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1989-1990 DIRECTORY OF HMOs AND PPOs

NEWSPAPER

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Directory aids employers

The *Business Insurance* 1989-1990 Directory of HMOs and PPOs is our third annual directory of managed health care delivery systems.

This is the most comprehensive and easy-to-use directory of HMOs and PPOs published. Unlike other directories, the *Business Insurance* directory includes detailed information in an easy-to-read prose style.

In addition, this special directory issue, which is published as a 53rd issue of *Business Insurance*, includes articles assessing HMOs and PPOs and spotlighting trends in the marketplace. The combination provides users with a ready reference to HMOs and PPOs operating around the country while also providing information on the general managed care marketplace. It will be useful not only to seasoned benefit managers but also to professionals new to employee benefits management.

The listings on the HMOs and PPOs provide information on the specific services provided. The standard HMO package is described, as well as available options. The PPO listings note specialty services and describe what organization provides utilization review services, which are vital to successful PPO operation.

The *Business Insurance* directory of HMOs also is unique in listing the number of employer groups enrolled and the number of employees and dependents enrolled rather than just a total membership figure. We believe this is an important piece of information for employee benefit managers considering the selection of an HMO.

The PPO listings include the number of employees and dependents with access to the PPO network, which is different from reporting the geographic population with access to the network providers.

Also unique to this directory is the publication of HMO rate information. Community rates are noted, when reported by the HMO.

In addition, HMOs and PPOs operating nationwide were encouraged to provide listings for each state in which they operate to provide readers with information on the HMOs and PPOs operating in individual states. The listing of each HMO and PPO also notes whether the organization provides consolidated billing for multistate employers.

Included in the directories are 380 health maintenance organizations and 689 preferred provider organizations. The information was requested from the HMOs and PPOs by a questionnaire mailed by *Business Insurance*.

We publish this directory as an editorial service to our readers who need to locate HMOs and PPOs for their employees. The HMOs and PPOs do not pay to be listed.

For a complete guide explaining the information in the directories, turn to page 14 for HMOs and page 60 for PPOs.

Any HMO or PPO not listed in this issue should write to be included in the mailing list for the 1990-1991 Directory of HMOs and PPOs. Please write Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

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Managed health care

HMOs grow healthier in last year

By JERRY GEISEL

The HMO industry is well on the road to financial recovery.

One year ago, much of the industry was drowning in a sea of red ink. Financial losses at some of the nation's largest health maintenance organizations were staggering.

For example, HMOs affiliated with Blue Cross and Blue Shield plans lost $220 million last year, while CIGNA Corp. lost $132 million on its HMO operations in 1988.

And the financial woes of a one-time giant HMO company—Maxicare Health Plans Inc. of Los Angeles—were so severe that in March it filed for protection from its creditors under Chapter 11 of the federal Bankruptcy Act. Maxicare lost $250.5 million during the first nine months of 1988.

But the outlook for an industry that until recently was battered by severely underestimating health care inflation, intense competition, high start-up costs and, in some cases, overly ambitious expansion plans, is brightening.

At least the HMO executives think so.

Of the 43 HMOs responding to a survey conducted last month by the Group Health Assn. of America, a Washington, D.C.-based HMO trade group, about 68% said their financial performance will improve this year compared with 1988, while 28% said their performance will be about the same. Just 5% of the surveyed HMOs expect a deterioration in their financial results.

In addition, 72% of the HMOs surveyed by the GHAA expected to be profitable or, in the case of non-profit HMOs, show an operating surplus this year, while 26% said they would not and 2% were not sure or did not know.

Similarly, 72.9% of 243 HMOs responding to a survey conducted earlier this year by InterStudy, an Excelsior, Minn.-based research organization, expected to earn a net profit from their HMO operations during fiscal 1989.

And, a new InterStudy survey of 35 national HMO firms—or firms that operate HMOs in at least two states—found that all but one of the surveyed HMO operators expect their financial results to improve in 1989.

"Indications appear to suggest that the HMO industry's financial condition is considerably stronger than a year ago," said Marsha Gold, director of research and analysis at the GHAA.

"In the aggregate, HMOs are in considerably better financial condition in 1989," agreed Seth Shaw, a first vp with Prudential Bache Securities Inc. in New York.

HMOs of all sizes are enjoying improved operating results.

For example, the Blues, whose 93 HMOs provide coverage to 4.5 million enrollees, expect to break even this year after 1988's steep losses.

"Clearly, the last year has been a period of financial recovery for us," said Richard Maturi, executive director of managed care programs with the Blue Cross/Blue Shield Assn. in Chicago.

CIGNA, which now has 1.5 million HMO enrollees, expects to be at about the break-even point for its HMOs, which operate in 31 markets through its managed care unit—CIGNA Healthplans Inc.

Continued on next page

Top 10 general service HMOs

Ranked by number of employees and dependents in employer groups as of Sept. 30, 1989

Plan (Sponsor)	Employees and dependents in employer groups	Participating employer/payer groups	Estimated enrollees as of Jan. 1, 1990	Tax status
Kaiser Permanente Medical Care Program (The Permanente Medical Groups, Kaiser Foundation Hospitals, Kaiser Foundation Health Plans)	6.2 million	More than 34,000[1]	6.2 million	Not for profit
Blue Cross & Blue Shield Plan HMOs (Blue Cross & Blue Shield Assn.)	4.5 million[2]	N/A	4.7 million[3]	Varies
CIGNA Healthplans Inc. (CIGNA Corp.)	1.5 million	More than 5,612	N/A	For profit
PARTNERS National Health Plans (Aetna Life Insurance Co./VH Enterprises)	1.2 million	23,852	1.3 million	For profit
U.S. Healthcare Inc.	1 million	11,000	N/A	For profit
Health Insurance Plan of Greater New York	885,000	4,000	1.1 million	Not for profit
Health Net	720,128	2,600	720,000	Not for profit
PruCare (The Prudential Insurance Co. of America)	667,071	N/A	660,000[1]	For profit
FHP Healthcare	500,000	3,000	500,000	For profit
MetLife Healthcare Network (Metropolitan Life Insurance Co.)	404,882	3,900[4]	400,000	For profit

[1]As of Dec. 31, 1988 [2]As of June 30, 1989 [3]As of June 30, 1990 [4]Estimate N/A: Not available

Note: Humana Health Care Plans (HMO & PPO) reports 925,000 members as of Sept. 30, 1989

Source: *BI* survey

BI/HOLLY SEGUINE

Employers, PPOs seek new efficiencies

By JERRY GEISEL

Both employers and preferred provider organizations are charting new courses to make PPOs a more efficient system of providing health care.

Employers are revamping the design of their health care programs to make PPOs more attractive to employees than unmanaged indemnity plans.

PPOs, meanwhile, are tightening controls over hospital and physician payments, expanding beyond the traditional horizons of basic hospital and medical services to such areas as home health care, and are adopting new strategies to try to better control the area where employers' health care expenses are rising the fastest: outpatient services.

PPOs also are adding new reimbursement options, like Exclusive Provider Organizations, limiting employees' choices of providers and somewhat blurring the distinction between PPOs and health maintenance organizations.

And, PPOs are providing employers with more information to show how they are helping to control health care costs as well as moving toward adopting an accreditation program, which will give employee benefit managers meaningful information to help them choose among hundreds of available PPOs.

These changes come amidst increased employer uncertainty over whether PPOs really can put the lid on soaring health care costs.

Indeed, 55% of benefit managers recently surveyed by benefit consultant A. Foster Higgins & Co. Inc. of New York reported that they were unable to measure the effect their PPO arrangements have had on their overall health care costs (*BI*, Nov. 6).

This uncertainty follows the widespread optimism in the mid-1980s, when the PPO boomlet began, that PPOs would be the medicine to cure or at least tame health care inflation.

Numerous health care experts predicted in 1985 that the rise of PPOs and other managed care alternatives, like HMOs, would mean that the days of double-digit health care premium hikes would soon be over (*BI*, July 22, 1985).

These experts said that the prospect of health care providers agreeing to provide services at fixed and discounted charges—subject to utilization review—inevitably would bring down medical care costs.

Certainly, in those four years PPOs staked out and began to command a significant portion of the nation's health care delivery system.

For example, in 1985, *Business Insurance* reported, based on interviews with health care experts, that less than 1% of health care services was delivered through PPOs.

Today, though, following years of massive efforts by insurers, hospitals, physicians, and, in some cases, employers, PPOs have become an accepted health care delivery option.

For example, the American Managed Care & Review Assn., a Washington, D.C.-based research organization, estimates that about 36.25 million people, or 16% of the population, had access to a PPO program last year.

Close to 11 million people have access to PPOs affiliated with Blue Cross/Blue Shield Plans, while seven other PPO operators each have networks that are available to more 1 million employees and dependents (see chart).

At the same time, the number of PPOs has increased to almost 700 from about 300 in 1985.

But the growing reach of the PPO umbrella has not protected employers from the ravages of health care inflation. Indeed, during the last two years, employers have been smacked with some of the biggest increases ever in the cost of their health care benefits programs, with 30% annual increases common.

But galloping health care inflation does not mean that PPOs and other managed care alternatives have failed, benefit experts stress.

"To say that managed care is a failure is ludicrous. It would be more apt to say that true managed care has not yet been tried," said Glenn Meister, a managing consultant in Foster Higgins' Los Angeles office.

Continued on page 6

Largest general service PPOs

Ranked by number of employees and dependents with access to the network as of Sept. 30, 1989

PPO (Sponsor)	Employees and dependents with access to the network	Participating employer/payer groups	Estimated users Jan. 1, 1989	Tax status
Blue Cross & Blue Shield Plan PPOs (Blue Cross & Blue Shield Assn.)	10.7 million[1]	N/A	11.7 million[2]	Varies
MetLife Network (Metropolitan Life Insurance Co.)	2.4 million	210	2.4 million	For profit
Affordable Health Care Concepts	2.2 million	150	2.2 million	For profit
Beech Street Inc.	1.8 million	565	2 million	For profit
PARTNERS National Health Plans (Aetna Life Insurance Co./VH Enterprises)	1.22 million	4,078	1.3 million	For profit
Travelers Preferred PPOs (The Travelers Insurance Co.)	1.21 million	3,923	1.4 million	For profit
Private Healthcare Systems Ltd.	1.17 million	N/A	1.3 million	For profit
Med Network/Med $ense (Admar Corp.)	1.1 million	21,852	1.2 million	For profit
PruCare/Prudential Plus (The Prudential Insurance Co. of America)	946,231[3]	N/A	975,000	For profit
American Health Network (American General Group Insurance Co.)	869,000	912	900,000	For profit

[1]As of June 30, 1989 [2]As of June 30, 1990 [3]As of Oct. 16, 1989 N/A: Not available

Note: Humana Health Care Plans (HMO & PPO) reports 925,000 members as of Sept. 30, 1989.

Source: *BI* survey

BI/HOLLY SEGUINE

HMO market

Continued from previous page

"We have been in a recovery mode," said William Sharkey, senior vp-national marketing for CIGNA in Bloomfield, Conn.

U.S. Healthcare Inc. of Blue Bell, Pa., which has about 1 million enrollees, earned a net profit of $19.3 million during the first nine months of this year compared with profits of $3.6 million for all of 1988.

The Harvard Community Health Plan, a non-profit HMO in Brookline, Mass., with 395,000 enrollees, had an operating surplus of $8.9 million in fiscal 1989, which ended Sept. 30, almost double its $4.8 million operating surplus during its prior fiscal year.

And, Lincoln National Corp., a Fort Wayne, Ind.-based insurer, reported a $1 million profit during the third quarter of 1989 on the HMOs it operates in 17 markets. That marks the first time Lincoln National has reaped a profit on its HMOs since 1986.

The insurer attributes the new profitability to premium increases, tighter underwriting and better medical claim cost controls.

The HMO industry's recovery has not gone unnoticed on Wall Street.

During the first 11 months of the year, stock prices rose an average of 255% for eight publicly traded HMOs tracked by *Business Insurance*: FHP International, HMO America Inc., Pacificare Health System, Safeguard Health Enterprises, Sierra Health Services, United Healthcare Corp., United Medical Corp., and U.S. Healthcare Inc.

The big run up in stock prices "are a reflection of an industry that has recovered from the losses of 1988," said Prudential Bache's Mr. Shaw.

Unquestionably, big rate increases for HMO subscribers are the principal reason for HMOs' financial recovery.

Last year, HMO premiums rose by an average of 17.2%, according to InterStudy.

And, HMO premiums climbed by about the same percentage this year, according to the GHAA.

In 1990, the 43 HMOs recently surveyed by the GHAA expect to raise premiums by an average of 16%.

These recent rate hikes far exceed earlier HMO premium increases.

For example, between Dec. 31, 1985, and Dec. 31, 1986, average HMO premium increases were well under 3%, according to the GHAA, while HMO premiums between January 1987 and January 1988 rose just less than 12%.

"Spurred on by a desire to expand, HMOs bought market share at the expense of reduced profit margins. This strong competition for the health insurance dollar" held premiums artificially low in the last few years, InterStudy noted in a report, "The Bottom Line: HMO premiums and profitability, 1988-89," released earlier this year.

"There had been some cut-throat pricing practices," agreed Andy Smith, a senior vp in the New York office of EQUICOR Inc., the Nashville, Tenn.-based joint health care venture of Equitable Life Assurance Society of the U.S. and Hospital Corp. of America.

But, the industry's premium hikes illustrate a change in HMOs' pricing strategy, some say.

HMOs now say they are willing to raise premiums and see market share slip rather than continue to lose money on their operations.

"HMOs have gotten smart on pricing. They have stopped playing market share," said Prudential Bache's Mr. Shaw.

"In some markets, we are seeing an end to the fierce price competition that damaged the industry in the past," said Tom Billet, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

"While HMOs are part of our managed care strategy, we want to be sure they are not a drain on profits," said Dale Wolfe, a vp with Travelers Corp. in Hartford, Conn. Enrollment in Travelers' HMOs this year declined 30% to 105,000 from 150,000 partly because of a 35% rate hike and partly because Travelers pulled its HMOs out of the health insurance program for federal employees after the program showed no signs of becoming profitable, Mr. Wolfe said.

HMOs' ability to raise premiums has been helped by even sharper rate hikes by indemnity insurers, which boosted rates last year generally by between 30% and 35%.

"Indemnity carriers' rate hikes gave HMOs the opportunity to raise rates after years in which rates were artificially low," said Pat Richter, a consultant with Hewitt Associates in Lincolnshire, Ill.

"HMOs were able, because of what had been happening in the indemnity market, to price premiums more aggressively," said Lynn Gruber, vp-managed care research at InterStudy.

But, rate hikes, as well as other factors, have cooled HMO enrollment growth.

According to InterStudy, nationwide HMO enrollment in 1988 climbed just 5.4% to 31.9 million from 30.3 million. And, during the first six months of this year, enrollment rose only 1.7% to 32.5 million.

This slowdown in growth since 1988 is in contrast to what InterStudy describes as the "furious" growth patterns of the mid-1980s.

For example, between December 1984 and December 1985, HMO enrollment shot up 25.7% to 21 million from 16.7 million. And, between December 1985 and December 1986, enrollment leaped 22.9% to 25.8 million from 21 million, according to InterStudy.

But, it is unlikely that the heady growth rates of the mid-1980s will resume anytime soon.

"In the mid-80s, plans emphasized market share growth by offering low premiums. Today, HMOs have turned to controlled growth and substantial premium hikes to improve on their 1986, 1987 and 1988 financial performance," according to InterStudy.

As enrollment growth has cooled, the number of HMOs has declined.

As of July 1, there were 590 HMOs in the United States, down from 607 on Jan. 1 and 653 on Jan. 1, 1988, and 626 in December 1986.

These small but steady declines in the number of HMOs contrasts with the huge rise of HMOs during the boom of the mid-1980s.

For example, between December 1984 and December 1986, the number of HMOs surged to 626 from 337, according to InterStudy.

The steady drop in the number of HMOs is almost certain to continue as a wave of consolidations and mergers, already under way, continues to sweep the industry, experts say.

"I doubt if we will see many new players in the HMO market. This is a period of consolidations, joint ventures and mergers," said David Brenneman, a vp with benefit consultant Noble Lowdnes in East Orange, N.J.

Indeed, there were HMO mergers and acquisitions galore this year. HMOs that either were acquired or that were negotiating acquisitions this year include:

- Rutgers Community Health Plan, a Somerset, N.J.-based HMO with 80,000 enrollees, which was acquired by HIP, short for Health Insurance Plan of Greater New York.
- Healthways of New York Inc., a Tarrytown, N.Y.-based HMO with 150,000 enrollees, which was acquired by PARTNERS National Health Plans, the joint health care venture of Aetna Life Insurance Co. and Voluntary Hospitals of America.
- Health Plan of Mid America, a Kansas City, Mo.-based HMO with 21,000 enrollees, which was purchased by Principal Health Care Inc., the managed care unit of the Principal Financial Group, a huge diversified financial services organization in Des Moines, Iowa.

Principal Health Care Inc. also purchased AmeriPlan Health Services, a Jacksonville, Fla., HMO with about 23,000 members.

- Total Health Systems Inc., a Great Neck, N.Y., HMO with about 115,000 enrollees. The proposed acquisition of Total Health Systems, announced in November by EQUICOR, still must be approved by state regulators and Total Health Systems' stockholders (*BI*, Nov. 13).

"There is a real consolidation of the industry taking place," said InterStudy's Ms. Gruber.

More acquisitions of smaller HMOs by their bigger rivals seem inevitable because of the growing cost of operating an HMO.

"To compete effectively, you must be on the cutting edge of technology, and technology requires a lot of money," said T. Tolbert Chisum, a vp with Aetna Life Insurance Co. in Middletown, Conn.

The most recent wave of acquisitions, though, are fundamentally different from some of the blockbuster acquisitions of a few years ago in which smaller HMOs, such as Maxicare, purchased HMOs several times their own size (see related story).

Many of the more recent acquisitions involve modestly sized HMOs—those with between 20,000 and 150,000 enrollees—that purchasers want to add to meet an objective in a very specific market.

For example, Aetna's purchase of Healthways allowed Aetna to enter the New York HMO market, Aetna's Mr. Chisum said.

And, HIP's purchase of Rutgers Community Health Plan allowed HIP to offer HMOs to employers in most parts of New Jersey. HIP, through an affiliate, was active in Northern and Southern New Jersey, while Rutgers operated in central New Jersey.

"Purchasing Rutgers allowed us to become a statewide organization with no overlap in systems. It was like a hand fitting into a glove," said Stephen Lewis, HIP's senior vp-corporate affairs in New York.

Even the next acquisition that may unfold—CIGNA recently confirmed that it is negotiating with Equitable and HCA Corp. to purchase EQUICOR—fits the pattern of a much larger HMO operator purchasing a significantly smaller HMO player. EQUICOR has about 350,000 members in its HMOs compared with CIGNA's 1.5 million.

If the acquisition and consolidation trend continues, employers will have fewer, but larger HMOs, from which to choose. Indeed, already 70% of all HMO members are enrolled in 35 national HMO firms, while these national firms own or operate 60% of all HMOs, according to InterStudy.

HMO executives say the trend toward consolidation is in the buyer's interest.

"There will be a smaller number of HMOs, but they will be better financed and able to satisfy the employer's need for a wide range of products and services," said Roger Birnbaum, president and chief executive officer of HIP/Rutgers Health Plan.

Employers themselves are a driving force behind the consolidation of the industry. Benefit managers want to pare back the number of HMOs they offer to employees to reduce administrative expenses as well as increase the clout they can have with their HMOs, said Hewitt Associates' Ms. Richter.

"It is very expensive for a national employer to deal with so many organizations," said Robert Dankmyer, vp-employee benefits at Marriott Corp. in Washington, D.C, which now offers more than 80 HMOs.

"By consolidating HMOs, we will have more leverage with the HMOs and be in a better position to deal with them on a problem," Mr. Dankmyer said.

Meanwhile, some smaller, independent HMOs are banding together to retain the business of multi-state employers.

For example, The HMO Group, an alliance of 15 independent HMOs with about 2 million enrollees, was organized to enable national employers to offer a network of smaller, high quality HMOs without the hassle of dealing with multiple HMOs, said Daniel Wolfson, president of The HMO Group in Somerset, N.J.

"We give employers the best of both worlds. Members of The HMO Group are local plans that are sensitive to the needs of providers and employers in a community, but an employer doesn't have the administrative difficulties" associated with offering multiple HMOs, Mr. Wolfson said, noting that The HMO Group offers a common enrollment form and soon will have a centralized billing system.

While the HMO industry is consolidating, innovation in the field has not slowed.

More HMOs, for example, are offering open-ended or point-of-service options in which enrollees decide whether to use the HMO or

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'Spurred on by a desire to expand, HMOs bought market share at the expense of reduced profit margins. This strong competition for the health insurance dollar' held premiums artificially low in the last few years, an InterStudy report notes.

Maxicare focuses on special markets to speed recovery

By JERRY GEISEL

LOS ANGELES—Maxicare Health Plans Inc., a one-time high-flying health maintenance organization whose aggressive acquisitions helped lead it into bankruptcy, says it is poised for a financial recovery next year.

Just two years ago, Los Angeles-based Maxicare—now awaiting bankruptcy court approval of a reorganization plan—was the nation's third-largest HMO with 2.4 million members.

That growth had been fueled by acquisitions. In 1986 alone, Maxicare tried to become a national powerhouse by doubling its enrollment through acquisitions of HealthAmerica Corp., a Nashville, Tenn.-based HMO with 850,000 members, and HealthCare USA Inc., an Orange, Calif.-based HMO with 200,000 members.

"Maxicare represented the most aggressive attempt of an HMO to become a national player" through acquisitions, said Gino Nalli, a consultant with The Wyatt Co. in Washington, D.C.

But these acquisitions left Maxicare with a crushing debt load that helped plunge the company into financial turmoil.

Losses for the first nine months of 1988, the most recent figures available, were $250.5 million, probably the largest nine-month loss ever incurred by an HMO.

Last year, the board of directors ousted Fred Wasserman and Pamela Anderson, the husband and wife who were Maxicare's co-founders and top executives, and brought in Peter J. Ratican, an entertainment industry financial executive, as chairman and chief executive officer.

Maxicare began a massive restructuring, selling or discontinuing a slew of HMOs. Despite those efforts, the company in March filed for protection from its creditors under Chapter 11 of the federal Bankruptcy Act while it reorganizes.

Today, service—not growth—is Maxicare's top priority.

"Size does not matter as much as providing high quality medical care services to members. Service is the bottom line," said Mr. Ratican, who has seen enrollment fall more than 75%—to below 400,000—in a year.

Maxicare, Mr. Ratican says, is trying to meet the specialized needs of individual markets.

For example, in heavily Spanish-speaking Los Angeles, it recently put together a network of bilingual providers.

"We had been hearing for some time from employers and employees that this was a service that was needed. We listened to try to meet their needs," Mr. Ratican said.

He acknowledges that Maxicare, which has cut back operations from more than two dozen states to seven, grew much too fast.

Mr. Ratican describes the remaining markets as solid and is optimistic that Maxicare can hold on to enrollment until it emerges from Chapter 11.

There are some encouraging signs. An annual company survey during the summer found 85% of 4,700 members who responded were satisfied with services from the HMO.

That rate is "comparable to Maxicare's satisfaction rates from the previous years. This indicates that Maxicare members continue to receive quality medical care—even during the period of reorganization," said Daniel Ershoff, Maxicare's vp-research.

During the bankruptcy proceedings, the HMO has kept its provider network largely intact.

"The provider community has rallied behind us. They understand Maxicare's commitment to quality care," Mr. Ratican said.

Financially, Maxicare will have considerably lightened its debt load when it emerges from Chapter 11. Under the outline of a reorganization plan unveiled in October, creditors would receive at least $78.8 million in cash and $67 million in 10-year notes. In the reorganization plan, Maxicare listed about $750 million owed to creditors (*BI*, Oct. 30).

"We will have gotten rid of a lot of debt. Our message to employers is that Maxicare will be here for the long term. We want to continue to be part of the process of providing quality health care," Mr. Ratican said. ■

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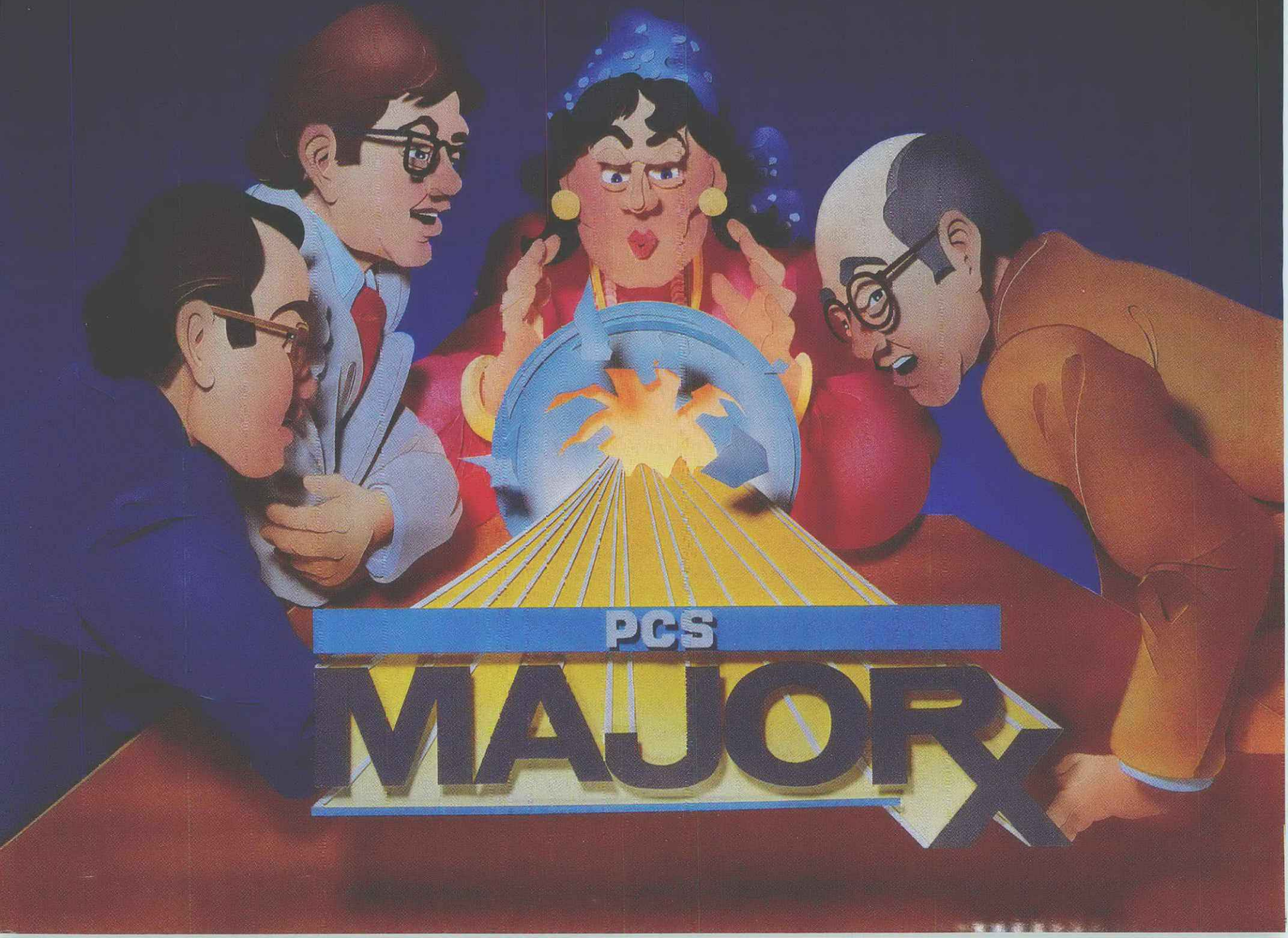
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PPO market

Continued from page 3

In fact, many employers, having learned from their earlier mistakes with PPOs, are redesigning their health care plans to make more effective use of PPOs.

Perhaps one of the biggest mistakes during PPOs' infancy was encouraging employees to use PPOs through ultrarich benefit reimbursement schedules. In some cases, employers sweetened benefits so that services delivered through a PPO were fully covered, while employees were subject to a 20% coinsurance requirement for services received through the indemnity plan.

But employers have begun to realize that loading a PPO with lush benefits could offset the savings it produced. "The PPO could end up costing more because of plan design," Mr. Meister said.

As a result, employers are adding cost sharing requirements to the PPO.

"Everyone is finally realizing that a PPO can't be a free ride for the employee. It can't be like an entitlement program," said Jerry Payne, vp-marketing with Preferred Health Network, a physician and hospital-owned PPO in Monterey Park, Calif., that is available to 740,000 employees and dependents.

And, the differentials between services provided in and outside the PPO are widening. While differentials once were as low as 10%, differentials of 20% and 30% now are common.

"There has to be a strong financial reason for employees to use the PPOs," said Janis Milroy, director of product management for Travelers Insurance Co. in Hartford, Conn., which offers 60 PPOs nationwide to 1.2 million employees and dependents.

At the same time, PPOs rapidly are changing the way they reimburse providers in the network, moving away from discounts and toward approaches that put providers more at risk.

During the early days of the PPO movement, hospitals, for example, typically discounted their standard charges 15% or 20% to users of the network.

But purchasers of health care have discovered flaws in the discount approach.

"Health care providers would 'game' the system. They would provide vast quantities of services per patient to offset the discounts," said David Brenneman, a vp with benefit consultant Noble Lowdnes in East Orange, N.J.

Instead of discounts, PPOs increasingly will set a per diem limit in which hospitals, for example, will receive a fixed daily reimbursement, regardless of services actually provided.

In other cases, payments may be based on the medical procedure or diagnosis of the patient, known as the DRG, or diagnostic related groups, approach.

"About 80% of our contracts with hospitals are per diem. That means we will pay a fixed amount per day. That is a lot more effective than a discount," said Richard Toral, chairman of Med Network, an Orange, Calif.-based PPO available to about 1.1 million employees and dependents.

While per diem and DRGs are frequently used as a payment method for PPOs, there are many variations on those methods.

For example, 18 St. Louis-area hospitals that participate in a PPO organized by Blue Cross/Blue Shield of Missouri are guaranteed minimum payments of $5,000 for certain inpatient medical procedures. Even if hospital expenses are as much as $15,000, the hospital would only receive $5,000. A hospital would receive a certain percentage of expenses over $15,000, with the exact percentage depending on the Blue's agreement with individual hospital.

By capping hospital reimbursement, hospitals are encouraged to provide cost-effective care, said Gary Jacobs, vp-provider contracting and reimbursement at BC/BS of Missouri.

At the same time, the Blues' PPO in Missouri has adopted an innovative approach to prevent hospitals from jacking up charges for medical procedures performed on an outpatient basis to make up for tighter controls on inpatient services.

Under the outpatient arrangement, the hospitals must provide the Missouri Blue's PPO with additional discounts if the percentage of revenues it receives from outpatient services increases by more than a certain percentage in a year.

PPOs also are branching out into new areas to bring a greater chunk of health care services under the managed care umbrella.

For example, Blue Shield of California next month will begin offering a PPO for various home health care services.

"This is an area that has been growing by leaps and bounds, but there has been no uniformity in costs and charges," said Terrie Pryce, contracting manager for alternate care services in the Los Angeles office of Blue Shield of California.

Providers of health care services that join the Blue's alternate care PPO will be paid on a fee schedule.

"We expect savings of 20% to 25%," Ms. Pryce said.

PPOs also are offering new options—known as Exclusive Provider Organizations—that in some ways give the the PPOs an HMO flavor.

'About 80% of our contracts with hospitals are per diem. That means we will pay a fixed amount per day. That is a lot more effective than a discount,' says Richard Toral, chairman of Med Network, an Orange, Calif.-based PPO.

EPO arrangements vary considerably among PPOs. Under one type, an employee agrees to "lock" into a network—a subset of the PPO's most efficient providers—for a year to receive the highest benefits. These benefits would be greater than what the employee would receive in the PPO where the employee decides—on a service by service basis—whether to use providers in the network.

In some cases, employers are contracting directly with hospitals for discounted charges (see stories, page 12).

But PPO experts are skeptical whether many employers have the clout or resources to establish PPOs.

"Setting up networks is a very complex business," said John Moynahan, executive vp of Metropolitan Life Insurance Co. in New York, which offers PPOs in about 45 markets to 2.4 million employees and dependents.

"It requires a commitment that is beyond most employers," he said.

"I doubt if there will be a groundswell of interest among employers in establishing their own PPOs," said Peter Boland, president of Boland Healthcare Consultants in Berkeley, Calif.

What employers do want to know is whether PPOs save them money. And, some PPOs now have the medical care claims data to prove that they are highly cost effective providers of health care.

For example, CAPP CARE, a PPO based in Fountain Valley, Calif., recently compared the cost of claims inside and outside of the network.

The average cost of a coronary artery bypass inside the network was $26,651 in 1988, compared with an average of $50,520 outside the network, the company found.

And the average cost of an appendectomy in the PPO was $4,939 compared with $8,103 outside the network.

"These kind of savings show what can be achieved when you identify cost-effective providers of health care and reach agreements with them," said CAPP CARE Chairman and Chief Executive Officer Dr. Edward Zalta.

With hundreds of PPOs hawking their networks, employers may feel they face a bewildering array of choices.

Some assistance may soon be at hand.

The American Assn. of Preferred Provider Organizations, a Chicago-based PPO trade group, and MedStrategies, a health care consulting firm with offices in Georgia and Virginia, have formed a joint venture to develop a PPO accreditation program.

Extensive field testing of the accreditation program already has begun, with CAPP CARE receiving the highest rating possible.

Accredited PPOs will provide employee benefit managers with much more information about a PPO's structure and operational performance, said Dr. William Amos Jr., president of MedStrategies of Georgia Inc. in Atlanta.

"Accreditation is a positive and necessary step forward for the managed care industry," said Mark Jasper, president of Benefit Panel Services Inc., a Los Angeles-based PPO. ■

HMO market

Continued from page 4

receive services outside of the network.

For example, Group Health Inc., a Minneapolis-based HMO, offers an open-ended HMO option, known as CareSpan, in which members receive 100% coverage for inpatient and most outpatient care when they use the HMO, while members must pay a $200 deductible and 20% of bills for services received outside of the network.

The opened-ended HMO "allows employers to offer a cost-effective, managed care program, while giving employees an opportunity to use non HMO-providers," said George Halvorson, president of Group Health Inc.

"This has been our fastest growing product," said Ann Gjelten, vp-marketing at Blue Cross and Blue Shield of Minnesota in St. Paul, which has been offering an open-ended HMO program, known as Aware Gold, since 1986.

Employers are no longer willing to accept traditional community rating, says Mr. Anderson.

And, HMOs, responding to recent changes in federal law, have been overhauling the way they set rates.

Under 1988 amendments to the HMO Act of 1973, federally qualified HMOs can use a type of experience rating—known as adjusted community rating. Under this method, federally qualified HMOs can set advanced, fixed premiums based on an employer's own past and projected claims experience.

However, the law does not allow for true experience rating. For example, an HMO cannot make retrospective adjustments if claims turn out higher than expected.

Adjusted community rating supplements two rating methods federally qualified HMOs previously had been using:

- Community rating. Under this method, HMOs set rates based on the costs of the entire community they serve.
- Class rating. Under this method, the HMO can break down the cost experience of classes of its population—such as age and gender groups—and develop separate community rates for the groups. Then, the HMO can charge the employer community rates to reflect the age and gender demographics of employees in the HMO.

Clearly, adjusted community rating is taking hold. For example, 47% of HMOs surveyed by the GHAA said they planned to use some type of adjusted community rating next year.

For example, Kaiser Foundation Health Plan, the nation's largest HMO with 6.2 million enrollees, will begin to phase in adjusted community rating next year for larger accounts.

"The evidence was overwhelming that employers, especially large national companies, were no longer willing to accept traditional community rating," said Dick Anderson, Kaiser's vp-medical economics and statistics in Oakland, Calif.

And, HMOs are responding to other changes in federal law. The 1988 law modified the equal contribution rule, which had required employers to make the same contribution toward the premiums charged by federally qualified HMOs as they make toward their largest non-HMO plan.

Some employers now are making the same percentage contribution toward HMO premiums as for other health care plans, rather than paying equal dollar amounts for both types of plans.

"For the most part, HMOs have become resigned that they will not receive 'equal dollars,' " said Hewitt Associates Ms. Richter.

And, employers are taking a more aggressive attitude in their rate negotiations with HMOs.

For example, the Commonwealth of Massachusetts successfully negotiated with the 16 HMOs it offers to reduce rate hikes to an average of 18% after the HMOs proposed rate hikes averaging 23%.

"You have to look at rate hikes as proposals that should be the subject of good, old-fashioned negotiations," said Dolores Mitchell, executive director of the Massachusetts Group Insurance Commission in Boston. ■

Duva forms association to promote managed care

By JERRY GEISEL

MORRISTOWN, N.J.—The benefit manager of a company that is blazing a trail in managed care is organizing an association for employers interested in managing their employees' health care.

"We want to find out what is working and what is not. We want to educate the buyer on what managed care approaches have the best chance of working," said Joseph W. Duva, corporate director of employee benefits for Allied-Signal Inc. in Morristown, N.J.

The new group, Managed Health Care Assn., held its first meeting last month in New York before an overflowing audience of benefit managers and already has laid out its general objectives.

They include:

- Furthering the growth of managed health care by employers to better control health care costs.
- Working with member companies to overcome provider resistance to managed care programs.
- Working to eliminate inappropriate and unnecessary care.
- Serving as a spokesman for employers with managed care programs to government entities and the media.
- Maintaining data on managed care programs and exchanging information to ease their implementation.
- Exchanging information and results at periodic meetings.

"We want to develop a managed care laboratory for employers to dissect the results," Mr. Duva said, adding that managed care is only in its infancy.

But despite is youth, Mr. Duva said, the Allied-Signal program is already racking up impressive results.

Known as the "Health Care Connection," the company's program replaced a multitude of health maintenance organizations and indemnity plans with HMOs administered by CIGNA Corp.

While employees are enrolled in CIGNA Healthplan HMOs nationwide, employees can use non-network providers, albeit at sharply reduced coverage levels.

And, in an arrangement—believed to be the first of its kind—Allied-Signal was guaranteed that its health care costs will not increase by more than a stipulated percentage in a three-year period that started in March 1988 (*BI,* Feb. 22, 1988).

If cost increases exceed the stipulated amount, which neither Allied-Signal nor CIGNA will disclose, the insurer must absorb the added cost.

Even though the program is not fully phased in and does not cover certain beneficiaries, such as retirees, Allied-Signal's health care costs rose just 4% last year, down from a 39% increase in 1987.

Mr. Duva attributes the curbing of cost increases to the reduction of unnecessary care among employees in the CIGNA HMOs.

"When you have a gatekeeper, you eliminate a lot of inappropriate and unnecessary care," Mr. Duva said.

William Sharkey, senior vp-national marketing with CIGNA in Bloomfield, Conn., says the Allied-Signal program has been profitable and that CIGNA would consider "risk contract" proposals from other employers.

For more information about the Managed Health Care Assn., write to Joseph Duva, Corporate Director of Employee Benefits, Allied-Signal Inc., P.O. Box 2245-R, Morristown, N.J. 07960.

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Managers split on HMO/PPO benefits

By ALISON KITTRELL

Health maintenance and preferred provider organizations receive higher marks from benefit managers without HMO and PPO experience than from those who have used them to help control health costs, the annual *Business Insurance* HMO/PPO finds.

In *BI*'s survey of 114 benefit managers nationwide, 52%—including benefit managers with and without HMO experience—said they believe that HMOs help contain health care costs. Forty-one percent said HMOs do not contain costs, 4% said they did not know and 3% did not answer.

However, of the respondents with HMO experience, only 29% said HMOs actually helped manage their costs, while 54% said HMOs had not been useful, 6% said they did not know, and 11% did not answer.

A similar trend appears regarding PPOs: While 54% of all responding benefit managers said they help contain costs, only 24% of those with PPO experience said PPOs had helped contain costs.

Responses about the effectiveness of PPOs—and to a lesser extent, of HMOs—are skewed, in part, because many respondents do not have any actual experience.

In fact, 74 of the respondents, or 65%, do not have a PPO in place.

And, 22 respondents, or 19%, do not have an HMO. In addition, many of the benefit managers who have an HMO said that employee participation levels were too low to have an impact on costs.

The benefit managers give many reasons why HMOs and PPOs succeed—or fail—to hold down costs (see related story).

Most supporters say HMOs and PPOs help control costs by reducing utilization, implementing managed care, fostering competition and emphasizing preventive care.

The vp of employer relations for a Washington, D.C.-based company with 42 employees said HMOs work "by focusing on preventive treatment and limiting access."

Adverse selection is the most common reason cited by those who feel HMOs and PPOs fail to contain costs.

"The younger, healthier employees join HMOs while the older, sicker employees stay with their former physician and plan," said the director of compensation and benefits for a Ohio hospital with 3,000 employees.

But most benefit managers agreed that HMOs and PPOs provide quality health care.

Two-thirds of the respondents said HMOs provide quality care, while 16% said they do not, 14% did not know and 4% did not answer.

Most of those who said HMOs provide quality care cited HMOs' emphasis on preventive care and general satisfaction among their employees.

Those who questioned the quality of care HMOs provide said the organizations are too concerned about money, have too much turnover and have inferior doctors.

Sixty-three percent of respondents said PPOs provide quality care, while 6% said they do not, 11% did not know and 20% did not answer.

More benefit managers have had more problems with HMOs than with PPOs, the survey found.

Fifty-six percent of respondents with HMO experience report at least some problems with them, while only 13% of respondents with PPO experience have had problems.

Thirty-two percent of respondents reported having had no problems with an HMO.

Most problems noted by respondents involve administration.

The benefit manager at a research and development/government contractor with 1,400 employees said: "Administrative procedures are horrendous. Their accounting systems are outdated. I hate dealing with the three HMOs we offer."

The human resources director of a manufacturer with 850 employees cited a "lack of response to questions or in dealing with problems."

And, the human resources officer of a bank with 17,000 employees criticized their "poor telephone skills, long waits for appointments, unnecessary delays in reimbursement."

A few respondents raised even more serious complaints. For example, the director of compensation and benefits for a financial services company with 9,500 employees said he had experienced problems with "poor quality of doctors and services."

And, several respondents criticized HMOs involved in providing substance abuse or mental health care.

The benefits director for a utility with 11,000 employees complained of "limited coverage for substance abuse/mental health care compared with traditional coverage."

The director of administration for a forest products firm with 3,300 employees complained about "primarily chemical abuse benefit limitations."

But, at least one respondent took exception to the question.

"This question is invalid and unfair. We have always had minor day-to-day problems with insurance companies. Some HMOs and indemnity companies are worse than others. But there have been no significant problems that could not be corrected," said the general manager-employee services for a utility with 13,000 employees.

The survey also found that:

- By far, the largest number of employers that offer HMOs and PPOs report employee participation levels of 20% or less.

In 1989, 43% of employers offering HMOs had employee participation levels of 1% to 20%; 16% had levels of 21% to 40%; 15% had levels of 41% to 60%; 4% had levels of 61% to 80%; and 3% had levels of 81% to 100%.

In 1988, the HMO participation levels were: 44% with 1% to 20%; 18% with 21% to 40%; 13% with 41% to 60%; 4% with 61% to 80%; and 2% with 81% to 100%.

Of respondents offering HMOs or PPOs, 19% did not answer.

While 25% of the employers surveyed experienced an increase in HMO participation between 1988 and 1989, many of those increases were very small. And, respondents who reported large increases usually attributed them to the introduction or expansion of an HMO plan or large increases in employee contributions to alternative plans.

Enrollment in 20% of the plans dropped between 1988 and 1989. The most-often cited reasons were the elimination of an HMO, HMO premium increases and employee dissatisfaction.

Similar trends were seen in responses about PPOs, although most respondents were unable to answer the question about participation.

Few benefit managers are involved in contracting directly with preferred providers or physician groups and not many plan to do so. Only 10% said they currently contract directly, and about half of those do so individually rather than as part of an employer coalition.

Sixty percent said they do not contract directly, and only 21% of those said they have any plans to do so.

The other 30% either did not know or did not answer.

"Few employers have sufficient knowledge, resources and economic power to negotiate directly," said a former insurance manager for a telecommunications company with 120,000 U.S. employees.

- Less than half—41%—of respondents are taking a harder financial look at HMOs following Maxicare Health Plans Inc.'s bankruptcy.

However, many of the 42% who said they have not changed their standards noted that they had examined HMO finances carefully.

And, only 32% of the respondents say more states should establish guaranty funds for HMOs, while 34% disagree, 15% said they do not know, and 18% did not answer.

Most of those who oppose guaranty funds echoed the benefit manager of a service company with 2,700 employees who said, "It's a free market society."

"The well-funded (HMOs) will survive. There is no need to subsidize the speculators," said the benefit manager for a government agency with 14,000 employees.

The benefit manager for a manufacturer with 4,500 employees asserted that "free enterprise should govern their success and solvency. There is enough subsidy of improperly managed health care now."

And the benefit manager for a software graphics company with 650 employees asked: "Should the state, and therefore the taxpayer, be responsible for every insurance company's solvency? Why should HMOs receive special consideration?"

"Obviously, guaranteeing funds opens the door for poor accounting practices," warned the benefits coordinator for a public transportation company with 500 employees.

The director of personnel services for an educational institution with 1,450 employees urged: "Let HMOs police themselves."

"S&Ls, FHA, college loans have all been abused—so will anything else 'insured' by the government," said the vp of benefits and services for an aerospace company with 45,000 employees.

Virtually all of those supporting guaranty funds said they were needed to provide security.

For example, the benefit director for a manufacturer with 3,000 employees said the guaranty funds are needed "to provide some reasonable level of protection."

The group benefit manager for a banking firm with 24,000 employees cited a need "to provide a baseline of protection for individual customers."

And, the first vp for a financial services company with 42,000 employees said: "After the. . .Maxicare nightmare—absolutely!"

- Relatively few benefit managers have been able to negotiate experience-rated HMO premiums since the federal HMO Act was amended. Only 21% have been able to negotiate an experience rating, while 63% have not and 16% did not answer.

That trend, however, is expected to change, according to a survey that found more HMOs will offer adjusted community rating next year (see story, page 3). ■

Complaints abound, solutions don't

By ALISON KITTRELL

There are no better alternatives to HMOs and PPOs for controlling health care costs and ensuring quality health care, according to a majority of benefit managers responding to a *Business Insurance* survey.

Some of the 114 benefit managers responding to the annual *BI* HMO/PPO survey complain the organizations "skim the cream" by appealing primarily to younger, healthier employees.

And others charge that the organizations encourage overuse of medical facilities and procedures or that top-rated doctors are simply not available.

Some respondents who said that HMOs control costs agreed with an employee relations director for a municipality with 2,600 employees, who credited the organizations with "interjecting some element of competition into the medical marketplace."

That competition benefits all as it "reduces hospital utilization and impacts the utilization rate in the total community where they exist," said the employee benefits manager for a manufacturer with 14,000 employees.

Many other benefit managers said that the organizations also help to contain costs with their focus on preventive care.

If an employer has adequate usage, HMOs should contain costs, said the human resources director for a chemical company with 1,600 employees. "They are geared to preventive medicine and, over time, this should pay off."

HMOs primary benefit is that "people attend to illnesses before they become serious," said the human resources director for a heating and air conditioning company with 760 employees.

Survey respondents also praised the control HMOs can exert over providers and care.

The vp-personnel for a manufacturer with 650 employees cited their "controlled, efficient environments when compared to the alternatives."

A senior benefits analyst for a drug distribution and service merchandising company with 11,400 employees said: "In general, their managed care emphasis is more effective than fee-for-service. But they must consider adverse selection."

That "adverse selection hump" is the major problem cited by those who felt HMOs fail to contain costs.

"I am coming to believe that they skim the cream," said the benefits manager for an electronics company with 3,000 employees.

"HMOs only defer the cost of medical care," said the personnel director for a publisher with 125 employees. "Younger, healthier people select HMOs. When you are older and your health is more fragile, you need specialists, and they are not HMO-connected."

Many benefit managers also believe that HMOs encourage overuse of medical facilities.

An HMO "does not really promote wellness as much as it encourages multiple doctor's visits," said the manager of benefits and payroll for an oil and gas company with 650 employees.

One of the HMO system's central tenets—care is usually without deductibles or coinsurance costs to enrollees—promotes unwise consumer behavior by employees, some managers said.

"People tend to overuse (HMOs) because there is no or little direct cost to them," said the human resources director for a manufacturer with 850 employees.

HMOs "increase demand for services by making services appear free," said the compensation and benefits manager for a manufacturer with 2,500 employees.

But, HMO critics hasten to add, services are not free.

"There is nothing in the HMO structure to contain costs," said the employee services manager for a manufacturer with 325 employees. "Any 'savings' are due to cost-shifting."

In the debate over quality of care, HMOs won a clearer victory: Two-thirds of respondents said they provide good care.

"They are in the public eye and under scrutiny by employers, so they have no choice," said a retail grocery's manager of employee benefits.

Many benefit managers who said HMOs provide good care cited their emphasis on prevention.

That emphasis "helps identify health problems earlier," said the manager of benefits and compensation for a communications firm with 2,000 employees.

Several respondents said they could not make a blanket statement about the quality of care offered by HMOs, echoing the response by the supervisor of benefits for an engineering firm with 220 employees: "I don't think that the quality of health care in an HMO is any better or worse than non-HMO care. . .In any particular grouping of doctors, there will be some good and some not so good at their profession."

But 16% of respondents said HMOs do not provide quality care, with some finding HMO doctors are inferior to their counterparts outside the organizations.

"Top-rated doctors are not in HMOs," said the secretary/treasurer of a retail company with 185 employees.

"Contracted physicians are not usually the best at their profession," agreed the benefit manager for a building materials company with 15,000 employees.

A few respondents said the day-to-day care HMOs provide is adequate but that their handling of complex problems needs improvement.

HMOs "can do a good job for ordinary health problems. But it's still questionable if they can provide the best specialists for complex problems," said the personnel director for a manufacturer with 300 employees.

In general, a similar portrait emerges of PPO performance: A majority think they provide quality care and help contain costs.

Nearly two-thirds of respondents had no first-hand experience with preferred-provider organizations, so considerably fewer responded at length.

But, the comments that respondents provided raised many of the same issues that were raised in their commentary on HMOs.

PPO supporters said the organizations helped manage care and therefore costs.

Many respondents said that PPOs offer consumers a greater role in health care and a more personal relationship with doctors than do HMOs. Thus, employees are better consumers of health care and employees, employers and insurance companies have more leverage when seeking medical services.

In a PPO, "individual doctors have the incentive to provide quality care to retain patients and insurers," said the personnel manager for a furniture manufacturer with 650 employees.

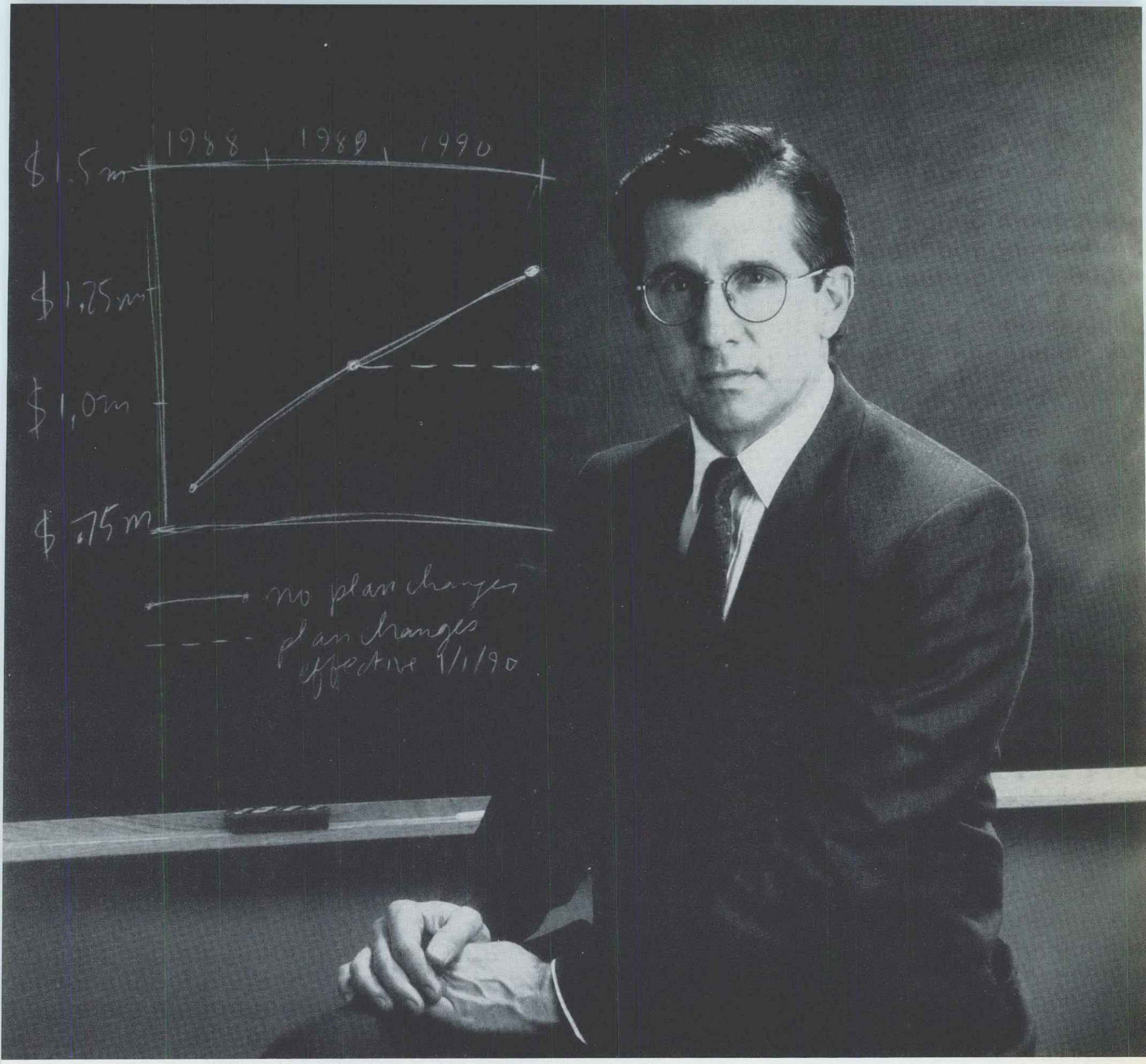
"Employees become more aware of the cost of benefits if their coinsurance is affected" by the choice of a PPO or a non-PPO provider, said the human resources manager for a service company with 1,000 employees.

But, opponents dismissed the reported savings as smoke and mirrors, and they bemoaned a lack of choice of providers in the networks.

Many respondents obviously hope that PPOs and HMOs will provide at least a tool for them in the struggle to control health care inflation.

Many no doubt would agree with the assistant vp-benefits and compensation at a banking company with 500 employees that is implementing a PPO on Jan. 1.

Asked whether the program will help curb benefit costs, he said: "We hope it will! If not, someone else will be completing this survey next year."



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More hospitals seek employer contracts

By KATHRYN J. McINTYRE

Hospitals increasingly are contracting directly with employers to provide health care services to employee groups at reduced prices, a new survey of hospital executives shows.

Nearly half the 111 respondents said they contract directly with employers, with more than one-third of the hospitals negotiating their first contract in the last two years.

The survey, "Perceptions of Hospital Managed Care Directors Regarding Direct Employer Contracting," was based on responses from executives in charge of managed care at government and non-profit hospitals nationwide with more than 500 beds. The survey was conducted in the fall by Witt Associates Inc., a health care consulting firm, in cooperation with *Business Insurance.*

The 111 responses came from a mailing of 490, for a response rate of 23%.

Of the respondents with direct contracts, 3.6% reported negotiating their first such agreement in 1983. Another 25% reported negotiating their first direct employer contract in 1988, and 8.9% did so this year.

The remaining hospitals with direct contracts began negotiations in 1984-1987.

Noting that more than one-third of the hospitals negotiated their first contract directly with an employer in the last two years, Allan Fine, senior associate at Witt Associates, said: "This is not a fad. This is not a gimmick. Direct employer contracts is where the field is going."

Among hospitals contracting directly, 63.6% said their first contract had been initiated by the employer while 29.1% said they initiated the first contract. Business coalitions were credited by 7.3% for initiating the first employer contract.

"Employers have to pursue this—be proactive," Mr. Fine suggested.

Among those contracting directly with employers, the number of contracts in force ranged from one to eight, with 5.4 being the average number of contracts.

Hospitals with less than $120 million in annual revenues reported an average of 2.4 contracts, those with $120 million to $200 million reported an average of 7.2 contracts and those with more than $200 million reported an average of 5.9 contracts.

Mr. Fine suggested that smaller hospitals may not be large enough to attract employers for direct contracting, while "the bigger the institution, the more bureaucratic it is and therefore the more arduous the process."

Hospitals with direct contracts cited the anticipated revenue from the contract as the most important factor, followed by the number of admissions, potential number of patient days, number of employees and acuity of the patient group.

Asked to comment on what restrictions are applied when considering whether to contract directly, 72% of respondents said the number of employees was important and 60% cited company location.

Interestingly, the employer's type of industry was considered an important restricting factor by only 20% of respondents.

"Don't rule yourself out because you think your industry would not be attractive," Mr. Fine advised employers. "If you have volume in a service area, you gain attention."

More than one-third—36.1%—of hospitals negotiating charges with employers predominantly discount billed charges. Almost a third—29.5%—said they use a variety of methods. Only 14.8% said they predominantly charge a per diem rate and only 3.3% predominantly use diagnostic related groups as the basis for billing employers.

"Employers tend to prefer per diem charges while hospitals tend to prefer a discount off billed charges," Mr. Fine observed. Before negotiating a discount off billed charges, employers should compare the charges of competing hospitals, he suggested.

Fifty-four of the responding hospitals will establish a single price for a variety of services within a specific medical category. The most popular category was obstetrics at 64.8% of the responding hospitals, followed by cardiac at 50%, substance abuse at 40.7% and psychiatric at 38.9%.

"At a minimum, employers should look closely at these product lines and negotiate these," advised Mr. Fine.

When negotiating with hospitals, Mr. Fine advises employers to "pursue win-win situations," so that neither party is left with a tremendous financial loss. "Explore relationships that can be mutually beneficial," he advised.

Employers that want utilization review data from hospitals they contract with generally will have to ask for it, the survey found. Fewer than a quarter of hospitals with direct contracts said they provide utilization review data regularly and voluntarily, while a third said they provide the data only upon request. Another 28.3% said they do not provide this data, while 15% said they provide it voluntarily but only irregularly.

Mr. Fine observed that "it is incumbent on employers to develop a plan for how they will interpret data and use it—to redesign benefit plans or seek out progressive health care services."

Hospitals generally said they permit a utilization review firm or insurer to conduct the reviews—85.1% and 83.6%, respectively. Third-party administrators are permitted to review services at 65.7% of the responding hospitals but only 16.4% of the hospitals said they would cooperate with a business coalition. Six percent said they permit no outside utilization review.

Generally, in smaller hospitals, the chief financial officer is responsible for managed care, while in larger hospitals the responsibility is handled by another executive whose title may be director of managed care, director of contracting, director of alternative delivery systems or vp of planning and marketing.

While the survey findings suggest that hospital chief financial officers as a group may not be seeking direct employer contracts as readily as those with another title who are in charge of managed care, when the chief financial officer is involved with employers, he or she aggressively pursues direct contracts.

For example, only 38.1% of chief financial officers said their hospitals had direct employer contracts while 61.9% of non-CFOs responding said the hospital has such contracts. But, those CFOs with direct contracts indicated an average of 7.9 such contracts, while non-CFOs averaged 4.5 contracts.

Respondents to the survey were based in 19 states and the District of Columbia, with the most responses from Illinois, 12%; Ohio, 11.1%; California and Pennsylvania, each 8.3%; Texas, 6.5%, and Michigan, North Carolina and Florida, each 5.6%.

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Highlights of the survey, "Perceptions of Hospital Managed Care Directors Regarding Direct Employer Contracting," are available free of charge by writing Witt Associates Inc., 1211 W. 22nd St., Oak Brook, Ill. 60521, Attn.: Shelley Bolnius.

Direct contracting with hospitals lauded

By CHRISTINE WOOLSEY

A partnership is forming between employers and health care providers as they attempt to control costs and improve the quality of health care in the next decade.

Dissatisfied with the cost containment results of national managed care networks negotiated by third parties, employers are increasingly negotiating directly with health care providers to create custom health care plans for large concentrations of employees.

In return for the employers' business, hospitals and physician groups typically promise lower prices and more appropriate health care utilization patterns.

"Managed care isn't a corporate business, it is a local business and employers lose leverage and control when they do it nationally," said Rebecca Levin, managed care coordinator at The Penrose-St. Francis Healthcare System in Colorado Springs, Colo.

Employers are not achieving the cost control they anticipated with national HMOs or PPOs, she said.

Direct contracting with health care providers "is really a component of managed care," said Alan Fine, senior associate at Witt Associates Inc., a Chicago-based health care management consultant. "HMOs and PPOs will continue, but this is setting the trend for the '90s. If you're a hospital or an employer, each of you—as provider and purchaser—has opportunities within this direct contract relationship," he said.

A survey conducted this fall by Witt Associates found nearly half the responding government and non-profit hospitals with more than 500 beds had such direct contracts.

General Motors Corp. took health care contracting into its own hands last year after its total self-insured health care bill topped $3 billion.

The Detroit-based automaker collected data from the 50 largest hospitals in the markets where its employees were concentrated, said Thomas J. Morr, GM's general director of employee benefits.

With the help of consultants, the company collected data on hospital stays by 260 GM employees and dependents at each hospital, resulting in about 13,000 case histories.

"Those 13,000 case histories were reviewed by medical professionals who looked at the appropriateness of the admissions, length of stays and an overall reading of quality as measured by outcomes," Mr. Morr explained. The data was then shared with the hospitals, which primarily are located in Indiana and Ohio.

"We've established some targets on desired levels of appropriate care, the number of admissions and lengths of stay, and have established direct contracts with those facilities that meet these criteria," Mr. Morr said. However, he stressed that the agreements are designed to provide incentives and disincentives to health care providers, not employees.

"The intent was not to reinvent the wheel (by creating another HMO or PPO plan). It was revenue neutral," he said. "We really meant to provide incentives to hospitals that would provide quality care and better costs."

For example, Mr. Morr said, GM may set a target that 95% of the admissions must be ruled appropriate by a company utilization reviewer. Should the reviewer find 98% of admissions at one hospital are appropriate, the hospital may receive an extra 5% in fees.

"We treat hospitals in many of the same ways we treat other suppliers who get incentives for quality and cost," he said. "To the extent providers meet or exceed our standards, they get a reward. To the extent that they don't, they get penalized," Mr. Morr explained.

The plan is "transparent to our employees and has nothing to do with their choices," he added. GM employees and their dependents still can choose from a traditional indemnity plan, a PPO or HMO.

Though it is too early to estimate savings from the contract, "the initial reaction from the hospitals has been positive. They seem enthused about their ability to improve the quality of their services and find ways to improve their cost effectiveness as well," said Mr. Morr.

Charles A. Turner III, vp-alternative delivery systems at Mount Carmel Health in Columbus, Ohio, said his facility is eager to work directly with employers.

"Employers have clout. I'm more likely to listen to a corporate benefit manager" than an insurance executive, he said.

Mr. Turner noted that Mount Carmel Health has several direct contracts in the Columbus area—including one with Cleveland-based Parker-Hannifin Corp., a self-insured manufacturer employing 33,000.

"Direct contracting is really starting to take off," he said. Employers "are mad, they want to control costs. They're cutting out the middleman and saying, 'You can be my claims administrator or insurer but I want to be my own buyer,' " he explained.

Fully insured employers use insurers to set up HMOs and PPOs because the insurance company retains the risk.

But "self-insureds have been maintaining their own risk without maintaining the control. They want that control back, they want to control the negotiating authority," Mr. Turner said.

"There is no charge to employers for the use of the network," Mr. Turner noted. "What I'm negotiating for is volume for a better price." An employer who wants the hospital to review utilization, however, will have to pay more, he added.

However, many employers fear a conflict of interest could arise if a hospital policed it own activity, Mr. Turner noted. Employers who want a provider to work with a UR firm or third-party claims administrator should state so in the contract, he said.

Hospital charges in direct contracts can be negotiated by a percentage discount off all billed charges, per diem or through diagnostic related groups.

"We're not averse to accepting risk, but we'll want more exclusivity," Mr. Turner said.

In addition to the added patient volume a contract can deliver, Mr. Turner said he considers a company's prestige, adding: "Employers have forgotten the golden rule: Those who have the gold, rule."

Mr. Turner also said he is apt to be more flexible when a large employer proposes a contract.

But employer size is not critical in deciding to set up a direct contract, said Dale V. Gawley, director of alternative delivery systems at Community Hospitals of Central California in Fresno, Calif. "We're trying to set up longer-range plans, start a relationship and work together."

Community Hospitals has been contracting directly with employers since a 1983 state law allowed the arrangements, he said.

"Skipping the intermediary and selling a package directly to employers weeds out the middle person and sets up a good flow of feedback and timely information" between both parties, Mr. Gawley said.

Health care providers and employers both concede that the contracts will not miraculously curb rising health care costs. And, they both stress the importance of establishing clear goals an employer wants to achieve with a direct contract.

One employer, for example, may simply want to realize short-term savings from a volume discount, while another may be looking for a long-term relationship.

"Direct contracting is not a final solution to the cost containment problem, it's an important step forward and one which deals effectively with price but leaves the major issue of utilization for another step," said Charles R. Buck, staff executive for health care management programs at General Electric Co. in Fairfield, Conn.

GE is "taking a region by region approach," he said. For example, in areas where avoiding overhead costs from an insurance company or receiving provider discounts would produce short-term savings, the company would opt for direct contracts with health care providers.

He said GE is targeting direct contracts, "in those regions where we have 500 to 2,500 employees" and the company is soliciting responses from local hospitals.

"We are well into our first location and early results are positive, but it's still too early" to predict the savings the agreements may produce.

Community Hospitals' Mr. Gawley said employers are beginning to see that traditional managed care plans with HMOs and PPOs have not adequately contained costs.

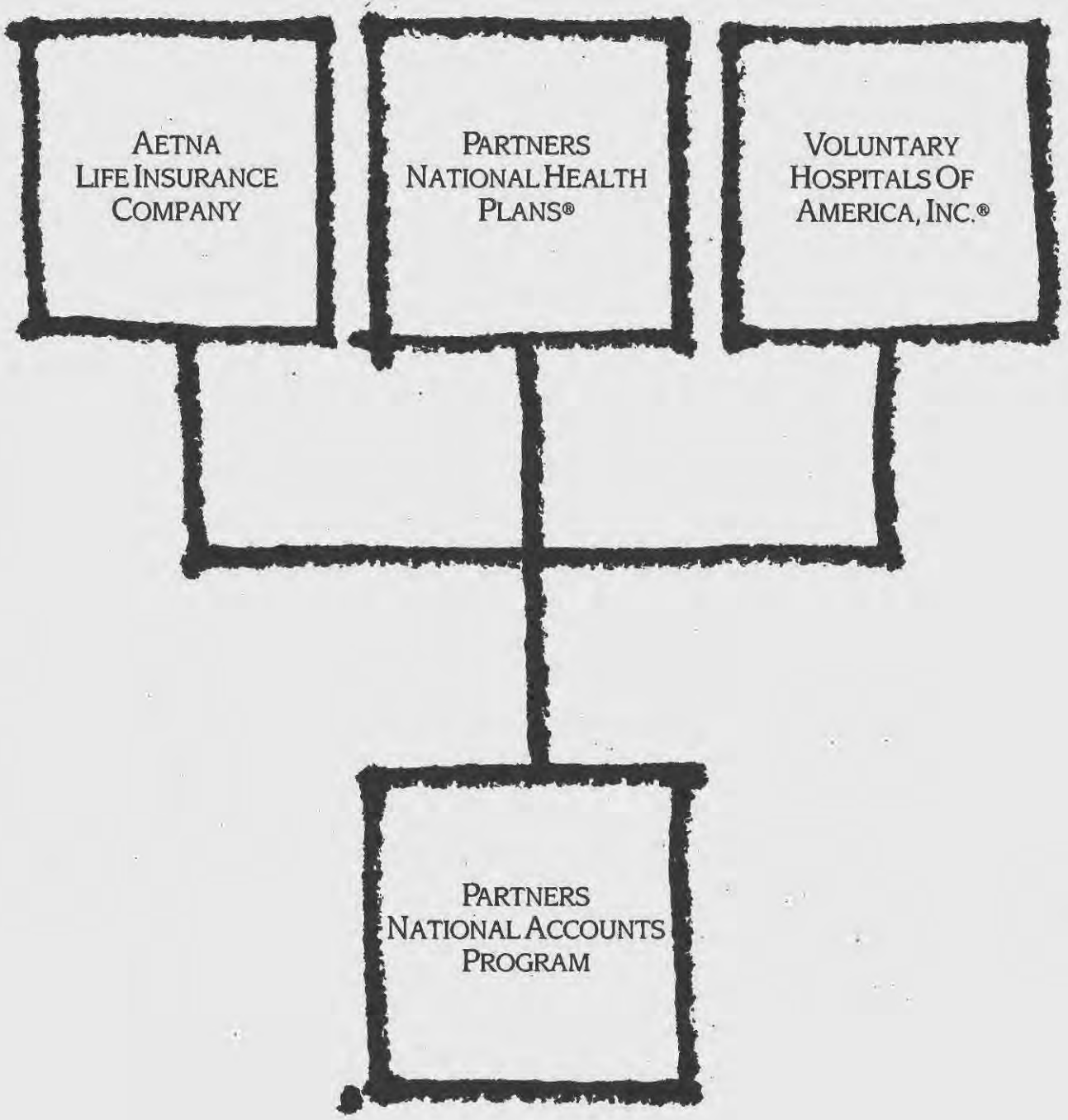
Hospitals or physician groups seeking a good relationship with local employers have to "cut waste as much as we can so employers will see that we are sincere. We want to get the employer's loyalty, give them a viable option and once they see the merits in this that will build a bridge over the long term," he said.

Palo Alto, Calif.-based Hewlett-Packard Co. signed its first direct contract in 1984 with El Camino Hospital in the Santa Clara Valley, said Susan Morconi, health benefits administrator at the computer manufacturer. The company currently offers its more than 87,000 employees 90 HMOs nationwide and is reviewing another 120 health plans.

"We're offering HMOs and they are an excellent choice for a lot of employees. But suppose you want more choice or additional benefits?" Ms. Morconi asks. Designing a custom plan for employees who would use Hewlett-Packard's preferred hospitals and physicians was a logical step, she said.

Hewlett-Packard employees are split evenly in the two plans—half in HMOs and half in the directly contracted plan, Ms. Morconi said.

"It was clear to us years ago that health care costs would not go down," Ms. Morconi explained. She said directly contracting for health care services was a business decision. "We decided we better manage our health care like we do other sectors of our business," she said. ■



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Health maintenance organizations listed



Health Maintenance Group-Birmingham Division

936 S. 19th St., Birmingham, Ala. 35205; 205-985-5589

Operational date: May 1977.
Certified in: Alabama.
Model type: Group.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Alabama.
Staff: 69 primary physicians; three administrative staff members; one marketing staff member; 100% board certified physicians.
Facilities: One hospital.
Service area: Jefferson, Shelby, Bibb, Blount, Chilton, Coosa, Cullman, Fayette, St. Clair, Talladega, Tuscaloosa, Walker and Winston counties in Alabama.
Locations: One administrative site, six primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO.
Rating options: Community rating: $99 single, $266 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 168 employer/payer groups; 8,480 employees and dependents; 9,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.22 days. 4.32 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: Not reported.
Officers: William H. Mandy, president; Joseph B. Bolen III, executive director; Dr. Robert C. Geller, medical director.

Humana Health Plan of Alabama Inc.

500 Lowell Drive, Suite F, Huntsville, Ala. 35801; 205-534-8411

See Humana Health Care Plans under Kentucky.

Humana Health Plan of Alabama Inc.

2368 Fair Lane Drive, Building E-41, Montgomery Ala. 36116; 205-277-1511

See Humana Health Care Plans under Kentucky.

Humana Health Plan of Alabama Inc.

404 Avalon Ave., Muscle Shoals, Ala. 35660; 205-383-0737

See Humana Health Care Plans under Kentucky.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Southeast Health Plan

104 Inverness Center Place, Suite 600, Birmingham, Ala. 35242; 205-991-6000; 800-826-0879

Operational date: January 1985.
Certified in: Alabama.
Model type: IPA.
For profit.
Sponsorship: Group of doctors, hospitals and insurers.
Staff: 451 primary physicians; 691 specialists; 15 marketing staff members; 85% board certified physicians.
Facilities: 23 hospitals; 85 pharmacies; two diagnostic labs.
Service area: Autauga, Blount, Chilton, Elmore, Jefferson, Montgomery, Shelby, St. Clair, Tuscaloosa and Walker counties in Alabama.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 160 employer/payer groups; 5,300 employees with single coverage; 9,850 employees with family coverage; 36,300 employees and dependents; estimated 45,000 enrollees as of Jan. 1, 1990. Hospital stay averages 4.49 days. 83 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: Not reported.
Officers: Dr. Ronald E. Henderson, president/chairman; George B. Salem, executive vp/chief executive officer; Dr. Richard P. McLaughlin, medical director; Andrew M. Wood III, vp-marketing; Nan M. Priest, vp/general manager; Anthony J. Crowe, vp-corporate development; C. Gregory Weyandt, vp-finance.



Arizona Healthplan

1717 W. Northern Ave., Suite 217, Phoenix, Ariz. 85021; 602-870-7555

Operational date: June 1987.
Certified in: Arizona.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 351 primary physicians; 876 specialists; 110 administrative staff members; 24 marketing staff members; 125 patients per physician; 85% board certified physicians.
Facilities: 32 hospitals; one pharmacy; one diagnostic lab.
Service area: Apache, Cochise, Gila, Graham, Greenlee, Maricopa, Mohave, Navaho, Pima, Pinal, Santa Cruz and Yanapai counties in Arizona.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment is not allowed.
Users: 100 employer/payer groups; 5,742 employees with single coverage; 6,339 employees with family coverage; 86,185 employees and dependents. Hospital stay averages 3.5 days.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Dr. Clyde A. Wright, general manager; Dr. Richard E. Standridge, medical director; Mark Blanka, sales director.

CIGNA Healthplan of Arizona Inc.

11001 N. Black Canyon Highway, Suite 400, Phoenix, Ariz. 85029; 602-942-4462

Operational date: November 1972.
Federally qualified.
Certified in: Arizona.
Model type: Staff.
For profit.
Sponsorship: CIGNA Corp.
Staff: 128 primary physicians; 180 specialists; 145 administrative staff members; 24 marketing staff members; 1,443 patients per physician; 70% board certified physicians.
Facilities: 18 hospitals; one pharmacy; one diagnostic lab.
Service area: Maricopa and Pinal Counties in Arizona.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by the HMO.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 309 employer/payer groups; 19,251 employees with single coverage; 26,064 employees with family coverage; 182,505 employees and dependents. Hospital stay averages 4.9 days.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Dr. Clyde A. Wright, general manager; Dr. Zachery B. Gerbarg, medical director; Mark Besh, sales director.

CIGNA Healthplan of Arizona Inc.

4907 E. Broadway, Suite 100, Tucson, Ariz. 85711; 602-571-6500

Operational date: January 1981.
Federally qualified.
Certified in: Arizona.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 32 primary physicians; 145 specialists; six administrative staff members; nine marketing staff members; 965 patients per physician; 66.7% board certified physicians.
Facilities: Four hospitals; two diagnostic labs.
Service area: Pima County in Arizona.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedure, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 120 employer/payer groups; 10,000 employees with single coverage; 8,000 employees with family coverage; 37,124 employees and dependents. Hospital stay averages 4.5 days. 240 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Terry L. Nimnicht, general manager; Dr. Thomas Purdon, medical director; Leonard R. Grover, sales director.

EQUICOR Health Plan Inc.

5353 N. 16th St., Suite 380, Phoenix, Ariz. 85016; 602-264-4057

Operational date: January 1987.
Certified in: Arizona.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 132 primary physicians; 708 specialists; eight administrative staff members; six marketing staff members; 78 patients per physician; 75% board certified physicians.
Facilities: 18 hospitals; 300 pharmacies and two diagnostic labs (includes those participating in EQUICOR Health Plan of Tucson).
Service area: Apache, Coconino, Gila, Lapaz, Maracopa, Mohave, Navajo, Yavapai and northern Pinal counties in Arizona.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Vision, substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment is not allowed.
Users: 122 employer/payer groups; 10,388 employees and dependents; 11,252 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.

Continued on page 16

Outline of HMO data

The third annual *Business Insurance* directory of health maintenance organizations contains information on 380 individual HMOs.

The directory is published as an editorial service. There is no charge to the HMOs to be included.

HMOs are listed alphabetically under the state in which they operate. When an HMO operating in two or more states provided consolidated figures for all HMOS within its network, the consolidated listing is footnoted. The names, addresses, telephone numbers and any additional information provided on the affiliated HMOs in each state are listed under the states serviced, with a reference to the consolidated listing.

Each listing begins with the name, address and telephone number of the HMO. Operational information follows, including **operational date, federal qualification and state certification.**

The **model type** of the HMO is also listed. Group models contract with independent, multispecialty physician groups. Independent practice associations (IPAs) contract with independent physicians or small, single-specialty physician groups, who are able to maintain private practices along with the HMO contract. Staff model HMOs directly employ salaried physicians to serve patients. Network models contract for services with two or more large IPAs. Mixed model HMOs are a combination of two or more model types.

The **tax status** as a for profit or not for profit HMO is listed, followed by information on the sponsorship of the HMO.

Also requested was information on **staff and facilities** as of Sept. 30, 1989.

Staff information includes the number of primary physicians, number of specialists, number of administrative and number of marketing staff members, average number of patients per primary physician and the percentage of board certified physicians in the HMO.

The **facilities** heading contains information on the number of participating hospitals, pharmacies and diagnostic labs.

Service area follows, noting the number of locations, including administrative and primary care sites (except for IPA model HMOs.)

Information was requested on the **services** the HMO offers, including standard and optional features of coverage. Who performs diagnostic testing and lab work for the HMO also is noted.

Available **rating options** and community rates as of Sept. 30 (if provided by the HMO) are reported along with the availability of non-federally qualified programs to employers. Information on Federal Health Care Financing Administration contracts and individual enrollment (such as retirees) are also listed.

Information on **users** as of Sept. 30 was requested, including the number of employer/payer groups contracting with the HMO; the number of employees with single coverage; the number of employees with family coverage; and the number of employees and dependents in employer groups serviced by the HMO. HMOs were also asked to estimate the total number of enrollees as of Jan. 1, 1990. The average length of hospital stay by HMO members and the rate of hospital admissions per 1,000 members also were requested.

If the HMO provides **utilization reports** to payer groups, their availability is noted.

Information on **billing,** including whether the HMO provides direct billing for premiums under COBRA and whether a national accounts program with consolidated billing is available to multistate employers, is noted.

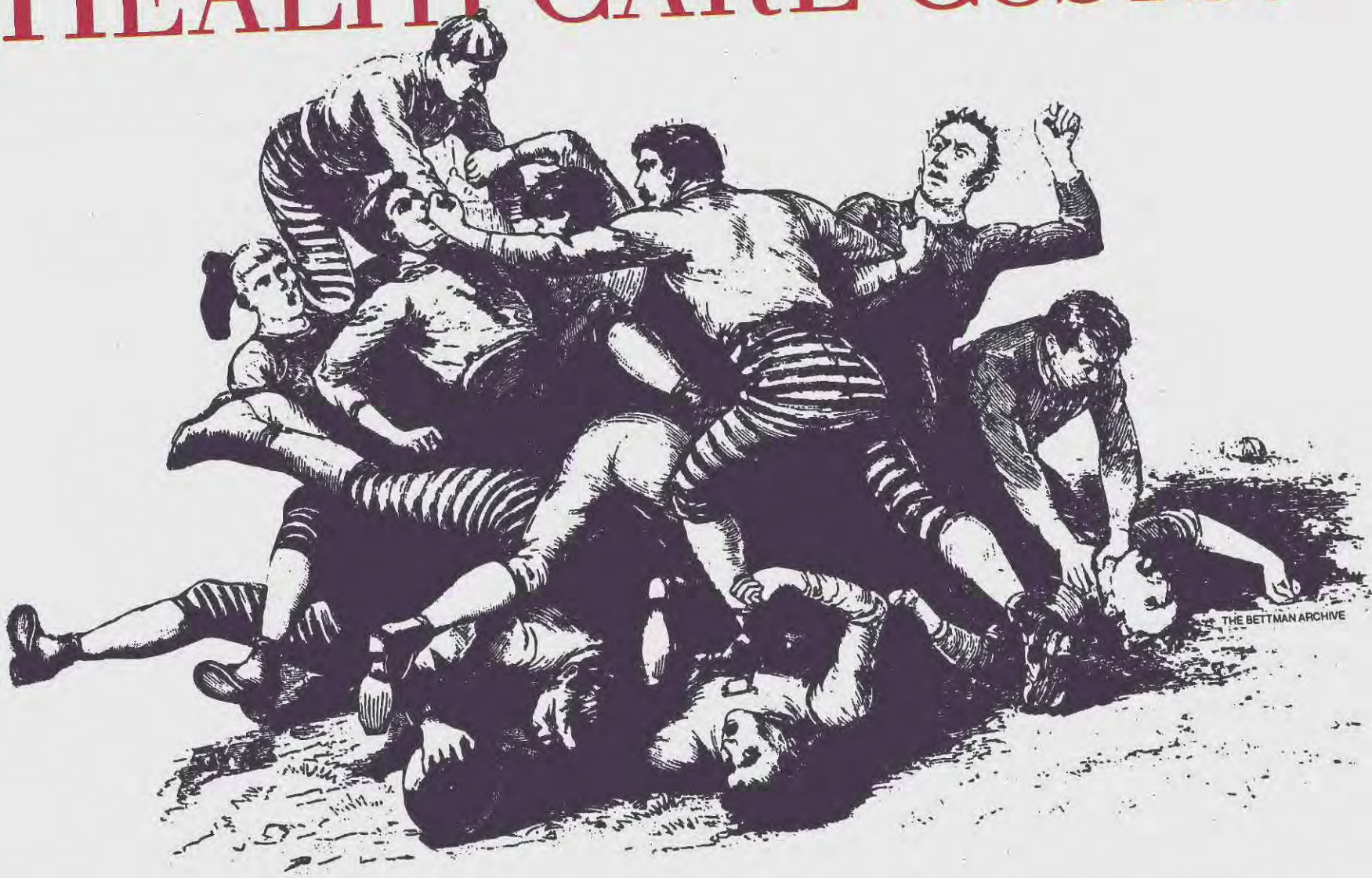
Gross revenues in 1988 and estimated 1989 revenues, based on total premiums paid on behalf of enrollees, also were requested.

Names and titles of **officers** complete the listings.

If you wish to determine in which states multi-state HMOs operate, refer to the alphabetical index of networks on page 99.

Information for the directory was gathered from responses to a *Business Insurance* questionnaire. Although every effort is made to obtain complete and accurate information, *Business Insurance* is unable to verify the information and relies on the responses of the HMOs.

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Vice President, MB66
Aetna Life Insurance Company
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Hartford, CT 06156
(203) 636-1890

Aetna

Continued from page 16

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $21.8 million in 1988; $32.4 million estimated for 1989.

Officers: Dr. Arnold I. Kisch, president; Doug Lottes, marketing director.

EQUICOR Health Plan Inc.

2033 E. Speedway, Tucson, Ariz. 85719; 602-881-9009

Operational date: April 1986.
Certified in: Arizona.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Eqitable HCA Corp.
Staff: 56 primary physicians; 165 specialists; three administrative staff members; three marketing staff members; 189 patients per physician; 75% board certified physicians.
Facilities: Eight hospitals; 300 pharmacies and two diagnostic labs (includes those participating in EQUICOR Health Plan Inc. of Phoenix).
Service area: Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee and southern Pinal counties in Arizona.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Vision, substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment is not allowed.
Users: 138 employer/payer groups; 10,615 employees and dependents; 10,746 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $10.5 million in 1988; $16 million estimated for 1989.
Officers: Dr. Arnold I. Kisch, president; Dr. Michael Gavin, executive director/medical director; Doug Lottes, marketing director.

FHP Healthcare

1615 S. 52nd St., Tempe, Ariz. 85281; 602-966-9252

See FHP Healthcare under California.

HMO Arizona

2444 W. Las Palmaritas, Phoenix, Ariz. 85021; P.O. Box 13466, Phoenix, Ariz. 85002; 602-864-4252
Operational date: July 1987.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Arizona.
Service area: Maricopa and Pima counties in Arizona.
Users: 24,500 employees and dependents as of June 1989.
Gross revenues: Not reported.

Humana Health Plan Inc.

Anchor Centre III, 2231 E. Camelback Road, Suite 208, Phoenix, Ariz. 85016; 602-381-4300

See Humana Health Care Plans under Kentucky.

Intergroup of Arizona

2800 N. 44th St., Suite 500, Phoenix, Ariz. 85008; 602-381-7804
Operational date: March 1981.
Federally qualified.
Certified in: Arizona.
Model type: Network.
For profit.
Sponsorship: Professional Management Group of Arizona.
Staff: 250 primary physicians; 750 specialists; 150 administrative staff members; 24 marketing staff members; 750 patients per physician; 90% board certified physicians.
Facilities: 46 hospitals; one pharmacy network with 80 locations; five diagnostic labs.
Service area: Maricopa and Pima counties in Arizona.
Locations: Two administrative sites, 30 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $100 single, $291 family; by class. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 800 employer/payer groups; 37,200 employees with single coverage; 39,800 employees with family coverage; 165,000 employees and dependents; 185,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 72 admissions per 1,000 members.
Management reports: Provided for large groups annually or quarterly.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $92 million in 1988; $150 million estimated for 1989.
Officers: Rick Barrett, chief executive officer; Dr. Philip E. Dew, vp-medical affairs; Scott Trenter, marketing manager-northern region, Sharyn Breck, marketing manager-southern region; Elizabeth McNamee, vp-northern region; Pete Peterson, vp/chief financial officer; Frank Connell, vp/chief operating officer.

Lincoln National Health Plan Inc.

7776 Pointe Parkway W., Suite 100, Phoenix, Ariz. 85044; 602-438-1005

See Lincoln National Health Plan under Indiana.

Metlife Healthcare Network of Arizona Inc.

1314 N. Third St., Suite 300, Phoenix, Ariz. 85004-1751; 602-252-3846

Operational date: July 1985.
Certified in: Arizona.
Model type: IPA.
For profit.
Sponsorship: Group of doctors, hospitals and Metropolitan Life Insurance Co.
Staff: 176 primary physicians; 653 specialists.
Facilities: 12 hospitals.
Service area: Maricopa County in Arizona.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: J.C. Hulsey, president; K. Garast, vp.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



HMO Arkansas

P.O. Box 1460, Little Rock, Ark. 72203; 501-221-8015

Year founded: December 1985.
Federally qualified.
Certified in: Arkansas.
Model type: IPA.
For profit.
Sponsorship: Arkansas Blue Cross & Blue Shield.
Staff: 120 primary physicians; 800 specialists.
Service area: Pulaski, Saline, Lonoke, Faulkner, Sebastian, Crawford, Logan, Scott, Franklin and Johnson counties in Arkansas.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $95 single, $250 family, by class; by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael W. Brown, executive director; Robert Benafield, medical director; Marietta McCray, marketing director.



AVP Vision Plans

165 Du Bois, Santa Cruz, Calif. 95060; 408-425-0989; 800-443-4994

Operational date: July 1985.
Certified in: California.
Model type: Mixed network.
For profit.
Sponsorship: Optics East Inc.
Staff: More than 600 primary physicians; 45 ophthamologists; five administrative staff members; 11 marketing staff members.
Service area: California.
Locations: Two administrative sites.
Services: Standard package includes vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Individual enrollment allowed.
Users: More than 150 employer/payer groups; more than 21,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided annually, quarterly or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Stephen Shaw, president; D.K. Kim, executive director; Dr. Robert Greenley, medical director; John Curva, marketing director.

Blue Shield HMO

P.O. Box 7168, San Francisco, Calif. 94120-7168; 415-677-2600

Operational date: June 1988.
Certified in: California.
Model type: Network.
Not for profit.
Sponsorship: Blue Shield of California.
Staff: 305 primary physicians; 824 specialists; 65 administrative staff members; 11 marketing staff members; 90% board certified physicians.
Facilities: 11 hospitals; 431 pharmacies; 30 diagnostic labs.
Service area: Alameda, Contra Costa, Placer, Sacramento, Santa Clara and Yolo counties in California.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services (outpatient), durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, psychiatric services (inpatient). Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 67 employer/payer groups; 892 employees with single coverage; 651 employees with family coverage; 3,112 employees and dependents; 5,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 47 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Thomas C. Paton, chief executive officer; Charles W. Stewart, president/chief operating officer; Robert C. Nickel, senior vp-HMO; Dr. Arthur J. Riesenfeld, medical director; Cindy Gentry Barron, director-HMO marketing/enrollment; Charles L. Parcell, senior vp-marketing/sales.

CaliforniaCare

21555 Oxnard St., P.O. Box 70000, Van Nuys, Calif. 91470; 818-703-2600.

Operational date: June 1986.
Model type: Mixed network.
Not for profit.
Sponsorship: Blue Cross of California.
Users: 218,069 total membership as of June 1986.
Service area: 31 counties in California.

California Chiropractic IPA

1770 Tribute Road, Suite 201, Sacramento, Calif. 95815-4494; 916-646-3477; 800-638-4557 in California

Operational date: August 1988.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.
Staff: Eight administrative staff members; two marketing staff members; 100% board certified physicians.
Service area: California.
Locations: One administrative site.
Services: Chiropractic.
Rating options: Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 14,000 employees and dependents; 17,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided semiannually or upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $60,000 in 1988; $150,000 estimated for 1989.
Officers: Dr. Stephen J. Curry, president/medical director; Robert G. Britton, chief executive officer; Dr. Thomas Gallaugher, vp; Dr. David Eskew, secretary.

CareAmerica Health Plans

20520 Nordhoff St., Chatsworth, Calif. 91311-6191; 818-407-2222

Operational date: January 1986.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: UniHealth America.
Staff: 1200 primary physicians; 2900 specialists; 143 administrative staff members; 37 marketing staff members; 85 patients per physician; 90% board certified physicians.
Facilities: 48 hospitals; 300 pharmacies; five diagnostic labs.
Service area: Los Angeles, Ventura, Orange, San Bernardino and Riverside counties in California.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,400 employer/payer groups; 61,200 employees with single coverage; 14,600 employees with family coverage; 102,000 employees and dependents; 110,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days.
Management reports: Provided for companies with more than 100 employees.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $63 million in 1988; $81 million estimated for 1989.
Officers: Larry D. Gray, president; Dr. Arthur Southham, executive vp; Dr. Sanford Bloom and Dr. Julius Bartoli, medical directors; Kandis Larkey, marketing director; Paul Kimmins, chief financial officer.

CareAmerica-Southern California Inc.

20520 Nordhoff St., Chatsworth, Calif. 91311-6191; 818-407-2222

Operational date: December 1985.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: UniHealth America.
Staff: 1,200 primary physicians; 3,800 specialists; 140 administrative staff members; 22 marketing staff members; 80 patients per physician; 75% board certified physicians.
Facilities: 48 hospitals; prescription drug card program.
Service area: Los Angeles, Orange, Riverside, San Bernardino and Ventura counties in California.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, durable medical equipment, chiropractic. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $99 single, $270 family; by class; by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,500 employer/payer groups; 25,000 employees with single coverage; 20,000 employees with family coverage; 90,000 employees and dependents; 101,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days. 64 admissions per 1,000 members.
Management reports: Provided annually upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $40 million for 1988; $74 million estimated for 1989.
Officers: Larry Gray, president; Dr. Arthur Southam, executive director; Dr. Julius Bartoli, medical director; Dr. Kandis Larkey, marketing director; Robert White, vp-administration; Lisa Rubino, vp-member services; Jim Agronick, vp-provider relations.

CIGNA Healthplan of California Inc.

9808 Scranton Road, Suite 400, San Diego, Calif. 92121; 619-457-5361.

Operational date: May 1984.
Federally qualified.
Certified in: California.
Model type: IPA.

Continued on page 18

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Evanston IL 60201 312 866-2800

Professional Liability and Specialty Insurance

Continued from page 16

For profit.
Sponsorship: CIGNA Corp.
Staff: 262 primary physicians; 982 specialists; 10 administrative staff members; seven marketing staff members; 167 patients per physician; 85% board certified physicians.
Facilities: 15 hospitals; one pharmacy.
Service area: San Diego County, Calif.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental services, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.
Users: 43,459 employees and dependents.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Dr. J. Sim Tan, general manager/medical director; George McQueen, sales director.

CIGNA Healthplan of Northern California Inc.

1999 Harrison St. Suite 1000, Oakland, Calif. 94612-3508; 415-273-8440.

Operational date: August 1987.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 304 primary physicians; 1,179 specialists; 10 administrative staff members; five marketing staff members; 22 patients per physician; 85% board certified physicians.
Facilities: 17 hospitals; one pharmacy.
Service area: Alameda, San Mateo, Contra Costa, Santa Clara, Marin, San Francisco and Sonoma counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 105 employer/payer groups; 537 employees with single coverage; 1,372 employees with family coverage; 8,407 employees and dependents; Hospital stay averages 4.4 days; 61 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Nina Auger, general manager; Claudia Alt, sales director.

CIGNA Healthplan of California Inc./Ross Loos Medical Group

505 N. Brand Blvd., Suite 500, Glendale, Calif. 91203; 818-500-6262.

Operational date: 1929.
Federally qualified.
Certified in: California.
Model type: Staff.
For profit.
Sponsorship: CIGNA Corp.
Staff: 196 primary physicians; 219 specialists; 23 administrative staff members; 65% board certified physicians.
Facilities: 10 hospitals.
Service area: Los Angeles, Orange, Riverside and San Bernardino counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,491 employer/payer groups; 1,020 employees with single coverage; 2,552 employees with family coverage; 384,043 employees and dependents; Hospital stay averages 4.14 days; 63.6 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Bert Wagener, general manager; Dr. James Bowerman, medical director; Connie Zastoupil, sales director.

CIGNA Private Practice

505 N. Brand Blvd., Suite 500, Glendale, Calif. 91203; 818-500-6262.

Operational date: November 1985.
Federally qualified.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 751 primary physicians; 2,767 specialists; 102 administrative staff members; 191 marketing staff members; 133 patients per physician.
Facilities: 46 hospitals; one diagnostic lab.
Service area: Los Angeles, Orange, Riverside and San Bernardino counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics and hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 10,259 employees with single coverage; 32,613 employees with family coverage; 108,493 employees and dependents; Hospital stay averages 4.6 days; 53 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Howard Flushman, general manager; Louis Filiatrault, medical director; Jay Sherman, sales director.

Coast Health Plan

5150 El Camino Real, Suite C-10, Los Altos, Calif. 94022; 415-967-5217

Operational date: August 1987.
Certified in: California.
Model type: IPA.
Not for profit.
Sponsorship: El Camino Hospital District.
Staff: 185 primary physicians; 238 specialists; 24 administrative staff members; four marketing staff members; eight patients per physician; 100% board certified physicians.
Facilities: Five hospitals; two pharmacy chains; 25 diagnostic labs.
Service area: Santa Clara and southern San Mateo counties in California.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 53 employer/payer groups; 2,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.4 days; 49 admissions per 1,000 members.
Management reports: Provided quarterly for major clients.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $2 million in 1988; $4 million estimated for 1989.
Officers: Denise L. Shull, president/chief executive officer; Dr. Lawrence A. William, medical director/secretary; Bebe Hoppe, marketing director; Neilson S. Buchanan, chairman; Dr. Larry H. Kretchmar, vice chairman; Randall D. Frakes, vp; Dr. Lawrence A. William, secretary; Armando J. Bautista, assistant treasurer.

Contra Costa Health Plan

595 Cender Ave., Suite 100, Martinez, Calif. 94553; 415-646-2920

Operational date: 1980.
Federally qualified.
Certified in: California.
Model type: Staff.
Not for profit.
Sponsorship: Contra Costa County.
Staff: 36 primary physicians; 43 specialists; 27 administrative staff members; nine marketing staff members; approximately 425 patients per physician.
Facilities: One hospital.
Service area: Contra Costa County, Calif.
Locations: One administrative site, five primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, obstetrics/gynecology. Options include vision, dental, durable medical equipment, podiatry. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 19 employer/payer groups; 3,400 employees and dependents; 15,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.3 days.
Revenues: Not reported.
Officers: Milton S. Camhi, executive director; Dr. William Walker, medical director; Elissa Leidey, acting marketing director; Richard Harrison, director-provider affairs; Bobbi Baron, planning director.

Delta Care/PMI

5122 Katella Ave., Suite 206, Los Alamitos, Calif. 90720, 213-493-6661.; 800-821-2058

Operational date: November, 1968.
Certified in: California, Colorado, Florida, Georgia, Illinois, New Mexico, Nevada, Texas, Utah and Minnesota.
Model type: IPA and network.
Not for profit.
Sponsorship: Insurer.
Staff: More than 550 primary physicians; more than 325 specialists; 112 administrative staff members; 27 marketing staff members.
Service area: California, Colorado, Florida, Georgia, Illinois, New Mexico, Nevada, Texas, Utah and Minnesota.
Locations: Three administrative sites.
Services: Standard package includes vision, dental.
Rating options: Community rating, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 1,100 employer/payer groups; 125,000 employees with single coverage; 250,000 employees with family coverage; more than 485,000 employees and dependents; more than 500,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided monthly or quarterly on request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $39.5 million in 1988; $42.5 million estimated for 1989.
Officers: James P. Moon, president; Dr. Steven Bull, executive dental director; Lee Schreider, vp-marketing/underwriting.

EQUICOR Health Plan of California Inc.

12707 High Bluff Drive, Suite 200, San Diego, Calif. 92138; 619-259-6712.

Operational date: April 1981.
Certified in: California.
Model type: Group, IPA and network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 615 primary physicians; 2,373 specialists; 10 administrative staff members; eight marketing staff members; 48 patients per physician; 75% board certified physicians.
Facilities: 85 hospitals; chain of pharmacies; six diagnostic labs.
Service area: Los Angeles, Orange, Ventura, Santa Barbara and San Luis Obispo counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drug, dental. Vision, substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 125 employer/payer groups; 29,483 employees and dependents; 36,000 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $18:6 million in 1988; $27.2 million estimated for 1989.
Officers: Joseph P. Radigan, president; Mark C. Wells, executive director; Dr. Norman Charney, medical director; Scott R. Reed, marketing director.

FHP Health Care*

9900 Talbert Ave., Fountain Valley, Calif. 92708; 714-963-7233

Operational date: 1961.
Federally qualified.
Certified in: Arizona, California, Guam, New Mexico, Utah.
Model type: Group, IPA and staff.
For profit.
Sponsorship: FHP International Corp.
Staff: 1,200 primary physicians; 2,200 specialists; 4,000 administrative staff members; 500 marketing staff members; 400 patients per physician; 97% board certified physicians.
Facilities: 80 hospitals; 100 pharmacies; 60 diagnostic labs.
Service area: Los Angeles, Orange, Riverside, Ventura and San Bernardino counties in California; Maricopa, Pinal and Pima counties in Arizona; Salt Lake, Utah, Weber, Davis, Summit, Wasatch and Tooele counties in Utah; Bernalillo, Valencia, Sandoval and Santa Fe counties in New Mexico; Guam.
Locations: 10 administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, obstetrics/gynecology. Options include experimental procedures, vision, dental, durable medical equipment, podiatry. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $100 single, $250 family; by class, by age/sex. Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 3,000 employer/payer groups; 280,000 employees with single coverage; 55,000 employees with family coverage; 1.8 million employees and dependents. Hospital stay averages three days.
Management reports: Provide quarterly.
Billing: Provides direct billing fo premiums under COBRA. National ac counts program with consolidate billing available.
Gross revenues: $503.5 million i 1988; $699.1 million estimated fo 1989.
Officers: W.W. Price III, president Dr. Robert Gumbiner, chairman/chie executive officer-FHP Internationa Corp.; Dr. Allan Mintz, vp-medical af fairs; Alfred F. Schmid, vp-marketing Hal Johnson, Pat Vitacolonna, Burk Gumbiner and David Engelberg, se nior vps.

* Figures are corporate, including al HMOs sponsored by FHP Internationa Corp.

FHP Health Care

18000 Studebaker Road, Cerritos, Calif. 90701; 213-809-5399

See FHP Health Care under California.

Freedom Plan Inc.

25 W. Carrillo, Santa Barbara, Calif. 93101; 805-564-0072

Operational date: January 1988.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: Group of doctors and hospitals.
Staff: 70 primary physicians; 141 specialists; 17 administrative staff members; three marketing staff members; 90 patients per physician.
Facilities: Six hospitals; 19 pharmacies; three diagnostic labs.
Service area: Santa Barbara County, Calif.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include experimental procedures, prescription drugs, vision, dental, substance abuse, psychiatric services. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 121 employer/payer groups; 465 employees with single coverage; 8,000 estimated enrollees as of Jan. 1, 1990. 157 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Leeba Lessin, chief executive officer; Dr. Robert McGinnis, medical director; Steve Van Wart, marketing director; Larry Keller, finance director.

Golden West Dental & Vision Plan

888 W. Ventura Blvd., Suite 7, Camarillo, Calif. 93010; 805-987-8941

Operational date: April 1974.
Certified in: California.
For profit.
Sponsorship: Golden West Health Plan Inc. and others.
Staff: 25 administrative staff members; seven marketing staff members; 100% board certified dentists and optometrists.
Facilities: More than 500 dental offices; more than 350 vision care offices.
Service area: Arizona, California, Nevada, New Mexico, Oregon and Washington.
Locations: Four administrative sites.
Services: Standard package includes vision and dental. Options include dental and vision PPOs, dental reimbursement.
Rating options: By class dental: $4-$16 single, $16-$42 family. Vision: up to $9 single, $3-$18 family. Experience rating also used.
Enrollment options: Individual enrollment allowed.
Users: Approximately 450 employer/payer groups; 75,000 estimated enrollees as of Jan. 1, 1990.

Continued on page 20

Ready to say Uncle?

Frustrated by the failure to hold the line on soaring health care costs, many business leaders are calling for some type of national health plan. Who can blame them?

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Continued from previous page

Management reports: Provided annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $4 million in 1988; $6 million estimated for 1989.

Officers: Karl H. Lehmann, president/executive director; Candee Bolyog, provider relations; William Ayres, marketing director; Daphne Becker, chief financial officer.

Health Net

P.O. Box 9103, Van Nuys, Calif. 91409; 818-719-6776

Year founded: March 1979.
Federally qualified.
Certified in: California.
Model type: Network and IPA.
Not for profit.
Sponsorship: Independent.

Staff: 3,556 primary physicians; 6,116 specialists; 560 administrative staff members; 120 marketing staff members; 202 patients per physician; 80% board certified physicians.

Facilities: 249 hospitals; 1,300 pharmacies.

Service area: 34 counties in California.

Locations: Nine regional offices.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include experimental procedures, prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $97.22 single, $281.94 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 2,600 employer/payer groups; 149,516 employees with single coverage; 106,785 employees with family coverage; 720,128 employees and dependents; 720,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 55 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $494.6 million in 1988; $707.2 million estimated for 1989.

Officers: Roger F. Greaves, president; Jerry Cooper, executive director; Dr. Leonard Knapp, medical director; Rita Duarte, marketing director; Ken Lewis, Beverly Fittipaldo and John Rue.

The Health Plan of America

505 S. Main St., Suite 300, Orange, Calif. 92668; 714-972-9200

Operational date: December 1979.
Federally qualified.
Certified in: California.
Model type: IPA.
Not for profit.
Sponsorship: St. Joseph Health System.

Staff: 2,100 primary physicians; 5,500 specialists; 18 marketing staff members; 48 patients per physician; 89% board certified physicians.

Facilities: 91 hospitals; approximately 2,000 pharmacies.

Service area: 27 counties in California.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, durable medical equipment, hearing aid, prosthetic devices, hospice. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 800 employer/payer groups; 21,300 employees with single coverage; 24,600 employees with family coverage; 101,000 employees and dependents; 110,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 65 admissions per 1,000 members.

Management reports: Provided as contracted.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $76 million in 1988; $90 million estimated for 1989.

Officers: Lawrence N. Kugleman, president/chief executive officer Dr. John H. Austin, executive vp/medical director; David Horn, executive vp; Eleanor V. Brewer, senior vp-corporate services; Donna J. Rockenbach, senior vp/chief financial officer.

Inter Valley Health Plan

300 S. Park Ave., Suite 300, Pomona, Calif. 91766; 714-623-6333.

Operational date: July 1979.
Federally qualified.
Certified in: California.
Model type: IPA.
Not for profit.
Sponsorship: Pomona Valley Hospital Medical Center.

Staff: 261 primary physicians; 904 specialists; 98 administrative staff members; 12 marketing staff members; approximately 23 patients per physician; 95% board certified physicians.

Facilities: 20 hospitals; 122 pharmacies; 15 diagnostic labs.

Service area: San Bernardino, Riverside and East Los Angeles counties in California.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include vision, dental, podiatry. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $94.01 single, $384 85 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 300 employer/payer groups; 11,000 employees with single coverage; 14,000 employees with family coverage; 25,000 employees and dependents; 36,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages two days.

Management reports: Provided annually.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $45.3 million in 1988; $55.5 million estimated for 1989.

Officers: James Taylor, president; Dr. Alexander Bckor, medical director; C. Lawrence Thomas, marketing director; Donald McCain, vp-finance.

Kaiser Foundation Health Plan Inc.-Northern California Region

1950 Franklin St., Oakland, Calif. 94612; 415-987-1000

See Kaiser Permanente Medical Care Program corporate listing under California.

Kaiser Foundation Health Plan Inc.-Southern California Region

393 E. Walnut, Walnut Center, Pasadena, Calif. 91188; 818-405-5000

See Kaiser Permanente Medical Care Program corporate listing under California.

Kaiser Permanente Medical Care Program*

1 Kaiser Plaza, Oakland, Calif. 94612; 415-271-5953

Operational date: 1945.
Federally qualified.
Certified in: California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Kansas, Maryland, Massachusetts, Missouri, New York, North Carolina, Ohio, Oregon, Texas, Virginia, Washington.
Model type: Group.
Not for profit.
Sponsorship: The Permanente

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edical Groups, Kaiser Foundation ospitals, Kaiser Foundation Health lans.

Staff: June 30, 1989: 6,873 primary hysicians; 61,049 administrative staff embers; more than 300 marketing aff members; 879 members per physian; 76% board certified physicians.

Facilities: Year-end 1988: 30 Kaier Foundation hospitals, more than 100 dditional hospitals.

Service area: California, Oregon, Vashington, Hawaii, Ohio, Colorado, istrict of Columbia, Maryland, Virinia, Texas, Connecticut, New York, lassachusetts, North Carolina, South arolina, Kansas, Missouri, Georgia.

Locations: 15 administrative sites, 20 primary care sites.

Services: Standard package includes ospitalization; laboratory; X-ray; preentive medicine; inpatient; outpatient; eriodic check-ups; prescription drugs npatient; substance abuse; psychiatric ervices; podiatry in some regions; obtetrics/gynecology; physical, occupaional and speech therapy; hemodiaysis; extended care services in a skilled ursing facility; home healthcare services. Options includes prescription drugs, outpatient, vision in some regions, dental in some regions, durable medical equipment in some regions. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Several regions offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: Year-end 1988: More than 34,000 employer/payer groups; 926,000 employees with single coverage; 1.3 employees with family coverage; 6.2 million employees and dependents as of Sept. 30, 1989; 6.2 million estimated enrollees as of Dec. 31, 1989. Hospital stay averages 5 days.

Management reports: Provided upon request quarterly or annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $5.6 billion in 1988.

Officers: James A. Vohs, chairman/president/chief executive officer.

* Figures are corporate, including all HMOs sponsored by Kaiser Permanente Medical Care Program.

Lincoln National Health Plan of California

2655 Camino del Rio N., San Diego, Calif. 92608; 619-299-6464

See Lincoln National Health Plan under Indiana.

Lincoln National Health Plan of California

21800 Oxnard St., Suite 600, Woodland Hills, Calif. 91367; 818-883-3193

See Lincoln National Health Plan under Indiana.

Maxicare Health Plans Inc.*

5200 W. Century Blvd., Los Angeles, Calif. 90045; 213-568-9000

Operational date: 1973.
Federally qualified.
Certified in: California, Illinois, Indiana, Louisiana, North Carolina, South Carolina, Wisconsin.
Model type: Group and IPA.
For profit.
Staff: 900 administrative staff.
Facilities: 2,300 pharmacies.
Service area: California, Illinois, Indiana, Louisiana, North Carolina, South Carolina and Wisconsin.
Locations: Eight administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, obstetrics/gynecology. Options include prescription drugs, dental, substance abuse, psychiatric services, durable medical equipment, podiatry. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 380,000 employees and dependents; 380,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $1.1 million in 1988.
Officers: Peter J. Ratican, chief executive officer/chairman/president; Dr. Samuel Warburton, medical director; Robert L. Dawson, senior vp-marketing; Eugene Froelich, chief financial officer/executive vp/director; Gareth Hughes, executive vp/director.

* Figures are corporate, including all HMOs sponsored by Maxicare Health Plans Inc.

Maxicare Northern California

1 Bay Plaza, 1350 Bayshore Highway, Burlingame, Calif. 94010; 415-375-8600

See Maxicare Health Plans Inc. corporate listing under California

Maxicare Southern California

5200 W. Century Blvd., Fourth Floor, Los Angeles, Calif. 90045; 213-568-9000

See Maxicare Health Plans Inc. corporate listing under California

MetLife Healthcare Network of California

4500 E. Pacific Coast Highway, Suite 600, Long Beach, Calif. 90804; 213-498-5200

Operational date: June 1986.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 1,209 primary physicians; 2,980 specialists.
Facilities: 57 hospitals.
Service area: Alameda, Santa Clara, San Mateo, San Francisco, Contra Costa, Orange, San Bernardino, Riverside, Los Angeles and Ventura counties in California.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Individual enrollment not allowed.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: James Hulsey, chief operating officer.

National Med

1524 McHenry Ave., Suite 425, Modesto, Calif. 95350; 209-527-3350; 800-468-8600

Operational date: May 1985.
Federally qualified.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: National Medical Enterprises Inc.
Staff: 179 primary physicians; 269 specialists; 43 administrative staff members; eight marketing staff members; 90% board certified physicians.
Facilities: 12 hospitals; 124 pharmacies; 58 diagnostic labs.
Service area: San Joaquin, Stanislaus and Merced counties in California.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent

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MassMutual
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Continued from previous page
facilities.

Rating options: Community rating: $97 single, $255 family; by age/sex, experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.

Users: 475 employer/payer groups; 22,785 employees and dependents; 25,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided upon request.

Gross revenues: $14.9 million in 1988; $21.2 million estimated for 1989.

Officers: Clive Riddle, executive director; Dr. Eric J. Ostrom, medical director; Paul Vogelzang, marketing director.

PacifiCare Health Systems

5995 Plaza Drive, Cypress, Calif. 90630; 714-952-1121

Operational date: 1978.
Federally qualified.
Certified in: California Oregon, Oklahoma, Texas, Washington.
Model type: Network.
For profit.

Service Area: Ventura, Los Angeles, San Diego, Riverside, Orange, San Bernardino counties in California; Benton, Clackamas, Columbia, Lincoln, Linn, Marion and Multnomah counties in Oregon; Bexar, Travis, Hays, Williamson counties in Texas; Tulsa, Creek, Rogers, Wagoner counties and the cities of Shawnee and Oklahoma City in Oklahoma.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, obstetrics/gynecology. Options include prescription drugs, vision, dental, chiropractic. Substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 605,768 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided upon request.

Billing: National accounts program with consolidated billing available.

Gross revenues: $434.1 million in 1988; $650.6 million estimated for 1989.

Officers: Terry Hartshorn, president/chief executive officer; Dr. James Moffat, vp/medical director; Hal Hylton, vp-marketing/development; John Siefker, senior vp; Alan Hoops, executive vp/chief operating officer; Wayne Lowell, chief financial officer.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Private Medical-Care Inc.

5122 Katella Ave., Los Alamitos, Calif. 90720; 213-493-6661; 714-978-6624

Operational date: 1968.
Certified in: California, Colorado, Florida, Georgia, Illinois, Minnesota, New Mexico, Tennessee, Texas and Utah.
Model type: IPA.
Not for profit.
Sponsorship: Delta Dental Plan of California.
Staff: 472 primary dentists; 360 specialists; 103 administrative staff members; 30 marketing staff members; approximately 800 patients per dentist.
Service area: California, Colorado, Florida, Georgia, Illinois, Minnesota, New Mexico, Tennessee, Texas and Utah.
Locations: Four administrative sites.
Services: Standard package includes dental.
Rating options: By class, experience rating.
Enrollment options: Individual enrollment allowed.
Users: 700 employer/payer groups; 510,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided quarterly, semiannually or annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $35 million in 1988; $40 million estimated for 1989.
Officers: James P. Moon, president; Dr. Steven Bull, medical director; Bill Jones, marketing director-Delta Dental Plan of California; Randy Brecher, vp-finance/operations; Marilyn Masters, vp-research/underwriting.

SCAN Health Plan

521 E. Fourth St., Long Beach, Calif. 90802; 213-435-0380

Operational date: March 1989.
Certified in: California.
Model type: IPA.
Not for profit.
Staff: 38 primary physicians; 160 specialists; 13 administrative staff members; 11 marketing staff members; 75.4 patients per physician; 100% board certified physicians.
Facilities: One hospital; 78 pharmacies; three diagnostic labs.
Service area: Los Angeles and Orange counties in California.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $24.95 single.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 2,894 estimated enrollees as of Jan. 1, 1990. Hospital stay averages seven days; 302 admissions per 1,000 members.
Gross revenues: $13.8 million in 1988; $13.8 million estimated for 1989.
Officers: Sam Ervin, president; Dr. Tim Schwab, medical director; Denny Freidenrich, marketing director; Ray Lyons, director-services/benefits; Keith Quinlivan, director-finance.

TakeCare Health Plan

2300 Clayton Road, Suite 1000, Concord, Calif. 94524-4059; 415-246-1300.

Operational date: May 1978.
Federally qualified.
Certified in: California.
Model type: Network.
For profit.
Staff: 1,629 primary physicians; 2,429 specialists; 150 administrative staff members; 55 marketing staff members; 90% board certified physicians.
Facilities: 115 hospitals; approximately 2,000 pharmacies.
Service area: 26 counties in California.
Locations: One administrative site; 202 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 1,200 employer/payer groups; 44,469 employees with single coverage; 32,163 employees with family coverage; 210,459 employees and dependents; 214,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 2.8 days; 109.4 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $28.5 million in 1988; $200 million estimated for 1989.
Officers: R. Judd Jessup, executive director; Dr. Gerard D. Sarnat, medical director; Charlene L. Massei, marketing director; Curtis Terry, director-health services; Dennis L. Gates, director-finance.

Travelers Health Network

770 E. Shaw, Suite 326, Fresno, Calif. 93710; 209-225-6667

Operational date: September 1985.
Federally qualified.
Certified in: All 50 states.
Model type: IPA.
For profit.
Sponsorship: The Travelers Insurance Cos.
Staff: 58 primary physicians; 160 specialists; 13 administrative staff members; seven marketing staff members; 39 patients per physician; 80% board certified physicians.
Facilities: Six hospitals; 10 pharmacies; four diagnostic labs.
Service area: Fresno and Madera counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs. Vision, substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $129 single, $365 family; by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 81 employer/payer groups; 648 employees with single coverage; 961 employees with family coverage; 2,236 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days; 68 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Terry Herold, executive director; Dr. David Epstein and Dr. Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director.

Travelers Health Network

501 J St., Suite 206, Sacramento, Calif. 95814-2326; 916-443-6667

Operational date: September 1985.
Federally qualified.
Certified in: All 50 states.
Model type: IPA.
For profit.
Sponsorship: The Travelers Insurance Cos.
Staff: 110 primary physicians; 491 specialists; 13 administrative staff members; seven marketing staff members; 33 patients per physician; 76% board certified physicians.
Facilities: Five hospitals; one pharmacy; one diagnostic lab.
Service area: Sacramento, Nevada, Placer, Yolo and El Dorado counties in California.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs. Vision, substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $129 single, $365 family; by class; by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 81 employer/payer groups; 648 employees with single coverage; 961 employees with family coverage; 3,656 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days; 68 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Dr. David Epstein and Dr. Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director.

VIP Health Plan

P.O. Box 5087, Oxnard, Calif. 93031-5087; 805-988-0277

Operational date: September 1982.
Federally qualified.
Certified in: California.
Model type: IPA.
For profit.
Sponsorship: Ventura County Independent Physicians.
Staff: 165 primary physicians; 213 specialists; 25 administrative and marketing staff members; 156 patients per physician; more than 92% board certified physicians.
Facilities: 15 hospitals; chain of pharmacies; nine diagnostic labs.
Service area: Ventura County, Calif.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, outpatient psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, inpatient psychiatric services, chiropractic. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, experience rating. Offers non-federally qualified programs to government agencies.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 185 employer/payer groups; 25,834 employees and dependents; 26,600 estimated enrollees as of Jan. 1, 1990. Hospital stay averages three days.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $16.1 million in 1988; $26 million estimated for 1989.
Officers: Paul R. Roberts, president; Dr. Charles Cho, medical director; Lisa Shippy, marketing director; Thomas A. Diaz, chief financial officer.



CIGNA Healthlan of Colorado Inc.

950 S. Cherry St., Denver, Colo. 80222; 303-782-9109

Operational date: July 1986.
Federally qualified.
Certified in: Colorado.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 248 primary physicians; 698 specialists; two administrative staff members; two marketing staff members; 92 patients per physician; 75% board certified physicians.
Facilities: 12 hospitals; one pharmacy; two diagnostic labs.
Service area: Adams, Arapahoe, Boulder, Denver, Douglas, and Jefferson counties in Colorado.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 84 employer/payer groups; 4,084 employees with single coverage; 6,073 employees with family coverage; 23,719 employees and dependents. Hospital stay averages 3.4 days; 28.8 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: James M. Cameron, general manager; Dr. David Berenbeim medical director; Ric Bailey, sales director.

Comprecare Inc.

12100 E. Iliff Ave., Suite 200, Aurora, Colo. 80014; 303-695-6685

Operational date: 1974.
Federally qualified.
Certified in: Colorado.
Model type: IPA.
For profit.
Sponsorship: American Medical International.
Staff: 692 primary physicians; 1,208 specialists; 250 administrative staff members; 26 marketing staff members; 263 patients per physician; 80% board certified physicians.
Facilities: 27 hospitals; 201 pharmacies; one diagnostic lab.
Service area: Denver, Jefferson, Adams, Arapahoe, Douglas, Elbert, Larimer, Weld, Grand, Gilpin, Summit, Clear Creek, Boulder, Teller and El Paso counties in Colorado.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 500 employer/payer groups; 182,000 employees and dependents; 182,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.2 days; 328 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $151 million in 1988; $182 million estimated for 1989.
Officers: Eric D. Sipf, chief executive officer; Dr. Val C. Dean, medical director; Mark Mathias, vp-marketing.

EQUICOR Health Plan Inc.

3665 JFK Parkway, Fort Collins, Colo. 80525; 303-229-0851

Operational date: May 1989.
Certified in: Colorado.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 19 primary physicians; 41 specialists; two administrative staff members; three marketing staff members; 75% board certified physicians.
Facilities: Three hospitals; one diagnostic lab.
Service area: Weld and Larimer counties in Colorado.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychi-

Continued on next page

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tric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. Arnold I. Kisch, president; Roberta Swenram, executive director; Dr. Vincent Miles, medical director; Rick Rios, marketing director.

EQUICOR Health Plan Inc. (Colorado Springs)

621 17th St. Suite 2450, Denver, Colo. 80293; 303-293-3701

Operational date: July 1989.
Certified in: Colorado.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 40 primary physicians; 90 specialists; six administrative staff members; eight marketing staff members; 18 patients per physician; 75% board certified physicians.

Facilities: Three hospitals; 60 pharmacies (includes those participating in EQUICOR Health Plan Inc.-Denver); 11 diagnostic labs.

Service area: Teller and El Paso counties in Colorado.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental; psychiatric and substance abuse services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: One employer/payer group; 750 employees and dependents.

Management reports: May be provided three times a year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. Arnold I. Kisch, president; Tom Oberle, executive director; Dr. Vincent Miles, medical director; Gary Redabaugh, marketing director; Paul Berteau.

EQUICOR Health Plan Inc. (Denver)

621 17th St., Suite 2450, Denver, Colo. 80293; 303-293-3701

Operational date: May 1989.
Certified in: Colorado.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 233 primary physicians; 483 specialists; six administrative staff members; eight marketing staff members; 75% board certified physicians.

Facilities: Eight hospitals; 60 pharmacies (includes those participating in EQUICOR Health Plan Inc.-Colorado Springs); six diagnostic labs.

Service area: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Laramer, Teller, Weld and El Paso counties in Colorado.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: Four employer/payer groups; 500 employees and dependents; 6,485 estimated enrollees as of Jan. 1, 1990.

Management reports: May be provided three times a year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $8.2 million estimated for 1989.

Officers: Dr. Arnold I. Kisch, president; Tom Oberle, executive director; Dr. Vincent Miles, medical director; Gary Redabaugh, marketing director.

Exclusive Healthcare of Colorado Inc.

c/o Mutual of Omaha, Standford Place 3, Suite 103, 4582 S. Ulster St. Parkway, Denver, Colo. 80237; 303-796-0021

Operational date: June 1989.
Certified in: Colorado.
Model type: Network.
For profit.
Sponsorship: Mutual of Omaha.

Staff: 250 primary physicians; 750 specialists; five administrative staff members; 90% board certified physicians.

Facilities: Five hospitals; 200 pharmacies; 10 diagnostic labs.

Locations: One administrative site, 200 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 2,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 350 admissions per 1,000 members.

Management reports: Provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Stephen Burnham, executive director; Dr. Grant Steffens, medical director.

HMO Colorado Inc.

700 Broadway, Suite 612, Denver, Colo. 80203-3441; 303-831-4114

Operational date: January 1980.
Federally qualified.
Model type: Mixed network.
Sponsorship: Blue Cross & Blue Shield of Colorado.
Service area: Adams, Arapahoe, Boulder, Douglas, Denver, El Paso, Jefferson, Larimer, Pueblo and Weld counties in Colorado.
Users: 67,585 employees and dependents as of June 1989.

Health Network of Colorado Springs Inc.

320 N. Academy Blvd., Suite 300, Colorado Springs, Colo. 80909; 719-475-5602

Operational date: April 1986.
Federally qualified.
Certified in: Colorado.
Model type: IPA.

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Continued from previous page

For profit.

Sponsorship: Physicians Network of Colorado Springs.

Staff: 50 primary physicians; more than 120 specialists; 22 administrative staff members; four marketing staff members; 99% board certified physicians.

Facilities: One hospital; eight pharmacies; diagnostic labs provided by participating hospitals and physicians.

Service area: Fremont, Park, Teller, Douglas, Elbert, El Paso and Lincoln counties in Colorado.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO.

Rating options: Community rating: $100.25 single, $257.16 family; by age/sex to employee groups of more than 50. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 150 employer/payer groups; 2,590 employees with single coverage; 3,966 employees with family coverage; 16,339 employees and dependents; 18,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.1 days. 102.4 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $5.9 million in 1988; $13.7 million estimated for 1989.

Officers: Ron Burnside, executive director; Dr. David Woolf, medical director; Mark Steider, marketing manager.

Humana Health Plan Inc.

Stanford Place 2, 7979 E. Tufts Ave. Parkway, Suite 304, Denver Colo. 80237; 303-741-5500

See Humana Health Care Plans under Kentucky.

Kaiser Foundation Health Plan of Colorado

10350 E. Dakota Ave., Denver, Colo. 80231-1314; 303-344-7200

See Kaiser Permanente Medical Care Program under California.

MetLife HealthCare Network-Colorado

1512 Larimer St., Bridge Level, Denver, Colo. 80202; 303-659-5331

Operational date: April 1986.
Certified in: Colorado.
Model type: IPA.
For profit.

Sponsorship: Metropolitan Life Insurance Co.

Staff: 2,508 primary physicians; 4,839 specialists.

Facilities: 20 hospitals.

Service area: Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson, Larimar, Pueblo, Teller and Weld counties in Colorado.

Locations: One administrative site.

Rating options: By class, experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: Provided.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Kathleen Garast, vp/chief operating officer.

PARTNERS National Health Plans

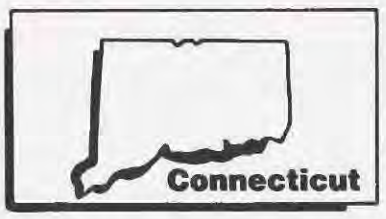
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Peak Health Plan of Colorado

4582 S. Ulster St. Parkway, Suite 1100, Denver Colo. 80237; 303-779-4700

See Lincoln National Health Plan under Indiana.



CIGNA Healthplan of Connecticut Inc.

P.O. Box 2975, Hartford, Conn. 06104; 203-725-2988

Operational date: June 1986.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
For profit.

Sponsorship: CIGNA Corp.

Staff: 435 primary physicians; 919 specialists; 14 administrative staff members; nine marketing staff members; 123 patients per physician; 70% board certified.

Facilities: 12 hospitals; one pharmacies; two diagnostic labs.

Service area: Hartford and Tolland counties in Connecticut.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehab and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 316 employer/payer groups; 10,108 employees with single coverage; 10,501 employees with family coverage; 53,840 employees and dependents; Hospital stay averages 5.9 days. 79.5 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Thomas G. Boyajy, general manager; Dr. Michael Cebrik, medical director; Ronald J. Miller, sales director.

Community Health Care Plan Inc.

221 Whitney Ave., New Haven, Conn. 06511; 203-773-8393

Operational date: 1971.
Federally qualified.
Certified in: Connecticut.
Model type: Mixed.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of Connecticut.

Staff: 80 primary physicians; 180 specialists; 55 administrative staff members; 15 marketing staff members; 1,800 patients per physician; 95% board certified physicians.

Facilities: 11 hospitals; eight pharmacies; two diagnostic labs.

Service area: New Haven, Fairfield, Middlesex and Hartford counties in Connecticut.

Locations: One administrative site, 10 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, durable medical equipment. Diagnostic testing and lab work performed by the HMO.

Rating options: Community rating: $173.84 single, $451.98 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.

Users: 1,600 employer/payer groups; 18,247 employees with single coverage; 14,525 employees with family coverage; 65,040 employees and dependents; 61,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 6.4 days. 68.1 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $88.9 million in 1988; $106.8 million estimated for 1989.

Officers: John A. Nelson, president/chief executive officer; Carl J. Maleri, executive vp/chief operating officer; Dr. Robert E. Scalettar, senior vp-clinical affairs; Dennis Schultz, vp-marketing; Salvatore Catardi, vp-finance; Donald R. Ingalls, vp-member relations/public affairs; J. James Karl, vp-human resources; Richard O. Garber, vp-health services; Edward C. Knapp, vp-information systems.

ConnectiCare Inc.

10 Waterside Drive, Farmington, Conn. 06032; 203-674-5700.

Operational date: April 1982.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
Not for profit.

Sponsorship: Independent.

Staff: 423 primary physicians; 695 specialists; 110 administrative staff members; eight marketing staff members; 175 patients per physician; 80% board certified physicians.

Facilities: Five hospitals; 150 pharmacies; six diagnostic labs.

Service area: Hartford, Tolland and Middlesex counties in Connecticut.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, home health, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $118.70 single, $296.74 family; by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 285 employer/payer groups; 13,936 employees with single coverage; 19,659 employees with family coverage; 77,193 employees and dependents; 85,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.1 days. 64.9 admissions per 1,000 members.

Management reports: Provided annually or upon upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $61 million in 1988; $80 million estimated for 1989.

Officers: William F. Pierce Jr., president; Charles Kuchenbrod and James Claffey, vps; Dr. Alan Spiro, medical director; Paul Rubin, vp-finance/administration; Diane Vigneau, vp-health services.

Constitution Health Network Inc.

321 Research Parkway, Meriden, Conn. 06450; 203-630-4800

Operational date: 1984.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of Connecticut.

Staff: 774 primary physicians; 1,062 specialists.

Facilities: 18 hospitals.

