,000 to the plans, the consent order stipulates that Republic National Bank of New York be appointed as the plans' independent investment manager.

Named as defendants in the department's suit were Joseph Barresi, administrator of the two plans, and trustees Mitchell Goldblatt, Jerome Brownfield and Phillip Gershenoff. ■

First, the fire station caught fire...

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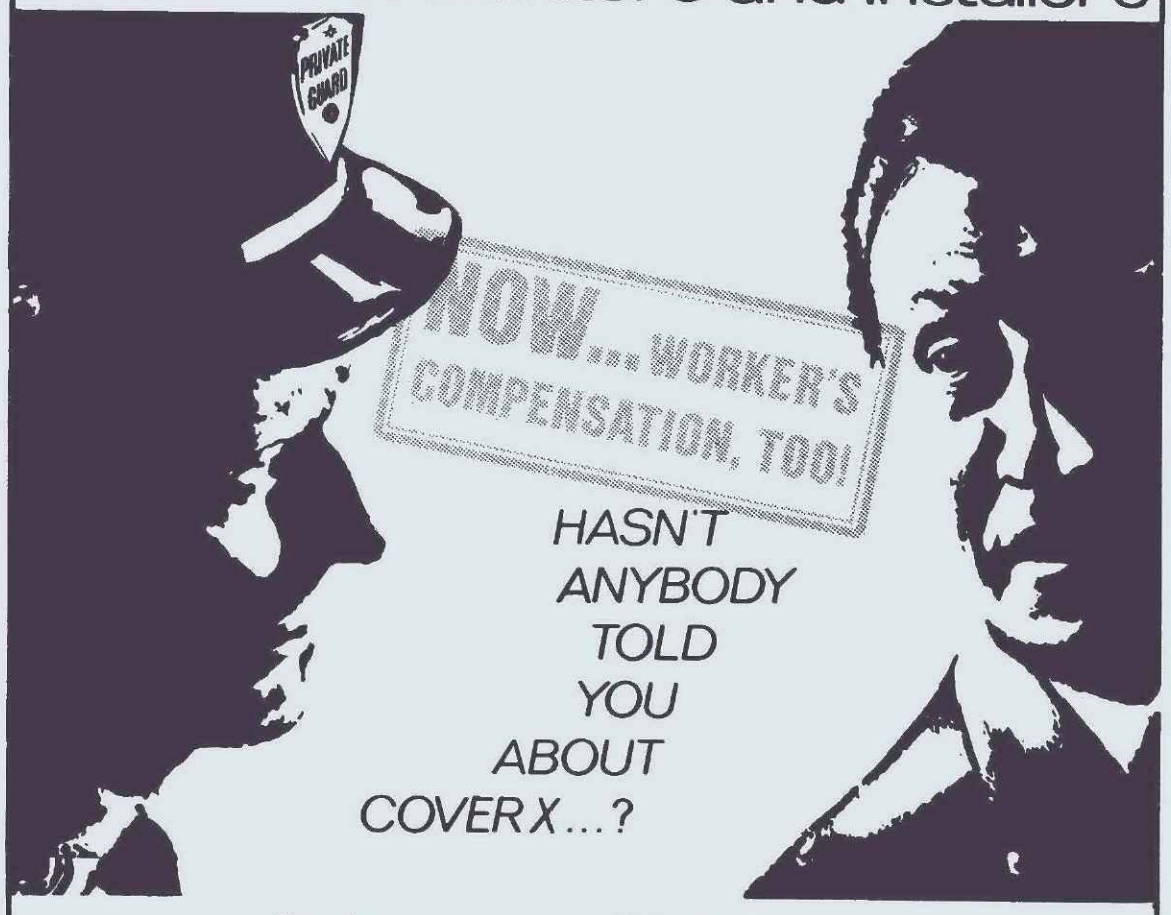

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Armco forms new facultative reinsurer

Armco Insurance Group Inc. has formed a new property/casualty facultative reinsurance management subsidiary, Armco National Reinsurance Management Corp.

The new unit will market, underwrite and manage facultative reinsurance throughout the United States for companies in the Armco group and eventually plans to provide the same services for non-affiliated companies.

Armco National Reinsurance will take over the Atlanta, Chicago, Houston, New York and San Francisco facultative reinsurance operations of Armco's Bellefonte Re Insurance Co. subsidiary.

D. Jay Carbine, formerly an executive vp with Bellefonte, will be president and chief operating officer of the new reinsurance subsidiary.

markets

HMO planned

CIGNA Healthplan Inc., a unit of CIGNA Corp., will form a new health maintenance organization to provide prepaid health care services to employers in Orlando, Fla.

The HMO will operate out of two Orlando centers scheduled to open in March 1984 July 1984.

Services provided will include physician office visits, laboratory tests, X-rays, prescription drugs, hospitalization and surgery. The HMO will also arrange referrals for special services in such areas as cardiology, urology and mental health counseling. A Medicare Supplemental Plan will also be available.

CIGNA Healthplan operates HMOs in four states with enrollments of more than 625,000 people. In Florida, CIGNA currently operates HMOs in Tampa, Clearwater, St. Petersburg and Miami.

Royal reorganization

Royal Insurance Co. has combined its marine and aviation division, specialty lines division and international department to form a new entity to be known as RAMS International.

RAMS—for Royal All-Marine & Specialty—will merge Royal's operations in several lines, including ocean and inland marine, bonds, burglary, boiler and machinery and international insurance.

Warren P. Noll, currently a Royal vp, will administer RAMS International.

Acquisitions

Four New Jersey brokerage firms have merged to form a new brokerage, **INSUREX Inc.**, providing standard and excess/surplus lines, group benefits and pension planning products and life and health insurance products. The four merging companies include **A.W. Marshall Co.**, **North Jersey Agency Inc.** and **C.J. Simons Brokerage**, all of Newark, and **NIA Excess Lines Inc.** of Bergen County. INSUREX has offices in Newark and Paramus, N.J.

Ivanhoe Insurance Group Ltd. of Toronto has merged with **Haddon S. Fraser Associates Ltd.**, a New York-based underwriting manager. Fraser had served as U.S. manager for one of the group's Canadian insurance companies, **Northumberland General Insurance Co.**

Poe & Associates Inc. has sold its **National Underwriters Inc.** subsidiary to **The Protective Insurance Underwriters Inc.** of Omaha, Neb., for $2.2 million cash. National Underwriters, based in Indianapolis, specializes in insurance programs for financial institutions.

Intercontinental Financial Group of North America, a financial services holding company, has bought **Ideal Mutual Insurance Co.**'s share of **Optimum-Ideal Managers Inc.**, a managing general agency based in Schaumburg, Ill.

Coldwell Banker-Thorsen Co., a real estate and insurance agency based in Oak Brook, Ill., has sold its insurance subsidiary, **Thorsen Insurance Services Inc.**, to **Charles M. Griffith Inc.**, an insurance agency based in Clarendon Hills, Ill.

AFIA Worldwide Insurance has opened a Nigerian office as a joint venture with **Taisho Marine & Fire Insurance Co. Ltd.** and Nigerian business leaders. The new office, **Fire, Equity & General Insurance Co. Ltd.**, is located at P.O. Box 5774, Lagos, Nigeria.

New offices

The Quaker Agency of Seagirt, N.J., has opened a Pennsylvania office at 5000 Tilghman St., Suite 225, Allentown, Pa. 18104.

Coronet Life Insurance Co. has moved to new offices at 225 W. 34th St., Suite 1309, New York, N.Y. 10122; 212-695-6893. ■

Ware named Guaranty National chief

comings & goings: industry

Roger Ware has been elected president and chief executive officer of Guaranty National Corp. in Englewood, Colo., and its wholly owned subsidiaries, Guaranty National Insurance Co. and Landmark American Insurance Co.

Mr. Ware replaces **Donovan Schallert**, who resigned in August for personal reasons.

Mr. Ware formerly was senior vp-marketing and field operations at Reliance Insurance Cos. in Philadelphia.

Guaranty National Insurance Co. is the nation's fourth-largest specialty lines insurer, based on 1982 gross premium volume.

Other excess/surplus changes:

Robert H. Libby, Richard A. Adler and **Robert N. Liston** promoted to executive vps at Shand, Morahan & Co. Inc. in Evanston, Ill.

Mr. Libby will now head corporate administration; he was formerly responsible for the Shand underwriting department. Mr. Adler, previously responsible for various reinsurance underwriting duties, is now executive vp-reinsurance marketing. Mr. Liston is now executive vp, responsible for underwriting.

Also at Shand, Morahan, **Grant R. Hubbard** and **Joe J. Thackaberry** named senior vps. Mr. Hubbard is now senior vp-business development. Mr. Thackaberry is now senior vp-underwriting and will oversee various errors and omissions and professional liability insurance programs.

Insurers

George W. Meehan elected executive vp of United States Aviation Underwriters Inc. in New York. Mr. Meehan formerly was senior vp, responsible for the direction and coordination of aviation underwriting operations and administration of the company's 23 field offices. U.S. Aviation Underwriters Inc. manages the United States Aircraft Insurance Group.

