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business insurance®

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update

MIG debtholders offer $50 million capital infusion

LOS ANGELES—Mission Insurance Group Inc. debtholders are willing to infuse an estimated $50 million into Mission American Insurance Co. in an attempt to remove the insurer from state conservatorship.

Discussions concerning the infusion will continue between the debtholders—led by investor Martin J. Whitman of M.J. Whitman &

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Godsend or gamble?

Critics question security of municipal program

By DOUGLAS McLEOD

LIVONIA, Mich.—A huge municipal self-insurance program in Michigan—serving 252 public entities and collecting an estimated $25 million in member contributions this year—is praised as a godsend by most of its members, but is criticized as potentially shaky by some competitors and consultants.

For many cities and counties in the state, the Michigan Municipal Risk Management Authority has been the best answer to the seemingly insoluble problem of finding municipal liability insurance.

While commercial insurers have abandoned the Michigan municipal market or imposed severe coverage restrictions and huge rate increases, MMRMA has filled the void with broad coverages, policy limits far higher than those available elsewhere and—in many cases—lower premiums than those quoted by competitors.

Some municipalities have no real alternative and MMRMA—formed in 1980—is not just the best, but the only practical choice, since coverage written by commercial insurers is too restrictive or too expensive and municipalities are afraid to fully self-insure.

Members generally praise the program, reporting no problems with claims handling and little concern with the way MMRMA is managed.

However, several critics—including insurance consultants, rival agents and even some MMRMA members—express concerns about the program, including:

- The extent to which MMRMA retains risk. MMRMA provides limits of up to $10 million per occurrence with no aggregate in excess of the typical member's self-insured retention of $50,000 per occurrence.

During MMRMA's 1984-85 fiscal year, all risk excess of members' self-insured retentions was ceded to commercial reinsurers.

Since then, however, MMRMA has itself assumed portions of each of the four layers comprising the reinsurance program and currently self-insures about 47% of the $10 million limit above members' retentions.

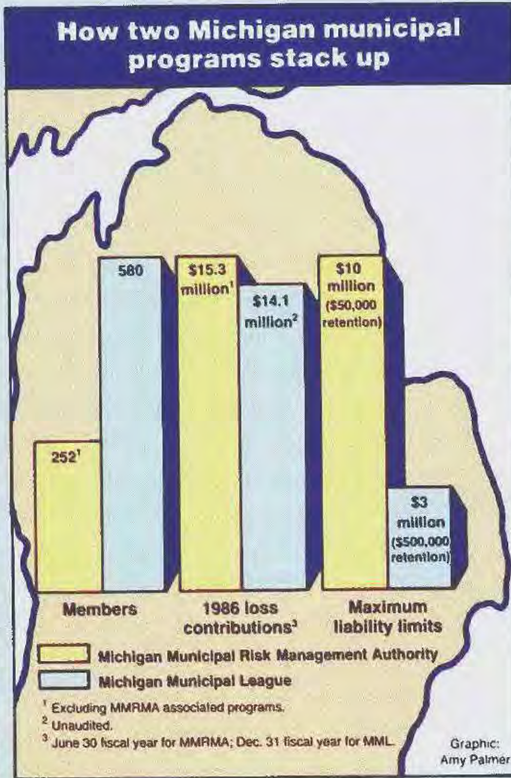
- The reliability of MMRMA's loss statistics and the adequacy of its reserves for incurred-but-not-reported losses.

For the 1985-86 fiscal year, MMRMA set aside $594,727—or about 3.9% of total member loss contributions of $15.1 million—to cover IBNR claims within the members' retentions. (Loss contributions are the equivalent of gross written premiums, and are used to fund loss within a member's retention; to purchase commercial reinsurance and fund the self-insured portions of the reinsurance program; and to cover MMRMA's expenses.)

- The scope of the commercial reinsurance coverage. Portions of the commercial reinsurance program may carry exclusions and coverage restrictions of which some MMRMA board members—officials of participating municipalities—are unaware. The exclusions were found in reinsurance documents obtained by *Business Insurance* and interviews with participating reinsurers.

MMRMA officials maintain that several such restrictions—including a sunset clause that phases out reinsurance coverage after three years—have not actually been agreed to, though reinsurance cover notes obtained by *Business Insurance* include the restrictions and one reinsurer confirms that the restrictions are part of the terms of at least one of MMRMA's four reinsurance layers.

- Discrepancies in the explanations by various MMRMA representatives of how the program works.



Graphic: Amy Palmer

- The adequacy of MMRMA's underwriting practices. Rival agents accuse MMRMA of issuing "lowball" quotations with little underwriting information.

In the course of a nine-month investigation, *Business Insurance* has also learned that at various times between 1984 and the present, portions of the reinsurance covering MMRMA and three sister liability insurance programs were retroceded to an offshore reinsurer owned by several individuals involved in servicing MMRMA. One of these is Wade Waterman, president and owner of Governmental Risk Managers Inc., MMRMA's management company.

MMRMA's retrocessions to Bermuda-based Cove Marine Insurance Co. Ltd. were not disclosed to the program's directors, Mr. Waterman said.

The MMRMA board had previously decided against using Cove as a direct reinsurer because it would not have "looked right," according to Gerald Buckless, county representative for Livingston County and an MMRMA director.

Upon learning that Cove was used as a retrocessionaire, Mr. Buckless expressed surprise, but he did not accuse Mr. Waterman of any wrongdoing.

Mr. Waterman—who is responsible for arranging the MMRMA's reinsurance along with broker Stewart Smith Intermediaries Inc. in New York—denied any conflict of interest in using Cove Marine, explaining that Cove was used only as a stop-gap measure while other reinsurance was sought (see story, page 69).

Mr. Waterman and MMRMA directors also dismiss the other doubts voiced by the program's detractors, maintaining that MMRMA's reserves are adequate and that its participation in the reinsurance program is fiscally sound.

MMRMA's loss experience is better than that of commercial municipal liability insurers, in part because of extensive risk management efforts and incident reporting procedures that alert MMRMA early to the existence of

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IEA syndicates cease writing until March 1

By DOUGLAS McLEOD

MIAMI—Syndicates on the Insurance Exchange of the Americas will not write any direct insurance or reinsurance business for the remainder of the month, while exchange and regulatory officials assess the impact on several syndicates of a number of loss-ridden reinsurance treaties.

At the urging of Florida Insurance Commissioner Bill Gunter, the IEA board of governors voted last week to stop writing all new and renewal business until March 1.

The exchange's board earlier this month had voted to discontinue only assumed treaty reinsurance underwriting (*BI*, Feb. 9).

Meanwhile, a Florida state judge has ordered four syndicates managed by Daum Management Inc. to show cause why they should not be placed in court-supervised rehabilitation.

Three of the syndicates—Syndicate One Inc., Syndicate Two Inc. and Syndicate Three Inc.—had earlier been ordered into rehabilitation by the exchange board.

The Florida Insurance Department, however, filed petitions for court-supervised rehabilitation for the three syndicates, as well as for Syndicate Four Inc., also managed by Daum.

Syndicates One, Two and Three may be insolvent by as

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Congress expected to act on Medicare

By JERRY GEISEL

WASHINGTON—With support coming from all parts of the political spectrum, Congress is virtually certain to pass legislation this session to protect retirees from catastrophic health care bills, experts say.

Congressional passage of an expanded Medicare program to reduce the vulnerability of the elderly to enormous medical and hospital bills is "as close to a slam-dunk in the legislative process as you ever will see," says Rep. Fortney (Pete) Stark, D-Calif.

Increasing Medicare benefits would be advantageous to many employers since their retiree health care costs would presumably be lowered if Medicare pays a larger share of retiree medical bills.

However, some benefit observers note that employers could wind up footing part of the cost required to expand the Medicare program, while others note that enactment of Medicare legislation could focus congressional attention on other health care proposals that are opposed by employers.

In recent weeks, congressmen and Reagan administration officials have been almost tripping over one another unveiling and crafting catastrophic retiree health care proposals.

For example, Rep. Stark, chairman of the House Ways and Means Health subcommittee, and ranking minority member Rep. Willis Gradison, R-Ohio, will introduce legislation later this month to expand Medicare so that a beneficiary's annual

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NEWSPAPER

update

Mission American plan offered

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Co. in New York—and the California Insurance Department. Insurance Commissioner Roxani M. Gillespie says the department is receptive to any plan to funnel money into Mission American.

The department placed Mission American under state control two weeks ago, at the same time it requested permission to liquidate Mission Insurance Co., which had been in conservatorship since October 1985 (*BI*, Feb. 9).

The bondholders, which own a majority of MIG's unsecured notes and debentures, are "certainly willing to make Mission American a viable concern," says Mr. Whitman. He says he and his associates now holds 54%, or about $38 million, of MIG's unsecured debt.

Despite the negotiations, questions about the company's fate remain unanswered.

For example, many of MIG's current 1,100 employees are expected to be laid off shortly, though no firm decision has been reached. "We're all here—waiting," MIG Treasurer Richard F. Ting said last week.

Ms. Gillespie says the department hopes to retain as many employees as possible at various MIG insurers to assist in day-to-day operations.

Also to be decided is whether Mission American will resume underwriting. It stopped writing new and renewal business Jan. 30.

Greater health coverage sought

WASHINGTON—The Reagan administration will ask the Treasury Department to study the impact of barring employers from taking full tax deductions on their health care costs if they do not offer coverage for catastrophic illnesses.

In addition, the administration announced late last week that it will help states develop proposals to require employers to offer catastrophic coverage in their group health plans.

As part of its effort to expand health care coverage, the administration also said it will work with states to craft proposals to form subsidized pools to provide health insurance for high-risk, uninsured individuals. The administration did not specify who should subsidize the pools.

And, the administration is asking the Treasury Department to study whether the tax code should be modified to allow the withdrawal of funds from Individual Retirement Accounts to pay for long-term care expenses or to establish so-called Individual Medical Accounts to pay for long-term care expenses.

The administration, joining a growing drive in Congress, also will propose legislation to expand Medicare to give the elderly more protection from catastrophic health costs (see story, page 1).

However, much to the disappointment of business lobbyists, the administration made no recommendation on whether employers should be given special tax incentives to prefund their retiree health care plans.

American Home cancels offer

NEW YORK—American Home Products Corp. has withdrawn its offer to purchase drug manufacturer A.H. Robins Co. Inc., pay all Dalkon Shield claims and bring Robins out of reorganization.

American Home said last week it withdrew the proposal due to difficulties in negotiations. "During the course of discussions with the interested parties, uncertainties surrounding the situation have not been clarified to our satisfaction," the company said. A company spokesman would not elaborate.

A Robins spokesman said the withdrawal came as surprise. "We were surprised. We really were," the spokesman said. "Negotiations were going forward pretty steadily."

American Home's proposal called for the acquisition of Robins on a tax-free basis to Robins shareholders and the creation of a "substantial trust fund" for the benefit of Dalkon Shield claimants that would have resolved all claims (*BI*, Feb. 9).

Asbestos ADR facility planned

PRINCETON, N.J.—The board of directors of the Asbestos Claims Facility has unanimously approved an "initial national alternative dispute resolution agreement" that seeks to handle asbestos claims out of court.

Lawrence Fitzpatrick, vp-law for the facility, said last week the program initially is intended to reach claimants who have the greatest need for compensation and who have had lawsuits pending for the longest period of time.

If the program proceeds satisfactorily, as anticipated, it will be expanded to include additional claimants, he said. Information on the ADR procedures will be released within the next two weeks.

The program's start-up will be dictated by the plaintiffs' response, Mr. Fitzpatrick said, adding that the facility should be processing claims within a few months. "We anticipate a mixed reaction" from the plaintiffs' attorneys, he said.

The facility has come under criticism from some plaintiffs' attorneys for not putting the alternative dispute mechanism in place more quickly (*BI*, July 21, 1986).

The facility was created by the Wellington Agreement, signed by a group of asbestos producers and insurers that agreed to settle their insurance coverage disputes as well as develop an ADR mechanism for settling claims.

X.L. writing E&O coverage

BARBADOS—X.L. Insurance Co. Ltd., the offshore insurer organized by Marsh & McLennan Inc. and Morgan Guaranty Trust Co., is now writing professional liability coverage.

M&M Executive Vp John Sinnott said X.L. will focus principally on the "advice industry," including lawyers, brokers, investment

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California courts disagree on retroactivity of Prop 51

By ROBERT A. FINLAYSON

LOS ANGELES—The California Supreme Court may decide whether Proposition 51 should be applied retroactively now that two state appellate courts have issued differing opinions.

The 2nd District Court of Appeal in Los Angeles ruled Feb. 4 in *Gregory Evangelatos vs. Student Science Service Inc.* that Proposition 51—which eliminates the application of joint and several liability to non-economic damages in third-party lawsuits—can be applied to all lawsuits pending when the ballot initiative was approved by voters on June 4, 1986.

Failing to apply the initiative retroactively would "frustrate" voters' intentions and would not produce a windfall of profits for insurers, the 2nd District Court ruled.

That decision directly conflicts with an opinion issued in September by the 1st District Court of Appeal in San Francisco, which ruled in *James Russell vs. Asbestos Claims Facility* that Proposition 51 can be applied only to causes of action that arise after the initiative's effective date (*BI*, Sept. 29, 1986).

It is widely expected that the state Supreme Court, once three vacancies are filled, will review the Evangelatos case to resolve the conflict between the appellate courts.

In September, the high court refused to review the 1st District's ruling in the Russell case, leaving that decision as the controlling rule of law in the state's trial courts (*BI*, Nov. 10, 1986). The Supreme Court also remanded to the appellate court in Los Angeles for reconsideration two Superior Court rulings on Proposition 51 that conflicted with the 1st District Court's decision, instructing the appellate court to see that decision.

However, because of the conflicting appellate court decisions, the four Southern California counties in the 1st District must follow the Evangelatos ruling, while the 12 Northern California counties in the 1st District must apply the Russell opinion. Courts outside the 1st and 2nd Districts can choose to follow either opinion.

A decision by the Supreme Court would end this statewide legal controversy over the application of Proposition 51 to thousands of tort lawsuits now pending in California trial courts. Attorneys in the state say that potentially millions of dollars in non-economic damages are at stake in these suits.

The central issue in the debate over Proposition 51's applicability to pending lawsuits is whether California voters intended for the initiative to take effect immediately and apply to lawsuits already filed, or at some point in the future when cases filed after its enactment reached trial.

In its ruling, the 2nd District Court said it found "unpersuasive" the 1st District Court's argument that Proposition 51 could be applied only to causes of action arising after its effective date due to the absence of any affirmative indication of intended retroactivity in the proposition.

The Russell decision "frustrates the legislative will of the voters" by postponing the effect of Proposition 51 for several years, the court said.

The court also rejected as "grammatically and logi-

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Court divides defense costs among insurers

By STEPHEN TARNOFF

SAN FRANCISCO, Calif.—Kaiser Cement Corp.'s excess liability insurers must share defense costs with the company's primary insurer for claims stemming from a 1980 loss exceeding $60 million, a state appellate court says.

In a decision beneficial to Oakland, Calif.-based Kaiser and its primary insurer, Truck Insurance Exchange, the California 1st District Court of Appeal rejected various arguments by Kaiser's excess insurers on why they should not have to pay defense costs.

The decision affirms a 1983 state Superior Court decision that also found Kaiser's excess insurers liable for defense costs.

Of the excess insurers litigating the issue, only Transcontinental Insurance Co. does not have to pay additional amounts because its policy provided that defense costs were included in policy limits, which were exhausted by indemnity payments, the court said.

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Syndicates not paying runoff policy claims

By CAROLYN ALDRED and STACY SHAPIRO

LONDON—Lloyd's of London syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. are refusing to pay asbestos-related losses on runoff reinsurance policies written for other Lloyd's syndicates.

Lloyd's underwriter Richard Outhwaite, the market's leading runoff reinsurance underwriter for Lloyd's syndicates, says he is refusing to pay the claims until he receives more information about the underlying policies, which cover asbestos risks.

Lloyd's syndicates reinsure long-tail liability risks to close their annual accounts under Lloyd's three-year accounting system. The underwriters and reinsurers estimate the amount of outstanding liabilities and the runoff reinsurers establish a premium for these runoff policies based on that estimate.

But, sources in London say asbestos claims may be coming into the market much more quickly than the Outhwaite syndicates anticipated, particularly since Lloyd's underwriters signed the landmark Wellington Agreement, which created an out-of-court mechanism for settling asbestos claims. A total of 7,000 asbestos cases have been settled by the Asbestos Claims Facility since it was established.

Mr. Outhwaite said it is possible other syndicates also may refuse to pay on runoff policies.

"The degree of foreseeability is the essence of the matter, and the same issues are involved in a number of runoff policies written in that period," Mr. Outhwaite said. "A syndicate can only give an informed estimate of what claims may occur and it is that informed estimate we have called into question."

The Outhwaite syndicates' refusal to pay the runoff claims could produce huge underwriting losses for several Lloyd's syndicates.

For example, members of syndicates managed by Stewart &

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inside

- As employers plot their strategy to control the latest surge in health care costs, they must keep in mind that communication is one of the keys to benefit cost containment, this week's editorial stresses. **PAGE 8**
- In speaking out, Carol Johnston, an associate consultant with Coopers & Lybrand in Chicago, contends that since many employers spend substantial sums of money on utilization review to control benefit costs, it is time for employers actively to assess the quality and effectiveness of their UR programs. **PAGE 46**
- A recent study by the Rand Corp.'s Institute for Civil Justice reveals that less than half of the estimated $29 billion to $36 billion spent on tort cases concluded in 1985 was paid as compensation to plaintiffs. **PAGE 72**
- Leonard Wilson, a principal at L.F. Rothschild, Unterberg, Towbin in New York suggests that as competition returns to the insurance industry, the ability of insurance brokers to maintain or expand their profit margins will become more difficult. **PAGE 83**

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Benefit cost control

Many employers going back to basics

By CAROL M. CAIN

Reeling from unabated health care inflation that averaged 7.7% last year, employers are returning to square one, tearing their benefit programs apart and putting them together again in an effort to stem the tide of rising costs.

Employers say they are increasingly finding that simply applying cost-containment techniques on a piecemeal basis no longer is a workable strategy, and now they must widescale look at their entire health care plan to determine how a variety of tools can be used to contain costs.

And, employers and consultants note, no new health care cost-containment techniques are appearing on the horizon.

Among the existing cost-containment tools widely in use—and even growing in popularity among employers—are self-funding, wellness programs, preferred provider organizations, negotiated provider contracts and utilization review, including second surgical opinion and pre-certification requirements, concurrent reviews and case management.

However, cost-shifting tactics, like increased deductibles and copayments, are becoming less effective, mainly because employees already are sharing much of the load.

Many larger employers are using a combination of cost-containment techniques, but they still are not seeing their medical costs drop, experts say.

And, smaller companies "are still trying to grapple" with cost-containment ideas like health maintenance organizations and preferred provider organizations.

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Employers taking bite out of dental care bills

Employee benefit managers are finding they can reduce dental care expenses by applying to dental plans the same health maintenance and preferred provider concepts they use in their group health care programs. Controlling dental costs has developed as a natural second step to getting a grip on medical costs, suggests one dental PPO founder. Page 12

Review of UR program key to effectiveness

In an era of continuing health care cost inflation, utilization review is a good investment for employers, experts say. But, they caution that UR programs are not the final solution to rising health care costs. And they emphasize that careful evaluation of the services offered—both before and after a program is implemented—is the key to achieving the best results. Page 32

Benefits experts wary of Medicare proposal

Employee benefit experts say they're wary about the feasibility of the Reagan administration's proposal to allow employers to provide Medicare benefits to their retired workers. The administration says the plan will save the government money and allow employers to integrate Medicare benefits with their current retiree health care plans. Page 34

Preferred provider organizations evolve as market impact expands

By DONNA DiBLASE

In today's alphabet soup of employee health benefits, the PPO—or preferred provider organization—is one of the fastest-growing, fastest-changing forms of alternative health care delivery systems.

About 500 PPOs currently are operating around the nation, most of which were developed between 1983 and 1986. In comparison, about 600 health maintenance organizations currently exist, most of which have developed during the 14 years since the federal HMO Act of 1973 was enacted.

"The growth of PPOs is remarkable, especially when you compare it to the way HMOs have grown since the federal HMO Act was passed," said Tom Billet, a senior consultant in the New York office of Johnson & Higgins.

"HMO growth is not even close to PPO growth. That growth is primarily the result of the non-regulatory, more flexible characteristics of PPOs," he added.

Since the explosion in the number of PPOs in the early 1980s, there have been many changes in the design and sponsorship of PPOs, consultants and PPO officials say.

But, as PPOs gain market share and popularity, employers need to be concerned about not only the cost-effectiveness of the delivery systems, but also the quality of health care they deliver, the experts say.

In addition, the prevalence of PPOs in today's competitive health care marketplace could cause many changes in other health care delivery systems, such as HMOs, experts predict.