Service area: Hartford Windham, Tolland, Litchfield, New Haven and Fairfield counties in Connecticut.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include vision, prescription drugs, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class, by age/sex.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment is not allowed.

Gross revenues: $95.5 million in 1988.

Officers: Anthony J. Martin, president; Dr. Robert Ragusa, medical director; William Rode, marketing director.

HealthCare Inc.

127 Washington Ave., North Haven, Conn. 06473; 203-234-2323; 800-662-7243

Operational date: June 1978.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of Connecticut.

Staff: 589 primary physicians; 964 specialists; 78 administrative staff members; 17 marketing staff members; 98.2 patients per physician.

Facilities: 10 hospitals; 98 pharmacies; 31 diagnostic labs.

Service area: New Haven, Middlesex, portions of Fairfield, New London, Litchfield and Hartford counties in Connecticut.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $150.48 single, $420.35 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Individual enrollment is not allowed.

Users: 763 employer/payer groups; 9,506 employees with single coverage; 13,513 employees with family coverage; 57,915 employees and dependents; 52,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.96 days. 480 admissions per 1,000 members.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing may be available.

Gross revenues: $70 million in 1988.

Officers: Anthony J. Martin, president/executive director; Dr. Robert Ragusa, medical director; Alex Ungerleider, marketing director; Robert Butler, vp-finance; Jack Gioglip, vp-sales.

Kaiser Foundation Health Plan of Connecticut Inc.

60 Washington St., Hartford Conn. 06106; 203-280-1200

See Kaiser Permanente Medical Care Program under California.

Oxford Health Plans

P.O. Box 4033, Darien, Conn. 06820-1433; 203-656-1442

Operational date: September 1984.
Federally qualified.
Certified in: New York and New Jersey.
Model type: IPA.
For profit.

Sponsorship: Oxford Health Plans Inc.

Staff: 1,600 primary physicians; 1,900 specialists; 165 administrative staff members; 20 marketing staff members; 15 patients per physician; 98% board certified physicians.

Facilities: 150 hospitals; network of pharmacies; 18 diagnostic labs.

Service area: New York City and boroughs, Suffolk, Nassau, Westchester and Rockland counties in New York; Bergen, Essex, Hudson, Middlesex, Morris, Passaic and Union counties in New Jersey.

Locations: Three administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by class. Does not offer non-federally qualified programs to employers

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 900 employer/payer groups; 11,000 employees with single coverage; 15,000 employees with family coverage; 52,000 employees and dependents; 65,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided monthly.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Stephen F. Wiggins, chairman/president; Donald V. Barrett, executive vp; Dr. Benjamin H. Safirstein, medical director; William Sullivan, vp-sales/marketing; Robert Smoler, vp-operations; Dr. Thomas A. Travers, vp-health care delivery; Edward Kremer, vp-information management.

PHS Inc.

120 Hawley Lane, Trumbull, Conn., 06611; 203-381-6400

Operational date: September 1977.
Federally qualified.
Certified in: Connecticut and Westchester County, New York.
Model type: IPA.
For profit.

Sponsorship: Group of doctors.

Staff: 2,375 primary physicians and specialists; 275 administrative staff members; 25 marketing staff members; 10 patients per physician; 85% board certified physicians.

Facilities: 24 hospitals; 41 diagnostic labs.

Service area: Fairfield, Hartford, Middlesex, New Haven, New London, Tolland and Windham counties in Connecticut; Westchester County in New York.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include experimental procedures, prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $146.66 single, $358.93 family; by class. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 1,100 employer/payer groups; 22,110 employees with single coverage; 30,753 employees with family coverage; 130,000 employees and dependents; 150,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.5 days. 83 admissions per 1,000 members.

Management reports: Provided on request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $121 million in 1988.

Officers: Michael E. Herbert, president; Robert Natt, chief operating officer; Dr. Richard O'Connor, medical director; Robin Dietrick, vp-marketing; George Schneider, chief financial officer; Lauren Casalveri, vp-member relations; Laura Pasquale, vp-operations; Amy Rich, vp-

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professional relations; Philip Passarine, president-PHS Inc. of New York.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Health Services of Connecticut Inc.

120 Hawley Lane, Trumbull, Conn. 06611-5313; 203-381-6400

Operational date: September 1977.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
For profit.
Sponsorship: PHS Inc.
Staff: 820 primary physicians; 1,030 specialists; 278 administrative staff members; 27 marketing staff members; 150 patients per physician; 75% board certified physicians.
Facilities: 17 hospitals; 691 pharmacies; 41 diagnostic labs.
Service area: Fairfield, New Haven, New London, Middlesex, Windham, Hartford, Litchfield and Tolland counties in Connecticut.
Locations: Five administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 1,000 employer/payer groups; 26,811 employees with single coverage; 29,572 employees with family coverage; 116,953 employees and dependents; 129,592 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.45 days; 432 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $119.4 million in 1988; $168.4 million estimated for 1989.
Officers: Michael E. Herbert, president; Robert L. Natt, senior vp; Dr. Richard O'Conner, medical director; Robin Deitrick, vp-marketing; Dr. Malcolm Beinfield, second vice-chairman; Joseph E. Nechasek, secretary/treasurer; Dr. Norman Weinstein, chairman/vice chairman.

PruCare of Connecticut

301 Merrit 7, Norwalk, Conn. 06851; 203-849-1800

Operational date: October 1988.
Federally qualified.
Certified in: Connecticut.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 159 primary physicians; 213 specialists; 17 administrative staff members; 10 marketing staff members; 97% board certified physicians.
Facilities: 13 hospitals; 142 pharmacies; 18 diagnostic labs.
Service area: Fairfield, New Haven and part of Litchfield counties in Connecticut.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, well baby care, ambulance, hospice, rehabilitative services. Options prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex.
Users: 2,028 employees and dependents; 2,233 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided annually.
Billing: Does not provide direct billing for programs under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: John G. Galbraith, director-group marketing, Dr. Stanley Kramer, medical director.



CIGNA Healthplan of Delaware Inc.

Chesterbrook Corporate Center, 701 Lee Road, Suite 300, Wayne, Pa. 19087; 215-889-2300

Operational date: May 1985.
Federally qualified.
Certified in: Delaware.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 139 primary physicians; 361 specialists; 17 administrative staff members; 15 marketing staff members; 145 patients per physician; 83% board certified physicians.
Facilities: Seven hospitals; one pharmacy; one diagnostic lab.
Service area: Kent, New Castle and Sussex counties in Delaware.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 88 employer/payer groups; 3,266 employees with single coverage; 4,261 employees with family coverage; 16,010 employees and dependents. Hospital stay averages 5.3 days; 112 admissions per 1,000 users.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Leo M. Carey, general manager; Dr. Norman Scott, medical director; Joseph Botta, sales director.

The HMO of Delaware Inc.

200 Hygeia Drive, P.O. Box 6008, Newark, Del. 19713; 302-421-2466

Operational date: August 1983.
Model type: Staff.
For profit.
Sponsorship: Blue Cross & Blue Shield of Delaware.
Service area: New Castle County, Del.
Users: 22,641 employees and dependents as of June 1989.

Total Health Plus

1 Brandywine Gateway, Wilmington, Del. 19802; 302-421-3222

Operational date: June 1986.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Delaware.
Service area: Kent, New Castle and Sussex counties in Delaware.
Users: 40,230 employees and dependents as of June 1989.

Continued on next page

Why so many of America's healthiest companies choose Kaiser Permanente.



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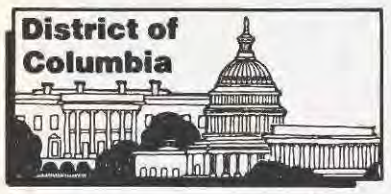
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Continued from previous page



CapitalCare Inc.

1921 Gallows Road, Tysons Corner, Va. 22180; 703-761-5400

Operational date: May 1985.
Federally qualified.
Model type: Mixed network.
For profit.
Sponsorship: Blue Cross & Blue Shield of National Capital Area.
Service area: District of Columbia; Anne Arundel, Frederick, Howard, Montgomery, Prince Georges and northern Charles counties in Maryland; Arlington, Fairfax, Loudoun and Prince William counties in Virginia.
Users: 57,193 employees and dependents as of June 1989.

Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.

4200 Wisconsin Ave. N.W., Washington D.C. 20016; 202-364-3300

See Kaiser Permanente Medical Care Program corporate listing under California.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



American Health Network HMO of Florida Inc.

1301 Gulf Life Drive, Jacksonville, Fla. 32207; 904-390-7000

Operational date: March 1987.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: American General Insurance Co.
Staff: 353 primary physicians; 762 specialists; seven administrative staff members; three marketing staff members; 18.5 patients per physician.
Facilities: 27 hospitals, two chains of pharmacies, one statewide lab contract.
Service area: Alachua, Broward, Clay, Duval, Hillsborough, Orange, Palm Beach, Pinellas, Seminole and Volusia counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, outpatient psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse, inpatient psychiatric services. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 14 employer/payer groups; 1,963 employees with single coverage; 1,251 employees with family coverage; 6,546 employees and dependents; 8,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.9 days.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $2.3 million in 1988; $5 million estimated for 1989.
Officers: Howard Korn, president; Ann Dehgan, executive director; Dr. James Menges, medical director; John Emerson, marketing director.

Capital Health Plan

2140 Centerville Place, Tallahassee, Fla. 32308; P.O. Box 13267; Tallahassee, Fla. 32317-3204; 904-386-3161

Operational date: June 1982.
Federally qualified.
Model type: Mixed network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Gadsden, Jefferson, Leon and Wakulla counties in Florida.
Users: 37,756 employees and dependents as of June 1989.

CIGNA Healthplan of Florida Inc.

1101 N. Lake Destiny Road, Suite 300, Maitland, Fla. 32751; 407-660-1344

Operational date: 1984.
Federally qualified.
Certified in: Florida.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 70 primary physicians; 212 specialists; 14 administrative staff members; six marketing staff members; 492 patients per physician; 99% board certified physicians.
Facilities: Three hospitals; one pharmacy; one diagnostic lab.
Service area: Lake, Orange, Osceola, Seminole and Volusia counties in Florida.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Individual enrollment allowed.
Users: 111 employer/payer groups; 7,280 employees with single coverage; 7,773 employees with family coverage; 34,001 employees and dependents. Hospital stay averages four days; 64 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Bradley C. Arms, general manager; Dr. William A. Hammill, medical director; Leslie R. Miller, sales director.

CIGNA Healthplan of Florida Inc.

P.O. Box 24203, Tampa, Fla. 33623; 813-884-2400

Operational date: July 1981.
Federally qualified.
Certified in: Florida.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 46 primary physicians; 281 specialists; 22 administrative staff members; five marketing staff members; 817 patients per physician; 99% board certified physicians.
Facilities: Nine hospitals; one diagnostic lab.
Service area: Hillsborough and Pinellas counties in Florida.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by the HMO.
Rating options: Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 191 employer/payer groups; 9,714 employees with single coverage; 7,500 employees with family coverage; 39,024 employees and dependents. Hospital stay averages 3.6 days; 72 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Bradley C. Arms, general manager; Leslie R. Miller, sales director.

CIGNA Healthplan of South Florida Inc.

15600 N.W. 67th Ave., Suite 301, Miami Lakes, Fla. 33014; 305-862-6200

Operational date: July 1974.
Federally qualified.
Certified in: Florida.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 153 primary physicians; 643 specialists; 14 administrative staff members; six marketing staff members; 182 patients per physician; 80% board certified physicians.
Facilities: 29 hospitals; one pharmacy; one diagnostic lab.
Service area: Broward, Dade and Palm Beach counties in Florida.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 139 employer/payer groups; 7,616 employees with single coverage; 6,599 employees with family coverage; 27,181 employees and dependents. Hospital stay averages five days; 72 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Robert L. Harris, general manager; Dr. Eugene Komrad, medical director; Don Smith, sales director.

EQUICOR Health Plan of Florida Inc.

600 Corporate Drive, Suite 440, Fort Lauderdale, Fla. 33334; 305-938-9983

Operational date: July 1984.
Federally qualified.
Certified in: Florida.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 174 primary physicians; 464 specialists; 10 administrative staff members; 11 marketing staff members; 57 patients per physician; 75% board certified physicians.
Facilities: 25 hospitals; 58 pharmacies; one diagnostic lab.
Service area: Broward, Dade and Palm Beach counties in Florida.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 48 employer/payer groups; 9,947 employees and dependents; 11,045 estimated enrollees as of Jan. 1, 1990.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $10.4 million in 1988; $13.5 million estimated for 1989.
Officers: Jeffrey L. McWaters, president; Parveez Oliaii, executive director; Dr. JoEllen Brown, medical director; Bobbi Daniele, marketing director.

EQUICOR Health Plan of Florida Inc.

888 Executive Center Drive W., St. Petersburg, Fla. 33702; 813-576-9226

Operational date: April 1983.
Federally qualified.
Certified in: Florida.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 130 primary physicians; 294 specialists; 120 administrative staff members; 13 marketing staff members; 369 patients per physician; 75% board certified physicians.
Facilities: 21 hospitals; 56 pharmacies; two diagnostic lab.
Service area: Hillsborough, Pasco and Pinellas counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 100 employer/payer groups; 47,976 employees and dependents; 42,755 estimated enrollees as of Jan. 1, 1990.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $37.5 million in 1988; $42.9 million estimated for 1989.
Officers: Jeffrey L. McWaters, president; Larry Mitchum, executive director; Dr. Michael Jenkin, medical director; Vann Ransom, marketing director.

Health Options Inc.

532 Riverside Ave., P.O. Box 2210, Jacksonville, Fla. 32203-2210; 904-791-6206

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: 25 counties in Florida.

Health Options Inc. of Central Florida

2611 Technology Drive, Suite 212, Orlando, Fla. 32804; 407-894-7200; 800-545-6565

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Brevard, Osceola Orange, Polk and Seminole counties in Florida.

Health Options Inc.-Gainesville

2002 N.W. 13th St. Gainesville, Fla. 32609-2861; 904-371-8499

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Alachua, Gilchrist, Levy, Putman, Bradford and Union counties in Florida.

Health Options Inc.-Jacksonville

8665 Baypine Road, Jacksonville, Fla. 32256; 904-731-7967

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Duval, St. Johns, Clay, Baker and Nassau counties in Florida.

Health Options Inc.-Pensacola

700 S. Palafox St. Suite 2A, Pensacola, Fla. 32501; 904-484-7500

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Escambia and Santa Rosa counties in Florida.

Health Options Inc.-Sarasota

7120 Beneva Road, Suite 200, Sarasota, Fla. 34238; 813-922-1110

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Sarasota and Manatee counties in Florida.

Health Options Inc. of South Florida

3900 N.W. 79th Ave. Suite 475, Miami, Fla. 33166; 305-591-9955

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Palm Beach, Dade and southern Broward counties in Florida.

Health Options Inc.-Tampa Bay

1715 N. Westshore Blvd., Suite 400, Tampa, Fla. 33607; 813-289-8222

Operational date: October 1984.

Continued on next page

Continued from previous page
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Florida.
Service area: Hillsborough, Pasco, and Pinellas counties in Florida.

Heritage Health Plan of South Florida

7950 S.W. 53rd St., Suite 300, Miami, Fla., 33166; 305-591-3311

Operational date: September 1985.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: C&S Health Plan.
Staff: 240 primary physicians; 930 specialists; 10 administrative staff members; 10 marketing staff members; 100 patients per physician; 85% board certified physicians.
Facilities: 42 hospitals; three pharmacies; 45 diagnostic labs.
Service area: Dade, Broward and Palm Beach counties in Florida.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, podiatry. Options include vision, dental, substance abuse, psychiatric services. Obstetrics/gynecology may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: $98 single, $280 family; by class, by age/sex, experience rating.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 340 employer/payer groups; 16,166 employees with single coverage; 4,500 employees with family coverage; 12,287 employees and dependents; 24,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.9 days; 300 admissions per 1,000 members.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $38 million in 1988; $50 million estimated for 1989.
Officers: Jim Holloway, president; Neil E. Berman, vp; Warren Zundell, medical director; David Stewart, marketing director; Bill Coats, financial officer.

Humana Health Insurance Co. of Florida Inc.

1901 S. Congress Ave., Suite 430, Boynton Beach, Fla. 33426; 407-738-3065

See Humana Health Care Plans under Kentucky.

Humana Medical Plan Inc.

800 Corporate Drive, Suite 504, Fort Lauderdale, Fla. 33334; 305-776-1726

See Humana Health Care Plans under Kentucky.

Humana Medical Plan Inc.

1505 N.W. 167th St., Miami, Fla. 33169; 305-623-2100

See Humana Health Care Plans under Kentucky.

Humana Medical Plan Inc.

100 W. Gore St., Suite 300, Orlando, Fla. 32806; 407-843-5531

See Humana Health Care Plans under Kentucky.

Humana Medical Plan Inc.

Reflections Executive Office Center, 770 W. Granada Blvd., Suite 317, Ormond Beach, Fla. 32074; 904-677-8530

See Humana Health Care Plans under Kentucky.

Humana Medical Plan Inc.

The Lincoln Center, 5401 W. Kennedy Blvd., Suite 800, Tampa Fla. 33609; 813-286-8829; 813-287-6202

See Humana Health Care Plans under Kentucky.

JMH Health Plan

1611 N.W. 12th Ave., Miami, Fla., 33136; 305-549-6502

Operational date: September 1985.
Model type: Mixed: group and staff.
Not for profit.
Sponsorship: Public Health Trust of Dade County, Fla.
Staff: 77 primary physicians; approximately 1,400 specialists; eight administrative staff members; 10 marketing staff members; 108 patients per physician; 30% board certified physicians.
Facilities: One hospital; three pharmacies; nine diagnostic labs.
Service area: Dade County, Fla.
Locations: One administrative site, 12 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, dental, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include experimental procedures, substance abuse. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $154.38 single, $213.42 for two people, $289.25 family; by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: One employer/payer groups; 17 employees with single coverage; 194 employees and dependents; 12,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $6.1 million in 1988; $7.5 million estimated for 1989.
Officers: Ira Clark, president; Dr. Mark E. Reinecke, medical director/program administrator; Ruben J. King-Shaw Jr., marketing director; Paul H. Marineau, administrator.

Medical Center Health Plan Inc.

P.O. Box 11037, Pensacola, Fla. 32524; 904-484-4000

Operational date: July 1985.
Certified in: Florida and Alabama.
Model type: Network.
Sponsorship: Group of doctors.
For profit.
Staff: 153 primary physicians; 182 specialists; approximately 50 administrative staff members; three marketing staff members; 107 patients per physician; 85% board certified physicians.
Facilities: 20 hospitals; 100 pharmacies; two diagnostic labs.
Service area: Baldwin, Choctaw, Clarke, Conecuh, Covington, Crenshaw, Escambia, Geneva, Marengo, Mobile, Monroe, Sumter and Wilcox counties in Alabama; Escambia, Santa Rosa, Okaloosa, Walton, Holmes and Washington counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs, substance abuse, psychiatric services, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $110 single, $302 family; by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 68 employer/payer groups; 3,172 employees with single coverage; 3,306 employees with family coverage; 14,299 employees and dependents; 16,050 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.9 days.
Management reports: Provided quarterly or upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: For fiscal years ending June 30: $19.4 million in 1988; $20.9 million estimated for 1989.
Officers: John D. Davis, president/chief executive officer; Dr. Frank S. Pettyjohn, medical director; Charles Trinchitella, marketing manager; Dr. Charles Clevenger, chairman; Dr. Michael Redmond, secretary/treasurer; Russell F. Mohawk, chief operating officer/chief financial officer.

The Mental Health Programs Corp.

1000 Century Park Drive, Suite 425, Tampa, Fla., 33607; 813-289-8990

Operational date: 1980.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.
Staff: 603 specialists; 16 administrative staff members; two marketing staff members; 100% board certified physicians.
Facilities: 45 hospitals.
Service area: Hillsborough, Pinellas, Broward, Dade, Pasco, Orange, Manatee, Palm Beach, Polk and Marion counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, inpatient, outpatient, substance abuse, psychiatric services. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: Four employer/payer groups; 250,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.6 days.
Management reports: Provided monthly.
Billing: Does not provide direct billing for premiums under.
Gross revenues: Not reported.
Officers: Dr. Walter Afield, president; Jim Kent, chief operating officer/executive vp.

MetLife HealthCare Network of Florida Inc.

851 Tralfasar Court, Maitland, Fla. 32751-4132; 305-660-0444

Operational date: January 1986.
Federally qualified.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 1,761 primary physicians; 2,722 specialists.
Facilities: 42 hospitals.
Service area: 24 counties in Florida.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental.
Rating options: By class and experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Willian Young, president; John Hollkamp, vp.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Jacksonville

841 Prudential Drive, 12th Floor, Jacksonville, Fla. 32207; 904-391-3415

Operational date: August 1984.
Federally qualified.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 50 primary physicians; 122 specialists; 14 administrative staff members; 11 marketing staff members; 530 patients per physician; 100% board certified physicians.
Facilities: Three hospitals; eight pharmacies; two diagnostic labs.
Service area: Baker, Clay, Duval, Nassau and St. John counties in Florida.
Locations: One administrative site, 15 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 6,570 employees with single and family coverage; 28,514 employees and dependents; 30,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.9 days; 75 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: C. Richard Cook, director-group operations; Dr. William Moore, medical director; Christopher P. Wilson, regional group manager.

PruCare of Orlando

2301 Lucien Way, Suite 230, Maitland, Fla. 32751; 407-875-6600

Operational date: January 1984.
Federally qualified.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 30 primary physicians; 201 specialists; 48 administrative staff members; 11 marketing staff members; 1,235 patients per physician; 93% board certified physicians.
Facilities: Two hospitals; one pharmacy; two diagnostic labs.
Service area: Orange, Seminole, Osceola and Volusia counties in Florida.
Locations: One administrative site, five primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 38,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days; 58 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not available.
Officers: Andrew D. Crooks, director-group operations; Dr. Edward Lowenstein, medical director; John A. Joiner, regional group manager.

PruCare of South Florida

5900 N. Andrews, Suite 1000, Fort Lauderdale, Fla. 33309; 305-492-8244

Operational date: October 1986.
Federally qualified.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 338 primary physicians; 617 specialists; 56 administrative staff members; 13 marketing staff members; 19 patients per physician; 95% board certified physicians.
Facilities: 15 hospitals; one pharmacy; 14 diagnostic labs.
Service area: Dade, Broward and Palm Beach counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, physical therapy, speech therapy, skilled nursing, hospice care. Options include prescription drugs, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 6,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Christopher Sims, director-group operations; Dr. Edward J. Saltzman, medical director.

PruCare of Tampa

3450 W. Busch Blvd., Suite 245, Tampa, Fla. 33618; 813-932-1977

Operational date: July 1985.
Federally qualified.
Certified in: Florida.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 185 primary physicians; 322 specialists; 30 administrative staff members; eight marketing staff members; 72 patients per physician; 85% board certified physicians.
Facilities: 18 hospitals; 57 pharmacies; 21 diagnostic labs.
Service area: Hillborough, Pinellas and Pasco counties in Florida.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, durable medical equipment, podiatry, obstetrics/gynecology. Options include substance abuse. Psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 13,500 employees and dependents; 16,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days; 79 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Jeffrey J. Kovaleski, director-group operations; Dr. John

Continued on next page

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Perchalski, medical director; Timothy R. Keener, regional group manager.



American Dental Plan

8800 Roswell Road, Suite 295, Atlanta, Ga. 30350; 404-998-8936

Operational date: 1978.
Certified in: Florida, Georgia, Ohio and Texas.
Model type: IPA.
For profit.
Sponsorship: American Prepaid Professional Services Inc.
Staff: 1,500 primary dentists; 500 specialists; 50 administrative staff members; 1,500 marketing agents; 100% board certified dentists.
Service area: Florida, Georgia, Texas and Ohio.
Locations: Four administrative sites.
Services: Standard package includes dental.
Rating options: Community rating: $9.50 single, $22 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 2,200 employer/payer groups; 275,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided quarterly.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $20 million in 1988; $25 million estimated for 1989.
Officers: Steve Collins, president; Bob Berlin, dental director; Art Bartlett, marketing director.

CIGNA Healthplan of Georgia Inc.

P.O. Box 77350, 1360 W. Peachtree St. N.E., Midtown Plaza II, Suite 1300, Atlanta, Ga. 30309; 404-892-7833

Operational date: January 1982.
Federally qualified.
Certified in: Georgia.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 203 primary physicians; 1,138 specialists; 37 administrative staff members; eight marketing staff members; 196 patients per physician; 100% board certified physicians.
Facilities: 20 hospitals; one diagnostic lab.
Service area: 18 counties in Georgia.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 247 employer/payer groups; 8,447 employees with single coverage; 10,320 employees with family coverage; 41,665 employees and dependents. Hospital stay averages 4.1 days; 99 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.

Officers: Dr. S. Jeffrey Ackerman, general manager; Dr. Greg Morris, medical director; Tom Power, sales director.

HMO Georgia Inc.

3350 Peachtree Road, Atlanta, Ga. 30326; 404-842-8400

Operational date: July 1986.
Certified in: Georgia.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Georgia.
Staff: 130 primary physicians; 1,021 specialists; 13 administrative staff members; five marketing staff members; 60 patients per physician; 95% board certified physicians.
Facilities: 19 hospitals; 165 pharmacies; 33 diagnostic labs.
Service area: 67 counties in Georgia.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, inpatient, outpatient, periodic check-ups, limited vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs and dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 46 employer/payer groups; 1,823 employees with single coverage; 1,943 employees with family coverage; 8,044 employees and dependents; 9,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days; 90 admissions per 1,000 members.
Management reports: Provided monthly.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $9.4 million in 1988; $6.8 million estimated for 1989.
Officers: Robert Maynard, president/chief executive officer; T.E. Garner Jr., vp; Dr. Harold Gussack, medical director; Brenda Joiner, marketing director.

Kaiser Foundation Health Plan of Georgia Inc.

3355 Lenox Road N.E., Suite 1000, Atlanta, Ga. 30326; 404-233-0555

See Kaiser Permanente Medical Care Program corporate listing under California.

MetLife HealthCare Network of Georgia Inc.

47 Perimeter Center E., Suite 650, Atlanta, Ga. 30346; 404-396-0208

Operational date: July 1987.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 189 primary physicians; 323 specialists.
Facilities: 11 hospitals.
Service area: 13 counties in Georgia.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: William Young, president; John Hollkamp, finance officer.

PARTNERS National Health Plans

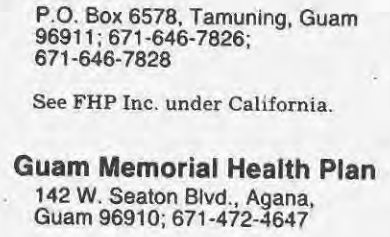
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Atlanta

3100 Cumberland Circle, Suite 1200, Atlanta, Ga. 30339; 404-955-8010

Operational date: May 1981.
Federally qualified.
Certified in: Georgia.
Model type: Mixed.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 59 primary physicians; 35 specialists; 30 administrative staff members; 25 marketing staff members; 628 patients per physician; 100% board certified physicians.
Facilities: Three hospitals; 28 pharmacies; two diagnostic labs.
Service area: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry and Rockdale counties in Georgia.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 8,622 employees with single coverage; 7,958 employees with family coverage; 39,427 employees and dependents; 41,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.04 days; 76.5 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Marilyn E. Schafer, vp-group operations; Dr. T. Ronald Tipton, medical director; F. Bart Hester, regional group manager.



FHP Inc.

P.O. Box 6578, Tamuning, Guam 96911; 671-646-7826; 671-646-7828

See FHP Inc. under California.

Guam Memorial Health Plan

142 W. Seaton Blvd., Agana, Guam 96910; 671-472-4647

Operational date: 1973.
Certified in: Guam and Commonwealth of the Northern Marianas.
Model type: IPA.
Not for profit.
Sponsorship: Guam Memorial Health Plan Associates.
Staff: 50 primary physicians; 20 specialists; 31 administrative staff members; four marketing staff members; 400 patients per physician; 100% board certified physicians.
Facilities: One hospital; 16 pharmacies; three diagnostic labs.
Service area: Guam; Saipan, Rota and Tinian, Commonwealth of the Northern Marianas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, obstetrics/gynecology. Options include experimental procedures, dental, durable medical equipment, podiatry. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 400 employer/payer groups; 32,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.6 days; 8.9 admissions per 1,000 members.
Management reports: Provided as required.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $14 million in 1988; $16 million estimated for 1989.
Officers: Frank B. Rosario, president/executive director; Ruben Basilio, medical director; James W. Gillan, marketing director.



Health Plan Hawaii

P.O. Box 860, Honolulu, Hawaii 96808; 808-944-2481

Operational date: July 1981.
Federally qualified.
Certified in: Hawaii.
Model type: Network.
Not for profit.
Sponsorship: Hawaii Medical Service Assn.
Staff: 281 primary physicians; 255 specialists; 40 administrative staff members; five marketing staff members; 64 patients per physician; 72% board certified physicians.
Facilities: 22 hospitals; 140 pharmacies; 27 diagnostic labs.
Service area: Hawaii.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $80.06 single, $223.38 family. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,653 employer/payer groups; 5,441 employees with single coverage; 3,835 employees with family coverage; 18,015 employees and dependents; 18,200 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.6 days; 53.7 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $9.5 million in 1988; $13.1 million estimated for 1989.
Officers: Ralph J. Keissling, president; Cliff K. Cisco, executive director; Dr. Herbert Uemura, medical director; Micheal Wong, marketing director; Paul Yamashita, director-HMO health services.

Kaiser Foundation Health Inc.-Hawaii Region

711 Kapiolani Blvd., Honolulu, Hawaii 96813; 808-834-5333

See Kaiser Permanente Medical Care Program corporate listing under California.



Peak Health Plan-An Idaho General Partnership

300 Mallard Drive, Suite 200, Boise, Idaho 83706; 208-343-3330

See Lincoln National Health Plan under Indiana.



Access Health Inc.

33 E. Congress Parkway, Suite 600, Chicago, Ill. 60605; 312-922-9338

Operational date: October 1986.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Rush-Presbyterian-St. Luke's Medical Center.
Staff: 700 primary physicians; 1,000 specialists; managed by Rush-Presbyterian-St. Luke's Health Plans Inc.; 1,000 patients per physician; 94% board certified physicians.
Facilities: 35 hospitals; 200 pharmacies; one diagnostic lab.
Service area: Cook, Will, Lake, McHenry and Kane counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Pharmaceutical and lab work done by contract with independent facilities.
Rating options: Community rating: $118 single, $330 family; by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 650 employer/payer groups; 36,000 employees and dependents; 40,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days; 68 admissions per 1,000 members.
Management reports: Provided semianually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $7.8 million in 1988; $26.3 million estimated for 1989.
Officers: Dr. Jerome Hahn, president/medical director; Mark Crantz, vp/marketing director; Frank Joebgen, vp-finance; Dr. Harold Firfer, vp-special projects; Edward Sandrick, vp-prepaid health plans; Preston Simons, vp-data processing; Dr. Glen Tomlinson, special consultant to the president; Kevin Necas, treasurer; Chris Limperis, secretary/general counsel.

American Health Care Providers Inc.

P.O. Box 160, Flossmoor, Ill. 60422; 708-957-2550

Operational date: April 1984.
Certified in: Illinois, Indiana and Arkansas.
Model type: Network.
For profit.
Staff: 2,400 primary physicians; 3,000 specialists; 20 administrative staff members; 12 marketing staff members; 22 patients per physician; 80% board certified physicians.
Facilities: 50 hospitals; 15 phar-

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nacies.
Service area: Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will, Winnebago, LaSalle and Livingston counties in Illinois; Faulkner, Lonoke, Pulaski, Saline, Crawford, Franklin, Johnson, Logan, Scott and Sebastian counties in Arkansas.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 350 employer/payer groups; 6,633 employees with single coverage; 10,644 employees with family coverage; 44,000 employees and dependents; 48,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days; 424 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $22 million in 1988; $36 million estimated for 1989.
Officers: Asif Sayeed, president; Joseph Garrett and David Parsons, executive directors; Dr. Thakrar and Dr. Horne, medical directors; David Lutz and Steven Stewart, marketing directors; Justin Himel, finance director.

Chicago HMO Ltd.

540 N. LaSalle St., Chicago, Ill. 60610; 312-751-4460

Operational date: May 1976.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: Network; contracts with physician groups and IPAs.
For profit.
Sponsorship: HMO America Inc.
Staff: 1,203 primary physicians; 1,853 specialists; 57 marketing staff members; 140 members per physician; 75% board certified physicians.
Facilities: 82 hospitals; 250 pharmacies.
Service area: DuPage, Cook, Kane, Lake, McHenry and Will counties in Illinois. Lake, LaPorte and Porter counties in Indiana; Kenosha County, Wis.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, limited vision, limited dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include dental, podiatry, eyewear, expanded substance abuse rehabilitation. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,063 employer/payer groups; 22,787 employees with single coverage; 40,403 employees with family coverage; 168,581 employees and dependents; Hospital stay averages 4.3 days; 92.4 admissions per 1,000 members.
Management reports: Provided quarterly or upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $105 million in 1988.
Officers: Dr. Robert Weinstein, president; Judith Brown, executive director; Dr. Mitchell Trubitt, medical director; Allan Glick, marketing director; Dr. Charles Kelly, vp; Arthur Adelman, secretary/treasurer.

CIGNA Healthplan of Illinois Inc.

1700 Higgins Road, Suite 600, Des Plaines, Ill. 60018; 708-699-5600

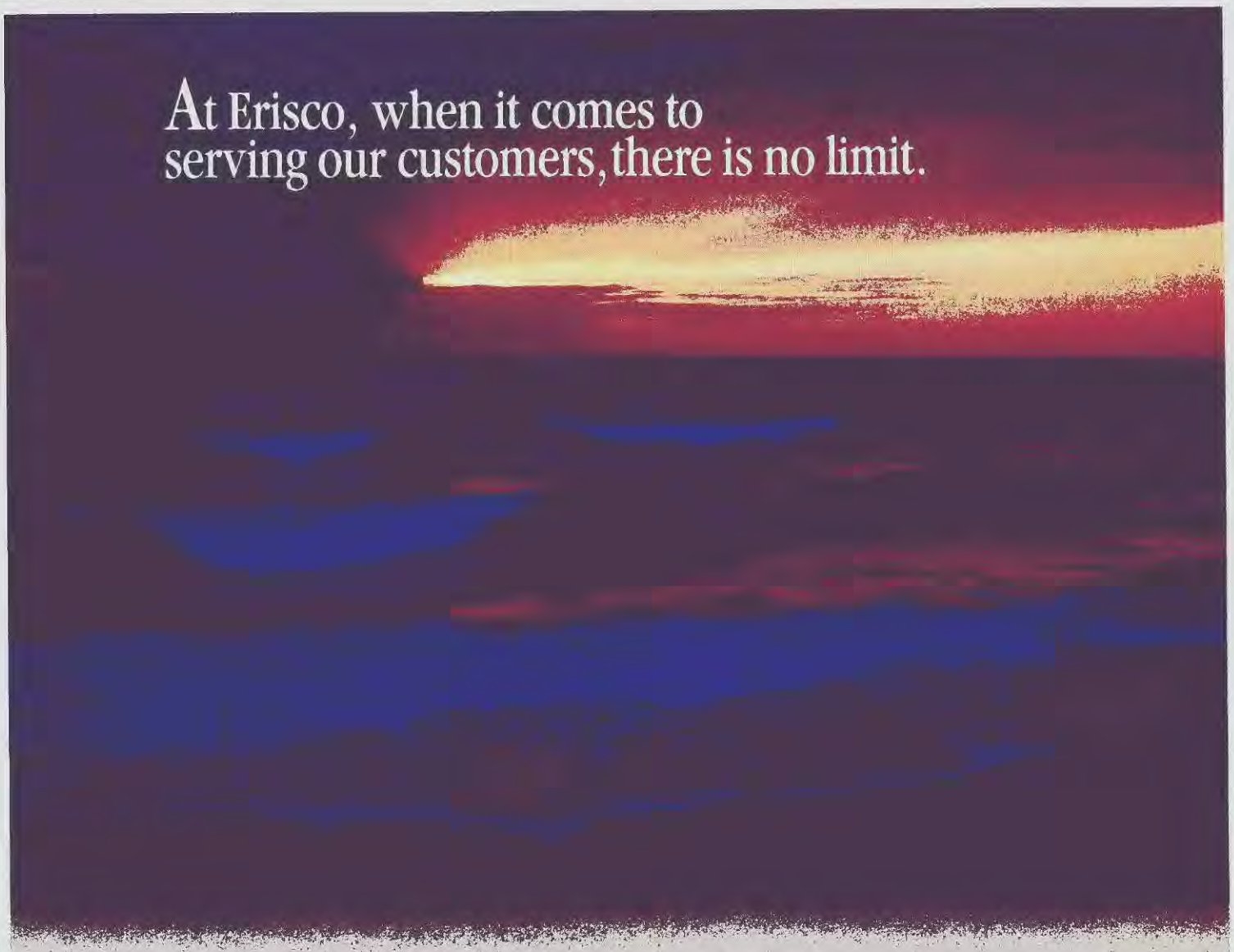
Operational date: June 1986.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 801 primary physicians; 2,062 specialists; 12 administrative staff members; 14 marketing staff members; 49 patients per physician; 85% board certified physicians.
Facilities: 31 hospitals; one pharmacy.
Service area: Cook, DuPage, Kane, Lake and Will counties in Illinois; Lake County, Ind.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 218 employer/payer groups; 8,312 employees with single coverage; 7,879 employees with family coverage; 34,417 employees and dependents. Hospital stay averages 4.8 days; 74 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Dr. Ernest Weis, general manager; Dr. William Larson, medical director; David Patterson, sales director.

COMPASS Health Care Plans

310 S. Michigan Ave., Suite 1300, Chicago, Ill. 60604; 312-294-0200

Operational date: 1984.
Certified in: Illinois.
Model type: IPA and staff.
Not for profit.
Sponsorship: Hospital.
Staff: 2,214 primary physicians; 1,200 specialists; five administrative staff members; 12 marketing staff members; 6.6 patients per physician; 90% board certified physicians.
Facilities: 31 hospitals; chain of pharmacies.
Service area: Cook, Lake, DuPage, Will and Kane counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, eyewear. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by the HMO.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 120 employer/payer groups; 2,182 employees with single coverage; 2,561 employees with family coverage; 11,376 employees and dependents; 15,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days; 335 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $7.7 million in

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a company of The Dun & Bradstreet Corporation

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1988; $10 million estimated for 1989.

Officers: Henry F. Keaton, president; Dr. John Keifer, medical director; Gail M. Hejnosz, vp-sales/marketing; Karen Paul, vp-provider relations, John Harter, vp-finance.

Dental Network USA

2 Transamerica Plaza Drive, Oakbrook Terrace, Ill. 60181; 708-691-1133

Federally qualified.
Certified in: Alabama, California, Canada, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Michigan, Nebraska, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Virginia and Wisconsin.
Sponsorship: Blue Cross & Blue Shield Assn.
Staff: 4,583 primary physicians and specialists; 129 patients per physician.
Service area: Alabama, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, Ohio, Oregon, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin and the U.S. Virgin Islands.
Locations: One administrative site.
Services: Standard package includes dental.
Rating options: Community rating, by class, by age/sex, experience rating.
Enrollment options: Individual enrollment allowed.
Users: 2,681 employer/payer groups; 82,761 employees with single coverage; 152,722 employees with family coverage; 589,417 employees and dependents; 610,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided quarterly.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Contacts: Sally Griffin, marketing manager; Dee Bailey, director-national marketing.

EQUICOR Health Plan Inc.

P.O. Box 3364, Chicago, Ill. 60654-0364; 312-644-7705

Operational date: April 1988.
Certified in: Virginia, Illinois and Indiana.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 463 primary physicians; 947 specialists; 20 administrative staff members; 20 marketing staff members; nine patients per physician; 75% board certified physicians.
Facilities: 28 hospitals; 416 pharmacies; three diagnostic labs.
Service area: Cook, DuPage, Kane, Lake, McHenry and Will counties in Illinois; Lake and Porter counties in Indiana.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 28 employer/payer groups; 4,466 employees and dependents; 9,205 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $5.8 million estimated for 1989.
Officers: William T. Hjorth, president; Oren Renick, executive director; Dr. John Benages, medical director; Wayne Feest, marketing director.

Great Lakes Health Plan Inc.

747 E. 22nd St., Suite 100, Lombard, Ill. 60148; 708-916-8400

See Lincoln National Health Plan under Indiana.

HMO Illinois

2001 Midwest Road, Oak Brook, Ill. 60521; 708-620-3000

Year founded: June 1977.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: Mixed.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Illinois.
Staff: 2,062 primary physicians; 4,518 specialists; 30 marketing staff members; 150 patients per physician; 85% board certified physicians.
Facilities: More than 125 hospitals; 4,500 pharmacies.
Service area: 56 counties in Illinois. Lake and Porter counties in Indiana.
Locations: Eight administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,500 employer/payer groups; 53,732 employees with single coverage; 72,079 employees with family coverage; 306,007 employees and dependents; 310,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.6 days; 73.1 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $238.3 million in 1988; $240 million estimated for 1989.
Officers: S. Martin Hickman, president; Frank E. Nicholson, vp; Dr. Arnold L. Widen, medical director; Kathleen E. Higgins, marketing director.

Health Chicago Inc.

950 Warrenville Road, Lisle, Ill. 60532; 312-964-6200

Year founded: October 1984.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: IPA.
For profit.
Sponsorship: Ingalls Health System, Health Corp. Affiliates and Memorial Health Services.
Staff: 850 primary physicians; 1,200 specialists; 180 administrative staff members; 36 marketing staff members; approximately 100 patients per physician; approximately 70% board certified physicians.
Facilities: 32 hospitals; 121 pharmacies and two pharmacy chains; 12 diagnostic labs.
Service area: Cook, DuPage, Kane, Lake, McHenry and Will counties in Illinois; Porter, Lake and LaPorte counties in Indiana.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: Not reported.
Officers: Norman J. Beles, president; Raymond J. Kostlec, executive vp; Dr. Wayne E. Mathy and Dr. David V. Weber, medical directors; John F. Doddy, vp-insurance services; Timothy F. Dickman, vp-network development; Patricia A. Moldovan, vp-operations.

Health Plan of Central Illinois

207 Main St., Peoria, Ill. 61602; 309-676-2300

Operational date: March 1983.
Certified in: Illinois.
Model type: IPA.
For profit.
Sponsorship: Central Illinois Individual Practices Assn.
Staff: 157 primary physicians; seven administrative staff members; five marketing staff members; 186 patients per physician; 100% board certified physicians.
Facilities: Three hospitals; more than 700 pharmacies; three diagnostic labs.
Service area: Seventeen counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 180 employer/payer groups; 2,852 employees with single coverage; 9,701 employees with family coverage; 36,815 employees and dependents; 28,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.6 days; 473 admissions per 1,000 members.
Management reports: Provided monthly.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $30 6 million in 1988; $33.2 million estimated for 1989.
Officers: Lloyd Mathwick, president; Dr. Fred Z. White, medical director; Daniel P. Franklin, senior vp; Marshall D. Heinold, vp-finance; Mark K. Smith, assistant vp-data processing.

Maxicare Illinois Inc.

150 N. Michigan Ave., Chicago, Ill. 60604; 312-220-9142

See Maxicare Health Plans Inc. under California

Med-Connect HMO of Illinois

15 Salt Creek Lane, Hinsdale, Ill. 60521; 708-850-2310

Year founded: September 1988.
Model type: Network.
For profit.
Sponsorship: Two hospitals and three insurers.
Staff: 325 primary physicians; 1,042 specialists; nine administrative staff members; 85% board certified physicians.
Facilities: 25 hospitals.
Service area: Cook, DuPage, Kane and Lake counties in Illinois.
Locations: One administrative site, 184 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs, vision, dental, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: One employer/payer group; 23 employees with single coverage; 17 employees with family coverage; 96 employees and dependents; 2,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages five days; 65 admissions per 1,000 members.
Management reports: Provided quarterly.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $50,000 estimated for 1989.
Officers: Daniel R. Schuh, president; Dr. Marvin Zolot, medical director.

MetLife HealthCare Network of Illinois Inc.

1375 E. Woodfield Road, Suite 110, Schaumburg, Ill. 60173; 708-619-2222

Operational date: September 1986.
Certified in: Illinois.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 1,129 primary physicians; 2,511 specialists.
Facilities: 43 hospitals.
Service area: Cook, DuPage, Kane, Kendall, Lake, McHenry and Rock Island counties in Illinois.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Thomas Maxfield III, president; Virgil Marsh, vp-operations.

Multicare HMO

400 W. Erie, Suite 400, Chicago, Ill. 60610-4005; 312-664-0035

Year founded: April 1984.
Certified in: Illinois.
Model type: Group and IPA.
For profit.
Sponsorship: Private sponsorship.
Staff: 700 primary physicians; 1,100 specialists; 25 administrative staff members; two marketing staff members; 70% board certified physicians.
Facilities: 30 hospitals, chain of pharmacies.
Service area: Cook, Lake, DuPage, McHenry and Kane counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $82.50 single, $258 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 220 employer/payer groups; 2,095 employees with single coverage; 1,121 employees with family coverage; 6,800 employees and dependents; 8,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.2 days; 350 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Dr. Peter E. Friedell president; Richard A. Lutz, executive director; Dr. Jere Freidheim, medical director; Yolanda Martinez, marketing director; Dr. Morris T. Friedell secretary; Christine Stout, provider relations manager.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Illinois

9450 W. Bryn Mawr, Rosemont, Ill. 60018; 312-671-8700

Operational date: May 1975.
Federally qualified.
Certified in: Illinois.
Model type: Network.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 860 primary physicians; 2,046 specialists; 92 administrative staff members; 30 marketing staff members; 95% board certified physicians.
Facilities: 43 hospitals; 300 pharmacies.
Service area: Cook, DuPage, Lake and portions of DeKalb, Grundy, Kane, Kendall, LaSalle and McHenry counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 10,739 employees with single coverage; 8,546 employees with family coverage; 39,433 employees and dependents; Hospital stay averages 4.3 days; 29.2 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Scott P. Serota, vp-health care management; Dr. Henry Hollander, medical director; Michael Dooley, marketing director.

Michael Reese Health Plan

2545 S. Martin Luther King Jr. Drive, Chicago, Ill. 60616; 312-808-3810

Operational date: July 1972.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: Staff.
Not for profit.
Sponsorship: Michael Reese Hospital & Medical Center.
Staff: 172 primary physicians; 535 specialists; 739 administrative staff members; 34 marketing staff members; 85% board certified physicians.
Facilities: 14 hospitals; one pharmacy; two diagnostic labs.
Service area: Cook, DuPage, Kane, Lake and Will counties in Illinois; Lake County in Indiana.
Locations: One administrative site, 19 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental, substance abuse, eyewear.

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Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $95.38 single, $256.66 family Offers non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 703 employer/payer groups; 41,982 employees with single coverage; 47,341 employees with family coverage; 193,740 employees and dependents; 203,873 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days; 346 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $213.3 million in 1988; $254.1 million estimated for 1989.

Officers: Barry Averill, president; Patrick Brady, executive vp; Dr. Stephen Contro, medical director; Andrea Stallworth, vp-marketing; Lucy San Diego, chief financial officer/vp-finance.

Rush Presbyterian-St. Lukes Health Plans Inc.

33 E. Congress Parkway, Suite 600, Chicago, Ill. 60605; 312-347-3420

Operational date: November 1971.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: Staff.
Not for profit.
Sponsorship: Rush-Presbyterian-St. Luke's Medical Center.

Staff: 126 primary physicians; 18 specialists; 1,000 patients per physician; 94% board certified physicians.

Facilities: 18 hospitals; 220 pharmacies; 19 diagnostic labs.

Service area: Cook, Will, Lake, DuPage, Kendall, McHenry and Kane counties in Illinois. Lake and Porter counties in Indiana.

Locations: One administrative site, 18 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by the HMO facilities.

Rating options: Community rating: $118 single, $330 family; by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 2,500 employer/payer groups; 31,770 employees with single coverage; 29,250 employees with family coverage; 132,500 employees and dependents; 133,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days; 73 admissions per 1,000 members.

Management reports: Provided semi-annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $127.3 million in 1988; $142 million estimated for 1989.

Officers: Dr. Jerome Hahn, president/medical director; Mark Crantz, vp; Frank Joebgen, vp-finance; Dr. Harold Firfer, vp-special projects; Preston Simons, vp-data processing; Dr. Glen Tomlinson, special consultant; Kevin Necas, treasurer; Chris Limperis, secretary/general counsel; Edward Sandrick, vp-prepaid health plans.

University of Illinois HMO Plan Trust

840 S. Wood St., Suite 180, Chicago, Ill. 60612; 312-996-3553

Year founded: 1986.
Certified in: Illinois.
Model type: Group.
Not for profit.
Sponsorship: The Board of Trustees of the University of Illinois.

Staff: 24 primary physicians; 450 specialists; 22 administrative staff members; no marketing staff members; 666 patients per physician; 80% board certified physicians.

Facilities: One hospital; two pharmacy chains; two diagnostic labs.

Service area: Cook County and surrounding counties in Illinois.

Locations: One administrative site, five primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 21,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 6.6 days; 170 admissions per 1,000 members.

Management reports: Not provided.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $3.5 million in 1988; $4.2 million estimated for 1989.

Officers: Craig Bazzani, president; Don Moy, interim director; Dr. H.C. Bonbrest, medical director; Donovan Riley, hospital director.



Farm Bureau Insurance Managed Care Plan Inc.

3737 N. Meridian St., Suite 201, Indianapolis, Ind. 46208; 317-921-3740

Operational date: August 1986.
Certified in: Indiana.
Model type: IPA.
For profit.
Sponsorship: United Farm Bureau Family Life Insurance Co.

Staff: 677 primary physicians; 1,015 specialists; 19 administrative staff members; four marketing staff members; 16 patients per physician.

Facilities: 36 hospitals; chain of pharmacies; 65 diagnostic labs.

Service area: Indiana.

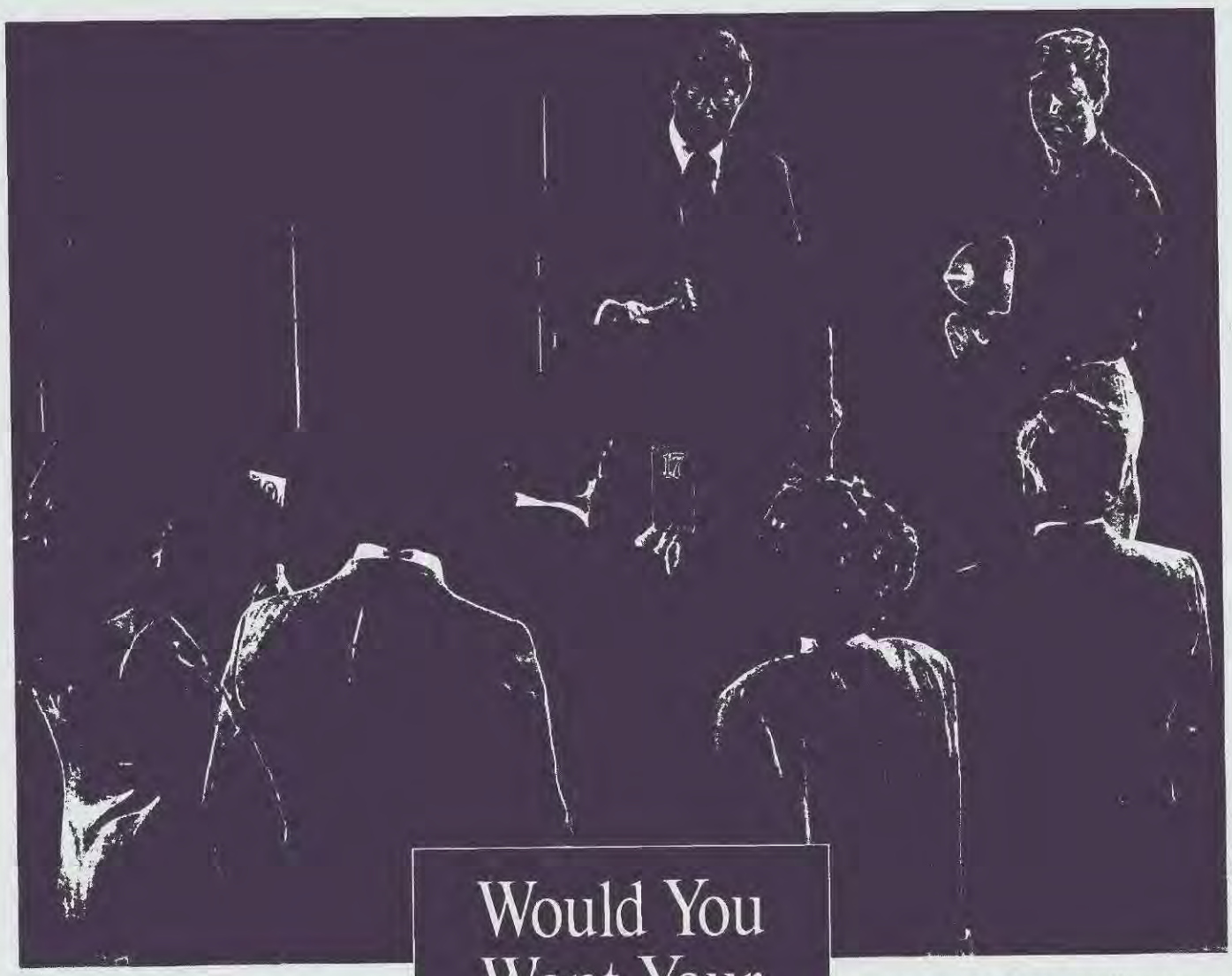
Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Experience rating.

Enrollment options: Does not contract with the Federal Health

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Continued from previous page
Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 52 employer/payer groups; 964 employees with single coverage; 2,921 employees with family coverage; 10,656 employees and dependents; 14,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.9 days. 91 admissions per 1,000 members.

Management reports: Not provided.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $4 million in 1988; $9 million estimated for 1989.

Officers: Andrew C. Johnston, president/chief executive officer; Dr. E. Henry Lamkin, medical director; Ron Fouts, director-marketing.

HMO America-Indiana Inc.

540 N. LaSalle St., Chicago, Ill. 60610; 312-751-4460

Operational date: January 1986.
Federally qualified.
Certified in: Illinois and Indiana.
Model type: Network.
For profit.
Sponsorship: HMO America Inc.

Staff: 1,203 primary physicians; 1,853 specialists; 57 marketing staff members; 140 patients per physician; 75% board certified physicians.

Facilities: 82 hospitals; 250 pharmacies.

Service area: DuPage, Cook, Kane, Lake, McHenry and Will counties in Illinois. Lake, LaPorte and Porter counties in Indiana. Kenosha County in Wisconsin.

Locations: One administrative site, 162 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, limited vision and dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include podiatry. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 1,063 employer/payer groups; 22,787 employees with single coverage; 40,403 employees with family coverage; 168,581 employees and dependents. Hospital stay averages 4.3 days. 92.4 admissions per 1,000 members.

Management reports: Provided quarterly upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $104.7 million in 1988.

Officers: Dr. Robert Weinstein, president; Judith Brown, executive director; Dr. Mitchell Trubitt, medical director; Allan Glick, marketing director; Dr. Charles Kelly, vp; Arthur Adelman; secretary/treasurer.

Humana Care Plan Inc.

9300 Shelbyville Road, Suite 700, Louisville, Ky. 40222; 502-423-1355

See Humana Health Care Plans under Kentucky.

Key Health Plan

333 N. Alabama, Suite 300, Indianapolis, Ind. 46236; 317-262-4560

Operational date: August 1984.
Federally qualified.
Certified in: Indiana.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Indiana.

Staff: 600 primary physicians; 1,200 specialists; 40 administrative staff members; 12 marketing staff members; 125 patients per physician; 95% board certified physicians.

Facilities: 38 hospitals; 200 pharmacies; two diagnostic labs.

Service area: Indiana.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental, podiatry and experimental procedures. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $90-120 single, $240-300 family; by class, by age/sex, experience rating. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 125 employer/payer groups; 60,000 employees and dependents; 60,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.17 days. 330 admissions per 1,000 members.

Management reports: Provided quarterly; monthly upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $90 million in 1988; $72 million estimated for 1989.

Officers: John Cuny, president/chief executive officer; Dr. John Fennig, medical director; David Anderson, technical director-marketing/underwriting; Jerry Wehmhoefer, chief financial officer.

Lincoln National Health Plan

1300 S. Clinton St., P.O. Box 2266, Fort Wayne, Ind. 46801; 219-427-7662

See Lincoln National Health Plan corporate listing under Indiana.

Lincoln National Health Plan USA*

Lincoln National Life Insurance Co., 1700 Magnavox Way, Fort Wayne, Ind. 46804; 219-427-2000

Operational date: 1975.
Certified in: Arizona, California, Colorado, District of Columbia, Idaho, Illinois, Indiana, Maine, Maryland, Missouri, Kansas, Kentucky, North Carolina, Ohio, Virginia.
Model type: Group, IPA, network and mixed.
For profit.
Sponsorship: Lincoln National Administrative Services Corp.

Staff: 4,500 primary physicians; 10,000 specialists; 96% board certified physicians.

Facilities: 400 hospitals; 1,208 individual pharmacies, 30 pharmacy chains; 120 diagnostic labs.

Locations: 19 administrative sites.

Services: Include hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology.

Users: 1,500 employer/payer groups; 450,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $76.3 million in 1988; $350 million estimated for 1989.

Officers: John P. Cole, executive vp/chief executive officer; Dr. Stephen George and Dr. Robert Gormley, medical directors/vps.

*Figures are corporate, including all Lincoln National Health Plans sponsored by Lincoln National Administrative Services Corp.

Maxicare Indiana Inc.

9480 Priority Way W. Drive, Indianapolis, Ind. 46240-3899; 317-844-5775

See Maxicare Health Pans Inc. under California.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Iowa

DeltaCare

636 Grand, Des Moines, Iowa 50309; 315-245-4536

Operational date: January 1986.
Certified in: Iowa.
Model type: Network.
Not for profit.
Sponsorship: Delta Dental Plan of Iowa.

Staff: 25 primary physicians; 12 specialists; one administrative staff member.

Service area: Polk and Warren counties in Iowa.

Locations: One administrative site.

Services: Standard package includes dental.

Rating options: Experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: Four employer/payer groups; 147 employees with single coverage; 392 employees with family coverage; 1,664 employees and dependents; 1,459 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $125,759 in 1988; $152,241 estimated for 1989.

Officers: Dr. Clement S. O'Meara, executive director.

HMO Iowa Inc.

1002 First Interstate Bank Building, 317 Sixth Ave., Des Moines, Iowa 50309; 515-244-6300

Operational date: December 1985.
Certified in: Iowa.
Model type: Group.
For profit.
Sponsorship: The Principal Financial Group.

Staff: 323 primary physicians; 47 specialists; nine administrative staff members; four marketing staff members; 100% board certified or board eligible physicians.

Facilities: 11 hospitals; more than 100 pharmacies; four diagnostic labs.

Service area: Polk, Story, Marion, Jasper, Marshall, Clarke, Dallas, Boone, Poweshiek and Warren counties in Iowa.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $95.51 single, $271.02 family; by class, by age/sex, experience rating.

Enrollment options: Individual enrollment not allowed.

Users: 125 employer/payer groups; 3,143 employees with single coverage; 7,136 employees with family coverage; 23,811 employees and dependents; 25,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.21 days. 363 admissions per 1,000 members.

Management reports: Provided yearly/upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $16.3 million in 1988; $21.8 million estimated for 1989.

Officers: Dr. Michael J. Richards, president; Thomas E. Press, vp/chief operating officer; Dr. Kevin J. Cunningham, medical director; Tami R. Marquardt, marketing director.

Heritage National Healthplan

11 Corporate E., 1910 E. Kimberly Road, Davenport, Iowa 52807; 309-344-4417

Operational date: August 1985.
Certified in: Illinois, Iowa, Wisconsin and Tennessee.
Model type: IPA.
For profit.
Sponsorship: John Deere & Co.

Staff: 3,500 primary physicians and specialists; 400 administrative staff members; 18 marketing staff members; 48 patients per physician.

Facilities: 60 hospitals; 890 pharmacies; 300 diagnostic labs.

Service area: Anderson, Blount, Knox, Loudon, Hawkins, Sullivan and Washington counties in Tennessee; 48 counties in Iowa; Carroll, Henry, Mercer, Rock Island, Whiteside, Grundy and Will counties in Illinois; Columbia, Dodge, Fond du Lac, Green Lake, Ozoukee and Washington counties in Wisconsin.

Locations: 12 administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental, podiatry, chiropractic services, oral surgery. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 250 employer/payer groups; 16,230 employees with single coverage; 45,580 employees with family coverage; 173,500 employees and dependents; 173,500 estimated enrollees as of Jan. 1, 1990. 91.5 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $138.5 million in 1988.

Officers: G. Michael Hammes, president; Regis D. Rulifson, vp; Richard R. Detweiler, vp/treasurer; George N. Dellos, marketing director; Charles P. Parsons, director-eastern region; James K. Thompson, director-western region.

Share Health Plan of Iowa

2700 Westown Parkway, Suite 200 West Des Moines, Iowa 50265; 515-225-1234

Operational date: July 1983.
Federally qualified.
Certified in: Iowa.
Model type: IPA.
For profit.
Sponsorship: United HealthCare Corp.

Staff: 86 primary physicians; 342 specialists; 35 administrative staff members; eight marketing staff members; 366 patients per physician; 98% board certified physicians.

Facilities: Six hospitals; 17 pharmacies; five diagnostic labs.

Service area: Polk and Warren counties in Iowa.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 308 employer/payer groups 6,214 employees with single coverage; 6,532 employees with family coverage; 27,955 employees and dependents; 33,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 361 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $22.6 million in 1988; $27.4 million estimated for 1989.

Officers: D. Michael Elliot, president/executive director; Dr. Don C. Green, medical director; Brendan Berigan, marketing director; Ron Fall, director-finance; Roy Fredrickson, director-development; Dianne Knoeck-Skinner, manager-provider relations; Bill Connet, manager-planning and development.

Total Health Network of Iowa

P.O. Box 7270, 636 Grand Ave., Des Moines, Iowa 50309; 515-245-5025

Operational date: December 1984.
Model type: IPA.
For profit.
Sponsorship: Blue Cross of Iowa and Blue Shield of Iowa.
Service area: 46 counties in Iowa.
Users: 25,748 employees and dependents as of June 1989.

Kansas

EQUICOR Health Plan Inc.

200 S. Santa Fe, Suite 5, Salina, Kan. 67401; 913-823-6015

Operational date: November 1983.
Federally qualified.
Certified in: Kansas.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 24 primary physicians; three administrative staff members; two marketing staff members; 206 patients per physician; 75% board certified physicians.

Facilities: Two hospitals; two pharmacies.

Service area: Salina County, Kan.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 300 employer/payer groups; 4,956 employees and dependents; 4,982 estimated enrollees as of Jan. 1, 1990.

Management reports: Not provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $3.6 million in 1988; $4.6 million estimated for 1989.

Officers: Robert A. Vohs, president; Ann Headrick, executive director; Dr. Adrian Walling, medical director; Gary Williams, marketing director.

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EQUICOR Health Plan Inc. (Kansas City)

9200 Indian Creek Parkway, Suite 200, Overland Park, Kan. 66210; 913-451-2020

Operational date: October 1984.
Federally qualified.
Certified in: Kansas and Missouri.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 175 primary physicians; 753 specialists; 12 administrative staff members; 12 marketing staff members; 51 patients per physician; 75% board certified physicians.
Facilities: 17 hospitals; one diagnostic lab.
Service area: Johnson, Leavenworth, Wyandotte and Miami counties in Kansas. Jackson, Cass, Clay, Platte and Ray counties in Missouri.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 161 employer/payer groups; 9,044 employees and dependents; 10,635 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $7.2 million in 1988; $9.6 million estimated for 1989.
Officers: Robert A. Vohs, president; Daryl Edmonds, executive director; Dr. Dick Brummett, medical director; Joel D. Ebben, marketing director.

EQUICOR Health Plan Inc. (Tri-Counties)

2959 N. Rock Road, Wichita, Kan. 67278; 316-636-1152

Operational date: July 1981.
Certified in: Kansas.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 14 primary physicians; 20 administrative staff members; nine marketing staff members; 72 patients per physician; 75% board certified physicians.
Facilities: Two hospitals; two pharmacies.
Service area: Harvey and Marion counties in Kansas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 20 employer/payer groups; 1,015 employees and dependents; 1,257 estimated enrollees as of Jan. 1, 1990.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Robert A. Vohs, president; D. Douglas Stratton, executive director; Dr. Adrian Walling, medical director; Gary Williams, marketing director.

EQUICOR Health Plan Inc. (Wichita)

2959 N. Rock Road, Wichita, Kan. 67226; 316-681-1152

Operational date: July 1981.
Federally qualified.
Certified in: Kansas.
Model type: Network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 234 primary physicians; 1,500 specialists; 20 administrative staff members; nine marketing staff members; 281 patients per physician; 75% board certified physicians.
Facilities: Five hospitals; 700 pharmacies.
Service area: Sedgwick, Butler, Sumner and Kingman counties in Kansas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 500 employer/payer groups; 65,855 employees and dependents; 63,350 estimated enrollees as of Jan. 1, 1990.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $58.9 million in 1988; $67.1 million estimated for 1989.
Officers: Robert A. Vohs, president; D. Douglas Stratton, executive director; Dr. Adrian Walling, medical director; Gary Williams, marketing director.

HMO Kansas Inc.

1133 Topeka Blvd., Topeka, Kan. 66611; 913-233-2751

Operational date: February 1984.
Federally qualified.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Kansas.
Service area: 28 counties in Kansas.
Users: 59,509 employees and dependents as of June 1989.

Kaiser Foundation Health Plan of Kansas City Inc.

6900 Squibb Road, Suite 201, Shawnee Mission, Kansas 66202; 913-384-9090

See Kaiser Permanente Medical Care Program corporate listing under California.

Lincoln National Health Plan of Kansas City Inc.

7300 College, Suite 100, Overland Park, Kan. 66210; 913-345-2240

See Lincoln National Health Plan under Indiana.

MetLife Healthcare Network-Kansas City Inc.

Building 9, Suite 185, 9200 Indian Creek Parkway, Overland Park, Kan. 66210-2012; 913-451-5656

Operational date: December 1986.
Certified in: Missouri and Kansas.

Continued on next page

EMPLOYEE BENEFITS BULLETIN:
COST-SAVING LTD SERVICES FROM CNA

How to shorten long term disabilities.

The sooner your disabled employees can return to work, the happier everyone will be. The costs of unfinished work, temporary workers, hiring and training replacements and group health and LTD coverage are all reduced. So is the emotional trauma for the employee.

That's why a monthly LTD benefit check was only the start of CNA's service to a young aircraft mechanic confined to a wheelchair after a serious fall. Through our LTD rehabilitation program, he also received free training in computer-assisted drafting. And when he graduates, we'll even help him find a job in his new career.

At the CNA Insurance Companies, we're aware of the personal suffering, as well as the financial burden, a prolonged disablement can cause. And we provide services that help you respond to both problems.

Our solutions go beyond what you might expect from an insurance company and they work for everyone's benefit, including yours. Call Peter Green at 312-822-2005.



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Group Benefits from CNA: Life & Health • AD & D • Vision • Dental • LTD • Flexible Benefits Programs • Pensions
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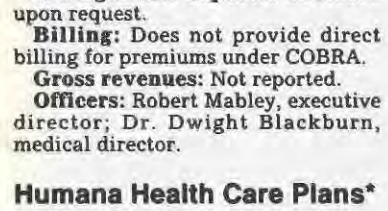
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Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 276 primary physicians; 570 specialists.
Facilities: 10 hospitals.
Service area: Jackson, Johnson and Wyandotte counties in Kansas; Cass, Clay and Platte counties in Missouri.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, professional services, periodic check-ups. Options include prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class; experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Not provided.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Charles Stark, president.



HMO Kentucky Inc.

9901 Linn Station Road, Louisville, Ky. 40223; 502-423-2520

Year founded: January 1986.
Federally qualified.
Certified in: Kentucky.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Kentucky.
Staff: 415 primary physicians; 2,761 specialists; 33 administrative staff members; 38 marketing staff members; 117 patients per physician.
Facilities: 575 pharmacies.
Service area: 48 counties in Kentucky.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating; by class; experience rating. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 200 employer/payer groups; 7,419 employees with single coverage; 12,038 employees with family coverage; 48,836 employees and dependents; 50,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.42 days. 100 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Robert Mabley, executive director; Dr. Dwight Blackburn, medical director.

Humana Health Care Plans*

500 W. Main St., Louisville, Ky. 40201; 502-580-1000

Operational date: 1933.
Federally qualified.
Model type: Varies by plan.
For profit.
Sponsorship: Humana Inc.
Staff: More than 8,000 primary physicians for all of Humana Health Care Plans HMOs and PPOs.
Facilities: More than 200 hospitals for all of Humana Health Care Plans HMOs and PPOs.
Service area: Network operates in Alabama, Arizona, California, Colorado, Florida, Indiana, Kentucky, Nevada, Tennessee and Texas.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental.
Enrollment options: Individual enrollment may be allowed.
Users: 925,000 employees and dependents for all of Humana Health Care Plans HMOs and PPOs.
Gross revenues: Not reported.
Officers: Wayne T. Smith, president-health care division.
*Figures are corporate for all HMOs (and PPOs when noted) sponsored by Humana Inc.

Humana Care Plan Inc.

9300 Shelbyville Road, Suite 700, Louisville, Ky. 40222; 502-423-1355

See Humana Health Care Plans corporate listing under Kentucky.

Humana Care Plan Inc.

101 Prosperous Place, Suite 300, Lexington, Ky. 40509; 606-254-2731

See Humana Health Care Plans corporate listing under Kentucky.

Humana Health Plan Inc.

9300 Shelbyville Rd, Suite 700, Louisville, Ky. 40222; 502-423-1355

See Humana Health Care Plans under Kentucky.

Humana Health Plan Inc.

101 Prosperous Place, Suite 300, Lexington, Ky. 40509; 606-254-2731

See Humana Health Care Plans under Kentucky.

MetLife HealthCare Network Kentucky Inc.

10509 Timberwood Circle, Suite 200, Louisville, Ky. 40223-5301; 502-423-3900

Operational date: December 1985.
Certified in: Kentucky and Indiana.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 382 primary physicians; 814 specialists.
Facilities: 25 hospitals.
Service area: 28 counties in Kentucky. Clark, Floyd and Harrison counties in Indiana.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class; experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided monthly, quarterly or semiannually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Steve Linehan, president.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



CIGNA Healthplan of Baton Rouge Inc.

Two United Plaza, 8550 United Plaza Blvd., Suite 700, Baton Rouge, La. 70809-2256; 504-922-4260

Operational date: March 1986.
Federally qualified.
Certified in: Mississippi and Louisiana.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 139 primary physicians; 443 specialists; nine administrative staff members; six marketing staff members; 136 patients per physician; 57% board certified physicians.
Facilities: 17 hospitals; one pharmacy; six diagnostic labs.
Service area: Ascension, Assumption, East Feliciana, Iberville, Point Coupre, St. Helena, St. James, Tangipahoa, West Baton Rouge and West Feliciana parishes in Louisiana; Amite, Pike and Wilkinson counties in Mississippi.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 63 employer/payer groups; 2,510 employees with single coverage; 4,201 employees with family coverage. Hospital stay averages 3.4 days. 105.4 admissions per 1,000 members.

Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Charles C. Neff, general manager; Dr. O.M. Thompson Jr., medical director; Caswell Fitzpatrick, sales director.

CIGNA Healthplan of Northern Louisiana Inc.

One Bellemead Centre, Suite 200, 6425 Youree Drive, Shreveport, La. 71105-4644; 318-798-4700

Operational date: September 1984.
Federally qualified.
Certified in: Louisiana.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 35 primary physicians; 53 specialists; seven administrative staff members; three marketing staff members; 578 patients per physician; 85% board certified physicians.
Facilities: Six hospitals; five pharmacies.

Service area: Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine and Webster parishes in Louisiana.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 36 employer/payer groups; 2,498 employees with single coverage; 3,486 employees with family coverage; 19,483 employees and dependents. Hospital stay averages 3.3 days. 83.2 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Charles C. Neff, general manager; Dr. Charles Knight Sr., medical director; D'Juana Moreno, sales director.

Maxicare Louisiana Inc.

Two Lakeway Center, 3850 N. Causeway Blvd., Suite 900, Metaire, La. 70002; 504-836-2022

See Maxicare Health Plans Inc. under California

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Travelers Health Network

Galleria One, Suite 2100, Galleria Blvd., Metairie, La. 70001; 504-836-5505

Operational date: September 1985.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 116 primary physicians; 535 specialists; 30 administrative staff members; six marketing staff members; 150 patients per physician; 80% board certified physicians.
Facilities: 15 hospitals; one pharmacy; one diagnostic lab.
Service area: Plaquemines, Orleans, Jefferson, St. Tammany, St. Bernard and St. John parishes in Louisiana.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse, durable medical equipment. Psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 106 employer/payer groups; 11,375 employees with single coverage; 6,125 employees with family coverage; 18,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 81.4 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Drs. Terry Sutton, Frank Barham and R. Dennis Collins, medical directors.



HMO Maine

P.O. Box 8883, Portland, Maine 04104; 207-856-6196

Operational date: December 1985.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Maine.
Service area: Franklin, Kennebec, Sagadahoc, Androscoggin, York, parts of Cumberland, Lincoln, Oxford, Somerset and Waldo counties in Maine.
Users: 10,894 employees and dependents as of June 1989.

Healthsource Maine Inc.

30 U.S. Route 1, Yarmouth, Maine 04096; 207-846-6430

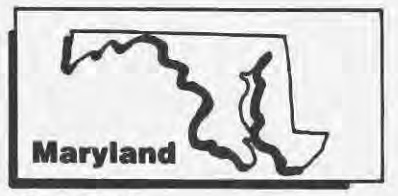
Operational date: April 1987.
Federally qualified.
Certified in: Maine.
Model type: IPA.
For profit.
Sponsorship: Doctors.
Staff: 165 primary physicians; 322 specialists; 20 administrative staff members; four marketing staff members; 42 patients per physician; 100% board certified physicians.
Facilities: 11 hospitals; 80 pharmacies; six diagnostic labs.
Service area: Maine.
Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $123.44 single, $308.67 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 75 employer/payer groups; 1,413 employees with single coverage; 1,651 employees with family coverage; 7,010 employees and dependents; 9,060 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 337 admissions per 1,000 members.
Management Reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $4 million in 1988; $6.8 million estimated for 1989.
Officers: Dr. David Schall, president; Richard White, executive director; Dr. Peter McGuire, medical director; Nancy Connelie, marketing director; Dr. David Haskell, vp; Dr. Mervyn Cooper, treasurer.

Wellcare of New England Inc.

75 John Roberts Rd. 51-C, South Portland, Maine 04106; 207-773-6994

See Lincoln National Health Plan under Indiana (as of March 1, 1990, plan name changes to Lincoln National Health Plan).



CareFirst

7939 Honeygo Blvd., Baltimore, Md. 21236; 301-529-2500

Operational date: November, 1977.
Federally qualified.
Certified in: Maryland.
Model type: Network.

Continued on next page

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For profit.
Sponsorship: HealthCare Corp. of America.
Staff: 192 primary physicians; 745 specialists; 109 administrative staff members; eight marketing staff members; 140 patients per physician; 67% board certified physicians.
Facilities: 24 hospitals; more than 800 pharmacies; 10 diagnostic labs.
Service area: Baltimore, Carroll, Cecil, Harford, Howard, Montgomery, Prince Georges, Frederick, Washington, Calvert, St. Mary's, Charles and Anne Arundel counties in Maryland; District of Columbia.
Locations: One administrative site, 43 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $86.69 single, $312.09 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 914 employer/payer groups; 21,659 employees with single coverage; 29,166 employees with family coverage; 111,209 employees and dependents; 114,240 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days. 73.3 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $83 million in 1988; $95 million estimated for 1989.
Officers: David D. Wolf, president; Dr. Jose Martinez, medical director; Richard A. Capizzi, marketing director; G. Mark Chaney, chief financial officer; James M. Turnock, secretary.

CIGNA Healthplan of Maryland Inc.

9700 Patuxent Woods Drive, Columbia, Md. 21046; 301-720-5800

Operational date: December 1986.
Federally qualified.
Model type: Maryland, District of Columbia and Virginia.
For profit.
Sponsorship: CIGNA Corp.
Staff: 450 primary physicians; 1,406 specialists; 23 administrative staff members; seven marketing staff members; 104 patients per physician; 80% board certified physicians.
Facilities: 26 hospitals; four pharmacies; one diagnostic lab.
Service area: Alexandria, Falls Church, Loudoun, Prince William and Arlington counties in Virginia. Baltimore, Fairfax, Howard, Prince Georges, Anne Arundel, Calvert, Carroll, Frederick, Charles, Hartford and Montgomery counties in Maryland. District of Columbia.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 397 employer/payer groups; 12,701 employees with single coverage; 12,621 employees with family coverage; 52,316 employees and dependents. Hospital stay averages 4.2 days. 277 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Bruce H. Sturm, general manager; Dr. James Springrose, medical director; El Kenyon, sales director.

Columbia-FreeState Health System

2 Knoll N. Drive, Columbia, Md. 21230; 301-539-8622

Operational date: October 1969.
Federally qualified.
Model type: Mixed network.
For profit.
Sponsorship: Blue Cross & Blue Shield of Maryland Inc.
Service area: Baltimore and Harford counties in Maryland; Central Maryland, Howard, Anne Arundel, Carroll, Montgomery and Prince Georges counties.
Users: 171,474 employees and dependents as of June 1989.

Healthplus Inc.

6611 Kenilworth Ave., Suite 300, Riverdale, Md. 20737; 301-927-3000

Operational date: September 1975.
Federally qualified.
Certified in: Maryland, Virginia and District of Columbia.
Model type: IPA.
For profit.
Sponsorship: Physician Health Services Foundation and Sanus Corp. Health Systems.
Staff: 605 primary physicians; 1,775 specialists; 122 administrative staff members; 15 marketing staff members; 185 patients per physician; 80% board certified physicians.
Facilities: 41 hospitals; 350 pharmacies; one diagnostic lab.
Service area: Prince Georges, Montgomery, Frederick, Howard, Anne Arundel, Calvert and Charles counties in Maryland. Arlington, Fairfax, Loudoun and parts of Prince William counties and the city of Alexandria, Va. District of Columbia.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $84.27 single, $257.04 family; by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 853 employer/payer groups; 51,695 employees with single or family coverage; 114,478 employees and dependents; estimated 126,000 enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 353 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $80.1 million in 1988; $107 million estimated for 1989.
Officers: Joseph Lynaugh, president; Jeff D. Emerson, executive director; Dr. David Anders, medical director; Douglas Hoffman, marketing director; Virginia M. Dollard, chief operating officer; Nannette G. Henderson, chief financial officer.

The Johns Hopkins Health Plan

1000 E. Eager St., Baltimore, Md. 21214; 301-522-9800

Operational date: October 1984.
Federally qualified.
Certified in: Maryland.
Model type: IPA.
Not for profit.
Sponsorship: Johns Hopkins Health System.
Staff: 154 primary physicians; 1,099 specialists; 320 administrative staff members; 90 marketing staff members; 85% board certified physicians.
Facilities: 22 hospitals; 87 pharmacies.
Service area: Baltimore, Anne Arundel, Carroll, Cecil, Harford, Howard, Montgomery, Prince Georges, Frederick and Washington counties in Maryland; District of Columbia.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 500 employer/payer groups; 61,174 employees and dependents; 95,251 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 6.3 days.
Management reports: Provided quarterly.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $49.7 million in 1988.
Officers: Barbara B. Hill, Dr. William Pawlick, vp; Deborah Origer, vp; Ancelmo Lopes, Juan Osler and Glen Steinbach, vps.

Lincoln National Health Plan Inc.

7200 Wisconsin Ave., Suite 801, Bethesda, Md. 20814; 301-986-0222

See Lincoln National Health Plan under Indiana.

PHN-HMO Inc.

5700 Executive Drive, Suite 104, Baltimore, Md. 21228; 301-747-9060

Operational date: January 1987.
Certified in: Maryland.
Model type: Network.
For profit.
Staff: 600 primary physicians; 610 specialists; 60 administrative staff members; eight marketing staff members; 31.3 patients per physician; 70% board certified.
Facilities: Six hospitals; 200 pharmacies; 10 diagnostic labs.
Service area: Baltimore, Anne Arundel, Howard, Carroll and Harford counties in Maryland.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by age/sex, experience rating.
Enrollment options: Individual enrollment not allowed.
Users: 68 employer/payer groups; 16,000 employees and dependents; 18,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days.
Management reports: Provided quarterly.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $9.2 million in 1988; $20 million estimated for 1989.
Officers: Peter S. O'Donnell, president; Dr. Sheldon Milner, medical director; Elizabeth Dana, marketing director; Michael P. Landymore, vp-finance; Jane E. Stafford, vp-operations; Marianne Panzini, vp-medical services.

Potomac Health

7939 Honeygo Blvd., Baltimore, Md. 21236; 301-529-2500

Operational date: 1983.
Certified in: Maryland.
Model type: Network.
For profit.
Sponsorship: HealthCare Corp. of America.
Staff: 81 primary physicians; 324 specialists; 109 administrative staff members; eight marketing staff members; 50 patients per physician; 51% board certified physicians.
Facilities: 24 hospitals; more than 800 pharmacies; 10 diagnostic labs.
Service area: Baltimore, Carroll, Cecil, Harford, Howard, Montgomery, Prince Georges, Frederick, Washington, Calvert, St. Marys, Charles and Anne Arundel counties in Maryland.
Locations: One administrative site, 18 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $101.18 single, $364.25 family; experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 130 employer/payer groups; 2,926 employees with single coverage; 5,181 employees with family coverage; 19,458 employees and dependents; 21,226 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.4 days. 66.4 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $6.2 million in 1988; $22 million estimated for 1989.
Officers: David D. Wolf, president; Dr. Jose Martinez, medical director; Richard A. Capizzi, marketing director; G. Mark Chaney, chief financial officer; James M. Turnock, secretary.



Berkshire Health Plan

395 Smith St., Pittsfield, Mass. 01201; 413-499-4009

Operational date: October 1984.
Certified in: Massachusetts.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Staff: 69 primary physicians; 135 specialists; 10 administrative staff members; marketing staff provided by sponsor.
Facilities: Four hospitals; 39 pharmacies; three diagnostic labs.
Service area: Berkshire County in Massachusetts; contiguous counties in Connecticut and Vermont.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $125.13 single, $325.34 family; by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 4,321 employees with single coverage; 4,879 employees with family coverage; 20,822 employees and dependents; 22,032 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days. 393 admissions per 1,000 members.
Management reports: May be provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $21.7 million in 1988; $22.6 million estimated for 1989.
Officers: Susan M. Babin, executive director; Dr. Rosario Noto, medical director; Barbara Tierney, marketing director; Carole Henderson, plan administrator.

CIGNA Healthplan of Massachusetts Inc.

1350 Main St., 15th Floor, Springfield, Mass. 01103; 413-733-1177

Operational date: March 1986.
Federally qualified.
Certified in: Massachusetts.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 105 primary physicians; 447 specialists; 12 administrative staff members; seven marketing staff members; 168 patients per physician; 94% board certified physicians.
Facilities: Six hospitals; one pharmacy; 10 diagnostic labs.
Service area: Hampden, Hampshire and Worcester counties in Massachusetts.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 312 employer/payer groups; 3,473 employees with single coverage; 3,654 employees with family coverage; 16,987 employees and dependents. Hospital stay averages 3.8 days. 78 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Timothy P. Fitzgerald, general manager; Christine L. Short, sales director.

Community Health Plan

59 Interstate Ave. West Springfield, Mass. 01089; 413-736-8376.

See Community Health Plan under New York.

Harvard Community Health Plan Inc.

10 Brookline Place W., Brookline, Mass. 02146; 617-731-7470

Operational date: October 1969.
Federally qualified.
Certified in: Massachusetts, New Hampshire and Vermont.
Model type: Group and staff.
Not for profit.
Staff: 426 primary physicians; 1,087 specialists; 806 administrative staff members; 80 marketing staff members; 1,164 patients per primary physician; 80%-90% board certified physicians depending on model.
Facilities: 47 hospitals; 760 pharmacies; 12 diagnostic labs.

Continued on next page

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Service area: Essex, Middlesex, Suffolk, Norfolk, Plymouth and parts of Bristol, Berkshire, Franklin, and Worcester counties in Massachusetts; Rockingham and Hillsboro counties in New Hampshire.

Locations: Four administrative sites, 34 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, podiatry, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $124.47 single, $334.84 family; by class; by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 107,072 employees with single coverage; 77,629 employees with family coverage; 358,610 employees and dependents; 408,488 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.6 days. 69.8 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $427.1 million in 1988; $531.5 million estimated for 1989.

Officers: Thomas O. Pyle, president; Daniel O. Anderson, chief operating officer; John Ludden, medical director; George P. Russell, vp-marketing; Maurice Lazarus, chairman; David Chin Jr., president/medical director-health centers division; Daniel Kaplan, president-medical groups division; William F. Frado Jr., vp-general counsel/secretary/clerk; Edward E. White Jr. and Roger A Moore, assistant secretaries/assistant clerks; Glenn Hackbarth, vp-policy/planning; Donald Berwick, vp-quality of care measurement; Miles Coverdale, vp-chief financial officer; Marcia K. Hoch, vp-professional programs; Robert Giroux, vp-human resources; Harold E. Putnam Jr., vp/treasurer; James C. Lewis, vp-information services; Alan Raymond, vp-public affairs; Stephen C. Schoenbaum, deputy medical director; Burt P Johnson, Louise Liangand and Roger Platt, associate medical directors.

Kaiser Foundation Health Plan of Massachusetts Inc.

100 University Drive, Amherst, Massachusetts 01002; 413-256-0151

See Kaiser Permanente Medical Care Program corporate listing under California

Lahey Clinic Blue Cross & Blue Shield Health Maintenance Plan

One Alewife Center, Cambridge, Ma. 02140; 800-448-2992

Operational date: November 1980.
Certified in: Massachusetts.
Model type: Group.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Staff: 25 primary physicians; 178 specialists; four administrative staff members; 99% board certified physicians.
Facilities: 11 hospitals; labs provided by Lahey Clinic.
Service area: Essex, Middlesex and Norfolk counties in Massachusetts.
Locations: Two administrative sites, one primary care site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO.
Rating options: Community rating: $140.19 single, $378.51 family; by class; by age/sex.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 6,845 employees with single coverage; 5,427 employees with family coverage; 22,539 employees and dependents; 22,461 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.1 days. 78 admissions per 1,000 members.
Management reports: May be provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $35.2 million in 1988; $36.1 million estimated for 1989.
Officers: Susan M. Babin, executive director; Dr. Marvin Wool, medical director; William R. Hickey, marketing manager; Janet May, plan administrator.

Medical East Community Health Plan

45 Bristol Drive, South Easton, Mass. 02375; 508-559-7250

Operational date: October 1982.
Federally qualified.
Certified in: Massachusetts.
Model type: Staff and group.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Staff: 84 primary physicians; 364 specialists; 217 administrative staff members; 50 marketing staff members; 1,036 patients per physician; 98% board certified physicians.
Facilities: 76 hospitals.
Service area: Essex, Sussex, Middlesex, Norfolk, Bristol and Plymouth counties in Massachusetts; Rockingham and Hillsborough counties in New Hampshire.
Locations: Seven administrative sites, eight primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO.
Rating options: Community rating: $133.43 single, $352.25 family; by class.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 2,600 employer/payer groups; 23,140 employees with single coverage; 16,317 employees with family coverage; 78,569 employees and dependents; 87,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days. 83.2 admissions per 1,000 members.
Management reports: May be provided.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $96.3 million in 1988; $120.5 million estimated for 1989.
Officers: T.L. Huston, president; W.A. Schlag, executive director; Dr. F.W. Schultz, medical director; J. Kane III, marketing director; Ronald K. Davy, regional executive director.

Medical West Community Health Plan

444 Montgomery St., Chicopee, Mass. 01020; 413-594-3111

Operational date: October 1978.
Federally qualified.
Model type: Mixed network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Service area: Hampden and Hampshire counties in Massachusetts.
Users: 154,601 members, when combined with Medical East, as of June 1989.

MetLife HealthCare Network of Massachusetts

120 Royall St., Canton, Mass. 02021; 617-821-2620

Year founded: March 1987.
Certified in: Massachusetts.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 335 primary physicians; 416 specialists.
Facilities: Eight hospitals.
Service area: Middlesex, Suffolk, Plymouth, Bristol, Essex and Norfolk counties in Massachusetts.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Deepak Jahagirdar, president.

Montachusett Health Plan

285 Central St., Leominster, Mass. 01453; 508-534-4100

Operational date: February 1984.
Certified in: Massachusetts and New Hampshire.
Model type: IPA.
Not for profit.
Sponsorship: Burbank Hospital and Blue Cross & Blue Shield of Massachusetts.
Staff: 28 primary physicians; 79 specialists; four administrative staff members; four marketing staff members; 277 patients per physician; 100% board certified physicians.
Facilities: Two hospitals; 54 pharmacies; two diagnostic labs.
Service area: Northern Worcester County in Massachusetts; portions of New Hampshire
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $139.54 single, $337.22 family.
Users: 565 employer/payer groups; 1,489 employees with single coverage; 1,839 employees with family coverage; 7,846 employees and dependents; 7,575 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.9 days. 82.8 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $9.1 million in 1988; $9.1 million estimated for 1989.
Officers: William Williams, president; Susan Babin, executive director; Dr. Robert Roy, medical director; Debra Kelliher, marketing director.

North Shore Health Plan

One Alewife Center, Cambridge, Mass. 02140; 617-956-3749

Operational date: May 1985.
Certified in: Massachusetts.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Staff: 51 primary physicians; 128 specialists; eight administrative staff members; 69% board certified physicians.
Facilities: 11 hospitals; chain of pharmacies; affiliated hospitals provide diagnostic labs.
Service area: Essex and Middlesex counties in Massachusetts.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $140.32 single, $364.83 family; by class; by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 2,786 employees with single coverage; 2,119 employees with family coverage; 9,824 employees and dependents; 9,924 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days. 90 admissions per 1,000 members.
Management reports: May be provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $8 million in 1988; $11.5 million estimated for 1989.
Officers: Susan M. Babin, executive director; William R. Hickey, marketing director; Janet May, plan administrator.

Pilgrim Health Care Inc.

10 Accord Executive Drive, P.O. Box 200, Norwell, Mass. 02061; 617-871-3950

Operational date: April 1981.
Federally qualified.
Certified in: Massachusetts and Rhode Island.
Model type: IPA.
Not for profit.
Sponsorship: Pilgrim Foundation.
Staff: 829 primary physicians; 1,831 specialists; 254 administrative staff members; 46 marketing staff members; 250 patients per physician; 100% board eligible or certified physicians.
Facilities: 52 hospitals; 337 pharmacies, including branches; seven diagnostic labs.
Service area: Barnstable, Bristol, Norfolk, Suffolk, Plymouth and portions of Essex, Middlesex and Worcester counties in Massachusetts. Providence, Newport and Bristol counties in Rhode Island.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups,

Continued on next page

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vision, dental (preventive for ages 3-11; oral surgery), substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $127.09 single, $330.45 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 3,175 employer/payer groups; 25,789 employees with single coverage; 30,216 employees with family coverage; 131,238 employees and dependents; 136,238 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 82.5 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $77.4 million in 1988; $137.1 million estimated for 1989.

Officers: Dr. Edward A. Pollard, president; Allan Greenberg, chief executive officer; Dr. Samuel K. Steward, medical director; Patricia L. Callahan, vp; Leslie Sutherland, treasurer; Glen Johnson, secretary; Dr. Gilbert Shapiro, vp.

Western Massachusetts Health Plan

1 Roundhouse Plaza, Northampton, Mass. 01060; 413-586-9161

Operational date: July 1986.
Certified in: Massachusetts.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Staff: 34 primary physicians; 73 specialists; 15 administrative staff members.
Facilities: Three hospitals; chain of pharmacies; four diagnostic labs.
Service area: Franklin, Hampshire and Hampden counties in Massachusetts.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $126.51 single, $328.93 family; by class; by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 2,057 employees with single coverage; 2,191 employees with family coverage; 9,320 employees and dependents; 12,277 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.5 days. 73 admissions per 1,000 members.
Management reports: May be provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $6.5 million in 1988; $11.7 million estimated for 1989.
Officers: Susan M. Babin, executive director; Dr. Donald Abel, medical director; Barbara Tierney, marketing manager; Margherite Tonelli, plan administrator.



Blue Care Network of East Michigan

4200 Fashion Square Blvd., Saginaw, Mich. 48603; 517-791-3200

Operational date: July 1976.
Federally qualified.
Model type: Mixed network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Michigan.
Service area: Genesee, Lapeer, Shiwassee, Saginaw, Bay, Isabella and Tuscola counties in Michigan.
Users: 73,404 employees and dependents as of June 1989.

Blue Care Network-Great Lakes

611 Cascade W. Parkway S.E., Grand Rapids, Mich. 49506; 616-957-5057

Operational date: March 1982.
Federally qualified.
Model type: Mixed: group and network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Michigan.
Service area: Eastern upper peninsula and lower northern Michigan; Battle Creek, Benton Harbor, Grand Rapids, Kalamazoo, Muskegon and St. Joseph counties in Michigan.
Users: 119,220 employees and dependents as of June 1989.

Blue Care Network-Health Central

1403 S. Creyts Road, Lansing, Mich. 48917; 517-322-8000

Operational date: October 1977.
Federally qualified.
Certified in: Michigan.
Model type: Network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Michigan.
Staff: 90 primary physicians; 272 specialists; four marketing staff members plus support from sponsor; 96% board certified physicians.
Facilities: 10 hospitals; pharmacies participating with sponsor; six diagnostic labs.
Service area: Ingham, Clinton, Jackson, Eaton and Livingston counties in Michigan.
Locations: One administrative site, 43 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include experimental procedures, prescription drugs, vision, dental, podiatry. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $98.16 single, $255.21 family; experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 707 employer/payer groups; 9,048 employees with single coverage; 15,925 employees with family coverage; 63,232 employees and dependents; 67,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.6 days. 62.2 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $65.6 million in 1988; $79.1 million estimated for 1989.
Officers: William J. Braman, chairman; Lee Lich, executive director; Dr. Geoffrey Linz, medical director; Robert Heintz, marketing director; Joseph Pirch, director-administration/treasurer; Deanna Kramp, director-health care services.

Blue Care Network of Southeast Michigan

27000 W. 11 Mile, Southfield, Mich. 48085; 313-354-7450

Operational date: May 1981.
Federally qualified.
Certified in: Michigan.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Michigan.
Staff: 558 primary physicians; 669 specialists; 168 administrative staff members; four marketing staff members.
Facilities: 44 hospitals.
Service area: Wayne, Oakland, Macomb, Washtenaw and Monroe counties in Michigan.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services, durable medical equipment, podiatry may be standard or optional.
Rating options: Community rating: $131.65 single, $327.94 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 813 employer/payer groups; 20,142 employees with single coverage; 26,585 employees with family coverage; 111,183 employees and dependents; 107,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.61 days. 385 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $169 million in 1988; $137 million estimated for 1989.
Officers: Janet B. Ofodile, executive director; Robert E. Church, medical director; Norma J. Hollis, marketing director; Marilyn Ogg, finance director.

Comprehensive Health Services Inc./The Wellness Plan

6500 John C. Lodge, Detroit, Mich. 48202; 313-875-9355

Operational date: November 1972.
Federally qualified.
Certified in: Michigan.
Model type: Mixed.
Not for profit.
Sponsorship: Independent.
Staff: 130 primary physicians; 124 specialists; 75 administrative staff members; 17 marketing staff members; 551 patients per physician.
Facilities: 28 hospitals; 500 pharmacies; 150 diagnostic labs.
Service area: Genesee, Macomb, Monroe, Muskegon, Oakland, Ottawa and Wayne counties in Michigan.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, durable medical equipment. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $102.85 single, $267.40 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 214 employer/payer groups; 2,783 employees with single coverage; 3,287 employees with family coverage; 14,261 employees and dependents; 14,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.45 days. 350 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $54.5 million in 1988; $62.7 million estimated for 1989.
Officers: Ellis J. Bonner, president; James W. Patton, executive director; Dr. N.S. Rangarajan, medical director; Robert B. Low, marketing director; Brian W. Davis, first vp-new business development; Lawrence T. Mathews, vp-financial operations.

Delta Care

Delta Dental Plan of Michigan, P.O. Box 30416, Lansing, Mich. 48909; 517-349-6000

Operational date: 1987.
Model type: IPA and network.
Not for profit.
Sponsorship: Delta Dental Plan of Michigan.
Staff: 168 primary dentists; 15 specialists; plan is administered by sponsor.
Service area: Michigan.
Locations: Two administrative sites.
Services: Standard package includes dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Four employer/payer groups; 728 employees with single coverage; 2,059 employees with family coverage; 8,361 employees and dependents; 9,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Delta Dental Plan of Michigan: Patrick P. Gribben Jr., president; E. Craig Lesley, marketing director; C. Richard Seitz, senior vp-marketing/external affairs.

DENCAP Dental Plans-Dental Maintenance Organization

7600 Second Ave., Detroit, Mich. 48202-2402; 313-972-1400

Operational date: September 1984.
Certified in: Michigan.
Model type: IPA.
For profit.
Sponsorship: Private.
Staff: 135 primary physicians; 35 specialists; eight administrative staff members; 14 marketing staff members; 96 patients per physician; 100% board certified physicians.
Service area: Wayne, Oakland, Macomb, Washtenaw, Lapeez, Genesee, Livingston, Ingram, Kalamazoo, St. Joseph, Lass and Van Buren counties in Michigan.
Locations: One administrative site.
Services: Standard package includes X-ray, preventive medicine, outpatient, experimental procedures, periodic check-ups, dental. Diagnostic testing and lab work performed in HMO facilities.
Rating options: By age/sex; experience rating.

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THE FAST TRACK TO A COMEBACK

Continued from previous page

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 68 employer/payer groups; 13,000 employees and dependents; 14,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided monthly.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: Not reported.

Officers: Joseph T. Lentine, president; Dr. James Feldman, medical director; James Gresham, marketing director.

Grand Valley Health Plan

4550 Cascade Road S.E., Grand Rapids, Mich. 49506; 616-949-2410

Operational date: December 1981.
Certified in: Michigan.
Model type: Staff and group.
For profit.
Sponsorship: Independent.

Staff: Eight primary physicians; 114 specialists; 28 administrative staff members; six marketing staff members; 1,000 patients per physician; 100% board certified physicians.

Facilities: Three hospitals.

Service area: Kent, Ottawa and Allegan counties in Michigan.

Locations: One administrative site, six primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, limited psychiatric services, limited durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed in the HMO facilities.

Rating options: Community rating, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 169 employer/payer groups; 3,170 employees with single coverage; 4,561 employees with family coverage; 17,937 employees and dependents; 19,250 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.4 days. 259.8 admissions per 1,000 members.

Management reports: Limited reports provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $11.9 million in 1988; $14.5 million estimated for 1989.

Officers: Roland F. Palmer, president; Dr. James T. Kirby, medical director; Thomas F. Ferraro, marketing director.

Mercy Alternative

34605 Twelve Mile Road, Farmington Hills, Mich. 48331; 313-489-6203

Operational date: January 1985.
Certified in: Michigan, Iowa and Indiana.
Model type: IPA.
Not for profit.
Sponsorship: Religious Sisters of Mercy and Mercy Health Services.

Staff: 550 primary physicians; 790 specialists; 184 administrative staff members; 12 marketing staff members; 551 patients per physician; 95% board certified physicians.

Facilities: 18 hospitals; 250 pharmacies.

Service area: Kent, Allegan, Ottowa, Ionia, Ingham, Eaton, Clinton, Shiawassee, Oceana, Newago, Muskegon, Washtenaw, Livingston and Wayne counties in Michigan; 16 counties in Iowa.

Locations: Five administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs, vision, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating; by class; by age/sex.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 750 employer/payer groups; 101,020 employees and dependents; 107,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.3 days.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $91.8 million estimated for 1989.

Officers: Dr. Richard P. Dorr, president; Phillip A. Little, executive vp/chief operating officer; Dr. Charles E. Morrill, medical director; Kimberly K. Horn, vp-corporate services/chief financial officer; Bruce A. Jacobs, vp-plan management.

MIDA Dental Plans Inc.

2000 Town Center, Suite 2200, Southfield, Mich. 48075; 313-353-6410

Operational date: 1981.
Certified in: Michigan, Ohio, Kentucky, Indiana, Missouri, Delaware and California.
Model type: IPA.
For profit.
Sponsorship: Stock ownership.

Staff: 1,223 primary dentists; 300 specialists; five marketing staff members; 492 patients per physician.

Service area: Michigan, Ohio, Indiana, Kentucky, Missouri, California, Pennsylvania, Virginia, Maryland, Delaware, Massachusetts, Georgia and District of Columbia.

Locations: Nine administrative sites.

Services: Standard package includes dental. Options include vision. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating; experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 1,207 employer/payer groups; 625,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided quarterly or annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. Walter Knysz Jr., president; Dr. Steven Patterson, dental director; Kenneth F. Bannon, Janet Oleszkowica and Phillip J. O'Brien.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Health Plan Inc.

309 N. Washington Square, Lansing, Mich. 48933; 517-484-7700

Operational date: October 1981.
Federally qualified.
Certified in: Michigan.
Model type: IPA.
Not for profit.

Staff: 616 primary physicians; 867 specialists; 125 administrative staff members; 17 marketing staff members; 200 patients per physician; 90%-95% board certified physicians.

Facilities: 32 hospitals; 322 pharmacies; 50 diagnostic labs.

Service area: 20 counties in Michigan.

Locations: Four administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 750 employer/payer groups; 101,020 employees and dependents; 107,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.3 days.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $106 million in 1988; $120 million estimated for 1989.

Officers: James M. Savage, president; Henry A. Boyd, executive vp/chief operating officer; Dr. James C. Askins, secretary/treasurer.

Physicians Health Plan of West Michigan Inc.

880 First St., Suite 501, Muskegon, Mich. 49440; 616-728-3900

Operational date: May 1984.
Federally qualified.
Certified in: Michigan.
Model type: IPA.
Not for profit.
Sponsorship: Hackley Hospital.

Staff: 119 primary physicians; 166 specialists; 18 administrative staff members; two marketing staff members; 171 patients per physician; 92% board certified physicians.

Facilities: Nine hospitals; 79 pharmacies; 10 diagnostic labs.

Service area: Muskegon, Ottawa, Oceana and Newaygo counties in Michigan.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 183 employer/payer groups; 2,353 employees with single coverage; 4,142 employees with family coverage; 20,344 employees and dependents; 7,538 estimated employees enrolled as of Jan. 1, 1990. Hospital stay averages five days. 65 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $15 million in 1988; $18.3 million estimated for 1989.

Officers: Ronald S. Franzese, president; Dr. Wayne L. Brenneman, medical director; David E. Young, marketing director.

Total Health Care Inc.

2500 Fisher Building, Detroit, Mich. 48202; 313-871-2000

Operational date: March 1976.
Federally qualified.
Certified in: Michigan.
Model type: IPA.
Not for profit.
Sponsorship: Independent.

Staff: 119 primary physicians; 40 specialists; additional specialists available for referral; 18 administrative staff members; nine marketing staff members; 150 patients per physician; 72% board certified physicians.

Facilities: 46 hospitals; more than 200 pharmacies.

Service area: Wayne, Oakland and Macomb counties in Michigan.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, outpatient psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, durable medical equipment, hearing aids, skilled nursing facility, orthotics and prosthetics, inpatient psychiatric services. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $105.67 single, $264.18 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 228 employer/payer groups; 860 employees with single coverage; 1,152 employees with family coverage; 4,814 employees and dependents; 5,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.97 days. 413 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $3.3 million in 1988; $4.3 million estimated for 1989.

Officers: Kenneth G. Rimmer, executive director; Dr. Robyn Arrington, medical director.



Blue Plus

3535 Blue Cross Road, P.O. Box 64179, St. Paul, Minn. 55164; 612-456-8000

Operational date: September 1974.
Federally qualified.
Model type: Mixed: group and network.
Sponsorship: Blue Cross & Blue Shield of Minnesota.
Service area: Eleven counties surrounding St. Paul and Minneapolis.
Users: 93,025 employees and dependents as of June 1989.

First Plan HMO

1620 London Road, Duluth, Minn. 55812; 218-724-3083

Operational Date: 1944.
Certified in: Minnesota.
Model type: Staff and network.
Not for profit.

Staff: 75 primary physicians; 165 specialists; 10 administrative staff members; three marketing staff members; 120 patients per physician.

Facilities: Five hospitals; 35 pharmacies.

Service area: St. Louis, Carlton and Lake counties in Minnesota.

Locations: Two administrative sites, 15 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $85-$100 single, $250-$325 family; by age/sex; experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 60 employer/payer groups; 9,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $7.5 million in 1988; $9.4 million estimated for 1989.

Officers: Milt Laisen, president; Steve Bjorum, executive director; Douglas Hiza, medical director; Earl Hamilton, marketing director.

NWNL Health Network Inc.

1295 Bandana Blvd. N., Atrium Building, Suite 220, St. Paul, Minn. 55108; 612-647-0305

Operational date: October 1984.
Certified in: Minnesota.
Model type: Network.
Not for profit.
Sponsorship: Northwestern National Life Insurance Co.

Staff: 245 primary physicians; 1,082 specialists; 39 administrative staff members; four marketing staff members; 25 patients per physician: 98% board certified physicians.

Facilities: 20 hospitals; 134 pharmacies; one diagnostic lab.

Service area: Anoka, Ramsey, Scott, Carver, Dakota, Washington and Hennepin counties in Minnesota.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $90 single, $240 family; by age/sex; experience rating.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 37 employer/payer groups; 3,556 employees with single coverage; 639 employees with family coverage; 5,850 employees and dependents; 10,400 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 242 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $16 million in 1988; $16 million estimated for 1989.

Officers: James D. Lauer, president; Dr. J. Bryan Warren, medical director; Dan Boos, vp-marketing; Margaret Liedholm, vp-operations; Cecelia Manlove, vp-health services; Michael Cornelison, controller.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Health Plan of Minnesota (PHP)

5601 Smetana Drive, P.O. Box 1587, Minneapolis, Minn. 55440; 612-936-1200

Operational date: 1974.
Certified in: Minnesota.
Model type: IPA.
Not for profit.

Staff: 2,111 primary physicians; 1,424 specialists; 300 administrative staff members; 50 marketing staff members.

Facilities: 74 hospitals; 564 pharmacies; eight diagnostic labs.

Service area: 38 counties in Minnesota.

Locations: Five administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By age/sex; experience rating.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 2,517 employer/payer groups; 104,797 employees with single coverage; 43,221 employees with family coverage; 183,265 employees and dependents; 317,640 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4 days. 68 admissions per 1,000 members.

Management reports: Provided monthly, quarterly or annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $364.8 million in 1988; $384 million estimated for 1989.

Officers: Dr. K. James Ehlen, chief executive officer/chairman; P. Robert Larson, chief operating officer; Dr. Allan J. Chernov, medical direc-

Continued on next page

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tor/vp-medical affairs; Arnold B. Hebert, vp-sales; Dennis Reese, vp-finance/administration; James W. Eppel, vp-network services; Joanne Sigstad, vp-medical management.

Share

3600 W. 80th, Bloomington, Minn. 55431; 612-830-3166

Operational date: June 1974.
Certified in: Minnesota.
Model type: Network.
Not for profit.
Sponsorship: Independent.
Staff: 517 primary physicians; 2,163 specialists; 285 patients per physician; 100% board certified physicians.
Facilities: 26 hospitals; 176 pharmacies.
Service area: Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, St. Louis, Scott and Washington counties in Minnesota; St. Croix and Pierce counties in Wisconsin.
Locations: One administrative site, 72 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: By age/sex.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 387 employer/payer groups; 24,935 employees with single coverage; 22,668 employees with family coverage; 99,524 employees and dependents. Hospital stay averages 3.61 days. 68 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $211.3 million in 1988.
Officers: Ted W. LaBedz, president; Dr. Edward Spenney, medical director; John Tadich, marketing director; Pamela Shaw, vp-finance/administration; Joyce Kenny, vp-medical delivery.



BlueChoice

4444 Forest Park, St. Louis, Mo. 63166-6828; 314-289-6201
1989.
Operational date: August 1988.
Federally qualified.
Certified in: Missouri and Illinois.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Missouri.
Staff: 204 primary physicians; more than 900 specialists; 32 administrative staff members; 16 marketing staff members; 98% board certified physicians.
Facilities: 18 hospitals; three pharmacy chains.
Service area: St. Louis, Jefferson, Franklin, St. Charles and Gasconade counties in Missouri; Madison and St. Clair counties in Illinois.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 400 employer/payer groups; 33,000 employees and dependents; 41,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.7 days. 342 admissions per 1,000 members.
Management reports: Provided quarterly.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Sy Kaplan, president; Randy Cupp, chief operating officer; Dr. Jim Coates, medical director; Ted Christianson, vp-sales; Eleanor Bencic, vp-operations.

CIGNA Healthplan of Kansas City

12 Wyandotte Plaza, 120 W. 12th St., Suite 810, Kansas City, Mo. 64105; 816-842-7833

Operational date: July 1986.
Federally qualified.
Certified in: Missouri and Kansas.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 300 primary physicians; 869 specialists; 14 administrative staff members; five marketing staff members; 139 patients per physician.
Facilities: 13 hospitals; one pharmacy; one diagnostic lab.

Service area: Cass, Clay, Jackson, Lafayette, Platte and Ray counties in Missouri. Douglas, Franklin, Johnson, Leavenworth, Miami and Wyandotte counties in Kansas.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 152 employer/payer groups; 8,507 employees with single coverage; 8,720 employees with family coverage; 46,037 employees and dependents. Hospital stay averages 4.2 days. 82 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Stuart P. Scheller, sales director.

CIGNA Healthplan of St. Louis

8182 Maryland Ave., Suite 301, Clayton, Mo. 63105; 314-726-7860

Operational date: January 1986.
Federally qualified.
Certified in: Missouri and Illinois.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 317 primary physicians; 1,116 specialists; six administrative staff members; 10 marketing staff members; 74 patients per physician.
Facilities: 17 hospitals; two pharmacies; one diagnostic lab.
Service area: Franklin, Jefferson, St. Charles and St. Louis counties in Missouri. Madison, Monroe and St. Clair counties in Illinois.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services,
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Continued from previous page
durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 24,756 employees and dependents.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dennis Edmonds, general manager; Dr. David Yontz, medical director; Ray Mulligan, sales director.

Group Health Plan Inc.

11475 Olde Cabin Road, St. Louis, Mo. 63141; 314-993-5955

Operational date: January 1982.
Federally qualified.
Certified in: Missouri and Illinois.
Model type: Staff and network.
For profit.
Sponsorship: Independent.

Staff: 67 primary physicians; 72 specialists; 234 administrative staff members; 20 marketing staff members; 1,582 patients per physician; 75% board certified physicians.

Facilities: 10 hospitals; 16 pharmacies; one diagnostic lab.

Service area: St. Louis, Warren, St. Charles, Franklin, Jefferson, Ste. Genevieve, Crawford and Gasconade counties and part of Lincoln county in Missouri. Monroe, Madison, St. Clair, Jersey and Calhoun counties and part of Clinton and Macoupin counties in Illinois.

Locations: One administrative site, 14 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, durable medical equipment. Diagnostic testing and lab work performed by the HMO.

Rating options: Community rating: $100 single, $280 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 550 employer/payer groups; 37,825 employees with single coverage; 19,575 employees with family coverage; 106,590 employees and dependents; 103,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.78 days, without Medicare. 72 admissions per 1,000 members without Medicare.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $83 million in 1988; $108 million estimated for 1989.

Officers: Ron M. Lodder, president/chairman; Donald B. Smallwood, executive vp; Dr. Margarethe Hagemann, vp/medical director; Stephen Williams, vp-sales; William Ginnow, vp-health services; Pat Petersen, vp-policy/planning; Stephen Schaefer, vp/controller.

Lincoln National Health Plan Inc. of Missouri

721 Emerson Road, Suite 655, St. Louis, Mo. 63141; 314-991-3938

See Lincoln National Health Plan under Indiana.

MetLife HealthCare Network-St. Louis

14500 S. Outer 40, St. Louis, Mo. 63017; 314-542-1400

Operational date: January 1969.
Certified in: Missouri and Illinois.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.

Staff: 320 primary physicians; 846 specialists.

Facilities: 14 hospitals.

Service area: Franklin, Jefferson, St. Charles and St. Louis counties in Missouri; Madison, Monroe and St. Clair counties in Illinois.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class, experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Charles Stark, president.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Kansas City

1300 E. 104th St., Suite 320, Kansas City, Mo. 64131; 816-941-4500

Operational date: May 1986.
Certified in: Missouri and Kansas.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 246 primary physicians; 269 specialists; 30 administrative staff members; 11 marketing staff members; 125 to 200 patients per physician.

Facilities: 11 hospitals; 58 pharmacies; three diagnostic labs.

Service area: Johnson and Wyandotte counties in Kansas. Cass, Clay, Jackson and Platte counties in Missouri.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental.

Rating options: Community rating by age/sex; by class; by age/sex.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: Provided at least annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: John Kennedy, director-health care management; Dr. Joseph Palazola, medical director; Steven Miller, regional group manager.

PruCare of St. Louis

12312 Olive Blvd., Suite 500, Creve Coeur, Mo. 63141; 314-542-4500

Operational date: July 1985.
Federally qualified.
Certified in: Missouri.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 376 primary physicians; 424 specialists; 74 administrative staff members; 17 marketing staff members; 103 patients per physician; 88% board certified physicians.

Facilities: 18 hospitals; 88 pharmacies; 45 diagnostic labs.

Service area: Franklin, Jefferson, St. Charles and St. Louis counties in Missouri. Madison, Monroe, Randolph and St. Clair counties in Illinois.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating by age/sex; by class; by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 15,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 87 admissions per 1,000 members.

Management reports: Provided at least annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Richard F. Rivers, vp-group operations; Dr. Richard H. Fallon, medical director; James J. Gebhardt, marketing director; Paul C. Conlin, director-health care management.

Total Health Care

1 Pershing Square, 2301 Main, Kansas City, Mo. 64108

Operational date: October 1981.
Federally qualified.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Kansas City.

Service area: Cass, Clay, Jackson and Platte counties in Missouri; Johnson and Wyandotte counties in Kansas.

Users: 62,778 enrollees as of June 1989.



HMO Montana

P.O. Box 8004, Helena, Mont. 59604; 406-444-8200

Operational date: March 1987.
Certified in: Montana.
Model type: Mixed.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of Montana.

Facilities: Blue Cross & Blue Shield member hospitals; 75 pharmacies.

Service area: Lewis & Clark, Missoula, Cascade, Park, Gallatin, Flathead and Ravalli counties in Montana.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO.

Rating options: By age/sex, experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 3,200 employees and dependents; 3,600 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 2.8 days.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: Not reported.

Officers: Randy Cline, executive director; Dr. Jim Crichton, medical director; Lee Shannon, marketing director; Jim Myers, operations/finance.



Exclusive Healthcare Inc.

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-2700

Operational date: June 1988.
Certified in: Nebraska.
Model type: Network.
For profit.
Sponsorship: Mutual of Omaha.

Staff: 108 primary physicians; 650 specialists; 15 administrative staff members; 70 patients per physician; 80% board certified physicians.

Facilities: Eight hospitals; 100 pharmacies; 10 diagnostic labs.

Service area: Douglas and Sarpy counties in Nebraska.

Locations: One administrative site, 250 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 8,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 350 admissions per 1,000 members.

Management reports: Provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $6 million in 1988; $12 million estimated for 1989.

Officers: Dick L. Easley, president; Dr. Wesley Wilhelm, executive director/medical director.

HMO Nebraska Inc.

2421 S. 73rd St., Omaha, Neb. 68124; 402-392-2800

Operational date: September 1985.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Nebraska.

Service area: 16 counties in Nebraska.

Users: 20,447 enrollees as of June 1989.



Health Plan of Nevada Inc.

P.O. Box 15645, Las Vegas, Nev. 89114-5645; 702-646-8196

Operational date: August 1982.
Federally qualified.
Certified in: Nevada.
Model type: Group and network.
For profit.
Sponsorship: Sierra Health Services.

Staff: 55 primary physicians; 258 specialists; 13 administrative staff members; 25 marketing staff members; 1,200 patients per physician; 85% board certified physicians.

Facilities: 10 hospitals; 27 pharmacies; three diagnostic labs.

Service area: Clark and southern Nye counties in Nevada.

Locations: One administrative site, six primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include vision, dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $83.69-$95.31 single, $309.65-$352.65 family; by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 700 employer/payer groups; 13,921 employees with single coverage; 14,810 employees with family coverage; 59,673 employees and dependents; 70,300 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.1 days. 57 admissions per 1,000 members.

Management reports: Provided on a case-by-case basis.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $119.5 million in 1988; $97.2 million estimated for 1989.

Officers: Erin MacDonald, president; Larry Howard, chief operating officer; Dr. Charles E. Signorino, medical director; John Luna, marketing director; Tom Greeson, treasurer; Dr. Anthony Carter, vp.

Humana Medical Plan of Nevada Inc.

3107 S. Maryland Parkway, Las Vegas, Nev. 89109; 702-737-7211

See Humana Health Care Plans under Kentucky.



Healthsource New Hampshire

Donovan Street Extended, P.O. Box 2041, Concord, N.H. 03302-2041; 603-225-5077

Operational date: November 1985.
Federally qualified.
Certified in: New Hampshire, Maine, South Carolina, Massachusetts.
Model type: IPA.
For profit.
Sponsorship: Healthsource Physicians.

Staff: 306 primary physicians; 545 specialists; 81 administrative staff members; 12 marketing staff members; 123 patients per physician; 80% board certified physicians.

Facilities: 24 hospitals; 175 pharmacies; eight diagnostic labs.

Service area: Grafton, Carroll, Belknap, Sullivan, Merrimack, Strafford, Rockingham, Cheshire and Hillsborough counties in New Hampshire.

Locations: One administrative site.

Services: Package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $136.65 single, $368.97 family. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 350 employer/payer groups; 5,945 employees with single coverage; 9,908 employees with family coverage; 37,594 employees and dependents; 42,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.1 days. 85.4 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $41.5 million in 1988; $46 million estimated for 1989.

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Officers: Dr. Merwyn Bagan, president; Sally W. Crawford, executive director; Dr. John S. Argue, medical director; Donna Klop Lencki, marketing director; Norman Payson, chief executive officer-Healthsource Inc.



CIGNA Healthplan of New Jersey Inc..

Chesterbrook Corporate Center, 701 Lee Road, Suite 300, Wayne, Pa. 19087; 215-889-2300

Operational date: December 1985.
Federally qualified.
Certified in: New Jersey.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 204 primary physicians; 650 specialists; 17 administrative staff members; 15 marketing staff members; 118 patients per physician; 83% board certified physicians.
Facilities: Nine hospitals; one pharmacy; one diagnostic lab.
Service area: Burlington, Camden and Gloucester counties in New Jersey.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 166 employer/payer groups; 3,190 employees with single coverage; 5,741 employees with family coverage; 21,500 employees and dependents. Hospital stay averages 5.2 days. 82 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Leo M. Carey, general manager; Dr. Norman Scott, medical director; Joseph Botta, sales director.

CIGNA Healthplan of Northern New Jersey Inc..

E. 15 Midland Ave., Paramus, N.J. 07652-2900; 201-262-7700

Operational date: January 1988.
Federally qualified.
Certified in: New Jersey.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 282 primary physicians; 688 specialists; four administrative staff members; five marketing staff members; 44 patients per physician; 95% board certified physicians.
Facilities: 54 hospitals; one diagnostic lab.
Service area: Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset and Union counties in New Jersey.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Users: 13,408 employees and dependents.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Stephen A. Rogers, general manager; Dr. David L. Levy, medical director; Karen Scibilia, sales director.

CoMED HMO, A Total Health Co.

3 Stewart Court, Denville, N.J. 07834; 201-361-8808

See Total Health Systems under New York.

Flagship Health Systems Inc..

959 Route 46, Parsippany, N.J. 07054; 201-299-2557

Operational date: January 1987.
Certified in: New Jersey.
Model type: IPA.
For profit.
Sponsorship: Delta Dental Plan of New Jersey.
Staff: 105 primary dentists; 145 specialists; 135 administrative staff members; 14 marketing staff members; 100 patients per dentist; 100% board certified.
Service area: New Jersey.
Locations: One administrative site.
Services: Standard package includes dental.
Rating options: Experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 70 employer/payer groups; 4,650 employees with single and family coverage; 10,700 employees and dependents.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $479,222 in 1988; $875,500 estimated for 1989.
Officers: Dr. Robert Ott, president; James Oxford, executive director; Dr. Roger Post, medical director; Douglas Smyth, marketing director.

Medigroup HMO Network

14 Commerce Drive, Cranford, N.J. 07016; 201-272-7775

Certified in: New Jersey.
Model type: Mixed.
For profit.
Sponsorship: Blue Cross & Blue Shield of New Jersey Inc..
Staff: 867 primary physicians; 1,463 specialists; 97 administrative staff members; 37 marketing staff members; 100 patients per physician; 95% board certified physicians.
Facilities: 95 hospitals.
Service area: New Jersey; Bucks County in Pennsylvania.
Locations: Five administrative sites, two primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $106.88 single, $290.73 family; by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 701 employer/payer groups; 68,718 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.4 days. 88.4 admissions per 1,000 members.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $42.8 million in 1988; $64.1 million estimated for 1989.
Officers: Donald M. Daniels, chief executive officer/president; Kathleen Passantino, vp-managed care; Dr. Stephen Kardos, senior vp-medical affairs; Donald Senkewicz, director-finance/rating/support services.

MetLife Healthcare Network-New Jersey

365 W. Passaic St., Rochelle Park, N.J. 07662; 201-587-2750

Operational date: May 1987.
Certified in: New Jersey.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 944 primary physicians; 1,488 specialists.
Facilities: 35 hospitals.
Service area: Bergen, Hudson, Essex, Morris, Monmouth, Middlesex, Mercer, Somerset, Union and Passaic counties in New Jersey.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Harry Blair, president; Arthur Friedman, vp.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of New Jersey

1 Campus Drive, Parsippany, N.J. 07054; 201-631-2633

Operational date: September 1977.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 1,166 primary physicians; 1,556 specialists; 283 administrative staff members; 68 marketing staff members; 39 patients per physician; 88% board certified physicians.
Facilities: 39 hospitals; 274 pharmacies; 10 diagnostic labs.
Service area: 18 counties in New Jersey.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 47,028 estimated total number of enrollees. Hospital stay averages 4.4 days. 102 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Ray Allen, vp-group operations; Robert Ferrini, Dana Kind and Rhonda Stock, executive directors; Dr. Jonathan Kaplan, Dr. Jules Rivkind and Dr. Philip Mercer, medical directors; Shelley Molnar and Justin Fiedler, marketing directors.



FHP Inc.

4300 San Mateo N.E., Albuquerque, N.M. 87110; 505-881-7900

See FHP Inc.. under California.

FIRSTSOURCE Inc.

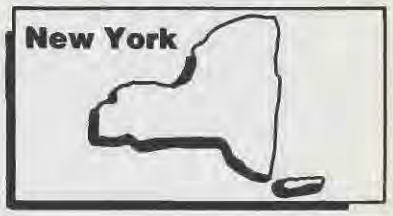
12800 Indian School Road N.E., Albuquerque, N.M. 87112; 505-291-6939

Operational date: September 1985.
Federally qualified.
Model type: IPA.
Not for profit.
Sponsorship: New Mexico Blue Cross & Blue Shield Inc..
Service area: Rio Arriba, Sandoval, Santa Fe, Bernalillo, Valencia, Torrance and Socorro counties in New Mexico.
Users: 7,794 employees and dependents as of June 1989.

Health Plus of New Mexico

P.O. Box 27489, Albuquerque, N.M. 87125; 505-823-0700

Operational date: January 1986.
Federally qualified.
Certified in: New Mexico.
Model type: IPA.
For profit.
Sponsorship: Southwest Community Health Services.
Staff: 99 primary physicians; 387 specialists; 70 administrative staff members; seven marketing staff members; 400 patients per physician; 100% board certified physicians.
Facilities: Five full service hospitals; 100 pharmacies; seven diagnostic labs.
Service area: Bernalillo, Sandoval and Valencia counties in New Mexico.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $93.62-$106.79 single, $248.27-$283.21 family; by age/sex, experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 195 employer/payer groups; 6,071 employees with single coverage; 6,544 employees with family coverage; 27,920 employees and dependents; 27,644 estimated enrollees as of Jan. 1, 1990. Hospital stay averages five days. 66.9 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $23 million in 1988; $27.7 million estimated for 1989.
Officers: Robert L. Simmons, president; Dr. Neil Kaminsky, medical director; J.J. Parsons, marketing director; Billie Peterman, director-finance; Carol Hinton, director-operations/support; Patrica Andrade, director-health care delivery services; Richard Stracqualursi, director-management information systems.



BlueCare Plus

Utica Business Park, 12 Rhoads Drive, Utica, N.Y. 13502; 315-798-4399

Operational date: November 1986.
Federally qualified.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Utica-Watertown Inc..
Staff: 226 primary physicians; 450 specialists; seven administrative staff members; five marketing staff members; 66 patients per physician; 75% board certified physicians.
Facilities: 30 hospitals; chain of pharmacies; 38 diagnostic labs.
Service area: Oneida, Madison, Herkimer, Chenango, Delaware, Otsego, Oswego, Fulton and Montgomery counties in New York.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Vision, substance abuse, psychiatric services are available as standard or optional packages. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $101.72 single, $252.91 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 221 employer/payer groups; 2,593 employees with single coverage; 3,487 employees with family coverage; 14,739 employees and dependents; 15,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages three days. 409 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $7.3 million in 1988; $13.1 million estimated for 1989.
Officers: Robert F. McLaughin, president; Dr. Fel G. Davies, medical director; Peter Falzarine, marketing director; Lawrence Calabarese, vp-underwriting/marketing coordinator; Robert E. Brown, vp-finance.

Blue Choice

Gateway Centre, 150 E. Main St., Rochester, N.Y. 14647; 716-454-1700

Operational date: January 1985.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of the Rochester Area.
Staff: 696 primary physicians; 1,184 specialists; 105 administrative staff members; 60 marketing staff members; 373 patients per physician; 76% board certified physicians.
Facilities: 16 hospitals; 620 pharmacies; 18 diagnostic labs.
Service area: Monroe, Livingston, Yates, Wayne, Seneca and Ontario counties in New York.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $80.90 single, $214.39 family. Offers non-federally qualified programs to employers.

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Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 3,500 employer/payer groups; 259,423 employees and dependents; 266,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5 days. 42 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $168.7 million in 1988; $222.8 million estimated for 1989.

Officers: Cleve Killingsworth, senior vp; Peter Wood, vp; Dr. Joseph Stankaitis, medical director; Kate Daniele, marketing director.

Capital District Physicians' Health Plan

5 Washington Square, Albany, N.Y. 12205; 518-452-1941

Operational date: May 1984.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Group of doctors.

Staff: 191 primary physicians; 632 specialists; 20 administrative staff members; eight marketing staff members; 415 patients per physician; 85% board certified physicians.

Facilities: Nine hospitals; chain of pharmacies; four diagnostic labs.

Service area: Albany, Columbia, Rensselaer and southern Saratoga counties in New York.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $103.86 single, $280.42 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 620 employer/payer groups; 17,155 employees with single coverage; 19,851 employees with family coverage; 81,908 employees and dependents; 81,069 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.75 days. 91 admissions per 1,000 members.

Management reports: Provided annually or upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $59 million in 1988; $78.4 million estimated for 1989.

Officers: Dr. John Carter, president; Vincent Portelli, executive director; Dr. Seth Blumberg, medical director; John Brannon, marketing director; William L. McHugh, executive vp; Michael Barrett, director-finance.

ChoiceCare Long Island

50 Charles Lindbergh Blvd., Uniondale, N.Y. 11553; 516-222-1460

Operational date: January 1986.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Joint venture between a hospital and a staff model HMO.

Staff: 301 primary physicians; 445 specialists; 40 administrative staff members; 13 marketing staff members; 63 patients per physician; 70% board certified physicians.