Raymond G. Bacon and **Gerald L. Geers** elected senior vps of Fireman's Fund Insurance Cos. in Novato, Calif. Messrs. Bacon and Geers are field operations executives. Mr. Bacon had been vp and Western states operations executive, while Mr. Geers had been vp and Central states operations exec utive.

Agents/brokers

Tony Ham joined Bain Dawes (London) Ltd. as a director. He will specialize in political and credit risks. Mr. Ham was previously with the Sedgwick Group P.L.C., also in London.

Peggy Jones named senior vp-operations for Regency General Agency in Dallas. She had been a special agent for Regency and was formerly a field adjuster for Comco Insurance Co.

Other suppliers

Peter Klingler appointed manager of the East Coast office of The Structured Settlements Co. in St. Petersburg, Fla.

He had been branch manager of ManuLife's Tampa, Fla., office. Structured Settlements provides third-party negotiations in settling personal injury and wrongful death claims.

C.C. Lefler, D.C. Chapman and **R.P. Albright** were promoted at Crawford & Co., an insurance adjusting firm in Atlanta. Mr. Lefler was named executive vp-marketing; Mr. Chapman named executive vp-finance and Mr. Albright was named senior vp-marketing at Crawford. ■

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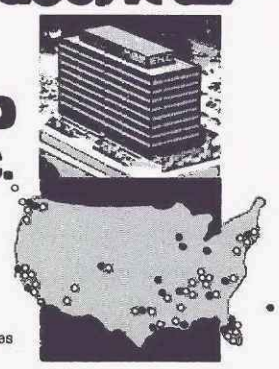

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Basketball player's punch stings reinsurers

Continued from page 1
to fight after a rebound. Mr. Washington punched Mr. Kunnert and in the ensuing fracas, several players, including Mr. Tomjanovich, scrambled to separate the two.

As Mr. Tomjanovich intervened, Mr. Washington turned and punched him in the face.

Mr. Tomjanovich was hospitalized with a broken jaw, broken nose, fractured skull and a concussion, which sidelined Mr. Tomjanovich, the Rockets' captain, for the remainder of the 1977-78 season.

Mr. Washington was fined $10,000 and suspended without pay for 60 days by National Basketball Assn. Commissioner Lawrence F. O'Brien.

Those few seconds in the third period set the stage for a labyrinthine, six-year series of lawsuits involving California Sports Inc., which owns the Lakers; its liability insurers; their reinsurers; and Frank B. Hall & Co. Inc., California Sports' broker.

At least one of the suits still has not been resolved.

Fireman's Fund Insurance Cos. provided the primary $50,000 layer of California Sports' comprehensive general liability package. Central National—fronting for a casualty insurance pool operated by managing general agent Cravens, Dargan & Co. Pacific Coast—provided two excess layers: the first for $950,000 excess of $50,000 and the second for $4 million excess of $1 million.

Other insurers carried additional layers of the CGL package for a total of $25 million in coverage, but these layers were not triggered.

Meanwhile, Central National had arranged reinsurance for each of the two excess layers.

Facultative reinsurance for $350,000 of the first excess policy was placed with Bellefonte Insurance Co., a unit of Armco Insurance Group Inc., while 87.5% of the second excess layer was facultatively reinsured with three companies: Prudential Reinsurance Co.; Birmingham Fire Insurance Co. of Pennsylvania, an American International Group Inc. affiliate represented by North American Managers Inc.; and Excess & Casualty Reinsurance Assn, a reinsurance pool.

Pru Re covered 50% of all losses under the second excess policy up to a maximum of $2 million; Birmingham covered 12.5% of the losses to a maximum of $500,000; and ECRA covered 25% of the losses to a maximum of $1 million.

In 1978, Mr. Tomjanovich and the Rockets filed separate actions against California Sports in U.S. District Court in Houston. Mr. Tomjanovich's suit sought $2.5 million in actual and punitive damages, while the Rockets sought $1.4 million in actual and punitive damages for the loss of Mr. Tomjanovich's services.

According to court papers, Fireman's Fund tendered its $50,000 limit to settle the two cases in June 1978, and a series of settlement negotiations followed. In the course of these, Central National turned down final demands of $750,000 from Mr. Tomjanovich and $700,000 from the Rockets.

After negotiations failed, the two lawsuits went to trial, and in August 1979 the Houston jury stunned insurers by awarding $3.3 million to Mr. Tomjanovich, including $1.5 million in punitive damages.

While Central National's appeal of the verdict was still pending, it settled with Mr. Tomjanovich for $2.13 million.

Under the terms of the settlement, Central National paid only about $1.4 million, with California Sports and Frank B. Hall each contributing $340,850.

The reason for the contributions was an ambiguous provision in the manuscripted CGL policy that was meant to exclude "persons under athletic contract with California Sports," according to Robert Schulman, a lawyer with the Los Angeles firm of Stephens, Berg, Lasater & Schulman, which represents Hall.

The vague wording of this so-called "athletics participant exclusion" raised questions about whether California Sports was covered at all for its liability in the incident, court papers say.

After the Tomjanovich verdict, the insurer also settled the Rockets' lawsuit for $750,000.

Although Central National paid all of the Rockets' settlement, it claims in a pending lawsuit against California Sports that the same athletics participant exclusion relieves it of any obligation to pay. California Sports has filed a cross-complaint against Frank B. Hall claiming that the broker is liable for judgments against it because of vague policy wording.

However, Central National did not pursue the action while its case against the reinsurers was still pending, according to Dale E. Fredericks, a lawyer with the San Francisco firm of Sedgwick, Detert, Moran & Arnold, which represents Central National.

Court papers indicate that one month before the verdict in Mr. Tomjanovich's suit, Central National informed Bellefonte that awards or settlements in the two suits might involve its reinsurance. But the insurer didn't notify Pru Re, Birmingham or ECRA of the lawsuits until four days after the $3.3 million award was announced.

A trial document filed by Pru Re shows that a Cravens, Dargan claims manager wrote to the reinsurer after the verdict, "Here's our file on this bomber. My sincere apologies for this late notice."

The three reinsurers subsequently refused to pay their share of the settlement, claiming that the late notice relieved them of any obligation under the contracts.

After denying liability, the reinsurers filed suit in Los Angeles County Superior Court asking the court to rule that they had no obligation to pay. Central National countered with its own suit claiming the reinsurers breached their duties by refusing to pay.

The two actions were consolidated before Superior Court Judge Paul G. Breckenridge Jr. and went to trial earlier this month.

The reinsurers argued that because Central National waited 16 months to notify them of the two lawsuits, its claim should be barred under a provision of the reinsurance contracts that requires prompt notice of "any occurrence or accident which. . .appears likely to involve this reinsurance."

"It's like saying, 'Yesterday I had lunch with your boss. Would you like to go?'" said Thomas L. Watters, whose Santa Monica law firm, Thomas L. Watters Inc., represents Birmingham and ECRA.

The reinsurers charged that Central National should have known that the lawsuits might pierce the second excess policy and trigger the reinsurance coverage. They pointed out that the lowest settlement demands in the two cases still amounted to $1.4 million and that a Cravens, Dargan attorney in Houston estimated that compensatory damages for Mr. Tomjanovich alone could reach $1 million.

Citing court decisions involving reinsurers in other states, Pru Re and the others said that late notice by itself was reason enough to deny coverage.

Central National defended its tardiness in reporting the claim by saying that it never expected awards to Mr. Tomjanovich and the Rockets to top $1 million. If the insurer didn't think the lawsuits appeared "likely" to involve the second excess reinsurers, it didn't have any duty to notify them, it said.

"We used our good judgment and were hit with a runaway jury verdict," Mr. Fredericks observed. "That's one of the risks reinsurers take—that the ceding company's judgment won't always be perfect."

Central National also pointed out that several California courts have held that insurers must prove prejudice to their interests in order to deny policyholders' claims on the basis of late notice. The same reasoning should apply to insurers' claims against their reinsurers, it argued.

Judge Breckenridge sided with Central National on that point, instructing the jury that the three reinsurers would have to show "actual and substantial prejudice" to their interests in order to avoid liability.

The jury apparently decided that there was no such prejudice, returning a $1.4 million verdict in favor of Central National on Oct 17. The verdict included $1.05 million —the reinsurers' share of the $1.2 million paid out after the first excess policy's limits were exhausted —plus $360,000 in interest.

Mr. Watters said the reinsurers haven't decided yet whether to appeal the case. Mr. Fredericks, however, said Central National may appeal because Judge Breckenridge refused to allow the insurer to collect punitive damages or attorneys' fees.

He added that the two sides may settle out of court before arguing an appeal, but wouldn't comment on whether settlement negotiations were already in progress.

Central National's pending lawsuit against California Sports for recovery of the Rockets' settlement "will probably disappear in the aftermath of this case," Mr. Fredericks said. Since Central National has collected from its reinsurers, it no longer has any interest in trying to collect from its policyholder, he explained.

