

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$68 a year

© Entire contents copyright 1988 by Crain Communications Inc. All rights reserved

Hall management subsidiary sues officers for breach of duty

CLAYTON, Mo.—An underwriting management subsidiary of Frank B. Hall & Co. Inc. is suing the unit's president and a former vp for breaching their fiduciary duties and violating their employment agreements in transactions with Safety Mutual Casualty Corp., which is managed by the Hall unit.

St. Louis-based Insurers Service Corp. alleges that ISC President Burton K. Werner, who is also chairman of Safety Mutual, and former ISC Vp Harold F.

Continued on next page

Lloyd's names must cover losses by today

By CAROLYN ALDRED

LONDON—The agency set up by Lloyd's of London to manage the affairs of members of loss-riddled syndicates formerly managed by Oakeley Vaughan (Underwriting) Ltd. is telling the syndicates' members to pay assessments by today to cover losses dating from the early 1980s.

The losses of three Oakeley Vaughan syndicates already total 20 million pounds (\$35 million), resulting in an average loss of about \$175,000 for about 190 syndicate members.

However, many members of the syndicates still are refusing to pay, claiming they would not have become or remained members of the Oakeley Vaughan syndicates if Lloyd's had made public a 1981 investigation of the syndicates. They also allege that Lloyd's failed to prevent the syndicates from overwriting their premium income capacity.

Lloyd's and dozens of members of Oakeley Vaughan syndicates are embroiled in several lawsuits over the losses.

At least 47 members of the Oakeley Vaughan syndicates have filed four lawsuits in London and Texas courts against Lloyd's and other defendants. Also, at least three members' agencies representing Oakeley Vaughan syndicate members are suing Lloyd's.

In turn, Lloyd's is suing 10 members' agencies and the Oakeley Vaughan syndicates' auditors, claiming that the agencies and auditors should pay if Lloyd's is found liable in the members' litigation.

Additional Underwriting Agencies (No. 6) Ltd., the runoff agency handling the affairs of Oakeley Vaughan members, sent letters last month advising syndicate members that "syndicate managers require your liabilities arising from syndicate results and cash calls to be discharged without further delay." The members were instructed to make their payments by today.

Syndicates 420, 551 and 862 and their incidental syndicates, now being run off by underwriting agency C.C.G.H. Ltd., face more than 20 million pounds in losses, according to records sent to members last year. As a result, the syndicates' members face an average loss of more than 100,000 pounds (\$175,000) each, and some may face losses of twice that amount, sources say.

Some syndicate members participated in a settlement last year with Oakeley Vaughan's errors and omissions underwriters, sources say. Settlements were made only with direct names—those represented by Oakeley Vaughan's own members' agency—rather than names who joined the syndicates through other members' agencies, said one direct name who did not wish to be identified.

The settlements with about 30 names were not disclosed, although one name told *Business Insurance* that the settlement was "less than 10%" of his liability for Oakeley Vaughan losses.

The lead E&O underwriter for Oakeley Vaughan is Lloyd's underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C., according

Continued on page 62

Grace's insurers told to pay asbestos property settlement

By MICHAEL BRADFORD

BEAUMONT, Texas—W.R. Grace & Co.'s liability insurers must indemnify the New York-based company for the bulk of an asbestos property damage settlement totaling more than \$50 million, a federal judge has ruled.

In a Feb. 4 summary judgment, U.S. District Judge Joe J. Fisher ordered 12 insurers that wrote approximately \$600 million in comprehensive general liability insurance limits for Grace between 1978 and 1985 to indemnify the company for its share of the settlement of asbestos property damage litigation brought by 83 Texas school districts.

The school districts originally sued Grace and other asbestos producers for \$175 million in compensatory damages, alleging that building products containing asbestos caused damage to about 600 school buildings when asbestos fibers were released into the buildings.

Attorneys in both the coverage dispute and the underlying litigation refuse to disclose the specific terms of the settlement with the school districts, citing a

confidentiality agreement.

However, an attorney who asked not to be identified confirmed that the settlement totaled \$50 million to \$75 million.

Attorneys in the case pointed out that U.S. Gypsum Corp. of Chicago, also named in the underlying litigation, would pay a portion of the settlement. The attorneys said that U.S. Gypsum would be responsible for less than half of the settlement, but they would not elaborate.

A U.S. Gypsum spokesman would not comment on either the settlement or the company's insurance coverage.

Judge Fisher's order in the Grace coverage dispute is a "major victory" for policyholders, said Robert Shulman, an attorney with the Washington law firm of Anderson Baker Kill & Olick, which represented Grace in the coverage litigation.

"This is significant, and we think it will carry the banner in litigation to come," he declared, comparing the ruling's significance to that of the 1981 decision in *Keene Corp. vs. Insurance Co. of North America*, which first espoused the "triple-trigger" coverage theory for asbestos

personal injury claims.

The Grace ruling is the second by a federal district court favoring policyholders in coverage disputes involving asbestos-related property damage claims.

In the only other decision on the issue, a U.S. District Court judge in Newark, N.J., in 1986 ruled that insurers of asbestos producer Lac D'Aminate Du Quebec must pay defense and indemnification costs arising from asbestos property damage and personal injury claims (*BI*, Aug. 19, 1985). That ruling now is being appealed.

Both the Lac and the Grace decisions cite the Keene decision and hold that asbestos-related property damage is a continuous process that triggers all of a defendant's liability insurance policies from the installation of asbestos-containing building materials through the removal and containment of those materials.

Grace filed suit against its insurers in April 1987, shortly after it entered settlement negotiations with the school districts. Grace sought a summary judgment ordering the insurers to indemnify it for any amount it might pay to the school

Continued on page 70

New non-discrimination rules force changes in 401(k) plans

By JERRY GEISEL

WASHINGTON—Employers are making bigger changes than expected in their 401(k) plans because of the 1986 tax law, but tax reform is not causing companies to drop their 401(k) plans.

A large group of employers—as many as 50% by some estimates—have had to cut back salary deferrals to 401(k) plans by higher-paid employees or make other plan changes to meet the tough non-discrimination rules contained in the Tax Reform Act of 1986.

By contrast, most employers were able to meet the liberal 401(k) non-discrimination rules that the tax reform law scrapped.

"Employers that never had problems passing the non-discrimination tests now find they have problems," said Maryann Laketek, a consultant with Hewitt Associates in Lincolnshire, Ill.

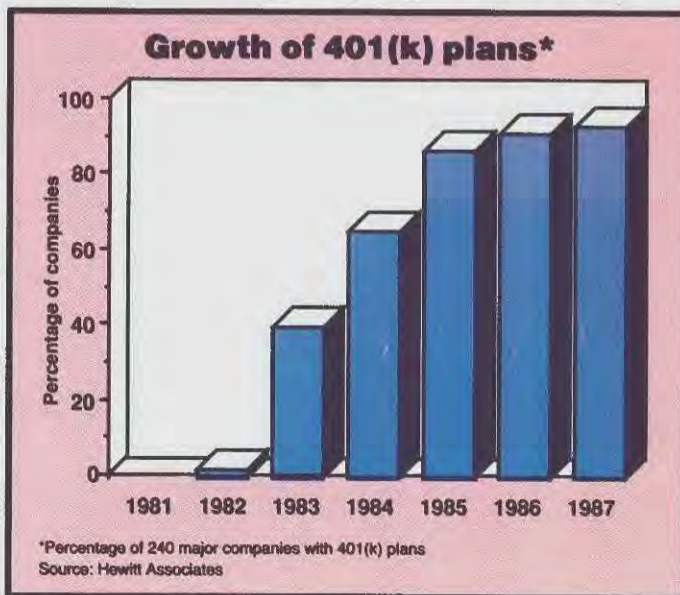
Some of the cutbacks in deferrals have been massive. For example, San Francisco-based BankAmerica Corp. has slashed the maximum pretax 401(k) deferral among highly paid employees to 6% from 15%.

"Tax reform has really punched our plan in the nose," said Paul Nordine, benefits consultant at BankAmerica.

Other employers have redesigned their 401(k) plans to give lower-paid employees a greater financial incentive to participate, including raising the amount by which employers match employees' salary deferrals.

Others companies have added loan provisions, a costly administrative burden, to shield employees from new taxes on 401(k) plan withdrawals and, thus, build interest in the plans.

In addition, employers also are finding that plan administration has become a headache because the new 401(k) rules are so



much more complicated.

For example, determining which workers are considered "highly paid" employees is more difficult, while a new "order of withdrawal" rule has immensely complicated calculating the amount of taxes an employee owes in situations where both

Continued on page 61

Benefit cost control . . . Page 3

Directory of utilization review providers . . . Page 26

NEWSPAPER

Update

Hall subsidiary sues officers

Continued from previous page

Ilg, who remains president and chief executive officer of Safety Mutual, failed to warn ISC about financial problems at Safety Mutual.

According to the suit, filed Feb. 4 in St. Louis County Circuit Court, St. Louis-based Safety Mutual recorded a \$12 million charge in the fourth quarter of 1985 to establish reserves for potentially uncollectible reinsurance covering umbrella liability policies written by Safety Mutual.

As a result, ISC's management fee was reduced by \$4.2 million (BI, April 7, 1986).

Safety Mutual wrote \$46.5 million in net premiums in 1986 and reported surplus of \$16.2 million as of Dec. 31, 1986.

The suit, which seeks undetermined compensatory and punitive damages, alleges that Messrs. Werner and Ilg never informed other ISC directors or Hall about the problems at Safety Mutual despite their duties as officers of ISC.

In addition, ISC charges that Messrs. Werner and Ilg later told Hall officials that ISC's management contract with Safety Mutual had to be amended because of the insurer's financial problems. The changes—some of which were not authorized by Hall or the ISC board—cost ISC about \$18 million in revenues in 1986 and 1987, the suit alleges.

Lewis R. Crist, Missouri's director of insurance, confirmed that Safety Mutual is being examined by the state Division of Insurance. However, he stressed that Safety Mutual "is still operating." He declined to comment further, except to say ISC and Safety Mutual are attempting to settle their dispute.

ISC received a temporary restraining order Feb. 8, prohibiting Safety Mutual or any of its officers or employees from denying ISC representatives access to documents and records. ISC subsequently filed a motion that the court cite Safety Mutual and certain officers for contempt for failing to comply with the temporary restraining order.

In response, Safety Mutual has asked the court to vacate the temporary restraining order. The court was scheduled to rule on the motion late last week.

Safety Mutual, ISC and Hall representatives would not respond to phone calls about the dispute.

Gallery's stolen artwork insured

NEW YORK—Art gallery Colnaghi (USA) Ltd. has insurance from Lloyd's of London underwriters for the loss of approximately \$6 million in paintings and drawings stolen from its Manhattan building last Monday in what may be the largest art theft ever reported in New York.

The thieves entered the gallery's four-story brownstone building on Manhattan's upper east side through a two-by-four-foot skylight and fled with 19 paintings and nine drawings—most by Dutch and Italian masters—after setting off an alarm at about 10:30 p.m.

Most of the stolen works were owned by the gallery, but several were on consignment. All will be covered by the gallery's insurance, according to a spokesman for Colnaghi (USA), the U.S. branch of London-based Colnaghi Ltd.

The spokesman confirmed that the gallery's coverage was placed with Lloyd's underwriters by Citicorp Insurance Brokers Ltd. in London, but he could not comment on the limits of the coverage. Citicorp officials in London could not be reached.

However, other brokerage sources say that Colnaghi (USA)'s policy limits are probably well in excess of \$6 million—possibly amounting to 20 million pounds (\$35 million)—and that other London insurers may have participated on the risk in addition to Lloyd's underwriters.

Colnaghi (USA)'s insurers have offered a reward of 10% of the value of any of the art works recovered, the spokesman said.

Agent liability appeal rejected

TEXARKANA, Texas—The Texas Supreme Court will not hear the appeal of a lower court ruling that an agent is not liable for a policyholder's losses when an insolvent insurer fails to pay a claim.

The court refused to hear an appeal by Jack E. Greer, who sued Higginbotham & Associates, a Fort Worth brokerage, when he could not recover a claim from Proprietors Insurance Co. a Delaware, Ohio-based insurer that was declared insolvent in August 1981 (BI, Sept. 28, 1987).

Mr. Greer, whose bowling alley in Marshall, Texas, was destroyed by fire in May 1981, alleged the brokerage was negligent in placing coverage with Proprietors.

A trial court jury awarded Mr. Greer \$772,000, but that verdict was overturned by the 6th District Court of Appeals in Texarkana.

Mr. Greer's lawyer could not be reached for comment. Diane E. Burkley, a Washington-based attorney who represented a coalition of agents' trade associations that supported Higginbotham, said she was "pleasantly surprised" by the Supreme Court's refusal to hear the case.

Updates continued on page 69

Errors & omissions

• Employers must value unfunded benefits in defined benefit pension plans using an interest rate of 7.3% in 1988 for calendar year plans to determine the premium they must pay to the Pension Benefit Guaranty Corp. A story in the Jan. 25 issue gave an incorrect interest rate.

• A Dupont Plaza Hotel employee already convicted for arson and murder for setting the Dec. 31, 1986, fire at the hotel in San Juan, Puerto Rico, has told authorities that three men who now are facing charges instructed him and two other previously convicted employees to start the fire. A story in the Feb. 5 issue incorrectly stated who allegedly ordered the fire to be set.

Searle faces new suits alleging IUD injuries

By LINDA J. COLLINS

PORTLAND, Ore.—Ten more women claiming they were injured by the CU-7 intrauterine device are suing IUD manufacturer G.D. Searle & Co.

And, plaintiffs' attorneys say the Skokie, Ill.-based company could be hit with a new wave of product liability litigation over the device—in addition to the hundreds of suits currently pending—if Searle loses a trial that could begin as early as next month in litigation in which between 20 and 30 women allege injuries caused by the CU-7.

In suits filed Jan. 22 and 25 in Multnomah County Civil Court in Portland, Ore., all 10 women allege they contracted pelvic inflammatory disease while using the IUD, commonly known as the Copper 7, and that the disease led to their infertility.

In addition, the women allege they suffered ectopic pregnancies or Fallopian tubal injuries that required surgical repair or removal because they used the device.

The Oregon suits were filed to meet a Jan. 27 filing deadline imposed by the state Legislature on IUD suits, explained plaintiffs' attorney Michael L. Williams, a partner in the Portland firm of Williams & Troutwine.

Oregon imposes an eight-year statute of limitations for filing product liability claims. For IUD claims, the statute of limitations begins running from the time the product is first used. However, the Legislature passed a law in 1987 "creating a window in the statute of limitations for IUD victims," Mr. Williams said.

The 10 suits seek to hold Searle responsible for strict liability, implied warranties and express warranties, and charge the manufacturer with negligence for failing "to ensure the safety of the product" and furnish consumers with "accurate information regarding both the safety and characteristics of the CU-7."

The suits also allege that Searle "fraudulently, intentionally and negligently concealed" information regarding the CU-7's characteristics and safety and that it "misrepresented the safety and efficacy of the CU-7 in its labeling, advertising and promotional materials."

The plaintiffs are not seeking specific amounts, but each must seek more than \$25,000 each under Oregon law to avoid arbitration, said Catherine C. Webber, an attorney with Williams & Troutwine.

However, Oregon caps non-economic damage awards at \$500,000.

Searle, which was acquired by St. Louis-based Monsanto Co. in October 1985, stopped manufacturing the IUD in January 1986, citing escalating product liability litigation and its inability to purchase product liability insurance for the contraceptive device (BI, Feb. 10, 1986).

A Searle spokeswoman could not specify how many CU-7 IUDs were sold but estimated that "about 1 million women were using the CU-7 at any given time" from its introduction in 1974 until the product was discontinued.

About 500 lawsuits involving the CU-7 are pending against the company. And, fewer than 500 other cases

Continued on page 69

Judge restricts coverage for Agent Orange payout

By DOUGLAS McLEOD

MORRISTOWN, N.J.—Diamond Shamrock Chemicals Co. will not be able to tap several general liability policies in force in the early 1980s to cover liabilities stemming from its production of the chemical defoliant Agent Orange, a state judge has ruled.

New Jersey Superior Court Judge Reginald Stanton ruled Feb. 5 that Diamond Shamrock cannot use policies with inception dates after Dec. 29, 1980, to cover its \$21.6 million share of the \$180 million 1984 settlement of a class-action lawsuit filed by Vietnam veterans against producers of Agent Orange, which contains the toxic chemical dioxin.

The class action was certified in federal court in Brooklyn, N.Y., on Dec. 29, 1980, and Judge Stanton concluded that "elementary concepts" of insurance and fair dealing preclude coverage of the Agent Orange claims under policies effective after that date unless insurers specifically agreed to cover losses arising from the litigation.

Judge Stanton also ruled that Diamond Shamrock may not recover cleanup costs and other losses relating to a dioxin-contaminated Newark plant site under policies incepting after June 4, 1983, when New Jersey Gov. Thomas Kean issued an executive order that the site be cleaned up.

In addition to cleanup costs, Diamond Shamrock faces several bodily injury and property damage suits over the contaminated site.

To apply policies that became effective after June 4, 1983, would amount to allowing insurance coverage for "expected" losses, the judge concluded.

The ruling is a favorable one for Aetna Casualty & Surety Co.—Diamond's primary liability insurer for more than three decades—and numerous excess liability insurers named in Diamond Shamrock's 1984 declaratory judgment action for coverage of Agent Orange-related liabilities.

However, the decision eliminates coverage under only a few of the policy years at issue in the case: Diamond Shamrock is seeking a ruling on coverage under policies written by Aetna and other insurers dating back to 1951.

Still to be determined is the issue of how coverage will be triggered under the policies in force before Dec. 29, 1980, for Agent Orange product liability claims and before June 4, 1983, for cleanup costs and other losses at the Newark plant site, where Diamond Shamrock manufactured Agent Orange.

New Jersey law provides for an "injury-in-fact" trigger, under which a policyholder would tap the coverage in force at the time an actual injury occurs, lawyers involved in the case say.

However, it is uncertain how the injury-in-fact theory would be applied in this case.

In an earlier ruling, Judge Stanton concluded that it is "legally irrelevant" whether the Vietnam veterans were actually injured by exposure to Agent Orange,

Continued on page 63

Inside

✓ In light of soaring hospital costs, this week's editorial urges employers to play a greater role in monitoring hospitals' finances and practices. **PAGE 8**

✓ In Perspectives, Timothy D. Beck of Warren, McVeigh & Griffin Inc. in Newport Beach, Calif., reports that a claims management review is the most effective way for an employer to determine whether employee health care claims costs are reasonable. **PAGE 39**

✓ Miami Valley Hospital of Dayton, Ohio, has been given permission by Bermuda regulators to incorporate a medical malpractice captive to cover its medical malpractice exposures. **PAGE 63**

✓ British asbestos producer Turner & Newall P.L.C. is seeking the dismissal of a \$170 million lawsuit, claiming that its asbestos-containing products have not caused plaintiff Chase Manhattan Bank any property damage. **PAGE 67**

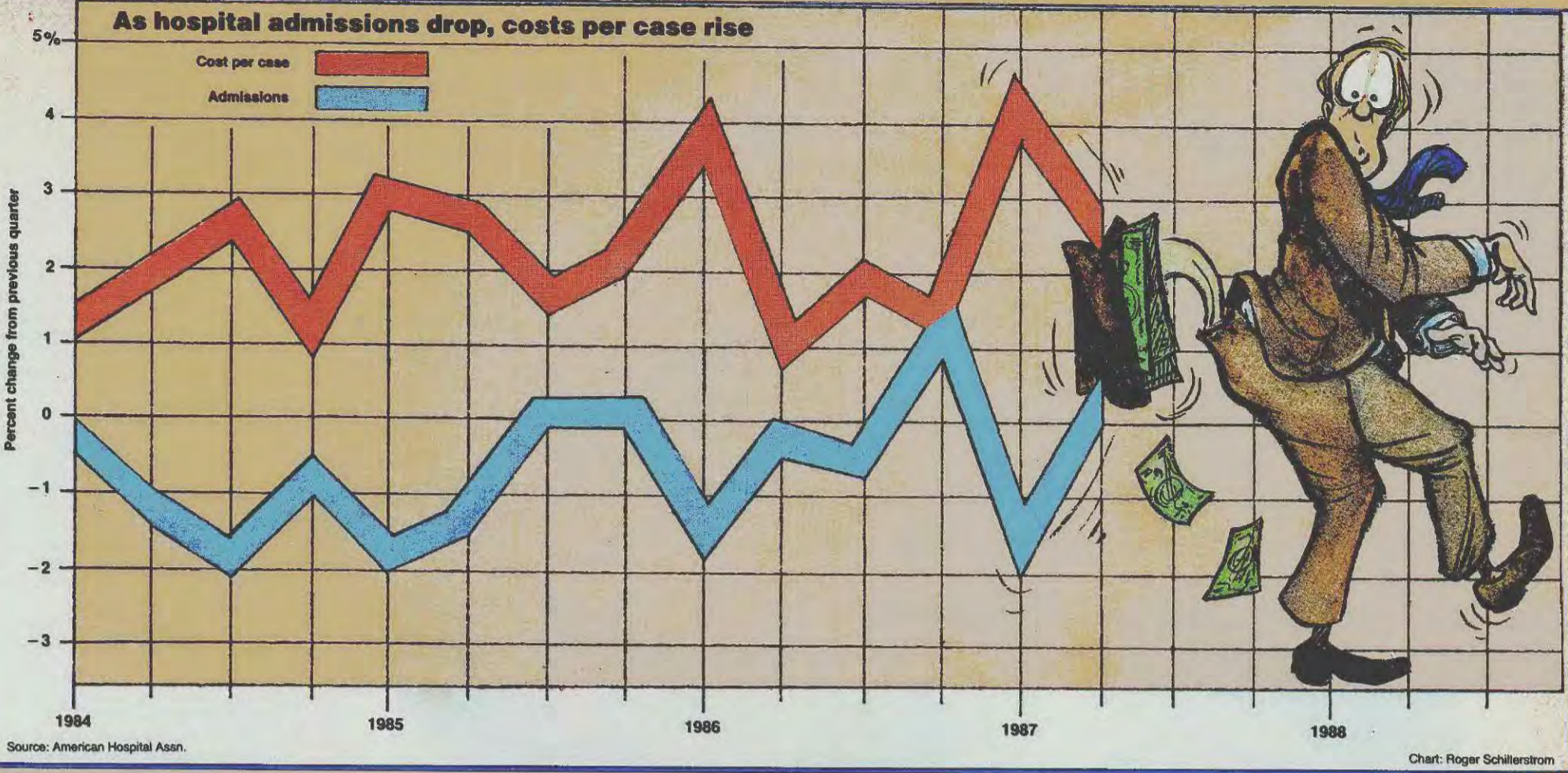
✓ The National Assn. of Insurance Commissioners is asking insurance industry representatives opposed to its proposed broker control model law to present written alternatives by March 1. **PAGE 69**

✓ Looking at fourth-quarter figures, Leonard M. Wilson, managing director at L.F. Rothschild & Co. Inc. in New York, concludes that the soft commercial insurance market has caused insurance brokers' earnings to fall short of expectations. **PAGE 71**

Departments

Around the states	59
Classifieds	66
Comings & goings: industry	67
Insurance services guide	70
Letters	8
London	64
Opinions	8
Perspectives	39
RMIS commentary	40
Spotlight report	3
Ticker	71

Vol. 22, No. 7—Business Insurance (ISSN 0007-6884) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1988 by Crain Communications Inc.



Costs out of control

Falling admissions boost hospital charges

By DEBORAH SHALOWITZ

Employers are feeling the sharp pinch of spiraling hospital charges, which are climbing faster than the general inflation rate.

And, little relief is in sight because the increases—due primarily to rising hospital operating costs—are unavoidable, hospital officials and health care say.

To make up for some of the increased expense of doing business, hospitals are shifting costs from some types of payers to others and raising charges dramatically for certain services, health care experts and hospital

officials say (see story, page 14).

Still, hospital officials hasten to point out that hospitals' profits are dropping and some hospitals are being forced out of business.

According to health care experts, hospital costs are rising due to a number of factors:

- Lower admissions have resulted in fewer patients among which to spread fixed costs (see chart).

- Hospitals are admitting a higher proportion of critically ill patients who require more sophisticated treatment, because cost containment programs are screening out patients with less severe illnesses.

- Increasing labor costs, particularly for nurses.

- The high cost of medical technology.

- Rising hospital malpractice insurance rates.

Medical costs have been rising faster than the general inflation rate for the past three years, as measured by the Consumer Price Index issued by the U.S. Labor Department's Bureau of Labor Statistics.

The medical care component of the CPI surged 5.8% in 1987, compared with a general inflation rate of 4.4%. In 1986, the medical care component of the CPI grew 7.7%, while the general

inflation rate swelled only 1.1%. And, in 1985, medical inflation measured 6.7%, compared with an overall CPI of 3.8%.

Meanwhile, average hospital room and board charges rose 9% in 1986, and average inpatient ancillary service charges—including pharmaceutical, laboratory and X-ray charges—rose 20% in 1986, according to a recent survey by Nashville, Tenn.-based EQUICOR.

As a result of these increases, the average charge per hospital stay in 1986 rose 19% over the previous year even though the average length of stay rose

Continued on page 11

Employers scrutinize UR programs

By DONNA DiBLASE

Utilization review vendors, which keep an eye on health care providers for employers, now are being watched themselves.

Employers increasingly are asking employee benefit consultants and other firms to audit their UR programs to make sure they are working as efficiently and cost-effectively as possible.

These evaluations can range from independent physician audits of medical records to on-site evaluations of

the UR vendor's staff and review procedures.

Consultants and employers point out that audits of the services delivered by a utilization review vendor to a particular employer are necessary, just as are audits of claims administration services.

"There's a lot of interest in" utilization review audits by employers, said Dr. Arnold Milstein, president of National Medical Audit, a San Francisco-based division of William M. Mercer-Meidinger-Hansen Inc. "It's partly derived from sensitivity to re-

cent large increases in health care costs. What's motivating employers is that they want to determine what is the maximum yield they can obtain from a utilization review program."

"There is a great deal of polish and glitz out there, especially in utilization review. Employers may be really impressed and not have the experience to see beyond this. I've always been a believer in proper auditing procedures because they're necessary," pointed out Samuel Kaplan, chairman of U.S. Administrators Inc. in Los Angeles, which offers third-party claims ad-

ministration and utilization review services.

Consultants providing audit services say an audit of an employer's existing review program can help to identify inefficiencies in either the vendor's administration of the program or in the way the employer has coordinated the UR program with its benefit plan.

Audits also can ensure that employers receive meaningful data from the utilization review vendor on how much the UR program is saving the employer, consultants add.

Continued on next page

Psychiatric case management firms specializing in substance abuse say drug rehabilitation can cut employers' health care costs.

Page 17

A joint labor-management effort produces effective health care cost containment programs for union members, case studies show.

Page 20

Most employers have no specific plan for managing the high cost of catastrophic illness claims, cost containment experts say

Page 23

Spotlight report

UR audits

Continued from previous page

Audits also can benefit utilization review vendors themselves, some consultants say. For example, these evaluations can help vendors see how their services compare with those of their competitors.

But, while most vendors agree that they also can benefit from audits, they stress that audits be carefully structured so that both the employer and the utilization review vendor can identify and correct problems.

According to several consultants, the typical employer interested in an audit of its utilization review program is one that has had the UR program for two to three years and simply wants to re-evaluate its effectiveness or has had a specific problem.

Most UR auditors note that the cost of an audit varies depending on the individual case and the ser-

vices performed by the auditor. One review vendor said the cost can vary between \$30,000 and \$50,000.

Utilization review audits primarily are performed by benefit consulting firms. Few companies exist that exclusively perform these types of reviews.

In a survey of utilization review vendors and other benefit consultants, most noted that the oldest—and perhaps most experienced—UR program auditor is National Medical Audit.

In a typical audit, NMA utilizes an independent board of practicing physicians and specialists to audit a sampling of medical records from a particular employer's review program. In the audit, the physicians determine the medical necessity of the treatment and length of hospital stay certified by the review vendor.

While NMA applies other evaluation methods, like on-site vendor

visits and financial analysis of the cost-effectiveness of the program, "the independent chart audit is the most conclusive method of seeing what's really happening. This method enables the auditor to look at the actual clinical decisions being made" by the UR vendor, explained Dr. Milstein.

Other consultants use a variety of audit and evaluation techniques to determine the effectiveness of an employer's review program.

For example, "our review is tied in with the claims audits we do for employers," said Carol Johnston, a senior consultant in the Actuarial, Benefits & Compensation consulting practice of Coopers & Lybrand in Chicago.

"We do a claims sample that shows us a significant portion of the cases that went through utilization review. We determine if the review program and the claims administrator are interfacing," she said.

The utilization review cases are evaluated based on the criteria used to determine the length of a hospital stay, the length of time the vendor took to respond to the call for pre-admission review and the documentation of the case, among other things, Ms. Johnston said.

Many consultants also closely examine the savings reports and data provided by vendors to employers.

"We look at the vendor's reports as well as any reports the employer gets from its insurer or claims administrator. The results of the program need to be evaluated by looking at actual claims experience," explained JoAnn T. Fritsch, a health care management consultant with The Wyatt Co. in Washington.

And, "we examine the internal procedures of the employer itself and how it administers the utilization review program," noted Thomas C. Billet, an assistant vp in

the Princeton, N.J., office of A. Foster Higgins & Co., the benefit consulting arm of Johnson & Higgins.

"We look at the process for compliance the employer has in place, like penalties or financial incentives employees face" for not following utilization review guidelines, he said. "In many cases, this is as important as how the review firm itself does its job."

Buck Consultants Inc. uses many of these same methods and "we look at the benefit plan design and what was relayed to the employer by the vendor in terms of what services would be delivered," said Annamaria Azzara, an associate consultant in Buck's New York office.

Regardless of the many evaluation and audit methods used, consultants, some vendors and employers point out there definitely is a need to more closely examine the results of utilization review programs. UR program audits, they say, are viewed by employers as a natural progression in health care cost management.

"What I'm hearing from employers is that auditing their utilization review programs makes sense, since most already audit their claims administrator," said Ms. Fritsch of The Wyatt Co.

"Before I contract with a vendor or end a contract, I want to know if I'm getting what I am paying for. We audit our claims administrator, so it only makes sense to audit our review program and vendor," noted Carol Burkhead, manager of the Medical Services Adviser program for Omaha, Neb.-based Northwestern Bell Telephone Co.

Northwestern Bell operates its own in-house utilization review program but retains Parkside Health Services Co. of Park Ridge, Ill., to assist in administering the program. The company plans to have these services audited by The Wyatt Co. later this year, she said.

"In general, utilization review is an extension of an administrative process—reviewing claims—except that it's done with a clinical aspect. I don't think that most employers realize this and the fact that just as you audit a claims processor, you should look at the reviewer," explained David Rahill, a principal with A. Foster Higgins in Princeton, N.J.

And, "given the number of vendors and the rate at which that number is growing, both selection and evaluation of the programs is a very important piece of health care cost management," Ms. Fritsch added.

Just as utilization review developed as a response to overutilization of health care services, "audits and evaluations are a natural to follow the proliferation of utilization review vendors," said Coopers & Lybrand's Ms. Johnston.

But, while most consultants agree that auditing utilization review vendors and the programs they administer for employers is important, some also suggest that the audits be performed only under certain circumstances.

"I think that utilization review audits are doing something for some employers, but they're not the answer for every employer," warned Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates.

"Like claim audits, utilization review audits shouldn't be performed unless there's a reason. Clearly, some situations seem to demand" actions like audits, he added, like inefficient performance and problems reported by employees or providers using the UR service.

In addition, utilization review audits are most cost-effective for large employers, with 2,500 employees or more, said NMA's Dr. Milstein.

Continued on page 6



© 1988, New England Mutual Life Insurance Company, Boston, MA

OUR 401(k) PLAN CAN HELP CHART A COURSE FOR YOUR EMPLOYEES' FINANCIAL FUTURE.

When it comes to 401(k) plans, no organization knows the ropes better than The New England, a family of financial services companies with over \$40 billion in assets under management.

Through The New England Employee Benefits Group, we've provided benefits for over 3 million people in 20,000 businesses. In fact, we're one of the industry leaders, with more than 1,000 401(k) plans in effect. Our extensive experience in plan design is enhanced by advanced plan administration technology. We offer one of the few centralized administration systems for servicing 401(k) plans. We also offer a broad range of competitive investment and insurance products to place in the plan. And we provide effective communications materials that introduce and explain the plan to everyone in it.

If you're interested in a 401(k) plan specifically designed to meet the needs of you and your crew, phone 1-800-222-2725, Ext. 335, for more information.

The New England. Your Financial Partner,
Your Financial Future.



The New England
Your Financial Partner

They're lucky. Six million other retired Americans are in a different boat.



For many Americans, retirement is exactly what they hoped for.

But for others, retirement can be complicated by poor health. One out of four Americans will require long-term care in a nursing home with an average annual cost of \$20,000 to \$30,000. How that care is paid for has become a complex issue.

History has shown that personal savings and programs like Medicare and Medicaid can't cover all the costs of retirement health care. Companies with retirement health benefits also face the problem of unfunded future liabilities.

Additional solutions must be found to address this retirement health care cost issue that will eventually affect every person, company and institution in our country.

At NWNL Group, we're developing an employee benefit program called LifeScope* that would provide for a person's retirement years and working years. What makes the LifeScope Program unique is its comprehensive approach to providing benefits. It is more than life insurance and a nursing home policy.

By managing the delivery of health care and planning for future needs, the LifeScope Program can find alternatives that make health care more affordable, while allowing individuals to live independently. The program's benefits would be voluntary, flexible and portable.

Many elements of the LifeScope Program have already been put into place through current NWNL Group benefit programs. Using our resources as the nation's

10th largest group insurance company, we will soon be adding more elements.

To find out more about NWNL Group and the LifeScope Program, contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call (612) 372-5784. Because now is the time to begin solving the problems of providing health care in the future.

NWNL GROUP
*The right benefits for today.
The right ideas for the future.SM*

Spotlight report

UR audits

Continued from previous page

"An employer that can look at its own data doesn't really need an audit," concluded Diane Rice, a benefit planning specialist for First Interstate Bancorp in Los Angeles.

"For an employer, the bottom line is, are we able to reduce hospital days and can the review firm substantiate this? If you have selected your review firm carefully in the first place and you know that you can get data that will show you savings," an audit is not necessary, she said.

The bank, which self-insures its

health benefits, has about 37,000 employees in 20 states. Minneapolis-based Health Risk Management Inc. performs most of the company's utilization review.

However, in California, the company's review is performed by Health Care Management Systems, a division of Blue Cross of California, which administers First Interstate's health claims and negotiates fees with hospitals.

The company has had excellent results with its program administered by HRM, achieving a cost-to-savings ratio of 1-to-3 and as high as 1-to-4 for some months, Ms. Rice said. "I don't see any reason to audit a firm that's doing an ex-

cellent job."

Consultants note that audits can help both employers and utilization review vendors pinpoint problem areas and take corrective action.

"Not only can we hopefully prove that a program is working well through an audit, but also, if we find problems, we can help to solve them," said Ms. Johnston of Coopers & Lybrand.

"An audit should be used to both evaluate as well as suggest corrective action and solutions," noted Dr. Milstein of NMA.

For example, audits can identify such problems as a low compliance rate with the UR program among

employees, which can be corrected by benefit plan design changes such as imposing financial penalties or by educating employees more about the program.

But, most consultants point to employers' need for reliable savings reports from vendors as the major reason for audits.

"One of the reasons audits are becoming more popular is the fact that review firms have not been delivering good data to employers. Most deliver a standard report that says what the program is saving, but does not explain exactly what the firm is doing to generate the savings," explained John C. Erb, assistant vp of A. Foster Higgins

HealthGroup, the Princeton, N.J.-based employee benefits consulting subsidiary of Johnson & Higgins.

And, Dr. Milstein of NMA noted, "the savings statements are not economically realistic. Many employers simply accept whatever savings and information the review systems generate."

Audits not only identify real savings, but also can help the vendor and employer develop a more meaningful system of collecting and reporting this information, some observers say.

This and other information obtained through audits can aid vendors by letting them know how their programs compare with those of their competitors, consultants and vendors say.

"Audits are a fairly good measure of your service and of the performance of a particular employee on your staff. It will really point out where your strengths and weaknesses are. It's kind of nice to see where you fall in comparison to other firms," noted Robert Belichick, West Coast sales director for Baxter/The Health Data Institute, a utilization review vendor in Santa Monica, Calif.

"None of the review systems shares any information, so nobody knows whether their program is more aggressive than another," explains Dr. Milstein. "At the start, most NMA clients were employers or health care purchasers. Now, at least a third of the time, we are contacted by review vendors wanting to improve their own systems."

While some UR vendors do not resent audits, they are not completely thrilled about being audited.

"Audits are a funny thing. It's like the Internal Revenue Service. Even if you've filed your taxes honestly, when the letter comes in the mail announcing an audit, there's always a feeling that 'I wish this wasn't happening to me,'" quipped Dr. Paul Bluestein, regional medical director for Corporate Health Strategies Inc. in Orange, Calif.

And, based on his experience with review vendors, Dr. Milstein said "it's fair to say there's ambivalence among vendors regarding audits. But, nobody likes to be evaluated; it's a fact of human nature. But anything that can be done to sort out the good review systems and reward success in this new industry, that's great."

And, utilization review vendors report some concerns about the methods used by UR auditors.

A major concern is that auditors consider the differing operational designs of different employers' review programs when auditing the effectiveness of the vendor's services, said Gary T. McIlroy, chief executive officer at Health Risk Management in Minneapolis.

For example, some employers structure their health plans so that there are no penalties or financial incentives for employees to comply with the UR program's procedures, he explained.

"There's a great deal of differing social parameters among employers' programs that review firms have to deal with that audit firms don't understand," he said.

"All of this has to be tempered by the employer's corporate culture. We perform review as the corporation wants it done," explained Lawrence Goelman, president of Huntington Beach, Calif.-based Cost Care Inc.

However, consultants who provide UR auditing services say they consider the employer's plan design in conducting an audit.

"This is a potential way an audit can go awry. We consider what the plan is that underlies the review program and determine whether any leakage of cases is due to weakness in the review program and what is due to the plan design," explained Dr. Milstein of NMA.

Dyer Wells & Associates



Behind every FASTRAK VS™ System stands a dedicated team of claims and administration experts.

Every FASTRAK VS™ group administration and claims processing system comes with something no one else can offer: FASTRAK VS expertise. Some of the most highly-skilled programmers and insurance professionals have pooled their talents to create this integrated, easy-to-use system featuring comprehensive yet easy-to-understand documentation. And anytime you have a question, this same expert staff is ready to help. Because at Dyer Wells & Associates, we're in the business of solving problems, not creating them.

Our Experience Shows.

We've spent years working for TPA's and insurance companies. And everything we know about

the business has gone into building a better system. FASTRAK VS is very cost efficient since it runs on the Wang VS family of minicomputers. The claims module automates all phases of claims adjudication and processing while the administration module

automates billing, premium collection and other functional support processes. The modules can even be purchased separately. FASTRAK VS increases user productivity and streamlines the entire decision-making process. Plus it offers COBRA

capability and easy-to-read financial, productivity, ad-hoc and claims experience reports.

Our Support Team Delivers.

Of course, it doesn't matter how many capabilities a system has if you don't know how to take full advantage of them. That's why our service and support team stands ready to help you anytime you call. In fact, call us right now. Or mail this coupon. We'd like to tell you more.

Please send more information on:

- FASTRAK VS Claims
 FASTRAK VS Administration
 FASTRAK VS Claims and Administration

Do you currently have Wang VS hardware? Yes No

Name _____

Title _____

Company _____

Address _____

City _____ State _____

Zip _____ Phone (____) _____

Dyer Wells & Associates

The Right Solutions. For 10 Years Running.

BI 21588

2251 Lake Park Drive, Smyrna, GA 30080 (404) 432-5888



Are some tools too dangerous for the Home?

Home Insurance isn't afraid of risks. For us, they mean opportunities.

We welcome clients who manufacture power tools, pharmaceuticals, pools, amusement park rides. Risks other insurance companies can't even understand.

The greater the hazard, the more imagination our skilled underwriters bring to bear.

We specialize in writing difficult-to-place casualty

risks. And we're determined to provide clients with the most responsive service in the market today.

Home has been giving clients that kind of service since our first days in business, back in 1853.

If you've got a "dangerous" risk, call Charles Abruzzo at (212) 530-7110 or Robert Spiro at (404) 980-8308.

Or write them at The Home Insurance Company, 59 Maiden Lane, New York, New York 10038.

Home Insurance
There's no place like it.

Opinions

The health care cost Catch-22

EMployee BENEFIT managers are learning that sometimes you can have too much of a good thing.

In the early 1980s, as health care costs increased by leaps and bounds, most employers turned to health care cost containment strategies—like utilization review, outpatient surgery and wellness programs—to reduce hospital admissions among their employees and to trim lengths of stay for workers that did require hospitalization.

The strategy appeared to pay off. Admissions did decline, and lengths of stay were shortened.

There's only one problem: Hospital costs are still rising through the roof.

As Associate Editor Deborah Shalowitz reports, lower utilization does not lower a hospital's overhead costs, like utility bills and capital requirements. So, faced with declining utilization, hospitals have raised the unit cost of the services they provide (see story, page 3).

Hence, utilization controls have translated into higher charges for unavoidable hospitalizations.

The solution to this Catch-22 is not simple. While employers surely should scrutinize what a hospital charges for its services, a prudent employee benefit manager must concede that hospital companies have a right to make a profit and non-profit hospitals should not be forced out of business.

However, there are some steps that employers can take to control their hospital bills:

- Continue to expand and perfect utilization review programs.

While utilization review—and the subsequent reduction in hospital services—can be singled out

as a cause of rising hospital charges, it is better to pay a bit more for necessary services than to pay for unnecessary hospitalizations. Employers should institute controls to ensure non-emergency hospital admissions are necessary and that hospitalized employees are released as soon as possible.

In fact, as we report this week, many employers now are auditing their utilization review programs to ensure they are truly effective.

- Negotiate the best possible deals with hospitals. One way to do this is to join a preferred provider organization, which negotiates favorable rates with local hospitals and other health care providers. Even if you are not in a PPO, locate the most cost-efficient hospitals in your community and urge your employees to seek treatment there.

- Become active in local health care issues.

Employers—which pay a hefty share of the nation's hospital bills through direct payments to hospitals and through their group health insurance premiums—should play a role in an industry in which they have such a great financial interest.

Join your local employer health care coalition, if you haven't already. Speak out at public hearings on local health care issues, like proposed hospital expansion that may not be necessary. Question whether a hospital needs an expensive new piece of equipment if a similar device at a neighboring facility is not used to capacity.

Despite medical breakthroughs, there will always be a need for hospitals and quality medical care will never come cheap. However, employers can—and should—make sure that the money they pay to hospitals is not wasted.

Letters

Insurers should give underwriters high status

To the editor: I have attended, as I know you have, innumerable seminars and meetings where the causes of the property/casualty insurance industry's problems have been discussed, examined, dissected and explained. I have listened attentively as insurance company executives, lawyers, brokers, financial analysts and the like have cited facts and figures and blamed the problems on our legal system, falling interest rates, cash-flow underwriting, natural disasters, overregulation, underregulation and the effects of the moon's gravitational pull.

Yet, with all these experts and with all these reasons, I rarely, if ever, have heard a speaker expound the theory that the property/casualty insurers have people in positions that do not know what they are doing.

This reality was clearly demonstrated to me by an advertisement that recently appeared in The New York Times. In that advertisement a major insurance company, which shall remain nameless, stated that it was looking for college graduates (or "equivalent experience") for underwriting positions. The ad says: "Six months of training and a key insurance position will be yours." It then goes on to state that after the six-month program of classroom and on-the-job training, trainees will be "Business Accounts Underwriters," who will be "responsible for evaluating, selecting, pricing and setting policy terms and conditions for commercial insurance accounts."

Does something appear to be wrong with this picture? Try to imagine this situation in your own companies. Would you want to hire a college graduate, give him or her six months' training and then say: "OK, now you're responsible for our long-range planning" or "Now you're responsible for our investment policy?"

I am sure that this insurer's training program is one of the highest caliber, but how can anyone, after the best six-month training program imaginable, be ready to evaluate risks that he or she has only the slightest concept of, understand the legal ramifications of an insurance contract when lawyers and jurists cannot decide what the contracts mean or be able to

distinguish between a safe product and a dangerous one?

Before the insurance industry starts looking outside of its own structure for a solution to its problems, it had better take a long, hard look at the foundation of its own house. It is time they gave underwriters the status and professionalism they and the insurance buyer deserve. I would hate to think that an underwriter with six months' training was evaluating my firm as a potential customer.

Thomas D. Lewison
Director-Risk Manager
Rorer Group Inc.
Fort Washington, Pa.

Supreme Court's actions can be predicted

To the editor: I noted with interest your brief report concerning the U.S. Supreme Court's denial of certiorari in *Maryland Casualty Co. vs. ARMCO Inc.*, the 4th U.S. Circuit Court of Appeals pollution and property damage case (*BI*, Jan. 18).

At the risk of throwing cold water on everyone's enthusiasm for this decision, the Supreme Court has long maintained—and its decisions show—that a denial of certiorari is not an accurate predictor as to the court's position on any matter.

The whole question of whether Com-

prehensive Environmental Response, Compensation and Liability Act cleanup costs are covered damages under a general liability insurance policy might get before the court if another circuit court were to reach a contrary decision on the matter.

All we can do is keep monitoring at this point, argue our position vigorously and hope for the best.

Thomas B. Alleman
Niewald, Waldeck, Norris & Brown
Kansas City, Mo.

More insurers entering D&O market

To the editor: Your overview of directors and officers liability in the Feb. 1 issue understandably listed only D&O insurers mentioned at a specific D&O seminar (*BI*, Feb. 1).

However, I believe readers should know that:

- There are several additional, sizable "new players" in the D&O market, including Old Republic Insurance Co., Great American Insurance Co. and Aetna Casualty & Surety Co., which has offered \$30 million in primary D&O capacity

since January 1988.

- Jeffrey W. Greenberg, president of National Union Fire Insurance Co. of Pittsburgh, Pa., equates newness in the market to inexperience. The issue is not newness but, rather, displaying a responsible, service-driven attitude toward clients and a demonstrated claims handling capability.

Richard Cartland
President
Executive Risk Management Associates
Simsbury, Conn.

Business Insurance®

Reporting weekly for corporate risk, employee benefit and financial executives

Publisher: Alfred Malecki (New York)

Associate Publisher/Editor: Kathryn J. McIntyre, A.R.M. (Chicago)

Managing Editor: James M. Burke (Chicago)

Assistant Managing Editor: Dave Lenckus (Chicago)

Assistant Managing Editor/Graphics: Holly E. Seguire (Chicago)

CHICAGO: Stacy Adler (Associate Editor)

Karen Brown (Assistant to the Editor)

Linda J. Collins (Agent/Broker Editor)

Meg Fletcher, A.R.M. (Associate Editor)

Mark A. Hofmann (Associate Editor)

Karen Huelsman (Copy Editor)

Mariou Jones (Directory Editor)

Laura Mazzuca (Agent/Broker Topics Associate Editor)

Amy Palmer (Graphic Artist)

Roger Schillerstrom (Editorial Cartoonist)

Paul Winston (Copy Editor)

Joanne Wojcik (Copy Editor)

Christine Woolsey (Editorial Assistant)

DALLAS: Michael Bradford (Associate Editor)

LONDON: Stacy Shapiro (International Editor)

Carolyn Aldred (Associate Editor)

LOS ANGELES: Donna DiBlase (Bureau Chief)

Glenn Huntley (Associate Editor)

NEW YORK: Douglas McLeod (Bureau Chief)

Kari Berman (Staff Reporter)

Judy Greenwald (Associate Editor)

Collin Nash (Editorial Assistant)

WASHINGTON: Jerry Geisel (Washington Editor)

Deborah Shalowitz (Associate Editor)

Advertising Director: Donald A. Walsh (New York)

Midwest Sales Manager: Robert L. Niesse (Chicago)

CHICAGO: Deborah D. Neale (District Manager)

Margaret Hikido (District Manager/

Classified Sales)

Elmer Kerstowske (Production Manager)

Eastern Advertising Manager: Martin J. Ross (New York)

NEW YORK: Charles A. Horvath (District Manager)

Jack Forrest (District Manager)

Courtney Bauer (District Manager)

LOS ANGELES: Michael J. Sharpe (Western Advertising Manager)

Director of Communications: Ronnie I. Drachman (New York)

EDITORIAL: Chicago: 312-649-5398

Dallas: 214-363-1066

London: 01-404-4228

Los Angeles: 213-651-3710

New York: 212-210-0100

Washington: 202-662-7200

ADVERTISING: New York: 212-210-0133

Chicago: 312-649-5276

Los Angeles: 213-651-3710

COMMUNICATIONS: New York: 212-210-0132

CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR.

Founder (1885-1973)

MRS. G.D. CRAIN

Chairman

S.R. BERNSTEIN

Chairman-executive committee

RANCE CRAIN

President

KEITH E. CRAIN

Vice chairman

MARY KAY CRAIN

Treasurer

MERRILEE P. CRAIN

Secretary

WILLIAM A. MORROW

Senior VP-operations

H.L. STEVENSON

Corporate editor

ALICE SIELOFF

Corporate marketing manager

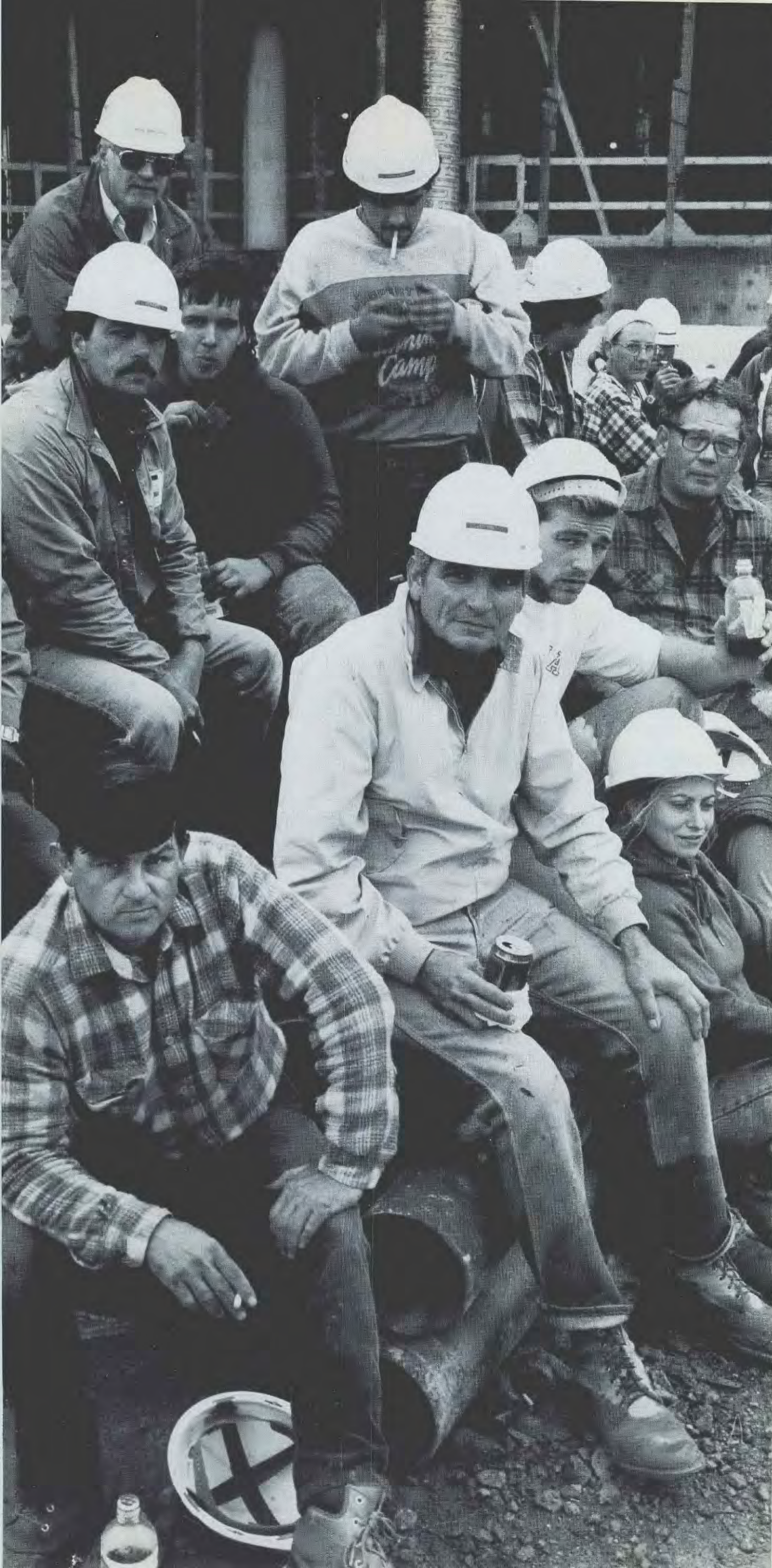
Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207 CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231; Suite 814, National Press Building, Washington, D.C. 20045; 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 20-22 Bedford Row, London WC1R 4EB, England. \$1.75 a copy. \$68 a year in U.S. Canada and all other foreign add \$16 for surface mail. Europe and Middle East only add \$47 for air delivery. First-class mail to U.S. and Canada only, add \$48. Bermuda only, \$105 per year expedited delivery. WILLIAM STRONG, vp-circulation. BARBARA KISCH, circulation manager. JOHN HUFFMAN, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207, or phone 800-992-9970 or 313-446-1611. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229.

BPA

Member of Business Publications Audit of Circulation

ABP

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.



How to contain health care costs and still have a conscience.

A strategy for the next five years.

If you're responsible for employee health care benefits, you've got a tough job.

The costs are staggering with no let up in sight. They're often the single largest drain on corporate profits.

Yet cost alone isn't the issue, because you're also responsible for the well-being of your employees.

So the question is, as you look to the future, where will you find the balance you need?

A careful look at the market should lead you to John Hancock.

Why? Because we've developed a long-term strategy to carry you into the next decade. A strategy based on cost-effective agreements between clients, providers and carriers. A strategy with first-rate medical care.

The first piece involves Hancock Preferred PPOs. Currently we have PPOs in major cities all over the country. Plus we're expanding through partnerships with the best existing PPOs in many additional markets. But if we need to be in a particular market where there isn't a PPO that meets our standards, we'll build one.

The second piece involves our Managed Health Services. They can be packaged with indemnity plans, PPOs, or any other delivery system you have.

We offer a sophisticated range of these services. Including medical management with nurse consultants. Hospitalization cost and utilization controls. Long-term disability review procedures. And specialized data analysis reports for management.

But most important, whether you choose our PPOs, our Managed Health Services, or a combination of the two, Hancock's strategy will give you more than a sense of fiscal responsibility. Because we understand one simple fact.