Facilities: All Long Island hospitals; all PCS pharmacies; one diagnostic lab; 14 sites.

Service area: Queens, Nassau and Suffolk counties in New York.

Locations: One administrative site, more than 800 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, dental, substance abuse, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $95.72 single, $248.87 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 269 employer/payer groups; 2,675 employees with single coverage; 4,822 employees with family coverage; 19,007 employees and dependents; 22,300 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.1 days. 99 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $11.6 million in 1988; $19.1 million estimated for 1989.

Officers: Dr. Arthur R. Goshin, president; David S. Reynolds, executive director; Dr. Edward Marine, medical director; Thomas D. Delaney, marketing director.

Community Blue, the HMO of Blue Cross of Western New York Inc.

1901 Main St., Buffalo, N.Y. 14208; 716-884-2800

Operational date: August 1985.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross of Western New York Inc.

Staff: 912 primary physicians; 845 specialists; 205 administrative staff members; 17 marketing staff members; 147 patients per physician; 67.8% board certified physicians.

Facilities: 37 hospitals; 376 pharmacies; 33 diagnostic labs.

Service area: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties in New York.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, hospice care. Options include prescription drugs, Medicare carve out program, additional mental health and substance abuse rehabilitation care, additional skilled nursing facility care, generic prescription drug program. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $86.92 single, $234.68 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 1,080 employer/payer groups; 14,647 employees with single coverage; 35,431 employees with family coverage; 133,714 employees and dependents; 140,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.52 days. 100.73 admissions per 1,000 members.

Management reports: Provided upon request, based on group site.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $99.5 million in 1988; $122.4 million estimated for 1989.

Officers: Richard A. Villari, vp; Jay Gould, operations director; Dr. Charles D. Bauer, medical director; Lisbeth L. Walls, marketing director.

Community Health Plan

1201 Troy-Schenectady Road, Latham, N.Y. 12110; 518-783-1864

Operational date: January 1977.
Federally qualified.
Certified in: New York, Massachusetts, Ohio and Vermont.
Model type: Mixed: primary staff model with contracted physicians in some regions.
Not for profit.

Staff: 450 primary physicians; 444 specialists; 450 administrative staff members; 57 marketing staff members; 91.3% board certified physicians.

Facilities: 81 hospitals; 194 pharmacies; 8 diagnostic labs.

Service area: 22 counties in New York; Bennington, Chittenden, Franklin, Lamoille, Rutland and Washington counties in Vermont; Berkshire, Franklin and Hampshire counties in Massachusetts; 20 counties in Ohio.

Locations: One administrative site, 111 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, obstetrics/gynecology. Options include prescription drugs, vision, durable medical equipment. Dental, substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: New York: community rating: $95.57 single, $242.47 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 4,300 employer/payer groups; 26,790 employees with single coverage; 34,832 employees with family coverage; 159,561 employees and dependents; 171,064 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.52 days. 352 admissions per 1,000 members.

Management reports: Provided to groups with 100 or more enrollees upon request annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $135.2 million in 1988; $183.8 million estimated for 1989.

Officers: John Baackes, president; Dr. Stanley Kilty, medical director; Maureen West, marketing director; Warren Paley, chairman; Joe Doolittle, vp; David Whitaker, treasurer.

Empire Blue Cross & Blue Shield Healthnet

622 Third Ave., New York, N.Y. 10017; 212-490-6222

Operational date: 1973.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Empire Blue Cross & Blue Shield.

Staff: 1,300 primary physicians; 2,500 specialists; 300 administrative and marketing staff members; 77 patients per physician; 85% board certified physicians.

Facilities: 175 hospitals; 4,000 pharmacies; 30 diagnostic labs.

Service area: 22 counties in New York.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Vision may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating.

Enrollment options: Individual enrollment not allowed.

Users: 2,400 employer/payer groups; 190,000 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: Not reported.

Officers: Dr. Stan Harris, medical director; David Willis, divisional vp-New York markets; A.A. Cardone, chairman.

Foundation Health Plan

8278 Willett Parkway, Baldwinsville, N.Y. 13027; 315-638-2133

Operational date: January 1985.
Federal qualification pending.
Certified in: New York.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Central New York.

Staff: 102 primary physicians; 221 specialists; 90% board certified physicians, 10% board eligible.

Facilities: Three hospitals; one diagnostic lab.

Service area: Broome, Tioga and parts of Chenango and Cortland counties in New York; parts of Sesquehanna and Bradford counties in Pennsylvania.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $107.47 single, $267.37 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 160 employer/payer groups; 26,716 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.09 days. 376 admissions per 1,000 members.

Management reports: May be provided .

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $22 million in 1988; $23.9 million estimated for 1989.

Officers: George W. Manton, president; Frederick F. Yanni, executive director; Dr. Edward Cox, medical director; James N. Jerose, senior vp-marketing; Michael McLean, vp-IPA operations.

Genesee Valley Group Health Association

150 E. Main St., Gateway Centre, Rochester, N.Y. 14647; 716-454-1700

Operational date: August 1973.
Model type: Group.
Sponsorship: Blue Cross & Blue Shield of New York.

Service area: Monroe, western Wayne, northwestern Ontario, northern Livingston counties in New York.

Users: 43,545 employees and dependents as of June 1989.

Group Health

150 E. Main St., Gateway Centre, Rochester, N.Y. 14647; 716-454-1700

Operational date: July 1973.
Certified in: New York.
Model type: Group.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of the Rochester area.

Staff: 33 primary physicians; 18 specialists; 10 administrative staff members; 60 marketing staff members; 99% board certified physicians.

Facilities: Two hospitals; four pharmacies.

Service area: Monroe, Wayne, Livingston and Ontario counties in New York.

Locations: Two administrative sites, four primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $82.43 single, $218.45 family.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 3,000 employer/payer groups; 43,000 employees and dependents; 43,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 70 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $52.1 million in 1988; $61.1 million estimated for 1989.

Officers: Cleve Killingsworth, senior vp; Margaret L. Montaglione, vp/chief operating officer; Dr. Mervyn U. Weerasinghe, medical director; Kate Daniele, marketing director; Laurie Paterson, finance director.

Health Insurance Plan of Greater New York

220 W. 58th St., New York, N.Y. 212-956-8000

Operational date: 1947.
Certified in: New York, New Jersey, Florida.
Model type: New York and New Jersey: group; Florida: IPA.
Not for profit.

Staff: 583 primary physicians; 296 specialists; 850 administrative staff members; 40 marketing staff members; 1,520 members per physician; 69% board certified physicians.

Facilities: New York: 23 hospitals; 1,506 pharmacies; 64 diagnostic labs.

Service area: Greater New York City area, Nassau, Suffolk and Westchester counties in New York; Broward, Dade, and Palm Beach counties in Florida; Hudson, Bergen, Essex, Passaic, Burington, Camden, Gloucester, Morris, Union, Hunterdon, Somerset, Middlesex, Mercer and Monmouth counties in New Jersey.

Locations: Three administrative sites; 55 medical centers in New York, 13 medical centers in New Jersey.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, podiatry, obstetrics/gynecology. Options include prescription drugs, dental, psychiatric services, durable medical equipment. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $84.03 single, $226.82 family.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 4,000 employer/payer groups; 247,927 subscribers with single coverage; 219,837 subscribers with family coverage; 885,453 subscribers and dependents; 895,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 6.1 days. 61 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $690.2 million in 1988; $841 million estimated for 1989.

Officers: Robert L. Biblo, president; Anthony L. Watson, executive vp; Bernard J. Neeck, senior vp-finance/chief financial officer; Stephen I. Lewis, senior vp-corporate affairs; Maxine Fass, general counsel/corporate secretary; Jesse H. Jampol, senior vp-professional affairs/medical director; Victoria Wicks, senior vp-marketing; Victor L. Rondina, senior vp-operations; Steve Cohen, senior vp-financial affairs/administration; Fred Blickman, vp-human resources; Daniel P. Kennedy, vp/underwriter; Karen Wintringham, vp-corporate development; JoAnne M. DiBella, assistant corporate secretary; Roger Birnbaum, president-HIP/Rutgers Health Plan; Warren D. Stowell, president-HIP Nestwork of Florida.

Independent Health-Hudson Valley

220 White Plains Road, Tarrytown, N.Y. 10591; 914-631-0939

Operational date: May 1986.
Federally qualified.

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Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Independent Health Association.
Staff: 322 primary physicians; 335 specialists; 22 administrative staff members; seven marketing staff members; 36 patients per physician; 96% board certified physicians.
Facilities: 41 hospitals; 160 pharmacies; six diagnostic labs.
Service area: Dutchess, Orange, Putnam, Rockland, Ulster and Westchester counties in New York.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: northern New York: $95.01 single, $243.23 family; southern New York: $105.37 single, $269.75 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.
Users: 325 employer/payer groups; 1,980 employees with single coverage; 2,919 employees with family coverage; 11,706 employees and dependents; 13,165 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.7 days. 115 admissions per 1,000 members.
Management reports: Provided annually upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $7.3 million in 1988; $11.8 million estimated for 1989.
Officers: Frank Colantuono, president; William Yurowski, executive director; Dr. Herbert Sperling, medical director; Peter Osinski, marketing director; William McHugh, executive vp; Mark Johnson, vp-finance/planning; Frederick B. Cohen, vp/general counsel.

Independent Health-Western New York

777 International Drive, Buffalo, N.Y. 14221; 716-631-3001

Operational date: February 1980.
Federally qualified.
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Independent Health Association.
Staff: 634 primary physicians; 783 specialists; 159 administrative staff members; 10 marketing staff members; 38.8 patients per physician; 72.8% board certified physicians.
Facilities: 27 hospitals; 320 pharmacies; one diagnostic lab, 25 hospital labs.
Service area: Allegany, Cattaraugus, Chatauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties in New York.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $71.20 single, $192.60 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 950 employer/payer groups; 20,267 employees with single coverage; 27,897 employees with family coverage; 126,597 employees and dependents; 129,600 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.83 days. 85 admissions per 1,000 members.
Management reports: Provided annually upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $80.9 million in 1988; $104 million estimated for 1989.
Officers: Frank Colantuono, president; William L. McHugh, executive vp; Dr. Robert M. Kohn, medical director; Jack L. Hoerner, marketing director; Mark Johnson, vp-finance/planning; Frederick B. Cohen,vp/general counsel.

Independent Prepaid Health Plan

8278 Willett Parkway, Baldwinsville, N.Y. 13027; 315-638-2133

Operational date: November 1985.
Federal qualification pending.
Certified in: New York.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Central New York Inc.
Staff: 135 primary physicians; 494 specialists; 90% board certified physicians.
Facilities: Six hospitals.
Service area: Onondaga and Oswego counties in New York; parts of Madison and Cayuga counties in New York.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, psychiatric services. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $100.67 single, $252.37 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 330 employer/payer groups; 27,268 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.18 days.
Management reports: May be provided.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $21.1 million in 1988; $28.5 million estimated for 1989.
Officers: George W. Manton, president; Frederick F. Yanni Jr., executive director; Dr. Bruce Chamberlain, medical director; James N. Jerose, senior vp-marketing; Michael McLean, vp-IPA operations.

Kaiser Foundation Health Plan of New York

7-11 S. Broadway, White Plains, N.Y. 10601; 914-256-0151

See Kaiser Permanente Medical Care Program corporate listing under California.

MVP Health Plan

108 Union St., Schenectady, N.Y. 12305; 518-370-4793

Operational date: July 1983.
Federally qualified
Certified in: New York.
Model type: IPA.
Not for profit.
Sponsorship: Community sponsored.
Staff: 490 primary physicians; 770 specialists; 110 administrative staff members; 10 marketing staff members; approximately 160 patients per physician; 76.5% board certified physicians.
Facilities: 31 hospitals; 1,183 pharmacies; three diagnostic labs.
Service area: 16 counties in New York.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $89.84 single, $224.61 family. Does not offer non-federally quali-

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fied programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 693 employer/payer groups; 12,623 employees with single coverage; 19,131 employees with family coverage; 77,588 employees and dependents; 85,074 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.33 days. 91 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $48.5 million in 1988; $72.5 million estimated for 1989.

Officers: David W. Oliker, president; Dr. Richard Lange, medical director; Mary Bianchi, associate marketing director; Joseph Doherty, financial director; R. Bruce Bickford, operations director.

MetLife Health Care Network-New York Inc.

1983 Marcus Ave., Suite 240, Lake Success, N.Y. 11042-1016; 516-326-5111

Operational date: 1987.
Certified in: New York and New Jersey.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 944 primary physicians; 1,488 specialists.
Facilities: 35 hospitals.
Service area: New York, Richmond, Kings, Queens, Bronx, Nassau, Suffolk and Westchester counties in New York; Mercer, Bergen, Morris, Passaic, Hudson, Union, Somerset, Middlesex, Monmouth and Essex counties in New Jersey.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups. Options include prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class, and experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Harry Blair, president; Arthur Friedman, vp.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Health Services of New York Inc.

Crosswest Office Center, Suite 212, 399 Knollwood Road, White Plains, N.Y. 10603-1900; 914-682-8006

Operational date: June 1987.
Federally qualified.
Certified in: New York.
Model type: IPA.
For profit.
Sponsorship: PHS Inc.
Staff: 225 primary physicians; 325 specialists; six administrative staff members; seven marketing staff members; 22 patients per physician; 90% board certified physicians.
Facilities: Seven hospitals; 205 pharmacies; seven diagnostic labs.
Service area: Westchester County in New York.
Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating by class. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 110 employer/payer groups; 1,272 employees with single coverage; 1,193 employees with family coverage; 5,029 employees and dependents; 6,703 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.7 days. 432 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $1.6 million in 1988; $5.9 million estimated for 1989.

Officers: Philip J. Passantino, president; Robert L. Natt, senior vp; Dr. Albert Sheehy, medical director; Robin Deitrick, vp-marketing; Dr. Lawrence Kadish, chairman; Dr. Percy Brazil, first vice chairman; Dr. John Williams, second vice chairman; Michael E. Herbert, secretary/treasurer; Dr. Peter N. Bogdan, Dr. Richard O'Connor, Al R. Orte, Dominick A. Bertoline.

Prepaid Health Plan

8280 Willett Parkway, Baldwinsville, N.Y. 13027; 315-638-2133

Operational date: March 1977.
Federally qualified.
Certified in: New York.
Model type: Group.
Not for profit.
Sponsorship: Health Services Medical Corp.
Staff: 60 primary physicians; 600 specialists; 1,500 patients per physician; 90% board certified physicians.
Facilities: Four hospitals; six pharmacies; one diagnostic lab.
Service area: Onondaga County and parts of Oswego, Madison, Cayuga counties in New York.
Locations: One administrative site, six primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, psychiatric services. Diagnostic testing and lab work performed by the HMO.

Rating options: Community rating: $92.77 single, $236.85 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 500 employer/payer groups; 53,076 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.14 days. 250 admissions per 1,000 members.

Management reports: May be provided.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $39.1 million in 1988; $44.8 million estimated for 1989.

Officers: Frederick F. Yanni Jr., president/executive director; Dr. Jeffrey S. Snieder, medical director; James N. Jerose Sr., senior vp-marketing.

Prepaid Health Plan/Slocum Dickson Medical Network

8278 Willett Parkway, Baldwinsville, N.Y. 13027; 315-638-2133; 315-797-1171

Operational date: November 1987.
Certified in: New York.
Model type: Network.
Not for profit.
Sponsorship: Health Services Medical Corp. of Central New York Inc.
Staff: 21 primary physicians; 63 specialists; 128 patients per physician; 90% board certified physicians.
Facilities: Eight hospitals.
Service area: Oneida, Herkimer and eastern Madison counties in New York.

Locations: Two administrative sites, 37 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $83.57 single, $207.90 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 65 employer/payer groups; 3,179 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.13 days. 251 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $545,000 in 1988; $2 million estimated for 1989.

Officers: Frederick F. Yanni Jr., president/executive director; Dr. Sidney Blatt, medical director; James N. Jerose, senior vp-marketing, Robert F. Wilkinson, executive vp.

PruCare of New York

Federal Plaza II, 140 Fell Court, Hauppauge, N.Y. 11788; 516-232-1943

Operational date: December 1987.
Federally qualified.
Certified in: New York.
Model type: IPA.
For profit.
Sponsorship: The Prudential Insurance Co. of America.
Staff: 848 primary physicians; 1,170 specialists; 60 administrative staff members; 30 marketing staff members; 94% board certified physicians.
Facilities: 44 hospitals; more than 675 pharmacies; three diagnostic labs.
Service area: New York, Kings, Queens, Bronx, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Dutchess, Putnam and Ulster counties in New York.
Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, well baby care, hospice, ambulance, rehabilitative services. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 28,192 employees and dependents; 31,185 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: William J. Marino, executive director; Dr. Cary Gutbezahl, medical director.

Total Health Systems Inc.*

1010 Northern Blvd., Great Neck, N.Y. 11021; 516-466-1000

Operational date: October 1986.
Federally qualified.
Certified in: New York and New Jersey.
Model type: IPA.
For profit.
Staff: 1,710 primary physicians; 2,504 specialists; 260 administrative staff members; 49 marketing staff members; 124 patients per physician; 85% board certified physicians.
Facilities: 96 hospitals; 1,357 pharmacies; two diagnostic labs.
Service area: Greater New York City; Nassau and Suffolk counties in New York; New Jersey.
Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, vision, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, dental, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $80.38 single, $220.33 family in New York; $88.20 single, $234.20 family in New Jersey. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries (New York plan only). Individual enrollment allowed.

Users: 602 employer/payer groups in New York; 1,389 employer/payer groups in New Jersey; 6,847 employees with single coverage in New York; 9,864 employees with single coverage in New Jersey; 11,589 employees with family coverage in New York; 22,391 employees with family coverage in New Jersey; 116,000 employees and dependents in both plans; 36,000 estimated enrollees as of Jan. 1, 1990 in New York; 85,500 estimated enrollees as of Jan. 1, 1990 in New Jersey. Hospital stay averages 3.86 days in New York; 4.9 days in New Jersey. 76 admissions per 1,000 members in New York; 81 admissions per 1,000 in New Jersey.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $62.9 million in 1988; $112 million estimated for 1989.

Officers: Jay Fabrikant, chief executive officer; Bruce L. Carpenter, president; Betty Kimmel, executive director-New Jersey plan; Linda Smith, executive director-New York plan; Peter Strassberg, executive vp; Annette P. Radick, marketing vp; Bruce Jacobsen, executive vp.

*If a breakdown is not provided, figures represent a combination of the New York and New Jersey plans.

Travelers Health Network

620 Erie Blvd. W., Suite 202; Syracuse, N.Y. 13204; 313-479-6667

Operational date: December 1985.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 120 primary physicians; 394 specialists; 35 administrative staff members; seven marketing staff members; 150 patients per physician; 80% board certified physicians.
Facilities: Four hospitals; chain of pharmacies; three diagnostic labs.
Service area: Onandaga, Madison, Oswego and Cayuga counties in New York.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, psychiatric services, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 158 employer/payer groups; 4,300 employees with single coverage; 3,400 employees with family coverage; 20,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.2 days. 45 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: May provide direct billing for premiums under COBRA.

Gross revenues: Not reported.

Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive director; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Drs. David Epstein and Jim Vance, regional medical directors Dr. David Ziegler, corporate medical director; Katherine Norton, executive director-Syracuse.

Travelers Health Network

701 Westchester Ave., White Plains, N.Y. 10604; 914-761-9103

Operational date: January 1987.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 850 primary physicians; 1,600 specialists; 30 administrative staff members; eight marketing staff members; 20 patients per physician; 90% board certified physicians.
Facilities: 120 hospitals; chain of pharmacies; three diagnostic labs.
Service area: Bronx, Kings, Queens, Staten Island, Nassau, New York, Suffolk, Rockland and Westchester counties in New York; Bergen, Essex, Hudson and Morris counties in New Jersey.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse (outpatient), psychiatric services (outpatient), podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse (inpatient), psychiatric services (inpatient), durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: Hospital stay averages 5 days. Less than 400 admissions per 1,000 members.

Gross revenues: Not reported.

Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Drs. David Epstein and Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director.



Carolina Physicians' Health Plan Inc.

4020 W. Chase Blvd., Suite 450, Raleigh, N.C. 27607; 919-833-8000

Operational date: April 1989.
Certified in: North Carolina.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.
Staff: Approximately 475 primary physicians; approximately 700 specialists; 80 administrative staff members; 10 marketing staff members; 84 patients per physician.
Facilities: 13 hospitals; chain of pharmacies.
Service area: 25 counties in North Carolina.
Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class, by age/sex, experience rating.

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Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 81 employer/payer groups; 7,284 employees with single coverage; 8,247 employees with family coverage; 40,333 employees and dependents; 45,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days. 84.6 admissions per 1,000 members.

Management reports: Provided quarterly, semiannually or annually.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $25.7 million in 1988; $46.6 million estimated for 1989.

Officers: James K. McNaughton, acting chief executive officer; John T. Roos, vp-marketing; Keith Benoit, chief financial officer; Larry Nason, vp-health services.

EQUICOR Health Plan of North Carolina Inc.

3605 Glenwood, Suite 340, Raleigh, N.C. 27612; 919-782-6507

Operational date: August 1986.
Certified in: North Carolina.
Model type: IPA.
For profit.

Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 82 primary physicians; 224 specialists; two administrative staff members; two marketing staff members; 16 patients per physician; 75% board certified physicians.

Facilities: Two hospitals; 36 pharmacies; one diagnostic lab.

Service area: Durham, Orange, Johnston, Franklin, Cumberland, Hoke, Sampson, Bladen, Harnett, Wake and Robesen counties in North Carolina.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse. Psychiatric services and durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: Nine employer/payer groups; 1,360 employees and dependents; 1,751 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided three times per year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $1.1 million in 1988; $2.3 million estimated for 1989.

Officers: J. Jack Horn, president; Joanne W. Tune, executive director; Dr. Phillip E. Stover, medical director; Mike Herger, marketing director.

Kaiser Foundation Health Plan of North Carolina

3120 Highwoods Blvd., Raleigh, N.C. 27604-1018

See Kaiser Permanente Medical Care Program corporate listing under California.

Lincoln National Health Plan Inc. (Advance Health Maintenance Organization)

5540 Centerview Drive, Suite 315, Raleigh, N.C. 27606; 919-851-0800

See Lincoln National Health Plan under Indiana.

Maxicare North Carolina Inc.

5550 77 Center Drive, Charlotte, N.C. 28217; 704-525-0880

See Maxicare Health Plans Inc. corporate listing under California.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Personal Care Plan

5901 Durham-Chapel Hill Blvd., P.O. Box 2291, Durham, N.C. 27702; 919-489-7431

Operational date: March 1982.
Federally qualified.
Model type: IPA.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of North Carolina.

Service area: North Carolina.

Users: 17,146 employees and dependents as of June 1989.

PruCare of Charlotte

2100 Rexford Road, Suite 320, Charlotte, N.C. 28211; 704-365-6070

Operational date: April 1985.
Federally qualified.
Certified in: North Carolina.
Model type: Group.
For profit.

Sponsorship: The Prudential Insurance Co. of America.

Staff: 59 primary physicians; 119 specialists; 19 administrative staff members; 13 marketing staff members; 552 patients per physician; 96% board certified physicians.

Facilities: Four hospitals; 24 pharmacies; one diagnostic lab.

Service area: Gaston, Lincoln, Mecklenburg, Rowan, Union and Cabarrus counties in North Carolina; York County in South Carolina.

Locations: One administrative site, 32 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include experimental procedures, prescription drugs, vision, dental, podiatry. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 7,345 employees with single coverage; 8,254 employees with family coverage; 35,567 employees and dependents; 36,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.5 days. 354 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Jerry Sykora, director-health care management; Dr. C. Raymond Fernandez, medical director; Robert C. Ward, director-group marketing.



Care Plan HMO

4510 13th Ave. S.W., Fargo, N.D. 58121; 701-282-1113

Operational date: October 1985.
Federally qualified.
Model type: Mixed network.
Not for profit.

Sponsorship: Blue Cross & Blue Shield of North Dakota.

Service area: Greater Fargo, Casseltown, Jamestown areas in North Dakota.

Users: 12,433 employees and dependents as of June 1989.

Continued on next page

Imagining Life Without Jack Seemed More Than She Could Bear



HRM's CarePASS® provider network helps keep your bottom line healthy.

Throughout their marriage, Jack and Sally have remained best friends. In raising their children, in good times and bad, they've taken on each day's challenge, confident in their bond of mutual love and support.

So when Jack had to have bypass surgery, Sally was beside herself. Just imagining life without Jack ... well, it seemed more than she could bear.

Today, Sally would tell you two positives about the whole ordeal. First, Jack came through healthy and vibrant. Secondly, her employer had HRM's CarePASS program.

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Continued from previous page



AdvaCare

385 Jackson Pike, P.O. Box 680,
Gallipolis, Ohio 45631;
614-446-5281

Operational date: June 1986.
Certified in: Ohio and West Virginia.
Model type: Group.
For profit.
Sponsorship: Hodge Clinic Inc. and Central Benefits Mutual Insurance Co.
Staff: 26 primary physicians; 37 specialists; six administrative staff members; one marketing staff member; 99% board certified physicians.
Facilities: Two hospitals; 43 pharmacies; one diagnostic lab.
Service area: Gallia, Meigs, Jackson, Lawrence, Pike, Scioto, Athens and Vinton counties in Ohio; Mason, Putnam, Cabell and Jackson counties in West Virginia.
Locations: One administrative site, five primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: By class, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 68 employer/payer groups; 610 employees with single coverage; 1,718 employees with family coverage; 6,227 employees and dependents; 5,800 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.9 days.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $5.5 million in 1988; approximately $8 million estimated for 1989.
Officers: John B. Reinhardt, president; Anthony Fata, vp-health network programs; Dr. J. Craig Stafford, medical director; Mike Fishburn, marketing director; Robert E. Daniel, secretary.

CIGNA Healthplan of Ohio Inc.

Rock Run Office Park, 5800
Lombardo Centre, Suite 200,
Cleveland, Ohio 44131-2533;
216-642-2920

Operational date: April 1987.
Federally qualified.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 384 primary physicians; 849 specialists; four administrative staff members; three marketing staff members; 72 patients per physician; 95% board certified physicians.
Facilities: 27 hospitals; two pharmacies; one diagnostic lab.
Service area: Ashland, Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit and Wayne counties in Ohio.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 96 employer/payer groups; 3,911 employees with single coverage; 7,943 employees with family coverage; 30,078 employees and dependents. Hospital stay averages 4.2 days. 68.3 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Pauline Degenfelder, general manager; Dr. Richard Sabransky, medical director; Edward J. Ryan, sales director.

CIGNA Healthplan of Ohio Inc.

Community Corporate Center, 445
Hutchinson Ave., Suite 900,
Columbus, Ohio 43235;
614-847-7100

Operational date: May 1986.
Federally qualified.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 204 primary physicians; 484 specialists; 21 administrative staff members; four marketing staff members; 128 patients per physician; 75% board certified physicians.
Facilities: 13 hospitals; two pharmacies; one diagnostic lab.
Service area: Delaware, Fairfield, Fayette, Franklin, Licking, Madison, Pickaway, Ross and Union counties in Ohio.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 136 employer/payer groups; 5,091 employees with single coverage; 6,822 employees with family coverage; 27,676 employees and dependents. Hospital stay averages 4.2 days. 82 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Joseph Rochester, general manager; Dr. Charles Derrow, medical director; Samuel Patterson, sales director.

Community Health Plan

817-C Eastgate S. Drive,
Cincinnati, Ohio 45245;
513-752-0500; 614-775-8181

See Community Health Plan under New York.

Family Health Plan

333 14th St., Toledo, Ohio 43624;
419-241-6501

Operational date: January 1986.
Certified in: Ohio.
Model type: IPA.
Not for profit.
Sponsorship: St. Vincent's Medical Center, Mercy Hospital, St. Charles Hospital.
Staff: 135 primary physicians; 550 specialists; 26 administrative staff members; nine marketing staff members; 149 patients per physician; 40% board certified physicians.
Facilities: Seven hospitals; 105 pharmacies; two diagnostic labs.
Service area: Lucas, Wood, Ottawa, Fulton and Sandusky counties in Ohio.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $118.70 single, $308.60 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 33 employer/payer groups; 1,729 employees with single coverage; 2,929 employees with family coverage; 11,503 employees and dependents; 12,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days. 447 admissions per 1,000 members.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $3.7 million in 1988; $9.7 million estimated for 1989.
Officers: Robert A. Campbell, president; Dr. J. Ross and Dr. W. Kleinberg, medical directors; David G. Bick, vp-sales/marketing; Chris A. Scherer, vp-operations/finance.

HMO Health Ohio

2060 E. Ninth St., Cleveland, Ohio
44115; 216-687-7538

Operational date: May 1978.
Model type: Mixed network.
Not for profit.
Sponsorship: Blue Cross & Blue Shield Mutual of Northern Ohio.
Service area: Ashland, Erie, Huron, Richland, Columbiana, Carroll, Cuyahoga, Holmes, Lake, Geauga, Medina, Mahoning, Lorain, Ashtabula, Portage, Stark, Summit, Tuscarawas, Trumbull and Wayne counties in Ohio.

Health Guard

3000 Guernsey St., Bellaire, Ohio
43906; 614-676-4623

Operational date: January 1975.
Federally qualified.
Certified in: Ohio and West Virginia.
Model type: Mixed: group, network.
Not for profit.
Sponsorship: Independent.
Staff: 79 primary physicians; 202 specialists; 25 administrative staff members; eight marketing staff members; 103 patients per physician.
Facilities: 11 hospitals; 143 pharmacies; five diagnostic labs.
Service area: Belmont, Muskingum, Harrison, Washington, Monroe, Guernsey, Stark, Mahoning, Columbiana, Trumbull and Jefferson counties in Ohio. Brook, Pleasants, Marshall, Monongalia, Ohio, Marion, Wetzel, Wood, Harrison and Tyler counties in West Virginia.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse, psychiatric services. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class. Offers non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 238 employer/payer groups; 2,109 employees with single coverage; 1,915 employees with family coverage; 8,169 employees and dependents; 11,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.08 days. 58 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $12 million in 1988; $12.7 million estimated for 1989.
Officers: Adrian G. Kutska, president/chief executive officer; Dr. Michael A. Stevens, medical director; Arthur Pugh, vp-marketing; Carol Czarneski, associate vp; Edward C. Douglas, chief financial officer; Beverly Henderson, vp-human resources; Joyce K. Larson, vp-provider relations.

Health Maintenance Plan

4665 Cornell Road, Suite 300,
Cincinnati, Ohio 45241;
513-247-6611

Operational date: 1974.
Certified in: Ohio.
Model type: Mixed: group, network.
Not for profit.
Sponsorship: Community Mutual Blue Cross & Blue Shield.
Staff: 725 primary physicians; 2,500 specialists; 120 administrative staff members; 39 marketing staff members; 172 patients per physician; 100% board certified physicians.
Facilities: 68 hospitals; 790 pharmacies; 10 diagnostic labs.
Service area: Ohio.
Locations: Seven administrative sites, 640 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: By class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 1,486 employer/payer groups; 19,556 employees with single coverage; 29,335 employees with family coverage; 120,542 employees and dependents; 145,267 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days. 385 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $109.3 million in 1988; $130.6 million estimated for 1989.
Officers: William G. Varnell, president; Dennis M. Jankowski, executive director; Dr. Leonard Ozeroff, medical director; Vincent J. Homan, marketing director; Kathleen J. Lutz, director-healthcare program analysis; Joseph S. Pollman, director-product support.

Health One

372 E. Center St., Marion, Ohio
43302; 614-387-6355

Operational date: October 1981.
Model type: Group.
Not for profit.
Sponsorship: Central Benefits Mutual Insurance Co.
Service area: Franklin, Licking, Delaware, Union, Madison, Pickaway and Fairfield counties in Ohio.

Health Power/Family Healthnet of Ohio

560 E. Town St., Columbus, Ohio
43215; 614-461-9900;
800-338-6207

Operational date: 1984.
Certified in: Ohio.
Model type: Mixed: IPA and network.
For profit.
Sponsorship: Sponsored by shareholders.
Staff: 203 primary physicians; 1,000 specialists; 46 administrative staff members; 18 marketing staff members; 100% board certified or board eligible physicians.
Facilities: 27 hospitals; chain of pharmacies; six diagnostic labs.
Service area: Family Healthnet of Ohio: Franklin, Delaware, Licking, Fairfield, Pickaway, Madison and Union counties in Ohio. Health Power: Clark, Green, Montgomery, Butler, Warren, Clermont and Hamilton counties in Ohio.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 115 employer/payer groups; 30,000 employees and dependents; 350 admissions per 1,000 members.
Management reports: Provided quarterly.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Patrick A. Talley, president.

HealthOhio Inc.

372 E. Center St., Marion, Ohio
43302; 614-387-6355

Operational Date: May 1976.
Federally qualified.
Certified in: Ohio.
Model type: IPA.
Not for profit.
Staff: 60 primary physicians; 250 specialists; 47 administrative staff members; six marketing staff members; 500 patients per physician; 60% board certified physicians.
Facilities: Nine hospitals; 42 pharmacies; five diagnostic labs.
Service area: Allen, Crawford, Delaware, Franklin, Hancock, Hardin, Knox, Logan, Marion, Morrow, Richland, Seneca, Union and Wyandot counties in Ohio.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class: $93.86 single, $251.71 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 260 employer/payer groups; 4,019 employees with single coverage; 5,970 employees with family coverage; 23,384 employees and dependents; 27,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.1 days. 366 admissions per 1,000 members.
Management reports: Provided monthly.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $24.6 million in 1988; $27.8 million estimated for 1989.
Officers: Charles W. Wright, chairman; N. Robert Jones, chief executive officer; Dr. S. Azim Bukhari, medical director; Weston L. Lambert, marketing director; Timothy A. Lauer, chief financial officer; Daniel R. Dreher, executive vp.

Kaiser Foundation Health Plan of Ohio

1100 Bond Court, 1300 E. 9th St.,
Cleveland, Ohio 44114;
216-621-5600

See Kaiser Permanente Medical Care Program corporate listing under California.

Lincoln National Health Plan

11260 Chester Road, Suite 800,
Cincinnati, Ohio 45246;
513-772-7325

See Lincoln National Health Plan under Indiana.

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MedChoice

3737 Sylvania Ave., Toledo, Ohio 43623; P.O Box 385, Toledo, Ohio 43691-0385; 419-473-7565

Operational date: January 1985.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield Mutual of Northern Ohio.
Service area: Lucas, Wood, Fulton and Ottawa counties in Ohio; Erie, Bedford, Whiteford and Luna Pier, Mich.

Medical Value Plan

405 Madison Ave., P.O. Box 2147, Toledo, Ohio 43603-2147; 419-244-2900

Operational date: January 1985.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: Toledo Clinic & Henry Ford Health Care Corp.
Staff: 140 primary physicians; 170 specialists; 80 administrative staff members; 10 marketing staff members; 357 patients per physician; 100% board certified physicians.
Facilities: Six hospitals; 160 pharmacies; one diagnostic lab.
Service area: Lucas, Wood, Fulton, Sandusky, Seneca, Ottawa, Henry and Erie counties in Ohio.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs, vision, durable medical equipment, wellness programs, employee assistance programs, skilled nursing, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $125 single; $350 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 150 employer/payer groups; 3,700 employees with single coverage; 9,600 employees with family coverage; 37,000 employees and dependents; 50,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.5 days. 95 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $34.3 million in 1988; $58.7 million estimated for 1989.
Officers: Robert W. Asmussen, president; David H. Smith, chief operating officer; Dr. Hal White, medical director; Brian P. Logue, marketing director.

MetLife Healthcare Network of Ohio Inc.

4 Commerce Park Square, Suite 400, 23200 Chagrin Blvd., Beachwood, Ohio 44122-5403; 216-464-8446.

Operational date: August 1985.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 1,213 primary physicians; 2,054 specialists.
Facilities: 48 hospitals.
Service area: Cuyahoga, Geauga, Lorain, Mahoning, Portage, Stark, Summit, Summit and Trumbull counties in Ohio.
Locations: Three administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class; experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Steve Linehan, president; Dr. Robert Newhardt, medical director; Roger Friend, vp.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Health Plan of Ohio Inc.

3650 Olentangy River Road, Columbus, Ohio 43214; 614-442-7100; 800-328-8835

Operational date: January 1980.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: Columbus & Franklin County Academy of Medicine; now publicly held.
Staff: 262 administrative staff members; 30 marketing staff members.
Facilities: 76 hospitals; 28 diagnostic labs.
Service area: 65 counties in Ohio.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, dental, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 525 employer/payer groups; 16,205 employees with single coverage; 25,063 employees with family coverage; 99,000 employees and dependents; 102,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.77 days; 79 admissions per 1,000 members.
Management reports: Provided upon renewal.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $88 million in 1988; $123 million estimated for 1989.
Officers: Dr. H. William Porterfield, president/chairman/chief executive officer; Ralph Preston, executive vp/secretary/general counsel; Dr. Robert Wall, vp/medical director; Tom DeLuca, senior vp-external operations; Richard Cornett, senior vp-administration; Gary Van Arsdale, senior vp-internal operations; Ron Yanai, vp-finance/treasury.

PruCare of Cincinnati

Suite 1850, 525 Vine St., Cincinnati, Ohio 45202; 513-621-2970

Operational date: March 1986.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 371 primary physicians; 610 specialists; 30 administrative staff members; 25 marketing staff members; 16 patients per physician; approximately 90% board certified physicians.
Facilities: Eight hospitals; chain of pharmacies; nine diagnostic labs.
Service area: Butler, Clermont, Warren and Hamilton counties in Ohio. Boone, Kenton and Campbell counties in Kentucky.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by contract with independent

Continued on next page

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Continued from previous page
facilities.

Rating options: Community rating, by class, by age/sex.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 908 employees with single coverage; 1,241 employees with family coverage; 5,047 employees and dependents; 8,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days. 89 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. J. Edward Greene, medical director; Art Dickerson, regional group manager; Lynne Gross, director-health care management.

PruCare of Central Ohio

Suite 350, 100 E. Campus Road, Columbus, Ohio 43235; 614-431-0980

Operational date: July 1985.
Federally qualified.
Certified in: Ohio.
Model type: Group.
For profit.

Sponsorship: The Prudential Life Insurance Co. of America

Staff: 167 primary physicians; 208 specialists; 12 administrative staff members; nine marketing staff members; 135.8 patients per physician; 90% board certified physicians.

Facilities: Six hospitals; seven pharmacies with 53 locations; one diagnostic lab.

Service area: Franklin, Union, Delaware, Licking, Fairfield, Pickaway and Madison counties in Ohio.

Locations: One administrative site, 94 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 4,677 employees with single coverage; 5,716 employees with family coverage; 22,679 employees and dependents; 25,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 300 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Matthew Davies, executive director/manager-health care services; Dr. David C. Gundlach, medical director; Fred Veazey, regional group manager.

PruCare of Northern Ohio

Suite 750, The Halle Building, 1228 Euclid Ave., Cleveland, Ohio 44115; 216-241-5623

Operational date: April 1989.
Certified in: Ohio.
Model type: IPA.
For profit.

Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 223 primary physicians; 613 specialists; 22 administrative staff members; eight marketing representatives; 91% board certified physicians.

Facilities: 14 hospitals; pharmacy chain; two diagnostic labs.

Service area: Cuyahoga, Geauga, Lake, Lorain, Medina, Summit and Portage counties in Ohio.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: Hospital stay averages 4.25 days. 41.5 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. Gordon K. Bell, medical director; Rick Chelko, director-group marketing; Jonathan Newpol, manager-health care services.

United Health Plan

1950 Morse Road, Columbus, Ohio 43229; 800-535-8388; 614-438-7500

Operational date: 1978.
Certified in: Ohio.
Model type: IPA.
For profit.
Sponsorship: Hospital.

Staff: 35 primary physicians; 200 specialists; 23 administrative staff members; three marketing staff members; 60% board certified physicians.

Facilities: Five hospitals; 120 pharmacies.

Service area: Franklin, Madison, Pickaway, Champaign, Delaware, Union, Licking, Fairfield and Fayette counties in Ohio.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, podiatry, obstetrics/gynecology. Options include dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 134 employer/payer groups; 10,250 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days. 380 admissions per 1,000 members.

Management reports: Provided annually for groups with more than 500 enrollees.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $7 million in 1988; $9 million estimated for 1989.

Officers: Richard A. Mitchell, president; Dr. A. Clifton Cage, medical director; April L. Patterson, marketing director.



BlueLines HMO

1437 S. Boulder Ave., Tulsa, Okla. 74119; 918-561-9900

Operational date: August 1984.
Federally qualified.
Certified in: Oklahoma.
Model type: IPA.
For profit.

Sponsorship: Blue Cross & Blue Shield of Oklahoma.

Staff: 220 primary physicians; 900 specialists; 60 administrative staff members; six marketing staff members; 209 patients per physician; 93% board certified physicians.

Facilities: 14 hospitals; 40 pharmacies; four diagnostic labs.

Service area: 16 counties in Oklahoma.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 240 employer/payer groups; 42,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days. 66 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $27 million in 1988; $43 million estimated for 1989.

Officers: Ralph S. Rhodes, president; Tom Bowser, senior vp; Dr. Wes Whittlesey, medical director; Tim McFall, vp-marketing; Lyndle Ellis, vp-finance; Robert Fitzsimmons, vp-operations.

EQUICOR Health Plan Inc.

5100 N. Brookline, 9th Floor, Oklahoma City, Okla. 73112; 405-943-7711

Operational date: June 1984.
Federally qualified.
Certified in: Oklahoma.
Model type: Network.
For profit.

Sponsorship: EQUICOR—Equitable HCA Corp.

Staff: 65 primary physicians; 116 specialists; 20 administrative staff members; three marketing staff members; 203 patients per physician; 75% board certified physicians.

Facilities: Nine hospitals; 65 pharmacies; two diagnostic labs.

Service area: Oklahoma, Cleveland, Logan, Kingfisher, Canadian, Pottawatomie, McClain, Grady and Lincoln counties in Oklahoma.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 170 employer/payer groups; 13,249 employees and dependents; 16,367 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided three times a year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $12.9 million in 1988; $18.6 million estimated for 1989.

Officers: David Weinstein, president/executive director; Dr. Kathleen Musser, medical director; Steve Curlee, marketing director.

Pacificare of Oklahoma

7134 S. Yale, Tulsa, Okla. 74136; 918-496-1200; 405-525-9200

See Pacificare under California.

PruCare of Tulsa

7912 E. 31st Court, Suite 300, Tulsa, Okla. 74145; 918-624-4700

Operational date: January 1983.
Federally qualified.
Certified in: Oklahoma.
Model type: Group.
For profit.

Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 24 primary physicians; 174 specialists; 25 administrative staff members; 11 marketing staff members; 1,000 patients per physician; 90% board certified physicians.

Facilities: Four hospitals; 14 pharmacies; five diagnostic labs.

Service area: Tulsa, Rogers, Muskogee, Osage, Washington and Creek counties in Oklahoma.

Locations: One administrative site, five primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 20,321 employees and dependents; 20,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.3 days. 75 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not available.

Officers: Delbert E. Snoberger, director-health care management; Dr. C.B. Rebsamen, medical director; David W. Dingley, marketing director.

Prudential Health Care Plan of Oklahoma Inc.-Oklahoma City Division

3330 N.W. 56th St., Suite 500, Oklahoma City, Okla. 73112; 405-942-6687

Operational date: April 1981.
Federally qualified.
Certified in: Oklahoma.
Model type: Group.
For profit.

Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 28 primary physicians; 93 specialists; 125 administrative staff members; 11 marketing staff members; 98% board certified physicians.

Facilities: Five hospitals; seven pharmacies.

Service area: Oklahoma, Canadian, Cleveland, Grady, Kingfisher, Lincoln, Logan, McClain and Pottawatomie counties in Oklahoma.

Locations: One administrative site, six primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 18,000 employees and dependents; 20,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.47 days. 79 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. M. Boyd Shook, medical director; Dave Dingley, marketing director; Mike Duncan, manager-health care services.



Good Health Plan of Oregon

1235 N.E. 47th, Suite 220, Portland, Ore. 97213; 503-249-2981

Operational date: January 1985.
Federally qualified.
Certified in: Oregon and Washington.
Model type: IPA.
Not for profit.

Sponsorship: Sisters of Providence Hospital.

Staff: 260 primary physicians; 840 specialists; 14 administrative staff members; five marketing staff members; 175 patients per physician; 90% board certified physicians.

Facilities: Eight hospitals; seven pharmacies; eight diagnostic labs.

Service area: Clackamas, Multnomah, Yamhill and Washington counties in Oregon; Clark county in Washington.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $92.03 single, $240.43 family; by class; by age/sex; experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: July 1989: 250 employer/payer groups; 8,051 employees with single coverage; 5,598 employees with family coverage; 40,870 employees and dependents; hospital stay averages 4.4 days. 67 admissions per 1,000 members.

Management reports: Provided semiannually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $37.1 million in 1988; $53.7 million estimated for 1989.

Officers: Don Brennen, president-Sisters of Providence Hospital; Mary McWilliams, executive director; Dr. James MacKay, medical director; Nancy Fuhrman, marketing director; Ted vonGlahn, chief operating officer.

Health Maintenance of Oregon

1800 S.W. First, Suite 505, Portland, Ore. 97201; 503-274-0755

Operational date: March 1987.
Federally qualified.
Model type: IPA.
For profit.

Sponsorship: Blue Cross & Blue Shield of Oregon.

Service area: Multnomah, Washington and part of Clackamas counties in Oregon.

Users: 32,291 employees and dependents as of June 1989.

Kaiser Foundation Health Plan of the Northwest

3600 N. Interstate Ave., Portland, Ore. 97227; 503-280-2050

See Kaiser Permanente Medical Care Program corporate listing under California.

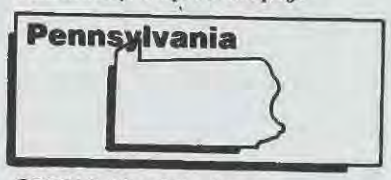
Pacificare of Oregon

Five Centerpoint, Suite 600, Lake Oswego, Ore. 97035; 503-620-9324

See Pacificare under California.

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CIGNA Healthplan of Pennsylvania Inc.

Chesterbrook Corporate Center, 701 Lee Road, Suite 300, Wayne, Pa. 19087; 215-889-2300

Operational date: June 1987.
Federally qualified.
Certified in: Pennsylvania.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 280 primary physicians; 332 specialists; 17 administrative staff members; 15 marketing staff members; 12 patients per physician; 83% board certified physicians.
Facilities: Seven hospitals; one pharmacy; one diagnostic lab.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.
Enrollment options: Individual enrollment not allowed.
Users: 102 employer/payer groups; 768 employees with single coverage; 889 employees with family coverage; 3,485 employees and dependents. Hospital stay averages 5.3 days. 79 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Leo M. Carey, general manager; Dr. Norman Scott, medical director; Joseph Botta, sales director.

Delaware Valley HMO Inc.

925 Baltimore Pike, P.O. Box 1111, Concordville, Pa. 19380; 215-358-5650

Operational date: January 1978.
Federally qualified.
Certified in: Pennsylvania and Delaware.
Model type: IPA.
For profit.
Sponsorship: Independence Blue Cross.
Staff: 972 primary physicians; 1,860 specialists; 180 administrative staff members; 20 marketing staff members; 90% board certified physicians.
Facilities: 55 hospitals; uses participating pharmacies of sponsor; one diagnostic lab.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania; Kent, New Castle and Sussex counties in Delaware.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, dental, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $104.92 single, $270.16 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 650 employer/payer groups; 17,723 employees with single coverage; 23,371 employees with family coverage; 93,245 employees and dependents; 108,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days.
Management reports: Provided quarterly.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $79.7 million in 1988; $81.4 million estimated for 1989.
Officers: Alfred F. Meyer, president; Dr. Bruce Hopper, medical director; James E. Dare, marketing director; Elaine T. Markezin, senior vp-operations; Dr. Gordon L. Tobias, senior vp-health services; James J. Thomas, chief financial officer.

Freedom Health Care

150 Strafford Ave., Wayne, Pa. 19087; 215-293-9338

Operational date: 1986.
Certified in: Pennsylvania.
Model type: Network.
For profit.
Sponsorship: Group of doctors and a hospital.
Staff: 360 primary physicians; 2,025 specialists; 44 administrative staff members; 11 marketing staff members; 75 patients per physician; 80% board certified physicians.
Facilities: 26 hospitals; pharmacy card service; 12 diagnostic labs.
Service area: Berks, Bucks, Chester, Delaware, Montgomery, Adams, Cumberland, Dauphin, Franklin Perry, Snyder and York counties in Pennsylvania.
Locations: Two administrative sites, 500 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, health education and wellness programs. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $81.71 single, $217.03 family. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 450 employer/payer groups; 4,293 employees with single coverage; 7,004 employees with family coverage; 27,000 employees and dependents; 30,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.2 days. 81 admissions per 1,000 members.
Management reports: Provided quarterly upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $19 million in 1988; $26 million estimated for 1989.
Officers: Robert A. Zelten, president; Dr. Joseph F. Carlow, medical director; Sharon Cohen, marketing director.

Geisinger Health Plan

Geisinger Office Building, Danville, Pa. 17822-3020; 717-271-8760

Operational date: February 1985.
Federally qualified.
Certified in: Pennsylvania.
Model type: Group.
Not for profit.
Staff: 142 primary physicians; 511 specialists; six administrative staff members; seven marketing staff members; 563 patients per physician; 99% board certified physicians.
Facilities: 19 hospitals; 90 pharmacies.
Service area: 21 counties in Pennsylvania.
Locations: One administrative site, 44 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $93.81 single, $243.91 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 458 employer/payer groups; 10,641 employees with single coverage; 31,995 employees with family coverage; 73,942 employees and dependents; 86,162 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.23 days. 74 admissions per 1,000 members.
Management reports: Provided upon request after group has been a member of the HMO for one year.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $41.3 million in 1988; $57.8 million estimated for 1989.
Officers: Dr. Howard G. Hughes, president; William A. MacBain, senior vp/administrative director; Dr. Duane E. Davis, senior medical director; A. Paul Holdren, vp-marketing/sales; George E. Kutz, controller.

Greater Atlantic Health Service

3550 Market St., Philadelphia, Pa. 19104; 215-823-8620

Operational date: 1972.
Federally qualified.
Certified in: Pennsylvania.
Model type: Staff, group and IPA.
For profit.
Sponsorship: Graduate Health System.
Staff: 400 primary physicians; 1,000 specialists; 70 administrative staff members; 10 marketing staff members.
Facilities: 40 hospitals; 150 pharmacies.
Service area: Bucks, Delaware, Philadelphia and Chester counties in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $89.48 single, $227.13 family; by class. Does not offer non-federally qualified programs to employers.
Users: 800 employer/payer groups; 50,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days. 351 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $35 million in 1988; $45 million estimated for 1989.
Officers: James C. New, president; Dr. Leon Cooper, medical director; Ernest Monfiletto, marketing director.

HMO of Northeastern Pennsylvania

70 N. Main St., Wilkes-Barre, Pa. 18711; 717-821-1241

Operational date: January 1987.
Federally qualified.
Certified in: Pennsylvania.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross of Northeastern Pennsylvania.
Staff: 121 primary physicians; 476 specialists; 27 administrative staff members; 37 marketing staff members; 242 patients per physician.
Facilities: 22 hospitals; 85 pharmacies; one diagnostic lab.
Service area: Bradford, Clinton, Lackawanna, Luzerne, Lycoming, Sullivan, Susquehanna and Wyoming counties in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $85.10 single, $213.50 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 360 employer/payer groups; 2,340 employees with single coverage; 5,030 employees with family coverage; 19,119 employees and dependents; 20,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.48 days. 74 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $7.6 million in 1988; $14.1 million estimated for 1989.
Officers: Gilbert D. Tough, president/chief executive officer; Thomas J. Ward, executive vp; Dr. Joseph T. Ichter, medical director; Michael A. Thomas, marketing director; Denise S. Cesare, chief operating officer.

HealthAmerica

5 Gateway Center, Pittsburgh, Pa. 15222; 412-553-7300

Operational date: June 1975.
Federally qualified.
Certified in: Pennsylvania.
Model type: Staff and network.
For profit.
Sponsorship: Coventry Corp.
Staff: 180 primary physicians; more than 600 specialists; 200 administrative staff members; 21 marketing staff members; 400 patients per physician; 91% board certified physicians.
Facilities: 13 hospitals; 60 pharmacies.
Service area: Butler, Beaver, Allegheny, Westmoreland, Washington, parts of Arstrong and Fayette counties in Pennsylvania.
Locations: One administrative site, seven health centers.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, obstetrics/gynecology. Options include prescription drugs, durable medical equipment. Vision, dental and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $90.40 single, $250.15 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Approximately 850 employer/payer groups; approximately 11,000 employees with single coverage; approximately 34,000 employees with family coverage; approximately 105,000 employees and dependents; 110,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days; 343 admissions per 1,000 members.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $104.8 million in 1988.
Officers: Dr. Peter Kongstevdt, chief executive officer; Mike Blackwood, president; Dr. Bruce Conaway, medical director, Tom Muray, vp-marketing.

HealthGuard of Lancaster Inc.

270 Granite Run Drive, Lancaster, Pa. 17601; 717-560-9049

Federally qualified.
Certified in: Pennsylvania.
Model type: Network.
For profit.
Sponsorship: Insurer.
Staff: 72 primary physicians; 210 specialists; 28 administrative staff members; four marketing staff members; 387 patients per physician; 92% board certified physicians.
Facilities: Four hospitals; 85 pharmacies; one diagnostic lab.
Service area: Lancaster County in Pennsylvania.
Locations: One administrative site, 26 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $74 single, $189.40 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 210 employer/payer groups; 3,672 employees with single coverage; 6,939 employees with family coverage; 26,254 employees and dependents; 27,100 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days; 248 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $14.3 million in 1988; $18.7 million estimated for 1989.
Officers: James R. Godfrey, president; Dr. R. Clair Weaver, medical director; Derek M. Radar, marketing director; Robert F. Black, director-administration.

Independent Health of Pennsylvania

150 E. Eighth St., Erie, Pa. 16501; 814-453-5090

Operational date: December 1985.
Federally qualified.
Certified in: Pennsylvania.
Model type: IPA.
For profit.
Sponsorship: Independent Health Assn.
Staff: 87 primary physicians; 100 specialists; five administrative staff members; seven marketing staff members; 111 patients per physician; 75% board certified physicians.
Facilities: Eight hospitals; 69 pharmacies; 10 diagnostic labs.
Service area: Erie County in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $81.19 single, $231.39 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 159 employer/payer groups; 1,320 employees with single coverage; 2,550 employees with family coverage; 9,866 employees and dependents; 10,580 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5 days. 91 admissions per 1,000 members.
Management reports: Provided annually upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $9.7 million in 1988; $9.3 million estimated for 1989.
Officers: Frank Colantuono, president; Geraldine D. Zurn, executive director; Dr. Paul Seiferth, medical director; Mary Larson, marketing director; William McHugh, executive vp; Mark Johnson, vp-finance/ planning; Frederick B. Cohen, vp/general counsel.

Keystone Health Plan Central

Senate Plaza, P.O. Box 8812, Camp Hill, Pa. 17011; 717-763-3280

Operational date: January 1983.
Model type: IPA.
For profit.
Sponsorship: Capital Blue Cross and Pennsylvania Blue Shield.
Service area: Harrisburg, Lehigh, Northampton and York counties in Pennsylvania.

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If your doctor prescribed a pill before diagnosing your condition, you'd get a new doctor.

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Unfortunately, this can lead to some costly side effects.

At The Hartford, we don't recommend a health care plan until we make a thorough analysis.

Of your market. Your type of business. What your employees need. And, just as important, what they don't.

This way, we can tailor a plan to meet the needs of *your* business, not ours.

We start with a careful examination of all the Preferred Provider Organizations in a given market, to determine which one is best. One immediate advantage is that the PPO and all standard cost containment efforts are managed at the local level.

The Hartford then expands these efforts with specialized programs, including large case management and psychiatric review.

The result is a health care plan that focuses on containing overall costs, not just prices.

And it works. In fact, in the 24 markets we currently service, we've been able to reduce our cost trends for PPO clients by as much as 8%.

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THE HARTFORD
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Bakersfield, Fresno. Los Angeles, Sacramento, San Diego, San Francisco, Washington D.C., Daytona, Ft. Lauderdale, Jacksonville, Miami, Orlando, Tampa, Kansas City (KS), Baltimore, Kansas City (MO), Minneapolis, Charlotte, Southern NJ, Philadelphia, Nashville, Houston, San Antonio, Seattle.

Continued from page 49

Users: 60,117 employees and dependents as of June 1989.

Keystone Health Plan East

3 Bala Plaza E., Bala-Cynwyd, Pa. 19004; 215-668-3087

Operational date: March 1987.
Federally qualified.
Certified in: Pennsylvania.
Model type: IPA.
For profit.
Sponsorship: Pennsylvania Blue Shield.
Staff: 625 primary physicians; 2,300 specialists; 90% board certified physicians.
Facilities: 45 hospitals.
Service area: Delaware, Philadelphia, Bucks, Chester and Montgomery counties in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed to COBRA beneficiaries only.
Users: 1,450 employer/payer groups; 55,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.4 days; 390 admissions per 1,000 members.
Management reports: Provided.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $8.6 million in 1988; $32 million estimated for 1989.
Officers: G. Fred DiBona Jr., president; John A. Daddis, executive vp; Richard Gilfillain, medical director; Linda Taylor, marketing director; Thomas Pappalardo, chief financial officer.

Keystone Health Plan West Inc.

681 Anderson Drive, Foster Plaza Six, Pittsburgh, Pa. 15220; 412-937-4300

Operational date: September 1986.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Western Pennsylvania.
Service area: Allegheny, Armstrong, Beaver, Butler, Washington and Westmoreland counties in Pennsylvania.
Users: 49,664 employees and dependents as of June 1989.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Philadelphia

200 Gibralter Road, Horsham, Pa. 19044; 215-672-1944

Operational date: August 1987.
Federally qualified.
Certified in: Pennsylvania.
Model type: IPA.
For profit.
Sponsorship: The Prudential Insurance Co. of America.
Staff: 746 primary physicians; 1,410 specialists; 22 administrative staff members; 16 marketing staff members; 9.5 patients per physician; 96% board certified or board eligible physicians.
Facilities: 21 hospitals; 99 pharmacies; one diagnostic lab.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 7,430 employees and dependents. Hospital stay averages 4.3 days; 350 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Kenneth Janda, executive director; Dr. Phillip Goldstein, medical director; Scott Ringold, director-group marketing.

PruCare of Pittsburgh

24th Floor, Centre City Tower Building, 650 Smithfield, Pittsburgh, Pa. 15222; 412-391-0464

Operational date: October 1989.
Certified in: Pennsylvania.
Model type: IPA.
For profit.
Sponsorship: The Prudential Insurance Co. of America.
Staff: 297 primary physicians; 511 specialists; 11 administrative staff members; 15 marketing staff members; 90% board certified physicians.
Facilities: Nine hospitals; 43 pharmacies; 20 diagnostic labs.
Service area: Armstrong, Allegheny, Beaver, Butler, Fayette, Washington and Westmoreland counties in Pennsylvania.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, skilled nursing, hospice care, chiropractic, chemotherapy, physical rehabilitation. Options include dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 5,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Lynne Gross, director-health care management; Dr. Michael Schlossberg, medical director; Chris Earl, regional group director; Lorraine Wagner, managing coordinator-utilization management; Deborah Cawley, associate manager.

U.S. Healthcare Inc.

980 Jolly Road, P.O. Box 1109; Blue Bell, Pa. 19422; 215-628-4800

Operational date: January 1976.
Federally qualified.
Certified in: Pennsylvania, New Jersey, New York, Connecticut, Delaware and Massachusetts.
Model type: IPA.
For profit.
Facilities: 200 hospitals; 3,000 pharmacies; 85 diagnostic labs.
Service area: Bucks, Berks, Chester, Delaware, Lehigh, Montgomery, Northampton, Philadelphia, Allegheny, Beaver, Butler, Fayette, Washington and Westmoreland counties in Pennsylvania; Fairfield, Litchfield, New Haven and Hartford counties in Connecticut; Suffolk, Middlesex, Essex, Worcester, Bristol, Rockingham, Norfolk and Plymouth counties in Massachusetts; Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester counties in New York; New Jersey; Kent, New Castle and Sussex counties in Delaware.
Locations: Five administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, healthy eating program, smoking cessation program, fitness reimbursement program. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $95.20 single, $261.60 family in Pennsylvania; $107.60 single, $284 family in New Jersey; $98.20 single, $252.90 f22amily in New York; $110.! single, $295.50 family in Connecticut; $95.20 single, $261.60 family in Delaware; $94.60 single, $258.20 family in Pittsburgh; $104.40-$110.90 single, $273.80-$290.80 in Massachusetts. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 11,000 employer/payer groups; 189,535 employees with single coverage; 136,148 employees with family coverage; 1 million employees and dependents. Hospital stay averages 4.8 days; 304 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $738.9 million in 1988; $975 million estimated for 1989.
Officers: Leonard Abramson, president; Costas C. Nicolaides, executive director/chief financial officer; Dr. Hyman R. Kahn, medical director; Michael J. Cardillo, mid-Atlantic marketplace; Dr. Richard Comell, New England marketplace; Dr. Michael A. Stocker, senior vp/general manager-greater New York marketplace; Samuel A. Hoffman, senior vp-operations; Marshall V. Rozzi, senior vp-medical delivery systems; Alan R. Letofsky, vp/general counsel/secretary; Thomas A. Masci Jr., vp-financial operations.



Healthplus De Puerto Rico

Metro Office Park, Victory Plaza, Street 1, Building 2, Suite 200, Caparra Heights, San Juan, Puerto Rico 00920-1705; 809-782-7900

Operational date: May 1986.
Federally qualified.
Certified in: Puerto Rico.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.
Staff: 577 primary physicians; 387 specialists; 35 administrative staff members; five marketing staff members; 24 patients per physician; 50% board certified physicians.
Facilities: 26 hospitals; 250 pharmacies; 100 diagnostic labs.
Service area: Puerto Rico.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $75 single, $200 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 95 employer/payer groups; 1,427 employees with single coverage; 3,457 employees with family coverage; 13,856 employees and dependents; 21,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.6 days; 79.7 admissions per 1,000 members.
Management reports: Provided monthly upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $4.6 million in 1988; $8.1 million estimated for 1989.
Officers: Jaime Figueroa, president, Dr. Herman Stubbe, medical director, Jose Malave, marketing director; Dr. Victor Gutierrez, chairman.



HMO Rhode Island

30 Chestnut St., Providence, R.I. 02903; 401-274-6674

Operational date: October 1986.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Rhode Island.
Service area: Kent, Providence, Newport, Washington and Bristol counties in Rhode Island.
Users: 8,816 employees and dependents as of June 1989.

MetLife Healthcare Network-Rhode Island

875 Centerville Road, Suite 3, Warwick, R.I. 02886; 401-822-3243

Operational date: June 1987.
Certified in: Rhode Island.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.
Staff: 140 primary physicians; 188 specialists.
Service area: Rhode Island.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Francis Brissette, president.

Ocean State Physicians Health Plan

Metro Center, 475 Kilvert St., Warwick, R.I. 02828; 401-737-6900

Operational date: January 1983.
Federally qualified.
Certified in: Rhode Island and Massachusetts.
Model type: IPA.
For profit.
Staff: 1,000 primary physicians; 625 specialists; 160 administrative staff members; eight marketing staff members; 50% board certified physicians.
Facilities: 17 hospitals; 150 pharmacies; 71 diagnostic labs.
Service area: Rhode Island. Bristol and Norfolk counties in Massachusetts.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By age/sex.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 950 employer/payer groups; 22,681 employees with single coverage; 24,954 employees with family coverage; 110,000 employees and dependents; 112,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days; 72 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $82.7 million in 1988; $101.8 million estimated for 1989.
Officers: Blair R. Snellentrop, chief executive officer; Dr. Anthony J. Kazlauskas, medical director; Edward A. Perry, vp-sales; James Moniz, chief financial officer.



Companion Health Care Corp.

300 Arbor Lake Drive, Suite 800, Columbia, S.C. 29223; 803-786-8466

Operational date: October 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of South Carolina.
Service area: Anderson, Greenville, Pickens, Berkeley, Dorchester, Charleston, Horry, Georgetown, Richland, Lexington and Spartanburg counties in South Carolina.
Users: 23,359 employees and dependents as of June 1989.

Maxicare South Carolina

535 North Pleasantburg Drive, Suite 210, Greenville, S.C. 29606; 803-233-7437.

See Maxicare Health Plans Inc. corporate listing under California.

Physicians Health Plan of South Carolina

4700 Forest Drive, Suite 104, Columbia, S.C. 29206; 803-787-6066.

Operational date: April, 1985.
Certified in: South Carolina.
Model type: IPA.
Not for profit.
Sponsorship: United HealthCare Corp.
Staff: 281 primary physicians; 351 specialists; 17 administrative staff members; six marketing staff members; 95% board certified physicians.
Facilities: 18 hospitals; 300 pharmacies; 26 diagnostic labs.
Service area: 18 counties in South Carolina.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, physical therapy, home health care, speech therapy. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By age/sex, experience rating.
Enrollment options: Does not

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contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 47 employer/payer groups; 1,203 employees with single coverage; 2,705 employees with family coverage; 10,834 employees and dependents; 14,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.5 days; 64 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $7.9 million in 1988; $9.9 million estimated for 1989.

Officers: Dr. Harold Moore, chairman; William E. Martin, chief executive officer, Dr. Hugh Dubose, medical director; V. John Nelson, sales manager; Beverly M. Smith, chief financial officer.



Dakotacare

1323 South Minnesota, Sioux Falls, S.D. 57105; 605-335-4000

Operational date: March 1986.
Certified in: South Dakota.
Model type: IPA.
For profit.
Sponsorship: South Dakota State Medical Assn.
Staff: 429 primary physicians; 331 specialists; eight administrative staff members; four marketing staff members; 68 patients per physician.
Facilities: 63 hospitals; 214 pharmacies; five diagnostic labs.
Service area: South Dakota.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, substance abuse. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,120 employer/payer groups; 6,395 employees with single coverage; 5,749 employees with family coverage; 27,235 employees and dependents; 28,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.9 days; 466 admissions per 1,000 members.
Management reports: Provided semi-annually upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $16.1 million in 1988; $23.8 million estimated for 1989.
Officers: Dr. Durward M. Lang, president; Robert D. Johnson, chief executive officer; Dr. Russell H. Harris, medical director; A. Kent Scribner, marketing director; L. Paul Jensen, executive vp; Kirk J. Zimmer, vp.



The Apple Plan

600 Jefferson Ave., P.O. Box 97, Memphis, Tenn. 38101; 901-529-9696

Operational date: June 1980.
Federally qualified.
Certified in: Tennessee.
Model type: IPA.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Memphis.
Staff: 347 primary physicians; 832 specialists; 140 administrative staff members; 300 patients per physician; 85% board certified physicians.
Facilities: 22 hospitals.
Service area: Shelby, Fayette, Tipton, Madison, Haywood and Lauderdale counties in Tennessee.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 272 employer/payer groups; 68,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.4 days; 108 admissions per 1,000 members.
Management reports: Provided annually upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $53.4 million in 1988.
Officers: Gene Holcomb, president; Tim Hogan, executive director; Dr. Alys Lipscomb, medical director; Arthur P. Waymire, chairman.

CareChoice

801 Pine St., Chattanooga, Tenn. 37401; P.O. Box 1407, Chattanooga, Tenn. 37402; 615-755-5600

Operational date: January 1985.
Model type: Mixed network.
For profit.
Sponsorship: Blue Cross & Blue Shield of Tennessee.
Service area: Chester, Lake, Madison, Obion, Weakley, Cannon, Davidson, Robertson, Rutherford, Sumner, Trousdale, Williamson, Wilson and part of Maury counties in Tennessee.
Users: 14,904 employees and dependents as of June 1989.

EQUICOR Health Plan Inc.

850 Ridge Lake, Suite 210, Memphis, Tenn. 38119; 901-683-3311

Operational date: January 1988.
Certified in: Tennessee.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 97 primary physicians; 329 specialists; 14 administrative staff members; six marketing staff members; 90 patients per physician; 75% board certified physicians.
Facilities: Six hospitals; 30 pharmacies; one diagnostic lab.
Service area: Shelby, Tipton and Fayette counties in Tennessee.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 36 employer/payer groups; 8,791 employees and dependents; 13,606 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided three times per year.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $589,000 in 1988; $8.2 million estimated for 1989.
Officers: J. Jack Horn, president; Joseph Eckert, executive director; Dr. James Bryant, medical director; Patrick Hoffman, marketing director.

EQUICOR Health Plan Inc. (Nashville)

155 Franklin Road, Suite 150, Brentwood, Tenn. 37027; 615-373-9584, ext. 302

Operational date: December 1984.
Certified in: Tennessee.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 121 primary physicians; 324 specialists; 40 administrative staff members; five marketing staff members; 157 patients per physician; 75% board certified physicians.
Facilities: 12 hospitals; 50 pharmacies; three diagnostic labs.
Service area: Davidson, Wilson, Rutherford, Sumner, Williamson, Robertson and Cheatham counties in Tennessee.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 115 employer/payer groups; 19,015 employees and dependents; 22,846 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided three times per year.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: $12 million in 1988; $21.9 million estimated for 1989.
Officers: J. Jack Horn, president; Tom Carroll, executive director/marketing director; Dr. Ann Wehr, medical director.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Memphis

845 Crossover Lane, Suite 200, Memphis, Tenn. 38117; 901-766-7908

Operational date: November 1982.
Federally qualified.
Certified in: Tennessee.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 29 primary physicians; 10 specialists; 12 administrative staff members; eight marketing staff members; 80% board certified physicians.
Facilities: One hospital; one pharmacy; one diagnostic lab.
Service area: Shelby County.
Locations: One administrative site, four primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse. Diagnostic testing and lab work performed by the HMO.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 32,400 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.6 days. 79 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Donna DeVaughn-Tidline, director-health care management; Dr. Manoj Narayanan, medical director; Peter E. Flick, director-group marketing.

PruCare of Nashville

227 French Landing Drive, Suite 200, Nashville, Tenn. 37228; 615-248-7100

Operational date: September 1980.
Federally qualified.
Certified in: Tennessee.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 34 primary physicians; 49 specialists; 24 administrative staff members; eight marketing staff members; 98% board certified physicians.
Facilities: Two hospitals; nine pharmacies.
Service area: Cheatham, Davidson, Robertson, Rutherford, Sumner, Williamson and Wilson counties in Tennessee.
Locations: One administrative site, six primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include substance abuse. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 30,318 employees and dependents; 30,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.9 days; 80 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Fred Dodson, director-group operations; Dr. Douglas C. Henry, medical director; Peter E. Flick, director-group marketing.

Tennessee First Health Plan

912 S. Gay St., Knoxville, Tenn. 37902; 615-546-2529

Operational date: March, 1986.
Model type: IPA.
For profit.
Sponsorship: Group of doctors, East Tennessee Baptist Hospital.
Staff: Five marketing staff members.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.
Gross revenues: Not reported.
Officers: W. Brent Casey, executive director; Raymond C. Bunn, medical director; Harry Alheid, marketing director; Gary Simmons.



American General Health Plan Inc.

2727 Allen Parkway, Houston, Texas 77019; 713-630-6400

Operational date: August 1989.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: American General Insurance Co.
Staff: 60 primary physicians; 145 specialists; three administrative staff members.
Facilities: Four hospitals; 94 pharmacies; one diagnostic lab contract.
Service area: Harris, Galveston, Brazoria, Fort Bend, Waller and Liberty counties in Texas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse, in vitro fertilization, mental and nervous disorders (inpatient), speech and hearing. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Two employer/payer groups; 144 employees with single coverage; 118 employees with family coverage; 720 employees and dependents; 1,000 estimated enrollees as of Jan. 1, 1990; hospital stay averages one day.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $404,000 estimated for 1989.
Officers: Howard Korn, president; Patricia Hill, acting executive director; Richard Nurgaard, acting medical director; Larry Hill, marketing director.

CIGNA Health Network Inc.

CIGNA Tower, 600 E. Las Colinas Blvd., Suite 1100, Irving, Texas 75039; 214-401-5389

Operational date: June 1986.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.
Staff: 185 primary physicians; 748 specialists; 29 administrative staff members; 13 marketing staff members; 69 patients per physician; 95% board certified physicians.
Facilities: 22 hospitals; one pharmacy; three diagnostic labs.
Service area: Collin, Dallas, Denton, Hood, Johnson, Parker, Rockwall and Tarrant counties in Texas.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services,

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durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by contract with independent facilities.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 112 employer/payer groups; 2,478 employees with single coverage; 3,116 employees with family coverage; 12,187 employees and dependents. Hospital stay averages 4.8 days. 69.6 admissions per 1,000 members.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Mark O. Johnson, general manager; Bruce Sammis, sales director.

CIGNA Healthplan of Texas Inc.

CIGNA Tower, Four Oaks Place, 1360 Post Oak Blvd., Suite 1270, Houston, Texas 77056-3021; 713-552-7800

Operational date: July 1982.
Federally qualified.
Certified in: Texas.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 191 primary physicians; 681 specialists; 40 administrative staff members; seven marketing staff members; 193 patients per physician.

Facilities: 44 hospitals; three diagnostic labs.

Service area: Austin, Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Houston, Liberty, Montgomery, San Jacinto, Walker and Waller counties in Texas.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 244 employer/payer groups; 7,888 employees with single coverage; 8,033 employees with family coverage; 31,852 employees and dependents. Hospital stay averages four days. 379 admissions per 1,000 members.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Patrick J. Brennan, general manager; Dr. Vernon Walters, medical director; Jim Haugland, sales director.

CIGNA Healthplan of Texas Inc.

CIGNA Tower, 600 E. Las Colinas Blvd., Suite 1100, Irving, Texas 75039; 214-869-8480

Operational date: June 1986.
Federally qualified.
Certified in: Texas.
Model type: Staff and IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 35 primary physicians; 224 specialists; 29 administrative staff members; 13 marketing staff members; 1,499 patients per physician; 95% board certified physicians.

Facilities: Two hospitals; one pharmacy; two diagnostic labs.

Service area: Collin, Dallas, Denton, Rockwall and Tarrant counties in Texas.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 286 employer/payer groups; 10,074 employees with single coverage; 12,227 employees with family coverage; 50,746 employees and dependents. Hospital stay averages 4.6 days. 64.2 admissions per 1,000 members.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Mark O. Johnson, general manager; Dr. John Gastright, medical director; Bruce Sammis, sales director.

Coastal Bend Health Plan

2502 Morgan, P.O. Box 3457, Corpus Christi, Texas 78463; 512-887-0101

Operational date: December 1985.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.

Staff: 152 primary physicians; 264 specialists; 37 administrative staff members; six marketing staff members; 110 patients per physician; 92% board certified physicians.

Facilities: Nine hospitals; 83 pharmacies; eight diagnostic labs.

Service area: Aransas, Kleberg, Nueces, San Patricio counties in Texas.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $96.10 single, $302.70 family; by class; by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 112 employer/payer groups; 38 employees with single coverage; 3,618 employees with family coverage; 16,497 employees and dependents; 18,351 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.8 days. 89.5 admissions per 1,000 members.

Management reports: Provided.

Billing: Does not provide direct billing for premiums under COBRA.

Gross revenues: $11.8 million in 1988; $14.8 million estimated for 1989.

Officers: Dr. F. James McCutchon, president; D. Tom Dwyer, executive director; Dr. William W. Burgin, medical director; Judy Hale, marketing director; Rick Medley, finance director.

EQUICOR Health Plan Inc.

12750 Merit Drive, Suite 1100, Dallas, Texas 75251; 214-770-4040

Operational date: November 1986.
Federally qualified.
Certified in: Texas.
Model type: IPA and network.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 141 primary physicians; 465 specialists; 13 administrative staff members; nine marketing staff members; 32 patients per physician; 75% board certified physicians.

Facilities: 20 hospitals; 275 pharmacies; one diagnostic lab.

Service area: Dallas, Tarrant, Collin, Rockwall, Ellis, Denton, Wise, Grayson, Fannin, Hunt, Kaufman, Johnson, Hood and Parker counties in Texas.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 23 employer/payer groups; 4,543 employees and dependents; 5,780 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided three times per year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $1.3 million in 1988; $6.4 million estimated for 1989.

Officers: James E. H. Ward, president; Bradley Balles, executive director; Dr. Ronald Atkins, medical director; Paul Harris, marketing director.

EQUICOR Health Plan Inc.

1300 Post Oak Blvd., Suite 1500, Houston, Texas 77056; 713-623-0244

Operational date: January 1985.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 123 primary physicians; 550 specialists; 15 administrative staff members; 10 marketing staff members; 206 patients per physician; 75% board certified physicians.

Facilities: 11 hospitals; 193 pharmacies; one diagnostic lab.

Service area: Harris, Austin, Chambers, Fort Bend, Galveston, Liberty, Matagorda, Brazoria, Montgomery, Waller and Wharton counties in Texas.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Substance abuse and psychiatric services may be standard or optional.

Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 160 employer/payer groups; 25,386 employees and dependents; 29,695 estimated enrollees as of Jan. 1, 1990.

Management reports: Provided three times per year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $20 million in 1988; $29.6 million estimated for 1989.

Officers: James E.H. Ward, president; Mike Steele, executive director; Dr. George Lewis, medical director; Harry Chapman, marketing director.

Humana Health Plan of Corpus Christi

3301 S. Alameda, Suite 506, Corpus Christi, Texas 78411; 512-854-8955

See Humana Health Care Plans under Kentucky.

Humana Health Plan of San Antonio

Med Center Plaza, 8431 Fredericksburg Road, San Antonio, Texas 78229; 512-558-1000

See Humana Health Care Plans under Kentucky.

Kaiser Foundation Health Plan of Texas

12720 Hillcrest Road, Suite 600, Dallas, Texas 75230; 214-458-5000

See Kaiser Permanente Medical Care Program corporate listing under California.

MetLife Healthcare Network-Texas

Suite 1000, 1329 Greenway Drive, Irving, Texas 75038-2510; 214-751-0777

Operational date: January 1987.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: Metropolitan Life Insurance Co.

Staff: 511 primary physicians; 721 specialists.

Facilities: 40 hospitals.

Service area: Collin, Dallas, Denton and Tarrant counties in Texas.

Locations: Two administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: By class and by experience rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Management reports: Provided.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. Warren Tingley, medical director; William Wagner, president.

Continued on next page

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For Information Contact:
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DENTAL BENEFIT PROVIDERS, INC.

Continued from previous page

Pacificare of Texas

8122 Datapoint Drive, Suite 1010, San Antonio, Texas 78229; 512-641-9800
See Pacificare under California.

PARTNERS National Health Plans*

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

Operational date: 1985.
Model type: Group, network and IPA.
For profit.
Sponsorship: Joint venture between Voluntary Hospitals of America and Aetna Life Insurance Co.
Staff: 12,792 primary physicians; 22,335 specialists; 100% board certified or board eligible physicians.
Facilities: 520 hospitals.
Locations: 31 administrative sites.
Service area: Alabama, Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Washington, Wisconsin.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, by experience rating. Offers federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 23,852 employer/payer groups; 487,810 employees and dependents; 1.3 million estimated enrollees as of Jan. 1, 1990.
Management reports: Provided quarterly or annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Donald E. Simmons, president/chief executive officer; Dennis Pedini, chief operating officer; Dr. Loren Vorlicky, medical director; Mark P. Hanrahan, vp-sales/marketing.

* Figures are corporate, including all HMOs sponsored by PARTNERS National Health Plans.

PruCare of Houston

Suite 500, 24 Greenway Plaza, Houston, Texas 77046; 713-993-3801
Operational date: October 1974.
Federally qualified.
Certified in: Texas.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 80 primary physicians; 33 specialists; 53 administrative staff members; 27 marketing staff members; 1,500 patients per physician; 95% board certified physicians.
Facilities: Two hospitals; 14 pharmacies.
Service area: Harris, Brazoria, Galveston, Montgomery, Fort Bend and Waller counties in Texas.
Locations: One administrative site, 10 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 119,925 employees and dependents; hospital stay averages 4.9 days. 71 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Vince Contorno, vp-health care management; Dr. Sheldon Joseph, medical director; DeWitt Smith, director-group marketing; David Butler, manager-administration.

PruCare of San Antonio

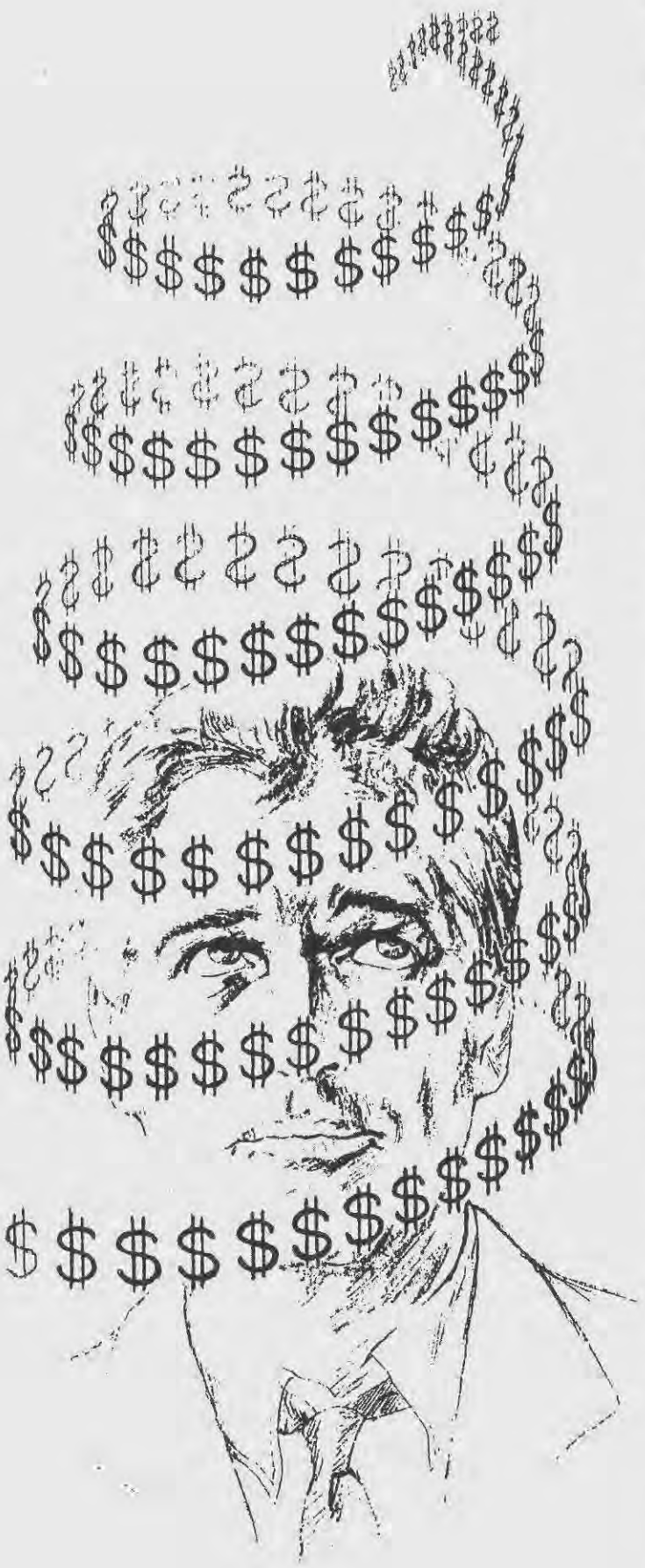
613 N.W. Loop 410, Suite 600, San Antonio, Texas 78216; 512-366-1921
Operational date: November 1984.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 118 primary physicians; 227 specialists; 11 marketing staff members; 203 patients per physician; 75% board certified physicians.
Facilities: 11 hospitals; 67 pharmacies; 13 diagnostic labs.
Service area: Bexar, Wilson, Comal, Guadalupe, Kendall, Atascosa, Bandera, Frio, Karnes and Medina counties in Texas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include experimental procedures, dental, podiatry, speech and audiology, inpatient psychiatric, invitro fertilization. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 19,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.6 days. 90 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Robert L. Smith Jr., executive director; Dr. C. William Metcalf, medical director; Phillip W. Sollomon, marketing director.

Prudential Health Care Plan Inc.

8303 MoPac Expressway, Suite 210, Austin, Texas 78759; 512-465-6661

Operational date: October 1980.
Federally qualified.
Certified in: Texas.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 62 primary physicians; 250 specialists; 42 administrative staff members; 11 marketing staff members; more than 94% board certified physicians.
Facilities: Five hospitals; 23 pharmacies; 11 diagnostic labs.
Service area: Travis, Hays, Bastrop, Willamson and northern Caldwell counties in Texas.
Locations: One administrative sites, 18 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

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Continued from previous page

Users: 60,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.4 days. 74 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: E.M. Keathley Jr., executive director; Dr. Norman Chenven, medical director; Herman Wright Jr., marketing director.

Prudential Health Care Plan Inc./PruCare of North Texas

6060 N. Central Expressway, Suite 750, Dallas, Texas 75206; 214-369-8480

Operational date: December 1985.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.
Staff: 469 primary physicians; 838 specialists; 75 administrative staff members; 28 marketing staff members; 95% board certified physicians.
Facilities: 24 hospitals; 90 pharmacies; 12 diagnostic labs.
Service area: Denton, Collins, Rockwall, Dallas, Tarrant, Parker, Hood, Johnson, Ellis and Kaufman counties in Texas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drug, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 3,556 employees with single coverage; 3,637 employees with family coverage; 15,378 employees and dependents. Hospital stay averages 4.4 days. 111 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Victor Lazzaro Jr., director-health care management; Dr. Robert Jacquim, director-medical services; Joel Suarez, director-group marketing; Rusty Folk, vp-group operations.

Rio Grande HMO Inc.

4150 Pinnacle, Suite 203, El Paso, Texas 79912; 915-542-1547

Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Texas Inc.; New Mexico Blue Cross & Blue Shield Inc.
Users: 13,364 employees and dependents.

Scott & White Health Plan

2401 S. 31st, Temple, Texas; 817-774-3000

Operational date: January 1982.
Federally qualified.
Certified in: Texas.
Model type: Group.
Not for profit.
Sponsorship: Scott & White Clinic; Scott, Sherwood & Brindley Foundation.
Staff: 113 primary physicians; 209 specialists; five administrative staff members; 11 marketing staff members; 488 patients per physician; 95% board certified physicians.
Facilities: Eight hospitals; 49 pharmacies; 13 diagnostic labs.
Service area: 20 counties in Texas.
Locations: Three administrative sites, 13 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $112.51 single, $290.46 family; by age/sex; experience rating. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 390 employer/payer groups; 12,508 employees with single coverage; 17,805 employees with family coverage; 70,046 employees and dependents; 73,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.72 days. 397 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $54.6 million in 1988; $73 million estimated for 1989.
Officers: Dr. Luther M. Brewer, president; Deny Radefeld, executive director; Dr. Charles D. Morehead and Dr. John C. Leadbeater, medical directors; Frank Nastars, marketing director; John L. Montgomery, vp; Louis S. Casey Jr., secretary; Dr. John W. Roberts, treasurer.

Texas Health Plans Inc.

8303 Mopac Expressway, Suite 450, Austin, Texas 78759; 512-338-6100

Operational date: April 1987.
Federally qualified.
Certified in: Texas.
Model type: IPA.
For profit.
Sponsorship: Physician's Corp. of America Inc.
Staff: 228 primary physicians; 449 specialists; 90 administrative staff members; 11 marketing staff members; 270 patients per physician; 90% board certified physicians.
Facilities: 19 hospitals; 170 pharmacies; 10 diagnostic labs.
Service area: 23 counties in Texas.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $101 single, $290 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 474 employer/payer groups; 16,572 employees with single coverage; 30,896 employees with family coverage; 61,697 employees and dependents; 73,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days. 66.8 admissions per 1,000 members.
Management reports: Provided upon request.
Gross revenues: $33 million in 1988; $56 million estimated for 1989.
Officers: Dr. Don Gessler, president; Dr. Glen Johnson, medical director; Tim Tasset, marketing director; Bob Trussell, vp-finance; Julie Silco, vp-operations.

Travelers Health Network-Austin

9442 Capital of Texas Highway N., Austin, Texas 78759; 512-338-6800

Operational date: October 1985.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 121 primary physicians; 314 specialists; 29 administrative staff members; seven marketing staff members; 245 patients per physician; 95% board certified physicians.
Facilities: Five hospitals; 24 pharmacies; one diagnostic lab.
Service area: Comal, Guadalupe, Bastrop, Travis, Williamson, Hays, Bell, Blanco, Burnett, Caldwell, Lee and Milam counties in Texas.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, substance abuse, durable medical equipment. Psychiatric services may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class: $128-$132 single, $395-$409 family.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 61 employer/payer groups; 4,817 employees with family coverage; 11,873 employees with single coverage; 31,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.2 days. 66.4 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA for groups over 500.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive director; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Connie Barron, executive director-Austin; Dr. Terry Sutton, Dr. Frank Berham and Dr. R. Dennis Collins, local medical directors; Dr. David Epstein and Dr. Jim Vance, regional directors; Dr. David Ziegler, corpate medical director.

Travelers Health Network-Dallas/Fort Worth

433 E. Las Colinas Blvd., Suite 750, Irving, Texas 75039; 214-506-0000

Operational date: May 1986.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 195 primary physicians; 436 specialists; 18 administrative staff members; six marketing staff members; 26 patients per physician; 90% board certified physicians.
Facilities: 22 hospitals; one pharmacy; one diagnostic lab.
Service area: Collin, Dallas, Denton, Ellis, Hood, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise and Hunter counties in Texas.
Services: Hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology may be standard or optional. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating and by class: $120 single, $400 family.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 50 employer/payer groups; 7,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.0 days. 72.8 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Halslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Dr. David Epstein and Dr. Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director.

Travelers Health Network-Houston

2000 Post Oak Blvd., Suite 1650, Houston, Texas 77056-9990; 714-622-6667

Operational date: 1985.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 170 primary physicians; 600 specialists; 23 administrative staff members; six marketing staff members; 38 patients per physician; 95% board certified physicians.
Facilities: 21 hospitals; one pharmacy; one diagnostic lab.
Service area: Montgomery, Harris, Brazoria, Waller, Galveston, Liberty and Fort Bend counties in Texas.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include experimental procedures, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating by class which incorporates age/sex.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: 44 employer/payer groups; 4,355 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.8 days. 80.5 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene Mc Griff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Dr. David Epstein and Dr. Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director; Jeff Freeman, executive director-Houston.

Travelers Health Network-San Antonio

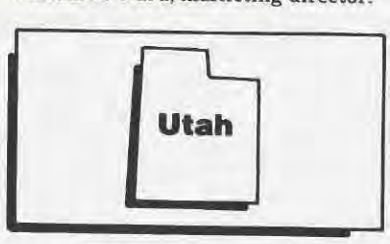
7550 1H 10 West, Suite 600, San Antonio, Texas 78229; 512-524-3300

Operational date: Jauary 1987.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.
Staff: 98 primary physicians; 394 specialists; 26 administrative staff members; five marketing staff members; 81.6 patients per physician; 89% board certified physicians.
Facilities: Seven hospitals; 25 pharmacies; eight diagnostic labs.
Service area: Atascosa, Bexar, Bandera, Comal, Guadalupe, Kendall, Medina and Wilson counties in Texas.
Services: Hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, dental, substance abuse, podiatry, obstetrics/gynecology may be standard or optional. Options include prescription drugs, vision, psychiatric services, durable medical equipment.
Rating options: Community rating by class.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 51 employer/payer groups; 2,423 employees with single coverage; 893 employees with family coverage; 6,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days. 75 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA to groups of 2,000 or more.
Gross revenues: Not reported.
Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Dr. David Epstein and Dr. Jim Vance, regional medical directors; Dr. David Ziegler, corporate medical director; Tom Jackson, executive director-San Antonio.

United Dental Care Inc.

14785 Preston Road, ‡680, Dallas, Texas 75240; 214-458-7474

Operational date: July 1986.
Certified in: Texas.
Model type: IPA, dental only.
For profit.
Sponsorship: Investors.
Staff: 275 primary physicians; 50 specialists; 28 administrative staff members; 14 marketing staff members; 275 patients per physician.
Service area: Texas.
Locations: Four administrative sites, 250 primary care sites.
Services: Standard package includes dental.
Rating options: By class, by age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 260 employer/payer groups; 15,000 employees with single coverage; 19,000 employees with family coverage; 75,000 employees and dependents; 100,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Officers: James B. Kingston, president; John F. Steen, vp/treasurer; William F. Ward, marketing director.



EQUICOR Health Plan of Utah Inc.

5295 S., 320 W., Suite 280, Salt Lake City, Utah 84107; 801-265-2777

Operational date: July 1986.
Certified in: Utah.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.
Staff: 193 primary physicians; 428 specialists; 13 administrative staff members; six marketing staff members; 73 patients per physician; 75% board certified physicians.
Facilities: 17 hospitals; 400 pharmacies; three diagnostic labs.
Service area: Davis, Utah, Salt Lake, Weber; parts of Box Elder, Cache, Morgan, Summit, Tooele, Wasatch counties in Utah.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision. Substance abuse, psychiatric services may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 81 employer/payer groups; 14,093 employees and dependents; 13,400 estimated enrollees as of Jan. 1, 1990.
Management reports: May be provided.
Billing: Provides direct billing for

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premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $9.1 million in 1988; $19.3 million estimated for 1989.

Officers: Dr. Arnold I. Kisch, president; Larry Dobson, executive director; Dr. Taylor Jeppson, medical director; Dave Greene, marketing director.

FHP Inc.

35 W. Broadway, Salt Lake City, Utah 84101; 801-355-1234

See FHP Inc. under California.

HealthWise

P.O Box 30270, Salt Lake City, Utah 84130-0270; 801-481-6176.

Operational date: September 1982.
Federally qualified.
Certified in: Utah.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Utah.

Staff: 394 primary physicians; 500 specialists; 94 patients per physician; 95% board certified physicians.

Facilities: 20 hospitals; 120 pharmacies; seven diagnostic labs.

Service area: Salt Lake, Weber, Davis, Box Elder, Cache, Morgan, Summit and Wasatch counties in Utah.

Locations: Three administrative sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, inpatient psychiatric. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 247 employer/payer groups; 3,877 employees with single coverage; 10,236 employees with family coverage; 37,882 employees and dependents; 37,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.6 days; 62 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.

Gross revenues: $36.1 million in 1988; $34 million estimated for 1989.

Officers: Jed H. Pitcher, president; Dr. W.K. Fitzpatrick Jr., medical director; Michael E. Tobin, executive vp.



Community Health Plan

789 Pine St., Burlington, Vt. 05401; 802-864-0693; 802-447-2343.

See Community Health Plan under New York.



EQUICOR Health Plan Inc. (Richmond)

4050 Innslake Drive, Glen Allen, Va. 23060; 804-273-1202

Operational date: May 1984.
Federally qualified.
Certified in: Virginia, Illinois and Indiana.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 200 primary physicians; 465 specialists; 130 administrative staff members; seven marketing staff members; 86 patients per physician; 75% board certified physicians.

Facilities: Three hospitals; 78 pharmacies; one diagnostic lab.

Service area: Amelia, Caroline, Charles City, Chesterfield, Dinwiddie, Goochland, Hanover, Henrico, King Will, Louisa, North Kent, Nottoway, Powhatas and Prince George counties in Virginia.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, psychiatric services. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 97 employer/payer groups; 40,221 employees and dependents; 42,000 estimated enrollees as of Jan. 1, 1990.

Management reports: May be provided three times per year.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $43 million in 1988; $45.8 million estimated for 1989.

Officers: William T. Hjorth, president; Charlie Brody, executive director; Stanley R. Clymer Jr., marketing director.

EQUICOR Health Plan Inc. (Virginia Beach/ Hampton Roads)

621 Lynn Haven Parkway, Suite 450, Virginia Beach, Va. 23452; 804-463-8606

Operational date: September 1984.
Federally qualified.
Certified in: Virginia, Illinois and Indiana.
Model type: IPA.
For profit.
Sponsorship: EQUICOR-Equitable HCA Corp.

Staff: 124 primary physicians; 638 specialists; five marketing staff members; 124 patients per physician; 75% board certified physicians.

Facilities: Nine hospitals; 162 pharmacies.

Service area: Gloucester, Mathews, Middlesex, Isle of Wight, James City, King and Queen, York counties in Virginia.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, substance abuse, psychiatric services. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 60 employer/payer groups; 15,386 employees and dependents; 16,065 estimated enrollees as of Jan. 1, 1990.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $15.6 million in 1988; $17 million estimated for 1989.

Officers: William T. Hjorth, president; Tim O'Hare, executive director; Dr. Timothy Saum, medical director; Stanley R. Clymer Jr., marketing director.

HMO Virginia Inc. (HMO Virginia Inc.)

2220 Edward Holland Drive, Richmond, Va. 23261; 804-254-3860

Operational date: December 1984.
Federally qualified.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Virginia.

Service area: Amelia, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Goochland, Hanover, Henrico, King William, Louisa, Lunenberg, New Kent, Nottoway, Powhatan and Prince George counties in Virginia.

Users: 24,827 employees and dependents as of June 1989.

Healthkeepers of Virginia Inc.

2220 Edward Holland Drive, Richmond, Va. 23261; 804-254-3860

Operational date: September 1986.
Model type: IPA.
For profit.
Sponsorship: Blue Cross & Blue Shield of Virginia.

Users: 6,810 employees and dependents as of June 1989.

Physicians CareFirst

1901 N. Moore St., Seventh Floor, Arlington, Va. 22209; 703-525-0602

Operational date: January 1986.
Federally qualified.
Certified in: Virginia, Maryland.
Model type: IPA.
For profit.
Sponsorship: HealthCare Corp. of America.

Staff: 445 primary physicians; 819 specialists; 28 administrative staff members; four marketing staff members; 35 patients per physician; 95% board certified physicians.

Facilities: 24 hospitals; 200 pharmacies; four diagnostic labs.

Service area: Montgomery and Prince Georges counties in Maryland; Loudoun, Prince William, Fairfax and Arlington counties in Virginia.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Substance abuse, psychiatric services, durable medical equipment may be standard or optional. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating: $96.89 single, $348.80 family. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 179 employer/payer groups; 3,203 employees with single coverage; 3,792 employees with family coverage; 15,594 employees and dependents; 16,600 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.7 days; 75.4 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: $16.1 million in 1988; $14 million estimated for 1989.

Officers: James M. Turnock, president; Suellen Rainey, executive director; Dr. Jose Martinez, medical director; Marcia Ritter, marketing director; G. Mark Chaney, chief financial officer; Michael L. Quinn, secretary.

PruCare of Richmond

1000 Boulders Parkway, Richmond, Va. 23225; 804-323-0900

Operational date: December 1982.
Federally qualified.
Model type: Group.
For profit.
Sponsorship: The Prudential Life Insurance Co. of America.

Staff: 124 primary physicians; 295 specialists; 31 administrative staff members; 13 marketing staff members; 194 patients per physician; 98% board certified physicians.

Facilities: Eight hospitals; 14 pharmacies; one diagnostic lab.

Service area: 17 counties in Virginia.

Locations: One administrative site, 55 primary care sites.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drug. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.

Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.

Users: 23,300 employees and dependents; 23,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.6 days; 79 admissions per 1,000 members.

Management reports: Provided annually.

Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: J. Philip Sheesley, director-group operations; Dr. Joseph R. Zanga, medical director; Michael L. Trent, marketing director.

Southern Health Services

P.O. Box C-32048, Richmond, Va. 23261; 804-747-3700.

Operational date: June 1985.
Federally qualified.
Certified in: Virginia.
Model type: IPA.
For profit.
Sponsorship: Group of doctors.

Staff: 750 primary physicians; 400 specialists; 60 administrative staff members; six marketing staff members; approximately 85 patients per physician; approximately 75% board certified physicians.

Facilities: 13 hospitals; 80 pharmacies; one diagnostic labs.

Service area: 16 counties in Virginia.

Locations: One administrative site.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating: $120 single, $325 family. Offers non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.

Users: 130 employer/payer groups; 6,840 employees with single coverage; 6,708 employees with family coverage; 13,548 employees and dependents; 32,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages five days; 415 admissions per 1,000 members.

Management reports: Provided quarterly.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: $25 million in 1988; $33 million estimated for 1989.

Officers: Laurence A. Kinzler, acting chief executive officer/vp-finance; Marshall A. Bwell, marketing director; Dr. Mark A. H. Smith, medical director.

Travelers Health Network

100 W. Plume St., Suite 720, Norfolk, Va. 23510-1019; 804-622-6711

Operational date: 1985.
Federally qualified.
Certified in: All states.
Model type: IPA.
For profit.
Sponsorship: Travelers Corp.

Staff: 130 primary physicians; 640 specialists; 26 administrative staff members; six marketing staff members; 88 patients per physician; 60% board certified physicians.

Facilities: 10 hospitals; 35 pharmacies; 12 diagnostic labs.

Service area: Norfolk, Portsmouth, Suffolk, Chesapeake and Virginia Beach counties in Virginia.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental. Diagnostic testing and lab work performed by contract with independent facilities.

Rating options: Community rating.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.

Users: 140 employer/payer groups; 15,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.5 days; 80 admissions per 1,000 members.

Management reports: Provided upon request.

Billing: Provides direct billing for premiums under COBRA.

Gross revenues: Not reported.

Officers: Michael Manley, president; Ted Haslam, chief operating officer/executive director; David Record, chief financial officer/executive officer; James Edmunds, regional vp-western region; Dene McGriff, regional vp-eastern region; Emery Dameron and Mike Gaffney, vps-operations; Drs. David Epstein and Jim Vance, regional medical directors, Dr. David Ziegler, corporate medical director; Mike Sherman, executive director-Norfolk office.



CIGNA Healthplan of Washington Inc.

701 Fifth Ave., 2940 Columbia Center, Seattle, Wash. 98104; 206-625-8800

Operational date: September 1985.
Certified in: Washington.
Model type: IPA.
For profit.
Sponsorship: CIGNA Corp.

Staff: 572 primary physicians; 636 specialists; eight administrative staff members; two marketing staff members; 15 patients per physician; 81% board certified physicians.

Facilities: 42 hospitals; 11 diagnostic labs.

Service area: 18 counties in Washington.

Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, skilled nursing and extended care facilities, short-term rehabilitation and physical therapy. Options include prescription drugs, vision, external prosthetics, hearing care. Diagnostic testing and lab work performed by contract with independent facilities.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 9,101 employees and dependents.

Management reports: May be provided.

Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing available.

Gross revenues: Not reported.

Officers: Dr. John M. Harris, general manager.

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Group Health Cooperative of Puget Sound

521 Wall St., Seattle, Wash. 98121; 206-448-6565

Operational date: January 1947.
Certified in: Washington and Idaho.
Model type: Staff and network.
Not for profit.
Sponsorship: Cooperative.
Staff: 520 primary physicians; 720 specialists; 1,500-1,800 patients per physician; 99% board certified physicians.
Facilities: 32 hospitals; 30 pharmacies; 30 diagnostic labs.
Service area: King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Benton, Yakima, Franklin and Whatcom counties in Washington; Bonner and Kootenai counties in Idaho.
Locations: Two administrative sites, 35 owned primary care sites, 400 primary care sites in referral networks.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, obstetrics/gynecology. Options include vision, dental, durable medical equipment, podiatry. Diagnostic testing and lab work performed in the HMO facilities.
Rating options: Age/sex, experience rating.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 3,500 employer/payer groups; 440,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 5.1 days.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $423 million in 1988; $514 million estimated for 1989.
Officers: Aubrey Davis, president/chief executive officer; Robert Flanagan, executive vp-administration; Phil Nudelman, executive vp-operations; Dr. Howard Kirz, medical director; Peter Brumleve, group vp-marketing.

Group Health Northwest

W. 1500 Fourth Ave., Spokane, Wash. 99204; 509-838-9100
Operational date: July 1977.

Federally qualified.
Certified in: Washington and Idaho.
Model type: Mixed: Staff, IPA and network.
Not for profit.
Sponsorship: Affiliated with Group Health Cooperative of Puget Sound.
Staff: 166 primary physicians; 321 specialists; 123 administrative staff members; 15 marketing staff members; 98.7% board certified physicians.
Facilities: 13 hospitals; 18 pharmacies; three diagnostic labs.
Service area: Spokane, Yakima, Benton and Franklin counties in Washington; Kootenai and Bonner counties in Idaho.
Locations: Three administrative sites, 42 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, contraceptive devices, maternity care, chiropractic services, health education, home health care. Options include dental. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating by class. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 465 employer/payer groups; 10,087 employees with single coverage; 11,706 employees with family coverage; 53,229 employees and dependents; 64,500 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.3 days.
Management reports: Provided annually.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $41 million in 1988; $50.5 million estimated for 1989.
Officers: Dr. Henry Berman, president/chief executive officer; Dr. Bill Burr, medical director; Sharon Fairchild, marketing director; Richard Umbdenstock, chairman; Greg Tracy and Mike Sweeney, vice chairmen; Paul Briggs, vp-finance; Jim Hill, operations director.

HMO Washington

1800 Terry Ave., Seattle, Wash. 98111; 206-340-6600.

Operational date: April 1986.
Model type: IPA and network.
For profit.
Sponsorship: Nine Blue Shield plans.
Staff: 481 primary physicians; 1,275 specialists; 23 administrative staff members; 35 patients per physician; 98% board certified physicians.
Facilities: 29 hospitals; 139 pharmacies; three diagnostic labs.
Service area: Clallam, Clark, King, Pierce, Snohomish, Spokane and Thurston counties in Washington.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include vision. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 280 employer/payer groups; 18,000 estimated enrollees as of Jan. 1, 1990.
Management reports: Provided quarterly.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Gross revenues: Not reported.
Officers: Mark S. Hawkin, president/executive director; Dr. Lester Reid, medical director; Deborah L. Banta, marketing director.

HealthPlus

P.O. Box 2113, Seattle, Wash. 98111; 206-670-4700

Operational date: January 1982.
Federally qualified.
Model type: Mixed.
Not for profit.
Sponsorship: Blue Cross & Blue Shield of Washington & Alaska.
Service area: 27 counties in Washington.
Users: 74,738 employees and dependents as of June 1989.

Pacific Health

401 2nd Ave. S., Seattle, Wash., 98104; 206-326-4645.

Operational date: 1985.
Model type: IPA.
Not for profit.
Sponsorship: Group of doctors.
Staff: 125 primary physicians; 28 administrative staff members; seven marketing staff members; 95% board certified.
Facilities: 13 hospitals; two pharmacies.
Service area: King and Snohomish counties in Washington.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, obstetrics/gynecology. Options include prescription drugs, vision, dental, podiatry. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by age/sex.
Enrollment options: Individual enrollment not allowed.
Users: 16,600 estimated enrollees as of Jan. 1, 1990. 280 admissions per 1,000 members.
Management reports: Provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: Not reported.
Officers: Nancy Silberg, president; Dr. Michael Boyd, medical director; Tyler Tabor, marketing director.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



Compcare Health Services Insurance Corp.

401 W. Michigan St., Milwaukee, Wis. 53201; 414-226-6744

Operational date: May 1971.
Federally qualified.
Certified in: Wisconsin.
Model type: Network.
For profit.
Sponsorship: Blue Cross & Blue Shield United of Wisconsin.
Staff: 500 primary physicians; 800 specialists; 40 marketing staff members; 260 patients per physician; more than 80% board certified physicians.
Facilities: 16 hospitals; 650 pharmacies.
Service area: Milwaukee, Waukesha, Kenosha, Racine, Walworth, Rock, Jefferson, Green, Washington, Ozaukee and Walworth counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, chiropractic services. Options include vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $111.26 single, $289.27 family; by class; by age/sex. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Approximately 1,200 employer/payer groups; 22,069 employees with single coverage; 40,192 employees with family coverage; 143,000 employees and dependents; 145,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.9 days. 71 admissions per 1,000 members.
Management reports: May be provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $124.1 million in 1988.
Officers: Thomas R. Hefty, president; Thomas M. Gazzana, vp; Dr. Richard Christenson, medical director; A.J. Hutson, marketing director; Mary Traver, secretary; Gail L. Hanson, treasurer.

Eau Claire Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: November 1974.
Certified in: Wisconsin.
Model type: IPA.
For profit.
Sponsorship: Insurer.
Staff: 240 primary physicians.
Facilities: Nine hospitals.
Service area: Chippewa, Dunn, Pepin and Eau Claire counties in Wisconsin.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Eight employer/payer groups; 403 employees with single coverage; 1,005 employees with family coverage; 3,707 employees and dependents. Hospital stay averages 5.4 days. 125 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $7.1 million in 1988.
Officers: Jeff Zriny, vp; Terry Bolz, executive director; Dr. C.V. Vihle, medical director.

Family Health Plan

12500 W. Bluemound Road, Elm Grove, Wis. 53122; 414-786-3338

Operational date: March 1979.
Federally qualified.
Certified in: Wisconsin.
Model type: Staff.
Not for profit.
Sponsorship: Cooperative.
Staff: 45 primary physicians; 120 specialists; 117 administrative staff members; 15 marketing staff members; 1,800 patients per physician; 100% board certified physicians.
Facilities: Eight hospitals; four pharmacies; four diagnostic labs.
Service area: Milwaukee, Waukesha, Washington, Ozaukee, Racine and Walworth counties in Wisconsin.
Locations: One administrative site, four primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, eye examinations. Options include vision, dental, oral surgery, hearing aid, transplants. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: Community rating: $99.96 single, $257.50 family; by class. Does not offer non-federally qualified programs to employers.
Enrollment options: Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 630 employer/payer groups; 14,831 employees with single coverage; 19,087 employees with family coverage; 68,132 employees and dependents. Hospital stay averages 4.73 days. 71.2 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $64.3 million in 1988.
Officers: Conrad Sobczak, executive director; James R. Chaillet, medical director; Michael Derdzinski, marketing director; Robert Dude, finance director.

Greater LaCrosse Health Plans Inc.

P.O. Box 38, LaCrosse, Wis. 54602-0038; 608-785-2644

Operational date: July 1986.
Certified in: Wisconsin.
Model type: Group.
For profit.
Sponsorship: Skemp Clinic, Franciscan Health System and Wausau Insurance Co.
Staff: 60 primary physicians; 11 administrative staff members; three marketing staff members; 60% board certified physicians.
Facilities: Four hospitals; one diagnostic lab.
Service area: LaCrosse, Monroe, Trempealeau, Buffalo, Jackson, Crawford and Vernon counties in Wisconsin.
Locations: One administrative site, 10 primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include experimental procedures, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class, by age/sex, experience rating. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment may be allowed.
Users: Five employer/payer groups; 1,000 employees with single coverage; 1,000 employees with family coverage; 2,000 employees and dependents; 4,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 2 days.
Management reports: Provided quarterly.
Billing: Provides direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $600,000 in 1988; $3 million estimated for 1989.
Officers: Jeffrey Zriny, John Laehn, executive director; Dr. David Westgard, medical director; Steven Kunes, administrator; John Nemec, treasurer; Richard Allen, secretary.

Greater Wisconsin Rapids Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: January 1980.
Certified in: Wisconsin.
Model type: IPA.
For profit.
Sponsorship: Insurer.
Staff: 64 primary physicians.
Facilities: One hospital.
Service area: Wood County in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: Seven employer/payer groups; 271 employees with single coverage; 330 employees with family coverage; 1,408 employees and dependents. Hospital stay averages 3.5 days. 98 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $1.1 million in 1988.
Officers: Jeff Zriny, vp; Terry Bolz, executive director.

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Green Bay Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: January 1973.
Certified in: Wisconsin.
Model type: IPA.
For profit.
Sponsorship: Insurer.
Staff: 386 primary physicians.
Facilities: Eight hospitals.
Service area: Brown, Oconto and Kewaunee counties in Wisconsin.
Locations: Two administrative sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 46 employer/payer groups; 3,591 employees with single coverage; 6,410 employees with family coverage; 25,475 employees and dependents. Hospital stay averages 3.8 days; 90.6 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $19.7 million in 1988.
Officers: Jeff Zriny, vp; Terry Bolz, executive director; Dr. Thomas Beno, medical director.

Group Health Cooperative of South Central Wisconsin

1 S. Park St., Madison, Wis. 53715; 608-251-4156

Operational date: March 1976.
Federally qualified.
Certified in: Wisconsin.
Model type: Staff and group.
Not for profit.
Sponsorship: Cooperative.
Facilities: Two hospitals; three pharmacies; five diagnostic labs.
Service area: Dane and surrounding counties in Wisconsin.
Locations: One administrative site, eight primary care sites.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision and dental care for children, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Options include prescription drugs, podiatry. Diagnostic testing and lab work performed by the HMO.
Rating options: Community rating: $85.11 single, $227.44 family. Offers non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 400 employer/payer groups; 9,899 employees with single coverage; 8,005 employees with family coverage; 36,130 employees and dependents; 37,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.4 days; 73.9 admissions per 1,000 members.
Management reports: Provided upon request.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $33 million in 1988; $37 million estimated for 1989.
Officers: Lawrence J. Zanoni, executive director; Dr. John Hansen, medical director; Thomas Mottard, marketing director; Edward Pautz, finance director.

Maxicare Health Insurance Co.

733 N. Van Buren St., Milwaukee, Wis. 53202; 414-271-6371

See Maxicare Health Plans Inc. corporate listing under California.

MetLife HealthCare Network-Wisconsin

1 Park Plaza, Suite 180, Milwaukee, Wis. 53224; 414-359-0312

Operational date: December 1986.
Model type: IPA.
For profit.
Staff: 411 primary physicians; 707 specialists.
Facilities: 14 hospitals.
Service area: Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties in Wisconsin.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: By class.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Management reports: Provided.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing available.
Officers: Thomas Manfield III, president; Virgil Marsh, vp-operations.

North Central Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: January 1972.
Certified in: Wisconsin.
Model type: IPA.
Not for profit.
Sponsorship: Insurer.
Staff: 275 primary physicians.
Facilities: Five hospitals.
Service area: Lincoln, Marathon, Langlade, Taylor, Vilas, Oneida, Portage and Shawano counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 48 employer/payer groups; 3,405 employees with single coverage; 7,470 employees with family coverage; 28,722 employees and dependents; Hospital stay averages 3.8 days; 73.1 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $27.6 million in 1988; $29 million estimated for 1989.
Officers: Jeff Zriny, vp; Ken Peterson, executive director; Dr. John Webb, medical director.

OshKosh Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: January 1989.
Model type: IPA.
For profit.
Sponsorship: Insurer.
Staff: 127 primary physicians.
Facilities: Two hospitals.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, experimental procedures. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to

Continued on next page



Managing Health Care Costs...

American Health Network PPOs

American Health Network (AHN) has served the employee benefit profession with excellence in managed care since 1983. As a wholly owned subsidiary of American General Group Insurance Company, AHN provides innovative solutions to controlling health care costs through effective utilization management, case management, and HMO/EPO and PPO development and administration.

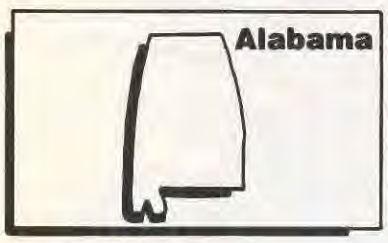
Regional Offices:
Dallas, Texas
Jacksonville, Florida
Sacramento, California

National Home Office:
3988 North Central Expressway
Dallas, Texas 75204
(214) 841-1000

American General Group Insurance Company

American® Health Network

Preferred provider organizations listed



Alabama Medical Coalition Inc.

900 Western America Circle, Suite 212, Mobile, Ala. 36609; 205-343-5251

Operational date: 1985.
Sponsorship: Springhill Memorial Hospital.
Ownership: Southern Medical Health Systems Inc.
For profit.
Staff: 430 primary physicians; four administrative staff members; one marketing staff member; 98% board certified physicians.
Facilities: Seven hospitals; two diagnostic labs.
Service area: Mobile and Baldwin counties in Alabama.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 17 employer/payer groups; 1,012 employees with single coverage; 1,706 employees with family coverage; 6,753 employees and dependents with access to the network; 8,376 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates of individual services; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Bill A. Mason, president; James W. Kelley Jr., executive director/marketing director; Dr. Liston James, medical director.

CNA Managed Care PPO-Birmingham

2302 Parklake Drive N.E., Atlanta, Ga. 30345; 404-491-5375

Operational date: May 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 676 primary physicians; 77% board certified physicians, 6% board eligible.
Facilities: Four hospitals.
Service area: Jefferson and Shelby counties in Alabama.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 9,900 employer/payer groups and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Charles Hart, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

Great-West Care-Birmingham

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: May 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 666 primary physicians; 73% board certified physicians.
Facilities: Four hospitals.
Service area: 18 counties in Alabama.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: One employer/payer group.
Compensation: The PPO negotiates hospital charges by a per diem rate and percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Health Choice

2100 Southbridge Parkway, Birmingham, Ala. 35283-0605; 205-326-9199
Operational date: 1984.
⅓080
Sponsorship: Hospitals, group of doctors.
Ownership: Healthnet of Alabama Inc.
Not for profit.
Staff: 800 primary physicians; 800 specialists; five administrative staff members; one marketing staff member; 98% board certified physicians.
Facilities: Nine hospitals; 250 pharmacies; four diagnostic labs.
Service area: Birmingham, Ala.
Services: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 593 employer/payer groups; 60,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and outside contractor.
Gross revenues: $10 million in 1988; $17 million estimated in 1989.
Officers: H. Scott Sheedy, executive director; Dr. Allan Goldstein, medical director.

Humana Health Plan of Alabama Inc.

500 Lowell Drive, Suite F, Huntsville, Ala. 35801; 205-534-8411

See Humana Health Plans under Kentucky.

Metropolitan Life Insurance Co.

Managed Care Service Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Alabama

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO-Alabama

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Alabama

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Continued on next page

More HMOs

Continued from previous page
enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 13 employer/payer groups; 649 employees with single coverage; 580 employees with family coverage; 2,578 employees and dependents; Hospital stay averages 4.3 days. 78.7 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Revenues: Not reported.
Officers: Jeff Zriny, vp; Terry Bolz, executive director.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physicians Plus Insurance Corp.

217 S. Hamilton, Suite 200, Madison, Wis. 53715; 608-282-8505

Operational date: January 1986.
Certified in: Wisconsin.
Model type: Group and network.
For profit.
Sponsorship: Physicians Plus Medical Group and Meriter Hospital Inc.
Staff: 300-500 primary physicians; six administrative staff members; five marketing staff members; 200 patients per physician.
Facilities: 11 hospitals; 185 pharmacies.
Service area: Dane, Dodge, Columbia, Iowa, Jefferson, Marquette, Sauk, Walworth and Richland counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, dental, optical lenses. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities.
Rating options: By age/sex, experience rating.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment allowed.
Users: 773 employer/payer groups; 10,691 employees with single coverage; 14,881 employees with family coverage; 60,261 employees and dependents; 55,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages four days. 81 admissions per 1,000 members.
Management reports: Not provided.
Billing: Provides direct billing for premiums under COBRA.
Gross revenues: $46.2 million in 1988; $56.7 million estimated for 1989.
Officers: Peggy Ann Smelser, president; Mark Minsloff, chief operating officer; Dr. Nicholas Mischler, medical director; Beth Zaher, marketing director; Mike Mohoney, chief financial officer.

Samaritan Health Plan Insurance Corp.

1101 N. Market St., Milwaukee, Wis. 53202-3114; 414-277-9000

September 1981.
Federally qualified.
Certified in: Wisconsin.
Model type: Mixed.
For profit.
Sponsorship: Aurora Health Care.
Staff: 596 primary physicians; 856 specialists; 11 administrative staff members; seven marketing staff members; 143 patients per physician.
Facilities: 20 hospitals; 298 pharmacies; 11 diagnostic labs.
Service area: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include prescription drugs, vision, dental, podiatry. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating: $123.28 single, $315.25 family. Does not offer non-federally qualified programs to employers.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 390 employer/payer groups; 9,682 employees with single coverage; 20,052 employees with family coverage; 71,258 employees and dependents; 78,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 4.91 days. 92 admissions per 1,000 members.
Management reports: Not provided.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $83.2 million in 1988; $81.1 million estimated for 1989.
Officers: James A. Schultz, chief executive officer; Dr. Winfred H. Stringer, vp/medical director; Michael Silgen, vp-marketing; John Hake, vp-finance.

Trane Health Protection Plan

2000 Westwood Drive, Wausau, Wis. 54401; 715-847-8866

Operational date: January 1979.
Certified in: Wisconsin.
Model type: IPA.
For profit.
Sponsorship: Insurer.
Staff: 372 primary physicians.
Facilities: Eight hospitals.
Service area: LaCrosse, Vernon, Trempealeau, Jackson and Monroe counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, experimental procedures, periodic check-ups, prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental.
Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: One employer/payer group; 638 employees with single coverage; 2,251 employees with family coverage; 7,757 employees and dependents; Hospital stay averages 3.6 days. 70.5 admissions per 1,000 members.
Management reports: Provided annually or upon request.
Billing: Does not provide direct billing for premiums under COBRA.
Gross revenues: $6.5 million in 1988.
Officers: Jeff Zriny, vp; Terry Bolz, executive director.

Wisconsin Health Organization

111 W. Pleasant St., Milwaukee, Wis. 53212; 414-223-3300; 800-289-0260

Operational date: September 1985.
Federally qualified.
Certified in: Wisconsin.
Model type: IPA.
For profit.
Sponsorship: Group of 10 hospitals.
Staff: 763 primary physicians; 1,549 specialists; 130 administrative staff members; 22 marketing staff members; 131 patients per physician; 100% board certified physicians.
Facilities: 14 hospitals; 350 pharmacies.
Service area: Racine, Kenosha, Walworth, Milwaukee, Waukesha and Ozaukee counties in Wisconsin.
Locations: One administrative site.
Services: Standard package includes hospitalization, laboratory, X-ray, preventive medicine, inpatient, outpatient, periodic check-ups, prescription drugs, vision, chiropractic, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Options include dental, oral surgery, hearing aids, eyewear. Diagnostic testing and lab work performed by contract with independent facilities.
Rating options: Community rating, by class, by age/sex. Does not offer non-federally qualified programs to employers.

Enrollment options: Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries. Individual enrollment not allowed.
Users: 1,000 employer/payer groups; 19,200 employees with single coverage; 33,100 employees with family coverage; 99,300 employees and dependents; 113,000 estimated enrollees as of Jan. 1, 1990. Hospital stay averages 3.5 days. 89 admissions per 1,000 members.
Management reports: Provided annually.
Billing: Does not provide direct billing for premiums under COBRA. National accounts program with consolidated billing not available.
Gross revenues: $52 million in 1988; $85 million estimated for 1989.
Officers: Kipton Kaplan, chief executive officer/president; Dr. Carl F. Myers, vp-medical affairs; Thomas R. Sobocinski, vp-marketing; Mark E. Daley, chief operating officer/vp-operations; Craig Kasten, vp-finance. ■

Guide to PPO listings

The third annual *Business Insurance* directory of preferred provider organizations contains information on 689 PPOs and is the most comprehensive source of information on individual PPOs.

The directory is published as an editorial service; there is no charge for PPOs to be included.

PPOs are arranged alphabetically under the state in which they operate. When a PPO operating in more than one state provided consolidated figures for all of its PPOs, the listing is footnoted that the figures are consolidated. At the very least, names, addresses and telephone numbers of individual PPOs are listed under the states serviced, with a reference to the consolidated listing.

Otherwise, in addition to the name, address and telephone number of each PPO, the listing includes headings indicating the PPO's **operational date**, **sponsorship** and whether it is **for profit** or **not for profit**.

Information on the PPO's **staff** as of Sept. 30, 1989, was requested, including: number of primary physicians; number of specialists and specialists available for referral; number of administrative staff members and marketing staff members; the average number of patients per physician; and the percent of physicians who are board certified.

The number of participating hospitals, pharmacies and diagnostic labs as of Sept. 30, 1989, was requested and is listed under the **facilities** heading.

The PPO's **service area** is provided next.

Information on **services provided** includes: specialty services offered, or those for which a network exists; whether employees can select non-PPO providers at the time of service; if the PPO will customize its plan design to meet employer specifications; and whether individual enrollment is allowed (such as retirees).

PPOs also were asked to provide information on **users** as of Sept. 30, 1989, including number of participating employer/payer groups; number of employees with single coverage; number of employees with family coverage; number of employees and dependents in participating employer groups with access to the network; and estimated total number of users as of Jan. 1, 1990.

The **compensation** heading contains information on how the PPO negotiates hospital charges, how it is compensated and how it charges for its services.

Utilization review methods used by the PPO and how they are implemented are detailed under the **control measures** heading.

Gross revenues for 1988 and estimated 1989 revenues, based on total claims paid to participating hospitals and physicians, were requested.

Names and titles of **officers** complete the listings.

If you wish to locate a PPO alphabetically by name, refer to the index following this directory. Names of the PPOs and states serviced are provided.

Also, an index listing which page each state's PPO listings begin is provided on page 2.

Information for the directory was gathered from responses to a *Business Insurance* questionnaire sent to PPOs.

Although every effort is made to obtain complete and accurate information, *Business Insurance* is unable to verify all information and relies on the responses provided by the PPOs.

Continued from previous page



PARTNERS National Health Plans-Alaska

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Health Network-Alaska

P.O. Box 60308; Los Angeles, Calif. 90060; 213-261-9066

See Preferred Heath Network under California.

Preferred Provider Arrangement

15200 Dayton Ave. N., Seattle, Wash. 98133; 206-361-3873

See Blue Cross of Washington & Alaska under Washington.



Arizona Medical Network

1600 W. Broadway, Suite 385, Tempe, Ariz. 85282; 602-921-8941

Operational date: June 1983.
Sponsorship: Hospital, group of doctors, community.
Not for profit.
Staff: 1,000 primary physicians; 580 specialists; four administrative staff members; two marketing staff members; average of 115 members per primary physician.
Facilities: 17 hospitals; 26 diagnostic labs.
Service area: Arizona.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO, Action Health, August International, Alta Review, American HTL Network, Care Review, Patient Advocate.
Gross revenues: Not reported.
Officers: Ed Sandadge, president; Tom Economidis, executive director; Dr. Charles Saffell, medical director; Catherine Bell, marketing director; Jim Burns, senior vp.

Arizona Preferred Provider

6464 E. Grant Road, Tucson, Ariz. 85715; 602-298-5297

Operational date: 1984.
Sponsorship: Private.
Not for profit.
Staff: 300 primary physicians; six administrative staff members; two marketing staff members; average of nine patients per primary physician; 100% board certified physicians.
Facilities: Five hospitals; 15 pharmacies; two diagnostic labs.
Service area: Pima, Maricopa and Cochise counties in Arizona.
Services provided: Specialty services include prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 20 employer/payer groups; 800 employees with single coverage; 5,000 employees with family coverage; 5,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, second surgical opinion, hospital bill audits; utilization review provided by outside contractor.
Gross revenues: Not reported.
Officers: Dwight W. Babcock, president; Kathy Dunn, executive director.

CNA Managed Care PPO-Phoenix

3530 Wilshire Blvd., Seventh floor, Los Angeles, Calif. 90010; 213-252-7124

Operational date: July 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 749 primary physicians; 72.9% board certified physicians, 16.3% board eligible.
Facilities: Nine hospitals and medical facilities.
Service area: Maricopa County, Ariz.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 9,200 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Zaven Kazazian, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Phoenix

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Tucson

Hartford, Conn. 06106; 203-726-6904.

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Phoenix

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Tucson

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee

First American Health Concepts Inc.

1811 S. Alma School Road, Suite 285, Mesa, Ariz. 85210; 602-897-1110

Operational date: September 1981.
Ownership: Shareholders.
For profit.
Staff: 5,000 primary providers; 20 administrative staff members; four marketing staff members.
Service area: All 50 states.
Services provided: Specialty services include vision. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 160 employer/payer groups; 8.4 million employees and dependents with access to the network; 9 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers, specified laboratories; the PPO charges a flat fee per eligible employee.
Gross revenues: $2.5 million in 1988; $3.1 million estimated in 1989.
Officers: Daniel E. Dahlstedt, president; J. Kent Massey, chief executive officer; Carolyn Fricke, secretary/treasurer; Daniel G. Slabaugh, vp-finance; Jacquelin Dabner, vp-administrative services.

Great-West Care-Phoenix

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: July 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 761 primary physicians; 64% board certified physicians.
Facilities: Nine hospitals.
Service area: Mohave, Yavapai, LaPaz, Maricopa, Yuma, Pima, Pinal, Gila, Coconino, Santa Cruz, Cochise and Graham counties in Arizona.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Nine employer/payer groups; 2,205 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Humana Health Care Plans

2231 E. Camelback Road, Suite 208, Phoenix, Ariz. 85016; 602-381-4300

See Humana Health Care under Kentucky.