He added that Central National "hasn't addressed" the question of whether it would revive the suit if the judgment against the reinsurers is reversed on appeal.

Mr. Schulman, Frank B. Hall's attorney, says that the Central National decision could be a "fairly significant development" for reinsurers in California if it is upheld on appeal.

California courts have ruled that in cases where an insurer is dealing with a relatively unsophisticated policyholder, the insurer must prove prejudice to its interest to deny a claim because of late notice.

But the trend in California law is not to require a showing of prejudice where the insurer and the policyholder are knowledgeable about insurance, he said. Judge Breckenridge's jury instructions go against this trend and, if upheld, could mark a change in the direction of the law, he suggested. ■

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Bill would increase pension liabilities

Continued from page 1
People may think they understand the bill, but they don't," warns James P. Klein, an attorney with consultant Towers, Perrin, Forster & Crosby in New York.

Even though the bill could be very burdensome for companies, "very few people know what is going on," said Theresa Stuchiner, a partner with Kwasha Lipton, an employee benefits consulting firm in Fort Lee, N.J.

What is going on, Washington observers say, is that same coalition of big-business groups and labor organizations that worked for passage of the Multiemployer Amendments Act is now working to enact the Clay-Erlenborn bill.

As was true with Multiemployer Amendments Act, the Clay-Erlenborn bill is designed to shore up the insurance program run by the PBGC, which is supported by the $2.60 premium employers pay to it.

Large employers in particular say it is too easy for employers to dump their underfunded pension plans onto the PBGC. As the PBGC has to guarantee the benefits of workers and retirees in underfunded plans that fail, it must seek increases in its insurance premium.

Big companies that are unlikely to fold their well-funded pension plans resent being slapped with ever-increasing PBGC insurance premiums to pay for benefits promised by poorly funded plans that fail.

Instead of raising premiums, large companies want loopholes tightened in the PBGC insurance program to make it less likely that the PBGC will get stuck paying benefits for underfunded plans.

But experts warn that while the Clay-Erlenborn bill may close some loopholes, it may cause more problems than it solves.

And the experts warn that the bill contains provisions that have nothing to do with protecting the PBGC insurance program, but were simply added in a bid to win union support for the legislation.

For example, under the bill an employer with a collectively bargained plan could not terminate a plan unless it first received approval from its union.

Even after a collective bargaining agreement expired, a company would have to wait another two years before it could terminate the plan.

Giving unions control over corporate pension plans "is a kind of a madness. . .a sheer madness," said Mr. Cummings.

Mr. Cummings and other experts point that giving unions "veto power" to decide whether companies may terminate their plans and set up new ones has nothing to do with shoring up the PBGC insurance program.

"What does this provision have to do with termination insurance?" asks TPF&C's Mr. Klein.

Observers say the provision was included to win union support for the bill.

"It was a quid pro quo. Big business agreed to include the provision as part of a deal with labor groups," a Washington labor law attorney said.

Another provision, one that requires firms to pay accrued but non-vested pension benefits, also seems to have little connection with protecting the PBGC insurance program.

Under that provision, employers no longer could terminate plans that lack sufficient assets to pay benefits, including those that are not vested.

Instead of terminating the plan, the employer would "freeze" the plan. Under the "freeze," benefit accruals would cease, but participants could continue to vest.

The employer would have to continue to contribute to the plan until all accrued benefits were funded.

For example, if an employee who had worked for a company for two years was covered by a plan with 10-year vesting, the company would have to fully fund and pay for the benefit the employee was entitled to for his two years of service.

While this provision assures that workers will get more benefits when their companies decide to shut down plans, it would have no effect on the PBGC insurance program.

The PBGC does not have to pay for accrued but non-vested benefits when a company shuts down an underfunded plan. The PBGC only pays guaranteed benefits, which are on average about 85% of vested benefits.

Other provisions in the bill clearly are designed to boost the PBGC, but may lead to legal problems.

For example, the bill calls for a retroactive increase in the PBGC annual insurance premium to $6 per plan participant, up from $2.60. This 131% increase would be effective retroactively to Jan. 1, 1983.

While some employers recognize that a premium increase is necessary because the PBGC is incurring more liabilities than it expected, they say the increase should not occur until next year.

A retroactive increase would be a "certain guarantee of protracted disruptive litigation, further adding to the inordinately large administrative costs of the system," according to George Pantos, counsel for the ERISA Industry Committee, a benefits lobbying group representing 121 large corporations.

The PBGC currently is involved in dozens of lawsuits from employers that are challenging a retroactive provision in the Multiemployer Amendments Act. That provision makes employers that withdrew from the plans before the bill's effective date—April 29, 1980, but after it was signed by President Carter on Sept. 26, 1980, liable for a share of the plan's unfunded vested benefits.

The Supreme Court this month agreed to a review the constitutionality of the retroactive provision (*BI*, Oct. 24).

Another provision that makes a company that sells a subsidiary contingently liable for a subsidiary's pension liabilities could have unintended effects, experts say.

Under that provision, a company that sells a subsidary generally is liable for a subsidiary's pension liabilities if the firm that buys the subsidiary fails within five years of the purchase. The provision would apply in situations where the subsidary's pension liabilities exceeded $500,000.

Some experts say that if this provision is enacted, employers will become more reluctant to sell subsidiaries if they know they could get stuck with pension liabilities if a buyer fails years after buying the subsidiary.

Instead, companies would be more likely to shut down the subsidiary, leading to a loss of jobs, said Mr. Cummings.

Experts recognize that there may have been cases where a large company may have sold a subsidiary to another firm to get rid of the subsidiary's pension liabilities. In such cases, the buyer then folds the subsidiary's pension plan.

If the firm that bought the subsidiary has little or no net worth, it does not face a financial penalty for folding the plan. The firm's maximum liability to the PBGC for the termination is 30% of its net worth, a meaningless penalty if the firm has zero net worth.

Experts say such sales are a fraud on the PBGC insurance system. These actions could be dealt with by adding an anti-fraud section in the Clay-Erlenborn bill in place of the broad section in the bill on seller's contingent liability, observers say.

"The contingent liability section needs more work," said Richard Fay, a Washington attorney with Reed, Smith, Shaw & McClay. ■

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Washington fund wants 55% hike

Continued from page 2
omy would make such hikes a hardship, said Tim Wisecarver, an actuary with the department.

For 1982, the department proposed a 10.5% increase in workers compensation rates, but finally adopted only a 5.5% increase. And for 1983, it proposed a 34% increase, but adopted only a 17% increase, Mr. Wisecarver said.

Because of these cutbacks, the trust funds lost $208.1 million for 1982 and so far in this year, says Sam Kinville, director of the state fund.

"We need to act now to prevent the possibility of the workers compensation trust funds becoming another Social Security mess," Mr. Kinville said.

The combination of the rate increase reductions and rapidly rising claims costs caused a $123 million deficit in the funds in 1982, Mr. Wisecarver said. The funds had $498 million in 1982 premium and investment income, but claims costs and operating expenses were $621 million.

There are funds to cover the losses at present, but by the end of 1983 funds may run out, he said.

Virtually all small- and medium-sized employers in Washington buy their workers compensation coverage through the 72-year-old state fund. Washington is one of only six states that has a monopolistic fund that prohibits commercial insurers from selling workers compensation coverage in the state. Although self-insuring workers compensation risks has been permitted since 1972, only 303 companies and four self-insurance groups have qualified.

In Washington, employees must contribute half of the premium paid by the employer to the medical aid fund and the supplemental pension fund. Employers pay the full premium for the accident, or lost-time, fund.

Washington is unique in the way it computes work comp premiums. Instead of basing premiums on payroll, it bases them on the number of hours worked by employees, explained Rick Slunaker, assistant director of the Industrial Insurance Division of the Department of Labor & Industries, which directly handles the state fund.

"If you have two carpenters, one union and one not, with the union carpenter making $10 an hour, and the other making $5 an hour. . .they're both working eight hours a day up on the roof and they're both still exposed to the same risk. We classify the work, rate the risk and assign a cost. . .and collect for workers' hours of exposure," Mr. Slunaker explained.

The average composite rate in Washington for all three funds is 24.68 cents per worker hour. Of that rate, employers pay about 17.9 cents per hour and employees pay 6.7 cents, Mr. Wisecarver said.

On the average, employers now pay $358.70 per employee per year based on a 2,000-hour year and employees pay $134.90, Mr. Slunaker said.

The proposed 55% rate hike would increase the average composite rate to 38.25 cents per worker hour. Employers would pay an average of 27.79 cents per hour or about $556 a year per employee and employees would pay an average of 10.45 cents per hour or about $209 per year.

Most employers in the state are unaware of the proposed rate increase, according to a spot-check of employers throughout the state by *Business Insurance*.

Some of the smaller logging operations in the state, which have fewer than 200 employees, will see rate increases of as much as 73% in some of their job classifications.

"I'm not sure we could handle that," one said.