A PPO is a contractual agreement between a health care purchaser—such as an employer or insurer—and a health care provider.

Under most agreements, the provider agrees to deliver health care services for prospectively negotiated fees in return for a certain market share of patients, benefits experts say.

The arrangements also usually include utilization review of health care services, as well as some type of quality assurance review of the services delivered.

PPOs differ from HMOs in that employees are not enrolled or locked into the PPO. Thus, they are not required to use only the providers participating in the PPO's network in order to receive coverage of their health expenses, although some employees receive reduced coverage if they go outside the PPO network. In addition, PPO coverage is paid for on a fee-for-service basis, unlike HMO coverage, which is prepaid in a monthly premium.

Because of this difference in provider reimbursement, PPOs, unlike HMOs, do not put providers at a financial risk to deliver only necessary care, experts say.

A lack of PPO reporting standards, as well as the lack of a universally accepted definition of a PPO, make it impossible to determine exactly the number of PPOs in existence.

Continued on next page

PPOs' growth

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However, some PPO membership organizations track these statistics through surveys.

For example, as of December 1986, 454 PPOs were operating nationwide, according to a directory of PPOs published by the American Medical Care & Review Assn. in Bethesda, Md. An additional 52 PPOs were in pre-operational stages at that time, according to the directory.

Eighty-nine new PPOs began operating last year, 68 of which became operational since June 1986, AMCRA reports. The states with the largest number of PPOs are California, with 101; Ohio, 45; Florida, 32; Illinois, 30; and Pennsylvania, 22 (see map, page 6).

In comparison, 596 HMOs were operating as of June 1986, according to Interstudy, a research organization in Excelsior, Minn. This is up from 480 HMOs as of December 1985.

The most significant trend in HMO growth has been the increase in the number of independent practice association model HMOs. This type of HMO most closely resembles a PPO, in that independent physicians contract to provide services both to HMO patients and to non-HMO patients.

Some 345 of the 596 HMOs as of June 1986 are IPAs, up from 245 IPAs as of December 1985.

The IPA is more popular among physicians because they can maintain a private practice while still having some guarantee of patient share through their HMO contracts. Some say that this could be the reason for the dramatic increase in the number of IPAs.

According to the AMCRA directory, the largest increase in the number of PPOs occurred between 1984 and 1985.

For example, 131 PPOs began operating in 1984, an increase from 66 in 1983. And, 134 PPOs became operational in 1985, according to the AMCRA directory.

AMCRA estimates that the PPO option now is available to about 30 million employees and dependents.

According to a directory compiled by the American Assn. of Preferred Provider Organizations, 369 PPOs were operating as of October 1986.

There were 325 PPOs as of October 1985, and 143 PPOs as of December 1984, according the AAPPO directory.

"PPOs picked up speed in late 1984," explained Sharon Graugnard, executive director of the Alexandria, Va.-based AAPPO. "1985 was a boom year, as there was a tripling in the number of operational PPOs. However, the growth in the number of PPOs has stabilized, with a moderate increase in 1986.

"The primary reason for this stabilization is the high cost of starting and operating a PPO," she explained. Most of the growth of PPOs over the last year has been limited to the expansion of regional PPOs and some consolidation of PPOs.

"The shakeout in the PPO marketplace already has started," said Edward Pickens, director of special projects for AMCRA.

"The weaker PPOs without a significant number of providers in a service area will not survive. If you don't have good utilization review and quality assurance review, you will not survive," he predicted.

Benefit experts agree that the inevitable shakeout in the PPO marketplace already has started.

"It's inevitable in some marketplaces—certainly some of the smaller PPOs are being acquired by the larger ones," said Cynthia Hosay, vp of health care cost management for consultant Martin E. Segal Co. in New York.

"We see a shrinking in the number of PPOs through mergers and acquisitions. This is because of competition, but also because I see the delivery of health care moving toward a national focus and there is a need for a PPO with national capability. That's probably why large insurers or third-party administrators are able to do more," Ms. Hosay said.

"The shakeout will be in those delivery systems that haven't been marketing successfully to employers," predicted Robert M. Colasanto, vp of San Diego-based PPO, Community Care Network.

CCN is a statewide community-based PPO directed by employers, health care providers and unions in the community. It was developed in 1982, in response to the cost-containment needs of the San Diego Employers Health Cost Coalition (*BI*, May 30, 1983).

"Successful marketing to employers depends on the integrity of the system to demonstrate savings to the employer," Mr. Colasanto said, adding that "the brightest future is for those systems that have strong employer support."

While the most common sponsorship of PPOs continues to be physician/hospital joint ventures, a major trend in the PPO marketplace is the increased activity by major health insurers, experts say.

Many insurers either have developed their own PPOs, or have contracted with existing PPOs.

According to AMCRA's directory, 160, or 31.6%, of the 506 PPOs listed are sponsored by health insurers and Blue Cross/Blue Shield plans. In 1985, only 77 PPOs listed in the directory were sponsored by insurers.

In comparison, almost 200 of the PPOs listed in the directory are sponsored by physician groups and hospitals. In addition, 16 of the PPOs in the directory are sponsored by HMO companies.

"The move toward payer-sponsored PPOs is going to increase dramatically," predicted Mr. Billet of Johnson & Higgins.

"PPOs at first were a reaction to loss of market share by providers. But, the change in sponsorship dovetails with a general movement in health care of payers wanting more control over health care costs," he explained.

In the Southern California market, "the most common PPO sponsorship among the large employers is insurer-sponsored PPOs," said Laird Post, a consultant in charge of the group benefits practice in the Los Angeles office of The Wyatt Co.

"There also are hospital and physician-sponsored PPOs, but they tend to appeal to the smaller employers," he said.

"I would say that the first PPOs were initiated by employers with outside groups," said Ms. Hosay of Martin E. Segal. "Insurance carriers came into the picture quite a bit later. Today, insurers and large third-party administrators are the most dominant."

"What began as individual hospital- or multihospital-based PPOs are not terribly viable. Insurers and TPAs have tremendous resources to develop PPOs," said Peter Boland, president of Berkeley, Calif.-based Boland Healthcare Consultants.

"Insurers will gain an increase in the PPO market in the next three years because of the number of policyholders they have and their access to capital to develop PPOs. Access to capital will be essential to make it through the shakeout now," Mr. Boland said.

"Another real wave now are joint ventures between hospital/physician groups and insurers," he added.

While most of the largest health insurers have developed their own PPOs, experts say many small and

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PPOs' growth

Continued from page 4

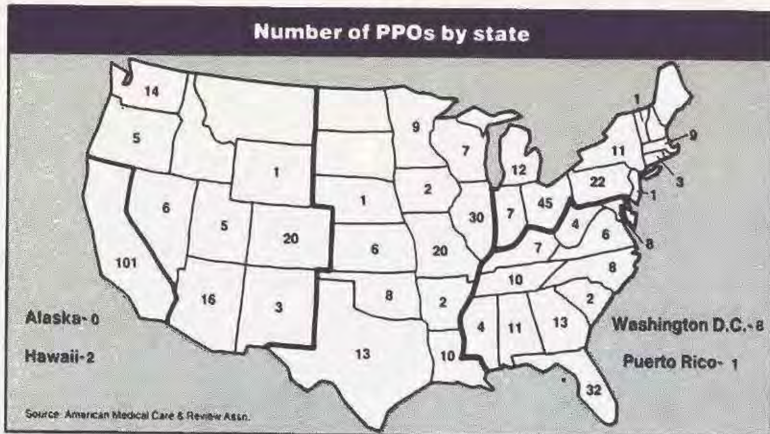
medium-sized insurers contract with existing PPOs to compete in the managed health care marketplace.

"Small insurance carriers that need a PPO come to companies like Admar to contract with a network. They can use us to be competitive in the group health environment," said Alan M. Jeffery, vp of marketing and development of the Admar Corp. in Orange, Calif.

Admar provides managed health care services through its HealthWatch utilization review program and its Med Network PPO, a statewide organization that includes about 8,000 physicians and 180 hospitals.

The company also provides health benefit claims administration through Admar Third Party Administration.

Cypress, Calif-based PPO Alliance, a statewide hospital-sponsored PPO, also contracts with health insurers.



"The bulk of our work comes from the contracts we put together for insurers," said Walter McCall, vp of marketing and sales.

Insurers that contract with the PPO include Denver-based Great West Life Assurance Co., New York-based Equicor and Minneapolis-based Northwestern National Life Insurance Co.

"We're seeing some big insurers and TPAs that want to acquire their own PPOs. But, insurance companies are using their PPOs—whether they're PPOs they've set up or PPOs they've contracted with—in order to go after the TPA market," Mr. McCall observed.

In addition to contracting with existing hospital- and TPA-sponsored PPOs, a group of 18 insurers have contracted with Private Healthcare Systems Ltd., a PPO network created by Great West Life Assurance Co. and the Health Data Institute in Lexington, Mass., to market the PPO nationwide (*BI*, Jan. 5; Oct. 7, 1985).

PHCS PPOs will be offered in 40 markets nationwide to the approximately 11 million people currently covered under conventional indemnity plans by the insurers, said Scott Marber, regional vp for the Lexington-based PPO network.

The PPO network currently operates in some 20 markets, he said.

While insurer- and TPA-sponsored PPOs will continue to be a major trend in the marketplace, employer-negotiated PPO contracts likely will occur only among large employers, experts say.

"We won't see too many employer-based PPOs because employers really don't have to form their own PPOs," said Laird Miller, chief executive officer of Minneapolis-based health care consultant, Health Systems Management Inc.

"There now are many alternative delivery systems that are willing to address the needs of the purchaser. The employer is the one who really is stimulating a lot of competition," Mr. Miller said.

Employer-negotiated PPOs, "are not going to be very common," said Wyatt's Mr. Post. "There may be some markets where employer coalitions can do it. But, a major trend will be to let someone else do it efficiently for the employer."

Employer-negotiated PPOs will exist mainly among large, self-insured employers, said Elliot A. Segal, a principal consultant in the Washington office of William M. Mercer-Meidinger Inc.

"These negotiated provider arrangements will continue among large employers that have their own stamp of what their benefit packages are. They need customized plans that insurance carriers can't fit with a cookie-cutter PPO," he explained.

However, some say that specialty PPOs—such as PPOs for psychiatric care and substance abuse—will continue to gain popularity (*BI*, Sept. 29, 1986).

"Specialty service PPOs are definitely going to increase," predicted Dr. John Mahoney, vp and director of Alexander & Alexander Inc.'s Health Strategies Group in Westport, Conn.

"Probably the more tangible one is a psychiatric PPO. Our clients are looking at increases in psychiatric costs" that exceed the increase in overall health care costs," he said.

The Florida Health Coalition Inc., an employer coalition based in Miami, has already taken the initial steps to develop psychiatric PPOs for its employer members.

The coalition, hoping to reduce mental health and substance abuse costs by 15%, is accepting proposals from psychiatric care management firms through the end of February.

It then will select two firms that agree to meet specific qualifications, such as providing an employee assistance program, an emphasis on outpatient treatment, inpatient services that emphasize brief confinements, case management procedures and detoxification care for drug abusers.

"The impetus for this project has been reports from employer-members that inpatient utilization of psychiatric service has been extremely high in 1986. Results from our data-collecting project indicate that claims paid for psychiatric and substance abuse have accounted for about 20% of South Florida employers' total health care costs," said Stephen L. White, executive director of the coalition.

The coalition hopes to have the PPOs available to its members by late spring, he said.

In addition to the growth of mental health PPOs, other specialty PPOs, such as pharmacy and dental PPOs, are growing, some sources noted (see story, page 12).

Along with the changes in sponsorship of PPOs, some experts say the design of the delivery systems also is changing.

"In 1982, PPOs were in their first generation," said Mr. Boland of Boland Healthcare Consultants. "They were hastily put together," emphasizing discounted fees for health care services.

"However, in their second generation, PPOs featured utilization management, quality assurance and accountability. They reduced costs by integrating a whole range

Continued on page 10

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opinions

Winning idea

As EMPLOYERS PLOT their strategy to control the latest surge in health care costs, they must keep in mind that communication is one of the keys to benefit cost containment.

If employees are confused about the purpose of cost-containment tools and do not understand how their newly restructured benefit program works, the employer's cost-containment effort will be doomed.

Employers must keep this in mind especially today. Despite almost a decade of cost-control vigilance, health care inflation is again on the rise. The medical care component of the Consumer Price Index increased 7.7% in 1986, compared with 6.2% increases in both 1984 and 1985. Compounding this, group health insurers have issued their bad news: Rates for traditional indemnity health care plans could increase as much as 20% this year.

If employees do not understand how their newly restructured benefit program works, the employer's cost-containment effort will be doomed.

Furthermore, employee benefit consultants are telling their clients not to expect a panacea: There are no new health care cost-containment measures on the horizon that will automatically reduce a company's health care costs upon their implementation.

But, as we report in this week's issue, employers still can put up a fight against rising health care costs.

Instead of using cost-containment devices—like utilization review programs, preferred provider organizations, wellness programs and increased employee cost sharing—on a piecemeal basis to achieve a "quick-fix" result, many benefit managers now are mapping out widescale cost-containment strategies to hold the line on health care inflation.

For many companies, that may mean introducing a totally redesigned health care plan to zero in on various factors responsible for increased health care costs.

Of course, just as employers are revamping their health care programs to meet a new challenge, they must also plot new, effective benefit communication strategies to inform their workers about the changes in their health care benefits.

Business Insurance recognizes the effort required to establish an effective and creative benefit communication program through the annual Employee Benefits Communications Awards competition. First-, second- and third-place awards are presented in five separate categories: audio-visual, booklets, computer communications, personalized correspondence and total communications programs.

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The deadline for nominations is April 30.

To request an entry form, contact: *Business Insurance,* EBC Registrar, 220 E. 42nd St., Suite 930, New York, N.Y. 10017; 212-210-0137.

Winning the battle against rising health care costs requires effective employee benefit communications. Why not win an award for your efforts at the same time?

letters

Trucking industry hit hard by insurance market forces

To the editor: I am a 40-year participant in the production side of the property and casualty insurance business especially dedicated to the service of the highway transport and public warehousing sector of the economy. I serve the California Trucking Assn. and currently serve on the actuarial and data base subcommittees of the less-than-celebrated A.B. 2677, California Legislature-mandated research into insurer and insurance institution behavior pertaining to trucking insurance.

The project, funded by a half-million dollars of transportation industry-derived money, is trying to determine what—besides past under-pricing of the insurance product—has suddenly diverted the support of the 10 or more major underwriters of highway transportation risks that had written more than 70% of our risks.

Why is it that even the marvelous Insurance Services Office is unable to explain to us what now is so wrong with our industry that was the focus of feverish competition five years ago?

We recently sought coverage and capacity from more than 10 insurers formerly prominently identified with substantial and sustained market capacity for our rather remarkable quality portfolio. Our results were disappointing. Our direct assault on the citadels of virtue and underwriting wisdom were less rewarding than indifference.

As the so-called "insurance crisis" shaped up on the horizon with unmistakable signs in 1982 and 1983, we wrote extensively in highway transportation industry literature about what was going to happen. A lot of our readers simply said that it was impossible as they proceeded down bucket-shop row to find the next company that would discount, straight away, the price offered by last year's insurer.

Even through 1985, buyers would not believe they were being cuckolded as successive waves of price-cutting descended on businessmen reeling from the hammering of a recession and the not-too-bright supply-side gambit of deregulation.

We have subsequently suffered through being called on to support, financially as well as with all spiritual power, the idea that the tort system was the real evil of society and the insurance industry in particular.

I also have suffered through 10 legislative hearings, innumerable trucking industry fact-finding hearings, regulatory agency inquiries and three years of verbal abuse by buyers aimed at their perceived tormentor—the insurance business. It appears to many buyers that insurance institutions have earned the same credibility that hostage-takers demand.

Through it all, we are surviving, somewhat. *Business Insurance* is one of those rare publications that carried balanced reporting of a difficult time for an industry trying to escape the restraints of high-button shoes and celluloid collars by replacing principles with uncontrolled and unscientific experimentation. *Business Insurance* articles often gave us the opportunity to move the emotions away from perceived tormenting issues for redirection to the facts and real issues. You did it bravely, carefully and articulately. We thank you for that. We appreciate the preponderance of light that pushes doublespeak out of the picture.

Les August
President
Motor Transport Insurance Services
Calabasas, Calif.

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.

What self-insurers really need to know

To the editor: As usual, your self-insurance spotlight report (*BI*, Jan. 26) provided much valuable information relative to both property/casualty and employee benefits third-party administrators. Unfortunately, the report did precious little in the way of detailing the very difficult environment many property/casualty self-insurers find themselves in today.

The issue would have been of far greater value if you would have explored the almost non-existent market for surety bonds that self-insurers rely on so heavily to secure their self-insured status in most states. Where'd the capacity go? Why? What alternatives are available?

There's also a definable movement afoot to create the self-insurer's equivalent of a state guaranty fund. What are the implications of such a development?

These are but two key topics that if developed with your usual thoroughness, would have made an informative issue an excellent one.

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PPOs' growth

Continued from page 6

of internal controls," he explained.

"In the third generation of PPOs, we're going to see a lot more emphasis on information systems that can relate to quality and utilization of services."

He continued: "Quality assurance is going to be a main issue and there will be an emphasis on cost-effectiveness rather than cost-cutting."

While observers agree that quality of the providers in a PPO is difficult to assess, they say there are certain factors that can indicate quality.

"There are a lot of PPOs out there that are sort of glossing over their quality procedures," said Mr. Billet of Johnson & Higgins. "Employers can look at the malpractice history of providers in the PPO and check that all providers are board-certified."

Mr. Miller of Health Systems Management suggests: "I would ask about the PPO's selection criteria as well as how they evaluate the performance of their providers. If they don't have a data system in place to keep track of this, then that says something to me," he said, such as that the PPO is not effectively monitoring quality.

"Quality is the $64,000 question," said James Kennedy, director of group services-Midwest in the Chicago office of Buck Consultants Inc. "Most PPOs look at malpractice, etc., but the jury is still out on how to measure quality."

Employers also need to evaluate the cost-effectiveness of PPOs, observers experts say.

However, some experts are skeptical about whether a "discounted" fee really is a savings for employers.

"We always ask PPOs to address this concern and to demonstrate the effectiveness of these discounts," said Wyatt's Mr. Post. "The reason we often don't see the results is because the discounts really aren't discounts."

Negotiated per-diem rates—or rates per hospital inpatient day—can be cost-effective. However, "sometimes the negotiated rate can be higher than what the hospital normally charges," he cautioned.

The key to determining whether a PPO discount really is a discount is to "consider both the price of the service and the units of the service delivered," said Mr. Miller of Health Systems Management.

"If the negotiated price is 20% off the normal price charged by the provider, but the provider delivers three times what should be delivered, then it's not a discount," he explained.

"Rather than just looking at discounts, we should look at a set fee that's appropriate for every service. The idea is we want to pay less money on a per-unit basis," he explained.

Los Angeles-based Security Pacific Corp. conducted a study of claims data in the two years after it implemented a PPO, said Mr. Jeffery of Admar, formerly a vp of employee benefits for Security Pacific.

The study—which was made possible by a grant from the Robert Wood Johnson Foundation Program for Research and Development on Health Care Costs—examined the claims data of the 18,000 Security Pacific employees and dependents that used Admar's Med Network PPO for health care.

The PPO was implemented in January 1984. The study evaluated the company's prior claims experience in 1982 and 1983 and then the results of the PPO based on claims experience through 1984 and 1985.

Security Pacific's total health benefits costs in 1983 were $21.5 million, according to the study. By implementing the PPO, the company projected that it could reduce this 1983 cost by $2.5 to $3.5 million.

"Employees were the ones that benefited the most from using the PPO. Security Pacific has been able to offer them more benefits at lower costs," Mr. Jeffery explained.

The study found that while the PPO did not reduce aggregate health benefits costs for the company, it enabled the company to offer employees more cost-effective care without increasing the cost to the company.

According to the study, the PPO reduced employees' share of the cost of outpatient services from 35.6% outside the PPO network to 11% inside the network. Employee cost sharing for inpatient services were about the same both inside and outside the network.

Under the plan, employees paid $10 for physicians' office visits and $5 for prescriptions if they used preferred providers. Normally, their annual deductible was $175 for single coverage and $525 for family coverage, plus a 20% copayment up to a maximum out-of-pocket expense of $1,000 annually.

Employees paid the same deductible and copayment for inpatient services regardless of whether they used a PPO hospital.

And, "the patient was not aware of which hospitals were PPO hospitals. But, because of the negotiated fees with these hospitals, employees' 20% copayment" usually was equivalent to the difference between the charges of the PPO hospitals and the non-PPO hospitals, Mr. Jeffery explained.

Most recently—in 1986—the Med Network PPO actually saved Security Pacific $1.6 million, Mr. Jeffery said. Combined with the HealthWatch utilization review program, the company has saved more than $4 million in health benefits costs.