This business requires an ability to take a hard, steady look at the costs. And a whole lot of heart.

And when you do business with us, you get both.

Real life, real answers.

John Hancock
Financial Services

Employer conducts own UR program

By DONNA DiBLASE

If she had it to do over, Northwestern Bell Telephone Co.'s health care utilization review manager says she would start another in-house program.

A UR program designed and administered by the employer "allows you to consider your own corporate culture and what your employees' expectations from the company are," explains Carol Burkhead, Medical Services Adviser program manager for the Omaha, Neb.-based subsidiary of US West Co.

But, even though the 2-year-old program saved the company about \$800,000 last year, she warns that the motivation for implementing an in-house UR program "can't be primarily saving money. You have to educate the health care consumer and until you do, you'll never affect the bottom line."

Along with the ability to tailor a program to fit a workforce's specific needs, there are several advantages for an employer that designs and administers its own utilization review program, according to Ms. Burkhead and an employee benefit consultant specializing in helping employers design the programs.

However, certain issues must be considered by the employer interested in an in-house program, such as liability for employees' health and the time and effort of administering the program.

"Most employers, I believe, have an established awareness of their own corporate culture and also are the most knowledgeable about their own benefit plan design. An in-house program allows greater flexibility in design and the program can focus on an employer's particular problems," explained JoAnn T. Fritsch, a health care cost management consultant with The Wyatt Co. in Washington.

"An employer also can control the operational and service end by directing the activities of a utilization review program. An in-house program also eliminates the extra player when an employer is dealing with a claims administrator," she added, explaining that usually employers have little control over the cooperation between their UR vendor and their claims administrator.

In addition, "the service can be very personalized since the review staff deals only with one employer's employees. Employees like this and view utilization review as a benefit enhancement," she said.

In fact, "one of the differences with an in-house program is that I can staff the program so that I can give as much support to my employees as they need during an illness. An outside review firm has to take care of not only one employer's employees, but also those of many other employers," noted Ms. Burkhead.

Northwestern Bell's Medical Services Adviser program is staffed by four registered nurses and serves some 15,000 employees in five states and about 1,000 to 2,000 of the company's 9,000 retirees nationwide. About 10,000 employees are United Communications Workers union members.

The company self-insures its health benefits; Blue Cross & Blue Shield of Nebraska administers claims.

The company requires its review nurses to have at least five years of recent hospital experience and "we like for them to have different specialty areas. They have to be understanding but firm, and here we're also asking them to be benefits experts," she said.

In addition, the program uses consulting physicians to assist the

nurses in the review process.

The company also retains Park Ridge, Ill.-based Parkside Health Services Co. as a consultant and reviewer of the program, she said.

"We call this a case management program because we work through the case with the employee from the time they first contact the MSA staff. For example, if a person thinks they need a surgical procedure and wants a second opinion, we can provide them with referrals. And, our nurses explain the procedure and any alternatives available, as well as provide them with questions they should ask their doctor," Ms. Burkhead explained.

"Then, if the person is going to have the procedure, we don't certify or assign a length of the hospi-

tal stay at the time of admission. But, two or three days after surgery, we contact the person and suggest that they talk with their doctor about when they should be discharged," she added.

The MSA program also requires that certain procedures be performed on an outpatient basis, such as biopsies, foot surgery or removal of cysts.

The utilization review program includes financial incentives for compliance. For example, non-union employees who do not comply with the program face a reduction in coverage to 50% from the normal 80%-100% coverage for various procedures.

However, non-union employees do not have to contact the review program before routine admissions

like maternity admissions and can receive 100% coverage for having certain procedures performed on an outpatient basis, she said.

Union employees receive first-dollar coverage if they comply with the review program requirements, but pay \$250 per procedure or admission if they do not comply.

Employees can contest these penalties through the program's appeal process, she added.

The MSA program saved Northwestern Bell \$823,000 in 1987, Ms. Burkhead said. "We take very conservative savings figures from hospital records to determine this. For example, we look at the record and if we intervened and reduced a hospital stay of five days to three days, we figure in a two-day savings."

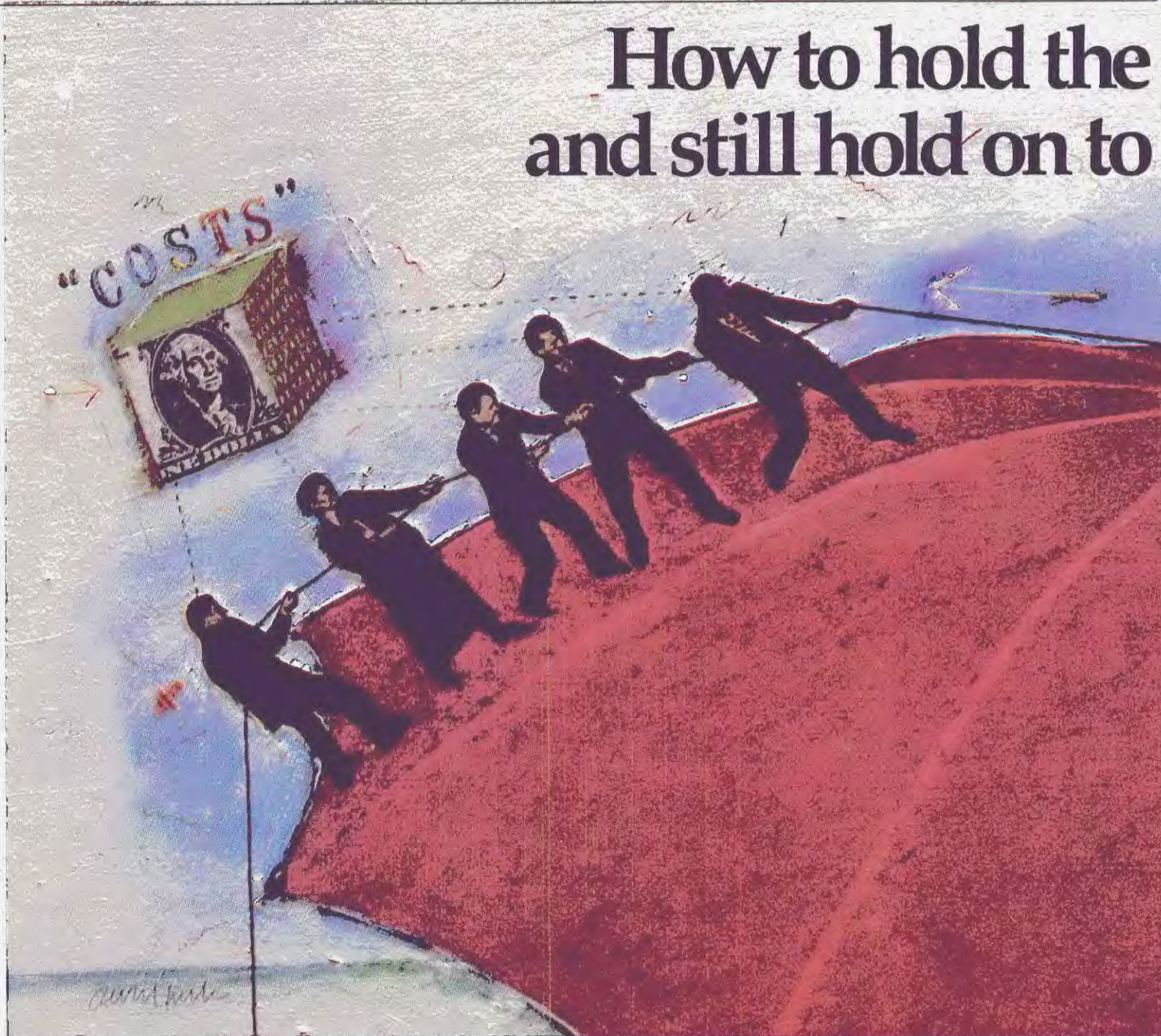
While the savings and control of an in-house utilization review program may be tempting, Ms. Fritsch cautions that these programs are not the best solution to every employer's health care cost problems.

For example, the approach is the most cost-effective and successful for self-insured employers with more than 10,000 employees.

And, "the state of employee relations is important to consider. This type of program will not work well if there isn't a good relationship between employees and management," she suggested.

In addition, employers must consider the cost of hiring nurses, training review staff and the administrative support for the program, she said.

Continued on next page



How to hold the and still hold on to

It's a war of wants.

Your employees want more benefits. You want to contain costs. Still, if you say "no," your best people may say "so long."

Now The Travelers introduces a new kind of employee service. One that won't tug at your company's purse strings.

It's called MoneyTracSM. A personal money management service that can immediately increase the value of your employees' total compensation package.

By helping them save, spend, borrow, invest and protect their money more intelligently. No matter how much money they make.

MoneyTrac is a package of money management services your employees will make use of every day. Brought right to where they work.

It's also savings accounts that reward higher balances with greater interest. Insurance and credit products with special

Continued from previous page

"Many large employers have in-house medical departments already, with a physician on staff that they can use in the review program. Some employers choose to develop a network of specialists that they can consult for the program," she added.

Ms. Burkhead would not disclose Northwestern Bell's costs in implementing its program.

Liability is another major issue employers must consider and become comfortable with before implementing an in-house program, according to Gino Nalli, a consultant with The Wyatt Co. in Washington.

"An employer must consider the extent to which it shares in the liability for a less than ideal medical outcome on a case that has gone through the review program. At least a contract with an outside vendor provides an arm's length distance from this," Mr. Nalli said.

Northwestern Bell has taken certain steps to limit its liability, Ms. Burkhead said.

"First of all, you must be very careful about not diagnosing an illness over the telephone. And, we also do not certify the number of covered hospital days before a patient is admitted to the hospital," she explained.

In addition, "by our benefit plan design and the nature of our physician looking at the case, we give advice, but don't say a procedure is not covered," she explained.

"Also, the individual's attending physician is still the accountable person for the health care the person receives. We do not diagnose illnesses and we also do not treat them," she emphasized.

And, regardless of how UR is administered, an employer must devote time and energy to explaining the new program, Ms. Burkhead noted.

Northwestern Bell introduced the review program to non-union management employees at the same time it changed this group's first-dollar coverage health plan to a comprehensive plan with deductibles and copayments. Both changes were communicated to the group through mailings to employees' homes as well as through employee meetings.

Union employees first learned of the review program through mailings to their homes. However, at the union's suggestion, the company reinforced communication to the 10,000 union employees by requiring supervisors to train employees to use the program, she explained.

The program is communicated on an ongoing basis through employee newsletters and occa-

sionally on a closed-circuit television program for employees, she said.

Employees have responded favorably to the review program, Ms. Burkhead said.

"Most employees have been very good about following the program. Others may not have understood why they needed a second opinion at first, but we work to help them understand the benefits of this," she explained.

For example, one employee discovered she had a malignant tumor in her breast and believed she needed surgery after seeing a physician. The woman also was under pressure from her husband and father to follow the physician's suggested treatment of a mastectomy.

However, after contacting the MSA nurses, she obtained a second surgical opinion and found there were alternative treatments, Ms. Burkhead noted. In the end, the employee informed the program staff that she was thankful for having obtained the second opinion.

Health care savings are not the most encouraging result of the MSA program, she said.

"As you look down the road at the way that we're changing health care purchasers' behavior, that's the real exciting thing," Ms. Burkhead noted. ■

Hospital costs

Continued from page 3

only 2%, EQUICOR's survey of 1,863 hospitals showed.

The survey indicated that hospitals in San Jose, Calif., showed the highest average charge per stay, \$8,697, compared with a national average of \$4,551.

Hospitals in Alexandria and Lake Charles, La., reported the lowest average charges per stay, \$1,885 each.

One reason average charges per hospital stay are up is because hospital admissions are down, health care experts say.

According to the American Hospital Assn. in Chicago, hospital occupancy has been falling since the 1970s, when occupancy averaged about 77%. By 1986, hospital occupancy had dwindled to 68.4% from 69% in 1985 and 72.5% in 1984, according to the AHA.

"Control of utilization of hospital services... has created decreasing overall utilization of hospital care," says Mitchell Goodstein, a consultant in the Minneapolis office of the Tillinghast division of Towers, Perrin, Forster & Crosby.

But because utilization does not affect fixed overhead costs, like capital requirements and utilities, hospitals end up with fewer patients to share these expenses.

Linda Ruth, a benefits consultant with Lincolnshire, Ill.-based Hewitt Associates, noted that a substantial portion of a hospital's labor costs are fixed: A hospital has to hire a basic number of nurses in case of emergencies.

Furthermore, because cost-containment procedures such as pre-admission certification tend to keep people out of hospitals longer, patients that are admitted tend to need more expensive acute care services, like intensive care, Ms. Ruth and other experts agreed.

The "illnesses of patients is increasing," so "the intensity (of care) is consistently rising," said Duncan Yaggy, chief planning officer for Duke University Hospital in Durham, N.C.

"People who are more intensely ill are more likely to require testing, X-rays" and other services, Mr. Yaggy said. A larger number of more seriously ill patients also drives up staff size, he added.

For example, the number of registered nurses per 100 patients nearly doubled to 91 in 1986 from 50 in 1972 at the 800-bed Hartford Hospital in Connecticut, said John K. Springer, vice chairman and chief executive officer.

The nursing shortage exacerbates the situation, the experts agreed.

The vacancy rate for registered nurse positions in hospitals more than doubled to 13.6% in 1986 from 6.3% in 1985, according to a spokeswoman for the American Nurses Assn., a trade group for registered nurses based in Kansas City, Mo. Currently, 87% of hospitals say they have openings for registered nurses, according to the nurses' group.

To fill vacancies and retain current nursing staffs, hospitals say they must raise nurses' salaries, which further increases their operating costs.

Experts and trade groups estimate that labor costs comprise between 60% and 70% of a hospital's annual budget.

Hartford Hospital raised salaries by about 18% for its 600 registered nurses in January to entice them to stay, Mr. Springer noted.

However, the American Nurses Assn. says starting salaries for registered nurses are creeping up slowly. The average starting salary for a registered nurse, who must have a bachelor's degree and professional certification, was \$20,964 in 1987, compared with \$20,340 in 1986, only a 3.1% increase.

Continued on next page

Line on benefits costs your best employees.



rate advantages. Professional help in developing a goal-oriented financial plan.

All tracked on an integrated monthly statement that can help your employees with their budgeting and bill paying. And can serve as their personal "roadmap" to financial peace of mind.

Meanwhile, your out-of-pocket costs are minimal. And The Travelers does all the administrative work.

Sound like a program that would pull

well in *your* company? Call our Vice President of Institutional Sales at 1-800-862-7355, and find out more.

MONEYMURACSM

A Financial Management System from **TheTravelers**

Insurance products are provided by The Travelers Insurance Company, The Travelers Indemnity Company, and their insurance affiliates.

Mortgages are provided by The Travelers Mortgage Services, Inc.

Equal Housing Lender.

Financial Planning Services are provided by Travelers Equities Sales, Inc.

Bank services are provided by The Massachusetts Company, Inc. Bank accounts are FDIC insured up to \$100,000 per depositor. Equal Opportunity Lender.

Equal Housing Lender.

© 1987 The Travelers Corporation

Hospital costs

Continued from previous page

"Nursing salaries have not risen faster than the overall inflation rate," said David Martin, a senior staff specialist in labor relations for the ANA.

And, to make matters worse, five years after entering nursing, hospital salaries tend to flatten out, so nurses often leave hospitals to work in other areas of the health care industry or to pursue different careers, he said.

Furthermore, because the patients admitted are sicker and require more intensive care, working in a hospital is becoming less desirable for nurses, Duke's Mr. Yaggy pointed out.

He added that the competition for other types health care workers—like technicians, computer technicians and financial executives—also is stiff, although less so than for nurses.

Another major reason that hospital operating expenses are rising is the high cost of new medical technology combined with the desire by hospitals to have the latest and best equipment, observers agree.

"It's the technological imperative at work," commented David Rahill, a principal with A. Foster Higgins HealthGroup in Princeton, N.J., the benefit consulting unit of Johnson & Higgins.

To maintain a hospital's image, doctors feel it must have the newest equipment available, he explained.

Teaching hospitals are particularly subject to pressure to purchase state-of-the-art technology, Mr. Yaggy explained, because many of the physicians associated with these hospitals are pioneers in their fields and need the most advanced equipment to continue their work.

"We have built a facility to pro-

vide state-of-the-art clinical medicine," Mr. Yaggy said. "If we don't have the technology, we are wasting money" that already has been spent in buildings and personnel, he added.

The problem is that "technology in the health care industry is rarely cost-reducing; it's almost always a cost-increaser," Mr. Rahill pointed out.

"There's no end in sight for what we can do to save lives and prolong lives, and it all costs money," observed Hewitt's Ms. Ruth.

A good example of how advanced technology can drive up a hospital's operating costs is development of the magnetic resonance imager, known as MRI, which performs many of the same diagnostic functions as a CAT scan, but at a much higher cost, health care officials explain.

Proponents of MRIs say they provide much more refined information than computerized axial

tomography—or CAT—scans, which greatly refined X-rays as a diagnostic tool when they were developed in the mid-1970s.

But while price tags for CAT scanners range from about \$500,000 to \$1 million, experts estimated, MRIs can cost hospitals between \$1.5 million and \$4 million.

And, many experts say that MRIs are not being used in place of CAT scans; they are used in addition to the older technology, which can drive up hospital bills even further.

Samuel X. Kaplan, chairman of U.S. Administrators Inc., a Los Angeles-based third-party claims administrator, said that "just as many X-rays and CAT scans" are being performed now as before the development of the MRI.

Tillinghast's Mr. Goodstein agreed that new technology is beginning to be used in addition to—not instead of—old technology.

Doctors feel compelled to order every possible test to avoid malpractice lawsuits, Mr. Goodstein explained.

Other high-tech equipment—besides MRIs and CAT scanners—popular with hospitals are machines used in laser eye surgery and in organ transplants and surgical staples, which are easier to use and dissolve faster than stitches, according to a spokesman for the Federation of American Health Systems, a Washington, D.C.-based trade group of for-profit hospitals.

Besides the high cost of technological advances, hospitals recently have had to contend with rising medical malpractice insurance rates.

According to a study by the U.S. General Accounting Office, community hospitals' total malpractice insurance costs—including premiums, contributions to self-insurance reserves and uninsured loss payments—increased 57% to \$1.34 billion in 1985 from \$849 million in 1983.

During this same period, 84% of the hospitals experienced decreases in inpatient days, the GAO study noted, with the total number of inpatient days decreasing about 13%.

But, hospital malpractice insurance costs recently have "started to level off," noted Jay Bikofsky, vp in J&H's national health group in New York.

Hospitals also are being hit with unanticipated costs from treating patients with acquired immune deficiency syndrome, pointed out Hartford Hospital's Mr. Springer.

For example, the hospital used 1.5 million more rubber gloves last year than in 1986 because the gloves are now used routinely as a protective measure when dealing with all patients, he said. The gloves, which cost 35 cents per pair, added more than \$500,000 to the hospital's budget, Mr. Springer said.

In the face of rising costs and declining occupancy, many hospitals are closing wings—or closing altogether.

The number of acute care hospital beds declined 27% between 1981 and 1985, according to a recent report issued by the National Committee for Quality Health Care, a Washington, D.C.-based coalition of health care providers and companies and professional firms in the health care field.

And, the group predicts that by the year 2000, some 40% of all hospitals in the United States will be closed or converted to other purposes. Public and rural hospitals seem to be in the most jeopardy, the report said.

Although hospital revenue growth has averaged almost 7% annually from 1984 through 1986, according to the American Hospital Assn., profits are declining because of increasing expenses, many of the experts said.

Hospitals need to make a profit, health care experts and hospital officials point out.

"Any organization must have an excess of revenues over expenses to cover capital development," said Ronald Kovener, vp in the Washington office of the Healthcare Financial Management Assn., an Oakbrook, Ill.-based group whose members are health care financial officials.

However, hospital profits "have slipped terribly" to about 3% of revenues last year and they could be lower this year, Mr. Kovener said.

"No margin, no mission" is the way Fairfax Hospital's spokesman put it. He explained that even not-for-profit hospitals need to generate working capital.

"Not-for-profit does not mean for-loss," observed Michael Hendershot, president of Chart-Tech Inc., an Evanston, Ill.-based hospital auditing and consulting firm. ■

A lot of companies promise you a managed health care solution.

And deliver just another quick fix.

All of a sudden, everyone—from insurance carriers to TPAs—is an "expert" in managed health care. But, when you ask the tough questions . . . how to cut costs without reducing quality of care . . . how to control utilization without damaging employee relations . . . so many managed care "cures" are about as effective as a bandage on a hemorrhage.

That's why you should call in a specialist . . . JBI. We have more than a decade of managed care experience—from administration of employer benefit plans and management information systems, to development and operation of HMOs and PPOs.

At JBI, we diagnose the root causes of high health care costs, and use this knowledge to help employers manage both the cost and quality of health care. We can help you incorporate quality-conscious, cost-effective managed

health care into a benefits program that meets the needs of your employees . . . and makes the best use of your company's health care dollar.

Five totally integrated components give the JBI MANAGED HEALTH CARE System the flexibility to meet your needs:

- **Claims Processing**—to pay claims quickly and accurately and generate data to support other system components . . .

- **Utilization Management**—to ensure appropriate, high-quality ambulatory and inpatient care . . .

- **Information Analysis**—to support cost management, provider evaluation, benefits comparisons and design . . .

- **PPO Networks**—to develop employer-directed provider networks or make arrangements with provider groups . . .

- **HMO Evaluation and Administration**—to identify high-quality, reasonable-cost HMOs, negotiate rates and more.

You can implement the full JBI MANAGED HEALTH CARE System. Or, integrate components into your existing program to make it more efficient and effective. JBI's goal is to improve your bottom line.

If you're in the market for comprehensive, customized managed health care solutions—and you don't want another quick fix—call the health benefits specialists at JBI today at 301/251-8600.

JBI

JURGOVAN & BLAIR INC.

7811 Montrose Road
Potomac, Maryland 20854
(301) 251-8600

ARE YOU TRYING TO PIECE TOGETHER A MULTINATIONAL BENEFIT PROGRAM?

WE HAVE IT ALL IN ONE PIECE.

The Group Management Division of the American International Group of Insurance companies makes putting all the pieces of your international benefit program together a piece of cake. Because you deal with a single source of expertise.

Besides the greater convenience of dealing with a single source, GMD offers another important benefit.

YOUR CONTROL IS GREATER

You get worldwide control because we have worldwide control.

Only GMD offers multinational benefit programs through wholly

owned or wholly managed international operations. Our overseas personnel work for and report to *us*, not to an unrelated "network partner."

If you'd like more information and a copy of our newsletter on the latest trends affecting multinational benefit programs, write to Group Management Division, American International Group, Dept. A, 70 Pine Street, New York, N.Y. 10270. Or call (212) 770-5060 or (212) 770-7407.

Group Management Division

Insurance Companies That Don't
Think Like Insurance Companies



Hospitals shift costs to cover losses

Medicare effects on hospital profits

	Average Increase in Medicare payments to hospitals ¹	Average Increase in hospital operating costs ¹	Average Increase in hospital profits ¹
1984	12.0%	6.4%	14.0%
1985	10.3	10.0	14.3
1986	3.0	10.4	8.0
1987 ²	3.0	10.0	2.0

¹ Per case ² Estimated

Source: Prospective Payment Assessment Commission in Washington, D.C.

By DEBORAH SHALOWITZ

Hospitals are shifting costs from some payers to others and raising charges dramatically for certain services to make up for revenue shortfalls caused by federal and private sector cost-containment measures, say health care experts and hospital officials.

Charges have increased the most for ancillary services, like X-rays, laboratory tests and pharmaceuticals, and for outpatient services and mental health and substance abuse programs.

Experts say hospitals use cost-shifting—which primarily affects self-funded employers and insured employers with traditional indemnity plans—to recapture revenue lost due to:

- Providing free care to the uninsured and indigent.

- Inadequate reimbursement from the federal government for Medicare beneficiaries.

- Discounted charges from health maintenance and preferred provider organizations.

Congress in 1983 required the Medicare program to pay hospitals a fixed amount for inpatient care for each Medicare beneficiary. The payment to the hospital is based on a patient's diagnosis and anticipated treatment. Medicare lists 473 of these classifications, known as diagnostic related groups, or DRGs.

Each year, the Health and Human Services Department and Congress updates the amounts payable to hospitals for each DRG.

Although during the first few years of this system Medicare payments per case exceeded hospitals' operating costs, hospital costs now exceed the amount Medicare pays (see chart).

According to Dr. Donald Young, executive director of the Prospective Payment Assessment Commission, an independent federal agency, average Medicare payments to hospitals in 1988 could rise as little as 1% to 2% over 1987 levels, triggering losses from Medicare patients.

Hospitals, to make up for lost revenue, are shifting their costs to other payers by increasing charges for ancillary and outpatient services, health care experts contend.

"Hospitals have traditionally raised their rates in the least-controlled environment," commented David Rosenbloom, president of The Health Data Institute, a Lexington, Mass., consultant. "Most hospitals are still getting paid their (full) charges for outpatient services," so this is a good area to absorb extra costs, he added.

Larry Lenahan, a benefit consultant with Buck Consultants Inc. in Harmon Meadow, N.J., pointed out that Medicare's DRG system does not apply to outpatient surgery—another reason to promote outpatient care.

According to the American Hospital Assn. in Chicago, revenue from outpatient services has grown to 17% of hospitals' total revenue in 1986, up from 11% in 1976.

Also, hospitals can charge different rates for operating and recovery rooms for outpatient and inpatient surgery, said David Rahill, a principal with A. Foster Higgins HealthGroup in Princeton, N.J.

Hospitals also are trying to market their inpatient mental health and drug abuse programs because "where you don't have agreement on treatment, it's much harder for an employer to monitor" costs, Mr. Rahill said.

And, many benefit plans "encourage people to seek (mental health) treatment on an inpatient basis," noted consultant Rose Venditti with the national benefit services division of Frank B. Hall Consulting Co. in Briarcliff Manor, N.Y.

Unbundling of services allows hospitals to bury costs if they want, warned some health care experts.

For example, an audit of one large hospital bill conducted by ALTA Health Strategies Inc. revealed that 119 bottles of intravenous fluid that wholesaled for \$40 were billed at \$342 each, said Peter O'Donnell, senior vp of the Salt Lake City-based third-party claims administrator. The highest retail price ALTA had previously seen for the IV fluid was \$140 per bottle, he added.

The ALTA audit was used to persuade the hospital to lower the charges for the IV fluid, reducing the total hospital bill by about \$20,000.

"That's an extreme example that illustrates the point" that when hospital costs are squeezed in one area, they will balloon in another, he concluded.

Mr. O'Donnell said that when auditing hospital bills, ALTA finds "greatly varying" charges for pharmaceuticals, X-rays and laboratory work.

However, one hospital auditing and consulting firm has concluded that hospitals are not routinely overcharging patients and payers.

More than half of 17,000 randomly selected patient bills examined in an 18-month audit of 30 hospitals in the Midwest and East were undercharged, according to Chart-Tech Inc. of Evanston, Ill. ■

TRAVIS SOFTWARE'S EMPLOYEE BENEFIT SYSTEMS

Save Time • Save Money • Save Errors



The Most Popular, Widely-Used COBRA ADMINISTRATION SOFTWARE

CORPORATE COBRA MANAGER

For complete, fast and accurate COBRA administration, over 1,100 firms and institutions have chosen Corporate Cobra Manager.

The system automatically produces up to 29 letters, forms and documents required by COBRA. Easy-to-use . . . requires beneficiary's name, qualifying event and elected benefit plans. All record-keeping, correspondence generation and premium computations are part of the system.

Travis Software Corp. supports and updates the Corporate Cobra Manager as new regulations arise or new features are added.

SUMMARY OF FUNCTIONS

- Notification of Eligibility
- Enrollment Form and Times
- Premium Calculations
- Handles Secondary Qualifying Events
- Tracking of Eligibility Periods for Each Participant
- Management Report Module
- Change of Address Function
- Termination Letters
- Automatic Generation of Letters and Forms
- Premium Delay Capability
- Monthly Premium and Eligibility Reports to Vendors
- Monthly Premium Notices or Coupons
- Late Premium Notices (user-specified)
- 2% Add-on (user-specified) can be delayed for compliance with state continuation laws
- Additional Copies for Files
- Complete Audit Trail
- Multi level Password

OPTIONAL FUNCTIONS (Add'l Cost)

- Custom Letter Writer
- Custom Report Writer
- Downloading

AS LITTLE AS SINGLE EMPLOYER VERSION **\$1295.** MULTI-EMPLOYER VERSION AS LOW AS **\$3750.**



The Easy, Economical Way to Administer FLEXIBLE BENEFIT PLANS

CORPORATE FLEX MANAGER

Designed for complete flexible benefit plan administration. Travis Software Corp. has documented, supported and updated the system so that operators need not be benefit plans experts.

Employee selections and deduction amounts are entered at the beginning of the plan year. The system prints verification and enrollment forms, reimbursement checks and performs duplicate claims checking.

Available in Single and Multi-Employer Versions.

SUMMARY OF FUNCTIONS

- Generates annual election forms for each employee.
- Automatic pre-stored interface with payroll system to track and post salary deduction data regardless of payroll frequency.
- Maintains balances for each participant in each account.
- Generates statements listing transactions for each participant's accounts.
- Automatically produces reimbursement checks for eligible benefits in accordance with parameters determined by IRC Section 125.
- Handles "full-flex" plans.
- Detects duplicate claim items.
- Verifies balance before payment and after, and automatically carries forward any balance to be paid.
- Generates an Explanation of Benefits form with each payment.
- Provides complete summary financial reporting.
- Benefit Verification Form.
- Pre-Election Form.
- Reimbursement frequency determined by employer.

NEW RETIREE PREMIUM BILLING SYSTEM

Administers Retiree Medical Plans, Reduced Benefit Plans and other "non-deduct" plans requiring payments by participants.

The program generates billings at user-selected frequency, maintains receivables aging file, tracks account status and supplies data on primary and supplemental carriers as well as management summary reports.

The system requires no special operator training and is only \$1295. (as low as \$895. to COBRA Manager Users.)

Reseller inquiries invited.

FOR FURTHER INFORMATION CALL

713-496-3737

All Systems are for use on IBM PC¹, PC/XT, PC/AT, Personal System 2, COMPAQ², or 100% compatibles, using PC-DOS or MS-DOS³, Series 2 or 3, and 512K main memory and a hard disk. No other software required.
¹TM of International Business Machines Corp.
²TM of COMPAQ Computer Corp.
³TM of Microsoft Corp.

TRAVIS SOFTWARE CORP.

1001 S. Dairy Ashford, Suite 206 • Houston, Texas 77077

Name _____
 Title _____
 Company _____
 Street _____
 City, State, Zip _____
 Telephone _____

PLEASE SEND MORE INFORMATION ON:

- CORPORATE COBRA MANAGER
- CORPORATE FLEX MANAGER
- RETIREE PREMIUM BILLING SYSTEM
- BENEFIT DISCRIMINATION TESTING MGR.
- OSHA REPORTING MANAGER

COMING! Benefit Discrimination Testing Manager

A system modeling employer compliance with the discrimination rules as outlined in The Tax Reform Act of 1986 (Section 89, IRC). Also, 401(k) discrimination testing will be modeled.

Available in single employer or multi-employer versions.

OSHA Reporting Manager

Automatically prepares reports required for safety compliance.

Case managers focus on specialties

By MARK A. HOFMANN

Specialized case management and utilization review firms are springing up across the country as more employees seek specialized health care services, like treatment for mental illness, back injuries and AIDS.

Some of these specialized UR vendors claim they can produce even greater savings than their non-specialized competitors.

"It's a natural response to the proliferation of specialty health care," said Stephen McGill, Midwestern regional practice leader in Chicago for A. Foster Higgins HealthGroup, the benefits consulting subsidiary of New York-based Johnson & Higgins.

"A lot of health care organizations have put their marketing force in specialty areas. As a result, the specialty UR firms crop up to help employers control costs in these areas," he added.

The growth in UR firms that specialize in mental health cases is primarily "demand-driven," according to William R. Maloney, executive director of Minneapolis-based PsychPACER, a subsidiary of the MCC Cos. Inc., which also manages mental health substance abuse treatment programs (see story, page 17).

Employers have become more sophisticated and are realizing that mental health costs cannot be measured the same way costs for treating physical afflictions are, Mr. Maloney explained. "They need somebody knowledgeable to do an assessment."

John C. Erb, assistant vp of Foster Higgins in its Princeton, N.J., headquarters, agreed.

"I'm four-square in favor of contracting directly with specialized psych UR firms" because they have specialized training, he said.

Larger employers are more likely than smaller employers to contract with a UR firm that specializes in mental health treatment review, according to the 1987 Foster Higgins Health Care Benefits survey of 2,016 companies.

While only 8% of the companies with 500 or fewer employees had such contracts, 30% of the companies with more than 40,000 employees did, the survey showed.

And, many multiple-service utilization review firms subcontract with psychiatric UR firms, according to Mr. Erb.

The growth of psychiatric UR firms also can be attributed to the increase in the use and cost of mental health services, health care experts say.

For example, psychiatric admissions for Aetna Life Insurance Co.'s group plan members increased 36% from 1984 through 1986.

The average inpatient stay for mental health treatment in 1985 was 24.5 days—four times the average for all hospital admissions—and the average cost per stay was more than \$8,000, or about twice the average cost for all diagnoses, according to data gathered by Metropolitan Life Insurance Co. (BI, Sept. 29, 1986).

Also contributing to the increase in mental health treatment are hospital chains, which are courting more inpatient business to fill empty beds, according to Dr. Kenneth A. Kessler, president of American PsychManagement Inc. in Arlington, Va., a mental health UR firm.

Indeed, the number of hospital psychiatric facilities increased 37% in 1985, according to figures supplied by Aetna.

"It's a matter of supply driving demand," Dr. Kessler said.

Because mental health treatment

rarely involves cut-and-dried diagnoses, specialized review is necessary, explained PsychPACER's Mr. Maloney.

For example, while a benchmark can be established for what constitutes an appropriate level of care for a broken leg, which is easily and uniformly diagnosed, mental health questions defy this "cook-book" approach, he pointed out.

Different psychiatrists may offer divergent diagnoses of the same problem, he added. "Elasticity of diagnosis is a big problem. Sometimes, diagnosis will depend on what the insurance will pay for."

To illustrate the effectiveness of American PsychManagement's specialized review program, Dr. Kessler cited the case of a large corporation that paid for 146 days

'It's a natural response to the (rise) of specialty health care,' says Mr. McGill.

of inpatient mental health care per 1,000 employees in 1984. The company at first contracted with a medical UR firm, which reduced the number of inpatient days to 142 the next year. But when Dr. Kessler's firm took over the account in 1986, it cut the number of inpatient days per 1,000 workers to 88.

Although Dr. Kessler would not

reveal which client he cited in his example, he did say his major clients include Xerox Corp., Southland Corp. and Nissan Motor Manufacturing Co.

American PsychManagement, which began operating in 1983, provides inpatient and outpatient review services directly to employers for flat annual fees ranging from \$3 to about \$7 per employee, depending on the type of services required.

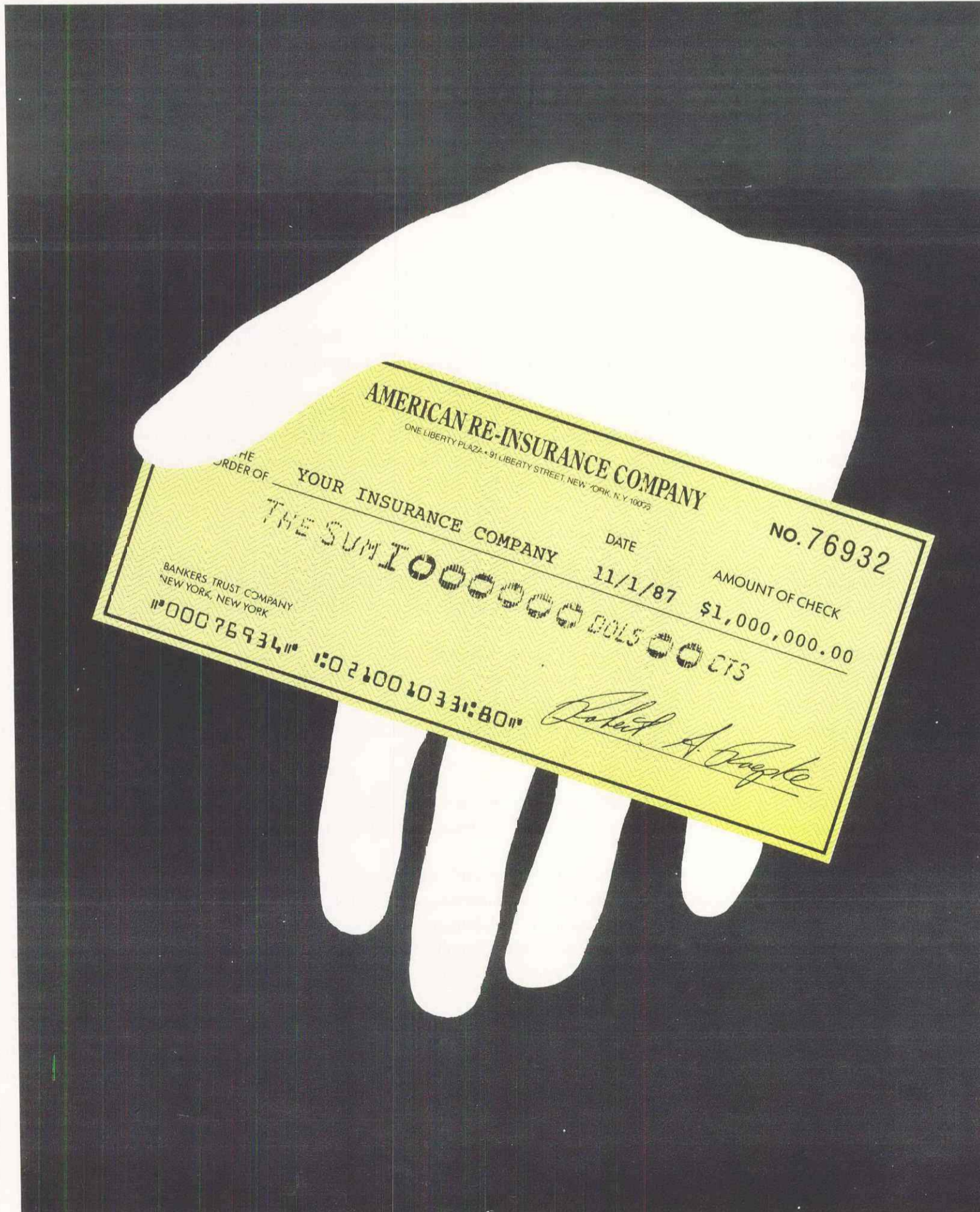
Aetna's Employee Benefits Division in Hartford, Conn., launched its Focused Psychiatric Review program in mid-1987 to contain inpatient psychiatric care costs without compromising quality of care, explains Dr. John S. Montgomery, the program's medical director.

The program is part of Aetna's Healthline, the insurer's precertification and UR program. Charges for the service are built into the Healthline fee and vary according to the services required by the client.

So far, Focused Psychiatric Review has handled about 4,000 inpatient cases, Dr. Montgomery said. Although he did not have more recent cost savings figures, he said the program had saved \$338,000 on 75 cases during its trial stage that ended in spring 1987.

Chiropractic review is another area in which UR service providers are specializing, said Lawrence Wolther, president and founder of the National Chiropractic Review

Continued on next page



Case managers say programs can contain substance abuse costs

By KARI BERMAN

NEW YORK—Psychiatric case management firms specializing in substance abuse say they can cut employers' health care costs by rehabilitating employees addicted to alcohol or drugs.

And, while these companies do not guarantee their rehabilitation programs, several are offering to re-treat patients if they "fall off the wagon."

Substance abuse rehabilitation and treatment can be an effective cost-containing vehicle for employers, as 12 case studies con-

ducted by the Department of Health and Human Services' Alcohol, Drug Abuse and Mental Health Administration reveal.

Substance abuse therapy not only reduced medical care costs between 26% and 69% for each treated employee, but also reduced the number of sick days per treated employee by 38% to 47%, a spokesman from the administration confirmed.

For example, a case study of the Philadelphia Police Department showed the department saved an estimated \$1,000 in employee benefit costs for every employee undergoing inpatient alcoholism treatment.

"Substance abuse programs can be cost containing if companies choose providers carefully and incorporate good utilization review programs," asserts Debbie Brandel, project director at Preferred Health Strategies, a case management and consulting firm in White Plains, N.Y.

"The cost to treat a chemically addicted employee is minimal in comparison to the expense of not treating them," says Edward Carels, senior vp at Comprehensive Care Corp., an Irvine, Calif.-based private provider of substance abuse services.

"Companies are finally realizing that they cannot afford not to treat an employee with a substance abuse problems because, if untreated, it will cost the employer a fortune in workers compensation, auto insurance and life insurance," he added.

Because substance abusers tend to experience physical ailments requiring medical attention more frequently than other workers, employers pay the price in benefit costs, sick days and lost productivity, health care experts concur.

According to a study conducted by the Chicago-based American Hospital Assn., substance abuse adds \$60 billion to \$100 billion each year to the cost of various costs.

Employers can combat the cost of substance abuse by providing treatment and rehabilitation as part of their employee benefit programs, either in-house as part of an employee assistance program or by contracting with an outside provider.

Comprehensive Care, a 16-year-old preferred provider organization for substance abuse, maintains Care Units in 200 hospitals and directly owns and operates 24 treatment centers nationwide.

"We offer employers a preferential rate based on volume in exchange for their commitment to use CompCare exclusively," Mr. Carels explained.

If a company opts to contract with CompCare, employees are able to take advantage of all aspects of the program, which includes five years of continuous follow-up care.

"We have the 'CarePromise' which commits CompCare to provide ongoing treatment for recovering patients for up to five years," Mr. Carels said.

In addition, if an individual suffers a relapse during the five-year span, CompCare will re-treat him up to two additional times at no added charge to the employer.

After the five-year follow-up period is over, CompCare patients are entitled to a lifetime counseling services at any of its affiliated facilities around the country.

Continued on next page

nancial Services in Boston, which has offered an AIDS case management service for slightly less than two years.

The cost of treating AIDS patients from diagnosis to death varies greatly, Mr. Sang said, ranging from about \$40,000 to more than \$100,000. Much of the variation stems from the services available at a given location and how much care is provided on an outpatient basis (BI, Feb. 8).

For example, San Francisco residents, faced with a high incidence of AIDS cases, began developing alternatives to prolonged inpatient care for AIDS victims. Through the development of community support services, including at-home care through volunteer networks, the cost of treating AIDS patients from diagnosis to death declined to about \$40,000 in the Bay Area, making AIDS costs in the region among the lowest in the country, Mr. Sang said.

By recommending alternatives to inpatient care, the Hancock program registered an even greater savings, averaging a savings of more than \$56,000 per AIDS case during its first year of operation, Mr. Sang said.

Hancock's AIDS review program is available at no additional cost to group insurance clients that already subscribe to Hancock's medical case management program. Case management services cost \$85 to \$115 per hour. ■

You can count the days it takes us to pay your claims on one hand.

That's our policy. Five days after confirmation of damages and coverage, your check is on its way. Because we're American Re. And we make prompt payments a reality.

We've committed a higher percentage of our resources to claims service programs than any other reinsurer. Exclusive programs in Arson Identification and Prevention. Massive Injury Management. Catastrophe Management. Litigation Management.

Come to American Re. We're everything we claim to be.



American Re-Insurance Company

One Liberty Plaza, 91 Liberty Street, New York, NY 10006 (212) 618-7000

Atlanta • Boston • Chicago • Columbus • Dallas

Hartford • Kansas City • Los Angeles • Minneapolis • New York • Philadelphia • San Francisco

Bogota • Cairo • London • Melbourne • Montreal • Santiago • Singapore • Sydney • Tokyo • Toronto

Substance abuse

Continued from previous page

"The rate of relapse for substance abusers is high, and we try to take as many steps as possible to keep former patients on the right path," Mr. Carels explained.

All former patients receive an identification "Gold Card" that is used to indicate they belong to the program and have have paid for follow-up care. In addition, patients have access to a 24-hour emergency hot line that offers advice and information.

"Employers, employees and families are pleased with the CompCare program, and the former patients often send people to us for similar help," says a spokeswoman for the Golden Valley Health Center in Golden Valley, Minn., which operates one of CompCare's larger Care Unit facilities.

"The ultimate bottom line is keeping costs down, and we believe

Larger employers 'tend to give more aid because they have the resources. This is often not a one-shot deal, and we find that companies are usually willing to (pay for re-treatment) if needed,' Charles Heinecke of MCC says.

that over a five-year period, CompCare can lower employers' costs for chemically addicted employees by 15%," including treatment, lost work days, etc., asserts Mr. Carels, who estimated the average cost of inpatient substance abuse rehabilitation to be approximately \$8,500.

While CompCare maintains that it can reduce employer costs associated with chemical dependency by 15%, St. Paul, Minn.-based MCC Cos. Inc., a mental health care provider, estimates that its system saves employers 20% or more.

Health maintenance organizations, PPOs and insurers subcontract for mental health and substance abuse services from MCC, a spokesman explained.

MCC, which was launched in 1974, now provides psychiatric case management, EAPs, crisis intervention and inpatient and outpatient counseling to approximately 900,000 individuals in 10 cities. Fees, which are paid on a capitated basis, vary depending on the number and types of services provided.

"The amount of coverage offered

by every plan varies depending on the specific situation," according to Charles Heinecke, clinical director of chemical dependency services at MCC.

Although MCC says that 50% to 70% of former patients contacted after six months claim sobriety, MCC offers neither guarantees nor free re-treatment for those who have a relapse.

Larger employers "tend to give more aid because they have the resources. This is often not a one-shot deal, and we find that companies are usually willing to (pay for re-treatment) if needed," Mr. Heinecke said.

St. Paul-based Minnesota Mining & Manufacturing Co. reports satisfactory results from its MCC-administered program, according to Dr. Jack Stoltzfus, employee assistance corporate manager at 3M.

"I have been very impressed with the treatment at MCC and do not hesitate to recommend the pro-

gram to employees who want help with chemical dependency problems," he said.

However, he did not have data reflecting 3M's savings to date because the manufacturer only began using the MCC program last year.

Jay Hauge, director of St. Mary's Chemical Dependency Services at Riverside Medical Center in Minneapolis, reports that 68% of the patients enrolled in that program are successfully treated the first time.

Although St. Mary's will not offer free re-treatment, the program does include two years of free follow-up care that provides support and continued therapy.

"After the two years, if a former patient has a crisis, we will continue to help. Usually if inpatient re-treatment is called for, employers are willing to pay for the costs a second time," Mr. Hauge said.

The St. Mary's program requires payment in full upon registration. Two years of a combination of inpatient and outpatient treatment costs \$5,500, while outpatient treatment only costs \$2,000.

"We do our best. To guarantee success is both outrageous and impossible. These are human beings, not cars, and each has to be taught how to restructure a life," Mr. Hauge pointed out.

Psychology Assistance Health Plan, a Milpitas, Calif.-based psychiatric HMO servicing 125,000 employers with with a panel of 1,000 physicians, offers free re-treatment to those who relapse within the first six months of treatment, according to President John C. Brady.

Psychology Assistance—which provides its services through insurers, other HMOs or directly to employers—successfully rehabilitates 50% to 60% of its after initial treatment, according to Mr. Brady.

Employers pay for Psychology Assistance's services on a capitated basis, usually \$5 per month per participant, Mr. Brady estimated.

"We have 25 contracted hospitals, and our system includes 16 to 20 days of inpatient care followed by outpatient treatment," Mr. Brady explained.

"We can also help companies reduce costs through our inpatient utilization review program that double-checks all treatment to make sure that charges are accurate," reports Mr. Brady. "Companies should not have to pay excess costs for helping their employees toward recovery," he added.

Some self-insured employers, like Armonk, N.Y.-based International Business Machines Corp., are battling substance abuse in-house by providing treatment through their EAPs.

At IBM, substance-addicted employees, retirees and their families are able to seek help through the company's EAP, which provides up to eight short-term counseling sessions at no charge. After the initial meetings, the EAP counselor makes an evaluation and treatment recommendation.

"IBM is self-insured, so if inpatient treatment is needed, it is covered by the company's major medical plan, which provides for 80% of the cost," according to Rita A. Black, program administrator of information activities at IBM.

"Our primary concern is for the well-being of the employee," Ms. Black said.

Although she would not disclose the how much in health care costs IBM has saved as a result of the rehabilitation program, she did say, "It makes economic and cost-containing sense to attempt to reduce substance-related problems by treating them as effectively as possible.

"Employees want to be productive and the company wants them to be productive, so getting treatment is in everyone's best interest," she added. ■

J&H INFOLINE

INFORMATION AND IDEAS ON RISK MANAGEMENT AND BENEFITS FROM JOHNSON & HIGGINS

NO. 26

J&H Forms Alternative Markets Division.

Will manage risk retention as separate discipline.

The rise in formation of alternative risk financing vehicles continues strong despite the advent of a softening insurance market.

Within the last 18 months, alternative underwriting capacity has established historic highs utilizing such forms as: single-parent captives, risk retention groups, special-purpose insurers, and insurers formed from a combination of investor and conventional insurance market capital.

J&H has taken a leadership position in building much of this new capacity by creating special group programs with offshore insurance companies. In addition, J&H helped organize a combination of insurance-market and financial-market capital for AEIA¹ and ERIC². More recently, we helped develop the Consolidated Catholic Casualty Risk Retention Group.

The creation of the Alternative Markets Division, formalizes J&H long-term activity in risk retention capital projects. Besides recognition as the world's leading manager of captive facilities, the unit also brings to the table dedicated resources in plan design, policy design, capital formation, captive formation and reinsurance intermediation.

For more information on participating in an alternative market facility, call your J&H office or Richard J. Rice. 212-574-8600.

¹American Excess Insurance Association. ²ERIC Reinsurance Co.

School system teaches cost control lesson

By JERRY GEISEL

MIAMI—While health care costs climb out of control for many employers, the Dade County Public Schools system in South Florida is saving millions of dollars in health care expenditures a year.

The system's preferred provider organization and a comprehensive pre-admission and utilization review program have saved the nation's fourth-largest public school system close to \$12 million between 1984 and July 1, 1987, says Susan N. Weiner, assistant superintendent in the office of risk management of Dade County Public Schools in Miami.

"The success of the program has surprised even me. I'm overwhelmed," said Ms. Weiner, who convinced the school system's insurer, Metropolitan Life Insurance Co., to set up the PPO.

Metropolitan implemented the PPO—known as Met-Elect—on Jan. 1, 1984, nine weeks after the school system wrapped up a collective bargaining agreement with its labor unions.

"Sometimes, a program turns out even better than expected," added Ms. Weiner, a member of the 1985 *Business Insurance* Risk Management Honor Roll (*BI*, April 15, 1985).

Indeed, the numbers are impressive: Health care costs for Dade County school employees using the PPO are substantially lower than those receiving services from non-PPO providers.

For example, in the first six months of 1987, the average cost per hospital confinement for school system employees using the PPO was \$4,131, compared with an average confinement expense of \$5,823 for employees using services outside the PPO.

In addition, the average length of stay at a PPO facility was six days, compared with 6.7 days at non-PPO facilities.

And, while other employers sometimes have to struggle to persuade employees to use a PPO, the school system has not had much difficulty. Between 60% and 70% of employees currently use hospitals in the PPO, compared with about 40% immediately after the program began.

"The quality and convenience of the PPO hospitals is high, and the word on the employee grapevine gets around quickly," Ms. Weiner said.

From the start, the Dade County Public Schools system has been an example of what a determined employer can do to bring health care costs under control.

After the Dade County Public Schools in 1983 won union approval to change its health care program, Metropolitan began negotiations with a select number of South Florida hospitals that were efficient health care providers.

Metropolitan turned to Corporate Health Strategies, a Westport, Conn.-based health care information management subsidiary of Metropolitan, for help in pinpointing the most efficient providers.

With a data bank of hundreds of thousands of claims incurred by Metropolitan clients over a 15-month period, CHS was able to compare the efficiency of hospitals serving school employees.

CHS broke down those claims to fit into one of 469 categories, or diagnostic-related groups. "By assigning DRGs, the efficiency level of hospitals could be compared," explained Clement Golia, vp-network management with CHS. For example, CHS could compare the average cost of a gall bladder operation at different hospitals.

By analyzing claims, CHS found

huge variations in the efficiency of hospitals. "Some hospitals were performing 20% more efficiently than average, while others were 50% less efficient than average," recalled Bill Rosenberg, a vp with CHS.

Pinpointing efficiency was essential for negotiating with hospitals, he said.

For example, a hospital that was willing to discount its rates 38% to participate in the PPO was rejected because the DRG analysis revealed the hospital was very inefficient, Mr. Golia said.

"A sophisticated buyer like Dade needs data to discern pricing behavior," Mr. Rosenberg said.

Armed with this hospital efficiency information, Metropolitan began negotiations with about 20

hospitals. Ultimately, five hospitals and 900 physicians who agreed to discount services were selected for the PPO.

In turn, the Dade County school system altered its health care program, which covers about 24,000 employees. Employees who used the PPO had health care services covered in full. Employees who used non-PPO providers paid 20% of their expenses, with a cap on out-of-pocket expenses.

"Plan redesign was essential. You have to make it sweeter for employees to use the PPO. And, the hospitals and doctors have to know that they will gain a greater market share by joining the PPO," Ms. Weiner explained.

Since the program began, the number of hospitals in the PPO has

expanded to 14, and the number of participating physicians has increased to more than 2,000.

Some of the hospitals that eventually joined the PPO initially refused to discount rates but have since changed their minds, Mr. Rosenberg said.

"Some Miami hospitals said: 'We won't discount fees.' They began to come around when they saw they were losing market share," he said, noting that hospitals' profitability is tied to their occupancy rate.

While selecting the most efficient hospitals and winning pricing concessions has been important to the success of the PPO, discounts are just one way the Dade County Public Schools system is cutting health care costs.

"Discounts have a value, but

only to a point," Ms. Weiner said, noting that other cost containment techniques also are essential.

For example, to receive full reimbursement for elective surgery, employees and their physicians must first consult with a CHS medical action center in Miami for a pre-hospital admission review.

In addition, once an employee is admitted to a hospital, Medical Foundation Services Inc., a Miami-based medical review firm, analyzes whether the medical care received by patients is appropriate.

"We are the review agents. We are watching and suggesting, where appropriate, alternatives to continued hospitalization," explained Lois Osman, the Medical Foundation's director of operations.

The
flexible,
bendable,
stretchable,
find-the-
best-way
group.

We'll bend over backward to tailor specialized, individualized solutions in response to needs that arise in your group health care programs.