Another lumber and manufacturing company indicated the increase could prompt it to look into self-insurance.

"I would assume that some employers would consider (the rate increase) to be a factor to look a little closer at self-insurance," Mr. Slunaker said. "But I think that most employers that think they are eligible (to self-insure) are in the program already or in the pike with their applications right now.

"We certainly hope the rate increase is not going to cause anybody to go bankrupt or have a great deal of financial difficulty."

Employers are not saying much on the increase yet.

"We have a meeting of our members and the workers compensation task force Oct. 28 where the Department of Labor & Industries will make its presentation," said Lawrence Stevens, vp and chief counsel for the Assn. of Washington Business in Olympia, which represents 40,000 to 50,000 employers in the state. "After that meeting, we will formulate a response, though when you see a 55% increase you want to make a knee-jerk reaction."

Another group looking at the proposal is the Washington Contract Loggers Assn., which has about 300 members.

"We've just gotten the information and are beginning to evaluate it," said Manager Chet Diehl. He said it would go on record opposing such a large increase.

Both employer groups are sending out information about the proposed increase. In fact, the AWB in its newsletter will publish the proposed rates for all classifications, Mr. Stevens said.

The Nov. 9 hearing will be at 9 a.m. in the Department of Social & Health Services Auditorium, Office Building 2 in Olympia. Information about the proposal is available from the Department of Labor & Industries at 206-753-2127. ■

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Illinois insurer and 2 officers face federal fraud charges

Continued from page 2

The federal indictment issued last month charges Heritage Insurance Co., Aero Brokers Corp., a Heritage subsidiary, and Messrs. Giacinto and Hancir with nine counts of fraud derived from an alleged scheme "to defraud the State of Missouri . . .of (its) right to conscientious, loyal, faithful, disinterested and unbiased services."

The indictment also accuses the Heritage officers of paying a $30,000 bribe to Mr. McFerron to obtain confidential information that would allow the insurer to win the state of Missouri's automobile coverage.

It also alleges that the men attempted to conceal the alleged bribes from state investigators by falsifying documents and mailing them, a violation of federal mail fraud statutes.

A spokesman for Heritage Insurance vigorously denied the charges and told *Business Insurance* that the insurer's defense attorneys expect to prove the company and its officers innocent of any wrongdoing.

"The charges made in the indictment are false. Neither Heritage Insurance Co. nor its officers is guilty of any wrongdoing in the sale of insurance to the state of Missouri.

"Missouri state officials brought similar charges last year but, after a thorough investigation, the state prosecutor advised the judge hearing the case that no bribery occurred.

"The state prosecutor has advised lawyers for the company, Mr. Giacinto and Mr. Hancir that the state charges will be dismissed," the spokesman continued. "The charges filed in Kansas City (in federal court) are essentially the same charges that the state is dismissing.

"Lawyers for all three defendants look forward to proving their clients innocent as they did in the state's case."

The spokesman added that testimony during the state trial has already formed a basis for Heritage's innocence.

"Harvey McFerron, the state official in question, has stated under oath that he was not bribed and that he did nothing out of the ordinary for Heritage or its officers. Heritage was awarded the state insurance contracts on the basis of sealed bids, which Missouri state officials have stated under oath were not tampered with in any way.

"In fact, in 1980, shortly after the state of Missouri awarded these bids, a California insurance consultant hired by the state of Missouri reviewed these policies and found nothing wrong with them," the spokesman said.

Mr. Callahan, the assistant Cole County prosecutor, confirmed that he will probably seek dismissal of the charges against Messrs. Giacinto and Hancir, but said that the motion to dismiss was only a formality to complete the transfer of the investigation to federal authorities.

Heritage, a multiline underwriter that has been assigned a C plus rating by A.M. Best Co., received the Missouri insurance business through a now-defunct St. Louis brokerage, Insurance Brokers & Consultants Inc., the insurer's exclusive agent in Missouri and several other states, and Aero Brokerage Corp., a Heritage surplus lines brokerage subsidiary based in the insurer's Lincolnwood headquarters.

Mr. Blumeyer, formerly vp and director of Insurance Brokers & Consultants and currently president of A.B. Carter Inc., another St. Louis agency, was indicted by the state grand jury but has not been indicted by the federal body. Cole County's Mr. Callahan moved for dismissal of the state charges against Mr. Blumeyer earlier this month.

"I'm relieved," Mr. Blumeyer remarked after the motion had been filed. "We've known all along that we did nothing wrong."

Robert B. Schneider, the assistant U.S. attorney in charge of the Heritage investigation, said that he is not seeking charges against Mr. Blumeyer, who will testify on behalf of the prosecution.

No trial date has been set for the case. ■

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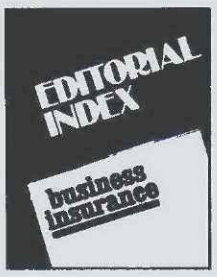

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U.S. insurers still cover Lebanese risks

Continued from page 2

donment of a commercial project as a result of war or violence.

Despite the obviously increased risks in Beirut, U.S. underwriters say they will still consider applications for political and credit risk coverage on Lebanese operations.

"We don't get a lot of requests for coverage in Lebanon and if we did, it would be extremely expensive," says Robert S. Frank, manager of political risk insurance at the Chubb Group of insurance companies in Short Hills, N.J. "It doesn't take an expert to realize that that's a delicate situation."

War risk rates, which normally are 0.1% of the goods' value per year, could range as high as 1% of value per day in Lebanon, he says.

Mr. Frank says Chubb receives one or two requests every couple of months from companies seeking coverage for employees traveling in Lebanon for business or pleasure and perhaps a request every five or six months for coverage on exports to the war-torn country.

"We don't see a lot of coverage requests for business in Nicaragua right now either," he says. Such coverage would more likely be provided by insurers domiciled in countries less hostile to Nicaragua's current Sandanista government.

Mr. Frank said he did expect one impact of the Beirut bombing to be a sudden upsurge in the number of requests by corporations for political risk coverage for operations or employees in other politically unstable countries.

"This happens anytime there's an international crisis," he says. "The impact of the bombings will have more to do with the demand for political risk insurance."

"We're open for coverage on a very restricted basis," John A. Hanson, president of the Foreign Credit Insurance Assn. in New York, says of Lebanon. "But there's just not much of a demand in a market like that because of the turmoil."

FCIA markets credit risk insurance that is underwritten by the Export-Import Bank of the United States (BI, July 11).

"(Lebanon) used to be a fairly good market" for political risk insurers, notes James A. Dorrian, vp of political risk insurance at AFIA Worldwide Insurance, the jointly owned overseas underwriting arm of a consortium of U.S. insurers.

"At this point there is very little demand. I just don't see the demand at all," he said.

"We haven't written anything there in years," added Robert E. Svensk, who heads AIG Political Risk Inc., a unit of American International Group Inc.

The Overseas Private Investment Corp., the Washington-based government agency that is the nation's largest political risk insurer, still writes political risk insurance for Lebanese exposures under an agreement reached with the Lebanese government in 1981, says an OPIC staff member, who asked not to be named.

"But I think after this weekend you'll find companies won't want to go there," the staff member added. "We've had a little bit of interest in the last year or two when there has been a quiet period, but there are no calls coming in right now."

Unlike U.S. commercial insurers, OPIC can routinely include coverage for losses arising from war, revolution, insurrection or civil strife, said the OPIC staffer.

Although U.S. political risk insurers say they're still willing to write coverage in Lebanon, London underwriters say they're very hesitant to provide the coverage.

"The general climate means that underwriters will take a pessimistic view of Lebanon and underwriting (political risk) contracts in the area," says Julian Radcliffe, director of the credit and political risk division of Hogg Robinson Group P.L.C. in London.

In addition, London underwriters are hiking rates for war risk coverage on ships and goods bound for Lebanon.

Both the Joint Hull War Risk Rating Committee and the Joint Cargo War Risk Rating Committee, which represent both Lloyd's and other London underwriters, are quoting rates for Lebanon on a "held-cover" basis. That means the underwriters may charge whatever rates they desire and they can cancel coverage on short notice.

But in the United States, an official at the American Cargo War Risk Reinsurance Exchange, a New York clearinghouse that helps provide war risk insurers with reinsurance, said that the exchange had not increased its rates.

Also, London underwriters are hesitant to provide all-risk property policies to companies with property in Lebanon after a U.S. court recently ruled that Holiday Inns Inc. could collect on such a policy for damage to its Beirut hotel during the 1970s.

A U.S. District Court in New York rejected Aetna Insurance Co.'s contention that recovery should be barred by the policy's war risk exclusion, deciding the action in Lebanon at that time was "a series of factional civil commotions" covered by the policy's "strikes, riots and civil commotions" endorsement. Aetna, a CIGNA Corp. unit that led the policy for AFIA, plans to appeal the ruling (*BI*, Oct. 3).

"There is no great enthusiasm to write this book of business right now until this case is decided," said Stephen Merrett, chairman of Merrett Holdings P.L.C., a Lloyd's underwriting management agency.