The growth of the PPO movement has fostered intense competition in the health care marketplace—competition that could force big changes in other alternative health care delivery systems, like HMOs, experts say.

"One thing PPOs did was to make the HMOs honest," asserts Mr. McCall of the PPO Alliance. "We had shadow pricing and adverse selection, etc. But, now we're starting to see the positive impact of competition.

"As a result, HMO premiums have stabilized and HMOs now are willing to share data," he added.

Some say the two types of delivery systems may even merge to form a new type of system in the future.

"I don't think we're going to see many more PPOs, but we're going to see them merge into total managed health care systems that will be both indemnity and HMO with employees making a choice of providers at the point of receiving service. There won't be an annual enrollment or election," predicted Wyatt's Mr. Post.

"There will be maybe 10 national managed health care systems that will offer these triple-option managed health care products," he added.

And, Mr. Segal of Mercer-Meidinger predicts that by 1995, "We could have about 20% of (employees) enrolled in HMOs and another 50% to 60% in PPOs.

"There's going to be a little bit of melding of the two, but there will also be some market segmentation," he said.

"This will occur because some people will want a closed panel of providers and some people will want open access. Some will want to be more price conscious and will choose HMOs, and others will be willing to pay the copayment to be able to choose their own provider through PPOs," he explained. ■

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Dental PPOs, HMOs trim benefit costs

By STEVE TARAVELLA

Benefit managers are taking a bite out of their annual dental bills by applying to their dental care plans the same cost-containment concepts they use in their group health care programs.

Employers are turning to dental capitation programs, which are similar to health maintenance organizations, or to dental preferred provider organizations in an effort to better manage the cost of their group dental benefits.

Controlling dental costs has developed as a natural second step to getting a grip on medical costs, suggests one dental PPO founder. The employers that can save the most are those whose current indemnity plans offer generous reimbursement levels, like 80% to 100% of eligible expenses, consultants say.

Since the costs of dental services—like X-rays or cleaning—are more predictable than medical costs, dental care is easier to package. Therefore, it is easier to persuade dental professionals than medical professionals to participate in negotiated provider arrangements.

By the nature of their business, dentists are perhaps "more attuned to the need to get patients" than medical doctors are, suggests Sharon Graugnard, executive director of the American Assn. of Preferred Provider Organizations in Washington.

Because dentistry is basically preventive medicine, there is real potential to hold down dental costs, dental practitioners explain. And, to make sure unnecessary procedures are not performed, utilization review is a key part of most dental care program alternatives.

About 20 capitation plans, or dental maintenance organizations, now operate in California, where the plans are most developed, says Roy Gonella, a principal at William M. Mercer-Meidinger Inc. in Los Angeles.

DMOs operate much like their HMO counterparts, in that employers prepay a certain monthly fee per dental enrollee.

By contrast, about 10 dental PPOs are now available nationwide, Ms. Graugnard estimates. PPOs are fee-for-service operations that offer the employer discounted fees in exchange for using certain practitioners. Dental PPOs typically charge an administrative fee of between 50 cents and $1 per enrollee per month.

According to the National Assn. of Employers on Health Care Alternatives, the number of dental PPOs has increased 150% from the four that the Key Biscayne, Fla.-based group was able to identify in late 1985 for publication in its Blue Book Digest of PPOs. However, only one of the 10 dental PPOs the group was able to identify is operating nationally.

Some employers are even offering employees access to both a dental PPO and a DMO.

Group dental care has become "one of the boom areas in the specialty PPO world," observes Ms. Graugnard. Other specialty PPOs have sprouted in fields like podiatry, optometry, pharmacy, chiropractics and mental health care.

One such dental PPO is offered by 3-year-old American Health Benefits in Washington, D.C.

American Health Benefits, which claims to be able to reduce an employer's annual group dental bill by about 20%, has about 130 member dentists in the Washington area and covers about 10,000 lives, including dependents. Among its users are two local communication workers unions.

Another group dental care system is Preferred Care Inc., which operates dental PPOs in six states: Florida, Illinois, Michigan, Ohio, Washington and Wisconsin.

About 6,500 of Preferred Care's 10,000 dentist members work in these states. The network contracts with the remaining 3,500 for their services for employers in other states—like Minnesota, New York and New Jersey—on an ad hoc basis.

Preferred Care says it can trim 20% to 35% from an employer's annual dental bill, depending on utilization by and the nature of the employee base.

The network's business is "growing by leaps and bounds," says Dr. Fred S. Weiner, Preferred Care's founder and president in Chicago.

The network currently provides services for an estimated 550,000-plus lives.

About 750 of these are Mary Thompson Hospital employees and their dependents. Thompson dental enrollees came aboard last June, after the hospital withdrew from a traditional dental indemnity plan written by Blue Cross/Blue Shield of Illinois.

After only six months of using the PPO, the Chicago hospital experienced a cost savings of about 60%—far greater than the 20% to 35% savings initially projected, reports Gwen Rodriguez, the hospital's personnel director. Benefits are identical to those offered under the BC/BS plan.

And, whereas the hospital received only quarterly utilization reports under the previous indemnity plan, it now receives claim reports monthly and biweekly from an outside third-party administrator, she points out.

Far larger than Preferred Care is Delta Dental Plan of California, which covers some 5.5 million lives in that state alone. The plan's providers include a whopping 96%—or 16,000—of the state's dentists.

Clients, mostly employers, paid Delta Dental $575 million in gross premiums in 1986, according to Jerry Holcombe, vp-public and professional services in San Francisco.

Delta Dental, the oldest group dental plan in the United States, is similar to a medical PPO but does not require member dentists to discount their fees by a specific amount. Rather, it contracts with dentists who file rates within acceptable norms, Mr. Holcombe explains.

Mr. Holcombe says the number of lives covered by Delta Dental of California has grown about 5% annually during the past 15 years.

Metropolitan Life Insurance Co.'s Preferred Dentists Program perhaps has seen more substantial growth. Met Life's PPO began in January 1986 and already covers more than 300,000 lives in 55 employer groups, estimates Alan Vogel, manager-dental programs.

With about 9,000 member dentists, the PPO is strong in Florida and California and is beginning to penetrate New York. Because the

Continued on page 14

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Dental plans

Continued from page 12

PPO incorporates Metropolitan Life's claims processing, the network is presently available only to Metropolitan Life policyholders, he says.

Metropolitan Life's PPO is one of seven insurer-sponsored dental PPOs that support the Insurance Dentists of America in Saratoga, Calif. IDOA provides services to Metropolitan Life, Travelers Corp., Equitable Life Assurance Society of the United States, Mutual of Omaha Insurance Co., Transamerica Occidental Life Insurance Co., John Hancock Mutual Life Insurance Co. and The New England.

IDOA has compiled a pool of about 23,000 dentists nationwide from which these insurers can choose PPO member providers. The insurers are not bound to solicit members solely from the IDOA pool, and the dentists may join any or all of the PPOs they wish.

The dentists do not pay to have their name added to IDOA's list, which is updated monthly. Nor do the insurers charge the dentists, who contract with them independently of IDOA.

Rather, the insurers pay IDOA a fee that is based on the number of employees enrolled in their PPO. Pursuant to a sliding scale, insurers with more enrolled employees pay IDOA less per life than those with fewer enrolled employees, says Dr. Richard Garwood, IDOA's president.

But the real benefit of IDOA's service is not a smooth enrollment process, Dr. Garwood points out: It's utilization review.

IDOA receives monthly claims data from the insurers on dental utilization, which it distributes to all seven insurers.

Of the approximately 480 distinct, coded dental procedures, IDOA provides utilization ratios on 140 of the more commonly abused procedures.

For example, insurers are informed by IDOA of the number of times a particular dentist reports a routine extraction as a surgical extraction, thereby qualifying for a greater reimbursement.

IDOA arrives at its ratios by comparing the practices of member dentists with established norms, based on the practices of dentists nationwide, Dr. Garwood says. This data—provided by the same insurers from information they gather from routine dental claims submitted daily—is stored in a comprehensive data base and updated twice annually.

The insurers are given utilization reports monthly but also can seek special utilization reports, usually for an additional fee, Dr. Garwood explains.

Some provider organizations offer both DMO and PPO options.

For example, an affiliate of the American Health Benefit PPO also offers a DMO in New Jersey, Virginia, Maryland, South Carolina and Washington, D.C.

This arrangement, offered by Randmark Management Inc., the AHB affiliate, is about 8 years old and covers 150,000 lives.

The arrangement offers employers greater savings potential than the PPO, according to Dr. Randy Widen, Randmark's president. The DMO, with about 500 member dentists, can offer about a 30% savings from what an employer would spend on a traditional indemnity plan, the company estimates, compared with the 20% estimated savings by the PPO.

And, a subsidiary of Delta Dental of California—called PMI—offers a prepaid capitation program called DELTA Care that now covers more than 3,000 lives.

HealthWest Foundation in Chatsworth, Calif., is one employer that left its self-insured indemnity plan for a dual-choice program, offering employees both PPO and DMO dental options. Under the new program, about 3,000 HealthWest employees have access to the Delta plan and to Safeguard Health Plans, a dental capitation plan based in Anaheim, Calif.

HealthWest, which operates nine not-for-profit hospitals, expects to save 8%-12% annually over the cost of its previous, self-insured dental program. The new program began Jan. 1 and was brokered by Keenan & Associates in Torrance, Calif.

Some observers contend that DMOs offer employers greater savings potential than dental PPOs.

"The prepaid plan can save at least twice as much as a PPO can save," says Mr. Gonella of Mercer-Meidinger.

One of the largest DMOs is offered by Prudential Insurance Co. of America. That plan covered 715,000 total lives at year-end 1986, the company estimates. ■

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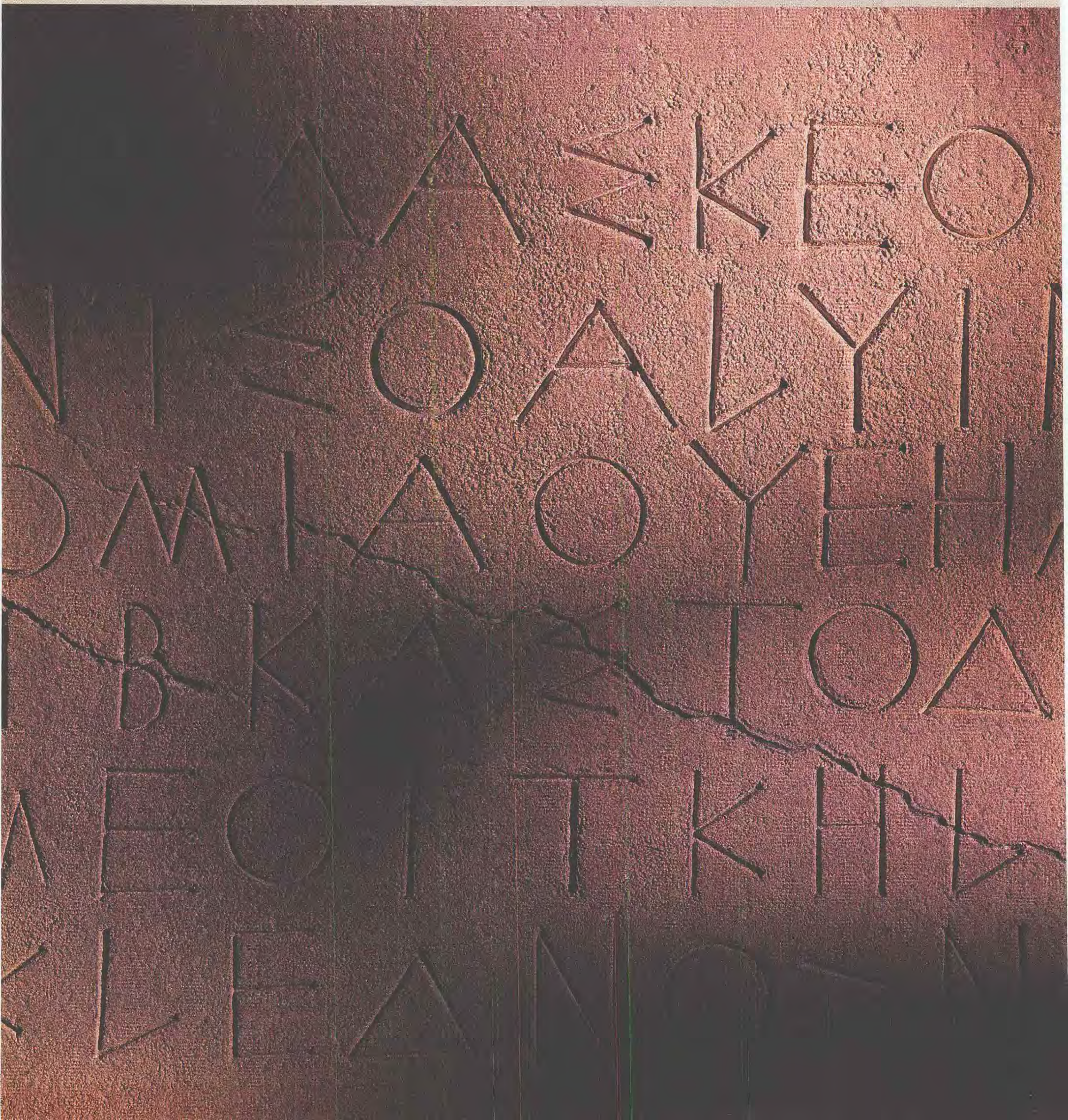

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Cost control

Continued from page 3

"For some, HMOs are like a new toy. HMOs didn't want to deal with these little firms in the past," notes Pamela D. Mitroff, manager of health care cost management for the Illinois State Chamber of Commerce in Chicago.

But employers and consultants seem to agree: With no new tools on the market to whittle rising medical costs, the alternative is to make sure every possible technique is being used to its fullest.

"We've gotten all the gain we're going to get in this first round," said Rosemary Goudy, director of welfare benefit plan consulting for Coopers & Lybrand in Chicago.

Employers now need to put together the best package they can, but make the plan flexible to meet different employees' needs, she advised.

When the army of cost-containment measures now being used first were introduced, they did lower costs. But in many instances, the "waste" that was quickly trimmed from the plans is now gone, notes Lance Tane, chairman of the benefits practice for The Wyatt Co. in Washington.

"There are no new tricks or techniques. . . .It is important for employers to take a step back and continue to redesign their plans. Simply increasing copayments and deductibles is not enough," he said.

Employers already are acting on that message.

For instance, FMC Corp. in Chicago is totally rethinking its health care cost and utilization problems, said Kenneth J. Morrissey, corporate benefits manager.

"We're spending a lot of time and money analyzing our claim data," he said.

And at IC Industries, also in Chicago, the company's self-funded medical indemnity plan is being "completely reworked," said Raymond B. Werntz, director of employee benefits.

"We redesigned it to compete with HMOs, because we don't see HMOs saving money over the long term," he said.

HMOs "reversed something we started four or five years ago," Mr. Werntz said, referring to a move by the company to make employees pay for inappropriate medical decisions. Instead, HMOs eliminate deductibles and copayment fees.

In addition, HMOs also restrict care, Mr. Werntz believes. "It's a closed system," he said, explaining that employees can only use certain providers. "When medicine is changing so fast, what you don't want to do is confine yourself."

Employers are seeing an increasing need for health care services for substance abuse and stress management, but "HMOs don't do a very good job with those," he said.

IC Industries' new benefit plan, slated to go into effect April 1, will eliminate the $200 deductible but increase the employee copayment to 10% from the current 5%.

It also extends the principles of case management to outpatient care as well as inpatient care.

"By injecting more case management, we are doing more, like an HMO would do, but it's not a closed system," Mr. Werntz said.

Employers in California also are taking a broader approach, according to Clark E. Kerr, vp of corporate health programs at the Bank of America in San Francisco. He also is president of the California Council of Employer Health Care Coalition.

"We have to grapple with the entire picture. What we've done has been piecemeal," Mr. Kerr said.

Employers need to apply cost-containment measures to their whole benefit system, not only to a single element, such as inpatient hospital costs.

Allied-Signal Inc. in Morristown, N.J., also is "going back to the drawing board," according to Joseph W. Duva, corporate director of employee benefits.

Mr. Duva said that in trying to develop a "strategic plan" the employer is asking: "What should we be doing with all that's out there?"

Rather than reacting, Mr. Duva said, employers should be "looking at what's there now and what will be there in the future."

And, "don't take it piecemeal," he advised. "Try to look at it as a business plan."

Similar approaches are being taken by other employers.

"Employers are at a stage of taking stock. They're asking what's working and why, and what's not working and why," said James D. Mortimer, president of the Midwest Business Group on Health in Chicago.

Continued on page 20

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Cost control

Continued from page 18

"We think employers will redouble their efforts in health care management. And it will not be patchwork," he said, "but a far-reaching strategy."

But, experts warn, some employers will not take an overview approach, and instead will try to apply traditional cost-containment options in an attempt to find a quick fix.

"We see a lot of trend-setting. . .of employers getting sucked in," said Linda Havlin, a consultant with Hewitt Associates in Lincolnshire, Ill.

"One CEO comes back from a meeting or talks with another CEO and tells the benefits manager, 'They're doing this, why aren't we?' " Ms. Havlin said.

But the more savvy managers realize that certain strategies will work for some companies and not for others, she said.

"The best managers set out their own strategy," Ms. Havlin added.

It's important for employers to tailor their cost-containment efforts, agreed Susan Peard, a senior consultant with Coopers & Lybrand in Chicago.

"What works for a department store may not work for a food service company," Ms. Peard said.

A managed care program built into an employer's health care plan is one way to take a strategic approach, said William E. Hembree, director of the Health Research Institute in Walnut Creek, Calif.

Managed care includes concurrent utilization review, case management, pre-certification and a claims audit after discharge from the hospital, he explains.

Those "tools" have been around for a while, acknowledges Mr. Hembree. "But what's significant is the change in attitude. In the past, employers said, 'I will go out and buy a reimbursement policy and *they* will take care of it.' This (approach) is history for employers that are insightful.

"Today, employers are saying that a hands-off posture is costing too much money. 'I'm not a payer now, I'm a buyer,' they're saying," according to Mr. Hembree.

One example of this is how benefit managers are dealing with their utilization review programs. Instead of just contracting with a UR firm for services, some employers now are auditing those services (see story, page 33.)

"There is definitely room for improvement in a lot of insurance utilization review programs around the country," said James P. Kennedy, director of group services for the Midwest with Buck Consultants Inc. in Chicago.

"Many consulting firms now have claims audit departments that have been expanded to do UR audits as well," he said.

"Just because you have a PPO or a UR program, don't take it for granted," Mr. Kennedy advised.

And, to measure a UR program's effectiveness, "you have to have the right kind of data and it has to be credible," he said.

Mr. Kennedy said that to measure the success of a UR program, it's important to compare the data from the insurer or TPA with regional or normative data.

Such double and triple review also is recommended by Wyatt's Mr. Tane: "(Employers) must assure that money spent is spent efficiently, especially for programs like utilization review and second surgical opinions," he said.

And, this need for scrutiny applies to other cost-containment measures, not just utilization review, said Cynthia K. Hosay, vp of health care cost management at Martin E. Segal Co. in New York.

"Employers are not looking for the same kind of quick fix any more. They are looking more to monitor their PPOs and HMOs. . .to see if these alternative delivery systems are living up to their promises," Ms. Hosay said.

While employers are reviewing segments of their benefit programs, insurers are developing ways to combine managed care services under a single group health insurance contract to include HMOs, PPOs and an indemnity plan.

Although these types of plans vary, they usually involve no change for employees in their health care alternatives. Employees still may choose from an HMO, a PPO or an indemnity option.

However, for the employer, a change to these plans means that all three options are administered by a single insurer under one contract, resulting in easier administration and, frequently, cost savings.

Such plans are being marketed under various names. For instance, CIGNA Corp. has introduced "FlexCare," while Metropolitan Life Insurance Co. calls its program "triple-option" (*BI*, Sept. 29, 1986).

"More companies are talking about them. They have appeal," Mr. Duva said.

Allied-Signal has talked to insurers about such plans, but "few carriers can give you what you need" when the employer is spread out geographically, he said.

Bank of America also has been approached, according to Mr. Kerr. But the bank's management feels such a plan doesn't allow competition among providers.

And, employers have to weigh whether the ease of having all three options under one administrator is better than offering the same three options separately from different providers, Hewitt's Ms. Havlin said.

For instance, if the HMO in the package is the worst HMO in town, the employer has to ask whether its employees will use it, she said.

In contrast to interest in the newer cost-containment measures, employers are finding less effectiveness in some of the original cost-containment steps, such as increasing deductibles and copayment levels.

A survey released early last year by the Health Research Institute found that fewer employers plan to shift health costs onto employees (*BI*, March 31, 1986).