Mutual
of Omaha
Companies
Group Operation

The Managed-Cost Professionals.™

For more information on Mutual of Omaha's ability to customize a health care plan just for your situation, send your business card to John McCandless, Director of National Accounts, Mutual of Omaha, Group Operation, Mutual of Omaha Plaza, Omaha, NE 68175

Unions help plan cost-containment efforts

By MEG FLETCHER

Employee benefit managers should enlist the involvement of union leaders when planning health care cost containment strategies for union employees, labor and management leaders say.

Case studies show that a joint labor-management effort produces better cost management programs, which employees accept more readily than if union representatives had not been involved.

"It is our belief that through cooperation between labor and management, the cost of employee health care benefit programs can be better managed and the quality of these programs improved," according to a letter from AFL-CIO President Lane Kirkland and TRW

'Any dollar unnecessarily spent on health care could have gone to pensions, wages, vacation time or any other of the union's economic goals,' says Patrick Killeen, assistant director of the United Auto Workers' Social Security Department.

Inc.'s Chairman Ruben F. Mettler.

Messrs. Kirkland and Mettler co-chair the Labor-Management Group, a 15-year-old private organization made up of AFL-CIO union leaders and chief executive officers of corporate members of the Business Roundtable.

The letter accompanied "Policy Issues in Health Care," a 63-page report with case studies that was

prepared by the Labor-Management Group and released late last year. This report updates a 1978 review of health care costs conducted by the group.

"Business and labor have been deeply concerned with further rapid increases in health care costs," the report explains. "The Consumer Price Index rose 68% in the period 1978-86, while the med-

ical care component rose 98% in the same period."

Employer contributions for group health insurance premiums rose at an average annual rate of nearly 14% between 1975 and 1985, ranging in some years to as high as 40%, the report said. In 1986, employer contributions exceeded \$108 billion, according to the U.S. Department of Commerce.

Although this money is coming out of management's pockets, unions want it to be spent wisely.

"Any dollar unnecessarily spent on health care could have gone to pensions, wages, vacation time or any other of the union's economic goals," said Patrick Killeen, assistant director of the United Auto Workers' Social Security Department in Detroit.

In the early 1980s, labor was often in the forefront of proposing cost-containment measures as an alternative to employer-mandated cutbacks in benefit programs, said Meredith Miller, an AFL-CIO employee benefits specialist.

"With cost containment, both labor and management come at it differently," she said. "But they can come together on a mutual path."

That common path can lead to cost-containment policies that both sides typically support, including:

- Joint labor-management health care cost-containment committees within companies.

- Benefit plan modifications to incorporate cost containment.

- Educational programs that make employees more knowledgeable health care consumers.

- Workplace safety programs.

However, labor and management don't always agree on how to meet these common goals.

"Labor and management have generally had a difference of opinion on the issue of cost-sharing, which involves out-of-pocket payments, sharing premium cost of paying all or part of the cost of insurance for dependents," according to the Labor-Management Group's report.

"Management holds the view that cost-sharing induces employees to use health care services more efficiently, believing that the existence of financial incentives increases user awareness about the cost of health services.

On the other hand, "Unions generally do not believe that cost-sharing reduces health care costs, but simply shifts them from employers to employees," the report said. "Unions also believe that cost-sharing affects access to care by creating financial barriers to early diagnosis and treatment and, in the long run, higher costs. Labor believes further that cost-sharing penalizes health care users while holding providers harmless."

In addition to analyzing cost-containment policies, the report cites case studies that illustrate what some private and public employers accomplished by establishing joint labor-management committees to devise cost-control measures.

For example, General Motors Corp. considers the joint labor-management committee that it established after a 1982 bargaining agreement "extremely vital" in generating support for cost-containment measures among the 2.3 million workers and dependents covered by the automaker's health care benefit program, said Beach Hall, GM's assistant director for health care benefits.

The GM-UAW Committee on Health Care Benefits, which is funded by the company, is still "very" active, he added.

Key cost-containment measures introduced April 1, 1985, included a new PPO option and expansion of the automaker's HMO option, which both have seen a steady increase in plan participants, the report says.

And, for employees choosing an indemnity plan option, GM had stressed precertification and utilization review, second surgical opinions and case management.

In addition, GM isolated substance abuse treatment as a separate benefit through a separate insurer and added another staff member to monitor the progress of individuals during treatment.

The cost management program's goal was a 10% cost reduction in health care costs in constant dollars—which are dollars indexed to

Continued on page 22

To celebrate our 1st birthday, we're giving our clients \$30 million.

Our first year of providing Aetna Directors and Officers liability insurance was so successful, Aetna has raised its capacity from \$25 million to \$30 million per policy.

Aetna's D&O coverage is not only exceptionally stable, well written, reliable and reasonably priced, it now offers the highest limits of any admitted insurance company.

So, it's our clients who are doing most of the celebrating. To learn more, call or write: ERMA, 82 Hopmeadow Street, P.O. Box 2002, Simsbury, CT 06070 (203) 244-8900.



IN TODAY'S QUAGMIRE OF ENVIRONMENTAL RISKS, YOU NEED HELP TO KEEP FROM GETTING STUCK.

To help protect your business in the fast-changing maze of environmentally-sensitive risks, you need a virtual battery of experts on your side.

OUR POLICY IS TO GIVE YOU MORE

As a pioneer in Pollution Liability insurance, National Union is at the forefront in developing coverages to meet changing conditions.

To address the growing complexity of risks, we've recruited a special team of engineers, lawyers and other professionals who are also experts in environmental issues.

MORE EXPERTISE/BETTER SOLUTIONS

To find the solutions you need, we analyze your situation from top to bottom. Everything from the operational safety of your facility to waste disposal hazards, and from the way you handle raw materials to the transport and disposal of pollutants—both hazardous and non-hazardous.

HIGHER LIMITS/BROADER PROTECTION

Our new aggregate limits for Pollution Liability to \$15 million, plus auto and general liability coverage, provide broad

protection. We can even arrange excess liability insurance; something you'd expect from the leader.

Find out how National Union is working to help you meet and maintain today's complex environmental standards with minimum risk. Ask your agent or broker to contact your nearest National Union representative:

New York	212/770-7036
Philadelphia	215/981-7113
Chicago	312/930-5483
Dallas	214/220-6143
Los Angeles	213/480-3568

(Note: For automobile and general liability coverage, call our New York office at 212/770-6854.)

We're ready now to help you stay on solid ground.

National Union Fire Insurance Company of Pittsburgh, Pa.

Insurance Companies That Don't
Think Like Insurance Companies



Spotlight report

Unions

Continued from page 20
the CPI—over a three-year period.

GM is still evaluating the program's outcome in light of the fact that the cost of GM's health care benefits totaled \$2.3 billion in 1984, \$2.1 billion in 1985 and \$2.2 billion in 1986, Mr. Hall said.

"We turned the trend line downward and decreased the slope, but costs are up in 1987," he said. "However, I don't think they are up as sharply as if we had done nothing."

The UAW's Mr. Killeen said workers now accept cost-containment measures more readily because they know they grew out of collective bargaining and they have the union to turn to if problems develop.

Later this year, GM is adopting new mandatory deductible and co-payment provisions for salaried employees who choose its traditional indemnity plan. These measures will not apply to union employees whose benefits are determined through collective bargaining, Mr. Hall added.

However, the UAW's Mr. Killeen emphasizes, "We have plenty of cost sharing in the program already."

The Commonwealth of Pennsylvania also found that instituting cost-containment measures in conjunction with union representatives "was a good process," said Pamela Brand, chief of the state's group insurance section.

Working with representatives of the American Federation of State, County and Municipal Employees, Pennsylvania Council 13, the state adopted a precertification program at the start of 1985 for some AFSCME members.

That program saved the state an estimated \$4.8 million that year, including \$3.7 million in hospital inpatient costs and \$1.1 million in surgical costs, when compared with plans that did not require precertification, Ms. Brand said.

However, cost savings from precertification in subsequent years are harder to quantify because the plans used for comparison purposes in 1985 also have now adopted precertification measures, she explained.

A PPO option offered by the state in 1985 was discontinued in October 1987, although it saved \$250,000 in 1985 and \$700,000 in 1986, Ms. Brand said.

The PPO option was withdrawn because some enrolled employees had difficulty accessing PPO member providers, said Norma Goodling, special assistant to the AFSCME local's executive director. Contributing to the problem was the refusal of medical providers at two major facilities to participate in the program, she added.

When the joint committee was formed at the union's request, Pennsylvania guaranteed that the AFSCME workers would not lose any health care benefits in exchange for the union's acceptance of a cap on the state's contribution toward health care coverage of \$1,650 per employee for fiscal year 1984-85, the second year of the contract. And, if costs totaled less than \$1,650 per employee, the difference for all employees would be credited to an unfunded reserve to offset health care costs in future years, Ms. Brand said.

A subsequent collective bargaining agreement that runs through June 30, 1988, calls for continuation of the joint committee and for maintenance of the \$1,650 cap on state contributions to health care coverage through fiscal 1986-87.

With the help of the cost containment measures, the state's actual per-employee contributions totaled less than \$1,650 per employee for each of the program's first two years—\$1,407 for fiscal 1984-85, and \$1,543 for fiscal

'Labor and management have generally had a difference of opinion on the issue of cost-sharing, which involves out-of-pocket payments, sharing premium cost of paying all or part of the cost of insurance for dependents,' observes the report.

1985-86, Ms. Brand. The per-employee cost for fiscal 1986-87 is still being determined, but is estimated at \$1,675, she said.

AFSCME's Ms. Goodling said "a major, intangible" benefit of the joint-labor committee effort was educating employees to become intelligent consumers of health care.

But that education process takes time, as the Bargaining Unit Benefits Board for Oregon state employees learned. BUBB is a union-administered benefits bargaining board, with joint labor-management representation.

Rapid implementation of cost containment measures in 1982-83 was "very painful" for union employees in Oregon said Cheryl Willcoxon, the state's benefit administrator. As a result, state employees initially resisted cost-containment measures, including preadmission certification, second surgical opinions and concurrent review programs, she said.

Despite that initial resistance, those measures saved \$1.2 million after the first 15 months and savings continue today, she added.

BUBB has since switched from a

concurrent review to a case management program, which has saved "a tremendous amount" of money, especially in mental health, cancer and heart disease cases, Ms. Willcoxon said. State employees now view case management as an advantage because it ensures that they are receiving the most appropriate care, she added.

Besides helping implement health care cost-containment measures, joint labor-management committees can deal with broader health care policy issues, the the Labor-Management Group suggests. For example, the committees can:

- Negotiate joint insurance-purchasing arrangements among small employers to improve their ability to purchase health care coverage on a more cost-effective basis.

- Help form health care coalitions that bring labor and management representatives in contact

with health care providers and insurers through activities including data collection and interpretation, trustee education and capital expenditure review.

- Demand more labor and business representatives on the boards of local hospitals.

- Promote legislation that would repeal statutes inhibiting PPO development.

However unions also have proposed legislation establishing minimum standards for such plans, including solvency requirements, internal quality assurance programs and utilization controls, the report said.

The report added that most employers disagree with labor's support of state-mandated benefits, state-mandated reporting of provider specific data and state-regulated hospital payment systems that limit annual increases in reimbursement for in-hospital services. ■



In touch.

FAVORABLE PATIENT OUTCOME

It means being in touch with what's most important to every individual relying on the health care system.

Focusing on timely, appropriate, professional care, Crown Life's objective is to return individuals to the people who count on them the most — whether it is a family member, a friend or a fellow employee.

Crown Life's commitment to the optimal recovery of each patient goes far beyond benefits, aiming towards the most Favorable Patient Outcome. We assist patients in assessing their personal

health care options in order to obtain appropriate levels of care. The benefits are shared by all — individual, family, employer and coworkers.

Crown Life is providing personalized care while meeting the challenges of today's complex managed care system. For more information, call your nearest Crown Life Group Office or call our toll-free number today.

1-800-247-2184

Crown Life . . . Beyond Benefits . . .
Favorable Patient Outcome

Firms lack strategy for handling big claims

By MICHAEL BRADFORD

Most employers still lack a comprehensive plan for managing the high cost of catastrophic illness claims, experts agree.

While some employers try to hold down the cost of treating traumatic injuries and sickness by identifying catastrophic cases early and using case management services that provide appropriate but lower-priced care, many other employers are unenlightened about ways to keep those costs down.

Most employers are unprepared for catastrophic illness costs because they are rarely affected by those claims, suggested Laird Miller, president of Health Systems Management Inc., a Minneapolis-based health care consultant.

"Most employers haven't had an AIDS case, most employers haven't had a transplant or a burn case" or other types of high-cost claims, he remarked. "And so they don't even think about them until they happen."

When health care professionals refer to catastrophic illnesses, they include not only ailments like cancer, cardiovascular disease and acquired immune deficiency syndrome, but also head and back injuries, organ transplants, premature births, burn cases and other expensive medical conditions.

John Garner, president of Garner Consulting in Pasadena, Calif., said case management techniques can effectively reduce the cost of catastrophic illnesses. However, "most employers still need to do

'You start managing the high-risk mother the day' she knows she's pregnant, Mr. Miller explains.

more in that area," he observed.

"A lot of companies have put in case management, but a lot still don't have it yet," said Mr. Garner.

Small and self-insured companies should be especially careful about protecting themselves from costs created by catastrophic illnesses, according to Mr. Miller.

"In an effort to try and save money... if they go a little bit more

bare than they should have, then they're very vulnerable to those expenses," he said.

Mr. Garner said he has seen some smaller companies "where budgets were blown" because the employer did not have proper stop-loss insurance coverage or case management techniques in place to cope with a catastrophic illness claim.

Jackie Mazoway, product manager of medical case management for Intracorp, a Wayne, Pa.-based subsidiary of CIGNA Corp., said, "I think the problem is that employers are aware of the term 'case management' but, depending on who you talk to, it is defined differently."

In addition, most employers are not knowledgeable enough about what kind of program would best

suit their needs, she said.

Ms. Mazoway said an employer should quiz a prospective case management provider extensively to determine the scope of its services, the amount of its experience and how the program could help keep the cost of catastrophic claims low.

Those claims, she added, often zoom into six figures.

For example, claims can top \$100,000 for the delivery and care of a premature baby and the cost to treat a head injury may top \$200,000 before rehabilitation begins, Ms. Mazoway said.

Typical AIDS claims, she reported, total from \$40,000 to \$60,000, amounts lower than experts first projected, but still high.

Health care professionals "didn't know what they were dealing with in the beginning" when diagnosing AIDS, she said. But now that there are better systems in place to identify AIDS and less testing is needed, the claim amounts are not as high as originally expected, she explained (*BI*, Sept. 7, 1987).

Those costs may rise, however, because of the advent of the azidothymidine, or AZT, an expensive drug that is used to treat AIDS patients, Ms. Mazoway said.

It is estimated that AZT treatment costs \$8,000 to \$10,000 annually per patient.

"AIDS patients are going to live longer" with the help of AZT, Ms. Mazoway explained. As a result, the cost of caring for AIDS patients will increase, she added.

Ms. Mazoway and others agree that the ability to detect an illness early is an integral part of an effective case management program.

"Case management is a piece of managed care," Ms. Mazoway explained. Generally, employers have several cost-containment methods in place and "those that have utilization review will have a better program. They can identify illnesses earlier."

Identifying an illness in its first stages, an injury as soon as it occurs or a potential medical problem before it develops allows a case manager to develop the most cost-effective way to provide care, experts say.

For example, Mr. Miller pointed out that the best way to manage the costs involved with a premature birth is to provide care before the delivery.

"Much of that is preventable. You don't want to contain the cost of a high-risk baby; you want to prevent it," Mr. Miller said.

"You start managing the high-risk mother the day" she knows she's pregnant, he said, explaining that proper medical advice and monitoring is crucial if a pregnant woman smokes, drinks too much or takes drugs—"all of which tend to increase the probability" of having a premature baby, Mr. Miller pointed out.

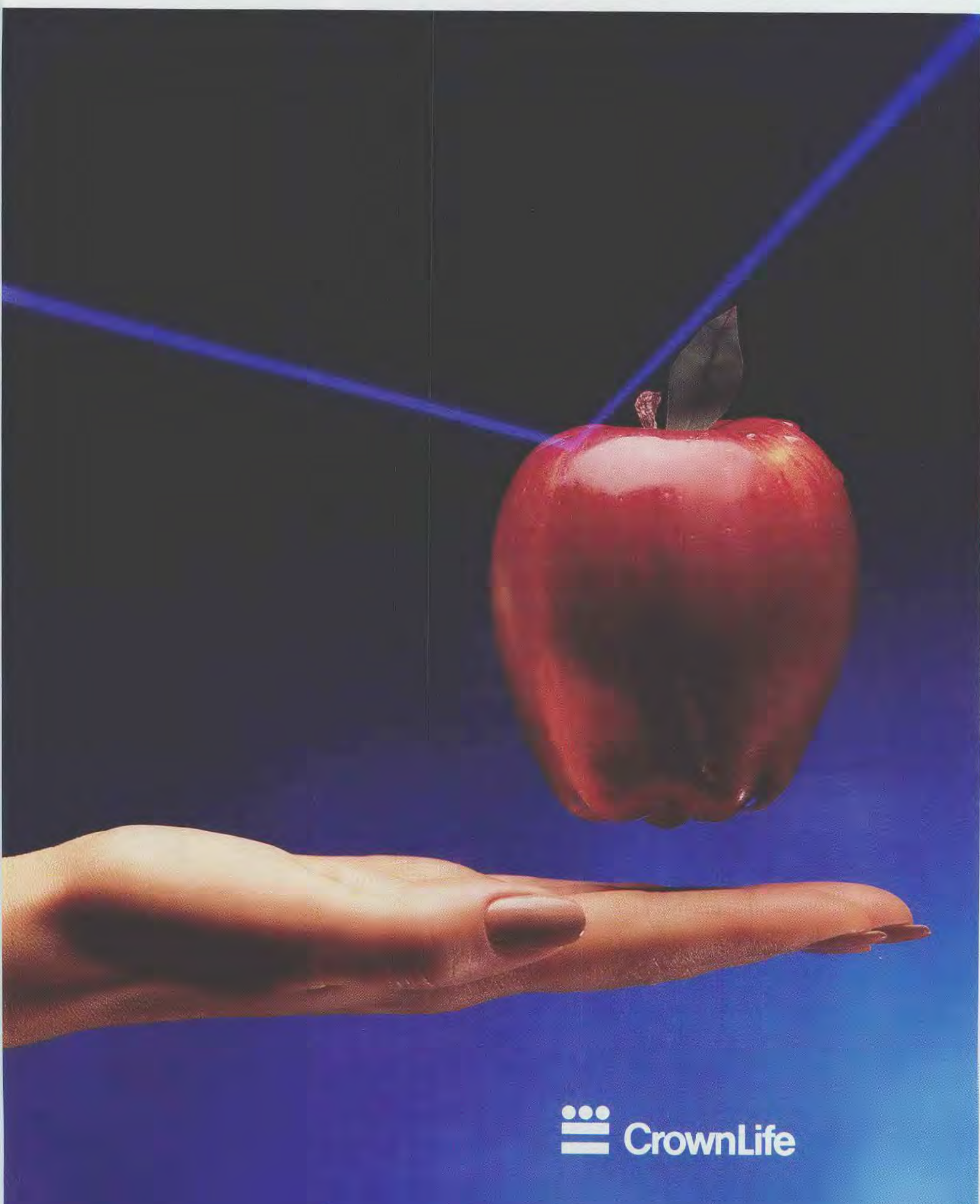
Mary Abramowski, manager of medical case management at Northwest National Life Insurance Co. in Minneapolis, said that once an illness is identified, it should be treated at home if possible.

"This is where you see the greatest dollar-savings: by providing care in the home," she remarked. And that holds especially true for AIDS cases.

She said Northwest National's case management program saved one of its policyholders more than \$133,000 for one of the first AIDS cases the program handled.

The patient, a 31-year-old named Luciano, was already in the hospital when Northwest took over management of his care, Ms. Abramowski explained. After determining that the patient wanted to

Continued on next page



 **CrownLife**

Working Without a Net?

Like the highwire performer, it's risky—with no room for error.

Catastrophic injuries occur infrequently, but when they do, your health plan can't afford to be working without a net—Cost Care's Catastrophic Case Manager Network. With hundreds of full-time Case Management experts, the Network effectively manages and contains the costs of catastrophic injuries anywhere in the country.

Cost Care's Network is there when you need it.

COST CARE™

Call:
Ray Foose, Director Marketing
1-800-762-3029 Nationwide



CATASTROPHIC CASE
MANAGEMENT

Catastrophic care

Continued from previous page
spend his last days at home, she found that the employer's health care plan would not allow that kind of treatment.

However, a contractual agreement between the doctor, employer and health care provider allowed Luciano to leave the hospital on the condition that Northwest coordinate a program that would provide him with the proper care.

"From a dollar-savings, comparing hospital expenses to home care, everybody wins," said Ms. Abramowski.

CURAFLEX Health Services Inc., a Houston company that specializes in providing home-based care, reports that providing care at home can cut the cost of some catastrophic health care services in half. For example, the company can arrange chemotherapy treatments for cancer patients in their

'Comparing hospital expenses to home care, everybody wins,' says Ms. Abramowski.

homes, cutting that cost to about \$5,000 from \$10,000 per month, a spokeswoman said.

Such savings "extend to virtually all areas of health care," said Greg Moore, senior vp of CURAFLEX. "For example, an abdominal hysterectomy, one of the most common operations in the United States, can be performed in a day-surgery center with post-surgical home care at a 43% cost savings" compared with the amount generally charged by hospitals.

Employers appear to be getting the message that there are techniques that can help them control catastrophic illness costs, according to a New York-based benefit consultant.

"More and more often, the work we do here is helping employers to implement cost-containment provisions that are directed at controlling those catastrophic costs," remarked Bonnie Gellas, vp of Marjorie Gross & Co.

Ms. Gellas, whose firm specializes in communicating employee benefits programs to workers, said employers are more frequently requesting help in explaining "pre-certification, medical case management, home health care and extended-care facility options; anything that's going to help an employer reduce costs."

Many employers also are asking workers to contribute part of the cost of health care coverage for the first time, said Ms. Gellas, in an effort to "make them aware that there is a price tag involved and that as the contributions go up it's directly related to the fact that the plan's expenses are going up because of catastrophic costs." ■



The cost of your group insurance premiums has taken a turn for the worse.

Finally, a cure for skyrocketing group insurance premiums: Centerre Trust's Self-Funding Trust.

While Self-Funding may seem like a new concept to some, it's a completely reliable, self-supporting program that Centerre Trust has been implementing for clients since 1974. With complete success. Not only does Centerre Trust have the personnel, the experience and the systems to help you put together a Self-Funding Trust program that will improve your bottom line—we have the investment approach that

keeps Self-Funding plans fully funded, through a unique process called Protective Portfolio Management. It provides you with the highest possible return available consistent with the objective of an assured minimum.

For a brochure with complete details on how Centerre Trust's Self-Funding Trust can turn health costs around for your company, call Dick Hibbs at (314) 436-9673.

From The Reprint Department Of:

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives

Reprints/Permission

If you want copies of articles appearing in BI to distribute at corporate or industry meetings, or for promotional mailings — or permission to produce your own reprints — contact the BI Reprint Dept. We've expanded to provide you with fast, low-cost service. (Minimum print order is 100 copies.) Call or write:

REPRINT DEPARTMENT
Business Insurance
220 East 42nd Street
New York, NY 10017
(212)210-0229.

Article Photocopies

If you missed an article in BI and would like a photocopy — send your request along with \$3⁰⁰ per copy / per article and a self-addressed envelope to the BI Reprint Dept. Please specify issue date and headline of article. Only pre-paid written requests will be fulfilled.

Issue Sales

For a copy(\$s) of any back issue of *Business Insurance*, contact Single Copy Sales. Call (313)446-1609.

CENTERRE TRUST COMPANY

Centerre Trust Company of St. Louis 510 Locust Street St. Louis, MO 63101

Market for utilization review services grows

By CHRISTINE WOOLSEY

A sophisticated and competitive utilization review marketplace is emerging as the concept of managed care becomes more widely accepted and as UR demonstrates its effectiveness.

The *Business Insurance* directory of utilization review service providers, which begins on the following page, includes information on 96 vendors—39% more than in 1987, when *BI*'s first directory of utilization review providers listed 69 vendors.

Employers and other health care payers initially were slow to embrace utilization review because it requires an additional step in the treatment process, explained Gordon Martin, vp of Healthwatch operations, the UR division of Orange, Calif.-based Admar Corp. But despite the inconvenience, "the payer's out-of-pocket expense is less than if we hadn't intervened at all," he noted.

Many employers are experiencing health care savings from utilization review, and some believe an educated and well-informed workforce will add to that savings.

"It will be a very short period of time before it will be an aberration for employers not to have UR," Mr. Martin predicted.

The information included in this year's directory of UR providers was gathered from questionnaires sent by *Business Insurance* to companies that requested them.

Vendors included in the directory market unbundled utilization review services directly to members of employer-sponsored group health plans on behalf of the employer. The directory does not include companies that offer utilization review services only in addition to the purchase of other services, like insurance.

The most common services offered by UR companies include:

- Preadmission certification.
- Concurrent review of hospital treatment.
- Length of stay determination.
- Discharge planning.
- Retrospective review.
- Second surgical opinion.
- Case management.

The most popular UR services, according to the directory listings, are group health and psychiatric and substance abuse services.

Dental services were reviewed by 26% of the companies listed, while 28% reviewed workers compensation services. In addition, of those companies with quantifiable answers, 14% reviewed chiropractic services, 3% reviewed vision services and 4% specifically said they reviewed health care services for acquired immune deficiency syndrome.

Companies listed in this year's directory also were asked to provide the percent of 1987 gross revenues generated from providing utilization review services directly to employers. According to the survey, about half of the firms listed generated 50% or more of their revenues from providing UR services directly to employers, while 49% generated the majority of revenues from providing services to insurance companies, preferred provider organizations, health maintenance organizations and third-party administrators.

As employers exert more control over their health benefits, UR service providers are increasingly being pushed to develop programs offering more than just the traditional preadmission review services, says Virginia Dollard, vp-health benefits management at Jurgovan & Blair, a Potomac, Md.-based UR provider.

"The off-the-shelf UR product is

going by the wayside and you see a more customized approach," she said. "We have to develop very targeted UR strategies that focus on the needs of the population."

For example, case management review services are steadily evolving, said Ellie Brokaw, director of medical services at Admar Corp., a managed health care provider based in Orange, Calif. In most case management programs, alternative treatments and settings are sought for patients with cata-

strophic or long-term illnesses.

"With case management, you're no longer just determining a medical necessity, but making sure the patient is getting the right care in the right setting," Ms. Brokaw explained.

Most vendors agree that case management programs can cut health care costs significantly, as well as make the patient's recovery more comfortable. But, as home health care becomes a popular option, costs such as transportation,

social services and family support eventually may have to be evaluated, Ms. Brokaw points out.

One service UR vendors are providing less frequently is hospital bill auditing, which several years ago was a major focus by employers aiming to reduce health care costs. The majority of UR companies listed in the *BI* survey do not provide this service or only occasionally audit hospital bills.

Some health care experts attribute this decline to increased accu-

racy in hospital billing because of computerization, while others say providers' awareness of this scrutiny has had an effect.

It's had a sort of "sentinel effect," Ms. Dollard claims. "Hospitals knew someone was watching, so they've become more accurate."

"Hospital bill auditing is a very fine tool when you have a questionable case," Mr. Martin added. However, the sophistication of utilization review eliminates the need

Continued on next page

The Rock® is behind you all the way.



You have too many decisions ahead of you to have less than Prudential Reinsurance behind you. The Rock rests on solid resources and years of experience.

We're out in front of most others with the sophistication of our underwriting, too. A sound statistical base helps us narrow down classes of business and define risk to give you rates that

reflect your particular situation.

Our personalized service doesn't stop half-way either. The same underwriter who first gets to know you and your business is the one who'll be there over the long haul.

Having The Rock behind you all the way is the only way.

The Rock in Reinsurance

Prudential Re 

© 1987 Prudential Reinsurance Company, a subsidiary of The Prudential Insurance Company of America.

Your best bet for setting up:

- CAPTIVES ■ FRONTING
- RRG'S and RPG'S ■ POOLS
- AGENCY PROGRAMS

Your best bet is experienced management



Corporate
Risk
Consultants

24370 Northwestern Hwy., Southfield MI 48075
1-800-482-2726 In Michigan: (313) 352-0880
Ask For Bob Engle or Dick Marshall

BI's directory of providers of utilization review services

A

Action Health Care Inc.

301 E. Bethany Home Road, Suite C278, Phoenix, Ariz. 85012; 602-265-0681

Year founded: 1987; began providing utilization review services in 1987.

Parent company: Cavco Industries.

Services provided: 100% of gross revenues from providing utilization review services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, management reports and electronic data transfer.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation services, wellness programs, chiropractic services.

Staff: Four total staff members; professional staff members include two registered nurses; 15 physicians

and 350 nurses on a retainer basis.

Clients: Five total and employer clients; 80% with fewer than 500 employees, 20% with 500-999 employees; 3,000 lives served.

1987 gross revenues: Not reported.

Charges: Per employee, 75 cents-\$2.50; per case, \$50-\$200; by the hour, \$50 and up.

Principal officers: Al Ghelfi, chief executive officer; Stella VanNess, president; David Stewart, executive vp; Ruth Smith, secretary/treasurer.

ALTA Health Strategies Inc.

2614 S. 1935 W., Salt Lake City, Utah 84119; 801-373-7300

Year founded: 1960; began providing utilization review services in 1986.

Services provided: 11% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; occasional hospital bill audit, outpatient psychiatric and substance abuse services, diagnostic medical, rehabilitation and hospice services; 89% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, vision services, prepaid prescription drug services, chiropractic services, podiatric services.

Staff: 750 total staff members; 63 professional staff members, including 45 registered nurses, 10 licensed practical nurses, eight medical records technicians; 28 physicians on a retainer basis.

Clients: 89 total clients; 18% with fewer than 500 employees, 30% with 500-999 employees, 32% with 1,000-2,499 employees, 11% with 2,500-4,999 employees, 9% with more than 5,000 employees; 260,000 lives serviced.

Branch offices: Atlanta; Boise, Idaho; Denver; Houston; Milwaukee; Minneapolis; Phoenix, Ariz.; Pittsburgh; St. Louis; San Francisco and Santa Ana, Calif.

1987 gross revenues: \$40 million total, \$4.3 million from utilization review services for employers.

Charges: Per employee, per case.

Principal officers: Terry Nofsinger, president; Dennis K. Burge, senior vp-administration; Carole L. Kennedy, senior vp-managed care programs; Keith K. Kinghorn, executive vp-east region; Peter S. O'Donnell, senior vp-managed care; Robert B. Shomer, executive vp-west region; Lane A. Summerhays, senior vp-finance; Carvel Whiting, senior vp.

Continued on next page

Utilization review market

Continued from previous page

for every other bill to be audited, he said. Now, "we tend to look at catastrophic cases," he added.

One area of growth for UR firms is that of dental care review, according to Ms. Dollard. However, "it is less of a priority than psychiatric service (review), which is also emerging as a need," she said.

Mr. Martin agreed, saying dental, vision and mental health review services are becoming more popular.

According to many UR service vendors, employers are becoming more interested in reviewing outpatient services, especially mental health and substance abuse services.

"A lot of employers are looking at outpatient services so they can retain an employee who may have a drug or alcohol problem," said Mr. Martin.

"We see the hospital as a catastrophic treatment center," Ms. Dollard explained, emphasizing the need for more outpatient mental health care services. However, she said, "the incentive given in benefit designs is hospitalization because (employees) will be covered."

"In some ways the treatment field has limited its ability to offer (outpatient) services by hanging its head on the 28-day program for everyone," Mr. Martin said. "We've worked toward home health care in lieu of hospitalization whenever possible," he added.

Although outpatient treatment can be more cost-effective, it also involves a high degree of subjectivity that could add to the difficulty UR firms have in evaluating these charges, the vendors say. ■

EXPERTISE

Our commitment:

Expertise and know-how are the tools of our trade. Treaty or facultative, we can provide the technical expertise you need. —we are people you can depend on.

RECO



Expertise • Stability • Service

THE REINSURANCE CORPORATION OF NEW YORK

80 MAIDEN LANE, NEW YORK, N.Y. 10038 • (212) 363 4440

Chicago • Los Angeles • London

...the Complete System You Can Count On!

ABACUS, fourth generation data processing system designed for Third Party Administrators, Insurance Carriers and Self-Insureds! Administration, Billing, Accounting, Claims and Utility functions to effectively administer your insurance administration program.

ABACUS, Provides:

- Comprehensive Multi-Policy billing system
- Commission Processing
- Multiple Carrier capability.
- Automatic Calculation of benefits & premiums.
- Claim Calculation.
- Complete Integrated Claims Pkg.
- Check Service
- Ad Hoc Reporting
- Stoploss Reporting
- COBRA Administration.
- PPO Administration.
- Claim Adjudication.

ABACUS, is a fully integrated management information system incorporating premium quality Hewlett-Packard equipment. When combined with our years of experience and ongoing support, ABACUS gives a total TPA system solution.

FOR MORE INFORMATION, CALL OR WRITE:

ABACUS

3100 McCORMICK • PENSACOLA, FL 32514

(904) 478-6477

A DIVISION OF SUNCOAST SYSTEMS, INC.

Continued from previous page

American Health Network Inc./Florida Health Network

3988 N. Central Expressway, Dallas, Texas 75204; 214-841-1000

Year founded: 1983; began providing utilization review services in 1983.

Parent company: American General Corp.

Services provided: Utilization services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management, patient counseling, home health care review; occasional retrospective review.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 34 total staff members; 33 professional staff members, including three physicians, 30 registered nurses; one physician on a retainer basis.

Clients: 1,546 total clients; 94% with fewer than 500 employees, 3% with 500-999 employees, 2% with 1,000-2,499 employees, less than 1% with 2,500-4,999 employees, less than 1% with more than 5,000 employees; 292,694 lives serviced.

Branch offices: Jacksonville, Fla.; Sacramento, Calif.

1987 gross revenues: Not reported.

Charges: Per employee.

Principal officers: Howard Korn, chief executive officer/president-American General Group Insurance Co.; Frank Greaney, president-American Health Network; Dr. Kenneth L. McDonough, medical director.

American PsychManagement Inc.

1560 Wilson Blvd., Suite 1000, Arlington, Va. 22209; 703-528-2255

Year founded: 1983; began providing utilization review services in 1983.

Services provided: 5% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, mental health workers compensation; 95% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 69 total staff members; 27 professional staff members, including two physicians, 10 registered nurses; 11 professionals on a retainer basis, including 10 physicians.

Clients: 30 total clients; 16 employer clients; 12.5% with 500-999 employees, 18.75% with 1,000-2,499 employees, 18.75% with 2,500-4,999 employees, 50% with more than 5,000 employees; 1 million lives serviced.

1987 gross revenues: \$11.6 million total, \$550,000 from utilization review services for employers.

Continued on next page

P&C Administrators Self-Insured Associations Managers, Risk Retention Groups

Give us a call about PACCASSO™ our multi-line, property/casualty claims administration & risk management reporting system.

PACCASSO combines accurate, flexible claims handling with comprehensive reporting of loss, experience, and development data.

It has numerous features for the TPA user or others with multiple clients or members. Let us tell you about PACCASSO's state of the art!



CONWAY COMPUTER CONSULTANTS, INC.

Box 12801 · Jackson, MS 39236
Telephone: (601) 932-5504

How to use directory of U.R. providers

The annual *Business Insurance* directory of utilization review service providers lists companies that provide utilization review directly to members of employer-sponsored group health plans on behalf of the employer.

Business Insurance defines utilization review as reviewing inpatient and/or outpatient hospital care and services through programs such as preadmission review, concurrent review, length of stay determination, discharge planning, retrospective review and second surgical opinions.

The listings begin with the company name and address, followed by the year the company was founded, the year it began offering utilization review services and the parent company, if applicable.

The percentage of 1987 gross revenues generated from providing utilization review services to employers is noted, followed by specific programs the company provides. Also listed is the percentage of 1987 revenues generated from other services, including utilization review for insurers, PPOs, HMOs and third-party claims administrators.

The types of health care services the company reviews and staff information follow. Staff members are provided in full-time equivalents, except for those on retainer.

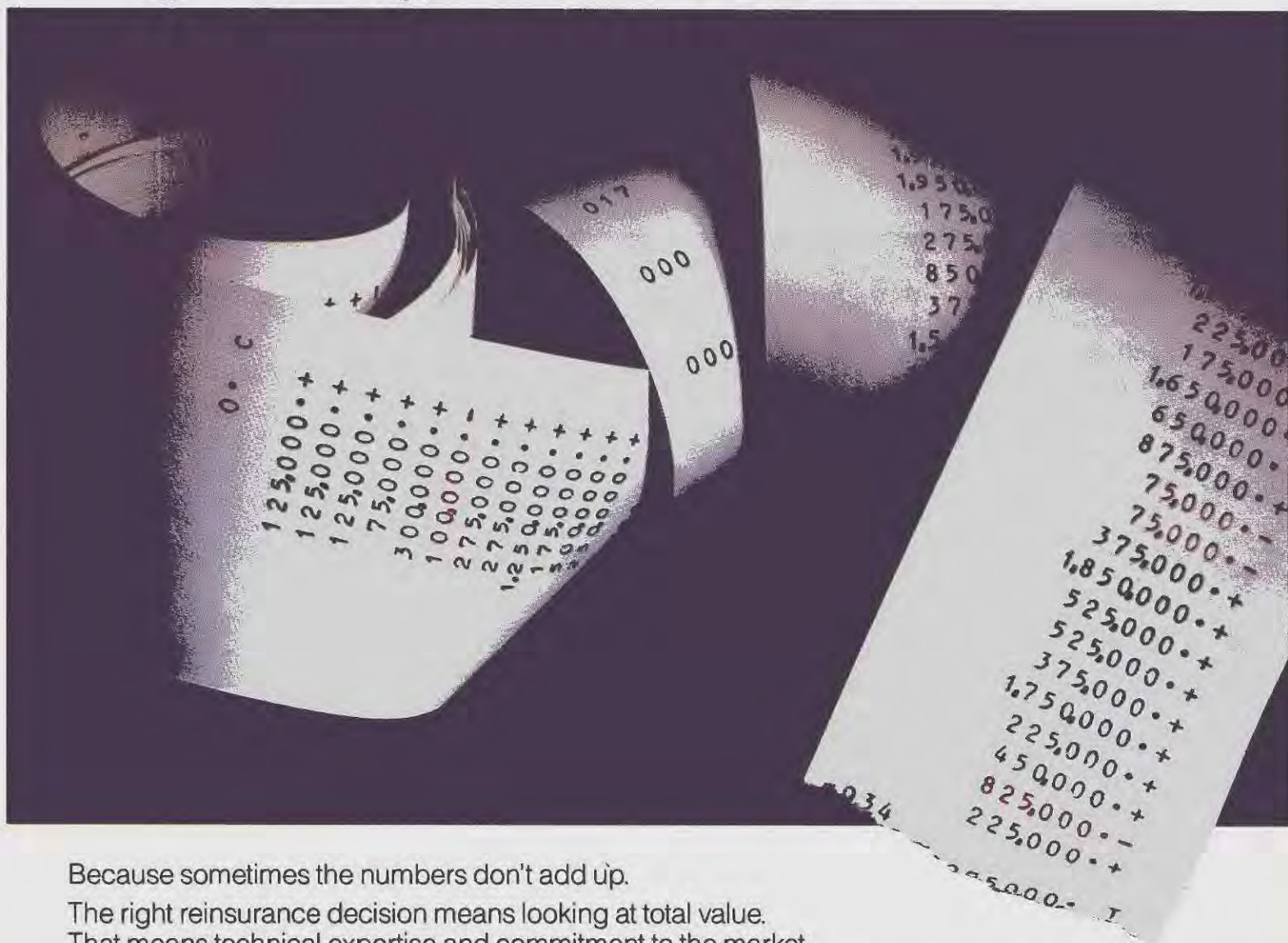
Number and size of clients and locations of branch offices are listed. Gross revenues are included when supplied by the company.

The company's billing methods and names and titles of principal officers complete the listings.

Companies were asked to complete and return a BI questionnaire to be included in the directory. Each firm's listing is based on its responses to that questionnaire. There are no public documents available to allow BI to verify the information provided.

The directory is published as an editorial service; there is no charge for companies to be included. If you would like to receive a questionnaire to be listed in the 1989 directory of utilization review service providers, please write to Christine Woolsey, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

If you only look at the numbers, you may miss the total.



Because sometimes the numbers don't add up. The right reinsurance decision means looking at total value. That means technical expertise and commitment to the market. It means industry knowledge and the willingness to share it. At Lincoln National, our success depends on being a reinsurance resource you can count on — for capacity and much, much more. Almost 80 years of experience make us a powerful resource. And when you're a client, our strengths are yours to draw upon. The lowest price doesn't always reflect the highest value. That's as true in reinsurance as it is everywhere else. So when you're considering reinsurance, look at the numbers. Then look carefully at the total.



The Reinsurance Resource.
1300 S. Clinton Street
P.O. Box 1110
Fort Wayne, IN 46801

Spotlight report

Continued from previous page

Charges: Per employee, \$3-\$6.95; per case, \$200-\$300.

Principal officers: Dr. Kenneth A. Kessler, president; Dr. Daniel Patterson, vp-medical affairs; J.T. Morris, vp-finance.

Associated Agencies Inc./RMSCO Management Services

651 W. Washington Blvd., Chicago, Ill. 60606-2193; 312-707-9000

Year founded: 1889; began providing utilization review services in 1982.

Services provided: Utilization review services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, second surgical opinion, hospital bill audit; occasional discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Three total staff members who are professionals, including one physician, two licensed practical nurses; one physician on a retainer basis.

Clients: 26 total clients; 56% with fewer than 500 employees, 31% with 500-999 employees, 13% with 1,000-2,499 employees.

1987 gross revenues: Not reported.

Charges: Per employee.
Principal officers: Patricia Vile, vp-RMSCO Management Services.

Associated Medical Review Services Inc.

2821 Richland Ave., Metairie, La. 70002; 504-885-9365

Year founded: 1985; began providing utilization review services in 1985.

Services provided: 75% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review,

precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 25% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation services.

Staff: Six total staff members; three professional staff members, including one registered nurse, two medical records technicians; 12 physicians and four nurses on a retainer basis.

Clients: 77 total clients, two employer clients; 50% with 500-999 employees, 50% with 1,000-2,499 employees; 28,875 lives serviced.

1987 gross revenues: Not reported.

Principal officers: Katherine M. Belchic, president; Pamela Chauff, vp; Vincent J. Varisco, secretary; A.J. Blanchat, treasurer.

Associates for Health Care Inc.

150 N. Sunnyslope Road, Brookfield, Wis. 53005; 414-784-9007

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 50% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management; 50% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, home health care services, durable medical equipment, vision services.

Staff: 15 total staff members; six professional staff members, includ-

ing four registered nurses, two licensed practical nurses; eight physicians on a retainer basis.

Clients: 700 total clients; 96% with fewer than 500 employees, 1% with 500-999 employees, 1% with 1,000-2,499 employees, 1% with 2,500-4,999, 1% with more than 5,000 employees; 60,000 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee per month, \$1.60-\$2.

Principal officers: Richard L. Blomquist, president; Dianne M. Kiehl, vp-administration; George W. Coffman, vp-marketing.

Association for Organizational & Human Development

1701 Lake Ave., Suite 250, Glenview, Ill. 60025

Year founded: 1986; began providing utilization review services in 1986.

Parent company: AOHD Management Co. Inc.

Services provided: Utilization services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, provider analysis; occasional discharge planning, hospital bill audit.

Services reviewed: Psychiatric and substance abuse services.

Staff: Six total staff members, including one physician, one psychologist; 50 professionals on a retainer basis, including 40 physicians, three nurses, five psychologists, two social workers.

Clients: Not reported.

Branch offices: Chicago.

1987 gross revenues: Not reported.

Principal officers: Dr. Ronald L. Kirschner, president; Joel Schiller, vp-marketing.

Axiom Review

33 Bleeker St., Millburn, N.J. 07042; 201-379-6300

Year founded: 1975; began providing utilization review services in 1975.

Parent company: The Axiom Group.

Services provided: 8% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination; occasional hospital bill audit, outpatient psychiatric and substance abuse services, case management; 92% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services.

Staff: 140 total staff members; professional staff members include eight physicians, 80 registered nurses, five licensed practical nurses, 20 medical records technicians; 300 physicians and 25 nurses on a retainer basis.

Clients: 21 total clients, 10 employer clients; 60% with fewer than 500 employees, 30% with 500-999 employees, 10% with 1,000-2,499 employees.

Branch offices: Wayne, N.J.; Denver; Washington; Chicago.

1987 gross revenues: \$4.8 million total, \$384,000 from utilization review services for employers.

Charges: Per employee, per case.

Principal officers: Dr. Edgar Santoro, chairman; Dennis J. Duffy, president; Dr. T. Connolly, treasurer; M. Nemets, R. Jones and E.P. Weiland, vps.

How to control

COBRA

risk with Celtic

Today's self-insured employer falls into two categories: those already bitten by COBRA claims, or those waiting to get bit. If you want control over your COBRA claims risk, Celtic has some solutions.

COBRA's administration headaches are nothing compared to the costly nightmare self-insured employers face—high claims from adverse risk selection.

Managing this risk seems almost impossible: there's no past experience and little means of reducing your exposure.

But Celtic Life Insurance Company, the leader in post-termination health coverages, has some solutions. Celtic has a family of products that allows you to:

- Totally eliminate your COBRA obligation for some beneficiaries.
- Reduce your claims risk for all beneficiaries.
- Satisfy the spirit as well as the letter of the law.

The intent of COBRA is to provide persons terminating from an employer's plans with access to group health coverage and rates. That's just what these coverages from Celtic do—while helping you control your COBRA risk exposure:

Transition CoverageSM offers terminating beneficiaries an alternative to COBRA coverage or no medical insurance at all. It's inexpensive major medical protection on a temporary basis for up to six months. And, it requires beneficiaries to opt out of COBRA.

Continuation Coverage* extends your health care program as required by COBRA. However, the major part of your claims risk is reinsured by Celtic (all claims in excess of \$2500 per beneficiary annually up to your individual stop loss). It's administered by your own TPA.

Conversion Coverage allows individuals terminating from Continuation Coverage to convert to another major medical plan.

Each of these coverages is a stand alone product available separately or combined. And Celtic doesn't require you to purchase any other insurance, so you only buy what you want.

For more information about how Celtic can put you in control of your COBRA risk, please send your business card to Jim Daly.

Underwritten by



Celtic Life Insurance Co.
208 South LaSalle Street
Chicago, IL 60604 (312) 332-5401
Celtic is A rated by A.M. Best Company

*Not available in all states. Offered only through qualified TPAs. For more information, contact Celtic.



Beech Street Inc.

2 Ada, Irvine, Calif. 92718; 714-727-9300

Year founded: 1951; began providing utilization review services in

Continued on next page

Continued from previous page 1981.

Services provided: 10% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, inpatient psychiatric and substance abuse services, outpatient mental health services; occasional retrospective review; 90% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation, long term care services for senior citizens.

Staff: 40 total staff members; 27 professional staff members, including one physician, 21 registered nurses, four licensed practical nurses, one medical records technician; 19 physicians on a retainer basis.

Clients: 491 total and employer clients; 20% with fewer than 500 employees, 10% with 500-999 employees, 30% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 10% with more than 5,000 employees. 635,400 lives serviced.

Branch offices: Phoenix, Ariz., Houston.

1987 gross revenues: \$2.8 million from utilization review services for employers.

Charges: Per employee, per case.

Principal officers: Edwin M. Crawford, president/chief executive officer; Ronald D. Osborne, executive vp/chief operating officer.

Behavioral Health Group

6075 Poplar Ave., Suite 720,
Memphis, Tenn. 38119;
901-761-5200

Year founded: 1987; began providing utilization review services in 1988.

Parent company: Health Industries of America Inc.

Services provided: Utilization review services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, behavioral health program assistance, grievance administration, provider consultation; occasional hospital bill audit.

Services reviewed: Psychiatric and substance abuse services.

Staff: Seven total staff members; six professional staff members, including one physician.

Charges: Per employee, 20 cents and up; per case, \$350 and up.

Principal officers: James L. Rout, president; Phillip E. Prosser and Kenneth D. Robinson, senior vps.

Bethesda Provider Organization

5200 DTC Parkway, Suite 510,
Englewood, Colo. 80111;
303-771-4258

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 30% of gross revenues from providing utilization services to employers, including preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 70% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: Six total staff members; professional staff members include one physician, two registered nurses.

Clients: 15 total clients.

1987 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Dr. Samuel Schiff, medical director; Lois Huffman, operations director.

Blue Cross & Blue Shield of Virginia

2015 Staples Mill Road, P.O. Box
27401, Richmond, Va. 23279;
804-287-2105

Year founded: 1936; began providing utilization review services in 1980.

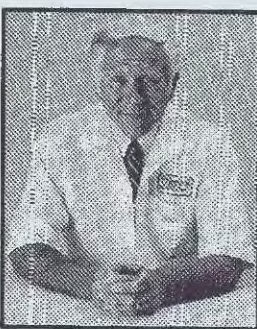
Services provided: 1% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, medical claims review, quality assurance, fraud and abuse investigations; occasional second surgical opinion, hospital bill audit; 99% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 104 total staff members; 69

Continued on next page

Self-funded health care managers/packagers-



Revco
DISCOUNT DRUG

Deal direct with Revco Discount Drug Centers and save employee benefit dollars.

Let Revco be your program's pharmacy provider and/or claims processor utilizing our 2,000 in-store pharmacies and/or our mail service pharmacy.

- REVCO'S THIRD PARTY PLANS:**
- promote low cost generic drugs
 - are wholesale price based
 - have low fees
 - are flexible

Find out how Revco can help you meet your cost containment goals.



Revco D.S., Inc.
Group Marketing Dept.
1925 Enterprise Parkway
Twinsburg, Ohio 44087
(216) 425-9811 ext. 2662

HAS LACK OF AVAILABILITY LOCKED YOU IN?



LET HAYDEN OPEN THE DOOR TO EXCESS AND CONTINGENT INSURANCE.

At last, there is a company devoted exclusively to the excess liability and contingency market for the Sports/Leisure/Entertainment Industry. Its name - Hayden Management Group, Inc., a newly formed affiliate of the K & K Insurance Group.

authority, non-appearance, event cancellation, prize indemnity, and rain insurance coverages - - Hayden Management Group, Inc.

Hayden can fill your client's needs. Give us a call at 219-427-5700.
1712 Magnavox Way
P.O. Box 2338
Fort Wayne, IN 46801

Now there is a facility available to brokers throughout North America for hard-to-place excess liability with a \$10,000,000 limit of



Spotlight report*Continued from previous page*

professional staff members, including three physicians, 62 registered nurses, three licensed practical nurses, one medical records technician; 35 physicians on a retainer basis.

Clients: More than 1,000 total and employer clients; 95% with fewer than 999 employees, 4% with 1,000-4,999 employees, 1% with more than 5,000 employees; 850,000 lives serviced.

1987 gross revenues: \$1.3 billion total, \$750,000 from utilization review services for employers.

Charges: Per employee, per case.

Principal officers: Dr. Richardson Grinnan, vp-medical affairs; Tim O'Shea, director-cost containment; J. Gavin Dickie, manager-managed care.

Blue Shield of California/ Utilization Review Division

2 North Point Plaza, San Francisco, Calif. 94133; 415-445-5000

Year founded: 1939; began providing utilization review services in 1966.

Services provided: Utilization review services include 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, outpatient psychiatric and substance abuse services, case management.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 38 total staff members who are professionals, including four physicians, 34 registered nurses; 80 professionals available for consulting, including 75 physicians on a retainer basis.

Clients: 3,976 total clients, 3,831 employer clients. 1.3 million lives serviced.

1987 gross revenues: Not reported.

Principal officers: Thomas C. Paton, chairman/chief executive officer; Charles W. Stewart, president/ chief operating officer; Charles L. Parcell, senior vp.

C

CAPP CARE Inc.

17390 Brookhurst, Suite 280, Fountain Valley, Calif. 92708; 714-963-8065

Year founded: 1982; began providing utilization review services in 1983.

Services provided: 2% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination; occasional outpatient psychiatric and substance abuse services; 98% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 120 total staff members; 52 professional staff members, including three physicians, 23 registered nurses, 26 medical records technicians.

Clients: 18,000 total clients, 12 employer clients. 750,000 lives serviced.

Branch offices: Tucson, Ariz.; Houston; Indian Beach Harbor, Fla.; Cleveland.

1987 gross revenues: Not reported.

Charges: Per employee per month, \$1.60 excluding mandatory second opinion.

Principal officers: Dr. Edward Zalta, chairman/chief executive officer; Michael E. Henry, president/ chief operating officer; Robert Broaddus, senior vp-operations.

CareAmerica Inc.

301 E. Main St., Suite 114, Barrington, Ill. 60010; 312-382-7470

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 35% of gross revenues from providing utilization services to employers, including preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 15% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 10 total staff members.

Clients: 1% with fewer than 500 employees, 2% with 500-999 employees, 5% with 1,000-2,499 employees, 27% with 2,500-4,999 employees, 65%

with more than 5,000 employees.

1987 gross revenues: Not reported

Charges: Per employee, per case, flat annual fee.

Principal officers: F. Jerome Coquillard, president.

Compass Health Management Inc.

24 Drayton St., Suite 320, Savannah, Ga. 31401; 912-236-7213

Year founded: 1980; began providing utilization review services in 1982.

Services provided: 45% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, surgical fee review; occasional retrospective re-

view, hospital bill audit; 55% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation services.

Staff: 43 total staff members; 30 professional staff members, including one physician, 11 registered nurses, three licensed practical nurses, one medical records technician; 24 physicians and one nurse on a retainer basis.

Clients: More than 1,500 total clients, more than 500 employer clients; 30% with fewer than 500 employees, 20% with 500-999 employees, 30% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 5% with more than 5,000 employees; 250,000 lives serviced.

Branch offices: Atlanta.

1987 gross revenues: Not reported.

Charges: Per employee, 95 cents-\$2; by the hour, \$48-\$55.

Principal officers: Jeff V. Aycock, president; M. Elizabeth Hand, vp-marketing; Carol D. Grene, vp-review services.

ConServCo

3903 Northdale Blvd., Tampa, Fla. 33624; 813-969-0701

Year founded: 1981; began providing utilization review services in 1985.

Services provided: Utilization review services include frequent 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; occasional outpatient psychiatric and substance abuse services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation, chiropractic services.

Staff: 700 total staff members; 600 professional staff members, including more than 200 physicians, more than 225 registered nurses; one physician on a retainer basis.

Continued on next page



JUDGEMEN

Continued from previous page

Clients: 10% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 70% with more than 5,000 employees.

Branch offices: Wayne, Pa.
1987 gross revenues: Not reported.

Charges: Per employee, \$1.25; per case.

Principal officers: Dennis Huffman, president.