Maricopa Foundation for Medical Care

326 E. Coronado Road, Phoenix, Ariz. 85004; 602-252-4042; 800-624-4277

Operational date: 1969.
Sponsorship: Group of doctors.
Ownership: Physician members.
Not for profit.
Staff: 2,850 primary physicians; 31 administrative staff members; two marketing staff members; 85% board certified physicians.
Facilities: 34 hospitals; 60 diagnostic labs.
Service area: Pima, Maricopa and other counties in Arizona.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 737 employer/payer groups; 38,300 employees with single coverage; 19,239 employees with family coverage; 57,539 employees and dependents with access to the network; 166,863 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Precertification, concurrent hospital treatment review, length of stay determination, second surgical opinion, outpatient service predetermination; utilization review provided by the PPO.
Gross revenues: $2.2 million in 1988; $2.4 million estimated in 1989.
Officers: Dr. Neil O. Ward, president; Anthony D. Mitten, executive director; Robert A. Williams, marketing director.

Metropolitan Life Insurance Co.-Managed Care Services Group

276 Post Road W., Westport, Conn., 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See Partners National Health Plans under Texas.

Preferred Care

6464 E. Grant Road, Tucson, Ariz. 85715; 602-298-5297

Operational date: October 1983.
Sponsorship: Blue Cross & Blue Shield of Arizona.
Staff: 2,430 primary physicians.
Facilities: 30 hospitals.
Service area: Cochise, Maricopa and Pima counties in Arizona.
Compensation: The PPO negotiates hospital charges by DRGs.
Control measures: Preadmission hospital review, second surgical opinion, case management.
Gross revenues: Not reported.

Preferred Health Network

P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

See Preferred Health Network under California.

Rural Arizona Network

P.O. Box 276, Cottonwood, Ariz. 86326; 800-331-9562

Operational date: June 1987.

Continued on next page

Continued from previous page
Sponsorship: Group of doctors.
For profit.
Staff: 255 primary physicians; 135 specialists; six administrative staff members; one marketing staff member; average of 192 patients per primary physician; 92% board certified physicians.
Service area: All 13 rural Arizona counties.
Services provided: Specialty services include vision, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 13 employer/payer groups; 23,036 employees and dependents with access to the network; 26,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $1.3 million in 1988; $3.6 million estimated in 1989.
Officers: Dr. Edward R. Curtis, president/medical director; Catherine W. Bell, executive director; Tom Economidis, marketing director; Dr. Wesley Ronberger, Dr. Henry Kaldenbaugh and Dr. John Lingenfelter.

Sound Benefit Concepts Inc.

7664 E. Windrose Drive, Scottsdale, Ariz. 85260; 602-991-8517

Operational date: October 1989.
Sponsorship: Private.
For profit.
Staff: Projected for 1990: 2,500 specialists; four administrative staff members; two marketing staff members.
Service area: All 50 states.
Services provided: Specialty services include hearing aid distribution network. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Compensation: The PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a fee for administrative services when a purchase occurs.
Control measures: Retrospective review of audiological exam results and prescribed aid to ensure appropriate dispensing; utilization review provided by the PPO.
Officers: Thomas P. Apker, president; Debra A. Apker, executive director.

Southwest Preferred Dental Organization Inc.

5151 N. 16th St., Suite E-222, Phoenix, Ariz. 85016; 602-483-1121

Operational date: April 1987.
Sponsorship: Privately owned.
For profit.
Staff: 110 primary physicians; 25 specialists; two administrative staff members; one marketing staff member; average of 473 patients per primary physician; 100% board certified physicians.
Service area: Arizona, New Mexico and Southern California.
Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: More than 400 employer/payer groups; 7,500 employees with single coverage; 13,500 employees with family coverage; 52,000 employees and dependents with access to the network; 58,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Precertification; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: John B. Lutz, president; Dr. Michael Steinberg, medical director; Julie Lutz, marketing director; C.P. Goree.

Travelers Preferred-Metro Phoenix

951 Mariners Island Blvd., Suite 680, San Mateo, Calif. 94404; 415-341-0810

Operational date: March 1987.
Sponsorship: The Travelers Insurance Cos.
For profit.
Staff: 1,121 primary physicians.
Facilities: Eight hospitals.
Service area: Maricopa County, Ariz.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 31 employer/payer groups; 6,002 employees with single coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Roland King, executive director; Gail M. Ptacek, health plan manager.



Prudential Plus of Little Rock

10800 Financial Centre Parkway, Suite 499, Little Rock, Ark. 72211; 501-227-7776

Operational date: November 1987.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 267 primary physicians; 175 specialists; 13 administrative staff members; one marketing staff member.
Facilities: Five hospitals; one diagnostic lab.
Service area: Faulkner, Grant, Lonoke, Pulaski and Saline counties in Arkansas.
Services provided: Specialty services include dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, IV therapy, physical therapy, speech therapy, ostomy. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is not allowed.
Users: 14,000 employees and dependents in participating employer groups with access to the network. 15,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Susan K. Sharkey, manager-health care services; Dr. William H. Riley, medical director; Tracy H. Baker, regional group manager.



AVP Vision Plans

165 Du Bois St., Santa Cruz, Calif. 95060; 800-443-4994; 408-425-0989

Operational date: July 1985.
Ownership: Optics East.
For profit.
Staff: More than 600 primary physicians; 45 specialists; five administrative staff members; 11 marketing staff members; average of 35 patients per primary physician.
Facilities: Two eye lens labs.
Service area: California.
Services provided: Specialty services include vision. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is allowed.
Users: More than 150 employer/payer groups; more than 21,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by claims administrators; the PPO charges a fee for service.
Control measures: Retrospective review; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Stephen Shaw, president; D.K. Kim, executive director; Dr. Robert Greeley, medical director; John Curva, marketing director.

Affordable Health Care Concepts

2525 Natomas Park Drive, Suite 250, Sacramento, Calif. 95833; 916-925-7800

Operational date: 1983.
Sponsorship: Corporate.
For profit.
Staff: 11,000 primary physicians; 85% board certified physicians.
Facilities: 350 hospitals; 120 diagnostic labs.
Service area: California, Oregon, Washington, Nevada, Arizona, New Mexico, Colorado, Utah, Texas, Tennessee, Kentucky, Illinois, Missouri, Wisconsin, Virginia, District of Columbia, Georgia and Florida.
Services provided: Specialty services include dental, substance abuse, psychiatric services. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is not allowed.
Users: 150 employer/payer groups; 2 million employees and dependents with access to the network; 2.2 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: Not reported.
Officers: Daniel Brunner, president; Dr. Alan Korn, medical director; Pat Dills, marketing director.

American Health Network Inc.

1610 Arden Way, Suite 165, Sacramento, Calif. 95815; 916-649-6601

See American Health Network under Texas.

Augnet

Suite 1000, 1 City Blvd. W., Orange, Calif. 92668; 714-938-2600

Operational date: 1986.
Ownership: August International Corp.
For profit.
Staff: 8,000 primary physicians; 6,000 specialists; five administrative staff members; two marketing staff members; average of 250-300 patients per primary physician; 98% board certified physicians.
Facilities: 155 hospitals; two diagnostic labs.
Service area: California; greater metropolitan Portland and Umatilla, Multnomah, Clackamas, Columbia counties in Oregon; Bernalillo County in New Mexico.
Services provided: Specialty services include opthamology, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is not allowed.
Users: 1,000 employer/payer groups; 260,000 employees with family coverage; 610,000 employees and dependents with access to the network; 620,750 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, per case; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals or a combination of methods.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Michael J. Lewis, president; Bonnie Yatabe, executive director-PPO/bill review services; William Thompson, medical director; George Bregante, marketing director; Charles Cressman III, vp-sales; Kirk Andrews, chief financial officer/vp-finance.

BPS Inc. (Benefit Panel Services)

888 S. Figueroa St., Suite 1400, Los Angeles, Calif. 90017; 213-489-2694

Operational date: 1983.
Sponsorship: Independent.
For profit.
Staff: 6,000 primary physicians; 3,000 specialists; 100 administrative staff members; three marketing staff members; minimum of 40 patients per primary physician; 90% board certified physicians.
Facilities: 110 hospitals; more than 125 diagnostic labs.
Service area: 22 counties in California.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is allowed.
Users: 1,600 employer/payer groups; 240,000 employees and dependents with access to the network; 260,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination; utilization review provided by the PPO.
Gross revenues: $50 million in 1988; $100 million estimated in 1989.
Officers: Virginia L. Downie, marketing director.

Beech Street Inc.*

2 Ada, Suite 200, Irvine, Calif. 92718; 714-727-1353

Operational date: 1984.
Sponsorship: Private.
Ownership: Privately held.
For profit.
Staff: 11,952 primary physicians; 5,378 specialists; 15 administrative staff members; eight marketing staff members; 100% board certified physicians.
Facilities: 582 hospitals.
Service area: California, Arizona, Texas, Georgia, Wisconsin, Ohio, Alabama, Alaska, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Nevada, New Mexico, North Carolina, South Carolina, Tennessee, Vermont, Virginia, Florida, Pennsylvania, Indiana, Kansas, Washington, Oregon, Arkansas.
Services provided: Specialty services include substance abuse, psychiatric services. Employees can select non-PPO providers at time of service, PPO plan design can be customized to meet employer specifications, individual enrollment is allowed.
Users: 565 employer/payer groups; 454,063 employees with single coverage; 592,878 employees with family coverage; 1.8 million employees and dependents with access to the network; 2 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals, a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Ron Ooley, president/chief financial officer; Lester Sacks, senior vp-medical affairs; Jeffrey DeGrandpre, vp; Tom Gannon, vp-PPO contracting; Laura Moore, senior vp-workers compensation; Clark Wingfield, senior vp-health benefits.
* Figures are corporate, including all PPOs sponsored by Beech Street Inc.

Business Health Services Workers Compensation PPO

7311 Greenhaugh Drive, Sacramento, Calif. 95831; 916-391-4155

Operational date: 1988.
For profit.
Facilities: 200 hospitals.
Service area: California.
Users: Six employer/payer groups.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a percent of savings.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. E. Scott Rosenbloom, president.

CNA Managed Care PPO-Los Angeles

3530 Wilshire Blvd., 7th Floor, Los Angeles, Calif. 90010; 213-252-7124

Operational date: April 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 4,205 primary physicians; 76.7% board certified physicians, 9.7% board eligible.
Facilities: 40 hospitals and medical facilities.
Service area: Los Angeles, Orange, Riverside, San Bernardino, Ventura, Santa Barbara and Imperial counties in California.
Services provided: Specialty services include substance abuse, psy-

Continued on next page

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chiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 34,000 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Zaven Kazazian, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Sacramento

50 Fremont St., San Francisco, Calif. 94105; 415-243-4982

Operational date: November 1987.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 715 primary physicians; 83.4% board certified physicians, 9.7% board eligible.

Facilities: Nine hospitals and medical facilities.

Service area: Sacramento, San Joaquin, Butte, Yuba, Placer and Stanislaus counties in California.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 5,500 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Robert Shaffer, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-San Diego

3530 Wilshire Blvd., Seventh Floor, Los Angeles, Calif. 90010; 213-252-7124

Operational date: April 1987.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 1,195 primary physicians; 80.2% board certified physicians, 7.3% board eligible.

Facilities: Nine hospitals and medical facilities.

Service area: San Diego County, Calif.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 1,800 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Zaven Kazazian, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-San Francisco

50 Fremont St., San Francisco, Calif. 94105; 415-243-4982

Operational date: August 1986.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 2,782 primary physicians; 76.6% board certified physicians.

Facilities: 20 hospitals and medical facilities.

Service area: San Francisco, San Mateo, Santa Clara, Alameda, Contra Costa, Marin, Sonoma and Napa

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counties in California.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 9,900 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Robert Shaffer, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

California Preferred Providers Inc.

25 W. Carrillo, Santa Barbara, Calif. 93101; 805-963-0566

Operational date: April 1984.
Sponsorship: Hospitals and a group of doctors.
For profit.

Staff: 226 primary physicians; 157 specialists; 17 administrative staff members; three marketing staff members.

Facilities: Nine hospitals; 18 pharmacies; three diagnostic labs.

Service area: Santa Barbara, San Luis Obispo and Ventura counties in California.

Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 200 employer/payer groups; 30,057 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination; utilization review provided by the PPO and Sentinel Medical Review.

Gross revenues: Not reported.

Officers: Leeba Lessin, chief executive officer/president; Michael Clare, medical director; Steve Van Wart, marketing director.

CAPP Care*

17390 Brookhurst, Suite 280, Fountain Valley, Calif. 92708; 714-963-8065

Operational date: 1984.
Sponsorship: Independent.
For profit.

Staff: 38,000 primary physicians; 35 administrative staff members; 10 marketing staff members; approximately 70% board certified physicians.

Facilities: 481 hospitals.

Service area: Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Louisiana, Michigan, Missouri, Nebraska, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, Wisconsin.

Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.

Users: Approximately 30,000 employer/payer groups; more than 250,000 employees and dependents with access to the network; 325,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, review of physician office activity; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Michael E. Henry, president/chief operating officer; Dr. Dorcas Eaves, medical director; Thomas R. Acosta, vp-marketing; Dr. Edward Zalta, chairman/chief executive officer.

* Figures are corporate, including all CAPP Care PPOs.

Chiropractic Health Plan of California

P.O. Box 190, Clayton, Calif. 94517; 415-672-0106; 805-495-0345

For profit.

Staff: 710 primary physicians; four administrative staff members; two marketing staff members; 100% board certified physicians.

Service area: California.

Services provided: Specialty services include chiropractic care. PPO plan design can be customized to meet employer specifications.

Compensation: The PPO is compensated by claims administrators; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Retrospective review, outpatient service predetermination, case management; utilization review provided by Preferred Utilization management.

Gross revenues: Not reported.

Officers: Dr. Lloyd Friesen, president/marketing director; Dr. Ronald S. Cataldo, executive director/medical director.

CIGNA FlexCare Preferred Provider Organization-Los Angeles

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-San Diego

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-San Francisco

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Community Care Network

9265 Sky Park Court, Suite 200, San Diego, Calif. 92123; 619-278-2273

Operational date: 1984.
Sponsorship: Independent.
Tax status: For profit; not for profit in California and Arizona.

Staff: 10,800 primary physicians; more than 7,000 specialists; 200 administrative staff members; eight marketing staff members; 98% board certified physicians.

Facilities: 300 hospitals; 90 diagnostic labs.

Service area: Maricopa and Pima counties in Arizona; California; Adams and Denver counties in Colorado; District of Columbia; 17 counties in Virginia; Montgomery and Prince Georges counties in Maryland; Cook, DuPage, Kane, Lake, McHenry and Will counties in Illinois; Lake and Porter counties in Indiana; Hinds County, Miss.; Butler County, Mo.; Valencia County, N.M.; Bastrop County, Texas; Utah County, Utah; Milwaukee, Waukesha, Ozaukee and Washington counties in Wisconsin.

Services provided: Specialty services include dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 536 employer/payer groups; 6.9 million employees and dependents with access to the network (includes workers compensation); 7.2 million estimated employees and dependents with access to the network as of Jan. 1, 1990 (includes workers compensation).

Compensation: The PPO negotiates hospital charges by per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals or a combination of methods.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, medical necessity determinations, ambulatory review; utilization review provided by the PPO and by outside contractors.

Gross revenues: $500 million in 1988; $650 million estimated in 1989.

Officers: George S. Murphy, chief executive officer; Robert M. Colasanto, president; Dr. Eugene V. Helsel, medical director; Patrick Sullivan, marketing director; Nancy B. Plaxico, vp-purchaser affairs; Sandra McLaren Foote, vp-provider affairs; Douglas J. Reeves, vp-information systems; Richard C. Morgan, vp-administration/finance.

Cost Care Exclusive Provider Network

P.O. Box 3239, Huntington Beach, Calif. 92647; 714-842-4909; 800-762-3029, ext. 5000

Operational date: August 1987.
Ownership: Cost Care Inc.
For profit.

Staff: 10,000 primary physicians; 17 administrative staff members; 10 marketing staff members; 90% board certified physicians.

Facilities: 110 hospitals; 80 diagnostic labs.

Service area: California.

Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 150 employer/payer groups; 64,000 employees and dependents with access to the network; 90,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, optional case management, 100% provider bill review; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Lawrence Goelman, president; Patricia Batt, executive director; Dr. Alan Greenfield, medical director.

DELTA Preferred Option

P.O. Box 7736, San Francisco, Calif. 94120; 415-972-8300

Operational date: 1987.
Sponsorship: Delta Dental Plan of California.
Not for profit.

Staff: 1,600 primary dentists; 240 specialists; administrative and marketing services provided by sponsor.

Service area: California.

Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.

Users: 59 employer/payer groups; 21,525 employees with single coverage; 97,432 employees with family coverage; 268,000 employees and dependents with access to the network; 160,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Computer profiles, treatment review, patient treatment computer check; utilization review provided by the PPO.

Gross revenues: Delta Dental Plan of California: $722 million in 1988; $801 million estimated in 1989.

Officers: Dr. Erik D. Olsen, president; Dr. John F. Fields, dental director; Don B. Conkling, marketing director; William T. Ward, Joseph C. Jaeger.

Dual-Plus Insurance Administrators

911 Studebaker Road, Suite 250, Long Beach, Calif. 90815; 213-598-6681

Operational date: 1972.
Sponsorship: Private.
For profit.

Staff: 18,000 primary physicians; approximately 9,000 specialists; 32 administrative staff members; six marketing staff members.

Facilities: 500 hospitals.

Service area: Arizona, California, Georgia, Mississippi and Colorado.

Services provided: Specialty services include vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 600 employer/payer groups; 7,800 employees with single coverage; 3,000 employees with family coverage; 13,000 employees and dependents with access to the network; 20,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Dr. Joseph W. Noble, chief executive officer/medical director; Kelly Dickens, vp/chief operating officer.

El Camino Preferred Physicians Medical Group Inc.

777 Cuesta Drive, Suite 200, Mountain View, Calif. 94040

Operational date: April 1983.
Sponsorship: Group of doctors.

Staff: Approximately 360 primary physicians; one administrative staff member.

Facilities: One hospital.

Service area: Santa Clara County, Calif.

Services provided: Specialty services include vision, psychiatric services, podiatry, obstetrics/gynecology.

Users: 17 employer/payer groups.

Compensation: The PPO charges annual dues to physicians.

Gross revenues: Not reported.

Officers: Dr. Larry Kretchmar, president; Dr. Richard Slavin, treasurer; Dr. Richard Gilman, secretary.

EQUICOR Preferred-California

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Exclusive Provider System

P.O. Box 8422, Newport Beach, Calif. 92658-8422; 714-759-1707

Operational date: April 1987.
Sponsorship: Private.
For profit.

Staff: 75 primary physicians; two administrative staff members; one marketing staff member; 90% board certified physicians.

Service area: California.

Services provided: Specialty services include industrial and occupational medicine. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 30 employer/payer groups; 10,000 employees with single coverage.

Compensation: The PPO is compensated by employers/payers, claims administrators; the PPO charges a percent of services rendered by participating doctors/hospitals.

Control measures: Case management; utilization review provided by the PPO.

Gross revenues: $120,000 in 1988; $350,000 estimated in 1989.

Officers: Karen J. Gillett, president; Fred Gillett.

Foundation for Medical Care of Santa Clara County

1101 S. Winchester Blvd., Suite F-164, San Jose, Calif. 95128; 408-248-9400

Operational date: 1960.
Sponsorship: Hospitals and a group of doctors.

Not for profit.

Staff: 1,600 primary physicians; three administrative staff members.

Facilities: Eight hospitals, five diagnostic labs.

Service area: California.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment may be allowed.

Users: 316 employer/payer groups.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, retrospective review, second surgical opinion; utilization review provided by Review Service Inc.

Gross revenues: Not reported.

Officers: Dr. James R. Dickson, president; Charles W. Maschal Jr., executive director; Dr. Donald L. Allari, vp; Dr. Allan S. Vishoot, secretary; John Working, treasurer.

Golden West Dental & Vision Plan

888 W. Ventura Blvd., Suite 7, Camarillo, Calif. 93010; 805-987-8941

Operational date: April 1987.
Sponsorship: Knox Keene Licensed Plan.
Ownership: Golden West Health Plan Inc.
For profit.

Staff: 500 dental and 350 vison offices; 25 administrative staff members; seven marketing staff members; 100% board certified physicians.

Service area: California, New Mexico, Arizona, Nevada, Washington, Oregon.

Services provided: Specialty services include dental and vision. Em-

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ployees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment may be allowed.

Users: Approximately 200 employer/payer groups; estimated 15,000 employees and dependents with access to the network.

Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Officers: Karl H. Lehmann, president/executive director; Candee Bolyog, provider relations; William Ayres, marketing director; Daphne Becker, chief financial officer.

Great West Care-Central California

8505 E. Orchard Road,
Englewood, Colo. 80111;
303-889-3519

Operational date: November 1989.

Sponsorship: Private Healthcare Systems Ltd.

For profit.

Staff: Approximately 1,500 primary physicians; 67% board certified physicians.

Facilities: 14 hospitals.

Service area: Kern, San Bernardino, San Luis Obispo, Santa Barbara, Ventura, Fresno, San Joaquin and Stanislaus counties in California.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh, vp; David Grapko, manager; Jim Motz, vp.

Great-West Care-Los Angeles/Orange County

8505 E. Orchard Road,
Englewood, Colo. 80111;
303-889-3519

Operational date: April 1987.

Sponsorship: Great-West Life Assurance Co.

Ownership: Private Healthcare Systems Ltd.

For profit.

Staff: 4,489 primary physicians; 73% board certified physicians.

Facilities: 30 hospitals.

Service area: Ventura, Los Angeles, San Bernardino, Riverside and Orange counties in California.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 65 employer/payer groups; 19,318 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Sacramento

8505 E. Orchard Road,
Englewood, Colo. 80111;
303-889-3519

Operational date: November 1987.

Sponsorship: Great-West Life Assurance Co.

Ownership: Private Healthcare Systems Ltd.

For profit.

Staff: 734 primary physicians; 72% board certified physicians.

Facilities: Nine hospitals.

Service area: Madera, Fresno, Calaveras, Yolo, El Dorado, Amador, Butte, Yuba, Sutter, Nevada, Plumes and portions of Sacramento counties in California.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-San Diego

8505 E. Orchard Road,
Englewood, Colo. 80111;
303-889-3519

Operational date: September 1987.

Sponsorship: Great-West Life Assurance Co.

Ownership: Private Healthcare Systems Ltd.

For profit.

Staff: 1,222 primary physicians; 74% board certified physicians.

Facilities: Eight hospitals.

Service area: San Diego County, Calif.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: One employer/payer group; 31 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

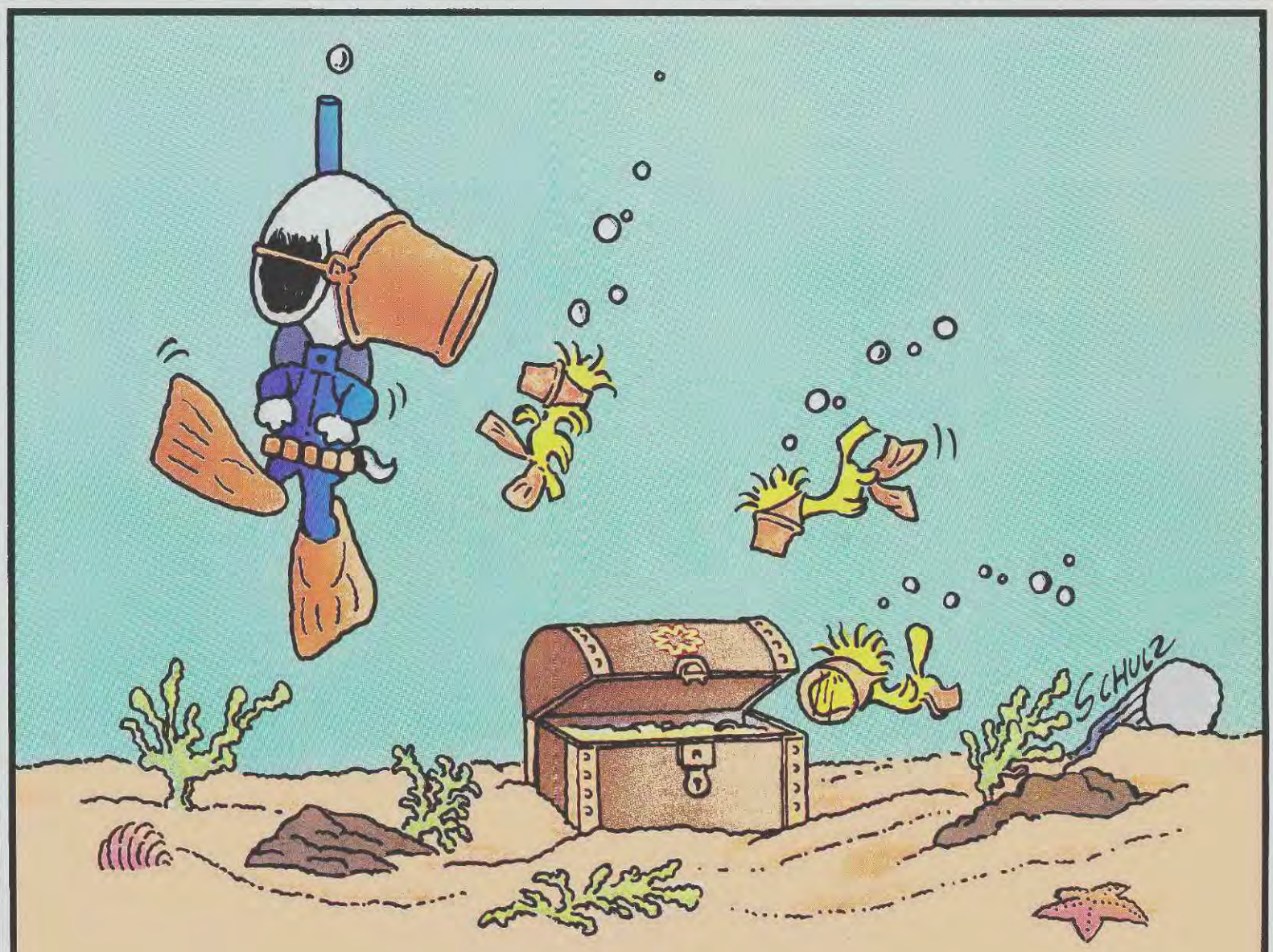
Great-West Care-San Francisco

8505 E. Orchard Road,
Englewood, Colo. 80111;
303-889-3519

Operational date: August 1986.

Sponsorship: Great-West Life Assurance Co.

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Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 2,699 primary physicians; 77% board certified physicians.
Facilities: 16 hospitals.
Service area: Marin, Mendocino, Humboldt, Trinity, Lake, Sonoma, Napa, Solano, Alameda, Santa Clara, Santa Cruz, San Benito, San Francisco, San Mateo and Contra Costa counties in California.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 149 employer/payer groups; 23,058 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps, David Grapko, manager.

John Hancock Preferred Health Plan-California

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Hartford's PULSE Plan of Northern California

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: April 1987.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 1,577 primary physicians; 1,220 specialists.
Facilities: 42 hospitals; 37 diagnostic labs.
Service area: Alameda, Contra Costa, San Mateo, San Francisco, Santa Clara, Fresno and Sacramento counties in California.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 30 employer/payer groups; 9,492 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, large case management; utilization review provided by the PPO, Health Data Institute and American Psychiatric Management.
Gross revenues: Not reported.
Contact: Jinnie K. Simonsen, regional sales manager, The Hartford Insurance Co., 455 Market St., San Francisco, Calif. 94105; 415-995-3200.

Hartford's PULSE Plan of Southern California

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: April 1987.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 2,757 primary physicians; 1,915 specialists.
Facilities: 76 hospitals; 32 diagnostic labs.
Service area: Los Angeles, Kern, Orange, Ventura, San Diego, Riverside and San Bernadino counties in California.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 70 employer/payer groups; 22,147 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, large case management; utilization review provided by the PPO, Health Data Institute and American Psychiatric Management.
Gross revenues: Not reported.
Contact: Arthur L. Smith, regional sales manager, 13191 Crossroad Atrium, Suite 320, City of Industry, Calif. 91746; 213-695-8111.

Health Care Aware Inc.

31255 Cedar Valley Drive, Suite 215, Westlake Village, Calif. 91362; 818-707-7244

Operational date: 1976.
Ownership: Corporate.
For profit.
Staff: More than 800 primary physicians; 12 administrative staff members; five marketing staff members; 15% board certified physicians.
Service area: California.
Services provided: Specialty services include dental, psychiatric services, podiatry, chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: Over 70 employer/payer groups; 1.2 million employees with family coverage; three million employees and dependents with access to the network.
Compensation: The PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $4.7 million in 1988; more than $5 million estimated for 1989.
Officers: Dr. Frederick Derfler, president/chief executive officer; Dr. Martin Snyder, executive vp; Addie Derfler, marketing consultant; Hi Hand, executive vp-finance; Phyllis Katz, vp-administration; Lorraine Grey, director-operations.

Health Options Medical Group Inc.

333 Sunrise Ave., Roseville, Calif. 95661; 916-781-1650

Operational date: 1987.
Sponsorship: Group of doctors.
For profit.
Staff: More than 100 primary physicians; two administrative staff members.
Facilities: Two hospitals.
Service area: Placer County in California.
Compensation: The PPO negotiates hospital charges through individual plans with the hospital.
Officers: Dr. Richard T. Yates, president; Dr. Dwight Odom and Dr. Philip Raimondi.

Humana Insurance Co.

West Anaheim Medical Plaza, 3010 W. Orange Ave., Suite 210, Anaheim, Calif. 92804; 714-220-2444

See Humana Health Care Plans under Kentucky.

Insurance Dentists of America

20480 Blauer Drive, Saratoga, Calif. 95070; 408-867-1960

Operational date: September 1983.
Sponsorship: Six insurance companies.
For profit.
Staff: 29,053 dentists; 4,358 specialists; eight administrative staff members; three marketing staff members.
Service area: All states.
Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment may be allowed.
Users: 1,027 employer/payer groups; approximately 800,000 employees with single or family coverage.
Compensation: The PPO is compensated by insurers; the PPO charges a flat fee per eligible employee.
Control measures: Retrospective review; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. Richard L. Garwood, president; Dr. William G. Downes, vp; Dr. Gordon D. Marx, vp-professional relations.

Interplan Corp.

1150 W. Robinhood Drive, Suite 2C, Stockton, Calif. 95207; 209-473-0811

Operational date: August 1984.
Ownership: Privately owned.
For profit.
Staff: 11,500 primary physicians; 6,970 specialists; 11 administrative staff members; one marketing staff member; average of 168 patients per primary physician; 95% board certified physicians.
Facilities: 240 hospitals; 300 diagnostic labs.
Service area: California; Nevada; portions of Oregon, Washington and Idaho.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 78 employer/payer groups; 125,000 employees with single coverage; 125,000 employees with family coverage; 280,000 employees and dependents with access to the network; 280,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, per case; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee, a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, claims review; utilization review provided by the PPO and outside contractors.
Gross revenues: $300 million in 1988; $340 million estimated in 1989.
Officers: Daniel P. Sheehy, president; Phoebe Brown, vp.

Lincoln National Preferred Plan

3875 Hopyard Road, Pleasanton, Calif. 94566; 415-847-7000

See Lincoln National Preferred Plan under Indiana.

Lincoln National Preferred Plan

2655 Camino del Rio N., Suite 300; San Diego, Calif. 92108-1612; 619-299-6910

See Lincoln National Preferred Plan under Indiana.

Lincoln National Preferred Plan

21800 Oxnard St., Suite 600, Woodland Hills, Calif. 91367; 818-883-5193

See Lincoln National Preferred Plan under Indiana.

Med Network/Med$ense*

850 Town & Country Road, Orange, California 92688; 714-953-9600

Operational date: January 1979.
Ownership: Admar Corp.
For profit.
Staff: 25,878 primary physicians; 14,148 specialists; 128 administrative staff members; 11 marketing staff members; 65% board certified physicians.
Facilities: 339 hospitals; 1,353 pharmacies.
Service area: Network operates in Arizona, California, Colorado, District of Columbia, Massachusetts, Missouri, Kansas, New Mexico and Texas.
Services provided: Specialty services include prescription drug, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications within specialized limitations; individual enrollment is allowed.
Users: 21,852 employer/payer groups; 478,432 employees with family coverage; 1.1 million employees and dependents with access to the network; 1.2 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; utilization review provided by Healthwatch.
Gross revenues: Not reported.
Officers: Richard H. Toral, chief executive officer/chairman; Joe Manheim, assistant vp-contract/development; Dr. Vincent Duda, medical director; Randall Burt, director-marketing; Virginia Pascual, executive vp/chief operating officer.

* Figures are corporate, including all Med Network and Med$ense PPOs sponsored by Admar Corp.

Metropolitan Life Insurance Co.

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-California

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

OUCH

2400 Venture Oaks Way, Sacramento, Calif. 95833; 916-924-5200

Operational date: January 1986.
Sponsorship: Private.
For profit.
Staff: 23,500 primary physicians; 18,800 specialists; 300 administrative staff members; 19 marketing staff members; 80% board certified physicians.
Facilities: 426 hospitals; five pharmacies; 47 diagnostic labs.
Service area: California, Arizona, New Mexico and Texas.
Services provided: Specialty services include dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 70 employer/payer groups; 2.8 million employees and dependents with access to the network (includes workers compensation); 3.5 million estimated employees and dependents with access to the network as of Jan. 1, 1990 (includes workers compensation).
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a percent of savings.
Control measures: Preadmissior hospital review, precertification concurrent hospital treatment review, length of stay determination discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, outpatient concurrent and retrospective review; utilization review provided by the PPO.
Gross revenues: $201 million in 1988; $312 million estimated in 1989.
Officers: W. Robert Keen, president; James Cameron, chief executive officer; Dr. Max Negri, medical director; Terry Borchers, vp-marketing.

PM Group's PPO*

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

Operational date: January 1984.
Sponsorship: Insurer.
For profit.
Staff: 43,000 primary physicians.
Facilities: 567 hospitals.
Service area: Arizona, Alabama, California, Colorado, Florida, Illinois, Indiana, Michigan, Missouri, Nebraska, New Mexico, Ohio, Oregon, Tennessee, Texas, Utah, Washington, Wisconsin.
Services provided: Specialty services include vision, dental, substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 466 employer/payer groups; 67,000 employees with single or family coverage; 102,143 employees and dependents with access to the network; 106,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by CAPP CARE Inc.
Gross revenues: Not reported.
Officers: Bill Ferris, president.

* Figures are corporate, including all PM Group PPOs sponsored by Pacific Mutual Life Insurance Co.

PPO Alliance

21800 Oxnard St., Suite 550, Woodland Hills, Calif. 91367; 818-710-7762

Operational date: 1984.
Ownership: UniHealth America and Adventist Health System West.
For profit.
Staff: 10,200 primary physicians; 5,712 specialists; 30 administrative staff members; four marketing staff members; 11 average of patients per primary physician; 85% board certified physicians.
Facilities: 144 hospitals.
Service area: California and Nevada.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 555 employer/payer groups; 500,000 employees and dependents with access to the network; 800,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, case pricing; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by

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acific Review Services or other outde contractor.
Gross revenues: Not reported.
Officers: John C. Funk, president; ılie Jennings, marketing director.

'PO of Ventura County

625 E. Santa Clara St., Ventura, Calif. 93001; 805-656-1113

Operational date: August 1983.
Sponsorship: Ventura County oundation for Medical Care.
Not for profit.
Staff: 640 primary physicians; 325 pecialists; four administrative staff nembers; two marketing staff mem-ıers; 85% board certified physicians.
Facilities: 11 hospitals; two diag-ıostic labs.
Service area: California.
Services provided: Specialty ser-ices include prescription drug, vi-ion, dental, substance abuse, psychi-atric services, durable medical equipment, podiatry, obstetrics/gyn-ecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 348 employer/payer groups; 6,000 employees with single coverage; 6,000 employees with family coverage; approximately 14,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $10 million in 1988; $16 million estimated in 1989.
Officers: Dr. W. Cloyce Huff, president; Riley McWilliams, executive director; Dr. Richard Loft, medical director; Richard Michel, marketing director.

Pacific Chiropractic Resources

1770 Tribute Road, Suite 201, Sacramento, Calif. 95815-4494; 916-646-3477; 800-638-4557 in California.

Operational date: August 1985.
Sponsorship: Group of doctors.
For profit.
Staff: 300 primary chiropractors; eight administrative staff members; two marketing staff members; 100% board certified physicians.
Service area: California.
Services provided: Specialty services include chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Approximately 400,000 employees and dependents with access to the network; 500,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by health care providers; the PPO charges a percent of services rendered by participating doctors/hospitals.
Control measures: Precertification, retrospective review, case management; utilization review provided by the PPO.
Gross revenues: $4 million estimated in 1989.
Officers: Dr. Stephen J. Curry, president/medical director; Robert G. Britton, chief executive officer; Dr. Thomas Gallaugher, vp; Dr. David Eskew, secretary.

Pacific Providers Medical Group Inc.

2080 Century Park E., Suite 1703, Los Angeles, Calif. 90067; 213-553-2080

Operational date: 1983.
Sponsorship: Group of doctors.
For profit.
Staff: 125 primary physicians; 100 specialists; 95% board certified physicians.
Facilities: One hospital; one diagnostic lab.
Service area: Western Los Angeles area in California.
Services provided: Specialty services include vision, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can not select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Five employer/payer groups; approximately 10,000 employees with single coverage; 10,000 employees with family coverage; 5,000 employees and dependents with access to the network; 25,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by claims administrators; the PPO charges by RVS discounts.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination; utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Dr. Howard M. Moss, president/executive director/medical director.

PARTNERS National Health Plans-California

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Physical Therapy Provider Network Inc.

21243 Ventura Blvd. Suite 241, Woodland Hills, Calif. 91324; 818-883-7876

Operational date: May 1985.
Sponsorship: Group of physical therapists.
For profit.
Staff: More than 400 primary therapists; six administrative staff members; two marketing staff members.
Service area: California.
Services provided: Specialty services include physical therapy.
Users: 58 employer/payer groups; 1.5 million employees and dependents with access to the network; 1.5 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO charges dues from members.
Control measures: Retrospective review, case management; utilization review provided by the PPO.
Gross revenues: $2.5 million in 1988; $3 million estimated in 1989.
Officers: Michael Weinper, president; Nancy Rothenberg-Landis, executive director; Janis Peterson, marketing director.

Preferred Health Network

P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

Operational date: July 1983.
Sponsorship: Hospitals and a group of doctors.
For profit.
Staff: Approximately 12,000 primary physicians; 7,200 specialists; 120 administrative staff members; 12 marketing and sales staff members; 155 average of patients per primary physician; 100% board certified physicians.
Facilities: 128 hospitals; 128 diagnostic labs.
Service area: California, Alaska, Washington, Oregon, Nevada, Arizona and Illinois.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry, obstetrics/gynecology, chiropractic, workers compensation. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 6,420 employer/payer groups; 700,000 employees and dependents with access to the network; 748,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, prospective review of office visits and certain services; utilization review provided by the PPO.
Gross revenues: $3.2 million in 1988; $5.9 million estimated in 1989.
Officers: Richard M. Mastaler, president/chief executive officer; Dr. Kenneth Epstein, medical director; Jerry T. Payne, marketing director.

Preferred Plus of Northern California

1295 State St., Springfield, Mass. 01111; 413-788-8411, ext. 3192

Operational date: January 1985.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 2,450 primary physicians.
Facilities: 55 hospitals.
Service area: Alameda, Contra Costa, Fresno, Marin, Napa, Sacramento, Santa Clara, Santa Cruz, San Francisco, San Joaquin, San Mateo, Solano and Sonoma counties in California.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 227 employer/payer groups; 101,093 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Frank J. Racioppo Jr., regional sales director, 413-777-3383.

Preferred Plus of Southern California

1295 State St., Springield, Mass. 01111; 413-788-8411, ext. 3192

Operational date: July 1984.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 2,450 primary physicians.
Facilities: 55 hospitals.
Service area: Kern, Los Angeles, Orange, Riverside, Ventura, San Bernadino and San Diego counties in California.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 158 employer/payer groups; 43,345 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Robert K. Patton, regional sales director, 818-507-5194.

Private Healthcare Systems Ltd.-California

The Atrium, 19100 Von Karman Ave., Suite 600, Irvine, Calif. 92715; 714-476-9816

Markets include Seattle; Phoenix; Sacramento, Los Angeles, San Diego and San Francisco, Calif.

See Private Healthcare Systems Ltd. under Massachusetts.

Prudent Buyer Plan

21555 Oxnard St., Woodland Hills, Calif. 91367; 818-703-2345

Ownership: Blue Cross of California.
Facilities: 245 hospitals.
Service area: California.
Users: 1.3 million employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate.
Control measures: Preadmission hospital review, concurrent hospital treatment review; utilization review provided by the PPO.
Gross revenues: Not reported.

Prudential Plus of the Bay Area

1400 Fashion Island Blvd., Suite 210, San Mateo, Calif. 94404; 415-345-5599

Operational date: October 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 1,208 primary physicians; 735 specialists; 43 administrative staff members; 42 marketing staff members; average of 69 patients per primary physician; 95% board certified physicians.
Facilities: 29 hospitals; 130 pharmacies; 29 hospital labs; additional lab contracts with multiple locations.
Service area: Santa Clara, San Mateo, Contra Costa, Alameda, San Francisco, Marin and Sonoma counties in California.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 42,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Kathleen Swenson, executive director; Dr. Arthur Small, medical director; Robert Quellmalz, marketing director.

Prudential Plus of San Diego

9171 Towne Centre Drive, Suite 380; 619-457-4534

Operational date: August 1986.
Sponsorship: Insurer.
Ownership: The Prudential Life Insurance Co. of America.
For profit.
Staff: 1,244 primary physicians; 690 specialists; 36 administrative staff members; 12 marketing staff members; average of 100 patients per primary physician; 95% board certified physicians.
Facilities: 13 hospitals; 45 pharmacies; 12 diagnostic labs.
Service area: San Diego County in California.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design cannot be customized to meet employer specifications; individual enrollment is not allowed.
Users: 175 employer/payer groups; 6,000 employees with single coverage; 8,000 employees with family coverage; 27,500 employees and dependents with access to the network; 31,500 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Richard E. Badger, executive director; Dr. Sol Lizerbram, medical director; Armando Jackson, marketing director.

Prudential Plus of Southern California

5800 Canoga Ave., Woodland Hills, Calif. 91367; 800-433-3150

Operational date: July 1987.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 4,745 primary physicians; 3,784 specialists; 300 administrative staff members; 64 marketing staff members; average of 82 patients per primary physician; 95% board certified physicians.
Facilities: 40 hospitals; two pharmacy chains; 40 diagnostic labs.
Service area: Los Angeles, Ventura, San Bernardino, Orange and Riverside counties in California.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 23,376 employees with single coverage; 17,606 employees with family coverage; 78,606 employees and dependents with access to the network; 85,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: Not reported.
Officers: Amy Knapp, executive director; Jeff Kamil, medical director; Bob Clendenin, marketing director.

Psychology Systems

615 S. Main St., Milpitas, Calif. 95035; 408-263-8046

Operational date: 1982.
Sponsorship: Private.
For profit.
Staff: 1,100 primary physicians; 400 specialists; 10 administrative staff members; four marketing staff members; average of 200 patients per primary physician.
Facilities: 65 hospitals.
Service area: Network operates in 16 states.
Services provided: Specialty services include substance abuse, psychiatric services. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 327 employer/payer groups; 51,000 employees with family coverage; 63,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective re-

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view, hospital bill audits, outpatient service predetermination, case management for mental health; utilization review provided by outside contractors.

Gross revenues: $2.5 million in 1988; $3 million estimated in 1989.

Officers: John C. Brady II, president/executive director; Craig Noble, medical director; Richard Falls, marketing director; Dr. Wykstra.

Scripps Clinic Health Network

10666 N. Torrey Pines Road, La Jolla, Calif. 92037; 619-554-2758

Operational date: January 1988.
Sponsorship: Northwestern National Life Insurance Co. and Scripps Clinic and Research Foundation.
For profit.
Staff: 850 primary physicians; 700 specialists; nine administrative staff members; three marketing staff members; average of 34 patients per primary physician; 90% board certified physicians.
Facilities: 14 hospitals; 10 diagnostic labs.
Service area: San Diego County in California.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Nine employer/payer groups; 2,350 employees with single coverage; 2,350 employees with family coverage; 10,270 employees and dependents with access to the network; 19,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO charges by per diem rate, a percent discount off customary rates for individual services; employers/payers compensate the PPO for its services; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, preauthorization of all procedures costing more than $300; utilization review provided by the PPO.
Gross revenues: $3.7 million in 1988; $5.3 million estimated in 1989.
Officers: Northwestern National Life Insurance Co.: Frederic Sattler, vp-health care management; Wesley Smith, regional vp. Scripps Clinic Health Network: Karen Ferrell, director; Gregory Semerdjian, medical director.

South Bay Independent Physicians Medical Group Inc.

3480 Torrance Blvd., Suite 220, Torrance, Calif. 90503; 213-543-8805

Operational date: June 1984.
Sponsorship: South Bay Independent Physicians Medical Group Inc.
For profit.
Staff: 350 primary physicians and specialists; three administrative staff members; one marketing staff member; 95% board certified physicians.
Facilities: Seven hospitals.
Service area: Los Angeles County in California.
Services provided: Specialty services include vision, substance abuse, psychiatric services, durable medical equipment, home health care, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 160 employer/payer groups.
Compensation: The PPO is compensated by health care providers; the PPO charges membership dues from providers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Dr. David A. Bray, president; Frederic King, executive director; C. Lynn Thomas, marketing director.

Travelers Preferred-Fresno

501 J. St., Suite 206, Sacramento, Calif. 95814; 716-443-6667

Operational date: March 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 324 primary physicians.
Facilities: Seven hospitals.
Service area: Fresno, Kings, Madera and Tulare counties in California.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Four employer/payer groups; 1,645 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Terry Herold, executive director; Doug Elkins, sales manager.

Travelers Preferred-Northern California

951 Mariner's Island Blvd., Suite 680, San Mateo, Calif. 94404; 415-341-0810

Operational date: July 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 3,916 primary physicians.
Facilities: 28 hospitals.
Service area: Alameda, Contra Costa, Lake, Marin, Mendocino, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma counties in California.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 509 employer/payer groups; 31,089 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Roland King, executive director; Gail M. Ptacek, health plan manager; Christine Metz and Ronald Wimer, sales managers.

Travelers Preferred-Sacramento

501 J St., Suite 206, Sacramento, Calif. 95814; 916-443-6667

Operational date: February 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 686 primary physicians.
Facilities: Nine hospitals.
Service area: Amador, El Dorado, Placer, Sacramento and Yolo counties in California.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11 employer/payer groups; 4,112 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Terry Herold, executive director; Doug Elkins, sales manager.

Travelers Preferred-San Diego

9555 Chesapeake Drive, P.O. Box 23545, San Diego, Calif. 92123; 619-268-7500

Operational date: April 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 2,452 primary physicians.
Facilities: 28 hospitals.
Service area: Imperial and San Diego counties in California.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 472 employer/payer groups; 20,588 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Michael Ganey, vp-planning/development; Ernie Garcia, sales manager.

Travelers Preferred-Southern California

2600 Michelson Drive, Suite 600, Irvine, Calif. 92715; 714-553-9444

Operational date: June 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 5,150 primary physicians.
Facilities: 42 hospitals.
Service area: Los Angeles, Orange, Riverside, San Bernardino, Santa Barbara, Kern and Ventura counties in California.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 182 employer/payer groups; 45,502 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Beverly Federlein, director-operations; Reid S. Dienhart and John L. Jacobs, sales managers.

Western Health Network

100 Foster City Blvd., Foster City, Calif. 94404; 415-573-8041

Operational date: April 1983.
Sponsorship: American Western Life Insurance Co.
Ownership: Stockholders.
For profit.
Staff: 18,853 primary physicians; 15,100 specialists; seven administrative staff members; two marketing staff members.
Facilities: 283 hospitals; 65 diagnostic labs.
Service area: All counties except Imperial in California; Colorado; Arizona.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design cannot be customized to meet employer specifications; individual enrollment is not allowed.
Users: 3,500 employer/payer groups; 10,600 employees with single coverage; 12,700 employees with family coverage; approximately 60,000 employees and dependents with access to the network; 65,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: $47 million in 1988; $47 million estimated in 1989.
Officers: James R. Henry, president/marketing director; Dr. Steven Howard, medical director.



CNA Managed Care PPO-Colorado

4500 Cherry Creek Drive, Denver, Colo. 80222, 303-759-7100

Operational date: December 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,608 participating physicians; 75.8% board certified.
Facilities: 15 hospitals and medical facilities.
Service area: Denver, Boulder, Adams, Arapahoe, El Paso, Jefferson and Douglas counties in Colorado.
Services provided: Specialty services include obstetrics/gynecology, substance abuse and psychiatric services. Employees can select non-PPO providers at time of service. PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11,300 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Contacts: Dennis Lory, manager-major group sales, 303-759-7100; Kenneth H. Currier, manager-cost containment development 312-822-6206; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Denver

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Denver

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Fort Collins/Greely

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Family Healthcare Inc.

105 E. Vermijo Ave., Suite 600, Colorado Springs, Colo. 80903; 719-635-1194

Operational date: October 1983.
Sponsorship: Group of doctors.
Not for profit.
Staff: 180 primary physicians; 152 specialists; one administrative staff member; one marketing staff member; 95% board certified physicians.
Facilities: Three hospitals.
Service area: El Paso and Teller counties in Colorado.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 40 employer/payer groups; 18,000 employees and dependents with access to the network; 21,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion; utilization review provided by the PPO and outside contractors.
Gross revenues: Not reported.
Officers: John Hildebrandt, president; Gail McCue, executive director; Dr. Jerry Graul, medical director; Dr. Thomas Dalsaso and Dr. Robert Sayre.

Great West Care-Colorado Front Range

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: December 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 1,765 primary physicians; 71% board certified.
Facilities: Eight hospitals.
Service area: 26 counties in Colorado.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 23 employer/payer groups; 8,490 employees and dependents with access to network.
Compensation: The PPO negotiates hospital charges by per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination,

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ischarge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utization review provided by Private Iealthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior p; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; tobert Kavanagh and Jim Motz, vps; David Grapko, manager.

Humana Health Care Plans

Stanford Place 2, 7979 E. Tufts Ave. Parkway, Suite 304, Denver, Colo. 80237; 303-741-5500

See Humana Health Care Plans under Kentucky.

Key Health Care Inc.

1655 Lafayette St., Suite 203, Denver, Colo. 80218; 303-866-8160

Operational date: July 1979.
Sponsorship: Group of doctors.
For profit.
Staff: 225 primary physicians; 225 specialists; one administrative staff member; 90% board certified physicians.
Service area: Metropolitan Denver.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 17 employer/payer groups; approximately 170,000 employees with family coverage; 400,000 estimated employees and dependents with access to the network.
Compensation: The PPO is compensated by employers/payers. The PPO charges a percent of services rendered by participating doctors/hospitals.
Control measures: Utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Dr. Leroy Sides, president/medical director; Nancy McCarroll, executive director; Dr. R. Jack Warren, vp; Dr. Joseph Zbylski, secretary.

Lincoln National Preferred Plan

5725 Mark Dabling Blvd., Colorado Springs, Colo. 80919; 719-548-8600

See Lincoln National Preferred Plan under Indiana.

Lincoln National Preferred Plan

4582 S. Ulster St. Parkway, Denver, Colo. 80237; 303-85-5407

See Lincoln National Preferred Plan under Indiana.

Metropolitan Life Insurance Co.-Colorado

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mountain Medical Affiliates

100 Fillmore, Suite 200, Denver, Colo. 80206; 303-333-9944

Operational date: October 1980.
Sponsorship: Hospitals and a group of doctors.
For profit.
Staff: 1,200 primary physicians; 700 specialists; 18 administrative staff members; three marketing staff members; 90% board certified physicians.
Facilities: Five hospitals; one diagnostic lab.
Service area: Metropolitan Denver.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 80 employer/payer groups; 135,000 employees and dependents with access to the network; 140,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.
Control measures: Precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, case management; utilization review provided by Byerly & Co. and other outside contractors.
Gross revenues: Not reported.
Officers: Ms. Tobie G. Miller, executive director; Dr. Peter L. Durante, medical director; Barbara Brett, marketing director.

Mutually Preferred-Colorado

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO-Colorado

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Colorado

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Dental Care Inc.

1311 Jerry Murphy Road, Pueblo, Colo. 81001; 800-548-2164

Operational date: 1984.
Sponsorship: Direct Dental Services Inc.
For profit.
Staff: 100 participating dentists; two administrative staff members; one marketing staff member.
Service area: Colorado.
Services Provided: Dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: Five employer/payer groups; 800 employees with single coverage; 100 employees with family coverage; more than 1,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by claims administrators; the PPO charges a flat fee per family.
Control measures: State peer review.
Gross revenues: More than $50,000 estimated in 1989.
Officers: Dr. Mel M. Tekavec, president; Bev Berge, executive director; Suzan Shepard, marketing director; Carol Tekavec, secretary/treasurer.

Prime Health Plan

700 Broadway, Denver, Colo. 80273; 303-831-2131

Operational date: September 1984.
Sponsorship: Blue Cross & Blue Shield of Colorado.
For profit.
Staff: More than 3,500 primary physicians and specialists; 10 administrative staff members; 40 marketing staff members.
Facilities: 32 hospitals.
Service area: Colorado.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Approximately 1,200 employer/payer groups; 61,700 employees with family coverage; 134,500 employees and dependents with access to the network; 140,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and Equifax.
Gross revenues: Not reported.
Officers: John Galbraith, president-Blue Cross & Blue Shield of Colorado; C. David Kikumoto, vp-marketing/provider affairs; Dr. George Kandel, medical director; W. John Chenier, vp-sales.

Preferred Plus of Colorado

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: April 1988.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,911 primary physicians.
Facilities: 18 hospitals.
Service area: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer and Weld counties in Colorado.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service, PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 14 employer/payer groups; 5,089 employees and dependents with access to the network.
Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Kelly L. Camp, account executive-Massachusetts Mutual Life Insurance Co., 303-694-9595.

Prudential Plus-Colorado

4643 S. Ulster St., Suite 1000, Denver, Colo. 80237; 303-796-6100

Operational date: August 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 777 primary physicians; 300 specialists; six administrative staff members; 15 marketing staff members; 91% board certified physicians.
Facilities: 11 hospitals; one pharmacy; one diagnostic lab.
Service area: Boulder, Adams, Gilpin, Clear Creek, Jefferson, Douglas and Arapahoe counties in Colorado.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, therapy facilities, home health care, pathology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 5,766 employees with single coverage; 4,814 employees with family coverage; 18,312 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Mark Donahue, network manager; Dr. Nancy Ashbach, M.B.A., medical director; Gerald Ellis, director-group marketing; Kenneth E. Bates, vp-health care management.

Travelers Preferred-Colorado

7600 E. Orchard Road, Denver, Colo. 80111; 303-740-2055

Operational date: December 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,669 primary physicians.
Facilities: 15 hospitals.
Service area: 15 counties in Colorado.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 81 employer/payer groups; 15,638 employees with single and family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Sally Sjobeck, director-operations; Dan H. Carlson, sales manager.

Continued on next page



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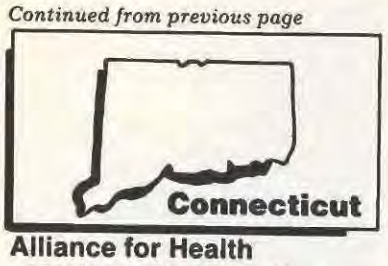
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Continued from previous page



Alliance for Health

370 Bassett Road, North Haven, Conn. 06473; 203-239-8978

Operational date: July 1987.
Sponsorship: Blue Cross & Blue Shield of Connecticut Inc.
Staff: 1,350 primary physicians.
Facilities: Five hospitals.
Service area: Connecticut.
Users: 8,700 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services.
Control measures: Preadmission review, second surgical opinion; utilization review provided by outside contractors.
Gross revenues: Not reported.

Century 2000

Blue Cross & Blue Shield of Connecticut Inc., 370 Bassett Road, North Haven, Conn. 06473; 203-239-8978

Operational date: July 1986.
Sponsorship: Blue Cross & Blue Shield of Connecticut Inc.
Staff: 2,475 primary physicians.
Facilities: 36 hospitals.
Service area: Connecticut.
Users: 40,130 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by DRGs.
Control measures: Preadmission review, second surgical opinion; utilization review provided by outside contractors.
Gross revenues: Not reported.

CIGNA FlexCare Preferred Provider Organization*

Hartford, Conn. 06106; 203-726-6904

Operational date: Varies by location; first location became operational August 1984.
Sponsorship: CIGNA Corp.
For profit.
Staff: 25,568 primary physicians; 17,500 specialists; average of 75-100 patients per primary physician; 65%-70% board certified physicians.
Facilities: 388 hospitals.
Service area: Atlanta; Puerto Rico; Orlando, Miami and Tampa, Florida; Chicago; Detroit; Kansas City and St. Louis, Mo.; Milwaukee; Minneapolis; Denver; Los Angeles, San Diego and San Francisco; Seattle; New Orleans; Dallas, Houston; Knoxville and Memphis, Tenn.; Tulsa and Oklahoma City, Okla.; Cleveland and Youngstown, Ohio; Indianapolis; Philadelphia; Pittsburgh; Albuquerque, N.M.; Phoenix and Tucson, Ariz.; Portland, Ore.
Services provided: Varies by site. Employees can select non-PPO providers at time of service; individual enrollment is not allowed.
Users: Approximately 625 employer/payer groups; 300,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; physicians reimbursed through negotiated or maximum fee schedules; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Precertification, concurrent hospital treatment review; utilization review provided by the PPO and Intracorp.
Gross revenues: Not reported.
Officers: G. Robert O'Brien, president; Dr. Michael R. Soper, medical director; Kenneth A. Burdick, marketing director.
* Figures are corporate, including all CIGNA Flexcare Preferred Provider Organization PPOs sponsored by CIGNA Corp.

MetLife Network*

276 Post Road W., Westport, Conn. 06880; 203-454-6100

Operational date: January 1984.
Sponsorship: Metropolitan Life Insurance Co.
For profit.
Staff: 73,000 physicians; average of 42 patients per primary care physician.
Facilities: 600 hospitals.
Service area: Network operates in Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin and District of Columbia.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 210 employer/payer groups; 2.4 million employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs or by volume discounts; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, high-risk pregnancy identification, ambulatory utilization review; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Robert A. Chernow, vp-managed care services group; Harry F. Blair, vp-network management; Clement L. Golia, vp-network development; Dr. Paul W. Frankel, national medical director.
* Figures are corporate, including all MetLife Network PPOs sponsored by Metropolitan Life Insurance Co.

Metropolitan Life Insurance Co.-Connecticut

Managed Care Services Group, 276 Post Road W., Westport, Conn. 068n20; 203-454-6100

See Metropolitan Life Insurance Co. corporate listing under Connecticut.

Oxford Health Plans

220 Post Road, Darien, Conn. 06820; 203-656-1442

Operational date: June 1986.
Sponsorship: Lincoln National Life Insurance Co.
For profit.
Staff: 3,000 primary physicians; 1,500 specialists; 100 administrative staff members; 30 marketing staff members; 94% board certified physicians, 6% board eligible.
Facilities: 60 hospitals; network of pharmacies; 16 diagnostic labs.
Service area: Bergen, Essex, Pasaic, Morris, Union, Hudson and Middlesex counties in New Jersey; Bronx, Kings, New York, Queens; Richmond, Westchester, Rockland, Nassau and Suffolk counties in New York; Fairfield County in Connecticut.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 35,000 employees and dependents with access to the network; 40,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management, DRG validation; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Stephen F. Wiggins, president; Dr. Ben Safirstein, medical director; William Sullivan, vp-marketing; Robert Smoler, vp-operations; Tom Travers, vp-health care delivery; Ted Kremer, vp-management information systems; Donald Barrett, executive vp-legal affairs.

PARTNERS National Health Plans-Connecticut

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare Plus-Connecticut

301 Merritt 7, Norwalk, Conn. 06851; 203-849-1800

Operational date: February 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 159 primary physicians; 213 specialists; 17 administrative staff members; 10 marketing staff members; 97% board certified or board eligible physicians.
Facilities: 13 hospitals; 142 pharmacies; 18 diagnostic labs.
Service area: Fairfield, New Haven and part of Litchfield counties in Connecticut.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 4,924 employees and dependents with access to the network; 5,467 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: John G. Galbraith, executive director; Dr. Stanley Kramer, medical director.

Travelers Preferred-Connecticut

1 Tower Square, 2 SHS, Hartford, Conn. 06183; 203-954-2387

Operational date: February 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 948 primary physicians.
Facilities: Nine hospitals.
Service area: Hartford, New Haven, Fairfield and Tolland counties in Connecticut.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 17,277 employees with single coverage and family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Mary Ann Shea, executive director; Ellen White, health plan manager; John Keilman, Robert Dully, Richard Mathewsor. and Robert Watkins, sales managers.



Blue Cross & Blue Shield Preferred Provider Plan

550 12th St. S.W., Washington, D.C. 20065; 202-479-8719

Operational date: June 1987.
Sponsorship: Insurer.
Not for profit.
Staff: 3,800 primary physicians; 3,000 specialists; 80% board certified physicians.
Facilities: 25 hospitals.
Service area: District of Columbia; Prince Georges and Montgomery counties in Maryland; Arlington and Fairfax counties in Virginia.
Services provided: Specialty services include prescription drug, vision, dental, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 929 employer/payer groups; 6,662 employees with single coverage; 3,520 employees with family coverage; 18,939 employees and dependents with access to the network; 500,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: Not reported.
Officers: B.W. Giulani, president/chief executive officer; S. Sieverts, vp-health care finance; Dr. J. Kleh, medical director.

CNA Managed Care PPO-Washington D.C.

1101 Market St., 25th Floor, Philadelphia, Pa. 19107; 215-351-3842

Operational date: July 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,131 primary physicians; 79% board certified physicians.
Facilities: 17 hospitals and medical facilities.
Service area: District of Columbia; Montgomery and Prince Georges counties in Maryland; Fairfax County in Virginia.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 85,500 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Bill Gabel, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

Great-West Care-Washington, D.C.

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: July 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 1,355 primary physicians; 72% board certified physicians.
Facilities: 17 hospitals.
Service area: District of Columbia; Arlington, Loudoun, Faquier, Prince William and Fairfax counties in Virginia; Montgomery, Frederick, Carroll and Washington counties in Maryland.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollmer is not allowed.
Users: 12 employer/payer groups; 848 employees and dependents wit access to the network.
Compensation: The PPO negotiate hospital charges by per diem rate, by percent discount off customary rate for individual services; the PPO i compensated by employers/payers; th PPO charges a flat fee per eligible em ployee.
Control measures: Preadmissio hospital review, precertification, con current hospital treatment review length of stay determination, dis charge planning, retrospective review second surgical opinion, hospital bil audits, case management; utilizatio review provided by Private Healthcar Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacClennan, senio vp; Jeffrey Kraines, medical director Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps David Grapko, manager.

Hartford's PULSE Plan of The National Capital Area

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: April 1988.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 420 primary physicians; 1,061 specialists.
Facilities: 14 hospitals; five diagnostic labs.
Service area: Washington D.C.; Montgomery and Prince Georges counties in Maryland; Arlington and Fairfax counties in Virginia.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 15 employer/payer groups; 5,484 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, large case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Ronald G. Compton, regional sales manager, 703-836-0222.

John Hancock Preferred Health Plan-District of Columbia

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Metropolitan Life Insurance Co.-District of Columbia

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-District of Columbia

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Plus of the National Capital Area

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: April 1988.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,100 primary physicians.
Facilities: 16 hospitals.
Service area: District of Columbia; Montgomery and Prince Georges counties in Maryland; Arlington and Fairfax counties in Virginia.

Continued on next page

Continued from previous page

Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under certain specialized circumstances; individual enrollment is not allowed.

Users: 56 employer/payer groups; 16,279 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Contacts: Robert F. Moran, regional sales director-Massachusetts Mutual Life Insurance Co.

Travelers Preferred-Washington D.C.

Travelers Health Network, 3 Parkway, Philadelphia, Pa. 19102; 215-496-0040

Operational date: April 1987.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 1,111 primary physicians.

Facilities: Nine hospitals.

Service area: District of Columbia; Charles, Montgomery and Prince Georges counties in Maryland; Arlington, Fairfax, Loudoun, and Prince William counties in Virginia.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 231 employer/payer groups; 8,164 employees with single or family coverage.

Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Gross revenues: Not reported.

Officers: Pat Hedden, director-operations; John McIntosh, sales manager.



Metropolitan Life Insurance Co.-Delaware

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.



AV-MED Managed Care Inc.

9400 S. Dadeland Blvd., Miami, Fla. 33156; 305-665-5437; 800-228-0660

Operational date: 1983.

Ownership: SantaFe Healthcare.

For profit.

Staff: 3,805 primary physicians; 2,570 specialists; three administrative staff members; eight marketing staff members; average of 42 patients per primary physician; 100% board certified physicians.

Facilities: 83 hospitals; 778 pharmacies; 19 diagnostic labs.

Service area: 19 counties in Florida.

Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 416 employer/payer groups; 16,824 employees with single coverage; 8,101 employees with family coverage; 51,438 employees and dependents with access to the network; 55,141 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by per diem rate; the PPO is compensated by claims administrators; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Douglas Cueny, president/executive director; Dr. Jerome Beloff, medical director; Cary Badger, marketing director; Dr. Gerald O'Neil, chief operating officer.

CNA Managed Care PPO-Jacksonville

2303 N. Semoran Blvd., Orlando, Fla. 32807; 407-677-2328

Operational date: February 1987.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 258 participating physicians; 81% board certified physicians.

Facilities: Five hospitals and medical facilities.

Service area: Duval, Alachua, St. Johns, Marion, and Clay counties in Florida.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed..

Users: 13,200 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Tim O'Brien, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Miami

2303. N. Semoran Blvd., Orlando, Fla. 32807; 407-677-2328

Operational date: December 1986.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 702 participating physicians; 72% board certified physicians.

Continued on next page

1989/1990

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Facilities: 15 hospitals and medical facilities.
Service area: Dade and Broward counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 9,600 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Tim O'Brien, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Orlando

2303 N. Semoran Blvd., Orlando, Fla. 32807; 407-677-2328

Operational date: March 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 276 primary physicians; 78% board certified physicians.
Facilities: Five hospitals and medical facilities.
Service area: Orange, Osceola, and Seminole counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 7,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Tim O'Brien, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Tampa/ St. Petersburg

2303 N. Semoran Blvd., Orlando, Fla. 32807; 407-677-2328

Operational date: September 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 466 primary physicians; 81% board certified physicians, 15% board eligible.
Facilities: 10 hospitals and medical facilities.
Service area: Hillsborough, Pinellas, Pasco and Hernando counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 12,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Barbara T. Gray, executive director.

CarePASS-Florida

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Miami

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Orlando

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Tampa

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Dimension PPO

290 N.W. 165th St., P-400, Miami, Fla. 33169; 305-949-8869

Operational date: May 1988.
Sponsorship: Group of hospitals and McDonough Caperton Insurance Group.
For profit.
Staff: 1,600 primary physicians; 10 administrative staff members; eight marketing staff members.
Facilities: Seven hospitals.
Service area: Dade County, Fla.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: More than 2,000 employer/payer groups; 52,500 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Barbara T. Gray, executive director.

EQUICOR Preferred-Miami/ West Palm Beach/ Fort Lauderdale

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Tampa Bay

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Florida Health Choice Plan

5300 W. Atlantic Ave., Suite 302, Delray Beach, Fla. 33484; 407-496-0505

Operational date: March 1984.
Sponsorship: Five hospitals.
Not for profit.
Staff: 2,371 primary physicians; 1,324 specialists; 11 administrative staff members; three marketing staff members.
Facilities: 18 hospitals.
Service area: Palm Beach, Dade and Broward counties in Florida.
Services provided: Specialty services include dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 176 employer/payer groups; 125,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Charles A. Lindgren, president/chief executive officer/ marketing director; Dr. Franklin B. Ott, medical director.

Florida Health Network

1301 Gulf Life Drive, Jacksonville, Fla. 32207; 904-390-7608

See American Health Network under Texas.

Florida Vision Service Plan

2002 N. Lois Ave., Suite 220, Tampa, Fla. 33607; 813-872-6559

Operational date: April 1968.
Sponsorship: Group of doctors.
Not for profit.
Staff: 550 primary physicians; 14 administrative staff members; three marketing staff members.
Facilities: 19 ophthalmic labs.
Service area: Florida.
Services provided: Specialty services include vision care. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed unless a qualified IRC Section 125 plan.
Users: 140 employer/payer groups; 275,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers; the PPO charges by retention based upon the type and size of the plan.
Control measures: Precertification; utilization review provided by the PPO.
Gross revenues: $5.2 million in 1988; $6.3 million estimated in 1989.
Officers: Allen L. Garrett, president.

Great-West Care-Jacksonville

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: February 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 272 primary physicians; 73% board certified physicians.
Facilities: Five hospitals.
Service area: 20 counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Miami

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: December 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 760 primary physicians; 72% board certified physicians.
Facilities: Nine hospitals.
Service area: Broward, Charlotte, Collier, Dade, Glades, Hendry, Lee, Martin, Monroe, Okeechobee, Palm Beach and St. Lucie counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10 employer/payer groups; 1,306 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Orlando

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: March 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 297 primary physicians.
Facilities: Three hospitals.
Service area: Brevard, Lake, Osceola, Seminole and Volusia counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Three employer/payer groups; 227 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Tampa

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 465 primary physicians.
Facilities: Five hospitals.
Service area: DeSoto, Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinnellas, Polk, Sarasota and Sumter counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Seven employer/payer groups; 1,188 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Halifax Health Network

444 Seabreeze Blvd., Suite 810, Daytona Beach, Fla. 32118; 904-253-2198

Operational date: July 1986.
Sponsorship: Hospitals and a group of doctors.
Not for profit.
Staff: 215 primary physicians; 185 specialists; one administrative staff member; one marketing staff member.
Facilities: Three hospitals; one diagnostic lab.
Service area: Volusia County, Fla.
Services provided: Specialty services include dental, substance abuse, durable medical equipment, home health. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10 employer/payer groups.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: David Seal, president/ executive director; Dr. Alvin Smith, medical director; Lou Orban, marketing director.

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John Hancock Preferred Health Plan-Florida

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Hartford's PULSE Plan of Florida

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: May 1988.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 1,001 primary physicians; 3,230 specialists.
Facilities: 41 hospitals.
Service area: Duval, Clay, Volusia, Orange, Seminole, Hillsborough, Pasco, Pinellas, Palm Beach, Broward and Dade counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11 employer/payer groups; 3,588 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, large case management, psychiatric management; utilization review provided by the PPO and outside contractors.
Gross revenues: Not reported.
Contact: Michael P. Parker, regional sales manager.

Humana Health Insurance Co. of Florida Inc.

151 Mary Esther Cutoff, Suite 404, Mary Esther, Fla. 32569; 904-244-6695

See Humana Health Care Plans under Kentucky.

Humana Health Insurance Co. of Florida Inc.

1505 N.W. 167th St., Miami, Fla. 33169; 305-623-2100

See Humana Health Care Plans under Kentucky.

Humana Health Insurance Co. of Florida Inc.

100 W. Gore St., Suite 300, Orlando, Fla. 32806; 407-843-5531

See Humana Health Care Plans under Kentucky.

Humana Health Insurance Co. of Florida Inc.

770 W. Granada Blvd., Suite 317, Ormand Beach, Fla. 32074; 904-677-8530

See Humana Health Care Plans under Kentucky.

Humana Health Insurance Co. of Florida Inc.

5401 W. Kennedy Blvd., Suite 800, Tampa, Fla. 33609; 813-286-8829; 813-287-6202

See Humana Health Care Plans under Kentucky.

Medical Card System

7975 Miami Lakes Drive, Suite 420, Miami Lakes, Fla. 33016

Operational date: Estimated January 1990.
Ownership: Baxter Healthcare Corp.
For profit.
Staff: Estimated 1,200 primary physicians; four administrative staff members; two marketing staff members; 90% board certified physicians.
Facilities: Estimated 22 hospitals; two pharmacy chains.
Service area: Dade, Broward and Palm Beach counties in Florida.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; insurance companies; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; utilization review provided by the PPO.
Officers: Felipe Benedit, president; John H. Barker, executive vp; Raymond Parra, medical director.

The Mental Health Programs Corp.

1000 Century Park Drive, Suite 425, Tampa, Fla. 33607; 813-289-8990

Operational date: 1986.
Sponsorship: Private.
For profit.
Staff: 250 primary physicians; 603 specialists; 16 administrative staff members; two marketing staff members; 100% board certified physicians.
Facilities: 45 hospitals.
Service area: Hillsborough, Pinellas, Broward, Dade, Pasco, Orange, Manatee, Palm Beach, Polk and Marion counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 20 employer/payer groups; 300,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee or per case reviewed.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management, employee assistance programs; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. Walter Afield, president/chief executive officer; Jim Kent, executive vp/chief operating officer.

Metropolitan Life Insurance Co.-Florida

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mid-Florida Preferred Inc.

109 Ave. E N.E., Winter Haven, Fla. 33881; 813-299-5151

Operational date: October 1984.
Sponsorship: Hospital.
Ownership: Mid-Florida Medical Services Inc.
Not for profit.
Staff: 270 primary physicians; 240 specialists; two administrative staff members; average of 750 patients per primary physician; 95% board certified physicians.
Facilities: Seven hospitals; two pharmacies; one diagnostic lab.
Service area: Polk and Highlands counties in Florida.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 60 employer/payer groups; 30,000 employees and dependents with access to the network; 30,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by volume discount; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and Employers Health Care Coalition.
Gross revenues: Not reported.
Officers: H. Leonard Porter III, president/executive director; Dr. James D. Morgan, medical director; Joel Thomas, marketing director.

PM Group's PPO-Florida

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Florida

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Patient Care

532 Riverside Ave., Jacksonville, Fla.; 904-739-4502

Operational date: October 1984.
Sponsorship: Blue Cross & Blue Shield of Florida Inc.
Not for profit.
Staff: 11,500 primary physicians; 18 administrative staff members; 70 marketing staff members.
Facilities: 122 hospitals.
Service area: 58 counties in Florida.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry, obstetrics/gynecology, chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: More than 4,500 employer/payer groups; 842,384 employees and dependents with access to the network; more than 1 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs; the PPO is compensated by employers/payers, individual policy holders; the PPO charges a premium.
Control measures: Preadmission hospital review, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $499.5 million in 1988; $550 million estimated in 1989.
Officers: Ernest N. Brodsky, vp-product management division; Jim Wallace, product director/marketing director; Dr. Paul Manson, medical director.

Preferred Plus of Central & Northern Florida

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: November 1987.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 3,500 primary physicians.
Facilities: 37 hospitals.
Service area: Hillsborough, Pasco, Orange, Seminole, Volusia, Duval, Clay, Nassau, Escambia, Santa Rosa, Alchua and Pinellas counties in Florida.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under special circumstances; individual enrollment is not allowed.
Users: 28 employer/payer groups; 11,383 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Robert H. Pariseau, account executive-Massachusetts Mutual Life Insurance Co.

Preferred Plus of South Florida

1295 State St., Springfield, Mass. 01111; 413-788-8411, ext. 3192

Operational date: June 1986.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 3,400 primary physicians.
Facilities: 56 hospitals.
Service area: Dade, Broward and Palm Beach counties in Florida.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under special circumstances; individual enrollment is not allowed.
Users: 43 employer/payer groups; 16,351 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Donald T. Calvert, senior account executive-Massachusetts Mutual Life Insurance Co.

PruCare of Jacksonville

841 Prudential Drive, 12th Floor, Jacksonville, Fla. 32207; 904-391-3415

Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 83 primary physicians; 152 specialists; 14 administrative staff members; 11 marketing staff members; average of 102 patients per primary physician; 100% board certified physicians.
Facilities: Three hospitals; eight pharmacies.
Service area: Baker, Clay, Duval, Nassau and St. Johns counties in Florida.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: C. Richard Cook, director-group operations; Dr. Richard L. Schumacher, vp-medical services; Christopher P. Wilson, regional group manager.

PruCare of Orlando

2301 Lucien Way, Suite 230, Maitland, Fla. 32751-7086; 407-875-6600

Operational date: September 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 141 primary physicians; 229 specialists; 48 administrative staff members; 11 marketing staff members; average of 117 patients per primary physician; 75% board certified physicians.
Facilities: Six hospitals; 13 pharmacies; two diagnostic labs.
Service area: Lake, Osceola, Orange, Seminole and Volusia counties in Florida.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 18,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Andrew D. Crooks, director-group operations; Dr. Richard L. Schumacher, vp-medical services; John A. Joiner, regional group manager.

PruCare of South Florida

5900 N. Andrews Ave., Suite 1000, Fort Lauderdale, Fla. 33309; 305-492-8244

Operational date: May 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 338 primary physicians; 617 specialists; 56 administrative staff members; 13 marketing staff members; average of 94 patients per primary physician; 95% board certified physicians.
Facilities: 15 hospitals; one pharmacy; 14 diagnostic labs.
Service area: Broward, Dade and Palm Beach counties in Florida.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, rehabilitation, physical therapy, patient transportation, radiology, speech therapy, dialysis treatment, hospice care, audiology, skilled nursing. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 32,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Christopher Sims, director-group operations; Dr. Richard L. Schumacher, vp-medical services.

PruCare of Tampa

3450 W. Busch Blvd., Suite 245, Tampa, Fla. 33618; 813-932-1977

Operational date: July 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 187 primary physicians; 322 specialists; 30 administrative staff members; eight marketing staff members; average of 94 patients per primary physician; 85% board certified physicians.
Facilities: 18 hospitals; 57 pharmacies; 21 diagnostic labs.
Service area: Hillsborough, Pinellas and Pasco counties in Florida.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

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Users: 17,726 employees and dependents with access to the network; estimated 20,000 employees and dependents with access to the network as of Jan. 1, 1990.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Jeffrey J. Kovaleski, director-group operations; Dr. Richard L. Schumacher, vp-medical services; Timothy R. Keener, regional group manager.

Travelers Preferred-Central Florida

2 Corporate Drive, Suite 250, Clearwater, Fla. 34622; 813-875-3455

Operational date: March 1987.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 655 primary physicians.

Facilities: Eight hospitals.

Service area: Lake, Orange, Osceola, Seminole and Volusia counties in Florida.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 81 employer/payer groups; 6,850 employees with single coverage and family coverage.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Gross revenues: Not reported.

Officers: Tom Andrews, director; John Olewski, sales manager.

Travelers Preferred-North Florida

111 Riverside Ave., Suite 220, Jacksonville, Fla. 32202; 904-355-5203

Operational date: March 1987.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 688 primary physicians.

Facilities: 10 hospitals.

Service area: Alachua, Clay, Columbia, Duval, Marion, Nassau, Putnam and St. Johns counties in Florida.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 41 employer/payer groups; 3,398 employees with single coverage and family coverage.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Gross revenues: Not reported.

Officers: Tom Andrews, director; John Olewski, sales manager.

Travelers Preferred-South Florida

150 S. Pine Island Road, Plantation, Fla. 33324; 305-474-9408

Operational date: April 1986.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 2,951 primary physicians.

Facilities: 18 hospitals.

Service area: Broward, Dade and Palm Beach counties in Florida.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 480 employer/payer groups; 27,839 employees with single coverage and family coverage.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Gross revenues: Not reported.

Officers: Amalia Kane, health service coordinator; Francis C. Williams, sales manager.

Travelers Preferred-West Central Florida

2 Corporate Drive, Suite 250, Clearwater, Fla. 34622; 813-441-9456

Operational date: December 1986.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 734 primary physicians.

Facilities: 10 hospitals.

Service area: Polk, Hillsborough, Pasco and Pinellas counties in Florida.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 105 employer/payer groups; 47,040 employees with single coverage and family coverage.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Gross revenues: Not reported.

Officers: Valerie Payne, provider relations; John Olewski, sales manager.



American Dental Plan Inc.

8800 Roswell Road, Suite 295, Atlanta, Ga. 30350; 404-998-8936

Operational date: 1978.

Ownership: American Prepaid Professional Services.

For profit.

Staff: 1,500 primary dentists; 250 specialists; 100% board certified dentists.

Service area: Florida, Georgia, Ohio and Texas.

Services provided: Specialty services include dental care. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.

Users: 2,000 employer/payer groups; 275,000 employees and dependents with access to the network; 275,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Retrospective review, second surgical opinion, case management; utilization review provided by the PPO.

Gross revenues: $19 million in 1988; $25 million estimated in 1989.

Officers: Steve Collins, president; Dr. Bob Berlin, medical director; Art Bartlett, vp-marketing/dental services.

CNA Managed Care PPO-Atlanta

CNA Insurance Cos., 2302 Parklake Drive N.E., Atlanta, Ga. 30345; 404-491-5375

Operational date: November 1986.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 788 primary physicians; 77% board certified physicians.

Facilities: 13 hospitals and medical facilities.

Service area: Clayton, Gwinnett, Cobb, DeKalb and Fulton counties in Georgia.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 18,000 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Charles Hart, manager-major group sales, Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Atlanta

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Circle of Care

P.O. Box 790, Columbus, Ga. 31902; 404-576-3875

Operational date: June 1983.

Ownership: Columbus Regional HealthCare System Inc.

For profit.

Staff: 153 primary physicians; 32 specialists; four administrative staff members; two marketing staff members; 100% board certified or board eligible physicians.

Facilities: Two hospitals.

Service area: Muscogee, Chattahoochee and Harris counties in Georgia; Lee, Russell and Barbour counties in Alabama.

Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.

Users: 464 employer/payer groups; 193,210 employees and dependents with access to the network; 195,00 estimated employees and dependent with access to the network as of Jar 1, 1990.

Compensation: The PPO negoti ates hospital charges by a percer discount off customary rates for indi vidual services; the PPO is compen sated by employers/payers, healtl care providers, claims administra tors; the PPO charges a flat fee pe eligible employee, percent of service rendered by participating doctors hospitals.

Control measures: Utilization review provided by outside contractors.

Gross revenues: Not reported.

Officers: Charles Payne, president Robert Carden, executive director Dr. Larry Brightwell, medical director; Wally Veawdry, marketing director.

Great-West Care-Atlanta

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: November 1986.

Sponsorship: Great-West Life Assurance Co.

For profit.

Staff: 748 primary physicians; 67% board certified physicians.

Facilities: 11 hospitals.

Service area: 35 counties in Georgia.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 29 employer/payer groups; 6,287 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Lincoln National Preferred Plan

3715 Northside Parkway, Building 300, Suite 600, Atlanta, Ga. 30327; 404-240-0202

See Lincoln National Preferred Plan under Indiana.

Metropolitan Life Insurance Co.-Georgia

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-Georgia

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Private Healthcare Systems Ltd.

Northpark Town Center, 1000 Abernathy Road, Suite 840 N.E., Atlanta, Ga. 30328; 404-394-1084

See Private Healthcare Systems Ltd. under Massachusetts.

PruCare Plus of Atlanta

3100 Cumberland Circle, Suite 1200, Atlanta, Ga. 30339; 404-955-8010

Operational date: July 1986.

Sponsorship: The Prudential Life Insurance Co. of America.

Continued on next page

Q.

What do the benefits departments of these companies have in common?

AT&T Allied-Signal **American Airlines** Atlantic Richfield
Boise Cascade CBS **Coca-Cola** Colgate-Palmolive
Federal Express **General Motors** General Signal Corp.
Heinz USA Honeywell **ITT** Kraft Mead Corporation
Miller Brewing PPG Pitney Bowes **Polaroid**
Proctor & Gamble Sara Lee Upjohn **Westinghouse Electric**

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A.

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Brookfield, Wisconsin 53008-0069
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ontinued from previous page
For profit.
Staff: 218 primary physicians; 319 pecialists; 30 administrative staff iembers; 24 marketing staff members; average of 127 patients per priiary physician; 96% board certified hysicians.
Facilities: 12 hospitals; 60 phariacies; two diagnostic labs.
Service area: Cherokee, Clayton, obb, DeKalb, Douglas, Fayette, orsyth, Fulton, Gwinnett, Henry nd Rockdale counties in Georgia.

Services provided: Specialty serices include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical quipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design cannot be customized to meet employer specifications; individual enrollment is not allowed.

Users: 6,435 employees with single coverage; 6,183 employees with family coverage; 26,440 employees and dependents with access to the network; 30,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.
Officers: Marilyn E. Schafer, vp-operations; Dr. Frank Houser, medical director; F. Bart Hester, regional group manager.

SouthCare Medical Alliance

3715 Northside Parkway, 400 Northcreek, Suite 300, Atlanta, Ga. 30327; 404-231-9911

Operational date: September 1985.
Sponsorship: Hospitals and a group of doctors.
Not for profit.
Staff: 842 primary physicians; 710 specialists; five administrative staff members; three marketing staff members; 80% board certified physicians.
Facilities: 11 hospitals.
Service area: Metropolitan Atlanta.

Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology and workers compensation. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: More than 800 employer/payer groups; 160,000 employees and dependents with access to the network; 175,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by per diem rate and by a percent discount on billed charges; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee and negotiates a percentage of savings.
Control measures: Utilization review is provided by outside contractor.

Gross revenues: $790,883 in 1988; $1 million estimated in 1989.
Officers: Larry L. Madlem, president/chief executive officer; Rebecca McQueen, vp-administration; Dr. Angier Wills, medical director; Al Teets, vp-marketing.

Travelers Preferred-Atlanta

Travelers Health Network, 211 Perimeter Center Parkway, Atlanta, Ga. 30346; 404-395-4850

Operational date: October 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 759 primary physicians.
Facilities: 13 hospitals.
Service area: Cobb, Coweta, DeKalb, Douglas, Fulton, Gwinnett and Rockdale counties in Georgia.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Officers: Tom Andrews, director-development; Debbie Costello-Smith, director-operations; Gary Holt, sales manager.

Voluntary Incentive Program

3348 Peachtree Road N.E., Atlanta, Ga. 30326; 404-262-8499

Operational date: October 1984.
Sponsorship: Blue Cross & Blue Shield of Georgia.
Staff: 4,645 primary physicians.
Facilities: 79 hospitals.
Service area: Georgia.
Users: 158,108 employees and dependents with access to the network.
Control measures: Preadmission hospital review, admission review, concurrent hospital treatment review, second surgical opinion, individual case management, discharge planning; utilization review provided by the PPO.



PARTNERS National Health Plans-Hawaii

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

The Queen's Health Care Plan Inc.

2 Waterfront Plaza, Suite 200, 500 Ala Moana Blvd., Honolulu, Hawaii 96813; 808-522-7500

Operational date: September 1989.
Sponsorship: The Queen's Medical Center and a group of doctors.
For profit.
Staff: 556 primary physicians; 322 specialists; 60 administrative staff members; three marketing staff members; 230 average of patients per primary physician; 77% board certified physicians.
Facilities: 14 hospitals; three pharmacies; three diagnostic labs.
Service area: Hawaii.
Services provided: Specialty services include vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 60 employer/payer groups; 112,037 employees and dependents with access to the network; 56,019 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Charles Holland, president; Sue Christofferson, executive vp; Dr. Ronald Lee and Dr. George Bussey, medical directors.



Assn. for Organizational & Human Development

7346 N. Monticello St., Skokie, Ill. 60076; 708-679-2575

Operational date: 1987.
Sponsorship: Private.
For profit.
Staff: 90 primary physicians; 450 specialists; eight administrative staff members; two marketing staff members; 80% board certified physicians.
Facilities: 10 hospitals.
Service area: Cook, Lake, Will, DuPage, McHenry and Kane counties in Illinois; Porter, La Porte and Lake counties in Indiana; Wisconsin.
Services provided: Specialty services include substance abuse, psychiatric services. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: Two employer/payer groups; 5,000 employees with single coverage; 35,000 employees with family coverage; 135,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $1.5 million estimated in 1989.
Officers: Dr. Ronald L. Kirschner, president/medical director; Karen Gallegos, marketing director.

CNA Managed Care PPO-Chicago

CNA Plaza-22W, Chicago, Ill. 60685; 312-822-7626

Operational date: September 1986.
Sponsorship: CNA Financial Corp.
For profit.

Staff: 1,480 primary physicians; 79% board certified physicians.
Facilities: 27 hospitals and medical facilities.
Service area: Cook, Lake, DuPage, Kane and Will counties in Illinois; Lake County in Indiana.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 34,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Tom Dolatowski, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Chicago

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Delta Dental Plan of Illinois

7321 W. Lake St., River Forest, Ill. 60305; 312-771-0800

Operational date: 1988.
Sponsorship: Insurer.
Not for profit.
Staff: 600 primary physicians; 100 specialists; five administrative staff members; 12 marketing staff members.
Service area: Cook, Will, DuPage and Lake counties in Illinois.
Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Compensation: The PPO is compensated by employers/payers; the PPO charges a premium per employee unit and per family unit.
Control measures: Precertification, retrospective review, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. Harold L. Martin, president; Dr. Lee J. Schwartz, medical director; Robert L. Kiriakos, marketing director; Patricia Vance, vp-operations.

EQUICOR Preferred-Chicago

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Chicago Area

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: May 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 1,387 primary physicians; 73% board certified physicians.
Facilities: 23 hospitals.
Service area: Northeast Illinois and northwest Indiana.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 62 employer/payer groups; 8,024 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

John Hancock Preferred Health Plan-Illinois

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

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HealthNetwork, Inc.

1420 Kensington Road, Suite 203, Oak Brook, Ill. 60521-2106; 708-954-2900, 800-345-7848

Operational date: February 1985.
Sponsorship: Six hospitals.
For profit.
Staff: 3,200 primary physicians; 1,400 specialists; 25 administrative staff members; five marketing staff members; average of 60 patients per primary physician; 85% board certified physicians.
Facilities: 72 hospitals; 1,000 pharmacies.
Service area: Illinois, Northwest Indiana, Southeast Wisconsin.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 500 employer/payer groups; 115,000 employees and dependents with access to the network; 138,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals, percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $20 million in 1988; $50 million estimated in 1989.
Officers: George C. Phillips Jr., president; Mitchell Wasserman, marketing director; Donna Wolak, vp-finance.

Lincoln National Preferred Plan

747 E. 22nd St., Lombard, Ill. 60148; 312-916-4270

See Lincoln National Preferred Plan under Indiana.

Med-Connect Network

15 Salt Creek Lane, Hinsdale, Ill. 60521; 708-850-2310

Operational date: November 1989.
Sponsorship: Two hospital systems and three insurers.
For profit.
Staff: 1,019 primary physicians; 584 specialists; nine administrative staff members; average of eight patients per primary physician; 85% board certified physicians.
Facilities: 27 hospitals.
Service area: Cook, Lake, DuPage, Will, Kane and McHenry counties in Illinois.
Services provided: Specialty services include vision, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 78 employer/payer groups; 3,400 employees and dependents with access to the network; 6,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $44,000 estimated in 1989.
Officers: Daniel R. Schuh, president; Dr. Marvin Zolot, medical director.

Metropolitan Life Insurance Co.-Illinois

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Illinois

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO-Illinois

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

Participating Provider Option

233 N. Michigan Ave., Chicago, Ill. 60611; 312-938-6000

Operational date: January 1985.
Sponsorship: Blue Cross & Blue Shield of Illinois.
Staff: 6,182 primary physicians.
Facilities: 166 hospitals.
Service area: Illinois.
Users: 657,501 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate.
Control measures: Preadmission review, admission review, concurrent review, discharge planning, second surgical opinion, individual case management; utilization review provided by outside contractors.
Gross revenues: Not reported.

PARTNERS National Health Plans-Illinois

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PATH Health Network

205 W. Touhy Ave., Suite 200, Park Ridge, Ill. 60068; 708-698-4858

Operational date: March 1987.
Sponsorship: Lutheran General Health Care System.
Ownership: Parkside Health Management Corp.
For profit.
Staff: 1,732 primary physicians; 1,238 specialists; nine administrative staff members; four marketing staff members; average of 146 patients per primary physician; 70% board certified physicians.
Facilities: 24 hospitals.
Service area: Cook, Lake, DuPage, Kane, McHenry, Kendall and Will counties in Illinois.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: More than 500 employer/payer groups; 30,000 employees with single coverage or family coverage; 72,000 employees and dependents with access to the network; 85,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee, percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $4.4 million in 1988; $6.7 million estimated in 1989.
Officers: Stephen R. Tiwald, president; Dr. Walter A. Hollinger, medical director; James L. Dunlavy, marketing director.

Preferred Health Network

P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

See Preferred Health Network under California.

Preferred Plus of Northern Illinois

1295 State St., Springfield, Mass. 01111; 413-788-8411, ext. 3192

Operational date: February 1987.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,600 primary physicians.
Facilities: 42 hospitals.
Service area: Cook, Lake, Kane, DuPage, Will and McHenry counties in Illinois.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under certain special circumstances; individual enrollment is not allowed.
Users: 20 employer/payer groups; 10,814 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Bernard J. Comeau, regional sales director-Massachusetts Mutual Life Insurance Co.

Private Healthcare Systems Ltd.

O'Hare International Center, 10275 W. Higgins, Suite 390, Rosemont, Ill. 60018; 312-299-7560

See Private Healthcare Systems Ltd. under Massachusetts.

PruCare of Illinois-PruCare Plus

9450 W. Bryn Mawr, Rosemont, Ill. 60018; 312-671-8700

Operational date: January 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 2,928 primary physicians; 2,046 specialists; 92 administrative staff members; 30 marketing staff members; 95% board certified physicians.
Facilities: 44 hospitals; 300 pharmacies.
Service area: Cook, DuPage, Lake, DeKalb, Grundy, Kane, Kendall, LaSalle and McHenry counties in Illinois; portions of Lake County, Ind.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 5,370 employees with single coverage; 4,273 employees with family coverage; 84,397 employees and dependents with access to the network.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, disability management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Scott P. Serota, vp-health care management; Dr. Henry Hollander, medical director; Michael Dooley, marketing director.

Rush Contract Care

33 E. Congress, Suite 701, Chicago, Ill. 60605; 312-347-4502

Operational date: September 1986.
Sponsorship: Rush-Presbyterian-St. Luke's Health Plans Inc.
Not for profit.
Staff: 1,483 primary physicians; 712 specialists; 42 administrative staff members; three marketing staff members; 100% board certified physicians.
Facilities: 31 hospitals.
Service area: Cook, DuPage, McHenry, Will and Lake counties in Illinois; Lake and Porter counties in Indiana.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: Two employer/payer groups; 128,573 employees and dependents with access to the network; 142,495 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; utilization review provided by the PPO.
Gross revenues: $30 million estimated in 1989.
Officers: Dr. Jerome Hahn, president; Gordon Mallett, director; Dr. Glen Tomlinson, medical director.

Travelers Preferred-Chicago

120 S. Riverside Plaza, Suite 954, Chicago, Ill. 60606; 312-930-9797

Operational date: June 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 2,137 primary physicians.
Facilities: 28 hospitals.
Service area: Cook, DuPage, Kane, Lake, McHenry and Will counties in Illinois.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 564 employer/payer groups; 30,752 employees with single coverage or family coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Felicia Wilhelm, executive director; Paul J. Grewe, David P. Harris, Richard C. Nichols, John T. Westby, Robert T. Garrison, sales managers.



Blue Cross & Blue Shield o Indiana/Preferred Care of Indiana

, 120 W. Market St., Indianapolis, Ind. 46204; 317-263-5797

Operational date: March 1985.
Staff: 6,536 primary physician 88% board certified physicians.
Facilities: 81 hospitals.
Service area: Indiana.
Users: 374,550 employees and de pendents with access to the network
Control measures: Preadmissio hospital review, concurrent hospita treatment review, discharge plan ning, second surgical opinion, cas management; utilization review per formed by the PPO.
Gross revenues: Not reported.

CNA Managed PPO-Indianapolis

CNA Plaza-22W, Chicago, Ill. 60685; 312-822-7626

Operational date: August 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 701 primary physicians; 78% board certified physicians, 8% board eligible physicians.
Facilities: Six hospitals and medical facilities.
Service area: Marion County, Ind.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11,500 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Tom Dolatowski, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Indiana

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Indianapolis

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Great-West Care-Indianapolis

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 686 primary physicians.
Facilities: Six hospitals.
Service area: Boone, Clinton, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Putnam, Rush, Shelby and Tipton counties in Indiana.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO

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oviders at time of service; PPO an design can be customized to eet employer specifications; indidual enrollment is not allowed.
Users: Four employer/payer oups; 450 employees and depenents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem ite, by a percent discount off cusmary rates for individual services, DRGs; the PPO is compensated by nployers/payers; the PPO charges a at fee per eligible employee.
Control measures: Preadmission ospital review, precertification, oncurrent hospital treatment reiew, length of stay determination, ischarge planning, retrospective reiew, second surgical opinion, hospial bill audits, case management; utization review provided by Private lealthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior p; Jeffrey Kraines, medical direcor-Private Healthcare Systems Ltd.; obert Kavanaugh and Jim Motz, ps; David Grapko, manager.

EQUICOR Preferred-Gary
1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Indianapolis
1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Humana Health Insurance Co.
9300 Shelbyville Road, Suite 700, Louisville, Ky. 40222; 502-423-1355

See Humana Health Care Plans' corporate listing under Kentucky.

Indiana Pro Health Network Inc.
8060 Knue Road, Suite 228, Indianapolis, Ind. 46250; 317-841-5501

Operational date: March 1985.
Sponsorship: Hospital.
Not for profit.
Staff: 750 primary physicians; 400 specialists; 11 administrative staff members; one marketing staff member; 80% board certified physicians.
Facilities: 14 hospitals; three pharmacies.
Service area: Boone, Clinton, Hamilton, Hancock, Hendricks, Henry, Johnson, Marion, Morgan, Shelby and Vigo counties in Indiana.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 10 employer/payer groups; 40,125 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, by claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Ted E. Milkey, president; Julie A. Phegley, executive director; Dr. Thomas H. Fisher and Dr. Samuel K. Cramer, medical directors.

Lincoln National Preferred Plan (USA)*
1700 Magnavox Way, Fort Wayne, Ind. 46804; 219-427-2000

Operational date: 1987.
Sponsorship: Lincoln National Life Insurance Co.
Ownership: Lincoln National Administrative Service Corp.
For profit.
Staff: 20,000 primary physicians; 18,000 specialists; 100% board certified physicians.
Facilities: 550 hospitals; 2,500 pharmacies; 300 diagnostic labs.
Service area: 26 states.
Services Provided: Employees can select non-PPO Providers at time of service; the PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 2,600 employer/payer groups; 350,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Lincoln National Review.
Gross revenues: Not reported.
Officers: John P. Cole, executive vp/chief executive officer; Dr. Robert Gormley and Dr. Stephen George, medical directors.

* Figures are corporate, including all PPOs sponsored by Lincoln National Life Insurance Co.

Mutually Preferred-Indiana
Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO-Indiana
17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Indiana
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Plus of Indiana
1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: September 1987.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,040 primary physicians.
Facilities: 12 hospitals.
Service area: Boone, Hendricks, Marion, Hamilton, Hancock, Johnson, Madison, Shelby, Allen, Clinton and Morgan counties in Indiana.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under specialized circumstances; individual enrollment is not allowed.
Users: 41 employer/payer groups; 9,492 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Daniel L. Hindman, account executive-Massachusetts Mutual Life Insurance Co.

PruCare Plus-Indiana
8332 Woodfield Crossing Blvd., Suite 200, Indianapolis, Ind. 46280; 317-253-3020

Operational date: October 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 496 primary physicians; 298 specialists; 17 administrative staff members; 12 marketing staff members; 75% board certified physicians.
Facilities: 10 hospitals; one pharmacy; one diagnostic labs.
Service area: Hamilton, Hancock, Hendricks, Johnson and portions of Boone, Henry, Madison, Montgomery, Morgan, Putnam and Shelby counties in Indiana.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 3,317 employees with single coverage; 3,977 employees with family coverage; 18,414 employees and dependents with access to the network; 19,606 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. Thomas Ferrara, executive director; Dr. John Saalwaechter, medical director; Mark A. Lewis, marketing director.

Travelers Preferred-Fort Wayne
120 S. Riverside Plaza, Suite 954, Chicago, Ill. 60606; 312-930-9797

Operational date: February 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 140 primary physicians.
Facilities: Two hospitals.
Service area: Allen and Wells counties in Indiana.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee or percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Felicia Wilhelm, executive director; Scott Dennis, sales manager.

Travelers Preferred-Indianapolis
120 S. Riverside Plaza, Suite 954, Chicago, Ill. 60606; 312-930-9797

Operational date: February 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 475 primary physicians.
Facilities: Four hospitals.
Service area: Hancock, Hendricks, Johnson, Morgan, Boone, Shelby, Hamilton, Madison, Marion and Tippecanoe counties in Indiana.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Two employer/payer groups; 765 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, by a percent of services rendered, by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Robert D. Ray, president; Dr. John May, medical director; Rick Corbett, marketing director.



ALLIANCE Select
636 Grand Ave., Des Moines, Iowa 50309; 515-245-5123

Operational date: 1987.
Sponsorship: Blue Cross & Blue Shield of Iowa.
Not for profit.
Staff: 2,372 primary physicians.
Facilities: 114 hospitals; 27 diagnostic labs.
Service area: Iowa.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications for major accounts; individual enrollment is allowed.
Users: 45,295 employees with single coverage; 64,938 employees with family coverage; 255,761 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate for large hospitals, by prospective payment for rural hospitals; the PPO is compensated by employers/payers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO and the Iowa Foundation for Medical Care.
Gross revenues: Not reported.
Officers: Robert D. Ray, president; Dr. John May, medical director; Rick Corbett, marketing director.

CarePASS-Iowa
8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

PARTNERS National Health Plans-Iowa
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



Choice Care
1133 Topeka Ave., Topeka, Kan. 66629; 913-295-4700

Operational date: January 1986.
Sponsorship: Blue Cross & Blue Shield of Kansas.
Staff: 4,110 primary physicians.
Facilities: 44 hospitals.
Service area: 30 counties in Kansas.
Users: 116,652 employees and dependents.
Compensation: The PPO negotiates hospital charges by per diem rate or by DRGs.
Control measures: Preadmission review, concurrent review, second surgical opinion, individual case management; utilization review provided by the PPO.
Gross revenues: Not reported.

CIGNA FlexCare Preferred Provider Organization-Kansas City
Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Kansas City
1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Wichita
1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Kansas City
8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: July 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Health Care Systems Ltd.
For profit.
Staff: 1,090 primary physicians; 64% board certified physicians.
Facilities: 14 hospitals.
Service area: Metropolitan Kansas City in Kansas and Missouri.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Two employer/payer groups; 55 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Hartford's PULSE Plan of Kansas City
Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

See Hartford PULSE Plan under Missouri.

John Hancock Preferred Health Plan-Kansas
P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Lincoln National Preferred Plan
7300 College, Suite 100, Overland Park, Kan. 66210; 913-345-2240

See Lincoln National Preferred Plan under Indiana.

Preferred Chiropractic Care
4820 E. Kellogg, Wichita, Kan. 67218; 316-685-0447

Operational date: 1984.
Sponsorship: Insurers, hospitals and a group of doctors.
For profit.
Staff: 100 primary physicians; five administrative staff members; two marketing staff members.
Facilities: 15 hospitals.
Service area: Kansas, Texas, Florida and Oklahoma.
Services provided: Specialty services include chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: Four employer/payer

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groups; 100,000 employees with family coverage.

Compensation: The PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Retrospective review; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Dr. Brad Dopps, president; Dennis Owens, executive/marketing director.

Preferred Health Care Inc.

345 Riverview, Suite 101, P.O. Box 307-C, Wichita, Kan. 67201; 316-268-0345

Operational date: February 1985.
For profit.
Ownership: Hospitals and physicians.
Staff: 1,100 primary physicians; nine administrative staff members; two marketing staff members; 80% board certified physicians.
Facilities: 46 hospitals; 10 diagnostic labs.
Service area: Kansas.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 136 employer/payer groups; 97,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a percent of services rendered by participating doctors/hospitals.
Control measures: Precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: Not reported.
Officers: Marlon R. Danner, president; Linda Malcom, vp-administration; Stan Vaughan, vp-finance.

Preferred Health Professionals

4400 College Blvd., Suite 300, Overland Park, Kan. 66211; 913-339-4400

Operational date: July 1983.
Sponsorship: Preferred Health Providers and Preferred Health Professional.
Not for profit.
Staff: 1,025 primary physicians; 526 specialists; 26 administrative staff members; six marketing staff members; 70% board certified physicians.
Facilities: 21 hospitals; two pharmacies including one pharmacy chain; 15 diagnostic labs.
Service area: Johnson, Wyandotte and Leavenworth counties in Kansas; Jackson, Cass, Clay, Platte, Johnson and Lafayette counties in Missouri.
Services provided: Specialty services include prescription drug, vision, substance abuse, psychological services, durable medical equipment, podiatry, obstetrics/gynecology, home nursing and therapy. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 613 employer/payer groups; 156,843 employees and dependents with access to the network; 165,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO and outside contractors.
Gross revenues: Not reported.
Officers: Dan Anderson, president; Kathleen O'Connor, executive director; Dr. O. Dale Smith, medical director; Jerry W. Baxter, marketing director; Marcie G. Wiener, operations director; Karen Barancik, manager consumer/provider relations.

Preferred Mental Health Management Inc.

2108 W. 75th St., Suite 400, Prairie Village, Kan. 66208; 913-677-1642

Operational date: April 1987.
For profit.
Staff: 40 primary physicians; 80 specialists; eight administrative staff members; two marketing staff members; 100% board certified physicians.
Facilities: 27 hospitals; one diagnostic lab.
Service area: Kansas, Texas, Colorado, Illinois, Oklahoma and Florida.
Services provided: Specialty services include substance abuse, psychiatric services, employee assistance. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 38 employer/payer groups; 94,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, case management; utilization review provided by the PPO and outside contractors.
Gross revenues: Not reported.
Officers: Dr. Leslie Ruthven, president; Dr. Thomas J. FitzGerald, executive/marketing director.



CNA Managed Care PPO-Louisville

1010 Market St., Suite 560, St. Louis, Mo. 63178; 314-342-7945

Operational date: October 1987
Sponsorship: CNA Financial Corp.
For profit.
Staff: 186 primary physicians; 81.1% board certified physicians, 14.6% board eligible physicians.
Facilities: Four hospitals and medical facilities.
Service area: Jefferson County, Ky.
Services provided: Specialty services include obstetrics/gynecology, substance abuse and psychiatric services. Employees can select PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10,300 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Bill Carrol, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Kentucky

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

Great-West Care-Louisville

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: October 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare System Ltd.
For profit.
Staff: 188 physicians.
Facilities: Four hospitals
Service area: Crawford, Washington, Harrison, Floyd, Clark and Scott counties in Indiana; northern Kentucky.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: One employer/payer group.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services. The PPO is compensated by employers/payers. The PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Humana Health Plan Inc.

9300 Shelbyville Road, Suite 700, Louisville, Ky. 40222; 502-423-1355

See Humana Health Care Plans' corporate listing under Kentucky.

Humana Health Plan Inc.

101 Prosperous Place, Suite 300, Lexington, Ky. 40509; 606-254-2731

See Humana Health Care Plans' corporate listing under Kentucky.

Humana Health Care Plans*

500 W. Main St., Louisville, Ky. 40201; 502-580-1000

Operational date: 1933.
Ownership: Humana Inc.
For profit.
Staff: More than 8,000 primary physicians for all of Humana Health Care Plans HMOs and PPOs.
Facilities: More than 200 hospitals for all of Humana Health Care Plans HMOs and PPOs.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Wayne T. Smith, president-health care division.

Figures are corporate for all PPOs (and HMOs when noted) sponsored by Humana Health Care Plans.

Option 2000

9901 Linn Station Road, Louisville, Ky. 40223; 502-423-2099

Operational date: December 1984.
Sponsorship: Blue Cross & Blue Shield of Kentucky.
For profit.
Facilities: 115 hospitals.
Service area: Kentucky.
Users: 207,190 employees and dependents with access to the network.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion, case management.
Gross revenues: Not reported.

PARTNERS National Health Plans-Kentucky

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



American LifeCare

650 Poydras St., Suite 1900, New Orleans, La. 70130; 504-561-0600

Operational date: August 1985.
Sponsorship: Private.
For profit.
Staff: 980 primary physicians; 490 specialists; 10 administrative staff members; four marketing staff members; average of 100 patients per primary physician; 96% board certified physicians.
Facilities: 22 hospitals; one diagnostic lab.
Service area: Louisiana; Hancock and Harrison counties in Mississippi.
Services provided: Specialty services include substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 240 employer/payer groups; 104,000 employees and dependents with access to the network; 116,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and outside contractors.
Gross revenues: Not reported.
Officers: Ed Michael Reggie; Nan M. Wallis, executive director; Dr. Irving Blatt, medical director.

CNA Managed Care PPO-New Orleans

1005 Ford Road, Suite 300, Dallas, Texas 75234; 214-620-5350

Operational date: September 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 572 primary physicians; 73.8% board certified physicians, 7.5% board eligible.
Facilities: Six hospitals and medical facilities.
Service area: Orleans and Jefferson parishes in Louisiana.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Gary Brown, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-New Orleans

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

First Choice Health Plan

P.O. Box 98029, Baton Rouge, La. 70898; 504-295-2296

Operational date: January 1985.
Sponsorship: Blue Cross & Blue Shield of Louisiana.
Staff: 1,245 primary physicians.
Facilities: 35 hospitals.
Service area: 29 parishes in Louisiana.
Users: 73,105 employees and dependents with access to the network.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion; utilization review provided by outside contractors.
Gross revenues: Not reported.

Great-West Care-New Orleans

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: November 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 664 primary physicians; 77% board certified physicians.
Facilities: Six hospitals.
Service area: Jefferson, Livingston, Orleans, Plaquemines, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Tammany, Tangipahoa and Washington parishes in Louisiana.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Two employer/payer groups; 153 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

John Hancock Preferred Health Plan-Louisiana

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Healthcare Advantage Inc.

3450 Chestnut St., New Orleans, La. 30119; 504-897-8686; 800-326-4465

Operational date: July 1989.
Sponsorship: Hospitals.
For profit.
Staff: 250 primary physicians; 130 specialists; one administrative staff member; one marketing staff member;

Continued on next page

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5% board certified physicians.
Facilities: Seven hospitals; one diagnostic lab.
Service area: Orleans, Jefferson, St. Tammany, St. John the Baptist, Tangipahoa, Lafayette and Iberia parishes in Lousisiana; Harrison and Hancock counties in Mississippi.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications.
Users: Eight employer/payer groups; 450 employees with single coverage; 419 employees with family coverage; 1,995 employees and dependents with access to the network; 5,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $400,000 estimated in 1989.
Officers: Gary Marchand, president; Jane Cooper, executive vp/chief operating officer; Dr. Mike Diodene, medical director; Adele Matherne, director-sales; George Saucier, secretary/treasurer.

Metropolitan Life Insurance Co.-Louisiana

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-Louisiana

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Principal Health Care Preferred of Louisiana Inc.

3421 N. Causeway Blvd., Suite 600, Metairie, La. 70002; 504-834-0840

Operational date: January 1985.
Sponsorship: Principal Health Care Inc.
Ownership: Principal Financial Group.
For profit.
Staff: 508 primary physicians; 352 specialists; seven administrative staff members; 80% board certified physicians.
Facilities: 19 hospitals; three pharmacies including a pharmacy chain; one diagnostic lab.
Service area: St. Charles, Orleans, Jefferson, St. Bernard, St. Tammany and Plaquemines parishes in Louisiana.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by claims administrators, insurance companies; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO and by outside contractors.
Gross revenues: Not reported.
Officers: Kenneth Linde, president; Barry K. Baker, executive director.

Travelers Preferred-New Orleans

Galleria 1, Suite 2100, Galleria Boulevard, Metairie, La. 70001; 504-836-5505

Operational date: December 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,066 primary physicians.
Facilities: 15 hospitals.
Service area: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Tammany and Tangipahoa parishes in Louisiana.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 27 employer/payer groups; 8,402 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Beth Richards, executive director; William G. Noonan III, sales manager.



Medical Network Inc.

P.O. Box 15253, Portland, Maine 04101; 207-773-5116

Operational date: February 1988
Sponsorship: Medical Network Inc.
For profit.
Staff: 187 primary physicians; 145 specialists; two administrative staff members; one marketing staff member; 100% board certified physicians.
Facilities: Two diagnostic labs.
Service area: Maine.
Services provided: Substance abuse, psychiatric services, podiatry, obstetrics/gynecology, chiropractic, physical therapy. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Users: 85 employer/payer groups; 12,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers, claim administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO and Health Care Compare.
Gross revenues: Not reported.
Officers: Dr. William X. Maxwell, president; Joseph J. Bean, executive director; Dr. Robert Kramer, medical director.

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PARTNERS National Health Plans-Maine

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.



CMG Health

25 Crossroads Drive, Suite 140, Owings Mills, Md. 21117; 301-581-5000

Operational date: 1986.
Ownership: Private.
For profit.
Staff: 300 primary physicians; 10 administrative staff; three marketing staff members; 100% board certified physicians.
Service area: Maryland, District of Columbia, Virginia, Delaware, Kansas, Missouri, Iowa.
Services provided: Substance abuse, psychiatric services. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 2,300 employer/payer groups; 500,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Alan Shusterman, president; Dr. Ronald Cann, medical director; Charles Rhodes, vp-sales/marketing; Diane Woltereck, vp-operations.

CNA Managed Care PPO-Baltimore

1101 Market St., 25th Floor, Philadelphia, Pa. 19107; 215-351-3842

Operational date: January 1989.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 787 primary physicians; 67.6% board certified physicians, 8.6% board eligible.
Facilities: Five hospitals and medical facilities.
Service area: Baltimore, Howard and Harford counties in Maryland.
Services provided: Substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Five employees and dependents.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Bill Gabel, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Maryland

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

Dental Benefit Providers Inc.

7200 Wisconsin Ave., Suite 800, Bethesda, Md. 20814; 301-654-6900; 800-445-9090

Operational date: January 1984.
Ownership: Private.
Staff: 3,000 primary dentists; 2,000 specialists; 150 administrative staff members; eight marketing staff members; average of 200 patients per primary dentist; 100% board certified or board eligible dentists.
Service area: Maryland; Virginia; District of Columbia; Illinois; Massachusetts; California; San Antonio and Austin, Texas; Georgia; Northeastern Ohio; Alabama.
Services provided: Specialty services include dental. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Approximately 600,000 employees and dependents with access to the network; 600,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers
Gross revenues: Not reported.
Officers: Dr. Ralph Foxman, president; Edward Murphy, executive director; Dr. Carlton Gong, dental director.

Hartford's PULSE Plan of the National Capital Area

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

See Hartford PULSE Plan under District of Columbia.

Health Care 2000

660 Kenilworth Drive, Towson, Md. 21204; 301-296-8326

Operational date: 1984.
Ownership: Fidelity Health Systems Corp.
For profit.
Staff: 800 primary physicians; 500 specialists; seven administrative staff members; one marketing staff member; 96% board certified physicians.
Facilities: 15 hospitals; 500 pharmacies; five diagnostic labs.
Service area: Maryland.
Services provided: Specialty services include prescription drugs, vision, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10 employer/payer groups; 250,000 employees and dependents with access to the network.
Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee and percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Mitchell Diamond, president/executive director; Dr. Richard Maffezzoli, medical director.

Hopkins Preferred Network

1000 E. Eager St., Baltimore, Md. 21262; 301-444-5400

Operational date: December 1986.
Sponsorship: The Johns Hopkins Health Plan and The Johns Hopkins Health Systems.
For profit.
Staff: 1,200 primary physicians; 1,000 specialists; three administrative staff members; three marketing staff members; average of 100 patients per primary physician; 97% board certified physicians.
Facilities: 10 hospitals.
Service area: Central Maryland.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 15 employer/payer groups; 5,000 employees with single coverage; 5,000 employees with family coverage; 20,000 employees and dependents with access to the network; 20,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management; utilization review provided by outside contractors.
Gross revenues: Not reported.
Officers: Barbara B. Hill, president; Ancelmo Lopes, vp-operations; William Pawluk, vp-medical affairs; Deborah L. Origer, vp-marketing; Alen Steinbach, vp-finance; Jayn Osler, vp-research/development.

Mutually Preferred-Maryland

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

National Capitol PPO

7979 Old Georgetown Road, Suite 400, Bethesda, Md. 20814; 301-654-6853

Operational date: January 1988.
Sponsorship: Privately sponsored.
For profit.
Staff: 1,800 primary physicians; 1,100 specialists; nine administrative staff members; two marketing staff members; average of 80 patients per primary physician; 90% board certified physicians.
Facilities: 23 hospitals.
Service area: District of Columbia; Arlington, Alexandria and Fairfax counties in Virginia; Montgomery, Howard, Anne Arundel and Baltimore counties in Maryland.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 180 employer/payer groups; 60,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Elliot A. Segal, president/chief executive officer; Robert A. McCluskey, vp/chief operating officer; Arthur A. Rubin and Robert A. Berenson, medical directors; Karen M. Lange, marketing director.

PHN-PPO Inc.

5700 Executive Drive, Baltimore, Md. 21228; 301-747-9060

Operational date: May 1985.
Ownership: Health Networks of America and six hospitals.
For profit.
Staff: 1,913 primary physicians; 1,773 specialists; 63 administrative staff members; nine marketing staff members; 80% board certified physicians.
Facilities: Six hospitals; more than 300 pharmacies; 15 diagnostic labs.
Service area: Baltimore, Harford, Howard, Anne Arundel, Carroll and Cecil counties in Maryland.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 80 employer/payer groups; more than 15,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers, the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $108,000 in 1988.
Officers: Peter S. O'Donnell, president/chief executive officer; Dr. Sheldon Milner, medical director; Elizabeth Dana, marketing director; Jane Stafford, vp-operations; Michael Landymore, vp-finance.

Preferred Plus of Greater Baltimore

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: November 1986.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,920 primary physicians.
Facilities: Eight hospitals.
Service area: Baltimore, Howard, Ann Arundel, Harford and Carroll counties in Maryland.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 62 employer/payer groups; 13,663 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Contact: Robert F. Moran, marketing director, 301-323-8400.

PruCare of Baltimore

300 E. Lombard St., Suite 610, Baltimore, Md. 21202; 301-783-2900

Operational date: January 1988.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 274 primary physicians; 369 specialists; two administrative staff members; five marketing staff members; average of 31 patients per primary physician; 96% board certified physicians.
Facilities: 13 hospitals; two pharmacy chains; 14 diagnostic labs.
Service area: Baltimore, Harford, Howard and Anne Arundel counties in Maryland.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employe specifications under certain circumstances.
Users: More than 380 employer payer groups; 10,000 estimated employees and dependents with acces to the network as of Jan. 1, 1990.
Control measures: Preadmissior hospital review, precertification concurrent hospital treatment review, length of stay determination discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management on-site concurrent review; utilizatior review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. David M. Solomon, medical director; Larry Marable, marketing director/regional group manager; David Coulter, manager-health care services.

Select Care

Blue Cross & Blue Shield of Maryland Inc., 700 E. Joppa Road, Baltimore, Md. 21204; 301-561-7603

Operational date: January 1985.
Facilities: 42 hospitals.
Service area: 23 counties in Maryland.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion, case management.
Gross Revenues: Not reported.

Travelers Preferred-Central Maryland

3 Parkway, Philadelphia, Pa. 19102; 215-496-0040

Operational date: December 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,289 primary physicians.
Facilities: Nine hospitals.
Service area: Anne Arundel, Baltimore, Carroll, Harford and Howard counties in Maryland.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 54 employer/payer groups; 4,483 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Pat Hedden, director-operations; Carl Walker, sales manager.



Assured Health System Inc.

20 Mall Road, Burlington, Mass. 01803; 617-273-9966

Operational date: Anticipated in April 1990.
Sponsorship: Private.
For profit.
Service area: Anticipated sites in Massachusetts, Illinois, Colorado, Texas and California.
Services provided: Specialty services include substance abuse, psychiatric services, employee assistance programs. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers, claims administra-

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irs; the PPO charges a flat fee per igible employee.

Control measures: Preadmission ospital review, precertification, con-irrent hospital treatment review, ngth of stay determination, discharge lanning, retrospective review, outpa-ent service predetermination, case anagement, employee assistance pro-rams; utilization review provided by ie PPO.

Officers: Dr. Ronald Geraty, presi-ent; Dr. Peter Panzarino, medical irector; Keith Dixon, marketing vp; avid Zarchan and James Wrich, se-ior vps.

:NA Managed Care PPO-Boston

100 Newport Ave., North Quincy, Mass. 02269; 617-984-4865

Operational date: July 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,201 primary physicians; 8.9% board certified physicians.
Facilities: 19 hospitals and medical acilities.
Service area: Norfolk, Suffolk, Essex and Middlesex counties in Massa-husetts.
Services provided: Specialty ser-vices include substance abuse, psychiat-ic services, obstetrics/gynecology. Em-ployees can select non-PPO providers at ime of service; PPO plan design can be ustomized to meet employer specifica-ions; individual enrollment is not al-owed.
Users: 15,000 employees and depen-lents with access to the network.
Compensation: The PPO negotiates ospital charges by a per diem rate, by a ercent discount off customary rates for individual services; the PPO is compen-sated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, con-current hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Officers: Doug Mason, manager-major group sales; Kenneth H. Cur-rier, manager-cost containment devel-opment; Dr. Phillip L. Bryson, associate medical director.

Delta Dental Plan of Massachusetts

P.O. Box 9104, 10 Cabot Road, Medford, Mass. 02155; 617-391-2700

Operational date: 1967.
Sponsorship: Delta Dental Plan of Massachusetts.
Not for profit.
Staff: 4,384 primary dentists; 120 administrative staff members; 19 marketing staff members.
Service area: Massachusetts.
Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment may be allowed.
Users: 1,548 employer/payer groups; 104,486 employees with single coverage; 135,657 employees with family coverage; 443,628 employees and dependents with access to the network; 480,311 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates dentists' charges by a fee system; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, administration fee.
Control measures: Professional reviews; utilization review provided by the PPO.
Gross revenues: $59.7 million in 1988; $69 million estimated in 1989.
Officers: Dr. Robert E. Hunter, president; Dr. Michael Segal, dental director; George Wezniak, controller; Thomas Raffio, director-operations; Marcia Richter, director-professional relations; Scott O'Gorman, director-underwriting; Sarah Ashe, director-human resources.

Great-West Care-Boston

8505 E. Orchard Road, Englewood, Calif. 80111; 303-889-3519

Operational date: April 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 1,427 primary physicians.
Facilities: 18 hospitals.
Service area: Bristol, Essex, Lexington, Middlesex, Norfolk, Plymouth and Worcester counties in Massachusetts.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: One employer/payer group; 42 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vp; David Grapko, manager.

John Hancock Preferred Health Plan*

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

Operational date: 1985.
Sponsorship: John Hancock Mutual Life Insurance Co.
For profit.
Staff: 33,273 primary physicians; 20,795 specialists; 33 administrative staff members; average of eight patients per primary physician; 90% board certified physicians.
Facilities: 349 hospitals; 68 diagnostic labs.
Service area: Eastern Massachusetts, California, Texas, Illinois, Southeast Michigan, Southern Florida, Kansas, Missouri, Oregon, Washington, Louisiana, Ohio, Pennsylvania, District of Columbia.
Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, rehabilitation. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 220 employer/payer groups; 21,000 employees with single coverage; 49,000 employees with family coverage; 175,000 employees and dependents with access to the network; 212,500 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management, alternate care review; utilization review provided by the PPO through John Hancock Managed Health Services.
Gross revenues: $91 million in 1988; $85 million estimated in 1989.
Officers: Christie Sommers, general director; Dr. Steven Peskin, medical director; Mary Emsheimer, marketing director.

* Figures are corporate, including all John Hancock Preferred Health Plan PPOs sponsored by John Hancock Mutual Life Insurance Co.

Healthy Choice

440 Lincoln St., Worcester, Mass. 01605; 508-856-0110

Operational date: 1987.
Sponsorship: State Mutual Life Assurance Co. of America.
For profit.
Staff: 30,000 primary physicians; 20,000 specialists.
Facilities: 400 hospitals.
Service area: Ohio, Georgia, Texas, Maryland, Alabama, Massachusetts, California, Illinois, Colorado, Michigan, Indiana, Florida, Missouri, Kansas, Kentucky, Tennessee, Wisconsin, Minnesota, North Carolina, South Carolina, Louisiana, Oklahoma, Pennsylvania, Arizona, Virginia.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 550 employer/payer groups; 18,800 employees with single coverage; 15,800 employees with family coverage; approximately 80,000 employees and dependents with access to the network; 100,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient surgery service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: State Mutual Life Assurance Co. of America: Penny Noyes, director-group managed care; Larry Blanchard, associate vp-sales.

Master Health Preferred

100 Summer St., Boston, Mass. 02110; 617-956-2000

Operational date: September 1989.
Sponsorship: Blue Cross & Blue Shield of Massachusetts.
Not for profit.
Staff: 3,000 primary physicians; 2,100 specialists; 280 marketing staff members; 100% board certified or board eligible physicians.
Facilities: 45 hospitals; 1,465 pharmacies; 51 diagnostic labs.
Service area: Massachusetts except Berkshire and Franklin counties.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, chiropractic, hospice care, cardiac rehabilitation, physical therapy. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: One employer/payer group; 83 employees with single coverage; 47 employees with family coverage; 248 employees and dependents with access to the network; 6,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges by a variety of financial arrangements available.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO and Peer Review Analysis.
Gross revenues: Not reported.
Officers: John Larkin Thompson, president-Blue Cross & Blue Shield of Massachusetts; Dr. David Maltz, medical director; Joan S. Kelley, marketing director; Joseph R. Driscoll, senior vp-marketing.

Options for Healthcare

990 Washington St., Suite 329N, Dedham, Mass. 02026; 617-461-4500

Operational date: September 1988.
Sponsorship: Private.
For profit.
Staff: 850 primary physicians; 600 specialists; three administrative staff members; two marketing staff members; 70% board certified physicians.
Facilities: 18 hospitals; 35 pharmacies; five diagnostic labs.
Service area: Middlesex, Essex, Norfolk, Plymouth and Suffolk counties in Massachusetts.
Services provided: Specialty services include durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications.
Users: Four employer/payer groups; 3,500 employees with single coverage; 8,000 employees and dependents with access to the network; 10,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of savings or percent of gross billed charges.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not available.
Officers: Gay Goldsmith, executive director; Dr. Langdon Burwell, medical director; Lisa Firestone, marketing director.

Pioneer Health Care-The PPO

1275 Elm St., West Springfield, Mass. 01089; 413-737-8558

Operational date: August 1985.
Sponsorship: Pioneer Health Care Inc.
Not for profit.
Staff: 750 primary physicians; 455 specialists; 25 administrative staff members; two marketing staff members; 95% board certified physicians.
Facilities: 10 hospitals; 170 pharmacies; 15 diagnostic labs.
Service area: Western and Central Massachusetts.
Services provided: Specialty services include prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design cannot be customized to meet employer specifications; individual enrollment is not allowed.
Users: 400 employer/payer groups; 5,000 employees with single coverage; 11,400 employees with family coverage; 40,000 employees and dependents with access to the network; 45,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audits, case management; utilization review provided by the PPO.
Gross revenues: $19.8 million in 1988; $21 million estimated in 1989.
Officers: Dr. Paul D. Titus, president-Pioneer Health Care Inc.; Bruce E. Suchy, president-Pioneer Management Systems; Dr. F.C. Schwendenmann, medical director; Thomas McConnell, marketing director.

Preferred Plus of Eastern Massachusetts

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: May 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 4,006 primary physicians.
Facilities: 30 hospitals.
Service area: Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, southern Worcester and Suffolk counties in Massachusetts; southern Hillsborough and Rockingham counties in New Hampshire.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service, PPO plan design may be customized to meet employer specifications, individual enrollment is not allowed.
Users: Nine employer/payer groups; 4,956 employees and dependents with access to the network.
Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO on a local basis.
Gross revenues: Not reported.
Officers: Joseph M. Quinn Jr., regional sales manager-Massachusetts Mutual Life Insurance Co.