And, even in light of the 7.7% rise during 1986 in the medical care component of the Consumer Price Index, employers are not planning to resort to cost shifting, experts say.

"There's only so much employees can absorb and employers are beginning to realize that," said Ms. Havlin.

"I'm wary about pushing too high. It will keep people away from care and then push costs higher later," agreed Bank of America's Mr. Kerr.

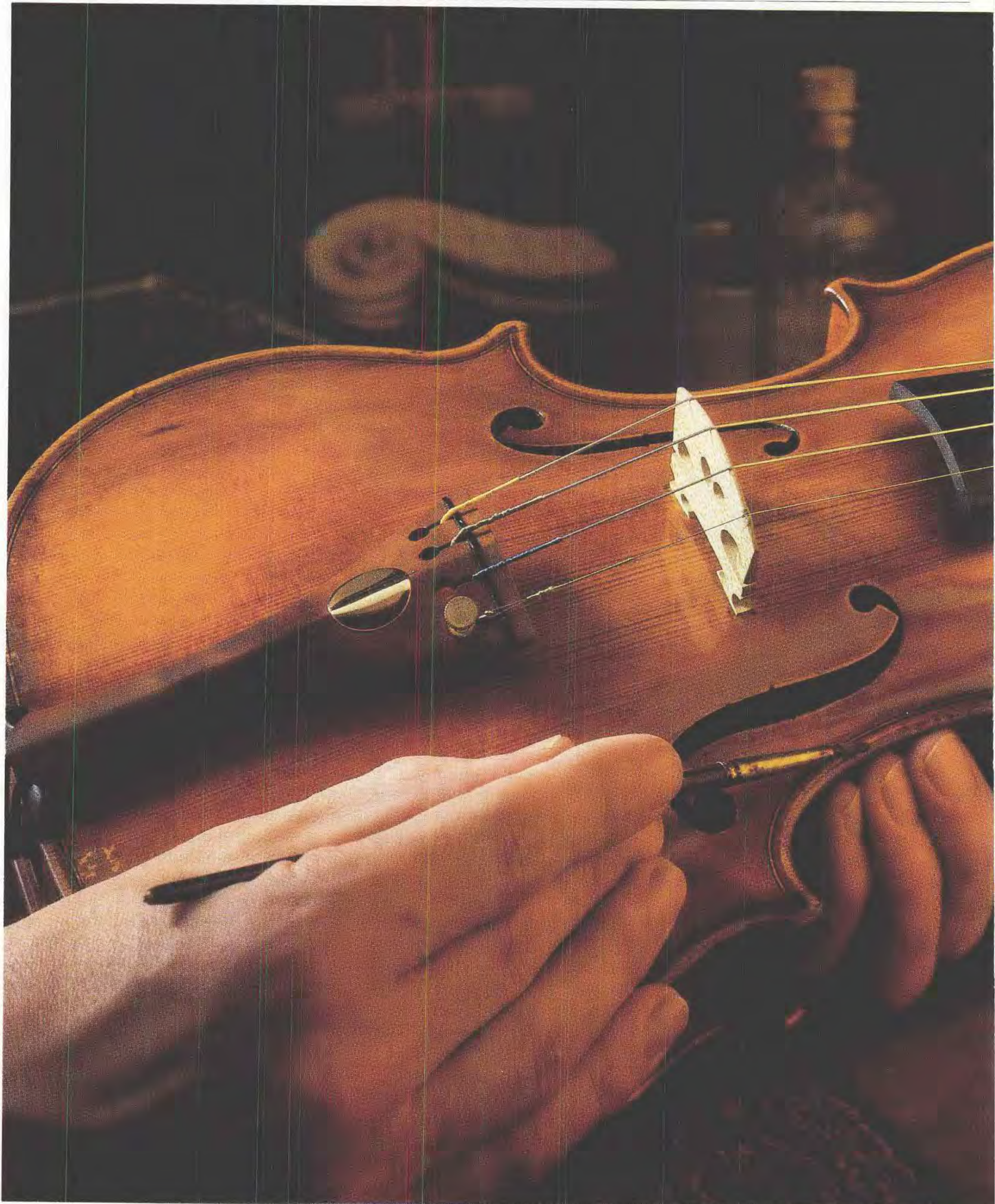
The strategy of increasing deductibles and copayments still is being used by some small and medium-sized companies hit hard by increasing costs and feel they need a quick fix, Ms. Hosay said.

But, despite the use of all cost-containment options available to them, employers still are feeling the bite of increasing medical costs.

"All this (cost-containment activity) and we're still not seeing a dent between the CPI and medical inflation," Mr. Kerr said.

"We're kind of groping with what's going on in the medical community," said Gloria Gomes, manager of employee benefits for Litton Industries Inc. in Beverly Hills, Calif. It's difficult for employers to figure out where health cost increases re coming from and why, she said.

Continued on next page



Continued from previous page

John Garner, a principal with the Los Angeles office of Towers, Perrin, Forster & Crosby, listed three reasons for increasing health care costs:

- Technology.
- Changes in utilization patterns.
- The fact that health care is a labor-intensive business.

"Medical costs will continue to go up," said Wyatt's Mr. Tane. "The technology is on the horizon and it's expensive.

"We're on the edge of a breakthrough to understanding the human body and how to deal with it. But who will pay for it?" Mr. Tane said.

Employers are asking similar questions and, if they are to avoid paying the bulk of those costs, they must take a more active role in medical cost issues at national, state and rural levels, said Mr. Werntz of IC Industries.

Defensive medicine, care for the elderly and care for the indigent are all areas that ultimately may be funded by employers, he said.

"But you can do just so much," Mr. Werntz said, adding that employers cannot control social and economic forces.

"So unless we become more active politically, there will be changes made that can do us harm," he said. He advocated employer coalitions and such groups like the Illinois Health Care Cost Containment Council.

Business also should make its voice heard more on hospital boards, HRI's Mr. Hembree said. This already is happening, he said, noting that business representatives on hospital boards are taking a more active role.

All agree that there are no simple solutions. But, "the big solutions are going to be political and governmental," Mr. Werntz said. And, he added, employers must be a part of this. ■

New laws adding to cost of benefits administration

By CAROL M. CAIN

'All kinds of things are piling up. (Federal requirements) are harder to work with, much harder to understand, and you need higher quality people,' says Raymond B. Werntz, director of employee benefits for IC Industries in Chicago.

Federal legislation is driving up the cost of administering employee benefit programs, employers and consultants report.

"I think one way or another, it is costing more to understand and comply with new federal legislation," said Cynthia K. Hosay, vp of health care cost management at Martin E. Segal Co. in New York.

To keep up with these federal requirements, employers are:

- Buying additional computer software.
- Hiring additional staff, if the budget allows. If not, benefit managers and their staffs are working overtime.
- Paying for more services from consultants and attorneys.

Administering federal benefit mandates is a "distraction" for employee benefit managers and their staffs, said James D. Mortimer, president of Midwest Business Group on Health in Chicago.

These requirements not only add to the administration of health benefit plans, they also force benefit managers to postpone working on other projects, including the development of cost-containment programs, he said.

The two major pieces of federal legislation that are making employers grimace are the Consolidated Omnibus Reconciliation Act, which was signed into law April 7, 1986, and the Tax Reform Act, signed Oct. 22, 1986.

"I don't think the federal government has any idea what COBRA has done to the employer," said Linda Havlin, a consultant with Hewitt Associates in Lincolnshire, Ill.

"I see utter frustration on clients' faces. They blurt out: 'I'm just not going to offer benefits anymore.' They don't mean that, but they are so frustrated," she said.

COBRA requires most public and private employers to extend group health care coverage to employees' widowed, divorced or separated spouses for up to 36 months. And, except when fired for gross misconduct, former employees can obtain coverage for up to 18 months after they leave a company.

Only those employers with fewer than 20 employees and certain religious organizations are exempt from these provisions.

To pay for the administration of this continuation coverage, COBRA allows employers to tag onto the premium an additional 2%. But that's not near enough, employers say.

Among other things, the Tax Reform Act imposes new non-discrimination rules on all group health plans in 1988. The thrust of this provision is to ensure that qualified benefit plans do not favor highly compensated employees over lower-paid employees. If a plan if found to be discriminatory, highly compensated employees would be taxed on the cost of portion of the benefit is found to be excessive.

It's not easy for employers to assess exactly how much these new federal requirements will cost over the long haul, but administration will cost more, experts agree.

"It's difficult (to figure the costs) because there are so many intervening variables," said William E. Hembree, director of Health Research Institute in Walnut Creek, Calif.

Susan Peard, a senior consultant with Coopers & Lybrand in Chicago, noted that employers pay administrative fees to their insurer, their utilization review firm, their consulting firm and perhaps other vendors.

"As benefits become more complex, you have to pay out more for the administration of them," she said.

"All kinds of things are piling up," noted Raymond B. Werntz, director of employee benefits for IC Industries in Chicago.

"(Federal requirements) are harder to work with, much harder to understand; and you need higher quality people," Mr. Werntz said.

Continued on next page

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Administration

Continued from previous page

Employers also are discovering that they need computer programs and outside help in order to handle these additional administrative tasks.

"An awful lot bought software packages to take care of COBRA. But consultants can't go in there to send out the notifications," said John Garner, a principal with consultant Towers, Perrin, Forster & Crosby in Los Angeles.

"I heard of a few that hired more staff, but there are not that many that have that option," Mr. Garner added.

Many employers, however, like Pacific Telesis Group in San Francisco, take care of notifying eligible employees under COBRA, then hire an insurer to handle the claims.

"We just started Jan. 1. . . .We knew we weren't going to do the full administration in-house. We would need more staff," reports Marianne Allio, a benefits specialist with Pac Tel.

'It's good news for consulting firms, especially for short-term projects,' says Mr. Kennedy.

The communications firm put the claims handling contract for COBRA compliance out to bid because two different insurers—Connecticut General Life Insurance Co. and Aetna Life and Casualty Co.—write the company's health care program. Aetna won the contract.

While she says it's too early to tell how much the service will cost over the years, Ms. Allio believes "it will cost more than the 2% allowed under the law."

Aetna's charges for COBRA administration vary depending on the size and complexity of the employer, said Thomas J. Taylor, an Aetna account executive in San Francisco. For the average employer, however, there is an initial $500 set-up fee, a $20 set-up fee for each case and $2 per month per case thereafter.

"Employers must do the notifying, but Aetna does all the transactions," Mr. Taylor said of the program, which currently is being marketed only to Aetna clients, though the insurer is providing this service for several non-Aetna clients.

Other insurers offer similar services and, according to consultants, are in the best position to provide such programs because they are set up to handle claims administration.

But companies other than insurers also are marketing COBRA administration packages, which consultants say usually are quite expensive.

For instance, one firm was offering to do billing, collection and subsequent notification for a start-up cost of $25 per case and a $10 monthly charge per case thereafter, said Paul Kral, senior vp of client services for U.S. Administrators Inc., a third-party administrator located in Los Angeles.

U.S. Administrators is not yet offering COBRA administration services, he said.

However, Ms. Peard from Coopers & Lybrand says some administrators are charging similar set-up fees and then $5 or $2 per case per month.

But even at $2 per case per month, Ms. Peard believes administration costs may exceed the 2% additional premium that the law allows employers to charge.

These fees at some point may decrease, however, Ms. Peard and others believe, because these early subscribers are paying the cost to establish the programs, she said.

COBRA administration costs "should be flattening out because of better software," added Alf Gimbel, senior vp of Byerly & Co. Inc., an employee benefit consulting firm in Denver.

But until COBRA and changes in the tax law become more understandable, employers probably will find they need to rely more on their consultants or attorneys for interpretation and advice.

"I think probably the consultants are happy," commented Clark E. Kerr, vp of corporate health programs for Bank of America in San Francisco.

"It's good news for consulting firms, especially for short-term projects, including the evaluation of software packages," said James P. Kennedy, director of group services in the Midwest for Buck Consultants. ■

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Employers urge changes in HMO regulation

By ROBERT A. FINLAYSON

Employers are looking for broad changes in federal health maintenance organization regulations in their quest for lower HMO rates.

In addition to the Reagan administration's proposal to repeal the so-called equal contribution rule in the federal HMO Act of 1973, employers also want to eliminate community rating and mandatory dual choice regulations.

Employers contend that much of the HMO Act and associated federal regulations are unnecessary and are keeping HMO premiums inflated.

For example, the equal contribution rule requires employers to contribute the same per-employee amount to federally qualified HMOs as they contribute to the medical indemnity plans they provide.

Community rating stipulates that a federally qualified HMO must base the premium it charges on the experience of all of its subscribers, rather than individually rating each group based on its own experience.

Dual choice requires that employers must offer their employees an HMO option if a federally qualified HMO approaches the employer.

"Managed care plans no longer need special protection by the government to perform well in the health care market," William Roper, administrator of the federal Health Care Financing Administration, told a recent HMO conference in Washington, D.C., summing up most employers' views.

However, many HMOs fear the repeal of the equal contribution rule would put their industry at a competitive disadvantage, because employers could lower their contributions to HMOs to the point where employees' share of the premium would be so high, it would act as a disincentive to joining an HMO.

HMOs also claim that while employers want to eliminate community rating, they would be reluctant to pay higher premiums when their experience justifies a higher rate.

And without the dual choice provision, some employers would not offer HMOs to their employees, the HMOs contend.

"The whole issue here is that the employers want to be able to negotiate with the HMOs," observed Fred W. Wasserman, chairman and chief executive officer of Maxicare Healthplans Inc. in Hawthorne, Calif. "The problem with changing the regulations is that unless you change the benefits that HMOs are required to provide, it's inconsistent.

"Frankly, I think the larger HMOs would (rather) like to see the (HMO) Act terminated, if we're going to go and start carving sections out of it," he said.

Employers see the administration's January proposal to repeal the equal contribution rule as the harbinger of a significant change in the way employers deal with HMOs (*BI*, Jan. 19).

"I think you're going to see many changes this year, especially if the treatment of equal contributions by employers for indemnity and HMO plans goes away," said David McIntire, director of employee benefits for General Mills Inc. in Minneapolis.

Last year, the administration proposed repealing the HMO Act. Although that proposal went nowhere, it is expected that the administration will try again this year to convince Congress to repeal or radically alter the law.

But, employers say they are not necessarily looking for repeal of the HMO Act, but rather are seeking a regulatory environment in which HMOs would be no more costly than employer-sponsored indemnity plans.

Employers contend that younger, healthier employees opt for community-rated HMO coverage, while older employees—who use more health care services—opt for coverage under the typically experience-rated indemnity plan, which drives up the premium for the indemnity plan.

"Ideally, we would like to share in the efficiency that the HMOs promise, but I don't think the employer community is being that aggressive," noted David Repko, health care cost manager for J.C. Penney Co. Inc. in Dallas.

"I think many employers are at the stage where what they are really trying to achieve is not losing any money by having offered HMOs," Mr. Repko added.

But, "in the absence of regulatory change, employers are going to become more and more reluctant to deal with HMOs," warned Willis Goldbeck, president of the Washington Business Group on Health.

It is not clear whether the repeal of the equal contribution rule alone would have a significant impact on the HMO marketplace, since many employers are already using a loophole in the HMO Act that allows them to adjust their HMO contributions.

The loophole allows employers to use demographic studies of employee groups that have selected the HMO option to determine the employers' contribution toward HMO coverage. Employers have been able to demonstrate that employees who enroll in HMOs are typically younger and healthier than those selecting employer-sponsored indemnity plans.

Based on such findings, employers have persuaded some HMOs to set up non-fede2rally qualified subsidiaries, which are not subject to the equal contribution rule.

By using this procedure, the employer can adjust its contribution to the HMOs to reflect the expected lower utilization pattern of younger employees most likely to opt for HMO coverage.

"We took a look at what the HMOs were charging us vs. our own plan experiences and took a look at the demographics of the people in the HMO and the people in our indemnity plan and thought we were significantly overpaying the HMOs for the people that were being covered by them," noted Alan Peres, manager of health care utilization for Illinois Bell Telephone Co. in Chicago.

"Making adjustments for the nature of the group that selected HMO coverage is going to result in a decrease in the contribution that the employer would otherwise make to the HMO if they just looked at the cost of their indemnity plan and took an average of that," explained Mr. Repko.

Under that scenario, the employer winds up paying the same amount per employee that it would

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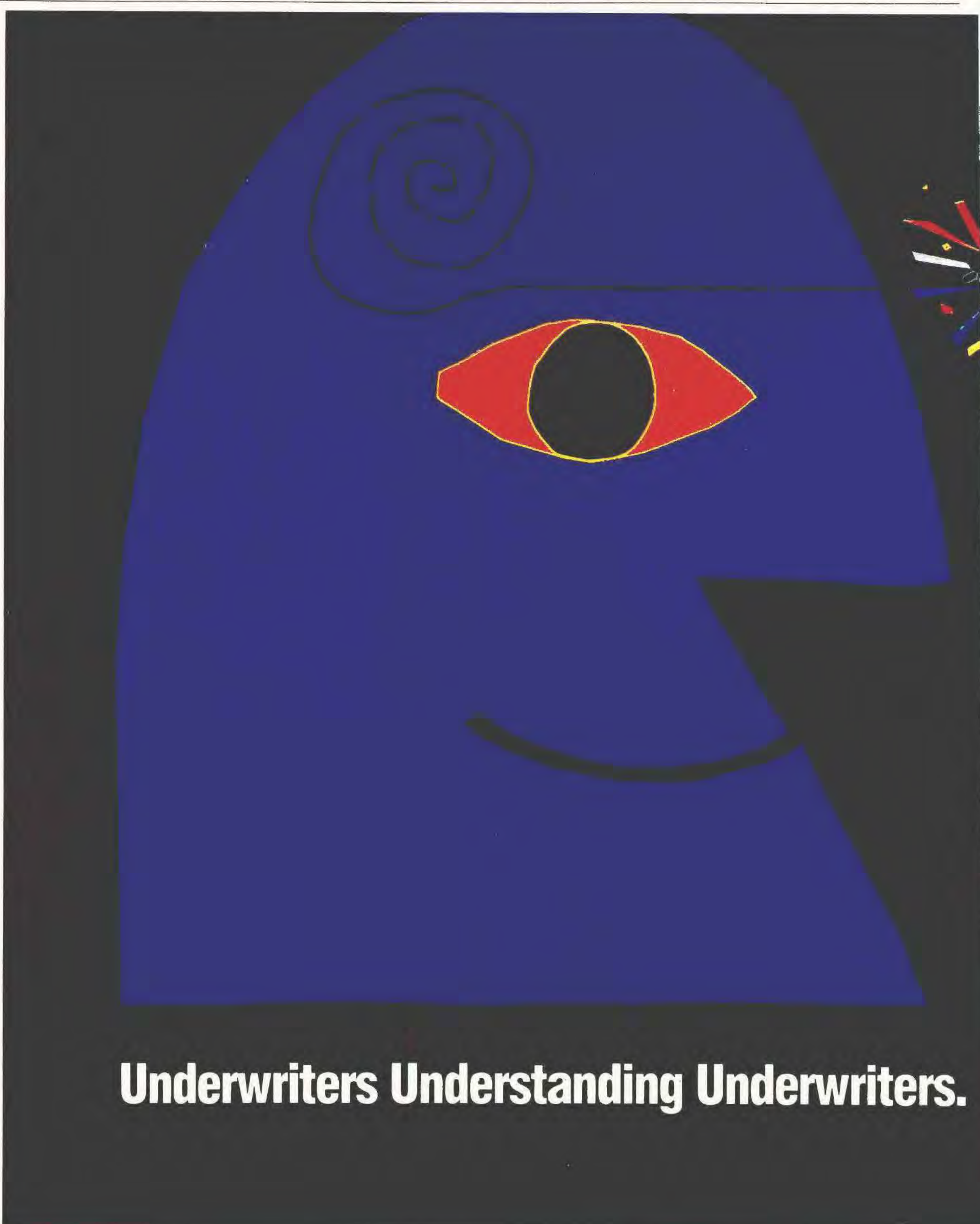

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have paid if the employee was enrolled in the employers' indemnity plan, he noted.

Penney and Illinois Bell were two of the first employers to adjust their HMO contributions based on the demographics of their enrollees (*BI*, Dec. 23, 1985).

However, the HMO industry is strongly opposed to repealing the equal contribution rule, noted Mark Joffe, general counsel of the Group Health Assn. of America, a Washington-based HMO trade group.

"It's unfair to HMOs to give employers free license to reduce their contribution to HMOs. That would be unfair to the employees who join HMOs, as well as place HMOs at a competitive disadvantage," Mr. Joffe said.

He also said the proposal is inconsistent with the purposes of the HMO Act. Mr. Joffe maintained that in situations where the employer lowers its contribution to HMO plans, those plans will lose membership, "because the amount of money paid out of pocket is a very big determinant of what sort of health coverage a person elects."