"At the moment, or so we thought, you cannot buy war risk insurance on land, so we are watching the Holiday Inns case with great interest," he explained.

However, AFIA, whose member companies would be responsible for the Holiday Inn claims if the case is upheld, is still active in the Lebanse property insurance market.

"Yes, people are still writing property insurance in Lebanon," said a property underwriter with AFIA in New York. "But available depends on the area," he said without elaborating. ■

Few Grenada claims expected

LONDON—Underwriters say they doubt if there will be any significant losses triggered by last week's invasion of Grenada by U.S. troops.

For instance, Julian Radcliffe, director of the credit and political risk division of Hogg Robinson Group P.L.C., said he did not know of a "single contract" covering political risks in Grenada.

A spokesman for one British firm operating on Grenada, Plessy Airports Ltd., would not comment on its insurance arrangements. Plessy is building the controversial new airport on the Caribbean island, one of the spots where U.S. troops landed last week.

Lloyd's and other London marine underwriters could not name any ships or cargo that have been endangered by the conflict, but cargo insurers are quoting rates for war risk coverage in the vicinity of the island on a held-cover basis, which means they can deviate from standard London rates. ■

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Government, Associations, Unions, Educational Institutions	1,024
Commercial Consumers Sub-total	**23,176**
Insurance Agents & Brokers	9,639
Insurance Cos.	5,384
Financial Institutions	385
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,779
Others allied to the field	1,020
TOTAL	**42,383**

*Source: Business/Occupational breakdown of qualified circulation, May 2, 1983 issue, as submitted to BPA for June 1983, BPA Publisher's Statement.

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Plan would compensate future Manville claimants

Continued from page 1
stein suggests $1 be placed in the sinking fund for future claimants.

"The aggregate amount paid off in cash (to unsecured creditors) will be equal to the aggregate amount supplied to the sinking fund," he added.

One year after consummation of the reorganization plan, 1/20 of the sinking fund will be used to pay, on a pro rata basis, new claims that are determined during that year.

Then, Manville's profits for that year will be used to give additional payments to all creditors whose claims have been liquidated to that point, including all the asbestos claimants and unsecured creditors that received payments upfront at the time of reorganization. This is intended to equalize payments received by all current and future claimants.

The process will repeat itself for 20 years until the sinking fund is exhausted.

Not included in the pool of funds divided between current unsecured creditors and the sinking fund would be any reimbursement Manville receives from its insurers or the government, which Manville contends is liable for asbestos injuries, too. This money would go only to asbestos claimants.

It is unclear at this point if any of that money would go into the sinking fund.

"I want you to consider these proposals and any others that will create some sort of sinking fund or something equal, tantamount to that, and will equalize treatment of future claimants as their claims arise with payments accorded to prior asbestos claimants and commercial creditors," he said.

Judge Edelstein also suggested to plaintiffs' attorneys that asbestos claimants, including future claimants, agree to have their cases heard and decided by an arbitration panel, or possibly the bankruptcy court, and give up their right to a jury trial.

"One thing you and your colleagues should consider very carefuly, is the concern that I have, and you should all have, on the additional burdens that this court may have to sustain with respect to future claimants. if you don't give up some of your rights to a jury trial," Judge Edelstein said.

"Breaking the backs of the courts of this land, including this one, is not going to have a salutory effect. There is a complete limitation on our ability to serve all needs, because our numbers are small and our caseload is large," Judge Edelstein added.

Also at the hearing, a representative of Manville's insurers repeated the desire to devise and participate in a plan that would allow Manville to purchase claims-made insurance policies to provide for future claims (*BI*, Sept. 19).

Under a claims-made policy, the insurer on the risk when the claim is made is liable. The insurance coverage for future claims could be renewed each year with premiums adjusted based on Manville's ability to pay.

Francis McCarthy, Travelers Corp.'s general counsel, told the court that the insurer has helped design such a claims-made program that would be funded from Manville's future operating revenues.

"We corroborate to the Court the availability and design and desire to participate in such a program of several of Manville's carriers," Mr. McCarthy said.

Manville and 27 insuers are currently litigating in California the nature and scope of insurance coverage for asbestos claims. Manville claims it is entitled to more than $600 million in insurance.

Travelers was Manville's primary insurer from the 1940s to the early 1970s. It, Home Insurance Co. and syndicates at Lloyd's of London have reportedly offered the manufacturer $250 million to pay current asbestos plaintiffs' claims.

At the Oct. 27 hearing in bankruptcy court, Judge Lifland suggested that a moratorium be placed on all proposed or pending litigation between the parties involved in the Manville bankruptcy while they attempt to draft a consensual reorganization plan.

Judge Lifland gave the parties another extension after John Jerome, attorney for the commercial unsecured creditors, told the court that the differences between the asbestos litigants and Manville could be resolved.

Prior to Mr. Jerome's request, Manville had offered to submit its reorganization plan to the bankruptcy court, explaining that negotiations between it and the asbestos litigants had broken down last week.

Robert Rosenberg, an attorney representing the asbestos plaintiffs, requested that the period for filing the reorganization plan not be extended, adding that the plan Manville was filing was "an illusory non-plan."

Manville filed for reorganization in August 1982, citing an overwhelming number of asbestos claims. It was facing 16,500 claims at the time and predicted that more than 30,000 additional claims could be filed by the year 2000. ■

Fund official hopes suits can be settled

MADISON, Wis.—The general manager of the Wisconsin Insurance Security Fund says he hopes remaining legal challenges by nine insurers over the fund's assessment practices can be settled.

James R. Fox, the security fund's general manager, said he hopes a meeting can be set up soon among officials from the fund, the state and insurers that had disputed the constitutionality of the guaranty fund's funding formula, which was used to cover policies written by the insolvent Reliable Life & Casualty Co.

The insurers also challenged the fund's assessment method, which charges life insurers doing business in the state on the basis of premium volume in all states where an insolvent company did business, not just Wisconsin.

Although these suits have been settled, another remains outstanding. That suit claims that a $200 deductible should be applied on individual life and health insurance claims paid by the fund, as is done in Wisconsin with claims made against insolvent property/casualty insurers.

Mr. Fox said he thinks this deductible does not apply to life insurance claims.

Three of the nine insurers—The Prudential Insurance Co., Transamerica Occidental Life Insurance Co. and Transamerica Occidental Life Insurance Co. of Illinois—filed suits in state court.

A federal suit by six other insuers has been dismissed because the court determined the matter was under state jurisdiction. ■

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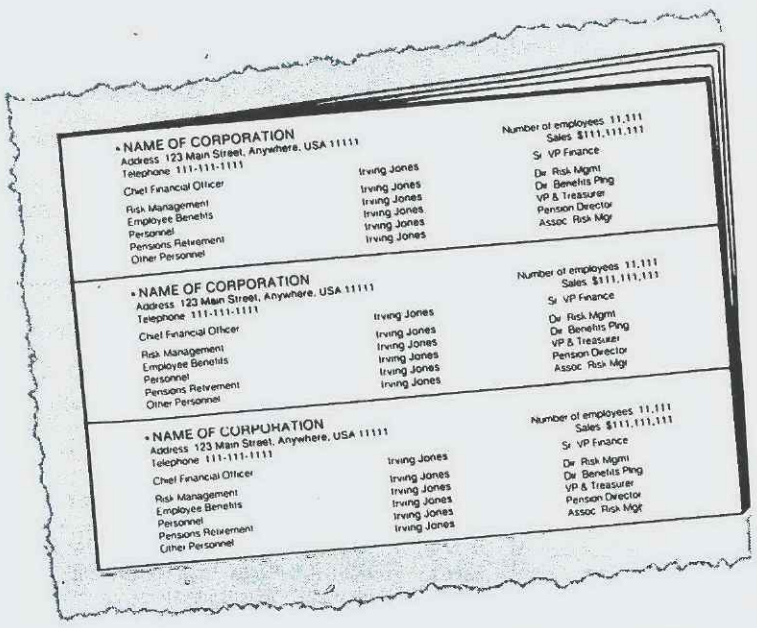

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K mart learns hard lesson in warehouse fire

Continued from page 2
fire, which was the most expensive single-building fire in U.S. history.

While K mart had fire protection devices in the warehouse that would have been adequate for many types of fires, they could not handle the highly volatile aerosol cans that exploded and spread the fire as they flew through the air.

"I would say the lesson, if anything, is that if you have an aerosol fire in a large building of this type, with the fixed protection (primarily sprinklers) inadequate and with combustible products stored from one end to the other, it will burn to the ground," concluded Mr. Marsh.

Other fire protection experts pointed to more specific lessons dramatized by the fire:

- Isolate aerosols and other flammables from general merchandise with MFL (maximum fire loss) walls and heavy sprinkler protection or remove them from the warehouse to a detached structure.
- Divide warehouses into smaller segments with MFL fire walls and protect any openings with fire doors rather than deluge curtains (curtains of water at portals meant to keep fire from passing through).
- Store aerosols in racks equipped with full sprinklering at each tier, or in pallets limited to one level (5 feet) high, with sprinklers capable of delivering up to 0.6 gallons of water per minute per square foot.