Corporate Health Strategies

276 Post Road W., Westport, Conn. 06880; 203-454-6155

Year founded: 1981; began providing utilization review services in 1983.

Parent company: Metropolitan Life Insurance Co.

Services provided: 53% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient service predeter-

mination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review; 47% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 300 total staff members; 172 professional staff members, including 12 physicians, 160 registered nurses; two physicians on a retainer basis.

Clients: 675 total and employer clients; 60% with fewer than 500 employees, 16% with 500-999 employees, 11% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 8% with more than 5,000 employees; 4.6 million lives serviced.

Branch offices: Marietta, Ga.; Dayton, Ohio; Houston; Lisle, Ill.; Orange, Calif.; Tulsa, Okla.

1987 gross revenues: Not reported.

Charges: Per employee per month, per case, by the hour.

Principal officers: Robert A. Chernow, president/chief executive officer; Leon I. Hyman, president/

chief operating officer; Clement Golia and William Rosenberg, vps; Dr. Carl Mankowitz, vp/medical director.

Corporate Healthcare Management

% Medical Case Management, 661 Anderson Drive, Building 7, Pittsburgh, Pa. 15220; 412-928-9400

Year founded: 1983; began providing utilization review services in 1983.

Parent company: EQUICOR-Equitable HCA Corp.

Services provided: 85% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; 15% of gross revenues from other services.

Services reviewed: Group health

services, dental services, psychiatric and substance abuse services.

Staff: 200 total staff members; 95 professional staff members, including five physicians, 80 registered nurses, 10 medical records technicians; 15 physicians on a retainer basis.

Clients: 5,000 total and employer clients; 50% with fewer than 500 employees, 28% with 500-999 employees, 15% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 2% with more than 5,000 employees; 5 million lives serviced.

Branch offices: Brea, Calif.; New York; Nashville, Tenn.

1987 gross revenues: Not reported.

Charges: Per employee, 30 cents-\$2; per case, 50 cents-\$1.50.

Principal officers: Richard E. Freiburger, chief marketing officer.

Cost Care Inc.

17811 Beach Blvd., Huntington Beach, Calif. 92647; 714-842-4909

Year founded: 1981; began providing utilization review services in

1981.

Services provided: Utilization review services include frequent 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, outpatient psychiatric and substance abuse services, case management, high-risk pregnancy identification and case management, patient information and referral service, long-term disability review, exclusive provider networks.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 220 total staff members.

Clients: More than 4,800 total clients; 2.3 million lives serviced.

Branch offices: Pasadena, Calif.; Seattle; Houston; Dallas; Memphis, Tenn.; Tampa, Fla.; Chicago; Cleveland; New York.

1987 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee.

Principal officers: Lawrence Goelman, president; Andrew Campbell, executive vp.

Cost Management Technologies

4435 Main St., Suite 810, Kansas City, Mo. 64111; 816-531-6300

Year founded: 1986; began providing utilization review services in 1986.

Ownership: Joint venture of Competitive Medical Management Inc. and Lincoln National Life Insurance Co.

Services provided: 27% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services; occasional retrospective review, outpatient service predetermination, case management; 73% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Six total staff members, three professional staff members who are registered nurses.

Clients: 189 total clients, 184 employer clients; 94% with fewer than 500 employees, 4% with 500-999 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees; 70,000 lives serviced.

Branch offices: Reseda, Calif.; Peoria, Ill.; Raleigh, N.C.; St. Louis.

1987 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: John N. Hatfield, president.

Crawford & Co.

P.O. Box 5047, Atlanta, Ga. 30302; 404-256-0830

Year founded: 1941; began providing utilization review services in 1984.

Services provided: 5% of gross revenues from providing utilization services to employers, including 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, outpatient psychiatric and substance abuse services, case management, provider audit services; 95% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation.

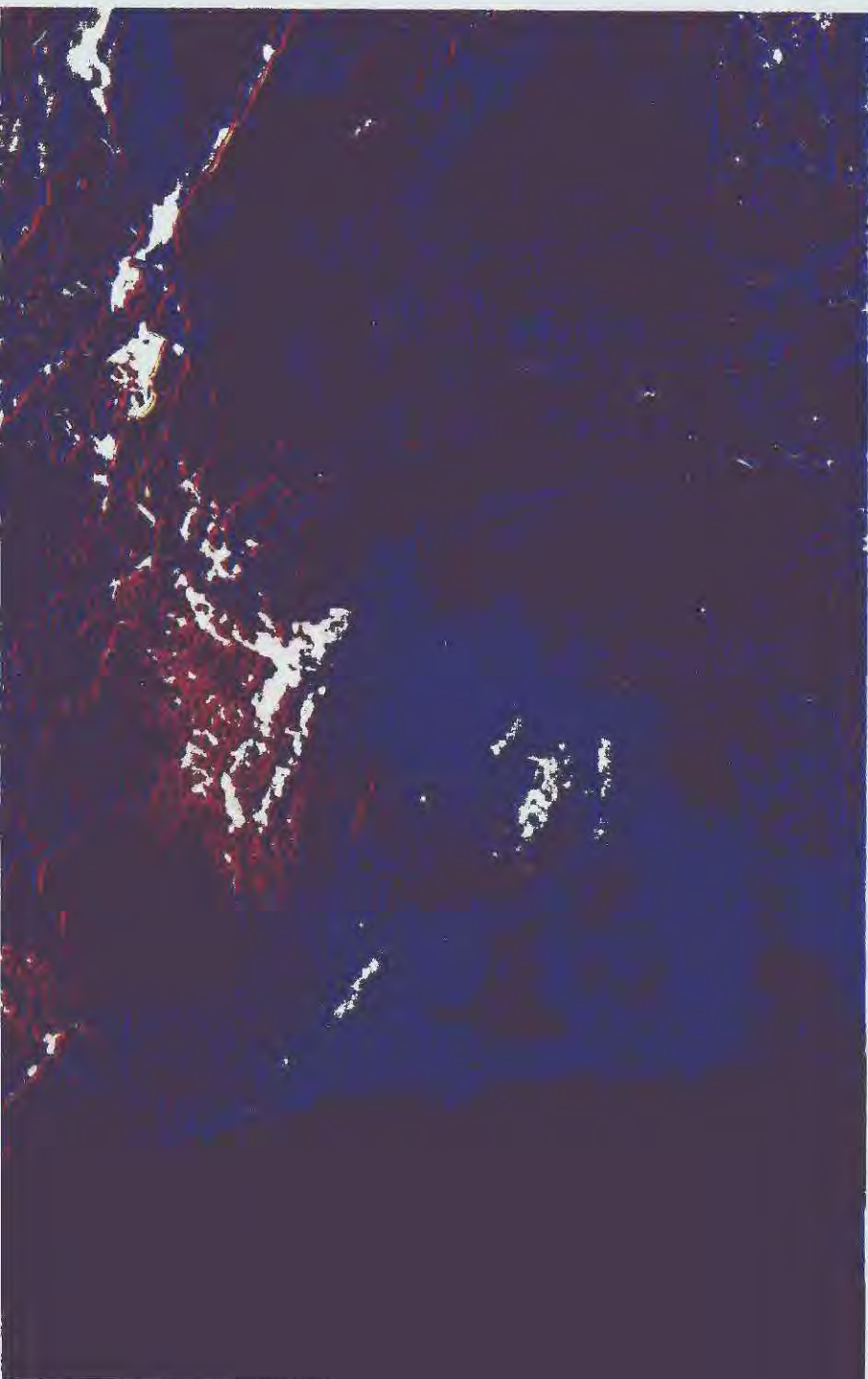
Staff: More than 750 total staff members; 607 professional staff members, including five physicians, 580 registered nurses, 12 licensed practical nurses, 10 medical records technicians; four physicians and 10 nurses on a retainer basis.

Clients: Not reported.

Branch offices: 167 offices in the United States, one office in Canada.

1987 gross revenues: Approximately \$50 million total, approximately \$2.5 million from utilization

Continued on next page



EMPLOYERS REINSURANCE

Even the most careful judgment doesn't eliminate risk.

But when your plan calls for hitting the water, head first, a hundred feet below, judgment can help make sure water is what you hit.

So you carefully judge everything. From the wind resistance to your mental resistance.

And when you're ready, you go.

That's what we've done at ERC for over 70 years. And that's why we're in such a strong financial position today. And why our Best's rating continues to be an A+.

Now we've decided to take on even more of those same, carefully calculated risks. Are we ready for it?

Just take a look at our capacity. Then, judge for yourself.

IT VS RISK.

Spotlight report

Continued from previous page
review services for employers.

Charges: Per employee, per case.
Principal officers: F. L. Minix, chairman/chief executive officer; P.A. Bollinger, executive vp-services; D.R. Chapman, executive vp-finance; C.C. Lefler, executive vp-marketing; G.B. Lynch III, vp-health/rehabilitation.

D

DataMed Inc.

3000 Dundee Road, P.O. Box 339,
Northbrook, Ill. 60062-0339;
312-291-1296.

Year founded: 1985; began providing utilization review services in 1986.

Services provided: 90% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review,

precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, employee education programs; occasional case management; 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 27 total staff members; 15 professional staff members, including nine physicians, four registered nurses, two medical records technicians; four physicians and two nurses on a retainer basis.

Clients: 34 total and employer clients; 80% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees; 16,950 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, 50 cents-\$2.30.

Principal officers: Louis R. Mor-

gan, vp.

E

Efficient Health Systems Inc.

5215 Old Orchard Road, Suite 360,
Skokie, Ill. 60077; 312-967-7800

Year founded: 1984; began providing utilization review services in 1985.

Services provided: 90% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, home health care, employee assistance programs; occasional retrospective review. 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 75 total staff members.

Clients: 900 total clients; 800,000 lives serviced.

Branch offices: New York.

Charges: Per employee, by the hour.

Principal officers: Harve A. Ferrill, chairman; James E. Adams, president.

Equifax Services Inc.

P.O. Box 4081, D-10, Atlanta, Ga.
30302; 404-885-8000

Year founded: 1899; began providing utilization review services in 1971.

Parent company: Equifax Inc.
Services provided: Utilization services include frequent hospital bill audit; occasional retrospective review; unrelated charge review.

Services reviewed: Group health services.

1987 gross revenues: Not reported.

Charges: Per case by the hour.

F

FOCUS Healthcare Management

7101 Executive Center Drive, Suite 160,
Brentwood, Tenn. 37027;
615-377-9936

Year founded: 1986; began providing utilization review services in 1987.

Services provided: 91% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, outpatient surgery certification and review; occasional retrospective review, hospital bill audit; 9% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 21 total staff members; eight professional staff members, including two physicians, six registered nurses, 25 physicians on a retainer basis.

Clients: 84 total and employer clients; 89% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees, 1% with more than 5,000 employees.

1987 gross revenues: Not reported.

Charges: Per employee per month, \$1.50; per hour, \$45.

Principal officers: Stryker Warren Jr., president; David Iskowe, executive vp; Nadine Wilkerson, vp-operations; Thomas J. Murray, vp-marketing.

G

Great-West Life Assurance Co.

8505 E. Orchard Road, Englewood,
Colo. 80111; 303-889-3031

Year founded: 1892; began providing utilization review services in 1985.

Parent company: Power Corp.
Services provided: Utilization review services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management, catastrophic case management; occasional retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 188 total staff members; 120 professional staff members, including two physicians, 74 registered nurses; 15 physicians on a retainer basis.

Clients: 200,000 total clients, 1,300 employer clients; 95% with fewer than 500 employees, 3% with 500-999 employees, 2% with 1,000-2,499 employees; 400,000 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee.
Principal officers: Alan MacLennan, senior vp-group insurance; James D. Motz, vp-group insurance; David Grapko, manager-health care management.

H

John Hancock Financial Services

P.O. Box 111, Boston, Mass. 02117;
617-421-6000

Year founded: 1862; began providing utilization review services in 1984.

Services provided: Utilization review services include preadmission hospital review, precertification,

Continued on next page

LET US MANAGE YOUR CLAIMS!



HRM Managed CarePLUSSM brings a new dimension to employee health benefits and claims management. **Medical expertise.**

Our teams of medical specialists manage your health care costs—and assess the quality of care—BEFORE, DURING and AFTER each patient's treatment. Then we process the claim—promptly and accurately.

This fully integrated system of utilization review and claims processing also gives you instant access to valuable data so you can see the results immediately.

We don't just CLAIM to save you money. We MANAGE YOUR CLAIMS to make sure you do. Call toll-free today to find out how.

1 (800) 824-3882

HRM[®]
TOGETHER WE CAN MAKE
A HEALTHY DIFFERENCE.

© Copyright Health Risk Management, Inc., Minneapolis, Minnesota. Services include utilization review, provider contracting/purchasing, large case management, mental health management, claims processing, employee communications and data analysis.

Continued from previous page
concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management, patient advocate and employee information programs, HMO evaluation and negotiation services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 126 total staff members; 49 professional staff members, including one physician, 48 registered nurses; four physicians and one social worker on a retainer basis.

Clients: 191 total clients; 40% with fewer than 500 employees, 22% with 500-999 employees, 17% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 16% with more than 5,000 employees; 506,000 lives serviced.

Branch offices: Detroit, Chicago, Dallas, San Francisco, Atlanta.

1987 gross revenues: \$7 million from utilization review services for employers.

Charges: Per employee per month, \$1.25-\$2.50; by the hour, \$80-\$115.

Principal officers: David D'Alessandro, senior vp-group benefit services; William Caulfield, senior vp-corporate benefit services; Robert Marra, vp-group marketing.

Health Benefits Group Inc.

941 Chatham Lane, Suite 103,
Columbus, Ohio 43221;
614-451-2105

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 90% of gross revenues from providing utilization services to employers, including preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, physician bill audit, consulting and training for employers with in-house utilization review programs; 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Six total staff members; four professional staff members, including three registered nurses; seven professionals on a retainer basis, including four physicians.

Clients: 104 total clients; 94% with fewer than 500 employees, 3% with 500-999 employees, 2% with 1,000-2,499 employees, 1% with 2,500-4,999 employees; 51,000 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, 65 cents-\$1.30; per case; flat annual fee; percent of savings.

Principal officers: John Swenderman, president; Dean Conley, executive vp.

Health Care Evaluation Inc.

1212 W. Robinhood Drive, Suite
3-D, Stockton, Calif. 95207;
209-951-6711

Year founded: 1968; began providing utilization review services in 1968.

Services provided: 64% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; occasional retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, ambulatory review, claims review, employee assistance program review; 36% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 52 total staff members; 30 professional staff members, including 22 registered nurses, two licensed practical nurses, six medical records technicians; 50 physicians on a retainer basis.

Clients: 107 total clients, 106 employer clients; 3% with fewer than 500 employees, 4% with 500-999 employees, 30% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 33% with more than 5,000

employees; 1.8 million lives serviced.

Branch offices: Bakersfield, Sacramento, Fresno and Martinez, Calif.

1987 gross revenues: \$2.2 million total, \$1.5 million from utilization review services for employers.

Charges: Per employee, 70 cents-\$1.05; per case, \$40-\$50; by the hour for consulting, \$35-\$150.

Principal officers: Dr. John W. Kellar, medical director.

The Health Data Institute

20 Maguire Road, Lexington,
Mass. 02173; 617-863-2000

Year founded: 1981; began providing utilization review services in 1981.

Parent company: Baxter Healthcare Corp.

Services provided: 50% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical

Continued on next page

IS IT REALLY A DRUG PROBLEM?

Mental Health and Substance Abuse problems are delicate and require a special kind of case management.

But the first step is knowing *exactly* what to treat. Only Cost Care utilizes:

- ✓ Over 270 clinical indicators to unmask hidden personal problems.
- ✓ Staff physicians and psychiatrists reviewing every case.
- ✓ Review of both physical and mental health related admissions.

We treat your employees the way their doctors do—case by case.

COST CARE™

Call:
Ray Foose, Director Marketing
1-800-762-3029 Nationwide



MENTAL HEALTH/SUBSTANCE ABUSE
CASE MANAGEMENT



Cost-effective
personalized care.

That's the
AdvantEDGESM
advantage.

It's the best of both worlds; sophisticated healthcare management on an individual basis. As a result of our partnership in Private Healthcare Systems Ltd., our AdvantEDGE program gives patients access to an objective utilization review program offering quality personalized care and cost effectiveness.

We utilize a comprehensive Utilization Review. A professional medical team uses an extensive computerized data bank to monitor each patient's care. This process follows that patient's care from the moment their doctor advises that hospitalization is necessary,

through the treatment plan, and provides for their discharge planning.

A complicated process made uncomplicated. Another advantage of our AdvantEDGE is simplicity. Telephone procedures spare doctors the need to deal with mountains of forms, correspondence and red tape. Yet, the process is as sophisticated as the medical environment it serves.

Taking advantage of our AdvantEDGE is as easy as 800-334-9038. Call us direct or contact your local Washington National group office.



Washington
National®

INSURANCE COMPANY
EVANSTON, ILLINOIS 60201

Spotlight report

Continued from previous page
opinion, hospital bill audit, case management, medical chart audit, evaluation of utilization review programs, workplace absenteeism management programs; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 50% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, acquired immune deficiency syndrome cases.

Staff: 300 total staff members; 230 professional staff members, including 15 physicians, 50 registered nurses, one licensed practical nurse, 10 medical records technicians; 100 physicians, 150 nurses on a retainer basis.

Clients: 5% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 90% with more than 5,000 employees; 6 million lives serviced.

Branch offices: Los Angeles, Boston, Chicago.

1987 gross revenues: Not reported.

Charges: Per employee, \$1.15-

\$1.40; by the hour.

Principal officers: David L. Rosenbloom, president; Dr. Kevin O'Grady and Joanne K. Hilferty, vps.

Health Economics Corp.

1300 W. Mockingbird Lane, Dallas, Texas 75247; 214-905-4400

Year founded: 1984; began providing utilization review services in 1984.

Parent company: Halliburton Co.

Services provided: 20% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, healthcare information program, data analysis and reporting, managed care program development and management; occasional hospital bill audit; 80% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 303 total staff members; 49 professional staff members, including two physicians, 36 registered nurses, seven licensed practical nurses, four medical records technicians; one physician on a retainer basis.

Clients: 124 total clients, 95 employer clients; 52% with fewer than 500 employees, 23% with 500-999 employees, 14% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 5% with more than 5,000 employees; 463,646 lives serviced.

Branch offices: Oklahoma City, Houston.

1987 gross revenues: \$8.3 million total, \$1.7 million from utilization review services for employers.

Charges: Per employee per month, \$1-\$2.75; by the project for consulting.

Principal officers: Stephen F. Coady, president/chief executive officer; Richard D. Starkweather, vp-utilization review; Pat Caudle, vp-marketing; Tom Freeman, vp-cor-

sulting services.

Health International Inc.

1840 Century Park E., Suite 670, Los Angeles, Calif. 90067; 213-551-840

Year founded: 1979; began providing utilization review services in 1985.

Services provided: 40% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit, on-site review, medical chart review, benefit planning, computerized claims analysis, provider network development and analysis; 60% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance

abuse services.

Staff: 18 total staff members; 10 professional staff members, including two physicians, seven registered nurses, one medical records technician; 18 physicians on a retainer basis.

Clients: 25% with fewer than 500 employees, 60% with 500-999 employees, 10% with 1,000-2,499 employees, 2% with 2,500-4,999 employees, 3% with more than 5,000 employees.

1987 gross revenues: Not reported.

Charges: Per employee, \$1.40-\$1.65.

Principal officers: Dr. Donald K. Kelly, chairman/chief executive officer; Michael C. Peerboom, president/ chief operating officer; Suzanne D. Kelly, vice chairman; Gregory S. Perez, vp-marketing; Dr. Howard H. Stone, medical director.

Health Management

Network Inc.

155 Franklin Road, P.O. Box 908, Brentwood, Tenn. 37024-0908; 615-371-1300

Year founded: 1983; began providing utilization review services in 1983.

Parent company: First Choice Health Plan Inc.

Services provided: 80% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion; 20% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Seven total staff members; five professional staff members, including two physicians, three registered nurses; five physicians and 10 nurses on a retainer basis.

Clients: 155 total and employer clients; 92% with fewer than 500 employees, 5% with 500-999 employees, 2% with 1,000-2,499 employees, 1% with 2,500-4,999 employees; 20,685 lives serviced.

1987 gross revenues: \$385,000 total.

Charges: Per employee, 95 cents-\$2.25; per case.

Principal officers: Sandi Henderson, president; Greg McNair, vp-marketing; Marion Adams, vp-administration.

Health Management Resources Inc.

4501 Vestal Parkway E., Binghamton, N.Y. 13903; 607-798-0410

Year founded: Ernst Health Management Inc. was founded in 1974; began providing utilization review services in 1974; name changed to Health Management Resources Inc. Feb. 1, 1988.

Services provided: 80% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, inpatient psychiatric and substance abuse services; 20% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 18 professional staff members, including one physician, 16 registered nurses, one medical records technician.

Clients: 30 total clients, 12 employer clients; 30% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 45% with more than 5,000 employees; 35,000 lives serviced.

1987 gross revenues: \$300,000 total, \$230,000 from utilization review services for employers.

Charges: Per employee \$1.23-\$2.54; per case, \$500-\$800.

Principal officers: P.J. Kearse, president; J.F. Spring, chairman.

Continued on next page

ARE X-RAY AND LAB CHARGES THREATENING TO EAT YOU ALIVE?

If you are like most purchasers of health care, they probably are.

That is why CAPP CARE scrutinizes physician billing patterns. If a physician fragments the billing for a panel of blood tests, violates a global surgical fee, or over utilizes X-Rays, you'll hear about it. And if the doctor happens to be a member of our PPO network, you'll receive a refund.

We know that hospital charges are only part of the story. Ambulatory charges are running wild, too. And CAPP CARE can help you bring them under control.

Don't let health care costs drive you up a tree.



CAPP CARE Good Medicine IS Good Business

Participating Carriers: Allstate, American Community Mutual, American United Life, Farmland, Home Life, John Alden Life, Nationwide, Northbrook, Pacific Mutual, Paul Revere, Provident Mutual, LNUM, Employers' Insurance of Wausau-A Mutual Company Shareholder

For more information write CAPP CARE • Division B • PO Box 8110 • Fountain Valley, CA 92728-8110

Continued from previous page

Health Management Services Inc.

5181 Cascade Road, Grand Rapids, Mich. 49506; 616-956-6903

Year founded: 1983; began providing utilization review services in 1984.

Services provided: 96% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, home care coordination, PPO home care network; occasional hospital bill audit, outpatient service predetermination, 4% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 15 total staff members; nine professional staff members, all of whom are registered nurses; 36 physicians, one nurse on a retainer basis.

Clients: 220 employer clients; 94% with 500-999 employees, 5% with 1,000-2,499 employees, 1% with 2,500-4,999 employees; 23,000 lives serviced.

1987 gross revenues: \$550,000 total, \$530,000 from utilization review services for employers.

Charges: Per employee per month, 93 cents-\$2; per case per hour, \$50-\$75.

Principal officers: Jane E. McCreary, president.

Health Management Strategies International Inc.

1301 Pennsylvania Ave. N.W., Washington, D.C. 20004; 202-639-5822

Year founded: 1985; began providing utilization review services in 1985.

Parent company: Group Hospitalization & Medical Services Inc.

Services provided: 78% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, outpatient service predetermination; 22% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 70 total staff members; 33 professional staff members, including one physician, 30 registered nurses, two medical records technicians; 25 physicians on a retainer basis.

Clients: 227 total clients, 224 employer clients; 81% with fewer than 500 employees, 9% with 500-999 employees, 4% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 2% with more than 5,000 employees; 1.3 million lives serviced.

1987 gross revenues: \$3.8 million total, \$2.8 million from utilization review services for employers.

Charges: Per employee.

Principal officers: E. Seton Shields, president; Dr. A.B. Zients, medical director; Brian E. McCagh, vp-marketing.

Health Related Services Inc.

301 Fifth Avenue Building, Pittsburgh, Pa. 15222; 412-765-1444

Year founded: 1984; began providing utilization review services in 1985.

Parent company: Blue Cross of Western Pennsylvania.

Services provided: 80% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, in-

patient psychiatric case management; 20% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, acquired immune deficiency syndrome cases.

Staff: 171 total staff members; 83 professional staff members, including three physicians, 80 registered nurses; 80 physicians on a retainer basis.

Clients: 12,000 total clients, 525 employer clients; 10% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 65% with more than 5,000 employees; 1.6 million lives serviced.

Branch offices: Erie and Johnstown, Pa.

1987 gross revenues: \$15 million total, \$11 million from utilization review services for employers.

Charges: Per employee, \$1.50-\$2.60; per hour, \$65-\$100.

Principal officers: David P. Lyle, chief operating officer; Roy S. Thomas Jr., vp-marketing/communications; David M. O'Brien, vp-product management/development.

Health Resources Ltd.

P.O. Box 246, 3 N. Lancy St., Pittsfield, Maine 04967; 207-487-5135

Year founded: 1979; began providing utilization review services in 1985.

Services provided: 30% of gross revenues from providing utilization

services to employers, including frequent 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; occasional outpatient psychiatric and substance abuse services, monthly health and medical bulletin, patient advocacy and education programs; 70% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 13 total staff members; eight professional staff members, including five registered nurses, three licensed practical nurses; five physic-

ians on a retainer basis.

1987 gross revenues: Not reported.

Charges: By the hour, \$42-\$48.

Principal officers: Mary E. Orloski, president; Lynne S. Parkhurst, vp-review services.

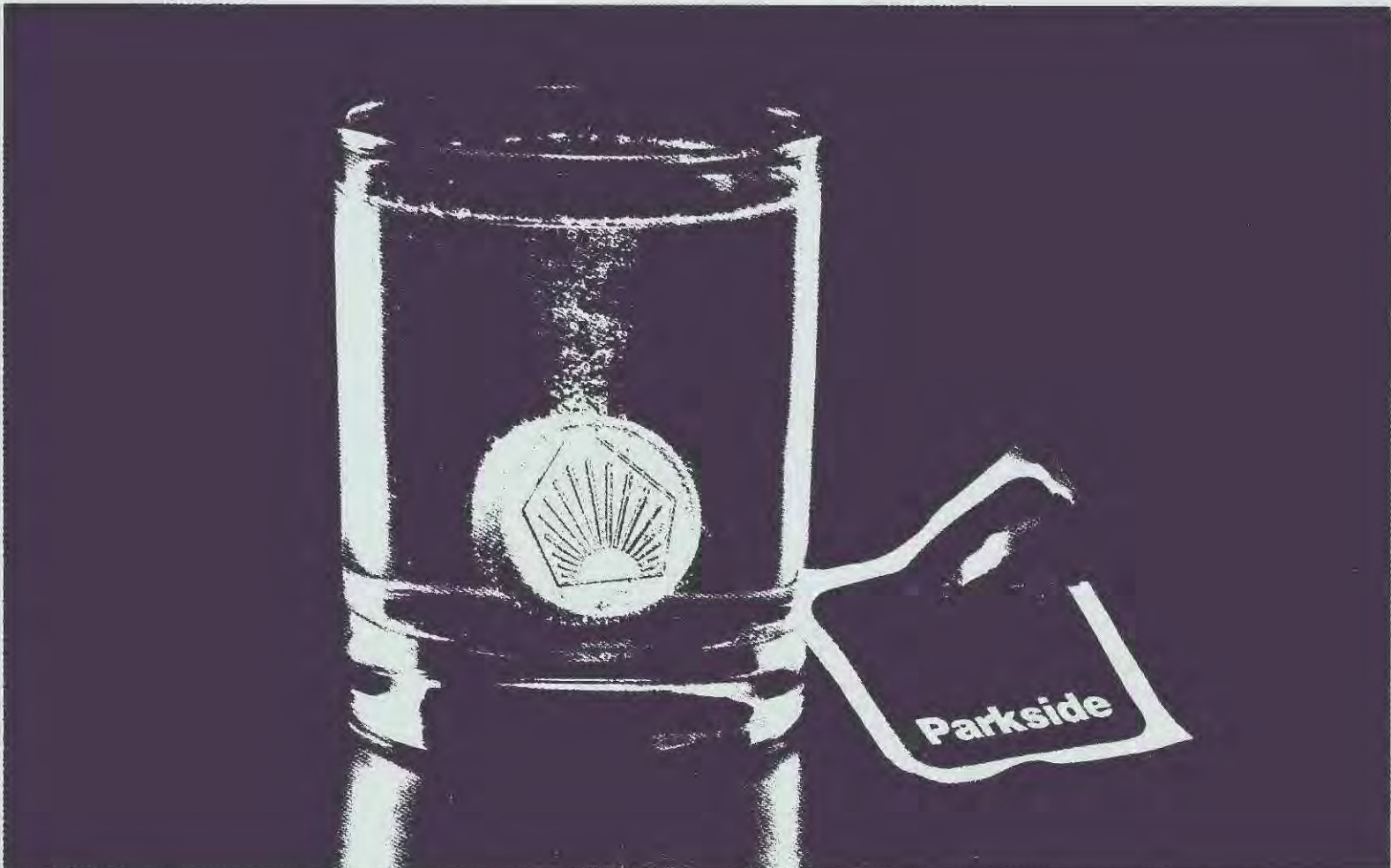
Health Risk Management Inc.

8000 W. 78th St., Suite 270, Minneapolis, Minn. 55435; 612-829-3500

Year founded: 1977; began providing utilization review services in 1984.

Services provided: 75% of gross revenues from providing utilization

Continued on page 41



Parkside has the cure for the runaway cost of your employee health care!

Offering a comprehensive employee health care plan usually leaves you with two choices:

- a quality program that strains or drains your budget, or
- a reduction in the quality of your plan in order to avoid a budget deficit.

Now there is a cure for this dilemma!

The cure is Parkside Health Management Corporation. Parkside is a leader in the implementation and operation of health care cost containment programs. Parkside offers a variety of services on a national basis to companies and organizations of all sizes.

Parkside's managed care services include:

- Certification
- Comprehensive Utilization Review
- The management of cases involving disability, catastrophic or long term illnesses, injuries and rehabilitation, high risk maternity and neonatal conditions, and psychiatric care.
- And more.

Serving you, the employer and your employees!
Parkside programs are unequalled in flexibility and

efficiency and any of them can be adapted to fit your needs. Parkside can assure peace of mind for your employees, and also save you, the employer, a significant piece of your health care budget.

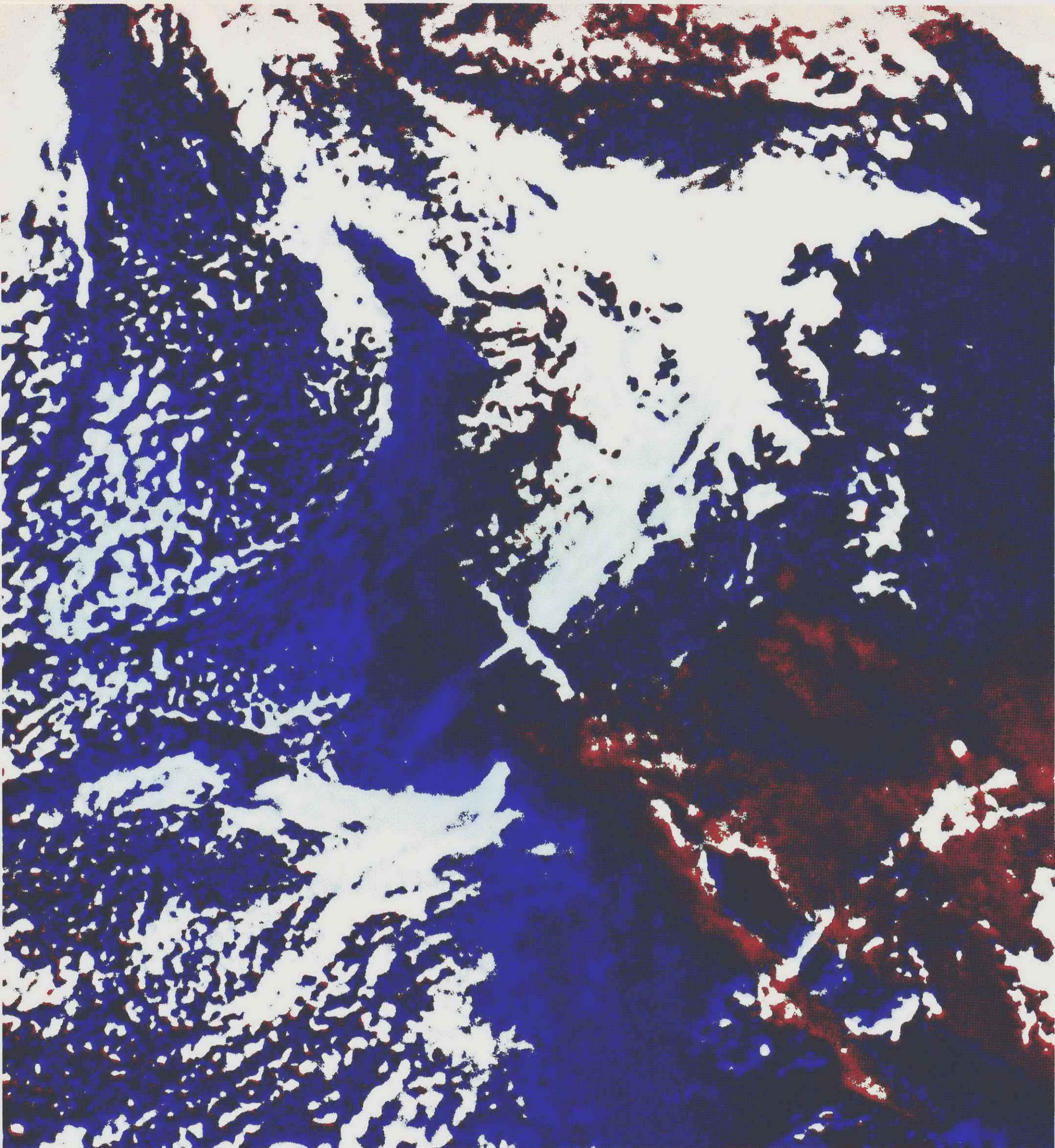
Parkside is the cure!

Call Betty Mahaffey, a Parkside professional, direct at 312/698-4844. And you will find Parkside's experience and expertise is the cure for your unnecessary or unwarranted health care expenses.



Parkside Health Management Corporation

205 W. Touhy Ave., Park Ridge, IL 60068 Toll free 800/843-1978
In Illinois, call collect 312/698-4848



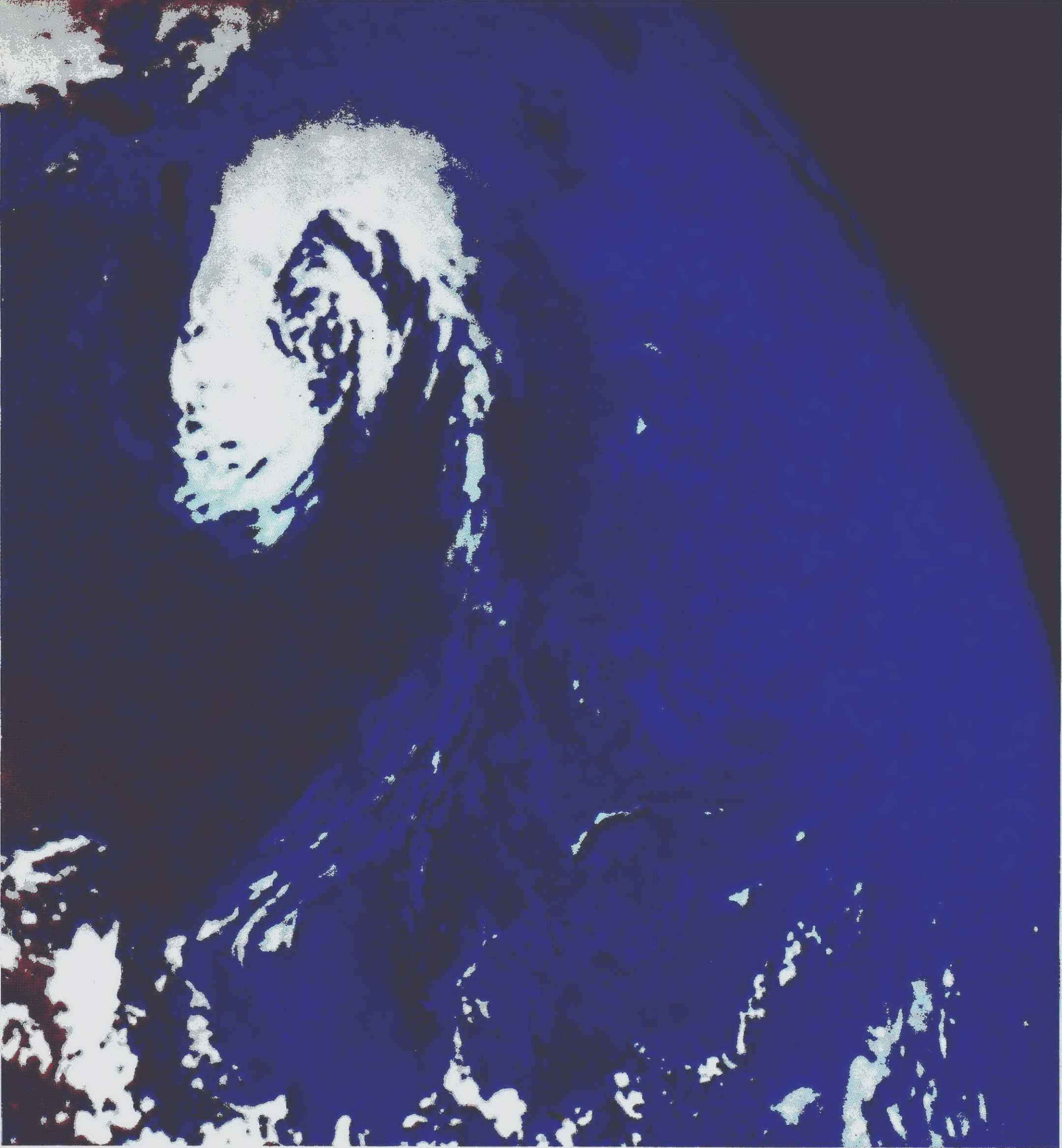
Finally, an HMO for peo

We're called, appropriately enough, HMO-USA. And as you might have guessed, we're the only HMO that spans the country. This also makes us the only HMO you may ever need.

Say, for example, you'd like to centralize all your operations. With HMO-USA, nothing

could be easier. A single contract will cover your company in over 200 markets. And a single bill will cover all your employees coast-to-coast.

To make things simpler still, every month, along with your bill, we can give you a detailed breakdown. And we can do so almost any way



People who live around here.

you'd like. By region of the country. Corporate division. Or even by corporate level.

One more thing you'll appreciate: getting easy answers to your employee questions. Even if they come from 35 people in 35 different states. Just one call is all it takes.

To find out more about how we can help, just pick up the phone and call: 1-800-4-HMO-USA. We're the HMO that's right around the corner.

Wherever your corner may be.



**Blue Cross
and
Blue Shield**
Association



EVER TRY TO PUT A LID ON RISING DENTAL COSTS?



In recent years, the cost of dental care has risen even faster than the cost of medical care.

As a country, we're spending nearly \$27 billion on trips to the dentist. By 1990 that figure is expected to reach over *\$42 billion*.

If the dental cost explosion doesn't subside, many people may simply postpone seeing a dentist. So a minor dental problem turns into a major problem. And a costly one.

What does all of this mean to an employer? Loss of productivity. Dental problems have resulted in the loss of over 100 million working hours a year. What's more, a company's benefits budget may not be able to support unmanageable dental costs.

At CIGNA, our companies have long been committed to making dental costs less painful. We've worked closely with the dental community for the last twenty years, designing dental plans that are responsive to employers' benefit needs. And

we've succeeded not only in holding down costs but in improving the quality of care.

We were the first major insurer to offer our own prepaid dental plan in addition to traditional indemnity plans. Plans that encourage preventive care.

We've even revolutionized claim review, with a unique three-tier process. It combines review by professionals with the most sophisticated claims processing system available. And, in 1985 alone, we saved our clients over \$138 million.

If you'd like to know more about our dental plans, please write to Jon Selteneim, B247, CIGNA Companies, Hartford, Connecticut 06152.

Putting a lid on dental costs. It's one more example of CIGNA's commitment to personalized service to business.

CIGNA

CLAIMS REVIEW

Auditing administrators can save employers wasted expenditures

By Timothy D. Beck

PERFORMANCE of a claims management review is the most effective way for an employer to determine whether employee health-care claims costs are reasonable.

At least 70% of all employee claims costs result from hospital confinements and related surgical expense. Whether the employer is insured or self-insured, any effective cost control effort must be directed at reducing these costs. This goal can be achieved by a CMR, which identifies incorrectly paid claims so the employer can take steps to reduce or eliminate:

- ✓ Unnecessary hospitalization and surgery.
- ✓ Longer than necessary hospital confinements.
- ✓ Unnecessary weekend admissions.
- ✓ Charges for services or items not provided.
- ✓ Charges in excess of reasonable fees.
- ✓ Improper coordination of benefits payments.
- ✓ Fraudulent claims.

Frequently, insurance companies and third-party administrators pay out many dollars not required by plan provisions. Identification and elimination of improper claims payments can result in a greater cost reduction than can be achieved by the highly touted "cost-containment" programs.

A CMR identifies how to recover sums improperly paid. More importantly, it reveals what can be done to prevent similar mistakes in the future.

Incorrect claims processing results in the flow of misleading or inaccurate information to management. A CMR can determine the accuracy of information provided to the employer and the need for changes. It forms a basis for acceptance or rejection of proposed premium increases, plan liabilities or charges.

The "sentinel effect" carries far beyond the conclusion of a specified CMR. It alerts processors that they are subject to scrutiny at any time and accountable to the employer for their work.

The CMR answers the following questions:

- ✓ How many mistakes are being made and how much are they costing?
- ✓ Who is making these mistakes?
- ✓ Why are they occurring?
- ✓ What can be done to prevent future mistakes?
- ✓ How can claims services be improved?
- ✓ How can internal controls be improved?
- ✓ Are essential loss experience records maintained?

Is management receiving adequate reports?

A CMR consists of a claims-file audit, a systems-and-procedure review and a personnel evaluation.

The claims-file audit typically will reveal some overpayment of claims. More importantly, the audit identifies the actions needed to prevent or minimize repetition of incorrect practices. Claims processing mistakes are frequent and costly.

The systems-and-procedures review examines the internal controls used by the administrator for claims-processing security and quality control. It reveals bottlenecks in the system and suggests changes to increase efficiency and reduce costs.

Specifically, the systems-and-procedures review discloses:

- ✓ "Turnaround time" involved in payment of claims.
- ✓ Workload and efficiency of each claims processor.
- ✓ Appropriateness of reports to management.
- ✓ Whether there is a complaint-and-rebuttal system adequately monitored by claims processing management.

Whether adequate record-keeping systems and control logs are maintained and monitored by claims processing management.

Whether adequate provisions for security and quality control are present within the claims processing system.

The personnel evaluation review determines to what degree the claims-processing organization is appropriate for the client. This involves an assessment of whether the claims-processing staff is sufficient to handle the volume of claims and is adequately trained, and whether procedures are in place for continuing education of the staff.

In addition, the personnel evaluation review assesses whether plan documents are understood by all claims-processing staff, responsibilities are appropriately delegated, work flow is properly identified and claims processing procedures are well-defined and documented.

An employer considering a CMR of its employee benefit program has an extensive variety of audits available. The type of audit used determines to what degree the audit achieves its purpose. It also affects the cost of an audit because the type of audit determines the number of claims to be audited.

The primary purpose of a claims audit is to discover the number and types of claim-payment errors and who is making them. No two claims are

Identification and elimination of improper claims payments can result in a greater cost reduction than can be achieved by the highly touted 'cost-containment' programs.

identical. The list of differences is endless. In many claims there are as many as four to 15 points at which an error can be made in claim processing.

Audits show that there are a limited number of identifiable types of claims in which most costly processing errors occur. Unless an audit contains a representative number of these different major claim categories, the audit will not produce reasonable results.

Any audit should be representative of the population from which it is selected, otherwise the results of the audit will be distorted. Most claims audits should be structured so that the sample is composed of one-twelfth of the payments in the audit selected from each month of the audit period.

There are two common approaches in determining how many items should be audited in a known number of claims to provide a credible confidence in the results:

- ✓ A sampling of 2% to 5% of actual single claim payment transactions.
- ✓ An audit sample of the total claims population, based on predetermined confidence and error assumptions and application of generally accepted statistical methods.

The number of claims audited is the primary factor in determining the cost of the audit. It is important that an employer or plan sponsor take part in determining the number of claims or payments that will be audited.

The interplay of three variable factors make up the "credibility formula" for an audit. The credibility that can be given to the audit results is based on the following three factors:

- ✓ The confidence level factor. This is the measure of credibility that is to be given to the audit conclusions.
- ✓ The error level factor. Since all administrators do not function at the same level of efficiency, it is necessary in setting the size of a sample audit to assume an error factor for the administrator.
- ✓ The variation factor. This is the point by which the audit findings may vary from the established criteria and still be considered within a generally

acceptable confidence level.

Each possible combination of the three factors can result in a different number of claims to be audited.

Using any combination of the above variables will permit an actuary to determine the specific number of claims or payments that should be audited for the confidence level desired. As an alternative, an experienced auditor can use published statistical sampling tables to identify the number of items that should be audited in a given population under specified criteria for the three variables discussed.

In addition to the number of claims audited, there are other factors that affect the cost of an audit. For example, a fully computerized system typically requires from 25% to 35% more field time to audit if claim documents are retained in batches and/or microfilm records.

Other factors that affect audit cost are the degree of cooperation the audit team receives from the personnel of the claim office being audited and the ease of access to claim documents by the audit team. Another factor is on-line access to the claims processing system for paid claims and eligibility data and availability of hard copy printouts.

An evaluation of the claim administrator's performance begins with a careful review of the CMR report. The CMR report should provide the employer with a brief management summary illustrating the accuracy and quality of the claims processing and commenting on the audit finds. Such a report should include:

- ✓ The number of underpayments and overpayments found during the audit.
 - ✓ The errors identified by cause.
 - ✓ A special analysis of coordination of benefit teams.
 - ✓ A time-study analysis of all claims audited from the time a claim was received for processing to the time the claim was paid or denied.
- The CMR report should also provide a narrative discussing how the audit was conducted with an extensive comment on the administrator's systems and procedures, internal quality and security controls. The narrative should include recommendations for correcting all discovered claims payment errors and procedural weaknesses.

A careful CMR of an employee benefit plan can provide several advantages:

- ✓ Improved efficiency and reduced costs in administering the plan.
- ✓ Greater control over operating procedures, work flow, accuracy, quality and service.
- ✓ Improved management information.
- ✓ Realignment of claim processing functions.
- ✓ Identification of the knowledge, training and experience of the claims processing staff.

The claims administration process must be continuously reviewed to ensure that it is efficient and in compliance with plan documents. A better understanding of the general operations, organization and work flow of the claim administrator assists the employer in recognizing areas for improvement.

Routine claims management reviews are an important step toward effectively controlling the administration and cost of an employer's health care plan. Management would not normally turn over millions of dollars to be spent by an internal unit or a subcontractor without auditing the expenditure. Why should it do so on its employee health care benefits program?

Timothy D. Beck is manager of employee benefits for Warren, McVeigh & Griffin Inc. in Newport Beach, Calif. He is a consultant on employee benefit issues related to plan design, alternative funding methods, cost containment, claims management systems and administration.



Banks and RMIS

Few vendors market services to financial institutions

FROM TIME TO TIME, I get the urge to depart from my usual focus on the specific functions or purposes of risk management information systems. Instead, I would like to step back and look at the RMIS as applied to a specific industry.

I had a recent opportunity to speak at the American Bankers Assn.'s annual conference on risk management and security in Orlando, Fla. The topic to be covered concerned RMIS applications for financial institutions.

Joining me on a panel discussion was Mark P. Charron, practice director for financial institutions at D.A. Betterley Risk Consultants Inc., and Richard F. Denning, president of Risk Sciences Group in Atlanta.

Covering this vast subject in an hour was challenging, if not impossible. Nevertheless, the panel presented a good framework for RMIS applications for financial institutions. What follows is a synthesis of our major observations and conclusions.

Citicorp, America's largest bank holding company, reportedly turns on 20,000 personal computers each day along with 1,000 mainframe processors, not to mention thousands of automatic teller machines. At least half of Citicorp's 100,000 employees worldwide use a computer at some time each day.

However, despite this illustration of the banking industry's overwhelming utilization of and dependence on computers, there are surprisingly few vendor-supplied RMIS installations.

Instead, many bank risk managers have created their own systems with adapted commercial software packages such as Lotus 1-2-3, d-Base 3 and other popular products. There also may be a few bank risk managers who are using their bank's mainframe system for certain procedures.

I personally am not aware of much marketing activity by the vendors in the financial institutions industry. That was confirmed in part by the appearance of only one vendor—Corporate Systems—at the exhibition area of the ABA's conference.

This would seem to be a major opportunity for the RMIS vendors in terms of a target market, as well as an opportunity for the risk managers of the banking industry.

Perhaps the primary reason for the lack of vendor interest in this untapped market is that bank RMIS are primarily exposure driven, not claims driven. You will recall that RMIS were principally developed in the late 1960s and early 1970s to provide a better mechanism for tracking claim losses that were provided by insurance companies.

That is still true today. But, as the insurance manager evolved into the risk manager, the need for an automated system grew. Not only

could claims be tracked, but they also could be paid by the system with check writing capabilities, risk financing options could be compared, costs of risks could be allocated to appropriate departments and subsidiaries, other exposures could be identified and monitored, etc. Yet this evolution grew entirely out of the claims function.

Despite the evolution of systems into exposure/quantitative areas, vendors still focused on the high claim volume organization, providing other capabilities as an afterthought. They still do.

The objective of an RMIS for financial institutions is the same as for other industries: It is a tool assisting the risk manager to identify, track, analyze and manage risk information crucial to the firm. Better information management is likely to result in improved operations and

likely hardware environment would be a microcomputer. The function of an RMIS primarily would focus on monitoring of such key information as certificates of insurance, property schedules, insurance schedules and some claims tracking from loss runs supplied by insurance companies.

The software applications, from the panelists' viewpoint, would most likely be adaptation of commercial software packages such as Lotus, d-Base 3 or other similar spreadsheet and data base management packages. There also would be the alternative of certain vendors supplying stand-alone micro-based systems at a cost of between \$5,000 and \$20,000 depending on the vendor/system and the desired applications.

We do not see much use for vendor-supplied mainframe or minicomputer systems within

hardware—mainframe, micro-, minicomputer or combinations of any of the three—is available to these users.

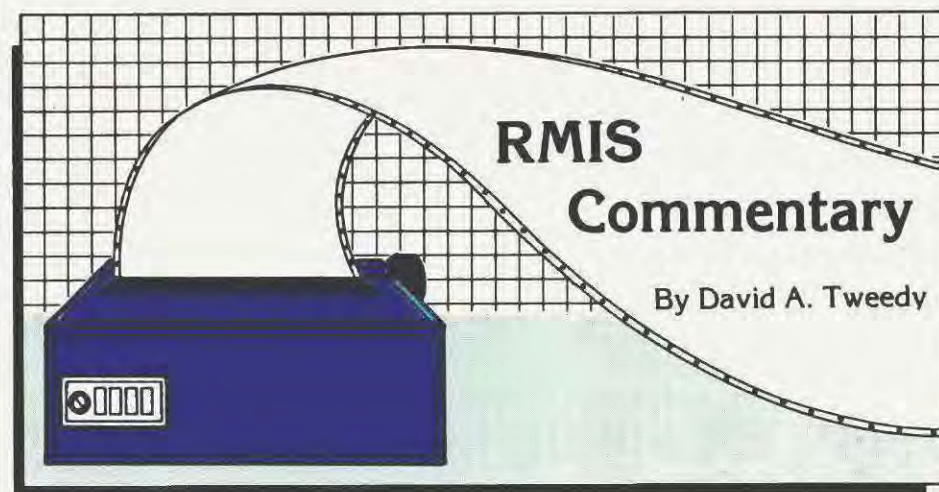
The software available, however, is not expanded to include the traditional vendors, either providing time-sharing or vendor-supported mainframe RMIS, or stand-alone systems in either micro- or minicomputer configurations. In addition to systems created by risk managers, there is now the opportunity to obtain, lease or purchase products from traditional vendors, be it time-sharing, vendor-supported or stand-alone systems.

The system focus has now shifted to information management rather than just monitoring. For instance, banks with more than \$25 billion in assets may be self-insured and self-administered for workers compensation and general liability exposures, in addition to being actively involved in claims management. The system would therefore need to be able to cut checks and reconcile with the bank's financial structure. Cost of risk allocation would be much more important a management tool in strategic planning as the risk manager assists in evaluating mergers and acquisitions in other situations.

In addition to those specific applications listed before, which also apply here, additional uses under the category of risk management administration including budgeting, while additional applications under the category of decision support analysis include: retrospectively rated plan analysis; retention cost analysis; benefit analysis; and reserve analysis (claims management function).

To summarize, preparing for the conference gave me a unique opportunity to study RMIS as applied to a specific industry. In particular, it was interesting that this was an industry that, as yet, has been relatively untapped by traditional RMIS vendors. However, the risk managers in the banking industry have great need for the reports and information that can be provided by an RMIS.

It will be interesting to see how these risk managers' needs are perceived by vendors and the unique applications involved.



reduced cost of risk. We have seen that there is a high degree of need for exposure and quantitative analysis. What, then, are the likely applications of an RMIS that is geared to financial institutions?

To set the proper perspective for seminar attendees on specific applications, it was necessary to divide the banking industry into distinct, recognizable segments. In this case, we chose asset size. The four categories were:

- Total assets less than \$1 billion.
- Total assets between \$1 billion and \$5 billion.
- Total assets between \$5 billion and \$25 billion.
- Total assets more than \$25 billion.

Obviously, these are arbitrary division points. I recognize that certain banks, despite small asset size, may be involved in operations requiring more RMIS applications and vice versa.

But this matrix was helpful for quantifying in the attendees' minds the likely hardware environment (micro-, minicomputer or mainframes), software packages (Lotus or vendor supplied), system emphasis (information monitoring or management) and specific applications required.

For the first two categories, comprising banks with total assets of less than \$5 billion, the most

these groups. The risk manager is quite cost-conscious and a micro is more than able to meet his needs.

I have divided the specific applications required by banks with assets less than \$5 billion into three major categories:

- Risk management administration. The applications under this category include: property schedules; liability schedules; claims monitoring; management reports; certificates of insurance; reporting form coverages; application information; historical listing of occurrence policy; trust property schedules; and joint ventures.
- General data storage. These applications include storage of: bank security manual; robbery/training manual; kidnap and extortion plan; inventory of security devices (form P1); report of crime (form P2); and compliance with Bank Secrecy Act (preservation of records).
- Decision support analysis. These applications include: exposure inventory; limits analysis; loss prevention analysis; and cost of risk allocation/budgeting.