While it's unlikely the GHAA will convince the administration to change its position regarding repeal of the equal contribution rule, Mr. Joffe said the association is considering suing HCFA if the rule is repealed, on the grounds that the move would violate the intent of the HMO Act.

Most employers say they understand the concerns of HMOs, but they say employers will act responsibly and not lower their HMO contributions to dissuade employees from enrolling in HMOs.

Speaking as chairman of the HMO committee of the Washington Business Group on Health, Illinois Bell's Mr. Peres says most employers will not drastically cut HMO contributions, because it is not in the employers' best interests.

"If you have an employer that has a significant number of employees in an HMO, which many of them do, you're not going to turn around and do something that will set up a significant employee-relations problem," Mr. Peres explained.

"I know that the HMOs are afraid that some employers will say that they're not going to contribute anything to HMOs, while others will contribute an unreasonably low amount. But I think for the overwhelming majority of employers, particularly large employers, that's not going to happen," he said.

Mr. Peres and other employers also pointed out that the proposal to eliminate the equal contribution rule specifically states that an employer making no contribution to HMOs would be viewed by the government as violating the dual-choice rule.

Beyond the repeal of the equal contribution rule, many benefit managers and consultants say community rating is the next battle ground.

"Community rating is something that goes right to the core of how HMOs are given their incentive" to control health-care costs, Penney's Mr. Repko said.

In fact, some employers already are negotiating employer-specific rates with HMOs by working through non-federally qualified subsidiaries, Mr. Goldbeck of the WBGH pointed out.

"More and more employers have become aware of the fact that other employers have been successful at convincing HMOs to accept employer-specific rates," he noted, adding that HMOs have become more inclined in recent years to accept employer-specific rating without a fight.

"I can understand why individual HMOs would be concerned, but from the standpoint of national policy, I believe it's the right way to go," Mr. Goldbeck said.

Employers, particularly those with very large employee populations, say they want more information from HMOs about employee utilization patterns, and they want rates based on those utilization patterns.

General Mills embarked on a program two years ago with several HMOs to develop a uniform system for collecting and reporting utilization data on its HMO enrollees.

General Mills hopes eventually to use this data to negotiate premium rates with HMOs, Mr. McIntire said. But he warned that not all employers will lower their HMO premium under such a system.

"There will be some companies that have been with an HMO and paying basically a community rate that may be unhappy once they know what their own company experience is, because they find out that they have been overpaying the HMO," he said.

"But there are also going to be some other companies that find out they've really been doing OK, because they've been getting a value that's much more than what they've been paying in the way of capitation," he explained.

"So there are going to be some happy employers and some unhappy employers once we get to the point where you can start looking at HMOs on an experience-rated basis," Mr. McIntire said.

Some employers say they are concerned that experience-rated premiums would remove any cost-saving incentives built into HMOs.

"When an employer starts negotiating based on experience for a total HMO premium, that's when I get concerned," Mr. Repko noted.

"I'm not so sure it really doesn't destroy a lot of the incentives we hoped to put in place with HMOs," he added. "Once you start negotiating based on experience, there is a risk of turning HMOs into a kind of fee-for-service system."

Other employers warn that not all companies will necessarily end up paying a lower rate to HMO plans under an experience-rating system.

Even more far-reaching than the issue of experience rating is the issue of whether the dual-choice rule—which requires employers with more than 25 employees to offer federally qualified HMOs to their employees if the HMO asks to serve the employees—should be repealed.

This rule forms the backbone of the HMO Act, and most benefit experts acknowledge that without it, the HMO industry probably never would have flourished as quickly as it did in the 1970s and early 1980s.

But now, as with the equal contribution rule, employers are questioning whether the requirement is necessary in view of HMOs' size and market impact.

"The mandatory dual-choice requirement of the current law is something that we think needs to be reviewed and questioned as to whether it's appropriate anymore," said Mr. Repko.

Employers will ask Congress to review the need for a requirement that protects an industry that many employers feel no longer needs a helping hand from Uncle Sam, he said.

But HMOs see the dual-choice rule as the heart of the HMO Act. "If you don't have mandatory dual choice, you don't have an HMO Act," says Maxicare's Mr. Wasserman. "I don't know of many employers who don't want an HMO Act. They may want changes, but most of them want to offer HMOs because without them there's no competition (in the health care market)," he says. ■

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Wellness plan savings are difficult to measure

By MEG FLETCHER

It's easier for an employer to determine how much a wellness program will cost than how much it will save.

While some of the companies offering these health promotion programs can provide sophisticated studies of their results, a typical benefit manager may not have the resources needed to conduct such analyses (see story, page 28).

"Measuring savings due to wellness is very difficult," said actuary Tom Donlon, a principal in the Chicago office of consultant William M. Mercer-Meidinger Inc.

Indirect benefits like improved employee morale can be assessed through attitude surveys, but it is hard to quantify cost savings because of such variables as the demographics of the participating employees, their general health and even the status of the economy, most benefit experts agree.

Benefit managers—especially those at small and medium-sized employers—who are considering establishing wellness programs need to analyze their employee population and decide what they want a wellness program to do and what they are willing to spend in both cash and resources before choosing a program, advises Ann Stuchiner, a consultant at Hewitt Associates in Lincolnshire, Ill.

Benefit managers also should question how well the program will work for their size employee group, says Molly McCauley, manager of health promotion for American Telephone & Telegraph Co. in Basking Ridge, N.J.

And, a benefit manager seeking a wellness program should make sure a monitoring component is built into the program, Mercer-Meidinger's Mr. Donlon said.

"The offerings of programs are light years ahead of the measurement of the programs," said William E. Hembree, director of Walnut Creek, Calif.-based Health Research Institute.

A survey of the wellness practices of New England employers conducted by Mercer-Meidinger found that 60% of the employers spend less than $10,000 per year on health awareness and wellness activities; 15% spend between $10,000 and $50,000; 3% spend between $50,000 and $100,000; and 6% spend more than $100,000. The remaining 12% did not know their company's wellness program budget (*BI*, Feb. 3, 1986).

The cost of offering a wellness program includes direct costs, such as fees paid to vendors, and indirect costs, such as lost employee time during participation.

A great portion of direct costs depends on the method of delivery, noted Paul Backlund, a principal consultant in the Chicago office of The Wyatt Co.

For example, programs that enlist the services of organizations like the American Cancer Society may be less expensive than those programs offered through a private, for-profit, company, he said.

Other direct costs include facility construction or modification, promotional materials and sometimes incentive payments to employees for participating.

An employer can reduce its program costs by requiring an employee contribution—either by charging fees or by requiring that wellness activities be completed on employees' personal time.

Employers primarily hope to benefit directly from wellness programs by controlling medical claims and reducing absenteeism. They also seek to benefit through such intangibles as improved morale and job satisfaction.

David R. Anderson, manager of Minneapolis-based Control Data Corp.'s Staywell Information Services, said employee attitude changes are the first to occur after implementation of a wellness program, and can be "pretty dramatic" as employees realize their employer really cares.

AT&T found "employees who participate in health promotion modules certainly feel they are more productive and energetic and that their quality of work has improved as a result," according to a report on the program in the Journal of Occupational Medicine.

Continued on page 28

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Wellness savings

Continued from page 26

"In the long run, these feelings of improved work quality and productivity may be just as beneficial to employees and to employers as the more objective health risk indicators, if these feelings reduce stress for participating employees," the report said.

The Health Research Institute may help shed some light on evaluating program effectiveness this spring when it reports the results of a survey of 500 companies with wellness programs.

Only about 3% of employers responding to HRI's 1985 biennial survey of cost containment programs measure the effect of their health improvement programs on medical care costs. However, the number of respondents studying employee absenteeism increased to 3.4% in 1985 from 1.7% in 1983, the 1985 HRI study showed.

Nearly three-fourths of the employers in Mercer-Meidinger's survey of New England employers used employee participation in evaluating the success of their programs. About 13% of these employers measured cost savings, primarily by analyzing health claims submitted and average sick days; other employers used health insurance premiums as a measurement.

However, it is becoming more difficult to measure the benefits of wellness programs because of the cost-containment effects of such benefit options as health maintenance organizations, which do not keep health care cost data on the same basis as more traditional fee-for-service programs, said Roger W. Reed, manager of Blue Cross/Blue Shield of Indiana's Wellness Resource Center in Indianapolis.

But employers with HMOs still can measure the effect of their wellness programs through participation levels and program effectiveness yardsticks like pounds lost in weight reduction programs, Mr. Reed said.

While measurements differ, the majority of wellness program managers contacted agreed that savings tend to increase over time, in part because some start-up costs do not recur.

"The longer the program is in place, the greater the savings," said Mr. Reed.

Johnson & Johnson found that for the first three years of its program, annual savings exceeded that of the previous year, said Frank W. Barker, president of Johnson & Johnson Health Management Inc., a new subsidiary created to market the company's wellness program in New Brunswick, N.J.

However, E.I. du Pont de Nemours & Co. in Wilmington, Del., says the greatest drop in absenteeism due to illness is seen in the first two or three years, then it levels off.

The greatest savings should be over time because of the chronic nature of many illnesses that wellness programs seek to prevent, said Dr. Robert Dedmon, staff vp of medical affairs for Kimberly-Clark Corp. in Neenah, Wis.

But, those introducing a wellness program should expect a short-term increase in claims following employees' health assessments, as employees remedy newly identified problems.

But, at least one company isn't concerned about quantifying its program: Nissan Motor Manufacturing Corp. USA in Smyrna, Tenn., defines wellness as "the progressive realization of a personal, predetermined worthwhile goal in any of six areas—spiritual, mental, physical, occupational, social or family," explained wellness specialist Margot Nash.

Nissan programs are presented to 12- to 15-member work groups. Individuals set goals, such as weight reduction, and the group supports them. "We know that it works," Ms. Nash said. "We trust the process." ■

4 employers now marketing wellness plans

By MEG FLETCHER

"We saved ourselves money; let us save it for you," could be the advertising slogan for four employers that are marketing their wellness programs to other companies.

Johnson & Johnson, Control Data Corp., E.I. du Pont de Nemours & Co. and Blue Cross/Blue Shield of Indiana all are touting cost savings in marketing their wellness programs to other firms.

Other employers, including American Telephone & Telegraph Co., are reporting favorable results from their wellness programs, but are not putting the programs on the market.

While the employers marketing their wellness programs provide statistics to back up their claims of health care cost savings, some consultants point out that many variables must be considered when measuring a program's effectiveness (see story, page 26).

And, calculating how much an employer can expect to save also is difficult because program sponsors use different methods to measure and report cost/benefit data.

A typical wellness program includes an assessment of an employees' health risks and specific health promotion activities or services such as weight reduction, nutrition, smoking cessation and fitness programs.

Most programs are presented on company premises and on primarily personal time, although the initial health assessment is often conducted on company time.

Companies marketing their wellness programs to other employers typically charge for each wellness activity or service on a per-employee basis. The cost varies, based on the size of the employee population and the number of activities or services provided.

The Health Research Institute in Walnut Creek, Calif., reports that some rules of thumb for annual program costs on a per-employee basis are: self-care education, $2.24; stress management, $1.48; lifestyle change, 75 cents; back care, 72 cents; first-aid, 61 cents; nutrition education, 53 cents; weight control, 37 cents; smoking cessation, 36 cents; medical consumer education, 13 cents.

Employers marketing their own wellness programs include:

- Johnson & Johnson.

Annual hospital costs for participants in Johnson & Johnson's Live for Life wellness program increased only about half as much as those for a control group of J&J employees from January 1979 through 1983, according to a study commissioned by the company.

Hospital costs rose an average of $42.50 annually for Live for Life participants, compared with a $76 annual increase for non-participants. In addition, hospital admissions and hospital days increased more slowly at a J&J site offering the program. No significant differences were reported for outpatient or other health care costs.

Absenteeism due to illness declined 17% among wellness program participants, and the number of days lost due to work-related injuries also declined significantly, said Frank Barker, president of Johnson & Johnson Health Management Inc., a new subsidiary created specifically to market the wellness program.

The study, which gauged the effectiveness of a typical J&J wellness program, covered 11,406 employees in 18 states, which were divided into two study groups and

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Wellness plans

Continued from page 28
a control group.

The annual cost of operating the program was $200 per employee in 1980, but because the program has become more efficient, the cost per employee dropped to $150 in 1986, Mr. Barker said.

J&J is marketing its Live for Life program directly to employers or through hospital providers, currently located in Massachusetts and Florida. J&J expects to expand its provider network nationwide by year-end, Mr. Barker said.

The J&J program, which includes stress management, can provide administrative and information management systems to track participation and the program's effectiveness.

- Control Data Corp.

Control Data estimates that its Staywell program, launched in 1979, saved the Minneapolis-based company about $1.8 million annually in health care claims.

The program's effect is evaluated using a complex data base that links risk factors and program participation to health care claims and experience; tracks individual risk factor change over time; and links risk factor change to demographic characteristics, Staywell participation, sick leave and health care claim trends.

Additional results will be available in the future because the company has made a 10-year commitment to evaluate its program, said David R. Anderson, manager of Staywell's information services.

In addition to basic wellness program offerings, the program includes stress management and back care programs.

As of 1985, at least 62% of eligible Control Data employees participated in at least one activity offered under the Staywell program, while 37% completed a risk profile and participated in activities.

Control Data is marketing program components nationwide on an unbundled basis for all sizes of employee groups. The program is offered through more than 50 health care providers nationwide.

- Du Pont.

Du Pont reports that disability wage costs for hourly employees dropped 18% to 25% through its Take Time for Health program.

The study tracked between 3,500 and 4,000 hourly and salaried employees for three years at one site and five years at another.

In addition to the basic wellness program activities, the program offered by the Wilmington, Del.-based company includes stress management, back wellness and blood pressure control.

Du Pont currently is marketing its program to employers, although it has not been formally announced, said Robert L. Bertera, manager of health promotions programs.

- Blue Cross/Blue Shield of Indiana.

For every dollar invested, Blue Cross/Blue Shield of Indiana's Stay Alive & Well program saved $2.51 in health care claims and the cost of absentee days, said Roger W. Reed, manager of the health insurer's Wellness Resource Center.

These results were revealed in a study financed by a grant from the W.K. Kellogg Foundation. The study tracked 667 participating employees and a control group of 892 employees from January 1978 through April 1982.

BC/BS of Indiana will review additional data from early 1982 through 1985 with funds from a second grant from the Kellogg Foundation.

The Indianapolis-based BC/BS affiliate spent $867,000 on its wellness program in its first five years, including not only direct costs but the cost of employees' wages and benefits while they participated in all activities—except fitness—on company time. The program broke even after 36 months, the insurer says.

BC/BS of Indiana is now offering its program in that state directly to employers or through 27 provider hospitals.

Other companies that report favorable results from their wellness programs—but are not marketing them to other employers—include:

- AT&T.

Nearly 2,000 participants in AT&T's TLC Concept Program in 1983 and 1984 showed greater overall improvements in exercise levels, in their ability to stop smoking, in perceptions of their own health and in stress-linked behavior than employees who did not participate.

The conclusions stemmed from an analysis of measurable health risk data and employee attitudes.

In addition to basic wellness programs, AT&T's TLC program offered stress management, interpersonal communications, back injury prevention programs, cancer screening and cholesterol reduction programs, according to Molly McCauley, AT&T's manager of health promotion in Basking Ridge, N.J.

An ongoing evaluation is comparing program operating costs—including the costs of employee participation on some company time.

- Kimberly-Clark Corp.

Kimberly-Clark's Health Management Program has tapered the increase in health care costs for employees at its Neenah, Wis., base, according to a 1986 report evaluating the company's program.

Before the program was established in 1977, health care costs among Neenah employees averaged $750 per plan participant—approximately the same as the per-capita health care cost component of the Consumer Price Index. But in 1985, health care costs in Neenah averaged approximately $1,250 per plan participant, compared with CPI per-capita health care costs of about $1,400.

However, the report acknowledges that the health improvement program is one of several factors that could have helped bring down health costs in Neenah. Other factors could include demographics and regional variations in health care fees.

In addition to basic wellness activities, Kimberly-Clark's Neenah plant has a $2.5 million fitness facility, offers classes in first-aid and cardiopulmonary resuscitation and provides occupational health nursing services.

The program, which is open to spouses and retirees, costs about $400 per employee annually for Kimberly-Clark's 5,500 Wisconsin employees, or about $2 million, according to Dr. Robert Dedmon, staff vp of medical affairs.

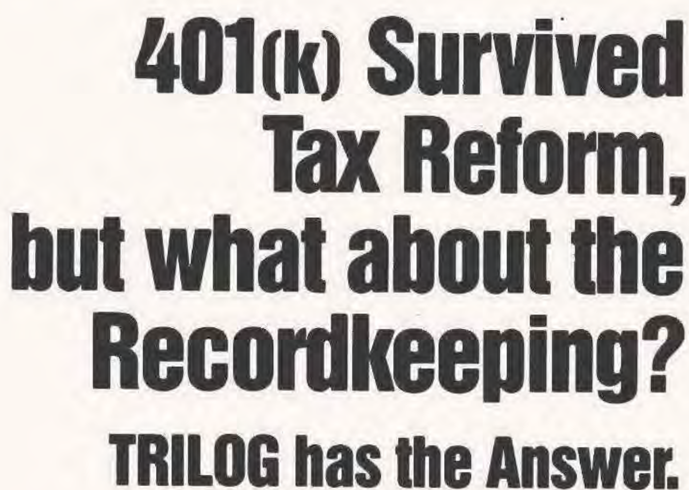
- United Methodist Publishing House.

Early results show that United Methodist Publishing House's TryUMPH for Health program reduced medical claim costs and lowered absenteeism costs by $17,000 for 238, or 20%, of its employees eligible for health benefits.

More than 600 employees, or 49% of the workforce, participated in some component of the program in its first 18 months, at an initial cost to the company of $3.50 per month per employee, or $54,600.

In addition to basic wellness activities and services, the Nashville, Tenn.-based employer offered stress management and safety-related programs, primarily on employees' personal time, said Sharonne Lincoln, UMPH's manager of health and safety promotion.

The company also converted an unused part of a printing plant into a fitness facility. ■



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Interest in wellness programs surge

By MEG FLETCHER

Employer interest in providing wellness programs for employees is soaring and that, in turn, is prompting expansion and changes in the programs, experts say.

"There is such a growing interest in wellness programs," said William E. Hembree, director of Walnut Creek, Calif.-based Health Research Institute.

The responses of a "core group" of 263 employers surveyed over a four-year period revealed the percentage offering wellness programs grew from 5% in 1982 to 14% in 1984, and more than doubled to 36% in 1986, according to the 1986 Group Benefits Survey by The Wyatt Co. (*BI*, Dec. 8, 1986).

In its complete survey of 1,418 employers, Wyatt found that 49% have some type of health promotion and/or wellness program. But, only 28% have more than one of the programs surveyed: back care, hypertension monitoring, smoking cessation, stress management and weight control.

HRI's biennial survey of the 1,500 largest U.S. employers found they are providing education and wellness programs at "a much higher level" than in the past.

The proportion providing self-care education, nutrition education and weight-control programs all have increased markedly from 1983 to 1985, the report said.

Other programs on the rise are stress management, back care, on-site medical consumer education and health assessments, it said.

"Health promotion and wellness programs are aimed at fostering awareness, changing attitudes, and identifying alternatives so that employees can make more informed decisions and modify their behavior to better achieve and maintain a desired level of mental and physical health," Wyatt explained in its survey.

To meet those goals, some employers are expanding their wellness offerings with such programs as physical fitness, blood-pressure testing, cancer screening, first-aid, safety and interpersonal communications. These and other programs like physical examinations, prenatal care and testing for diabetes and glaucoma may be offered as a separate wellness program or through employers' medical plans.

Employers are also interested in wellness programs because "the state of the art of wellness programs is changing rapidly," Mr. Hembree said.

New approaches are being taken to measure the savings through a wellness program, and some employers that have gathered such data are marketing their wellness programs (see story, page 28).

This improved data is convincing employers that they can help reduce employees' lifestyle-related problems, which are blamed for more than half of all deaths, according to studies quoted by Janice Hand, a consultant for Hewitt Associates in Lincolnshire, Ill.

Although wellness programs are primarily voluntary, at least one employer is making a broad smoking cessation program mandatory.

Chicago-based USG Acoustical Products Co. announced plans last month to require its plant employees to quit smoking both in and out of the workplace or lose their jobs.

The company says its policy is motivated by concern for its workers' health, although others suggest it may be a way for the company to protect itself from future lawsuits by its workers who handle fibers that may cause lung ailments.

More companies are expected to take similar steps, predicted Paul Backlund, a principal consultant in Wyatt's Chicago office.

In addition, some wellness programs are broadening the population of eligible participants to include retirees and spouses.

And, employers are using a wide variety of vehicles to communicate wellness programs to employees.