Preferred Plus of Western Massachusetts

1295 State St., Springfield, Mass. 01111; 413-739-7122, ext. 705

Operational date: March 1986.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 504 primary physicians.
Facilities: Eight hospitals; 18 diagnostic labs.
Service area: Hampden, Hampshire and Franklin counties in Massachusetts; northern Hartford County, Conn..
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: 89 employer/payer groups; 28,968 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO on a local basis.
Gross revenues: Not reported.
Contact: Stanley I. Kusiak, regional sales director-Massachusetts Mutual Life Insurance Co.

Private Healthcare Systems Ltd.*

20 Maguire Road, Lexington, Mass. 02173; 617-861-5500

Operational date: July 1985.
Sponsorship: Benefit Trust Life Insurance Co., Business Men's Assurance Co. of America, Central Life Assurance Co., Confederation Life Insurance Co., CNA Financial Corp., General American Life Insurance Co., Great-West Life Assurance Co., The Guardian Life Insurance Co. of America, Jefferson-Pilot Life Insurance Co., MONY Financial Services, The Mutual Benefit Life Insurance Co., The New England Mutual Life Insurance Co., Phoenix Mutual Life Insurance Co., State Mutual Life Insurance Co., Time Insurance Co., Washington National Life Insurance Co., Western Life Insurance Co.
For profit.
Staff: 31,000 primary physicians; approximately 16,000 specialists; 100 administrative staff members; 87% board certified physicians.
Facilities: 412 hospitals.
Service area: 26 regional offices and 40 market areas.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; individual enrollment is not allowed.
Users: 1.2 million employees and dependents with access to the network; 1.3 million estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management utilization review provided by the PPO.

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Gross revenues: Not reported.

Officers: Gene P. Guselli, general manager; Donna Golden, senior vp; Dr. Jeffrey Kraines, medical director.

* Figures are corporate, including all Private Healthcare Systems Ltd. PPOs sponsored by the 17 insurance companies listed.

Private Healthcare Systems Ltd.

20 Maguire Road, Lexington, Mass. 02173; 617-861-5500

Markets include Philadelphia; Pittsburgh; Boston; Baltimore; District of Columbia.

See Private Healthcare Systems Ltd. corporate listing under Massachusetts.

PruCare Plus of Massachusetts

800 Boylston St., Suite 1550, Boston, Mass. 02199; 617-236-2602

Operational date: May 1986.
Sponsorship: The Prudential Life Insurance Co. of America.
For profit.
Staff: 2,000 primary physicians; 1,145 specialists; 67 administrative staff members; 43 marketing staff members; average of 50 patients per primary physician; 89% board certified physicians.
Facilities: 40 hospitals; 200 pharmacies; 23 diagnostic labs.
Service area: Worcester, Essex, Middlesex, Barnstable, Bristol, Suffolk, Norfolk and Plymouth counties in Massachusetts.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 39,989 employees and dependents with access to the network; 38,335 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Jeannine M. Rivet, vp; Dr. Alan Ziskind, statewide medical director; Ray Dutcher, director-Boston group office; Ernest R. Bourassa, director-health care management.

Travelers Preferred-Boston

200 State St., Boston, Mass. 617-330-1333

Operational date: March 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 2,483 primary physicians.
Facilities: 20 hospitals.
Service area: Essex, Middlesex, Norfolk, Suffolk and Worcester counties in Massachusetts; Hillsbourough, Merrimack, Rockingham and Stratford counties in New Hampshire.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 196 employer/payer groups; 20,660 employees with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Mary Ann Shea, executive director; Joseph Robinson, sales manager.



Blue Preferred Plan

26900 W. 11 Mile Road, Southfield, Mich. 48086; 517-699-3100

Operational date: April 1985.
Sponsorship: Blue Cross & Blue Shield of Michigan.
Staff: 7,800 primary physicians.
Facilities: 119 hospitals.
Service area: 54 counties in Michigan.
Users: 345,520 employees and dependents with access to the network.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion.
Gross revenues: Not reported.

CNA Managed Care PPO-Detroit

30200 Telegraph Road, Suite 300, Birmingham, Mich. 48010; 313-433-2550

Operational date: June 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 773 primary physicians; 74.3% board certified physicians, 8.2% board eligible.
Facilities: 11 hospitals and medical facilities.
Service area: Wayne, Oakland and Macomb counties in Michigan.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 8,600 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: John Cavanaugh, manager-major group sales; Kenneth H. Currier, manager-cost containment; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Detroit

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CompPro Inc.

30057 Orchard Lake Road, Suite 200, Farmington Hills, Mich. 48018; 313-851-0700

Operational date: June 1987.
Sponsorship: MedView Inc.
For profit.
Staff: 10,000 primary physicians; 6,000 specialists; 34 administrative staff members; three marketing staff members; 80% board certified physicians.
Facilities: 325 hospitals; 700 pharmacies; 35 diagnostic labs.
Service area: Michigan, California, Texas and Illinois.
Services provided: Specialty services include prescription drugs, durable medical equipment, podiatry, utilization review, medical and rehabilitation case management, technical and professional review, bill auditing. Employees cannot select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 100,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by MedView Inc.
Gross revenues: $6 million in 1988; $12.5 million estimated in 1989.
Officers: Robert J. Mackey, president; Debra J. Cerre, vp/chief operating officer; Dr. Henry Shevitz, medical director; David Aegel, executive vp; Robert Marks, vp.

Delta Dental Preferred Provider Organization

P.O. Box 30416, Lansing, Mich. 40909; 517-349-6000

Operational date: January 1988.
Sponsorship: Delta Dental Plan of Michigan.
Not for profit.
Staff: 875 primary physicians; 105 specialists; 550 administrative staff members; 50 marketing staff members.
Service area: Michigan.
Services provided: Specialty services include dental. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 45 employer/payer groups; 20,600 employees with single coverage; 57,500 employees with family coverage; 227,000 employees and dependents with access to the network; 235,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, administrative fee based on expected claims activity.
Control measures: Computerized analysis of practice patterns, predetermination of claims, post-treatment review of services; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Patrick P. Gribben Jr., president-Delta Dental Plan of Michigan; E. Craig Lesley, marketing director-Delta Dental Plan of Michigan; C. Richard Seitz, senior vp-marketing/external affairs-Delta Dental Plan of Michigan.

EQUICOR Preferred-Detroit

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great Lakes Health Plan

356 Trust Building, Grand Rapids, Mich. 49503; 616-235-4487

Operational date: October 1988.
Ownership: Grand Benefits Inc.
For profit.
Staff: 1,100 primary physicians; 40% of physicians are specialists; four administrative staff members; two marketing staff members; 100% board certified physicians.
Facilities: 32 hospitals.
Service area: Michigan and Ohio.
Services provided: Specialty services include psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers, claims administrators; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by HHS Inc.
Gross revenues: Not reported.
Officers: David K. Silliven, president/marketing director; Craig A. Groendyk, Michael Gale and Gail Wallace.

Great-West Care-Detroit

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: June 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 882 primary physicians; 75% board certified physicians.
Facilities: 11 hospitals.
Service area: St. Clair, Oakland, Macomb, Livingston, Jackson, Washtenaw, Wayne, Monroe and Ingham counties in Michigan.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 11 employer/payer groups; 1,123 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Grand Rapids

8505 E. Orchard Road, Colo. 80111; 303-889-3519

Operational date: January 1988.
Sponsorship: Great-West Life Assurance.
Ownership: Family Health Plan of Michigan.
For profit.
Staff: 126 primary physicians.
Facilities: Two hospitals.
Service area: Mason, Lake, Oceana, Newaygo, Mecosta, Ottawa, Kent, Allegan and Barry counties in Michigan.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Control measures: Utilization review provided by Private Healthcare Systems Ltd.
Gross Revenues: Not reported.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director-Private Healthcare Systems Ltd.; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

John Hancock Preferred Health Plan-Michigan

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

IBA Healthcare Plan

458 W. South St., Kalamazoo, Mich. 49005; 616-343-1562

Operational date: May 1986.
Sponsorship: IBA Health & Life Assurance Co.
Ownership: Bronson Healthcare Group.
For profit.
Staff: 1,400 primary physicians; 1,100 specialists; five administrative staff members; 75% board certified physicians.
Facilities: 30 hospitals.
Service area: Michigan.
Services provided: Specialty services include prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 1,760 employer/payer groups; 18,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, or by a percent discount off customary rates for individual services by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Larry O'Brien, president; Helen Hughes, vp-medical services/claims; Dr. Thomas Bergland, medical director; Betty Salmon, vp-sales; Perry Talicska, vp-finance/chief operating officer.

National Foot Care Program Inc.

22255 Greenfield, Suite 550, Southfield, Mich. 48075; 313-559-2579

Operational date: February 1984
Ownership: Value Health Inc.
For profit.
Staff: 37 primary physicians; 5 specialists; five administrative staff members; seven marketing staff members; 75% board certified physicians.
Facilities: 18 hospitals.
Service area: Seven counties in Michigan.
Services provided: Specialty services include podiatry. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Three employer/payer groups; 245,000 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by approved program payment/all inclusive rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination; utilization review provided by the PPO.
Gross revenues: $3.4 million in 1988; $3.4 million estimated in 1989.
Officers: Dr. Claude Oster, president/executive director/marketing director; Dr. Robert Willoughby, medical director; Robbie Romeo, vp-operations.

National Rehabilitation System

P.O. Box 97, Lathrup Village, Mich. 48076; 313-559-0544

Operational date: Pre-operational.
Sponsorship: Private.
For profit.
Staff: 20 primary physicians; two administrative staff members; 50% board certified physicians.
Services provided: Specialty services include durable medical equipment, rehabilitation. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Dr. Claude Oster, president/medical director; Ronald Feinberg, executive vp.

PM Group's PPO-Michigan

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under Cali-

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POM

28588 Northwestern Highway, Suite 380, Southfield, Mich. 48034; 313-357-7766

Operational date: March 1984.
Sponsorship: Independent.
For profit.
Staff: 4,500 primary physicians; 000 specialists; 18 administrative aff members; six marketing staff embers.
Facilities: 51 hospitals; 30 diag- ostic labs.
Service area: Michigan.
Services provided: Specialty ser- ces include substance abuse, psyc- iatric services, durable medical quipment, podiatry, obstetrics/gyn- cology. Employees can select non- PO providers at time of service; PO plan design can be customized meet employer specifications; in- ividual enrollment is allowed.
Users: 220,000 employees and de- endents with access to the network; 35,000 estimated employees and de- endents with access to the network s of Jan. 1, 1990.
Compensation: The PPO negoti- tes hospital charges by DRGs; the PO is compensated by employers/ ayers; the PPO charges a flat fee per ligible employee, percent of services endered by participating doctors/ ospitals.
Control measures: Preadmission ospital review, concurrent hospital reatment review, length of stay de- ermination, discharge planning, ret- ospective review; utilization review rovided by the PPO and outside ontractors.
Gross revenues: $54.3 million in 988; $101.3 million estimated in 989.
Officers: David Miller, president; Richard Rogel, chief executive offi- er; Dr. Allan Waldman, vp/medical director; Jay Levin, vp/marketing director.

PARTNERS National Health Plans-Michigan

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Plus of Michigan

1295 State St., Springfield, Massachusetts 01111; 413-788-8411

Operational date: June 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,513 primary physicians.
Facilities: 23 hospitals.
Service area: Detroit, Macomb, Oakland, Wayne, Kent and Grand Rapids counties in Michigan.
Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design may be customized to meet employer specifications; individual enrollment is not allowed.
Users: Two employer/payer groups; 610 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Ernesto Segura, senior account executive-Massachuestts Mutual Life Insurance Co., 413-788-8411.

Prudential Plus/Michigan

3000 Town Center, Suite 2160, Southfield, Mich. 48075; 313-358-2840

Operational date: February 1988.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 963 primary physicians; 653 specialists; three administrative staff members; five marketing staff members; 70% board-certified physicians.
Facilities: 27 hospitals; two pharmacies; four diagnostic labs.
Service area: Macomb, Oakland and Wayne counties in Michigan.
Services provided: Specialty services include prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 1,700 employees with single coverage; 2,049 employees with family coverage; 8,237 employees and dependents with access to the network; 9,500 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Mark Zickel, manager-health care management; Dr. Thomas M. Batchelor, medical director; Bob Brown, director-group marketing; Kenneth E. Bates, vp-health care management.

Travelers Preferred-Detroit

200 W. Madison, Suite 2830, Chicago, Ill. 60606; 312-609-2938

Operational date: November 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,237 primary physicians.
Facilities: 20 hospitals.
Service area: Macomb, Oakland and Wayne counties in Michigan.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: Two employer/payer groups; 2,306 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Kathleen Feary, plan manager; Matthew MacEwen, sales manager.

Travelers Preferred-Western Michigan

200 W. Madison, Suite 2830, Chicago, Illinois 60606

Operational date: December 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 434 primary physicians.
Facilities: Five hospitals.
Service area: Kent, Muskegon, Ionia, Montcalm and Ottawa counties in Michigan.
Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 65 employer/payer groups; 13,454 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by The Travelers Insurance Co.
Gross revenues: Not reported.
Officers: Kathleen Feary, health plan manager; Russell J. Etzel and Matthew MacEwen, sales managers.

ValueRx Pharmacy Program Inc.

22255 Greenfield, Suite 550, Southfield, Mich. 48075; 313-423-8000

Operational date: March 1985.
Sponsorship: Affiliated pharmacies.
Ownership: Value Health Inc.
For profit.
Staff: 80 administrative staff members; 22 marketing staff members.
Facilities: 4,845 pharmacies.
Service area: Michigan, Ohio, Illinois, Iowa, Missouri, Connecticut and Florida.
Services provided: Specialty services include prescription drugs. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 1,240 employer/payer groups; 345,000 employees and dependents with access to the network; 348,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers, health care providers, claims administrators; the PPO charges a flat fee per eligible employee, fee for service.
Control measures: Retrospective review; utilization review provided by the PPO.
Gross revenues: $34.5 million in 1988; $50 million estimated in 1989.
Officers: William J. McBride, president; Fran Maiers, executive director; Klaus Hiefer, pharmacy director; Relk Lee, marketing director.



AWARE Gold

3535 Blue Cross Road, St. Paul, Minn. 55164; 612-456-8524

Operational date: November 1984.
Sponsorship: Blue Cross & Blue Shield in Minnesota.
Staff: 9,897 primary physicians.
Facilities: 160 hospitals.
Service area: Minnesota.
Users: 673,167 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion.
Gross revenues: Not reported.

CNA Managed Care PPO-Minneapolis/St. Paul

CNA Plaza-22W, Chicago, Ill. 60685; 312-822-7626

Operational date: September 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 680 primary physicians; 84% board certified physicians.
Facilities: 12 hospitals and medical facilities.
Service area: Hennepin, Ramsey, Scott and Anoka counties in Minnesota.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 4,500 employees and dependents with access to the network.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.
Gross revenues: Not reported.
Officers: Tom Dolatowski, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS*

8000 W. 78th St. Suite 270, Minneapolis, Minn. 55435; 612-829-3500

Operational date: 1985.
Sponsorship: Health Risk Management Inc.
For profit.
Staff: 4,300 primary physicians; 4,300 specialists; 210 administrative staff members; 28 marketing staff members; average of 315 patients per primary physician; 97% board certified physicians.
Facilities: 170 hospitals; 650 pharmacies.
Service area: Arizona, Iowa, Illinois, Indiana, Florida, Kentucky, Maryland, Pennsylvania, South Dakota, Texas, Virginia, West Virginia.
Services provided: Specialty services include prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, home health care, in-home infusion therapy, head therapy. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 20 employer/payer groups; 143,500 employees with single or family coverage; 358,750 employees and dependents with access to the network; 358,750 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per use, by capitation.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officers: Marlene Travis, president; Dr. Kenneth Diamond, executive director/vp; Dr. James Meyer, medical director; Christina Cavitt, marketing director; Dr. Gary McIlroy, chief executive officer; Steven Osterkamp Sr., vp-marketing/sales.

* Figures are corporate, including all CarePASS PPOs sponsored by Health Risk Management Inc.

Carespan

2829 University Ave. S.E., Minneapolis, Minn. 55414; 612-623-1919

Operational date: January 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 327 primary physicians; 886 specialists; average of 2,000 patients per primary physician; 97% board certified physicians.
Facilities: 21 hospitals; 75 pharmacies; 23 diagnostic labs.
Service area: Hennepin, Ramsey, Washington, Anoka, Scott, Dakota, Carver, Isanti, Chisago, Rice, Wright and Sherburne counties in Minnesota; Greenbush and Princeton townships in Mille Lacs County, Mich.; Pierce and St. Croix counties in Wisconsin.
Services provided: Specialty services include prescription drugs, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 10,545 employees with single coverage; 10,876 employees with family coverage; 46,908 employees and dependents with access to the network; 48,750 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: Not reported.
Officer: George Halvorson, president; Rollin Lacy, Ken Bates and Roger Swenson, vps; Dr. Robert Burgfechtal and Dr. Paul Brat, medical directors; Jim Ebbitt and Annette Wagener, marketing directors.

CIGNA FlexCare Preferred Provider Organization-Minneapolis

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Family Health Plan Inc.

3800 W. 80th St., Suite 1450, Bloomington, Minn. 55431-4494; 612-896-1200

Operational date: 1983.
Sponsorship: Hospitals and physicians.
Ownership: Privately owned.
For profit.
Staff: 1,700 primary physicians; 1,000 specialists; 40 administrative staff members; three marketing staff members; average of 130 patients per primary physician; 70% board certified physicians, 30% board eligible.
Facilities: 21 hospitals; 304 pharmacies; 23 diagnostic labs.
Service area: Minnesota and Western Wisconsin.
Services provided: Specialty services include prescription drugs, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.
Users: 500 employer/payer groups; 30,000 employees with single coverage; 30,000 employees with family coverage; 120,000 employees and dependents with access to the network; 135,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; the PPO is compensated by employers/payers or health care providers; the PPO charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.
Gross revenues: $38 million in 1988; $42.5 million estimated in 1989.
Officers: M. Nazie Eftekhari, president/executive director; Dr. Brian Ebeling, medical director.

Great-West Care-Minneapolis

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 683 primary physicians; 81% board certified physicians.
Facilities: 17 hospitals.
Service area: Minneapolis and surrounding counties in Minnesota; St. Croix and Polk counties in Wisconsin.
Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to

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meet employer specifications, individual enrollment is not allowed.

Users: 17 employer/payer groups; 3,778 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Alan MacLennan, senior vp; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Hartford's PULSE Plan of Minneapolis

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: October 1987.

Sponsorship: The Hartford Insurance Co.

For profit.

Staff: 1,819 primary physicians; 1,282 specialists.

Facilities: 29 hospitals; three diagnostic labs.

Service area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington and Wright counties in Minnesota; St. Croix County in Wisconsin.

Services provided: Specialty services include substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: Seven employer/payer groups; 4,591 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Michael A. Prochno, regional sales manager.

Mutually Preferred-Minnesota

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PARTNERS National Health Plans-Minnesota

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred One

1000 Landmark Tower, 345 Saint Peter St., St. Paul, Minn. 55102; 612-293-3650

Operational date: April 1984.

Sponsorship: Hospital and physicians.

Not for profit.

Staff: 2,600 primary physicians; 1,290 specialists; 50 administrative staff members; one marketing staff members; 90% board certified physicians.

Facilities: 29 hospitals; four diagnostic labs.

Service area: 19 counties in Minnesota; Pierce, Polk and St. Croix counties in Wisconsin.

Services provided: Specialty services include vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is allowed.

Users: 3,300 employer/payer groups; 39,600 employees with single coverage; 32,400 employees with family coverage; 180,000 employees and dependents with access to the network; 190,000 estimated employees and dependents with access to the network as of Jan. 1, 1990.

Compensation: The PPO negotiates hospital charges by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: $40 million in 1988; $75 million estimated in 1989.

Officers: Marcus Merz, president/chief executive officer; Dr. Ken Dedeker, medical director; Jim Miller, vp-marketing; Dave Olsen, director-operations; Kathy Notarino, director-utilization review/quality assurance; Mary Lewis, director-finance.

Preferred Plus of Minnesota

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: July 1986.

Sponsorship: Massachusetts Mutual Life Insurance Co.

For profit.

Staff: 3,000 primary physicians.

Facilities: 18 hospitals.

Service area: Hennepin, Ramsey, Washington, Dakota, Scott, Carver, Anoka, Crow Wing, southern Mille Lacs, northeastern Sherburne and western Isanti counties in Minnesota.

Services provided: Specialty services include psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications under certain specialized circumstances; individual enrollment is not allowed.

Users: 16 employer/payer groups; 3,022 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers or health care providers; the PPO charges a flat fee per eligible employee or a percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: Not reported.

Officers: Charles C. Nordhaus, national account executive, Massachusetts Mutual Life Insurance Co.

Select Care Inc.

1700 W. 82nd St., Suite 100, Bloomington, Minn. 55431; 612-885-5700

Operational date: January 1983.

Sponsorship: Lifespan Inc.

Not for profit.

Staff: 1,600 primary physicians; 800 specialists; 28 administrative staff members; four marketing staff members; 97% board certified physicians.

Facilities: 28 hospitals; 31 diagnostic labs.

Service area: 18 counties in Minnesota; Burnett County in Wisconsin.

Services provided: Specialty services include prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, chiropractic. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: More than 1,500 employer/payer groups; 115,000 employees and dependents in participating employer groups with access to the network; 55,000 estimated employees and dependents with access o the network as of January 1, 1990.

Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers or by health care providers or by claims administrators; the PPO charges a flat fee per eligible employee per month or by a percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by the PPO.

Gross revenues: $17.8 million in 1988; $33.6 million estimated in 1989.

Officers: Jack G. Davis, president; Dr. Richard Frey, medical director; Michael Thielen, marketing director; Leroy Meyering, chief financial officer.

Travelers Preferred-Twin Cities/Select Care

2221 University Ave., Suite 202, Minneapolis, Minn. 55414; 612-623-7701

Operational date: July 1988.

Sponsorship: The Travelers Insurance Co.

For profit.

Staff: 1,453 primary physicians.

Facilities: 22 hospitals.

Service area: Wisconsin; more than 15 counties in Minnesota.

Services provided: Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: Five employer/payer groups; 2,536 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services or by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee or percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; utilization review provided by The Travelers Insurance Co.

Officers: Pam Pauly, manager-provider relations; Ronald C. White, sales manager.



Blue Cross & Blue Shield of Mississippi

Lakeland Drive E. at Flynt, Jackson, Miss. 39280; 601-932-3704

Operational date: February 1985.

Sponsorship: Blue Cross & Blue Shield.

Staff: 926 primary physicians.

Facilities: 27 hospitals.

Service area: 61 counties in Mississippi.

Users: 75,361 employees and dependents with access to the network.

Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion, case management.

Gross revenues: Not reported.

Metropolitan Life Insurance Co.-Mississippi

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Mississippi

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PARTNERS National Health Plans-Mississippi

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PM Group's PPO-Mississippi

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.



Blue Cross & Blue Shield of Missouri

4444 Forest Park Blvd., St. Louis, Mo. 63108; 314-658-4490

Operational date: January 1985.

Sponsorship: Blue Cross & BLue Shield.

Staff: 2,579 primary physicians.

Facilities: 36 hospitals.

Service area: 39 counties in Missouri.

Users: 266,615 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate.

Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion, case management.

CIGNA FlexCare Preferred Provider Organization-St. Louis

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CNA Managed Care PPO-Kansas City

CNA Financial Corp., 1010 Market St., Suite 560, St. Louis, Mo. 63178, 314-342-7945

Operational date: July 1987.

Sponsorship: CNA Financial Corp.

For profit.

Staff: 1,011 primary physicians; 67.4% board certified physicians, 12.6% board eligible.

Facilities: 16 hospitals.

Service area: Jackson and Clay counties in Missouri; Douglas and Wyandotte counties in Kansas.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: 13,300 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; utilization review provided by Private Healthcare Systems Ltd.

Gross revenues: Not reported.

Officers: Bill Carrol, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-St. Louis

CNA Financial Corp., 1010 Market St., Suite 560, St. Louis, Mo. 63178, 314-342-7945

Operational date: March 1987.

Sponsorship: CNA Financi Corp.

For profit.

Staff: 817 primary physician 70.1% board certified physician 7.7% board eligible.

Facilities: 12 hospitals and med cal facilities.

Service area: St. Louis, Frankl and St. Charles counties in Missou Madison and St. Clair counties in I linois.

Services provided: Specialty se vices include substance abuse, psy hiatric services, obstetrics/gyneco ogy. Employees can select non-PP providers at time of service; PP plan design can be customized t meet employer specifications; ind vidual enrollment is not allowed.

Users: 18,000 employees and de pendents with access to the networl

Compensation: The PPO negotiate hospital charges by per diem rate, b a percent discount off customar rates for individual services, b DRGs; the PPO is compensated b employers/payers, health care pro viders, claims administrators; th PPO charges a flat fee per eligibl employee, percent of services ren dered by participating doctors/hospi tals.

Control measures: Preadmissio hospital review, precertification concurrent hospital treatment re view, length of stay determination discharge planning, retrospective re view, second surgical opinion, hospi tal bill audits, outpatient service pre determination, case management utilization review provided by Pri vate Healthcare Systems Ltd.

Officers: Bill Carrol, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

EQUICOR Preferred-St. Louis

1801 W. End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Kansas City

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

See Great-West Care-Kansas City under Kansas.

Hartford's PULSE Plan of Kansas City

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: June 1988.

Sponsorship: The Hartford Insurance Cos.

For profit.

Staff: 540 primary physicians; 562 specialists.

Facilities: 14 hospitals.

Service area: Clay and Jackson counties in Missouri. Douglas, Johnson, Platte and Wyandotte counties in Missouri.

Services provided: Specialty services include substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; PPO plan design can be customized to meet employer specifications; individual enrollment is not allowed.

Users: Five employer/payer groups; 1,582 employees and dependents with access to the network.

Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services, the PPO is compensated by employers/payers, the PPO charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, utilization review and outpatient services are provided by the PPO. Large case management and psychiatric management are also integrated with these services.

Gross revenues: Not reported.

Officers: Carolyn S. Adair, regional sales manager, The Hartford Insurance Co.

HealthLink Inc.

9666 Olive St. Road, Suite 500, St. Louis, Mo. 63132; 800-624-2356

Operational date: July 1985.

Sponsorship: Hospitals.

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For profit.
Staff: 2,351 primary physicians; 300 specialists; 11 administrative staff embers; seven marketing staff members; 80% board certified physicians.
Facilities: 47 hospitals.
Service area: Eastern Missouri, uthern and central Illinois.
Services: Specialty services: substance abuse, psychiatric services, podiry, obstetrics/gynecology. Employees n select non-PPO providers; plan design can be customized; individual enllment is allowed.
Users: 670 employer/payer groups; 19,000 employees and dependents with twork access; 230,000 estimated as of n. 1, 1990.
Compensation: The PPO negotiates ospital charges by per diem rate; is ompensated by employers/payers, ealth care providers; charges a flat fee er eligible employee, percent of serces rendered by participating doctors/ospitals.
Control measures: Preadmission ospital review, precertification, conurrent hospital treatment review, ength of stay determination, discharge lanning, retrospective review, second urgical opinion, hospital bill audits, utpatient service predetermination, ase management; provided by the PO.
Officers: John O'Rourke, president; Dr. Kirk Flury, medical director; David tt, marketing director; Elise Reynolds, irector-operations; Homer Schmitz, irector-finance/evaluation.

John Hancock Preferred Health Plan-Missouri
P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Lincoln National Preferred Plan
721 Emerson Road, Suite 655, St. Louis, Mo. 63141; 314-991-3938

See Lincoln National Preferred Plan under Indiana.

Metropolitan Life Insurance Co.-Missouri
Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Missouri
Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PARTNERS National Health Plans-Missouri
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Health Plans of Missouri
1900 N. Providence, Suite 301, Columbia, Mo. 65201; 314-442-2230

Operational date: 1986.
Sponsorship: Insurer, investor.
For profit.
Staff: 265 primary physicians; three administrative staff members; one marketing staff member; 98% board certified physicians.
Facilities: Four hospitals.
Service area: Central Missouri.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 400 employer/payer groups; 19,250 employees and dependents with network access; 22,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs; is compensated by employers/payers, charges a flat fee per eligible employee.
Control measures: Precertification; provided outside contractors.
Officers: Sy Kaplan, president.

Preferred Plus of Missouri
1295 State St., Springfield, Mass. 01111; 413-788-8411, ext. 3192

Operational date: October 1987.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 2,379 primary physicians.
Facilities: 34 hospitals.
Service area: Parts of St. Louis, Jefferson, Franklin, St. Charles, Butler, Boone, Callaway, Audrain, Howard, Cooper and Moniteau counties in Missouri; Clinton, Madison, Monroe, St. Clair, Jackson, Union and Williamson counties in Illinois.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 14 employer/payer groups; 4,774 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers, health care providers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Ralph E. Barsanti, regional sales director-Massachusetts Mutual Life Insurance Co.

Prudential Health Care System
12312 Olive Blvd., Suite 500, Creve Coeur, Mo. 63141; 314-542-4500

Operational date: January 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 800 primary physicians; 424 specialists; 74 administrative staff members; 17 marketing staff members; average of 103 patients per primary physician; 88% board certified physicians.
Facilities: 18 hospitals; 88 pharmacies; 45 diagnostic labs.
Service area: Franklin, Jefferson and St. Charles counties in Missouri; Madison, Monroe, Randolph and St. Clair counties in Illinois.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 48,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion; provided by the PPO.
Officers: Richard F. Rivers, vp-group operations; Dr. Richard H. Fallon, medical director; James J. Gebhardt, marketing director; Paul C. Conlin, director-health care management.

Prudential Health Care System
1300 E. 104th St., Suite 320, Kansas City, Mo. 64131; 816-941-4500

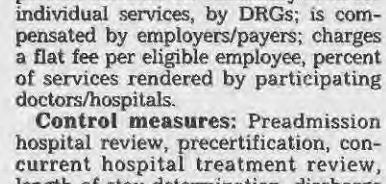
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 246 primary physicians; 269 specialists; 30 administrative staff members; 11 marketing staff members; average of 125-200 patients per primary physician.
Facilities: 11 hospitals; 58 pharmacies; three diagnostic labs.
Service area: Johnson, Leavenworth, Miami and Wyandotte counties in Kansas; Cass, Clay, Jackson and Platte counties in Missouri.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 22,000 Employees and dependents with network access; 25,000 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: John Kennedy, executive director; Dr. Joseph Palazola, medical director; Steven Miller, marketing director.

Travelers Preferred-Kansas City
Travelers Health Network, 231 S. Bemiston, Suite 715, St. Louis, Mo. 63105; 913-661-0211

Operational date: October 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 791 primary physicians.
Facilities: 13 hospitals.
Service area: Johnson, Wyandotte and Cass counties in Kansas; Clay, Jackson and Platte counties in Missouri.
Users: 18 employer/payer groups; 2,847 employees with network access.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers, charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by the Travelers Insurance Co.
Officers: Sally Sjobeck, director-operations; Arch E. Patterson, sales manager.

Travelers Preferred-St. Louis
Travelers Health Network, 231 S. Bemiston, Suite 715, St. Louis, Mo. 63105; 314-727-0930

Operational date: 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,720 primary physicians.
Facilities: 15 hospitals.
Service area: Madison, Monroe and St. Clair counties in Illinois; Franklin, Jefferson, St. Charles and St. Louis counties in Missouri.
Users: 93 employers/payers; 4,947 employees with network access.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by the Travelers Insurance Co.
Officers: Felicia Wilhelm, executive director; Gregory T. Taylor, sales manager.



Blue Cross & Blue Shield of Nebraska
7261 Mercy Road, Omaha, Neb. 68180; 402-390-1848

Operational date: October 1987.
Sponsorship: Blue Cross & Blue Shield.
Staff: 135 primary physicians.
Facilities: One hospital.
Service area: Lancaster County in Nebraska.
Users: 1,914 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, retrospective review.

Lincoln National Preferred Plan
400 Blackstone Center, 302 S. 36th St., Omaha, Neb. 68131; 402-342-2420

See Lincoln National Preferred Plan under Indiana.

Mutually Preferred*
Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

Operational date: 1985.
Sponsorship: Insurer, hospitals, group of doctors.
Staff: 33,000 primary physicians and specialists; 80% board certified or board eligible physicians.
Facilities: 475 hospitals; 13,500 pharmacies.
Service area: Lincoln and Omaha, Nebraska; 15 additional states.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 250,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Mutual of Omaha Care Review.
Gross revenues: $100 million estimated in 1989.

PARTNERS National Health Plans-Nebraska
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PM Group's PPO-Nebraska
17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.



Great-West Care-Nevada
8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: May 1986.
Sponsorship: Great West Life Assurance Co.
Ownership: Preferred Healthcare Network.
For profit.
Staff: 521 primary physicians.
Facilities: 14 hospitals.
Service area: 17 counties in Nevada.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Humana Health Health Insurance of Nevada Inc.
3107 S. Maryland Parkway, Las Vegas, Nev. 89109; 702-737-7211

See Humana Health Care Plans under Kentucky.

Managed Care Systems
1321 S. Maryland Parkway, Las Vegas, Nev. 89104; 702-384-0800

Operational date: July 1988.
Sponsorship: Private.
For profit.
Staff: 500 primary physicians; 300 specialists; nine administrative staff members; three marketing staff members; 95% board certified physicians.
Facilities: Seven hospitals; 115 pharmacies; 12 diagnostic labs.
Service area: Washoe and Clark counties in Nevada.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: Seven employer/payer groups; 3,000 employees with single coverage; 2,900 employees with family coverage; 8,200 employees and dependents with network access; 17,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $2.1 million in 1988; $7 million estimated in 1989.
Officers: Joe Lawrence, president/executive director; Dr. Kenneth Mower, medical director; G.W. Kring, marketing director.

Metropolitan Life Insurance Co.-Nevada
Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Nevada
Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

Preferred HealthCare Network Inc.
1105 Terminal Way, Suite 114, Reno, Nev. 89502; 702-322-3077

Operational date: 1983.
Sponsorship: Private.
For profit.
Staff: 350 primary physicians; 200 specialists; two administrative staff members; three marketing staff members; average of 11 patients per primary physician; 85% board certified physicians.
Facilities: 16 hospitals; 45 pharmacies; three diagnostic labs.
Service area: Washoe, Clark and Eldorado counties in Nevada.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, allergies, anesthesiology, cardiology, endocrinology, gastroenterology, general surgery, neurology, oncology, optometry, orthopedic surgery, physical therapy, radiology, and urology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 170 employer/payer groups; 125 employees with single coverage; 40,000 employees and dependents with network access; 40,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second

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surgical opinion, case management; provided by the PPO.

Officers: Bryce W. Griffith, president; Dr. Robert Mammen, medical director; Sandra L. Harris, secretary/treasurer.

Preferred Health Network

P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

See Preferred Health Network under California.

Preferred Plans Inc.

2235 E. Flamingo Road, Suite 406, Las Vegas, Nev. 89119; 702-737-6005

Operational date: February 1987.
Ownership: Heller Associates.
For profit.
Staff: 230 primary physicians; 170 specialists; four administrative staff members; one marketing staff member; 80% board certified physicians.
Facilities: 10 hospitals; 30 pharmacies; six diagnostic labs.
Service area: Lake Tahoe region in California; Nevada and northern Arizona.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 5,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management; provided by Preferred Review Inc.
Officers: Glen E. Ogden, president; Frank J. Heller; Philip Steffenson.

Prudent Buyer Plan

P.O. Box 1927, Las Vegas, Nev. 89101; 702-382-3302; P.O. Box 10330, Reno, Nev. 89520; 702-829-4000

Operational date: August 1985.
Sponsorship: Blue Cross & Blue Shield of Nevada.
Staff: 800 primary physicians.
Facilities: 15 hospitals.
Service area: Carson City, Nev.; Churchill, Clark, Douglas, Esmeralda, Humboldt,,Lincoln, Lyon, Nye, Storey and Washoe counties in Nevada.
Users: 26,900 employees with single coverage or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services.
Control measures: Preadmission review, concurrent review, second surgical opinion, individual case management; provided by the PPO.



Metropolitan Life Insurance Co.-New Hampshire

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

New Hampshire HEALTH CHOICE

Box 5001, 263 Drakeside Road, Hampton, N.H. 03842; 603-926-4566

Operational date: January 1989.
Sponsorship: Employee Benefit Plan Administration & Healthsource N.H.
For profit.
Staff: 225 primary physicians; 425 specialists; 15 administrative staff members; five marketing staff members; 65% board certified physicians.
Facilities: 18 hospitals; 26 pharmacies; 15 diagnostic labs.
Service area: New Hampshire.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Four employer/payer groups; 1,178 employees and dependents with network access; 2,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits; provided by the PPO.
Officers: Wendy J. Frosh, chief operating officer; John S. Argue, medical director.



Lifecare Management Systems Inc.

51 Upper Montclair Plaza, Montclair, N.J. 07043; 800-232-7388, 201-744-9040

Operational date: March 1988.
Sponsorship: Private.
For profit.
Staff: 175 primary providers; 175 specialists; seven administrative staff members; two marketing staff members.
Facilities: 10 hospitals.
Service area: New Jersey; surrounding areas of Pennsylvania and New York.
Services: Specialty services: mental health, substance abuse, psychiatric services. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Three employer/payer groups; 300 estimated employees and dependents with network access as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers, claims administrators; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; provided by the PPO and by outside contractors.
Gross revenues: $155,000 estimated in 1989.
Officers: Dr. Nicholas P. Armenti, president/executive director; Dr. Hans Gregorius, medical director; Dr. Bruce Miller, marketing director; Carmen Armenti, vp-finance; Marie Armenti, secretary.

Metropolitan Life Insurance Co.-New Jersey

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-New Jersey

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Provider Program

33 Washington St., Newark, N.J. 07102; 201-456-2495

Operational date: July 1989.
Sponsorship: Blue Cross & Blue Shield of New Jersey.
Staff: 11,356 participating physicians.
Facilities: Network of hospitals.
Service area: New Jersey.
Compensation: The PPO negotiates hospital charges by DRGs.
Control measures: Preadmission review, admission review, concurrent review, discharge planning, second surgical opinion, individual case management; provided by outside contractors.

PruCare of New Jersey

1 Campus Drive, Parsippany, N.J. 07054; 201-631-2633

Operational date: January 1985.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 1,166 primary physicians; 1,556 specialists; 283 administrative staff members; 68 marketing staff members; average of 65 patients per primary physician; 88% board certified physicians.
Facilities: 39 hospitals; five pharmacies; 10 diagnostic labs.
Service area: 21 counties in New Jersey.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology and chiropractic. Employees can select non-PPO providers; plan design cannot be customized; individual enrollment is not allowed.
Users: 76,041 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, hospital review; provided by the PPO and outside contractors.
Officers: Ray Allen; Robert Ferrini, Dana Kind and Rhonda Stock, executive directors; Drs. Jonathan Kaplan, Jules Rivkind and Philip Mercer, medical directors; Shelley Molnar and Justin Fiedler, marketing directors.



CIGNA FlexCare Preferred Provider Organization-Albuquerque

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-New Mexico

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Health Plus Inc.

P.O. Box 27489, Albuquerque, N.M. 87125; 505-823-0700

Operational date: 1988.
Sponsorship: North American Life & Casualty Co.
For profit.
Staff: 486 primary physicians; 387 specialists; 70 administrative staff members; seven marketing staff members; 100% board certified physicians.
Facilities: Five hospitals; 100 pharmacies; seven diagnostic labs.
Service area: Bernalillo, Sandoval and Valencia counties in New Mexico.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 28 employer/payer groups; 571 employees with single coverage; 784 employees with family coverage; 3,000 employees and dependents with network access; 3,032 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs; is compensated by employers/payers; charges an administrative fee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits; provided by the PPO.
Gross revenues: $385,000 in 1988; $2.5 million estimated in 1989.
Officers: Robert L. Simmons, president; Dr. Neil Kaminsky, medical director; J.J. Parsons, marketing director; Billie Peterman, director-finance; Carol Hinton, director-operations/support; Patricia Andrade, director-health care delivery services; Richard Stracqualursi, director-management information systems.

PM Group's PPO-New Mexico

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

Preferred Provider Program

12800 Indian School Road N.E., Albuquerque, N.M. 87112; 505-291-3526

Operational date: March 1988.
Sponsorship: BLue Cross & Blue Shield of New Mexico.
Staff: 345 primary physicians.
Facilities: Four hospitals.
Service area: Bernalillo County in New Mexico.
Users: 8,000 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, case management; provided by the PPO.



CareNet

455 Commerce Drive, Amherst, N.Y. 14150; 716-691-8556

Operational date: 1989.
Ownership: North American Administrators Inc.
For profit.
Staff: 400 primary physicians; 250 specialists; seven administrative staff members; two marketing staff members; 100% board certified physicians.
Facilities: 10 hospitals; 150 pharmacies; three diagnostic labs.
Service area: Erie, Chautauqua, Niagara, Onondaga, Madison, Oneida and Herkimer counties in New York.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: One employer/payer group; 100 employees with single coverage; 500 employees and dependents with network access; 2,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs or by outpatient discounts; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; provided by the PPO.
Gross revenues: $300,000 estimated in 1989.
Officers: Ronald K. Zoeller, president; Dr. Arthur Orlick, medical director; E. Timothy Danahy, vp; David W. Miller, treasurer.

Fraternal Medical & Dental Services Inc.

295 Madison Ave., New York, N.Y.; 212-353-1400

Operational date: 1929.
Sponsorship: Societies and employers.
Not for profit.
Staff: 130 primary physicians; 40 specialists; three administrative staff members; one marketing staff members; 100% board certified physicians.
Facilities: 15 diagnostic labs.
Service area: New York, Bronx, Queens, Brooklyn, Nassau, Staten Island, Suffolk and Westchester counties in New York.
Services: Specialty services: vision, dental, durable medical equipment, podiatry, obstetrics/gynecology. Employees cannot select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 17 employer/payer groups; 19,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Retrospective review, case management; provided by the PPO.
Gross revenues: $63,400 in 1988; $65,000 estimated in 1989.
Officers: Susan Siwek, president; Dr. Irving H. Parnes, medical director; David Nussbaum, marketing director; Dr. Saul Schwalb, dental director.

Innovative Employee Service Systems Inc.

159 Express St., Plainview, N.Y. 11803; 518-436-7458

Operational date: 1984.
Ownership: Davis Optical.
For profit.
Staff: 750 primary physicians.
Services: Specialty services: vision. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 2 million estimated employees and dependents with network access as of Jan. 1, 1990.
Officers: Lawrence S. Davis, president; Bill Pastore, senior vp; Kathy W. Siko, vp.

Multiplan Inc.

200 Park Ave. S. New York, N.Y. 10003; 212-477-3880

Operational date: 1971.
For profit.
Facilities: 150 hospitals.
Service area: New York, New Jersey and Connecticut.
Services: Specialty services: psychiatric services. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 100 employer/payer groups; 500,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by percentage of DRG charges; is compensated by employers/payers, claims administrators; charges a flat fee per eligible employee, percentage of the savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by the PPO.
Officers: Donald Rubin, president; Roxanne Young and Edward Gluckmann, vps; Edward Rothstein, marketing director.

PARTNERS National Health Plans-New York

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare Plus New York

301 Merritt 7, Norwalk, Conn. 06851; 203-849-1800

Operational date: March 1987.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 848 primary physicians; 1,170 specialists; 46 administrative staff members; 30 marketing staff members; 94% board certified or board eligible physicians.
Facilities: 44 hospitals; 675-700 pharmacies; three diagnostic labs.
Service area: New York, Kings, Queens, Richmond, Bronx, Westchester, Nassau, Suffolk, Dutchess, Orange, Putnam, Ulster and Rockland counties in New York.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, hospice, ambulance, physical and speech therapy. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 35,116 employees and dependents with network access; 38,115 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: William J. Marino, executive director; Dr. Cary Gutbezahl, medical director.

Shield Care Network

1000 Guaranty Building, Buffalo, N.Y. 14202; 716-847-1616

Operational date: January 1990.
Sponsorship: Blue Shield of Western New York Inc.
Not for profit.
Service area: Erie, Allegany, Cattaraugus, Chautauqua, Genesee, Niagara, Orleans and Wyoming counties in New York.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by DRGs or discount off outpatient rate; is compensated by employers/payers; charges an administrative cost built into premium.

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Control measures: Preadmission hospi- review, precertification, concurrent spital treatment review, length of stay termination, discharge planning, retro- ective review, second surgical opinion, se management; provided by the PPO.
Officers: John Manyon, president; Dr. verne E. Campbell, medical director; lward Lucy, marketing director.

ravelers Preferred-Greater Metropolitan New York

701 Westchester Ave., White Plains, N.Y. 10604; 914-761-9103

Operational date: November 1988.
Sponsorship: The Travelers Insurance .
For profit.
Staff: 1,986 primary physicians.
Facilities: 18 hospitals.
Service area: Bronx, Kings, Nassau, ew York, Queens, Richmond, Suffolk and 'estchester counties in New York.
Services: Employees can select non- PO providers; plan design can be cus- mized; individual enrollment is not al- wed.
Users: Eight employer/payer groups; 2,061 employees with network access.
Compensation: The PPO negotiates ospital charges by per diem rate, by a ercent discount off customary rates for idividual services or by DRGs; is com- ensated by employers/payers; charges a at fee per eligible employee or a percent f services rendered by participating doc- rs/hospitals.
Control measures: Preadmission hospi- al review, precertification, concurrent ospital treatment review, length of stay etermination, discharge planning, retro- pective review, second surgical opinion, ospital bill audits, case management; pro- ided by The Travelers Insurance Co.
Officers: Mary-Ann Browne, PPO coo- dinator; Robert L. Sweeney, Leonard Gil- eany, Algie Andrews, Robert Ehinger, eter Noonan and Jerome Misiewicz, sales nanagers.

Travelers Preferred-Syracuse

600 Erie Place, Syracuse, N.Y. 13204; 315-479-6667

Operational date: October 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 133 primary physicians.
Facilities: Four hospitals.
Service area: Cayuga, Madison, Onondaga and Oswego counties in New York.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 217 employees with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee or by a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Kathryn Norton, executive director; Robert J. Mahoney, sales manager.



Carolina Preferred Care

2150 Country Club Road, Suite 160, Winston-Salem, N.C. 27104; 919-721-1844; 704-597-7001

Operational date: 1984.
Sponsorship: Private.
For profit.
Staff: 420 primary physicians; 300 specialists; 18 administrative staff members; two marketing staff members; 90% board certified physicians.
Facilities: 15 hospitals.
Service area: Mecklenburg, Guilford, Cabarrus, Gaston, Union, Burke, Randolph, Rockingham, Catawba, Alexander and Forsyth counties in North Carolina; Charleston, Florence, Dorchester, Berkeley, Darlington, York and Lancaster counties in South Carolina.
Services: Specialty services: vision, psychiatric services, obstetrics/gynecology, hearing. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 428 employer/payer groups; 61,000 employees and dependents with network access; 63,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Otto W. Mueller, president; Dr. William Lorentz, Jr. medical director; Kenneth L. Stanford, marketing director; Billie Davis, vp.

EQUICOR Preferred-Charlotte

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Raleigh

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Family Health Plan

P.O. Box 222097, Charlotte, N.C. 28222; 704-364-8215

Operational date: May 1987.
Sponsorship: Metrocare National Inc.
For profit.
Staff: 183 primary physicians; 135 specialists; 21 administrative staff members; one marketing staff members; 94% board certified physicians.
Facilities: Nine hospitals.
Service area: Mecklenburg, Catawba, Forsyth and Guilford counties in North Carolina; Greenville and Spartanburg counties in South Carolina.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology, home health care. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 123 employer/payer groups; 8,606 employees with single coverage; 5,737 employees with family coverage; 34,600 estimated employees and dependents with network access as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers, health care providers, claims administrators; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, precertification of home health care services; provided by the PPO.
Gross revenues: $10 million estimated in 1989.
Officers: Dale A. White, president; Eric Pousard, director-network services; Dr. James N. Shearer, medical director; Stephen A. Gregg, chairman; Dr. Bruce Taylor, secretary.

Great-West Care-The Carolinas

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: April 1989.
Sponsorship: Insurer.
Ownership: Family Health Plan of North Carolina.
For profit.
Staff: 310 primary physicians.
Facilities: Nine hospitals.
Service area: Mecklenburg, Cleveland, Lincoln, Union, Orbanus, Forsyth, Guilford, Randolph, Wake, Johnston, Pitt and Edgecomb counties in North Carolina; Greenville, Anderson, Pickins, Spartanburg, Union, Cherokee and Laurens counties in South Carolina.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacClennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Hartford's PULSE PLan of North Carolina

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: July 1988.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 48 primary physicians; 140 specialists.
Facilities: Two hospitals.
Service area: Mecklenburg County in North Carolina.
Services: Specialty services: psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Two employer/payer groups; 634 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, large case management; provided by the PPO and by outside contractors.
Contact: Peter M. Arnette, regional sales manager.

Health Care Savings

4200 Park Road, Charlotte, N.C. 28209; 704-527-6261

Operational date: January 1985.
Sponsorship: Hospitals and a group of doctors.
Ownership: Carolina Doctors Care.
For profit.
Staff: 1,100 primary physicians; 400 specialists; six administrative staff members; two marketing staff members; average of 500 patients per primary physician; 85% board certified physicians.
Facilities: Eight hospitals; 40 pharmacies; two diagnostic labs.
Service area: Mecklenburg, Iredell, Union, Catawba, Guilford, Alamance, Gaston, Cabarrus and Stanly counties in North Carolina; York County in South Carolina.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 2,000 employer/payer groups; 10,000 employees with single coverage; 15,000 employees with family coverage; 53,000 employees and dependents with network access; 40,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; provided by the PPO.
Officers: Dr. Lawrence Cutchin, president/medical director; Dr. Kevin Soden, medical director; Dick Dunn, marketing director; Lenda Pridgen, vp-administration.

HealthCHOICE of Gaston County

P.O. Box 2814, Gastonia, N.C. 28053-2814; 704-597-7055

Operational date: March 1989.
Sponsorship: Medical Alliance of Gaston County Inc. and an administrator.
Not for profit.
Staff: 76 primary physicians; 53 specialists; two administrative staff members; one marketing staff member; 77% board certified physicians.
Facilities: One hospital; one diagnostic lab.
Service area: Gaston, Cleveland and Lincoln counties in North Carolina; York County in South Carolina.
Services: Specialty services: vision, psychiatric services, obstetrics/gynecology, urgent care centers. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: Six employer/payer groups; 1,040 employees and dependents with network access; 1,455 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by MedReview, ProReview and other outside contractors.
Officers: Kenneth L. Stanford, executive/marketing director; Dr. Robert H. Lester, medical director.

Lincoln National Preferred Plan

5540 Centerview Drive, Suite 527, Raleigh, N.C. 27606; 404-851-0800

See Lincoln National Preferred Plan under Indiana.

PARTNERS National Health Plans-North Carolina

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Care

P.O. Box 2291, Durham, N.C. 27702; 919-490-4124

Operational date: March 1987.
Sponsorship: Blue Cross & Blue Shield of North Carolina.
Not for profit.
Staff: 3,764 primary physicians and specialists.
Facilities: 13 hospitals.
Service area: 15 counties in North Carolina.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 486 employer/payer groups; 22,972 employees and dependents with network access; 25,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs; is compensated by employers/payers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audits, case management; provided by the PPO.
Officers: Thomas A. Rose, president; Earl N. Ridout, executive director; Dr. Don W. Bradley, medical director; Roger Philyaw, marketing director.

Preferred Plus of North Carolina

1295 State St., Springfield, Mass. 01111; 413-788-8411 ext. 3192

Operational date: July 1986.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 200 primary physicians.
Facilities: Two hospitals.
Service area: Guilford and Burke counties in North Carolina.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized; individual enrollment is not allowed.
Users: 16 employer/payer groups; 1,133 employees and dependents with network access.
Compensation: The PPO is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Robert M. Godfrey, account executive-Massachusetts Mutual Life Insurance Co.

PruCare of Charlotte

2100 Rexford Road, Suite 320, Charlotte, N.C. 28211; 704-365-6070

Operational date: 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 60 primary physicians; 115 specialists; 19 administrative staff members; 13 marketing staff members; average of 42 patients per primary physician; 96% board certified physicians.
Facilities: Four hospitals; 24 pharmacies; one diagnostic lab.
Service area: Cabbarus, Gaston, Lincoln, Mecklenburg, Rowan and Union counties in North Carolina; York County in South Carolina.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design cannot be customized; individual enrollment is not allowed.
Users: 740 employees with single coverage; 840 employees with family coverage; 2,602 employees and dependents with network access; 2,800 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Jerry Sykora, director-health care management; Dr. Richard L. Schumacher, vp-medical services; Robert C. Ward, director-group marketing.

Travelers Preferred-Charlotte

7201 Glenforest Drive, Suite 306; Richmond, Va. 23226; 804-282-2411

Operational date: July 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 290 primary physicians.
Facilities: Five hospitals.
Service area: Cabarrus, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly and Union counties in North Carolina; York County in South Carolina.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 65 employer/payer groups; 3,581 employees with single coverage or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Carol Richards, health services coordinator; Joseph W. Reynolds, sales manager.

Travelers Preferred-Greensboro

7201 Glenforest Drive, Suite 306, Richmond, Va. 23226; 804-282-2411

Operational date: 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 394 primary physicians.
Facilities: Three hospitals.
Service area: Alamance, Davidson, Davie, Forsyth and Guilford counties in North Carolina.
Services: Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: 47 employer/payer groups; 4,680 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Carol Richards, health services coordinator; Gerald S. Smith, sales manager.



CNA Managed Care PPO-Akron

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 283 primary physicians; 79.2% board certified.
Facilities: Three hospitals and medical facilities.
Service area: Summit County in Ohio.
Services: Specialty services: substance

Continued on next page

Continued from previous page
abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.

Users: 1,800 employees and dependents with network access.

Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.

Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Cincinnati

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 625 primary physicians.
Facilities: Eight hospitals and medical facilities.
Service area: Hamilton and Butler counties in Ohio; Kenton County in Kentucky.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 12,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the Private Healthcare Systems Ltd.
Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Cleveland

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: January 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 783 primary physicians; 74.6% board certified.
Facilities: Twelve hospitals and medical facilities.
Service area: Cuyahoga, Geauga, Lorain and Lake counties in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 8,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the Private Healthcare Systems Ltd.
Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Columbus

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 422 primary physicians; 82.5% board certified.
Facilities: Three hospitals and medical facilities.
Service area: Franklin County in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 12,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Dayton

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: July 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 457 primary physicians; 76.1% board certified, 14.7% board eligible physicians.
Facilities: Four hospitals and medical facilities.
Service area: Montgomery and Butler counties in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 16,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Cleveland/Youngstown

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

The Emerald Health Network Inc.

7530 Lucerne Drive, Middleburg Heights, Ohio 44130; 216-243-2030

Operational date: January 1984.
Sponsorship: Hospitals.
For profit.
Staff: 3,500 primary physicians; 1,700 specialists; 95 administrative staff members; 13 marketing staff members; 80% board certified physicians.
Facilities: 25 hospitals.
Service area: Cuyahoga, Lorain, Lake, Medina, Summit, Portage, Stark, Mahoning, Trumbull counties in Ohio; Mercer County in Pennsylvania.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Over 400 employer/payer groups; 18,000 employees with single coverage; 46,000 employees with family coverage; 157,000 employees and dependents with network access; 162,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers, health care providers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, onsite concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review; provided by the PPO.
Gross revenues: $72 million in 1988; $110 million estimated in 1989.
Officers: Burt Bundgus, president/chief executive officer; Dr. David M. Montgomery, chief medical officer; Sam A. Yovanno, vp-marketing; James Spear, senior vp-finance/administration; Gail Schaffer, vp-legal affairs.

Great-West Care-Cincinnati

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 659 primary physicians; 75% board certified physicians.
Facilities: Seven hospitals.
Service area: Southwest Ohio and southeast Indiana.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Cleveland

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: January 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 840 primary physicians; 71% board certified physicians.
Facilities: Nine hospitals.
Service area: Ashtabula, Lake, Geauga, Cuyahoga, Lorain and Erie counties in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Four employer/payer groups; 382 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Columbus

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 474 primary physicians.
Facilities: Three hospitals.
Service area: 19 counties in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Nine employer/payer groups; 2,998 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Dayton

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: June 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 498 primary physicians; 73% board certified physicians.
Facilities: Four hospitals.
Service area: Mercer, Darke, Shelby, Miami, Clark, Montgomery, Greene, Preble, Clinton, Butler and Warren counties in Ohio.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

John Hancock Preferred Health Plan-Ohio

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Health Response

793 W. State St., Columbus, Ohio; 43222; 614-225-5832

Operational date: 1985.
Ownership: Mount Carmel Health.
Not for profit.
Staff: 500 primary physicians; 308 specialists; five administrative staff members.
Facilities: Two hospitals; one pharmacy.
Service area: Franklin County in Ohio.
Services: Specialty services: psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee, participation fee for providers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits; provided by the PPO.
Officers: William McGuire, president; Charles Turner III, executive director; Dr. Dudley Briggs, medical director.

Health Service Preferred Inc.

6730 Roosevelt, Franklin, Ohio 45005; 513-424-3351

Operational date: January 1989.
Ownership: Private.
For profit.
Staff: 948 primary physicians; 395 specialists; 26 administrative staff members; four marketing staff members; 78% board certified physicians.
Facilities: 10 hospitals; 73 pharmacies; 11 diagnostic labs.
Service area: Hamilton, Clermont, Warren, Butler, Montgomery, Greene and Darke counties in Ohio; Campbell, Kenton and Boone counties in Kentucky; Dearborn County in Indiana.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: Two employer/payer groups; 225 employees with single coverage; 337 employees with family coverage; 1,500 employees and dependents with network access; 4,600 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, physician fee review; provided by Health Service Review.
Officers: Donald J. Barker, preside
Mary H. Martin, vp-operations; Dr. J
chard Dammel, medical director; Willi
D. Stief, vp.

Lincoln National Preferred Plan

11260 Chester Road, Suite 800, Cincinnati, Ohio 45242; 513-772-7325

See Lincoln National Preferred Pl
under Indiana.

Metropolitan Life Insurance Co.-Ohio

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance C
under Connecticut.

Midwest Medical Preferred Providers Inc.

35 River St., Chagrin Falls, Ohio 44022; 216-247-4315

Operational date: August 1986.
Sponsorship: Claims administrator.
For profit.
Staff: More than 2,000 primary phys
icians; 500 specialists; four administrativ
staff members; one marketing staff mem
bers; 85% board certified physicians.
Facilities: 40 hospitals; 500 pharmacies
20 diagnostic labs.
Service area: Ohio.
Services: Specialty services: prescrip
tion drug, vision, substance abuse, psychi
atric services, durable medical equipment
podiatry, obstetrics/gynecology, physica
therapy, chiropractic. Employees can selec
non-PPO providers; plan design can b
customized; individual enrollment is al
lowed.
Compensation: The PPO negotiates
hospital charges by per diem rate, by a
percent discount off customary rates for
individual services or by DRGs; charges
a flat fee per eligible employee, percent
of services rendered by participating doc
tors/hospitals.
Control measures: Preadmission hospi
tal review, precertification, concurrent
hospital treatment review, length of stay
determination, discharge planning, retro
spective review, second surgical opinion,
hospital bill audits, outpatient service p
determination, case management; provided
by the PPO and outside contractors.
Officers: Rita P. Lehman, president;
Arthur W. Chandler, vp.

Mutually Preferred-Ohio

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

Ohio Health Choice Plan

2322 E. 22nd St., Cleveland, Ohio 44115; 216-363-1444

Operational date: February 1983.
Sponsorship: St. Vincent Charity Hospital & Health Center.
Not for profit.
Staff: 5,300 primary physicians; approximately 2,809 specialists; 31 administrative staff members; five marketing staff members; average of 32 patients per primary physician; 68% board certified physicians.
Facilities: 69 hospitals; utilizes pharmacies of affiliated PPOs; 35 diagnostic labs.
Service area: 36 counties in Ohio; Boone, Kenton and Campbell counties in Kentucky.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: More than 1,500 employer/payer groups; 118,800 employees and dependents with network access; 123,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Russell C. Eckles, executive director; Dr. Pierce H. Mullally, medical director; James Francisco, marketing manager.

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ı Group's PPO-Ohio

7360 Brookhurst St., Fountain /alley, Calif. 92708; 714-760-4027

ee PM Group's PPO under California.

ARTNERS National Health Plans-Ohio

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

ee PARTNERS National Health Plans der Texas.

eferred Patient Plan Network

525 Metro Place N., Suite 300, Dublin, Ohio 43017; 614-766-0061

Sponsorship: Health Care Cost Man-ement Agency.
Ownership: CoMed Management Inc.
For profit.
Staff: 16,000 primary physicians; 10 ad-nistrative staff members; 12 marketing ıff members; 85% board certified physic-ıs.
Facilities: 400 hospitals.
Service area: Alaska, Arizona, Califor-a, Colorado, Florida, Georgia, Illinois, ›uisiana, Missouri, North Carolina, Ohio, :egon, Texas, Utah, Virginia, Washing-n, District of Columbia.
Services: Specialty services: substance ıuse, psychiatric services, durable medi-l equipment, obstetrics/gynecology, ›me health care. Employees can select ›n-PPO providers; plan design can be ıstomized; individual enrollment is not lowed.
Users: 5,500 employer/payer groups; 20,000 employees and dependents with etwork access; 220,000 estimated as of ın. 1, 1990.
Compensation: The PPO negotiates ›spital charges by per diem rate, by a ercent discount off customary rates for ıdividual services or by case rates for ›lect services; is compensated by employ-rs/payers, claims administrators, insur-nce companies; charges a flat fee per eli-ible employee.
Control measures: Preadmission hospi-al review, precertification, concurrent ospital treatment review, length of stay etermination, discharge planning, second urgical opinion, outpatient service prede-ermination, case management, ambulatory ervices review; provided by the PPO and utside contractors.
Gross revenues: Approximately $11 illion in 1988; $13 million estimated in 989.
Officers: Janice Spillane, president; Dr. Dudley Briggs, medical director; Diane chrimpf, marketing director; Krista Ball, p-health care management services.

Preferred Plus of Cincinnati

1295 State St., Springfield, Mass 01111; 413-788-8411

Operational date: March 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 866 primary physicians.
Facilities: Nine hospitals.
Service area: Clermont, Hamilton, But-er and Warren counties in Ohio; Boone, Kenton and Campbell counties in Ken-tucky.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized; individual enrollment is not allowed.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Lawrence T. Marcagi, regional sales manager-Massachusetts Mutual Life Insurance Co.

Preferred Plus of Northern Ohio

1295 State St., Springfield, Mass. 01111; 413-788-8411 ext. 3192

Operational date: August 1988.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 3,000 primary physicians.
Facilities: 23 hospitals.
Service area: 15 counties in Ohio; Mercer and Lawrence counties in Penn-sylvania.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers, PPO plan design can be customized, individual en-rollment is not allowed.
Users: 11 employer/payer groups; 4,493 employees and dependents with network access.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Wayne A. Reese, regional sales director-Massachusetts Mutual Life Insur-ance Co.

Primary Health Services

35 River St., Chagrin Falls, Ohio 44022; 216-247-3414

Operational date: February 1983.
Sponsorship: Claims administrator.
For profit.
Staff: 3,500 primary physicians; 1,000 specialists; four administrative staff mem-bers; one marketing staff member; average of 1,025 patients per primary physician; 85% board certified physicians.
Facilities: 40 hospitals; 500 pharmacies; 20 diagnostic labs.
Service area: Ohio.
Services: Specialty services: prescrip-tion drug, vision, substance abuse, psychi-atric services, durable medical equipment, podiatry, obstetrics/gynecology, physical therapy, chiropractic. Employees can select non-PPO providers; plan design can be customized; individual enrollment is al-lowed.
Users: Over 700 employer/payer groups; 205,000 employees and dependents with network access; 205,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services or by DRGs; is com-pensated by employers/payers, claims ad-ministrators, insurance companies, other PPOs; charges a flat fee per eligible em-ployee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO and outside contractors.
Officers: Arthur W. Chandler, presi-dent/marketing director; Dr. Frank P. Vargo, medical director.

Private Healthcare Systems Ltd.

8600 Governors Hill Drive, Suite 211, Cincinnati, Ohio 45249; 513-677-3200

Markets include Akron, Cleveland, Co-lumbus, Cincinnati and Dayton, Ohio.
See Private Healthcare Systems Ltd. under Massachusetts.

PruCare of Central Ohio

100 E. Campus Road, Columbus, Ohio 43235; 614-431-5601

Operational date: March 1988.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 172 primary physicians; 197 spe-cialists; 12 administrative staff members; nine marketing staff members; average of 18 patients per primary physician; 89% board certified physicians.
Facilities: Six hospitals; seven phar-macies with 53 locations; two diagnostic labs.
Service area: Franklin, Union, Dela-ware, Licking, Fairfield, Pickaway and Madison counties in Ohio.
Services: Specialty services: prescrip-tion drug, dental, substance abuse, psychi-atric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 55 employer/payer groups; 638 employees with single coverage; 779 em-ployees with family coverage; 3,174 em-ployees and dependents with network ac-cess; 3,500 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO.
Officers: Matthew Davies, executive director/manager-health care services; Dr. David C. Gundlach, medical director; Fred Veazey, regional group manager.

PruCare of Cincinnati

525 Vine St., Suite 1850, Cincinnati, Ohio 45202; 513-621-2970

Operational date: March 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 371 primary physicians; 611 spe-cialists; 30 administrative staff members; 25 marketing staff members; average of 75 patients per physician; 85%-95% board certified physicians.
Facilities: Eight hospitals; chain of pharmacies; nine diagnostic labs.
Service area: Butler, Clermont, Warren and Hamilton counties in Ohio; Boone, Kenton and Campbell counties in Ken-tucky; Dearborn County in Indiana.
Services: Specialty services: prescrip-tion drug, substance abuse, psychiatric services, durable medical equipment, podi-atry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 5,451 employees with single cov-erage; 7,446 employees with family cover-age; 30,281 employees and dependents with network access; 30,000 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO.
Officers: Dr. J. Edward Greene, med-ical director; Art Dickerson, regional group manager; Lynne Gross, director-health care management.

PruCare of Northern Ohio

The Halle Building, 1228 Euclid Ave., Suite 750, Cleveland, Ohio 44115; 216-241-5625

Operational date: 1988.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 223 primary physicians; 613 spe-cialists; 22 administrative staff members; eight marketing staff members; average of 12 patients per primary physician; 91% board certified physicians.
Facilities: 14 hospitals; one pharmacy; two diagnostic labs.
Service area: Cuyahoga, Geauga, Lake, Lorain, Medina, Summit and Portage counties in Ohio.
Services: Specialty services: prescrip-tion drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecol-ogy. Employees can select non-PPO pro-viders; plan design can be customized.
Users: 4,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO.
Officers: Dr. Gordon K. Bell, medical director; Rick Chelko, director-group mar-keting; Jonathan Newpol, manager-health care services.

Travelers Preferred-Cincinnati

1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545

Operational date: October 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 870 primary physicians.
Facilities: Seven hospitals.
Service area: Butler, Clermont and Hamilton counties in Ohio; Boone, Camp-bell and Kenton counties in Kentucky.
Services: Employees can select non-PPO providers; plan design can be cus-tomized; individual enrollment is not al-lowed.
Users: 1,170 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers; charges a flat fee per eligible employee, percent of ser-vices rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by The Travelers Insurance Co.
Officers: Marilyn Nixon, director-oper-ations; Bruce D. Johnson, sales manager.

Travelers Preferred-Columbus

One Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545

Operational date: October 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 561 primary physicians.
Facilities: Seven hospitals.
Service area: Delaware, Fairfield, Fayette, Franklin, Licking, Marion, Pick-away and Ross counties in Ohio.
Services: Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: Seven employer/payer groups; 1,893 employees with single or family cov-erage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers; charges a flat fee per eligible employee, percent of ser-vices rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by The Travelers Insurance Co.
Officers: Marilyn J. Nixon, director-op-erations; Harold J. Peterson, sales man-ager.

Travelers Preferred-Dayton

1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545

Operational date: 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 464 primary physicians.
Facilities: Nine hospitals.
Service area: Allen, Auglaize, Clark, Greene, Miami, Montgomery, Preble, Shelby, Logan, Mercer and Warren coun-ties in Ohio; Mercer County in Pennsylva-nia.
Services: Employees can select non-PPO providers; plan design can be cus-tomized; individual enrollment is not al-lowed.
Users: Six employer/payer groups; 1,673 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers; charges a flat fee per eligible employee, percent of ser-vices rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by The Travelers Insurance Co.
Officers: Marilyn Nixon, director-oper-ations; Bruce D. Johnson, sales manager.

Travelers Preferred-Northeast Ohio

1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545

Operational date: June 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,639 primary physicians.
Facilities: 23 hospitals.
Service area: Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne counties in Ohio; Mercer County in Pennsylvania.
Services: Employees can select non-PPO providers; plan design can be cus-tomized; individual enrollment is not al-lowed.
Users: 22 employer/payer groups; 12,120 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers; charges a flat fee per eligible employee, percent of ser-vices rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by The Travelers Insurance Co.
Officers: Marilyn Nixon, director-oper-ations; John Zilly, sales manager.

Travelers Preferred-Toledo

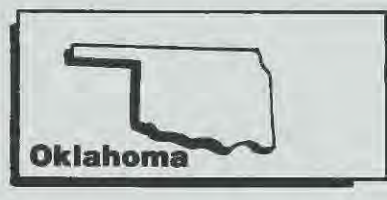
1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545

Operational date: June 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 328 primary physicians.
Facilities: Three hospitals.
Service area: Fulton, Lucas and Ot-tawa counties in Ohio.
Services: Employees can select non-PPO providers; plan design can be cus-tomized; individual enrollment is not al-lowed.
Users: 224 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers; charges a flat fee per eligible employee, percent of ser-vices rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by The Travelers Insurance Co.
Officers: Kathleen Feary, plan manager; Matt MacEwen, sales manager.

U.S. Health Plan

3794 Olentangy River Road, Columbus, Ohio 43214; 614-457-0227

Operational date: May 1985.
Sponsorship: Two hospitals.
For profit.
Staff: 1,320 primary physicians; 934 spe-cialists; 13 administrative staff members; three marketing staff members.
Facilities: 13 hospitals; 13 diagnostic labs.
Service area: Franklin, Delaware, Marion, Hardin, Union, Morrow, Clark, Fairfild and Scioto counties in Ohio.
Services: Specialty services: prescrip-tion drug, dental, substance abuse, psychi-atric services, podiatry, obstetrics/gynecol-ogy. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 90 employer/payer groups; 42,562 employees and dependents with network access; 30,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services or by DRGs; is compensated by employers/payers, health care providers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management, outpa-tient mental health treatment review; pro-vided by the PPO.
Gross revenues: $8 million in 1988; $10 million estimated in 1989.
Officers: Dr. John W. Perkins, presi-dent/chief executive officer; Dr. Howard Lowery, chairman; Richard Birdsall, vp-administrative services; Dr. Roy Miller, medical director; John W. Guy, vp-mar-keting; Mike Bourland, treasurer/chief fi-nancial officer; Steve Garlock, secretary.



CNA Managed Care PPO-Oklahoma City

1005 Ford Road, Suite 300, Dallas, Texas 75234; 214-620-5350

Operational date: February 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 226 primary physicians; 75.2% board certified physicians.
Facilities: Five hospitals and medical facilities.
Service area: Oklahoma and Cleveland counties in Oklahoma.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gyn-ecology. Employees can select non-PPO providers, plan design can be customized, individual enrollment is not allowed.
Users: 15,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, or by a percent discount off customary rates for individual services; is compensated by em-ployers/payers; charges a flat fee per eligi-ble employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by Private Healthcare Systems Ltd.
Officers: Gary Brown, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

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CIGNA FlexCare Preferred Provider Organization-Tulsa/Oklahoma City

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CompMed

P.O. Box 14044, Tulsa, Okla. 74159; 918-622-5333

Operational date: January 1983.
Sponsorship: St. John Medical Center.
Ownership: Utica Care Management.
For profit.
Staff: 850 primary physicians; 690 specialists; 13 administrative staff members; three marketing staff members; average of 200 patients per primary physician; 50% board certified physicians.
Facilities: Nine hospitals; eight diagnostic labs.
Service area: Oklahoma.
Services: Specialty services: vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 181 employer/payer groups; 80,000 employees and dependents with network access; 82,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, retrospective review, second surgical opinion, case management; provided by the PPO and outside contractors.
Officers: David Pynn, president/executive director; Dr. Robert Hudson, medical director; John Brandt, marketing director; Bette Newfield, vp-administration.

EQUICOR Preferred-Oklahoma City

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Oklahoma City

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: February 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 229 primary physicians.
Facilities: Four hospitals.
Service area: 28 counties in California.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Two employer/payer groups; 365 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Metropolitan Life Insurance Co.-Oklahoma

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-Oklahoma

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Plus of Oklahoma

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: June 1988.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 688 primary physicians.
Facilities: Eight hospitals.
Service area: 18 counties in Oklahoma.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized; individual enrollment is not allowed.
Users: 22 employer/payer groups; 9,288 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: James G. Ryan, account executive-Massachusetts Mutual Life Insurance Co.

Prudential Plus

3330 N.W. 56th St., Suite 500, Oklahoma City, Okla. 73112; 405-942-6687

Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 152 primary physicians; 213 specialists; 25 administrative staff members; 11 marketing staff members; 85% board certified physicians.
Facilities: Five hospitals; 17 pharmacies; one diagnostic lab.
Service area: Oklahoma, Canadian, Cleveland, Grady, Kingfisher, Lincoln, Logan, McClain and Pottawatomie counties in Oklahoma.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 16,000 employees and dependents with network access.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Dr. M. Boyd Shook, medical director; Dave Dingley, marketing director; Mike Duncan, manager-health care services.

Prudential Plus Tulsa

7912 E. 31st Court, Suite 300, Tulsa, Okla. 74145; 918-624-4700

Operational date: July 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 153 primary physicians; 209 specialists; 24 administrative staff members; 15 marketing staff members; average of 80 patients per primary physician.
Facilities: Six hospitals; 15 pharmacies; two diagnostic labs.
Service area: Tulsa, Rogers, Muskogee, Osage, Washington and Creek counties in Oklahoma.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 3,390 employees with single coverage; 4,192 employees with family coverage; 12,800 employees and dependents with network access; 13,000 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, restricted procedure/services list; provided by the PPO.
Officers: Del Snoberger, director-health care management; Dr. C.B. Rebsamen, medical director; David W. Dingley, regional group manager.

Prudent Purchaser Option

1215 S. Boulder Ave., Tulsa, Okla. 74119; 918-560-3093

Operational date: 1984.
Sponsorship: Blue Cross & Blue Shield of Oklahoma.
Staff: 2,000 primary physicians.
Facilities: 34 hospitals.
Service area: 28 counties in Oklahoma.
Users: 167,490 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by DRGs.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, case management; provided by the PPO.

Sooner Health Plan

3555 N.W. 58th St., Suite 400, Oklahoma City, Okla. 73112; 405-942-7818

Operational date: 1984.
Sponsorship: Four hospitals.
Not for profit.
Staff: 550 participating physicians; one marketing staff member; 80.2% board certified physicians.
Facilities: Four hospitals.
Service area: Oklahoma.
Services: Specialty services: vision, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers, health care providers; charges a flat fee for some services, membership fee for providers.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, case management; provided by the PPO.
Officers: Dr. R.C. Brown, president; Steve West, executive director; Dr. William E. Hood, medical director; Hal Patton, marketing director; Terrie Adams-Beck, director-utilization review.

Travelers Preferred-Oklahoma City

5310 E. 31st St., Tulsa, Okla. 74135; 918-665-8165

Operational date: June 1989.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 319 primary physicians.
Facilities: Seven hospitals.
Service area: Canadian, Cleveland, Garfield, Kingfisher, Lincoln, Logan, Oklahoma, Payne and Pottawatomie counties in Oklahoma.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Three employer/payer groups; 1,502 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Patsy Arrington, health plan manager; Ben F. Lewis Jr., sales manager.

Travelers Preferred-Tulsa

5310 E. 31st St., Tulsa, Okla. 74135; 918-665-8165

Operational date: 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 504 primary physicians.
Facilities: Four hospitals.
Service area: Tulsa and Rogers counties in Oklahoma.
Services provided: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 115 employer/payer groups; 10,051 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Patsy Arrington, health plan manager; Ben F. Lewis Jr., sales manager.



CIGNA FlexCare Preferred Provider Organization-Portland

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Eugene

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Portland

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Portland

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Managed Healthcare Northwest (CAREMARK).
Not for profit.
Facilities: 12 hospitals.
Service area: Northwest Oregon and Southwest Washington.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Six employer/payer groups.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Jeffrey Kraines, medical director; Robert Kavanaugh, marketing director; David Grapko and Jim Motz, vps.

John Hancock Preferred Health Plan-Oregon

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Managed Healthcare Northwest Inc.

2701 N.W. Vaughn, Suite 710, Portland, Oregon 97210; 503-224-0409; 800-648-6356

Operational date: March 1985.
Sponsorship: Hospitals and physicians.
For profit.
Staff: 1,150 primary physicians; 735 specialists; 23 administrative staff members; three marketing staff members; average of 224 patients per primary physician; 65% board certified physicians.
Facilities: 12 hospitals; three diagnostic labs.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 60,000 employees and dependents with network access; 64,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers, by health care providers or by claims administrators; charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals, a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Robert Pallari, president/chief executive officer; Sally LaFollette, s director; Doug Fenstermaker, chairman

Metropolitan Life Insurance Co.-Oregon

Managed Care Services Group, 27 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance under Connecticut.

Mutually Preferred-Oregon

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebras

PM Group's PPO-Oregon

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Oregon

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Pla under Texas.

Preferred Health Network

P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

See Preferred Health Network und California.

Preferred Option

100 S.W. Market St., Portland, Ore. 97207; 503-225-5447

Operational date: January 1987.
Sponsorship: Blue Cross & Blue Shiel of Oregon.
Staff: 2,685 primary physicians.
Facilities: 24 hospitals.
Service area: Oregon; Clark County Wash.
Users: 264,168 employees and depen dents with network access.
Control measures: Preadmission hospi tal review, concurrent hospital treatmen review, discharge planning, second surgica opinion, case management; provided by th PPO.

Preferred Plus of Oregon

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: 1989.
Sponsorship: Massachusetts Mutua Life Insurance Co.
For profit.
Staff: 950 primary physicians.
Facilities: 12 hospitals.
Service area: Clackamas, Multnomah and Washington counties in Oregon; Clark and Skamania counties in Washington.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized individual enrollment is not allowed.
Users: 24 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Philip K. Francis, account executive, Massachusetts Mutual Life Insurance Co.

Travelers Preferred-Portland

951 Mariners Island Blvd., Suite 680, San Mateo, Calif. 94404; 415-341-0810

Operational date: March 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,012 primary physicians.
Facilities: Six hospitals.
Service area: Clackamas, Multnomah and Washington counties in Oregon; Clark County, Wash.
Services provided: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 14 employer/payer groups; 1,011 employees with single or family coverage.

Continued on next page

Compensation: The PPO negotiates spital charges by per diem rate, by a cent discount off customary rates for ividual services or by DRGs; is com-sated by employers/payers; charges a : fee per eligible employee, by a per-t of services rendered by participating tors/hospitals.

Control measures: Preadmission hospi- review, precertification, concurrent spital treatment review, length of stay ermination, discharge planning, retro-ctive review, second surgical opinion, spital bill audits, case management; pro-ed by The Travelers Insurance Co.

Officers: Roland King, executive direc-; Gail Ptacek, health plan manager; ld P. Stone, sales manager.

antage PPO

1235 N.E. 47th Ave., Suite 200, Portland, Ore. 97213; 503-288-0115

Operational date: 1983.
Sponsorship: Hospital.
Not for profit.
Staff: 1,000 primary physicians; 650 spe-alists; 10 administrative staff members; o marketing staff members; 90% board rtified physicians.
Facilities: 11 hospitals; 28 diagnostic bs.
Service area: Multnomah, Washington, ackamas, Yamhill, Wasco and Columbia unties in Oregon; Clark County, Wash.
Services: Specialty services: dental, ibstance abuse, psychiatric services, du-ble medical equipment, obstetrics/gyne-logy. Employees can select non-PPO pro-ders; plan design can be customized; dividual enrollment is allowed.
Users: 3,325 employer/payer groups; 2,000 estimated with network access as of n. 1, 1990.
Compensation: The PPO negotiates ospital charges by a per diem rate, by a ercent discount off customary rates, by RGs; is compensated by employers/ ayers; charges a flat fee per eligible em-loyee.
Control measures: Preadmission hospi-al review, precertification, concurrent ospital treatment review, length of stay etermination, discharge planning, retro-pective review, second surgical opinion, utpatient service predetermination, case anagement; provided by the PPO.
Gross revenues: $12.5 million in 1988; 30 million estimated in 1989.
Officers: Mary McWilliams, president/ hief executive officer-Sisters of Provi-ence Health Plans; Jack A. Friedman, ex-cutive director; Dr. James McKay, medi-al director; Phillip D. Jackson, marketing irector; Judith Hanes, health services irector.

Pennsylvania



Access Care

70 N. Main St., Wilkes-Barre, Pa. 18711; 717-829-8500

Operational date: March 1986.
Sponsorship: Blue Cross of Northeast-ern Pennsylvania and Pennsylvania Blue Shield.
Not for profit.
Staff: 2,094 primary physicians; 295 specialists.
Facilities: 35 hospitals; 149 pharma-cies.
Service area: 13 counties in Pennsyl-vania.
Services: Specialty services: prescrip-tion drug, dental, substance abuse, psychi-atric services, durable medical equipment, obstetrics/gynecology. Employees can se-lect non-PPO providers; plan design can-not be customized; individual enrollment is not allowed.
Users: 135 employer/payer groups; 9,380 employees with single coverage; 19,819 employees and dependents with network access; 21,000 estimated as of Jan. 1, 1990.
Compensation: The PPO is compen-sated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, second surgical opinion, case management; provided by the PPO.
Officers: Gilbert Tough, chief executive officer; Thomas Ward, executive director; Joseph Ichter, medical director; Michael A. Thomas, marketing director.

Alpha Health Network

415 Holiday Drive, Foster Plaza, Pittsburgh, Pa. 15220; 412-937-1396

Operational date: July 1985.
Sponsorship: Hospitals.
Not for profit.
Staff: 600 primary physicians; 800 spe-cialists; 14 administrative staff members; two marketing staff members; 83% board certified physicians.
Facilities: 42 hospitals.
Service area: Western and central Pennsylvania.
Services: Specialty services: dental, substance abuse, psychiatric services, du-rable medical equipment, podiatry, obstet-rics/gynecology, rehabilitation, infant care, radiology, burns. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 180 employer/payer groups; 76,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by health care providers and insurers; charges a flat fee per eligible em-ployee, fees for doctors and hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO and outside contractors.
Officers: William D. Gross, president/ executive director; Dr. Donald E. Fetterolf, medical director; David Babbitt, market-ing director; Linda Wostein, provider rela-tions director; Mary Jo Fisher, benefit ser-vice director.

Berkshire Health Plan

Sixth Street at Spruce Street, Reading, Pa. 19601; 215-372-8044

Sponsorship: Hospital and a group of doctors.
Not for profit.
Staff: 440 primary physicians; 350 spe-cialists; five administrative staff members; one marketing staff member; 60% board certified physicians.
Facilities: Five hospitals.
Service area: Berks, Schuylkill, Lan-caster, Montgomery and Chester counties in Pennsylvania.
Services: Specialty services: substance abuse, psychiatric services, durable medi-cal equipment, podiatry, obstetrics/gyne-cology. Employees can select non-PPO pro-viders; plan design can be customized; individual enrollment is not allowed.
Users: 70 employer/payer groups; 17,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers, claims administrators; charges a flat fee per eligi-ble employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service prede-termination, case management; provided by outside providers.
Gross revenues: $10.1 million in 1988; $13 million estimated in 1989.
Officers: Edward J. Wargo, president; Dr. C. Harold Cohn, medical director.

CNA Managed Care PPO-Philadelphia

1101 Market St., 25th floor, Philadelphia, Pa. 19107; 215-351-3842

Operational date: March 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,163 primary physicians; 81.7% board certified physicians.
Facilities: 20 hospitals and medical fa-cilities.
Service area: Philadelphia, Chester, Bucks, Montgomery and Delaware coun-ties in Pennsylvania; Gloucester, Burling-ton and Camden counties in New Jersey.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gyn-ecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 25,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by em-ployers/payers; charges a flat fee per eligi-ble employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by Private Healthcare Systems Ltd.
Officers: Bill Gabel, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Pittsburgh/ Harrisburg

4 Summit Drive, Independence, Ohio 44131; 216-328-7870

Operational date: 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,300 primary physicians; 68.3% board certified physicians.
Facilities: 13 hospitals and medical fa-cilities.
Service area: Allegheny, Butler and Dauphin counties in Pennsylvania.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gyn-ecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 10,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate or by a percent discount off customary rates for individual services; is compensated by em-ployers/payers; charges a flat fee per eligi-ble employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by Private Healthcare Systems Ltd.
Officers: Hal Demmerle, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Pennsylvania

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Philadelphia

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Pittsburgh

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Pittsburgh

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Family Health Plan Inc.

460 N. Gulph Road, Suite 500, King of Prussia, Pa. 19406; 215-337-4242

Operational date: February 1986.
Ownership: Insurers.
For profit.
Staff: 1,350 primary physicians; 818 specialists; 40 administrative staff members; two marketing staff members; 74% board certified physicians.
Facilities: 36 hospitals; 29 diagnostic labs.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania; Atlantic, Cape May, Bur-lington, Camden, Salem, Ocean, Cumber-land and Gloucester counties in New Jer-sey.
Services: Specialty services: substance abuse, psychiatric services, durable medi-cal equipment, podiatry, obstetrics/gyne-cology, physical therapy, home health care. Employees can select non-PPO providers; plan design can be customized; individual enrollment may be allowed.
Users: 105 employer/payer groups; 67,085 employees and dependents with network access; 92,500 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers, health care providers, claims administrators; charges a flat fee per eligible employee, percent of services rendered by participating doctors/ hospitals.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $30 million in 1988; $35 million estimated in 1989.
Officers: Peter S. Linder, president; Leon W. Jalbert, executive director/mar-keting director; Dr. Donald Lieberman, medical director; Kathleen Davis Mor-rissey, vp-operations.

John Hancock Preferred Health Plan-Pennsylvania

P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Hartford's PULSE Plan of Philadelphia

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: April 1988.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 381 primary physicians; 534 spe-cialists.
Facilities: 23 hospitals; four diagnostic labs.
Service area: Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania; Burlington, Camden and Gloucester counties in New Jersey.
Services: Specialty services: substance abuse, psychiatric services, durable medi-cal equipment, podiatry, obstetrics/gyne-cology. Employees can select non-PPO pro-viders; plan design can be customized; individual enrollment is not allowed.
Users: Six employer/payer groups; 3,014 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by discounts off DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination; provided by the PPO and outside contractors.
Contact: Elisabeth A. Secosky, regional sales manager; 609-627-9400.

Health Corp. of America-Preferred Provider Network

1160 W. Swedesford Road, Berwyn, Pa. 19312-1096; 215-640-0300

Operational date: 1985.
Ownership: Health Corp. of America.
For profit.
Staff: 500 primary physicians; 55 spe-cialists; 24 administrative staff members; two marketing staff members; 100% board certified physicians.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania; Illinois; Northern Missouri; District of Columbia.
Services: Specialty services: prescrip-tion drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecol-ogy, workers compensation. Employees can select non-PPO providers; plan design can be customized; individual enrollment is al-lowed.
Users: 7,400 employer/payer groups; 475,000 estimated employees and depen-dents with network access as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers, claims administrators; charges a percent of sav-ings.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO.
Gross revenues: $3.7 million in 1988; $5.5 million estimated in 1989.
Officers: Joseph R. Cusumano, presi-dent/chief executive officer; William J. Camp, vp-marketing/executive director.

InterGroup-Select Provider Network

259 Radnor-Chester Road, Suite 210, Radnor, Pa. 19087; 215-293-1200

Operational date: March 1985.
Sponsorship: Employers, insurers, hos-pitals, administrators.
For profit.
Staff: 750 specialists; five administrative staff members; three marketing staff mem-bers.
Facilities: 70 hospitals.
Service area: 18 counties in Pennsylva-nia; Atlantic, Cape May, Camden, Mercer, Gloucester and Burlington counties in New Jersey; New Castle County in Delaware.
Services: Specialty services: substance abuse, psychiatric services, durable medi-cal equipment, workers compensation, em-ployee assistance programs. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 2,125 employer/payer groups; 220,000 employees and dependents with network access; 225,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compen-sated by employers/payers, health care providers, claims administrators, insurers, multiemployer trusts; charges a flat fee per eligible employee.
Control measures: Preadmission hospi-tal review, precertification, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, case management; pro-vided by outside contractors.
Officers: G. Martin Dudley, president; Roger Halverson and John Strube, vps; David R. Vaughn, chairman; John George, executive vp.

Metropolitan Life Insurance Co.-Pennsylvania

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-Pennsylvania

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Pennsylvania Health Care Plan

4117 Penn Ave., Pittsburgh, Pa. 15224; 412-621-9697

Operational date: April 1986.
Sponsorship: Hospital.
Not for profit.
Staff: 1,200 primary physicians; 550 spe-cialists; three administrative staff mem-bers; three marketing staff members; 95% board certified physicians.
Facilities: 25 hospitals; more than 15 pharmacies; three diagnostic labs.
Service area: 12 counties in Pennsylva-nia; Brooke, Hancock, Ohio, Marshall and Wetzel counties in West Virginia; Jeffer-son, Belmont, Columbiana, Monroe, Harri-son and Tuscarawas counties in Ohio.
Services: Specialty services: prescrip-tion drug, vision, substance abuse, psychi-atric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 74 employer/payer groups; 1,160 employees with single coverage; 5,040 em-ployees with family coverage; 18,000 em-ployees and dependents with network ac-cess.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospi-tal review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-spective review, second surgical opinion, hospital bill audits, outpatient service pre-determination, case management; provided by the PPO.
Officers: M. Sylvia Schuler, president; M. Daniel Splain, executive director; Dr. Roy J. Cammarata, medical director; Eliza-beth Stolkowski, marketing director.

Personal Choice

1800 Center St., Camp Hill, Pa. 17011; 717-763-3754; 215-448-2243

Operational date: July 1986.
Sponsorship: Blue Cross of Greater Philadelphia and Pennsylvania Blue Shield.
Staff: 5,825 primary physicians.
Facilities: 16 hospitals.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
Users: 26,758 employees and dependents with network access.
Control measures: Preadmission hospi-tal review, concurrent hospital treatment

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review; provided by the PPO.

Preferred Care Inc.

550 Pinetown Road, Suite 250, Fort Washington, Pa. 19034; 215-628-8108

Operational date: 1987.
Ownership: OCWEN Financial Group.
For profit.
Staff: 1,855 primary physicians; 620 specialists; 22 administrative staff members; five marketing staff members; average of 41 patients per primary physician; 65% board certified physicians.
Facilities: 36 hospitals; 12 diagnostic labs.
Service area: Pennsylvania and New Jersey.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, workers compensation. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 1,375 employer/payer groups; 22,165 employees with single coverage; 18,135 employees with family coverage; 72,035 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by DRGs, bids on large cases; is compensated by employers/payers; charges a flat fee per eligible employee, a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning; provided by outside contractors.
Gross revenues: $7.5 million in 1988; $8.3 million estimated in 1989.
Officers: Larry W. Driscoll, president; Richard L. Matthew, marketing director; Robert C. North Jr., chairman; Rory Brown, treasurer.

Preferred Healthcare Systems Inc.

620 Howard Ave., Altoona, Pa. 16601; 814-949-3099

Operational date: 1986.
Sponsorship: Altoona Hospital and physician group.
Not for profit.
Staff: 234 primary physicians; 234 specialists; one administrative staff member; one marketing staff member.
Facilities: Three hospitals.
Service area: Blair, Bedford, Centre, Fulton, Huntingdon, Mifflin, Juniata and Clearfield counties in Pennsylvania.
Services: Specialty services: durable medical equipment, podiatry, obstetrics/gynecology, audiology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 146 employer/payer groups; 6,000 employees and dependents with network access; 6,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by claims administrators; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion; provided by the PPO.
Officers: Donald E. Snyder, president; Kathy J. Meckley, executive director; Dr. Ira B. Kron, medical director; Thomas J. Link, marketing director.

Preferred Plus of the Delaware Valley

1295 State St., Springfield, Mass. 01111; 413-788-4111

Operational date: July 1988.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,255 primary physicians.
Facilities: 31 hospitals.
Service area: Delaware, Chester, Bucks, Montgomery and Philadelphia counties in Pennsylvania; Camden, Gloucester, Salem, Burlington, Ocean, Atlantic, Cape May and Cumberland counties in New Jersey.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized; individual enrollment is not allowed.
Users: 33 employer/payer groups; 9,905 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers, health care providers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Contact: Thomas S. McIlwain, regional sales manager.

Preferred Plus of Western Pennsylvania

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,250 primary physicians.
Facilities: 25 hospitals.
Service area: Washington, Fayette, Westmoreland, Cambria and Blair counties in Pennsylvania.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design may be customized; individual enrollment is not allowed.
Compensation: The PPO is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Contact: James J. Stewart, regional sales director.

Preferred Provider Program

1800 Center St., Camp Hill, Pa. 17011; 713-763-3754

Operational date: January 1985.
Sponsorship: Pennsylvania Blue Shield.
Staff: 15,008 primary physicians.
Service area: Pennsylvania.
Users: 30,388 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion, case management; provided by the PPO.

PruCare of Philadelphia

200 Gibralter Road, Horsham, Pa. 19044; 215-672-1944

Operational date: August 1987.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 746 primary physicians; 1,410 specialists; 22 administrative staff members; 16 marketing staff members; average of 29 patients per primary physician; 96% board certified or board eligible physicians.
Facilities: 21 hospitals; 99 pharmacies; one diagnostic lab.
Service area: Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized.
Users: 29,073 employees and dependents with network access.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination; provided by the PPO.
Officers: Kenneth W. Janda, executive director; Dr. Philip Goldstein, medical director; Scott Ringold, director-group marketing.

PruCare of Pittsburgh

24th Floor, Centre City Tower Bldg., 650 Smithfield, Pittsburgh, Pa. 15222; 412-391-0464

Operational date: April 1988.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 297 primary physicians; 511 specialists; 11 administrative staff members; 15 marketing staff members; average of 10 patients per primary physician; 90% board certified physicians.
Facilities: Nine hospitals; 43 pharmacies; 20 diagnostic labs.
Service area: Armstrong, Allegheny, Beaver, Butler, Fayette, Washington and Westmoreland counties in Pennsylvania.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, home health care, skilled nursing, hospice, chiropractic, radiation therapy. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 6,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, ambulatory surgery and emergency room review; provided by the PPO.
Officers: Lynne Gross, health care management; Dr. Michael Scholssberg, medical director; Chris Earl, regional group manager; Lorraine Wagner, managing coordinator; Deborah Cawley, associate manager.

Travelers Preferred-Greater Philadelphia/Southern New Jersey Area

3 Parkway Plaza, Philadelphia, Pa. 19102; 215-557-6091

Operational date: January 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,709 primary physicians.
Facilities: 25 hospitals.
Service area: Burlington, Camden and Gloucester counties in New Jersey; Bucks, Chester, Mercer, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 13 employer/payer groups; 13,234 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Pat Hedden, health plan manager; Peter W. Silcox, sales manager.

Travelers Preferred-Pittsburgh/Southwestern Pennsylvania Area

1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219; 412-338-5545

Operational date: June 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,065 primary physicians.
Facilities: 16 hospitals.
Service area: Allegheny, Beaver, Butler, Fayette, Lawrence, Washington and Westmoreland counties in Pennsylvania.
Services provided: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Two employer/payer groups; 1,644 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Marilyn J. Nixon, health plan manager; William K. Wohlgemuth, sales manager.

VHA East Health Plans

200 Berwyn Park, Suite 202, Berwyn, Pa. 19312; 215-296-2558

Operational date: January 1988.
Sponsorship: VHA East.
For profit.
Staff: 603 primary physicians; 450 specialists; two administrative staff members; one marketing staff member; 80% board certified physicians.
Facilities: 16 hospitals.
Service area: Philadelphia, Bucks, Chester, Delaware, Montgomery, Lehigh, Northampton and Berks counties in Pennsylvania.
Services: Specialty services: vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Three employer/payer groups; 10,400 employees with single coverage; 19,200 employees with family coverage; 65,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers, claims administrators; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, case management; provided by outside contractors.
Gross revenues: $12.5 million estimated in 1989.
Officers: Michael J. Daly, president; David E. Edman, vp.



CIGNA FlexCare Preferred Provider Organization-Puerto Rico

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

Medical Card System Inc.

Royal Bank Center, Suite 1600, Hato Rey, P.R. 00917; 809-758-2500

Operational date: March 1984.
Ownership: Baxter Healthcare Corp.
For profit.
Staff: 4,000 primary physicians; 3,000 specialists; 70 administrative staff members; five marketing staff members; average of 225 patients per primary physician; 85% board certified physicians.
Facilities: 56 hospitals; 228 pharmacies; 184 diagnostic labs.
Service area: Puerto Rico.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 450 employer/payer groups; 21,000 employees with single coverage; 48,000 employees with family coverage; 220,800 employees and dependents with network access; 230,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate; is compensated by insurance companies; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; provided by the PPO.
Gross revenues: $110 million in 1988; $135 million estimated in 1989.
Officers: Jose Arbizo, president; Dr. Jose Benmaman, medical director; Guillermo Melendez, vp-marketing; Jose Duran, vp-operations; Domingo Rodriguez, vp-finance.



Metropolitan Life Insurance Co.-Rhode Island

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.



Preferred Personal Care

Alpine at I-20, Columbia, S.C. 29219; 803-788-3860

Operational date: 1986.
Sponsorship: Blue Cross & Blue Shield of South Carolina.
Not for profit.
Staff: 2,230 primary physicians; 1,600 specialists; average of 25 patients per primary physician.
Facilities: 24 hospitals; 350 pharmacies.
Service area: South Carolina.
Services: Specialty services: substance abuse, psychiatric services, durable m
cal equipment, podiatry, obstetrics/g
cology, cardiology, orthopedics, pathol
radiology, anesthesiology, oncology, p
atrics, neonatology, urology, ophthalr
ogy, neurology. Employees can select r
PPO providers; plan design can be cu
mized; individual enrollment may
allowed.
Users: 120,000 employees and dep
dents with network access; 130,000 e
mated as of Jan. 1, 1990.
Compensation: The PPO negoti
hospital charges by DRGs; is compens
by employers/payers.
Control measures: Preadmission ho
tal review, precertification, concurr
hospital treatment review, length of s
determination, discharge planning, re
spective review, hospital bill audits, c
management; provided by the PPO.
Officers: M. Edward Sellers, presid
Tom Faulds, executive vp; Dr. Ashby J
dan, medical director; Wally Blalock, I
Nystrom, Jim Hart and Hugh McElde
senior vps.

Travelers Preferred-Charleston

Travelers Health Network, 24 Mark St., Suite 210, Charleston, S.C. 29401; 803-723-7835

Operational date: March 1988.
Sponsorship: The Travelers Insura
Co.
For profit.
Staff: 157 primary physicians.
Facilities: Two hospitals.
Service area: Berkeley, Charleston a
Dorchester counties in South Carolina.
Users: Two employer/payer groups; 2
employees with single or family coverag
Compensation: The PPO negotiat
hospital charges by a per diem rate, by
percent discount off customary rates f
individual services, by DRGs; is compe
sated by employers/payers; charges a fl
fee per eligible employee, percent of se
vices rendered by participating docto
hospitals.
Control measures: Preadmission hosp
tal review, precertification, concurre
hospital treatment review, length of st
determination, discharge planning, retr
spective review, second surgical opinio
hospital bill audits, case management; pr
vided by The Travelers Insurance Co.
Officers: Jimmy White, health pla
manager; Ralph M. Crafton, sales ma
ager.



CarePASS-South Dakota

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.



CNA Managed Care PPO-Memphis

2302 Parklake Drive N.E., Atlanta, Ga. 30345; 404-491-5375

Operational date: March 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 609 primary physicians; 67% board certified physicians.
Facilities: Six hospitals and medical facilities.
Service area: Shelby, Weakley and Fayette counties in Tennessee; Crittenden County, Ark.; De Soto County, Miss.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 19,200 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Charles Hart, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

Continued on next page

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NA Managed Care PPO-Nashville

2302 Parklake Drive N.E., Atlanta, Ga. 30345; 404-491-5375

Operational date: 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 270 primary physicians; 77% ard certified physicians.
Facilities: Eight hospitals and medical ilities.
Service area: Anderson, Dickson, Rortson, Coffee, Sumner, Maury and Daison counties in Tennessee.
Services: Specialty services: substance use, psychiatric services, obstetrics/gynology. Employees can select non-PPO oviders; plan design can be customized; dividual enrollment is not allowed.
Users: 9,700 employees and dependents th network access.
Compensation: The PPO negotiates spital charges by per diem rate or by a rcent discount off customary rates for dividual services; is compensated by emoyers/payers; charges a flat fee per eligie employee.
Control measures: Preadmission hospil review, precertification, concurrent spital treatment review, length of stay etermination, discharge planning, retropective review, second surgical opinion, spital bill audits, outpatient service pretermination, case management; provided y Private Healthcare Systems Ltd.
Officers: Charles Hart, manager-major roup sales; Kenneth H. Currier, managerst containment development; Dr. Phillip Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Knoxville

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider rganization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Memphis

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider rganization under Connecticut.

EQUICOR Preferred*

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

Operational date: Varies by plan.
Sponsorship: EQUICOR Inc.
For profit.
Staff: 26,130 primary physicians; 15,660 specialists; 55% board certified physicians.
Facilities: 342 hospitals; 10 diagnostic labs.
Service area: Arizona, California, Colorado, Florida, Illinois, Indiana, Kansas, Missouri, Michigan, North Carolina, New Mexico, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington.
Services: Specialty services: vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized.
Users: 352 employer/payer groups; 151,385 employees with coverage; 378,462 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management, psychiatric consultation service; provided by the PPO.
Gross revenues: $34.8 million estimated in 1989.
Officers: William Hjorth, president/chief executive officer; Dr. David Ottensmeyer, chief medical officer; James Murphy, marketing/regional operations; Dennis Whimpey, chief financial officer.
* Figures are corporate for all EQUICOR PPOs sponsored by EQUICOR Inc.

EQUICOR Preferred-Chattanooga

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Memphis

1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

FOCUS Healthcare Management Inc.-CompNET

7101 Executive Center Drive, Suite 160, Brentwood, Tenn. 37027; 615-377-9936

Operational date: Varies by site.
Ownership: FOCUS Healthcare.
For profit.
Staff: 256 primary physicians; 16 administrative staff members; five marketing staff members; 100% board certified physicians.
Facilities: 173 hospitals; one pharmacy; 33 diagnostic labs.
Service area: Network operates in Alabama, Florida, Georgia, Illinois, Missouri Pennsylvania and Texas.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, rehabilitation, pain clinics, home health care, ambulance, chiropractors, hospice. Employees can select non-PPO providers; plan design can be customized.
Users: 105 employer/payer groups.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers, claims administrators; charges percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $3.2 million in 1988; $20.6 million estimated in 1989.
Officers: Stryker Warren Jr., president; David S. Iskowe, executive director; Dr. Harold Ferguson, medical director; M. Elizabeth Hand, marketing director.

Great-West Care-Chattanooga

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: October 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Facilities: One hospital.
Service area: Southeast Tennessee; Dade, Catoosa, Walker, Whitfield, Murray, Chattooga and Gordon counties in Georgia.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: One employer/payer group; 10 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Knoxville

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: February 1989.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 515 primary physicians.
Service area: Knox, Granger and Blount counties in Tennessee.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Memphis

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: March 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 626 primary physicians; 68% board certified physicians.
Facilities: Six hospitals.
Service area: Network operates in Tennessee, Mississippi and Arkansas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: One employer/payer group.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Nashville

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 299 primary physicians.
Facilities: Eight hospitals.
Service area: 40 counties in Tennessee.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: One employer/payer group.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Hartford's PULSE Plan of Nashville

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: 1989.
Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 141 primary physicians; 273 specialists.
Facilities: Five hospitals.
Service area: Cheatham, Davidson, Robertson, Rutherford, Sumner, Williamson and Wilson counties in Tennessee.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, outpatient service predetermination, large case management; provided by the PPO and outside contractors.
Contact: Joseph W. Jolly, sales manager.

Health Net Inc.

4535 Harding Road, Suite 100, Nashville, Tenn. 37205; 615-269-4564

Operational date: May 1984.
Sponsorship: Hospitals, physicians, employers, administrators.
Not for profit.
Staff: 11,207 primary physicians; four marketing staff members.
Facilities: 22 hospitals; 64 pharmacies; three diagnostic labs.
Service area: 22 states.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 1,348 employer/payer groups; 49,606 employees with family coverage; 177,517 employees and dependents with network access; 185,000-200,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers, health care providers, claims administrators; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management, peer review of services; provided by the PPO.
Officers: John L. Chapman, president/chief executive officer; J. Dale Hawkins, senior vp/chief operating officer; Dr. William Crenshaw, medical director; Ernest E. Davis, vp; George Lillie and Neda Lewis, directors.

Humana Insurance Co.

Osborne Office Center, Suite 510, Chattanooga, Tenn. 37411; 615-899-5291

See Humana Health Care Plans under Kentucky.

Metropolitan Life Insurance Co.-Tennessee

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PM Group's PPO-Tennessee

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Tennessee

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Care

801 Pine St., Chattanooga, Tenn. 37402; 615-755-5996

Operational date: March 1985.
Sponsorship: Blue Cross & Blue Shield of Tennessee.
Not for profit.
Staff: 5,895 primary physicians.
Facilities: 130 hospitals.
Service area: Tennessee.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment may be allowed.
Users: 2,353 employer/payer groups; 130,848 employees with single coverage; 158,049 employees with family coverage; 735,000 employees and dependents with network access; 771,500 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; charges by percent of charges.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management; provided by the PPO.
Gross revenues: $383.8 million in 1988; $446.7 million estimated in 1989.
Officers: J. Robert McGuff, president; William Nuckols, executive vp/chief administrative officer; Dr. Richard Armstrong, medical director; Ken Tolliver, vp-marketing; Robert Wortman, executive vp-internal affairs.

Preferred Provider Organization

85 N. Danny Thomas Blvd., Memphis, Tenn. 38103; 901-529-3041

Operational date: 1985.
Sponsorship: Memphis Hospital Services & Surgical Assn. Inc.
Staff: 1,800 primary physicians.
Facilities: 16 hospitals.
Service area: Fayette, Haywood, Lauderdale, Shelby and Tipton counties in Tennessee.
Users: 76,000 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion, case management.

Private Healthcare Systems Ltd.

1 American Center, 3100 West End Ave., Suite 650, Nashville, Tenn. 37203; 615-386-9194

Markets include Memphis and Nashville, Tenn.; New Orleans; Louisville; Richmond, Va.

See Private Healthcare Systems Ltd. under Massachusetts.

Prudential Plus of Memphis

845 Crossover Lane, Suite 200, Memphis, Tenn. 38117; 901-766-7100

Operational date: 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 106 primary physicians; 280 specialists; 12 administrative staff members; eight marketing staff members; average of 37 patients per primary physician; 95% board certified physicians.
Facilities: One hospital; two pharmacies; one diagnostic lab.
Service area: Shelby County in Tennessee.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can not be customized; individual enrollment is not allowed.
Users: 4,100 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Donna DeVaughn-Tidline, director-health care management; Dr. Manoj Narayanan, medical director; Peter S. Flick, director-group marketing.

Prudential Plus of Nashville

227 French Landing Drive, Suite 200, Nashville, Tenn. 37228; 615-248-7100

Operational date: July 1987.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 68 primary physicians; 120 specialists; 24 administrative staff members; eight marketing staff members; average of 24 patients per primary physician; 98% board certified physicians.
Facilities: Five hospitals; 31 pharmacies; one diagnostic lab.
Service area: Cheatham, Davidson, Robertson, Rutherford, Sumner, Williamson and Wilson counties in Tennessee.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 1,613 employees and dependents with network access; 1,700 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Fred Dodson, director-group operations; Dr. Richard L. Schumacher, vp-medical services; Peter E. Flick, director-group operations.

Travelers Preferred-Knoxville

44 Vantage Way, Suite 450, P.O. Box 1168, Nashville, Tenn. 37202; 615-747-5396

Operational date: 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 305 primary physicians.
Facilities: 10 hospitals.
Service area: 13 counties in Tennessee.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 18 employer/payer groups; 1,227 employees with single or family coverage.
Compensation: The PPO negotiates

Continued on next page

Continued from previous page
hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.

Officers: Lois T. Brown, health plan manager; Jack Passafiume, sales manager.

Travelers Preferred-Nashville

44 Vantage Way, Suite 450, Nashville, Tenn. 37202; 615-747-5396

Operational date: 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 366 primary physicians.
Facilities: 14 hospitals.
Service area: Cheatham, Davidson, DeKalb, Dickson, Macon, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson and Wilson counties in Tennessee.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 32 employer/payer groups; 1,764 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Lois T. Brown, health plan manager; Jerry J. Martin, sales manager.



American Health Network

3988 N. Central Expressway, Dallas, Texas 75204; 214-841-1000

Operational date: August 1985.
Sponsorship: American General Group Insurance Co.
For profit.
Staff: 28,381 primary physicians; 117 administrative staff members; 35 marketing staff members.
Facilities: 400 hospitals; seven pharmacies; six diagnostic labs.
Service area: 40 counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 912 employer/payer groups; 869,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Howard L. Korn, president; Martin R. Kreis, senior vp; Dr. Richard P. Norgaard, medical director; Henry A. Arnold, marketing director-western region; Venessa Wood, director-eastern region.

Benesys/Managed Mental Health Services

1775 St. James Place, Suite 200, Houston, Texas 77056; 713-871-0821

Operational date: May 1989.
Sponsorship: Private.
For profit.
Staff: 25 primary physicians; 50 therapists.
Facilities: 11 hospitals.
Service area: Texas.
Services: Specialty services: substance abuse, psychiatric services. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: One employer/payer group; 70,000 employees and dependents with network access; 120,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Dr. Thomas A. Blocher, president; Joseph V. Smith, executive director; Dr. James F. Considine, medical director; Dorothy E. Windham, marketing director.

CNA Managed Care PPO-Austin

6565 W. Loop South, Suite 450, Bellaire, Texas 77401; 713-663-5320

Operational date: October 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 240 primary physicians; 90.4% board certified physicians.
Facilities: Three hospitals and medical facilities.
Service area: Travis, Burnet and Williamson counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 4,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Vera Cantrell, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Dallas/Fort Worth

1005 Ford Road, Suite 300, Dallas, Texas 75234; 214-620-5350

Operational date: 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 645 primary physicians; 75.8% board certified physicians.
Facilities: 12 hospitals and medical facilities.
Service area: Dallas, Tarrant, Denton and Collin counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 17,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Gary Brown, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-Houston

6565 W. Loop South, Suite 450, Bellaire, Texas 77401; 713-663-5320

Operational date: 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 1,244 primary physicians; 70.1% board certified physicians.
Facilities: 20 hospitals and medical facilities.
Service area: Harris and Fort Bend counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 6,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Vera Cantrell, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CNA Managed Care PPO-San Antonio/Corpus Christi

6565 W. Loop South, Suite 450, Bellaire, Texas 77401; 713-663-5320

Operational date: 1986.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 323 primary physicians; 76.8% board certified physicians.
Facilities: Six hospitals and medical facilities.
Service area: Bexar and Nueces counties in Texas.
Services: Specialty services: substance abuse, psychiatric services. obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 15,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Vera Cantrell, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Texas

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

CIGNA FlexCare Preferred Provider Organization-Dallas

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

CIGNA FlexCare Preferred Provider Organization-Houston

Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Dallas

1801 W. End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Houston

1801 W. End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Austin

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: October 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 244 primary physicians; 74% board certified.
Facilities: Two hospitals.
Service area: 23 counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Dallas

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 674 primary physicians; 68% board certified.
Facilities: Seven hospitals.
Service area: 23 counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 20 employer/payer groups; 7,686 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Houston

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 1,275 primary physicians; 72% board certified.
Facilities: 15 hospitals.
Service area: Austin, Waller, Harris, Colorado, Wharton, Matagorda, Brazoria, Galveston, Fort Bend, Chambers and Liberty counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Six employer/payer groups; 871 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Great-West Care-San Antonio

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: 1986.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 450 primary physicians; 69% board certified.
Facilities: Five hospitals.
Service area: 30 counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

HEC Select North Texas PPO

1300 W. Mockingbird Lane, Dallas, Texas 75218; 214-905-4421

Operational date: February 1989.
Ownership: Health Economics Corp.
For profit.
Staff: 461 primary physicians; 339 specialists; five administrative staff members six marketing staff members; 30 average patients per primary physician.
Facilities: 17 hospitals; one pharmacy
Service area: Dallas, Collin, Dento Tarrant, Hood and Johnson counties Texas.
Services: Specialty services: prescription drug, podiatry, obstetrics/gynecolog Employees can select non-PPO provide plan design can be customized; individu enrollment is not allowed.
Users: Two employer/payer group 15,000 employees and dependents wi network access; 17,000 estimated as of Ja 1, 1990.
Compensation: The PPO negotiat hospital charges by per diem rate or a percent discount off customary rates f individual services; is compensated by em ployers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hosp tal review, precertification, concurre hospital treatment review, length of st determination, discharge planning, retr spective review, second surgical opinio outpatient service predetermination, ca management; provided by the PPO or outside contractors.
Officers: Stephen Coady, president; D Laurence Dotin, medical director; Herbe Maxwell, vp-sales/marketing; Nancy Co leman, vp-claims administration.

HEC Select South Texas PPO

2400 W. Loop South, Houston, Texa 77027; 713-621-9330

Operational date: 1986.
Ownership: Health Economics Corp.
For profit.
Staff: 1,248 primary physicians; 918 specialists; five administrative staff members six marketing staff members.
Facilities: 13 hospitals; one pharmacy.
Service area: Harris, Fort Bend, Galveston and Brazoria counties in Texas.
Services: Specialty services: prescription drug, podiatry, obstetrics/gynecology Employees can select non-PPO providers plan design can be customized; individua enrollment is not allowed.
Users: 18,000 estimated employees an dependents with network access as of Jan 1, 1990.
Compensation: The PPO negotiate hospital charges by per diem rate or b a percent discount off customary rates fo individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurren hospital treatment review, length of sta determination, discharge planning, retrospective review, second surgical opinion outpatient service predetermination, case management; provided by the PPO or outside contractors.
Officers: Stephen Coady, president; Dr Laurence Dotin, medical director; Herbert Maxwell, vp-sales/marketing; Nancy Coleman, vp-claims administration.

Haltom Physicians P.A.

2919 Markum Drive, Fort Worth, Texas 76117; 817-831-0321

Sponsorship: Group of doctors.
For profit.
Staff: 160 primary physicians; three administrative staff members; one marketing staff member; 2,000 average of patients per primary physician; 90% board certified physicians.
Facilities: Four diagnostic labs.
Service area: Texas, Arkansas, Louisiana, Oklahoma and New Mexico.
Services: Specialty services: workers compensation. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 20 employer/payer groups.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a fee per review.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $400,000 in 1988; $600,000 estimated in 1989.
Officers: Dr. John E. McNeff, president/medical director; Lynn Pentacost, executive director; K. Phillips, marketing director.

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hn Hancock Preferred Health Plan-Texas

'.O. Box 111, Boston, Mass. 02117; 17-572-7036

ee John Hancock Preferred Health Plan ler Massachusetts.

rtford's PULSE Plan of Houston

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: February 1989.
Sponsorship: The Hartford Insurance

For profit.
Staff: 982 primary physicians; 1,987 cialists.
Facilities: 30 hospitals; two diagnostic s.
Service area: Harris and Galveston unties in Texas.
Services: Specialty services: substance use, psychiatric services, podiatry, obtrics/gynecology. Employees can select n-PPO providers; plan design can be stomized; individual enrollment is not owed.
Users: Four employer/payer groups; 196 employees and dependents with net-rk access.
Compensation: The PPO negotiates spital charges by per diem rate or by percent discount off customary rates for dividual services; is compensated by em-oyers/payers; charges a flat fee per eligi-e employee.
Control measures: Preadmission hospi-l review, precertification, concurrent spital treatment review, length of stay termination, retrospective review, sec-nd surgical opinion; provided by the PO.
Officers: Jerome S. Range, regional sales anager.

lartford's PULSE Plan of San Antonio

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Operational date: 1989.
Sponsorship: The Hartford Insurance o.
For profit.
Staff: 200 primary physicians; 575 specialists.
Facilities: Nine hospitals.
Service area: Bexar County in Texas.
Services: Specialty services: substance buse, psychiatric services, physical therpy, podiatry, obstetrics/gynecology. Emloyees can select non-PPO providers; plan lesign can be customized; individual enollment is not allowed.
Compensation: The PPO negotiates ospital charges by per diem rate or by percent discount off customary rates for ndividual services; is compensated by emloyers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospial review, precertification, concurrent ospital treatment review, length of stay letermination, retrospective review, second surgical opinion; provided by the PPO.
Officers: Jerome S. Range, regional sales manager.

Humana Insurance Co.

3301 S. Alameda, Suite 506, Corpus Christi, Texas 78411; 512-854-8955

See Humana Health Care Plans under Kentucky.

Humana Insurance Co.

Med Center Plaza, 8431 Fredericksburg Road, San Antonio, Texas 78229; 512-558-1000

See Humana Health Care Plans under Kentucky.

Lincoln National Preferred Plan

433 E. Las Colinas Blvd., Irving Texas 75039; 214-869-1000

See Lincoln National Preferred Plan under Indiana.

Medical Care Referral Group

4100 Rio Bravo, Suite 211, El Paso, Texas 79902; 800-247-7114

Operational date: April 1986.
Sponsorship: Joseph R. Halow Co. Inc.
For profit.
Staff: 370 primary physicians; 186 specialists; seven administrative staff members; four marketing staff members.
Facilities: Seven hospitals; 22 pharmacies; eight diagnostic labs.
Service area: Texas, Georgia, Arkansas, Mississippi and Tennessee.
Services: Specialty services: prescription drug, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 14 employer/payer groups; 50,000 employees and dependents with network access; 55,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, second surgical opinion, case management; provided by the PPO.
Officers: Lorri Halow, president; Joe Halow, executive director; David Rendou, marketing director.

Metropolitan Life Insurance Co.-Texas

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Texas

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

National HealthCare Alliance Inc.

770 S. Post Oak Lane, Suite 445, Houston, Texas 77056; 713-439-0123

Operational date: January 1988.
Sponsorship: Entrepreneurial.
For profit.
Staff: 1,200 primary physicians; 12 administrative staff members; two marketing staff members; 80% board certified physicians.
Facilities: 44 hospitals; 160 pharmacies; 40 diagnostic labs.
Service area: Harris, Montgomery, Fort Bend, Brazoria, Chambers and Ector counties; cities of Corpus Christi, Dallas, Fort Worth and Austin in Texas.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology; chiropractic. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 700 employer/payer groups; 60,000 employees and dependents with network access; 65,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion; provided by the PPO or insurers.
Gross revenues: $4 million in 1988; $30 million estimated in 1989.
Officers: Thomas C. Yarrell, president; Dr. John Baird, medical director; Francis L. Browning, chairman/chief executive officer.

PM Group's PPO-Texas

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

Operational date: 1985.
Sponsorship: Aetna Life Insurance Co. and VHA Enterprises.
Ownership: PARTNERS National Health Plans.
For profit.
Staff: 57,888 primary physicians; 33,640 specialists; 100% board certified physicians.
Facilities: 683 hospitals.
Service area: 33 states.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 4,078 employer/payer groups; 1.2 million employees and dependents with network access; 1.3 million estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Donald E. Simmons, president/chief executive officer; Dennis Pedini, chief operating officer; Dr. Loren Vorlicky, medical director; Mark Hanrahan, vp-sales/marketing.

Preferred Choice

7800 IH 10 West, Suite 528, San Antonio, Texas 78230; 512-340-9692

Operational date: October 1985.
Sponsorship: Santa Rosa Health Care Corp.
For profit.
Staff: 584 primary physicians; 428 specialists; 7.5 administrative staff members; one marketing staff member; 218 patients per primary physician; 85% board certified physicians.
Facilities: Six hospitals; two diagnostic labs.
Service area: Bexar, Guadalupe, Wilson, Comal, Kendall, Bandera, Medina, Frio and Atascosa counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is allowed.
Users: 110 employer/payer groups; 6,822 employees with single coverage; 6,822 employees with family coverage; 34,110 employees and dependents with network access; 45,378 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers or health care providers; charges a flat fee per eligible employee or by a percent of services rendered by participating doctors/hospitals, by a percent of savings.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $3.8 million estimated in 1989.
Officers: Peter F. Maddox, president; Lori L. Hitzeman, executive director; Dr. Hugh L. Wolff, medical director.

Preferred Plus of North Texas

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: March 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 1,300 primary physicians.
Facilities: 22 hospitals.
Service area: Collin, Dallas, Denton, Ellis, Hood, Johnson, Kaufman, Parker, Rockwall, Tarrant and Wise counties in Texas.
Services: Specialty services: psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; individual enrollment is not allowed.
Users: Four employer/payer groups; 7,320 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Officers: Thomas J. Halloran, regional sales director.

Preferred Plus of South and West Texas

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: March 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 5,837 primary physicians.
Facilities: 103 hospitals.
Service area: 29 counties in Texas.
Services: Employees can select non-PPO providers; individual enrollment is not allowed.
Users: 10 employer/payer groups; 4,411 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers or by health care providers; charges a flat fee per eligible employee or by a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion; provided by the PPO.
Officers: Michael C. Weaver, senior account executive.

Premier HealthCare Group

12600 Northborough, Suite 300, Houston, Texas 77067; 713-873-8682

Operational date: 1986.
Sponsorship: Health Administration Services Inc.
Not for profit.
Staff: 654 primary physicians; 578 specialists; three administrative staff members; four marketing staff members; 64% board certified physicians.
Facilities: 23 hospitals.
Service area: Harris and Montgomery counties in Texas.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 15 employer/payer groups; 43,000 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Health Administration Services Inc.
Officers: Lauren Cullen, executive director; William B. Loweth, marketing director.

Private Healthcare Systems Ltd.

5215 N. O'Connor Blvd., Suite 1775, Irving, Texas 75039; 214-869-1451

Markets include Denver; San Antonio, Austin, Dallas and Houston, Texas; Oklahoma City.

See Private Healthcare Systems Ltd. under Massachusetts.

ProAmerica Network Inc.

714 Main St., Fort Worth, Texas 76102; 800-523-3669

Operational date: 1986.
Sponsorship: Transport Life Insurance Co.
Ownership: PriMerica Corp.
Staff: 20 administrative staff members.
Facilities: 919 hospitals.
Service area: 38 states and District of Columbia.
Services: Specialty services: substance abuse. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 358 employer/payer groups; 963,536 employees and dependents with network access; 1.4 million estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a combination system; is compensated by employers/payers, claims administrators; charges a percentage of savings to client.
Control measures: Provided by outside contractors.
Gross revenues: $596,000 in 1988; $2.1 million estimated in 1989.
Officers: Norman M. Bruce, chief operating officer; Dr. Wilson Weatherford, medical director; Krista Kay Nickovich, vp; Patsy M. Heath, vp-provider relations.

The Prudential Insurance Co.

8303 Mopac Expressway, Suite 210, Austin, Texas 78759; 512-465-6661

Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 120 primary physicians; 254 specialists; 42 administrative staff members; 11 marketing staff members; 94% board certified physicians.
Facilities: Five hospitals; 23 pharmacies; 11 diagnostic labs.
Service area: Travis, Hays, Bastrop, Williamson and Caldwell counties in Texas.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 141 employer/payer groups; 15,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by outside contractors.
Officers: E.M. Keathley Jr., executive director; Dr. Norman Chenven, medical director; Herman Wright Jr., marketing director.

Prudential Plus

6060 N. Central Expressway, Suite 750, Dallas, Texas 75206; 214-361-3802

Operational date: January 1987.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 469 primary physicians; 836 specialists; 75 administrative staff members; 29 marketing staff members; 95% board certified physicians.
Facilities: 24 hospitals; 90 pharmacies; 12 diagnostic labs.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers.
Users: 8,573 employees with single coverage; 6,426 employees with family coverage; 54,269 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Victor Lazzaro Jr., executive director-Health Care Management; Dr. Robert Jacquim, director-medical services; Joel Suarez, director-group marketing; Rusty Folk, vp-group operations.

Prudential Plus

613 N.W. Loop 410, Suite 600, San Antonio, Texas 78216; 512-366-1921

Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 163 primary physicians; 266 specialists; 11 marketing staff members; 110 average of patients per primary physician; 80% board certified physicians.
Facilities: 11 hospitals; 41 pharmacies; 13 diagnostic labs.
Service area: Bexar, Bandera, Frio, Atascosa, Wilson, Comal, Guadalupe, Karnes, Medina and Kendall counties in Texas.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 19,000 estimated employees and dependents with network access as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Robert L. Smith Jr., president; Dr. C. William Metcalf, medical director; Phillip W. Solomon, marketing director.

Prudential Plus-Houston

24 Greenway Plaza, Suite 500, Houston, Texas 77046; 713-993-3801

Operational date: January 1987.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 390 primary physicians; 405 specialists; 53 administrative staff members; 27 marketing staff members; 140 average of patients per primary physician; 98% board certified physicians.
Facilities: 17 hospitals.
Service area: Harris, Brazoria, Galveston, Montgomery, Fort Bend and Waller counties in Texas.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design cannot be customized; individual enrollment is not allowed.
Users: 25,232 employees with single cov-

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erage; 28,192 employees with family coverage; 53,424 employees and dependents with network access.

Control measures: Precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.

Officers: Vince Contorno, vp-healthcare management; Dr. James Gengelbach, medical director; Dewitt Smith, director-group marketing; David Butler, manager-administration.

Travelers Preferred-Austin

9442 Capital of Texas Highway North, Arboretum Plaza Two, Suite 600, Austin, Texas 78759; 512-338-6800

Operational date: March 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 327 primary physicians.
Facilities: Five hospitals.
Service area: Hayes, Travis and Williamson counties in Texas.
Services: Employees can select non-PPO providers at time of service; plan design can be customized; individual enrollment is not allowed.
Users: Seven employer/payer groups; 3,857 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Connie Barron, executive director; John Novelli, sales manager.

Travelers Preferred-Dallas/ Fort Worth

433 E. Las Colinas Blvd., Suite 750, Irving, Texas 75039; 214-506-0000

Operational date: March 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 717 primary physicians.
Facilities: 22 hospitals.
Service area: Collins, Dallas, Denton, Kaufman and Tarrant counties.
Services provided: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 63 employer/payer groups; 19,023 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: David Barker, executive director; John R. French, sales manager-Dallas; Robert G. Campbell Jr., sales manager-Fort Worth.

Travelers Preferred-Houston

2000 Post Oak Blvd., Houston, Texas 77056; 713-622-6667

Operational date: March 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 864 primary physicians.
Facilities: 23 hospitals.
Service area: Portions of Brazoria, Fort Bend, Galveston, Harris, Montgomery and Waller counties in Texas.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 40 employer/payer groups; 29,366 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Jeff Freeman, executive director; Richard C. Spears, sales manager.

Travelers Preferred-San Antonio

7550 IH 10 West, San Antonio, Texas 78230; 512-524-3300

Operational date: April 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 530 primary physicians.
Facilities: Nine hospitals.
Service area: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Kerr, Medina and Wilson counties in Texas.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 26 employer/payer groups; 3,623 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Thomas C. Jackson, executive director; Thomas G. Day, sales manager.



Great-West Care-Salt Lake City/Ogden

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Ownership: Premier Medical Network.
For profit.
Staff: 607 primary physicians.
Facilities: Six hospitals.
Service area: Davis, Morgan, Weber, Cache and Box Elder counties in Utah.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers at time of service; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

PM Group's PPO-Utah

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

Travelers Preferred-Salt Lake City

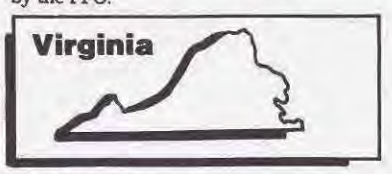
420 E. South Temple, Suite 420, Salt Lake City, Utah 84111; 801-531-6336

Operational date: May 1988.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 792 primary physicians.
Facilities: Nine hospitals.
Service area: Davis, Salt Lake, Utah, Wasatch, Summit and Weber counties in Utah.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 11 employer/payer groups; 3,736 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Sally Sjobeck, director-operations; James V. Skillings, sales manager.