For banks in the third and fourth asset categories, comprising banks with from \$5 billion to more than \$25 billion in total assets, the RMIS changes in scope and emphasis. The whole framework of



David A. Tweedy is a senior consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of *Betterley Risk Management Commentary* and the author of *RMIS Update*, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management systems appears the third Monday of the month.

Continued from page 35

services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, outpatient second surgical opinion, prior negotiation of doctor fees; 25% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 185 total staff members; 107 professional staff members, including 40 physicians, 55 registered nurses, seven licensed practical nurses, five medical records technicians; four nurses on a retainer basis.

Clients: 90 total clients; 1% with fewer than 500 employees, 3% with 500-999 employees, 9% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 72% with more than 5,000 employees.

Branch offices: Phoenix, Ariz.

1987 gross revenues: Not reported.

Charges: Per employee per year, \$7-\$38; per case, \$32-\$184.

Principal officers: Dr. Gary T. McIlroy, chief executive officer/chairman; Marlene Travis, president/chief operating officer; Al Gourley, executive vp; Tim Temple and Bruce Kelley, vps.

Health Service Review Inc.

6730 Roosevelt, Franklin, Ohio
45005; 513-422-0063;
800-334-6469; 800-334-6468 in Ohio

Year founded: 1983; began providing utilization review services in 1984.

Services provided: 90% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, case management; occasional retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services; 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 12 total staff members; seven professional staff members, including one physician, six registered nurses; 30 physicians on a retainer basis.

Clients: 96 total clients, 83 employer clients; 77% with fewer than 500 employees, 8% with 500-999 employees, 10% with 1,000-2,499 employees, 5% with 2,500-4,999 employees; 90,000 lives serviced.

1987 gross revenues: \$350,000 total, \$315,000 from utilization review services for employers.

Charges: Per employee, \$1-\$1.75.

Principal officers: Thomas L. Wiley, president; Donald J. Barker, Karen Mehl and William D. Stief, vps.

HealthCare COMPARE Corp.

3200 Highland Ave., Downers Grove, Ill. 60515-1223;
312-719-9000

Year founded: 1982; began providing utilization review services in 1984.

Services provided: 29% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, medical information hotline, disability review; 71% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 320 total staff members; 212 professional staff members, including 15 physicians, 189 registered nurses, eight medical records technicians; 10 physicians on a retainer basis.

Clients: 11,850 total and employer clients, all employers; 85% with fewer than 500 employees, 4% with 500-999 employees, 5% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 2% with more than 5,000 employees; 794,000 employees serviced.

1987 gross revenues: \$11.6 million total, \$3.4 million from utilization review services for employers.

Charges: Per employee, per case.

Principal officers: Dr. Robert J. Becker, chairman; James C. Smith, president; Ronald H. Galowich, executive vp.

HealthCare Pharmacy Providers Inc.

1220 Senlac Drive, Carrollton, Texas 75006; 214-446-4882

Year founded: 1987; began providing utilization review services in 1987.

Parent company: FoxMeyer Corp.
Services provided: Utilization review services include substance abuse case management.

Services reviewed: Group health services.

Staff: Two total staff members.

Clients: Not reported.

Branch offices: Denver, Dallas.

1987 gross revenues: \$1.2 million total.

Charges: Per employee, 20 cents-50 cents; per case, \$40-\$100.

Principal officers: Frederick R. Curtiss and Robert E. Davis, managing directors.

HEALTHMARC Inc.

9900 Brent Road, Minneapolis, Minn. 55343; 612-936-1205

Year founded: 1984; began providing utilization review services in 1984.

Parent company: United Health Care Inc.

Services provided: 50% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning,

PPO referral, eligibility screening, prescription drug coverage review; 50% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 50 total staff members; 36 professional staff members, including 34 registered nurses, one licensed practical nurse, one medical records technician; five physicians on a retainer basis.

Clients: 450 total clients, 430 employer clients; 60% with fewer than 500 employees, 15% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees; 220,000 lives serviced.

Branch offices: Pasadena, Calif.

1987 gross revenues: Not reported.

Charges: Per employee, \$1.60-\$2.35; per case, \$100-\$135.

Principal officers: Mark Tierney, president; Kate Whittington, vp.

HEALTHPRO Inc.

339 Main St., Suite 200, Worcester, Mass. 01608; 617-757-5440

Year founded: 1975; began providing utilization review services in 1976.

Services provided: 56% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management; occasional outpatient service predetermination; 44% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 59 total staff members; 49 professional staff members, including seven physicians, 25 registered nurses, six medical records technicians.

Continued on next page

Believing is not seeing.



In today's complex health care marketplace, what you think you see can hurt a lot. So if you're going to invest in Health Care Cost Management, don't take anyone's word for it, make sure you know what you're getting. There's no substitute for meeting with staff and physicians, checking the power of support systems, and the efficiency of service. Only one company provides you with 100% case-by-case staff physician review, complete client services, state-of-the-art support systems, and all of the programs and features you need. Take a good, hard look, then come and see us. If you haven't seen Cost Care, you haven't seen Total Managed Care.

The harder you look, the better we look.

COST CARE™

Offices Nationwide



Call:
Ray Foose
Vice President, Marketing
800-762-3029

Utilization Review
Hospital/Surgery/
Outpatient

Case Management
Medical/Psychiatric/
Substance Abuse/
High Risk Pregnancy

Workers' Compensation

Spotlight report

Continued from previous page
cians; 10 physicians, three nurses on a retainer basis.

Clients: 22 total clients, 10 employer clients; 10% with 1,000-2,499 employees, 40% with 2,500-4,999 employees, 50% with more than 5,000 employees; more than 1 million lives serviced.

1987 gross revenues: More than \$3 million total, \$1.7 million from utilization review services for employers.

Charges: Per employee per month, 25 cents-\$1.25; per day plus percent of savings; per hour, \$125 plus expenses.

Principal officers: Dr. Karl Benedict Jr., president; Valerie Dwyer, executive director.

HealthWatch Medical Review System

850 Town & Country Road,
Orange, Calif. 92668;
714-953-9600

Year founded: 1973; began providing utilization review services in 1983.

Parent company: The Admar Group Inc.

Services provided: 55.6% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management; 44.4% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 217 total staff members; 80 professional staff members, including two physicians, 33 registered nurses, 44 licensed practical nurses, one medical records technician; one physician on a retainer basis.

Clients: 8,450 total clients, Three employer clients; 100% with more than 5,000 employees; 434,622 lives serviced.

Branch offices: Dedham, Mass.

1987 gross revenues: \$7.8 million total, \$4.3 million from utilization review services for employers.

Charges: Per employee, \$1-\$1.50; per case, \$60-\$80; percent of savings per month.

Principal officers: Richard H. Toral, chief executive officer; Virginia Pascual, executive vp; Roger Ellis Lightholder, vp/general counsel-investor relations; Alan Jeffery, vp-marketing/development; Gordon Martin, vp-HealthWatch operations; Robert D. Glaza, vp-third party administration.

Humana Medical Quality Cost Management

18th Floor, Humana Building, P.O. Box 1438, Louisville, Ky. 40201; 502-580-1814

Year founded: 1983; began providing utilization review services in 1983.

Parent company: Humana Insurance Co.

Services provided: Utilization review services include frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, case management; occasional second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, quality assurance studies.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 62 total staff members; 51 professional staff members, including 35 registered nurses, five licensed practical nurses, four medical records technicians; eight physicians on a retainer basis.

Clients: 5,052 total clients, 5,000 employer clients; 78% with fewer than 500 employees, 7% with 500-999 employees, 9% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 3% with more than 5,000 employees; 558,000 lives serviced.

Branch offices: Lexington, Ky.; Chattanooga, Tenn.; Chicago; Tampa, Orlando, Jacksonville, Fort Lauderdale and Miami, Fla.; Richmond, Va.; Augusta, Ga.; Montgomery and Huntsville, Ala.; Denver; Corpus Christi, San Antonio and

Dallas, Texas; Phoenix, Ariz.; Anaheim, Calif.; Las Vegas and Reno, Nev.

1987 gross revenues: \$429 million total, \$4.1 million from utilization review services for employers.

Charges: Per employee, \$1.40-\$2.

Principal officers: Dr. Ronald Lankford, vp.

Innovative Health Systems Inc.

P.O. Box 2255, Hudson, Ohio 44236; 216-653-5808

Year founded: 1984; began providing utilization review services in 1985.

Services provided: 41% of gross revenues from providing utilization services to employers, including frequent chiropractic bill review, chiropractic concurrent and retrospective review; occasional case management;

59% of gross revenues from other services.

Services reviewed: Chiropractic services.

Staff: Four total and professional staff members; including three physicians, one medical records technician; two physicians on a retainer basis.

Clients: 20 total clients; 5% with fewer than 500 employees, 45% with 500-999 employees, 50% with 2,500-4,999 employees.

1987 gross revenues: \$85,000 total, \$35,000 from utilization review services for employers.

Charges: By the hour, \$100.

Principal officers: J.R. Bestgen, president; G.M. Bedocs, vp/treasurer; W. Kuleck, secretary/vp-marketing.

Integrated Health Systems Inc.

120 Northwoods Blvd.,
Worthington, Ohio 43085;
614-888-3929

Year founded: 1985; began providing utilization review services in

1987.

Parent company: Health Matrix Corp.

Services provided: 20% of gross revenues from providing utilization services to employers, including frequent precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, case management; occasional preadmission hospital review, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services; 80% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Nine total staff members; five professional staff members, including one physician, four licensed practical nurses.

Clients: Three total clients, two employer clients; 50% with 1,000-2,499 employees, 50% with more than 5,000 employees. 54,750 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Bradley C. Engel, president/chief financial officer; Jonnie E. Geis, chief operating officer.

Intracorp

701 Lee Road, Wayne, Pa. 19067; 215-687-9450

Year founded: 1970; began providing utilization review services in 1984.

Parent company: CIGNA Corp.
Services provided: Utilization review services include frequent 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; occasional psychiatric and substance abuse services; medical information telephone line, preadmission hospital review for workers compensation cases.

Continued on next page

CertiFacts—The Comprehensive Utilization Review System

The only system to integrate utilization review with health claims administration...

CertiFacts from Erisco can maximize the cost-containment potential of preadmission certification and utilization review. This fully automated, online system draws upon Erisco's 15 years of experience developing advanced computer systems software for employee benefits. CertiFacts integrates with ClaimFacts, the health claims management system from Erisco, to provide the vital link for claims adjudication, utilization reporting and cost analyses.

Here's a typical situation—an employee's wife is expecting a baby. You'll see the benefits of CertiFacts before, during and after hospitalization.

before

Thanks to CertiFacts' online, single-screen processing, everything moves smoothly, starting with the employee's first call to his preadmission review service. The system verifies employee eligibility by checking plan provisions in the ClaimFacts database. CertiFacts records the physician's plan for the anticipated normal delivery. Should the physician indicate an alternate treatment plan, it would be

reviewed online using objective criteria developed for CertiFacts by board-certified specialists.

At every point CertiFacts promotes personal communication among the reviewer, the employee and the physician's office. This includes agreement on the level of care, the treatment plan, when admission should occur and length of stay.

during

When a medical problem results in a Caesarean section, instead of the planned delivery, CertiFacts takes the changes in stride. The physician contacts the review service to extend the wife's length of stay, and to revise the treatment plan.

CertiFacts automatically keeps an online diary that tracks the case from its onset. It flags and confirms significant dates for the reviewer, including admis-



Continued from previous page
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 3,418 total staff members.
Clients: 24,685 total clients; 6.7 million lives serviced.
Branch offices: Utilization review services available in Philadelphia; Atlanta; Chicago; Dallas; Anaheim, Calif. Case management services available in 135 locations.
1987 gross revenues: Not reported.
Charges: \$1.10-\$1.35 per employee per month for preadmission and concurrent review services, \$60-\$77 per hour for case management services.
Principal officers: Warren Fuller, president; Katherine Perry, chief financial officer; Dick Anderson and Greg Riedi, senior vps.

viding utilization review services in 1983.
Services provided: 95% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, DRG validation; occasional discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 5% of gross revenues from other services.
Services reviewed: Group health services, dental services, psychiatric and substance abuse services.
Staff: 160 total staff members; 104 professional staff members, including one physician, 85 registered nurses, eight medical record technicians; 550 physicians on a retainer basis.
Clients: Five total clients.
1987 gross revenues: Not reported.
Charges: Per employee, per case, per project.

Principal officers: Theodore O. Will, executive vp; Dr. Raphael Nenner, medical director; Dr. Thomas J. Sheehy Jr., president-board of directors.

J

Jurgovan & Blair Inc.
 7811 Montrose Road, Potomac, Md. 20854; 301-251-8600

Year founded: 1977; began providing utilization review services in 1978.
Parent company: American International Group Inc.
Services provided: 3.2% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, ambulatory utilization review, data analysis; 96.8% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation, short-term disability cases.
Staff: 270 total staff members; 11 professional staff members, including two physicians, nine registered nurses; one physician and six nurses on a retainer basis.
Clients: 10 employer clients; 20% with fewer than 500 employees, 50% with 500-999 employees, 20% with 1,000-2,499 employees, 10% with 2,500-4,999 employees; 25,000 lives serviced.
1987 gross revenues: \$24 million total, \$763,369 from utilization review services for employers.
Charges: Per employee, \$1.10-\$2.20; catastrophic case management, \$65 per hour; reduction of fees for percent of savings.
Principal officers: Thomas Blair,

president; Joe Bruno, chief financial officer.

K

Kepple & Co. Inc.
 1811 W. Altorfer Drive, Peoria, Ill. 61615; 309-692-7330

Year founded: 1982; began providing utilization review services in 1986.
Services provided: 15% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit; occasional retrospective review, second surgical opinion, case management; 85% of gross revenues from other services.
Continued on next page

Island Peer Review Organization Inc.
 95-25 Queens Blvd., 10th Floor, Rego Park, N.Y. 11374; 718-896-7230

Year founded: 1983; began pro-

& after

sion, continued stay review and discharge. It monitors the treatment plan and the appropriateness of any revisions. And, by alerting the physician and reviewer to agreed-upon dates and treatments, it contributes to cost management.

Because of CertiFacts, the review service was able to offer efficient, personalized attention and fast response to the employee and everyone concerned. The physician obtained quick approvals and rapid agreement to changes when needed. All charges were paid promptly and accurately by ClaimFacts based on its own data as well as information provided by CertiFacts. And at all times, confidentiality and security were completely protected.

This linking of preadmission certification to claims data makes true healthcare management possible by providing meaningful reports for measurement, analysis and review.

If you're an insurance carrier or TPA, we'd like to show you how CertiFacts can help you compete more effectively by offering a unique service to your customers.

If you're a self-administered organization considering a pre-

admission review program of your own, we'd like to demonstrate how CertiFacts can provide you with savings in the administration of your program.

CERTIFACTS CLAIMFACTS
Erisco—The benefits of information

And now CertiFacts for minis, too.

That's right. All the advantages of Erisco's proven mainframe software, on a mid-range computer. But there's more.

Your own IBM 9370. From Erisco.
 Now you can obtain both the software and the hardware from us, in a one-stop solution. You get all the flexibility and versatility of ClaimFacts and CertiFacts, along with the modularity and performance of an IBM 9370. And from both companies comes a well-recognized, long-term commitment to customer service.

A total solution in a compact package.
 The IBM 9370 fits easily in almost any office, with no special wiring or air conditioning. The modular design lets it grow along with your needs.

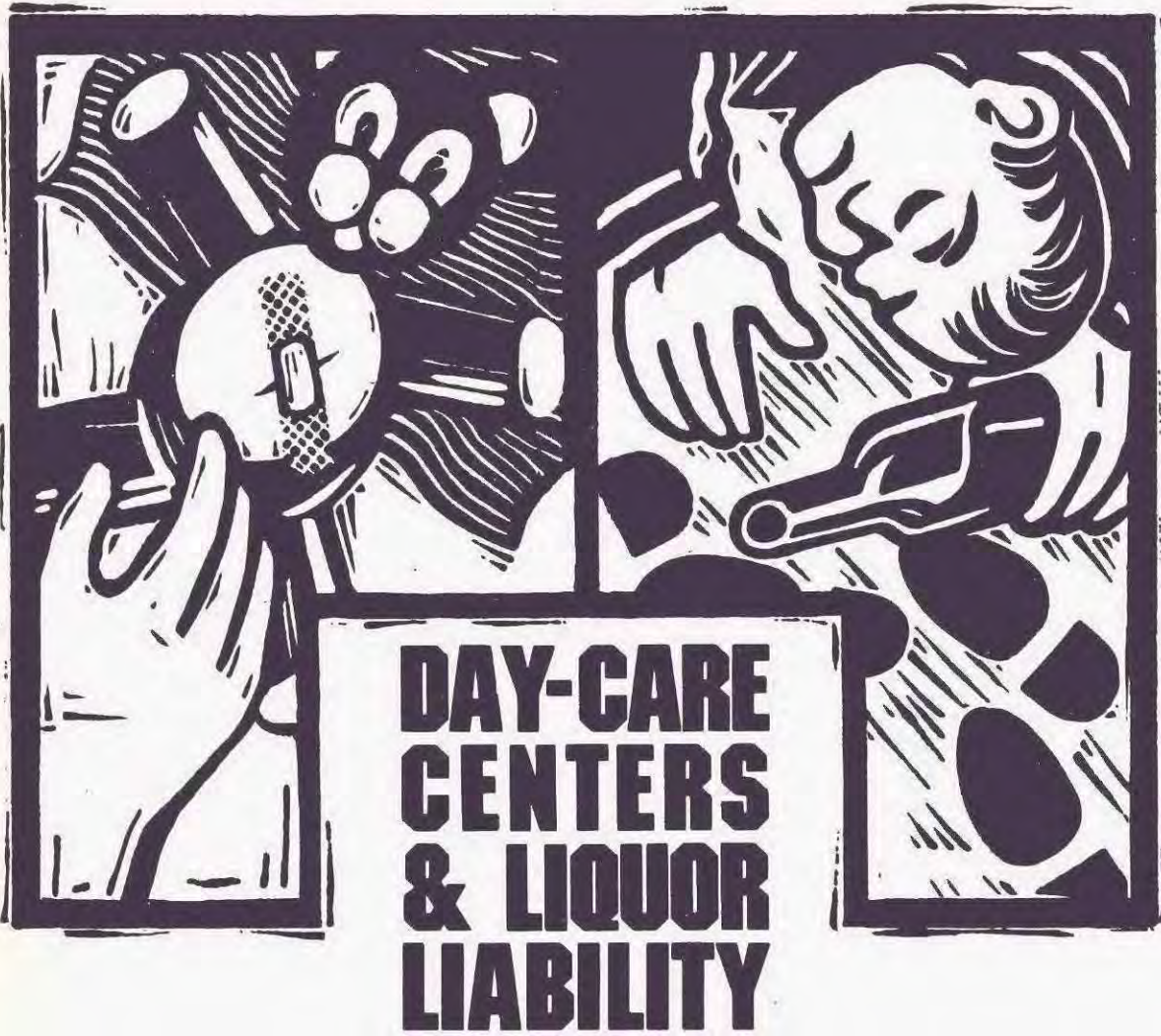
CertiFacts, ClaimFacts and the IBM 9370—a dedicated solution for controlling the bottom line of your health care dollars.

For more information.
 To learn more about CertiFacts or other Erisco benefits software, call or write the Sales Department at Erisco, 1700 Broadway, N.Y., NY 10019, (212) 765-8500.

IBM 9370 is a trademark of International Business Machines Corp.

ERISCO
 a company of
DB The Dun & Bradstreet Corporation





DAY-CARE CENTERS & LIQUOR LIABILITY

SPECIALIZED COVERAGE FOR SPECIALIZED RISK
 UNDERWRITTEN BY . . .

BEL-AIRE INSURANCE COMPANY

For complete information call Jim Henderson:
 1 - 800 - 231 - 4545 (then dial) 7772
 (314) 997 - 3660

Continued from previous page

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Four total staff members who are professionals, including one physician, three registered nurses.

Clients: 21 total clients, 19 employer clients; 76% with fewer than 500 employees, 19% with 500-999 employees, 5% with 1,000-2,499 employees; 8,500 lives serviced.

1987 gross revenues: \$1.3 million total, \$200,000 from utilization review services for employers.

Charges: Per employee.

Principal officers: Michael D. Kepple, president; Norman LaConte, chairman; Kevin Roberts, vp/secretary/treasurer.

Key Care Health Resources

5587 W. 73rd St., Indianapolis, Ind. 46268; 317-298-6600; 800-367-4207

Year founded: 1986; began providing utilization review services in 1987.

Parent companies: Health Care Ventures and Health Data Institute.

Services provided: 42% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; occasional retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, short-term disability case review, long-term care case management, case management; 58% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, short and long term disability services, acquired immune deficiency syndrome cases.

Staff: 38 total staff members, including 20 registered nurses; three physicians and one nurse on a retainer basis.

Clients: 1,000 total clients; 32% with fewer than 500 employees, 26% with 500-999 employees, 27% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees.

1987 gross revenues: \$2.5 million total, \$1.1 million from utilization review services for employers.

Charges: Per employee per month, 25 cents-\$1.70; per case, \$500-\$2,000; percent of savings; combination of

methods.

Principal officers: Erick E. Hanson, general manager.

M

MCC Cos./psychPACER Utilization Review

1401 W. 76th St., Minneapolis, Minn. 55423; 612-861-6330

Year founded: 1974; began providing utilization review services in 1974.

Services provided: 1% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 99% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 307 total staff members; 134 professional staff members, including 25 registered psychiatric nurses, 22 medical records technicians; 13 physicians on a retainer basis.

Clients: 145 total clients, 114 employer clients; 89% with fewer than 500 employees, 7% with 500-999 employees, 3% with 1,000-2,499 employees, 1% with more than 5,000 employees; 1.1 million lives serviced.

Branch offices: Cincinnati and Dayton, Ohio; Springfield, Mass.; Wilmington, Del.; Richmond and Hampton Roads, Va.; Charleston, S.C.; Louisville, Ky.; Knoxville, Chattanooga and Nashville, Tenn.; Shreveport, La.; St. Louis; Denver.

1987 gross revenues: \$25 million total, \$250,000 from utilization review services for employers.

Charges: Per employee per month, 16 cents-40 cents.

Principal officers: Phillip R. Peterson, president; J. Randall Cox, vp-marketing/development; Mark Tidgewell, vp-finance; James Stoebner and Joseph Strahan, vps-operations.

Medcost Inc.

P.O. Box 26001, Greensboro, N.C. 27420; 919-547-4333

Year founded: 1983; began providing utilization review services in 1984.

Parent company: Jefferson-Pilot Life Insurance Co.

Services provided: 48% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination; occasional discharge planning, retrospective review, second surgical opinion, case management; 52% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 37 total staff members, including 19 registered nurses; 40 physicians available to provide services.

Clients: 66 total clients, 11 employer clients; 64% with fewer than 500 employees, 9% with 500-999 employees, 9% with 1,000-2,499 employees, 9% with 2,500-4,999 employees, 9% with more than 5,000 employees; 354,000 lives serviced.

Branch offices: Charleston, S.C.; Charleston, W.Va.

1987 gross revenues: Not reported.

Charges: Per employee, 75 cents-\$1.35.

Principal officers: Otto W. Mueller, president; Billie J. Davis, vp.

Medical Claims Review Services Inc.

7315 Wisconsin Ave., Suite 500W, Bethesda, Md. 20814-3292; 800-356-2775

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 30% of gross
Continued on next page

* Special Risk
 Accident & Health

- * Individual
- * Group
- * High Limit Disability
- * Professional Sports
- * High Limit Accident



IAF

Arranged on behalf of Agents and Brokers by
INTERNATIONAL ACCIDENT FACILITIES, INC.

15 Broad Street, Boston, MA 02109-3887 •
 Tel: (617) 742-6660, Telex: 94-0241, FAX 6177425373

Suite 4-H, 3300 Northeast Expressway, Atlanta, GA 30341-1332 •
 Tel: (404) 452-1311

Suite 170, 8204 Elmbrook Drive, Dallas, TX 75247 •
 Tel: (214) 634-1861

Suite 105, 5901 N. Cicero Ave., Chicago, IL 60646 •
 Tel: (312) 794-8937

Continued from previous page
 revenues from providing utilization review services to employers, including frequent length of stay determination, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, outpatient utilization review provider audits; occasional preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, second surgical opinion, hospital bill audit, case management; 70% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation services.

Staff: 30 total staff members; 17 professional staff members, including four physicians, five registered nurses, eight medical records technicians; four physicians and three nurses on a retainer basis.

Clients: 60 total clients, nine employer clients; 15% with 500-999 employees, 15% with 2,500-4,999 employees, 70% with more than 5,000 employees; more than 100,000 lives serviced.

Branch offices: Fort Lauderdale, Fla.; Van Nuys, Calif.

1987 gross revenues: \$2.3 million total, \$700,000 from utilization review services for employers.

Charges: Per case; per procedure reviewed, \$1-\$1.90.

Principal officers: Dr. Ronald E. Gots, president; Thomas C. McCarthy, executive vp; Dr. Ignacio Rodriguez, associate medical director; John J. Madigan and Jack V. Casbolt, vps.

Medical Cost Management Corp.

332 S. Michigan Ave., Suite 858, Chicago, Ill. 60604; 312-341-0217

Year founded: 1986; began providing utilization review services in 1986.

Services provided: 50% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, medical peer review, fee adjudication, occasional hospital bill audit, outpatient psychiatric and substance abuse services, case management; 50% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, chiropractic services, podiatric services.

Staff: 10 total staff members; eight professional staff members, including one physician, seven registered nurses; 295 physicians and five nurses on a retainer basis.

Clients: 70 total clients, 35 employer clients; 75% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 5% with 2,500-4,999 employees; 35,000 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee per case, flat annual fee.

Principal officers: Michael J. O'Connor, president; Dr. Andrew J. Brislen, vp; Dr. David S. Fox, secretary; Dr. C. Larkin Flanagan, treasurer.

Medical Foundation Services Inc.

3625 N.W. 82nd Ave., Suite 211, Miami, Fla. 33166; 305-593-0404

Year founded: 1973; began providing utilization review services in 1973.

Services provided: 80% of gross revenues from providing utilization review services to employers, including 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, outpatient psychiatric and substance abuse services, case management; 20% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric

and substance abuse services.

Staff: 35 total staff members, including seven physicians, 15 registered nurses, five medical records technicians, 1,500 physicians on a retainer basis.

Clients: 125 total and employer clients; 85% with fewer than 500 employees, 5% with 500-999 employees, 3% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 4% with more than 5,000 employees; 150,000 lives serviced.

1987 gross revenues: \$1.2 million total.

Charges: Per employee per month; by the hour for retrospective review, \$40.

Principal officers: Lois Osman, director-operations; John Storza, executive director; Dr. Robert Furlong,

medical director.

Medical Review Corp.

237 South St., Morristown, N.J. 07960; 201-267-2233

Year founded: 1982; began providing utilization review services in 1983.

Services provided: 65% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, employee advisory tele-

phone service, physical therapy predetermination, private duty nursing, stop loss audits; occasional hospital bill audit, outpatient service predetermination; 35% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 30 total staff members; 25 professional staff members, including two physicians, 10 registered nurses, two licensed practical nurses, one medical records technician; 35 physicians and two nurses on a retainer basis.

Clients: 50 total clients; 20% with fewer than 500 employees, 20% with 500-999 employees, 15% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 25% with more than

5,000 employees.

1987 gross revenues: Not reported.

Charges: Per employee, \$1.10-\$1.75; per case, \$50-\$200; by the hour.

Principal officers: B. Marc Allen, chairman/chief executive officer; Peter Stalker III, vp.

Medtrac Inc.

2550 University Ave., Suite 240N, St. Paul, Minn. 55114; 612-646-2848; 800-328-8181

Year founded: 1969; began providing utilization review services in 1969.

Parent companies: Corroon & *Continued on next page*

"We're saving 6 to 8 percent on healthcare costs...and that's after we've paid the staff, paid for the computer, the software and the maintenance."

— Tom Cole, Director of Benefits and Compensation, Amway Corp., Ada, MI.

"Escalating healthcare costs and a desire to stay directly in contact with our employees and their concerns made us move to self-administered medical claims in 1980. We wanted a healthcare program that met employee needs, met our budget and, at the same time, helped Amway control costs and reduce turn-around time on claims. RIMS provided our solution: QicClaim® software.

"The people here using the system everyday rely on RIMS technical expertise and the fact that QicClaim was developed by experts in the insurance field. They understand our concerns and our terminology, and RIMS' dedication to client support means our questions are answered quickly and correctly.

"QicClaim allows us to duplicate the insurance environment internally, and the cost control pieces are incredible. It maintains eligibility history, calculation history and claim history, and other cost savings come in the accuracy we have now in record keeping and analysis. Even upgrades and enhancements go without a glitch.

"Now we're staying involved with our employees, and RIMS stays involved with us."



For more information or the name of an authorized administration professional near you, contact the Director of Marketing at Resource Information Management Systems, Inc., 500 Technology Drive, Naperville, IL 60540-2599, 312/369-5300.

RIMS RESOURCE INFORMATION MANAGEMENT SYSTEMS, INC.

The Leader in Benefits Administration Software

The leading benefits administration package just got better...RIMS' new generation of software solutions is now available in Cobol.

Spotlight report

Continued from previous page
Black Corp. and The Foundation for Health Care Evaluation.

Services provided: 20% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, inpatient psychiatric and substance abuse services, quality of care review; occasional hospital bill audit, outpatient service predetermination, criteria development, consulting; 80% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services.

Staff: 26 total staff members, including 19 registered nurses. 700 physicians on a retainer basis.

Clients: 423 total clients, 58 employer clients; 85% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees, 2.5% with 2,500-4,999 employees, 2.5% with more than 5,000 employees; 374,867 lives serviced.

Branch offices: Nashville, Tenn.
1987 gross revenues: Not reported.

Charges: Per employee, \$1-\$1.60; per case, \$55-\$85; by the hour.

Principal officers: Ronald G. Cameron, president/chief executive officer; Patricia L. Hanson, executive vp/director-internal operations; L. Erik Norbom, Christina L. Ryberg and Ronnie Stenson, regional sales managers.

MedView

30057 Orchard Lake Road, Suite 200, Farmington Hills, Mich. 48018; 313-851-0700

Year founded: 1983; began providing utilization review services in 1983.

Services provided: 90% of gross revenues from providing utilization services to employers, including frequent 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; 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation services.

Staff: 50 total staff members; 40 professional staff members, including two physicians, 38 registered nurses; more than 100 physicians on a retainer basis.

Clients: 87 total clients, 84 employer clients; 30% with fewer than 500 employees, 15% with 500-999 employees, 40% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees; more than 1 million lives serviced.

Branch offices: Chicago, Los Angeles.

1987 gross revenues: Not reported.

Charges: Per employee, 90 cents-\$3.50; by the hour, \$40-\$80; percent of savings.

Principal officers: Robert Mackey, president; David Segel, senior vp.

MED-VALU

6375 Shier-Rings Road, Dublin, Ohio 43017; 614-764-2282

Year founded: 1981; began providing utilization review services in 1983.

Parent companies: Managed Health Care Inc. and Coordinated Rehabilitation Services Inc.

Services provided: 10% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation medical review, disability management, employee assistance programs,

health and wellness programs; occasional hospital bill audit; 90% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation services.

Staff: 35 total staff members; 25 professional staff members, including three physicians, 20 registered nurses, two medical records technicians; two physicians and 15 nurses on a retainer basis.

Clients: 44 total clients, four employer clients; 100% with more than 5,000 employees; 175,000 lives serviced.

Branch offices: Okemos, Mich.; Brea, Ohio; Indianapolis; Madison, Wis.; Fort Lauderdale, Fla.

1987 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee, by the hour.

Principal officers: Managed Health Care Inc.: Michael Linde, president; Frank Anzelmo and Mary Ellen O'Grady, vps. Coordinated Rehabilitation Services Inc.: Kathleen Etienne, president.

Member Service Administrators

P.O. Box 3028, Tulsa, Okla. 74102; 800-672-2378

Year founded: 1983; began providing utilization review services in 1984.

Parent company: Blue Cross & Blue Shield of Oklahoma.

Services provided: 50% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management; occasional outpatient service predetermination, benefit analysis and consulting; 50% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 40 total staff members who

are professionals, including one physician, eight registered nurses, one licensed practical nurse, one medical records technician; six physicians on a retainer basis.

Clients: 55 total clients; 30% with fewer than 500 employees, 30% with 500-999 employees, 30% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Branch offices: Oklahoma City.
1987 gross revenues: \$2.5 million total.

Charges: Per employee, 75 cents-\$3; per case, \$10-\$70; flat annual fee; percent of savings.

Principal officers: Richard D. McCutchen, executive vp; Rocky L. Rockett, vp-operations.

Memphis Business Group on Health

2714 Union Extended, Suite 200, Memphis, Tenn. 38112; 901-323-1808

Year founded: 1985; began pro-

viding utilization review services in 1986.

Services provided: 50% of gross revenues from providing utilization services to employers, including 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, outpatient psychiatric and substance abuse services, case management; 50% of gross revenues from other services.

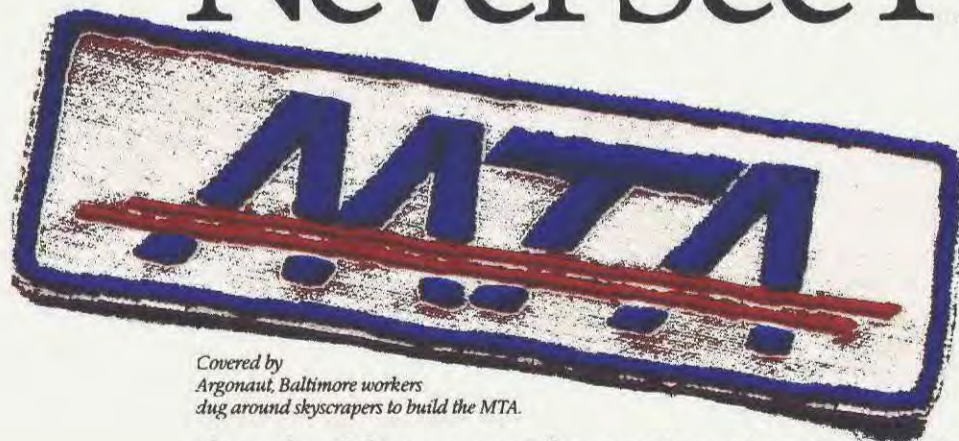
Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Seven total staff members, including one physician, five registered nurses; 85 physicians on a retainer basis.

Clients: 11 total clients, all employers; 3% with fewer than 500 employees, 92% with 500-999 employees, 1% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 1% with more than 5,000 employees;
Continued on next page



Some Of Our Best Never See The Light



Covered by Argonaut, Baltimore workers dug around skyscrapers to build the MTA.

About the only thing more complex

than building a rapid transit project is insuring it.

To provide workers' comp and liability coverage for thousands of workers in dozens of trades is only slightly more challenging than squaring the circle.

But we did it. With an idea.

One master program, an owner-controlled "wrap up," that covers every contractor and subcontractor on a project. And lowers



Argonaut protection helped Atlanta's transit system expand to 27.5 miles. Returned premiums of over \$5 million.

N

Continued from previous page
140,000 lives serviced.

1987 gross revenues: \$1.6 million total; \$800,000 from utilization review services for employers.

Charges: Per employee.
Principal officers: Bob Ellis, Bruce Osborne, Fred Bowman and Mary Ann Camp.

Metropolitan Life Insurance Co.

1 Madison Ave., New York, N.Y.
10010-3690; 203-454-6155

See Corporate Health Strategies Inc., page 31.

Millennium Management Corp./Physicians & Hospitals Alliance

3921 N. Meridian, Indianapolis, Ind. 46231; 317-924-2400

Year founded: 1983; began pro-

viding utilization review services in 1987.

Services provided: 4% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional length of stay determination; 96% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 46 total staff members; nine professional staff members, including three physicians, six registered nurses.

Clients: 43 total clients, 18 employer clients; 100% with fewer than 500 employees; 58,400 lives serviced.

Branch offices: South Bend, Ind.

1987 gross revenues: Not reported.
Charges: Per employee; by the hour, \$50-\$100.

Principal officers: Robert E. Ivancevich, president; Sheila Touquan, vp/general counsel; Patricia Richards, director-medical management services.

Mutual Health Services Co.

1240 Huron Road, Cleveland, Ohio 44115; 216-522-8500

Year founded: 1972; began providing utilization review services in 1986.

Parent company: Blue Cross & Blue Shield Mutual of Ohio.

Services provided: 36% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management, podiatric predetermination, physical medicine

review; occasional hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 74% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 22 total staff members; 18 professional staff members who are registered nurses; 10 physicians on a retainer basis.

Clients: 11 total clients; 18% with fewer than 500 employees, 18% with 500-999 employees, 9% with 1,000-2,499 employees, 18% with 2,500-4,999 employees, 36% with more than 5,000 employees; 179,000 lives serviced.

Branch offices: Salem, N.H.

1987 gross revenues: \$11 million total, \$400,000 from utilization review services for employers.

Charges: Per employee per year, \$15-\$20; per case, \$65-\$80.

Principal officers: James Harless, president/chief executive officer; John Burry Jr., chairman; Robert Bauer, treasurer; David G. Bick, vp-sales/support.

National Chiropractic Review Service Inc.

600 Cramer Building, Route 38, Mount Holly, N.J. 08060; 609-267-3838

Year founded: 1974; began providing utilization review services in 1974.

Services provided: 20% of gross revenues from providing utilization services to employers, including prospective and retrospective chiropractic review, thermography review; 80% of gross revenues from other services.

Services reviewed: Chiropractic services.

Staff: More than 50 total staff members; 15 professional staff members, including 14 physicians, one registered nurse.

Clients: Approximately 400 total clients.

1987 gross revenues: Not reported.

Charges: Per review, \$100.
Principal officers: Dr. Lawrence Wolther, chiropractic director/president.

National Health Network Inc.

500 Sugar Mill Road, Building B, Atlanta, Ga. 30350; 404-998-0328

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 40% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 60% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, Medicaid and Medicare.

Staff: 42 total staff members; 37 professional staff members, including two physicians, 28 registered nurses, two licensed practical nurses, five medical records technicians; 65 physicians and 25 nurses on a retainer basis.

Clients: 5% with fewer than 500 employees, 5% with 500-999 employees, 20% with 1,000-2,499 employees, 50% with 2,500-4,999 employees, 20% with more than 5,000 employees.

Branch offices: Orlando, Fla.; Birmingham, Ala.; Charleston, S.C.; Charlotte, N.C.

1987 gross revenues: Not reported.

Charges: Per employee, per case, percent of savings.

Principal officers: Robert E. Truscheit, president/chief executive officer; Shane Allender, vp/chief operating officer.

National Health Services Inc. (Careview)

12300 W. Center St., Milwaukee, Wis. 53222; 414-778-5151

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 30% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 70% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 20 total staff members; eight professional staff members, including two physicians, six registered nurses.

Clients: 10,000 total and employer clients; 97% with fewer than 500 employees, 3% with more than 5,000 employees. 250,000 lives serviced.

Continued on next page

Ideas Of Day.



premiums through reduced claims costs.

For that kind of flexible thinking, more rapid transit construction projects have come to us than to any other insurer in the last 20 years.

And what a fresh approach does for rapid transit, it also does for agriculture and industry and services. For big clients and small.

For you. Please call Michael Crall, President, 415/326-0900.

Because no matter how varied our clients may be, we're really always protecting the same thing:

Profits.

And that's the idea, isn't it?



The first phase of Los Angeles' mammoth rapid transit construction is now under way.

Argonaut

CHIROPRACTIC CLAIMS MANAGEMENT MADE EASY...

NATIONAL CHIROPRACTIC REVIEW SERVICE, INC. OFFERS YOU A SPECIAL 15 MINUTE VIDEOTAPE ON CHIROPRACTIC CLAIMS PROCESSING.

National Chiropractic Review Service will introduce you to a unique and simple procedure designed to eliminate the problems and guesswork in managing chiropractic claims.

If cost-effective chiropractic claims management is one of your company's goals, complete and return the lower portion of this ad to receive a copy of our chiropractic claims management videotape.



Serving the Claims Industry Since 1974

National Chiropractic Review Service, Inc.
600 Cramer Building, Route 38 • Mt. Holly, NJ 08060
(609) 267-3838

Yes! I'm interested in controlling chiropractic claim costs! Please send me a copy of your videotape addressing chiropractic claims management for a viewing period of two weeks, at no charge.

Name _____

Title _____

Company _____

Address _____

City, State, Zip _____

Telephone Number _____

Video Format: VHS _____ BETA _____

Return to:
National Chiropractic Review Service, Inc.
600 Cramer Building, Route 38, Mt. Holly, NJ 08060
Att: Barbara Gutstadt, R.N.

Continued from previous page

Branch offices: Dallas.
1987 gross revenues: \$1.3 million total.

Charges: Per employee, \$1-\$1.25.
Principal officers: Mark W. Williams, president; Donald L. White and Thomas F. Curtis, executive vps.

P

PCC/Drug Data Systems Inc.
828 Hollywood Way, Burbank, Calif.
91505; 818-843-8551

Year founded: 1968; began providing utilization review services in 1963.

Parent company: Drug Data Systems Inc.

Services provided: 75% of gross revenues from providing utilization services to employers, including concurrent hospital treatment review, retrospective review, hospital bill audit; 25% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation.

Staff: Not reported.

Clients: 1,600 total clients; 5% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 55% with more than 5,000 employees. 2.5 million lives serviced.

1987 gross revenues: Not reported.

Charges: Per case.

Principal officers: Dr. Alvin Saldiner, president.

Pacific Review Services

5995 Plaza Drive, Cypress, Calif.
90630; 714-220-3700

Year founded: 1984; began providing utilization review services in 1984.

Parent company: Lutheran Hospital Society.

Services provided: 90% of gross revenues from providing utilization

services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, outpatient surgical review, concurrent review; occasional hospital bill audit, review of alternative care facilities; 10% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 85 total staff members; three physicians on a retainer basis.

Clients: 1,190 total clients, 400 employer clients; 30% with fewer than 500 employees, 25% with 500-999 employees, 25% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees; 490,000 lives serviced.

Branch offices: Cerritos, Calif.

1987 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Terry Hartshorn, president; John Seifker, vp; Carmen Ness, executive director.

Parkside Health Management Corp.

205 W. Touhy Ave., Park Ridge, Ill.
60068; 312-698-4848

Year founded: 1980; began providing utilization review services in 1980.

Parent company: Lutheran General Health Care System.

Services provided: 70% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, inpatient and outpatient psychiatric review, disability case review, maternity and neonatal case management, contract services; occasional hospital bill audit, outpatient service predetermination; 30% of gross revenues from other services.

Services reviewed: Group health

services, psychiatric and substance abuse services, chiropractic services, workers compensation services.

Staff: 160 total staff members; 50 professional staff members, including one physician, 48 registered nurses, one licensed practical nurse; 22 physicians and three nurses on a retainer basis.

Clients: 77 total and employer clients; 31% with fewer than 500 employees, 16% with 500-999 employees, 29% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 14% with more than 5,000 employees; more than 1 million lives serviced.

Branch offices: Cleveland and Toledo, Ohio; Atlanta.

1987 gross revenues: \$7.5 million total, \$5 million from utilization review services for employers.

Charges: Per employee, 50 cents-\$2.50; per case, \$25-\$350.

Principal officers: Robert P. French, president; Marsha Ballard, vp/chief operating officer.

Peer Review Analysis Inc.

380 Pleasant St., Malden, Mass.
02148; 617-322-6400

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 12% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management, physician review, HMO and PPO reviews; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 88% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 18 total staff members; 10 professional staff members, including one physician, six registered nurses, two licensed practical nurses, one medical records technician; 70 physicians and one nurse on a retainer basis.

Continued on next page

2nd Annual Conference ASBESTOS RISKS FOR OWNERS, LENDERS, MANAGERS & INSURORS

March 15-16, 1988 Sheraton Palace Hotel San Francisco, CA

A comprehensive program for the Financial/Insurance/Property Management Industries focusing on the legal issues involved when asbestos is present, who is responsible and how you can protect your company from lawsuits. Find out how changing legislation affects property management, the current trends in insuring buildings and how risk managers are dealing with the problem.

To register or to receive a course announcement, call the Education Division, toll-free
1-800-445-0682

Sponsored by:

Hall-Kimbrell ENVIRONMENTAL SERVICES

Continued from previous page

Clients: 109 total clients, 80 employer clients; 69.5% with fewer than 500 employees, 12.5% with 500-999 employees, 8% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees.

1987 gross revenues: \$1.5 million total, \$175,000 from utilization review services for employers.

Charges: Per employee per month, \$1-\$1.75; per case per referral, \$55-\$80; per hour, \$125-\$175; on retainer.

Principal officers: Dr. Barry Manuel, chairman; Russell Robbins, president; Charles Smith, treasurer.

Peer Review Systems Inc.

3700 Corporate Drive, Suite 250, Columbus, Ohio 43229-4996; 614-895-9900

Year founded: 1974; began providing utilization review services in 1974.

Services provided: 30% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, long-term care utilization review and quality assurance; 70% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 155 total staff members; 110 professional staff members, including three physicians, 95 registered nurses, 12 medical records technicians.

Clients: 206 total clients, 77 employer clients; 5% with fewer than 500 employees, 60% with 500-999 employees, 25% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees. 174,682 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee per month, \$1-\$1.50.

Principal officers: Robert P. Stone, chief executive officer.

Peerview Inc.

1415 Directors Row, Fort Wayne, Ind. 46808; 219-482-4692

Year founded: 1977; began providing utilization review services in 1977.

Parent companies: Indiana Foundation for Medical Care and Indiana Medical Review Organization.

Services provided: 98% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion; occasional discharge planning, hospital bill audit, case management; 2% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 220 total staff members; 144 professional staff members, including four physicians, 130 registered nurses, 10 medical records technicians; 300 physicians on a retainer basis.

Clients: 20 total clients, four employer clients; more than 1 million lives serviced.

Branch offices: Indianapolis and Terre Haute, Ind.; Louisville, Ky.

1987 gross revenues: \$8.9 million total.

Charges: Per employee per month, 95 cents-\$2; per case, \$25 and up.

Principal officers: Dr. Fouad Halaby, president; Michael Claphan, executive vp-marketing; Philip Morphew, executive vp-finance.

Physical Therapy Review Services

P.O. Box 69, Woodlyn, Pa. 19094-0069; 215-874-1248

Year founded: 1986; began providing utilization review services in 1986.

Services provided: 100% of gross revenues from providing utilization services to employers, including frequent concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case

management, physical therapy retrospective and concurrent review, independent physical therapy evaluations; occasional precertification, hospital bill audit.

Services reviewed: Group health services.

Staff: 18 total staff members; 17 licensed physical therapists on a retainer basis.

Clients: 60 total clients.

1987 gross revenues: Not reported.

Charges: Flat annual fee per review.

Principal officers: David W. Clifton Jr., director/owner; Leslie Buksar Clifton, business manager.

Preview-Health Benefits Management of Ohio Inc.

3737 Sylvania Ave., Toledo, Ohio 43696; 419-473-7472; 800-533-1133

Year founded: 1983; began providing utilization review services in 1983.

Parent company: Blue Cross Blue Shield of Ohio.

Services provided: 80% of revenues from providing utilization services to employers, including certification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management; 20% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 33 total staff members; 10 professional staff members, including three physicians, 17 registered nurses.

Clients: 74 total clients, 73 employer clients; 63% with fewer than 500 employees, 14% with 500-999 employees, 16% with 1,000-2,499 employees, 7% with more than 5,000 employees; 208,634 lives serviced.

1987 gross revenues: \$1.5 million total, \$1.2 million from utilization review services for employers.

Charges: Per employee per month, \$5-\$20.

When it comes to selling group life, put the power of the Sun behind you.

If you're a broker who sells larger group life plans, you'll want to get the full story on Sun Financial Group. We offer the financial strength, professional support, and attractive pricing that allow you to compete effectively in today's corporate marketplace.

To feel the power of the Sun for yourself, simply contact our nearest office: Atlanta, Baltimore, Boston, Chicago, Cleveland, Detroit, Houston, Indianapolis, Los Angeles, New Orleans, Philadelphia, Pittsburgh, Seattle, Tampa, and San Juan.



Sun Financial Group

Sun Life of Canada and affiliates
Wellesley Hills, MA 02181

arge planning, retrospective re-hospital bill audit.
Services reviewed: Group health services, psychiatric and substance abuse services, pharmacy services.
Staff: Eight professional staff members, including one physician, registered nurses.
Clients: Three total clients; 100 lives served.
1987 gross revenues: \$350,000
Charges: Per employee; flat fee; by the hour, \$55-\$75.
Principal officers: Gail A. Shafman, managing partner; Richard P. Baker, general partner.

R

public-RSB Cos. Inc.
 280 Iroquois Drive, Naperville, Ill. 60540; 312-420-6800

As of March 1, 1988, new address will be 1717 Park Place, Naperville, Ill. 60540
Year founded: 1964; began pro-

IMMEDIATELY

Miracles take a tad longer.

As experienced underwriters for major domestic and overseas insurers we offer brokers and agents previously unheard of capabilities in the realms of accident/health/special risk.

P.S. You can now consult us for all your Medical Excess Loss needs.

We calmly await your challenge.



Lockwood, Dipple & Green, Incorporated

300 Unicorn Park Drive, Woburn, MA 01801 • Phone (617) 938-9010
 561 Seventh Avenue, New York, NY 10018 • Phone (212) 921-5680
 1730 Clifton Place, Minneapolis, MN 55403 • Phone (612) 870-9284

viding utilization review services in 1983.

Services provided: 18% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, home health care and private duty nursing evaluation, DRG validation audits, workers compensation audits, per diem audits, rehabilitation management, utilization review consulting for program analysis, alternative delivery system networks, rehabilitation programs, home health care; 82% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, acquired immune deficiency syndrome cases.

Staff: 375 total staff members; 153 professional staff members, including five physicians, 143 registered nurses, five medical records technicians; 52 physicians on a retainer basis, national physician network of more than 26,000 physicians.

Clients: 3,172 total clients, 347 employer clients; 6% with fewer than 500 employees, 24% with 500-999 employees, 9% with 1,000-2,499 employees, 11% with 2,500-4,999 employees, 50% with more than 5,000 employees; 817,500 lives serviced.

Branch offices: Parsippany, N.J.; Atlanta; Houston; Los Angeles.

1987 gross revenues: \$25 million total, \$5 million from utilization review services for employers.

Charges: Per employee, 85 cents-\$1.75; per case, \$35-\$95.

Principal officers: Richard E. Mandel, president; Steven E. Nelson, senior vp; Deanna Sirtaut, vp.

Rush Contract Care

910 W. Van Buren St., Chicago, Ill. 60607; 312-942-8270

Year founded: 1984; began providing utilization review services in 1984.

Parent company: Rush-Presbyterian-St. Luke's Medical Center.

Services provided: 20% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; benefit counseling, employee orientations, physician referral, reports and analyses; occasional hospital bill audit; 80% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: 18 total staff members; 14 professional staff members, including two physicians, two registered nurses.

Clients: 357 employer clients; 45,500 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, \$1.25.

Principal officers: Dr. Jerome J. Hahn, medical director; Gordon M. Mallett, director; Allan Fine, director-marketing/sales.

S

SA Care

P.O. Box 6123, Salt Lake City, Utah 84106; 801-272-8811

Year founded: 1976; began providing utilization review services in 1986.

Services provided: 100% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, length of stay determination, retrospective review, outpatient psychiatric and substance abuse services, verification of benefits and eligibility; occasional concurrent hospital treatment review, discharge planning, second surgical opinion, hospital bill audit, outpatient service predetermination, case management.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: Seven total staff members who are professionals, including three registered nurses, one licensed practical nurse, three medical records technicians.

Clients: 40 total clients, 35 employer clients; 80% with fewer than 500 employees, 11% with 500-999 employees, 6% with 1,000-2,499 employees, 3% with more than 5,000 employees; 20,000 lives serviced.

1987 gross revenues: \$100,000 total.

Charges: Per employee, \$1.25-\$2.75; per case, \$35-\$125.

Principal officers: Richard L. Smith, chief executive officer; Wesley Argyle, attorney; Tony Thompson, controller.

Sanus Preferred Services

% HealthPlus, 6611 Kenilworth Ave., Riverdale, Md. 20737; 301-927-4300

Year founded: 1986; began providing utilization review services in 1987.

Parent company: Sanus Corp. Health Systems.

Services provided: 100% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion, hospital bill audit.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 11 total staff members who are professionals, including one physician, nine registered nurses, one licensed practical nurse.

Clients: Two total and employer clients; 50% with 1,000-2,499 employees, 50% with more than 5,000 employees; 1,250 lives serviced.

Charges: Per employee per month, \$1.80-\$3.40; per case, \$50-\$75.

Principal officers: Joseph T. Lynaugh, president; Jeff D. Emerson, vp; Douglas C. Hoffman, marketing director.

SaveCare Inc.

20520 Nordhoff, Chatsworth, Calif. 91311; 818-407-2290

Year founded: 1983; began providing utilization review services in 1983.

Parent company: Healthwest Foundation.

Services provided: 70% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, outpatient service predetermination; occasional discharge planning, retrospective review, second surgical opinion, case management; 30% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Five total staff members; three professional staff members who are doctors; 12 professionals on a retainer basis.

Clients: 12,400 total clients; 8,500 employer clients; 99% with fewer than 500 employees, 1% with 2,500-4,999 employees; 20,900 lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, 75 cents-\$1.35.

Principal officers: Jerry Torgerson, executive director; Thomas Armstrong, administrative director.

Second Opinion Consultants Inc.

P.O. Box 621, Millwood, N.Y. 10546; 800-446-4606; 800-446-4626 in New York

Year founded: 1983; began providing utilization review services in 1984.

Services provided: 100% of gross revenues from providing utilization services to employers, including second surgical opinion, case management, disability review, claims review.

Continued on next page

Continued from previous page

Services reviewed: Group health services, chiropractic services.

Staff: 20 total staff members; nine professional staff members, including one physician, four registered nurses, one licensed practical nurse; one physician on a retainer basis.

Clients: More than 3,500 total clients; more than 2 million lives serviced.

1987 gross revenues: Not reported.

Charges: Per case, \$155; flat annual fee.

Principal officers: Dr. Madelon Lubin Finkel, president/chief executive officer; David J. Finkel, chief financial officer.

The Sunderbruch Corp.

3737 Woodland Ave., Suite 622,
West Des Moines, Iowa 50265;
515-224-6426

Year founded: 1975; began providing utilization review services in 1975.

Services provided: 70% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, hospital quality review and assessment; occasional hospital bill audit, case management; 30% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, disability services, chiropractic services, hospice services.

Staff: Professional staff members include four physicians, 80 registered nurses, four medical records technicians; 60 physicians and 10 nurses on a retainer basis.