According to a 1984 study of 1,185 companies by Hewitt Associates, vehicles used to provide health education information to non-union employees include articles in regular employee newsletters, used by 66% of the companies; specially designed booklets or pamphlets, used by 52%; special mailings or newsletters, used by 46%; audiovisual presentations, used by 38%; paycheck stuffers, used by 37%; seminars or workshops, used by 28%; listening activities used by 13%; and medical advice services, including telephone hot lines, used by 12%.

And, E.I. du Pont de Nemours & Co. in Wilmington, Del., offers self-help kits for employees who want a personal program, says Robert L. Bertera, manager of health promotion programs. ■

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Utilization review programs paying off

By DONNA DiBLASE

In an era of continuing health care cost inflation, utilization review is a good investment for employers, experts say.

But, they caution that these programs are not the final solution to rising health care costs.

And they emphasize that careful evaluation of the services offered by utilization review vendors—both before and after a program is implemented—is the key to achieving the best results.

"Utilization review is definitely still a good investment. Employers that have not added these programs will be cost-shifted against" by other providers in the same markets, said James Kennedy, director of group services-Midwest for Buck Consultants Inc. in Chicago.

"Utilization review is very powerful," agreed William Hembree, director of the Health Research Institute in Walnut Creek, Calif. "But it's not the end. Even if we achieve 10% savings, we're still paying the other 90%."

And, at today's health care prices, the remaining 90% can be very expensive—and will become even more costly in the future.

For instance, the medical care component of the Consumer Price Index rose 7.7% in 1986, compared with a 1.1% increase in the overall CPI, according to the Bureau of Labor Statistics.

In light of such health care inflation, employers welcome any chance for savings.

"Our review program is a no-lose situation," said Carl Angel, director of compensation and employee benefits for Sheraton Corp., the Boston-based hotel subsidiary of ITT Corp. "The problem is that I wish we could do more because it's not even keeping us even with inflation of health care costs."

Sheraton implemented a utilization review program a year ago for its 10,000 salaried non-union employees.

The Advocate program, administered by John Hancock Mutual Life Insurance Co., includes pre-admission review, concurrent review and case management for long-term or catastrophic illnesses.

Employees are required to call a toll-free number to have non-emergency hospital admissions certified. Coverage—which is usually 100%—is reduced to 80% if an employee's hospital admission is not certified.

"We're just coming up on the end of our first year with the program and we're seeing a net savings of about $800,000 in a benefits program in which claims usually are over $12 million," Mr. Angel said.

"We don't want to over-inflate those numbers. Most insurance companies say you can save 10% to 15% with these programs. But our goal going into this was to achieve savings of between 6% and 9%. I think we're going to come up at about 8%," he said.

Other companies are finding even greater savings. For example, St. Louis-based Park 'n' Fly Services Corp.'s utilization review program has helped the company achieve a 27% reduction in claims paid during the 11-month period between Feb. 1, 1986 and Dec. 31, 1986, said Marie P. Dressel, assistant to the director of operations.

She said that meant a savings of $76,000 over the corresponding period a year earlier for Park 'n' Fly, which operates parking lots near airports in several major cities.

The company's utilization review program, administered by Lombard, Ill.-based HealthCare COMPARE, covers about 300 employees, Ms. Dressel said. "Our premiums have stabilized and with employees sharing in the costs, that makes them pretty happy."

Park 'n' Fly's program, implemented in July 1985, includes pre-admission certification, mandatory outpatient surgery for certain procedures, second surgical opinions and pre-admission testing.

If employees do not have their hospital admissions reviewed, their benefit is reduced to 50% from 80%, she said.

"We got into cost-containment programs early, but now employers really are starting to use the programs," Ms. Dressel said.

So are other employers.

In a 1986 survey of 1,418 employers by benefit consultant The Wyatt Co., 36% percent said they had some type of utilization review program in place.

Some 32% had programs that included pre-admission certification; 29% had concurrent review; 45% had mandatory second opinion programs; and 18% had case management programs for long-term or catastrophic illnesses.

Pre-admission certification programs offer the greatest potential for savings, experts say, but case management programs also can cut health care costs significantly.

In most case management programs, alternative treatments are suggested for patients with catastrophic or terminal illnesses, such as spinal cord injuries or cancer.

Registered nurses and physicians review the cases and coordinate home health care or other services that may not usually be covered under the employer's plan but that may be more cost-effective and comfortable for the patient.

The programs usually are coordinated with the discharge planning aspect of a utilization review program: Cases are pinpointed for case management when either incurred costs or total inpatient days approach a certain limit.

"Probably the area where employers see the largest long-term savings is in case management programs," said Linda Havlin, a consultant with Lincolnshire, Ill.-based Hewitt Associates.

HRI's Mr. Hembree said, "Case management is something we'll see more of, and we will see more savings from the programs. The case manager will do things that haven't been done in the past."

"I think the payers of health care are beginning to realize that by moving care in these cases, they can save money and make the employee more comfortable," said Dr. Robert J. Becker, chairman of HealthCare COMPARE.

A basic case management program can produce savings of 8% to 20% for every dollar spent to administer the program, he said.

A portion of Sheraton's savings from its utilization review program can be attributed to case management, Mr. Angel said.

"We're picking out very high-risk cases for case management, and we've used it for about 15 cases. Two or three of those cases already were in excess of $250,000 to $300,000," he said. "There's an

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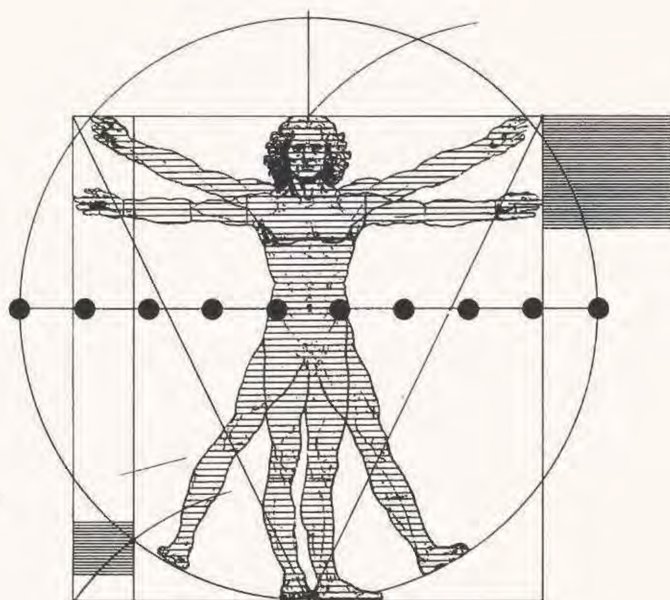

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Continued from previous page

awful lot more that can be done with case management."

No matter what the utilization review includes, savings will be based on the aggressiveness and efficiency of the reviewers and can vary tremendously, experts say.

"Your savings are going to be directly related to the aggressiveness of the utilization review vendor," said Walt Wood, a consultant for Wyatt in Washington. "You need to match the review firm's aggressiveness with the employer's philosophy" of cost containment.

"If an employer goes with the umbrella approach—pre-admission certification, second opinions, concurrent review and case management—you're buying total control," said Hewitt's Ms. Havlin. "The savings with a program like this can range between 6% and 8%."

For example, Salt Lake City-based American Stores Co. experienced a 9% reduction in hospital admissions per 1,000 employees in the first year of its Caring Call program, which is administered by Blue Cross & Blue Shield plans in several states.

Under the program, employees must call a toll-free number to have hospital admissions certified, or they pay a $300 penalty, said Tom Nielsen, vp of benefits for the supermarket and drugstore company. He could not estimate the percentage of health claim dollars saved by the program, which covers 54,000 employees.

Caring Calls' pre-admission certification triggers concurrent review while the employee is in the hospital, second opinions for surgery and case management for catastrophic illnesses.

"We feel that the review of alternative care is the key part of the whole program. Through that, we were able to achieve the decrease in hospital admissions," Mr. Nielsen said.

Greyhound Corp. in Phoenix, Ariz., trimmed its health care costs by about 3% in the first year it had a utilization review program.

"In the second year of the program, that may be a touch higher—maybe about 5% of total plan costs," said Tom Gray, director of employee benefits.

Greyhound's program, administered by Minneapolis-based Health Risk Management Inc., was implemented a little more than two years ago, he said. It includes pre-admission certification, second surgical opinions, concurrent review and discharge planning.

In addition, the review firm negotiates fees with hospitals based on Medicare's diagnostic-related groups and with physicians and surgeons based on reasonable and customary fees, Mr. Gray said.

About 5,000 employees in several states are covered under the program, which is used in conjunction with Greyhound's self-insured indemnity health plan.

There is no specific penalty for not complying with the program, he said. But employees do risk paying the full cost of care if they don't have an admission reviewed or don't get a second surgical opinion and it is later determined that the procedure was unnecessary.

Employees covered by the indemnity plan pay varying deductibles and co-payments.

Orlando, Fla.-based Red Lobster has saved about $700,000 a year through MediCALL, its 2-year-old in-house utilization review plan.

"Our program is a pre-notification program. We simply require that employees contact us when they are going to be admitted to a hospital," but there is no certification or length of stay assignment, said Jon Reiker, manager of compensation for the restaurant chain.

Instead, the review staff of three registered nurses obtains information on the employee's health condition and coordinates a personal education and communication program related to the employee's condition, he said.

"What we found is that by working with the employees and keeping them educated and informed, they can make cost-effective decisions on their own," he explained.

If employees do not notify the review staff when they are admitted, they pay a penalty of 50% of physician's fees, up to a maximum of $200, he said. The program covers about 15,000 employees.

Red Lobster contracted with Park Ridge, Ill.-based utilization review firm, Parkside Health Services Corp., to provide a panel of physicians for the company's second opinion program. "Our nurses arrange any second opinion appointments for employees, using the panel provided by Parkside," Mr. Reiker said.

Continued on next page

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Utilization review

Continued from previous page

And, as part of its consulting services, Parkside also periodically reviews the company's pre-notification program and its case management files, he said.

"I can honestly say this is the best thing we've done in our benefits plan," he said.

In a random sampling of one-third of the employees using the program, most viewed it as a valuable personalized educational program, Mr. Reiker added.

Consultants say employers could save even more by carefully evaluating the review firm's performance.

"There's no question that there's a wide range of savings from these programs," said Mr. Hembree of HRI. "What's incumbent on the employer is to make a strong assessment before they sign on with a firm. If they choose a poor firm, they're actually adding to costs."

"Some employers are having quality and administration audits performed on utilization review firms," said Geraldine Alpert, consultant for William M. Mercer-Meidinger Inc. in Stamford, Conn. "There's a greater degree of sophistication among employers. We've seen a big change from employers' perspectives, but we're still not seeing a lot of changes on the vendors' or insurers' parts—they're not aggressive enough."

Before implementing a review program, employers should evaluate "how much fat there is to reduce in an indemnity plan," said Dr. Arnold Milstein, director of National Medical Audit Inc., a San Francisco-based division of Mercer-Meidinger. "There is tremendous room for improvement. You can have a review system that only trims one-third or one-fourth of the fat."

National Medical Audit has performed audits of the medical records of about 200 utilization review firms.

The firm has a full-time staff of physicians and technical staff, but it also uses a network of more than 100 independent board-certified physicians experienced in utilization review and quality assurance.

NMA's physician-reviewers examine a random sampling of hospitalizations approved by a utilization review vendor and then determine whether the admission and the length of stay assigned were medically necessary. NMA then assigns an "error rate"—the percent of admissions approved that were not necessary.

"A medical records audit is the most effective evaluation of a review firm because you can go past the firm's own presentation of results, find the error rate and then statistically compare the firm to others," he explained.

And, the error rates of the 200 firms NMA audits vary greatly, he said.

For example, audits of two firms "that were selected after a careful search and that looked like A-plus systems on paper" revealed a considerable difference in savings to the employer, he said.

One firm produced a net savings per case of $359, with savings of $5.50 for every dollar invested in the program. The other firm produced a net savings per case of $1,470, with savings of $17.29 for every dollar invested, he explained.

There are several factors that account for the varying effectiveness, Dr. Milstein said, including:

- The reviewer's knowledge of a specific diagnosis. "A good review system will take care to match the case with the appropriate specialist," he said.
- The reviewer's ability to persuade the attending physician to provide cost-effective, quality treatment in the proper setting. "A good system will hire reviewers that can be persuasive," he said.
- The standards used to assess health care options as part of the utilization review process.
- Anticipation of physician hostility toward utilization review.
- A health benefit plan that is supportive of the review program. For example, if the purpose of the review is to limit unnecessary hospital admissions, the employer's benefit plan should provide good coverage of outpatient care. ■

Benefit experts question new Medicare proposal

By JERRY GEISEL

WASHINGTON—The Reagan administration's proposal to allow employers to provide Medicare benefits to their retired workers will be a boon to employers, retirees and the federal government, the administration says.

However, employee benefit experts are wary about the plan's feasibility.

Under the proposal, called the Private Health Plan Option, employers that sign contracts with the Health Care Financing Administration, the federal agency that administers Medicare, would receive 95% of what HCFA estimates it would cost it to provide Medicare benefits for those employers' retirees.

This 5% cut in Medicare expenditures could save the federal government billions of dollars—assuming large numbers of employers with big retired workforces participate in the voluntary program. The government now spends more than $70 billion annually to provide Medicare benefits to about 28 million retirees.

The plan also would benefit employers, the administration says, because it believes that employers can provide Medicare benefits more economically than the government. Under the plan, employers will collect the difference, if any, between the amount received from the government and the amount paid in benefits. However, the employer would be liable if benefit costs exceeded the government payment.

"The employer truly is at risk," said Richard Murdock, vp at Johnson & Higgins HealthGroup in Princeton, N.J.

Currently, both the Medicare program and some employers, under supplemental plans, provide health benefits for retirees. This two-tier system makes it difficult for employers to negotiate with providers for discount rates or implement cost-containment techniques for retirees, like preferred provider organizations, experts say.

By offering all post-retirement health care coverage for retirees, "Employers will gain market leverage in dealing with providers. This would enhance a company's health care purchasing power," says Kevin Moley, director of HCFA's Office of Prepaid Health Care, which is promoting the private plan option.

"It would be more efficient to have one entity pay retirees' health care bills," said John Hickey, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

Sophisticated employers with experience in managing health care costs could provide Medicare benefits at a lower cost than the government, the administration says, which is why the government would give employers only 95% of the amount it estimates it would spend to deliver the benefits.

"The (health care) management techniques that the private sector deploys are far in advance of what the Medicare system uses," says HCFA's Mr. Moley.

Retirees also would benefit. Among other things, retirees would receive post-retirement health care benefits from one source, eliminating confusion about whether Medicare or the supplemental employer plan covers an expense.

However, benefit experts say that while the administration proposal sounds great in theory, they question how well it would work in practice.

By far the biggest concern is for how long the federal government, with big budget deficits, would continue the 95% reimbursement rate after the program was launched.

"How soon would be it be before the 95% became 90% or 89%?" asks Mr. Murdock.

"There is uncertainty whether reimbursement rates would hold up in an era of budget deficits. There is a lack of confidence among employers," adds Willis Goldbeck, president of the Washington Business Group on Health.

Continued on next page

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850 Town & Country Road, Orange, CA 92668

Continued from previous page

There is good reason for this concern.

Last year, despite signed contracts, the government during a seven-month period cut to 94% from 95% the reimbursement rate paid to health maintenance organizations that provide Medicare benefits to about 700,000 retirees.

While that 1% cut—ordered to help the government comply with deficit reduction targets mandated by the Gramm-Rudman balanced budget law—was later restored, it aroused considerable anger and resentment in the HMO community.

"It caused concern whether the government was a fair business partner," said Patricia Billings, legislative director for the Group Health Assn. of America, a major HMO trade association in Washington.

Even if the government doesn't cut the 95% reimbursement rate now proposed, it is uncertain whether employers could profitably pay Medicare benefits, even though the administration says employers, especially those that already provide supplemental post-retirement health care programs, could be big winners.

HMOs' experience in providing Medicare benefits to retirees indicates that even the leaders in managed care are finding it difficult to make a profit with a 95% reimbursement rate.

"It is safe to say that very few HMOs are making much profits under Medicare risk contracts," says Ms. Billings of the GHAA.

For example, last year, the Harvard Community Health Plan in Brookline, Mass., lost about $1 million in providing benefits to about 4,000 retirees under a HCFA Medicare risk contract.

While some of the loss was a result of higher-than-expected utilization of services, the loss also was caused by a flaw in the reimbursement structure, explained Alan Raymond, Harvard's director of public affairs.

In calculating what it will cost Medicare to provide benefits, the government looks at health care costs in the area where enrollees live, Mr. Raymond said.

That methodology can shortchange HMOs when enrollees live in lower-cost rural or suburban areas, but receive health care services in high-cost urban areas, HMO executives say.

"Certainly, there are inequities in the reimbursement structure," says Sy Kaplan, executive director of alternative delivery systems at Blue Cross/Blue Shield Assn. in Chicago.

Even if the current inequities in the reimbursement structure can be eliminated, Medicare risk contracts still may not be a good idea for every employer, observers say.

Only companies that already are successfully managing their health care costs should consider entering into Medicare risk contracts, they say.

"This is for companies who already have taken cost-containment steps. You don't want to learn cost containment after you've entered into a Medicare risk contract," said William J. Arnone, a benefit consultant in the Los Angeles office of Buck Consultants Inc.

And, before signing a Medicare risk contract, a prudent employer would want to determine the availability of cost-effective alternative health care delivery systems, like HMOs or PPOs, in areas where its retirees are concentrated, noted John Erb, an assistant vp with J&H HealthGroup.

In addition, given the difficulty of explaining to the elderly how alternative health care delivery systems, like HMOs and PPOs, work, a company would have to be committed to superior benefits communications programs.

"This isn't for companies whose only relationship with retirees is sending a monthly pension check," said Buck's Mr. Arnone.

For employers that self-administer their group health plans, taking on the responsibility of providing Medicare benefits to retirees would significantly increase the amount of health care claims to be processed.

"The elderly use health care services at a much greater rate than younger employees," said Christy W. Bell, executive director of the Fallon Community Health Plan, a Worcester, Mass.-based HMO.

While doubts remain on just how many employers will sign Medicare risk contracts—assuming Congress gives its approval—benefit experts say the proposal deserves to be tested.

"It is a good concept. It makes sense to turn to the private sector, which has the expertise in health care management," said Mr. Kaplan of BC/BS. ■

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Directory of utilization review providers

a

Admar Corp./HealthWatch Medical Review System
850 Town & Country Road, Orange, Calif. 92668; 714-953-9600, ext. 266

Year founded: 1969; began providing utilization review services in 1983.
Parent company: The Admar Group Inc.
Services provided: 5% 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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 95% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 208 total staff members. 45 professional staff members, including one physician, 35 registered nurses, eight licensed vocational nurses, one medical records technician. Two professionals on a retainer basis who are physicians.
Clients: Three employer clients; 33% with 1,000-2,499 employees, 67% more than 5,000 employees.
Branch offices: Dedham, Mass.
1986 gross revenues: $5.3 million total, $239,456 from utilization review services for employers.
Charges: Per employee per month, $1.25; percent of savings.
Principal officers: Richard H. Toral, president/chairman; Virginia Pascual, executive vp; Alan M. Jeffery, vp-marketing/development.

ALTA Health Strategies Inc.-ALTA Review
2614 S., 1935 W., Salt Lake City, Utah 84119; 801-973-7300

Year founded: 1960, reorganized in 1986; began providing utilization review services in 1987.
Services provided: Utilization review services include frequent preadmission hospital review, precertification, continued hospital treatment review, length of stay determination, discharge, planning, second surgical opinion, outpatient surgery predetermination, case management, disability management; occasional retrospective review.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 23 professional staff members estimated at year-end 1987, including one physician, 20 registered nurses, two medical records technicians. 25 professionals on a retainer basis estimated at year-end 1987, including 15 physicians, 10 nurses.
Gross revenues: $36 million total in 1986, $1.1 million from utilization review services for employers estimated at year-end 1987.
Charges: Per employee, per case, flat annual fee, per hour.
Principal officers: W. Terry Nofsinger, president; Robert B. Shomer, senior vp; Steven N. Burrows, vp.

American Health Network
3988 N. Central Expressway, Dallas, Texas 75204; 214-824-0131

Year founded: 1983; began providing utilization review services in 1983.
Parent company: American General Corp.
Services provided: Utilization review 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: 32 total staff members. Professional staff members include two physicians, 29 registered nurses. Professionals on a retainer basis include one physician.
Clients: 764 employer clients; 89% with fewer than 500 employees, 5% 500-999, 3% 1,000-2,499, 2% 2,500-4,999, 1% more than 5,000.
Branch offices: Sacramento, Calif.; Jacksonville, Fla.
1986 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.