ValueCare

P.O. Box 25956, Salt Lake City, Utah 84125-0956; 801-481-6179

Operational date: October 1984.
Sponsorship: Blue Cross & Blue Shield of Utah.
Staff: 1,400 primary physicians.
Facilities: 17 hospitals.
Service area: 10 counties in Utah.
Users: 61,246 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion; provided by the PPO.



CNA Managed Care PPO-Richmond

1101 Market St., 25th Floor, Philadelphia, Pa. 19107; 215-351-3842

Operational date: August 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 271 primary physicians; 75.3% board certified physicians.
Facilities: Five hospitals and medical facilities.
Service area: Henrico, Dinwiddie, Chesterfield, Powhatan and Hanover counties in Virginia.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 7,700 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate or by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Bill Gabel, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CarePASS-Virginia

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

EQUICOR Preferred-Hampton Roads/Virginia Beach

1801 W. End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

EQUICOR Preferred-Richmond

1801 W. End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Great-West Care-Richmond

8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 274 primary physicians.
Facilities: Five hospitals.
Service area: Amelia, Brunswick, Chesterfield, Dinwiddie, Greensville, Henrico, Isle of Wright, Nottoway, Southampton, Suffolk, Surry and Sussex counties in Virginia.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Two employer/payer groups; 100 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanagh and Jim Motz, vps; David Grapko, manager.

Hartford's PULSE Plan of the National Capital Area

Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

See Hartford PULSE Plan under District of Columbia.

KeyCare

2015 Staples Mill Road, Richmond, Va. 23279; 804-342-2322

Operational date: July 1983.
Sponsorship: Blue Cross & Blue Shield of Virginia.
Not for profit.
Staff: 4,447 primary physicians; 2,105 specialists; three administrative staff members; 85% board certified physicians.
Facilities: 55 hospitals; five diagnostic labs.
Service area: 54 counties in Virginia.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, physical therapy, chiropractic, speech therapy. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: 2,044 employer/payer groups; 198,000 employees and dependents with network access; 200,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Norwood Davis, chief executive officer-Blue Shield & Blue Cross of Virginia; Edward C. Peple Jr., director-KeyCare programs; Richardson Grinnan, chief operating officer.

Metropolitan Life Insurance Co.-Virginia

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

PARTNERS National Health Plans-Virginia

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

PruCare of Richmond

1000 Boulders Parkway, Richmond, Va. 23225; 804-323-0900

Operational date: October 1986.
Sponsorship: The Prudential Insurance Co. of America.
For profit.
Staff: 124 primary physicians; 295 specialists; 31 administrative staff members; 13 marketing staff members; average of 92 patients per primary physician; 98% board certified physicians.
Facilities: Eight hospitals; 14 pharmacies; one diagnostic lab.
Service area: 21 counties in Virginia.
Services: Specialty services: prescription drug, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design cannot be customized; individual enrollment is allowed.
Users: 12,000 employees and dependents with network access; 10,000 estimated as of Jan. 1, 1990.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service p determination, case management; provi by the PPO.
Officers: J. Philip Sheesley, direc group operations; Dr. Richard L. Sc macher, vp-medical services; Michael Trent, regional group manager.

PsychManagement Solution

1560 Wilson Blvd., Suite 1000, Arlington, Va. 22209; 703-528-225

Operational date: August 1985.
Sponsorship: Privately held mana ment corporation.
For profit.
Staff: 2,047 mental health/substa abuse specialists; 100 administrative st members; 15 marketing staff membe 100% board certified physicians.
Facilities: 187 hospitals.
Service area: Nationwide.
Services: Substance abuse, psychiat services. Employees can select non-P providers; plan design can be customiz individual enrollment is not allowed.
Users: 255 employer/payer grou 146,875 employees with family covera 352,500 employees and dependents w network access; 500,000 estimated as Jan. 1, 1990.
Compensation: The PPO negotiat hospital charges by per diem rate; is co pensated by employers/payers; charges flat fee per eligible employee.
Control measures: Preadmission hos tal review, precertification, concurre hospital treatment review, length of st determination, discharge planning, retr spective review, hospital bill audits, outp tient service predetermination, case ma agement; provided by the PPO.
Gross revenues: $6.3 million in 198 $11.6 million estimated in 1989.
Officers: Saul Honigstein, presiden Rick Helfrich, chief financial officer; D Daniel Patterson, medical director; Jol Hill, marketing director; Elizabeth Friber assistant vp-clinical operations; Tina Blas assistant vp-provider network operations

Travelers Preferred-Norfolk

100 W. Plume St., Norfolk, Va. 23510; 804-622-6711

Operational date: May 1988.
Sponsorship: The Travelers Insuranc Co.
For profit.
Staff: 507 primary physicians.
Service areas: Cities of Chesapeak Norfolk, Portsmouth, Suffolk and Virgini Beach in Virginia.
Facilities: Seven hospitals.
Services: Employees can select non PPO providers, plan design can be cus tomized, individual enrollment is not al lowed.
Users: Seven employer/payer groups 1,111 employees with single or family cov erage.
Compensation: The PPO negotiate hospital charges by per diem rate, by percent discount off customary rates fo individual services, by DRGs; is compen sated by employers/payers; charges a fla fee per eligible employee, percent of ser vices rendered by participating doctors hospitals.
Control measures: Preadmission hospi tal review, precertification, concurren hospital treatment review, length of stay determination, discharge planning, retro spective review, second surgical opinion hospital bill audits, case management; pro vided by The Travelers Insurance Co.
Officers: Mike Sherman, executive director; Susan J. Fiske, sales manager.

Travelers Preferred-Richmond

3 Parkway, Philadelphia, Pa. 19102; 215-557-6091

Operational date: March 1987.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,020 primary physicians.
Facilities: Six hospitals.
Service area: Chesterfield, Colonial Heights, Dinwiddie, Hanover, Henrico and Prince Georges counties; cities of Hopewell, Petersburg and Richmond in Virginia.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 52 employer/payer groups; 4,961 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retro-

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ive review, second surgical opinion, tal bill audits, case management; pro- l by The Travelers Insurance Co.
ficers: Pat Hedden, director of opera- ; Robert Moore, sales manager.

jinia Health Network
00 Beaufont Springs Drive, Suite 0, Richmond, Va. 23225; 4-320-3837

erational date: 1988.
onsorship: Hospitals.
r profit.
aff: 600 primary physicians; 323 spe- sts; one administrative staff member; marketing staff member; 83% board fied physicians.
cilities: 10 hospitals.
rvice area: 22 counties and 17 cities irginia.
rvices: Specialty services: substance e, psychiatric services, durable medi- equipment, podiatry, obstetrics/gyne- gy. Employees can select non-PPO pro- rs at time of service; plan design can be omized; individual enrollment is al- ed.
sers: Eight employer/payer groups; 6 employees and dependents with net- k access; 16,506 estimated as of Jan. 1,).
ompensation: The PPO negotiates pital charges a per diem rate, by a ent discount off customary rates for vidual services, by DRGs; is compen- d by employers/payers; charges a flat per eligible employee, percent of ser- es rendered by participating doctors/ pitals.
ontrol measures: Preadmission hospi- review, precertification, concurrent pital treatment review, length of stay ermination, discharge planning, retro- ctive review, second surgical opinion, pital bill audits, outpatient service pre- ermination, case management; provided outside contractors.
fficers: James W. Brittain, president; Robert O. Williams, medical director; J. vid Keplinger, vp-marketing.

Washington



ternative Choice Plan
Fourth & Battery Building, Suite 600, Seattle, Wash. 98121; 206-443-6383

Operational date: 1985.
Sponsorship: Washington Physicians rvice/Whatcom Medical Bureau.
Staff: 150 primary physicians.
Facilities: One hospital.
Service area: San Juan and Whatcom unties in Washington.
Users: 11,110 employees and dependents ith network access.
Control measures: Preadmission hospi- l review, second surgical opinion, con- rrent review, outpatient surgery, pro- ded by the PPO.

NA Managed Care PPO-Seattle
50 Fremont St., San Francisco, Calif. 94105; 415-243-4982

Operational date: August 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 514 primary physicians; 87.2% oard certified physicians.
Facilities: Eight hospitals and medi- al facilities.
Service area: King, Snohomish and Pierce counties in Washington.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gyn- ecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 9,900 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by Private Healthcare Systems Ltd.
Officers: Robert Shaffer, manager-major group sales; Kenneth H. Currier, manager-cost containment development; Dr. Phillip L. Bryson, associate medical director.

CIGNA FlexCare Preferred Provider Organization-Seattle
Hartford, Conn. 06106; 203-726-6904

See CIGNA FlexCare Preferred Provider Organization under Connecticut.

EQUICOR Preferred-Seattle/ Tacoma/Everett
1801 West End Ave., Nashville, Tenn. 37203; 615-340-3254

See EQUICOR Preferred under Tennessee.

Family Health Plan
11400 S.E. Eighth St., Suite 265, Bellevue, Wash. 98004; 206-455-9936

Operational date: July 1986.
Sponsorship: Metrocare National Inc.
For profit.
Staff: 1,200 primary physicians; 520 specialists; four administrative staff members; two marketing staff members.
Facilities: 33 hospitals; two diagnostic labs.
Service area: 16 counties in Washington.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 1,250 employer/payer groups; 90,000 employees and dependents with network access; 125,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers, health care providers, insurers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $744,000 in 1988; $1.1 million estimated in 1989.
Officers: Candace Sellers, president; Jeffrey W. Davis, vp; Dr. Thomas Taylor; medical director; Steve Gregg, chairman.

First Choice Health Network Inc.
1100 Olive Way, Suite 1480, Seattle Wash. 98101-1838; 206-292-8255

Operational date: January 1985.
Sponsorship: Hospitals and a group of doctors.
For profit.
Staff: 2,354 primary physicians; 1,544 specialists; 12 administrative staff members; one marketing staff member; average of 60 patients per primary physician; 77% board certified physicians.
Facilities: 42 hospitals; four diagnostic labs.
Service area: Washington and Oregon.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology, chiropractic, physical therapy; Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is allowed.
Users: 3,768 employer/payer groups; 112,000 employees and dependents with network access; 150,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs, by per-case rates; is compensated by employers/payers; charges a flat fee per eligible employee, percent savings and per admission.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, patterns of treatment, case management; provided by the PPO.
Officers: Clayton S. Field, president/executive director; Dr. Anna H. Chavelle, medical director; Ross D. Heyl, vp-marketing; Randy Barker, chief financial officer/vp-finance; Sherry G. Perry, vp-patient care services.

Great-West Care-Seattle
8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: August 1987.
Sponsorship: Great-West Life Assurance Co.
Ownership: Private Healthcare Systems Ltd.
For profit.
Staff: 879 primary physicians.
Facilities: Nine hospitals.
Service area: King, Snohomish, Kittitas, Pierce, Yakima, Lewis, Thurston, Kitsap and Mason counties in Washington.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Four employer/payer groups; 607 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Great-West Care-Washington State
8505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3519

Operational date: January 1989.
Sponsorship: Great-West Life Assurance Co.
Ownership: Family Health Plan of Washington.
For profit.
Staff: 462 primary physicians.
Facilities: 14 hospitals.
Service area: Lewis, Chenlan, Spokane, Walla Walla, Yakima, Grant, Lincoln, Whatcom and Cowlitz counties in Washington.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

John Hancock Preferred Health Plan-Washington
P.O. Box 111, Boston, Mass. 02117; 617-572-7036

See John Hancock Preferred Health Plan under Massachusetts.

Hartford's PULSE Plan of Seattle
Hartford Plaza, Hartford, Conn. 06115; 203-547-5000

Sponsorship: The Hartford Insurance Co.
For profit.
Staff: 450 primary physicians; 550 specialists.
Facilities: 13 hospitals; two diagnostic labs.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, large case management; provided by the PPO.

Metropolitan Life Insurance Co.-Washington
Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Mutually Preferred-Washington
Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-5100

See Mutually Preferred under Nebraska.

PM Group's PPO-Washington
17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Washington
5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Choice
Fourth & Battery Building, Suite 600, Seattle, Wash. 98121; 206-443-6383

Operational date: May 1985.
Sponsorship: Washington Physicians Service/Columbia Health Service.
Staff: 170 primary physicians.
Facilities: Two hospitals.
Service area: Clark County, Wash.
Users: 6,873 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, ambulatory surgery, physician peer review, morning admissions; provided by the PPO.

Preferred Health Network
P.O. Box 60308, Los Angeles, Calif. 90060; 213-261-9066

See Preferred Health Network under California.

The Preferred Plan
E. 3900 Sprague Ave., Terminal Annex, Spokane, Wash. 99202; 509-536-4644

Operational date: February 1986.
Sponsorship: Medical Service Corp. of Eastern Washington.
Staff: 737 primary physicians.
Facilities: Seven hospitals.
Service area: Benton, Franklin, Grant, Spokane and Whitman counties in Washington.
Users: 44,840 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion, case management; provided by the PPO.

The Preferred Plan
1114 Broadway Plaza, Tacoma, Wash. 98402; 206-597-6500

Operational date: January 1985.
Sponsorship: Pierce County Medical.
Not for profit.
Staff: 1,108 primary physicians; 906 specialists; 260 administrative staff members; 35 marketing staff members; 95% board certified physicians.
Facilities: 10 hospitals; seven diagnostic labs.
Service area: Pierce and southern King counties in Washington.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: 1,100 employer/payer groups; 70,000 employees and dependents with network access; 75,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $100 million in 1988; $106 million estimated in 1989.
Officers: Donald P. Sacco, president; Dr. Lester A. Reid, medical director; Martin R. Andrews, marketing director.

Preferred Plus of Washington
1295 State St., Springfield, Wash. 01111; 413-788-8411

Operational date: 1989.
Sponsorship: Massachusetts Mutual Life Insurance Co.
For profit.
Staff: 3,827 primary physicians.
Facilities: 47 hospitals.
Service area: Washington except Clark and Skamania counties.
Services: Specialty services: substance abuse, psychiatric services, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; PPO plan design may be customized; individual enrollment is not allowed.
Users: 146 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.
Contact: Philip K. Francis, account executive-Massachusetts Mutual Life Insurance Co.

Preferred Provider Arrangement
15700 Dayton Ave N., Seattle, Wash. 98133; 206-361-3873

Operational date: April 1986.
Sponsorship: Blue Cross of Washington & Alaska.
Staff: 5,286 primary physicians.
Facilities: 68 hospitals.
Service area: Washington; Anchorage, Fairbanks, Ketchikan and Seward counties in Alaska.
Users: 177,388 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, case management; provided by the PPO.

Preferred Provider Plan
Fourth & Battery Building, Suite 600, Seattle, Wash. 98121; 206-443-6383

Operational date: July 1986.
Sponsorship: Washington Physicians Service/Gray's Harbor Medical Bureau.
Staff: 75 primary physicians.
Facilities: One hospital.
Service area: Gray's Harbor and Pacific counties in Washington.
Users: 876 employees and dependents with network access.
Control measures: Preadmission hospital review, second surgical opinion, outpatient service predetermination, case management; provided by the PPO.

Preferred Provider Programs
Fourth & Battery Building, Suite 600, Seattle, Wash. 98121; 206-443-6383

Operational date: May 1985.
Sponsorship: Washington Physicians Service.
Staff: 650 primary physicians.
Facilities: Eight hospitals.
Service area: Clark, Gray's Harbor, Pacific, San Juan, Snohomish and Whatcom counties in Washington.
Users: 30,796 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion, case management; provided by the PPO.

Sound Health
1501 Fourth Ave., Suite 500, Seattle, Wash. 98101; 206-622-6111

Operational date: 1986.
Sponsorship: Four Hospitals.
Not for profit.
Staff: 3,827 primary physicians; 2,682 specialists; 80 administrative staff members; 10 marketing staff members; 90% board certified physicians.
Facilities: 47 hospitals; 19 diagnostic labs.
Service area: 29 counties in Washington, Oregon and Alaska.
Services: Specialty services: substance abuse, psychiatric services, durable medical equipment, podiatry, home health, hospice, radiology, nurse practitioners, obstetrics/gynecology. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: 1,917 employer/payer groups; 185,000 employees and dependents with network access; 201,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services, by DRGs, per case; is compensated by employers/payers, Hospitals, claims administrators; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; provided by the PPO and outside contractors.
Officers: Gerald Coe, president; Donald Stewart, medical director; Eve Stern, marketing director.

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TLC

Fourth & Battery Building, Suite 600, Seattle, Wash. 98121; 206-443-6383

Operational date: April 1986.
Sponsorship: Washington Physicians Service.
Staff: 360 primary physicians.
Facilities: Five hospitals.
Service area: Snohomish County in Washington.
Users: 2,228 with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, second surgical opinion, outpatient surgery, same day admit listed procedures, case management; provided by the PPO.

Travelers Preferred-Puget Sound

951 Mariners Island Blvd., Suite 680, San Mateo, Calif. 94404; 415-341-0810

Operational date: 1986.
Sponsorship: The Travelers Insurance Co.
For profit.
Staff: 1,230 primary physicians.
Facilities: Nine hospitals.
Service area: King, Pierce and Snohomish counties in Washington.
Services: Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.

Users: 48 employer/payer groups; 3,000 employees with single or family coverage.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services, by DRGs; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by The Travelers Insurance Co.
Officers: Roland King, executive director; Gail M. Ptacek, health plan manager; Robert A. LaPlant, sales manager.

West Virginia

CarePASS-West Virginia

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

See CarePASS under Minnesota.

MedSelect of West Virginia

One Hillcrest Drive, Charleston, W. Va. 25326; 304-347-1527

Operational date: 1986.
Sponsorship: Jefferson-Pilot and MCIG Inc.
For profit.
Staff: Three administrative staff members; one marketing staff member.
Facilities: 20 hospitals.
Service area: West Virginia and surrounding counties of Ohio, Virginia and Kentucky.
Services: Hospital only. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.

Users: 140 employer/payer groups; 17,000 employees and dependents with network access; 22,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audits, case management; provided by MedCert.
Gross revenues: $5.4 million in 1988; $6.2 million estimated in 1989.
Officers: Collen Briggs, executive director; Dave Cook, marketing director.

Metropolitan Life Insurance Co.-West Virginia

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co.

Preferred Blue

200 Kanawha Blvd. E., Charlesto W. Va. 25301; 304-347-7600

Operational date: 1985.
Sponsorship: Blue Cross & Blue S of West Virginia.
Not for profit.
Staff: 1,200 primary physicians; 680 cialists; four administrative staff mem eight marketing staff members; avera 10 patients per primary physician; board certified physicians.
Facilities: 21 hospitals.
Service area: West Virginia and ad ing counties of Ohio.
Services: Specialty services: pres tion drug, vision, substance abuse, psy atric services, durable medical equipm obstetrics/gynecology. Employees can lect non-PPO providers; plan design ca customized; individual enrollment is allowed.
Users: 240 employer/payer groups; 3 employees with single coverage; 7,700 ployees with family coverage; 23,000 ployees and dependents with network cess; 24,000 estimated as of Jan. 1, 199
Compensation: The PPO negoti hospital charges by per diem rate or case; is compensated by employers/pay charges a flat fee per eligible emplo percent of services rendered by particip ing doctors/hospitals.
Control measures: Preadmission ho tal review, precertification, concurr hospital treatment review, length of s determination, discharge planning, ret spective review, second surgical opini outpatient service predetermination, c management, subscriber assistance; p vided by Blue Cross & Blue Shield of W Virginia.
Gross revenues: $12.8 million in 19 $14.2 million estimated in 1989.
Officers: James W. Heaton, president

Continued on next p

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rd A. Deluca, executive director; Patrick Williams Jr., Thomas Clark ee Pratt, medical directors; Shir- acobs, director-operations; Ken , director-regional sales/marketing es; Gary Lavender, director-spe- ccounts.

erred Plus f West Virginia

95 State St., Springfield, Mass. 111; 413-788-8411

erational date: March 1988.
onsorship: Massachusetts Mutual Insurance Co.
r profit.
aff: 1,200 primary physicians.
cilities: 15 hospitals.
rvice area: Ohio and Marshall coun- n West Virginia; Belmont and south- efferson counties in Ohio.
rvices: Specialty services: psychiatric ces, obstetrics/gynecology. Employees elect non-PPO providers; plan design be customized; individual enrollment t allowed.
ers: Three employer/payer groups; employees and dependents with net- c access.
ntrol measures: Preadmission hospi- eview, precertification, concurrent ital treatment review, length of stay rmination, discharge planning, retro- tive review, second surgical opinion, atient service predetermination, case agement; provided by the PPO.
ontact: James J. Stewart, regional s director-Massachusetts Mutual Life rance Co.



sociates for Health Care Inc.

150 N. Sunnyslope Road, Brookfield, Wis. 53005; 414-784-9007; 800-952-8661

Operational date: 1984.
Sponsorship: Private.
For profit.
Staff: 545 primary physicians; 330 specialists; 240 administrative staff members; 0 marketing staff members; average of 0 patients per primary physician.
Facilities: 15 hospitals; 26 pharmacies; 1 diagnostic lab.
Service area: Milwaukee, Waukesha, Washington, Ozaukee and Kenosha counties in Wisconsin.
Services: Specialty services: prescription drug, vision, dental, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology, chiropractors, physical therapy. Employees can select non-PPO providers; plan design can be customized; individual enrollment is allowed.
Users: More than 1,045 employer/payer groups; 50,250 employees and dependents with network access; 65,325 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning; provided by the PPO.
Officers: Richard L. Blomquist, president; Robert J. Zimmerman, marketing director; Judy A. Grimes, vp.

CNA Managed Care PPO-Milwaukee

CNA Plaza, 22 W, Chicago, Ill. 60685; 312-822-7626

Operational date: April 1987.
Sponsorship: CNA Financial Corp.
For profit.
Staff: 693 primary physicians; 57% board certified physicians.
Facilities: Nine hospitals and medical facilities.
Service area: Kenosha, Milwaukee, Ozaukee, Sheboygan and Waukesha counties in Wisconsin.
Services: Specialty services: substance abuse, psychiatric services, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 3,800 employees and dependents with network access.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, case management; provided by Private Healthcare Systems Ltd.
Officers: Alan MacLennan, senior vp; Dr. Jeffrey Kraines, medical director; Robert Kavanaugh and Jim Motz, vps; David Grapko, manager.

Metropolitan Life Insurance Co.-Wisconsin

Managed Care Services Group, 276 Post Road W., Westport, Conn. 06880; 203-454-6100

See Metropolitan Life Insurance Co. under Connecticut.

Network Exclusive Provider Option Inc.

111 W. Pleasant St., Milwaukee, Wis. 53212; 414-233-3300; 800-289-0260

Operational date: October 1987.
Sponsorship: 14 hospitals.
Ownership: CareNetwork Inc.
For profit.
Staff: 2,312 primary physicians; 1,549 specialists; 130 administrative staff members; 22 marketing staff members; average of 10 patients per primary physician; 100% board certified physicians.
Facilities: 14 hospitals; 350 pharmacies.
Service area: Milwaukee, Waukesha, Ozaukee, Washington and Sheboygan counties in Wisconsin.
Services: Specialty services: prescription drug, vision, chiropractic, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can not select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: 30 employer/payer groups; 3,100 employees with single coverage; 1,950 employees with family coverage; 7,800 employees and dependents with network access; 12,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Kipton Kaplan, chief executive dirctor/president; Dr. Carl F. Myers, vp-medical affairs; Thomas R. Sobocinski, vp-marketing; Mark E. Daley, chief operating officer/vp-operations; Craig Kasten, vp-operations/systems.

PM Group's PPO-Wisconsin

17360 Brookhurst St., Fountain Valley, Calif. 92708; 714-760-4027

See PM Group's PPO under California.

PARTNERS National Health Plans-Wisconsin

5215 N. O'Connor Road, Irving, Texas 75039; 214-869-2500

See PARTNERS National Health Plans under Texas.

Preferred Health Insurance Corp.

1101 N. Market St., Milwaukee, Wis. 53202; 414-347-0500

Operational date: 1987.
Ownership: Samaritan Health Plan and Wausau Insurance Cos.
For profit.
Staff: 1,200 primary physicians; 727 specialists; two administrative staff members; 30 marketing staff members.
Facilities: 14 hospitals; network of pharmacies.
Service area: Milwaukee, Waukesha, Washington, Ozaukee, Racine and Kenosha counties in Wisconsin.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, obstetrics/gynecology. Employees can select non-PPO providers; PPO plan design can be customized; individual enrollment is not allowed.
Users: 81 employer/payer groups; 1,176 employees with single coverage; 2,145 employees with family coverage; 8,493 employees and dependents with network access; 10,000 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a per diem rate, by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a flat fee per eligible employee.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, case management; provided by the PPO.
Gross revenues: $4.5 million estimated in 1989.
Officers: James M. Magalska, president; James H. Yahnke, executive director; Dr. A. Yale Gerol, medical director; William Hattendorf and Michael Silgen, marketing directors.

Preferred Provider Option

401 W. Michigan St., Milwaukee, Wis. 53201; 414-224-6000

Operational date: January 1984.
Sponsorship: Blue Cross & Blue Shield United of Wisconsin.
Staff: 1,650 primary physicians.
Facilities: 23 hospitals.
Service Area: 22 counties in Wisconsin.
Users: 50,925 employees and dependents with network access.
Control measures: Preadmission hospital review, concurrent hospital treatment review, discharge planning, second surgical opinion, case management; provided by outside contractors.

Wausau Preferred Care-Appleton

2000 Westwood Drive, Wausau, Wis. 54402; 715-847-6896

Operational date: January 1989.
Sponsorship: Wausau Insurance Co.
For profit.
Staff: 92 primary physicians; 59 specialists; eight administrative staff members; six marketing staff members; average of 33.4 patients per primary physician; 98% board certified physicians.
Facilities: Two hospitals; one diagnostic lab.
Service area: Outagamie and Winnebago counties in Wisconsin.
Services: Specialty services: vision, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Seven employer/payer groups; 129 employees with single coverage; 1,102 employees and dependents with network access; 2,000 estimated as of Jan. 1, 1990.
Compensation: The PPO is compensated by employers/payers; charges a standard rate to policyholders.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $2.8 million estimated in 1989.
Officers: Tom Langman, administrator.

Wausau Preferred Care-Eau Claire

2000 Westwood Drive, Wausau, Wis. 54402; 715-847-6896

Operational date: July 1989.
Sponsorship: Wausau Insurance Co.
For profit.
Staff: 219 primary physicians; 140 specialists; five administrative staff members; three marketing staff members; 70% board certified physicians.
Facilities: Two hospitals; five diagnostic labs.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Compensation: The PPO negotiates hospital charges by a per diem rate; is compensated by employers/payers; charges a standard rate to policyholders.
Control measures: Concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Officers: Scott Layman, administrator.

Wausau Preferred Care-La Crosse

2000 Westwood Drive, Wausau, Wis. 54402; 715-847-6896

Operational date: April 1989.
Sponsorship: Wausau Insurance Co.
For profit.
Staff: 187 primary physicians; 112 specialists; four administrative staff members; four marketing staff members; average of 8.5 patients per primary physician; 75% board certified physicians.
Facilities: Four hospitals; one pharmacy; one diagnostic lab.
Service area: La Crosse, Buffalo, Crawford, Jackson, Monroe, Trempealeau and Vernon counties in Wisconsin.
Services: Specialty services: prescription drug, vision, substance abuse, psychiatric services, durable medical equipment, podiatry, obstetrics/gynecology. Employees can select non-PPO providers; plan design can be customized; individual enrollment is not allowed.
Users: Two employer/payer groups; 122 employees with single coverage; 156 employees with family coverage; 638 employees and dependents with network access; 700 estimated as of Jan. 1, 1990.
Compensation: The PPO negotiates hospital charges by a percent discount off customary rates for individual services; is compensated by employers/payers; charges a standard single/family rate to policyholders.
Control measures: Preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, case management; provided by the PPO.
Gross revenues: $43,000 estimated in 1989.
Officers: Steve Kunes, administrator. ■

Guide to multi-state plans

American Health Network: PPO-California, Florida, Texas
Beech Street PPO: PPO-California
Blue Cross & Blue Shield Sponsored Plans: HMO & PPO-Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Virginia, Washington, Wisconsin, Wyoming; HMO only-Alabama, Delaware, Maine, Massachusetts, Montana, New Jersey, North Dakota, Texas; PPO only-Louisiana, Mississippi, Nevada, South Dakota, West Virginia
CNA Managed Care: PPO-Alabama, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, Washington, Wisconsin
CAPP CARE: PPO-See California
CarePASS: Arizona, Florida, Illinois, Indiana, Iowa, Kentucky, Maryland, Minnesota, Pennsylvania, South Dakota, Texas, Virginia, West Virginia
CIGNA Corp. Sponsored Plans: HMO & PPO-Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Missouri, Ohio, Pennsylvania, Texas, Washington; HMO only-Delaware, Maryland, Massachusetts, New Jersey; PPO only-Indiana, Louisiana, Minnesota, New Mexico, Puerto Rico, Oklahoma, Oregon, Tennessee, Wisconsin
Community Health Plan Inc.: HMO-Massachusetts, New York, Ohio, Vermont
Delta Care: HMO-See California
EQUICOR Sponsored Plans: HMO & PPO-Arizona, California, Colorado, Florida, Illinois, Kansas, North Carolina, Oklahoma, Tennessee, Texas, Virginia; PPO only-Indiana, Michigan, Missouri, New Mexico, Oregon, Pennsylvania, Washington; HMO only-Utah
FHP Healthcare: HMO-Arizona, California, Guam, New Mexico, Utah
Family Health Plan: PPO-Minnesota, North Carolina, Washington
Great-West Care: Alabama, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin
John Hancock Preferred Health Plan: PPO-California, District of Columbia, Florida, Illinois, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Ohio, Oregon, Pennsylvania, Texas, Washington
Hartford's Pulse Plan: PPO-California, District of Columbia, Florida, Kansas, Maryland, Minnesota, Missouri, North Carolina, Pennsylvania, Tennessee, Texas, Virginia, Washington
Health Insurance Plan of Greater New York: HMO-See New York
HealthPlus Inc.: HMO-Washington, Maryland
Healthsource: HMO-Maine, New Hampshire
Humana Health Care Plans: HMO & PPO-Alabama, Arizona, Colorado, Florida, Indiana, Kentucky, Nevada, Texas; PPO only-Tennessee
Independent Health: HMO-New York, Pennsylvania
Kaiser Foundation Health Plan Inc.: HMO-California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Kansas, Massachusetts, North Carolina, Ohio, Oregon, Texas, New York
Lincoln National Sponsored Plans: HMO & PPO-California, Indiana, Kansas, Maryland, Missouri, North Carolina, Ohio; HMO only-Arizona; PPO only-Colorado, Georgia, Illinois, Nebraska, Texas
Maxicare Health Plans Inc.: HMO-California, Illinois, Indiana, Louisiana, North Carolina, South Carolina, Wisconsin
Med Network: See California
MetLife Sponsored Plans: HMO & PPO-Arizona, California, Colorado, Florida, Georgia, Illinois, Missouri, New Jersey, Ohio, Rhode Island, Texas, Wisconsin; HMO only-Kansas, Kentucky, Massachusetts, New York; PPO only-Alabama, Connecticut, Delaware, District of Columbia, Louisiana, Mississippi, Nevada, New Hampshire, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, Wisconsin
Mutually Preferred: Alabama, Arizona, California, Colorado, Illinois, Indiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, Ohio, Oregon, Texas, Washington
PM Group's PPO: Alabama, Arizona, California, Colorado, Florida, Illinois, Indiana, Michigan, Mississippi, Nebraska, New Mexico, Ohio, Oregon, Tennessee, Texas, Utah, Washington, Wisconsin
Pacific Mutual's PPO: PPO-Arizona, Washington, California, Colorado, Florida, Illinois, Ohio, Texas, North Carolina, Oregon
Pacificare Health Systems: HMO-California, Oklahoma, Oregon, Texas
Partners National Health Plans: HMO & PPO-Alabama, Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington, Wisconsin
Physicians Health Services: PPO-Connecticut, New York
Preferred Care: PPO-Arizona, Mississippi, Missouri, North Carolina, Tennessee
Preferred Health Network: PPO-Alaska, Arizona, California, Illinois, Nevada, Oregon, Washington
Preferred Plus: PPO-California, Colorado, District of Columbia, Florida, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Washington, West Virginia
Preferred Provider Program: Hawaii, New Jersey, New Mexico, Pennsylvania, Washington
Private Healthcare Systems Ltd.: PPO-California, Georgia, Illinois, Massachusetts, Ohio, Tennessee, Texas
Prudential Insurance Co. of America sponsored plans: HMO & PPO-Connecticut, Florida, Georgia, Illinois, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia; PPO only-Arkansas, California, Colorado, District of Columbia, Indiana, Maryland, Massachusetts, Michigan
Prudent Buyer Plan: PPO-California, Nevada
Select Care Inc.: PPO-Maryland, Minnesota
Travelers Sponsored Plans: HMO & PPO-California, Louisiana, New York, Texas, Virginia; PPO only-Arizona, Colorado, Connecticut, District of Columbia, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington
U.S. Healthcare Inc.: HMO-See Pennsylvania ■



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Update

Top 20 brokers Jardine, Financial Guardian to merge

SAN FRANCISCO—Top 20 brokers Jardine Emett & Chandler Inc. and Financial Guardian Group Inc. have announced plans to merge.

Under terms announced last week, Jardine, the nation's ninth-largest broker based on 1988 gross revenues of $96 million, will acquire all outstanding common shares of FG, the 14th-largest broker based on 1988 gross revenues of $35.2 million, for $11 per share.

Jardine is the U.S. insurance bro-

Continued on next page

Capacity short for Soviet risks



Rates up 30% to 100% for contract coverage

By STACY SHAPIRO

LONDON—Capacity for political risk insurance covering the cancellation or repudiation of contracts involving the Soviet Union is down sharply and rates have increased.

Nine months ago, as much as $100 million in limits could be assembled in the worldwide market for a contract frustration policy involving the Soviet Union.

Today, however, "it would be difficult to place $30 million to $40 million," says Anthony Palmer, marketing director of Berry Palmer & Lyle Ltd., one of London's leading political risk brokers.

And rates are going up 30% to 100%.

The main reason for the tightening market for contract frustration insurance is the huge demand for this coverage by Western companies supplying goods to the Soviet Union or involved in construction contracts there.

Since Soviet President Mikhail Gorbachev introduced "glasnost," his policy of greater openness with the West in 1986, Western companies have increasingly invested in and traded with the Soviet Union. As a result, these companies have been flocking to buy political risk insurance policies that cover contract frustration, or losses sustained because of the cancellation or repudiation of contracts as a result of political acts by the Soviet government.

Contract frustration policies usually include coverage for export credit risks, which protects against losses stemming from non-payment for goods after they have been received by a foreign buyer.

The demand for contract frustration policies in the Soviet Union increased even more after the Chinese government cracked down on students in Tiananmen Square in Beijing in June (*BI*, June 12), according to Mr. Palmer.

Western companies "looked at China and wondered what would happen if the Soviet

Continued on page 60

Texas takes the bull by the horns

Work comp reforms expected to control litigation, cost surge

By MICHAEL BRADFORD

AUSTIN, Texas—A sweeping workers compensation reform law enacted last week in Texas is expected to control rising costs, principally by reducing litigation and doctor shopping by injured workers.

The new law, effective Jan. 1, 1991, will scrap most of Texas' unusual trial de novo system, which has led to nearly all Industrial Accident Board decisions being challenged with an appeal for a jury trial.

Instead, appeals of work comp awards handed down by a member of the newly created Texas Workers Compensation Commission will be subject to additional administrative appeals steps before they can reach a jury trial.

And workers will be permitted to switch doctors only with the permission of the insurer or the commission, a six-member panel that will replace the state's three-member Industrial Accident Board.

In addition, large employers in Texas will be able to self-fund workers compensation risks for the first time beginning in 1993 under the law that ends more than a year of debate over how to reform the state's expensive workers compensation system.

Texas businesses and insurers are praising the law, which also:

- Requires the use of an impairment rating schedule instead of loss of wage-earning capacity to determine disability benefits.
- Calls for improved workplace safety.
- Raises the relatively low weekly disability benefits injured workers receive to a level comparable to those of other states.
- Mandates work comp rate rollbacks if they are actuarially sound.



The law was called "the most hard-fought and the most significant piece of legislation to come out of the Texas Legislature in 20 years" by Gov. Bill Clements when he signed it last Wednesday. The legislation was passed last Tuesday during the second special session of the Legislature called specifically to address the work comp issue.

"Let there be no mistake, the black eye on our business community has just been lifted," the governor declared. "No longer will jobs and new investment go to other states because of our workers compensation laws."

During the reform debate, advo-

Continued on page 61

Insurers vow to fight state antitrust suit

By MICHAEL BRADFORD

AUSTIN, Texas—Insurance industry defendants in the Texas antitrust lawsuit say they expected a state judge's recent decision not to dismiss the case and are vowing to fight the suit rather than settle out of court.

"We put a very high price on our reputation," said one insurer defendant, rejecting even the idea of an out-of-court settlement.

Without explanation, Texas District Court Judge Peter Lowry earlier this month rejected insurers' motion for summary judgment (*BI*, Dec. 11).

Insurers had asked for dismissal on the grounds that the suit is baseless and part of a personal attack by Texas Attorney General Jim Mattox. Defendants also cited the September dismissal of a similar antitrust suit in federal court (*BI*, Oct. 30).

Discovery proceedings in the Texas case will begin soon and are expected to last at least a year, say defendants and a spokeswoman for Mr. Mattox.

While most of the insurer defendants now say they did not expect Judge Lowry to dismiss the Texas action, they were far more optimistic immediately after the September dismissal of the federal suit. At the time, defendants' attorneys said the federal ruling was "very helpful" and "added credibility" to their argument and that "the facts are identical."

But a spokesman for the Texas attorney general had said that industry defendants were "dreaming," because the state and federal lawsuits were unrelated.

"It was just one ruling, from one district judge in California," the attorney general's spokeswoman reiterated last week.

In seeking a summary judgment, the Texas defendants frequently cited U.S. District Judge William

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Update

Jardine, FG plan to merge

Continued from previous page
kerage unit of Jardine Matheson Holdings Ltd. of Hong Kong and Bermuda.

The merger is subject to approval by FG's board and federal and state regulators.

Seventy-five percent of FG's 2 million outstanding shares are owned by employees. Former employees and retirees hold the rest.

While the merged brokerage operations are projected to produce combined 1989 gross revenues of about $139 million, the new company will not move ahead in the *Business Insurance* rankings of the 20 largest U.S. brokers. The eighth-largest broker, Arthur J. Gallagher & Co., produced 1988 gross revenues of $156 million (*BI,* June 26).

For 1989, Jardine projects about $104 million in gross revenues, and FG expects to generate about $35 million in gross revenues, according to George W. Brown, Jardine president and chief executive officer.

As a result of the merger, San Francisco-based Jardine will pick up new locations in Detroit, Wichita, Kansas City and Anchorage.

Jardine has 35 U.S. offices and 1,100 employees. Kansas City, Mo.-based FG has 12 offices and 390 employees.

Separately, FG announced that it and former managing general agency subsidiary World American Underwriters Inc. have settled a longstanding fraud suit filed by Omaha Indemnity Co. Among other things, the suit charged World American with concealing premiums (*BI,* April 28, 1986). Terms of the settlement were not disclosed.

FG and World American had been named in 1986 litigation that Omaha Indemnity also filed against MGA Royal American Managers Inc., several RAM affiliates and top RAM officers.

Omaha Indemnity won a $225 million arbitration award against RAM earlier this year (*BI,* June 12). The suit against RAM affiliates and officers is pending.

Members flee Lloyd's syndicate

LONDON—About 1,500 of the 1,870 members of Lloyd's of London excess-of-loss reinsurance syndicate 298 have resigned because members face an estimated loss of 32 million pounds ($57.9 million) on XL claims from the Piper Alpha oil platform loss, said Hugo Pilch, a director of Gooda & Partners Ltd., which manages the syndicate.

The reduction in membership cuts the syndicate's capacity 86.6% to 6 million pounds ($9.7 million at current exchange rates) for 1990 from 44.7 million pounds ($80.9 million at year-end 1988 exchange rates) this year.

Due to the drop in underwriting capacity, syndicate 298—which already has written about 3 million pounds of premiums ($4.8 million) for the 1990 account—will not write any more business for 1990. But, the managing agency plans to appoint a new underwriter for the syndicate to replace Stan Andrews, who resigned, and it intends to continue writing in 1991, Mr. Pilch said.

Several other Lloyd's syndicates also have been hit hard by the Piper Alpha losses spiralling through LMX policies (*BI* Nov. 13; Aug. 28; May 29). Sources predict that more syndicates, particularly in the LMX market, will face massive claims and membership losses.

Saunders sentenced for fraud

PHILADELPHIA—Jonathan P. Saunders has been sentenced to six years in prison and ordered to pay $617,499 in fines and restitution for fraud related to his operation of two offshore insurers.

U.S. District Judge Robert S. Kelly sentenced Mr. Saunders Dec. 11 to six years on each of five fraud charges and five years on each of 21 other fraud charges on which a federal jury convicted him in July. The prison terms are to run concurrently.

The jury found Mr. Saunders guilty of mail, wire and bank fraud and other charges related to his operation of North American Fire & Casualty Co. and Commercial Inland & Marine Indemnity Co., both purportedly based in St. Kitts, British West Indies (*BI,* July 31).

Mr. Saunders was indicted last December for misrepresenting the insurers' finances, trying to open a U.S. trust account for Commercial Inland with a phony check and receiving nearly $200,000 in premiums for Commercial Inland policies from five agents.

Mr. Saunders will be credited for time served since his conviction.

Jury hits Toyota for $43 million

HOUSTON—Toyota Motor Corp. says it has sufficient product liability insurance to cover a $43.2 million award to a Houston woman whose family burned to death in a 1982 car fire.

However, the company will ask a Texas district judge in Houston to set aside a Dec. 13 jury award of $18.2 million in actual damages and $25 million in punitive damages, which are insurable in Texas, said Douglas West, vp and general counsel-products for co-defendant Toyota Motor Sales-U.S.A. Inc., Toyota's Torrance, Calif.-based subsidiary.

Mr. West said Toyota, which already has exhausted its self-insured retention, as well as its first layer of excess liability insurance for 1982, has an additional excess layer written by Japanese insurer Tokio Marine & Fire Insurance Co. Ltd. Great American Insurance Co. in Cincinnati writes its highest layer, he said.

Plaintiff Nike Adegbite's husband and two daughters were killed on a Houston highway when their 1973 Toyota Corona station wagon was struck from behind by a van and burst into flames. Ms. Adegbite was not seriously injured.

An empty spare tire carrier punctured the fuel tank, causing the fire, argued Ms. Adegbite's attorney, Stan Pfeiffer of the Houston firm Whittington, Pfeiffer & Vacek. He contended that Toyota should have instructed drivers to always have the spare in place to act as a cushion in case of rear-end impact.

The plaintiff also will seek $13.5 million in prejudgment interest.

Continued on page 62

Errors & omissions

• A section of copy was inadvertently omitted from the Dec. 4 Ask a Benefit Actuary column. The restored copy appears on page 35.

NAIC adopts new rules for reinsurance brokers

By MEG FLETCHER

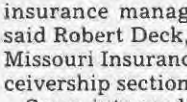
LAS VEGAS, Nev.—Reinsurance intermediaries can expect closer scrutiny from the companies that use them as well as from state regulators following adoption of a new model act by the National Assn. of Insurance Commissioners.

The Reinsurance Intermediary Model Act, approved at the NAIC winter meeting Dec. 3-7, calls for this scrutiny and sets up guidelines for intermediaries and the insurers or reinsurers that use them.

By enacting the model law, states can extend many of the safeguards in the new NAIC Managing General Agents Act and New York state regulations to cover most reinsurance managers and brokers, said Robert Deck, supervisor of the Missouri Insurance Department receivership section (*BI,* Sept. 25).

Some intermediaries involved in recent insolvencies have skirted efforts at regulatory control, Mr. Deck said.

"The main thrust is for regulators to get jurisdiction over people that have the pen of a reinsurer," said Stewart Keir, assistant bureau chief of the New York Insurance Department's Property/Casualty Insurance Bureau. The act is also needed to regulate reinsurance brokers who may handle large amounts of money, he said.



Under the model law, a reinsurance intermediary-broker and reinsurance intermediary-manager would often need to be licensed as either a reinsurance intermediary or as a "licensed producer," which can include being licensed as a reinsurance intermediary, an agent or a broker.

For example, a broker with an office in one state, say New Jersey, must be a licensed producer in New Jersey. A broker with an office in another state could meet the requirement if he were licensed: a a producer in New Jersey; or as non-resident reinsurance interme diary in New Jersey; or as a li censed producer in a state wit laws similar to New Jersey's.

The model law is the same for reinsurance intermediary-manage in those situations. But in addition if the manager is representing New Jersey-domiciled reinsure the manager also must be license as a producer in New Jersey.

The model law allows a commis sioner to refuse to issue a reinsur ance intermediary license if th applicant is "untrustworthy." I also gives a commissioner the au thority to require a manager to fil a bond of unspecified amount t protect each reinsurer with whic it deals.

A manager is defined as a perso or unit that has the authority t bind or manage all or part of the assumed reinsurance business of a

Continued on page 5

Outwaite runoff policy settled for $42 million

By CAROLYN ALDRED

LONDON—Lloyd's of London underwriter Richard Outhwaite will pay more than $41 million to settle a runoff reinsurance policy he wrote for a syndicate formerly underwritten by Lloyd's Chairman Murray Lawrence.

Mr. Outhwaite has agreed to pay $41.9 million to settle a 66.66% share of an unlimited runoff reinsurance policy he wrote for syndicate 362, managed by Murray Lawrence & Partners Ltd.

The settlement is the latest of about a dozen deals Mr. Outhwaite has made to settle claims on runoff reinsurance policies he wrote for fellow Lloyd's underwriters and London market companies in the early 1980s.

This year alone Mr. Outhwaite's settlements with eight syndicates and companies could cost members of his syndicate's 1982 underwriting year at least $250 million (*BI,* Nov. 13; July 31; July 3).

As a result, syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., has successfully capped previously unlimited liability policies, reducing the uncertainty faced by members of the syndicate's still-open 1982 underwriting account.

Mr. Outhwaite also is still disputing claims from at least three runoff reinsurance contracts he wrote for Lloyd's syndicates that arbitration umpires already have declared valid.

In settling with syndicate 362, Mr. Outhwaite agreed to pay $13.33 million in cash Jan. 1; $13.87 million July 1; and $14.67 million Jan. 1, 1996.

The payments represent about two-thirds of syndicate 362's estimated outstanding and incurred-but-not-reported losses of $62 million due under the policy.

In return, Mr. Outhwaite will not be liable for any further losses.

If total incurred losses remain less than $62 million by Dec. 31, 2001, syndicate 362 will reimburse syndicate 317/661 a prorated amount.

In a press release outlining the agreement, the Murray Lawrence

Continued on page 62

BI offers directory of HMOs, PPOs

The 1989-1990 *Business Insurance* Directory of HMOs and PPOs is now available.

The directory, published as a 53rd issue of *Business Insurance,* was mailed late last week to all *Business Insurance* subscribers.

The 100-page directory contains detailed information on 380 health maintenance organizations and 689 preferred provider organizations.

The issue also includes articles on the HMO and PPO marketplaces, employee benefit managers' views on managed health care and the growing trend among employers to contract directly with hospitals for health care services for their employees.

Single copies of the *Business Insurance* 1989-1990 Directory of HMOs and PPOs car. be purchased for $25, plus postage, by contacting Jack Kennedy, Single Copy Sales, *Business Insurance,* Crain Communications Inc., 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-992-9970.

Inside

✔ The U.S. Commerce Department report on the Risk Retention Act is a good first step toward clarifying the regulation of risk purchasing groups, says this week's editorial. **PAGE 8**

✔ This week's employee benefit market report, beginning on page 3, continues with a look at the long-term disability insurance market and the market for dental coverage on **PAGES 19-24**

✔ In Perspectives, attorney Tomas Russell describes the liberal capitalization laws that make Illinois an attractive captive insurance company domicile. **PAGE 35**

✔ Liquidator Charles Kempe says his top priority is to proceed with the liquidation of Mentor Insurance Ltd. without further distractions. **PAGE 59**

✔ Analyst Leonard M. Wilson says brokers' earnings are likely to accelerate next year, regardless of how firm insurance rates become. **PAGE 63**

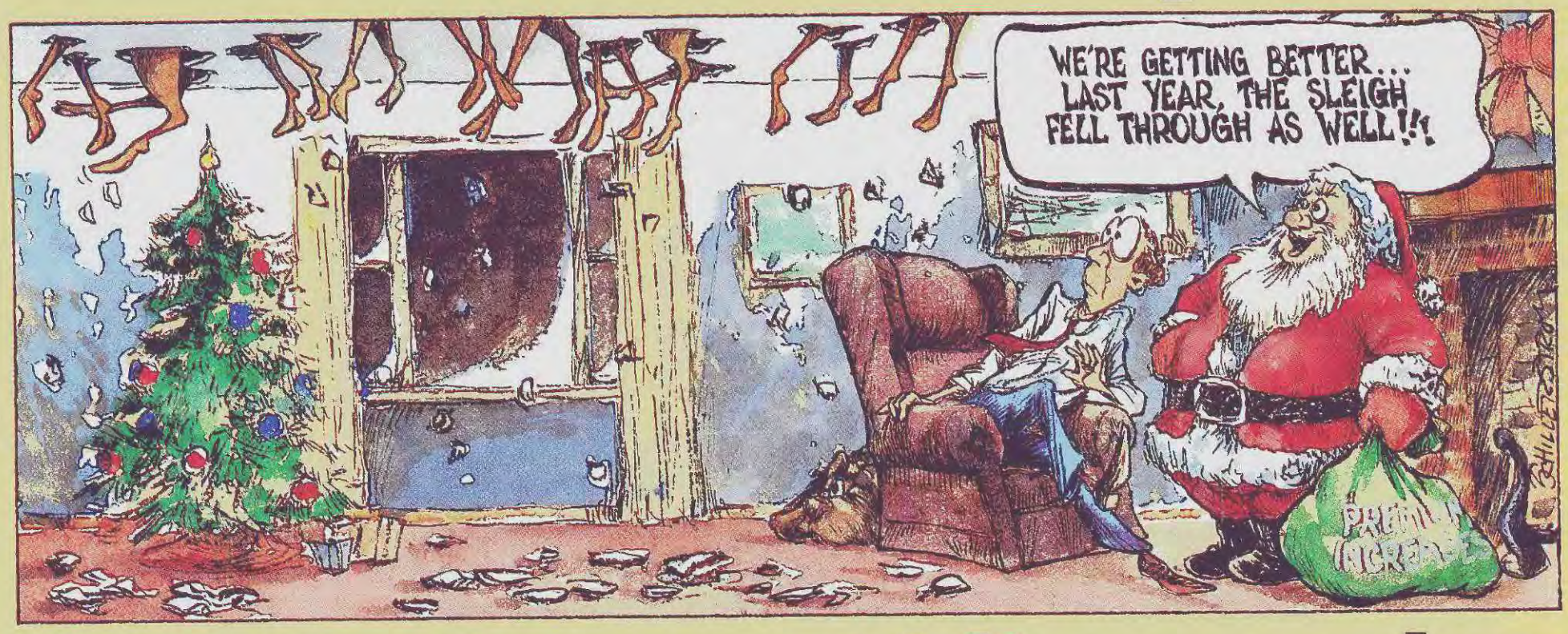
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Spotlight report

Benefits marketplace



Health plan cost hikes easing

But '90 premiums up 10%-30%

By MICHAEL SCHACHNER

Employee benefit managers' holiday season will not be quite so glum this year, yet there won't be an abundance of holiday cheer.

The size of group health indemnity plan and health maintenance organization premium increases is expected to plateau and may even decline in many cases next year.

But, indemnity plan premiums, which soared between 20% and 50% in 1989, still are expected to increase between 20% and 25% and, in some cases, could rise as much as 30% next year.

Self-insured employers expect health care costs to increase between 10% and 25% in 1990, which is about the same pace at which their costs were increasing in mid-1989 (*BI*, Aug. 21).

And, employers that offer HMOs can expect those premiums to generally increase between 10% and 20% next year, although at least one HMO expects to increase premiums for some employers as much as 30%.

The forecast of somewhat lower premium increases in 1990 is possible because health insurers and HMOs now are more confident that their rates have caught up with health care cost inflation, benefit experts say.

For example, while the projected trend lines for 1990 health care cost increases range from 20% to 24%—the same as in 1989—indemnity plan insurers say they will not be raising premiums next year above the projected trend lines, as they have in previous years.

Trend lines take into account several factors, including the projected increase in overall health care cost inflation; the effects of cost-shifting against indemnity plans by Medicare, Medicaid and managed care plans; the added cost of technological advances; and catastrophic claims.

While health care cost inflation appears to be moderating somewhat, health care costs continue to increase substantially more than the overall rate of inflation. And, that will prompt insurers and employers next year to vigorously endorse managed care as the only means of bringing skyrocketing health care costs under control, benefit experts say.

The medical care component of the Consumer Price Index rose at an annual rate of 6.2% through October, while the overall index rose only 3.7% for the same period, according to the Bureau of Labor Statistics.

In 1988, the medical care component of the index leaped 6.5%, following a several-year low of 6.1% in 1987. Meanwhile, the overall inflation rate rose 4.1% in 1988.

Health insurers increased premiums for traditional group indemnity plans between 15% and 20% in 1988, with some plans imposing increases of as much as 35% to 40%.

And on the heels of those 1988 premium increases, employers with indemnity plans this year were socked with increases of 20% to 50%.

But, because profit margins for insurers began to improve this year (*BI*, Nov. 27), the rate of increase in indemnity plan premiums is expected to level off in 1990 and, in some cases, drop, insurers and consultants say.

"It clearly looks as though the price recovery from past inadequacies will be completed with Jan. 1 renewals," said Chip Sharkey, vp-employee benefits marketing for CIGNA Corp. in Hartford, Conn.

"Rate increases will fall back to basic medical care escalation as the year goes on," he said.

CIGNA plans to increase indemnity plan premiums between 20% and 30% next year, he said.

"There are signs that things are working out," said Linda Havlin of Hewitt Associates,

Continued on next page

10 largest employee benefit consultants

Ranked by benefit consulting revenues. 1989 figures are estimates.

Name (Parent)	Benefit consulting[1] Gross revenues (in millions) 1989	1988	% change	Total operations Gross revenues (in millions) 1989	Offices (U.S./total)	Employees
William M. Mercer Inc. (Marsh & McLennan Cos. Inc.)	$557	$465[3]	19.8%	$626	47/101	6,707
TPF&C (Towers, Perrin, Forster & Crosby Inc.)	406	325	24.9	688	28/53	5,150
The Wyatt Co. (Independent)	332	281[3]	18.1	382	30/65	3,500
Hewitt Associates (Independent)	205	172[3]	19.2	242	27/56	3,200
Alexander Consulting Group Inc. (Alexander & Alexander Services Inc.)	149[2]	127[3]	17.3	196[3]	18/82	1,730
A. Foster Higgins & Co. Inc. (Johnson & Higgins)	145[2]	120[3]	20.8	190[2]	50/80	1,500
Buck Consultants Inc. (Independent)	132	109	21.1	132	16/28	1,300
Coopers & Lybrand-Actuarial, Benefits & Compensation Group (Coopers & Lybrand)	86	68	26.5	86	22/28	1,061
Martin E. Segal Co. (Independent)	61[2]	53	15.1	63.5[2]	14/16	642
Godwins International Holdings Inc. (Frank B. Hall & Co. Inc.)	59	53[3]	11.3	65	27/83	900

[1]Excludes revenues from claims administration, compensation consulting, insurance commissions (where no consulting is involved), and other non-benefit consulting. [2]*BI* estimate [3]Restated

Source: *BI* survey

BI/HOLLY SEGUINE

Top consultants double revenues in just four years

By CHRISTINE WOOLSEY

Revenues racked up by the 10 largest employee benefit consulting firms continue to increase at an annual clip of about 20%.

Consulting revenues among the Top 10 employee benefit consulting firms leaped 20.2% this year to $2.13 billion from $1.77 billion in 1988, according to information supplied by consultants and estimates made by *Business Insurance*.

Last year, the firms estimated their 1988 revenues at $1.8 billion, but several of the consultants have since restated those revenues.

This year's rise in consulting revenues for the largest firms follows a 20% increase last year, 25% in 1987 and 19.5% in 1986.

The consultants reached two milestones in 1989.

Most significantly, revenues earned by the 10 largest firms exceeded $2 billion for the first time.

That represents a doubling of revenues in the last four years. In 1985, revenues for the Top 10 exceeded $1 billion for the first time.

In addition, one benefit consultant—William M. Mercer Inc.—produced more than $500 million in consulting revenues, the first time a single benefit consulting firm generated more than $500 million in revenues in one year. Mercer is the largest employee benefit consultant based on estimated 1989 benefit consulting revenues of $557 million.

This year, every one of the 10 largest employee benefit consulting firms increased its revenues by a double-digit percentage. By contrast, in each of the three previous years, at least one firm failed to rack up a double-digit percentage increase in revenues.

And, consultants said, revenues would have increased even more this year if Congress had not repealed Section 89, the section of the Internal Revenue Code that required companies to collect an immense amount of data and run complex tests to prove that their health care plans did not discriminate in favor of highly compen-

Continued on page 10

Health plan costs

Continued from previous page
an employee benefits consultant based in Lincolnshire, Ill. "The picture isn't all black. There is light at the end of the tunnel."

"We have caught up from the previous years and the whole industry has, too," said David Taaffe, director of group underwriting for The Prudential Insurance Co. of America in Newark, N.J.

"Rates should rise equal to forecasted trend increases," he said.

Prudential is estimating a 21% increase in premiums next year for health care indemnity coverage at companies with more than 500 employees and about a 24% increase for smaller companies.

Doug Peters, vp-representation and public affairs for Chicago-based Blue Cross & Blue Shield Assn., pointed out that, based on third-quarter results, BC/BS plans nationwide expect a $1.2 billion gain in reserves in 1989, following a $1.1 billion loss of reserves last year.

As a result, indemnity plan rate increases will range between 10% and 20% next year, compared with 15% to 25% hikes in 1989, he said.

"Obviously, it's a cyclical business and has been for 30 years," Mr. Peters said.

After two years of 40% increases in indemnity plan premiums, Fort Wayne, Ind.-based Lincoln National Corp. plans to raise indemnity plan premiums by only about 27% in 1990, said John P. Cole, executive vp-employee benefits.

"This year was profitable, mostly through managed care impacting the bottom line," he explained.

New York Life Insurance Co. in New York plans to increase indemnity plan premiums by about 20% in 1990, although employers with worse-than-average loss experience will be hit with greater premium increases, said Senior Vp Jay Wendt.

New York-based Metropolitan Life Insurance Co. will increase premiums for traditional indemnity plans next year by 20% to 22%, which is the same level it increased indemnity plan premiums in 1989, said Tony Trani, vp-group insurance marketing.

And, Principal Mutual Insurance Co., which primarily writes group health insurance for employers with fewer than 100 employees, will increase indemnity plan premiums by about 24% next year, said Larry Davis, associate director of group underwriting for the Des Moines, Iowa-based company.

In 1989—which was a "catch-up" year, according to Mr. Davis—indemnity plan and HMO premiums increased by about 35% on the average.

Aetna Life & Casualty Co. of Hartford, Conn., will be raising group health care indemnity plan premiums in 1990 by around 15% for small employers and 20% to 22% for large employers, according to Charles T. Bell, vp-employee benefits.

In comparison, self-insured employers expect their health care plan costs to increase between 10% and 19%.

For example, Kohler Co. in Kohler, Wis., projects health care costs will rise by about 10% next year, said Dan DeBaker, employee benefits manager.

Kohler increased individual deductibles to $200 from $50 and family deductibles to $500 from $150 in April when it replaced a basic major medical program with a comprehensive medical plan that includes a PPO option.

Under the new program, deductibles for individuals who seek care through the network are reduced by $150 for hospital admissions and $50 if care is provided on an outpatient basis, Mr. DeBaker said.

Minneapolis-based Dayton-Hudson Corp., which offers employees a self-insured health care indemnity plan with several levels of deductibles, projects that health care costs will increase by 17% to 19% in 1990 after single-digit increases during each of the past five years, according to Fred Hamacher, vp compensation and benefits.

"We had a lot of big claims recently and I can't explain why," Mr. Hamacher said.

In addition, Dayton-Hudson has contracted with about 20 HMOs and expects to see premiums also rise 17% to 19% for those plans.

Nevertheless, "we are very comfortable with our plan compared to what's going on in the outside world," Mr. Hamacher said.

But at Genentech Inc., a San Francisco-based pharmaceutical manufacturer that self-insures its health care plan, health care costs, including the company's premium for stop-loss coverage, will increase by about 25% in 1990, said Linda Fitzpatrick, director of compensation and benefits.

However, that rate of increase would be lower than last year's 38% increase, she noted.

Genentech offers employees HMO enrollment or an indemnity plan. The HMO option currently provides first-dollar coverage with no out-of-pocket expenses for employees.

Genentech self-insures its health care costs up to $100,000 per person annually.

Aetna writes stop-loss coverage above $100,000, but fewer than five claims reach that level annually, Ms. Fitzpatrick said.

Employers with managed care programs can expect to see just slightly smaller HMO premium increases next year, though still significantly smaller than expected indemnity plan premium increases.

HMOs increased premiums in 1989 by an average of 16.9%, according to studies by InterStudy, a managed care research firm in Excelsior, Minn., and the Group Health Assn. of America, an HMO trade group in Washington, D.C.

And in 1990, HMOs will increase premiums by approximately 16%, according to a recent survey of 43 HMOs conducted by the GHAA.

Specifically, 45% of the surveyed HMOs—which together have 11.8 million enrollees—reported that premiums will increase between 10.1% and 15%, and 29% reported that premiums will rise between 15.1% and 20%. In addition, 12% said premiums would rise by between 20.1% and 25%, and 12% said their premium increase would be less than 10%.

Two percent of the HMOs said premiums would rise next year by at least 30.1%.

Individual HMOs contacted projected 1989 premium increases roughly in line with the GHAA survey results.

CIGNA Healthplans Inc.'s HMO premiums will increase by 14% or 15%, compared with 24% to 30% increases in 1989, according to Mr. Sharkey.

"We have done a lot of restructuring to improve cost controls," he said.

CIGNA's HMOs, which have more than 1.5 million enrollees, have tightened up on medical cost and utilization management, bringing a greater standardization to operations, he noted.

Travelers Corp. HMOs will raise premiums by 15% to 25% in 1990, said Dale Wolfe, vp of the Hartford, Conn.-based company.

In 1989, though, premiums increased by an average of 35%, he noted. But this year's increase was unusually high to make up for earlier losses, Mr. Wolfe explained.

With premium income now meeting the cost of claims, "there is no need to catch up. We finally

Continued on page 6



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Opinions

Clarify risk group regulation

A NEW SET OF RECOMMENDATIONS from the U.S. Commerce Department is a good first step toward overhauling the federal Risk Retention Act (*BI*, Dec. 11).

The most important change would mean that only one state—the state that a purchasing group declares as its principal place of business—regulates risk purchasing groups and their insurers' risk purchasing group activities.

However, any state would have the right to challenge the financial solvency of any purchasing group insurer.

This recommendation, if accepted by Congress, would replace a highly ambiguous section in the 1986 Risk Retention Act amendments that leaves unclear which and how many states can regulate risk purchasing groups and the risk purchasing group activities of insurers.

This ambiguity about the extent of state regulation has led to a slew of litigation and uncertainty, which runs contrary to the interest of buyers, insurers and regulators.

Buyers are reluctant to establish risk purchasing groups, while insurers are reluctant to write coverages for the groups because they can't be sure which state rules apply.

And, how can regulators do their jobs if they don't know how extensively they can regulate risk purchasing groups and their insurers?

Central to one-state regulation of risk purchasing group insurers is that the insurers, under a Commerce Department recommendation, would have to meet certain minimum financial standards for capital and surplus.

This recommendation is reasonable and vital. Before an insurer is allowed to write purchasing group business, buyers need assurance that the insurer has the financial resources to pay claims.

Wisely, though, the Commerce Department report did not propose what those financial standards should be.

It recognized that only Congress, after receiving testimony from a broad spectrum of experts, can develop those rules.



The Commerce Department also is right on target in recommending that buyers—not insurers or brokers—must control risk purchasing groups. While the expertise of insurers and brokers is essential in helping buyers establish a purchasing group, a group only can succeed if buyers are in charge.

We hope the Commerce Department report does not collect dust, and instead becomes a blueprint for congressional action.

Indeed, this is the time—in a non-crisis atmosphere—to make the Risk Retention Act a more effective law.

With the appropriate changes in place, risk retention and risk purchasing groups can meet their full potential of being meaningful alternative risk financing mechanisms the next time commercial insurance coverages dry up or become unreasonably expensive.

Letters

Insurer not same as company hit by Hugo

To the editor: Recent news stories emanating from South Carolina concerning the insolvency of Grange Mutual Fire Insurance Co. of South Carolina (*BI*, Dec. 4) may cause some confusion in the minds of Georgia policyholders of our company, Grange Mutual Casualty Co.

Grange Mutual Casualty Co. has no connection whatsoever with Grange Mutual Fire Insurance Co.

We are based in Columbia, Ohio, and operate in five states, including Georgia.

We also differ in our financial stability, maintaining an extremely strong company with more than $400 million in assets and $150 million in policyholders' surplus.

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Because your magazine is widely distributed, some of our policyholders or prospective policyholders may be readers of *Business Insurance* and we appreciate the opportunity to clarify the situation.

J. Frederick Reid
Chairman, President and
Chief Executive Officer
Grange Mutual Casualty Co.
Columbus, Ohio

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.

Technical errors found in loss control article

To the editor: There are two technical errors in the article, "New Products Aid Loss Control Effort" (*BI*, Nov. 20) that you need to be aware of.

First, quick response sprinkler links, while available in temperature ratings lower than those commonly found in industrial occupancies, don't necessarily operate at lower temperatures as compared to conventional links.

Rather, it takes less time for the quick response link to reach its operating temperature.

The measure of link sensitivity is known as the Response Time Index. Residential sprinkler research showed that the link's temperature is but one of several variables in determining speed of sprinkler actuation.

The lower the RTI, the quicker the sprinkler will respond in a given fire scenario. Conventional sprinklers have RTIs of 200 to 700. Quick response and early suppression fast response sprinklers have RTIs below 55.

Stated differently, given two identical 165 degree Fahrenheit-rated sprinklers, one of which has a 50 RTI element and the other having a 400 RTI element, both will operate when the *element* reaches 165 F. However, the 50 RTI element sprinkler will operate first—possibly significantly quicker, depending on the type of fire and other variables—as it reaches 165 F more quickly. It is a "faster" element.

Thus, your statement that the quick response link "melts at a lower temperature" is not technically correct.

The second error involves your statement that substitutes must be found for Halons 1301 and 1211 "because the chlorofluorocarbons in Halon have been found to be extremely detrimental to the ozone layer."

Halon 1301, chemically known as bromotrifluoromethane, doesn't contain a chlorine atom. Therefore, it technically is not a *chloro*fluorocarbon. Halon 1211, chemically called bromochlorodifluoromethane, does contain a chlorine molecule and can be correctly called a chlorofluorocarbon.

I feel you need to be aware of these inaccuracies as you strive for editorial excellence.

Lawrence K. Marks
National Manager,
Property Technical Services
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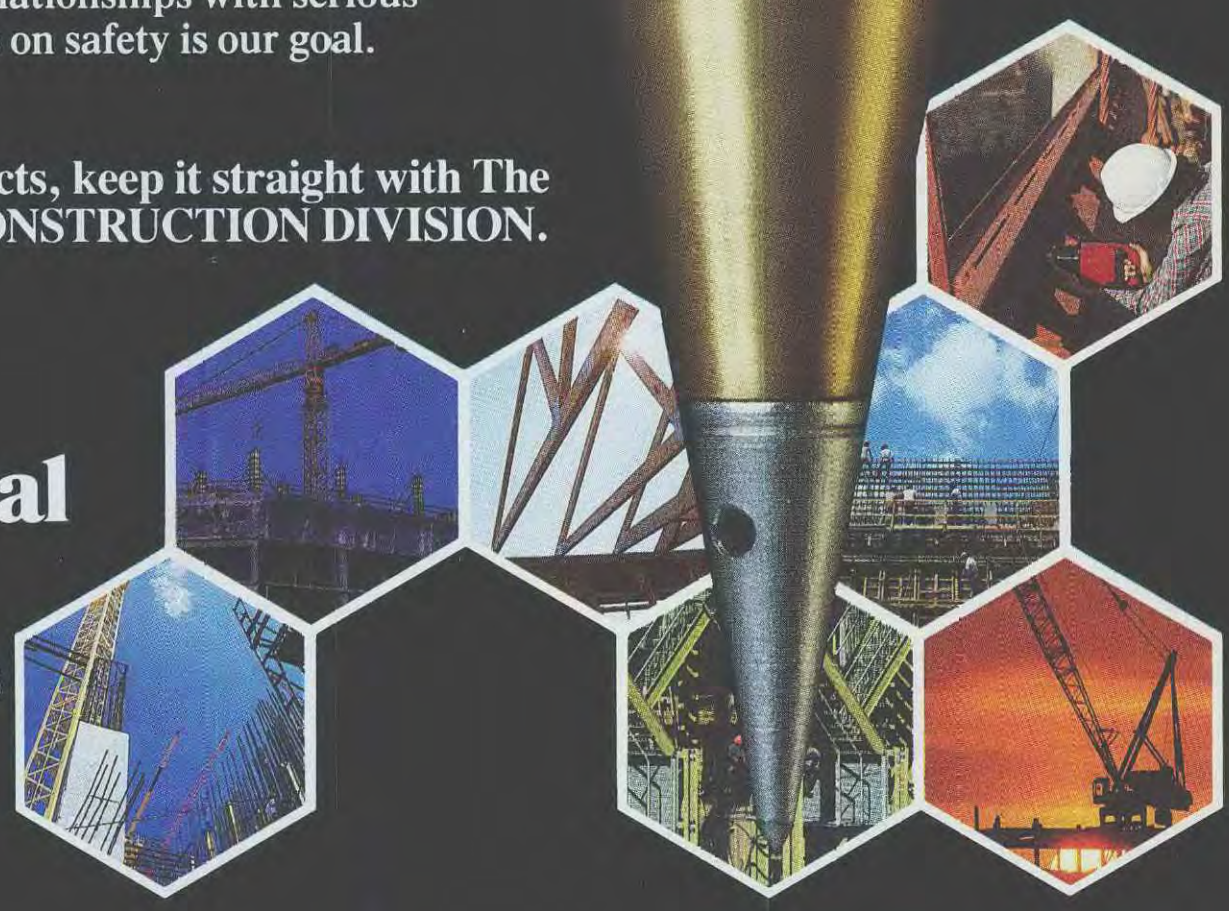
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Top consultants

Continued from page 3
sated employees.

While Section 89 was not actually repealed until November, benefit consultants' concentrated Section 89 consulting with employers by and large ground to a halt in April when it first became apparent that Congress either would overhaul or scrap the thoroughly despised law.

While no one knows exactly how much consulting work Section 89 would have generated if the law had stayed on the books, the amount certainly would have been well into the hundreds of millions of dollars.

And, a healthy chunk of those Section 89 consulting revenues would have been snared by the 10 largest consultants.

Even though the repeal of Section 89 cost them revenues, consultants shed no tears over the law's demise.

"Section 89 was disaster legislation. The public rose up in arms because the government went way too far," said Jerome Halperin, vice chairman of Coopers & Lybrand-Actuarial, Benefits & Compensation Group in Detroit. Coopers & Lybrand is the eighth-largest benefit consultant based on estimated 1989 employee benefit consulting revenues of $86 million.

"It was good that Congress put Section 89 out of its misery," said William Giegerich, president and chief executive officer of Buck Consultants Inc. in New York, the seventh-largest consultant based on benefit consulting revenues of $132 million.

Section 89's "inflexibility and complexity outweighed the social issues," observed Dale Gifford, a partner and Midwest Regional Manager with Hewitt Associates in Lincolnshire, Ill. Hewitt is the fourth-largest benefit consultant based on estimated 1989 employee benefit consulting revenues of $205 million.

Indeed, some firms welcomed Section 89's repeal because it gave them more time to concentrate on other benefit consulting projects for employers.

"We much prefer to help clients with benefit design rather than compliance efforts," said Robert Brochu, an executive vp with Mercer in New York.

While the repeal of Section 89 means employers and employee benefit consultants have one less benefit compliance issue to grapple with, there is no shortage of other problems for which employers are turning to their consultants for help.

Among these issues, "there are three 'Big Cs': compliance, communication and cost control," said Michael H. Davis, president and chief executive officer of The Wyatt Co. in Boston, the third-largest benefit consultant based on estimated 1989 employee benefit consulting revenues of $332 million.

For example, employers turned to consultants for help to comply with new pension vesting rules and new integration rules that detail how employers may coordinate or integrate their pension plans with Social Security.

"The pension integration rules are causing major employers to take another look at their retirement income strategies," said Robert Krinsky, president of Martin E. Segal Co. in New York, the ninth-largest consultant based on estimated 1989 benefit consulting revenues of $61 million.

At the same time, consultants devoted a lot of time and effort communicating to clients how the accounting rules proposed by the Financial Accounting Standards Board on recognizing the cost of retiree health care programs would affect corporate earnings and net worth.

And, with medical care costs continuing to rise at a torrid pace, health care consulting is the area with the highest rate of growth, said Charles Feartree, executive vp with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in New York. TPF&C is the second-ranked consultant based on estimated 1989 benefit consulting revenues of $406 million.

"Employers are reviewing their health care programs and deciding what they should do. They are looking to us for advice when they consider design changes," said Mercer's Mr. Brochu.

At the same time, the growth of international benefit consulting is driving up revenues for the largest consultants.

"As clients become more global in their operations, the benefit consulting business becomes more global," said Wyatt's Mr. Davis.

Indeed one benefit consulting firm alone—Hewitt Associates—opened offices or started joint ventures in 10 different countries this year.

Now, Hewitt joins the ranks of the employee benefit consultants with more offices outside the United States than at home, which include Mercer and Wyatt.

If there are any clouds on the horizon that could put a damper on benefit consultants' growth, they are not apparent to the executives of the Top 10 firms.

"We are optimistic about the future," said Wyatt's Mr. Davis.

"This is a dynamic business where the answers needed for today may be quite different than a few years ago," said Mercer's Mr. Brochu.

Even though the repeal of Section 89 cost them revenues, consultants shed no tears over the law's demise. 'We much prefer to help clients with benefit design rather than compliance efforts,' says Robert Brochu, an executive vp with Mercer.

And, consultants say, there is no sign of a slackening of some of the factors—such as legislative activity in Washington—that are driving the growth of their businesses.

Indeed, while legislators, humiliated by the Section 89 debacle may take more time in the future in drafting benefits legislation Washington's interest in benefit legislation has not abated, consultants agree.

The repeal of Section 89 "may not result in less legislation, but perhaps more sensible legislation," said David J.D. McLeish, chairman and chief executive officer of Godwins International Holdings Inc. in Briarcliff Manor, N.Y. Godwins is the 10th-largest benefit consultant based on estimated 1989 benefit consulting revenues of $59 million.

"We haven't seen the end or even a big slowdown" in benefits legislation, observed A.M. D'Alessandro, chief executive officer of The Alexander Consulting Group Inc. in Lyndhurst, N.J., the fifth-largest based on estimated 1989 benefit consulting revenues of $145 million.

Continued on next page

Hugo knocked the power out of almos



When Hurricane Hugo swept through the Carolinas devastating homes and businesses, much of metropolitan Charlotte—including the Kemper office—was left without power for days.

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The lights are back on now, most of the claims have been resolved, and most of the special task force members have returned to their home territories.

Continued from previous page

"Our legislators have discovered benefits as a way to get money," Mr. D'Alessandro added.

While the employee benefit consulting business may seem to be a veritable gold mine, consultants stress that competition among the largest firms never has been more intense.

"The competition is getting stronger and stronger," said Mercer's Mr. Brochu.

"The competition is intense, and there is a lot more of it," concurred Wyatt's Mr. Davis.

With business continuing to expand, the top executives of the nation's largest consulting firms say the biggest challenge they face is recruiting and retaining professional staff.

The challenge to hire qualified employees "overshadows everything else," said John Feldtmose, president of A. Foster Higgins & Co. Inc. in New York, the sixth-largest consultant based on estimated 1989 benefit consulting revenues of $145 million.

"Finding and training people and educating people" is a major challenge, said Segal's Mr. Krinsky. "You really need to know a lot to be good in this field," he said.

That search for talent is leading to big increases in employment rosters at the 10 largest benefit consultants.

This year, the 10 largest benefit consultants added 3,635 staffers, bringing total staff size to 25,690, up 16.5% from 22,055 in 1988.

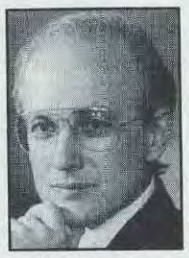
Profiles of the 10 largest employee benefit consultants follow:

William M. Mercer Inc.

The world's largest benefit consulting firm, William M. Mercer Inc., is experiencing bullish growth.

The New York-based company saw strong growth in all areas of its consulting business, enabling it to cross the $500 million revenue threshold this year. It is the first time a benefit consultant has hit that milestone.

Estimated consulting revenues increased 19.8% in 1989 to $557 million from a restated $465 million in 1988.



Mr. Brochu

And, Mercer executives predict that similar revenue growth will continue next year.

Indeed, the consultant next year should be the first to pass the $600 million mark.

"We expect clients to continue to place a high value on our services," said Robert Brochu, executive vp in charge of Mercer's U.S. operations.

In previous years, a good chunk of Mercer's revenue growth was fueled by major acquisitions: In 1984, Mercer merged with Louisville, Ky.-based Meidinger Inc., and in 1987 Mercer merged with A.S. Hansen Inc. in Deerfield, Ill.

But recently Mercer's revenue increases largely have been generated by internal growth.

Mr. Brochu said federal legislative and regulatory developments have boosted business.

For example, new rules laid down by the Tax Reform Act of 1986 on how employers can integrate or reduce pension benefits by Social Security benefits "require a lot of attention from employers," Mr. Brochu explained.

In addition, changing demographics and the aging of the workforce will force employer clients to pay close attention to retirement issues.

"From a medical viewpoint and early retirement viewpoint, employers are going to have to decide how to fund" these liabilities, Mr. Brochu said.

Employers also will have to decide what portion of the responsibility employees should bear. "Those areas require heavy investments by client companies. And they require a lot of effort on our part in terms of staff and systems," he said.

As far as Mercer's consulting business is concerned, Mr. Brochu said, "It's a matter for us to stay on top of the issues and hire people who are flexible enough to adapt to the marketplace."

To keep pace with the increase in business, Mercer increased its staff by 12% in 1989—to 6,707 employees from 5,982 in 1988.

But, Mercer reported a 65% increase in its benefits consulting staff to 4,544 from 2,752 in 1988.

The large increase reflects new hires as well as changing its professional consulting staff classifications to include university level recruits and technical staff.

Mr. Brochu noted that only 20 of the 725 new staff members were hired through acquisitions the company made in 1989.

"In spite of our history of acquisitions, we never believed growth by acquisitions offers any advantage over organic growth," he said.

Mercer "has done well recruiting at the college level in the United States, Canada and the United Kingdom. But we've also been successful hiring senior people from corporations, academia, other consulting firms and law firms," he explained.

In addition, Mercer has recruited some top talent from the ranks of government. For example, earlier this year, Harry Conaway, who drafted a wide variety of benefit regulations while a tax lawyer for the U.S. Department of Treasury, joined Mercer's Washington, D.C., office.

Mercer—known for its global presence—also continued to further develop its overseas staff.

"In terms of additions to our staff, we've experienced even stronger additions outside North America," Mr. Brochu said, pointing out that 43% of Mercer's employees are located in major countries outside the United States.

For example, "in Australia our staff grew by 48% last year," Mr. Brochu said. "We have about 400 employees there in five different offices."

Mercer opened a new office in Perth, Australia, last year through the acquisition of Campbell, Cook & King, an actuarial and benefits consulting firm.

In addition, Mercer opened Canadian offices in Mississauga and North York, both near Toronto.

The firm also closed offices in Columbus, Ga., Grand Rapids, Mich., and Wichita, Kan.

Mercer now has more offices—101—than any other benefit consultant. The firm has 47 U.S. offices, 13 in Canada and 41 in other countries.

And, Mercer does not plan to slow down its global expansion, Mr. Brochu said.

"One of our objectives is to be in each major country in Europe," he said. "Italy is next on our list."

TPF&C

TPF&C, the nation's second-largest benefit consultant, also racked up the second highest percentage increase in benefit consulting revenues this year.

Estimated benefit consulting revenues at TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. in New York, rose 24.9%, to $406 million from $325 million in 1988.

TPF&C Executive Vp Charles E. Peartree said that while U.S. revenue growth lagged in 1989, inter-

Continued on next page

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Top consultants

Continued from previous page
national benefit consulting business experienced very high growth —particularly in the United Kingdom and Australia.

Mr. Peartree attributed growth in the United Kingdom to more British clients, rather than strictly subsidiaries of U.S. multinationals, hiring TPF&C.

Benefit consulting in Canada also picked up, with "employee benefit and compensation legislation fueling a considerable amount of that growth," he said.

"It has been a bit of an unusual year in that historically the company grew in sync," Mr. Peartree commented. But, he expects TPF&C's U.S. consulting business to keep pace with international business in 1990, and projected 15% to 20% growth in total benefit consulting revenues in 1990.

"Clearly the whole area of health care cost containment will be significant in the U.S.," causing employers to turn to benefit consultants for advice on design issues.

Indeed, retiree health care liabilities and managed care issues comprised a major portion of the consultant's business in 1989, Mr. Peartree said.


Mr. Peartree

"Our flexible benefits business was up 31% worldwide and group and welfare consulting increased about 27%" in 1989, he said.

In addition, TPF&C experienced a 17% increase in pension-related assignments and an 18% increase in communications consulting, he added. And, the consultant saw a 23% increase in benefits administration projects in English-speaking countries, he said.

The company made no acquisitions in 1989, but did initiate a joint venture with Rauser GmbH, an independent pension consulting firm in Reutlingen, West Germany.

TPF&C already has a West German consulting office in Frankfurt, but the recent affiliation with Rauser will allow the firm to "establish a presence in Southern Germany and also affiliate ourselves with the real German pension business," Mr. Peartree said.

Benefit consulting staff grew nearly 5% in 1989 to 3,250 as of Oct. 31, up from 3,022 in 1988. Mr. Peartree said he expects TPF&C to hire approximately the same number of new staffers in 1990.

"Staff increases are not moving in lock step with revenue increases," he said, pointing out that the consultant's increased use of computers may be a factor in this trend. "The computer is doing a lot of things humans used to do. Computing power is what you need" for a significant amount of the assignments benefits consultants tackle.

Mr. Peartree said virtually every TPF&C employee uses a personal computer in some way. "It is present across all practices and all levels of our staff—from senior executives to the paraprofessional staff and administrative and clerical employees," he said.

New hires go through training programs that incorporate PC techniques, he continued. And, the consultant operates four major international data centers—in Woking, England; Toronto; Philadelphia; and Sydney, Australia.

"The world can link in to any one of them," Mr. Peartree said.

TPF&C has made a significant investment in developing this practice support, which includes research capabilities, data base maintenance and survey information. "We feel that investment is essential and for many of our clients, the fact that we're one firm worldwide" is quite appealing, he said.

In addition to a worldwide data source, TPF&C consultants can tap into the resources of its parent company, Mr. Peartree pointed out. "We have through our Towers Perrin family an opportunity to draw on these resources and avail our clients of a breadth of practice not available elsewhere," Mr. Peartree commented. For example, the consultant often relies on health care actuaries from Tillinghast to work on specific projects that may require their expertise.

The Wyatt Co.

A well-defined focus on its major lines of business has helped The Wyatt Co. maintain its rank as the nation's third-largest employee benefit consultant.

While the consultant has quantitatively changed over the last five years—increasing revenues, clients and staff—its mission remains unchanged: focus on client demands.

Estimated 1989 consulting revenues were $332 million, up 18.1% from a restated $281 million in 1988.

"Revenue growth met our expectations," said Wyatt President and Chief Executive Officer Michael H. Davis, who is based in Wyatt's Boston office.

Higher revenues "represent growth throughout the world in all our operations," Mr. Davis said.

He noted that both foreign and U.S.-based multinational companies are seeking advice on how their benefits and compensation programs will be affected by the coming abolition of trade barriers in Western Europe.


Mr. Davis

Consulting revenues also continue to rise in the Pacific Rim, where economic expansion proceeds at a rapid pace, he said.

Wyatt this year opened its 34th and 35th foreign offices, in Taipei, Taiwan, and in Gothenburg, Sweden.

Consulting in "Europe and Asia will continue to grow at dramatic rates because those are some of the major economies of the world," Mr. Davis said.

In the United States, Wyatt is helping more employers adapt their benefit programs plans to meet the needs of a changing workforce.

Changing demographics will influence employers' hiring decisions. "And because of the aging population, retiree benefit programs will become increasingly important," he said.

But, Wyatt also experienced rapid growth this year in flexible and group benefit plan consulting for active employees, he added.

"Companies are looking for ways and advice on how to stem health care cost increases," Mr. Davis said.

Wyatt has no specific plans to develop new consulting services in 1990. "We're trying to stay on top of what our clients are interested in," especially employee education programs, health care consulting and software services, he said.

Wyatt also will provide more help in developing training, performance management and educational programs for employees, Mr. Davis said.

Constantly rising health care costs "puts the obligation on the employer to educate employees to make the right decisions" when choosing among the different medical plans offered by an employer. Employees that must decide where and how to invest their 401(k) plan contributions also need education.

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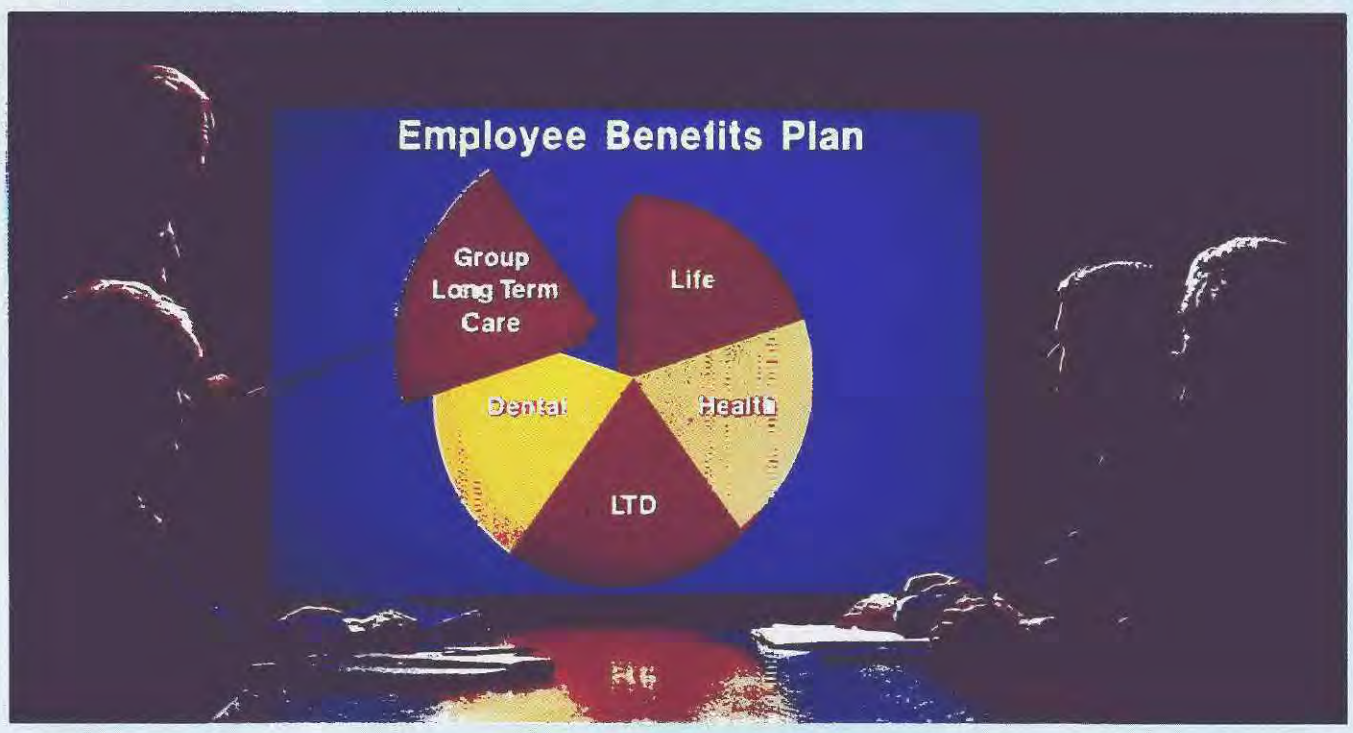
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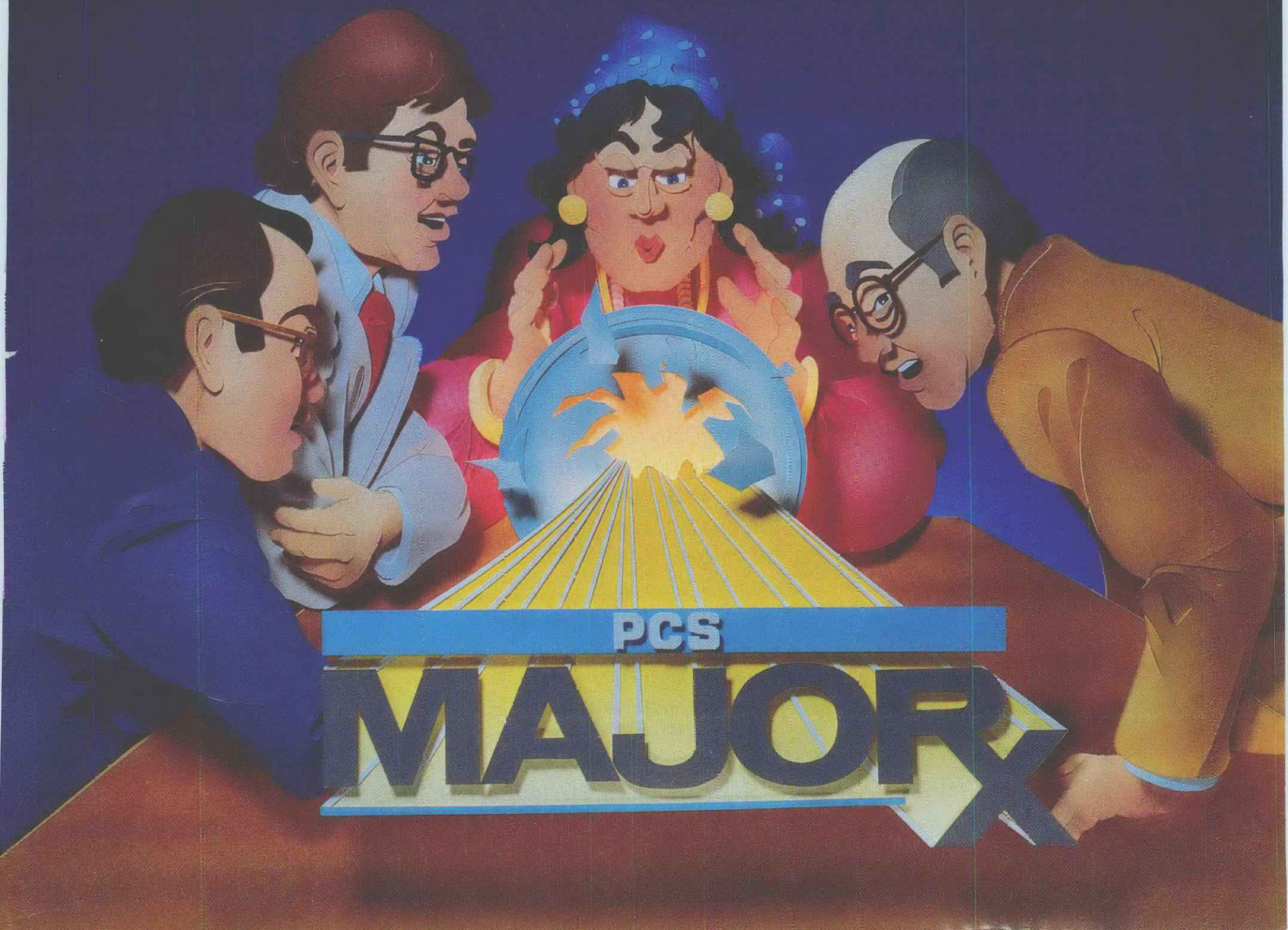
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Top consultants

Continued from page 12

Among the highlights for the firm in 1989 was the creation of Wyatt Software Services Inc., which now has about 30 staff members in Lake Oswego, Ore., Mr. Davis said.

"Its focus is to respond to our clients' demand for highly technical software packages for benefit program administration," Mr. Davis said.

Although Wyatt offers computer software and consulting through its main benefits consulting practice, its "conclusion was that the best way to deliver this product was through a business with a single focus," he said.

Wyatt added 700 employees in 1989—its biggest increase ever—bringing its total staff to 3,500.

But Mr. Davis doubts that revenues and staff in 1990 will rise as much as they did in 1989.

"When you increase staff 20%, it takes some time to digest," he explained.

New employees "have a lot to learn about the company and the business, so our growth rate may slacken a little," he said.

Mr. Davis, former Wyatt chief financial officer and treasurer, replaced V. Clark Beaird, who retired in July, as president and chief executive officer.

During the year, Wyatt made only one acquisition—McGuinn & Lawley, a Philadelphia-based pension actuarial consulting firm.

"Acquisitions in a business like ours have to be looked at very carefully," Mr. Davis said.

"Our major asset is our people," and acquiring a business typically means acquiring its existing employees.

In contrast, when a company hires "internally, one at a time, you can be sure that they will have the same level of quality" as existing staff members.

Hewitt Associates

International benefits consulting has been a driving force behind Lincolnshire, Ill.-based Hewitt Associates revenue growth over the last several years.

In fact, 1989 marks the first year the independent consultant operates more offices abroad than in the United States. Hewitt now has 27 U.S. and 29 foreign offices.

With 1989 estimated gross benefit consulting revenues at $205 million, a 19.2% increase over restated 1988 revenues of $172 million, Hewitt remains the nation's fourth-largest employee benefit consulting firm.

And, says Hewitt Partner and Midwest Regional Manager Dale Gifford, those revenue increases "met or exceeded all of our expectations going into the year."

"It was a landmark year for us in terms of the growth in our international business," he said.

Previously, the consultant's international business thrust was related to foreign operations of U.S.-based corporations. "Now many of those companies are foreign-owned and the foreign parent companies are working with our overseas offices," Mr. Gifford explained.

Hewitt opened 10 foreign offices in 1989: Brisbane, Australia; Dublin, Ireland; Geneva, Switzerland; Guadalajara, Mexico; Jakarta, Indonesia; London; Madrid, Spain; Manila, Philippines; Milan, Italy; and Singapore. Some are joint ventures.

"Our expansion internationally is really in response to our clients," Mr. Gifford said. "An additional reason related to 1992 and Europe's economic unification," he added.

Mr. Gifford pointed out that Hewitt also opened three U.S. offices: Bedminster, N.J.; Charlotte, N.C.; and Pittsburgh. The consultant plans to open a Richmond, Va., office in 1990.

Mr. Gifford said health care consulting, including flexible benefit plans consulting, grew rapidly in 1989, increasing as much as 50% from 1988.

Hewitt, for example, has helped design or implement close to 600 full-fledged flexible benefit plans and flexible spending account programs, more than any other benefit consulting firm.

Pension administration consulting also grew dramatically, with revenues rising 44% this year.

"The major thrust came from companies with multiple pension plans that wanted a better handle" on more efficiently operating their pension programs, Mr. Gifford explained.

"The fires were also fueled by Washington," he said.

He noted that Hewitt clients who were required to "fuss with" their pension plans because of new rules on how those plans can be integrated with Social Security decided to look at their plans more broadly. For example, employer clients turned to Hewitt for advice on how to explain and administer their plans more effectively, he said.



Mr. Gifford

In addition, the "actuarial part of our business grew at a significantly higher rate" than it did in 1988, said Mr. Gifford. He also noted that companies are paying more attention to post-employment benefit liabilities.

On the pension side, Hewitt introduced personal computer software, known as Future$aver, that will help answer employees' questions about savings and retirement plans, Mr. Gifford said.

The program allows employees—and benefits administrators—to forecast future benefits from defined benefit or defined contribution plans and Social Security payments.

It is interactive, meaning users can change assumptions, like savings rates or retirement ages, and measure the effect on future benefits.

The program allows users to:

- Project an employee's savings account balance.
- Illustrate the performance of the investment funds offered by the employer.
- Project savings pension plan and Social Security growth to show total benefits at retirement—both in dollars and as a percentage of final pay.

Hewitt designed the program to allow younger workers to plan savings programs and older employees to estimate retirement income. In addition, administrators can use the tool for pre-retirement counseling.

The system is currently being used by one of Hewitt's major clients, and a handful of additional clients have bought the system. The cost of the system depends on the customization requested by an employer.

The Future$aver program will help human resource generalists answer employees' questions about their retirement benefit, Mr. Gifford said.

Mr. Gifford noted that Hewitt faces increased competition from non-traditional sources like banks and payroll software firms that are attempting to develop benefit administration modules.

In addition, money management firms are looking to cash in on pension plan record keeping systems, he said.

Continued on next page



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Continued from previous page

Although Hewitt is known for its xpertise in software systems, Mr. Gifford said, "Our goal has been nd will continue to be recognition s the premier, full-service benefit onsulting firm."

The Alexander Consulting Group Inc.

Estimated benefit consulting evenues for The Alexander Consulting Group Inc. jumped 17.3% to $149 million in 1989 from a restated $127 million in 1988, pushing he consultant up a notch in the *Business Insurance* Top 10 rankngs.

Based on gross revenues from benefit consulting, Alexander Consulting Group ranks as the fifthargest benefit consultant this year.

And, along with the excellent growth in revenues the company experienced this year, the firm's reputation as a consultant has blossomed, said A.M. D'Alessandro, president and chief executive officer of the Lyndhurst, N.J.-based employee benefits consulting subsidiary of broker Alexander & Alexander Services Inc.

"People know we're a major player in the field," he said.

Alexander Consulting Group's revenues from health care consulting, flexible benefits assistance and pension projects each grew 20% in 1989, Mr. D'Alessandro noted.

And, although business from communications projects and defined contribution assignments increased, both grew at a somewhat lower rate than in previous years, he said.

"In 1989, we've basically tried to catch our breath and expand what's been done," Mr. D'Alessandro said.

Still, the company had time to add a Benefits Administration Services section to its consulting practice. The new unit audits employee benefit plans to make sure they are in compliance with federal rules and regulations.

In addition, Alexander Consulting Group consultants will "review the administrative tasks and techniques to make sure everything is being done" to assure that a corporation's benefit plans run smoothly and cost-efficiently, Mr. D'Alessandro explained.



Mr. D'Alessandro

The firm also set up an investment division to provide asset modeling and investment performance studies for its clients, he noted.

And, another new area, "organizational human resource management," could produce big business growth, Mr. D'Alessandro said.

Alexander Consulting Group plans to do a lot of work with recently merged companies that will need consulting advice on blending a variety of different benefits plans, he said.

To capitalize on this after-merger market will require strategic planning, he said. "We'll be conducting employer research and corporate culture studies to look at how companies are coming together," he said.

Alexander Consulting Group will provide reference tools and training sessions for these clients on how to administer their benefit plans.

All of these projects have reinforced the fact that Alexander Consulting Group has formed its own distinct personality.

"We've changed enormously. Five years ago we were still looking at being an integral part of A&A, but today we're totally independent," Mr. D'Alessandro said.

"We weren't as heavily into consulting in the past—today we are," he said, noting that over the last five years Alexander Consulting has gained the talent, reputation, client base and revenues to make it a major player.

"That may sound a little egotistical, because that is my tenure in office," he quipped.

Mr. D'Alessandro said the company will continue to build its basic core of business over the next five years.

But, he noted, the company will be innovative when responding to clients' demands. "The buyer is much more sophisticated than before and employers will demand true value in consulting."

A. Foster Higgins & Co. Inc.

It was an aggressive year for A. Foster Higgins & Co. Inc., the nation's sixth-largest employee benefits consultant.

"We're ending up slightly ahead of plan," noted John Feldtmose, president of the New York-based subsidiary of broker Johnson & Higgins.

Estimated 1989 gross revenues from benefit consulting totaled $145 million, up 20.8% from restated 1988 revenues of $120 million.

The lion's share of revenue came from health and welfare consulting business.

"Our strength and strategy revolves around our health and welfare business," Mr. Feldtmose said. "Health care cost containment consulting grew by a very high rate, and that's been driving our business. That's where our expertise lies."

Foster Higgins had expected its pension business to be somewhat stagnant compared with previous years, but "surprisingly pension business grew by as much as 10% to 15%," he said.

Mr. Feldtmose attributes much of the success to Foster Higgins' "pure consultants" strategy. Unlike companies that may rely on a "product approach, selling different products and ideas" like flexible benefits or managed care, Foster Higgins wants to be an objective problem-solver for employers.

"The client is looking for an unbiased, objective viewpoint," he said.

The consultant will be recruiting staff from competitors, the health care industry and government agencies as it seeks to meet its 15% to 20% annual staff increase, Mr. Feldtmose said.

In the last year, the staff grew 7% to 1,500 from 1,400.

Nurses and hospital administrators will become commonplace in the benefits consulting arena as employers look for different perspectives on how to manage rising health care costs, Mr. Feldtmose predicted.

"We're hiring people with expertise in specialty areas" who will offer clients specific skills from their individual disciplines, said Edward J. Davey Jr., a Foster Higgins principal in New York.

The consultant will use health care professionals to examine health maintenance organization arrangements and will hire more health and welfare actuaries and attorneys, Mr. Feldtmose said.

"We think we can give clients specialized attention across the board," Mr. Davey said.

Meanwhile, the senior executive ranks swelled from 21 principals to 35, Mr. Feldtmose pointed out.

Among executives joining the firm in 1989 were Robert Phillips, an executive vp in Los Angeles in charge of the consultant's regional operations. Mr. Phillips was formerly employed by TPF&C.

Thomas Burke, former U.S. Department of Health & Human Ser-

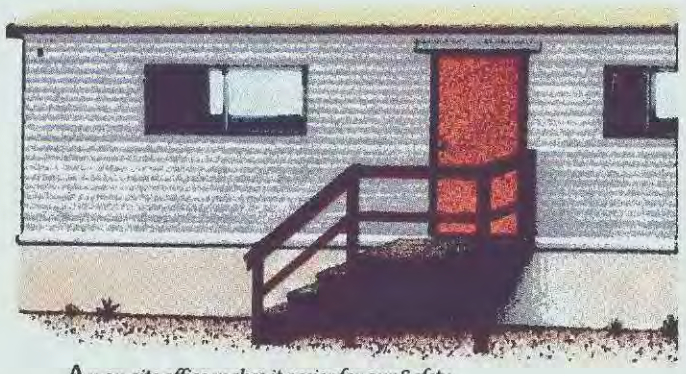
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Top consultants

Continued from previous page

vices chief of staff, has become a Foster Higgins principal. "He knows the health care system and benefits backward and forward," Mr. Feldtmose observed.

However, Foster Higgins was the only consultant among the top six the did not add either a foreign or a U.S. office in 1989.

The consultant, though, did gain 350 new clients in the last two years, he said, but he would not disclose the total number of clients.

The consultant targets employers with 1,000 to 10,000 employees. New clients are "mostly large corporations, but we've picked up a number of public sector clients" including eight more states, Mr. Feldtmose said.

"Almost every client has come from a major competitor—one of the Top 10," he noted. He attributed this to the success of Foster Higgins' major reorganization in early 1988, when it became a fee-based consultant and a separate J&H unit.

"The reorganization, change of name and marketing has really paid off in huge dividends," Mr. Feldtmose said. These changes "really hit the books in 1989, and we've had great momentum," he said.

Buck Consultants Inc.

As it filled in the gaps in its business, Buck Consultants Inc. saw estimated revenues increase 21% in 1989 to $132 million from $109 million.

"Now we have a full range of services," said William Giegerich, president and chief executive officer of the New York-based independent consultant. "We have everything from soup to nuts."

Mr. Giegerich said health and welfare consulting remains one of the strongest sectors of Buck's business. "Health and welfare went up like crazy for us. It has been the fastest growing service for three or four years now, and I don't see an end in sight," he said.



Mr. Giegerich

Buck does not develop detailed projections, but "there is so much going on in the health and welfare area the future looks rosy," he said.

Mr. Giegerich said 1989 revenue growth exceeded the firm's expectations. "We don't have a particular target for growth per se. But just as a gut feel, the actual results were higher than our guess would have been."

The firm's administrative, tax and legal consulting business increased 25% since 1988, while pension benefits and actuarial projects "didn't grow as much or as fast," he said.

In keeping with its goal of annual foreign expansion, the consultant opened four new foreign offices in 1989.

But, it was a bit unusual that all of the consultant's openings were outside of the United States, Mr. Giegerich said.

Buck this year has added offices in Calgary, Alberta; Montreal; Madrid, Spain; and Sydney, Australia.

"We feel Spain will be an expanding market" because private pension will become more common as the Spanish government has frozen social security benefits, Mr. Giegerich said.

Australia already has an established consulting community, and Buck "wants to be a part of it," he said.

Twelve of the company's 28 offices are now outside the United States. Mr. Giegerich said the company will continue to expand both domestically and internationally.

But, he said, expansion will present a challenge for Buck: "The greatest challenge for Buck to me is to stay non-bureaucratic as we continue to grow."

Because the company is employee-owned, it is able to attract a certain individual to its consulting staff, he said. "We want to have a small company feel because that is what makes people more productive."

Mr. Giegerich said Buck has few management positions by design, making it easier for consultants to interact with one another and draw on each other's expertise.

Coopers & Lybrand Actuarial, Benefits & Compensation Group

Revenue growth at Coopers & Lybrand-Actuarial Benefits & Compensation Group in 1989 was the strongest of The Top 10 benefits consultants ranked by *Business Insurance.*

Estimated 1989 gross benefit consulting revenues were $86 million, up 26.5% over 1988, reported the Detroit-based division of the accounting firm Coopers & Lybrand.

However, Coopers & Lybrand remained No. 8 in the *BI* rankings of benefit consultants nationwide.

"It was an excellent year," said Jerome Halperin, vice chairman in charge of actuarial and benefits consulting. "We exceeded revenue expectations in certain cases."

The increase is a feather in the hat of the consulting firm's 28 U.S. and international offices because the company made no acquisitions or mergers in 1989.

Like many other Top 10 benefits consultants, Coopers & Lybrand's health care consulting, which was up 45% over 1988, provided much of 1989 growth.

Unlike some of its competitors, however, Coopers & Lybrand saw revenue grow sharply from retiree medical benefits consulting.

Proposed Financial Accounting Standards Board rules for retiree health care benefits played a significant role in that success, Mr. Halperin said.

The rules would require companies to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the employee is eligible for post-employment health care coverage. In addition, retiree health care liabilities would have to appear on corporate balance sheets.

The Financial Executives Institute in Morristown, N.J., hired the consultant to study how the proposed rules would affect 25 major employers.

The study has since become "the Bible of post-employment benefits" and has generated significant business for Coopers & Lybrand, Mr. Halperin said. Ten of those 25 employers now use Coopers & Lybrand.

Another growth area for the consultant is its computer systems division. This year, the consultant completed Benefactor, a personal computer data base that enables users to perform various benefit analyses.

In addition, InfoLine, a telephone voice response benefit information system, is "a mechanical wizard," Mr. Halperin said.

It allows employees to tap specific benefit information by telephone. For example, employees can inquire about 401(k) balances.

"The beauty of it is many companies have people who answer these questions all day long," Mr. Halperin said. The system can free benefits personnel up to work on more complicated projects.

And, InfoLine can be used to in-

Continued on next page

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Spotlight report

Top consultants

Continued from page 16

form employees about job postings or to conduct employee opinion surveys.

Coopers & Lybrand already has conducted such a survey in which it sent letters to its employees and asked them to respond by punching their answers into the telephone system.

Another advantage of the system is that employees can complete the survey from their own homes, he added.

Mr. Halperin said Coopers & Lybrand will continue to focus on innovative technology to help its clients administer increasingly complex benefits plans. For example, the company is working on a project that will use artificial intelligence in the claims auditing area.

"Technology and data will be critical issues" in the coming years, he said. And a "firm with access to good data will be sought after. Artificial intelligence will be a hot area, and we hope to be a leader in that."

Martin E. Segal Co.

In its 50th year, New York-based Martin E. Segal Co. climbed a notch in the *Business Insurance* employee benefit consultants rankings to No. 9.

Estimated benefit consulting revenues for the independent consultant totaled about $61 million in 1989, up 15% from $53 million in 1988.

The increase was the second-smallest among the Top 10 employee benefit consultants.

However, the increase was historically high for a company with consistent 10% to 12% annual growth, said Robert D. Krinsky, president.

Mr. Krinsky attributes much of the revenue increase to the hiring of 29 new people in 1989. "That's the main reason we've grown. We've hired a mixture of entry level employees to give us long-term growth and some senior people to help us" with the busiest portions of the practice, Mr. Krinsky said.

"The longevity of our employees and our consistency remain the factors that set us apart" from competitors, he said.

Segal's philosophy is to educate clients so they can make their own decisions, Mr. Krinsky said. "We don't have a desire to push them in a certain direction."

Segal gained a "significant" number of new clients last year, Mr. Krinsky said.

Of the company's more than 3,000 clients, 52% are multiemployer plans, down slightly from 1988. The remainder are corporations and state and local governments.

And 85% of Segal's clients—the same as in 1988—have at least 500 employees.

The company does a great deal of retiree health plan consulting for its new clients, particularly concerning proposed Financial Accounting Standards Board rules that would require employers to recognize retiree health care costs and liabilities on their financial statements, he said.

"It's not a new area, but we're suggesting to employers that even if FASB doesn't decide to do much with (retiree health benefit obligations), those liabilities are still there" and Segal will help them sort through the options, Mr. Krinsky said.

Segal also is keeping a close eye on possible congressional action on long-term and dependent care, he said.

Segal, which has fewer foreign offices than any other Top 10 consultant, also plans to concentrate more on international benefits consulting.

The company continues to operate 14 U.S. offices and two in Canada.

"We're looking at international opportunities, and I think we'll have more of an international presence in five years," Mr. Krinsky predicted.

The elimination of insurance trade barriers in the European Community will lead to increased international consulting revenues for Segal, he said.

"We worked with a number of European firms on specific projects, but really nothing formal," he said.

Godwins International Holdings Inc.

Despite an 11.3% increase in estimated consulting revenues, Godwins International Holdings Inc. slipped into 10th place from No. 9 a year ago among the Top 10 consultants ranked by *Business Insurance.*

After a slight decrease in benefit consulting revenues in 1988, estimated 1989 revenues increased to $59 million from a restated $53 million—the smallest increase among the Top 10 consultants.

But, "the company expects healthy growth in 1990," said David J.D. McLeish, chairman and chief executive officer of the Briarcliff Manor, N.Y.-based consulting subsidiary of Frank B. Hall & Co. Inc., which has completely revamped its operations and is merging consulting divisions.

In the United States, health care consulting business increased the most for Godwins.

In the United Kingdom, defined benefit consulting was the most profitable.

And, "all of our business areas doubled in Australia," Mr. McLeish said.

Godwins opened new offices this year in Aberdeen, Scotland; Melbourne, Australia; and Sharjah, United Arab Emirates.

Godwins acquired Benefits Media Inc., an independent benefit consultant based in Nashville, Tenn., which will retain its 12 staff members and become a Godwins subsidiary, Mr. McLeish said.



Mr. McLeish

Godwin hopes to fuel worldwide expansion by acquisitions, but he added that these acquisitions are the company's biggest challenges. "We are very acquisition-minded, it's one of our goals."

Despite being in an expansion mode, Godwins consolidated its Stockton, Calif., office into its Walnut Creek, Calif., operation.

Godwins was the only Top 10 benefit consultant that did not increase staff substantially in 1989. Its staff remained at about 900 Among the additions are the Brian P. Zwarych, chief financial officer for Godwins Holdings International Inc., and David A. Edwards the managing director of Godwin Australia PTY Ltd.

Godwins' "house policy" sets the consultant apart from its competition, Mr. McLeish said. Each client receives "Godwins' advice, not just the advice from an individual consultant. "Our consultants bring a project in front of the whole Godwins organization, and we give advice based on the whole organization's viewpoint," he said.

Godwins also is known for its aggressive political lobbying, Mr McLeish pointed out. "There is a tendency of the competitors to be more reactive: They don't try to influence legislation at an early stage," he said.

But "we feel it's part of our role in the industry to address these issues and shape them." ■

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Deals available in stable LTD market

By ADRIENNE C. LOCKE

Many bargains still exist in the ong-term disability insurance narket as the market enters its econd year of stabilized prices for nost employers.

For example, some LTD insurers ire competing for some small and nedium-sized employers in an ef- ort to improve market share.

Other LTD insurers also will cut premiums if employers agree to nore stringent claims management requirements.

However, some signs indicate that the U.S. economy may be slowing, which historically means increased LTD claims and, as a result, higher premiums.

And, increased LTD benefits offered by some insurers actually may be leading to a rise in the number of claims, some observers assert.

For the past year, LTD prices in general have been stable, and no hardening is expected in the short term.

"Up until the last 12 months, prices have been coming down, but we expect stability in the market," said John S. Roberts, vp of LTD risk management at UNUM Life Insurance Co. in Portland, Maine.

"There may be a few carriers that increase or decrease prices, but as a general rule, it will be flat," he said.

The market has been stable for the last year or so because loss ratios have been good, explained Jack Verravas, assistant director of LTD at The Travelers Corp. in Hartford, Conn.

And, as long as loss ratios remain low, "the LTD market should continue to be stable," he said.

"My overall impression is that the market has been fairly stable," said John Stakem, vp and practice director in the Baltimore, Md., office of Alexander & Alexander Services Inc.

For example, Mr. Stakem said an employer with a low-risk white collar group with good claims experience can expect to pay next year as little as 25 cents per $100 of payroll for a 60% benefit level, the same as in 1989 and 1988.

However, a high risk group can expect to pay as much as $1.75 per $100 of payroll—again, the same as in 1989 and 1988.

Although rates have been relatively stable this year, observers note there is strong competition among LTD insurers for small and medium-sized accounts as some LTD insurers attempt to expand their market share.

"I have run into cases where accounts are purposely under bid" just so the insurer can get its foot into the door, said Frank Ericson, director of long-term disability at Aetna Life & Casualty Co. in Hartford, Conn.

Peter O'Brien, national practice director of health and welfare benefits at Ernst & Young in New York, called the competition for smaller accounts "more fickle" than for larger accounts.

"The price and product is consistent with larger accounts, because no one is going to underprice their customers," said Edward Muldoon, vp in charge of long-term disability at Prudential Insurance Co. of America in Roseland, N.J.

"But with the smaller accounts, there is a lot of competitiveness," he said.

Some LTD insurers also are offering a discounted rate to employers that agree to tighter LTD claims management controls, said Jay Catlin, a benefits consultant in the Seacacus, N.J., office of Buck Consultants Inc. (see story, page 20).

But, there are signs that the U.S. economy may be slowing, observers say.

And, if employers begin laying off employees as a result, employers could see LTD insurance premiums increase.

Mr. Verravas of Travelers believes that any serious trouble in the economy will force LTD prices up, because more claims will be filed and losses will increase.

Mr. Muldoon of Prudential explained that employee attitudes about job security can affect the number of LTD claims.

For example, some employees work every day with what could be considered a disabling injury or illness because they want to work, he said.

But if they fear being laid off, they might be inclined to file for disability, he added.

Some employees that foresee layoffs look to disability benefits as a better alternative to forced unemployment, agreed James DiOrio, senior manager and national director of health and welfare benefits at Price Waterhouse in New York.

In addition, some employers contribute to this problem, according to Mr. DiOrio.

"Sometimes it doesn't make a difference whether the plan is insured or self-insured, we have found a lot of people that were not really disabled but were knowingly carried on LTD by an employer," Mr. DiOrio pointed out.

In addition, mergers and acquisitions can contribute to increases in LTD claims—particularly with larger accounts—because of the normal streamlining of staff after a merger, said Mr. O'Brien of Ernst & Young.

But James Wallerstein, a group consultant actuary with Noble Lowndes in the Garden City, N.Y. does not project any drastic economy downturns soon.

"I don't know as yet that we have seen enough of a downturn to affect the LTD market," he said.

But "the carriers are watching the economy carefully, and if they see a slow down, they will increase prices," he added.

"I don't think that the whole economy will slow down, but I think parts of it will," like the defense and automotive industries, said Mr. Ericson of Aetna.

While LTD providers look at the same economic indicators as financial analysts do to determine the strength of the economy, they also look very closely at the economy of a particular business, said Mr. O'Brien of Ernst & Young.

For example, a box manufacturer in a recession would see a reduced demand for its product, compared with a cancer research lab that would probably be doing business despite an economic slowdown, he said.

"LTD providers see a mild setback in the economy, so they will be cautious with everything so they don't find themselves underwriting an industry that will be hit by a recession," he said.

UNUM, for example, looks at the LTD market "by each section and watches the claims results in each cell" on a monthly basis, Mr. Roberts said.

UNUM next screens LTD claims

Continued on next page

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LTD market

Continued from previous page
by location to determine if any changes have a local orientation, he said.

The last claims screen tries to determine whether increased claims activity is created by problems with a particular company or how the coverage was written.

Mr. Roberts explained that sometimes policies are written in a way that encourages claims. "It might be that we have offered replacement ratios that are too high, or the definition of disability is too liberal," he said.

For example, UNUM noticed that their physicians block of business was doing very poorly. After screening the claims, UNUM discovered that it was only specialists, such as obstetricians and anesthesiologists, who were filing increased claims.

When UNUM studied its policy, the insurer discovered that these physicians could be eligible for long-term disability even though the physicians could perform other medical duties outside of their specialties.

Some observers also fear that LTD claims may rise because of the increased benefit levels that some LTD insurers are providing.

While benefit levels generally are staying close to 60%, some LTD insurers are offering LTD benefit plans with a 66 67% benefit level.

Mr. Catlin of Buck Consultants feels that such a level is too high for contributory plans. With the tax breaks for the employee contribution, the reimbursement comes very close to full salary and creates an incentive to stay on disability, he explained.

But Mr. O'Brien of Ernst & Young does not think a 66.67% benefit level will lead to increased claims.

"It depends on the mind-set of the claimant," he asserted. "If he has decided to drop out of the workforce, it doesn't matter what the return level is. He has decided to stay home and has found a physician to back him up on his claim," he said.

Mr. Ericson of Aetna agrees. However, he added: "I don't think that 66.67% will become a trend."

Some LTD insurers also are offering variations on traditional LTD insurance products.

For example, employers insured with UNUM can offer LTD coverage to their employees on a voluntary basis through payroll deductions, Mr. McCarthy said. This method of providing LTD coverage is attractive because LTD benefits the employee draws would be tax-free since the employee paid taxes on the insurance premium, he said.

If the employee paid only part of the premium for the coverage, the benefit payout would be taxed proportionately, he added. ■

Claims handling key to limiting LTD abuse

By ADRIENNE C. LOCKE

An employer's commitment to effective management of long-term disability claims is one of the most important ways to assure the best price possible for LTD coverage, observers say.

But, employers also must be selective when choosing an LTD insurer, experts warn.

Employers can minimize abuse of LTD benefits by establishing a good claims handling process to screen out most frivolous claims and by purchasing policies with LTD insurers that clearly spell out coverage, said Kevin McCarthy, second vp of long-term disability products and markets at UNUM Insurance Co. in Portland, Maine.

"Sometimes it is very difficult to determine whether a person is disabled. That's why you have to have the resources available to assist you," he said.

The potential for abuse has increased because covered disabling ailments now often include mental and nervous disorders that are stress-related, said Peter O'Brien, national practice director of health and welfare benefits at Ernst & Young in New York.

In addition, LTD claims related to muscular and skeletal problems, such as lower back pains, continue to increase, he said.

But, these types of claims are very difficult to verify, he said.

"Almost 40% of these conditions are spawned by psychosomatic illnesses. How can you hope to make a determination on a LTD claim if the symptoms are vague?" he asked.

"Employers need to spend dollars to control claims dollars," said Jay Catlin, a benefits consultant in the Seacacus, N.J., office of Buck Consultants Inc.

For example, employers should take a stronger rehabilitative approach with employees on long-term disability, he said.

If they do, some LTD insurers will discount rates, he said.

Some LTD experts warn that employers also must be careful when selecting an LTD insurer.

Some insurers have oversold their LTD products and have been forced to try to sell off their LTD books of business because they do not have the long-term reserves to cover all of the policies written, said Edward Muldoon, vp in charge of long-term disability at Prudential Insurance Co. of America in Roseland, N.J.

LTD insurers "can't just jump in and out of the LTD market," he said.

"You have to be in it and be in it for the long run. If there is a recession in the economy, it would mean big trouble for those overextended companies on the fringes."

Mr. McCarthy of UNUM says that employers should look for a LTD insurer that has a proven financial commitment to the market and the capacity to adapt to market fluctuations.

Other qualities employers should look for in an LTD insurer include:

- A product that meets the growing and changing needs of a business.
- Experience in claims processing and management and adequate resources to be effective.
- The capability to help qualified claimants file for Social Security disability benefits.

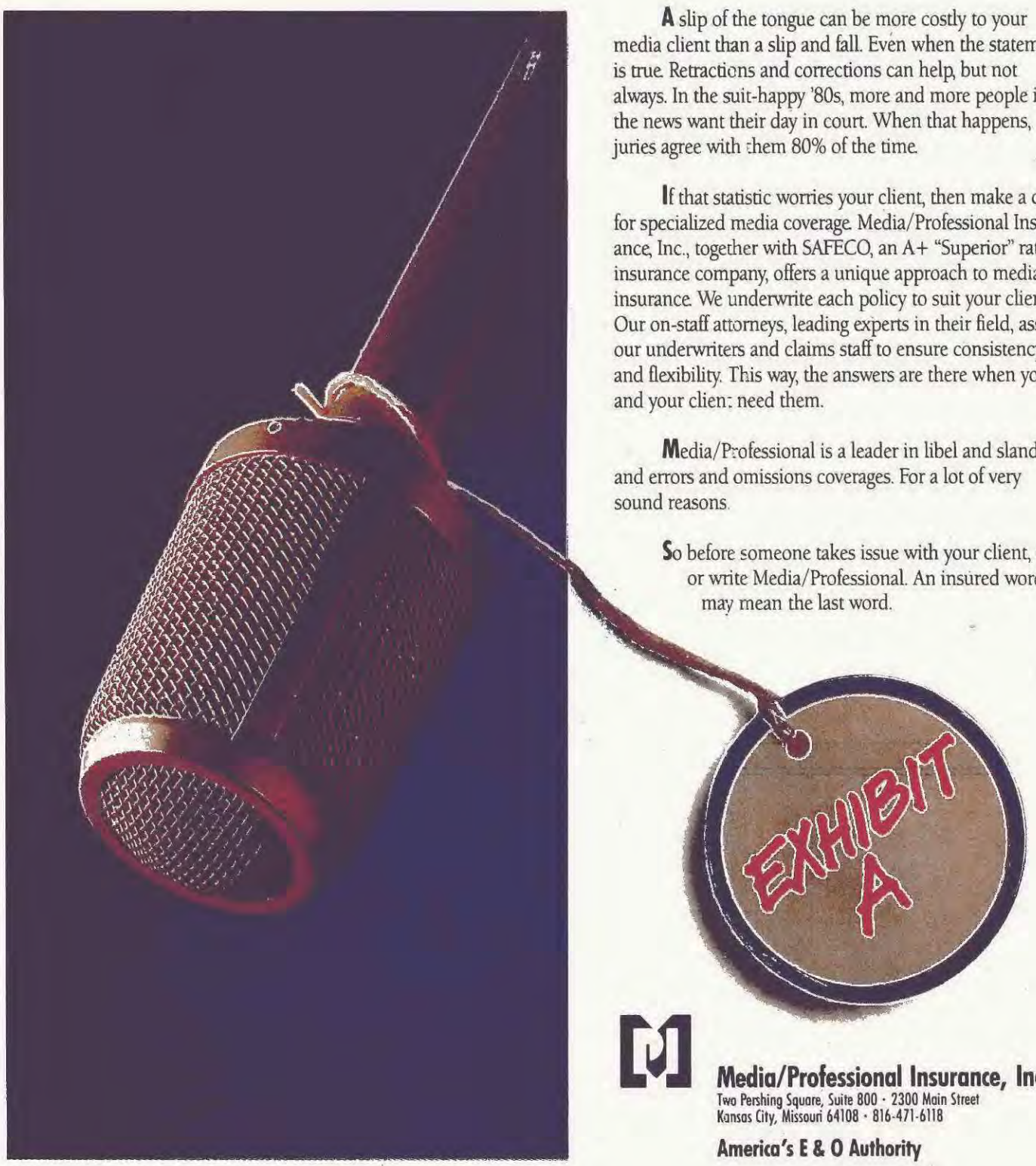
Most LTD plans include a provision under which LTD coverage is offset by Social Security benefits.

However, if the claimant does not seek the Social Security benefit to which he or she may be entitled, the LTD plan would then pay the full benefit.

But, many claimants do not file for the government disability payment because it is a difficult and time-consuming process, pointed out James DiOrio, senior manager and national director of health and welfare benefits at Price Waterhouse in New York.

"Social Security rejects a majority of claims on the first application," partially because its definition of disability is much more stringent than definitions used by LTD providers, he said. ■

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Managed care controls dental bills

Dental HMOs, PPOs growing

By LOUISE KERTESZ

Managed care programs are softening the bite that annual increases in dental care costs take out of employers' pocketbooks.

And managed dental care plan enrollment is rising rapidly as more employers, realizing the plans' effectiveness as cost containment tools, steer employees into prepaid dental health maintenance organizations and discounted fee-for-service dental preferred provider organizations.

While employer-provided dental plan enrollment has remained constant—at about 100 million people—since 1984, the estimated portion in prepaid plans has increased sharply, from 5% in 1987 to 7%-8% now, said Ronald Hurt, director of dental plan marketing for CIGNA Corp.

Growth in managed dental care is expected to continue throughout the next decade: By 1995, 15%-20% of the market will be in prepaid plans, predicts the Health Care Finance Administration.

Indeed, group dental's major players—The Blue Cross & Blue Shield Assn., CIGNA Corp., Prudential Life Insurance Co. of America, Aetna Life & Casualty Co., The Travelers Insurance Co. and Delta Dental Plans—all report rapid growth in managed dental plans.

Even EQUICOR Inc. jumped on the prepaid dental care bandwagon last July by adding a capitated plan to its indemnity and preferred provider product offerings.

Managed dental care typically comes in two forms: capitated dental programs, which are similar to medical HMOs in that employees can choose only network providers; and discounted fee-for-service arrangements similar to medical PPOs.

Rate increases for both are being held to single digits, while annual hikes for traditional dental indemnity plans can hit 15%, insurers and consultants report.

Because managed dental care program rates are up an average of 9% for 1990, increases in the combined rate for indemnity and managed care options will be about 11% to 12%, said Ann Lemmon, a benefit consultant at Hewitt Associates in Lincolnshire, Ill.

Employers offering both managed dental care and traditional indemnity coverage are charged a combined rate by an insurer, she explained.

"The very fact that the (combined) rate of increase has remained steady at 11% shows that the managed approach is beginning to take hold," Ms. Lemmon said.

Managed care rates are up an estimated 5% to 10% for 1990, compared with indemnity plan increases of 8% to 12%, said Roy Gonella, a principal with William M. Mercer Meidinger Hansen Inc. in Los Angeles.

The difference between 1989 managed care rate increases of 6% to 7% and this year's slightly higher increase can be attributed to increased use of dental PPOs, which control costs less effectively than HMOs, said Ms. Lemmon.

Premiums for the BC/BS Dental Network of America, one of the nation's largest managed dental care programs with 590,000 covered employees, are up 6% to 7% compared with BC/BS indemnity plan increases of up to 15%, said Leonard E. (Scotty) Wood III, senior vp of marketing in Chicago.