Clients: 70 total clients, 62 employer clients; 1% with fewer than 500 employees, 9% with 500-999 employees, 20% with 1,000-2,499 employees, 45% with 2,500-4,999 employees, 25% with more than 5,000 employees; 2.2 million lives serviced.

Branch offices: Des Moines, Iowa; St. Louis; Lincoln, Neb.

1987 gross revenues: \$10 million total.

Charges: Per employee, \$1.25-\$1.50.

Principal officers: Richard McMaster, chief executive officer; Charles Swisher, executive director-St. Louis office; Rebecca A. Hemann, vp-operations; Margaret Coleman, vp-marketing development.

T

**TPA of America Inc.-
Administrative
Operations Division**

2999 W. Sixth St., Los Angeles,
Calif. 90020; 213-738-1448

Year founded: 1952; began providing utilization review services in 1984.

Services provided: 5% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management, optical and dental networks, mail-order prescription drug program; 95% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, podiatric services, chiropractic services.

Staff: 35 total staff members; 31 professional staff members, including one physician, 26 registered nurses, two licensed practical nurses, two medical records technicians; three physicians and one nurse on a retainer basis.

Clients: 34 total clients; 7% with fewer than 500 employees, 15% with 500-999 employees, 18% with 1,000-2,499 employees, 2% with 2,500-4,999 employees, 58% with more than 5,000 employees; 247,000 lives serviced.

Branch offices: Columbia, Md.

1987 gross revenues: \$30 million total, \$1.5 million from utilization

review services for employers.

Charges: Per employee, \$1.25-\$2; per case, \$25-\$100; by the hour for case management, \$115-\$125; per month, \$4,500-\$18,000; maternity program per case, \$125.

Principal officers: Robert J. Cardinal, senior vp-administrative operations and president-American Benefit Plan Administrators Inc.; Sam Sanbar, senior vp-American Benefit Plan Administrators Inc.; Janice K. Albert, president-Healthcare Strategies Inc.

U

U.S. Administrators Inc.


3540 Wilshire Blvd., Los Angeles,
Calif. 90010; 213-383-1100

Year founded: 1962; began providing utilization review services in 1968.

Parent company: Crownx Inc.
Services provided: 12.4% of gross
Continued on next page

HOT

The
1987/88
Business Insurance Directory
of Corporate Buyers of Insurance,
Benefit Plans and Risk Management Services



\$75 each. All orders must be prepaid.
Make check payable to: Business Insurance Directory.
Mail to:
Business Insurance Directory: Single Copy Sales
965 East Jefferson Avenue, Detroit, MI 48207

For further information, or to charge your order by phone, please call: **Fanny Franklin (313) 446-0477**



This old phonograph still plays, but there is no comparison of sound quality.

Likewise, many firms provide Utilization Review services . . . Yet the results leave much to be desired.

Action Health Care provides State-of-the-Art U.R. services that get results for:

- Medical
- Workers Compensation
- Dental
- Wellness Programs

Choosing the correct U.R. firm will mean substantial savings for you and your company with increased quality of care for those covered participants.

At Action Health Care, we guarantee that your savings return will be greater than our fee when you purchase our full service package.

The savings to the employer and the attention to the employee will be music to your ears!

**Action Health Care
There With The Answers . . .
When You Need Them.**

STATE of the A.R.T U.R.



For More Information Please Contact

Action Health Care, Inc.
301 E. Bethany Home Road Suite C-278
Phoenix, Arizona 85012
(602) 265-0681 Ext. 360
1-800-433-6915

Spotlight report

Continued from previous page
revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management; 87.6% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services.

Staff: 818 total staff members; 78 professional staff members, including three physicians, 75 registered nurses; 27 physicians on a retainer basis.

Clients: 60 total clients, 55 employer clients; 6% with fewer than 500 employees, 10% with 500-999 employees, 17% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 47% with more than 5,000 employees; 1.4 million lives serviced.

Branch offices: Calabasas and

North Hollywood, Calif.; Pittsburgh.

1987 gross revenues: Not reported.

Charges: Per employee per month, \$1-\$3.50.

Principal officers: Samuel X. Kaplan, founder/chairman of the board; Geoffrey T. Wood, president/chief executive officer; Matthew W. Kaplan, executive vp-marketing; Ted White, senior vp.

Universal Managed Care Inc.

70 N. Main St., Wilkes-Barre, Pa. 18711; 717-821-1223

Year founded: 1985; began providing utilization review services in 1985.

Parent company: Blue Cross of Northeastern Pennsylvania.

Services provided: 20% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service

predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion; 80% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation.

Staff: 23 total staff members; 15 professional staff members, including one physician, 13 registered nurses, one licensed practical nurse.

Clients: 27 total clients, 23 employer clients; 60% with fewer than 500 employees, 25% with 500-999 employees, 6% with 1,000-2,499 employees, 9% with 2,500-4,999 employees; 216,090 lives serviced.

1987 gross revenues: \$1.3 million total, \$238,500 from utilization review services for employers.

Charges: Per employee per month, 43 cents-83 cents; by the hour, \$55; by the hour for hospital bill audits, \$39.

Principal officers: Gilbert Tough, chairman; Thomas Ward, executive vp.

University Healthcare Marketing Inc.

1316 Thayer Ave., P.O. Box 24-1590, Los Angeles, Calif. 90024; 213-820-2769

Year founded: 1982; began providing utilization review services in 1986.

Parent company: California Corp.

Services provided: 50% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional precertification, discharge planning; 50% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.

Staff: Eight total staff members, including two physicians, two registered nurses, four medical records technicians; one physician and one nurse on a retainer basis.

Clients: 15 total clients, 12 employer clients; 80% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees; 5,500 lives serviced.

1987 gross revenues: \$145,000 total, \$76,000 from utilization review services for employers.

Charges: By the hour, \$35-\$110; per case, \$150-\$250; flat annual fee, \$22,500-\$39,500; \$650 per day for consultation.

Principal officers: Daniel M. Wilner, president; Phillip Disselkoe, vp; Clarence Henderson, vp-utilization review.

V

ValuTrac Health Care Management Services

1815 S.W. Marlow, Suite 209, Portland, Ore. 97225; 503-297-3806

Year founded: 1983; began providing unbundled utilization review services in 1986.

Parent company: Metrocare National Inc.

Services provided: 30% of gross revenues from providing utilization services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, patient education, health advisory telephone service; occasional hospital bill audit, outpatient psychiatric and substance abuse services; 70% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, workers compensation services.

Staff: Staff includes eight physicians, 30 registered nurses; 200 physicians on a retainer basis.

Clients: 660 total clients, five employer clients; 80% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees; 180,000 lives serviced.

Branch offices: Bloomington, Minn.; King of Prussia, Pa.; Linwood, N.J.; Charlotte, N.C.; Bellevue, Wash.; Grand Rapids, Mich.; Jackson, Miss.

1987 gross revenues: Not reported.

Charges: Per employee, 10 cents-\$2; by the hour, \$75; flat annual fee, \$6,000 per month per on-site nurse; percent of savings based on volume.

Principal officers: Steve Gregg, president; Joan Copeland, vp-operations; Dale White, regional vp-development.

W

Western Medical Review

23840 Hawthorne Blvd., Torrance, Calif. 90505; 213-378-2248

Year founded: 1977; began providing utilization review services in 1977.

Services provided: 100% of gross revenues from providing utilization services to employers, including frequent 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, outpatient psychiatric and substance abuse services, case management.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, workers compensation services.

Staff: 42 total staff members; 31 professional staff members, including one physician, 22 registered nurses, three licensed practical nurses, five medical records technicians; 50 physicians on a retainer basis.

Clients: Approximately 300 total and employer clients; 1.5 million lives serviced.

1987 gross revenues: Not reported.

Charges: Per employee, 80 cents-\$1.85.

Principal officers: Donald P. Balzano, executive director; Victoria M. Nishioka, review manager; Dr. Ronald Kaufman, medical director. ■

IF YOU'RE
BEING
TREATED
LIKE
SMALL
POTATOES,
WE'D
LIKE TO
BUTTER
YOU UP.

If you're having trouble getting through to your employee benefits broker; if you're being passed from rep to rep, or if your account's been re-assigned to a lower level supervisor, someone is sending you a very clear message: You're too small to get the attention you deserve.

At Herbert L. Jamison & Co., we specialize in handling the employee benefits programs for companies with 200-2000 employees.

We understand exactly what companies of this size want because we've been working with them for close to 40 years.

Why not give us a call. You won't get any small talk from us.

HERBERT L. JAMISON & CO.

345 Park Avenue South
New York, NY 10010
(212) 686-2233



Additional plans added to HMO, PPO listings

The following health maintenance organizations and preferred provider organizations were omitted from the *Business Insurance* 1988 Directory of HMOs and PPOs, published in December 1987. Readers are encouraged to detach the following addendum and place it with their copy of the HMO/PPO directory.

HMO-California

The Health Plan of America
505 S. Main St., Suite 300, Orange, Calif. 92668; 714-972-9200

Operational date: December 1980.
Federally qualified: October 1982.

Certified in: California.
Model type: IPA.
Not for profit.
Sponsorship: St. Joseph Health System.

Staff: 2,350 physicians; 3,487 specialists; 29 marketing staff members; 39 patients per primary care physician; 85% board certified physicians.

Facilities: 65 hospitals; network of approximately 1,500 pharmacies; 45 diagnostic labs.

Service area: 25 counties in California.

Services: Standard package includes free or up to \$5 office co-payment, 100% hospitalization, preventative benefits; options include free or up to \$3 co-payment prescription drug plan, vision, dental, alcohol and substance abuse program (offered throughout California), durable medical equipment, hearing aids. Rating options include community rating and community rating by class; community rates: vary by region and benefit plan, single rate standard plan with \$5 co-payment, \$74-\$92. Diagnostic testing and lab work performed by contract with independent facilities. Does not offer non-federally qualified programs to employers. Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Locations: Four regional offices.
Users: 736 employer/payer groups; 15,000 employees with single coverage; 22,000 employees with family coverage; 79,000 employees and dependents; approximately 85,000 enrollees as of Jan. 1, 1988. Hospital stay averages 3.3 days. 75 admissions per 1,000 members. Individual enrollment allowed under COBRA and individual conversion.

Management reports: Provided upon request.

Billing: Provides direct billing for claims under COBRA.

Gross revenues: \$66 million in 1986; approximately \$74 million in 1987.

Officers: Lawrence N. Kugelman, president; Dr. John H. Austin, medical director; Pamela Maple, marketing director; Donna Rockenbach, senior vp/chief financial officer; Eleanor Brewer, senior vp; Davina Lane, senior vp/general manager.

Western Health Plan of Southern California

5050 Palo Verde, Suite 118, Montclair, Calif. 91763; 714-625-2347

Operational date: March 1986.
Federally qualified: October 1986.

Certified in: California.
Model type: IPA.
For profit.
Sponsorship: Western Health Plans Inc.

Staff: 390 physicians; 1,110 specialists; 29 administrative staff members; seven marketing staff members; 85% board certified physicians.

Facilities: 30 hospitals; 17 pharmacy chains, additional independent pharmacies; 10 diagnostic labs.

Service area: San Bernardino,

Riverside, Orange and eastern Los Angeles counties in California.

Services: Options include inpatient mental health, prescription drug. Rating option: community rating; community rates: based on per member per month. Diagnostic testing and lab work performed by contract with independent facilities. Does not offer non-federally qualified programs to employers. Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

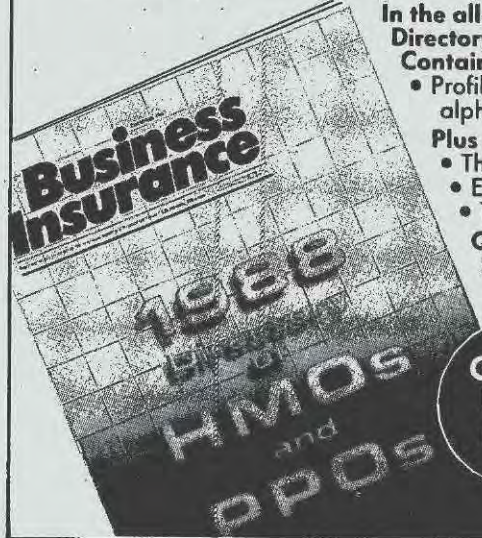
Users: 55 employer/payer groups; 1,750 employees with single coverage; 2,376 employees with family coverage; 12,000 estimated enrollees as of Jan. 1, 1988. Individual enrollment allowed.

Management reports: Not provided.

Billing: Direct billing for claims. *Continued on next page*

GET IN TOUCH WITH US...

and we'll put you in touch with all the facts you want on alternative health care providers.



In the all-new 1988 Business Insurance Directory of HMOs and PPOs.
Contains:
• Profiles of 884 HMOs and PPOs listed in geographical and alphabetical order
Plus reports on:
• The state of the HMO and PPO marketplaces
• Employee benefit managers' opinions on HMOs and PPOs
• The development of HMO guaranty funds
Quantity discount available.
\$25 per copy. 25% discount on orders of five or more copies.
Call 313-446-1609 or write to:

ORDER NOW
Printing limited

Business Insurance
1988 Directory of HMOs and PPOs
Single Copy Sales
965 E. Jefferson
Detroit, MI 48207



So, we unbundled our Defined Benefit Administrative Services.

At Met Life, our Defined Benefit Administrative and record-keeping services—PENSTAR—are now unbundled and separately available to you. Whether or not we handle your pension funds.

Now you can obtain the quality and value of defined benefit services you seek. Now, you'll have more individualized service because we provide just one single professional contact to handle your account.

Met Life gives you more than sixty years experience in defined benefit administration and state-of-the-art systems. We'll work hard to please you.

For more information, contact Chet Vinci, Director-Marketing, Pensions Administration & Technology, Metropolitan Life Insurance Company, One Madison Avenue, New York, N.Y. 10010. Telephone: (212) 578-7574.

GET MET. IT PAYS.



Continued from previous page under COBRA not available. National accounts program with consolidated billing not available.

Gross revenues: \$13 million estimated for July 1987 through June 1988.

Officers: Joyce Truby, executive vp; Drs. Richard M. Burns, Robert Deliman and John J. DiMare, medical directors; Martha Bishton, marketing director.

HMO-Florida

Comprehensive American Care Inc.

2850 Douglas Road, Coral Gables, Fla. 33134; 305-441-1140

Operational date: March 1973.
Federally qualified: December 1981.

Certified in: Florida.
Model type: Staff.
For profit.

Staff: 104 physicians; 175 specialists; 54 administrative staff members; 30 marketing staff members; 70% board certified physicians.

Facilities: Approximately 30 hospitals; more than 200 pharmacies; two diagnostic labs.

Service area: Dade, Broward,

Palm Beach and Hendry counties in Florida.

Services: Standard package includes state and federal packages plus options; options include prescription drug, vision, dental, hearing aids, skilled nursing, mental health, chiropractic, podiatric, prosthetic devices, durable medical equipment. Rating option: community rating; community rates: \$65 single, \$135 two-party, \$199 three or more for standard package. Diagnostic testing and lab work performed by the HMO and by contract with independent facilities. Offers non-federally qualified programs to employers. Contracts with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Locations: Five.
Users: 148 groups; 12,027 commercial subscribers; 11,003 commercial dependents; 23,030 members; 57,000 enrollees as of Jan. 1, 1988. Hospital stay averages nine days; 7.03 admissions per 1,000 members. Individual enrollment allowed.

Management reports: Provided monthly, quarterly or annually.

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

Gross revenues: \$78 million in 1986; approximately \$90 million in 1987.

Officers: Robert E. Galloway, president; Dr. Charles Wilhelm, medical director; Nancy Mehl, marketing

director; Wilfredo V. Gonzalez, senior vp-finance; Luis Lamela, senior vp-operations; Stuart Eiseman, chief operating officer; Benjamin Leon Jr., chairman of the board.

HMO-Ohio

Medical Value Plan

136 N. Summit St., Toledo, Ohio 43604; 419-244-2900

Operational date: May 1986.

Certified in: Ohio.

Model type: IPA.

For profit.
Sponsorship: Toledo Clinic and Henry Ford Healthcare.

Staff: 170 physicians; 90 specialists; six administrative staff members; six marketing staff members; approximately 120 patients per physician; 40% board certified physicians.

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

Service area: Lucas, Wood, Fulton, Ottawa, Sandusky, Erie, Seneca and Henry counties in Ohio.

Services: Standard package includes \$0-\$10 copayment for basic health services; options include vision, prescription drug, durable medical equipment, skilled nursing facility, hearing aid. Diagnostic testing

and lab work performed by contract with independent facilities. Does not contract with the Federal Health Care Financing Administration to enroll Medicare beneficiaries.

Users: 215 employer/payer groups; 30% of employees with single coverage; 70% of employees with family coverage; 17,500 enrollees as of Jan. 1, 1988. Hospital stay averages four days. Individual enrollment not allowed.

Management reports: Provided upon request.

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

Gross revenues: \$1.5 million in 1986; approximately \$13 million in 1987.

Officers: Robert W. Asmussen, president; Drs. R.E. Scherbarth and Donald Marshall, medical directors; Brian P. Logue, marketing manager; David H. Smith, chief operating officer.

PPO-Arizona

Arizona Preferred Provider

6464 E. Grand Road, Tucson, Ariz. 85715; 602-298-5297

Operational date: 1984.

Not for profit.

Ownership: Privately owned.

Staff: 600 physicians; 10 administrative staff members; 100% board certified physicians.

Facilities: Four hospitals; five pharmacies.

Service area: Pima, Cochise and Maricopa counties in Arizona.

Services: Variety of specialty services offered; individual enrollment is allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: 5,000 employees and dependents with access to the network.

Compensation: The PPO is compensated by employers/payers, by health care providers.

Control measures: Utilization review services provided by outside contractors.

Officers: Dwight W. Babcock, president; Joanne Smith, director/general manager.

PPO-California

Pacific Industrial Chiropractic Consultants

4683 Mercury St., Suite E, San Diego, Calif. 92111; 619-292-1017

Operational date: September 1985.

For profit.

Ownership: Privately owned.
Staff: 100 physicians; 100 specialists; six administrative staff members; 20 marketing staff members; 10% board certified physicians.

Service area: California.

Services: Specialty services include chiropractic; individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design cannot be customized for employers.

Users: 25 employer/payer groups; 200,000 employees and dependents with access to the network.

Compensation: The PPO is compensated by health care providers; the PPO charges a percent of services rendered by participating doctors/hospitals.

Control measures: Concurrent review, frequency of visit review, procedural/diagnostic review; utilization review services provided by the PPO.

Gross revenues: More than \$500,000 in 1986; approximately \$1 million in 1987.

Officers: Dr. W. Joseph Roach, president; Dr. Mark A. Hubka, medical director; Michael T. McGuire, marketing director; Richard J. Sparhawk, chief executive officer; Roger M. Wilsie, vp-finance.

Preferred Plus of Northern California (San Francisco/Oakland, San Jose, Napa Valley, Sacramento, Stockton)

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: January 1985.

For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 960 physicians; 625 specialists.

Continued on next page

How to get greater control over health benefit plan costs

If you're looking for an on-line/real-time way to process health claims...if you'd like to reduce payment errors, lower administrative costs and improve productivity...you have reason enough to look into Genelco's new Health Benefit Management System.

But if you're also looking for more detailed claims data to help you make the right decisions in the critical areas of cost containment and utilization review — then learning more about this one-of-a-kind health claims system is an absolute must.

More than a quick and easy way to process claims.

With the extraordinary amount of claims data generated by this system, you'll be able to...

- tell where and how benefit dollars are being spent
- monitor utilization to identify cases of over-usage of benefits (or under-usage of cost-saving alternatives)
- quickly spot large or unusual claims requiring special handling
- accommodate a full range of modern cost-containment benefit features, including pre-authorization, concurrent review, second surgical opinion and others

...and much more. Over a dozen different basic reports have been developed, and a nearly unlimited number of variations are available to provide precisely the data you need to maximize control over your health plan costs. Plus each report can be scheduled to appear when it best suits your needs.

Choose from multiple "comfort zones" of service.

You can use our system to process claims in-house with our full support, or pay claims on a time-sharing basis using Genelco's computer services. You can even have us pay claims for you with no obligation to purchase our system.

As a large claims adjudicator ourselves (we process over \$100 million in claims annually), we developed our new Health Benefit Management System to provide a comprehensive, long term solution to the need for greater efficiencies in the benefits field. What this amazing system is doing for us now, it can do for you, too.

Ask for our free brochure.

Just clip and mail the coupon below. We'll rush our free brochure to you right away. For faster service, call

1-314-962-2040

Don't delay. Contact us now to learn why Genelco's new Health Benefit Management System should be your foundation for effective health plan management and cost control.

YES, I WANT TO LEARN MORE ABOUT GENELCO'S NEW HEALTH BENEFIT MANAGEMENT SYSTEM!

- Send me your free brochure
 Please contact me

Your Name/Title _____

Company Name _____

City _____

State _____

Zip _____

Telephone (be sure to include your area code) _____

GENELCO
1600 South Brentwood Boulevard
Suite 500
St. Louis, Missouri 63144
314-962-2040



A Benefits Staff of 105 for \$1 a Day?



You could hire a complete employee benefit support staff of 105 for about \$1.00 per day. Among them are experienced individuals preparing educational programs, and a full-time research group investigating the latest issues and trends. Editorial, composition and printing personnel are publishing journals, monthly newsletters and dozens of research reports and books.

And four professional librarians are updating the world's most extensive collection of benefit information in anticipation of your call to research a topic—free of charge.

This entire staff is available for a "salary" of about \$1.00 per day—your International Foundation membership fee.

Write or call the International Foundation today for a copy of the staff's résumé, "salary requirements" and work samples.



International Foundation
OF EMPLOYEE BENEFIT PLANS

P.O. Box 69 • Brookfield, WI 53008-0069 • (414) 786-6700

Continued from previous page
Facilities: 28 hospitals.

Service area: Marin, San Francisco, Contra Costa, Alameda, Santa Clara, Sacramento, Solano and Sonoma counties in California.

Services: Employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Users: 175 employer/payer groups; 62,190 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate, by percent discount off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Frank Racioppo, regional sales director, Massachusetts Mutual Life Insurance Co., 415-777-3383.

Preferred Plus of Southern California (Los Angeles/ Long Beach, Riverside/ San Bernardino, Orange County, San Diego, Bakersfield)

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: July 1984.
For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 1,440 physicians; 860 specialists.

Facilities: 50 hospitals.

Service area: Ventura, Los Angeles, San Bernardino, Orange, Riverside and San Diego counties in California.

Services: Employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Users: 121 employer/payer groups; 28,610 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate, percent discount off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Robb Patton, regional sales director, Massachusetts Mutual Life Insurance Co., 213-933-9514.

PPO-District of Columbia

Preferred Plus of the National Capital Area (Washington D.C.)

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: Will become operational in early 1988.

For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 700 physicians.

Facilities: 11 hospitals.

Service area: Washington, D.C.; Montgomery and Prince Georges counties in Maryland; Arlington, Fairfax and Alexandria counties in Virginia.

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Compensation: Hospital charges negotiated by per diem rate, by percent off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating

doctors/hospitals.

Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Robert F. Moran, regional sales director, Massachusetts Mutual Life Insurance Co., 301-323-8400.

PPO-Florida

Preferred Plus of Florida (Tampa, Orlando, Daytona Beach, Jacksonville, Pensacola)

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: November 1987.

For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 1,016 physicians; 648 specialists.

Facilities: 21 hospitals.

Service area: Hillsborough, Pasco, Orange, Seminole, Volusia, Duval, Clay, Nassau, Escambia and Santa Rosa counties in Florida.

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Compensation: Hospital charges negotiated by 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Robert H. Pariseau, account executive, Massachusetts Mutual Life Insurance Co., 813-879-8700.

Preferred Plus of South Florida (Miami, Fort Lauderdale, West Palm Beach)

1295 State St., Springfield, Mass. 01111; 413-788-8411

Operational date: June 1986.

For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 1,268 physicians; 665 specialists.

Facilities: 28 hospitals.

Service area: Broward, Dade and Palm Beach counties in Florida.

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Users: Eight employer/payer groups; 2,560 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate, by 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Donald Calvert, senior account executive, Massachusetts Mutual Life Insurance Co., 305-963-3115.

PPO-Georgia

Circle of Care

P.O. Box 790, Columbus, Ga. 31902-404-576-3875

Operational date: June 1983.

For profit.

Sponsorship: Columbus Regional Health Care System.

Staff: 140 physicians; 140 specialists; five administrative staff members; two marketing staff members.

Facilities: Two hospitals; 15 pharmacies.

Continued on next page

ALTA
HEALTH STRATEGIES, INC.

Makes It Happen

By bringing together and delivering the managed care services needed to produce powerful results:

INTEGRATED

Utilization Review	and	Claims Administration	Provider Networks	Data Analysis
<ul style="list-style-type: none"> • Hospital Admission Review • Health Information • Focused Surgical Review • Case Management • Outpatient Services Review • Psychiatric & Chemical Dependency Review 		<ul style="list-style-type: none"> • Flexible Benefit Plans • Medical Plans • Dental Plans • Vision Plans • Prescription Drug Plans • Disability Plans 	<ul style="list-style-type: none"> • Preferred Provider Organizations • Exclusive Provider Organizations 	<ul style="list-style-type: none"> • Information that measures program effectiveness • Ad hoc Reporting • Consolidated Reporting

A Total Managed Health Care Company Serving Clients in all 50 States

For more information, contact J. Murphy Winfield
 ALTA Health Strategies, Inc., 2614 South 1935 West
 Salt Lake City, Utah 84119 (801) 974-6419



These three doctors are the best in their field.



Two of them are helping you save money.

All three are recognized experts, but two of them have managed to reduce their costs, while continuing to offer high quality medical care.

That's why they were chosen to be among the doctors and hospitals of the ALPHA Health Network.

ALPHA is Pennsylvania's leading Preferred Provider Network, a proven, established network.

If you're an employer or insurance company, look at the ALPHA record.

It speaks for itself.

Better Health Care, Better Cost, Better Quality



128 N. Craig Street
Suite 208
Pittsburgh, PA 15213
(412) 682-6625



CAPITAL IDEA!

RIMS Capital Conference '88
Washington, D.C., April 17-22

A full package of professional benefits for benefits professionals.

- **12 TARGETED SEMINARS**...in HMO's, managed care plans, high exposure claims, post-employment benefits, substance abuse/mental illness, utilization management in the 1990s ...and more.
- **SPECIAL SESSION: Mandating Minimum Health Coverage**
- **TRADE EXHIBITION**...featuring risk management/employee benefits products and services from leading suppliers.

New to the Field? RIMS Employee Benefits Track Program covers the basics...in group health, life, disability and flex benefits...and previews future trends.

26th Annual Risk Management and Employee Benefits Conference
(Detailed Conference and Exhibitors' brochures (212) 286-9292)

*** FLAG THE DATE! ***



205 East 42 Street, New York, NY 10017

Continued from previous page

Services: Specialty services include dental, psychiatric, optometry, medical supplies; individual enrollment is allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: 396 employer/payer groups; 67,915 employee members; 122,247 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by percent off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers, by claims administrators; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission and concurrent review; utilization review services provided by outside contractors.

Officers: Robert Carden, executive director; Sandy Levine, marketing director.

PPO-Illinois

Health Preferred of Mid-America

1165 N. Clark St., Suite 406,
Chicago, Ill. 60614; 312-337-5200

Operational date: October 1986.

For profit.

Sponsorship: Seven hospitals.

Ownership: Group of hospitals.

Staff: 2,253 physicians; more than 1,000 specialists; 10 administrative staff members; one marketing staff member; approximately 100 patients per physician; 97% board certified.

Facilities: 24 hospitals; more than 25 diagnostic labs.

Service area: Illinois.

Services: Specialty services include psychiatric, home health care, hospice services; individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: 62 employer/payer groups; approximately 37,000 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by percent discount off customary rates for individual services, DRGs; the PPO is compensated by health care providers, by claims administrators; the PPO charges by flat fee per eligible employee, percent of services rendered by participating doctors/hospitals.

Control measures: Preadmission certification, second surgical opinion, admission review, concurrent and retrospective review, random chart audits; utilization review services provided by the PPO.

Gross revenues: \$3.5 million in 1986; \$6.5 million estimated for 1987.

Officers: Henry Kutch, chairman; David Everhart, vice chairman; Felicia S. Wilhelm, president; Dr. Alvin Somberg, medical director; Phil Loughnane, director-finance; Susan Caragher, director-utilization review/quality assurance; James Champer, secretary/treasurer.

PATH Network

P.O. Box 698, Park Ridge, Ill.
60068; 312-698-4802

Operational date: March 1987.

For profit.

Ownership: Parkside Health Management Corp.

Staff: 1,200 physicians; 700 specialists; six administrative staff members; three marketing staff members; 90% board certified physicians.

Facilities: 21 hospitals.

Service area: McHenry, Lake, Kane, Cook, DuPage and Will counties in Illinois.

Services: Specialty services include mental health; individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: More than 400 employer/payer groups; 23,000 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate, by 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 and concurrent review, discharge planning, major case management, psychiatric case management, retrospective review, provider profiles; utilization review services provided by the PPO.

Officers: Robert P. French, president-Parkside Health Management Corp.; Dr. Monika Cohen, medical director.

Preferred Plus of Northern Illinois (Chicago)

1295 State St., Springfield, Mass.
01111; 413-788-8411

Operational date: February 1987.

For profit.

Sponsorship: Massachusetts Mutual Life Insurance Co.

Staff: 720 physicians; 375 specialists.

Facilities: 26 hospitals.

Service area: Cook, Lake, Kane, DuPage, Will and McHenry counties in Illinois.

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.

Users: Four employer/payer groups; 24,378 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate, by 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Wayne Malzone, regional sales director, Massachusetts Mutual Life Insurance Co., 312-977-1170.

Rush Contract Care

910 W. Van Buren, Chicago, Ill.
60607; 312-942-8270

Operational date: September 1986.

Not for profit.

Ownership: Rush-Presbyterian-St. Luke's Medical Center.

Qualified as a Competitive Medical Plan.

Staff: 1,300 physicians; 650 specialists; 19 administrative staff members; four marketing staff members; 100% board certified physicians.

Facilities: 24 hospitals.

Service area: Cook, DuPage, Will, Lake, Kane and McHenry counties in Illinois; Lake county in Indiana.

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: 425 employer/payer groups; 46,500 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by 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 and concurrent review, discharge planning, case management, second surgical opinion, physician referral, benefit counseling, employee orientation programs; utilization review services provided by the PPO.

Officers: Gordon M. Mallett, director; Dr. Jerome J. Hahn, medical director; Allan Fine, director-marketing/sales.

PPO-Indiana

Preferred Plus of Indiana (Indianapolis, Fort Wayne)

1295 State St., Springfield, Mass.
01111; 413-788-8411

Operational date: September 1987.

Continued on next page

Continued from previous page

For profit.
Sponsorship: Massachusetts Mutual Life Insurance Co.
Staff: 812 physicians; 581 specialists.
Facilities: 14 hospitals.
Service area: Boone, Hendricks, Marion, Hamilton, Hancock, Johnson and Allen counties in Indiana.
Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.
Compensation: Hospital charges negotiated by 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.
Contact: Dan Hindman, account executive, Massachusetts Mutual Life Insurance Co., 317-844-5154.

mission review, concurrent review, retrospective review; utilization review services provided by the PPO.
Contact: Stan Kusiak, regional sales director, Massachusetts Mutual Life Insurance Co.; 413-781-4540.

PPO-Minnesota

Preferred Plus of Minnesota (Minneapolis/St. Paul)
 1295 State St., Springfield, Mass. 01111; 413-788-8411
Operational date: July 1986.
For profit.
Sponsorship: Massachusetts Mutual Life Insurance Co.
Staff: 1,011 physicians; 415 specialists.
Facilities: 12 hospitals.
Service area: Hennepin, Ramsey, Washington, Dakota, Scott, Carver and Mille Lacs counties in Minnesota.
Services: Employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.
Users: Eight employer/payer groups; 1,230 employees and dependents with access to the network.
Compensation: Hospital charges negotiated by per diem rate, by percent discount off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.
Contact: Field Olson, account executive, Massachusetts Mutual Life Insurance Co., 612-544-9503.

PPO-Maryland

Preferred Plus of Greater Baltimore
 1295 State St., Springfield, Mass. 01111; 413-788-8411
Operational date: November 1986.
For profit.
Sponsorship: Massachusetts Mutual Life Insurance Co.
Staff: 867 physicians; 625 specialists.
Facilities: 19 hospitals; six diagnostic labs.
Service area: Baltimore, Howard, Anne Arundel, Harford and Carroll counties in Maryland.
Services: Employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.
Users: 10 employer/payer groups; 7,303 employees and dependents with access to the network.
Compensation: Hospital charges negotiated by per diem rate, by 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.
Contact: Robert F. Moran, regional sales director, Massachusetts Mutual Life Insurance Co., 301-323-8400.

PPO-Missouri

HealthLink Inc.
 9666 Olive Street Road, St. Louis, Mo. 63132; 314-432-5465
Operational date: June 1985.
For profit.
Sponsorship: Group of hospitals.
Staff: 1,200 physicians; 600 specialists; 40 administrative staff members; five marketing staff members; 100% board certified or board eligible physicians.
Facilities: 23 hospitals; network of pharmacies; 23 diagnostic labs.
Service area: 42 counties in Illinois and Missouri, including the St. Louis metropolitan area.
Services: Individual enrollment is allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.
Users: 303 employer/payer groups; 176,512 employees and dependents with access to the network.
Compensation: Hospital charges negotiated by per diem rate, percent discount off customary rates for individual services; the PPO is compensated by health care providers; the PPO charges a fee for service.
Control measures: Preadmission certification, concurrent and retrospective review, second surgical opinion; utilization review services provided by the PPO.
Officers: John O'Rourke, executive director; Dr. Kirk Flury, medical director; David Ott, marketing director; Dr. Homer Schmitz, director-operations; Ted Eilerman, chairman of the board.

PPO-Massachusetts

Preferred Plus of Western Massachusetts
 1295 State St., Springfield, Mass. 01111; 413-788-8411
Operational date: March 1986.
For profit.
Sponsorship: Massachusetts Mutual Life Insurance Co.
Staff: 400 physicians; 237 specialists.
Facilities: Six hospitals; 11 diagnostic labs.
Service area: Hampden and Hampshire counties in Massachusetts; northern Hartford county in Connecticut.
Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.
Users: 89 employer/payer groups; 24,630 employees and dependents with access to the network.
Compensation: Hospital charges negotiated by per diem rate, by 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 certification, outpatient surgery, second surgical opinion, emergency ad-

Services: Individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design may be customized for employers.
Compensation: Hospital charges negotiated by per diem rate, by percent discount off customary rates for individual services; the PPO is compensated by employers/payers, by health care providers; the PPO charges a flat fee per eligible employee, a percent of services rendered by participating doctors/hospitals.
Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.
Contact: Ralph Busanti, regional sales director, Massachusetts Mutual Life Insurance Co., 314-878-6933.

PPO-North Carolina

Preferred Plus of North Carolina (Greensboro, High Point)
 1295 State St., Springfield, Mass. 01111; 413-788-8411
Operational date: July 1986.
For profit.
Sponsorship: Massachusetts Mutual Life Insurance Co.
Staff: 140 physicians; 60 specialists.
Facilities: Two hospitals; two diagnostic labs.
Service area: Guilford County in North Carolina.
Services: Individual enrollment is not allowed; employees can select

Continued on next page

STRUCTURED SETTLEMENTS

STRENGTHEN YOUR POSITION




You can count on Structured Financial Associates' experience in creative settlements as a unique resource for your use in personal injury claims. Our backgrounds in insurance, law, economics, claims, and financial planning, combined with our unwavering commitment to service, have proven instrumental in successful settlements. SFA's advantages extend not only to injured persons, but to you as well. Insurers, self-insureds, and attorneys repeatedly count on us to strengthen their positions in difficult claims, and that is why SFA was the fastest growing structured settlement firm in the industry last year.

With offices nationwide, an SFA settlement specialist can be with you at your next settlement conference, or as close as your phone, to respond immediately to your concerns, keeping negotiations moving toward successful completion. SFA - Strengthening your position

Call today for your **FREE Settlement Reference Manual.**
1-800-638-5890



STRUCTURED FINANCIAL ASSOCIATES, INC.
 OFFICES NATIONWIDE



In 60 days, U/R on your own.

Tired of having someone else run your U/R? Our free seminar will show you why you should do it yourself.

When an outside firm runs your Utilization Review, you have little if any control over how well the service works. And the profits are going into their pockets, not yours.

CareReview will show you how to perform your own in-house U/R for greater control and profitability. It's a system that can be easily integrated with your present claims administration process in just 60 days. And with our exclusive Physician-Developed Criteria® you'll get a medical doctor's standard of care on every review.

To explain fully the advantages of in-house U/R, CareReview will be holding a free seminar in selected cities. To register, please complete and mail the coupon below. We'll send you an informational packet in return.

Please complete and mail to: CareReview, 12300 W. Center Street, Milwaukee, WI 53222. Yes, I would like to attend your free seminar on the benefits of in-house U/R.

(Please check one)

<input type="checkbox"/> Detroit, MI, March 21	<input type="checkbox"/> Indianapolis, In, March 24	<input type="checkbox"/> New York, NY, April 12
<input type="checkbox"/> Youngstown, OH, March 22	<input type="checkbox"/> Chicago, IL, March 25	<input type="checkbox"/> Philadelphia, PA, April 13
<input type="checkbox"/> Columbus, OH, March 23	<input type="checkbox"/> Boston, MA, April 11	<input type="checkbox"/> Columbia, MD, April 14

I would like to attend your seminar but the city and/or date makes it inconvenient.

Name _____
 Title _____ Company _____
 Address _____
 City _____ State _____ Zip _____
 Telephone () _____
 BI

CareReview.

Continued from previous page
non-PPO providers at time of service; PPO plan design may be customized for employers.

Users: Two employer/payer groups; 218 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 certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Robert M. Godfrey, account executive, Massachusetts Mutual Life Insurance Co., 919-273-6953.

Control measures: Preadmission certification, outpatient surgery, second surgical opinion, emergency admission review, concurrent review, retrospective review; utilization review services provided by the PPO.

Contact: Thomas S. McIlwain, account executive, Massachusetts Mutual Life Insurance Co., 215-687-5810.

VHA East Health Plans Inc.
150 Monument Road, Suite 200,
Bala Cynwyd, Pa. 19004;
215-668-2111

Operational date: January 1988.
For profit.
Sponsorship: VHA East Inc. and 11 hospitals.

Staff: 2,000 physicians and 1,400 specialists projected by July 1, 1988; three administrative staff members; one marketing staff member.

Facilities: 21 hospitals; pharmacies and diagnostic labs provided at participating hospitals.

Service area: Bucks, Chester, Delaware, Montgomery, Philadelphia, Lehigh, Northampton and Berks counties in Pennsylvania.

Services: Specialty services include mental health; individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Compensation: Hospital charges negotiated by per diem rate, by percent discount off customary rates for individual services, by DRGs; the PPO is compensated by employers/payers; the PPO charges a flat rate per eligible employee.

Control measures: Precertification, concurrent review, second surgical opinion, case management, discharge planning, retrospective review; utilization review services provided by the PPO and by outside contractors.

Officers: Michael J. Daly, president; David E. Edman, vp.

HMO/PPO directory errors corrected

Listings for the following HMOs and PPOs listed in *Business Insurance's* 1988 Directory of HMOs and PPOs, published last December, contained incorrect information. Paragraphs containing the corrected information are printed

below. Readers are invited to photocopy, cut and paste the corrected paragraphs over the original company listings.

Medigroup-Central Inc.

HMO, New Jersey, page 39.

Users: 146 employer/payer groups; 347 employees with single coverage; 371 employees with family coverage; 2,342 employees and dependents; 3,381 estimated enrollees as of Jan. 1, 1988. Hospital stay averages 2.3 days; 60.6 admissions per 1,000 members. Individual enrollment not allowed.

Medigroup-Metro Inc.

HMO, New Jersey, page 39.

Users: 243 employer/payer groups; 1,349 employees with single coverage; 1,161 employees with family coverage; 9,021 employees and dependents; 10,867 estimated enrollees as of Jan. 1, 1988. Hospital stay averages 4.5 days; 61.8 admissions per 1,000 members. Individual enrollment not allowed.

Medigroup-North Inc.

HMO, New Jersey, page 39.

Users: 165 employer/payer groups; 183 employees with single coverage; 349 employees with family coverage; 2,075 employees and dependents; 2,171 estimated enrollees as of Jan. 1, 1988. Hospital stay averages 4.9 days; 81 admissions per 1,000 members. Individual enrollment not allowed.

Medigroup-Shoreline Inc.

HMO, New Jersey, page 39.

Users: 260 employer/payer groups; 1,240 employees with single coverage; 1,731 employees with family coverage; 10,083 employees and dependents; 10,827 estimated enrollees as of Jan. 1, 1988. Hospital stay averages 4.9 days; 80.5 admissions per 1,000 members. Individual enrollment not allowed.

Medigroup-South Inc.

HMO, New Jersey, page 39.

Users: 224 employer/payer groups; 692 employees with single coverage; 1,046 employees with family coverage; 6,275 employees and dependents; 6,361 estimated enrollees as of Jan. 1, 1988. Hospital stay averages 5.4 days; 49.2 admissions per 1,000 members. Individual enrollment not allowed.

Healthkeepers

HMO, Virginia, page 55.

2235 Staples Mill Road,
Richmond, Va. 23230;
804-254-3860

Virginia Health Maintenance Organization Inc. (HMO Plus)

HMO, Virginia, page 56.

2235 Staples Mill Road,
Richmond, Va. 23230;
804-254-3860

Pacific Mutual's PPO*

PPO, California, page 62.

Operational date: January 1985.

For profit.
Sponsorship: Pacific Mutual Life Insurance Co.

Staff: 28,200 physicians; 72% board certified.

Facilities: 328 hospitals.

Service area: California, Oregon, Ohio, Washington, Colorado, Arizona, Texas, Illinois, Florida and Utah.

Services: Specialty services vary by location and may include dental, chiropractic and vision; individual enrollment is not allowed; employees can select non-PPO providers at time of service; PPO plan design can be customized for employers.

Users: 280 employer/payer groups; 147,554 employees and dependents with access to the network.

Compensation: Hospital charges negotiated by per diem rate and discounts; the PPO is compensated by employers/payers; the PPO charges a flat fee per eligible employee.

Control measures: Prior authorization, concurrent and ambulatory review, psychiatric and catastrophic case management; utilization review services provided by the PPO.

Gross revenues: Not reported.

Officers: Thomas C. Sutton, president; Dr. William Marr, medical director; Warren Clark, vp-sales.

* Figures are corporate and include all locations of PPOs sponsored by Pacific Mutual Life Insurance Co.

Dental Benefit Providers Inc.

PPO, Maryland, page 69.

7200 Wisconsin Ave., Suite 800,
Bethesda, Md. 20814;
301-654-6900

Clarification

Fort Wayne, Ind.-based Lincoln National Life Insurance Co. has a total of 435,000 enrollees in its health maintenance organization, the majority of whom are enrolled in its HealthWin subsidiary. The story on page 3 of the HMO/PPO Directory inadvertently stated that all 435,000 were enrolled in HealthWin.

PBGC asks court to restore LTV plans

NEW YORK—The Pension Benefit Guaranty Corp. is petitioning a U.S. District Court for a summary judgment ordering LTV Corp. to restore the company's terminated steel-division pension plans.

Dallas-based LTV has not recognized a September order by the PBGC restoring the three defined benefit plans to the company (BI, Sept. 28, 1987). The plans were involuntarily terminated by the PBGC in January 1987, after LTV said it could not afford to make contributions to the massively underfunded plans.

By returning the plans to LTV, the PBGC could cut its deficit, estimated at about \$4 billion, in half.

The PBGC's motion, filed late last month in U.S. District Court for the Southern District of New York, said LTV should be required to resume responsibility for the plans because:

- LTV's finances have improved substantially.
- New plans essentially continue the terminated plans.
- LTV has demonstrated a willingness to fund retirement programs at levels comparable to those before termination.

The motion cites a financial analysis provided to the committee of unsecured creditors in LTV's bankruptcy proceedings indicating LTV could now support the plans.

LTV has committed to making contributions of more than \$90 million annually to fund defined contribution plans set up following the termination of the defined benefit plans.

"These contributions obviously could be used instead to satisfy minimum funding obligations under the restored plans," the PBGC claims in its motion. "Assuming that they would be so used and that LTV Steel obtained funding waivers for the restored plans for the 1984-'86 plan years, the total prospective annual cost of funding the restored plans would be approximately \$260 million.

"Thus, the incremental effect of full restoration, based on company figures regarding the cost of the follow-on plans, is \$170 million. The PBGC believes that the effect may be even less."

A PBGC official said LTV's current commitment to its defined contribution plan for steelworkers is nearly \$200 million.

The operating profit for LTV's steel division nearly quadrupled to \$374.8 million in 1987 from \$95.8 million in 1986. However, the motion did not cite the recently released year-end figures or the steel unit's increase in third-quarter operating income.

"The pension insurance program was not established to provide interim financing or bailouts to employers like LTV Steel or to assist such employers to gain a competitive edge, the petition says.

A spokeswoman said a summary judgment is sought because "the PBGC believes there are no material facts in dispute."

LTV's Washington attorney Frank Cummings, a partner with LeBoeuf, Lamb, Leiby & MacRae, said he is "distressed" by the tone of the filing as well as the request for summary judgment.

"They not only said there aren't any issues of fact, but that no one is entitled to discover if there are any facts. Is this agency of government so above the law that it can do whatever it pleases?"

"They (PBGC) have attempted an end run and are attempting to advance their financial position outside the bankruptcy court," Mr. Cummings said.

—Crain News Service

OUR COMPUTERS ONLY SPEAK MANAGED HEALTHCARE!

Health International is pleased to introduce
and offer to the industry

HEALTH INTERNATIONAL SYSTEMS

Health International Systems offers completely integrated Insurance Company, HMO, PPO, TPA, UR, and all employer related healthcare cost reporting and analysis via on-line access and processing through our system. Standard UR and claims reporting and analysis is provided, customization is our specialty. Reporting is timely and senior management compatible.

For information please contact:

Michael C. Peerboom

President/COO

Health International Systems

1840 Century Park East, Suite 670

Los Angeles, California 90067

(213) 551-1840

HEALTH INTERNATIONAL



Kansas malpractice reforms are unconstitutional: Court

TOPEKA, Kan.—Kansas' cap on medical malpractice awards is unconstitutional, a state court judge says.

In the case of *Kansas Malpractice Victims Coalition vs. Fletcher Bell*, Shawnee County Judge Franklin Theis ruled last month that the cap violated the due process provision and equal protection clause of the Kansas Constitution.

In addition to the caps, Judge Theis ruled that structured annuity provisions of the malpractice law were unconstitutional.

Ted Fay, an attorney with the Kansas Insurance Department, said that an appeal is planned.

A 1986 law enacted by the Kansas Legislature limited non-economic damage awards in medical malpractice cases to \$250,000. Economic damage awards could be added to any non-economic damage awards, up to a total of \$1 million.

If the plaintiff could prove that the amount awarded for future medical expenses was insufficient, the plaintiff could seek additional compensation—up to a total of \$3 million—from a state fund (*BI*, Aug. 18, 1986).

Judge Theis' decision marked the second time in less than a year that a portion of Kansas' 1986 medical malpractice reform package had been struck down.

In July 1987, the Kansas Supreme Court held that a provision allowing the disclosure of collateral sources in medical malpractice cases violated the state constitution's equal protection guarantees by discriminating against one class of tort claimants (*BI*, Aug. 10, 1987).

"After the Supreme Court decision, we were not taken by surprise. We thought it might be coming down the road," said Gerhard Metz, director of taxation for the Kansas Chamber of Commerce & Industry in Topeka. Mr. Metz also coordinates the legislative efforts of the Kansas Tort Reform Coalition.

Tort reform advocates want to broaden the scope of tort reform laws in Kansas, Mr. Metz said. "Generic reforms" affecting all areas of civil law—not just medical malpractice—may be more likely to withstand legal challenges, he said.

The state's House Judiciary Committee currently is examining four tort reform bills supported by the coalition, Mr. Metz said. The proposed laws, which would apply to all types of cases rather than just malpractice cases, would allow periodic payments in damage cases, cap non-economic and punitive damages and allow the disclosure of collateral sources of compensation.

—By Mark A. Hofmann

BC/BS rate hikes

ALBANY, N.Y.—The New York Insurance Department approved average rate increases of 32% and 34.9% for community-rated contracts in the two regions of Blue Shield of Northeastern New York, a division of Blue Shield of Western New York.

The hikes, which affect 97,000 subscribers in 18 counties, were effective Feb. 1.

In addition, in December, the New York Insurance Department approved an average 14.9% rate hike effective Jan. 1 for Blue Shield of Western New York's community-rated health insurance contracts in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties. About 630,000

Around the states

members are affected.

Community-rated plans apply to groups of fewer than 50 people as well as individuals, according to a department spokesman. Rates for larger groups are experience-rated, based on the group's claims history and are not subject to departmental approval.

A company spokesman said most of the rate hike for subscribers in northeastern New York is needed to pay the projected \$14.9 million increase in 1988 claims costs. In addition, the department has approved using \$200,000 of the funds raised through the rate increases to help restore the division's statutory reserves.

The division, which was taken over by the Buffalo-based Blue Shield of Western New York last year but is still treated in many respects as a separate company by the Insurance Department, had \$889,000 in reserves as of Sept. 30, 1987.

According to New York statutes, however, based on its anticipated 1987 premium volume of \$101 million, BS of Northeastern New York should have had reserves equal to 6.5% of its premium, or about \$6.5 million.

The department spokesman said the department anticipates the deficit will be made up by a combination of funds from the division's experience-rated contracts as well as loans from BS of Western New York, which is in strong financial shape.

BS of Northeastern New York's Region I, which was granted a 32% hike, includes Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties. Region II serves Dutchess, Orange, Putnam, Sullivan and Ulster counties.

—By Judy Greenwald

MET coverage

PHOENIX, Ariz.—Washington National Insurance Co. of Evanston, Ill., has agreed to continue the master policy for an Arizona-based multiemployer trust that the insurer had announced it would cancel in December.

The settlement came last month in a consent order signed by the company and the Arizona Department of Insurance.

State Insurance Director Vern R. Pierson had scheduled a hearing on Jan. 22 to determine if the state should order Washington National to continue the policy with Insurance Plan of America Trust of Phoenix.

The hearing was canceled after the consent order was signed, an Insurance Department spokeswoman said.

The Insurance Department, following an investigation, alleged that Washington National had improperly canceled the policy for individual participants in the trust.

The consent order requires Washington National to continue coverage through the trust until the expiration of each participating employer's rate guarantee period or until another insurer provides coverage.

Insurance Plan of America includes about 1,300 employers with 24,000 workers and dependents, mostly in Arizona and California. The trust provides medical, vision, dental and life insurance benefits.

Washington National notified Insurance Plan of America in November that it was canceling the

master policy effective Dec. 31, citing "extraordinary losses" totaling millions of dollars since the trust was established in July 1986, a company official said (*BI*, Nov. 16, 1987).

Insurance Plan of America fought Washington National's plan to end its insurance policy immediately following the announcement in November.

The trust won a permanent injunction from the federal 9th Circuit Court of Appeals in Phoenix, forcing Washington National to extend the policy, said James R. Cone, IPA president and plan administrator.

Mr. Cone said he was pleased with the outcome of the court case and the investigation by the Insurance Department. "We have finally accomplished what should have never happened," he said.

Washington National has agreed to drop its appeal of the permanent injunction as part of the settlement and signing of the consent order, said Terrence M. Jenkins, the insurer's senior vp.

But IPA still has some concerns about other aspects of the settlement and will not drop the court injunction unless it is satisfied with all details, Mr. Cone said. A major concern is whether Washington National will pay \$40,000 in legal expenses incurred by the trust, he said.

Mr. Jenkins declined to say if the insurer would pay the legal fees, adding that the company had "several side agreements" with IPA and that any legal costs were minor compared to the claims liability stemming from the continued coverage.

—By Glenn Huntley

I'm Covered. I've Earned My CEBS.

"Like the weather, the field of employee benefits is in a constant state of change. But, as a Certified Employee Benefit Specialist (CEBS), I'm prepared to effectively and professionally handle those changes."

The CEBS designation is awarded to individuals who successfully complete a series of ten college level courses and examinations covering the design and operation of employee benefit plans. The program is cosponsored by the International Foundation of Employee Benefit Plans and the Wharton School of the University of Pennsylvania.

"Join the thousands of benefit professionals who have their careers covered. Contact the CEBS Department at the International Foundation."

Christine Metz, CEBS
Manager
Travelers Insurance Company
West Palm Beach, Florida



Certified Employee Benefit Specialist Program
International Foundation of Employee Benefit Plans
P.O. Box 69, Brookfield, WI 53008-0069, (414) 786-6700



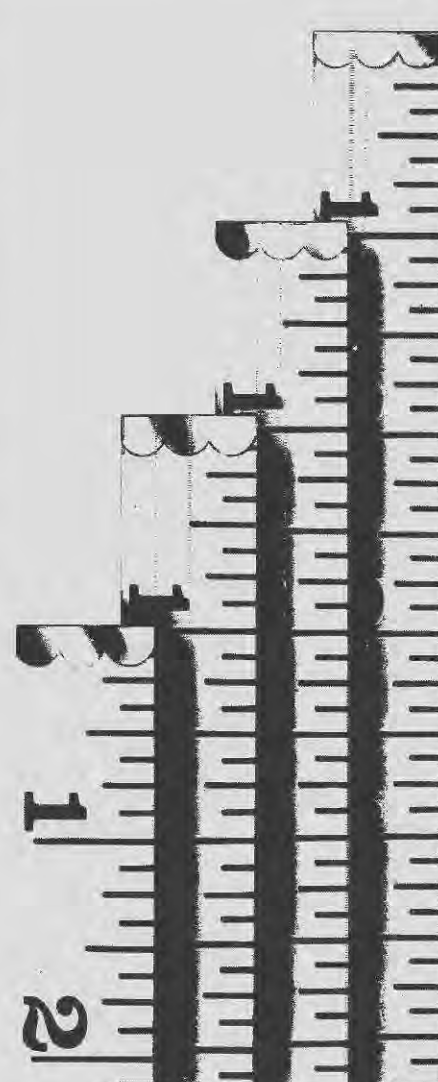
Capital Accumulation Benefits tailor-made by Corroon & Black.

Capital Accumulation Plans, tailor-made for you by Corroon & Black, help you implement the most attractive incentives selected from the many options available (including savings plans, 401(k)s, and profit sharing), while making sure your costs are manageable.

Your problems are unique. Our solutions are, too. As one of America's most innovative employee benefit consultants and brokers, we fashion creative, value-added solutions through keen thinking of seasoned professionals. And provide the best personal service at every level.