Associated Medical Review Service Inc.
2821 Richland Ave., Metairie, La. 70002; 800-325-9754

Year founded: 1985; began providing utilization review services in 1985.
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, second surgical opinion, case management; occasional retrospective review, hospital bill audit; 50% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Four total staff members. One professional staff member. 25 professionals on a retainer basis, including 20 physicians, five nurses.
Clients: 2,000 employer clients; 100% with fewer than 500 employees.
1986 gross revenues: Not reported.
Charges: Per capita, flat fee.
Principal officers: Katherine Belchic, president; A.J. Blanchatt, vp; Vincent J. Varisco, secretary; Pamela Chauff, treasurer.

Associates for Health Care
122 W. 22nd St., Oak Brook, Ill. 60521; 312-572-8499

Year founded: 1983; began providing utilization review services in 1984.
Services provided: 60% 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; 40% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: Ten total staff members. Six professional staff members, including three registered nurses, one licensed practical nurse, two medical records technicians. Seven professionals on a retainer basis, all of whom are physicians.
Clients: 298 employer clients; 96% with fewer than 500 employees, 2% 500-999, 1% 1,000-2,499, 1% 2,500-4,999.
Branch offices: Milwaukee.
1986 gross revenues: Not reported.
Charges: Per employee, $1-$2.
Principal officers: Richard N. Blomquist Sr., chairman of the board; Richard L. Blomquist Jr., president.

Continued on facing page

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Guide to directory of UR providers

The first directory of utilization review service providers published by *Business Insurance* includes 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 opinion.

Each listing begins 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 any).

The percent of 1986 gross revenues generated from providing utilization review services to employers is noted, followed by specific programs the company provides. Also included is the percent of 1986 gross revenues generated from other services, including utilization review for insurance companies, PPOs, HMOs and third-party claims administrators.

Next are paragraphs describing the types of health care services the company reviews, and staffing. Staff members are provided in full-time equivalents; except for those on a retainer, consulting or per-case basis.

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

Ways in which the company bills for its services and names and titles of principal officers complete the listings.

Companies were asked to fill out and return a *BI* questionnaire to be included in the directory, and each company's listing is based on its responses to that questionnaire. There are no public documents available to allow *BI* to verify the information. *BI* publishes the directory 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 1988 directory of utilization review service providers, please write to Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

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Continued from facing page

Association for Organizational & Human Development Inc.
1701 Lake Ave., Glenview, Ill. 60025; 312-729-9280

Year founded: 1986; began providing utilization review services in 1986.
Parent company: AOHD Management Co. Inc.
Services provided: Utilization review 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, focused audits; occasional discharge planning, hospital bill audits.
Services reviewed: Psychiatric and substance abuse services.
Staff: Eight total staff members. One professional staff member who is a physician. 47 professionals on a retainer basis, including two physicians, five nurses, 40 psychologists and social workers.
Clients: Will begin providing utilization review services to employers in 1987.
1986 gross revenues: Not reported.
Charges: Per employee per month, per case, per hour.
Principal officers: Ronald L. Kirschner, chief executive officer; Christine Temple, vp-administrative services; Joel Schiller, vp-marketing.

b

Bethesda Provider Organization
5200 DTC Parkway, Suite 510, Englewood, Colo. 80111; 301-771-4258

Year founded: 1983; 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, outpatient service predetermination, outpatient psychiatric and substance abuse services; occasional second psychiatric opinion, second opinion for alcohol and chemical dependency; 35% of gross revenues from other services.
Services reviewed: Psychiatric and substance abuse services.
Staff: Six total staff members. Professional staff members include one physician, one registered nurse.
Clients: Not reported.

Continued on next page

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1986 gross revenues: Not reported.
Charges: Per employee, per case.
Principal officers: Sally Belshaw, director; Sam Schiff, medical director; Nancy Graves, director-utilization review/provider relations.

Blue Cross & Blue Shield of Illinois-MSA Unit

233 N. Michigan Ave., Chicago, Ill. 60601; 312-938-6786

Year founded: 1937; began providing utilization review services in 1972.
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.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 55 professional staff members, including 54 physicians, 50 registered nurses; 15 professionals on a retainer basis who are physicians.
Clients: Total employer clients not reported; 40% with fewer than 500 employees, 30% 500-999, 15% 1,000-2,499, 10% 2,500-4,999, 5% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee.
Principal officers: S. Martin Hickman, president-Blue Cross & Blue Shield of Illinois; Bradford Buxton, vp-health services research.

Blue Shield of California-Utilization Review Division

2 North Point, 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, psychiatric and substance abuse services, dental services.
Staff: 31 total staff members who are professionals, including four physicians, 27 registered nurses. Professionals on a retainer basis include 75 physicians available for consultation.
Clients: 3,092 employer clients.
1986 gross revenues: Not reported.
Charges: Negotiated with employer.
Principal officers: Thomas C. Paton, president; Charles W. Stewart, senior executive vp; Charles L. Parcell, senior vp.

C

CareAmerica Inc.

301 E. Main St., Suite 114, Barrington, Ill. 60010; 312-382-7470

Year founded: 1982; began providing utilization review services in 1982.
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, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit; 50% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Not reported.
Clients: Total clients not reported; 1% with fewer than 500 employees, 4% 500-999, 45% 2,500-4,999, 50% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee; no charge if no savings to employer.
Principal officers: Jerome Coquillard, president; Gina Burgess, vp.

Chicago Health Economics Council (CHEC)

6160 N. Cicero, Suite 320, Chicago, Ill. 60646; 312-282-8613

Year founded: 1982; began providing utilization review services in 1983.
Services provided: 85% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion; occasional outpatient psychiatric and substance abuse services, quality of care review; 15% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: All staff members work on a contractual basis.
Clients: 19.2% with fewer than 500 employees, 15.3% 500-999, 26.9% 1,000-2,499, 23.1% 2,500-4,999, 15.5% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee, 30 cents-$1.29; per case, $28.
Principal officers: Thomas Parfitt, chairman; James Anderson, vice chairman; Leonard Muller, secretary.

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 review 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, review of surgical fees prior to surgery; occasional retrospective review, hospital bill audit; 55% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: 36 total staff members. 25 professional staff members, including 11 registered nurses, three licensed practical nurses, one medical records technician. Five professionals on a retainer basis who are physicians.
Clients: 1,500 employer clients; 15% with fewer than 500 employees, 30% 500-999, 30% 1,000-2,499, 15% 2,500-4,999, 10% more than 5,000.
Branch offices: Atlanta.

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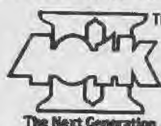

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1986 gross revenues: $1.5 million total, $675,000 from utilization review services for employers.

Charges: Per employee per month, 90 cents-$1.75; per case, $45 per hour and up.

Principal officers: Jeff Aycock, president; Carol Grene, vp-review services; Elizabeth Heller, vp-marketing.

CONSERVCO

10004 N. Dale Mabry Highway, Suite 104, Tampa, Fla. 33618; 800-525-5590

Year founded: 1981; began providing utilization review services in 1986.

Parent company: Constitution State Service Co.

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 service predetermination, outpatient psychiatric and substance abuse services, case management, chiropractic review, preadmission and inpatient psychiatric review services.

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

Staff: 153 total staff members, all of whom are professionals, including one physician, 152 registered nurses.

Clients: Not reported.

Branch offices: San Jose, Calif.; Voorhees Township, N.J.; Dallas.

1986 gross revenues: Not reported.

Charges: Per employee per month, $1.25-$2; per case, per hour.

Principal officers: Dennis L. Huffman, president; Larry A. Mattingly, executive vp; Catherine D. Johnson, Robert Marquess, Terry Oetting and Charles DiPrimio, vps.

Coordinated Rehabilitation Services Inc.

4740 Marsh Road, Okemos, Mich. 48864; 517-349-4967

Year founded: 1981; began providing utilization review services in 1983.

Services provided: 30% 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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, home care management, employee assistance programs, vocational rehabilitation; occasional retrospective review, hospital bill audit; 70% of gross revenues from other services.

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

Staff: 13 total staff members. Professional staff members include five registered nurses.

Clients: Four employer clients; 3% with fewer than 500 employees, 17% 500-999, 47% 1,000-2,499, 33% 2,500-4,999.

1986 gross revenues: $514,000 total, $154,200 from utilization review services for employers.

Charges: Per employee, $1-$2.25; per case, $65 per hour.

Principal officers: Kathleen M. Etienne, president; Jill A. Kurtz, secretary; Andrew R. Zimmerle, treasurer.

Corporate Health Strategies Inc.

2 Whitney Ave., New Haven, Conn. 06510; 203-789-2989

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 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, outpatient psychiatric and substance abuse services, case management, concurrent ambulatory review; occasional hospital bill audit; 47% of gross revenues from other services.

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

Staff: 246 total staff members. 111 professional staff members, including 13 physicians, 98 registered nurses. Three professionals on a retainer basis who are physicians.

Clients: 470 employer clients; 58% with fewer than 500 employees, 18% 500-999, 10% 1,000-2,499, 5% 2,500-4,999, 9% more than 5,000.

Branch offices: Los Angeles; Tulsa, Okla.; Aurora, Ill.; Dayton, Ohio; Kingston and New York, N.Y.; Atlanta; Miami; Westport, Conn.

1986 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Robert Chernow, chief executive officer.

Corporate Healthcare Management Co.

195 Broadway, Suite 14003, New York, N.Y. 10007; 212-618-5873

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

Parent company: Equicor-Equitable HCA Service Corp.

Services provided: 80% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional precertification, outpatient service predetermination, outpatient psychiatric and substance abuse services; 20% of gross revenues from other services.

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

Staff: 300 total staff members. 98 professional staff members, including three physicians, 75 registered nurses, 10 licensed practical nurses, five medical records technicians. 35 professionals on a retainer basis, including 15 physicians, 20 nurses.

Clients: 1,800 employer clients; 50% with fewer than 500 employees, 15% 500-999, 15% 1,000-2,499, 10%

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THE AT WORK PROGRAM®

Continued from previous page
2,500-4,999, 10% more than 5,000.
Branch offices: Brea, Calif.; Pittsburgh and Coraopolis, Pa.; Nashville, Tenn.
1986 gross revenues: Not reported.
Charges: Per employee per month, 75 cents-$2; per case, $50-$150; combination of per employee/per case.
Principal officers: Richard E. Freiburger, chief marketing officer.

Cost Care Inc.

17011 Beach Blvd., Huntington Beach, Calif. 92647; 714-842-4909; 800-762-3029

Year founded: 1981; began providing utilization review services in 1981.
Services provided: 80% 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; prescription home delivery service and utilization review, high-pregnancy identification and management; 20% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 216 total staff members. 129 professional staff members, including nine physicians. 37 professionals on a retainer basis, including 26 physicians; 6,000 physicians available for second surgical opinion.
Clients: More than 4,000 employer clients.
Branch offices: San Francisco and Pasadena, Calif.; Denver; Houston; Dallas; Memphis, Tenn.; Jacksonville and Palm Beach, Fla.; Charlotte, N.C.; Chicago; Lakewood, Ohio; New York; Philadelphia; Cambridge, Mass.; Seattle; Atlanta.
1986 gross revenues: Not reported.
Charges: Per employee, 85 cents-$2; per case, $55-$216; per hour.
Principal officers: Lawrence Goelman, president; Andrew G. Campbell, executive vp; Hugh Cone, vp-operations; Phillip Havener, vp-sales.

d

DataMed Inc.

3000 Dundee Road, Suite 415, Northbrook, Ill. 60062; 312-291-1296

Year founded: 1985; began providing utilization review services in 1986.
Services provided: 20% 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, outpatient psychiatric and substance abuse services, case management, employee education programs; 80% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 16 total staff members who are professionals, including nine physicians, six registered nurses. Four professionals on a retainer basis who are physicians.
Clients: 15 employer clients; 96% with fewer than 500 employees, 2% 500-999, 2% 1,000-2,499.
1986 gross revenues: $66,000 total.
Charges: Per employee, $1.35-$2.30.
Principal officers: Anthony J. Corso, president; Louis R. Morgan, vp.

Diamond Benefits Group

750 N. Diamond Bar Blvd., Suite 220, Diamond Bar, Calif. 91765-1038; 714-598-8499*
*As of April 1, new phone number will be 714-860-1149

Year founded: 1984; began providing utilization review services in 1985.
Parent company: Joint Health Ventures.
Services provided: 40% 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; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 60% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Four total staff members who are professionals, including three registered nurses, one licensed practical nurse. One professional on a retainer basis who is a physician.
Clients: 900 employer clients; 50% with fewer than 500 employees, 50% more than 5,000.
1986 gross revenues: $26,000 total, $10,700 from utilization review services for employers.
Charges: Per employee, $105-$130; per case, $45-$55; per individual bill audit, $40.
Principal officers: Colleen Comey, president; Kevin Jacobs, chief financial officer; Charles McGuirk, director-marketing.

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 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 and inpatient psychiatric and substance abuse services, case management, home health care, mail-order prescription drug programs, employee assistance programs; occasional outpatient service predetermination; 10% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 43 total staff members.
Clients: More than 650 employer clients.
Branch offices: New York.
1986 gross revenues: Not reported.
Charges: Per employee.
Principal officers: Harve A. Ferrill, chairman; Thomas E. Reynolds Jr., president; James E. Adams, senior vp-operations/development; John T. Mitchell, senior vp-sales/marketing.

Continued on facing page

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before

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during

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Continued from facing page

Ernst Health Management Inc.

4501 Vestal Parkway E., Binghamton, N.Y. 13905; 607-798-0410

Year founded: 1972; began providing utilization review services in 1972.

Services provided: 45% 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, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional retrospective review, outpatient psychiatric and substance abuse services, employee health education programs; 55% of gross revenues from other services.

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

Staff: 23 total staff members. 14 professional staff members, including one physician, 13 registered nurses. 51 professionals on a retainer basis, including seven physicians, 44 nurses.

Clients: 22 employer clients; 77% with 1,000-2,499 employees, 13% 2,500-4,999, 10% more than 5,000.

Branch offices: Elmira, Rochester, Syracuse, Albany and Larchmont, N.Y.

1986 gross revenues: $1 million total, $450,000 from utilization review services for employers.

Charges: Per employee per month, $1.95-$2.35; per hour, $50.

Principal officers: Kathleen Ernst, chairman; John F. Spring, chief executive officer; Patrick J. Kearse, president.

FOCUS Healthcare Management Associates Inc.

7101 Executive Center Drive, Suite 160, Brentwood, Tenn. 37027; 615-377-9936

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

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, outpatient service predetermination, outpatient psychiatric and substance abuse services; occasional hospital bill audit, case management.

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

Staff: 15 total staff members. Seven professional staff members, including three physicians, three registered nurses, one medical records technician. 27 professionals on a retainer basis, including 25 physicians, two nurses.

Clients: One employer client with more than 5,000 employees.

Branch offices: Atlanta.

1986 gross revenues: Not reported.

Charges: Per employee per month, $1.50-$12.50; per case.

Principal officers: Richard M. Cooper, president; David S. Iskowe, Stryker Warren Jr., Nadine Wilkerson, Mark Kishel and Thomas Murray, vps.

John Hancock Managed Health Services

John Hancock Place, T-20, P.O. Box 111, Boston, Mass. 02117; 617-421-5131

Year founded: 1865; began providing utilization review services in 1984.

Parent company: John Hancock Financial Services.

Services provided: 97.5% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, case management, patient advocate and absence awareness programs; occasional outpatient psychiatric and substance abuse services; 2.5% of gross revenues from other services.

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

Staff: 106 total staff members. 40 professional staff members who are physicians. Professionals on a retainer basis include one physician.

Clients: 120 employer clients; 44% with fewer than 500 employees, 19% 500-999, 15% 1,000-2,499, 7% 2,500-4,999, 15% more than 5,000.

Branch offices: Lynnfield, Mass.; Schaumburg, Ill.; Farmington Hills, Mich.; Richardson, Texas; Pleasant Hill, Calif.

1986 gross revenues: $2.4 million total, $2.3 million from utilization review services for employers.

Charges: Per employee; per hour, $65-$120.

Principal officers: Henry A. DiPrete, vp-Managed Health Care; James H. Sang, director-Managed Health Services.

Health Benefits Group

505 S. High St., Columbus, Ohio 43215; 614-228-1003

Year founded: 1984; began providing utilization review services in 1984.

Services provided: 90% 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, physician bill audits, consulting and training programs for companies that have in-house utilization review programs; 10% 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, including one physician, two registered nurses. Four professionals on a retainer basis who are physicians.

Clients: 82 employer clients; 95% with fewer than 500 employees, 3% 500-999, 1% 1,000-2,499, 1% 2,500-4,999.

Continued on page 48

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& 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.

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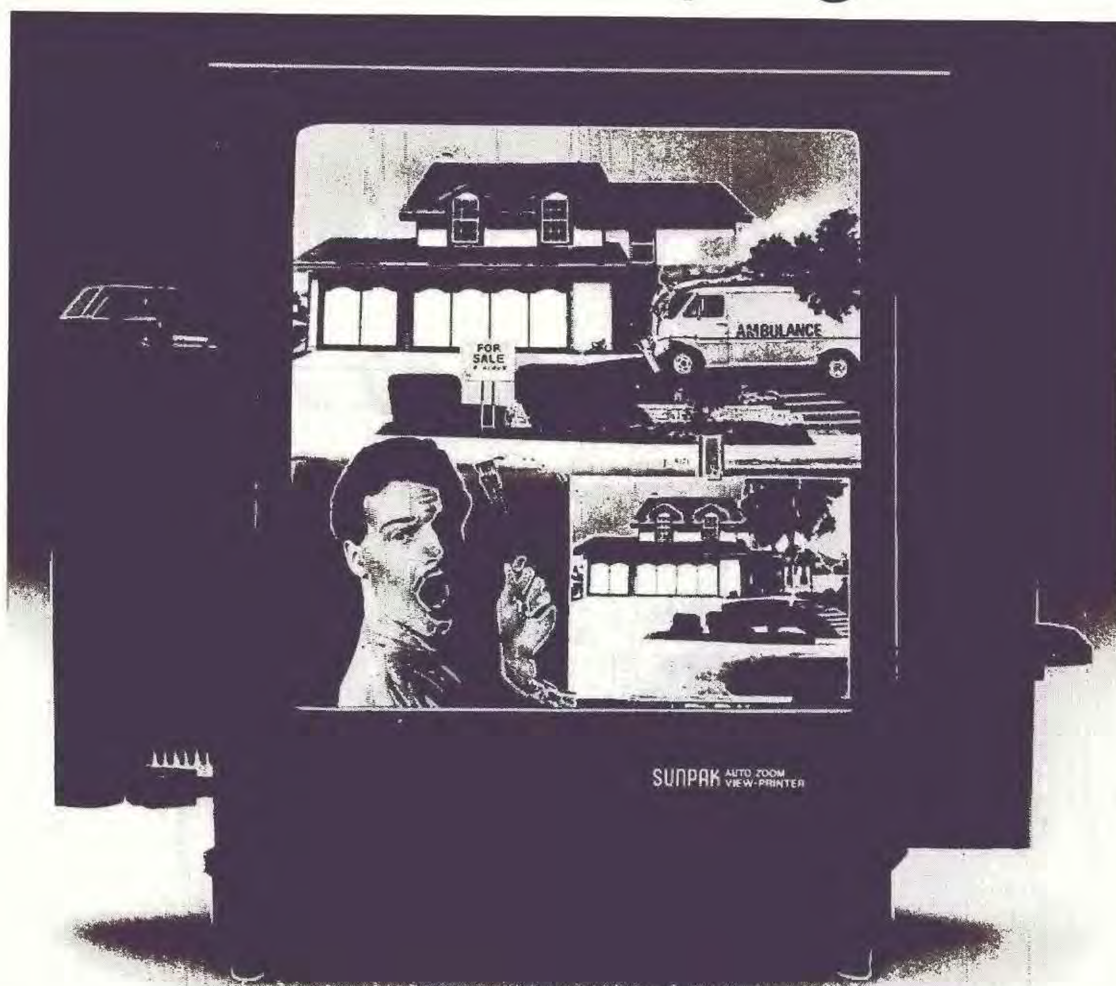

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SHOWING THE WAY

Good communication is key to acceptance of PPOs by employees

By Laurel A. Nicholson

LEGISLATIVE ACRONYMS for retirement issues have rapidly reproduced since ERISA, creating such inspired offspring as DEFRA, TEFRA, and REA. Likewise, the alphabet soup used for health care concepts is also multiplying. In addition to COBRA and the familiar HMO, we have added PPO and even EPO for our progressive health care managers.

What does all this mean to the average employee? Too often only a confused hodgepodge of terms that eventually demands more decisions, more choices on the employee's part. In short, it means the need for effective communication.

There is no question that preferred provider organizations are one of the fastest growing health care alternatives in this country. But it is an alternative that will not work if employees don't understand what a PPO is or how it works.

In order to accept new ways of health care delivery and achieve successful levels of enrollment and participation, employees need to understand why a PPO will benefit them.