"But the real differential is the quality of care—the fact that you're dealing with a select group of providers. It allows us to do a much better job of screening the dental participants and monitoring their practice patterns on an ongoing basis," asserts James Webb, president of BC/BS's dental network, based in Oak Park, Ill.

Enrollment in BC/BS's dental network has grown 35% a year since its 1984 start-up, boasts Mr. Webb.

In addition, "revenues are up 15% this year for managed care," said Mr. Wood. That represents some premium increases, but most of it is customer growth, he said.

Inquiries from major corporations suggest "exponential growth," including a 10% enrollment increase in 1990, Mr. Wood said.

"We're hearing quite a bit about companies considering cutting back on their dental coverage, and that's one of the reasons we think the dental HMO program will grow at a faster clip in the future than it has in the past," he said.

"They will either move completely into it or emphasize it more. We've gotten inquiries from major companies that probably until recently were not even aware there was such a thing as a dental HMO. The product has been getting a great deal of exposure," said Mr. Webb.

BC/BS' managed dental care programs already cover employees of United Airlines, Zenith Electronics Corp., LTV Corp., USX Corp. and the Big Three automakers, Mr. Webb said.

In addition, BC/BS plans administer capitated dental plans for other insurers, bringing total membership in BC/BS managed care dental plans to 1.1 million. About 4,600 dentists in 32 states participate in BC/BS dental networks.

Despite rapid growth, enrollment in BC/BS's dental network is only about 3.7% of enrollment in BC/BS's traditional dental indemnity plan, which has 15.8 million enrollees.

One incentive BC/BS is offering employers to adopt managed dental care plans: Guaranteeing a lower rate for managed care for two or three years to help customers stabilize combined rates; traditional indemnity plans rates are not guaranteed, Mr. Webb said.

The program is "generally able" to meet its target of 20% savings for managed dental plan customers, Mr. Wood said.

Monthly capitated premiums for families vary from $10 in a very basic plan to $25 to $30 for a rich plan, Mr. Webb said.

Other large insurers also are increasing rates less on managed dental plans than on their indemnity programs.

Estimated 1990 rates hikes for

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Dental costs

Continued from previous page

CIGNA's prepaid dental plans will be only about two-thirds the hike for indemnity plan rates: 7%-8% compared with 12%, Mr. Hurt said.

CIGNA offers three dental plans: an indemnity plan, a capitation plan with 15 schedules and a combination.

Only a capitated plan will hold down dental costs in the long term, Mr. Hurt emphasized.

Only dental HMOs give dentists incentives "to bring mouths to a healthy state and keep them there," he said.

The dentist in a capitated plan receives not only the monthly capitation payment but also supplemental payments for expensive and time consuming procedures that have to be performed and copayments by employees.

However, even with the supplemental payment for these expensive procedures, the dentist in the HMO will not receive as much as would a dentist billing an indemnity plan. Therefore, dentists in HMOs won't make a lot of money performing expensive services but they won't be unduly penalized if the services are required.

CIGNA's prepaid plans are growing "tremendously," Mr. Hurt boasts. Since the end of 1986, capitated plan enrollment has risen nearly fivefold, to 800,000, while indemnity plan enrollment has remained flat at 8 million since 1984, he said.

Much of the growth is attributed to contracts with such large employers as United Technologies Corp., MCI Communications Corp., Dow Chemical Co., Chevron Corp. and McDonnell Douglas Corp.

"From our perspective, the news is the interest we have seen in (managed dental care programs) by major national corporations in the past year," Mr. Hurt said. "As they struggle with trying to get medical costs under control and shifting some of the responsibility for health care to their employees, they are beginning to turn to prepaid dental to help in that effort."

A total of 3,500 dentists in 130 cities in 46 states participate in CIGNA's prepaid dental plans.

Prudential's rate for the combined managed care and indemnity plan will increase 10%-12%, said Marvin Zatz, vp of dental relations at Prudential's Roseland, N.J., office. Prudential does not offer the managed care dental product on a stand alone basis so Mr. Zatz could not provide a separate cost increase figure. However, the combined managed care/indemnity plan costs 5% to 10% less than a strictly indemnity plan.

Enrollment has nearly tripled—to 3 million—since 1987 for Prudential Life Insurance Co. of America's Dental Maintenance Organization. About 5,300 dentists participate in the plan, which is offered in 44 states.

Aetna's Preferred Dental Plan will increase rates 6% to 10% in 1990.

Premiums for Hartford, Conn.-based Aetna's prepaid dental plan are 15% to 20% lower than indemnity plan rates, said Lee Golub, an assistant vp in the insurer's Middletown, Conn., office.

Aetna would not disclose estimated rate hikes in its indemnity plan.

Aetna's capitated plan provides richer benefits for preventive services than the traditional plan, he said.

For example, no deductible is applied for any preventive work and some restorative work, and major restorative work is covered at 50%.

And, Aetna encourages dentists to perform preventive procedures through negotiated fees.

Aetna plans to double the enrollment by the end of 1990 in the managed dental care program, which it only began "to really market enthusiastically" last March, said Mr. Golub.

Aetna wants enrollment, currently 110,000, to hit 1 million by 1992. Its indemnity dental plan now covers 4.5 million.

"Both our customers and our potential customers are asking for this type of plan to help control dental costs," Mr. Golub said, referring to the managed care plan.

Citing better cost controls by HMOs, Aetna also is phasing out a PPO dental plan in New York state, which began the same time as its dental HMO elsewhere, said Mr. Golub. Aetna has filed for New York approval of its HMO and plans to fold the PPO into the HMO.

'The focus of new dental sales is going the managed-care dental route,' says Mr. Terwilliger.

The dental HMO is now available in 22 major cities and by next year the insurer plans to set up plans in nine additional states and increase participation of dentists to 1,800.

Travelers says cost savings in its dental PPO are holding its combined dental plan rate increase to 9%-10%, although Travelers would not break down the rate hikes.

A lower rate hike in its PPO—Preferred D—brings down the combined rate hike by about 1%, said Glenn Terwilliger, director of the insurer's employee benefit department in Hartford, Conn.

Travelers entered the managed dental care market with a PPO rather than an HMO because of higher turnover rates and other problems associated with dental HMOs, he said.

Annual turnover among Travelers PPO dentists is about 8%, while turnover among HMO dentists can exceed 50%, he said. "A capitated program puts the burden of risk squarely on the dentists," and they don't like it.

"A dentist is trained to give appropriate care. If he sees a lot of patients, his monthly capitation fee won't match his expenses," Mr. Terwilliger said.

In addition, Travelers faulted some HMO practices, such as restricting the number of times a patient can be referred to a specialist, he said.

Enrollment in Preferred D has increased by 20% in the past six months, to 250,000 employees—a third of indemnity program enrollment—he said.

"It's very, very clear to us that the focus of new dental sales, or business that we get from other carriers, is going the managed-care dental route," said Mr. Terwilliger.

The Travelers' dental PPO, established in 1984, includes 12,000 dentists who have agreed to discount fees 20% to 25%.

Monthly PPO premiums vary with geographic area, but average about $30 per family for a plan that pays 100% for preventive care, 80% for restorative and 50% for major work, he said.

Delta Dental would not disclose rate increases for its three dental plan options.

Delta, the nation's oldest and largest prepaid dental insurer with a total enrollment of 17.5 million, offers: Delta Premier, a fee-for-service plan; Delta Preferred Option, or DPO, which is a "subset" of the larger PPO in which dentists agree to charge lower fees; and an HMO-like capitation plan.

Monthly premiums for the DPO are $25 to $30 per family, which is 15% to 20% less than Premier.

And Delta Dental's capitated plan costs employers 15% less than the DPO, said Jerry Holcomb, vp of public and professional services at Delta Dental Plan of California in San Francisco.

DPO was set up "in recognition of the fact that purchasers were looking for something identifiably different from a traditional fee-for-service program," Mr. Holcomb explained.

"Carriers have been creative in the past couple of years to try to meet purchasers' demands. They are, I believe, overwhelmed with the cost of some of the packages they have put together and are looking for ways to reduce that cost without affecting the quality of the program."

DPO still allows employees the option of using any dentist they want, as does the PPO, but there are incentives—such as a lower copayment or waived deductible—if they choose dentists in the network.

DPO is offered only in California and has about 350,000 enrollees.

Approximately 100,000 dentists participate in Delta Premier. In California, 5% of the 16,000 dentists in the state Delta plan participate in the Delta Preferred Option.

The HMO, covering an estimated 500,000 individuals nationwide, is marketed and sold through PMI Inc., a wholly owned subsidiary of Delta California and California-based Delta Dental Plans.

EQUICOR Dental Select—an HMO that was established last July, is available in Colorado, California and Illinois but has no enrollees yet—is one of the newest entries in prepaid plans.

Employers that choose Dental Select will pay premiums 20% below those of EQUICOR's dental indemnity program, said Dan Wood, dental plan director in EQUICOR's

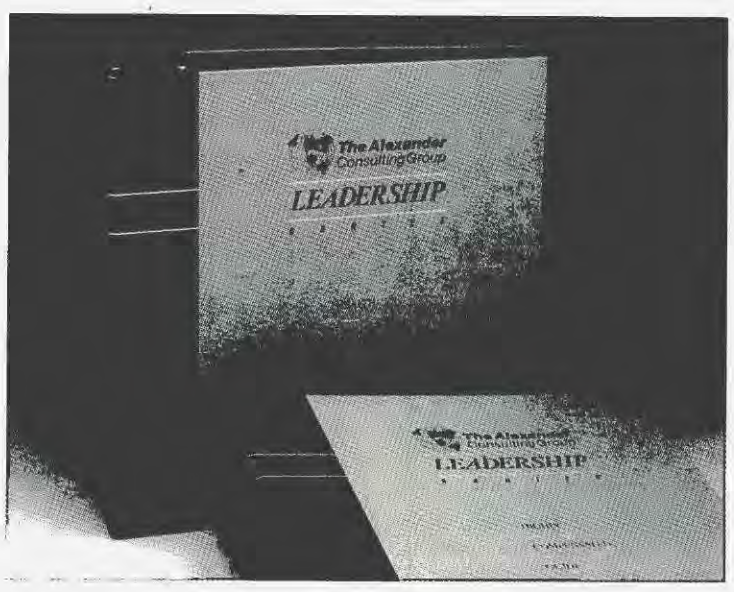
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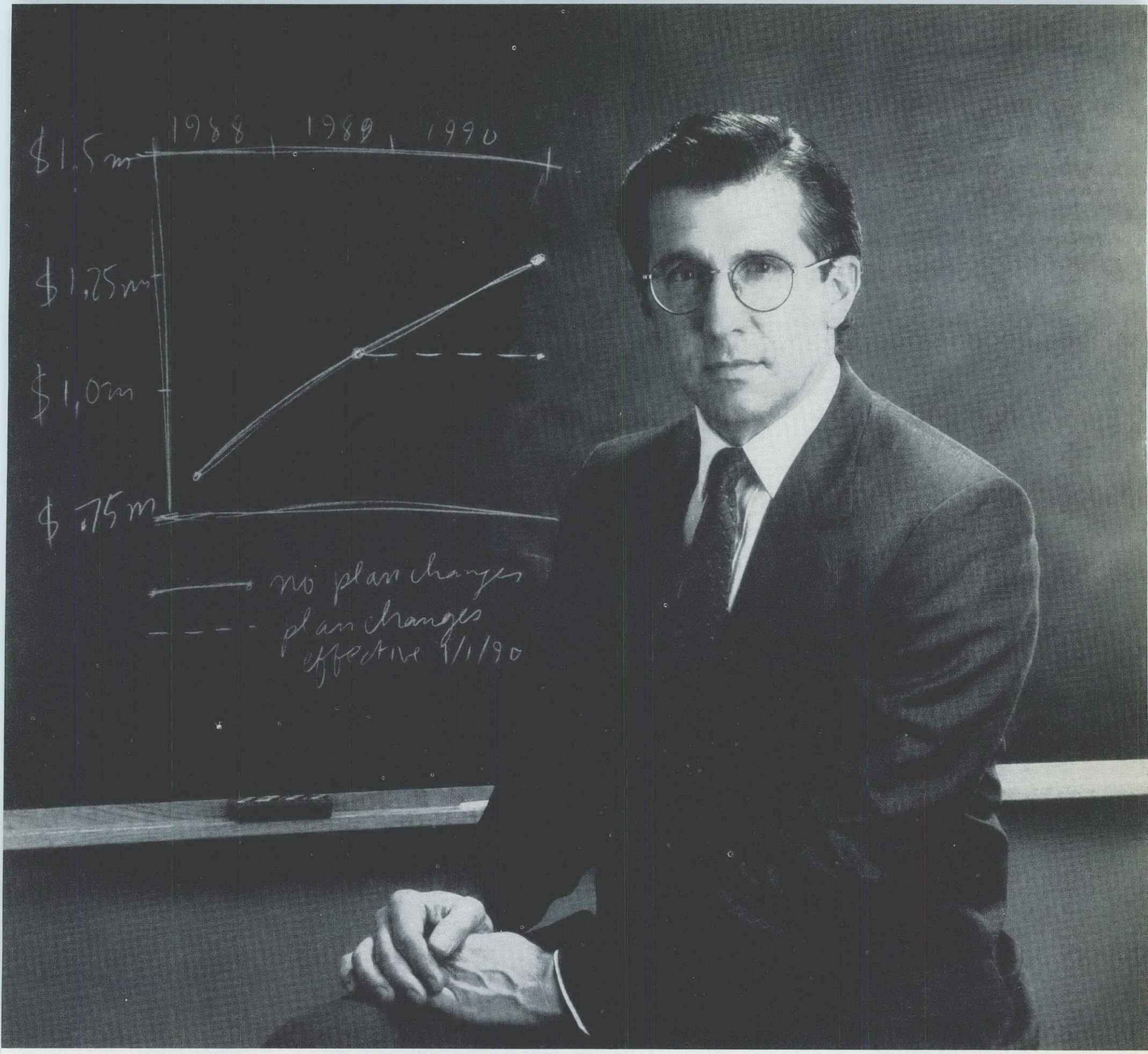


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Dental costs

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New York office.

"We're hopeful that if we can be competitive on a rate basis, it will grow," Mr. Wood said of the dental HMO.

Noting that employers are asking employees to contribute toward the cost of coverage, and therefore want to offer a richer plan, Mr. Wood said that EQUICOR's managed dental care program provides roughly 20% more coverage than does its indemnity plan.

In addition, savings on EQUICOR's PPO can total 5% to 8%, "if the employer is willing to put in disincentives" to going outside the network, said Mr. Wood.

EQUICOR insures 1.8 million employees in its dental indemnity plan and 120,000 in its fee-for-service PPO with 6,000 dentists, which was established two years ago. ■

Controlling dental plan costs

By LOUISE KERTESZ

Companies that offer dental benefits are getting their employees more involved in controlling costs by emphasizing stricter managed care, encouraging preventive care and making employees pay more of the bills.

More employers are steering their employees into capitated dental health maintenance organizations and fee-for-service preferred provider organizations to reduce their dental care costs.

And some employers are imposing greater disincentives to discourage their employees enrolled in PPOs from going outside the network.

"The more employees join the managed programs, the greater the savings for the employer," said Marvin Zatz, vp of dental relations at Prudential Insurance Co. of America's Roseland, N.J., office.

About 30% of employees with a dual option sign up for managed dental care as soon as it is offered, estimated Lee Golub, assistant vp in Aetna Life & Casualty Co.'s Middletown, Conn., office.

Currently, about 50% of employees who have dual options join a managed plan, said Mr. Zatz.

"Some big companies have been more aggressive and not hesitated at all to make it more difficult for their employees to select the open panel program," said Jerry Holcombe, vp of public and professional services at Delta Dental Plan of California in San Francisco.

"Some do not allow their employees to select other than PMI (Delta's HMO-like capitated plan) for the first year of their employment. Others make their employees pay for the premium difference between PMI and Premier," Delta's fee-for-service PPO, he said.

To further encourage use of its network dentists, The Travelers Insurance Co. allows policyholders' employees to "invite" their dentists to apply for affiliation with Travelers' PPOs.

In another effort to keep the lid on dental costs, employers are offering employees incentives to seek preventive care.

A recent survey by benefit consultant Hewitt Associates found more companies—53% in 1987 and 1988, up from 47% in 1984—waiving the deductible for certain preventive dental care procedures.

"We're seeing more plans that drop the deductible for preventive care and increase the deductible for major care," said Ann Lemmon, a benefit consultant at Lincolnshire, Ill.-based Hewitt.

"If you can get people in at the early stages where maybe they'll only need a filling instead of a root canal and a crown, that's the idea," Ms. Lemmon said.

A similar principle governs capitated plans such as CIGNA Corp.'s in which dentists "make more money keeping mouths healthy than doing a root canal," said Ronald Hurt, director of dental plan marketing in Hartford, Conn.

As a result, a school district in CIGNA's program saw a shift in utilization from more costly restorative procedures to diagnostic and preventive procedures, he said.

Requiring employees to contribute to the cost of dental care is another way employers are managing costs: According to Hewitt's survey, 44% of employers responding in 1988 required copayments, up from 41% in 1987 and 37% in 1984.

Some employers shifting more costs to employees are permitting them to set up flexible spending accounts, which allow employees to pay for dental care with pretax dollars.

Employers that do not yet offer a dental HMO or PPO are redesigning their dental indemnity programs to make them more cost-effective.

'The more employees join the managed programs, the greater the savings,' says Marvin Zatz.

For example, some employers are offering insured plans that pay only for basic services such as cleaning and fillings, while others are providing coverage at the opposite end of the spectrum—adopting catastrophic plans with very high deductibles so that insurance kicks in only when major work is required—Ms. Lemmon observed.

These "safety net" plans "are not real prevalent, but we're seeing more interest in them," Ms. Lemmon said.

"I think that financial managers will look more closely at redesigning more restrictive traditional (indemnity) programs. A number have already done so, and brokers will increasingly recommend alternative programs," Prudential's Mr. Zatz said.

Travelers currently is redesigning its fee-for-service PPO aimed at "changing the foundation of the benefit program to offer an employer choices" that will permit rate reductions, said Glenn Terwilliger, director of Travelers' employee benefit department in Hartford, Conn.

"We're looking line-by-line at our contractual benefit language," Mr. Terwilliger said.

Some of those changes may hinge on recent studies that have shown that because of technological advances, some dental procedures are being performed more frequently than necessary (*BI*, June 12).

For example, Travelers is considering modifications to its coverage such as reducing the standard frequency of X-rays. The insurer may also change coverage for crown and bridge replacement to every 10 years rather than every five years because technology has increased their life span. ■



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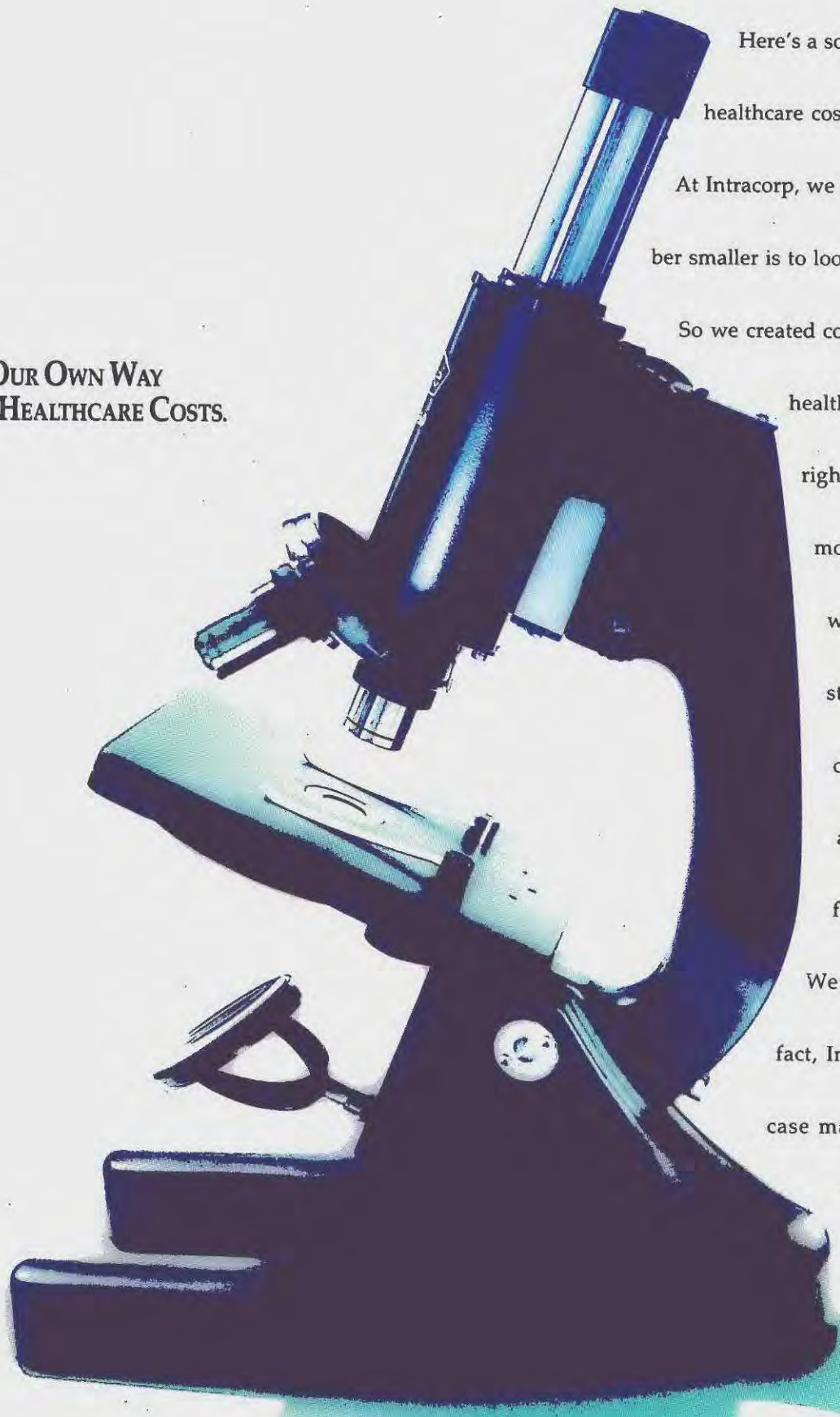
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Compensation: By the project; on retainer; by the hour: senior consultant-$200, consultant-$175, clerical-$36.
1988 gross revenues: Not reported.
Principal officers: John Salajka, president; David Goldenberg, executive vp; Patrick Zirkelbach, vp-systems; Craig Summers, vp-defined contribution plans; William Dahlin, vp-flexible benefits.

Advanced Benefits

141 Stony Circle, Suite 220, Santa Rosa, Calif. 95401; 707-575-5240

Services provided: 34% of gross revenues from benefit consulting, 66% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 30% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs.
Other services: 66% of business. Includes brokering, health care and other types of claims administration.
Staff: Seven total staff members; two professionals, including one CEBS, one CLU.
Clients: 218 total clients; 4% with more than 500 employees, 96% with fewer than 500 employees; 80% corporations, 20% municipalities; no minimum size client.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer.
1989 gross revenues: $600,000 total, $205,000 generated by benefit consulting.
Principal officers: James T. West, president; Mark H. Downing, vp.

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Aldrich & Cox Inc.

1900 Ridge Road, Buffalo, N.Y. 14224; 716-675-6300

Year founded: 1951.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 28.5% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, ongoing supervision including loss review and control, dealing with agents/brokers, annual plan review.
Employee benefit communications consulting: 1.5% of business.
Other services: 70% of business. Includes risk management consulting.
Staff: 15 total staff members; five professionals, including one MBA, one CEBS, one CLU, five CPCUs, two attorneys, three ARMs, two AMIMs, one ALCM.
Clients: 60 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 95% corporations, 5% individuals; no minimum size client.
Compensation: By the project; or retainer; by the hour, consultant $70-$125.
1989 gross revenues: Not reported.
Principal officers: Herbert Cox, chairman; Charles H. Cox, president; James B. Hood, executive vp; Michael B. Coyle, vp.

The Alexander Consulting Group

125 Chubb Ave., Lyndhurst, N.J. 07071; 201-460-6600

Year founded: 1898.
Parent company: Alexander & Alexander Services Inc.
Services provided: 76% of gross revenues from benefit consulting, 24% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 30% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.
Welfare plan consulting: 28% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 14% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
International benefit consulting: 4% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the United States.
Other services: 24% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration.
Locations: 18 locations in the United States; 33 foreign locations.
Staff: 1,754 total staff members; 1,140 professionals, including 71 FSAs, 64 ASAs, 28 MBAs, 21 CEBSs, 40 CLUs, one CPCU, eight Ph.D.s, eight CPAs, 19 attorneys, one M.D., two RHUs, three ISCEBSs, two ChFCs.
Clients: 20,500 total clients; 33% with more than 500 employees, 67% with fewer than 500 employees; 98% corporations, 1% multiemployer plans, 1% associations and municipalities; no minimum size client.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.
1989 gross revenues: $196 million total, $149 million from benefit consulting.
Principal officers: A.M. D'Alessandro, chief executive officer-worldwide operations; Donald Cleveland, chief operating officer-world-

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vide operations; C. Douglas Preston, hief operating officer-U.S. operaions-Alexander & Alexander Conulting Group; Brian E. Kennedy, hief executive officer-Canadian opations; R. Allan Durward, chief executive officer-British/European opations.

American International Healthcare

30 W. Gude Drive, Rockville, Md. 20850; 301-251-8600

Year founded: 1977.
Parent company: American International Group Inc.
Services provided: 19.2% of gross revenues from benefit consulting, 80.8% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 15.3% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 1% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
International benefit consulting: 2.9% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the United States.
Other services: 80.8% of business. Includes health care and other types of administration, managed care MIS systems and products.
Locations: Boston, New York; Flint, Mich.; Madrid, Spain; Tokyo, Japan; Singapore.
Staff: 150 total staff members; 20 professionals, including 20 MBAs, one attorney, 10 RNs, one M.D.
Clients: Total clients not reported; 90% with more than 500 employees, 10% with fewer than 500 employees; 80% corporations, 20% multiemployer plans; no minimum size client.
Compensation: By the project; on retainer; by the hour.
1989 gross revenues: $12 million total, $4 million from benefit consulting.
Principal officers: Thomas C. Ramey, president; Dwight L. Robertson and Kevin Brown, senior vps; Alfred J. Discepolo, senior vp/chief financial officer.

Arthur Andersen & Co.-Compensation & Benefits Consulting Group

69 W. Washington St., Chicago, Ill. 60602; 312-580-0069

Year founded: 1913.
Services provided: 60% of gross revenues from benefit consulting, 40% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 35% of business. Includes plan design consulting, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, retirement planning for individuals.
Welfare plan consulting: 15% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, cost management consulting, health strategies, flexible benefits consulting, compliance services.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, booklet preparation, audiovisual program preparation.
International benefit consulting: 5% of business. Includes consulting via overseas branch offices, consulting from the United States.
Other services: 40% of business. Includes compensation consulting.
Locations: New York; Washington D.C.; Houston; Dallas; Milwaukee; Kansas City, Mo.; Minneapolis; San Francisco; St. Louis.
Staff: 57 total staff members; 42 professionals, including one FSA, one MBA, one CEBS, one CLU, 23 CPAs, five attorneys.
Clients: 5,000 total clients; 40% with more than 500 employees, 60% with fewer than 500 employees; 90% corporations, 5% multiemployer plans, 5% individuals; no minimum size client.
Compensation: By the hour.
1989 gross revenues: $14 million total; $8 million from benefit consulting.
Principal officers: Alan A. Nadel, managing partner-worldwide practice; David M. Walker, partner/director-U.S. practice; Max I. Stucker, partner/director-international practice; Michael S. Kesner, partner/regional director-compensation/benefits; James G. Fry, director-medical benefits practice.

B

Barbanell Associates

3629 Sacramento St., San Francisco Calif. 94118; 415-929-1155

Year founded: 1962.
Services provided: 93.1% of gross revenues from benefit consulting, 6.9% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 21.3% of business. Includes plan design consulting, plan/

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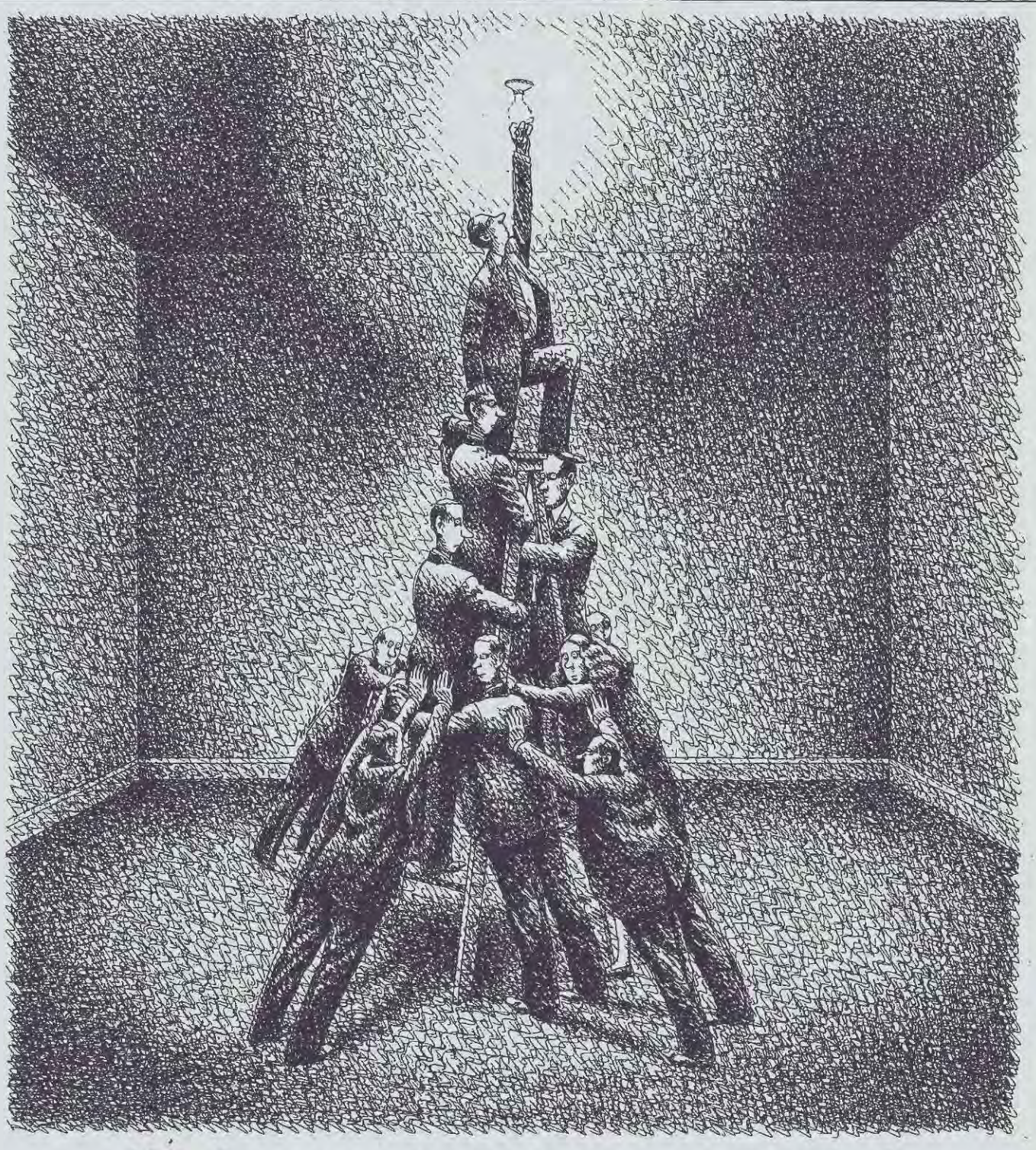
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Guide to benefit consultant directory

The annual directory of benefit consultants is compiled from responses to questionnaires sent to companies by *Business Insurance*.

The directory is published as an editorial service; there is no charge to consultants to be listed. However, to be included, companies must generate at least 30% or $500,000 of their gross revenues from benefit consulting.

Business Insurance defines benefit consulting as providing advice on benefit issues on a fee-for-service basis, excluding brokering insurance, health care and other types of claims administration, compensation consulting and other non-benefit related consulting.

Each listing includes the **year** the company was **founded** and its **parent company**, if any. If you are concerned about using consultants affiliated with brokers or insurers, you will want to check this section.

The **services provided** heading lists the percentages of gross revenues a company derives from benefit consulting and from other services it provides. In the paragraphs that follow, these percentages are broken down into the amount of gross revenues generated from **retirement and savings plan consulting, welfare plan consulting, employee benefit communication consulting, international benefit consulting** and any non-benefit related services the company may provide.

Also listed are locations of **branch offices** and subsidiaries conducting benefit consulting, total number of **staff** members, number of professional staff members assigned to benefit consulting and professional designations they hold. Also included is the number of current **clients** and their size and type.

Methods of billing for services are provided under the **compensation** heading.

When reported by the company, total estimated **1989 gross revenues** are provided, as well as the amount of estimated 1989 revenues generated from benefit consulting only.

If you wish to be put on the mailing list to receive a questionnaire for next year's directory, write Sara Harty, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.

The following are staff abbreviations:

AAI is Accredited Advisor in Insurance; **ACA** is Associate, Conference of Actuaries in Public Practice; **ALCM** is Associate in Loss Control Management; **AEP** Accredited Executive in Personnel; **AMIM** is Associate in Marine Insurance Management; **ARM** is Associate in Risk Management; **ASA** is Associate, Society of Actuaries; **AU** is Associate in Underwriting; **CACAF** is Fellow, Chartered Association of Certified Accountants; **CBC** is Certified Benefits Consultant; **CEBS** is Certified Employee Benefit Specialist; **CFA** is Certified Financial Analyst; **CFP** is Certified Financial Planner; **ChFC** is Chartered Financial Planner; **CIIA** is Associate, Chartered Insurance Institute; **CIIF** is Fellow, Chartered Insurance Institute; **CLU** is Chartered Life Underwriter; **CPA** is Certified Public Accountant; **CPC** is Certified Pension Consultant; **CPCU** is Chartered Property Casualty Underwriter; **DMD** is Doctor of Dental Medicine; **EA** is Enrolled Actuary; **FAF** is Fellow, Faculty of Actuaries; **FCA** is Fellow, Conference of Actuaries in Public Practice; **FCIA** is Fellow, Canadian Institute of Actuaries; **FCII** is Fellow, Chartered Insurance Institute; **FLMI** is Fellow, Life Management Institute; **FSA** is Fellow, Society of Actuaries; **IAA** is Associate, Institute of Actuaries; **IAF** is Fellow, Institute of Actuaries; **ICSAA** is Associate, Institute of Chartered Secretaries and Administrators; **IPMF** is Fellow, Institute of Personnel Management; **IPMM** is Member, Institute of Personnel Management; **ISCEBS** is Fellow, International Society of Certified Employee Benefit Specialists; **LAA** is Associate, Life Assurance Assn.; **LIA** is Liscenced Insurance Advisor; **LIC** is Liscenced Insurance Counselor; **MAAA** is Member, American Academy of Actuaries; **MBA** is Masters in Business Administration; **MCA** Member, Conference of Actuaries; **MD** is Medical Doctor; **MSPA** is Member, Society of Pension Actuaries; **NASD** is National Association of Security Directors; **Ph.D** is Doctor of Philosophy; **RDH** is Registered Dental Hygienist; **RHU** is Registered Health Underwriter; **RN** is Registered Nurse.

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trust legal document drafting, consulting on selection of investment managers.

Welfare plan consulting: 78.7% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Other services: 6.9% of business. Includes brokering.

Locations: Los Angeles.

Staff: Eight total staff members; four professionals, including one MBA.

Clients: 27 total clients; 44% with more than 500 employees, 56% with fewer than 500 employees; 40% corporations, 59% multiemployer plans, 1% individuals; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour, senior consultant-$175; consultant-$150; clerical-$17.

1989 Gross revenues: $745,000 total, $690,000 from benefit consulting.

Principal officers: Clifford Barbanell, president; Joseph L. Levey, vp; Harriet Barbanell, secretary/treasurer; Steve Harris, senior consultant.

Edward R. Beil Associates Inc.

6 E. 45th St., New York, N.Y. 10017; 212-697-2740

Year founded: 1974.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 28% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 62% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 7% of business. Includes general consulting on communications programs.

International benefit consulting: 3% of business. Includes consulting from the United States.

Staff: Six total staff members; including two MBAs, one CLU.

Clients: 58 total clients; 6.9% with more than 500 employees, 93.1% with fewer than 500 employees; 85% corporations, 1% individuals, 14% partnerships; no minimum size client.

Compensation: Commissions on insurance placed with underwriters; on retainer.

1989 gross revenues: $385,000 total, all from benefit consulting.

Principal officers: E.R. Beil, president; J.P. Indelli, treasurer; K.M. Beil, secretary.

Benefit Consultants Inc.

14500 S. Forty Outer Road, Suite 502, Chesterfield, Mo. 63017; 314-434-4620

Year founded: 1982.

Services provided: 60% of gross revenues from benefit consulting, 40% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 55% of business. Includes plan design con-

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sulting, insurer/broker selection consulting, evaluation of other service providers, claim administration audits, legal and regulatory compliance.

Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, booklet preparation.

Other services: 40% of business. Includes brokering, health care claims administration.

Staff: Seven total staff members; three professionals, including one CEBS, one CLU.

Clients: Total clients not reported; 40% with more than 500 employees, 60% with fewer than 500 employees; 70% corporations, 30% multiemployer plans; minimum size client, 50 employees.

Compensation: By the project, commissions for insurance placed with underwriters, on retainer, by the hour: senior consultant, $127.50; consultant, $85; clerical, $27.50; administrative, $52.50-$67.50.

1989 gross revenues: Not reported.

Principal officers: Alan N. Lemley, president.

Benefit Dynamics Inc.

The Bellevue, 200 S. Broad, Suite 425, Philadelphia, Pa. 19102; 215-875-8610

Year founded: 1989.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 70% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 10% of business. Includes plan design consulting, insurer/broker selection consulting, flexible benefit administration.

Employee benefit communications consulting: 20% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.

Staff: 36 total staff members; 25 professionals, including one MBA, one CLU, one CPA.

Clients: Total clients not reported; 85% with fewer than 500 employees; 90% corporations; no minimum size client.

Compensation: By the project; on retainer.

1989 gross revenues: $2 million generated from benefit consulting.

Principal officers: JoAnn Massanova, president/secretary; Carmon LaVerghetta, vp/treasurer.

Benefits Planning & Insurance Agency Inc.

300 Drakes Landing Road, Suite 170, Greenbrae, Calif. 94904; 415-461-8383

Year founded: 1978.

Services provided: 35% of gross revenues from benefit consulting, 65% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 20% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 65% of business. Includes brokering, health promotion and wellness.

Staff: 13 total staff members; five professionals, including one MBA, one CLU, one attorney.

Clients: Total clients not reported; 30% with more than 500 employees, 70% with fewer than 500 employees; 95% corporations, 5% multiemployer plans; minimum size client, 50 employees.

Compensation: Commissions for insurance placed with underwriters; on retainer.

1989 gross revenues: $1.4 million total, $490,000 from benefit consulting.

Principal officers: Robert J. Christadore, president; Victor A. Deicsnys, Gary W. High and Michael D. Michalski, principals.

Benefit Resource Management Group Inc.

301 Fifth Ave., Suite 2300, Pittsburgh, Pa. 15222; 412-645-4900

Year founded: 1987.

Parent company: Blue Cross of Western Pennsylvania.

Services provided: 40% of gross revenues from benefit consulting, 60% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan design consulting, record keeping and administration systems consulting, plan administration consulting

Welfare plan consulting: 25% of business. Includes plan design consulting, compliance activities, educational workshops.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs.

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211 East Chicago Avenue
Chicago, Illinois 60611-2678
Attention: Rita Hoffmann

ADA

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Other services: 60% of business. Includes general management consulting.

Staff: Six total staff members; five professionals, including four MBAs, one CEBS, one attorney.

Clients: 97 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 50% corporations, 10% multiemployer plans, 25% hospitals and other health care providers; no minimum size client.

Compensation: By the project; on retainer.

1989 gross revenues: Not reported.

Principal officers: Robert J. Schuetz, president; Barbara Croyle and Gene Keiden, senior consultants; Gregory Bivens, consultant; James Kennedy, business systems consultant.

Blomquist & Co.

1 Oakbrook Terrace, Suite 812, Oakbrook Terrace, Ill. 60181; 708-620-0200

Year founded: 1960.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 20% of business. Includes plan design consulting, actuarial work for defined benefit plans, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 60% of business. Includes plan design consulting, evaluation of other service providers, actuarial evaluations, stop-loss evaluations.

Employee benefit communications consulting: 20% of business. Includes general consulting on communications programs, booklet preparation, plan document, summary of material modifications.

Staff: 13 total staff members; eight professionals, including two MBAs.

Clients: 57 total clients; 98% with more than 500 employees; 30% corporations, 70% multiemployer plans; minimum size client, 100 employees.

Compensation: By the project; by the hour: senior consultant-$150; consultant-$40-$125.

1989 gross revenues: Not reported.

Principal officers: Jack A. Diem, president; Paul E. Hawkins, Kurt S. Starbuck and Ken L. Fisher, vps; William R. DeWaal, benefit specialist/consultant.

Booke & Co.

310 W. Fourth St., Winston-Salem, N.C. 27102; 919-748-1120

Year founded: 1941.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 82% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, plan administration consulting, asset accumulation/investment consulting, compensation consulting, on-line administration systems.

Welfare plan consulting: 11.5% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, cafeteria consulting and administration, welfare administration.

Employee benefit communications consulting: 6.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: Provides referrals.

Locations: Birmingham, Ala.; Columbus, Ohio.

Staff: 331 total staff members; including 13 FSAs, eight ASAs, 13 MBAs, 19 CEBS, three CLUs, three CPCUs, 11 CPAs, 10 attorneys.

Clients: 1,000 total clients.

Compensation: By the project; by the hour.

1989 gross revenues: Not reported.

Principal officers: Sam Booke Jr., chairman; Henry M. Booke, vice chairman; Joseph H. Ely, senior vp; Roger L. Vaughn, executive vp/chief actuary; Joseph L. Lineberry, senior vp.

The Boylston Group

132 Beech St., Roslindale Village, Boston, Mass. 02131; 617-327-7735

Year founded: 1986.

Services provided: 100% of gross revenues from benefit consulting.

Welfare plan consulting: 80% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, health care cost management.

Employee benefit communications consulting: 20% of business. Includes general consulting on communications programs, audiovisual program preparation.

Staff: Two professionals, including one CLU.

Clients: Six total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 80% corporations, 20% multiemployer plans; minimum size client, 150 employees.

Compensation: By the project; on retainer; by the hour: senior consultant-$125, consultant-$100.

1989 gross revenues: Less than $1 million from benefit consulting.

Principal officers: Michael J. Shoe and James M. Sargout, principals.

Brokers Group Services Ltd.

2200 S. Main St., Suite 302, Lombard, Ill. 60148; 708-620-0555

Year founded: 1980.

Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 21% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, selection of insurance companies.

Employee benefit communications consulting: 9% of business. Includes general consulting on communications programs, booklet preparation.

Other services: 70% of business, includes brokering, health care and other types of claims administration.

Staff: Four total staff members; four professionals.

Clients: Total clients not reported; 100% with fewer than 500 employees; 100% corporations; minimum size client, 20 employees.

Compensation: By the project; commissions for insurance placed with underwriters; by the hour.

1989 gross revenues: $670,000 from benefit consulting.

Principal officers: Richard Van Derveer, chairman/president; Robert Ambrose, treasurer; Jeanne Pariser, secretary.

Buck Consultants Inc.

2 Pennsylvania Plaza, New York, N.Y. 10121; 212-330-1000

Year founded: 1916.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: Services include plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: Services include plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, evaluation of post-retirement medical disabilities, managed care consulting, flexible benefits, group actuarial, dependent care consulting, employee focus groups.

Employee benefit communications consulting: Services include general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the United States, special assignments undertaken involving travel to other countries.

Locations: Atlanta; Boston; Chicago; Columbia, Md.; Dallas; Denver; Detroit; Fort Wayne, Ind.; Honolulu; Houston; Los Angeles; Pittsburgh; San Francisco; Secaucus, N.J.; Stamford, Conn.; District of Columbia; Antwerp and Brussels, Belgium; Calgary, Montreal and Toronto, Canada; Dublin, Ireland; Edinburgh, Scotland; Leeds and London, England; Madrid, Spain; Paris, France; Sydney, Australia.

Continued on next page

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Flexibility in a Maintenance Prescription Drug Program

Continued from previous page

Staff: 1,300 total staff members; 1,014 professionals, including 50 FSAs, 56 ASAs, 38 MBAs, seven CEBs, seven CLUs, six Ph.D.s, seven CPAs, 27 attorneys, 98 EAs, 45 professional designations assigned in England and Scotland.

Clients: 1,000 total clients; 80% corporations, 20% non-profit or government organizations; no minimum size client.

Compensation: By the project; by the hour.

1989 gross revenues: $132 million from benefit consulting and total.

Principal officers: William E. Giegerich, president/chief executive officer; Martin Paterson, chief executive-Buck Paterson Consultants Ltd. (London); Barry Sutton, president, GBB Buck Consultants Ltd. (Toronto); Michael Dunhill, managing director, Buck Consultants S.A. (Brussels); Warren Warburton chief executive, Buck Consultants Ltd. (Sydney).

R.J. Burns & Associates Inc.

2000 N. Racine Ave., Suite 3800, Chicago, Ill. 60614; 312-871-5110

Year founded: 1979.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 3% of business. Includes plan design consulting, actuarial work for defined benefit plans, plan administration consulting.

Welfare plan consulting: 80% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 15% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.

International benefit consulting: 2% of business. Includes consulting from the United States.

Staff: Two total staff members.

Clients: 12 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 90% corporations, 10% multiemployer plans; no minimum size client.

Compensation: By the hour: senior consultant-$200; consultant-$165.

1989 gross revenues: Not reported.

Principal officers: Richard J. Burns, president; David P. Hermes, treasurer.

Bushnell, Ducham & Co.

34 Roosevelt Highway, Colchester, Utah 05446; 802-655-3906

Year founded: 1970.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 45% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, plan termination consulting.

Welfare plan consulting: 45% of business. Includes plan design consulting, third party administrator/insurer/broker selection consulting, evaluation of other service providers, plan documents drafting, plan audits.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, computer system tie-ins for flexible benefits.

Staff: 11 total staff members; six professionals, including one ASA, one CEBS, one CLU.

Clients: 175 total clients; 25% with more than 500 employees, 75% with fewer than 500 employees; 85% corporations, 5% multiemployer plans, 10% government and non-profit organizations; minimum size client, 150 employees.

Compensation: By the project; by the hour: senior consultant-$185, consultant-$80-$120, clerical-$30-$50.

1989 gross revenues: $725,000 total, all from benefit consulting.

Principal officers: James Bushnell, president/treasurer; David Ducham, vp; Brent O'Donnell, secretary.

Business-Estate Underwriters Inc.

910 E. Washington St., Greenville, S.C. 29601; 803-242-9441

Year founded: 1966.

Services provided: 82% of gross revenues from benefit consulting, 18% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 8% of business. Includes plan design consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 74% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Other services: 18% of business. Includes brokering.

Locations: Asheville and Hickory, N.C.; Columbia, S.C.

Staff: 16 total staff members; 12

Continued on page 36

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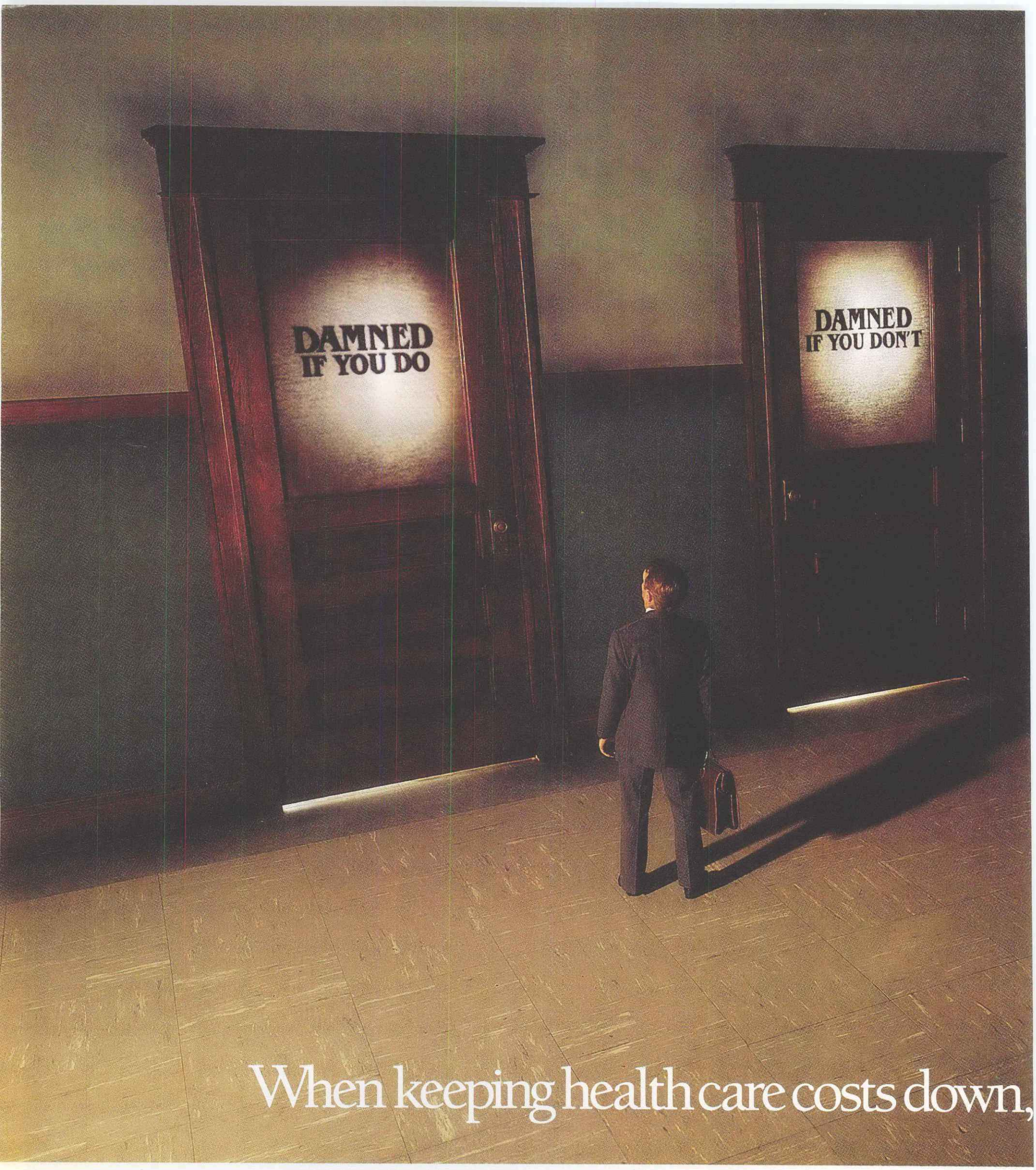
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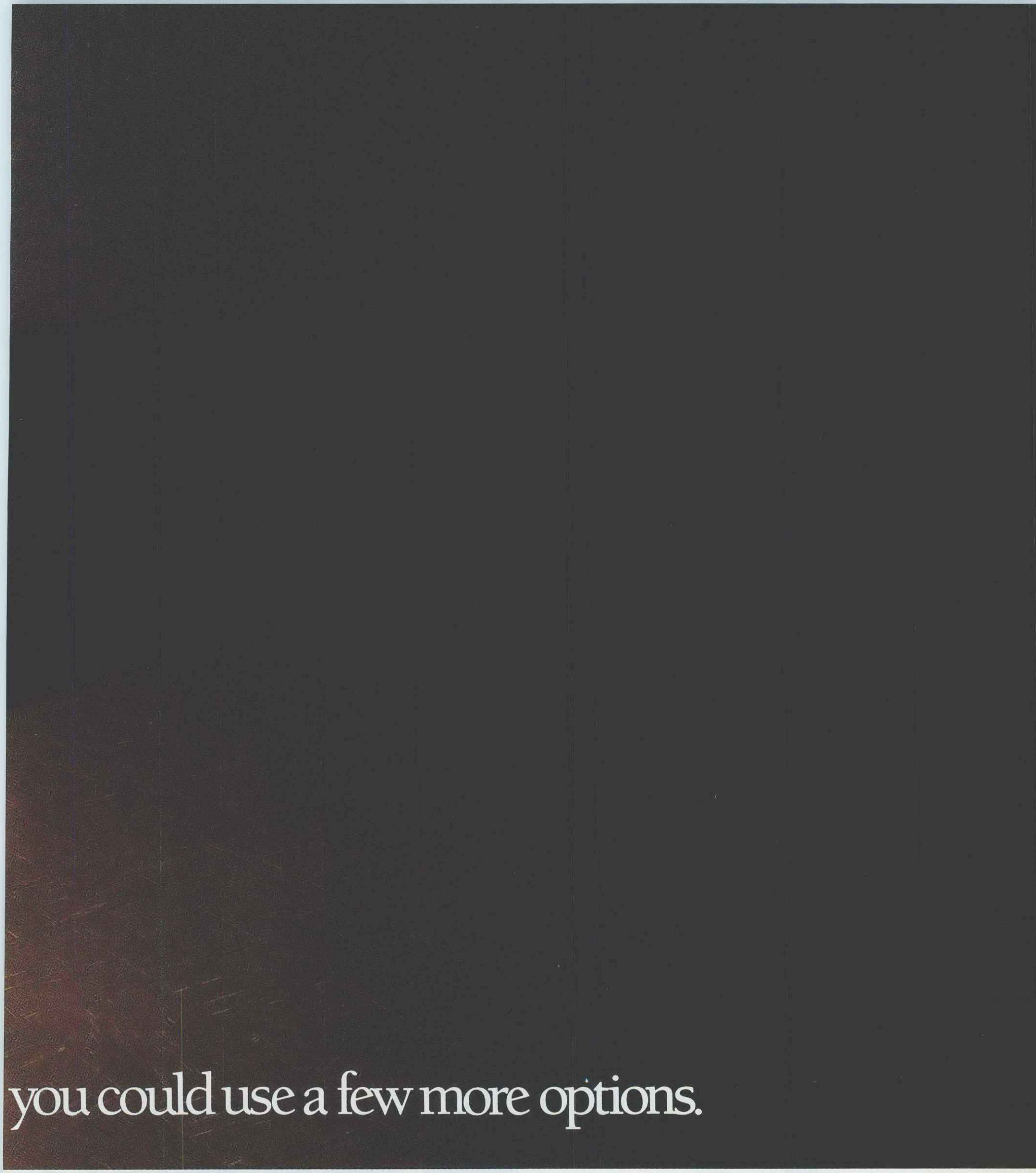


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Capitalizing an Illinois captive insurer

By Tomas Morgan Russell

THERE IS AN INCREASED EXPECTATION of the market hardening in the foreseeable future and that raises the expectation of an increase in the formation of captives and risk retention groups as alternative facilities to the traditional market. This article focuses on available solutions to the most difficult problem facing the organizers of new group captives and risk retention groups: the raising of statutorily required capital.

The newly amended Illinois Captive Insurance Company and Risk Retention Group statutes will be examined since they provide the greatest number of mechanisms for financing capitalization in the country. This is one of the reasons Illinois will become the national domicile of choice for the formation of captives and RRGs.

Obtaining the needed capital seems to be *always* the most difficult problem in the formation of a new company. In Illinois and nearly all states, the formation process consists of two stages. First, the preparation and review of the application, the offering memorandum and other documents and their approval by the Insurance Department and the subsequent issuance of a Permit to Solicit capital.

Second is the audit of the bank accounts and the examination of other financial instruments to establish the existence of the minimum statutory capital. This step culminates in the issuance of a Certificate of Authority to engage in the business of insurance and issue insurance policies.

The six Illinois capitalization methods are:

- Cash. The collection of plain old greenbacks is universally approved in all states and is universally difficult to achieve. It presents a classic "chicken and egg" problem. A new company cannot issue policies without the capital and it is very, very difficult to raise the capital if it cannot issue policies at the same time. This may be the reason purchasing groups outnumber risk retention groups by nearly seven to one.

In most states, the effort to raise capital must be accompanied by publishing notices of the intent to organize, purchase of fidelity bonds and establishment of full formal escrow accounts with accredited financial institutions. Illinois waives all of these usual requirements for captives and risk retention groups and the audit examination normally takes only an hour or two.

- Holding companies. At least in Illinois, it is possible to use the holding company mechanism to facilitate the financing of a new captive or risk retention group. The insurance company is formed as a stock company. All of the stock is owned by a holding company, which is also formed as a stock company. The insurance company issues policies to the policyholders, all of whom buy stock in the holding company. The holding company goes into debt to the financing institution by way of notes secured by pledges of the stock of the insurance company. The capital generated by these loans is then transferred to the insurance company in exchange for the stock. This transfer of capital is *unencumbered* so that it is treated as capital on the books of the insurance company and not as an asset offset by the liability of a debt or note.

The Securities and Exchange Commission has approved this structure as long as there is congruity among the stockholders of the holding company and the policyholders. The financing is usually provided by commercial sponsors. Trade associations or related foundations could also provide the financing. This holding company mechanism was successfully employed in the formation in Illinois of the Environmental Protection Insurance Co.

The advantages of using the holding company structure are that it permits quick capitalization and it eliminates the capital solicitation period during which the company cannot issue policies. It solves the "chicken and egg" problem because it enables the company to solicit capital from policyholders and issues policies at the same time from the very outset. The disadvantages are that the sponsors take the unsecured risk of the company failing to raise its own capital, the complexity of the structure (two companies rather than one) and the complexity of the financial transactions involved. On the other hand, it works.

- Secured Contractual Obligations. This is a method of capitalization unique to Illinois. The policyholder pays one-third of the capital in cash or cash equivalents at the outset. The remaining two-thirds of the capital consists of a contract, secured by liquid collateral, obligating the policyholder to pay the remaining two-thirds in three equal payments over the three calendar years after the issuance of the Certificate of Authority. This results in dividing the capital contribution into four payments. The contract must be secured by collateral acceptable to the Department of Insurance and the obligation is subject to acceleration; that is, payment in full on the demand of the Department of Insurance if the company gets into financial trouble.

The advantage is the spreading of the capital payments over four installments over three years. The disadvantages are that the contract must be collateralized by liquid investments, such as stock or a Letter of Credit, 33% of capital must still be in cash or cash equivalents and the contract must be subject to acceleration on demand.

- Letters of credit. Illinois permits the use of letters of credit for up to 80% of the required capital and surplus. LOCs may not be allowed to expire without the written approval of the director and must provide 30 days advance notice of expiration to the director.

Funds obtained by drawing down LOCs must be free of claims of any party. The issuing bank must be either an Illinois-chartered bank, a bank that is a member of the Federal Reserve System or a U.S. branch of a foreign bank approved by the Securities Valuation Office of the National Assn. of Insurance Commissioners. If LOCs are used in amounts in excess of the required statutory minimum capital and surplus, then the aggregate amount cannot exceed the policyholder surplus of the company. Also, without the approval of the director, no LOC may be allowed to expire in an amount in excess of 10% of surplus or net income. The Insurance Department has the authority to require the company to draw down its LOCs. If LOCs are used, notice of the fact must be given to prospective policyholders. The advantage is that cash outlays are lessened. The disadvantage is the cost of the LOC.

- Assignment of Investment Security. This mechanism uses the assignment of investment securities as the means of capitalization. It is popular with companies wishing to form "pure" captives but this method is available to group captives as well. The security, such as common stock, must usually be a permitted investment under the insurance code of the domiciliary state and the security must be liquid. Publicly traded stock would meet this requirement. The amount of a given security may be limited by the insurance code. Also, the company will still need some cash for operations.

- Subordinated debt. The Illinois statute permits a captive or RRG to borrow all of its capital at rates of up to prime plus 3%. There are no restrictions on the nature or type of the lender. It could be a trade association, a foundation, individuals or institutions in the capital markets. The loan is made pursuant to a contract approved by the Illinois Insurance Department.

The loan and interest can be paid only out of surplus in excess of an amount stipulated in the contract and repayments must be approved by the Insurance Department. The proceeds of the loan are carried on the books of account as a special surplus account or special capital account at the election of the company. The proceeds are considered in determining whether statutory minimum capital and surplus requirements have been met.

The subordinated debt mechanism also solves the "chicken and egg" problem and is a means of obtaining quick capitalization. The debt can be repaid as policyholders buy policies and contribute capital. In a sense, this mechanism can be looked upon as a "bridge financing" method. The disadvantage is the expense, which will be the interest rate of up to prime plus 3% less the return on the invested capital. Also, the company will forgo accruing investment returns as additional assets on its books.

Illinois provides for an array of six methods of capitalization of captives and RRGs. The financing methods should be of considerable interest to those considering forming these new companies in the coming harder market.

Tomas Morgan Russell was the principal draftsman of the 1987 Illinois captive statute and its 1989 amendments. He is an attorney with Hopkins & Sutter in Chicago and is a director of the National Risk Retention Assn. This article is an adaptation of an address he gave at the third annual meeting of the RRA in Washington, D.C.



Actuary's column corrected

A section of copy was inadvertently omitted from the Dec. 4 Ask a Benefit Actuary column explaining how to calculate whether a self-insured medical plan is subject to taxation. The affected section follows, with the missing text in bold:

If a plan discriminates with respect to eligibility, then a fraction of the reimbursements paid to highly compensated individuals under the plan is taxable income.

The numerator of the fraction is the total amount reimbursed to all **participants who are highly compensated individuals under the plan for the plan year, and the denominator is the total amount reimbursed to all** employees under the plan for the plan year.

Disciplinary action led to stress claim

The Court of Appeals of Oregon held that an employee's stress-related psychological condition was a compensable injury.

Robert H. Anderson was a 38-year-old policeman employed by the city of Lebanon, Ore., since 1978. Throughout his employment he had been the subject of poor performance evaluations and disciplinary measures. Mr. Anderson was also the target of numerous allegations that he had misused sick time and conducted personal errands while on patrol. After a domestic squabble involving his wife and girlfriend, he was suspended with pay pending an investigation. He filed this stress-related disability claim. The claim was denied and the compensation board affirmed. Mr. Anderson eventually was fired. This appeal ensued.

The appellate court said that if discipline was objectively stressful it would support a claim for a stress-related occupational disease. Here the court said the disciplinary actions, though justified, were objectively stressful and found the claim was compensable. *SAIF vs. Anderson*, Court of Appeals of Oregon, Nov. 23, 1988 (*BI*/02/Dec.-$10).

Legal briefs

This abstract was prepared by Cases Unlimited Inc. Copies of this decision are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number of the opinion.*

Continued from page 31
professionals, including four CLUs, one Ph.D., one CPA, two attorneys.

Clients: 210 total clients; 34% with more than 500 employees, 66% with fewer than 500 employees 90% corporations, 4% multiemployer plans, 6% individuals; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant-$175, consultant-$130, clerical-$45, administrative-$90.

1989 gross revenues: $1.8 million total, $1.4 million from benefit consulting.

Principal officers: Joseph E. Young, chairman; William A. Gantt Jr., president; Michael A. Hawkins, Richard A. Gantt, Donald E. Ward, P. Edwin Icard and Otis B. Kempson, vps.

Byerly & Co. Inc.

7600 E Orchard Road Suite 250S, Englewood, Colo. 80111
303-220-7575

Year founded: 1959.

Services provided: 88% of gross revenues from benefit consulting, 12% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 99% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, cost containment services compliance services.

Employee benefit communications consulting: 1% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 12% of business. Includes health care premium administration.

Locations: Chicago; Overland Park, Kan.; Baton Rouge and Metairie, La.; Cheyenne, Wis.

Staff: 65 total staff members; including two MBAs, six CEBs, two CLUs, one CPA, one attorney, four RNs.

Clients: 665 total clients; 5% with more than 500 employees, 95% with fewer than 500 employees; 85% corporations, 15% multiemployer plans; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour, senior consultant-$150-$250, consultant-$100-$150, clerical-$30-$50.

1989 gross revenues: $5.4 million total, $4.75 million from benefit consulting.

Principal officers: Robert N. Morehead, president; Alfred A. Gimbel, executive vp; Mark E. Hogan, senior vp; Gerald A. Peters, Bruce T. Tawson, William Raines and Jane Gruhl, vps; Vincent R. Peyton, president-Byerly & Co. of Kansas Inc.; Warren Tasset, president-Byerly & Co. of Wyoming Inc.; William A. Heine, president-Byerly & Co. of Louisiana Inc.; William E. Shannon, president-Byerly & Co. of Illinois Inc.

C

The CBI Group

100 S. Prospect Ave., Park Ridge, Ill. 60068; 708-698-1090

Year founded: 1983.

Parent company: Joseph Lemmer & Co.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 2% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting, labor negotiations.

Welfare plan consulting: 45% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, cafeteria plans, labor negotiations.

Employee benefit communications consulting: 2% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, cafeteria plans, labor negotiations.

International benefit consulting: 1% of business. Includes consulting from the U.S., referral to foreign correspondents.

Other services: 50% of business. Includes brokering, cafeteria plans administration.

Staff: Six total staff members; four professionals.

Clients: Total clients not reported; 30% with more than 500 employees, 70% with fewer than 500 employees; 70% corporations, 10% multiemployer plans, 5% individuals; 15% municipalities and school districts; minimum size client, 25 employees.

Compensation: By the project; on retainer; by the hour, senior consultant-$75-$150, consultant-$60-$125; research/administrative assistance-$50.

1989 gross revenues: Not reported.

Principal officers: Joseph Lemmer, president.

Capital Benefit Plans Inc.

One Torrington Office Plaza, Torrington, Conn., 06970; 203-496-0000

Year founded: 1975.

Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 30% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Other services: 70% of business. Includes brokering, employee benefit plan administration.

Staff: 17 total staff members; three professionals, including two MBAs, one CEBS.

Clients: Total clients not reported; 10% with more than 500 employees, 90% with fewer than 500 employees; 80% corporations, 20% sole proprietor and partnerships; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters.

1989 gross revenues: Not reported.

Principal officers: Robert E. Chain, president; Robert F. Parillo, chief operating officer.

Century Financial Services

9040 Kimberly Blvd., Suite 61, Boca Raton, Fla. 33434; 407-479-1313

Year founded: 1983.

Parent company: Cenvill Development Corp.

Services provided: 75% of gross revenues from benefit consulting, 25% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 60% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, financial plan monitoring, ERISA and Section 89 compliance, negotiation with insurers and services organizations, preparation of utilization review studies, general plan administration and claims settlement assistance, surveys, general research on benefits, state and federal legislative developments, benefit education programs.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.

Other services: 25% of business.

Staff: Eight total staff members; six professionals.

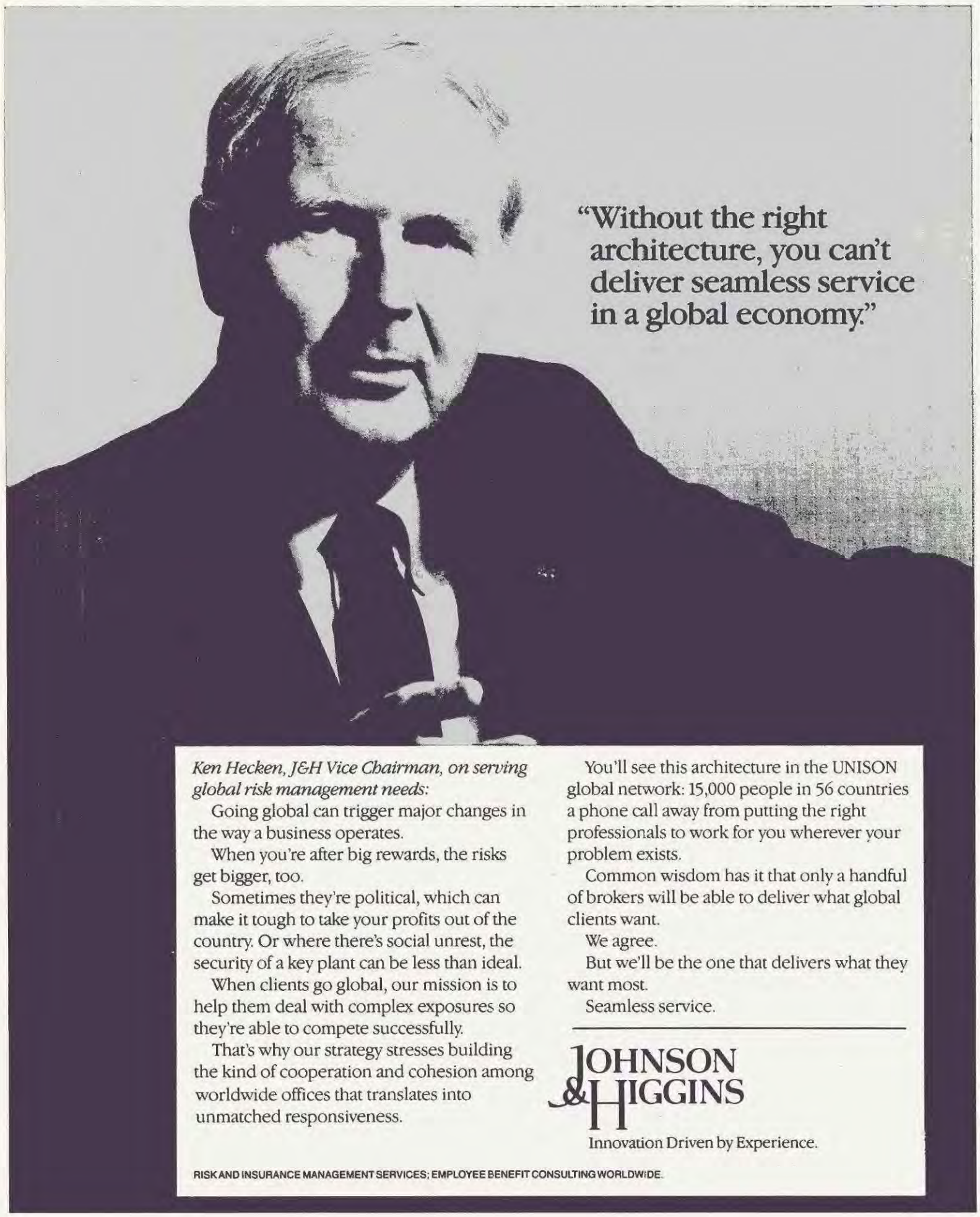
Clients: Total clients not reported; 40% with more than 500 employees, 60% with fewer than 500 employees; 88% corporations, 2% multiemployer plans, 5% individuals, 5% municipalities; minimum size client, 50 employees.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

1989 gross revenues: $536,250 generated from benefit consulting.

Principal officers: Ronald Re-

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Continued from previous page
shefsky, president; Richard J. Leonard, president-benefits consulting division; Mitchell L. McEwen, manager-benefits consulting division; Herbert C. Achtmeyer, vp-senior benefit consultant; Catharine B. Rudensey, assistant vp/senior benefit consultant.

CIGNA Employee Benefits Services Inc. (CEBSI)

Retirement plans: 350 Church St., Hartford, Conn. 06103; 203-725-2939;
Welfare plans: 900 Cottage Grove Road, Bloomfield, Conn. 06002; 203-726-5774

Year founded: 1946.
Parent company: CIGNA Corp.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: 90% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, retiree health care.
Welfare plan consulting: 5% of business. Includes plan design consulting, flexible benefits, tax and legal compliance.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, brochures, newsletters, interactive PC models.
Locations: Akron, Ohio.
Staff: 110 total staff members; 95 professionals, including four FSAa, 14 ASAs, one MBA, one CEBS, one CPA, 15 EAs, two HIAAs.
Clients: 800 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 75% corporations, 5% multiemployer plans, 20% tax-exempt employers; minimum size client, 25 employees.
Compensation: By the project; by the hour: senior consultant-$150-$215, consultant-$100-$150, clerical-$60, technicians-$70-$100.
1989 gross revenues: $11.5 million total, all from employee benefit consulting.
Principal officers: Russell W. Anderson, president-pension consulting; Raymond C. Linstrum, president-benefits consulting; Thomas M. Malloy and Richard Gabler, senior vps/consulting actuaries; Mark L. Lynch, vp/consulting actuary.

Consulting Group Inc.

Suite 200, Five County View Road, Malvern, Pa. 19355; 215-889-9100

Year founded: 1972.
Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 25% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers.
Welfare plan consulting: 12.5% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, flexible benefits plan design, communications installation and compliance testing.
Employee benefit communications consulting: 12.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
Other services: 50% of business. Includes administration of flexible benefits plans.
Staff: 45 total staff members; 20 professionals, including one CLU.
Clients: 100 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 100% corporations; minimum size client, 100 employees.
Compensation: On retainer; by the hour: senior consultant-$150, consultant-$100, clerical-$50.
1989 gross revenues: Not reported.
Principal officers: Alex Johns, chairman; Harriet Hankin, president; David M. Banet, senior vp; Ruth Ringwood, executive vp.

Coopers & Lybrand-Actuarial, Benefits & Compensation Group

400 Renaissance Center, Detroit, Mich. 48243; 313-446-7266
Year founded: 1961.
Parent company: Coopers & Lybrand.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.
Welfare plan consulting: Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

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Continued from previous page

International benefit consulting: Includes consulting from the U.S. provided through associated and member firms in 25 countries.

Locations: Albany, New York and Syracuse, N.Y.; Atlanta; Boston; Chicago; Cleveland and Columbus, Ohio; Dallas; Detroit; Houston; Los Angeles; Newport Beach and San Francisco, Calif.; Louisville, Ky.; Minneapolis; Parsippany, N.J.; Philadelphia; Seattle; Stamford, Conn.; Tampa, Fla.; District of Columbia.

Staff: 1,061 total staff members; 852 professionals.

Clients: 7,500 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; no minimum size client.

Compensation: By the project; by the hour.

1989 gross revenues: $86 million total, all from benefit consulting.

Principal officers: Jerome Y. Halperin, vice chairman-actuarial benefits/compensation group; Barry L. Blazer, regional partner-New York; Harold Dankner, partner/director national technical services unit; J. Larry Glass, regional partner-Northeast; James A. Hall, regional partner-casualty actuarial services; Reed A. Keller, regional partner-Southeast; John B. Phillips, regional partner-West; Harry D. Spring, regional partner-Southwest; David P. Sunderhaft, regional partner-Midwest.

Corporate Communicators Inc.

P.O. Box 393, Pleasant Valley, Conn. 06063; 203-738-0033

Year founded: 1983.

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Employee benefit communications consulting: 95% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, payroll stuffers, posters, benefit letters and employee newsletters.

Other services: 5% of business.

Staff: Five total staff members; three professionals, including one FLMI.

Clients: 60 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 80% corporations, 20% non-profit organizations; no minimum size client.

Compensation: By the project; by the hour: senior consultant-$75, consultant-$50, clerical-$12.

1989 gross revenues: Not reported.

Principal officers: Freeman M. Butland, president.

Corroon & Black: Local Office Benefit Divisions/C & B Consulting Group

Wall Street Plaza, New York, N.Y. 10005; 212-363-4100

Year founded: 1905.

Parent company: Corroon & Black Corp.

Services provided: 72% of gross revenues from benefit consulting, 28% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 29% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 35% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 8% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, marketing brochures.

International benefit consulting: 1% of business. Includes consulting via overseas correspondents, consulting from the U.S.

Other services: 28% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration, structured settlements.

Locations: 50 U.S. locations, 76 foreign affiliates.

Staff: 670 total staff members; 350 professionals, including those holding FSA, ASA, MBA, CEBS, CLU, CPCU, PhD, CPA and attorney designations.

Clients: 6,750 total clients; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

1989 gross revenues: $59.7 million total, $43.4 million from employee benefit consulting.

Principal officers: Warren J. Winer, president/chief executive officer-C & B Consulting Group; Thomas G. Eakes, chairman-Brokerage Services Group/Employee Benefits Operating Committee.

Crosby Benefit Systems Inc.

75 Second Ave., Suite 250, Needham Heights, Mass. 02194; 617-449-0500

Year founded: 1976.

Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 20% of business. Includes plan design consulting, insurer/broker selection consulting.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, audiovisual program preparation.

Other services: 70% of business. Includes brokering, general management consulting, health care and other types of claims administration.

Staff: 14 total staff members; four professionals.

Clients: 85 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 20% corporations, 80% non-profit organizations; no minimum size client.

Compensation: By the project.

1989 gross revenues: Not reported.

Principal officers: Leanne S. Anderson, president/chief executive officer; Harvey Crosby, treasurer.

Carl A. Curcio & Associates Inc.

Meridian Band Building, Suite 706, Easton, Pa. 18042; 215-250-0660

Year founded: 1979.

Services provided: 38% of gross revenues from benefit consulting, 62% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 15% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 15% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 8% of business. Includes benefit statement preparation, booklet preparation.

Other services: 62% of business. Includes brokering, general management consulting.

Staff: Four total staff members; two professionals, including one MBA.

Clients: 80 total clients; 22% with more than 500 employees, 78% with fewer than 500 employees; 50% corporations, 25% multiemployer plans, 5% individuals, 20% Taft Hartley trust groups; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; by the hour: senior consultant-$125, consultant-$75, clerical-$35.

1989 gross revenues: Not reported.

Principal officers: Carl A. Curcio Jr., president/owner/chief executive officer.

D

Deloitte & Touche-Actuarial, Benefits & Compensation Consulting Group

1633 Broadway, New York, N.Y. 10019; 212-492-4073

Year founded: 1947.

Services provided: 76% of gross revenues from benefit consulting,

Continued on next page

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Continued from previous page
24% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 55% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 15% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 2% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the U.S.

Other services: 24% of business.

Locations: Boston; Philadelphia; Washington, D.C.; Atlanta; Houston; Dallas; Tulsa, Okla; Detroit; Minneapolis and St. Paul, Minn.; Chicago; Hartford, Conn.; Los Angeles; San Francisco; Tampa, Fla.

Staff: 300 total staff members; 250 professionals, including 15 FSAs, 11 ASAs, 10 MBAs, 10 CEBSs, two CLUs, five Ph.D.s, 10 CPAs, 10 attorneys, four FCASs, one ACAS, 28 EAs, 32 MAAAs.

Clients: Total clients not reported; 80% with more than 500 employees, 20% with fewer than 500 employees; 90% corporations, 10% public entities.

Compensation: By the project; on retainer; by the hour: senior consultant-$90-$110, consultant-$75-$95, clerical-$40-$50.

1989 gross revenues: Not reported.

Principal officers: David E. Dresner, national director; Susan Achenbach, Ainar D. Ayala Jr., Bruce Bengston, Richard Berens, Jack R. Broesamle Jr., Frank Buck, Brian Cameron, Tim Garmager, Robert Ingram, James Karter, Jay Lingo, Jan Lommele, Robert Nadel, Steven Ogren, Jeremiah R. Riddle, Leon Smith, Mark Sobel, Robert Starkey, David L. Stone, Keith Swenson, Adrian Theriault and Jack Whiting, partners.

Donlon & Rysz Inc.

300 W. Adams St., Chicago, Ill. 60606; 312-726-0481

Year founded: 1988.

Services provided: 100% of gross revenues from benefit consulting.

Welfare plan consulting: 100% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, actuarial valuations of group health plans, health cost projections and pricing studies, determining effects on costs of changes in legislation and regulations, analysis of health costs and cost containment alternatives, development of HMO contribution rates, FASB valuations of retiree health plans, compliance testing under Sections 79, 125, 129, cafeteria plan design and pricing.

Staff: Four total staff members; three professionals, including two FSAs, one MBA, two MAAAs, one FCA.

Clients: 25 total clients; 90% with more than 500 employees, 10% with fewer than 500 employees; 95% corporations, 5% multiemployer plans.

Compensation: By the project; commissions for insurance placed with underwriters; by the hour: senior consultant-$175-$250, consultant:-$100-$175, clerical-$40-$60.

1989 gross revenues: Not reported.

Principal officers: Thomas M. Donlon and Charles J. Rysz, principals.

E

Empire Professional Services

1475 Winton Road N., Rochester, N.Y. 14609-5894; 716-654-7150

Year founded: 1974.

Parent company: Blue Cross & Blue Shield of the Rochester Area.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 78% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 16% of business. Includes plan design consulting, consulting on selection of investment managers, evaluation of other service providers.

Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 1% of business. Includes consulting from the U.S.

Staff: 20 total staff members; 15

Continued on next page

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Continued from previous page
professionals, including one FSA, one ASA, two MBAs.

Clients: 200 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 96% corporations, 2% multiemployer plans, 2% partnerships; no minimum size client.

Compensation: By the project; by the hour: senior consultant-$125-$150; consultant-$60-$70, clerical-$30, actuary-$125-$150.

1989 gross revenues: $550,000 from benefit consulting.

Principal officers: Nancy L. Beaman, president; Stephen Busscwitz, chief actuary.

Employee Benefits Supermarket

P.O. Box 729, San Jose, Calif. 95106-0729; 408-971-3271

Year founded: 1988.

Services provided: 60% of gross revenues from benefit consulting, 40% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 25% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 25% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, hospital evaluations.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 40% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration.

Staff: 15 total staff members; three professionals, including one MBA, three ARMs.

Clients: 300 total clients; 25% with more than 500 employees, 75% with fewer than 500 employees; 20% corporations, 40% multiemployer plans, 30% individuals, 10% agents and brokers; minimum size client, 10 employees.

Compensation: By the project; on retainer; by the hour.

1989 gross revenues: $810,000 total, $640,000 from benefit consulting.

Principal officers: Jeffrey Allen Burkes, president; Anne Miller, vp; Hakeem Al-Raheem, risk manager/consultant.

The Epler Co.

450 B St., Suite 750, San Diego, Calif. 92101-8002; 619-239-0831

Year founded: 1971.

Services provided: 85% of gross revenues from benefit consulting, 15% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 70% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers, executive benefit consulting.

Welfare plan consulting: 10% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, flexible benefit consulting, managed care systems consulting.

Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, surveys.

Other services: 15% of business. Includes compensation consulting.

Staff: 13 total staff members; including one ASA, two MBAs, one CPA.

Clients: 50 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 100% corporations; minimum size client, 25 employees.

Compensation: By the project; by the hour: senior consultant-$150, consultant-$100, clerical-$40.

1989 gross revenues: Not reported.

Principal officers: Jane Barry, chief executive officer/president; Lee Hindenach, executive vp; Richard Binford and Lin Ball, vps.

F

FlexBen Corp.

900 Wilshire Drive, Suite 304; Troy, Mich. 48084; 313-362-2120.

Year founded: 1983.

Services provided: 85% of gross revenues from benefit consulting, 15% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 8.5% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 51% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, flexible benefits.

Employee benefit communications consulting: 25.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, newsletters, videos.

Other services: 15% of business. Includes compensation consulting, brokering fees, general management consulting, health care and other types of claims administration.

Staff: 27 total staff members; 18 professionals, including two MBAs, one CLU, two CPAs.

Clients: 70 total clients; 70% with more than 500 employees, 30% with fewer than 500 employees; 90% corporations, 10% other; minimum size client, five employees.

Compensation: By the project; on retainer; by the hour: senior consultant-$90-$130, consultant-$50-$100, clerical-$20-$40.

1989 gross revenues: Not reported.

Principal officers: Anthony A, Paschke, president; David E. Wilson, senior vp/secretary/treasurer.

G

Arthur J. Gallagher & Co.-Gallagher Benefits Services

10 Gould Center, Rolling Meadows, Ill. 60008; 708-640-8500

Year founded: 1927.

Parent company: Arthur J. Gallagher & Co.

Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 2% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 24% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 70% of business.

Locations: White Plains, N.Y.; Miami and Tampa Bay, Fla.; Dallas; St. Louis; Denver; Chicago.

Staff: 131 total staff members; 55 professionals, including one CEBS, one CLU, two CPAs.

Clients: 400 total clients; 15% with more than 500 employees, 85% with fewer than 500 employees; 50% corporations, 50% multiemployer plans; minimum size client, 10 employees.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

Principal officers: Robert E. Gallagher, president; John P. Gallagher, executive vp; J. Patrick Gallagher, vp-operations; James W. Durkin Jr., vp; Michael J. Cloherty, vp.

Garner Consulting

510 S. Marengo Ave., Pasadena, Calif. 91101; 818-440-0969

Year founded: 1987.

Services provided: 83% of gross revenues from benefit consulting, 17% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 82% of business. Includes plan design consulting, evaluation of other service providers.

Employee benefit communications consulting: 1% of business. Includes benefit statement preparation.

Other services: 17% of business. Includes general management consulting, health care and other types of claims administration.

Staff: Three total staff members; two professionals, including one CLU, one CPA, one FLMI.

Clients: 24 total clients; 46% with more than 500 employees, 54% with fewer than 500 employees; 96% corporations, 4% multiemployer plans; no minimum size client.

Compensation: By the project; on retainer; by the hour.

1989 gross revenues: Not reported.

Principal officers: John C. Garner, president; Gert Reagan, vp.

Godwins International Holdings Inc.

549 Pleasantville Road, Briarcliff Manor, N.Y. 10510; 914-747-2002

Year founded: 1988.

Parent company: Frank B. Hall & Co.

Services provided: 90% of gross revenues from benefit consulting, 10% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 56% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting, investment and tax planning advice for employees and dependents.

Welfare plan consulting: 29% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, COBRA record keeping.

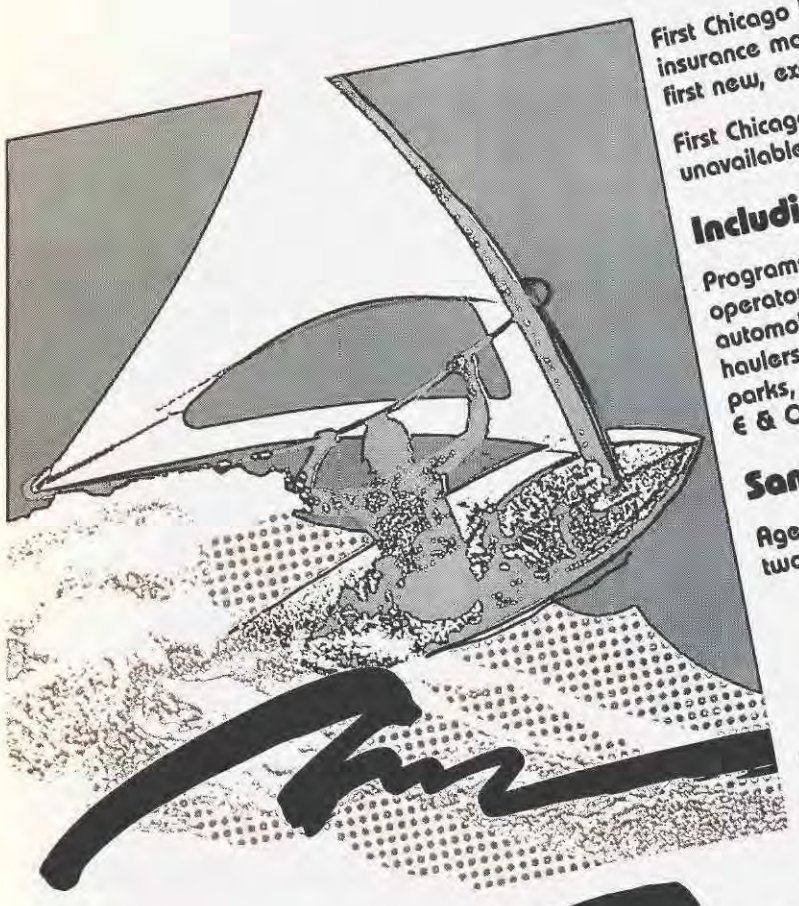
Employee benefit communications consulting: 3% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 2% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the U.S.

Other services: 10% of business.

Continued on next page

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Includes investment and tax planning advice for private individuals.

Locations: 26 locations in the U.S., 39 foreign locations.

Staff: More than 900 total staff members; 650 professionals including six FSAs, two FCAs, seven MAAAs, eight EAs, 15 CLUs, four ASAs, two MSPAs, six CEBSs, three ChFCs, two CPCs, one LIC, two CPAs, three NASDs, four CIIFs, 23 CIIAs, seven FAFs, 12 IAFs, one IAA, two ICSAAs, one IPMM, one IPMF, one LAA, one CACAF.

Clients: Not reported.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

1989 gross revenues: $65 million total, $59 million from benefit consulting only.

Principal officers: David J.D. McLeish, chairman/chief executive officer; Robert M. Bishop, president/chief operating officer-Godwins Overseas Inc.; J. Hunter Devine, managing director-Godwins Ltd.; Michael J. Reynolds, president/chief operating officer-Godwins Inc.

Grubbs & Co. Inc.

10216 Royal Road, Silver Spring, Md. 20903; 301-434-1540

Year founded: 1986

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 80% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, multiemployer plan consulting.

Welfare plan consulting: 10% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, actuarial work.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, conducting employee meetings.

Staff: Four total staff members; two professionals, including two FSAs.

Clients: 35 total clients; 40% with more than 500 employees, 60% with fewer than 500 employees; 88% corporations, 6% individuals, 6% governmental agencies; minimum size client, 25 employees.

Compensation: By the hour: senior consultant-$190-$240, clerical-$42, actuarial assistant-$64.

1989 gross revenues: $405,000 from benefit consulting.

Principal officers: Donald S. Grubbs Jr., president; Ralph J. Braskett, vp.

H

Halliwell & Associates Inc.

1800 Two Gateway Center, Pittsburgh, Pa. 15222; 412-288-0822

Year founded: 1973.

Services provided: 90.5% of gross revenues from benefit consulting, 9.5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 85% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 4% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, renewal negotiations, plan documentation, retired lives liability determination.

Employee benefit communications consulting: 1.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 9.5% of business. Includes risk management consulting.

Staff: 52 total staff members; 38 professionals, including one FSA, four ASAs, one MBA, three CEBSs, one CLU, two CPCUs, one CPA, one attorney, two ARMs.

Clients: 450 total clients; 11% with more than 500 employees, 89% with fewer than 500 employees; 81% corporations, 9% multiemployer plans, 10% municipalities; no minimum size client.

Compensation: By the project; on retainer; by the hour: senior consultant-$110-$130, consultant-$75-$110, clerical-$15-$60.

1989 gross revenues: $3.3 million total, $3 million from benefit consulting.

Principal officers: Paul D. Halliwell, president; David L. Wetherill, executive vp; David B. Thomas, vp; Thomas S. Baily, vp/president-Professional Risk Management Consultants.

Hay/Huggins Co. Inc.

229 S. 18th St., Philadelphia, Pa. 19103; 215-875-1553

Year founded: 1911.

Parent company: Saatchi & Saatchi P.L.C.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 55% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 25% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 10% of business. Includes consulting via overseas branch offices.

Locations: New York; Boston; Washington, D.C.; Atlanta; San Francisco; Los Angeles; Toronto; London.

Staff: 250 total staff members; 125 professionals, including 30 FSAs, 15 ASAs, 15 MBAs, 15 CEBSs, five Ph.D.s, five attorneys.

Clients: Total clients not reported; 60% with more than 500 employees, 40% with fewer than 500 employees; no minimum size client.

Compensation: By the hour: senior consultants-$250, consultants-$150, clerical-$75.

1989 gross revenues: Not reported.

Principal officers: Kenneth Shapiro, president/chief executive officer; Kurt Fichthorn, Edwin Hustead, Ed Koons, Don Semples, Joe Sapora, Allen Stiteler, senior vps.

Hazlehurst & Associates Inc.

400 Perimeter Center Terrace, Suite 850, Atlanta, Ga. 30346; 404-395-9880.

Year founded: 1971.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 90% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Locations: Seattle.

Staff: 130 total staff members; 100 professionals.

Clients: 200 total clients; 80% with more than 500 employees, 20% with fewer than 500 employees; 95% corporations, 2% multiemployer plans, 3% municipalities; minimum size client, 500 employees.

Compensation: By the project; by the hour: senior consultant-$190-$225, consultant-$125-$190, clerical-$35-$50.

1989 gross revenues: Not reported.

Principal officers: R. David Parsons, chairman/principal actuary; James G. Pope, president; David M.

Continued on next page

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Continued from previous page
Gladstone, executive vp.

Health Decisions Inc.

17187 N. Laurel Parkway Drive, Suite 213; Livonia, Mich. 48152; 313-462-2260

Year founded: 1986.
Services provided: 90% of gross revenues from benefit consulting, 10% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 70% of business. Includes plan design consulting, evaluation of other service providers, audits.
Employee benefit communications consulting: 20% of business. Includes enrollment.
Other services: 10% of business. Includes business communications.
Staff: Eight total staff members; five professionals, including one Ph.D.
Clients: 75 total clients; 50% with more than 500 employees; 50% with fewer than 500 employees; 80% corporations, 10% multiemployer plans, 10% government agencies; minimum size client, 100 employees.
Compensation: By the project; on retainer; by the hour: senior consultant-$90-$125, consultant-$75-$90, clerical-$25-$40, programmer-$40-$50.
1989 gross revenues: Not reported.
Principal officers: Si Nahra, president/owner; Judy Mardigan, owner.

What do the benefits departments of these companies have in common?

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Brookfield, Wisconsin 53008-0069
(414) 786-6700

Health Decisions Inc.

198 Western Ave., Suite 200, St. Paul, Minn. 55102; 612-227-5779

Year founded: 1986.
Services provided: 70% of gross revenues from benefit consulting, 30% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 70% of business. Includes health data review.
Other services: 30% of business. Includes health program consulting.
Locations: New Haven, Conn.
Staff: Seven total staff members; six professionals, including two Ph.D.s, one M.D.
Clients: 18 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 100% corporations; minimum size client 50 employees.
Compensation: By the project.
1989 gross revenues: First nine months: $558,000 total, $380,000 from benefits consulting.
Principal officers: Richard A. Huset, president; William A. Rush, director-research/development; Matthew Mackowski, chairman.

Health Economics & Market Analysis Inc.

210 S. Sixth St., Suite 310, Springfield, Ill. 62701; 217-793-1155

Year founded: 1987.
Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 50% of business. Includes health care data analysis for employers.
Other services: 50% of business. Includes health care and other types of claims administration.
Staff: Nine total staff members; five professionals, including four MBAs, one Ph.D.
Clients: Total clients not reported; 100% with more than 500 employees, 25% corporations, 75% claims administrators; minimum size client, 500 employees.
Compensation: By the project.
1989 gross revenues: $250,000 from benefit consulting.
Principal officers: James S. Tripp, president; Ray Wearle, chief economist; John McQuewn, vp-research/development; Kathleen Quinn, vp-administration; Joan Woodruff, vp-data processing.

HealthPlan Management Services

100 Hannover Park Road, Atlanta, Ga. 30350; 404-641-5850

Year founded: 1986.
Parent company: John Hancock Financial Services.
Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 40% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, managed care vendor evaluation, selection and administration.
Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, comparisons of HMO plans and telephone "hotline assistance".
Other services: 50% of business. Includes HMO program administration.
Staff: 16 total staff members; six professionals.
Clients: 25 total clients; 100% with more than 500 employees; 100% corporations.
Compensation: By the project; on retainer; by the hour.
1989 gross revenues: Not reported.
Principal officers: James F. Wermert, executive director.

Health Service Management Group

6730 Roosevelt, Franklin, Ohio 45005; 513-424-3351

Year founded: 1983.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 30% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, record keeping, actuarial, document drafting.
Other services: 70% of business, MIS system design and reporting, general management consulting, health care and other types of claims administration.
Staff: 27 total staff members; eight professionals, including one CLU, one attorney.
Clients: 200 total clients; 60% with more than 500 employees, 40% with fewer than 500 employees; 60% corporations, 35% multiemployer plans, 5% individuals; minimum size client, 50 employees.
Compensation: By the project; on retainer; by the hour: senior consultant-$90-$125, consultant-$70-$90.
1989 gross revenues: Not reported.
Principal officers: William D. Stief, president; Donald J. Barker, Mary H. Martin and Thomas Colvin, vps.

Health Systems Management

2840 W. River Parkway, Minneapolis, Minn. 55406; 612-729-1733

Year founded: 1986.
Services provided: 75% of gross revenues from benefit consulting, 25% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 60% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 15% of business.
Other services: 25% of business.
Staff: Two total staff members; two professionals.
Clients: Total clients not reported; 90% with more than 500 employees, 10% with fewer than 500 employees; 100% corporations; no minimum size client.
Compensation: By the project.
1989 gross revenues: Not reported.
Principal officers: Laird L. Miller, president; Joanne E. Miller, chief financial officer/partner.

Hewitt Associates

100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000

Year founded: 1940.
Services provided: 85% of gross revenues from benefit consulting, 15% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 50% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.
Welfare plan consulting: 20% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, flexible plan design and administration.
Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, employee listening, interactive software communication.
International benefit consulting: 5% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the U.S.
Other services: 15% of business. Includes compensation, health care and other claims administration.
Locations: 27 U.S. offices; 29 international offices.
Staff: 3,200 total staff members; 2,000 professionals, including 100 FSAs, 70 ASAs, 139 MBAs, eight CEBSs, eight CLUs, 18 Ph.D.s, 45 CPAs, 45 attorneys.
Clients: 2,300 total clients; 90% with more than 500 employees, 10% with fewer than 500 employees; 99% corporations, 1% multiemployer plans; no minimum size client.
Compensation: By the hour.
1989 gross revenues: $242 million total, $205 million from benefit consulting.
Principal officers: Peter E. Friedes, chief executive officer.

A. Foster Higgins & Co. Inc.

125 Broad St., New York, N.Y. 10004; 212-574-9000

Year founded: 1845 (parent company).
Parent company: Johnson & Higgins.
Services provided: 76% of gross revenues from benefit consulting, 24% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 31% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting, executive benefit consulting, administrative consulting.
Welfare plan consulting: 34% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, retiree health care, health care cost containment consulting, flexible benefit compensation consulting.
Employee benefit communications consulting: 6% of business.
International benefit consulting: 5% of business. Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the U.S.
Other services: 24% of business. Includes compensation consulting and brokering.
Locations: 50 U.S. locations; 30 foreign locations.

Continued on next page

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DENTAL BENEFIT PROVIDERS, INC.

Continued from previous page

Staff: 1,500 total staff members; professional designations held by staff include 45 FSAs, 57 ASAs, 48 MBAs, 35 CEBSs, 45 CLUs, eight Ph.D.s, eight CPAs, 24 attorneys.

Clients: Not reported; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

1989 gross revenues: $190 million estimated total, $145 million estimated from benefit consulting.

Principal officers: John N. Feldtmose, president.

Hofgard & Co.

1871 Folsom, Boulder, Colo. 80302; 303-442-1000

Year founded: 1956.

Services provided: 40% of gross revenues from benefit consulting, 60% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 10% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting, asset accumulation/investment consulting.

Welfare plan consulting: 25% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement and booklet preparation, audiovisual program preparation.

Other services: 60% of business.

Locations: Denver; Washington, D.C.

Staff: 25 total staff members; six professionals, including one CLU, one attorney.

Clients: 180 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 95% corporations, 5% individuals; no minimum size client.

1989 gross revenues: $1.3 million, $500,000 estimated from benefit consulting.

Principal officers: William G. Hofgard, president; Mark W. Hofgard and Linda Anderson, vps; Edna Hofgard, secretary/treasurer; Bruce Becker, controller.

Holzman Post Ludwig & Schwartz Chtd.

125 W. Wilke Road, Stuite 300, Arlington Heights, Ill. 60005; 708-392-2999

Year founded: 1978

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 80% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 5% of business. Includes plan design consulting.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement and booklet preparation.

Other services: 5% of business.

Staff: 35 total staff members; 27 professionals, including six CPAs, two attorneys, two enrolled actuaries.

Clients: Total clients not reported; 1% with more than 500 employees, 99% with fewer than 500 employees; 85% corporations, 15% individuals; no minimum size client.

Compensation: By the project; by the hour: senior consultant-$115-$180; consultant-$50-$90, clerical-$25-$40.

1989 gross revenues: $2.4 million total, $2.3 million from benefit consulting.

Principal officers: Mark Schwartz, president; Ira Post, treasurer; Bill Ludwig, vp; George Castillo, secretary.

Hunter & Associates

9842 Hibert St., Suite 152, San Diego, Calif. 92131; 619-578-7461

Year founded: 1984.

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 3% of business. Includes plan design consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 62% of business. Includes plan design consulting, legal plan document drafting.

Employee benefit communications consulting: 30% of business. Includes general consulting on communications programs, booklet preparation, plan summary drafting.

Other services: 5% of business. Includes general management consulting, health care and other types o claims administration, claims and personnel policy manuals.

Staff: Five total staff members; three professionals, including one MBA.

Clients: 60 total clients; 45% with more than 500 employees, 55% with fewer than 500 employees; 95% corporations, 5% multiemployer plans;

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Continued from previous page
minimum size client, 25 employees.

Compensation: By the project; by the hour: senior consultant-$140, consultant-$70.

1989 gross revenues: Not reported.

Principal officers: David H. Gluck, president; Susan L. Wayburn, vp; D. Bentley, office manager.

I

Independent Dental Consultants

301 N. Harrison St., Suite B173, Princeton, N.J. 08540; 201-286-9210

Year founded: 1988.

Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 50% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 30% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 20% of business. Includes professional claims review.

Staff: Eight total staff members; six professionals, including three DMDs, one RN, two RDHs.

Clients: Total clients not reported; 90% with more than 500 employees, 10% with fewer than 500 employees; 90% corporations, 10% multiemployer plans; minimum size client, 100 employees.

Compensation: By the project; by the hour: senior consultant-$150, consultant-$125, clerical-$75.

1989 gross revenues: Not reported.

Principal officers: Dr. Kenneth O'Connor, president.

Insurance Management & Planning

110 Cottage Hill, Suite 250, Elmhurst, Ill. 60126; 708-832-1330

Year founded: 1989.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 40% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation.

Other services: 50% of business. Includes insurance and risk management consulting.

Staff: Two total staff members; Two professionals, including one MBA.

Clients: 50 total clients; 100% with fewer than 500 employees; 50% corporations, 50% municipalities and public entities; minimum size client, 75-100 employees.

Compensation: By the project; by the hour; senior consultant-$160, consultant-$100.

1989 gross revenues: Not reported.

Principal officers: James F. Goodman, managing director.

J

JGK Associates

14464 Kerner Drive, Suite 100, Sterling Heights, Mich. 48078; 313-247-9055

Year founded: 1986.

Services provided: 90% of gross revenues from benefit consulting, 10% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 9% of business.

Welfare plan consulting: 72% of business.

Employee benefit communications consulting: 9% of business.

Other services: 10% of business. Includes writing.

Staff: One staff member.

Clients: 16 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 70% corporations, 10% multiemployer plans 20% associations; no minimum size client.

Compensation: By the project; on retainer; by the hour.

1989 gross revenues: Not reported.

Principal officers: Joseph G. Kozlowski, owner.

Continued on next page



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Reader Reply Service

Products & Services Listing

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InsurerTopics

A special editorial section
sent exclusively
to insurers and reinsurers

U.S. insurers need not fear takeovers

But restructuring begins without buy-out pressure

By MARK A. HOFMANN

The U.S. insurance business may seem like an island of tranquility in a sea of merger and acquisition tempests, but a creeping tide of internal change is reshaping the business, say many financial analysts.

The insurance business so far has escaped the violent restructuring forced upon other industries by corporate raiders, foreign speculators and desperate defensive maneuvers, but insurers are divesting themselves of less profitable units that are not related to their core business, analysts say.

Foreign investors will not likely heat up this glacial movement soon, although there is some interest in U.S. insurers, analysts add. Currently, European insurers, for example, are more concerned with making sure they are represented throughout Europe when the insurance trade barriers among European Community nations fall next year.

U.S. insurers, for their part, have not expressed much interest in expanding in Europe to take advantage of the cross-border trading of insurance, analysts note.

Mergers and acquisitions could be hastened, however, if the regulatory barriers to entering the insurance business imposed on banks and other financial services firms crumble, as many analysts expect.

Through all of this, U.S. regulators will have little impact, analysts predict.

"The industry is basically going through some restructuring moves," observes Michael A. Lewis, first vp and senior insurance analyst with Dean Witter Reynolds in New York. "It's stick to the knitting, so to speak."

"There is something of a focus on core business," agrees Gloria L. Vogel, associate director of Bear Stearns & Co. in New York.

"Slowly but surely, this industry has been restructuring," with insurers initiating the restructuring themselves, rather than having it forced upon them by corporate raiders, Ms. Vogel said.

Ms. Vogel cited the decision by Philadelphia-based CIGNA Corp. to sell Horace Mann Insurance Co., a Springfield, Ill.-based personal lines subsidiary, as an example of a company divesting itself of one type of business so it can concentrate its efforts on another. For CIGNA, which has also sold some life insurance units during the past two years, core business is commercial insurance, she said.

There also have been "selected instances of companies refining their focus," Ms. Vogel said.

For example, Houston-based American General Corp., a diversified financial services company, stepped out of the property/casualty business, selling its Baltimore-based Maryland Casualty Co. subsidiary to Zurich Insurance Co. of Zurich, Switzerland (*BI*, Feb. 20).

And, Long Grove, Ill.-based Kemper Group has consolidated its commercial national property/casualty insurance operations into a separate, mutual insurance unit while retaining all other operations under a stock corporation (*BI*, Jan. 30).

Individual insurance companies have found that they lack the expertise to make certain lines of business work well and are getting out of those lines, Ms. Vogel explained.

"I think the one-stop shopping concept is no longer as valid as it once was," she said.

"I don't think you see the kind of broad diversification you saw years ago," she said.

"Property/casualty companies are recognizing that they can't be all things to all people. The classic example is CIGNA," agreed Udayan D. Ghose, first vp and senior insurance analyst with Shearson Lehman Hutton Inc. in New York, referring to CIGNA Corp.'s sale of life insurance units.

"I think definitely" that there's a stick-to-the-knitting mode among insurers, Mr. Ghose said.

"It is stick to the knitting, divesting non-core businesses," said Joanne Morrissey, president of Firemark Consulting Inc. in Parsippany, N.J.

And, at least as far as the North American market is concerned, for U.S. insurers, sticking to core business increasingly means staying within U.S. borders.

"Generally speaking, companies have been shedding their Canadian operations," said Bear Stearns' Ms. Vogel.

For example, Baltimore-based United States Fidelity & Guaranty Co. recently announced that it had reached an agreement to sell its Canadian subsidiary—USF&G Insurance Co. of Canada—to Central Capital Corp. of Halifax, Nova Scotia, a holding company with insurance, asset management and trust operations (*BI*, Dec. 11).

The sale price was $80 million Canadian ($68.8 million)—$40 million Canadian in cash and $40 mil-

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Insurer Topics

Would-be suitors focus on profits, competitive edge

By MARK A. HOFMANN

The beauty of an insurer as a possible acquisition target is in the eye of the beholder.

Industry analysts, noting that buyers do not all look for the same characteristics when shopping for a company to purchase, say that size, book of business and location are just a few of the factors that fit into the equation.

While medium-sized insurance companies—or those capitalized at between $300 million and $1 billion—would probably be the "most interesting" merger candidates, size is not the key, said Michael A. Lewis, first vp and senior insurance analyst for Dean Witter Reynolds in New York.

"I think the major criteria is profitability or strong geographic representation or a good distribution system," Mr. Lewis said. Any distinct advantage an insurer has over competitors makes it more attractive to suitors, he said.

Gloria L. Vogel, associate director at Bear Stearns & Co. in New York, agreed that size may be a key factor only in discouraging suitors.

Ms. Vogel said that not everyone interested in acquiring an insurer would be able to put up the money to buy a company the size of Baltimore-based Maryland Casualty Co., which Zurich Insurance Co. of Zurich, Switzerland, purchased for $718 million earlier this year from Houston-based American General Corp. (*BI*, Feb. 20).



Ms. Vogel

However, a foreign insurance company that has no U.S. operations might favor a larger purchase over a small one, said Henry T. Tillman III, director responsible for insurance merger and acquisition activity at First Boston Corp. of New York.

To stake out its place in the U.S. market, such a buyer is more likely to seek an established insurer of "meaningful size," which would cost "several hundred million dollars," Mr. Tillman said.

"A few years ago, you would have said small insurers" were more attractive to investors than large companies, said Sean F. Mooney, senior vp and economist at the Insurance Information Institute in New York.

However, the sale of Maryland Casualty and the takeover of Los Angeles-based Farmers Group Inc. by B.A.T Industries P.L.C. has changed the landscape, Mr. Mooney said.

"In terms of size, I don't think you could say small companies are more vulnerable now than large ones," he said.

In fact, any investor looking to acquire a U.S. company might shun smaller insurers, said Gil Marmol, principal with international business consultant McKinsey & Co. in Dallas. Foreign investors might favor a larger company because of its visibility, he said.

Small insurers might not be worth the trouble of acquiring, said Joanne Morrissey, president of Parsippany, N.J.-based Firemark Consultants Inc.

Insurers with surpluses of less than $20 million are more trouble to acquire than they are worth because of the costs associated with the acquisition, she said.

However, smaller companies might find that merging with another small insurer is a means of assuring their continued existence, she said.

But, the days of purchasing companies lock, stock and barrel—including any unprofitable units—may be numbered, Ms. Morrissey said.

"Rather than acquiring large companies, companies are acquiring books of business," she said, noting that insurers are attempting to bolster their existing strengths and minimize their weaknesses as an integral

Continued on page 44F

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I haven't seen anyone who's overly aggressive, and why should they be?" Mr. Picoult asked.

European insurers and financial institu- risks because they don't understand our tort system" (*IT*, June 13, 1988).

"I don't think those fears have disap- interest in further involvement, said Henry T. Tillman III, the director responsible for the insurance mergers and acquisition efforts struction industry, then enter home financing and next purchase mortgage insurance companies, he suggested. ■

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First Nine Months 1989

First Boston Client	Description of Transaction	Approximate Size of Transaction
Aetna Life and Casualty Company	Divestiture of Aetna Life and Casualty Ltd. to Prudential Corporation PLC	$ 94,000,000
American General Corporation	Divestiture of Maryland Casualty Company to Zurich Insurance Company	740,000,000
American General Corporation	Divestiture of American General Group Insurance Companies to Associated Insurance Companies, Inc. (Pending)	195,000,000
Georgia US Corp., a subsidiary of Nationale-Nederlanden NV	Acquisition of Southland Life Insurance Company from The Franklin Life Insurance Company, a subsidiary of American Brands, Inc.	433,000,000
Kaufman & Broad, Inc.	Acquisition of Annuity Operations of Commercial Life Insurance Company from The Continental Corporation	65,000,000
Lincoln National Corporation	Divestiture of National Reinsurance Corporation to a group led by The Robert M. Bass Group Inc. (Pending)	*395,000,000
New England Life Insurance Company and Guardian Royal Exchange Assurance plc	Divestiture of 51% Equity in Connecticut National Life Insurance Company to Empire Life Insurance Company. (Pending)	Not Disclosed
Republic American Corporation	Merger for Cash with Penn Central Corporation	290,000,000
The Tokio Marine & Fire Insurance Co., Ltd.	Acquisition of 40% Equity Interest in First Insurance Company of Hawaii, Ltd. from The Continental Corporation	28,000,000
Travelers Corporation	Divestiture of Keystone Provident Life Insurance Company to Liberty Mutual Insurance Company	Not Disclosed
UNUM Corporation	Acquisition of Commercial Life Insurance Company from The Continental Corporation	179,000,000

*Plus equity interest

First Ideas, Then Results.



FIRST BOSTON

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Insurer Topics

Insurer M&A

Continued from page 44D

part of their merger and acquisition strategies.

For example, New York-based Continental Corp.'s proposed acquisition of the surety division of Woodland Hills, Calif.-based Transamerica Corp. represents this type of strategy, she said. That kind of deal is considerably more economical than swallowing a company whole, she added.

Meanwhile, the double whammy of Hurricane Hugo and the California earthquake should have little impact on the desirability of insurers as merger candidates, analysts say.

"Catastrophes come and go over a long term, and they tend to average out," Ms. Vogel said.

The III's Mr. Mooney said that potential buyers of insurers should be sophisticated enough to realize that handling catastrophes is integral to the property/casualty business.

But, the disasters underscore the need for price increases, said Udayan D. Ghose, first vp and senior insurance analyst for New York-based Shearson Lehman Hutton Inc.

"I think we're at the start of the next price recovery," Mr. Ghose said.

But, catastrophe-fueled price increases may not lead to major insurer restructuring, he added.

'I am not sure we'll see a spate of acquisitions" spurred by insurers' increased profitability, he said.

Investors remain very selective about acquisition targets, he said. ■

Discontent hits all insurers

ACLI head wants better lobbying, candor with client

By MARK A. HOFMANN

WASHINGTON, D.C.—The entire insurance industry suffers if only one segment loses consumer confidence, says the president of the American Council of Life Insurance.

"To some extent, it's a moot question" to ask whether life insurers, health insurers or property/casualty insurers have the worst image among consumers, said Richard S. Schweiker, president of the Washington, D.C.-based ACLI and a former senator and secretary of health and human services.

With the public angry at one sector of the industry, its fury will surely scorch other sectors, he said.

During his annual address to the ACLI last month, Mr. Schweiker emphasized that life insurance executives must recognize that the public lumps all insurers together, and he outlined a three-pronged program to improve life insurers' public image.

"The fact is, as much as we may like to divorce ourselves from our brothers and sisters in the property/casualty business, we can't," Mr. Schweiker said. "As the industry goes up and down, regardless of which segment is causing it to go up and down, we go up and down with it."

In an interview, Mr. Schweiker pointed out that personal automobile rates have stirred controversy in some states, notably in California, where they led to the passage of Proposition 103, which required insurers to reduce rates for most property/casualty lines 20% from November 1987 levels.



Mr. Schweiker

Even though the life insurance industry has nothing to do with setting auto rates, "generically and industrywide, we're still affected" by legislators' and consumers' image of auto insurers, he said.

In fact, he said, the passage of Proposition 103 spurred talks among the leaders of various components of the insurance industry to address consumer concerns jointly.

Recognizing the failure to differentiate among life, health and property/casualty insurers, several trade associations are launching a first-of-its-kind joint public relations effort called the National Insurance Consumer Helpline (*BI*, Dec. 11).

"I think this is the first in a series of things the industry can do," Mr. Schweiker said. "I think this can be a valuable thing."

The hot line actually is part of one prong—improved public relations—of Mr. Schweiker's image improvement program.

The hot line was built upon other such industry services already in place, most notably those run by the Washington, D.C.-based Health Insurance Assn. of America and the New York-based Insurance Institute of America.

In its first year, it is expected to handle about 100,000 questions and complaints.

The ALCI, the HIAA, the III, the Washington, D.C.-based American Insurance Assn. and the Schaumburg, Ill.-based Alliance of American Insurers plan to begin operating the hot line Jan. 2.

"All of us interact. The public doesn't differentiate. Many legislators don't differentiate," Mr. Schweiker explained.

In the interview, Mr. Schweiker said that the toll-free number will allow the insurance industry a chance to "defuse legitimate consumer complaints" while giving consumers a chance to tell insurers of all stripes what they think needs to be done to improve perceived problems.

The other elements of the life insurance industry's three-pronged image program are:

- Improving life insurers' "performance" by, for example, not promising consumers greater returns on life products than the insurers can realistically expect to deliver.

Life insurers have to assure that the sales illustrations used by agents selling life insurance products are accurate, he said.

- Maintaining and improving life insurers' effective political activities at both the state and national levels.

In the political arena, the life insurance industry is building personal contacts between lawmakers and company chief executive officers, Mr. Schweiker said. Building such one-on-one relationships might "tip the scales in favor of the industry's position on some key issue," he said. ■

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Soft market, Prop. 103 and taxes dominate 1988 reports in survey

IT briefs

NEW YORK—Tax concerns, California's Proposition 103 and the continuing soft property/casualty insurance market were among the chief issues discussed in insurer and broker 1988 annual reports, according to a survey recently released by New York-based KPMG Peat Marwick.

"Principles and Presentation: Insurance," drew its findings from a review of the 1988 annual reports of 75 property/casualty insurance companies and groups, 75 life and health insurers and 10 brokerages. A KPMG Peat Marwick spokesman said the companies examined represented a broad range of sizes, but most were larger concerns.

According to the study, despite the fact that the Tax Reform Act of 1986 is now several years old, 40% of the property/casualty insurers and 35% of the life/health insurers mentioned its continuing negative impact on earnings in their annual reports. Sixty percent of the broker reports also mentioned of the act's effect on earnings.

Also, more than 40% of property/casualty insurers in the survey discussed the possible impact of Proposition 103 on earnings within their chairman's letter. The continuing soft property/casualty market also drew chairmen's attention: 45% of the property/casualty insurers and 80% of the brokerage reports addressed the issue in their chairmen's letters.

One area, while not yet of major concern, that drew increased attention in 1988 was the possible repeal of the McCarran-Ferguson Act, which grants insurers a limited exemption from federal antitrust law.

Sixteen percent of the property/casualty insurers and the same percentage of life insurers mentioned the possibility of repeal in their 1988 reports. A year earlier, repeal was mentioned in only 11% of the property/casualty reports and 6% of the life reports.

Copies of the study are available by writing Robert Coords, KPMG Peat Marwick, 345 Park Ave., New York, N.Y. 10154.

Industry salaries

PHILADELPHIA—Insurance companies still pay lower salaries than do companies in other industries.

Even though salary increases for insurance industry managers, executives and technical professionals are projected to increase by a slightly larger percentage than those for comparable positions in other industries, insurance industry salaries continue to lag behind those of other industries, according to a survey taken in late September by Hay Group, a Philadelphia-based consultant.

A total of 158 insurance companies reported that their executives and managers would receive average salary increases of 5.9% next year, while technical and professional employees would receive 5.7% increases in 1990.

In comparison, an October survey of 615 companies representing a wide variety of non-insurance industries showed average salary increases of 5.7% for executives and managers and 5.5% for technical and professional employees.

Despite the larger percentage increases, insurance industry salaries still lag, Hay reports. The average annual salary for a first-level insurance manager is $38,000, while a similar position in other industries pays $44,200. Higher level managers receive $70,200 in

Continued on next page

Insurer Topics

ontinued from previous page

ısurance companies and $76,100 ı industry as a whole.

About 40% of the 158 insurers ırveyed were property/casualty ɔmpanies and the rest were life ısurers, said a spokesman for the lay Group.

For further information on ne two salary surveys, contact lavid Baker, national director of ısurance consulting, Hay Group, 29 S. 18th St., Philadelphia, Pa. 9103.

New officers

APPLETON, Wis.—Wayne D. Holdridge, a consulting actuary at he Tillighast/TPF&C in St. Louis, vas elected president of the Ap-ıleton, Wis.-based Society of In-ıurance Research at the non-profit esearch group's annual meeting in Denver last month.

John Ryan, vp of Access Re-ıearch, a Farmington, Conn.-based esearch and market consultant, ɔecame president-elect. Three vice ɔresidents were also elected: Susan Mott, research associate at Co-lumbus, Ohio-based Nationwide Insurance Co.; Stanley M. Hopp, assistant vp of Equifax Services in Atlanta; and Laura J. Shick of Laura J. Shick & Co. of Media, Pa., a research and planning consul-tant.

The group's 1990 annual meeting will be in Columbus, Ohio, Nov. 14-16. In addition, SIR plans to hold three other conferences in 1990.

The first of the 1990 conferences will deal with "Consumer Research: Issues and Methods" and will be held at the Disneyland Hotel in Anaheim, Calif., Feb. 21-23.

The "11th Annual Planning and Economics Conference" will be held at the Omni Hotel in Charles-town, S.C., May 9-11.

The topic of the third confer-ence has yet to be announced but the meeting will be held at The Hilton Hotel in Quebec City, Que-bec, Sept. 11-13.

The society is a non-profit orga-nization of insurance research and planning professionals with more than 600 members. SIR's major purposes are to stimulate research, foster the exchange of ideas among its members and provide educa-tional activities.

For further information contact: Debbie Krueger, administrative director, Society of Insurance Re-search, P.O. Box 933, Appleton, Wis. 54912; 414-730-8858.

Life salary survey

U.S. life insurance company chief executive officers and chief operating officers received salary increases averaging 8.5% in 1989, according to a recently released survey.

However, the size of salary in-creases this year does not represent a significant deviation from those of the previous four years, notes the "1989 Executive Compensation Survey" conducted by the Life Of-fice Management Assn. of Atlanta.

In contrast, Canadian life insur-ance CEOs and COOs received 1989 salary increases that averaged 10.4%, a full percentage point higher than the 1988 average, the survey noted.

Another LOMA study, "1989 Management Compensation Sur-vey," found that merit increases this year for life insurance com-pany managers averaged 5.9% in the United States and 6.3% in Can-ada. Responding companies pro-jected managerial merit raises next year of 5.5% in the United States and 6.2% in Canada.

Figures were based on the re-sponses of 264 LOMA member companies in North America.

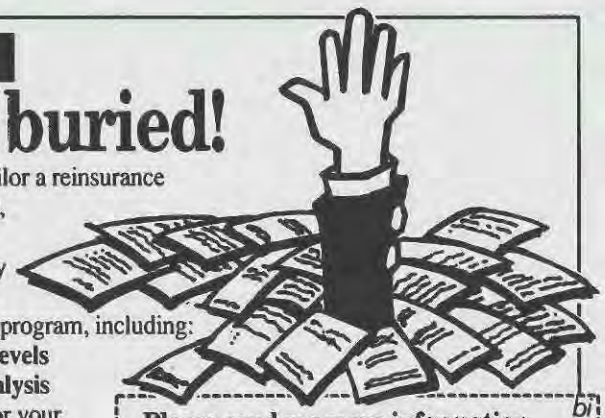
Zoila Galarza Vega, LOMA's compensation specialist, said that the figures are consistent with fig-ures gathered by The Conference Board in surveys across a wide va-riety of industries.

A companion LOMA report, "1989 Clerical and Branch Office Salary Survey," found that cus-tomer service representatives en-joyed the largest aggregate salary increases for clerical workers in both the United States and Can-ada.

Copies of "1989 Executive Com-pensation Survey" or "1989 Man-agement Compensation Survey" cost $210 for LOMA members and $425 for non-members. LOMA's "1989 Clerical and Branch Office Salary Survey" costs $150 for members and $350 for non-mem-bers. To order, contact LOMA's Services and Surveys Department, 5770 Powers Ferry Road, Atlanta, Ga. 30327; 404-951-1770. ■

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January

Consumer Relations

Insurance companies are working to improve their public image. This issue will explore consumer relations in an industry confronted by new legislation, regulation and consumer activism.

Issue: January 15, 1990
Ad Closing: January 3

February

Forging Coalitions

BI will report on what the four major industry trade groups are doing individually and collectively to promote insurance industry causes. And, this issue will review coalitions being forged with some consumer groups.

Issue: February 19, 1990
Ad Closing: February 6

March

Insurer-Agency Relations

Insurers are giving agents financial, marketing, training and other advice. But, are insurers getting their money's worth? In addition, this issue will examine how insurance companies are working toward improving relations with their distribution force.

Issue: March 19, 1990
Ad Closing: March 7

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Insurer Topics

Insurer Topics

Laws don't increase insured drivers: Study

By MARK A. HOFMANN

OAK BROOK, Ill.—Compulsory automobile liability insurance laws do not guarantee a reduction in the number of uninsured drivers, according to a recent study.

And, financial responsibility laws that do not necessarily require drivers to purchase insurance do not always lead to more uninsured motorists, says the study by the Oak Brook, Ill.-based All-Industry Research Advisory Council.

Overall, the percentage of uninsured vehicles in the United States has not changed significantly since 1984, says AIRAC's study, "Uninsured Motorists."

AIRAC is an insurance industry-supported research organization that issues periodic reports on issues of public concern, such as earthquake losses, the incidence of arson and automobile insurance costs.

To measure the effectiveness of compulsory insurance laws, AIRAC compared the ratio of uninsured motorist claims to bodily injury claims in states with compulsory laws to the ratio of uninsured motorists claims to bodily injury claims in states without such laws.

The ratio "produces a reasonable proxy for the number of injury accidents caused by uninsured or hit-and-run motorists," the report said.

The report relies on information collected by the National Assn. of Independent Insurers and the Insurance Services Office Inc., AIRAC consumer panel surveys and AIRAC's recent survey of closed claims.

For 1986, the last year for which the study evaluated this data, the national uninsured motorist claim frequency was 0.146 per year per 100 insured vehicles and the national bodily injury claim frequency was 1.131 per year per 100 insured vehicles. That resulted in a national ratio of 0.129, or 13 uninsured motorist claims for every 100 bodily injury claims.

In addition, the study compared uninsured motorist claims to bodily injury claims from 1976 through 1986 in states that had switched from financial responsibility laws that do not require motorists to purchase insurance to compulsory insurance laws.

But according to the report, the uninsured motorist/bodily injury claim ratios "suggest that uninsured motorist populations vary considerably from state to state, regardless of the type of state laws used to encourage the purchase of insurance."

States with high and low ratios "represent a mix of compulsory and non-compulsory laws."

For example, Colorado, which had the highest uninsured motorist to bodily injury claims ratio at 0.303, has a compulsory insurance law.

But, Florida, with the second-highest ratio at 0.297, has a financial responsibility law, as does Alabama, which has the third-highest ratio at 0.248.

California, which ranked fourth with a 0.233 ratio, has a compulsory insurance law, while fifth-ranked Tennessee, with a 0.222 ratio, has a financial responsibility law.

Among the next five states with the highest ratios, three have compulsory insurance laws and two have financial responsibility laws.

The effectiveness of enforcement is difficult to ascertain, according to the AIRAC report.

But, at the other end of the scale, four of the five states with the lowest uninsured motorist to bodily injury claims ratio have compulsory insurance laws: North Carolina, 0.046; Vermont, 0.051; Massachusetts, 0.058; and New York, 0.062.

But South Dakota, with the fourth lowest-ratio at 0.059, has a financial responsibility law.

Of the next five states with the lowest ratios, three have financial responsibility laws and two have compulsory insurance laws.

The study noted that the type of enforcement used to make motorists comply with compulsory insurance laws "might be expected to have a bearing on the effectiveness" of the laws.

But the effectiveness of enforcement is difficult to ascertain, according to the report.

"The decision whether or not to purchase insurance is influenced not only by the type of law but also by the socioeconomic status of the population. For example, rural states in the Northeast and North Central areas have small uninsured populations whether under compulsory laws or financial responsibility laws.

Hence, enforcement procedures in these states may appear to be effective when, in fact, the general population was merely predisposed to purchase insurance. Likewise, the poor economic conditions in some areas may offset the effectiveness of certain enforcement activities."

The study also found that the number of uninsured motorists in many states that changed from financial responsibility to compulsory liability insurance did not drop.

Among the 11 states tha adopted compulsory insuranc laws between 1976 and 1986, ther was no change in the number c uninsured motorists in six of thos states, and there was only a modes reduction in the number of unin sured motorists in two other state the study found.

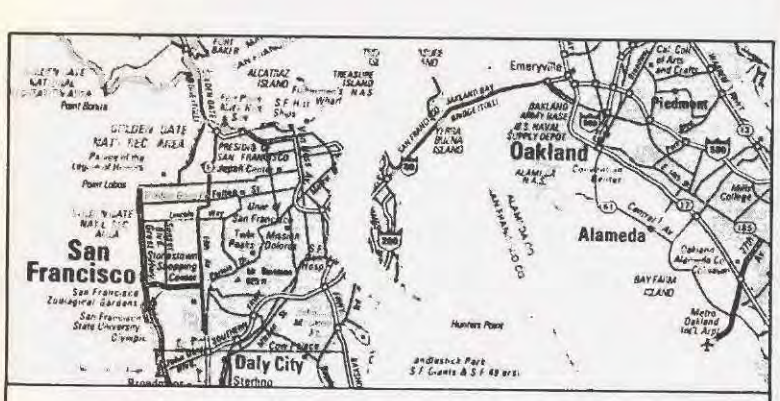
In only three of the states—Ari zona, Nebraska and West Virgini —the uninsured motorist pool de creased by more than 20%, accord ing to the study.

In fact, the percentage of unin sured vehicles in the United State as a whole has remained relatively stable since 1984, according to an nual AIRAC consumer surveys.

Respondents between 1982 anc 1983 reported that 10% of their ve hicles were uninsured. In 1984 that figure dropped to 7%. Since then, the percentage has fluctuatec between 5% and 7%, with respon dents reporting that 5% of their vehicles were uninsured in 1989.

•

Single copies of "Uninsured Motorists" are available free from the All —Industry Research Advisory Council, 1200 Harger Road, Suite 310, Oak Brook, Ill. 60521; 708-572-1177. Additional copies are $4 each.