For more information about how we measure up, contact your local Corroon & Black office or Richard I. Citron, National Benefits Division, Wall Street Plaza, New York, NY. (212) 363-4100.


CORROON & BLACK
for your benefits.



Financial guarantee insurer sees growth

By JUDY GREENWALD

NEW YORK—Financial guarantee insurers could capture up to one-quarter of the booming municipal bond market in 1988, their highest percentage ever, predicts one insurer.

David H. Elliot, president and chief operating officer of Municipal Bond Investors Assurance Corp. in White Plains, N.Y., spoke of "fairly promising" opportunities in 1988 for municipal bond insurers at an MBIA-sponsored seminar last month in New York.

Also speaking was New York City Comptroller Harrison J. Goldin, who called for repeal or amendments to the Tax Reform Act of 1986 that complicated the issuance of municipal bonds.

Mr. Elliot said the country's infrastructure needs are "enormous," estimating that \$160 billion a year between now and the year 2000—or a total of \$2 trillion—will be needed for improvements in education and other public programs. This will provide an "ample supply" of traditional bond issues

'The much-ballyhooed stock market crash only accelerated investor concerns' about their investments and intensified interest in insured municipal bonds as high-quality, safe investments, says David Elliot.

in which financial guarantee insurers can participate, he said.

In addition, the municipal bond market "continues to be dominated by the individual investors," Mr. Elliot said. This bodes well for the financial guarantee industry because individuals, as opposed to institutions, do not have the expertise to judge credit quality on their own, he said, and may be more apt to purchase issues that carry the Triple-A ratings conferred by municipal bond insurers on lower-graded issues.

Virtually 100% of last year's new-issue municipal bonds were either purchased directly by individuals or by vehicles such as unit investment trusts on their behalf,

he said.

A total of \$94 billion in new-issue, long-term, tax-exempt municipal bonds were sold last year, according to industry figures. During the first nine months of 1987, 21.4% of newly issued bonds were insured by financial guarantee insurers.

An estimated \$98.4 billion worth of such bonds will be sold this year, of which 23.7% will be insured, according to a survey of municipal bond professionals sponsored by MBIA.

"The much-ballyhooed stock market crash only accelerated investor concerns" about their investments and intensified interest in insured municipal bonds as

high-quality, safe investments, Mr. Elliot said.

Among other possibilities, there is also "tremendous potential" in secondary markets selling previously uninsured issues, said Mr. Elliot. Taxable bonds are another potential market for financial guarantee insurers, he said.

Mr. Elliot noted that last year a group of monoline financial guarantee insurers, including MBIA, insured securities backed by federal government loans, and he said future insurer participation in these sales is likely in 1988 (*BI*, May 4, 1987).

Mr. Elliot also said financial guarantee insurance has a role to play whether interest rates fall or rise.

If interest rates drop, financial guarantee insurers can participate in advance refunding issues. Advance refunding of municipal bonds is a procedure in which outstanding bonds are refinanced before their first call date by the proceeds of a new issue of securities, or refunding issue, that are sold at a lower, cheaper rate. Financial guarantee insurers can then issue a policy for the refunding issue.

On the other hand, if interest rates increase, municipal bond issuers can take advantage of the greater spread between Triple-A and lower-rated bonds.

For example, when interest rates rise, the Triple-A rating conferred by municipal bond insurers enables issuers to pay a lower interest rate—because the issue is less risky than an uninsured issue with lower ratings—which more than offsets the cost of the insurance.

Overall, Mr. Elliot concluded, the financial guarantee industry has a "pretty good story to tell."

Mr. Goldin, New York City's comptroller, said the Tax Reform Act of 1986, which limits the type and dollar amount of municipal bonds eligible for tax exemption, imposed "costly burdens and re-

strictions" on municipal bond issuers (*BI*, June 1, 1987).

These burdens include the enormous administrative work and time needed to determine on a case-by-case basis which municipal capital projects are eligible to be financed on a tax-exempt basis, Mr. Goldin said.

And, limits on the amount of tax-free municipal bonds that can be offered has hurt financial guarantee insurers' business.

"The extra costs incurred by municipalities because of those burdens and restrictions will have to be paid by local taxpayers; hopefully, they (Congress) will appreciate eventually that the extra costs are eroding in whole or in part whatever savings they might enjoy under TRA-86," said Mr. Goldin, referring to the Tax Reform Act of 1986.

New York City will continue to finance most of its capital program through tax-exempt bonds, and is certain to remain one of the nation's largest single issuers of general obligation securities, Mr. Goldin said. However, he added, while New York City will continue to market \$1 billion to \$2 billion of bonds each year over the next 10 years, "our housing and economic development programs will be significantly affected by the tax reform law."

"TRA-86 must be amended, through outright repeal, or a softening of some of its more burdensome and restrictive provisions, as they apply to legitimate governmental needs and purposes," said Mr. Goldin.

Other speakers included James A. Lebenthal, chairman and president of Lebenthal & Co., which sells tax-free municipal bonds, John T. McEvoy, a partner with Kutak Rock & Campbell in Washington, and David C. Clapp who heads the municipal finance department at Goldman Sachs & Co. ■

SERVICE

RISK MANAGEMENT SERVICES

The March 7 Risk Management Services feature will provide 140,333* readers with a full service issue, reporting on competitive market conditions and detailing risk management alternatives.

Risk managers must be aware of all options available to them—from establishing alternative risk financing, self-insurance, captives and risk retention, to renewals and purchasing.

To insure that all options have been explored, the employment of independent consultants has become an intrinsic part of risk management. On March 7 our Directory of Risk Management Consultants will provide readers of *BI* with direct access to these services.

Our readers are served by in-depth news and through coverage of trends that shape the market...our advertisers are served by an editorial environment for their messages that is needed and relied on by the readers.

When it comes to service the choice is crystal clear.

*includes pass-along

Business Insurance

Publishing March 7

Ad Closing February 23

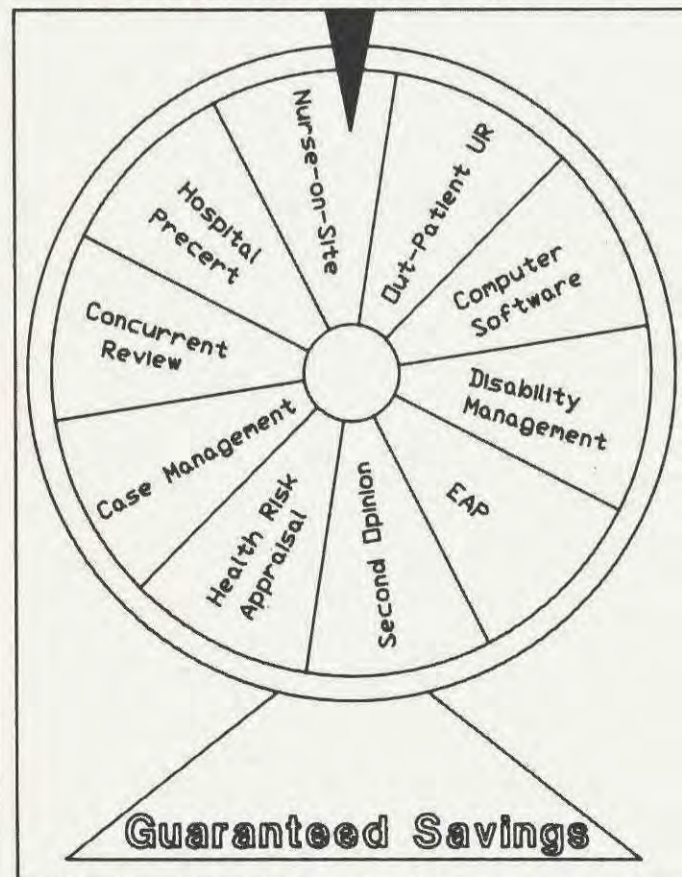
New York: 212-210-0228

Los Angeles: 213-651-3710

Chicago: 312-649-5276

MED-VALU

NO RISK COST CONTAINMENT



6200 Avery Road
Dublin, OH 43017
(614)764-2282

4740 Marsh Road
Okemos, MI 48864
(517)349-4967

401(k) plans

Continued from page 1
pretax and aftertax contributions are allowed.

"We don't like what tax reform did to us. The plan is less desirable overall. It is an increasing burden to operate. The rules are more complicated, putting much more pressure on payroll and data processing staff," said Kevin Flatley, vp-employee benefits at American Express Co. in New York.

"We have doubled the administrative energy that goes into managing the plans," said Gail Bentivegna, administrative systems director for Playboy Enterprises Inc. in Chicago.

"Compliance, once again, becomes king of the hill rather than strategic planning," said BankAmerica's Mr. Nordine.

While tough rules often are better than no rules or the uncertainty that employers had to endure while legislators considered a bewildering array of 401(k) proposals, tax reform has not ended the uncertainty about the plans.

For example, the Internal Revenue Service, after years of delay, still has not published rules on when employees can make in-service hardship withdrawals from 401(k) plans. In the absence of such rules, employers typically have allowed withdrawals under limited circumstances, including catastrophic medical expenses, educational expenses and down payment for a primary residence.

Despite the deep corporate anger over the 401(k) rule changes, benefit managers and consultants say it is inconceivable that employers would drop the plans.

"The plans have an accepted place in benefits and compensation," said Harry Gross, a partner with consultant Kwasha Lipton in Fort Lee, N.J.

Even after tax reform, a 401(k) plan remains the retirement savings vehicle that best meets both employers and employees' needs, experts say.

For employers, the cost of a 401(k) plan often is low and predictable, with easily understood and appreciated benefits.

"Where else do you get so much bang for the buck?" asked Jim Geld, a principal with William M. Mercer-Meindinger-Hansen Inc. in New York.

Employees still can make pretax contributions to 401(k) plans to save for their retirement and often receive a matching contribution from their employer.

"The beauty of a 401(k) plan is that it is a great way for employees to share in the cost of saving for retirement in a tax-effective way," said Gary Pines a principal in the Chicago office of TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

"After tax reform, our 401(k) plan remains our most popular plan," said Don Hillier, vp-human resources with MNC Financial Corp. in Baltimore.

In fact, benefit managers and consultants say, employees continue to make salary deferrals at roughly the same rate as before tax reform. Fears that lower-paid workers would stop contributing have proved—so far—unfounded.

"Over the year, we didn't lose anyone," said Russel Wert, director of benefit services at Aetna Life & Casualty Co. in Hartford, Conn.

But, there probably has been a slowdown in the rate at which new 401(k) plans are being formed. But that is strictly because the explosive growth of the plans in the early 1980s leaves little room for growth.

For example, among 240 major employers tracked by Hewitt Associates in the 1980s, some 91% in 1987 said they offered a 401(k) arrangement, up from just 2% in 1982 shortly after the IRS published proposed rules that made salary

reduction arrangements possible (see chart, page 1).

In fact, 401(k) plans are so widespread that an employer might not be competitive within an industry if it didn't offer a plan, said consultant Gary Blank, chairman of the defined contribution practice committee at The Wyatt Co. in San Francisco.

The biggest change and the biggest problem for 401(k) plans are the tougher non-discrimination rules in the 1986 tax law.

Under those rules, the average percentage of salary deferred by highly paid employees—generally considered those earning more than \$50,000 annually—cannot exceed the greater of these two amounts:

- 125% of the average deferral percentage (ADP) elected by lower-paid employees.

- The lesser of either 200% of the average ADP of the lower-paid employees or the ADP of the lower-paid plus 2%.

Those new tests replaced—generally on Jan. 1, 1987—the prior, more liberal rules. Under the old rules, the ADP of the top-paid one-third of a company's employees could not exceed the greater of two amounts:

- 150% of the ADP of the lower-paid two-thirds.

- 250% of the ADP among the lower-paid two-thirds as long as the difference between the average of the two groups does not exceed 3%.

Those new rules have forced many employers to drastically reduce salary deferrals by highly paid employees.

"The day in which a highly paid employee could put 16% of salary into a 401(k) is going by the wayside," said Greg Wiber, a principal with A. Foster Higgins & Co. Inc. in New York.

Some employers that slashed maximum salary deferrals for highly paid employees at the start of the year had to go even further when they saw that the difference between the ADPs of higher- and lower-paid workers was still too great for the plan to pass the non-discrimination tests.

For example, even after limiting deferrals for highly paid workers to 6% of salary at the start of 1987, BankAmerica by November had to reduce the maximum deferral for the remainder of the year to 5%.

An East Coast Fortune 100 company that did not want to be identified went even further and cut the maximum deferral for highly paid employees to 3% from a pretax reform high of 15%.

The cutbacks in deferrals for higher-paid employees illustrates how business groups fought the wrong battle when they concentrated their efforts during the tax reform debate on trying to stop Congress from lowering the maximum annual deferral to 401(k) plans from the previous \$30,000.

Legislators, after considering a variety of proposals, lowered the limit to \$7,000—with future indexing of the limit to inflation.

However, if companies have to limit deferrals for higher-paid employees to 4% or 5% of salary, only a few executives will be able to defer the maximum \$7,000.

"The focus should have been on the non-discrimination tests and not on the maximum deferral. A \$7,000 limit will not help if you can't pass the tests," said Edward J. Davey, a principal with Foster Higgins in New York.

Employers, though, are taking steps to increase deferrals by lower-paid workers, which would allow the higher-paid to defer more.

One strategy is to increase the percentage of a salary deferral that an employer will match with its own contribution, while lowering the maximum amount of salary it will match. This helps the lower-paid, who often can only afford to

defer a small percentage of salary.

American Express, for example, now fully matches deferrals equal to the first 3% of salary; it had been matching half of contributions up to the first 5% of salary.

Because it is so much easier to fail the non-discrimination rules, employers now say they must spend more time monitoring deferral rates by employees. Benefit managers explain they do not want to scramble at the end of a plan year to return excess contributions to higher-paid employees.

The IRS will slap a 10% excise tax on employers that fail to return excess contributions and investment income to employees within 2½ months after the close of the plan year.

And, because some banks have been sluggish in preparing statements detailing investment income attributable to excess contributions, employers could very well get hit with this tax, according to consultants.

"Things can get very messy. Deferral projections should be done at the beginning of the year," said Wyatt's Mr. Blank.

Some companies also are adding loan provisions to their 401(k) plans, a costly administrative task, to protect employees from the new tax law penalties on in-service withdrawal of funds and keep employees participating in the plans.

"We've had to add three people who only work loans. It is like having a small loan office," said Aetna's Mr. Wert.

About 20% of Aetna's 401(k) plan participants have taken advantage of the loan provision since it was added in April.

"To say that the loan provision was well-received would be an understatement," Mr. Wert said.

Other employers, though, say they want nothing to do with 401(k) loans.

"Loans are an administrative nightmare and require much more staff. We shied away from it," said Mr. Hillier of MNC Financial Corp.

Surprisingly, the biggest financial event of 1987—the October stock market crash—has had little

effect on the overwhelming majority of 401(k) plan participants.

Most plan participants typically have invested their contributions in guaranteed investment contracts, in which an insurer guarantees a fixed rate of return over a certain period of time, rather than more risky investment options, such as mutual stock funds.

"Over 90% of our participants are in GICs," so there was little material effect of the crash, said Playboy's Ms. Bentivegna.

"We have a lot of hourly employees and they tend to be pretty conservative. They understand the GIC," said Doug Wert, director of employee benefits at Kraft Inc. in

Glenview, Ill.

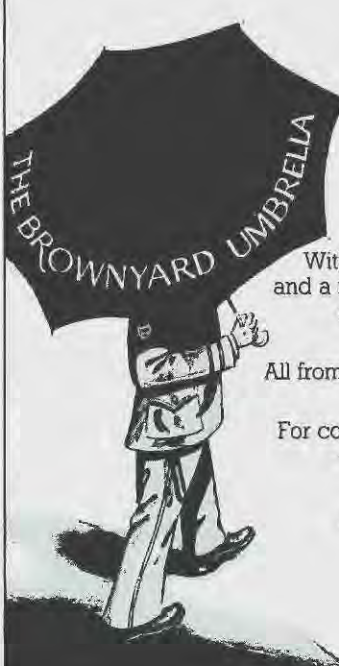
Still, some employees who invested in equity funds were hurt by the crash, and there is concern about giving employees more protection from future market slides.

Some employers are stepping up information they give employees about the risks of investing in equity funds. In addition, there has been some discussion about protecting employees by limiting their ability to shift accumulated 401(k) contributions into an equity fund when they near retirement age.

Employers don't want employees to say: "Why did you let me shoot myself in the foot," said Henry Saveth, a vp with Foster Higgins. ■

SECURITY GUARD, DETECTIVE AND PATROL AGENCIES—

Raise The Brownyard Umbrella:
\$5 million
worth of
protection!



Liability limits are no longer a problem. With our \$1,000,000 General Liability Policy and a new \$4,000,000 Umbrella Liability Policy, now you can enjoy \$5,000,000 in liability protection—an umbrella worth raising!


All from A+ Class XV insurance carriers, which are fully licensed in all 50 states.

For complete information on liability coverage—as well as Third Party Fidelity Bonding—call toll free.

SECURITY IS OUR FIRST CONCERN, TOO!

BROWNARD BROTHERS

20 Fourth Avenue, Bay Shore, NY 11706
800-645-5820 (In NY 516-666-5050)



Executive Benefits
tailor-made by
Corroon & Black.

An Executive Benefits Plan, tailor-made by Corroon & Black, will help you offer key executives highly attractive packages of supplemental retirement, deferred compensation and death and disability benefits, while keeping your costs manageable.

Your problems are unique. Our solutions are, too. As one of America's most innovative employee benefit consultants and brokers, we fashion creative, value-added solutions through keen thinking of seasoned professionals. And provide the best personal service at every level.

For more information about how we measure up, contact your local Corroon & Black office or Richard I. Citron, National Benefits Division, Wall Street Plaza, New York, NY. (212) 363-4100.

CB
CORROON & BLACK
for your benefits.

Oakeley Vaughan

Continued from page 3

to a source close to Oakeley Vaughan. Mr. Merrett refused to comment.

In three lawsuits filed in London's High Court on Aug. 28 and Dec. 3, 1987, at least 46 Oakeley Vaughan syndicate members are suing Lloyd's, claiming it failed to disclose details of an inquiry it instigated in 1981 into the affairs of Oakeley Vaughan. The lawsuits also claim that Lloyd's failed to properly supervise the Oakeley Vaughan syndicates.

The Lloyd's investigation, conducted by Henry Chester, led to the suspension of three Oakeley Vaughan employees in the fall of 1981 (BI, Oct. 5, 1981).

A message pinned to the Lloyd's notice board in October 1981 said the three employees were "guilty of acts or defaults discreditable to them as underwriters or otherwise in connection with the business of insurance in that they've failed to comply with established procedures in conducting business at Lloyd's."

The Lloyd's investigation also led to a reprimand of Oakeley Vaughan Chairman Charles St. George, which Lloyd's agreed not to make public, according to a confidential Dec. 4, 1981, letter sent to Mr. St. George by Lloyd's legal department.

The letter states that the Committee of Lloyd's agreed the reprimand should not be published "following representations made on your behalf by your brother, Mr. Edward St. George."

The letter reads: "It will be recalled by you that the Committee, having studied and deliberated upon the Chester Report and a supplementary report, concluded that, as chairman of Oakeley Vaughan (Underwriting) Ltd. you had failed to ensure that established procedures in the conduct of insurance business at Lloyd's

were adhered to within the company."

The letter also notes that at a meeting with then-Lloyd's Chairman Peter Green on Nov. 18, 1981, Charles St. George agreed to "relinquish all executive functions within Oakeley Vaughan."

Charles St. George would not comment for this story.

Oakeley Vaughan members told *Business Insurance* that if Lloyd's had disclosed details of its investigation, they would not have remained members of the syndicates, avoiding heavy losses incurred by the syndicates in the 1982 and 1983 underwriting years.

"Lloyd's has persistently refused to disclose the Chester Report or its findings" to members, says the members' pleadings, prepared by the London law firm of Elborne Mitchell & Co., which is representing all of the members in the three lawsuits.

The members' pleadings say Lloyd's commissioned the Chester inquiry to investigate "the degree of overwriting by Oakeley Vaughan and/or into its management," and it "revealed or ought to have revealed:"

- The extent of overwriting by Oakeley Vaughan syndicates.

- That Oakeley Vaughan failed to adhere to established procedures in the conduct of business at Lloyd's.

- That Oakeley Vaughan possessed insufficient management control to ensure that premium income was within limits.

- That Oakeley Vaughan's management was not sufficiently competent or prudent to conduct the affairs of names.

The pleadings contend that although Lloyd's was aware or should have been aware of this information, it "failed to take any satisfactory steps to protect the names" and "wrongfully permitted Oakeley Vaughan to continue underwriting."

Oakeley Vaughan "continued to

exceed the premium limits for the names participating in syndicates 420, 551 and 862 in the years 1981 and 1982," the pleadings say.

For example, syndicate 551 wrote premiums of nearly 12 million pounds in 1982 even though its total capacity was less than 5 million pounds, according to the pleadings.

As a result of Lloyd's failure to advise members of the report and failing to implement "any satisfactory safeguards to ensure that Oakeley Vaughan, if permitted to continue writing, only wrote within premium income limits," the members "suffered loss and damage," the pleadings say.

The members are waiting for Lloyd's to file its defense papers, said Stephen Bailey, a partner at Elborne Mitchell.

In Houston, Lloyd's member Jay D. Hirsch is suing Lloyd's, Oakeley Vaughan and the St. George brothers for mismanagement, negligence and violations of the Texas Deceptive Trade Practices Act and the Texas Insurance Code, confirmed Anthony F. Montgomery, Mr. Hirsch's attorney.

Mr. Hirsch, who is an attorney, and Mr. Montgomery are both with the Houston law firm of Hirsch, Glover, Robinson & Sheineff.

Although damages are unspecified in the original lawsuit, Mr. Montgomery said "we are in the process of amending our petition to seek several million dollars in damages to cover the syndicates' potential liabilities."

Violations of the Deceptive Practices Act and the Texas Insurance Code raises a potential for treble damages and the payment of attorney fees, he pointed out.

The litigation is currently pending in the U.S. District Court for the Southern District of Texas.

In addition, Mr. Hirsch has succeeded in obtaining an injunction "preventing Lloyd's from drawing down on his letter of credit," said Mr. Montgomery, referring to Mr.

Hirsch's member's deposit.

All members joining Lloyd's are required to make a deposit in a form approved by Lloyd's, such as a letter of credit or bank guarantee. The amount of the deposit depends on the amount of the member's premium income limit. A British name is required to provide a deposit of 20% of his overall premium limit and an overseas name is required to deposit 28% of the limit.

Lloyd's is currently "fighting jurisdiction," claiming the litigation should be pursued in London and not in Texas, said Mr. Montgomery.

Mr. Montgomery believes Lloyd's will settle the case out of court if it fails to obtain a venue change. "The defendants will settle rather than risk a multimillion-dollar settlement in the U.S.," he said.

In London, Greenshore Underwriting Agents Ltd., Hinton Hill Underwriting Agents Ltd., Philip Vos Underwriting Agents Ltd. and Linden Underwriting Ltd. are suing the Society of Lloyd's for negligence and breach of duty for failing to supervise the conduct of the Oakeley Vaughan syndicates. The suit says Lloyd's did not promptly publish "the results of enquiries conducted by them" and failed to implement with "reasonable promptness the recommendations of the Fisher Working Party published in May 1980."

The Fisher Working Party was set up in 1979 to examine how Lloyd's could best regulate itself, and the Fisher committee's report formed the basis of the Lloyd's Act of 1982.

Among the committee's recommendations was the establishment of a system to give early warning that a syndicate was likely to exceed its premium limit.

No one from AUA No. 6, C.C.G.H. or Lloyd's would comment on the pending litigation and the charges made by the members.

However, Lloyd's filed a lawsuit in London's High Court on Dec. 31 against 10 members' agencies seeking a declaration that the agencies are liable to the 40 members suing Lloyd's in High Court "for breach of a written contract of agency and negligence and breach of duty as agent or sub-agent responsible for the underwriting of syndicates 420, 551 and 862 (and incidental syndicates) at Lloyd's for the years of account 1976 to 1982."

Lloyd's also filed a separate lawsuit in the High Court on the same day against Oakeley Vaughan's accountants, Pannell Kerr Foster in London, and named partners in the firm. Lloyd's is seeking a declaration that the firm and the partners are liable for damages to the 40 litigating members for "negligence and/or breach of duty in auditing the accounts of syndicates 420, 551 and 862."

According to a report on non-marine syndicate 551 sent to members by runoff underwriter Barry Coleman last year, the 1982 and 1983 underwriting accounts have been kept open because of "uncertainties regarding the eventual outcome of three major problems." These are listed as:

- A reinsurance treaty written

by the syndicate for Insurance Corp. of Ireland P.L.C., the troubled insurer the Irish government bought for 1 pound from Allied Irish Banks in 1985.

According to a report by lawyers Elborne Mitchell & Co., Mr. Coleman is referring to a U.S. property reinsurance treaty underwritten by syndicate 551 for ICI in which syndicate 551 accepted a 4.76% line.

- Losses arising from the commercial auto liability account written by Will Darrah & Associates, a managing general agency in Myrtle Beach, S.C. (BI, Dec. 19, 1986).

"During 1986, the incurred situation has deteriorated badly and now stands at \$4.16 million," Mr. Coleman's report says. "The loss ratio on this account for the 1983 year, to the market as a whole, stands at over 405%."

- Losses related to municipal liability business written by underwriting agency Marincio Inc. of San Antonio, Texas.

Syndicate 551 suffered a loss of 9.2 million pounds (\$13.6 million) in 1982, the accounts say, representing a 18,803-pound loss on a standard 10,000-pound investment by a 1982 name on the syndicate.

As of year-end 1986, syndicate 551 had losses of 4.6 million pounds (\$6.8 million) in 1983, representing a 10,284-pound loss per 10,000 pound investment in 1983, the accounts show.

As of year-end 1986, aviation syndicate 862 reported a 3.45 million-pound (\$5.1 million) loss for 1980, representing losses to names of 19,832 pounds per 10,000-pound investment; a 62,420-pound (\$92,600) profit for 1981, representing profits of 29 pounds per 10,000-pound investment; a 326,574-pound (\$484,300) loss in 1982, or losses of 2,722 pounds per 10,000-pound investment; and a 159,534-pound (\$236,600) loss in 1983, representing losses of 1,864 pounds per 10,000-pound investment.

Marine syndicate 420's net loss for 1982, the only year remaining open, was 6.2 million pounds (\$9.2 million), representing a loss to names of 34,321 pounds per 20,000-pound investment, the accounts show.

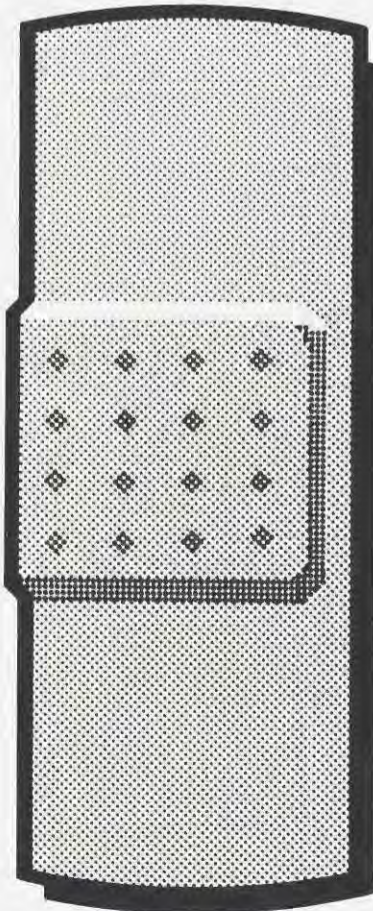
Members were advised of their individual losses as of July 22, 1987, in the letters AUA No. 6 sent last month. The letters also instructed the members to pay the losses by today, but did not indicate whether any action would be taken if members failed to do so.

However, if members refuse to pay the losses, Lloyd's could draw down on members' deposits, said Mr. Bailey of Elborne Mitchell.

Although several members agencies representing Oakeley Vaughan members are refusing to draw down on members' deposits, AUA No. 6 is entitled as a Lloyd's-appointed agency to draw down on all Oakeley Vaughan members' deposits, said a members' agency executive who did not wish to be identified.

Discussions currently are under way between Lloyd's and various members agencies over how to handle "hardship" cases—names with very heavy losses, said one source close to the discussions. ■

Tell us where it hurts. We'll make it better.



The Sagamore Health Network's latest solution to rising health care costs... UR/Sagamore. It's our proven third party Utilization Review. And it's available to any business or association whether or not they belong to the Sagamore Health Network.

UR/Sagamore provides benefit managers with a detailed reporting system and cost management before, during and after each insured member's medical usage. It protects providers from unnecessary uses of benefits while providing members with the medical benefits they need.

Call UR/Sagamore. Before it starts to hurt.

For information contact the Sagamore Health Network, 107 N. Pennsylvania Street, Indianapolis, IN 46204 317-634-0667 or in Indiana, call toll free 1-800-521-6139.

UR/Sagamore
HEALTH NETWORK

Storms cost total \$35 million

NEW YORK—Wind, hail, snow, flooding and tornadoes caused an estimated \$35 million in insured losses from Jan. 17-20 in portions of California, Arkansas, Mississippi, Tennessee and Alabama, according to the Property Claim Services division of American Insurance Services Group Inc.

The most extensive damage, estimated at \$25 million, occurred in California. Damage in Alabama was estimated at \$5 million, damage in Tennessee was estimated at \$3 million and damages in both Arkansas and Mississippi were estimated at \$1 million.

The estimate of insured property damage does not include flood losses, which are covered under the National Flood Insurance Program. The storm was assigned Catastrophe Number 50 by Property Claim Services.

Diamond Shamrock

Continued from page 2

observed one lawyer who requested anonymity. Instead, the judge indicated that the insurers' liability was created by the fact of the Agent Orange class-action suit itself.

The lawyer speculated that insurers could argue that Diamond Shamrock has no coverage for the Agent Orange claims, since its liability was created by the 1984 class settlement and Judge Stanton has excluded coverage under post-Dec. 29, 1980, policies.

Aetna, however, is unlikely to make such an argument, and insurers probably would not prevail on this theory in any case, lawyers say.

Michael P. Tierney, a lawyer representing Diamond Shamrock, noted that the "triple trigger" theory first espoused in the landmark 1981 *Keene Corp. vs. Insurance Co. of North America* ruling could be applied both to Diamond Shamrock's bodily injury and property damage liability claims.

The triple-trigger theory of liability, applied in asbestos injury cases, has afforded coverage under policies in force at the time of exposure to asbestos, during the latency period of asbestos-related disease and at the time disease manifests itself.

A form of this theory also has been applied in asbestos-related property damage cases, according to Mr. Tierney, with the New York firm of Cahill, Gordon & Reindel (see story, page 1).

However, Mr. Tierney would not say whether Diamond Shamrock plans to argue for the triple trigger theory.

Lawyers for several of Diamond Shamrock's insurers also refused to say what coverage theory they will present.

Also to be decided are the issues of how many separate "occurrences" the Agent Orange and Newark claims represent under the terms of the policies and whether sudden and accidental pollution exclusions in various policies bar recoveries for the Newark plant contamination, lawyers involved in the case say.

A schedule for the filing of motions on these issues is expected to be agreed on shortly.

Responding to an earlier set of pre-trial motions, Judge Stanton ruled on Dec. 11 that the government-imposed costs of cleaning up the polluted Newark site constitute "damages" under Diamond Shamrock's general liability policies. (*BI*, Jan. 25.)

Ruling from the bench, Judge Stanton also denied a motion by several excess insurers for a decision that Diamond Shamrock could not prove that bodily in-

juries and property damage had resulted from its products and operations.

Aetna and other insurers will ask the judge to reconsider his finding that the owned property exclusion in their policies does not apply to the Newark plant cleanup, according to Thomas Groark, a lawyer with the Hartford, Conn., firm of Day, Berry & Howard, representing Aetna.

Under the exclusion, Aetna contends that costs related to the cleanup of property owned by Diamond Shamrock are not covered.

Aetna and the excess insurers may also eventually appeal Judge Stanton's Dec. 11 ruling, according to lawyers.

Meanwhile, in a Feb. 5 letter to lawyers in the case, Judge Stanton disposed of coverage questions not addressed in his Dec. 11 oral opinion.

The judge excluded coverage for Newark dioxin claims under policies incepting after Gov. Kean's executive order, noting that "since it was clear from June 4, 1983, onwards that there was dioxin contamination for which Diamond Shamrock would be liable, loss thereafter was 'expected' so far as insurance law concepts are concerned."

However, Judge Stanton did not rule on the liability of Royal Indemnity Co., one of the excess insurers, under a policy that became effective Feb. 1, 1983, and ordered a trial on the

issue. The judge also denied coverage of Agent Orange product liability claims under policies incepting after the Vietnam veterans' class-action suit was certified in U.S. District Court for the Eastern District of New York on Dec. 29, 1980.

In his letter, the judge declined to cut off coverage as of an earlier date on the grounds that several individual Agent Orange product liability suits had been filed against Diamond Shamrock.

"The underlying tort causes of action in the Agent Orange cases are very tenuous and physical causation problems are very great for plaintiffs. Accordingly, a few cases would probably not have any great impact on the risk management thinking of Diamond Shamrock."

After the class certification, however, "the sheer magnitude of the Agent Orange litigation claims then pending required Diamond Shamrock to recognize that a loss might, in fact, have occurred.

"Elementary concepts of what insurance is supposed to be and of fair dealing precluded coverage for the Agent Orange product liability claims on liability policies incepting after Dec. 29, 1980, unless an insurer were to agree explicitly to cover any risk of loss arising out of the then pending litigation. There was no such explicit agreement," the judge wrote. ■

'The sheer magnitude of the Agent Orange litigation claims. . . required Diamond Shamrock to recognize that a loss might, in fact, have occurred,' Judge Stanton wrote.

Hospital forms captive for malpractice cover

HAMILTON, Bermuda—Miami Valley Hospital of Dayton, Ohio, has been given permission by Bermuda regulators to incorporate a medical malpractice captive.

The 772-bed general and acute care hospital previously self-insured its medical malpractice exposures.

The new captive, MedAmerica International Insurance Ltd., will write medical malpractice insurance for Miami Valley with limits of \$2 million per occurrence and \$6 million aggregate in malpractice coverage, said Peter Strong of Independent Management Group Ltd. in Bermuda, which will manage the captive.

Mr. Strong would not comment on the capital and surplus of the captive, but said it is adequate to cover Miami Valley's \$6 million in aggregate limits.

The captive has purchased reinsurance from Employers Reinsurance Corp. of Kansas City, Mo., Mr. Strong said.

Because Miami Valley is a non-profit hospital, it did not run into the same tax difficulties as many other captives looking at Bermuda as a potential domicile, he said.

"The hospital had already been self-insuring, but needed an insurance vehicle to obtain reinsurance," explained Mr. Strong. "They (Miami Valley) came to Bermuda, saw the infrastructure and liked what they saw," he added.

He said Bermuda has a reputation for not being receptive to

medical malpractice captives, a reputation that dates back to the 1970s when Harvard University had a difficult time gaining regulatory approval for a medical malpractice captive. Offended by the litany of questions Bermuda regulators asked, Harvard established its captive in the Cayman Islands.

But, Mr. Strong said Bermuda's quick approval of this captive—in seven days—indicates the domicile is, in fact, willing to accept medical malpractice captives.

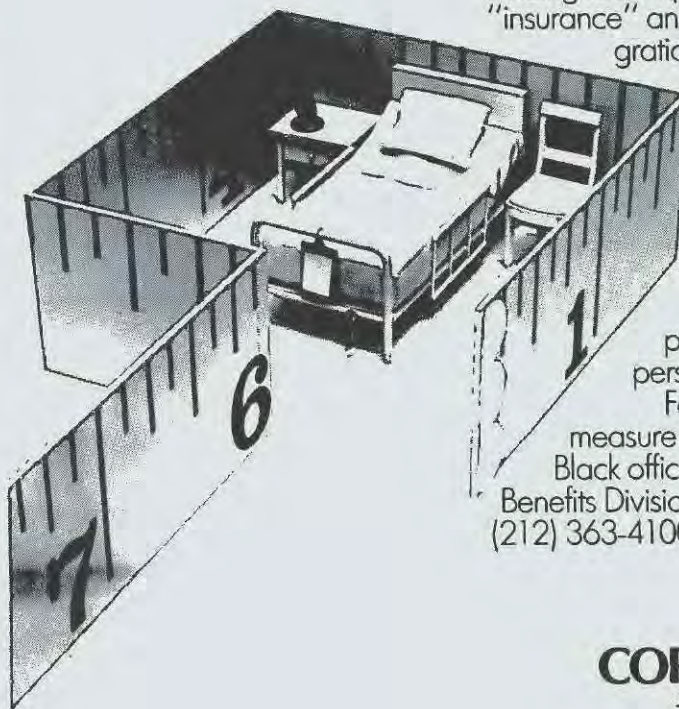
"This illustrates Bermuda's willingness to accept hospital malpractice for carefully organized captives," said Mr. Strong. "And it shows they are prepared to act promptly once all the required information is in place."

The hospital's board of directors will meet this month to consider final approval of the captive, said Mr. Strong, adding that the captive should be up and running by March 1, he explained.

The captive will be located in the Williams House on Reid Street in Hamilton.

Other parties involved in the formation of the captive include John Watson of Brower Insurance Agency in Dayton and Bala Nadarajah of the law firm of Hanson, O'Brien, Birney and Butler in Washington, D.C.

Mr. Nadarajah served from 1979 to 1986 as legal adviser to the Bermuda registrar of companies, which regulates the Bermuda captive industry. ■



Health Care Benefits tailor-made by Corroon & Black.

Health Care and Welfare Programs, tailor-made for you by Corroon & Black, can help you control and manage costs while implementing funding techniques with the right balance of "insurance" and "risk." We are pioneers in the integration of cost containment into flexible delivery systems.

Your problems are unique. Our solutions are, too. As one of America's most innovative employee benefit consultants and brokers, we fashion creative, value-added solutions through keen thinking of seasoned professionals. And provide the best personal service at every level.

For more information about how we measure up, contact your local Corroon & Black office or Richard I. Citron, National Benefits Division, Wall Street Plaza, New York, NY. (212) 363-4100.



CORROON & BLACK
for your benefits.

Crippled satellite may be a total loss

By **CAROLYN ALDRED**
and **STACY SHAPIRO**

London

LONDON—Satellite insurers will meet with technicians this week to discuss the condition of the malfunctioning West German TVSat satellite, which may be declared a total loss if repairs cannot be made by the end of this month.

TVSat—owned by Bundespost, the West German telecommunications monopoly—failed to deploy one of its solar panels after it was launched Nov. 20 by Arianespace, the European satellite launch agency.

The satellite is insured for 95 million deutsche marks (\$55.9 million) by underwriters around the world, including Lloyd's of London underwriters. The coverage was brokered by Funk International

GmbH of Hamburg, West Germany (BI, Dec. 14, 1987).

The technicians have called the meeting with insurers in Bonn to discuss a variety of alternatives to fix the satellite, Lebrecht Funk, president of the brokerage, said. It will be the second meeting between insurers and technicians since the satellite malfunctioned, he said.

Some of the alternatives might be financed by the insurers if they support the actions, said Mr. Funk.

Mr. Funk has told underwriters that there is a chance the satellite will not function at all. However, if the technicians are successful in opening the solar panel, the satellite may only be a partial loss de-

pending on the amount of fuel remaining and the number of transponders that can be used, he said.

TVSat is a major television satellite in Europe and cost hundreds of millions of dollars, reports say. But the insurance covering the probe does not cover Bundespost's contingency losses, Mr. Funk said.

"The sums insured do not cover 100% (of the risk), that's for sure. We could have found more capacity, but it was the choice of the ministry" to restrict coverage limits, he explained.

Aviation accounts

The defection of key aviation ex-

ecutives from Lloyd's of London's Stewart Wrightson Holdings P.L.C. has cost parent company Willis Faber P.L.C. at least 15 major airline accounts.

By the end of January, the airlines had moved their accounts from Willis Faber to Lloyd's broker Nicholson Stewart-Brown Ltd., to which key Stewart Wrightson aviation executives moved last month.

The accounts that have moved to Nicholson Stewart-Brown include the business of KSS Group, a group of airlines whose fleet is collectively valued at \$8 billion. The KSS account, which is co-brokered by Bowring Aviation Ltd., includes KLM Royal Dutch Airways, Swissair, Scandinavian Airlines System, Austrian Airlines, Finnair and Air U.K.

The other airlines moving to Nicholson Stewart-Brown include Air France; Korean Air Lines; Philippine Airlines Inc.; China Airlines Ltd. of Taiwan; World Airways Inc.; Presidential Airways; Markair; and East European airline Malev of Hungary.

Although Nicholson Stewart-Brown confirmed the airline account switches, the broker would not disclose how much in premiums or revenues the accounts produce.

One major airline that has not yet moved its account to Nicholson Stewart-Brown from Willis Faber is United Airlines, which had been Stewart Wrightson's largest U.S. aviation account.

The loss of the airline accounts follow the defection of at least 100 employees, including nearly a dozen key executives, from Stewart Wrightson following its acquisition by Willis Faber (BI, Nov. 9, 1987).

Many of the key executives and employees joined the former Stewart Wrightson-owned Nicholson Stewart-Brown, which will be the nucleus of a new Lloyd's brokerage partially backed by Chicago-based broker Rollins Burdick Hunter Co. The executives include Alan Colls, the former chairman of Stewart Wrightson Ltd. and a key aviation expert; Jonathan Palmer-Brown, former chairman of Stewart Wrightson Aviation Ltd.; and Peter Butler, former managing director of the aviation division (BI, Nov. 23, 1987).

The new brokerage, which is expected to be called Nicholson, Chamberlain & Colls Ltd., has not yet been formed, but observers expect final plans to be completed soon. RBH is expected to own between 35% and 40% of the new broker.

Lloyd's anniversary

Lloyd's of London will start its year-long celebration of its 300th anniversary this week by illuminating the new Lloyd's building in brilliant blue and white light, with a rose-colored glow flooding the building's 200-foot glass atrium.

The ceremony on Thursday will be attended by Queen Elizabeth, the Queen Mother, who is an honorary Lloyd's member. She will turn on the illumination, which may include fireworks fired from the top of the Lloyd's building.

The permanent lighting, conceived by specialist design company Imagination Ltd., will have an output of 261 kilowatts, or enough power for 12 three-story houses or one 20,000 square foot office block.

At the ceremony the Queen Mother will also unveil her portrait commissioned by Lloyd's from the artist Norman Hepple, which will hang in a dining room in the building.

While the actual opening date of Edward Lloyd's coffee house is not known, the first reference to insurance being transacted at the coffeehouse was found in the Feb. 18-21, 1688 edition of the London Gazette.

Although Lloyd's has not officially announced the events it plans to hold this year to celebrate its anniversary, some of the activities will include:

- A day-long seminar on March 2 for U.S. insurance brokerage executives. The seminar, to be hosted by Lloyd's Chairman Murray Lawrence, will be held on the royal yacht Britannia, which will be docked off Long Beach, Calif.

- Special awards for medical, scientific and business research to be granted by Lloyd's Tercentenary Foundation, chaired by former

Continued on next page

HOT OFF THE PRESS

The 1987/88 Business Insurance Directory of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services

It's hot off the press! It gives you instant access to the major buyers in the commercial insurance market. And it saves you time and money because the BI Directory 1987-88 contains more pertinent information than ever before.

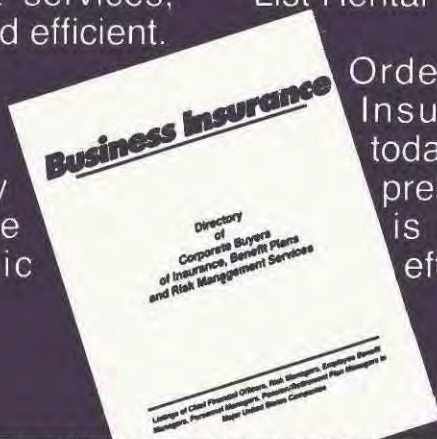
Whether you want to identify your corporate counterparts or reach corporate buyers of insurance, benefit plans and risk management services, the BI Directory is effective and efficient.

Vital information on over 2,200 U.S. corporations — they are listed alphabetically and indexed by employee population and geographic

location. There are approximately 9,000 individual corporate buyers listed by name, title and area of responsibility. The Directory also gives you company size - by employees and assets or sales.

Bonus: This year, for the first time ever, The Business Insurance Directory is available on computer tape. For further information contact Sharon Huffman, List Rental Manager, at 313-446-0476.

Order your 1987/88 Business Insurance Directory 1987-88 today. Remember, it's hot off the press so the information you get is up-to-date and more cost effective than ever before!



Business Insurance 1987/88 DIRECTORY of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services

I want _____ copies.

\$75 each. All orders must be prepaid.

Make check payable to: Business Insurance Directory.

Total Enclosed: \$ _____ or charge my Visa Mastercard

Account # _____

Exp. Date _____

Signature _____

name _____
title _____
company _____
address _____
city _____ state _____ zip _____
phone _____

For further information, or to charge your order by phone, please call: **Fanny Franklin (313) 446-0477**

Please send me Business Insurance subscription information

Mail this card and your check/money order to:

Business Insurance Directory: Single Copy Sales
965 East Jefferson Avenue, Detroit, MI 48207

BI 2/15

Continued from previous page

Lloyd's Chairman Peter Miller. The Council of Lloyd's has donated 1 million pounds (\$1.75 million) to set up the foundation, and Mr. Miller is appealing for more donations.

- A dinner on June 10 for leading figures in the London's financial, political, education and the Lloyd's communities.

- A polo match on June 22 at Windsor.

- Several balls, including one to be held June 21 by Lloyd's Saddle Club.

- A Sept. 17 celebration at Leeds Castle for the 2,000 employees of the Corporation of Lloyd's.

A set of stamps also will be issued focusing on the historical links between Lloyd's and the rest of the world.

Lloyd's has been planning the year of celebration for the last 12 months through the Tercentenary committee, headed by Lloyd's underwriter Michael Cockell.

Suggestion rejected

Members of the Council of Lloyd's of London's who are not Lloyd's names have decided against a recommendation of the government committee headed by Sir Patrick Neill that called for a report by these council members on the market's regulatory activities.

The Neill committee recommended that the council members nominated by the Bank of England should include a separate report in Lloyd's annual accounts on the progress of regulation at Lloyd's affecting the interest of Lloyd's names. The report also was to include an agenda for future reform.

However, the nominated council members unanimously agreed that they should not act separately from the rest of the Lloyd's Council. The nominated council members suggested that the entire council write the report instead, Lloyd's announced.

The council also rejected the Neill committee's suggestion that non-working and nominated members of the council have a separate staff.

Airline mutual

The aviation mutual insurance company set up by the International Air Transport Assn. last year has attracted 16 member airlines.

Airline Mutual Insurance Ltd., which is managed by Thomas R. Miller & Son Ltd., writes 5% of member airlines' all-risk hull insurance aviation liability insurance.

Although the mutual was fully reinsured in the London market during its first year of operation, it plans to retain a portion of the risk this year if members approve, said Dennis Viggers, insurance manager for the IATA.

Trade barriers falling

Continental European insurers are gearing themselves up to take advantage of the liberalization of Europe's trade barriers in 1992 and could leave London insurers in their wake, a Dutch broker warns.

Insurers in Switzerland, West Germany and France "seem to have set their goals. They are offering global programs to be serviced through their rapidly expanding networks. And they do have very substantial capacity available," said Gerald Kamphuisen, chairman of the corporate accounts division of Rotterdam-based broker Hudig-Langeveldt Group B.V.

National regulations that "still inhibit real international insurance trading will be lifted" within the European Community in 1992, and "those companies seem to prepare for that new era," Mr. Kamphuisen said in a speech last month

to the Institute of London Insurers.

The ministers of the 12 European Community member nations in December agreed to allow insurance companies based in one EC member state to underwrite large risks located in other states.

Currently, only the United Kingdom and the Netherlands allow cross-border insurance placement. The other EC member nations generally require risks to be insured by domestic insurers, though risks can be reinsured on an international basis (*BI*, Dec. 28, 1987).

The continental insurers are opening offices throughout Europe and are building and strengthening relations with their clients, said Mr. Kamphuisen.

For example, French insurers "are aggressively looking around buying companies and intermediaries, planning for the 1990s," he pointed out.

Increased capacity also is being offered by insurers on the continent, as was obvious during year-end renewals, said Mr. Kamphuisen, adding that "even in liability they do not hesitate to enter into programs, including the U.S., with capacities of 20 to 30 million pounds" (\$35 million to \$52.5 million).

Moreover, "if this trend sticks, the need for excess coverage will diminish and, thus, one of the traditional strongholds of the market in London could be jeopardized," he added.

"If the London market is now opening up for fire and business interruption business from the continent, I cannot help thinking that has more to do with the exchange rates of the dollar and the European currencies than with the wish to build a longstanding relationship with the customer," he noted.

While a French broker will be able to directly approach a German company to place a risk after 1992, Mr. Kamphuisen questioned whether the French broker will still have to go through a Lloyd's of London broker to place the business at Lloyd's.

Would not the continued use of Lloyd's brokers "be contrary to the trend to shorten the trajectory of the premium in order to reduce cost and to speed up communications and payments of premium and claims?" he added.

ECGD results

Government auditors have qualified the Export Credits Guarantee Department's annual accounts because of uncertainty over Third World debt provisions.

The government-owned agency, which writes export credit insurance for British companies trading abroad, increased its general accounting provision for sovereign debt to 1.12 billion pounds (\$1.8 billion at applicable exchange rates) for the year ended March 31, 1987, from 582 million pounds (\$861 million) in fiscal 1986.

"The general provision is a prudent allowance to reflect possibility that the amount of sovereign debt in the department's balance sheet may not in the future prove to be fully recoverable," said a statement issued by the ECGD.

However, the government's auditor has qualified the ECGD's audit certificate on two counts, said Michael Stephens, the ECGD's chief executive.

The auditor "is uncertain as to the adequacy of the general provision for loss on sovereign debt and disagrees with the accounting treatment for this," Mr. Stephens said.

"The international debt position poses severe problems for us as for all institutions concerned with international trade and financing. These problems will not be solved easily or quickly, he said."

Meanwhile, the agency announced a surplus of 177.5 million

pounds (\$285.8 million) for its export credit insurance operation for the year ended March 31, 1987, compared with a surplus of 238.6 million pounds (\$353.1 million) the previous year.

Claims paid during fiscal 1987 totaled 803.4 million pounds (\$1.29 billion, up from 777.1 million pounds (\$1.15 billion) the previous year.

St. Paul hikes capital

The St. Paul Cos. Inc. has increased the capital of its British-based underwriting subsidiaries by 11.5 million pounds (\$20.1 million) to 33 million pounds (\$57.8 million), according to Vartkis Boghos, managing director and chief executive of The St. Paul (UK) Ltd.

The capital of St. Paul Fire & Marine Insurance Company (UK) Ltd. was raised to 15 million pounds (\$26.3 million) from 10 million pounds (\$17.5 million), while the capital of the newly acquired St. Katherine Insurance Co. P.L.C. has been increased to 18.2 million pounds (\$31.9 million) from 11.7 million pounds (\$20.5 million).

Outhwaite payments

Lloyd's of London syndicate 317, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., must make provisional payment under excess-of-loss reinsurance contracts to reinsurers for claims they paid from the June 1985 explosion of an Air India Boeing 747 jetliner, an appellate judge ruled.

Air India has received \$98.5 million for the loss of the hull from its aviation insurer General Insurance Corp. of India. However, the cause of the explosion still remains a mystery and GIC's aviation all-risk and war risk reinsurers are in arbitration to decide which group should pay (*BI*, Sept. 14, 1987). Meanwhile, each set of reinsurers has paid 50% of GIC's claim until the arbitration is concluded.

A London Appeal Court dismissed syndicate 317's appeal that the wording of the excess-of-loss

reinsurance contract does not allow for the recovery of loan payments and found in favor of Lloyd's underwriters Kenneth Boden, John Tilling, Michael Gravett and Peter Hardy.

Jardine benefit unit

The Jardine Insurance Brokers Group is establishing a separate company to offer employee benefits consulting and personal financial planning.

Jardine Financial Consultants Ltd. will consist of two main divisions—the employee benefits consulting division for corporate clients, and the personal financial planning division to provide advice to corporation's employees or individuals.

The subsidiary will be headed by Martin Wakeley as chairman and Ron Walker as managing director.

Comings & goings

Philip Wroughton will become chairman and chief executive of

C.T. Bowring & Co., the Lloyd's of London broking subsidiary of Marsh & McLennan Cos. Inc., at the end of March. Mr. Wroughton succeeds Gil Cooke, who is retiring. Mr. Wroughton joined C.T. Bowring as a reinsurance broker in the North American division in 1961. His appointment as chairman was widely predicted (*BI*, Aug. 31, 1987).

Hamish Ritchie will succeed Mr. Cooke as chairman and a director of Bowring U.K. Ltd.

James Duffy, Stephen Oden, Thomas Poutney, David Rees and Edward Richardson have been promoted to directors of Bowring Aviation Ltd., a subsidiary of C.T. Bowring & Co. Ltd.

Roger Corley has been elected president of the Institute of Actuaries.

Michael J. Bohling has been appointed managing director of HRGM Marine Ltd., a subsidiary of Lloyd's of London broker Hogg Robinson & Gardner Mountain P.L.C. Mr. Bohling joined HRGM in 1984 as a director of the marine company.

DENTAFITS, INC.

Can Provide
STOP LOSS COVERAGE FOR

▶Dental ▶Vision
▶Prescription Drug
GROUP BENEFIT PLANS



For quotes or information call or write:
Debbie Boucher
P.O. Box 3209, 527 E. Rowland Ave.
Covina, CA 91722 (818) 967-2878
FAX (818) 332-5778



Flexible Benefits tailor-made by Corroon & Black.

A Flexible Benefits Program, tailor-made for you by Corroon & Black, will help you give employees a choice of benefit packages suited to their needs, help you integrate your benefit plans, take advantage of new tax laws, compete better in recruitment and keep costs low.

Your problems are unique. Our solutions are, too. As one of America's most innovative employee benefit consultants and brokers, we fashion creative, value-added solutions through keen thinking of seasoned professionals. And provide the best personal service at every level.

For more information about how we measure up, contact your local Corroon & Black office or Richard I. Citron, National Benefits Division, Wall Street Plaza, New York, NY. (212) 363-4100.



CORROON & BLACK
for your benefits.

The professional marketplace

RATES AND CLOSING TIME:

Rates: Display classified is \$92.75 per column inch, minimum of one inch. Straight classified is \$7.50 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional \$15.00 charge for all blind box ads. Only those responses which fit into a business size envelope will be forwarded. Responses are forwarded daily.

Closing: Published every Monday. Copy must in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for straight advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St. Chicago, IL 60611. For more information call 312-649-5340.