The Morrisville K mart warehouse did not meet all these specifications.

The building, which supplied goods to 375 stores from Maine to Virginia, contained "nearly everything you might see in any K mart store, except clothing," Factory Mutual says, including alcohol- and petroleum-based aerosols, propane torch kits, butane lighter fluid and automobile tires.

K mart inventories showed that about 47,000 gallons of aerosols and 101,000 gallons of high flash-point liquids in non-pressurized containers were scattered throughout the warehouse, Factory Mutual says.

Goods were stored on pallets or in racks to a height of 15 feet. There were no in-rack sprinklers.

The building's fire protection system included wet-pipe ceiling sprinklers capable of delivering up to 0.4 gallons of water per minute per square foot, driven by electric and diesel pumps; non-load bearing walls (walls that don't actually support the weight of the structure), which had three-hour fire ratings, that divided the building into four sections; deluge curtains at conveyor entrances, rather than fire doors; heat and smoke vents in each 2,304 square-foot storage bay; complete coverage by small hose stations and dry chemical fire extinguishers; and a proprietary alarm system.

"Unfortunately, the fire started in the aerosols," Mr. Marsh says. "There were many places in the building where, if the fire had started there instead, the protection would have been adequate."

A major factor in the quick spread of the fire was the intense heat generated by the carburetor cleaner, which is highly flammable itself and was in aerosol cans containing petroleum-based propellants, K mart's Ms. Powers says.

Aggravating this were the ballistic properties of the aerosol cans, which rocketed through deluge curtains, spreading the fire to other sections of the warehouse.

Aerosol cans also are more of a fire risk now than they used to be because the use of non-flammable fluorocarbons as propellant has been outlawed as a health hazard. "Now they're using hydrocarbons, which burn violently," pointed out Larry Davis, senior fire instructor for Industrial Risk Insurers.

"The aerosol cans weren't under water long enough to put them out," says Ms. Powers. "Deluge curtains are generally a good idea, but they didn't work well in this case."

In addition, she said, "Height and density were a problem with the pallets. The fire was at the bottom of the pallets and the sprinklers were close to the roof, about 30 feet higher. By the time the water got to the very hot fire it was unable to saturate it."

Factory Mutual and other insurers recommend limiting the height of palletized storage to five feet and concentrating larger volumes of water on aerosols than on general merchandise.

MFL-rated fire walls are given equal emphasis.

Such walls, essentially, are one-way. If one section of a building collapses, it pulls down the wall on that side, but leaves the next section's wall intact.

"If this building had been provided with truly MFL walls, the dollar loss would probably have been one-half to one-quarter what it was," Mr. Marsh says. "While there were walls, they were not fire walls from the standpoint of adequate protection."

Other sources agree, doubting whether the Morrisville facility's walls would have held even if rocketing aerosols had not breached their deluge curtains.

"No fire department can defend against a building with no fire doors and walls tied to the steel structure. When the steel falls, so do the walls," added another retail store risk manager.

Photo: Harry Sircely, Bucks County Courier Times

On June 21, 1982, a fire burned K mart's 1.2 million-square-foot Morrisville, Pa., warehouse to the ground, causing a $100 million loss.

As K mart rebuilds its warehouse and completes a 923,000 square-foot addition under way at the time of the fire, it is doing its best to see that similar fires do not happen again, Ms. Powers says.

"The main thing is that we've looked at our storage problem and taken steps to isolate and protect as fully as possible the dangerous products," she says.

"We've put a double MFL fire wall between the addition and the new building, which is divided into four quadrants by single MFL fire walls."

One quadrant will be specified for aerosol storage and the aerosol products kept in racks with sprinklers on each tier to deliver water more thoroughly to a fire than is possible with palletized storage.

In addition, she says, this quadrant will be surrounded on four sides by MFL fire walls and each opening protected by two three-hour fire doors.

"We have an extensive conveyor system," she says. "The deluge curtains used prior to the fire are being replaced by fire doors. When an alarm is triggered, the conveyors will drop out of the way and fire doors will slide down, forming a solid fire wall."

K mart also is revamping fire protection systems at its nine other warehouses on a case-by-case basis, Ms. Powers says, adding that Factory Mutual has reviewed all the plans.

"We feel the steps we have taken will give us the maximum protection," she says. "There's always something more you can do, but we definitely feel better about the protection it will be affording."

She hopes K mart's warehouses continue to be rated as highly protected risks.

Factory Mutual says its engineers had made recommendations to K mart concerning the aerosol storages before the fire and that K mart's management was working to correct the problems before the fire.

Another retailer's risk manager says his firm also is taking steps to contain aerosols since the K mart fire.

"We had some sophisticated systems in place already, but the fire certainly made us think," says Robert J. Dinges, director of risk management for the Dillon Co. of Hutchinson, Kan. Dillon has six warehouses but they are a good deal smaller than the Morrisville center.

"We've since isolated flammable goods from other materials and attempted to contain the ballistic effects of aerosols through a chain-link caging system."

But, others point out that part of the problem facing retailers is the time lag between the introduction of new products and the introduction of fire protection systems for them.

"We introduce products into warehouses six months before our insurers become aware of them," says one expert in the retail field.

"It may take another six months before we can address the problem. Although aerosols aren't new, the contents have changed. It takes fire protection about five years to react to a new product."

And no matter what steps are taken, they cannot guarantee the complete prevention of fire, Factory Mutual's Mr. Marsh emphasizes.

"It is my opinion that if someone has combustible materials stored in a building, they have to accept that sooner or later they will become ignited.

"They just have to be sure they have fixed fire protection to control the fire that follows." ■

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Delta Holdings buys Elkhorn Re

FORT LEE, N.J.—Delta Holdings Inc., an organization of 26 U.S. and European industrial corporations, has acquired Elkhorn Reinsurance Co. of Louisville, Ky., for $18 million in cash.

This is Delta Holdings' second insurance company acquisition in four months. Last July, the organization bought National Grange Mutual Insurance Co. of Keene, N.H., for $6 million in the first phase of its drive to build a worldwide network of insurance and reinsurance companies (*BI*, Aug. 1).

Delta Holdings' 26 shareholders are all owners of captive insurers that want to expand their underwriting of third-party business.

Elkhorn, a property/casualty reinsurer with 1982 gross written premiums of $48 million, was founded in 1965 as a captive affiliate of National Distillers & Chemical Corp. of New York.

Under the terms of the purchase agreement, National Distillers will transfer its own risks from Elkhorn to a newly formed insurer, DR Insurance Co., which will be domiciled in Kentucky.

Delta Holdings has acquired Elkhorn's third-party business only, says Jack Ryan, senior vp of American Risk Management Inc. in Fort Lee, which has managed Elkhorn since its inception and which also manages Delta Holdings.

Mr. Ryan said that Elkhorn was picked for acquisition because of its strong underwriting record and continuing A-plus rating from A.M. Best Co.

Elkhorn's staff and underwriting operations will be expanded under the new ownership and its name will be changed to Delta American Re Insurance Co., Mr. Ryan said.

Delta Holdings has followed the same course with National Grange, which became Delta America Insurance Co. after its acquisition last summer. National Grange, a property/casualty direct writer with $121 million in 1982 gross premiums, was licensed in 12 states when Delta Holdings bought it.

Since July, the insurer has picked up an additional license in Ohio, and Delta expects to win further licenses in California, Connecticut and Illinois in the near future, according to Mr. Ryan.

Although Delta is looking at "a number" of additional acquisitions, including the purchase of a London underwriter, it is not seriously considering any of these acquisitions for the near term, Mr. Ryan said. "Any London purchase will probably be delayed because of conditions in the London market." ■

Absence of storm losses masks British results

By ALAN H. CLIFTON
and PHILIP V. OLSEN
Special to Business Insurance

AT THIS TIME last year, we reported on the appalling first-half results of the British property/casualty insurance companies. The horrendous figures were in very large measure the consequence of the severe winter weather that hit both Europe and the United States in the first months of 1982.

Twelve months later, those subpar 1982 results can be compared with the insurers' latest results, and it's not too hard to guess that this year's numbers make for much more satisfactory reading.

The aggregate pretax earnings of the seven leading British insurers tracked by *Business Insurance* rose two-thirds in the first half of 1983 to 218 million pounds (about $327 million) from 131 million pounds ($196.5 million) for the same period in 1982.

The prime areas for the recovery were the United Kingdom itself and Canada, where better weather experience and an underlying improvement in underwriting conditions, particularly in personal lines, combined to produce a dramatic upturn.

The Canadian profits of the major British insurers soared from a meager 6 million pounds ($9 million) in 1982's first half to around 45 million pounds ($67.5 million) in the latest six-month period. Although these earnings are composed almost entirely of investment income, at least Canadian operations are once again solidly in the black.