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Issue of December 18

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230 W. Monroe, Suite 545, Chicago, Ill. 60606; 312-346-0155

Year founded: 1915.
Parent company: UNUM Corp.
Services provided: 45% of gross revenues from benefit consulting, 55% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 45% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, operating reviews, claims audit training.
Other services: 55% of business. Includes disability benefit consulting and administration.
Locations: Philadelphia.
Staff: 110 total staff members; 65 professionals, including three MBAs, three CEBSs, one CLU, two FLMIs, nine RNs.
Clients: 140 total clients; 80% with more than 500 employees, 20% with fewer than 500 employees; 100% corporations; no minimum size client.
Compensation: By the project; on retainer; by the hour: senior consultant $175, consultant $135, clerical $30.
1989 gross revenues: Not reported.
Principal officers: Richard A. Lewis, president; Richard H. Wille, executive vp; George Krzemien, vp/controller; Randall Schrader and Mary Lou Williamson, vps.

The Johnson Cos.

1 Summit Square, Route 413 & Double Woods Road, Langehorne, Pa. 19047; 215-968-4741.

Year founded: 1951.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 15% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.
Welfare plan consulting: 10% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, conducts employee meetings.
Other services: 70% of business. Includes defined contribution plan record keeping, actuarial services.
Locations: Boston; Dover, Del.; District of Columbia.
Staff: 387 total staff members; 250 professionals, including six MBAs, 15 CEBSs, seven CLUs, five CPAs, three attorneys.
Clients: Total clients not reported; 50% with more than 500 employees, 50% with fewer than 500 employees; 100% corporations; no minimum size client.
Compensation: Commissions for insurance placed with underwriters; on retainer; by the hour.
1989 gross revenues: Not reported.
Principal officers: Edwin T. Johnson, chief executive officer; R. Theodore Benna and J. Lawrence Hager Jr., principals; David O. Oberkircher and Trisha Brambley, vp.

Johnson & Muir Inc.

Meridian Bank Building, Suite 706, Easton, Pa. 18042; 215-250-0661

Year founded: 1984.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 10% of business. Includes plan design consulting, consulting on selection of investment managers.
Welfare plan consulting: 15% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.
Other services: 70% of business. Includes compensation consulting, brokering, general management consulting.
Locations: Allentown, Pa.
Staff: Seven total staff members; three professionals, including one MBA, one CEBS, one CLU.
Clients: Not reported.
Compensation: By the project; commissions for insurance placed with underwriters; by the hour: senior consultant $125.
1989 gross revenues: Not reported.
Principal officers: Carl. A. Curcio Jr., president/chief executive officer/treasurer; James W. Baker, vp/secretary.

K

KPMG Peat Marwick-Benefits & Compensation Group

767 Fifth Ave., New York, N.Y. 10153; 212-909-5000

Year founded: 1964.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: 75% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting, tax work.
Welfare plan consulting: 20% of business. Includes plan design consulting, consulting on selection of investment managers, evaluation of other service providers, managed care analysis.
Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
International benefit consulting: 1% of business. Includes consulting via overseas branch offices, consulting from the United States.
Staff: 275 professionals, including 24 FSAs, 28 ASAs.
Clients: 3,000 total clients; 80% with more than 500 employees, 20% with fewer than 500 employees; 90% corporations, 1% multiemployer plans, 5% individuals, 4% other; no minimum size client.
Compensation: By the hour.
1989 gross revenues: $45 million total, all from benefit consulting.
Principal officers: W.A. Hasler, vice chairman; L.L. Oliver, national practice director; J.T. Colburn, actuarial chairman.

Keenan & Associates

2355 Crenshaw Blvd., Suite 200, Torrance, Calif. 90501; P.O. Box 4328, Torrance Calif. 90510; 213-212-3344

Year founded: 1972.
Services provided: 48% of gross revenues from benefit consulting, 52% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 48% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Other services: 52% of business. Includes brokering, health care and other types of claims administration, risk management.
Locations: Chico, Riverside, Sacramento, San Diego, Campbell, Fresno, Emeryville, Santa Ana and Westlake Village, Calif.
Staff: 260 total staff members; 50 professionals, including one CEBS, eight CLUs, two CPCUs, one CPA, one attorney, two ChFCs, three ARMs, one FLMI.
Clients: 500 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 10% corporations, 90% public sector; minimum size client, 100 employees.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $175, consultant-$150, clerical-$40.
1989 gross revenues: $17.8 million total, $8.4 million from benefit consulting only.
Principal officers: John R. Keenan, chief executive officer; Frederick A. Johnson, president; Dave Balak, senior vp; Don Pope and Jarrell Walker, regional vps.

Kushner & Co.

2121 Hudson Ave., Suite 101; Kalamazoo, Mich. 49008; 616-342-1700

Year founded: 1982.
Services provided: 94.5% of gross revenues from benefit consulting, 5.5% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 4.3% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.
Welfare plan consulting: 85.2% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, flexible benefit consulting.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
Other services: 5.5% of business. Includes compensation consulting, general management consulting, health care and other types of claims administrations.
Staff: Five total staff members; four professionals, including two MBAs, one CEBS, one AEP.

Continued on next page

SET YOUR DATES

issue:	January 15
closing:	January 3
editorial feature:	Informational Literature
conference report:	Joint Insurance Industry Meeting
demographic section:	Insurer Topics: Consumer Relations
issue:	January 22
closing:	January 10
issue:	January 29 — Reader Service
closing:	January 16
editorial feature:	Self-Insurance — Directory: Claims Administrators
issue:	February 5
closing:	January 24
demographic section:	Agent/Broker Topics: Franchising/Clustering
issue:	February 12
closing:	January 31

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Continued from previous page
Clients: 114 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 100% corporations; minimum size client, 10 employees.
Compensation: By the project.
1989 gross revenues: $525,000 from benefit consulting.
Principal officers: Gary B. Kushner, president; Julie A. Workman, operations manager.

Kwasha Lipton
2100 N. Central Road, Fort Lee, N.J. 07024; 201-592-1300

Year founded: 1944.
Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 70% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, GIC selection and contract negotiations.
Welfare plan consulting: 10% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, group and flexible benefits software.
Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, management training programs.
International benefit consulting: 5% of business. Includes consulting via overseas correspondents, consulting from the United States.
Other services: 5% of business. Includes compensation consulting, software design, systems consulting.
Staff: 365 total staff members; 355 professionals, including 25 FSAs, 22 ASAs, 11 MBAs, one CLU, three CPAs, four attorneys, 38 MAAAs, two FCIAs, 10 FCAs, 12 MCAs.
Clients: 400 total clients; 97% with more than 500 employees, 3% with fewer than 500 employees; 98% corporations, 2% multiemployer plans; no minimum size client.
Compensation: By the project; by the hour.
1989 gross revenues: Not reported.
Principal officers: Richard C. Sears, chief executive partner; David Skovron, chief operating partner.

L

LFS Benefit Services
271 W. Cerritos Ave., Anaheim, Calif. 92805-6549; 714-774-8051; 800-227-3612 in California

Year founded: 1974.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 8% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.
Welfare plan consulting: 12% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
Other services: 70% of business. Includes brokering, health care and other types of claims administration, benefit billing and administration.
Staff: Eight total staff members; including one MBA.
Clients: 65 total clients; 80% with more than 500 employees. 20% with fewer than 500 employees; 95% corporations, 5% individuals; no minimum size client.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $120, consultant $100, clerical $40.
1989 gross revenues: $370,000 total, $111,000 from benefit consulting.
Principal officers: Alfred O. Long, president; Mark E. Long, vp-administration; Marcia E. Long, vp-marketing.

Lambert Associates
898 Ethan Allen Highway, Ridgefield, Conn. 06877; 203-431-6420

Year founded: 1987.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 27% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 3% of business. Includes general consulting on communications programs, booklet preparation.
Other services: 70% of business. Includes brokering.
Staff: Three total staff members; two professionals, including one CEBS, two CLUs, two CICs.
Clients: 48 total clients; 15% with more than 500 employees, 85% with fewer than 500 employees; 93% corporations, 7% multiemployer plans; no minimum size client.
Compensation: By the project; commissions for insurance placed with underwriters; by the hour: senior consultant $150, consultant $100.
1989 gross revenues: Not reported.
Principal officers: Maurice N. Lambert and Paul E. Lambert, partners.

Laventhol & Horwath-Retirement & Employee Benefit Consulting Associates Division
1845 Walnut St., Philadelphia, Pa. 19103; 215-299-1600

Year founded: 1915.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: 85% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.
Welfare plan consulting: 5% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement and booklet preparation.
Locations: Chicago; Boston; Lyndhurst, N.J.; Phoenix, Ariz.; New York.
Staff: 160 total staff members; 85 professionals, including seven ASAs, four CPAs, four attorneys.
Clients: Total clients not reported; 15% with more than 500 employees, 85% with fewer than 500 employees.
Compensation: By the project; by the hour: senior consultant $150-$250, consultant $110-$150, clerical $35-$50.
1989 gross revenues: $14 million from benefit consulting.
Principal officers: Leslie M. Laiken-New York; Samuel Savitz-Pennsylvania; David Schactman-Boston; Art Tepfer-Chicago.

M

The MacKinnon Co. Inc.
53-A Dwight Place, Fairfield, N.J. 07006; 201-808-9090

Year founded: 1969.
Parent company: Meeker Sharkey Financial Group Inc.
Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 30% of business. Includes plan design consulting, insurer/broker selection consulting.
Other services: 70% of business. Includes claims administration.
Locations: Cranford, N.J.
Staff: 22 total staff members; six professionals, including one CLU.
Clients: Total clients not reported; 32% with more than 500 employees, 68% with fewer than 500 employees; 82% corporations, 18% multiemployer plans; minimum size client, 30 employees.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $500, consultant $350, clerical $60.
1989 gross revenues: $1.4 million total, $450,000 from benefit consulting.
Principal officers: Thomas J. Sharkey, chairman; Walter A. MacKinnon, president; James A. Payton, vp-operations; Margaret L. Struble, vp-administration; Steve Demas, vp-marketing.

Managed Care Systems
8666 Westwind Circle, Eden Prairie, Minn. 55344; 612-944-2699

Year founded: 1986.
Services provided: 100% of gross revenues from benefit consulting.
Welfare plan consulting: 100% of business. Includes plan design consulting, evaluation of other service providers.
Staff: One.
Clients: 16 total clients; 75% with more than 500 employees, 25% with fewer than 500 employees; 100% corporations.
Compensation: By the project; on retainer; by the hour: consultant $150.
1989 gross revenues: Not reported.
Principal officer: Lee Wenzel, owner.

MedEval Corp.
1920 Highland Ave., Suite 316, Lombard, Ill. 60148; 708-629-5900

Year founded: 1982.
Welfare plan consulting: 100% o business. Includes medical recommendations to client companies tha self-insure and self-administer in come continuation plans.
Staff: 10 total staff members; tw professionals, including nine RNs.
Clients: 65 total clients; 100% witl more than 500 employees; 100% cor porations.
Compensation: By the project.
1989 gross revenues: Not reported.
Principal officers: Ronald F Smentek, president/founder; Dennis Streelman, vp/founder.

Med-Services Management Co.
1 Bala Ave., Suite 4C, Bala Cynwyd, Pa. 19004; 215-667-5155

Year founded: 1984.
Parent company: Keystone Health System.
Services provided: 35% of gross revenues from benefit consulting, 65% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 35% of business. Includes plan design consulting, evaluation of other service providers.
Other services: health care cost containment.
Staff: 14 total staff members; four professionals, including one CPA, six RNs.
Clients: Not reported.
Compensation: By the project, by the hour.
1989 gross revenues: Not reported.
Principal officers: Robert D. Bauer, chief executive officer; Mary Kay Dunne, vp-health care cost management; Kevin O'Brien, director-marketing.

William M. Mercer Inc.
1166 Ave. of the Americas, New York, N.Y. 10036; 212-345-7000

Year founded: William M. Mercer Inc. and Meidinger Inc. merged in February 1984; that company merged with A.S. Hansen in February 1987. Mercer was founded in 1937, Meidinger was founded in 1936, Hansen was founded in 1930.
Parent company: Marsh & McLennan Cos. Inc.
Services provided: 89% of gross revenues from benefit consulting, 11% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 65% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.
Welfare plan consulting: 20% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, health care cost management consulting, flexible benefits consulting.
Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs, benefit statement and booklet preparation, audiovisual program preparation, benefit communication systems.
International benefit consulting: Includes consulting via overseas branch offices, consulting via overseas correspondents, consulting from the U.S.
Other services: 11% of business. Includes non-benefits actuarial consulting, human resources.
Locations: 47 locations in the U.S, 54 foreign locations.
Staff: 6,707 total staff members; 4,544 professionals, including 461 FSAs, 297 ASAs, 150 MBAs, 34 CEBSs, 40 Ph.D.s, 155 attorneys, 113 EAs.
Clients: 17,000 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 97% corporations, 3% multiemployer plans.
Compensation: By the project; by the hour: senior consultant $225, consultant $100-$225.
1989 gross revenues: $626 million total, $557 million from benefit con-

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Continued from previous page
ulting.

Principal officers: Peter Coster, president; John G. Ireland, chairman; Robert A. Brochu, Ronald M. Walker and Thomas R. Waylett, executive vps.

Miller, Mason & Dickenson

123 N. Wacker Drive, Suite 1000, Chicago, Ill. 60606; 312-701-4800

Year founded: 1960.
Parent company: Aon Corp.
Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 50% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.
Welfare plan consulting: 20% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, actuarial and underwriting services.
Employee benefit communications consulting: 8% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
International benefit consulting: 2% of business. Includes consulting consulting via overseas correspondents, consulting from the U.S.
Other services: 20% of business. Includes compensation consulting, broker, health care and other claims administration, legal services.
Locations: Palo Alto, Oakland and Los Angeles, Calif.; Conshohocken, Pa.; Chicago; St. Louis; New York.
Staff: 450 total staff members; 350 professionals.
Clients: 1,050 total clients; 95% corporations, 5% individuals; no minimum size client.
Compensation: Commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant: $175-$250; consultant, $75-$175; clerical, $50-$75.
1989 gross revenues: $31.3 million total, $23.8 million from benefit consulting.
Principal officers: Patrick G. Ryan, chairman; Daniel T. Cox, president; Melville P. Dickenson and Richard A. Scott, vice chairmen.

Milliman & Robertson Inc.

1301 Fifth Ave., Suite 3800, Seattle, Wash. 98101; 206-624-7940

Year founded: 1947.
Services provided: 36% of gross revenues from benefit consulting, 64% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 31% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, asset accumulation/investment consulting.

Welfare plan consulting: 5% o. business. Includes plan design consulting, consulting on selection of investment managers.

Other services: 64% of business.
Locations: Albany and New York, N.Y.; Atlanta; Boston; Chicago; Cincinnati; Dallas; Denver; Hartford, Conn.; Houston; Indianapolis; Los Angeles; Milwaukee; Minneapolis; Omaha, Neb.; Philadelphia; Phoenix, Ariz.; Portland, Ore.; St. Louis; San Francisco; Washington, D.C.

Staff: 667 total staff members; including 158 FSAs, 54 ASAs, 24 FCASs, 10 ACASs, 236 MAAAs, 90 EAs.

Clients: Not reported, no minimum size client.
Compensation: By the project; on retainer; by the hour.
1989 gross revenues: $80 million total, $28.8 million from benefit consulting.
Principal officers: James A. Curtis, chairman/president; chief executive officer; W.R. Fleckenstein, financial vp/secretary; L.J. Lee, treasurer.

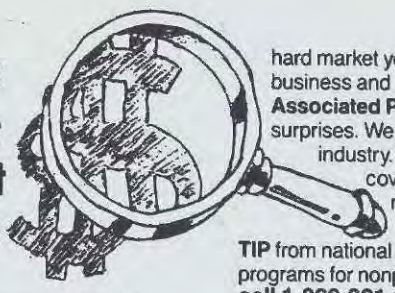
Mitchell & Hartmann Inc.

13400 Riverside Drive, Suite 107, Sherman Oaks, Calif. 91423; 818-907-6800

Year founded: 1964.
Services provided: 75% of gross revenues from benefit consulting, 25% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 62% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.
Welfare plan consulting: 10% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communica-

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tions consulting: 3% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.

Other services: 25% of business. Includes insurance company and HMO consulting actuarial services.

Staff: Eight total staff members; five professionals, including two FSAs.

Clients: Total clients not reported; 2% with more than 500 employees, 98% with fewer than 500 employees; 85% corporations, 15% partnerships or sole proprietorships; no minimum size client.

Compensation: By the hour: senior consultant $200-$240, consultant $100-$150, clerical $50-$60.

1989 gross revenues: Not reported.

Principal officers: Lawrence Mitchell, president; Jeffrey F. Hartmann, vp.

Mockenhaupt, Mockenhaupt, Cowden & Parks

11th Floor, One Gateway Center, Pittsburgh, Pa. 15222; 412-394-9300

Year founded: 1940.

Services provided: 65% of gross revenues from benefit consulting, 35% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 45.5% of business.

Welfare plan consulting: 13% of business.

Employee benefit communications consulting: 5.2% of business.

International benefit consulting: 1.3% of business.

Other services: 35% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration.

Locations: Philadelphia.

Staff: 105 total staff members; 60 professionals, including two FSAs, three ASAs, two MBAs, four CEBSs, two CLUs, two attorneys.

Clients: 400 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 60% corporations, 5% multiemployer plans, 35% public entities; minimum size client, 100 employees.

Compensation: By the project; on retainer; by the hour: senior consultant $200, consultant $100, clerical $40.

1989 gross revenues: $6 million total, $4 million from benefit consulting.

Principal officers: John P. Parks, president/principal; Richard C. Mockenhaupt, chairman/principal; Paul A. Mockenhaupt, vp/principal; Jere L. Cowden, vp/principal; Marlin Gatty, director.

R.C. Morris Inc.

8146 Skyline Lane, Chagrin Falls, Ohio 44022; 216-338-1862

Year founded: 1989.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 50% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 20% of business. Includes plan design consulting.

Employee benefit communications consulting: 30% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, employee benefit form generation.

Staff: Two total staff members; both professionals, including one MBA.

Clients: 10 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 100% corporations; no minimum size client.

Compensation: By the project; by the hour: senior consultant $75-$85, consultant $75, clerical $35.

Principal officers: Robyn C. Morris, president.

G. Murphy & Associates Inc.

2100 Manchester Road, Suite 305, Wheaton, Ill. 60187; 708-682-0030

Year founded: 1987.

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 40% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 40% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 15% of business. Includes general consulting on communications programs, booklet preparation, audiovisual program preparation.

Other services: 5% of business. Includes general management consulting, health care and other types of claims administration.

Staff: Seven total staff members; five professionals, including one CPA, one CFP.

Clients: 30 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 100% corporations.

Compensation: By the project; on retainer; by the hour: senior consultant $125, consultant $85, clerical $25.

1989 gross revenues: $650,000 total; $620,000 from benefit consulting.

Principal officers: Glenn E. Murphy, managing principal; Nicholas M. Zois and Lee P. Murphy, principals.

N

Nagler & Nagler/Sierra Benefits

817 S. Westgate, Los Angeles, Calif. 90049; 213-820-3933

Year founded: 1957.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 30% of business. Includes plan design consulting, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 10% of business. Includes plan design consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 50% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration.

Locations: San Francisco, San Diego, Sacramento, Stockton, Fresno and San Bernardino, Calif.

Staff: 37 total staff members; 16 professionals.

Clients: Total clients not reported; 10% with more than 500 employees, 90% with fewer than 500 employees; 97% corporations, 3% individuals; minimum size client, 25 employees.

Compensation: By the project.

1989 gross revenues: $1.8 million from benefit consulting.

Principal officers: Lawrence Nagler, chief executive officer; David Nagler, executive vp; Elise Barrett, Lee Rossello and Jon Wolin, vps.

National Insurance Advisory Services

1599 Washington St., Braintree, Mass. 02184; 617-848-4500

Year founded: 1979.

Services provided: 15% of gross revenues from benefit consulting, 85% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 15% of business. Includes plan design consulting, plan administration consulting, asset accumulation/investment consulting.

Other services: 85% of business. Includes compensation consulting, general management consulting, workers compensation cost control.

Staff: 13 total staff members; six professionals, including three MBAs, one CLU, one CPCU, five LIAs.

Clients: 120 total clients; 50% with more than 500 employees, 50% with fewer than 500 employees; 100% corporations; minimum size client, 100 employees.

Compensation: By the project, on retainer, by the hour.

1989 gross revenues: $1 million from benefit consulting.

Principal officers: James B. Conant, chief executive officer; Jack Keating, president.

Noble Lowndes U.S.A.

33 Evergreen Place, East Orange, N.J. 07019-0835; 201-675-8900

Year founded: 1983.

Parent company: Noble Lowndes & Partners.

Services provided: 97% of gross revenues from benefit consulting, 3% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 78% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 16% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, actuarial work.

Employee benefit communications consulting: 1% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 2% of business. Includes consulting consulting via overseas correspondents, consulting from the U.S.

Other services: 3% of business. Includes brokering.

Locations: New York; Garden City, N.J.; Philadelphia; Chicago; San Francisco; also operates from foreign offices of parent company.

Staff: 326 total staff members; 200 professionals, including 10 FSAs, nine ASAs, six CEBSs, two CPAs, four attorneys.

Clients: 2,000 total clients; 13% with more than 500 employees, 87% with fewer than 500 employees; 91% corporations, 8% multiemployer plans, 1% public entities; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $250, consultant $210, clerical $50-$60.

1989 gross revenues: $137 million total.

Principal officers: Edward H. Becker, chairman; Stephen G. Singer, president/chief executive officer; Fred Schick, Alex Sussman and Marshall Myers, vps.

P

Pension Planning Co. Inc.

355 Lexington Ave., New York, N.Y. 10017; 212-867-4100

Year founded: 1945.

Parent company: Republic Hogg Robinson Inc.

Services provided: 75% of gross revenues from benefit consulting, 25% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 52.5% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 15% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, claims management, system consulting, claims management audits, actuarial evaluation of self-insured plans.

Employee benefit communications consulting: 3.75% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 3.75% of business. Includes consulting via overseas branch offices, consulting from the U.S. via parent company.

Other services: 25% of business. Includes compensation consulting, health care and other types of claims administration.

Locations: Boca Raton, Fla.; Cleveland; Los Angeles; Detroit; Boston; Atlanta; Dallas; Philadelphia; Alexandria, Va.

Staff: 50 total staff members; 25 professionals, including one FSA, four ASAs, six MBAs, two CEBSs, four CLUs, two attorneys.

Clients: 700 total clients; 75% with more than 500 employees, 25% with fewer than 500 employees; 95% corporations, 4% multiemployer plans, 1% individuals; no minimum size client.

Compensation: By the project; on retainer; by the hour: senior consultant $175-$250, consultant $110-$150, clerical $50.

1989 gross revenues: Not reported.

Principal officers: James Kahn, president; Donald A. Lockwood, executive vp/senior actuary; Paul Robinson and Jack Warshavchik, vp/actuaries; Doug Rabbino, vp-group operations; Gena Buchwald, vp; Robert Heuer, vp-data processing.

Pension Resources

401 N. Michigan Ave., Chicago, Ill. 60611; 312-644-4422

Year founded: 1972.

Parent company: Friedman, Eisenstein, Raemer & Schwartz.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 95% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Employee benefit communications consulting: 5% of business. Includes general consulting on commu-

Continued on next page

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ontinued from previous page
ications programs, benefit statement preparation, booklet preparaon, audiovisual program preparaon, employee benefit meetings.

Locations: Rolling Meadows and incolnshire, Ill.

Staff: 30 total staff members; 22 rofessionals, including one ASA, ne MBA, one CPA, one attorney.

Clients: 800 total clients; 10% with ıore than 500 employees, 90% with ewer than 500 employees; 99% cororations, 1% individuals; no miniıum size client.

Compensation: By the project; by he hour: senior consultant $180, onsultant $125, clerical $35, plan dministrator $85.

1989 gross revenues: $1.8 million otal, all from benefit consulting.

Principal officers: Michael chwartz, president.

Carl A. Posse & Co. Inc.-Employee Benefit Division

4 Sentry Parkway, Blue Bell, Pa. 19422; 215-834-1410; 215-242-9080

Year founded: 1866.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 40% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, flexible benefit consulting.

Employee benefit communications consulting: 5% of business.

Other services: 50% of business. Includes compensation consulting, brokering, general management consulting.

Locations: Pottstown, Pa.

Staff: Eight total staff members; five professionals, including one CLU, one CPCU,

Clients: 160 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 87% corporations, 1% multiemployer plans, 2% individuals, 10% municipalities; minimum size client, 20 employees.

Compensation: By the project, commissions for insurance placed with underwriters, on retainer.

1989 gross revenues: Not reported.

Principal officers: John B. Walton and F. Bruce Walter, executive vps; John B. Jackson, senior vp; Roc D. Irey, vp; Daniel P. McCarthy, vp-compensation consulting.

Q

Quinlivan Benefits Consultants

1472 Commonwealth Ave., Boston, Mass. 02135; 617-239-8855

Year founded: 1989.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 25% of business. Includes retiree medical benefits consulting.

Welfare plan consulting: 50% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 25% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.

Locations: Hartford, Conn.

Staff: Five total staff members; three professionals.

Clients: 10 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 100% corporations; minimum size client, 50 employees.

Compensation: By the project.

1989 gross revenues: $165,000 total, all from benefit consulting.

Principal officers: Michael Quinlivan, principal; Michael Ostro and Deb Percival, communication consultants.

R

The RM Consulting Group Inc.

346 Westbury Ave., Carle Place, N.Y. 11514; 516-333-2001; 212-714-0960

Year founded: 1987.

Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 28% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, consulting on selection of investment managers.

Welfare plan consulting: 40% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers, evaluation of self-insured plans.

Employee benefit communications consulting: 10% of business.

International benefit consulting: 2% of business.

Other services: 20% of business. Includes brokering, health care and other types of claims administration.

Locations: New York.

Staff: 23 total staff members; 14 professionals, including one FSA, one ASA, one MBA, one CLU, one CPA, one attorney.

Clients: 105 total clients; 40% with more than 500 employees, 60% with fewer than 500 employees; 98% corporations, 2% multiemployer plans; minimum size client, 50 employees.

Compensation: By the project; commissions for insurance placed with underwriters; by the hour: senior consultant $100-$175, consultant $75-$125, clerical $40-$60.

1989 gross revenues: $1.2 million total, $1 million from benefit consulting.

Principal officers: Robert N. Munao, president; Myrna Feinman, senior vp; Howard Hagen, president-AIMS Inc. (subsidiary).

The Reimbursement Update

355 Oak Trail Drive, Double Oak, Texas 75067; 817-491-3593

Year founded: 1986.

Services provided: 40% of gross revenues from benefit consulting, 60% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 40% of business. Includes plan design consulting; provider contracting and reimbursement.

Other services: 60% of business. Includes general management consulting, health care and other types of claims administration, strategic planning, health care finance.

Staff: Not reported; professional designations held by staff include one CEBS, one Ph.D..

Clients: Not reported.

Compensation: By the project; on retainer; by the hour: senior consultant $150, consultant $100.

1989 gross revenues: Not reported.

Principal officers: Frederic R. Curtiss, president.

Risk Management Group Inc.

P.O. Box 357, Newtown Square, Pa. 19073; 215-359-1776

Year founded: 1984.

Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 16% of business. Includes plan design consulting, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 52% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 8% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 4% of business. Includes consulting from the United States.

Other services: 20% of business. Includes brokering, human resource information systems.

Locations: St. Louis.

Staff: Nine total staff members; six professionals, including two MBAs, one attorney.

Clients: 56 total clients; 60% with more than 500 employees, 40% with fewer than 500 employees; 100% corporations; minimum size client, 100 employees.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $150, consultant $90, clerical $45.

1989 gross revenues: Not reported.

Principal officers: Jerald D. Adair president/treasurer; Donald V. Barbuto, vp; Marianne Rafter, secretary.

S

San Diego Associates Inc.

2515 Camino Del Rio S., Suite 226, San Diego, Calif. 92108; 619-293-3388

Year founded: 1984.

Services provided: 30% of gross revenues from benefit consulting, 70% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 15% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 7.5% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 7.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 70% of business.

Continued on next page

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THE FAST TRACK TO A COMEBACK

Continued from previous page

Other services: 70% of business. Includes brokering, health care and other types of claims administration, pension administration.

Staff: Five total staff members, four professionals.

Clients: 50 total clients; 5% with more than 500 employees, 95% with fewer than 500 employees; 80% corporations, 5% individuals, 15% limited and general partnerships; no minimum size client.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $200, consultant $100, clerical $50.

1989 gross revenues: $360,000 total, $108,000 from benefit consulting.

Principal officers: David N. Peterson, president; Terie Theis, vp-operations.

Schmidt, Long & Associates

Four Seagate, Fifth Floor, Toledo, Ohio 43604; 419-249-7220

Year founded: 1984.

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 10% of business.

Welfare plan consulting: 60% of business.

Employee benefit communications consulting: 25% of business.

Other services: 5% of business. Includes brokering.

Staff: Six total staff members; four professionals.

Clients: 12 total clients; 100% with more than 500 employees; 100% corporations; minimum size client, 500 employees.

Compensation: By the project; on retainer; by the hour.

1989 gross revenues: $2 million from benefit consulting.

Principal officers: Timothy L. Schmidt, president/chief operating officer; Ralph W. Long, chief executive officer; Tedd A. Long, vp-marketing; James A. Mauntier, vp-operations.

Second Opinion Consultants Inc.

P.O. Box 621, Millwood, N.Y. 10546; 800-446-4606; 800-446-4626 in New York

Year founded: 1984.

Welfare plan consulting: 100% of business. Includes second surgical opinion administration, claims review, statistical reporting for health care cost containment.

Staff: 25 total staff members; including one MBA, one Ph.D., one CPA, one MD.

Clients: 3,000 total clients; 40% with more than 500 employees, 60% with fewer than 500 employees; 80% corporations, 20% multiemployer plans; no minimum size client.

Compensation: By the project; on retainer.

1989 gross revenues: Not reported.

Principal officers: Madelon Lubin Finkel, president/chief executive officer; David J. Finkel, chief financial officer; Dr. Norman Mazza, medical director.

Sedgwick James Ltd./James Benefits Division

600 Montgomery St., Third Floor, San Francisco, Calif. 94111; 415-983-5250

Year founded: 1858.

Parent company: Sedgwick James Ltd.

Services provided: 58% of gross revenues from benefit consulting, 42% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 7% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 50% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, executive benefits consulting.

Employee benefit communications consulting: 0.5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

International benefit consulting: 0.5% of business. Includes consulting via overseas branch offices, consulting from the U.S.

Other services: 42% of business. Includes brokering.

Locations: 45 locations in the United States.

Staff: 450 total staff members; 180 professionals.

Clients: Not reported.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour.

1989 gross revenues: $45 million total, $26 million from benefit consulting.

Principal officers: Carroll D. Cox, president; Rea B. Campbell, chief financial officer; E.W. Wood, Scot Smith II and Frank LeFurgy, executive vps/benefit directors.

Martin E. Segal Co.

730 Fifth Ave., New York, N.Y. 10019; 212-586-5600

Year founded: 1939.

Services provided: 96% of gross revenues from benefit consulting, 4% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 47% of business.

Welfare plan consulting: 40% of business.

Employee benefit communications consulting: 6% of business.

International benefit consulting: 3% of business.

Other services: 4% of business. Includes compensation consulting, brokering, general management consulting.

Locations: Atlanta; Boston; Chicago; Cleveland; Denver; Hartford, Conn.; Houston; Los Angeles; New Orleans; Phoenix, Ariz.; San Francisco; Seattle; Washington, D.C.; Edmonton, Alberta; Toronto.

Staff: 642 total staff members; 484 professionals, including 13 FSAs, 21 ASAs, 38 MAAAs, 44 EAs, four FCIAs, four MCAs, two FCAs.

Clients: 3,000 total clients; 85% with more than 500 employees, 15% with fewer than 500 employees; 48% corporations, 52% multiemployer plans; no minimum size client.

Compensation: By the project; on retainer; by the hour: $60-$300.

1989 gross revenues: $63.5 million estimated total revenues, $61 million estimated benefit consulting revenues.

Principal officers: Martin E. Segal, chairman; Robert D. Paul, vice chairman; Robert D. Krinsky, president; Howard Fluhr, executive vp; John F. Gentleman and Dale B. Grant, executive vps.

Sheppard Associates

106 N. Maryland Ave., Glendale, Calif. 91206; 818-247-9877

Year founded: 1985.

Services provided: 100% of gross revenues from benefit consulting.

Employee benefit communications consulting: 100% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, bulletins, articles, interactive software training.

Staff: 24 total staff members; 21 professionals, including three MBAs.

Clients: 146 total clients; 100% with more than 500 employees; 100% corporations and government entities; minimum size client, 500 employees.

Compensation: By the project.

1989 gross revenues: $2.4 million total, all from benefit consulting.

Principal officers: Donald L. Sheppard, president; Cayce B. Malone, executive vp; Brad Ottoson and Kathleen Sage, senior vps; Terry McKenzie and Beth Rand, vps.

Silva Financial Group

1590 The Alameda, Suite 100, San Jose, Calif. 95126; 408-554-6600

Year founded: 1976.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Other services: 50% of business. Includes compensation consulting, brokering, general management consulting, health care and other types of claims administration.

Staff: 14 total staff members; five professionals, including those holding MBA, CLU and CPA designations.

Clients: 150 total clients; 25% with more than 500 employees, 75% with fewer than 500 employees; 70% corporations, 10% multiemployer plans, 20% individuals; minimum size client, 50 employees.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer.

1989 gross revenues: $4 million from benefit consulting.

Principal officers: Robert E. Silva.

Siver Insurance Management Consultants

9400 4th St. N., Suite 119, St. Petersburg, Fla. 33702; 813-577-2780

Year founded: 1970.

Services provided: 40% of gross revenues from benefit consulting, 60% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan design consulting, consulting on selection of investment managers.

Welfare plan consulting: 34% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 1% of business.

Other services: 60% of business. Includes risk management consulting.

Staff: 27 total staff members; seven professionals, including three CLUs, six CPCUs, four attorneys, one ChFC, five ARMs, one AU, two AAIs.

Clients: 96 total clients; 90% with more than 500 employees, 10% with fewer than 500 employees; 44% corporations, 56% government entities; no minimum size client.

Compensation: By the project; by the hour: senior consultant $125-$195, consultant $70-$125, clerical $35-$45.

1989 gross revenues: $1.9 million total, $759,299 from benefit consulting.

Principal officers: Edward W. Siver, president; Robert I. Siver, vp/secretary/treasurer; Jim Marshall, vp.

Skalinder Wilkinson & Associates Inc.

20 N. Wacker Drive, Chicago, Ill. 60606; 312-368-7010

Year founded: 1984.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 60% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping and administration systems consulting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 20% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 20% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Staff: 12 total staff members; eight professionals, including two FSAs, two ASAs, one MBA, one CLU, three Ph.D.s, one attorney.

Clients: 80 total clients; 60% with more than 500 employees, 40% with fewer than 500 employees; 75% corporations, 20% multiemployer plans, 5% other entities; minimum size cli-

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nt, 100 employees.

Compensation: By the project; by ne hour: senior consultant $210-225, consultant $120-$140, data reparation $55.

1989 gross revenues: Not reorted.

Principal officers: Gregg L. Skander, Joseph H. Wilkinson and avid C. Feinstein.

Small Parker & Blossom Inc.

4200 N. Knoxville Ave., Peoria, Ill. 61614; 309-682-4200

Year founded: 1967.

Services provided: 82% of gross revenues from benefit consulting, 18% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 72% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 8% of business. Includes insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 2% of business. Includes benefit statement preparation.

Other services: 18% of business. Includes brokering, Section 125 plan administration.

Locations: Schaumburg, Ill.

Staff: 28 total staff members; 16 professionals, including one CLU.

Clients: Total clients not reported; 5% with more than 500 employees, 95% with fewer than 500 employees; 98% corporations, 2% individuals; no minimum size client.

Compensation: By the project; on retainer; by the hour: senior consultant $90-$120, consultant $70-$100, clerical $25-$40.

1989 gross revenues: $1.3 million total.

Principal officers: John D. Blossom, president/chief executive officer; Carol R. Sears, vp/actuary; Linda Byrne Blossom, vp/senior consultant.

Smith Kazazian Inc.

350 W. Arden Ave., Suite 201, Glendale, Calif. 91203; 818-409-0821

Year founded: 1987.

Services provided: 100% of gross revenues from benefit consulting.

Welfare plan consulting: 100% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Staff: Six total staff members; all professionals, including one EA.

Clients: 18 total clients; 100% with more than 500 employees; 100% corporations; minimum size client, 300 employees.

Compensation: By the hour: senior consultant $180-$300, consultant $140-$180.

1989 gross revenues: Not reported.

Principal officers: Vine Smith, president; Alice Kazazian, vp; George Graff and Mark Wycko, principals.

Southern Benefit Consulting

2900 Cahaba Road, Birmingham, Ala. 35223; 205-879-3777

Year founded: 1987.

Services provided: 60% of gross revenues from benefit consulting, 40% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 15% of business. Includes plan design consulting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 30% of business. Includes plan design consulting, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 15% of business.

Other services: 40% of business. Includes brokering.

Staff: 35 total staff members; 30 professionals, including two MBAs, 15 RNs, five LPNs.

Clients: 10 total clients; 90% with more than 500 employees, 10% with fewer than 500 employees; 100% corporations; minimum size client, 250 employees.

Compensation: By the project.

1989 gross revenues: Not reported.

Principal officers: R. Craig Fulford.

Stevens, Dowd & Co.

629 Lakeland E. Drive, Jackson, Miss. 39208-9732; 601-939-2902

Year founded: 1979.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 70% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, plan/trust legal document drafting, plan administration consulting.

Welfare plan consulting: 20% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes benefit statement preparation, booklet preparation.

Staff: 15 total staff members; six professionals, including one FSA, one MBA, one CEBS, two CLUs.

Clients: 400 total clients; 10% with more than 500 employees, 90% with fewer than 500 employees; 75% corporations, 25% individuals; no minimum size client.

Compensation: By the project; on retainer; by the hour: senior consultant $100, consultant $100, clerical $30.

1989 gross revenues: $800,000 total, all from benefit consulting.

Principal officers: Robert W. Dowd, president; James T. Stevens, secretary/treasurer; W. Tris Stevens vp.

J.E. Stone & Associates Inc.

5555 San Felipe, Suite 550, Houston, Texas 77056; 713-622-8930

Year founded: 1987.

Services provided: 100% of gross revenues from benefit consulting.

Retirement and savings plan consulting: 35% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.

Welfare plan consulting: 60% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers, claim reserve analysis for self-funded health plans.

Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.

Staff: Nine total staff members; seven professionals, including one ASA, two MBAs, one Ph.D.

Clients: 22 total clients; 74% with more than 500 employees, 26% with fewer than 500 employees; 100% corporations; minimum size client, 250 employees.

Compensation: By the project; by the hour: senior consultant $235, consultant $145, clerical $38.

1989 gross revenues: Not reported.

Principal officers: J.E. Stone, managing director; K.L. Haynes, principal/senior actuary; T.F. McCord, principal.

T

TMA

144 Idlewood Drive, Stamford, Conn. 06905; 203-968-2321

Year founded: 1987.

Services provided: 50% of gross revenues from benefit consulting, 50% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 5% of business. Includes plan design consulting, consulting on selection of investment managers.

Welfare plan consulting: 35% of business. Includes plan design consulting, insurer/broker selection consulting, flexible benefit program design, claims auditing

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs, booklet preparation, audiovisual program preparation.

Other services: 50% of business. Includes brokering, cafeteria plan and welfare plan consulting compensated on a commission basis.

Staff: Two total staff members; one professional.

Clients: 30 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 73% corporations, 27% not-for-profit organizations; minimum size client, four employees.

Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $110, clerical $45.

1989 gross revenues: $100,000 total, $50,000 from benefit consulting.

Principal officers: Thomas M. Maloof, principal.

TPF&C

245 Park Ave., New York, N.Y. 10167-0128; 212-309-3400

Year founded: 1934.

Services provided: 59% of gross revenues from benefit consulting, 41% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 34% of business.

Welfare plan consulting: 11% of business.

Employee benefit communications consulting: 6% of business.

International benefit consulting: 8% of business.

Other services: 41% of business. Includes compensation consulting, general management consulting, insurance consulting.

Locations: 27 U.S. locations, 26 foreign locations.

Staff: 5,150 total staff members; including 313 FSAs, 241 ASAs.

Clients: 8,000 total clients; 100% corporations; no minimum size client.

Compensation: By the hour.

1989 gross revenues: $688 million total, $406 million from benefit consulting only.

Principal officers: James E. Kielley, president/chief executive officer; Charles E. Peartree, executive vp; Donald E. Sullivan, vp-practices/products; Gary T. Hallenbeck, vp/manager-employee benefit services; Joseph N. Davi, vp/chief actuary.

Treacy & Rhodes Consultants

462 Stevens Ave., Suite 308, Solana Beach, Calif. 92075; 619-481-1191

Year founded: 1985.

Services provided: 85% of gross revenues from benefit consulting, 15% of gross revenues from activities other than benefit consulting.

Welfare plan consulting: 68% of business. Includes plan design consulting, evaluation of other service providers.

Employee benefit communications consulting: 17% of business. Includes general consulting on communications programs, benefit statement and booklet preparation, audiovisual program preparation.

Other services: 15% of business. Includes general management consulting.

Staff: 30 total staff members; 21 professionals, including three FSAs, four ASAs, one attorney.

Clients: Total clients not reported; 100% corporations.

Compensation: By the hour: senior consultant $200-$275, consultant $100-$200, clerical $50-$70, benefit analyst $80-$120.

1989 gross revenues: $3.2 million from benefit consulting.

Principal officers: Jane D. Rhodes, president; Michael E. Treacy, chief executive officer; Steve A. Eschbach, executive vp.

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U

Urbach Kahn & Werlin P.C.

66 State St., Albany, N.Y. 12207; 518-449-3166

Year founded: 1964.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: 55% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers.
Welfare plan consulting: 40% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 5% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
Locations: New York, Poughkeepsie, Glens Falls, White Plains and Buffalo, N.Y.; Burlington and Manchester, Vt.; Los Angeles.
Staff: 280 total staff members, including five MBAs, one CLU, one Ph.D., 60 CPAs, 15 attorneys, one EA.
Clients: 700 total clients; 15% with more than 500 employees, 85% with fewer than 500 employees; 80% corporations, 10% individuals, 10% government agencies; no minimum size client.
Compensation: By the project, on retainer, by the hour.
1989 gross revenues: Not reported.
Principal officers: Steven N. Fischer, Marilyn Pendergast, David A. Pratt, William F. Chandler and Howard M. Kahn.

V

A.W. Vidmer & Co.

111 Westwood Place, Suite 430, Brentwood, Tenn. 37027; 615-373-1964

Year founded: 1988.
Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.
Employee benefit communications consulting: 80% of business. Includes general consulting on communications programs, booklet preparation, audiovisual program preparation, interactive employee videos.
Other services: 20% of business. Includes advertising, marketing, graphic design.
Staff: Eight total staff members.
Clients: 55 total clients; 60% with more than 500 employees, 40% with fewer than 500 employees; 100% corporations; minimum size client, 100 employees.
Compensation: By the hour: senior consultant $100, consultant $80, clerical $40, data input $25.
1989 gross revenues: $590,000 total.
Principal officers: Antony W. Vidmer, president; Kathryne H. Vidmer, director-document processing.

W

WHP-First in Employee Benefits Inc.

14440 Myerlake Circle, Clearwater, Fla. 34620; 800-229-7947

Year founded: 1980.
Services provided: 40% of gross revenues from benefit consulting, 60% of gross revenues from activities other than benefit consulting.
Welfare plan consulting: 40% of business.
Other services: 60% of business. Includes health care and other types of claims administration.
Staff: 50 total staff members; six professionals.
Clients: 54 total clients; 20% with more than 500 employees, 80% with fewer than 500 employees; 99% corporations, 1% multiemployer plans; minimum size client, 100 employees.
Compensation: By the project.
1989 gross revenues: Not reported.
Principal officers: James L. Hanahan, president; Mark Heacox, vp-sales/marketing; Adrienne Glowatsky, vp-operations.

Walker & Co.

777 Davis St., San Francisco, Calif. 94111; 415-398-2655

Year founded: 1948.
Services provided: 75% of gross revenues from benefit consulting, 25% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 10% of business.
Welfare plan consulting: 50% of business.
Employee benefit communications consulting: 15% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
Other services: 25% of business. Includes brokering.
Staff: 35 total staff members; six professionals.
Clients: Total clients not reported; 35% with more than 500 employees, 65% with fewer than 500 employees; 30% corporations, 70% multiemployer plans; minimum size client, 25 employees.
Compensation: By the project; commissions for insurance placed with underwriters; on retainer; by the hour: senior consultant $175, consultant $100, clerical $35.
1989 gross revenues: Not reported.
Principal officers: David S. Walker, managing general partner; Arthur C. Mathews, partner.

Walston & Associates Inc.-Employee Benefit Consulting Division

2424 Herodian Way, Suite 100, Smyrna, Ga. 30080; 404-980-9423

Year founded: 1986.
Services provided: 100% of gross revenues from benefit consulting.
Retirement and savings plan consulting: 1% of business. Includes plan design consulting, consulting on selection of investment managers.
Welfare plan consulting: 95% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 4% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation.
Staff: Nine total staff members.
Clients: Total clients not reported; 100% corporations; minimum size client, 50 employees.
Compensation: By the hour: senior consultant $125, consultant $85, clerical $25.
1989 gross revenues: Not reported.
Principal officers: Thomas F. Walston II, president; Lois Walston, treasurer; Olan Hembree and Jim Wiley, vps.

Warren, McVeigh & Griffin Inc.

1420 Bristol St. N., Newport Beach, Calif. 92660; 714-752-1058

Year founded: 1968.
Services provided: 20% of gross revenues from continuous benefit consulting; 22% from welfare claims management audits; 58% from special projects, including plan design, benefit and cost analyses, excess insurance analyses, pooling feasibility studies, employee communication studies, expert witness testimony, welfare claims management reviews, self-funded and alternative funded feasibility studies, cost containment studies, brokerage, compensation and performance evaluations, design and evaluation of bid specifications, design and implementation of management information systems, publishing.
Locations: San Francisco.
Staff: 14 total staff members; professional designations held by staff include one RHU, one CPCU, one ARM.
Clients: No minimum size client.
Compensation: By the project; on retainer; by the hour: principal consultant $160-$200, senior consultant $120-$150, technical staff $100-$120, clerical $25-$45.
1989 gross revenues: Not reported.
Principal officers: C.C. Griffin, chief executive officer; Robert Wilkinson, senior vp; Timothy Beck, vp/managing consultant-employee benefits.

Williams, Thacher & Rand

630 Third Ave., New York, N.Y. 10017; 212-949-1344

Year founded: 1975.
Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 47.5% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.
Welfare plan consulting: 31.4% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.
Employee benefit communications consulting: 14.2% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation.
International benefit consulting: 1.9% of business. Includes consulting from the U.S.
Other services: 5% of business. Includes compensation consulting.
Locations: Baltimore; Washington, D.C.; Richmond, Va.; Indianapolis; Philadelphia.
Staff: 130 total staff members; 100 professionals, including two FSAs, seven ASAs, 10 MBAs, two CEBSs, two CLUs, one Ph.D., one attorney, 10 EAs.
Clients: 750 total clients; 30% with more than 500 employees, 70% with fewer than 500 employees; 88% corporations, 2% multiemployer plans, 10% partnerships; minimum size client, 100 employees.
Compensation: By the project; by the hour: senior consultant $200-$275, consultant $125-$180, clerical $35-$50.
1989 gross revenues: $11.5 million from benefit consulting.
Principal officers: Charles Thacher, Robert Williams, Thomas Rand and Terry Stokes.

R.H. Wohl & Associates/ In Plain English

P.O. Box 3300, Gaithersburg, Md. 20885; 301-340-2821

Year founded: 1977.
Services provided: 80% of gross revenues from benefit consulting, 20% of gross revenues from activities other than benefit consulting.
Employee benefit communications consulting: 80% of business. Includes general consulting on communications programs, benefit statement preparation, booklet preparation, audiovisual program preparation, employee surveys, policy manuals.
Other services: 20% of business. Includes general management consulting.
Staff: 10 total staff members; four professionals, including two MBAs, one CEBS.
Clients: 50 total clients; 90% with more than 500 employees, 10% with fewer than 500 employees; 90% corporations, 10% multiemployer plans; minimum size client, 20-150 employees, depending on services provided.
Compensation: By the project; on retainer.
1989 gross revenues: Not reported.
Principal officers: Ronald H. Wohl, president.

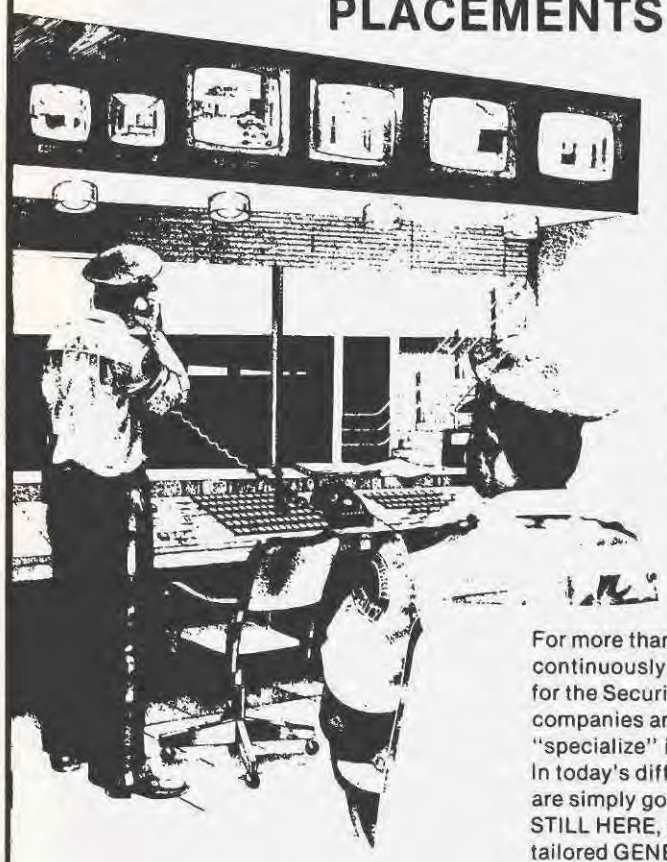
The Wyatt Co.

1850 M St. N.W., Suite 400, Washington, D.C. 20036-5801; 202-778-2626

Year founded: 1946.
Services provided: 87% of gross revenues from benefit consulting, 13% of gross revenues from activities other than benefit consulting.
Retirement and savings plan consulting: 61% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.
Welfare plan consulting: 8% of business. Includes plan design consulting, consulting on selection of in-

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Benefit consultants

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vestment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 7% of business. Includes general consulting on communications programs; preparation of benefit statements, booklets, audiovisual programs.

International benefit consulting: 11% of business. Includes consulting via overseas branch offices, consulting from the U.S.

Other services: 13% of business. Includes compensation consulting, risk management, surveys.

Locations: 30 locations in the U.S., 35 foreign locations.

Staff: 3,500 total staff members; 2,200 professionals, including 157 FSAs, 172 ASAs.

Clients: More than 13,000 total clients; 40% with more than 500 employees, 60% with fewer than 500 employees; 97% corporations, 2% multiemployer plans, 1% government entities; no minimum size client.

Compensation: By the hour.

1989 gross revenues: $382 million total; $332 from benefits consulting.

Principal officers: Michael H. Davis, president/chief executive officer; Leroy B. Parks Jr., vp/treasurer; Robert L. Barnes, Michael D. Evans and Albert C. Simmonds, vps.

Y

Yaffe & Co. Inc.

800 N. Charles St., Baltimore, Md. 21201; 301-332-1166

Year founded: 1976.

Services provided: 95% of gross revenues from benefit consulting, 5% of gross revenues from activities other than benefit consulting.

Retirement and savings plan consulting: 70% of business. Includes plan design consulting, actuarial work for defined benefit plans, record keeping for defined benefit and defined contribution plans, record keeping and administration systems consulting, plan/trust legal document drafting, plan administration consulting, consulting on selection of investment managers, asset accumulation/investment consulting.

Welfare plan consulting: 15% of business. Includes plan design consulting, consulting on selection of investment managers, insurer/broker selection consulting, evaluation of other service providers.

Employee benefit communications consulting: 10% of business. Includes general consulting on communications programs; preparation of benefit statements, booklets, audiovisual programs.

Other services: 5% of business. Includes compensation consulting.

Staff: 44 total staff members; 30 professionals, including two ASAs, two MBAs, two CEBSs, one CPA, one attorney.

Clients: 75 total clients; 65% with more than 500 employees, 35% with fewer than 500 employees; 100% corporations; minimum size client, 100 employees.

Compensation: By the project, on retainer, by the hour.

1989 gross revenues: Not reported.

Principal officers: Rian M. Yaffe, president/chief executive officer. ■

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Case Study

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Intermediary rules

Continued from page 2

reinsurer and acts as an agent for the reinsurer.

A broker is a person or unit that "solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance."

Both definitions exclude employees and most closely-controlled units of the insurance and reinsurance companies involved.

The 10-page act contains extensive mandatory contract provisions for both managers and brokers, including: holding funds in a qualified U.S. financial institution, remitting funds promptly, providing annual statements and keeping detailed records of transactions for up to 10 years.

Brokers must also disclose to the ceding company any relationship with the reinsurer with whom they are dealing.

Other provisions require that all contracts between a manager and a reinsurer be written and approved by the reinsurer's board as well as by the insurance commissioner.

In addition, a manager's claims-handling function is subject to reinsurer scrutiny through increased reporting requirements, including an annual statement of its financial condition prepared by an independent certified accountant.

The new model prohibits managers from: binding some types of retrocessions; appointing an ineligible producer; and committing an unknowing reinsurer to paying a claim, or settling a claim with a retrocessionaire, that will have a significant impact on its surplus.

Duties of insurers or reinsurers that use managers or brokers are also spelled out.

For example, such reinsurers must: obtain an annual actuarial certification attesting to the adequacy of loss reserves established by the manager; authorize all retrocessional or syndicate participation contracts; and exclude most manager representatives from serving on the reinsurer's board.

Under the act, a commissioner could fine any reinsurance intermediary, insurer or reinsurer who violates its provisions up to $5,000 per violation and revoke or suspend a license. A reinsurance intermediary also could be required to make restitution for the net losses he caused to an insurer or reinsurer.

The NAIC adopted a last-minute amendment proposed by industry representatives to exclude managers of a group, association, pool or organization of insurers that engages in joint underwriting or joint reinsurance, if they are subject to examination by the insurance commissioner of the state in which the manager's principal place of business is located.

Despite an industry request to water down one provision, the committee let stand a clause that makes a reinsurer strictly liable for acts of a reinsurance manager.

Following the final committee discussions on the model law, T. Darrington Semple Jr., chairman of the reinsurance industry advisory group, said, "It was a lousy bill. Now it is a better bill. It's still not the best." Mr. Semple is senior vp and general counsel of American Re-Insurance Co. in New York.

In related action, the NAIC amended the model MGA act to include reinsurance intermediaries who bind ceding reinsurance contracts.

However, the Special Insurance Issues Committee refused a National Assn. of Independent Insurers request to amend the MGA model to exclude all managers of reciprocal insurers, who are called "attorneys-in-fact." ■

Solvency issues top NAIC officials' agenda

By MEG FLETCHER

LAS VEGAS, Nev.—Policing insurer solvency is the primary goal of the National Assn. of Insurance Commissioners's newly elected officers.

A five-point plan to improve regulation of insurer solvency was adopted at the NAIC's winter meeting Dec. 3-7 in Las Vegas, Nev.

The plan's key objectives are: uniform evaluation of reinsurance-related issues; state implementation of minimum standards for financial regulation; assessment of the NAIC's current examination process; enhanced solvency support mechanisms; and review of capitalization and reserve requirements as well as annual statement disclosures.

Association subgroups are already discussing some of these issues, which proves "the NAIC and the regulatory process is alive and well and getting better," said newly-elected Vp Jim Long of North Carolina.

And the push for states to adopt minimum standards for financial regulation is ahead of schedule, according to David Gates of Nevada, the outgoing president.

There now is strong support for making the standards mandatory, rather than voluntary as originally proposed, said NAIC President Earl Pomeroy of North Dakota.

"There is a growing comfort level among insurance regulators to subject themselves to standards for minimum financial regulation and to have compliance verified by independent auditing," he added.

In addition to solvency issues, the NAIC also covered several other topics at its winter meeting, including:

Accounting manual change

The NAIC amended its accounting manual to curb the "sale" of future revenues or surplus, which frequently is done by life insurers to bolster surpluses.

The NAIC's Life, Accident and Health Accounting Manual now regards the "immediate recognition" of proceeds from the "securitization" of these future reserves and surpluses as "inappropriate."

The regulatory group also proposed establishing a liability for such proceeds, which could be reduced as the proceeds are repaid.

However, "application of this accounting treatment to existing transactions is at the discretion of the domiciliary state," reads a statement included in the manual that some interpret as allowing states to "grandfather in" such arrangements.

Several regulators are concerned that these "securitization" transactions—which can significantly alter a company's statutory financial results—may undermine solvency regulation.

But some of these transactions can be structured with sufficient safeguards, according to James Schacht, chief deputy director of the Illinois Insurance Department.

Health insurance issues

Two newly approved amendments to the NAIC Health Maintenance Organization Model Act are designed to help ensure that enrollees in financially troubled HMOs receive coverage.

'The NAIC and the regulatory process is alive and well and getting better,' says the NAIC's Mr. Long.

Under one provision, an HMO that has uncovered expenditures exceeding 10% of total health care expenditures must place an "insolvency deposit" with a state insurance commissioner or some other designee approved by the commissioner. The HMO Model Act defines uncovered expenditures as "the costs of health care services that are covered by a health maintenance organization, for which an enrollee would also be liable in the event of the organization's insolvency."

The deposit should have a market value of 120% of the HMO's outstanding liability for uncovered expenditures for enrollees in a state.

A more controversial amendment allows commissioners to assess HMOs doing business in a state to cover an insolvent HMO's uncovered claims and provide coverage for the insolvent HMO's subscribers.

That change in the HMO Model Act is not recommended for some states, like those with low HMO premium volume or a market dominated by a few organizations, according to a drafting note.

In other health insurance-related matters, the NAIC:

- Accepted for further review a Group Health Rate Review Mechanism Advisory Committee report on solutions to problems group with fewer than 25 employees face in obtaining health insurance.

The committee, composed of insurer representatives, was concerned about these groups' complaints about large premium increases, increased inability to purchase new or replacement coverage and the grounds for termination of existing coverage.

The representatives who drafted the 14-page report recommend better disclosure of coverage information to buyers both at the point-of-sale and in insurers' home offices; proscribing abusive rating and termination practices; actuarial certification of compliance with appropriate rating practices and perhaps legal intervention by regulators.

The committee concluded that it would be counterproductive to impose new restrictions on how insurers underwrite such groups.

- Adopted several measures related to Congress' repeal of the Catastrophic Coverage Act of 1988 (*BI*, Nov. 27).

IRIS data to be released

The regulators' association formally approved plans to release its analysis of individual insurers' 1989 financial data under its Insurance Regulatory Information System by late spring 1990.

The analytical data will increase the usefulness of the statistics contained in the IRIS reports, which the NAIC released publicly last fall (*BI*, Sept. 19, 1988). The NAIC began to re-evaluate its policy of keeping the information confidential after an Indiana University professor won a suit against the NAIC seeking its release.

Under the new format, an individual insurer's financial ratios will be compared with NAIC norms, and those falling outside appropriate ranges will be highlighted.

Rules for troubled companies

The NAIC imposed a new standard on rehabilitators.

An amendment to the Insurers Supervision, Rehabilitation and Liquidation Model Act aims to ensure timely payment of covered claims.

If the payment of claims is substantially suspended for six months at any time after the appointment of a rehabilitator and he or she has not filed an application for plan approval, the rehabilitator will be required to petition the court for an order of liquidation on the grounds of insolvency, according to the amendment, which the Illinois Insurance Department opposed.

Reinsurance offsets

The NAIC Rehabilitators and Liquidators Task Force postponed voting on when offsets should be allowed under reinsurance contracts.

Opposing sides were given 30 days to reach a compromise on the issue, which deals with the way insurers are allowed to reduce the amount of funds they owe an insolvent insurer by the amount the insolvent insurer owes them. The issue then may be called for a vote at the NAIC's spring zone meeting March 25-27 in Salt Lake City.

Indiana Insurance Commissioner John Dillon Jr.—a newcomer to the NAIC—will name members to a new drafting committee assigned with reaching the compromise, said David Levinson, task force chairman. ■

Case Study

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State regulation to survive GATT: Expert

By MEG FLETCHER

LAS VEGAS, Nev.—The U.S. stem of state insurance regulaon should remain intact if Genral Agreement on Tariffs and rade negotiations proceed as exected, an international expert redicts.

The 50-state U.S. system of inurance regulation won't face "sere change" if GATT negotiations Geneva, Switzerland, result in ew agreements on the internaonal trade of business services—ncluding insurance—next year, aid Henry G. Parker III, chairman f an advisory committee on interational issues for the National ssn. of Insurance Commissioners.

Mr. Parker said he is "cautiously ptimistic" that the final product f the GATT talks will be a strong, ultilateral agreement like that favored by U.S. representatives.

American delegates recently proposed that participating countries provide foreign insurers with market access including: clear and open rules and regulations; nondiscriminatory regulation; access to regulators and appeal of adverse decisions; and strong limits on subsidies, nationalization and monopolization of services.

This proposal reflects values embodied in the U.S. insurance market and consists of "market-based principles whose broad application internationally would assure fair competition in the context of prudent regulation," said Mr. Parker, a managing director of Chubb & Son Inc., a Chubb Corp. unit.

However, some delegates representing other countries at the GATT talks prefer a looser agreement that sets out a few non-binding principles that can be adopted in the future and perhaps on a sector-by-sector basis. Mr. Parker opposes this approach.

If the more rigorous GATT proposals are enacted, they are not expected to cause serious change in the U.S. regulatory system because members of the advisory committee "are not aware of any substantial state practices that discriminate against alien private insurers," Mr. Parker said.

NAIC

"State regulation itself is not a discriminatory trade practice" because it does not impose standards that are more strict on alien, nongovernmental insurers than are imposed on a state's own domestic insurers. Both types of insurers may need to be accepted by multiple states if they want a U.S. operation, he said.

Perhaps the most serious criticism of the U.S. state regulatory system is that approximately 30 states restrict operations of foreign government-owned insurers.

The disparate U.S. system is also perceived as troublesome by some representatives of the Western European countries that are hammering out directives to steer the European Common Market in the next decade, Mr. Parker said.

As the EC moves toward allowing insurers based in an EC country to freely market insurance throughout the entire community with only a single license, they are likely to want similar freedom to market their products throughout the United States, he said.

That will create pressure to change the U.S. system or face the possibility that European regulators will retaliate by refusing to let U.S.-based insurers to operate in Europe as freely as European domestic companies do.

New York Insurance Superintendent James Corcoran recommends that states streamline the insurer-approval process so that any insurer that has been formally accepted by one state—a "port of entry"—should be able to file for routine approval in any other state. The other states would then have six months to issue a license or explain why they refuse to do so.

The NAIC also decided to appoint working groups to: analyze the problems government-owned insurers face; evaluate the feasibility of Mr. Corcoran's proposal; discuss trade and service issues relating to Mexico; and plan the NAIC's 1990 international conference in Baltimore. ■

CEO Miller to chair Corroon & Black

Richard M. Miller has been lected chairman of Corroon & lack Corp., effective Jan. 1, and vill retain the title of chief executive officer.

Mr. Miller joined Corroon & lack in 1976 as chief operating fficer and was named president/ EO in 1988.

John R. Lamberson, now exective vp and chief operating offier, will succeed Mr. Miller as resident. He is also chairman of he firm's construction industry ivision.

Chairman **Robert F. Corroon**, who has held the title since 1975, vill step down Dec. 31, but remain director, chairman of the executive committee and a consultant.

Other agent/broker changes:

Larry C. Sundstrom joins Rollins Burdick Hunter Co. of Southern California in Los Angeles as senior vp and director of risk management services.

J. Randy Pugh named managing vp of Alexander & Alexander Inc.'s Kansas City office. He had been managing vp of the Albuquerque, N.M., and Midland, Texas, offices.

Johnson & Higgins announced these elections to vp: **Gregory N. Dekker**, in the aviation department; **Richard T. Brewer**, **Joseph P. Holloway** and **Harry Taylor**, in the casualty department; and **Jennifer McElroy**, in the financial group.

Jeffrey P. Thompson promoted to senior vp of Smith Insurance Services of Lawrenceville, N.J., from vp and manager.

Bob Livingston joined Greene-Hazel & Associates Inc. of Jacksonville, Fla., as vp.

Jeffrey G. Swarbrick appointed senior vp at Kelter-Thorner Inc. of Southfield, Mich., where he had previously been director of sales.

Fred A. Smith appointed vp-new business development for Roanoke International Insurance Agency Inc. in Los Angeles, a subsidiary of Roanoke Agency Inc. of Schaumburg, Ill.

Comings & goings: industry

Insurers

Richard M. Ravin appointed executive vp of Combined Insurance Co. of America, a Chicago-based Aon Corp. subsidiary. Mr. Ravin had been senior vp.



Mr. Ravin

Ted Brimacombe named vp-individual policy services for Transamerica Occidental Life Insurance Co. of Los Angeles. He had been vp-policyholder operations.

Patricia Minnucci elected president of the employee benefits division of Washington National Insurance Co. of Evanston, Ill., a unit of Washington National Corp.

Helen Hughes joined IBA Health & Life Assurance Co. of Kalamazoo, Mich., as vp-medical services and claims.

Kevin M. Quinley promoted to vp-risk services for Hamilton Resources Corp. of Fairfax, Va., and its captive, MEDMARC Insurance Co. Risk Retention Group Inc. of Montpelier, Vt., from claims manager.

Dale L. Baguhn promoted to vp-dental products for Blue Cross of California of Woodland Hills, Calif., from executive director of dental operations.



Mr. Tagami

Bert Tagami promoted to vp-unit statistical and dividend administration for Fremont Compensation Insurance Co., a Los Angeles-based subsidiary of Fremont Indemnity Co.

HMOs/PPOs

Jeanne Thimons promoted to vp-administration for United Health Plan, a Columbus, Ohio-based HMO, from claims administrator.

Dr. Stuart Brown named medical director for Partners Health Plan of Illinois and regional medical director for Partners National Health Plans. Partners is a managed care provider and a joint venture between Voluntary Hospitals of America and Aetna Life & Casualty Co.

Other suppliers

C. William Burke joined the Secaucus, N.J., office of Buck Consultants Inc. as an administrative consultant.

William D. Gavin named chairman and chief executive officer at Bierly & Associates Inc., a third-party administrator based in Pasadena, Calif. Bierly is a wholly owned subsidiary of HCI Claim Management Corp., which is a wholly owned subsidiary of The Hertz Corp.

Todd A. Stein named president of Brunswick Cos. of Akron, Ohio. In addition, **Mel Lyons** and **Morton M. Stein** named co-chairmen of the financial services firm. ■

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Ryder System, Inc., a long-time Erisco customer, wanted to add a prenatal education program for its employees. Thanks to Erisco's new Health Care Information Services, Ryder got precise reports on the incidence of premature births; vital information they needed to set up the new program. Ryder benefits from more efficient administration of its health care expenditures. And its employees benefit from still another innovative plan.

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Mentor liquidator ready to get on with task

HAMILTON, Bermuda—The Mentor Insurance Ltd. liquidation is proceeding steadily despite—not because of—dissident creditor activities, says liquidator Charles Kempe.

Speaking publicly for the first time since the Mentor dissidents' unsuccessful Nov. 1 bid to oust him and co-liquidator Michael Arnold, Mr. Kempe did acknowledge that the dissident campaign may have helped creditors to "become more focused" in the liquidation.

After the defeat of the dissidents' call for resignations, dissident legal representative Francis Mackie claimed that the continued pressure on the liquidators had revived a process that had been in the doldrums (*BI*, Nov. 6).

Mentor, a former captive of Ocean Drilling & Exploration Co. of New Orleans, was ordered liquidated by the Bermuda Supreme Court in 1985.

Mr. Kempe and his top adviser in the liquidation, Gareth Hughes, an accountant, said that continued progress toward a first interim dividend by the end of 1991 was not made possible by the efforts of Mr. Mackie and his clients but, rather, in spite of them.

They also disputed Mr. Mackie's claim to have secured a dividend payment earlier than had originally been intended.

"The date was always a moving target," said Mr. Kempe. "Our original objective was to pay an interim dividend by the end of 1990, but we were forced to temper that plan as our knowledge improved about Mentor's 20-year, long-tail liabilities. Even by the end of 1988, there was still a great deal of uncertainty about Mentor's book. We estimated at that time that about 70% of Mentor's liabilities had still to mature."

But this was the only confrontational note to emerge during an interview in which the liquidator stressed that his priority was to move on without further distractions.

And while strenuously rejecting Mr. Mackie's praise of dissidents as "lighting a fire" under the liquidators, Mr. Kempe said the creditors meeting, and the buildup to it, "perhaps" helped focus creditors' attention on the liquidation.

"Perhaps these dissidents did help the creditors become more focused than they had been," he allowed.

Bermuda briefs

"If there was anything to be learned from it at all, it was that we might have better informed some of the creditors about the liquidation and that this might have helped alleviate some of their concerns," he said.

Asked about the message behind the vote—in which 209 creditors representing claims of $458.2 million voted to retain and 140 creditors with $206.1 million in claims voted for removal—Mr. Kempe said, "A large majority of creditors showed their support for the liquidation as it is presently constituted, including the litigation."

Creditor turnout actually represented about $687 million of the $739 million in claims Mentor faces, said Mr. Hughes. "This shows an interested, more alert body of creditors and that has got to be good for the entire liquidation."

However, the "heat" of the meeting prevented agreement on the discounting of contingent debts, the last significant step before admitting agreed claims, he said.

"We now intend to apply to the Bermuda Supreme Court for directions to settle outstanding questions on discounting, such as when it should apply and at what rate," said Mr. Kempe.

The outcome, he said, may establish legal precedent on claims discounting in Bermuda.

Mentor's liquidation is still on track and will be "substantially complete" by the end of 1991, he said. "That's a major achievement in this industry."

Further developments in the suit now being brought in Bermuda against Mentor parent ODECO, Bermuda-based Pinnacle Reinsurance Ltd. and nine ODECO/Mentor directors, are unlikely until the new year when the Supreme Court will consider interlocutory pleadings, according to Mr. Kempe. ■

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Political risk cover

Continued from page 1

Union went the same way," he said.

Another reason for the tight market is that many of the contract frustration policies now in force are written on a three-year basis, locking up the underwriters' capacity.

Some believe that the capacity shortage will continue as long as demand for the coverage remains strong while others believe that the shortage could pass in a few weeks.

Indeed, the Export-Import bank in Washington may be permitted for the first time in recent years—by a presidential order or an act of Congress—to issue export credit insurance for U.S. companies' Soviet ventures.

Meanwhile, capacity is plentiful for policies covering confiscation, expropriation and nationalization of assets by the Soviet Union, including a new $400 million facility recently unveiled by Frank B. Hall & Co. Inc. (see related story).

In addition, capacity is widely available for political risk policies covering Western ventures in the Eastern bloc countries of East Germany, Hungary, Czechoslovakia, Yugoslavia, Poland, Romania and Albania (see related story).

This year "several hundreds of millions of dollars" of contract frustration limits have been written by political risk underwriters, said Kit Brownlees, head of the political risk division of broker Hogg Robinson & Gardner Mountain P.L.C. in London.

As a result of this demand on a small marketplace, contract frustration coverage for the Soviet Union "is very difficult to place now," confirmed Mr. Brownlees.

"There will be a need for more capacity for the Soviet Union because the demand (for the contract frustration coverage) has increased," agreed Louis Habib-Deloncle, president and director general of Paris-based political risk insurer Pool d'Assurance des Risques Internationaux & Speciaux.

"There's no capacity now because so much business was already written earlier in the year," added Mark Drummond-Brady, a director of Lloyd's broker Lloyd Thompson Ltd.

"There's been a steady supply of business over the last few years for three-year (political risk) policies in the Soviet Union. And because the Soviet Union was considered a good risk, people wrote it at low rates.

"But now, rates have gone up 30% to 50% because there's little capacity available," added Mr. Drummond-Brady.

Rates were around 1% of the insured value of the contract earlier this year, but now the rate can be as much as twice that, said Mr. Palmer of Berry, Palmer & Lyle.

At least one syndicate at Lloyd's has stopped writing large limits for contract frustration coverage involving the Soviet Union because much additional Soviet-related business would upset the balance of the syndicate's portfolio of risks.

The French political risk pool P.A.R.I.S. also has nearly reached its capacity limit for coverage involving the Soviet Union, confirmed Mr. Habib-Deloncle.

P.A.R.I.S., which only insures against contract frustration, will write 9.5 million European Currency Units ($11 million) per risk and up to 50 million ECU's ($58.1 million) in the aggregate per country, including the Soviet Union, he said. The pool "is not far from reaching" its aggregate limit for the Soviet Union, he added.

Much of the business P.A.R.I.S. has already written involving the Soviet Union is for West German manufacturers of light industrial equipment and small factory complexes, Mr. Habib-Deloncle said. The pool's rate for this coverage has gone up to no more than 1.5% of the insured value of the contract from 1% in September, which Mr. Habib-Deloncle described as a nominal increase.

London-based Pan Financial Insurance Co. Ltd. no longer is writing contract frustration coverage for risks in the Soviet Union, confirmed Guy Walker, manager of political risk for the company. Pan Financial can write up to 20 million pounds ($32.2 million) in the aggregate per country but has already reached its aggregate limit for the Soviet Union, he said.

"We have written it, but to such a degree that we have no further capacity for the Soviet Union," said Mr. Walker.

Some underwriters are wary about writing contract frustration coverage due to concern about the stability of the Soviet government. At least one London underwriter has stopped accepting Soviet risks in the last few months, even though he has the capacity to write it.

Underwriters "are worried about perestroika," said Mr. Palmer, referring to the policy of restructuring in the Soviet Union. "Instability breeds insecurity. And there's no doubt that there has been rapid change breeding instability and insecurity" in the Soviet Union.

"We have to be more cautious," added Mr. Habib-Deloncle of P.A.R.I.S.

However, one major political risk underwriter denies there is a capacity crunch, saying the volume of new business deals with the Soviet Union has not grown significantly and does not expect it will in the near future.

"The pace of change in the Soviet Union and the Eastern bloc has been so rapid that there has not been time for business transactions to catch up to it," said John Salinger, president of the political risk division of New York-based American International Underwriters, a unit of American International Group Inc.

The changes "have outstripped everyone's expectations," he said. "Undoubtedly this funding of capitalism will lead to a number of business opportunities" but not all of them will come to fruition, Mr. Salinger added.

Although it would take several political risk markets to find $100 million of capacity, "the $100 million deals aren't around" for the Soviet Union, he said.

Mr. Salinger, whose company can write up to $25 million per risk for contract frustration involving the Soviet Union, admits, though, that rates "probably have firmed up."

Like the political situation in the Soviet Union, things could change overnight in the market for political risk insurance.

New reinsurance treaties under negotiation for Jan. 1 renewals may infuse the private political risk insurance market with new capacity, said Mr. Palmer of Berry Lyle & Palmer.

However, Mr. Habib-Deloncle contends that "even after (Jan. 1) renewals in London, the price should remain high because the demand has grown."

A new source of capacity for U.S. firms could come from the Export-Import Bank, which by law cannot now issue export credit insurance for Soviet ventures.

The Ex-Im Bank is prohibited under the Jackson-Vannick amendment to the Trade Act of 1975 from offering financing "of any kind" to any country which does not allow free emigration, explained Joseph Fleig, senior loan officer of the bank. This includes the Soviet Union, he said.

Also, under the Export-Import Bank Act of 1945, the bank is banned from carrying on any activity involving Marxist-Leninist countries, he added.

However, the laws can be waived by a presidential order, Mr. Fleig said. And following President Bush's meeting with Soviet President Gorbachev in Malta, "there is consideration being given to either waive the (Jackson-Vannick) amendment or for Congress to repeal it," according to Mr. Fleig.

Non-U.S. companies can approach their governments' export credit guarantee agencies for export credit insurance.

For example, the British government's Export Credit Guarantee Department has written 560 million pounds ($901.6 million) in export credit insurance since 1987 for U.K. firms doing business with the Soviet Union, a spokeswoman for the department said.

The policies include a $72 million guarantee of a $300 million loan to support the modernization and expansion of a polypropylene plant in the Soviet Union; and credit insurance for a 34.4 million pound ($55.4 million) contract to manufacture commercial vehicles in the Soviet Union for the domestic and West European markets.

In addition to government agencies, buyers can try other alternatives to the private political risk insurance markets.

London-based Black Sea & Baltic General Insurance Co. Ltd., which is the contact office for the Soviet insurer Insurance Co. of the U.S.S.R. (Ingosstrakh) Ltd., has plenty of capacity for political risk coverage.

"Normally we could say that for our capacity regarding (political risk insurance in) the Soviet Union, the sky's the limit until Ingosstrakh tells us otherwise," said Rod Rawbone, deputy underwriter for Black Sea & Baltic. "The ultimate answer comes from Ingosstrakh." ■

Marine market offers confiscation cover

LONDON—Western companies with joint ventures in the Soviet Union are having no trouble finding insurance coverage for confiscation, expropriation and nationalization of assets by a foreign government, brokers and underwriters agree.

There is no capacity shortage for this type of coverage because London's marine underwriters are able to write the coverage under the war risk section of their premium income capacity and cede the business as war risks under their reinsurance treaties.

"We have a confiscation line slip for $130 million on any one risk" in the Soviet Union, said Mark Drummond-Brady, a director of Lloyd's of London broker Lloyd Thompson Ltd. in London. "There must be $250 million in the market worldwide for confiscation coverage" in the Soviet Union, he estimated.

In addition, a new facility was recently formed to provide $400 million in coverage for Western firms investing in Eastern Europe and the Soviet Union (*BI*, Dec. 4).

The facility—a joint venture of Frank B. Hall & Co. Inc. and Lloyd's broker Steel Burrill Jones Ltd.—primarily underwrites confiscation, expropriation and nationalization risks, confirmed Price Lowenstein, director of international political risk services for Frank B. Hall & Co. of California in San Francisco.

However, some brokers and underwriters in London who are not involved with the Hall facility are calling it a "marketing gimmick" because capacity for confiscation coverage is readily available. In addition, they contend the Hall coverage is too expensive, sometimes twice as much as coverage available in the open market.

Mr. Lowenstein, however, denies that the facility is a marketing ploy. Hall's facility also offers coverage for losses due to license cancellations because of the implementation of any new laws, orders, decrees or regulations by any country "which make it impossible to export or import into the Soviet Union," he said.

And the rating may be twice as much on the facility's coverage, "but that's because we are offering double the coverage for double the rate," Mr. Lowenstein said. "Most companies who are investing in the Soviet Union are buying the cover. In the open market you can buy confiscation. But this offers (additional) coverage for any action taken by the U.S. government."

—By Stacy Shapiro

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Insurers view East bloc risks

LONDON—Some political risk underwriters are getting nervous about the dramatic changes sweeping through Eastern Europe.

But that nervousness has not yet translated into any shortage of capacity for political risk insurance in the Eastern bloc. All types of political risk coverage remain plentiful for Western companies looking to insure ventures in Eastern Europe. Availability is primarily due to a lack of demand—many Western companies are waiting until the dust settles before investing in Eastern Europe.

However, demand for political risk coverages in Eastern Europe could explode at any time and underwriters are uncertain how to underwrite the risk.

Underwriters have been concerned about changes in Eastern Europe since the Berlin Wall toppled early in November.

The changes taking place nearly every day in the governments of East Germany and Czechoslovakia have led at least one Lloyd's of London political risk underwriter to increase rates 25% to 75% and to restrict policy terms to one year to 18 months instead of the three-year policies common for political risk coverage in the Soviet Union.

"There's a growing demand" for coverage in the Eastern bloc, observed Louis Habib-Deloncle, president and director general of the Paris-based political risk insurance pool, Pool d'Assurance des Risques Internationaux & Speciaux.

"But there are problems. The political risk problem won't be as big a problem as in Russia, but there will be economic problems. What is the financial situation and the future going to be?

"There is no shortage of capacity at this time (for Eastern Europe), but there will be a need for more capacity in the future," Mr. Habib-Deloncle said.

In Eastern Europe, "the risk is worse" since the changes began, added Mark Drummond-Brady, a director of Lloyd's broker Lloyd Thompson Ltd. "Before, the whole economy was state-controlled, backed by industry. Now, with increased privatization, there is concern over who you are dealing with. So it will be more difficult than ever to assess the risks in the Eastern European bloc."

However, "for East Germany, Czechoslovakia, Hungary, Romania, Yugoslavia, Bulgaria, and Albania the appetite is limited," Mr. Drummond-Brady noted. Demand at the moment for political risk insurance capacity is mostly for ventures involving the Soviet Union, he said.

But brokers and underwriters expect demand to grow.

"There's more demand for Hungary. There's always been for Poland though nothing compared to the Soviet Union," said Anthony Palmer, marketing director of Lloyd's broker Berry, Palmer & Lyle Ltd. There is also interest in coverage for Czechoslovakia and East Germany "but the crumbling of the Berlin Wall" hasn't resulted in increased interest.

However, there are 937 joint ventures being considered at the moment in Eastern Europe "and a lot of those will be looking for (political risk) cover sometime," noted Mr. Drummond-Brady.

—By Stacy Shapiro

'exas work comp

ontinued from page 1

ıtes pointed to companies that had ft the state citing high workers ›mpensation costs.

Texas employers' workers compen-ıtion costs have risen 140% since)84 to become the fifth highest in ıe nation, while injured workers in exas receive benefits lower than in 2 other states.

Although no one expects to see ·orkers compensation costs fall im-ıediately, the reforms are expected › control continuously rising rates, 'hich are surging 22% in 1990 fol-›wing increases of 18.7% in 1989, 5% in 1988 and 17.7% in 1987.

Insurers writing workers compen-ation coverage in Texas lost more ıan $580 million in 1988.

"It's an excellent bill," declared)ane Harris, president of the Texas ıssn. of Business. "It will get the sys-em under control, help expedite the .elivery of benefits and help control osts for employers."

"I'm very, very pleased," said ames E. Green, risk manager at Jus-in Industries Inc. in Fort Worth, who ıas lobbied for reform of the Texas vork comp system.

The bill provides "the opportunity –depending on how they implement t—to instill predictability and stabil-ty within the industry. Without it, ve can't control premiums," he said.

"We broke out the champagne," aid Mark T. Carter, director of cor-›orate risk management at The LTV Corp. in Dallas. "Let's just hope it's ıot premature," cautioned Mr. Carter, who also has pushed for workers comp reform.

Only plaintiffs lawyers and some ›rganized labor representatives are criticizing the new law.

"It's a bad law, and I don't think it's going to work," said Tommy Jacks, president-elect of the Texas Trial Lawyers Assn.

"The system of dispute resolution, which under current law is simple and efficient, is going to be replaced by one with more layers of proceed-ings. It translates into greater ex-pense and delay both to insurers and employers," he charged.

Under current law, both sides in a work comp claim dispute first meet informally before an Industrial Acci-dent Board hearing officer, which provides the opportunity to reach a settlement. At that meeting, a com-promise settlement is entered or the hearing officer makes an award on behalf of the Industrial Accident Board.

If either side is unhappy with the award, it can be appealed before a jury in state court.

Almost all claimants who appear before an IAB hearing officer file an appeal seeking a jury trial.

However, of the 12,000 appeals, only 400 to 600 ever reach a jury because settlements are finally reached. Employers often settle cases for more money than they otherwise would because they fear a jury trial.

The jury is not allowed to con-sider the IAB hearing officer's find-ings.

The new law retains the prehear-ing feature that allows for a settle-ment. However, the new law also allows the parties to choose bind-ing arbitration to settle the dispute.

If the case is not arbitrated, the dispute will proceed to an eviden-tiary hearing before a hearing offi-cer at the commission. The hearing officer will render a decision.

That decision can be appealed by either party to a three-member ap-peals panel of the commission.

Only after the appeals panel rules can an appeal be made to a jury.

And, the jury can be informed of the commission's findings.

Employers and insurers endorse this reform, even though it continues to permit more workers compensa-tion claim litigation than most states.

Only Maryland and Ohio also have trial de novo systems. Other states permit appeals of workers compensa-tion awards only on the grounds that the law was not correctly applied.

Mr. Green of Justin said the new Texas system of resolving disputes should help stabilize costs because it "will reduce the threat of frivolous litigation so that only the disputed cases are litigated."

Bill Huff, senior vp and general counsel for Employers Casualty Co. in Dallas, agreed that the shift to an administrative system will contribute toward stabilizing and eventually lowering rates.

In addition, the new law requires that attorneys' fees be based on "time and effort" and must be approved as "reasonable and necessary" by the commission.

Currently, attorneys receive up to 25% of litigated work comp awards.

"By the time the law has been op-erational for a couple of years, work-ers may find they will have a hard time finding lawyers" because law-yers will not be able to justify the expense of handling their cases for so little return, Mr. Jacks said.

While the reform law continues to allow claimants to select a doctor, changing physicians will be permit-ted only with approval of the insurer or the commission.

After 1992, only doctors on a list approved by the commission can be used, except in emergencies.

Under the self-insurance provi-sions of the new law, employers with annual workers comp premiums of $750,000 or more can self-insure be-ginning in 1993. Beginning in 1994, employers with annual premiums of $500,000 or more can self-insure.

Currently, only political subdivi-sions are permitted to self-insure their workers compensation expo-sure.

Companies that self-insure work-ers comp risks will be required to post a $300,000 deposit or 125% of their prior year's workers comp liabi-lities, whichever is greater. The amount can be deposited in cash, ne-gotiable securities, a surety bond or a letter of credit.

The employer also will be required to purchase at least $5 million in per occurrence excess insurance or rein-surance.

Employers applying to self-insure will be required to pay a $1,000 fee and must join the new Texas Certi-fied Self-Insurer Guaranty Assn., which was created by the bill.

The guaranty association will pay workers comp claims in the event the self-insured company cannot meet those obligations.

If the commission determines that an employer is impaired and cannot pay its workers comp claims, the as-sociation will begin paying those ob-ligations no later than 30 days after notification from the commission.

The association will first release the employer's security deposit and then will estimate whether assess-ments will have to be made to other fund members to pay the claims.

If assessments are necessary, they will be assessed proportionally ac-cording to a ratio of the employer's disability benefits paid in the preced-ing calendar year to the total of dis-ability benefits paid by all certified self-insurers in the preceding year.

The law does not specify a cap on assessments.

Mr. Green of Justin said that "it's too early to tell" whether his com-pany will self-insure under the new law. "But it's certainly an option available to us, as it is other busin-esses with a half-million in workers comp premiums."

But, Mr. Carter of LTV predicted that the option to self-insure will lure other large employers to the state.

Employers have been lobbying for the right to self-insure workers com-pensation in Texas since 1979.

Wayne R. Stratton, regional vp of the Alliance of American Insurers in Austin, noted that although the bill does not call for self-insurers to pay premium taxes, legislators intend to include that provision later to keep employers that self-insure and insur-ance companies "on the same foot-ing."

Although the bill does not allow smaller businesses to self-insure, it does allow:

- Similar small businesses to band together to purchase workers comp coverage under a single policy.
- Small businesses to buy cover-age containing deductibles to help them reduce their premiums.

In addition, the new law mandates that small employers receive pre-mium discounts of 10% if the busi-ness has no lost-time claims for one year and a 15% discount if there are no lost-time claims for two years.

The new law also adopts the American Medical Assn. impairment rating schedule to determine disabil-ity benefits instead of awarding ben-efits based on a loss of wage earning capacity.

Currently, in disputed cases the IAB hearing officer or jury deter-mines on a case-by-case basis an in-jured worker's loss of wage earn-ing capacity.

Mr. Green of Justin said the "use of an objective impairment rating schedule will bring about predict-ability" in benefit payment.

Mr. Huff of Employers Casualty praised the impairment rating sys-tem as an "objective way measur-ing loss."

However, Emmett Sheppard, legis-lative and political director for the Texas AFL-CIO in Austin, said he is disappointed with this reform.

Mr. Stratton of the Alliance praised the new law for its "increased emphasis on safety." The law re-quires:

- The commission to monitor workplace safety and identify em-ployers with high accident rates.
- Insurers to expand accident pre-vention programs.
- Protection from discrimination for employees who report workplace hazards.
- Extensive data to be gathered by the new commission on workplace safety and injuries.
- All employers with five or more employees—not just those with workers comp coverage—to imple-ment safety programs.
- Employers in businesses with high accident frequencies to obtain safety consultations and implement safety plans. "High accident frequen-cies" are not defined in the law.

The law also creates a Division of Risk Management for state agen-cies with a director who will serve as a "state risk manager."

Like risk managers at private cor-porations, the state risk manager will be involved in activities designed to reduce losses and improve workplace safety at state agencies.

"If the workplace safety provisions are implemented and are effective, they will reduce costs because in-juries are reduced," said an Alliance spokeswoman.

Despite the safety-oriented fea-tures of the law, the AFL-CIO charges that the bill does not go far enough in addressing workplace safety.

"I think we got everything we could get out of it, but it doesn't go far enough," said the AFL-CIO's Mr. Sheppard.

But, Mr. Sheppard welcomed the provision calling for the collection of data that will help identify where accidents are occurring. "At least we got that much," he said.

"We tried to push for stronger safety measures," Mr. Sheppard noted, like the establishment of a state Occupational Safety and Health Administration office and require-ments that would give workers the right to refuse to enter an unsafe workplace without fear of being fired.

But, under the new law, Texas workers will at least receive higher disability benefits, which now are ex-tremely low in comparison with other states.

The weekly maximum temporary disability benefit currently is calcu-lated at 66.67% of the worker's weekly wage to a maximum of $238, which is around 58% of the statewide average wage.

Under the new law, the worker will receive 70% to 75% of his aver-age weekly wage to a maximum of $416, which is the current statewide average weekly wage.

Only lower-paid workers will re-ceive 75% of their average weekly wage.

In addition, injured workers who return to work will receive supple-mental benefits if they do not earn at least 80% of their pre-injury wages. The supplemental benefit will be equivalent to 80% of the difference between post injury income and 80% of pre-injury income.

Insurers, risk managers and attor-neys agree that although the new law contains a rate rollback provision, it will not have an immediate effect on workers comp rates.

"Gov. Clements, the legislators and everybody else has said there will not be any rate relief for a couple or three years," Mr. Stratton pointed out.

The rate rollback provision calls for a 4% reduction below 1989 rates on workers comp coverage written next year, a 10% reduction below 1989 rates in 1991 and a 15% reduc-tion in 1992.

Mr. Stratton said insurers do not object to this provision because the State Board of Insurance could order the rollbacks only if, among other things, "statistical data or other in-formation" indicates the reductions are reasonable.

"That's fine with the insurance in-dustry," said Mr. Stratton, "as long as they can actuarially support the rollbacks."

The law also gives the State Board of Insurance the authority to permit insurers to write workers comp cov-erage at rates up to 25% less than those set by the board.

Mr. Huff of Employers Casualty said "it is impossible to speculate on how much rates will fall as a result of the legislation," because it is too early to know the effect of such factors as reduced attorney involve-ment in dispute resolution.

However, Mr. Huff said if there had been no reform of the system, the system would have eventually collapsed.

"More and more employers would have dropped the coverage and more carriers would have quit writing it," he speculated.

Mr. Green agreed that while it is impossible to predict how far rates may eventually fall, the legislation prevented collapse of the system.

However, the rollback provision will apparently have to be revised because it creates a conflict. Al-though the provision calls for a re-duction in 1990 rates, the law does not go into effect until 1991.

Jim Yancy, deputy commissioner in the State Board of Insurance's statutory implementation division, acknowledged the discrepancy and said he doubts that a rollback of 1990 rates will be implemented, al-though the provision regarding 1991 and 1992 may be left alone.

"I suspect there will be an effort to resolve some of these conflicts" in a special session slated for March, Mr. Yancy said.

Despite the sweeping reform in the new law, Texas continues as only one of three states where workers com-pensation insurance is not manda-tory. The others are New Jersey and South Carolina.

However, the vast majority of Texas employers buy workers comp insurance because those who do not lose the protection of the no-fault workers compensation system.

The act also renames the Texas Workers Compensation Assigned Risk Pool as the Texas Workers Compensation Insurance Facility and charges the facility with establishing a market assistance program. ■

Lloyd's cites underwriter for misconduct

London

Lloyd's Council has reprimanded a Lloyd's of London underwriter for failing to disclose his interest in a claims service company that con-ducted business with his syndicate.

Alec Sharp of syndicate 839 was found guilty of "misconduct detri-ental to the interests of Lloyd's" d two other charges of miscon-t related to the non-disclosure.

eputy underwriter David J. Mar-also was found guilty of "mis-detrimental to the interests s" but was not penalized.

disciplinary committee, opped 27 charges of di-and moral turpitude nst the two men.

Mr. Sharp had faced 19 charges while Mr. Marshall faced 12.

Messrs. Sharp and Marshall, who continue to underwrite for syndicate 839, are directors of Posgate & Denby (Agencies) Ltd. and directors of Cas-tle Underwriting Agents Ltd., which manages syndicate 839.

Until December 1986, Mr. Sharp held 55% and Mr. Marshall 35% of the shares in Castle Underwriting Services Ltd., which provided claims handling services for the syndicate.

The claims handling service com-pany was a separate entity and was never considered a subsidiary of Cas-tle Underwriting Agents, Mr. Sharp said.

Mr. Sharp, however, never told Castle Underwriting Agents or syn-dicate 839 members that he and Mr. Marshall owned Castle Underwriting Services, Lloyd's says.

The two sold the underwriting concern between November and De-cember 1986 to another service com-pany, Melden Sullivan Associates, for 100,000 pounds ($148,000 at appro-priate rates) and "loan stock" enti-tling them to 20% of Castle Under-writing Services' pretax profits for five years ending Dec. 31, 1991.

Directors of Castle Underwriting Agents discovered the sale of the ser-vices company and its previous ownership after May 1987 and dis-cussed the issue with the Lloyd's chairman, said Mr. Sharp. Those talks, which included Mr. Sharp, led to the Lloyd's disciplinary proceed-ing, he said.

Included in 16 of the charges against Mr. Sharp and 11 of the charges against Mr. Marshall—which were dropped by Lloyd's disciplinary committee—were allegations they made secret profits from the sale o the claims handling company.

But Mr. Sharp was found guilty of detrimental conduct for negotiat-ing an agreement between January 1986 and December 1986 with Castle Underwriting Services on behalf o Castle Underwriting Agents.

Mr. Sharp also pleaded guilty to a charge of misconduct for violat-ing the Disclosure of Interests Bylaw by not disclosing his material interest in the claims handling company.

Lloyd's has been ordered by the disciplinary committee to pay 70% of Mr. Sharp's legal fees and 85% of Mr. Marshall's.

—By Stacy Shapiro

Runoff policy

Continued from page 2

agency said Mr. Lawrence—re-elected this month as chairman of Lloyd's—has not been involved in negotiations with Mr. Outhwaite since Mr. Lawrence was first elected chairman in December 1987.

MLP also made a comparable settlement offer to syndicate 727, managed by S.A. Meacock & Co., which wrote the other one-third of the policy, said syndicate 362's current underwriter Richard Keeling.

Underwriter Michael Meacock told *Business Insurance* that he is "considering the offer" but would not say whether he will accept it.

Meanwhile, Mr. Meacock confirmed that he still is disputing his 20% share of a joint runoff reinsurance policy he wrote for syndicate 90, managed by Pulbrook Underwriting Management Ltd.

Mr. Outhwaite settled his 50% share of the contract with syndicate 90 last month (*BI*, Nov. 13).

"We're in dispute with the syndicate (number 90) and are going to arbitration," said Mr. Meacock.

He said he disputes the claims on "grounds of non-disclosure and misrepresentation of material facts."

Mr. Outhwaite also is still disputing claims from at least three runoff reinsurance contracts, although arbitration umpires have declared all three policies valid.

At least two of the ceding underwriters now are pursuing claims through London High Court.

Lloyd's underwriter Michael Cockell last month filed a lawsuit seeking nearly $3 million of claims filed against syndicate 317/661 this fall.

The suit points out that Lord Wilberforce, acting as an arbitration umpire, ruled Oct. 18, 1988, that Mr. Outhwaite was not entitled to void a runoff reinsurance contract written in 1982 to cover liabilities stemming from 1970 and past underwriting accounts of syndicates 347/570, managed by M.H. Cockell & Partners.

Mr. Outhwaite has paid Mr. Cockell nearly $10 million in claims this year.

He has not, however, paid nearly $3 million in claims presented to syndicate 317/661 by Mr. Cockell's broker Winchester Bowring Ltd. on Sept. 19, the suit alleges.

We will not 'be forced. . . to tear up our policy by the threat of litigation,' says Robert Hiscox.

The Cockell syndicate "is applying for a summary judgment to enforce the claims owed by Mr. Outhwaite," said Martin Bakes, a partner with Herbert Smith, the London law firm representing Cockell & Partners.

In addition, a High Court judge is scheduled to hear a dispute over a runoff contract written by syndicate 317/661 for syndicate 179/884, managed by Anton Managing Agency Ltd., on Feb. 19.

Although an arbitration umpire ruled in November 1988 that syndicate 317/661 could not void an unlimited runoff contract with syndicate 179/884, and a High Court judge in February dismissed Mr. Outhwaite's appeal. Mr. Outhwaite has paid only half the amount in claims presented to him (*BI*, July 3).

As a result, underwriter Richard Lark filed a motion seeking summary judgment that Outhwaite is liable for all claims filed.

Outhwaite filed a counterclaim seeking a summary judgment that underlying claims paid through the Asbestos Claims Facility are not recoverable under the runoff contract.

Both parties have agreed to drop those motions in favor of a three-day hearing before a High Court judge to decide the extent to which claims settled through the Asbestos Claims Facility should be reimbursed by Mr. Outhwaite, said Mark Humphries, an assistant lawyer with Linklaters & Paines, the London firm representing Mr. Lark.

Meanwhile, a second arbitration hearing between syndicate 317/661 and syndicate 33, managed by Roberts & Hiscox Ltd., is scheduled for early next year, said an Outhwaite spokesman.

An initial arbitration panel ruled that a runoff reinsurance contract written for syndicate 33 is valid.

The second arbitration panel will decide on the amount of claims Mr. Outhwaite must pay, the Outhwaite spokesman said.

"We are not going to be forced to commute our unlimited protection or to tear up our policy by the threat of litigation," said Robert Hiscox, chairman of Roberts & Hiscox Ltd. ■

Texas anti-trust

Continued from page 1

Schwarzer's dismissal of the federal litigation, which had been brought in March 1988 against 31 insurance industry defendants by several state attorneys general and eventually represented 19 plaintiff states (*BI*, Sept. 25).

Both the Texas and federal suits similarly charged insurers with boycotting certain lines of coverage.

But the Texas complaint, also filed in March 1988, goes beyond the federal antitrust action in accusing insurers of conduct to artificially inflate rates (*BI*, Nov. 7, 1988).

The Texas suit spells out defendants' alleged violations of state antitrust and deceptive practices statutes and seeks to prevent the Insurance Services Office Inc. from operating in the state.

The suit originally sought more than $480 million in fines, the largest of which—$100 million—is sought from ISO. The suit alleges that ISO committed 100 violations of the Texas Free Enterprise & Antitrust Act of 1983 (*BI*, March 27).

However, two of the defendants —Travelers Insurance Co. and St. Paul Fire & Marine Insurance Co. —settled with the Texas attorney general in October, each agreeing to pay $500,000 in attorneys fees and investigative costs (*BI*, Oct. 16).

The suit had sought fines totaling $50 million from Travelers and $25 million from St. Paul.

But ISO and other defendants interviewed are not entertaining ideas of settling.

Judge Lowry's decision not to dismiss the case "really only indicates that he wants more facts before making a final decision. We're still confident that once the judge, or jury if necessary, examines all the facts, the charges will be found to be completely baseless," said an ISO spokesman.

Will defendant Aetna Casualty & Surety Co. consider settling?

"No, no, no, not at all," a spokesman said. Travelers and St. Paul "looked at it as an economic issue. We put a very high price on our reputation."

"We frankly expected the outcome we got here," the Aetna spokesman noted.

"The judge didn't reach any conclusions about guilt or innocence. He looked at it as a procedural ruling. Now it's on to discovery and we can file motions to dismiss or go on to trial," he said.

"Once we get to where we are talking about evidence, the outcome will be the same as in the federal suit," he said.

A spokesman for Hartford Fire Insurance Co., another defendant, also said the insurer will not consider settling. Instead, Hartford plans to "evaluate what we need to do and prepare for trial. We have interrogations to answer and depositions to take," the spokesman said. "The case has just begun."

And, CIGNA Corp., the parent company of defendant Insurance Co. of North America, will "absolutely not" consider settling, said a spokesman.

The denial of the Texas defendants' motion for summary judgment was "very preliminary," said the CIGNA spokesman. "We still feel confident that we will prevail here. This is a matter of law and if there is a trial," insurers will win, he predicted.

The attorney general was not surprised at Judge Lowry's ruling, either, said a spokeswoman.

"I don't know what the judge considered. But all along, we have said that we didn't think the ruling in California would have any bearing on the case here in Texas," she said, referring the federal court dismissal of the consolidated antitrust action.

Plaintiffs are appealing the dismissal—which came before discovery proceedings had begun—to the 9th U.S. Circuit Court of Appeals.

Judge Lowry's decision shows there is "enough persuasive evidence to support the facts in our case. Furthermore, the defendants didn't meet the burden of proving the motions" they filed seeking dismissal, said the attorney general's spokeswoman.

"Our case is different from the case in California. Our case focuses on a domestic conspiracy through ISO," while the federal case relied more heavily on alleged wrongdoing by London companies, she said.

The Texas suit names Lloyd's of London non-marine syndicate 799 and its underwriter Robin A.G. Jackson, but not the syndicate's manager, Merrett Underwriting Agencies Management Ltd., which was named in the federal suit.

An attorney for Mr. Jackson and the syndicate said he planned to file separate motions for dismissal or repleading last week.

At least one insurer attorney admitted that he expected the Texas judge to dismiss the antitrust action.

"We believe that the cases are substantially similar and the judge's opinion in California was well-reasoned and based on previous case law. It's not clear why we didn't get similar reasoning in Texas," said James Kelleher, assistant vp and counsel at Boston-based Liberty Mutual Insurance Co.

Mr. Kelleher added: "We were obviously disappointed, but we think it's ultimately going to be a question of law. . .that will be construed in our favor.

"It's unfortunate that it couldn't happen now. It means in the short run that there will be a tremendous amount of money spent by both insurance companies and the state of Texas in the litigation."

Liberty Mutual is not considering settling and "intends to vigorously defend" itself, he said.

In an addition to the fine sought from ISO, the Texas suit is seeking maximum fines of: $55 million from Hartford; $50 million from Aetna; $50 million from INA; $50 million from Liberty Mutual; $50 million from United States Fidelity & Guaranty Corp.; $25 million from Fireman's Fund Insurance Cos.; and $25 million from the Reinsurance Assn. of America. ■

Update

CARIB accuses state of libel

MONTEREY, Calif.—An offshore medical malpractice insurer is suing the Indiana Insurance Department, charging regulators libeled the company in a letter to more than 100 doctors it insured through an Indiana purchasing group, including 16 in California.

In a complaint filed in California Superior Court in Monterey last month, Casualty Assurance Risk Insurance Brokerage Co. describes as misleading an Aug. 4 letter advising doctors that Guam-based CARIB was not licensed in any state or recognized by the National Assn. of Insurance Commissioners and that CARIB's certificate of authority was revoked by Guam regulators July 1.

The letters to doctors insured through Medical Liability Purchasing Group of Inc. of Indiana also noted that state guaranty funds may not cover claims CARIB fails to pay and that CARIB policies may not comply with state policy form requirements.

The letters also mentioned an Indianapolis federal judge's June 22 order permanently enjoining MLPG and its president. The order called MLPG "merely a front" for CARIB's direct mail insurance solicitations, which he said were false and deceptive (*BI*, June 26).

CARIB's suit also charges that the letters create a false impression that "CARIB is not a reliable insurer, is likely to default on its obligations, is likely to become insolvent and is likely not to pay claims."

A department spokesman would not comment on the suit, saying it has been referred to the state attorney general's office.

In an interview, CARIB Treasurer L. Allen Bramson confirmed that Guam regulators refused to renew the insurer's license July 1 and that a new CARIB has been incorporated in Micronesia to assume business previously written by the Guam company.

Creditors name liquidators

LONDON—Creditors of insolvent Lloyd's of London marine and reinsurance broker Rowbotham Baxter Ltd. have appointed liquidators after winning a courtroom battle with the broker's appointed administrator who sought to keep the broker operating.

The creditors—who are owed at least 21.9 million pounds ($35.3 million)—appointed Michael Jordan and Robin Addy, partners of accountant Cork Gully, a Coopers & Lybrand unit, as joint liquidators last week. They replace Christopher Morris, a partner of accountant Deloitte Ross Tohmatsu, who was appointed administrator when the broker ceased operations Nov. 13 (*BI*, Nov. 27).

The move follows court hearings earlier this month when creditors discovered that Mr. Morris was trying to secure a London High Court "administration order" to allow Rowbotham Baxter to reorganize and continue operating while sorting out its debts.

Lawyers of creditors who are owed 10% of the total debt objected at the hearing to allowing the broker to continue operating.

After a justice refused to grant the order, Rowbotham Baxter shareholders voted to voluntarily liquidate the company.

OSHA seeks $3.3 million fine

WASHINGTON—The Labor Department has proposed $3.3 million in fines—the fourth largest in OSHA history—against The Budd Co. for 843 alleged willful violations at a Philadelphia plant.

Most charges against the Troy, Mich.-based automotive panel manufacturer involve breaches of the federal workplace noise and hearing conservation standard.

Gerard F. Scannell, assistant secretary of labor for the Occupational Safety and Health Administration, said the most significant finding from OSHA's June investigation was the high incidence of hearing loss among workers. "The company has neither taken steps to ensure that all employees were tested properly, nor has it informed employees of this loss," he said.

OSHA found 529 alleged noise standard violations and 124 cases in which employees suffered hearing loss but were not informed.

Other allegations include record keeping violations.

The Budd Co. said it is "deeply concerned about any situation which may threaten the safety of its employees" and has been cooperating with the OSHA investigations.

The company has until Jan. 4 to contest the fines.

Briefly noted

Kansas Insurance Commissioner **Fletcher Bell**, who has the longest tenure among current state regulators, will not be a candidate in 1990 for the post that he has held since 1971. . . .Arizona-domiciled **Swanco Insurance Co.** has filed a writ of certiorari asking the U.S. Supreme Court to review an 8th U.S. Circuit Court of Appeals ruling that Swanco must be licensed in Iowa before it can write insurance for a risk purchasing group that includes Iowa residents. Swanco argues that the federal Risk Retention Act pre-empts state licensing rules (*BI*, July 24). . . .**Corroon & Black Corp.** plans to acquire Collier Cobb & Associates Inc. of Charlotte, N.C., through a pooling arrangement. Collier Cobb, which ranked as the 27th-largest U.S. broker in 1988, is expected to enhance Corroon & Black's major presence in the construction insurance market. . . .In a lawsuit that **Allstate Insurance Co. and Allstate Indemnity Co.** of Northbrook, Ill., have filed against California Insurance Commissioner Roxani Gillespie and the California Assigned Risk Plan, the insurers ask that a 112% CARP rate increase pending since February be approved; or that the insurers be allowed to increase rates for all business in the state 12.5% and 5.6%, respectively; or that the insurers be allowed to pull out of CARP. The insurers are losing a total of $1.2 million weekly because of CARP's "confiscatory rates". . . .An Anchorage Superior Court Judge last week refused to grant former **Exxon Corp. tanker captain** Joseph Hazelwood immunity from prosecution. Mr. Hazelwood sought immunity because he voluntarily reported the massive oil spill last March from the Exxon Valdez into Prince William Sound (*BI*, April 3). Alaska is set to go to trial against Mr. Hazelwood on Jan. 22 . . . .T U.S. Supreme Court refused to review a case in which a gro investors is suing **Peat Marwick Main & Co.** for $45 million. T alleges the accounting firm omitted and misrepresented facts in c memoranda for oil and gas partnerships. The case could expansion of accountants' and other consulting professionals' l

Brokers' earnings outlook good despite unpredictability of rates

By LEONARD M. WILSON

Special to Business Insurance

WE RECENTLY SPENT a pleasant hour with the president of an alphabet ouse. Our conversation ranged over a num-er of issues, including expectations for rices on commercial lines of insurance. The vidence on premium rates was still incon-clusive, he thought, but he was optimistic that a turn was in the offing.



Mr. Wilson

Later, after his visit, we began to think about earnings estimates for the publicly owned brokers. We were a little perplexed. Were rates in actuality going to advance in 1990, and if so how much? Security analysis requires readily quantifiable varibles if an earnings model is to be successully formulated. It goes without saying that he outlook for the public brokers is imporantly influenced by the degree of price hange. But there is more than a little murkness about the shape of the underwriting ycle in 1990.

Of necessity, we decided to adopt a dual cenario approach. Our first scenario asumed that premium rates will bottom in .990. Prices might be a neutral influence vith residual softness in the first half and a nodest firming in the second half. This would mean that a broad upturn in rates night not materialize until 1991.

The second scenario incorporated rate increases of 10% across a broker's full book of ousiness, perhaps a trifle optimistic at this uncture. Nevertheless, our labors aim at examining earning power under a set of plausible possibilities.

We ruled out the kind of v-shaped turn in pricing of the last cycle. Too many industry contacts have suggested that a steep advance in rates is not warranted. Moreover, neither brokers, underwriters nor buyers want a return to disruptive roller coaster pricing.

Our first and more conservative scenario calls for flat or neutral rates in a bottoming environment. On the face of it, this prospect would not appear to be especially constructive for insurance brokerage. Yet the arithmetic of model building reveals a fairly robust resumption of earnings progress.

With flat premium rates, domestic commissions can be expected to advance around 11% to 12%, mainly on the strength of new business. Reinsurance brokerage could match or exceed gains on the direct brokerage side. Employee benefits, depending upon the broker, might achieve growth of 10% to 15% year over year. Investment income should rise less than commissions, given a continuing gradual down-trend in money market interest rates. Aggregate revenues are calculated to increase a shade less than 11% for the year, achieved as we indicated, with no contribution from higher rates.

Possible improvement in earnings should be placed in the context of the past three years during which earnings for all the brokers were level.

Expenses in our model are geared to attainable revenue growth. Therefore, the acceleration in revenue gains as compared with 1989 would be likely to elicit faster expense growth. Three variables govern expense growth: the rise in the Consumer Price Index, programmed expansion of the headcount and the probable need for catch-up in compensation levels owing to the restraint of the past three years. In our model, we used a 9% increase in expenses comprised of 4% for inflation, 3% for head count and 2% for so-called catch-up compensation. Other operating expenses expand at a similar pace.

Using these estimates for revenue and expense increases, we arrived at a 17% advance in net income and earnings per share. Tax rates and share count were assumed to be unchanged. By any standards of performance, this would represent a creditable result.

Our second scenario, though, provides an even happier outcome. With a 10% increase in premium rates, domestic commissions could rise by 20%. However, none of the other categories, with the possible exception of reinsurance brokerage, are likely to register corresponding growth. As a consequence, in our more robust model, total revenues expand 17% to 18%.

Expenses also increase at a faster rate, based on a more generous expansion of head count and the linkage of compensation to higher profitability. The model allows for a 13% increase in costs compared with 1989. The positive spread between revenue and cost growth provides a powerful impetus to profits, which in our estimate advance 30% to 35%.

This is the arithmetic of model building. It derives a composite result. In the refined task of establishing estimates for each broker, there might be some variation depending upon business mix and internal goals with respect to expenses.

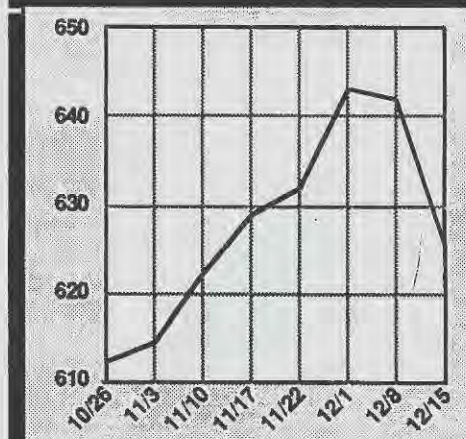
In both instances, earnings gains accelerate markedly. But this possible improvement should be placed in the context of the past three years during which earnings for all the brokers were level, or even trended slightly downward. If the brokers are to maintain a record of growth in the range of 13% to 15%, several years of strong progress would be needed beyond 1990.

What about an unthinkable third scenario: continued rate competition? So far, we have found few observers who take this position. Nonetheless, the jury appears as yet not to have rendered a decision on the authenticity of the hoped-for upturn in rates.

If rates were to soften after an ephemeral firming on the heels of twin catastrophes, it would be back to the computer for necessary and likely rueful revisions in earnings estimates for 1990.

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BI Insurance Index



Insurance industry stocks fell sharply last week, as the *Business Insurance Index* dropped 16.3 points to 625.7 on Dec. 15, from 642.0 on Dec. 8. Advancing issues were led by Liberty Corp., up 14.4%; Baldwin & Lyons Inc., up 10.3%; and AVEMCO Corp., up 4.7%. Decliners followed American Indemnity Financial Corp., down 11.8%; AmBase Corp., down 11.0%; and Hilb, Rogal & Hamilton Co., down 9.0%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 4.0 million shares traded. The *BI Index* lost 2.5% for the period; the Standard & Poor's 500 fell 0.3%; while the Dow Jones 30 Industrials gained 0.30% and theNew York Stock Exchange Composite was up 0.27%.

British Issues

Dec. 14 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Commi Union	494	27.4	29.3	5.9	494—482
Genl Accident	1173	16.8	68.0	5.8	1173—1167
Gdn Royal Exch	251	19.8	15.7	6.1	251—247
Royal	517	24.9	34.0	6.6	517—508
Sun Alliance	321	11.1	17.0	5.3	322-321
Brokers					
Bradstock	237	16.7	10.0	4.2	237—227
CE Heath	528	14.9	34.5	6.5	528—516
Hogg Robinson	167	11.7	9.7	5.7	169—167
Lloyd Thompson	273	18.2	9.3	3.4	273—273
PWS Holdings	47	12.7	2.7	5.7	48—47
Sedgwick Grp	300	22.2	16.0	5.3	301—298
Steel Brrl Jones	280	17.5	15.3	5.5	280—280
Willis Faber	268	18.9	15.3	5.7	272—266

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

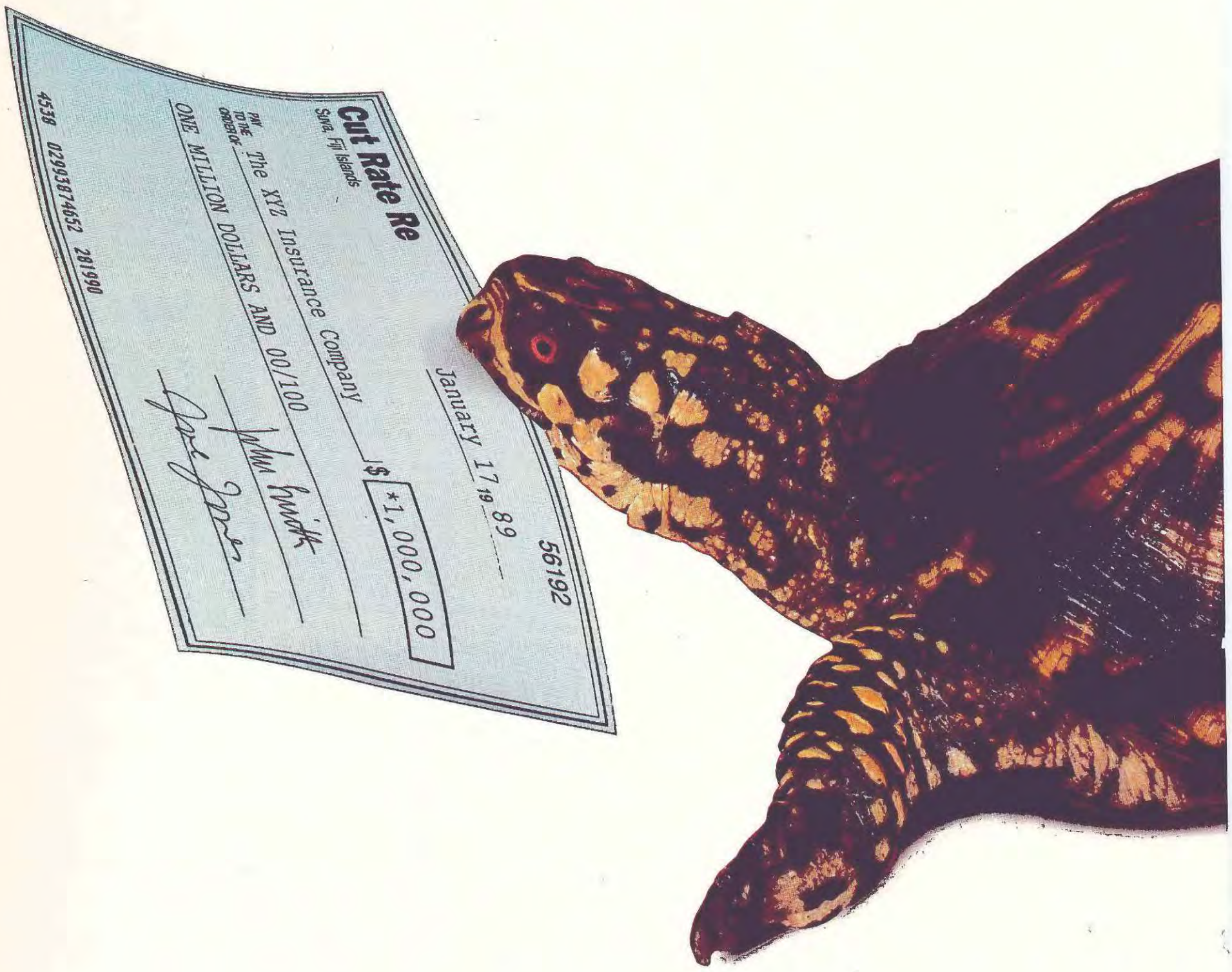
DEC. 15, 1989

12/11/89 THROUGH 12/15/89

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	32.38	-4.07	39.25	34.00	22.63	284	1.00	3.09	20	9.18	3.53
Corroon & Black	NYS	37.50	-4.15	18.11	41.00	29.13	172	1.24	3.31	17	12.73	2.95
Gallagher Arthur J. & Co	NYS	25.50	0.99	50.00	26.50	15.68	8	0.52	2.04	18	5.33	4.78
Frank B. Hall	NYS	3.00	0.00	0.00	4.63	2.50	150	0.00	0.00	-1	-2.80	-1.07
Hilb, Rogal & Hamilton	OTC	22.75	-9.00	64.12	25.75	13.25	112	0.32	1.41	20	4.60	4.95
Marsh & McLennan	NYS	81.25	-6.07	46.40	89.75	55.00	706	2.48	3.05	20	10.56	7.69
Poe & Associates	OTC	12.75	2.00	45.71	12.75	8.00	19	0.40	3.14	12	1.89	8.92
BROKERS	AVERAGE		-2.9	37.7					2.3	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	45.75	-1.08	54.43	46.50	29.25	100	0.40	0.87	10	25.06	1.83
Berkshire Hathaway Inc.	NYS	8625.00	2.99	85.48	8900.00	4625.00	1	0.00	0.00	28	2869.00	3.01
ITT (Hartford Group)	NYS	61.00	0.41	21.70	64.50	49.75	1491	1.60	2.62	10	56.33	1.08
Sears (Allstate)	NYS	38.00	0.00	-5.88	48.13	37.25	3986	2.00	5.26	13	37.75	1.01
CONGLOMERATES	AVERAGE		0.6	38.9					2.2	15		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	58.13	-4.52	24.00	62.50	46.00	1325	2.76	4.75	9	58.11	1.00
Ambase Corp.	NYS	12.13	-11.01	8.99	16.38	10.50	319	0.20	1.65	4	29.08	0.42
American General	NYS	31.88	-3.04	6.25	38.50	29.50	1201	1.48	4.64	10	34.68	0.92
American Heritage	NYS	28.75	-0.86	12.75	29.00	25.00	6	1.20	4.17	11	22.60	1.27
American Indemnity/Fin'l	OTC	7.50	-11.76	-28.57	13.00	7.50	5	0.56	7.47	-5	17.38	0.43
American International	NYS	105.63	-2.54	58.54	112.00	65.25	1552	0.48	0.45	13	41.92	2.52
Aon Corp.	NYS	40.63	-0.61	47.06	43.25	26.00	468	1.40	3.45	12	19.62	2.07
Argonaut Group	OTC	68.63	-0.36	57.76	69.50	43.25	152	1.00	1.46	8	36.83	1.86
AVEMCO Corp	NYS	24.88	4.74	-2.93	27.50	20.38	67	0.40	1.61	15	9.52	2.61
Baldwin & Lyons Inc	OTC	24.00	10.34	65.52	24.00	14.38	29	0.28	1.17	8	20.80	1.15
Belvedere Corp	ASE	5.50	0.00	22.22	6.50	4.25	84	0.04	0.73	17	8.03	0.68
Chandler Insurance	OTC	11.75	0.00	56.67	13.25	6.88	23	0.00	0.00	6	9.53	1.23
Chubb Corp.	NYS	94.13	-4.56	62.99	95.50	56.63	939	2.32	2.46	10	55.49	1.70
CIGNA Corp.	NYS	61.75	-1.40	33.51	66.75	45.75	738	2.96	4.79	11	66.64	0.93
CNA Financial Corp.	NYS	97.88	-4.98	66.60	108.75	57.63	318	0.00	0.00	9	54.87	1.78
Continental Corp.	NYS	32.13	-3.02	0.39	38.63	31.50	894	2.60	8.09	66	41.36	0.78
Durham Corp.	OTC	31.25	-4.58	-2.34	34.75	30.00	19	0.92	2.94	20	26.32	1.19
Orman's Fund	NYS	35.75	3.25	22.75	40.75	28.75	358	0.60	1.68	13	32.74	1.09
...l General Corp.	OTC	19.63	1.29	57.00	19.75	12.13	156	0.80	4.08	18	19.09	1.03
...surance Group	NYS	18.75	-5.06	68.39	21.75	10.25	30	0.00	0.00	9	7.29	2.57
...E Corp.	NYS	91.00	-1.89	65.45	96.25	54.38	864	1.36	1.49	15	29.04	3.13
...urance Co	OTC	30.75	-4.28	16.04	33.00	25.75	54	0.44	1.43	7	32.03	0.96
...roup	OTC	28.50	0.88	60.56	28.50	17.50	17	0.60	2.11	9	18.94	1.50
...Boiler	OTC	54.00	-0.23	45.95	59.25	33.00	232	1.60	2.96	14	18.94	2.85
Kansas City Life Ins.	OTC	35.75	0.70	4.38	36.00	32.25	80	1.04	2.91	19	39.22	0.91
Kemper Corp.	NYS	46.63	2.47	98.40	51.88	22.75	249	0.84	1.80	10	29.97	1.56
Lawrence Insurance Group	ASE	6.88	-3.51	-14.06	9.25	6.63	1	0.28	4.07	14	3.29	2.09
Liberty Corp.	NYS	42.75	14.38	17.53	42.75	32.50	20	0.80	1.87	18	31.82	1.34
Lincoln National	NYS	58.50	-2.30	35.26	62.88	42.75	213	2.60	4.44	11	49.19	1.19
NAC Re Corp.	OTC	38.25	-2.55	85.10	41.00	20.25	179	0.20	0.52	17	22.81	1.68
Navigators Group	OTC	27.25	-3.54	32.93	28.25	19.25	7	0.00	0.00	10	15.22	1.79
Nobel Insurance LTD.	OTC	2.25	0.00	-51.35	5.38	1.50	68	0.00	0.00	0	7.76	0.29
NWNL Companies	OTC	41.00	-5.48	33.33	44.13	26.88	350	1.20	2.93	10	37.50	1.09
Ohio Casualty Corp.	OTC	49.50	-0.50	38.46	52.50	35.00	221	2.08	4.20	7	33.30	1.49
Old Republic Int'l	OTC	28.00	-3.45	23.15	30.38	22.63	364	0.72	2.57	14	30.70	0.91
Orion Capital Corp.	NYS	24.13	-2.53	50.78	28.50	13.88	112	0.84	3.48	7	19.72	1.22
Phoenix RE Corp.	OTC	13.75	-6.78	41.03	15.50	8.75	148	0.20	1.45	11	12.99	1.06
Protective Life Corp.	OTC	14.25	-0.87	7.55	16.25	12.88	97	0.68	4.77	27	14.54	0.98
Provident Life	OTC	27.50	-7.17	41.94	30.13	17.75	232	0.80	2.91	9	23.24	1.18
Re Capital Corp.	ASE	14.75	0.85	59.46	14.88	8.88	44	0.00	0.00	13	12.60	1.17
RLI Insurance Corp.	NYS	8.50	-5.56	11.48	9.50	6.88	11	0.40	4.71	8	10.71	0.79
St. Paul Companies	OTC	62.75	1.41	45.93	63.50	42.00	872	2.20	3.51	8	43.47	1.44
SAFECO Corp.	OTC	39.25	1.95	67.91	39.25	23.13	1551	1.20	3.06	9	24.87	1.58
SCOR U.S. Corp.	NYS	14.50	1.75	68.12	14.50	7.00	102	0.40	2.76	15	10.61	1.37
Seibels Bruce Group	OTC	10.75	0.00	-4.44	13.63	10.25	412	0.80	7.44	-51	13.75	0.78
Selective Ins. Group	OTC	18.75	-5.66	-18.48	19.75	14.50	74	0.96	5.12	6	15.72	1.19
Stalesman Group Inc.	OTC	2.63	-4.55	-8.70	3.63	1.88	41	0.16	6.10	7	4.19	0.63
Tokio Marine & Fire	OTC	80.00	0.63	-12.81	95.50	66.00	9	0.92	1.15	34	70.93	1.13
Torchmark Corp.	NYS	55.50	-1.33	81.97	56.63	30.00	420	1.40	2.52	15	13.23	4.20
Transamerica	NYS	43.63	2.05	30.71	48.00	32.75	917	1.92	4.40	10	34.63	1.26
Trenwick Group Inc.	OTC	23.25	-1.06	63.16	26.88	13.50	159	0.36	1.55	11	16.91	1.37
United Fire & Casualty	OTC	33.25	2.31	9.02	34.50	29.00	4	1.20	3.61	9	22.56	1.47
USF&G Corp.	NYS	29.88	0.84	3.02	34.00	28.25	1692	2.80	9.37	47	22.87	1.31
UNUM Corp.	NYS	47.25	-1.56	76.64	49.00	26.38	708	0.60	1.27	13	31.20	1.51
USLIFE Corp.	NYS	44.50	-0.56	29.45	48.13	32.88	152	1.48	3.33	10	54.34	0.82
Washington National	NYS	27.75	0.91	4.23	29.13	24.00	55	1.06	3.89	-	32.90	0.84
Zenith National Ins.	NYS	18.88	0.67	7.09	21.50	16.00	38	0.84	4.45	9	13.81	1.37
INSURERS/REINSURERS	AVERAGE		-1.3	31.3					3.0	11.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	21.00	-5.62	78.72	52.75	10.88	853	0.00	0.00	10	3.54	5.93
HMO America Inc.	OTC	7.25	-4.92	672.92	10.63	0.94	225	0.00	0.00	-32	1.12	6.47
Pacificare Health Sys.	OTC	24.75	-8.33	98.00	30.38	6.00	145	0.00	0.00	26	6.35	3.90
Safeguard Health Enter.	OTC	8.25	-8.33	53.49	12.50	4.75	80	0.00	0.00	13	2.99	2.76
Sierra Health Services	ASE	8.75	-2.78	438.46	9.63	1.38	130	0.00	0.00	-9	0.62	14.11
United Healthcare Corp.	OTC	11.50	-2.13	170.59	12.63	3.88	370	0.00	0.00	23	0.34	33.82
United Medical Corp.	ASE	6.25	-1.96	16.28	7.25	4.25	12	0.00	0.00	2	5.70	1.10
U.S. Healthcare	OTC	14.63	0.86	160.00	15.50	5.25	791	0.20	1.37	35	3.07	4.76
HMOs	AVERAGE		-4.2	211.1					0.2	8		
ALL COMPANIES	AVERAGE		-1.2	29.3					2.6	10.9		

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