RETAIL TRUCK PRODUCERS WANTED

Due to program expansion, we are currently seeking experienced, licensed, retail truck producers to represent financially strong insurance carriers for **primary liability, physical damage and cargo** in most U.S. States.

Please reply to:
Box 2356
Business Insurance
740 Rush St.
Chicago, IL 60611-2590

MEDICAL MALPRACTICE PRODUCER

Nationwide risk retention group seeks full-time persons for New York, Florida, Texas, Illinois, California. Program sponsored by medical societies. Physicians highly motivated to purchase. Leads and identifiable prospects. Non-recoverable draw plus benefits. Potential compensation \$60,000-\$145,000.

NAPI
(800) 622-8488
CA (800) 255-5391

CAROLYN DAVIS ASSOCIATES, INC.

Staffing Consultants to the Insurance Industry
701 Westchester Avenue
Suite 308 W
White Plains, NY 10604
(914) 682-7040

EXECUTIVE V.P. C.O.O.

LOS ANGELES branch of National Broker needs proven executive capable of being CEO in one year, must have Southern California experience.

VICE PRESIDENT UNIT MANAGER

Chicago branch of top ten broker needs a manager for a unit of 12 people specializing in production of Jumbo accounts. Relocation package.

SENIOR V.P. CORPORATE

Upper Midwest headquartered broker needs proven manager to assist the President in supervision of branch offices. Relocation package.

UNIT MANAGER

Northern California major broker located south of San Francisco needs a senior producer who wants to manage their own production/service unit.

SALES V.P.

Southern California (Not L.A.). Mid-size broker needs individual to head sales force of 12 producers selling standard insurance and specialty programs. Equity possible.

PRODUCERS

Newport Beach Pasadena
San Francisco Chicago
San Deigo Phoenix



Richard Shoemaker, President
IR Search
7844 Madison Avenue, #106
Fair Oaks, CA 95628
(916)965-5511

NATIONAL LISTINGS

(partial)

MAJOR FLORIDA BROKER seeks aggressive commercial P&C sales person to service some existing accounts and to, primarily, expand Central Florida territory. Experience with all aspects of construction industry desirable. Interviewing immediately. Compensation is extremely negotiable.

Two listings, one in Tennessee and another in North Carolina calling for commercial P&C account executives to be responsible for both, in-house and outside, servicing of existing commercial business. Experience with national **DIRECT WRITING COMPANY** will draw attention of this prestigious client.

PERSONAL LINES writer is expanding into the states of Alabama, New Mexico, and Missouri. They seek persons with successful sales records in the area of auto, homeowner, and some life/health products. This is not commission only positions but rather **salary plus bonus** situations. This client also seeks personal lines **MANAGERS** in same states as mentioned above. Salary negotiable DOE.

GILBERT — HAFNER & CO.
Insurance Staffing Consultants
6060 N. Central #470, Dallas, TX 75206, (214) 361-9341

Risk Insurance Manager.

Abbott Laboratories is a \$4.4 billion leader in the health care industry. The strong and steady growth that has led to our leadership position has been fueled by the successful management of calculated risks of new products, strategies and market places. Our skill in managing risk extends beyond research and product decisions, however. We have a strong Risk Management organization dedicated to protecting our property, assets and other aspects of Abbott's net worth. It is this organization that currently seeks an **Insurance Manager**.

Reporting to the Director of Risk Management, the successful candidate will be responsible for the administration of the Property, Casualty and Benefits insurance/self-assumption programs of Abbott Laboratories, worldwide. Through the supervision of others, this individual will detect all non-business "risks" to Abbott's assets/net worth and will plan, budget and implement the self-assumption and/or insurance programs to properly protect against these risks. Aside from a Bachelor's degree, the ideal candidate will have at least 10 years of a pattern of success in Risk/Insurance Management; an insurance company; or with an insurance broker, including the management of professionals. A Master's degree, ARM and CPCU are pluses.

The outlook for your career development couldn't be better than it is at Abbott Laboratories. We are headquartered in the northern suburbs of Chicago in an attractive suburban area bordering Lake Michigan. We provide an excellent compensation program including profit sharing and retirement plans. Send your resume with earnings history, in confidence to: **Don Kraft/Corporate Placement, Dept. BI/2-15**. Abbott is an Affirmative Action Employer

ABBOTT
ABBOTT PARK IL. 60064
"Health Care Worldwide"

SENIOR SALES DIRECTOR

Major claim service organization seeks experienced business developer for contract sales to self insureds. Requires 6+ years sales management in brokerage or service organization, plus full knowledge of WC and P/C claims. Solid career opportunity, with outstanding salary/bonus package. Resume/salary history to:

Box 2387, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

The Professional Marketplace TARGETS your BEST JOB Candidates

MARKETING

REGIONAL MARKETING DIRECTOR

We're Intracorp, the nation's largest provider of healthcare cost management services. We now have an excellent opportunity for a Regional Marketing Director. You must be able to set sales targets and approaches to assigned multi-district customers. Working with marketing representatives you will help make those targets a reality.

The right candidate will have an undergraduate degree in business, nursing, vocational rehabilitation or a related area, 3-5 years related industry sales experience and the ability to work with multi-matrix reporting relationships is also required. You will need to travel and demonstrate your excellent written and oral communication skills.

We offer an excellent salary/benefits package. For immediate and confidential consideration, please send resume with salary requirements to:

INTRACORP
ATT: RVP
5500 Greenwood Plaza Blvd.
Suite 101
Englewood, CO 80111

We Encourage Qualified Minorities and Handicapped Individuals To Apply.
Equal Opportunity Employer

INTRACORP

BUSINESS OPPORTUNITIES

PROGRAM BUSINESS

Brokers and Agents looking for an insurance company to support their program or association should contact **Box 2134, Business Insurance, 740 Rush St., Chicago, IL 60611**. We are a firm specializing in program placement, development and control.

LOOKING FOR WORKERS COMPENSATION CARRIER (NYC). Please Reply to: **Box 2386, Business Insurance, 740 Rush St., Chicago, IL 60611-2590**

HELP WANTED

WANTED

Person to head Group Insurance Marketing Division for employee benefit consulting and retirement plan administration firm. Good growth prospects. Experience required 3-5 yrs. Compensation commensurate with experience **Pallas Planning & Pension Corp., Box 2749, Hagerstown, MD 21741, 301-739-4635**.

FIRE PROTECTION ENGINEER

Houston Based fire protection consulting firm has opening for fire protection engineer. Position requires formal education, at least B.S. in fire protection or engineering discipline. P.E. license desirable & minimum of 3 years field experience providing fire protection consulting, working for insurance co. or insurance broker. Knowledge of NFPA and/or HPR standards is required as well as experience working with CAD programs. Position requires moderate travel. Salary commensurate with experience. Send resume with salary history to: **Risk Engineering, Inc., 2500 City West Blvd., Ste. 2105, Houston, TX 77042**.

ALASKA WANTS YOU!

The State of Alaska Department of Commerce and Economic Development is recruiting for an Insurance Market Analyst III vacancy in Juneau. The starting minimum salary is \$3,113 per month plus excellent benefits. The required minimum qualifications call for two years of specialized experience equivalent in kind and level to Insurance Market Analyst II; or four years of underwriting experience. This experience must have included work in at least three lines of insurance. The department wishes to fill this vacancy as soon as possible. The application deadline is March 20, 1988. An official State of Alaska Employment Application form may be obtained by writing: **Division of Personnel, P.O. Box C, Juneau, Alaska 99811-0201**.

NOTICE INVITING PROPOSALS ON INSURANCE BROKER SERVICES

Notice is hereby given that sealed proposals will be received by the **Executive Director of the Department of Airports of the City of Los Angeles, Risk Management Bureau, #1 World Way, Los Angeles, California, 90045**, up to the hour of 4:00 p.m. Friday, February 26, 1988, from brokers and agents interested in providing broker services to assist the Risk Manager in establishing and maintaining an insurance program (liability and property) for the Department. The provisions of Section 10.8 through 10.8.6 of the Los Angeles Administrative Code, pertaining to non-discrimination and affirmative action in employment of City contracts will be a part of any contract awarded pursuant to this Notice Inviting Proposals. Proposals will be furnished upon application to the Department at the above stated address. Any inquiries in reference to the proposal should be directed to Ms. Susan Fields, Risk Manager, at the above stated address or phone (213) 417-0557.

NCCI

National Council on Compensation Insurance

INSURANCE SALES



THE CREME OF THE CROP...

That's how an opportunity with Florists' Mutual Insurance is best described. For over 100 years, we have provided specialty insurance services to the Floral/Horticultural industry, and our progress is in full bloom! Our growth levels have reached considerable proportions nationwide, yielding several promotions and creating outstanding opportunities for professionals who thrive on success. We are now seeking individuals with the following qualifications to join our unique organization:

- minimum 3 years commercial property/casualty sales experience
- college degree preferred
- willing to travel up to 80%

You must currently reside in either Washington or Oregon and be amenable to relocation within the two state region. In addition to an excellent opportunity with a company rated A+ by Best's, we provide an excellent salary, liberal benefits, and unlimited advancement potential. Join the creme of the crop! Please forward your resume, including salary history and requirements, in confidence to:

Vice President-Human Resources
FLORISTS' MUTUAL INSURANCE COMPANY
500 St. Louis Street
Edwardsville, IL 62026

an equal opportunity employer mvi

Asbestos didn't cause property damage: Firm

By STACY ADLER

NEW YORK—British asbestos producer Turner & Newall P.L.C. is seeking the dismissal of a \$170 million property damage lawsuit, claiming that its asbestos-containing product has not caused plaintiff Chase Manhattan Bank property damage.

In its dismissal motion, filed in U.S. District Court in New York on Feb. 1, Turner & Newall contends that New York-based Chase is actually seeking economic recovery for the cost of removing the asbestos. The asbestos producer argues that those costs do not constitute property damage.

Turner & Newall also argues the suit does not meet the criteria of a 1986 New York law that revived for one year claims that were time-barred under the state's statutes of limitation. Products other than asbestos covered by the New York law are DES (diethylstilbestrol), tungsten-carbide, clordane and polyvinyl chloride.

Turner & Newall also is suing several of its liability insurers that have refused to provide a defense in any of the asbestos property damage litigation filed against the asbestos producer.

Manchester, England-based Turner & Newall has been named in 2,334 asbestos cases in New York alone, 12 of which involve asbestos in buildings.

The Chase suit is one of the largest as-

bestos property suits filed by a private corporation against an asbestos producer. Chase is seeking \$70 million in compensatory damages and \$100 million in punitive damages.

The suit also is one of a string of recent suits filed by private corporations against asbestos producers to recover the costs of monitoring, detecting and removing asbestos. Some attorneys believe these suits may be the next wave of asbestos litigation.

So far, school districts and public entities have filed the majority of asbestos property damage suits. A federal district court in Beaumont, Texas, earlier this month ordered the liability insurers of W.R. Grace & Co. of New York to indemnify Grace for the \$50 million to \$75 million settlement it reached with 83 Texas school districts that claimed asbestos-containing products used in constructing the districts' schools has caused property damage (see story, page 1).

The Chase suit involves the use of Sprayed Limpet Asbestos as a fireproofing material during the construction of the 1 Chase Manhattan Plaza building in New York's financial district sometime around 1959.

Sprayed Limpet Asbestos was developed and manufactured by Turner & Newall and distributed in the United States by Keasbey & Mattison Co., a now-defunct Turner & Newall subsidiary in Pennsylvania.

Chase alleges in its suit that the Sprayed Limpet Asbestos has caused property dam-

age and creates a "potential health hazard."

"As a direct and proximate result of the defective, unsafe and unreasonably dangerous condition of Turner & Newall's Sprayed Limpet Asbestos product, Chase's property rights have been damaged and Chase has incurred and will continue to incur loss and damage," the suit says.

Chase says it has implemented at its own expense a comprehensive program to monitor the air in the building, has removed some asbestos and eventually "will face the expensive prospect of removing all of this material from 1 Chase Manhattan Plaza."

In addition, "The value of 1 Chase Manhattan Plaza has been substantially diminished because of the presence of Sprayed Limpet Asbestos," the suit says.

Chase charges that Turner & Newall is strictly liable, was negligent, breached express and implied warranties and committed fraud.

Chase alleges that Turner & Newall was negligent because the company failed to properly warn Chase, adequately test the products, develop alternative products, offer safe alternative products and remedy the condition at the bank's offices.

"Turner & Newall knew or should have known that Sprayed Limpet Asbestos was a dangerous and hazardous product and was not suitable for use in any structure," the suit alleges.

"Prompted by pecuniary motive, Turner & Newall withheld and suppressed... medical and scientific data (regarding the dangers of asbestos), depriving Chase of the opportunity to make an informed choice in selecting a fireproofing material," the suit says.

A Chase spokesman would not comment on the case while it is pending.

Thomas I. Sheridan III, an attorney with Richards & O'Neil in New York who represents Turner & Newall, said he hopes the motion for dismissal will "persuade the court that Chase is seeking recovery for purely economic loss, not property damage."

Mr. Sheridan also says he hopes to persuade the U.S. District Court not to follow a New York state court decision in the *City of New York vs. Keene Corp.* that asbestos in schools constituted property damage. That case is awaiting review by New York's highest court.

"The private building owner is a less sympathetic plaintiff than school districts or state and local government, and as a result, juries are less likely to be swayed by sympathy," Mr. Sheridan said.

Victor E. Schwartz, an attorney with the Washington, D.C., law firm of Crowell & Moring, agreed. "The courts are more likely to call this type of case a commercial (economic) loss when it involves a commercial entity," said Mr. Schwartz. He explained

Continued on next page

James Orr elected chairman of UNUM

James F. Orr III, president and chief executive officer of UNUM Corp. in Portland, Maine, has been elected chairman of the insurance holding company.

Mr. Orr succeeds Colin C. Hampton, who announced his retirement last fall. Mr. Orr joined UNUM in 1986 as president and chief operating officer, and assumed the post of CEO in 1987.

Other insurer changes:

Rolf F. Hueppi, chairman of the Zurich-American Insurance Cos. in Schaumburg, Ill., has been named chief general manager of the Zurich Insurance Co. in Zurich, Switzerland.

Edward J. Baran has been named chairman and president of BCS Financial Corp. in Chicago. BCS is a multiple line, for-profit insurance and financial services holding company owned by 64 Blue

Comings & goings: industry

Cross & Blue Shield plans and the Blue Cross & Blue Shield Assn. Mr. Baran formerly served as vice chairman, president and chief executive officer of Capitol Life Insurance Co. of Denver.

Robert J. Casper elected president and chief executive officer at The United States Life Insurance Co. in New York, a unit of USLIFE Corp. He replaces **James F. Betts**, who is now president and chief operating officer of USLIFE Corp. Mr. Casper previously served as executive vp at Home Life Insurance Co. of New York.

Robert M. Mauldin Jr. named president of Wesco Insurance Co., a Wilmington, Del.-based property/casualty unit of First Dela-

ware Financial Group. Additionally, Mr. Mauldin is named executive vp of First Delaware and senior vp of American Centennial Insurance Co., another First Delaware unit and parent of Wesco.

Erwin Cheldin elected chairman of Crusader Insurance Co. of Woodland Hills, Calif. He continues as president and chief executive officer. In addition, he is chairman and chief executive of its parent, Unico American Corp.

Reinsurance

LeRoy A. Vander Putten named president, chairman and CEO of Executive Re Inc. and its wholly owned subsidiary ERIC Re-

insurance Co. in Hartford, Conn. Previously, he served as vp and deputy treasurer at Aetna Life & Casualty Co., parent of Executive Re.

Mariellen Tarnutzer promoted to vp from reinsurance broker at Cravens & Co. in San Francisco.

K. Scott Norris joined Belvedere America Reinsurance Co. in New York as senior vp and underwriting manager. Previously, Mr. Norris served as chief underwriting and operating officer of AEGON Re in New York.

Other suppliers

Arthur R. McGimsey has been named president and chief operating officer of TPA of America Inc. in Los Angeles. He succeeds **Harry L. Auston**, who will continue as executive vp. Previously, Mr.

McGimsey served as executive vp of Houston-based American General Life Insurance Co., where he oversaw actuarial services, finance and data processing.

At William M. Mercer-Meindinger-Hansen Inc. in Los Angeles, **John J. O'Connell**, **George L. Romine**, **Jon D. Sutcliffe** were named principals. Mr. O'Connell previously was a senior consultant. Mr. Romine previously was an associate and Mr. Sutcliffe was head of Jon Sutcliffe & Associates in Los Angeles.

John Hamilton and **Richard Swaik** appointed vps at Alper Services Inc. in Chicago. Mr. Hamilton has directed the marketing and underwriting division for the past two years. Mr. Swaik has been with AuditRate Inc., the company's consulting division, for almost seven years.

Insurance services guide

Business Insurance Circulation Breakdown*
Commercial Consumers

Administrative:
CEO's Presidents and Owners 2,570
Vice-Presidents, General Managers and Other Administrative Personnel 3,210

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,787
Secretaries, Treasurers, controllers and other Financial Personnel 5,600

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 9,701

Sub-total 23,868

Associations 500
Government, Unions and Educational Institutions 914

Commercial Consumers
Sub-total 25,282

Insurance Agents and Brokers 10,858
Insurance Companies 7,140
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 4,617
Others Allied to the Field 1,792

TOTAL 49,689

* Source: Business/Occupational Breakdown of qualified circulation, May 25, 1987 issue, as submitted to BPA for June 1987 BPA Publisher's Statement.

HARVARD AIMES GROUP
Executive Search

Risk Management, Benefits and Insurance Professionals

6 Holcomb St PO Box 16006
West Haven, CT 06516
(203) 933-1976

For a **Concise and Logical Approach** to **Risk Management Recruiting**

LOGIC
Associates, Inc.

EXECUTIVE SEARCH CONSULTANTS

170 Broadway
New York, N.Y. 10038
(212) 227-8000

SENIOR INSURANCE BROKER FINANCIAL SERVICES

The nation's leading wholesale broker of commercial insurances is expanding its National Marketing team in New York City. As a key member of the Financial Services department, this Senior Broker specialist will be responsible for producing Directors & Officers Liability, Miscellaneous Errors & Omissions and Fidelity coverages.

The successful candidate will have well-established relationships in the retail insurance community and a demonstrated ability to produce premiums of at least \$5 million annually for these classes. Consideration will be given to candidates with a background in wholesale or retail brokerage, underwriting or risk management.

The proven professional we seek will share in one of the most comprehensive compensation and benefit packages in the industry. For confidential consideration, please send your resume to:

Swett & Crawford Group

Attn: Senior Vice President
National Marketing Division
3699 Wilshire Blvd., Suite 1200
Los Angeles, California 90010
No telephone inquiries please.

An equal opportunity employer. Principals only.

Director Government & Regulatory Relations

Financial Guaranty Insurance Company, a dynamic, well-capitalized leader in the financial guaranty industry, seeks a government and regulatory relations professional to direct the compliance function.

The successful candidate should have 3-5 years expertise handling reporting/quasi-legal issues for either a surety, property/casualty or mortgage insurance company. Candidate must be a self-starter who is well-organized and detail oriented, with strong communications skills and the ability to work with all levels of management. B. A. in business or accounting desired.

An attractive and highly competitive compensation package, along with a comprehensive benefits program, is offered with this opportunity to work for an industry leader. Please send resume to:

Anthony K. Farina, Vice President
Director of Human Resources
Financial Guaranty Insurance Company
175 Water Street
New York, NY 10038

FGIC

Chase litigation

Continued from previous page
that in most jurisdictions the statute of limitations for tort claims expires two to three years from the time a plaintiff realized it had a claim.

In its motion for dismissal, Turner & Newall says: "In 1959, no one even suspected that the low concentrations of asbestos fiber found in buildings might cause disease. Even today there is no medical or scientific evidence that it does."

In addition, Turner & Newall contends that Chase should have been aware of the dangers of asbestos because as early as the 1930s Chase was a banker for Keasbey & Mattison's, the defunct Turner & Newall subsidiary that distributed the asbestos product. Chase also was one of Turner & Newall's bankers from the early 1970s until the mid-1980s.

"Chase knew or should have

known, beginning in or about 1959, as much about the health effects associated with asbestos as a seller of asbestos or asbestos-containing products," according to the motion for dismissal.

Turner & Newall also argues that because Chase is a commercial buyer, it has no cause of action for a strict product liability claim.

Mr. Sheridan said New York's strict product liability law "was designed to protect consumers, not large corporations whose bargaining power is equal to that of manufacturers."

Turner & Newall says its defense has been seriously impaired because so much time has elapsed since Sprayed Limpet Asbestos was installed at the Chase Manhattan building. "Three decades after the fact, Chase witnesses may testify without fear of contradiction about what they were told by (Turner & Newall) men who are now dead."

Turner & Newall also argues in

its motion that the Chase suit should be dismissed because:

- Chase's count of breach of implied and express warranty should be dismissed because the bank did not actually have a contract with Turner & Newall or any of its subsidiaries. Chase's contract was with the general contractor involved in construction of 1 Chase Manhattan Plaza.

- Chase does not specify which Turner & Newall employee told which bank employee that the asbestos product was safe.

- English law, not U.S. law, should be applied when assessing punitive damages because Turner & Newall is a British company. English law does not allow punitive damages.

Mr. Sheridan says that because Chase is claiming continuous damage, all Turner & Newall insurance policies from 1959 to the present would be triggered if Chase is successful.

However, Turner & Newall's in-

surers claim that because there has been no property damage, they have no duty to defend the asbestos producer in underlying litigation.

Turner & Newall currently is litigating with several of its liability insurers, including Canadian Universal Insurance Co., First State Insurance Co., Lexington Insurance Co. and New England Reinsurance Corp., in a suit filed in March 1986 in U.S. District Court in New York.

"Insurers have an obligation to defend T&N from property damage claims, even if the claims are 'groundless, false or fraudulent,'" according to the wording in the comprehensive general liability policies, Mr. Sheridan said.

Together, Canadian Universal, First State, Lexington and New England Reinsurance wrote \$79 million in occurrence-based product liability coverage limits for Turner & Newall between 1980 and 1982. However, Mr. Sheridan said there were no limits on coverage

for defense costs in those policies.

Canadian Universal wrote primary coverage for Turner & Newall in 1980, and First State was the primary insurer in 1982 and 1983, Mr. Sheridan said.

A trial date in the Canadian Universal litigation has not been set.

Turner & Newall also is litigating with London-based Eagle-Star Insurance Group to recover defense costs.

British-based Eagle-Star subsidiary Midland Employers Mutual Assurance Co., which is in runoff wrote between 1 million and 3 million pounds (\$1.75 million to \$5.25 million at current exchange rates) in liability coverage annually for Turner & Newall between 1959 and 1972.

Litigation between Turner & Newall and Eagle-Star, which began in September 1986, is continuing in Virginia, Mr. Sheridan said.

Turner & Newall also was covered from 1980 to 1984 by a comprehensive global liability insurance program that covered U.S. risks, which also is the subject of litigation.

The lead underwriter on that coverage was Gerling Globale General & Reinsurance Co. Ltd. of London, a unit of Gerling Global Reinsurance Co. of West Germany. Gerling Globale wrote 4.5 million pounds (\$7.9 million at current exchange rates) of occurrence-based product liability coverage annually between 1980 and 1984.

The global coverage also included two excess layers of 10 million pounds (\$17.5 million) each. And, in 1982 and 1983, a third layer with limits of 25 million pounds (\$43.75 million) excess of 24.5 million pounds (\$42.9 million) was added to the coverage, bringing the total coverage for those years to 49.5 million pounds (\$86.6 million).

Insurers participating in the excess layers include a "laundry list" of Lloyd's of London syndicates and London market insurers, Mr. Sheridan said.

Gerling Globale is seeking a declaratory judgment from London courts that it has no duty to defend the asbestos producer in product liability litigation, Mr. Sheridan said.

At this time, no insurance company is paying for Turner & Newall's defense, he said.

Litigation involving private corporations suing asbestos producers for property damage could represent the next wave of asbestos litigation, according to at least one industry observer.

What is thought to be the first case of this type was filed in U.S. District Court in Boston in May 1985 when Prudential Insurance Co. of America sued eight asbestos producers, including Turner & Newall, for the cost of removing asbestos from Prudential Center in Boston (BI, July 8, 1985).

"I think the fear of the asbestos industry is that there will be thousands of these cases," said Barbara Wrubel, an attorney with Skadden, Arps, Slate, Meagher & Flom in New York, who follows asbestos property litigation.

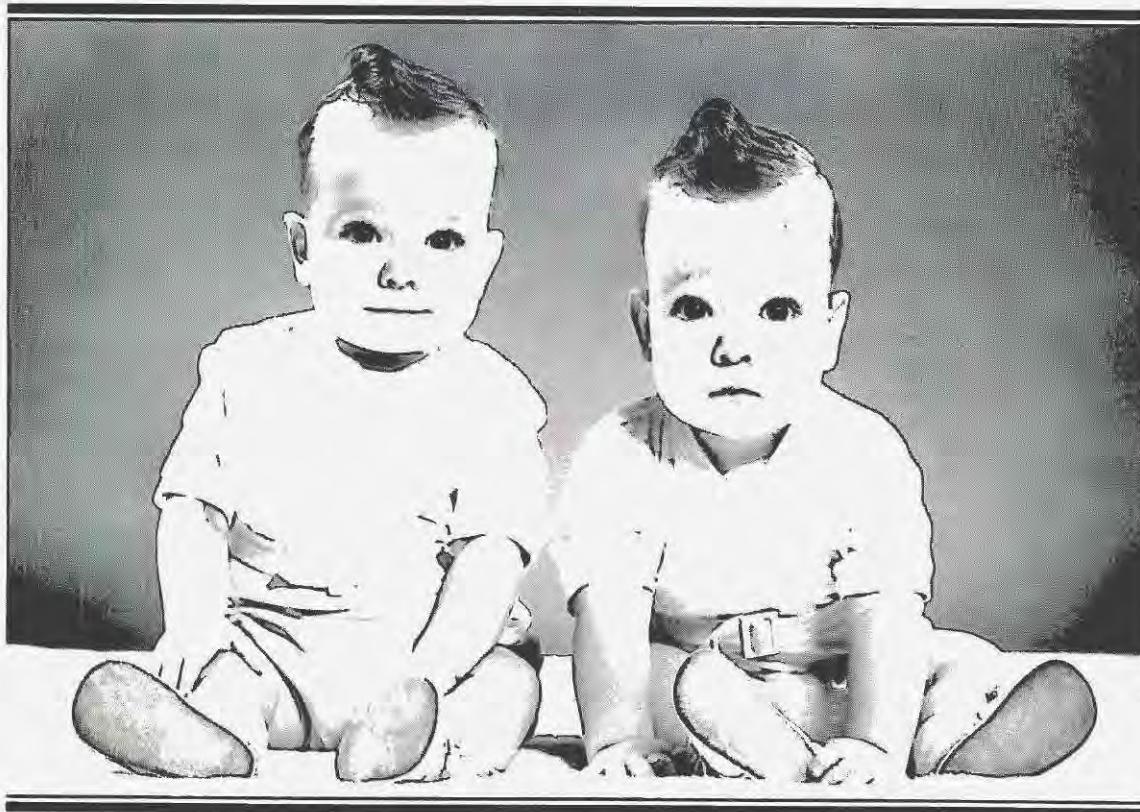
"It is possible that a trend may be coming," Ms. Wrubel said.

But she noted that in states other than New York that have not extended the statute of limitations, many corporations facing asbestos abatement have lost their ability to litigate.

"The statute of limitations in a lot of jurisdictions is going to block these claims," Mr. Schwartz agreed.

"There is no way for insurers to estimate this kind of loss," Mr. Schwartz added, pointing out that many insurers in their 1987 and 1988 product liability policies specifically are excluding coverage for economic recovery of the cost to remove hazardous material from buildings. ■

For the expected...



and the unexpected

There is only one newsmagazine that is the leader in covering the employee benefits market. For over 20 years Business Insurance has led the way in covering and uncovering the expected ... and the unexpected.

We've seen this multi-billion dollar industry through growth and groans by providing a balanced editorial package - from news breaking articles to industry features and market reports.

We've tracked the market through turbulent times, political battles, corporate change, social flux, and

medical mayhem. We've followed the complexities of this burgeoning industry - from the increase of health care suppliers to the intricacies of health care plans. Straightforward and unbiased reporting is why BI is the trusted source for employee benefit managers, their suppliers and consultants across the nation.

BI's editorial commitment mirrors our readers' commitment — relying on Business Insurance to guide, advise and report. Each week BI provides this highly

influential group of 140,333 executives with timely guidance and sharp focus. The right editorial product and this high calibre of reader assures advertisers the kind of exposure they depend on for results.

When it comes to the expected and the unexpected - the choice is crystal clear.

Business Insurance

a publication of Crain Communications Inc

CU-7 lawsuits

Continued from page 2

have been settled out of court less than another 500 have been dismissed, the spokeswoman said.

Of the 17 CU-7 lawsuits that have gone to trial, Searle has won 14, the spokeswoman said.

Two of the three judgments against Searle—one in 1979 and one in 1983—totalled about \$300,000 in damages, she said.

In the third case, a Marquette County, Mich., Circuit Court jury awarded the plaintiff \$255,000 in damages, and prejudgment interest has increased the award to more than \$500,000. Searle is appealing the verdict.

When the IUDs were discontinued, Searle said it had established a reserve with which to pay future CU-7-related losses not covered by product liability insurance it purchased from 1974 through 1986.

Searle refuses to disclose the amount of its reserve, the names of its former insurers or the amount of product liability coverage it purchased from 1974 to 1986.

However, two insurance brokers who specialize in pharmaceutical accounts said that large pharmaceutical companies typically purchased \$50 million—and sometimes up to \$100 million—of product liability insurance during that 12-year period. Deductibles or retentions of at least \$1 million per occurrence were common in those policies, they said.

Les Roberts, a securities analyst with Salomon Bros. Inc. in New York, said he believes that IUD litigation pending against Searle should "have no major effect on the earnings potential of Monsanto. This is not a smoking gun. Searle's losses so far have been nominal."

But, if Searle loses a product liability case pending in U.S. District Court in St. Paul, Minn., that may trigger additional litigation against Searle, according to Roger P. Brosnahan, a partner in the law firm of Robins, Zelle, Larson & Kaplan in Minneapolis, which is representing more than 150 women who claim they have been injured by the CU-7.

A federal court judge has merged discovery for a suit filed by Mr.

Brosnahan with 20 to 30 other suits also pending in Minnesota. The case is scheduled to go to trial in March or April.

Approximately 600,000 Searle documents—including the company's risk management documents—examined by the court show "there is no question the product was not properly tested, was marketed to an inappropriate group of women and that these women and their doctors were not adequately informed of the potential dangers of using the CU-7," Mr. Brosnahan said.

All of those documents are now subject to a confidentiality ruling, and no attorneys involved in CU-7 litigation are permitted to discuss the evidence prior to the trial.

However, all of the plaintiffs' attorneys *BI* contacted anticipate that a rash of new suits will be filed against Searle if it loses the Minnesota case.

While Searle has not lost many CU-7 cases to date, "no case has yet been tried with the benefit of the discovery materials produced in Minnesota," Mr. Brosnahan stressed.

The CU-7, which technically was classified as a copper-bearing intrauterine contraceptive, was approved for use as a drug by the Food and Drug Administration because of its copper content, "which creates an environment in the uterus that is believed to not be hospitable to pregnancy," the Searle spokeswoman explained.

The IUD had a three-year lifespan, after which a physician was to remove or replace it, the spokeswoman said.

The IUD, constructed of pharmaceutical plastic shaped like a figure 7, is wound with copper wire around its shank and had a tailstring.

Plaintiffs' attorneys in these and other suits have alleged that the tailstring carries bacteria to the uterus, promoting infections that can lead to pelvic inflammatory disease and infertility.

And, unlike other IUDs, "the CU-7 had the only IUD string that was (partially) outside the inserter tube, which meant it was exposed to bacteria during insertion," Mr. Brosnahan said.

In addition the tailstring was

"made of fused multifilament strands that tend to break apart over time" and breed bacteria, Mr. Williams and other attorneys involved in CU-7 litigation charge.

The attorneys also allege that the polypropylene plastic of which the tailstring is constructed has a "memory" and tended to resume its original shape—looped around the inserter tube—and draw up into the uterus after insertion, carrying bacteria with it.

However, Searle denies this charge. The "CU-7 string does not cause or promote infection. (It) is a monofilament strand. We do not believe the Copper 7 causes pelvic inflammatory disease or any of the other injuries that are alleged," the spokeswoman said.

Plaintiffs' attorneys in these and other IUD cases also claim Searle targeted its CU-7 marketing efforts to women who never had children, despite various medical studies that indicated IUDs are generally not suitable forms of birth control for those women.

Searle "shouldn't have marketed the CU-7 to women who still had hopes of having a family someday. The risk of permanent sterilization is higher than they were told about," Mr. Williams stressed.

Roger L. Pardieck, a partner of Pardieck & Gill P.C., a law firm in Seymour, Ind., that currently represents several women in CU-7 litigation, charges that Searle "introduced materials to the bodies of these women in the face of extensive literature and studies that said that any IUD is not suitable for use by nulliparous women. (Yet) that was their target."

But the Searle spokeswoman maintains: "The CU-7 was not marketed to an inappropriate group. Medical literature over the history of the CU-7 as well as FDA reviews and our own studies support this."

"With proper patient selection, the IUD compared to other contraceptive methods is very safe and effective," agreed Dr. J. Joseph Speidel, president of the Population Crisis Committee, a non-profit lobbying group in Washington, D.C.

However, "without proper patient selection, it can cause problems," he said. ■

Group to suggest alternative to broker control model law

By LAURA MAZZUCA

WASHINGTON—The National Assn. of Insurance Commissioners is asking insurance industry representatives opposed to its proposed broker control model law to present written alternatives by March 1.

The NAIC's Special Insurance Issues Committee met with representatives of an Ad Hoc Industry Committee last week to discuss the model law, which would restrict brokerages from placing business with affiliated insurers (*BI*, Dec. 14, 1987).

The proposed model law has been under fire from the insurance industry since its introduction by New York Insurance Superintendent James P. Corcoran at last summer's NAIC meeting (*BI*, June 29, 1987).

Written objections to the proposal by Ad Hoc Industry Committee, which was formed shortly after the proposal was introduced, were presented to the NAIC at its December meeting in Phoenix, Ariz. That, in turn, led to the Feb. 8 meeting.

At last week's meeting, the NAIC committee urged that the following provisions, which seek to eliminate conflicts of interest and potential insolvencies, be retained in the ad hoc committee's alternative proposal:

- Disclosure from brokers and insurers when there is any affiliation between the two.
- Disclosure of brokerage fees paid to affiliated brokers when business is placed with an affiliated insurer.
- Strict broker liability for policyholder losses due to an insurer insolvency if the broker places business with an affiliated insurer. If the broker places less than 10% of its business with the insurer, the percentage of the broker's liability would be equal to the percentage of business placed with the insurer. If more than 10% of the broker's business is placed with the

affiliated, the broker could be liable all losses stemming from the entire insolvency.

- Prohibition of the placement of business with an affiliated insurer unless separate accounting and tighter underwriting standards are maintained.

While industry representatives agree with the proposal's disclosure requirements, they fear that its strict liability stipulation could hurt market capacity, said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers and a member of the industry committee.

"We will try to meet the goals that the commissioners set," said Ronald D. Markovits, senior counsel at Rollins Burdick Hunter Co., a unit of Aon Corp. in Chicago. Mr. Markovits was appointed chairman of the industry committee by the NAIC committee's chairman, Mr. Corcoran, at the Feb. 8 meeting.

The industry committee is currently drafting language for its alternative proposal and will next meet with regulators at the NAIC's spring meeting, March 13-16 in Santa Fe, N.M., according to Mr. Markovits.

Attending the Feb. 8 meeting were Mr. Corcoran; NAIC President John E. Washburn, the Illinois insurance director; Alaska Insurance Director John L. George; New Jersey Deputy Insurance Commissioner David Grubb; and Donald A. Dowdell, general counsel for the Florida Department of Insurance.

The industry committee is composed of representatives from brokers Alexander & Alexander Services Inc., Fred S. James & Co. Inc., Marsh & McLennan Cos. Inc., and RBH. Industry associations represented on the committee include: the National Assn. of Casualty & Surety Agents, the National Assn. of Insurance Brokers, the National Assn. of Professional Surplus Lines Offices Ltd., the National Assn. of Professional Insurance Agents and the Risk & Insurance Management Society Inc. ■

Update

Rail worker drug tests rejected

WASHINGTON—The Reagan administration will appeal last week's federal appellate court decision overturning mandatory drug and alcohol testing of railroad workers involved in accidents.

In a 2-1 decision, the 9th U.S. Circuit Court of Appeals in San Francisco said the 1987 federal rules requiring such tests after major railway accidents violates constitutional protection against unreasonable search and seizure.

"Accidents, incidents or rule violations by themselves do not create reasonable grounds for suspecting that tests will demonstrate alcohol or drug impairment in any one railroad employee, much less an entire train crew," said the majority opinion.

The appellate ruling, which overturns a lower court decision, was blasted by federal safety officials as not in the public interest.

"The decision, if not reversed, will effectively end drug testing in the railroad industry," said Federal Railroad Administrator John H. Riley. "It denies federal safety authorities even the right to perform testing after an accident to determine whether drug use was involved, unless we have particularized evidence that one or more crew members were impaired. Such evidence is rarely, if ever, available."

The suit challenging the rules, which cover several hundred thousand railroad workers, was filed by several railroad unions.

1,000 cut from Met Life staff

NEW YORK—About 1,000 Metropolitan Life Insurance Co. employees accepted early retirement last month, saving the insurer \$50 million to \$100 million by reducing its 33,000 workforce 3%.

Met Life offered the early retirement option to employees throughout the company to streamline operations as the insurer increases automation, according to a spokeswoman.

Met Life is the third U.S. insurer this year to make major staff cuts. Last week, Empire Blue Cross & Blue Shield in New York eliminated between 100 and 125 jobs, mostly middle management, though all but about 25 of the affected workers were offered customer service jobs (*BI*, Feb. 8). And, Hartford Insurance Group last month trimmed its workforce by 400 and offered early retirement to an additional 134 long-time employees, citing slowing premium growth (*BI*, Jan. 25).

However, the Met Life spokeswoman stressed that the staff cuts are not linked to premium income. In fact, the insurer, which has not yet released its 1987 year-end figures, is projecting a "substantial" improvement over 1986's results, she said.

Lead smelter hit by OSHA fines

WASHINGTON—The Labor Department last week proposed near-record fines of \$2.78 million against the largest lead smelting facility in North America for hundreds of alleged violations of federal safety, health and record-keeping standards.

Doe Run Co.'s Herculaneum, Mo., smelting facility allegedly rotated contract employees in and out of high-lead exposure areas to minimize levels of lead in their blood and then fired the employees when their blood lead levels exceeded minimum standards, according to the Occupational Safety and Health Administration.

OSHA—which cited Doe Run for 147 allegedly willful health violations, 136 allegedly willful record-keeping violations and 30 other alleged violations—charges that Doe Run has violated some provision of virtually every section of the agency's lead standard and that it has failed to correct situations or maintain measures agreed to in previous settlements with the agency.

OSHA also is seeking an undetermined amount of back pay and benefits for contract employees who were fired.

Doe Run Co. denies that it has a policy of firing contract employees when their blood lead levels exceed minimum standards.

John Fitzsimmons, division manager of the Herculaneum smelter, said that "most of these cases are paperwork violations." He added that "others involve legitimate differences of opinion over highly technical matters. None that we know of threatens the health or safety of our workers."

Financial guarantee reinsurer

NEW YORK—Capital Reinsurance Co. has started operations as a monoline financial guarantee reinsurer with \$85 million in paid-in capital, says Michael E. Satz, president and chief executive officer.

The reinsurer expects to generate \$40 million in premiums this year, of which about 75% to 80% will be treaty business. The reinsurer will concentrate on reinsuring municipal obligations, although it will consider some non-municipal risks as well.

The reinsurer has a triple-A rating from Standard & Poor's Corp. and also is considering seeking a rating from Moody's Investors Service Inc., Mr. Satz said.

Major investors in the new company are USF&G Corp., Minnesota Power & Light Co. and Constellation Investments, a subsidiary of Baltimore Gas & Electric Co.

Mr. Satz said that other than sharing some of the same investors, including USF&G, the reinsurer has no special relationship with Capital Guaranty Insurance Co., a financial guarantee insurer.

Capital Re and New York-based Enhance Reinsurance Co., a subsidiary of Enhance Financial Services Inc., are the only two reinsurers to specialize in financial guarantee insurance.

Briefly noted

Ellen Throver, professor of insurance and director of The Insurance Center at Drake University in Des Moines, Iowa, has been elected president of The College of Insurance in New York, effective July 1. . . Florida Gov. Bob Martinez last week signed the bill passed in a special session of the Legislature that sets up a voluntary arbitration system to settle **medical malpractice claims** and caps non-economic damages at \$250,000 in some cases (*BI*, Feb. 8).

Asbestos ruling

Continued from page 1
districts.

None of Grace's insurers agreed to participate in the settlement negotiations with the school districts or agreed to indemnify Grace. But, none of the insurers disclaimed coverage or reserved their rights.

Grace's coverage suit named as defendants Continental Casualty Corp., a unit of CNA Financial Corp. that wrote primary liability insurance for Grace between 1978 and 1985, and a group of excess in-

surers including:

- AIU Insurance Co., Lexington Insurance Co., National Union Fire Insurance Co. of Pittsburgh, Pa., Granite State Insurance Co. and Birmingham Fire Insurance Co., all units of New York-based American International Group Inc.

- Allstate Insurance Co. in Northbrook, Ill., as successor to Northbrook Excess & Surplus Insurance Co.

- Bermuda Fire & Marine Insurance Co. in Bermuda.

- Gerling Konzern Allegemeine Versicherungsaktiengesellschaft in

Cologne, West Germany.

- Guarantee Insurance Co. in Wilmington, Del., a unit of Scottish & York Inc.

- Hartford Accident & Indemnity Co. in Hartford, Conn.

- Lloyd's of London syndicates and various London market insurance companies.

These insurers wrote combined limits of approximately \$75 million annually for Grace between 1978 and 1985, according to the court papers. Grace also had other liability coverage excess of the policies at issue in the case.

Grace's coverage was brokered by Marsh & McLennan Inc. An M&M spokesman in New York would not comment on the case.

Attorneys for the insurers say they are not sure whether they will appeal Judge Fisher's ruling.

An appeal is "certainly a viable option. Obviously the parties are reviewing the decision," said Jeff Carlisle of the Los Angeles firm of Lyndberg & Watkins, which represented four of the AIG units.

The insurers refused to indemnify Grace because they argued that the damages allegedly caused by the asbestos-containing building materials did not constitute property damage.

However, Judge Fisher ruled that the school districts' lawsuit "clearly alleges that Grace's products... have caused damage to the plaintiffs' buildings, including physical injury. Thus, for purposes of insurance coverage, the nature of the plaintiffs' claim is that of property damage caused by the presence and incorporation of Grace's products into the buildings and the deterioration of those products."

Jerold Oshinsky, another attorney with Anderson Baker Kill & Olick, said this finding is one of the most important points in Judge Fisher's decision.

"That's important because the insurance policies cover property damage and bodily injury" claims against asbestos producers, he explained.

A second important issue in the judgment relates to how the policies are triggered, Mr. Oshinsky noted.

Judge Fisher agreed with Grace's argument that each policy in question is triggered by the school districts' underlying claim.

The school districts' lawsuit, "by its very nature, describes property damage resulting in each and every policy period at issue in this case and, thus, required that each policy be triggered," Judge Fisher said.

Citing the 1985 Lac decision, he continued: "The only known decision to address the trigger-of-coverage issue in the context of a claim for asbestos-related property damage held that (the damage) was a continuous process which triggered all policies on the risk from the initial installation of asbestos-containing building materials through the removal or contain-

ment of those materials."

As a result of that "continuous trigger," Grace has the right to select "the year or years of coverage in which it wishes to assign the loss," Mr. Oshinsky observed.

Judge Fisher noted: "Because each triggered policy provides coverage for Grace's entire liability, subject to the limits of coverage, Grace may select which of its policies it wishes to provide coverage."

During oral arguments, attorneys for Guarantee, one of the excess insurers, argued that Grace did not properly inform the insurers of potential claims that could arise from the asbestos products. Insurers also alleged that Grace misrepresented its risk on the original insurance application.

However, Judge Fisher ruled against the insurers on both points.

Judge Fisher ruled that Grace had given proper notice of claims or potential claims, explaining that the policies required Grace only to submit notice to its broker, Marsh & McLennan, not the insurers. "Grace fully complied with this provision," he wrote.

Concerning the charge of misrepresentation, Judge Fisher said, "The application for insurance did not contain a single question relating to asbestos-containing building products. Rather, after numerous specific questions, the application contained a final, vague and open-ended question which read: 'additional information, if any.' Grace's response that it 'knew of no other relevant facts,' does not rise to the level of a misrepresentation or omission that would void coverage.

"An insured generally is under no duty to provide information on an application for insurance as to which the insurance company has made no specific inquiry, unless those facts are 'unusually threatening and not open to general observation,'" the judge said.

Mr. Oshinsky said last week that Grace's next step in the coverage dispute will be to ask the court to order the insurers to pay for Grace's defense costs in the underlying litigation and its expenses in the coverage dispute.

Meanwhile, school districts throughout Texas began receiving their portions of the settlement with Grace and U.S. Gypsum on Feb. 4, the same day that Judge Fisher signed the coverage order.

Martin Dies, an Orange, Texas, attorney who filed the original lawsuit in 1981 on behalf of the Dayton Independent School District, would not reveal specific figures related to the settlement but confirmed that the districts have begun receiving payments.

The largest single portion of the settlement, about \$14 million, will be paid to the Houston Independent School District for the cost of removing asbestos material from 122 school buildings, said James Heldt, the district's director of risk management.

Other districts also will receive

sizable sums.

An attorney for the Dallas Independent School District confirmed that the district was paid \$5.1 million from the settlement fund.

David Tiffin, executive director of financial services for the Richardson Independent School District, said his office has received about \$3 million. That money will be used to finance asbestos abatement procedures in Richardson schools during 1988 and 1989, he said.

The school districts originally filed suit against National Gypsum Co. in 1981, and later added other defendants including Grace, U.S. Gypsum and U.S. Minerals Products Co. According to court papers detailing the summary judgment in the coverage litigation, the districts sought \$175 million in compensatory damages from the asbestos manufacturers for alleged property damage to school buildings.

Mr. Dies said the suit also asked for an unspecified amount of punitive damages.

National Gypsum was eventually dismissed from the 1981 suit but faces a similar action filed by 65 school districts in a Texas state court in Jasper County.

However, the litigation in the federal court in Beaumont against U.S. Mineral Products is still pending.

Shepard Remis, an attorney with the Boston law firm of Goodwin, Procter & Hoar, which represented Grace in the litigation with the school districts, would not comment on why Grace decided to settle the suit, noting that that decision is part of the confidential settlement agreement.

However, Mr. Dies said he thinks Grace settled because it was afraid of a large punitive damage award. Grace already has been hit with punitive awards in other asbestos property damage cases and the school districts "had a very strong case," Mr. Dies remarked.

Grace in 1986 was ordered to pay \$1 million in punitive damages and \$284,000 in compensatory damages as part of \$2.4 million asbestos property damage award to Mercer University in Atlanta. National Gypsum was ordered to pay the remainder of the award (BI, April 21, 1986).

And, last August, the 4th U.S. Circuit Court of Appeals ruled that Grace was responsible for a \$6.8 million asbestos property damage award to the city of Greenville, S.C. (BI, Sept. 21, 1987). The original 1986 award of \$8.4 million in that case included \$6.4 million in compensatory damages and \$2 million in punitive damages. The compensatory award was subsequently reduced to \$4.8 million.

Grace claimed at the time it was fully insured for the Greenville award, but two of its insurers, Maryland Casualty Co. of Baltimore and Aetna Casualty & Surety Co. in Hartford, Conn., are disputing the coverage. ■

Insurance services guide

DENTAL CLAIMS MANUAL

All-Inclusive 402 Page Manual
Featuring All Major Specialties
(213) 681-3300



J.P. Kennedy Publishing Co.
776 E. Green Street
Pasadena, CA 91101

HAAG ENGINEERING CO.

Since 1924

Consulting Services

related to causes
and consequences of failures
Texas WATS 1-800-442-0814
Louisiana WATS 1-800-631-5192
U.S. WATS 1-800-527-0168

DENTAL PLAN & DENTAL P.P.O.

Ideal For
SELF FUNDED GROUPS
FULL SERVICE HMOs

Dual Choice/Prepaid

GOLDEN WEST DENTAL PLAN
Call for quotes 800/223-8165
Since 1974

ENVIRONMENTAL CLAIM AUDITS

&
RISK ASSESSMENTS

ACTUARIAL CONSULTING

Financial Evaluation of Environmental Losses

TILLER CONSULTING GROUP, INC.
2833 N. Geyer Road / St. Louis, MO 63131-3320 314/567-7480

RISKMASTER SOFTWARE

GENERAL CLAIMS
WORKER'S COMP
VEHICLE ACCIDENTS
CHECK WRITING
FOR: PC/MINI/MAINF
(313) 261-4440



ONSITE TRAINING
ONGOING SUPPORT



Tillinghast

INSTALLED IN OVER
37 STATES & CANADA

Use the Insurance
Services Guide to
reach your best
prospects.

Go In-House With U/R In Just 60 Days

Why risk your reputation with an
outside Utilization Review firm?

We'll show you how to go in-
house in just 60 days for greater
control and profitability.

Call 1-800-558-4353

(In Wisconsin, 1-800-242-2178).

CareReview.

EMPLOYEE HEALTH BENEFITS MANAGEMENT SYSTEM

IDEAL FOR SELF INSURED, TPA's, ASSOCIATIONS & CARRIERS

- ELIGIBILITY DETERMINATION
- FULLY ADJUDICATING
- PREPARES CHECKS, EOB's & FORM LETTERS
- HANDLES MULTIPLE EMPLOYERS & PLANS
- ON-LINE INQUIRIES
- VALIDATES ICD-9 & CPT-4 ENTRIES
- MANAGEMENT & AD HOC REPORTING
- CALCULATES PPO DISCOUNTING
- PAYS BY UCR & RVS SCHEDULES
- HAS UNLIMITED CLAIMS CAPACITY
- CREATES TEFRA REPORTS & 1099's
- IDENTIFIES DUPLICATE CLAIMS

VALUE LEADERS IN RISK AND BENEFIT MANAGEMENT SOFTWARE

INSTALLATIONS COAST TO COAST • CALL FOR A FREE DEMO DISKETTE

INSURANCE SOFTWARE PACKAGES, INC.

5118 N. 56TH ST., TAMPA, FL 33610 800-237-8133(US) 813-621-6069(FL) 212-608-1674(NY)

Temporary Claims Examiners

Qualified, experienced medical & dental claims examiners are available nationwide to assist you with claims processing.

On-site or off-site staff is available during regular hours, after hours and on weekends. Employee skills are exactly matched to your requirements in either group or individual claims on both manual and on-line processing systems.

As the leading national firm devoted exclusively to temporary assistance in claims processing, we have been the proven answer to claim backlog problems for over 300 companies. Call us to find out about how we can be a part of your solution.

Claim Services Resource Group, Inc.
800-331-5039 ■ 214-701-0606 (In Texas)

For advertising information in the INSURANCE SERVICES GUIDE
Contact: Margaret Hikido, 740 Rush Street, Chicago, Illinois 60611.
Telephone (312) 649-5340

Nurses start malpractice data base

The American Nurses' Assn., in cooperation with more than 100 other nursing associations, is establishing a national repository for medical malpractice claims filed against nurses.

The ANA hopes the claims information compiled in the National Nurses Claims Data Base will help nurses negotiate more favorable liability insurance rates within a few years.

Also participating in the project are 55 national and 50 state nursing associations, as well as nursing groups in Washington, D.C., Guam and the Virgin Islands.

Chicago Insurance Co., a subsidiary of Interstate Insurance Group, a unit of Fireman's Fund Insurance Cos., stopped writing new policies for nurse practitioners and raised the rates for most other nurses in May 1987, claiming it lacked sufficient claims data (BI, May 11, 1987). Chicago Insurance was at the time one of the only markets for nurse practitioner coverage.

To help eliminate the coverage shortage, the ANA in October formed a purchasing group that offered nurses

occurrence-based liability coverage underwritten by Los Angeles-based Transamerica Insurance Co. (BI, Oct. 12, 1987).

"In establishing this data base, nursing is taking a vital step to control its destiny," said Judy Huntington, who chairs the ANA Task Force on Liability Insurance.

The ANA hopes the data base also will help nurses defend medical malpractice claims. Nurses can receive information on the number of nurses sued, both in total and broken down by area of practice, and the amounts of the settlements. They can also receive a list of defense attorneys.

Woodsmall Risk Services, an independent risk management firm in Kansas City, Mo., is administering the data base, which has been operating since Jan. 1.

The ANA spokesman said the data base has been well received by the nursing industry.

For more information on the data base, contact Joe Gerlack, Woodsmall Risk Services, 5 Crown Center, Kansas City, Mo. 64108; 816-421-7788.

Intracorp's choice of medical review services makes everyone else's plain vanilla.



In the complex world of healthcare cost containment, "plain vanilla" solutions frequently won't work.

Because your company's medical review service requirements are not simple. Or identical to everyone else's.

That's why Intracorp offers a full range of service options to enable you to custom-design the review program your company needs.

Pre-admission certification/continued stay review from Intracorp generates an average 17% reduction in hospital days without compromising quality of care. In complex cases, our nurses can go on site to evaluate the need for continued hospital stay. We also offer the only psychiatric and substance abuse utilization review program in conjunction with the American Psychiatric Association. This organization establishes appropriate treatment practices for its 32,000 member psychiatrists.

Second surgical opinion eliminates the

expense and risk of unnecessary surgery—combining board-certified surgeons with Intracorp's knowledge of the medical community.

Medical case management services offer maximum coordination and control of high-cost, serious illness cases. This on site service is coordinated by registered nurses with critical care experience in various medical specialties.


Discharge planning allows your employees to recover at home rather than in the hospital.

Utilization analysis, a comprehensive review of all your medical costs, can help you structure your company's benefit program more effectively.

Whether you're a big business, a small business, or an insurer serving both, let our nationwide network help provide the range of quality healthcare services today's employees deserve. From pre-hospitalization

review to post-recovery analysis, and every step in between. The choice is up to you. Call for more information, toll free, 1-800-345-1075. (In PA, HI and AK, call collect, 1-215-687-9450). Or return the coupon.

Why settle for plain vanilla when you can have your choice of the menu?

Mr. Daniel H. Davis Director of Marketing 701 Lee Road Wayne, PA 19087	 BI-IC
Name/Title _____	
Company _____	
Street _____	
City _____	State _____ Zip _____
Phone _____	Ext. _____