Meanwhile, net operating profits from British property/casualty business have doubled for our sample of leading companies. The big gainers were Eagle Star Insurance Co. Ltd. (see related story), General Accident Fire & Life Assurance Corp. Ltd. P.L.C., Royal Insurance P.L.C. and Sun Alliance & London Insurance P.L.C.

According to our calculations, Eagle Star pushed its earnings from British operations to about 16 million pounds ($24 million) in the first half, up from virtually nothing, while General Accident eliminated an estimated net operating deficit last year of about 13 million pounds ($19.5 million). Royal doubled its British earnings to 30 million pounds ($45 million) and Sun Alliance trebled its earnings to an estimated 27 million pounds ($40.5 million).

Alan H. Clifton and Philip V. Olsen are analysts with London-based Kitcat & Aitken. They report quarterly on the British insurance industry for Business Insurance, in addition to supplying weekly earnings reports on British companies for BI Ticker.

British Issues

25 Oct Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	159	159.0	16.86	10.6	165—	158
Eagle Star	532	19.0	24.29	5.2	532—	522
Genl Accident	407	10.6	24.29	6.5	415—	405
Gdn Royal Exch	468	11.7	22.26	6.6	468—	452
Phoenix	338	14.7	25.00	7.7	348—	332
Royal	478	11.9	37.86	8.2	498—	478
Sun Alliance	1300	14.9	68.57	6.0	1313—	1225
Brokers						
CE Heath	293	7.3	21.07	7.8	293—	285
Hogg Robinson	130	10.0	8.57	7.3	130—	115
JH Minet	124	9.5	6.50	6.1	124—	120
Sedg Grp	220	11.0	10.00	5.2	220—	215
Stenhouse Hldg	99	9.0	7.86	8.4	101—	97
Stew Wrightson	255	8.5	20.43	8.9	258—	245
Willis Faber	550	11.5	25.00	5.5	557—	550

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

As intimated, these numbers are very gratifying, but they hardly indicate a trend as underwriting margins in Britain continue to erode. Stripping out the effects of the severe weather losses leaves the underlying picture clear: personal lines premium rates are rising, but not fast enough to offset expanding claims costs and worsening loss frequency, while commercial premiums are generally still drifting under the weight of fiercely competitive pricing.

So, as far as the British market is concerned, we've had the good news.

Moving from the revenue account to the balance sheet, the striking feature of the insurers' first-half performance is the further substantial strengthening of the net surplus assets position of the industry.

On average, the premium-to-surplus ratio for the top British insurers now stands at just 1.25-to-1. Even Commercial Union Assurance Co. P.L.C., which has in recent years come to be regarded as the most financially stretched of the British companies, is luxuriating at 1.66-to-1. At the other extreme, Eagle Star sports a ratio of only 0.8-to-1. Evidently, there is simply just not enough business around that's worth writing.

The firm stock market conditions on both sides of the Atlantic, which have helped produce the current financial health of industry in general, have not had a great effect on British insurance stocks. Investors remain unconvinced of the underwriters' ability to generate high, sustainable earnings and although the insurance sector has outpaced U.K. equities in general so far in 1983, prices have nonetheless moved sluggishly.

As a result, a major gap has appeared between the stock prices of the leading British insurance companies and their underlying book values.

The sharpest examples of this phenomenon are Sun Alliance, selling at a little more than half its 23 pounds-per-share ($34.50) net asset value, and Phoenix Assurance P.L.C., whose net assets are 2½ times its share price.

Turning to the brokerage sector of the industry, the four major Lloyd's brokerages whose financial years coincide with the calendar year have now reported their results for the first six months of 1983. By comparison with the U.S. alphabet brokers, the British companies' results look remarkably good.

The aggregate pretax earnings of the four —Sedgwick Group P.L.C., Willis Faber P.L.C., Minet Holdings P.L.C. and Stewart Wrightson Holdings P.L.C.—increased more than 25% in the first half to more than 88 million pounds ($132 million) from about 70 million pounds ($105 million) in the first six months of 1982.

This buoyant performance, however, has largely been a function of the severe weakness of the pound against other major international currencies, especially since the Lloyd's brokerages take in a high proportion of their revenues in foreign currencies.

Using the companies' own calculations, favorable currency rates are responsible for some 12.5 million pounds ($18.8 million) of the additional pretax earnings—or 18 percentage points of the reported overall 26% increase.

Much of the currency benefit comes from the Lloyd's brokers' business with U.S. clients. The average value of the U.S. dollar against the pound increased by 17% from midyear 1982 to the same time in 1983.

Leaving aside the relatively passive benefits of currency movements, the underlying growth of profits was considerably less substantial, an average of about 8% or a "real" aggregate pretax earnings increase of about 5.5 million pounds ($8.3 million).

Minet achieved the best real growth rate with a 28% advance to 10.8 million pounds ($16.2 million) from 8.4 million pounds ($12.8 million), while Stewart Wrightson's performance was the poorest, staying relatively level at 4.1 million pounds ($6.2 million). In between these two extremes Sedgwick is thought to have achieved real growth respectively of 4% to 42 million pounds ($63 million), while Willis Faber's earnings grew about 9% to 18.5 million pounds ($27.8 million).

In Minet's case, it has to be said that the company's excellent real first-half growth rate benefited both from a material increase in profit commissions from its Lloyd's underwriting agency subsidiaries and from extraordinary investment profits. If allowance is made for these influences, Minet profits probably rose less than 10%, an increase much closer to that of Sedgwick and Willis Faber.

In a somewhat similar vein, it is probable that Stewart Wrightson's poorer real performance is a function of the very difficult trading background experienced by its ship brokerage company, whose profits have been sharply cut.

Single-figure growth rates however, still stand up well in a comparison with the first-half progress of the major U.S. insurance brokerages (*BI*, Aug. 15). Like their U.S. counterparts, the Lloyd's brokers have been adversely affected by the decline in short-term interest rates which, generally, have cut investment income. On the other hand, the Lloyd's brokers' respectable figures were helped by their involvement in the international reinsurance business, which has grown more rapidly than other forms of brokerage.■

Financial briefs

Eagle Star

Eagle Star Holdings P.L.C., the parent company of Eagle Star Insurance Co. Ltd., is asking its shareholders to refuse to sell their stock to Allianz Verischerungs-A.G., the West German property/casualty insurer.

Allianz announced Oct. 19 that it would make a bid of 692 million pounds ($1.04 billion) for all remaining Eagle Star shares, or roughly 5 pounds a share. Allianz currently holds 30%.

The Eagle Star board, however, says that the shares are worth about 7.5 pounds apiece and is recommending that shareholders refuse the tender offer.

"The bid is ridiculous and inadequate," said Robert Durant, general manager and secretary of Eagle Star. "We have written to shareholders and told them to ignore the offer." ■

BI Industry Stock Report

OCT. 25, 1983 10/19/83 THRU 10/25/83

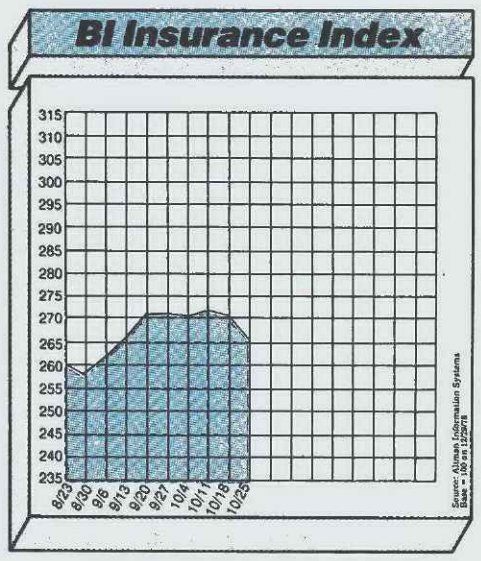
Insurance Cos		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	35.75	-2.1	8.7	2.64	7.4	36.13	35.63	905.6
American Bankers Ins Group	OTC	12.88	-3.7	10.1	0.50	3.9	13.00	12.88	58.8
American Gen Ins Co	NYSE	22.50	1.1	8.2	0.80	3.6	22.50	22.25	565.8
American Indty Finl Corp	OTC	17.63	0.0	12.2	1.12	6.4	17.75	17.63	2.9
American Intl Group Inc	OTC	62.75	-6.7	10.5	0.44	0.7	64.25	62.25	1,283.4
American Natl Ins Co	OTC	20.13	-1.2	8.0	0.96	4.8	20.63	20.00	63.9
American Sts Life Ins Co	OTC	42.00	1.2	11.5	0.88	2.1	42.00*	41.50	1.9
Aneco Reins Ltd	OTC	2.88	4.5	71.9	0.00	0.0	2.88	2.75	7.1
Avemco Corp	AMEX	20.25	1.2	12.5	0.58	2.9	20.38	19.50	20.5
Banks Iowa Inc	OTC	48.50	-1.0	17.8	1.52	3.1	49.00	48.50	0.6
Bitco Corp	OTC	20.25	0.0	8.7	1.33	6.6	20.25	20.25	20.5
Carolina Cas Ins Co	OTC	8.75	-2.8	0.0	0.32	3.7	9.00	8.75	1.2
Chubb Corp	OTC	60.25	-7.8	7.9	3.12	5.2	62.00	59.38	132.8
Combined Intl Corp	NYSE	37.13	-0.7	11.8	2.00	5.4	38.00	37.13	89.7
Continental Corp	NYSE	29.00	-3.7	39.2	2.60	9.0	30.13	29.00	326.6
Crawford & Co	OTC	14.75	-6.3	10.9	0.60	4.1	15.00	14.75*	8.7
Crown Life Ins Co	OTC	125.00	0.0	8.2	3.10	2.5	125.00	125.00	0.5
Employers Cas Co	OTC	33.00	-2.2	6.7	1.20	3.6	33.50	33.00	1.3
Equifax Inc	NYSE	27.75	-9.0	11.6	1.40	5.0	30.38	27.00	110.2
Excelsior Ins Co	OTC	20.50	0.0	17.2	0.00	0.0	20.50	20.50	1.1
Farmers Group Inc	OTC	39.13	-2.2	9.9	1.36	3.5	39.38	39.00	544.7
Foremost Corp Amer	OTC	29.25	-6.4	8.9	0.83	2.8	31.25	29.00	162.5
Fremont Gen Corp	OTC	12.63	-12.2	57.4	0.48	3.8	14.00	12.38	197.9
Great West Life Assurn Co	OTC	250.00	0.0	9.0	11.00	4.4	250.00	250.00	0.5
Hanover Ins Co	OTC	57.00	-5.8	7.1	0.88	1.5	59.50	57.00	9.0
Hartford Steam Boiler Insptn	OTC	54.00	0.0	11.3	3.00	5.6	54.00	54.00	1.7
Jefferson Natl Life Ins Co	OTC	41.00	-4.7	12.7	0.76	1.9	41.00	41.00*	2.3
Kemper Corp	OTC	39.50	-3.4	7.3	1.80	4.6	40.50	39.50	70.4
Lincoln Natl Corp Ind	NYSE	57.13	2.0	9.1	3.00	5.3	57.50	55.75	111.8
Mission Ins Group Inc	NYSE	29.25	3.1	10.9	1.00	3.4	29.25	28.00	150.2
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE	
Northwestern Natl Life Ins	OTC	36.25	-1.0	24.0	1.50	4.1	36.63	36.25	45.5
Ohio Cas Corp	OTC	45.38	-7.4	8.3	2.52	5.6	47.00	45.38	79.9
Old Rep Intl Corp	OTC	30.75	1.7	7.1	0.90	2.9	30.75	29.50	67.0
Orion Cap Corp	NYSE	29.25	-0.4	14.6	0.66	2.3	29.75	29.25	75.2
Preferred Risk Life Ins Co	OTC	20.25	-1.2	8.1	0.67	3.3	20.50	20.25	1.9
Provident Life & Acc Ins Co	OTC	64.50	-0.8	8.2	2.60	4.0	64.50	64.50	3.7
St Paul Cos Inc	OTC	57.00	-3.6	6.5	2.80	4.9	57.25	56.88	176.0
SAFECO Corp	OTC	57.25	-3.2	11.3	2.40	4.2	57.75	56.25	217.7
Sri Corp	OTC	19.00	-1.3	7.1	0.56	2.9	19.25	18.75	132.8
Seibels Bruce Group Inc	OTC	22.50	-7.7	13.3	0.80	3.6	22.88	22.50	18.4
Statesman Group Inc	OTC	11.00	-5.4	7.7	0.15	1.4	11.50	11.00	98.2
Tokio Marine & Fire Ins Co	OTC	107.50	-0.8	17.2	3.96	0.9	107.75	106.75	8.6

OCT. 25, 1983 10/19/83 THRU 10/25/83

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	NYSE	31.00	-3.9	8.0	1.80	5.8	31.50	31.00	1,135.6
United Fire & Cas Co	OTC	32.25	0.0	11.5	0.88	2.7	32.25	32.25	0.5
United States Fid & Gty Co	NYSE	56.00	0.9	11.1	3.84	6.9	56.00	55.00	151.1
United Svcs Life Ins Co	OTC	22.25	2.3	6.5	1.00	4.5	22.25	22.00	14.1
Usilife Corp	NYSE	27.00	1.9	7.9	0.88	3.3	27.00	26.38	206.5
Washington Natl Corp	NYSE	26.38	-5.0	11.7	1.08	4.1	27.38	25.88	75.2
Zenith Natl Ins Corp	OTC	16.00	-1.5	11.3	0.60	3.8	16.25	15.75	25.2
INSURANCE COMPANIES	AVERAGE			9.9		3.8			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	21.00	8.4	0.0	1.00	4.8	21.00	20.00	124.1
Baldwin & Lyons Inc	OTC	38.50	0.0	12.4	0.80	2.1	38.50	38.50	0.3
Corroon & Black Corp	NYSE	23.75	-1.6	16.4	1.80	7.6	24.13	23.75	39.4
Crump E H Cos Inc	OTC	9.88	1.3	13.5	0.40	4.1	9.88	9.75	17.4
Emett & Chandler Cos Inc	OTC	10.63	0.0	0.0	0.00	0.0	10.63	10.63	8.8
Hall Frank B & Co Inc	NYSE	26.63	-3.2	21.0	1.70	6.4	28.50	26.63	201.1
Integrated Res Inc	AMEX	31.75	-11.2	11.8	0.00	0.0	34.13	31.75	162.4
Marsh & Mclennan Cos Inc	NYSE	45.75	2.5	13.3	2.20	4.8	45.75	44.75	415.2
Poe & Assoc Inc	OTC	6.00	0.0	0.0	0.00	0.0	6.00	6.00	0.0
Reed Stenhouse Cos Ltd	OTC	12.00	0.0	20.0	0.60	5.0	12.00	12.00	4.2
AGENTS/BROKERS	AVERAGE			17.8		3.8			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	34.38	3.3	10.1	1.28	3.7	34.88	33.13	3,578.9
Anderson Clayton(Ranger/PanAm)	NYSE	28.38	2.3	16.2	1.32	4.7	28.50	27.00	14.6
Amco Inc	NYSE	18.25	-5.8	0.0	0.40	2.2	19.00	18.25	264.9
Baldwin Utd Corp	NYSE	2.50	-16.7	0.0	0.00	0.0	3.13	2.50*	633.5
CIGNA Corp	NYSE	45.00	-1.4	7.2	2.48	5.5	45.50	45.00	815.8
City Investing Co. (Home Ins.)	NYSE	34.13	-2.5	10.0	1.80	5.3	35.38	33.63	1,301.2
CNA Finl Corp (CNA)	NYSE	22.25	0.0	7.7	0.00	0.0	22.38	22.13	57.4
Control Data (Comml. Credit)	NYSE	45.00	-6.2	11.0	0.60	1.3	46.50	44.75	2,190.9
General Re Corp	NYSE	63.75	-1.2	13.3	1.28	2.0	65.63	63.50	492.3
Gulf Utd Corp	NYSE	29.00	0.4	8.8	1.32	4.6	29.00	28.75	377.5
ITT (Hartford Group)	NYSE	42.25	0.6	9.0	2.76	6.5	43.00	41.75	2,022.4
Optimum Hldg Corp	OTC	5.75	-6.1	18.5	0.00	0.0	6.00	5.75*	16.7
Sears Roebuck & Co. (Allstate)	NYSE	40.25	6.3	11.6	1.52	3.8	40.25	38.25	2,935.8
Teledyne Inc (Argonaut)	NYSE	164.13	-1.1	15.3	0.00	0.0	169.00	164.13	555.5
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.25	2.2	9.6	1.56	5.3	29.25	28.50	335.2
CONGLOMERATES/HOLDING COS.	AVERAGE			14.5		2.7			

*Record high/low since Jan. 1, 1983

System design: Altman Information Systems



The *Business Insurance* stock index dropped 4.6 points during the five-day trading period ending Oct. 25, dropping to 265.9 from 270.5. The index had fallen 3.2 points during the previous period. In the period ending Oct. 25, 14 stocks posted gains, 37 closed down and 13 were unchanged. The largest gains were reported by Alexander & Alexander Services Inc., 8.4%; Aneco Reinsurance Co. Ltd., 4.5%; Mission Insurance Group Inc., 3.1%; Marsh & McLennan Cos. Inc., 2.5%; and United Services Life Insurance Co., 2.3%. The largest losses were reported by Fremont General Corp., 12.2%; Integrated Resources Inc., 11.2%; Equifax Inc., 9.0%; Chubb Corp., 7.8%; and Ohio Casualty Corp., 7.4%. The *BI* stock index, which tracks a wide range of insurance industry issues, reported a 1.7% decrease, compared with an 0.8% decline in the New York Stock Exchange compoite and a 0.1% increase in the Dow Jones 30 industrials. –

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