Although the right communication approach depends on the type of alternative delivery system offered and how it fits with the employer's total medical program, there are four basic steps necessary to communicate a PPO:

- Announcement.
- Training.
- Employee meetings.
- Enrollment/confirmation.

In the first phase, announcement, education is the key factor. Employees need to understand why the organization has changed its medical plan, what factors have contributed to rising health care costs and what are the alternatives for controlling costs.

Many organizations begin this process with a letter from the president or vp of human resources to explain the rationale behind the changes. This executive letter is usually accompanied by a newsletter, or series of newsletters depending on the complexity of the changes, that explains the modifications to the health care program and introduces the concept of a PPO.

To help illustrate the cost advantages of using PPOs, the information should take an employee step-by-step through a "typical" hospital stay and list the corresponding costs and savings. By clearly showing how PPOs save money, employees will be able to see how the program can work for them.

The executive letter and newsletter should be mailed to the employees' homes to reach the entire benefit audience. Because health care decisions affect the employee's dependents, the information needs to be understood by the whole family.

Approximately two weeks after the final newsletter, a highlights brochure, summarizing the plan changes, should be mailed to the employees. Necessary enrollment forms should be included.

In addition, this package should include a provider directory—a critical factor to the success of this program. The directory lists the "preferred" physicians, hospitals and facilities and where they are located. Depending on the size of the PPO, it is likely that many employees' physicians may already by participating in the program.

The directory can easily become the most complex part of the communication process, particularly if there are a number of physician groups who are participating members of different hospitals and clinics. Not only are physicians particularly sensitive to name misspellings, there are also frequent additions and revisions to the directory as providers join or leave the local geographical area. And, of course, physicians often change medical affiliations with hospitals, clinics and physician groups throughout the year. So, maintaining an accurate, up-to-date directory can be a challenge.

Some of the most sophisticated directories are a result of direct contracting—where the middleman is effectively eliminated and the company negotiates directly with a variety of providers.

Depending on the size and the number of participating providers, the directory can be maintained on a word processor or personal computer, or on an in-house legal system data base. Most of the time a PC data base program or word processor is all that is needed.

The final announcement piece is an invitation to attend employee meetings. This can be posted on bulletin boards, distributed in a memo, or included with the highlights brochure.

It is at this point that organizations often take divergent viewpoints. Some organizations find all they need is to communicate the changes through printed materials and let employees return their medical enrollment forms. Other organizations with locations around the country take advantage of this opportunity to train their local human resource personnel to become comfortable with the new medical plan changes. But they don't feel it is necessary to hold employee meetings.

A third alternative is based on management's belief that health care delivery is a growing financial concern. It necessitates completing the total education effort involving training and employee meetings.

Obviously, the employer saves money whenever its workforce takes advantage of a PPO. The nice part is that the employee saves money, too. The objective of a PPO is to achieve maximum participation. That is where training can help.

Training brings the local human resource staff into the communication process and makes then aware of the PPO, how it works, its goals and its advantages. A day of training also clarifies the staff person's role and creates an enthusiastic local spokesperson for the new medical option.

If the organization intends to hold employee meetings, part of the one-day training session should be devoted to interpersonal skills improvement—how to conduct a meeting and hold the employees' attention and how to respond to questions. Role playing is a fun and educational technique and is easily woven into the curriculum to break up traditional classroom monotony while giving employees the chance to use the information they have learned. Manuals reviewing the plan facts and offering communication tips and techniques help to keep the information fresh and available, long after the training session ends.

Employee meetings are an important way of showing management's support for the PPO. They also allow employees a chance to review the main points of the plan and have their questions immediately answered.

It is common for an audio-visual program to be shown during the employee meetings illustrating how the new medical option works. By presenting employees in different life situations, a realistic audio-visual program breathes life into the concept of quality, cost-effective care.

The cost of producing a video presentation has declined over the past few years, making it as cost effective as slides. However, simple overheads can also be effective if the meeting leader has strong presentation skills.

After enrollment forms have been received, many organizations like to confirm employees' medical choice. This is an excellent opportunity to remind employees to take advantage of the PPO—regardless of the plan they selected.

Continued on page 47

Laurel Nicholson is practice leader of communication services for A.S. Hansen Inc. in Deerfield, Ill. Ms. Nicholson has helped communicate PPOs for several organizations including Apple Computer, Xidex Corp., Lockheed Missles & Space Co. and Ameritech.

Making UR pay

Reviewing a review program lets employers get best return

By Carol Johnston

speaking out

EMPLOYERS ACROSS the country have recognized the need for adopting some form of utilization review as an adjunct to their benefit plans. However, many of these employers are wondering just how well their programs are working.

The first thing to do when judging a utilization review program is to determine exactly what the program was designed to accomplish. Some programs provide pre-admission certification but no follow-up. Others might include discharge planning and case management. Still others provide all the bells and whistles, including professional health care counseling for non-hospital care.

Next, it should be determined whether the utilization review provider has met four basic criteria: Is the program consistent with contract provision? Are savings real? Is there a better way to provide UR services? Is this the right UR provider for my company?

Here are some guidelines to determine the answers:

- Is the utilization review program consistent with contract provisions?

What did the employer buy; what did the sales representative sell? All too often problems in a UR program start at this point.

The vendor may not have understood the company philosophy, the overall attitude the company has toward its employees and the attitude the employees have toward their employer and the benefits provided by that employer. If this important area has not been examined carefully prior to the design and implementation of the UR program, it is safe to say that compliance with the program will be compromised, primarily through employee misunderstanding and misinterpretation or, worse, employees may perceive impeded access to health care services.

- Are savings real?

Utilization review vendors are not licensed or regulated in any way, so much of what they propose to accomplish has to be taken at face value. Employers receive reports that show hospital days and dollars are saved, but how do they know that the cost savings are real? This is the question employers most often ask.

The first thing to do when judging a utilization review program is to determine what the program was designed to accomplish.

Unfortunately, the only avenues open to most employers when attempting to determine whether their programs are effective are with the vendors themselves. This is where the real razzle-dazzle becomes apparent.

Vendors become very protective of their product when asked to verify or substantiate claims of savings and effectiveness. This can vary from vendors whose reports are so convoluted that the employer gives up and accepts the results without pursuing the accuracy of those results, to vendors who, if questioned about claims of hospital days or dollars saved, fall back on the old "confidentiality" routine—meaning they can't show how their action resulted in savings.

The question is whether these dollars claimed to have been saved are "real" or are the result of something that would have occurred anyway, even without the use of utilization review. Here is an example:

Company X has a "pre-cert" program, meaning that the employees, before entering the hospital for an elective procedure, call a toll-free number. The employee gives the UR provider information concerning age, sex, diagnosis and the region of the country in which they live. The employee's case is then assigned a number of days that constitute a "certified" length of stay.

Our employee at company X is certified for seven days; however, by Day Five he feels great and is discharged. His employer receives a report that indicates the UR vendor "saved" the employer two hospital days.

In this case, one phone call made by the employee to a toll-free number, hardly justifies the UR vendor for taking credit for two saved hospital days.

But, here is another example:

The same employee receives a follow-up call on Day Four of his hospital stay from his UR provider. The discussion centers around his situation, his progress and other related issues, such as available help at home and so forth. The UR provider suggests that the employee, since he feels so well, discuss with his physician the possibility of going home earlier than anticipated. The physician agrees and the employee is released from the hospital.

This results in a two-day savings that the UR provider can report the the employer. The savings are attributable to the UR provider's interactions with company X's employee.

A utilization review program, to be truly beneficial, should be viewed by employees as a benefit enhancement.

- Is there a better way to provide utilization review services?

When an employer feels that his UR program isn't working, there are a number of solutions to the problem. He could just chuck the whole thing and go back to whatever existed before, or he can carefully examine why the program isn't working and fix it.

Many employers might feel that chucking the program is the easiest solution, when in reality it might be the worst possible answer. Undoing programs, especially those related to employee benefits, often results in employee distrust whenever a new program is introduced in the future. Fixing the program, however, can result in greater employee understanding, acceptance and compliance.

Some of the easiest fixes are increased communication and education efforts. In more difficult situations, redesign of contracted utilization review services might be necessary. That brings us to the last question.

- Is this the right utilization review provider for my company?

Employers—having reviewed their contract, including the reports and services available—often reach a point of recognizing the fact that the UR provider is not the right one for their benefit program.

For instance, a provider using a cut-and-dried, no-nonsense approach certainly won't be well-received by employees who are used to more subtle, friendlier handling.

The employer that reaches this conclusion is faced with the difficult—but not impossible—task of finding the right UR provider.

Careful evaluation of a provider's philosophy, standards, methods and protocols can result in an employer being able to select a UR vendor that will provide services that are understood, well-received and cost-effective.

As the use of UR grows, it becomes more apparent that some method of measuring the benefits provided by UR programs is necessary. The method of measuring the benefit and success of a UR program can take different forms.

One measure of success, which is often overlooked by employers, is whether their employees appreciate the program. Understandably, there are those that will question the necessity of having their employees appreciate UR, but consider this:

If employees view UR as a stumbling block, a "pain in the neck" or "just another thing I have to do before I can do what my doctor wants," the chances are very high that the UR program will be ineffective, costly with questionable results, too rigid and/or impersonal or any combination of things not necessarily conducive to good results.

Health care is—and probably always will be—a very personal thing to employees. Consequently, a UR program, to be truly beneficial, should be viewed by employees as a benefit enhancement—a program offered by their employer to help them become informed consumers of health care, not a restrictive device put in place to limit access to health care.

Very often, a survey of employees' attitudes will indicate that more effective communication of the benefits of the UR program will create a much more successful environment in which to realize cost savings.

For many employers, however, the real way to find whether a UR program is working is to review the reviewer. An independent review by qualified persons with first-hand knowledge of all aspects of utilization review is an effective way for an employer to justify the cost of a UR program balanced against the reported results. Such a review can also provide information needed to determine if the program needs further communication, plan revisions or a change of vendors.

When an employer considers a review of the reviewer, there are two important considerations.

First, can the employer accomplish the review or is qualified help needed. The magic word here is "qualified." A cost-effective, results-oriented review cannot be performed without the reviewers having significant experience with the various parameters and components of UR programs. These qualifications allow the review to be made at the lowest cost with the highest return to the employer by ensuring the review is fair, the information is appropriate and the results are substantiated.

Second, what is the information flow between the UR provider and the claims payer? Often a relatively successful UR program falls apart completely at this point. The program may provide realistic services, but if claims are being paid without interaction between the UR provider and the claims payer, an employer can easily see savings documented on UR reports while receiving claims reports showing increased claims experience and higher costs.

An employer that has contracted for a utilization review service deserves to receive a benefit for the cost of the service. However, it is often difficult to determine if in fact there is any benefit at all. An employer's attempt to review the reviewer, to determine employee appreciation, communication or education needs, program changes, claims payer interaction and the ability to prove or disprove cost savings requires first-hand knowledge of UR from concept to process and procedure.

Employers spend substantial sums of money on health benefits each year. Many also spend substantial sums on utilization review to control costs. Because of these expenditures, it is time for employers actively to assess their UR programs.

The results may be surprising!

Carol Johnston is an associate consultant with Coopers & Lybrand's Actuarial Benefit and Compensation Group in Chicago.

You can build RMIS on your own

CAN THE RISK management professional create and maintain his own risk management information system?

Yes, with some obvious qualifications.

To continue the theme discussed in last month's commentary, "Thinking Small" (*BI*, Jan. 19), this month we will examine non-vendor RMIS options that do not approach the cost of commercially sold systems.

Two obvious requirements necessary before a risk manager can create his or her own RMIS are some familiarity with personal computers and familiarity with common software packages such as LOTUS 1-2-3 or d-BASE-III, etc.

The next requirement is a consistent data source, principally composed of claim and exposure data. Insurance company loss runs and internal lists on vehicles, properties, payroll, personnel, square footage, locations, etc., are obvious sources.

Unfortunately, you are probably going to have to accept the given state of the loss information from the insurer since your RMIS probably will not have the necessary sophistication to be able to validate the data's quality. Also, you may have to wait 30 to 60 days for insurer loss runs.

Nevertheless, these should not be overly difficult obstacles. Your objective is to better manage the information flowing into your organization and to provide meaningful analysis of that data. Such difficulties, as long as they are understood beforehand, are acceptable.

The rule of thumb in categorizing these "hacked" systems is that there is no rule of thumb. They are as diverse as their creators. Some track claims, others list policies, some do simple modeling routines; some tie in with their corporate mainframe or even an RMIS vendor's mainframe. Usually, they are microcomputer-based, use popular spreadsheet or data base management system software and are very flexible, since their creators often change the format.

What kind of risk managers use such fabricated systems? Although most users are small to medium firms that are fully insured and need to track less than 100 claims, there are many larger corporate risk managers with their own self-programmed microcomputer systems.

Principally, the most common applications for the self-designed system are:

✔ Exposure base collection.

In all risk management information systems, the construction of the data base remains the fundamental and primary element in a successful system, whether it be a vast mainframe time-shared system or a PC-based, spreadsheet-oriented, self-designed system.

As the reporting needs and organization change, the exposure base may be altered to include a few more variables. The emphasis, naturally, remains on flexibility.

✔ Claims and incidents tracking.

Another important usage is the monitoring of claims. Some risk managers will create their own incident reporting data base and include the insurance company claim number as a cost reference item. The key purpose here is to monitor these claims, how their reserves change over time and their final resolution.

Since insurance companies, from time to time, have been known to make mistakes, such a claim tracking capability is essential if the risk manager wants to be sure of insurance company accuracy. Moreover, such a monitoring/tracking device is very useful in measuring the activity of the insurance company adjuster and whether he or she has been efficient in resolving the claim in a reasonably expeditious fashion.

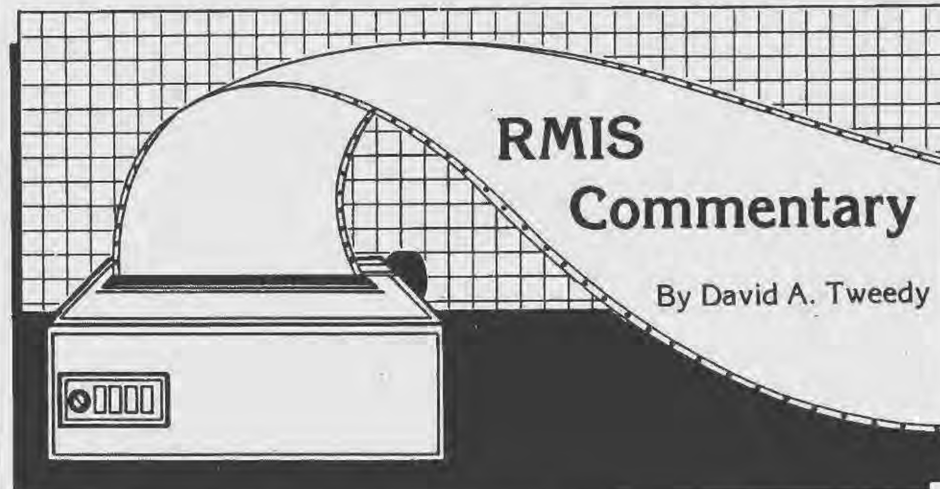
For example, if a risk manager knows that the claim is ready to be settled or closed, and yet sees no adjuster activity on the recent loss runs, that would enable him or her to check with the adjuster on the status of the claim.

In my past experience as a claims supervisor, I know there are often several claims on an adjuster's caseload that are either ready to close or settle. An informed risk manager can sometimes speed along claims resolution.

This tracking capability also gives the risk manager better cause to contend with reserve changes as he sees them developed from month to month from loss runs. Suppose, for example, the risk manager knows that an employee that has filed a workers compensation claim is ready to return to work, has his doctor's clearance, but yet sees the claim remain open for two extra months on the loss run. The RMIS report on open claims would be a valuable argument to officially close the claim and reduce reserves to actual incurred.

✔ Analytical reports.

It is here that there is the most diversity among risk managers using their own designed microcomputer RMIS.



One common report is the cost-of-risk allocation report to operating divisions or departments. We have found that some risk managers, even with large mainframe-based commercially provided RMIS, will still run their cost-of-risk allocation reports on Lotus 1-2-3 spreadsheets. A smaller firm may not need a cost-of-risk allocation, but may want to track premiums and losses by insurance line.

While we have not seen any exotic loss forecasting applications in such systems, we do know that historical losses are kept and tracked and compared against experience modification worksheets. The objective here is to be certain that the experience modification factor is based on the correct losses that have occurred over the past several years.

There are a lot of examples where, on a Lotus 1-2-3 spreadsheet, different retrospective rating options are evaluated and given certain loss levels. Furthermore, cash-flow impact is evaluated on different models such as insurance vs. self-insurance, etc.

It is important to understand the system's shortcomings. While all systems have their shortcomings, self-designed systems are especially suspect. Validation techniques, analytical programs and reports are all dependent upon its creator's accuracy—or inaccuracy. Therefore, any decisions based on your system's output should be thoroughly checked and rechecked.

It is equally important to back up your programs and data. Nothing much needs to be said here in explanation, especially to those who have made the fatal mistake of not saving programs and/or data.

The list of available RMIS options is growing. As the risk management professional becomes more adept at using the computer to track and evaluate the information flowing into the department, there will be more examples of self-designed systems.

This is an encouraging trend. The computer can be a valuable ally and tool of the risk manager in the performance of his or her job. However, the key warning is to be aware of the limitations of a self-designed system. After all, if a glitch is developed or mistakes are made through an incomplete analytical program, it is the risk manager taking that risk. Commercially produced software packages, though initially more expensive, have the backing of their creators as well as the service to alleviate any problems.

In next month's columns, I will provide a series of comparison factors for the potential RMIS buyer who will be inundated by the usual plethora of systems at the annual Risk & Insurance Management Society conference.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the assistant editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. His column on risk management information systems appears the third Monday of every month.

Mr. Tweedy

Communication of PPOs

Continued from page 45

Obviously, there are a number of ways that a PPO can work besides the one described here. It is important to remember that the communication approach will vary depending on the design.

For example, an employer may wish to offer both a PPO and and exclusive provider option (EPO). Under an EPO, the employer has contracted with specific providers to get the best possible costs for the employee. If an employee signs for an EPO, the employee must use only those exclusive providers. If the employee goes to an outside provider, he or she generally receives no reimbursement from the plan.

Obvious exceptions, such as out of town emergencies would not apply.

Under the EPO, employees must understand they are receiving exceptional cost savings in exchange for a smaller list of providers than would be offer through a PPO.

Remember, most PPOs use cost incentives to induce employees to use their services. Going to another provider often means a higher cost to the employee, but a basic level of reimbursement is usually allowed. Whenever disincentives are used, the communication materials must clearly explain how and when any cost reductions apply.

In the light of Tax Reform Act of 1986, which clearly gives the go-ahead to flexible compensation plans, employers may wish to consider communicating a PPO as a medical alternative incorporated into flex plan. In that case, the communication approach would be similar using expanded information.

But regardless of how an organization chooses to design a PPO, its ultimate success will be based on employee understanding and acceptance. PPOs won't work if they remain confusing acronyms. To be effective, PPOs need to spell out cost savings—and communication can make that happen.

Continued from page 41
1986 gross revenues: $200,000 total, $180,000 from utilization review services for employers.
Charges: Per employee, 65 cents-$1.30; 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 review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management, ambulatory review, claims review, employee assistance program review; occasional retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services; 36% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: 45 total staff members. 32 professional staff members, including 20 registered nurses, two licensed practical nurses, five medical records technicians. 50 professionals on a retainer basis who are physicians.
Clients: 105 employer clients; 3% with fewer than 500 employees, 4% 500-999, 30% 1,000-2,499, 30% 2,500-4,999, 33% more than 5,000.
Branch offices: San Francisco, Sacramento, Fresno and Bakersfield, Calif.
1986 gross revenues: $2.2 million total, $1.4 million from utilization review services for employers.
Charges: Per employee, 50 cents-$1.05; per case.
Principal officers: John W. Kellar, medical director; Daniel P. Sheehy, executive director; Elaine Hislop, director-review.

Health Care 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 drug utilization review and drug case management.
Services reviewed: Group health services.
Charges: Per employee per month, 20 cents-50 cents; per case, $40-$100.
Principal officers: Frederic R. Curtiss and Robert E. Davis.

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: Caremark.
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, case management, medical chart audits and analytical studies; occasional hospital bill audit; 50% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 210 total staff members. 180 professional staff members, including 15 physicians, 30 registered nurses, seven medical records technicians. 40 professionals on a retainer basis who are physicians.
Clients: Total clients not reported, 100% with more than 5,000 employees.
Branch offices: Chicago; Newport Beach, Calif.
1986 gross revenues: Not reported.
Charges: Per employee, per case, flat annual fee.
Principal officers: David Rosenbloom, president; Paul M. Gertman, chief scientist; Stephen K. Holland, vp-managed care.

Health Dimensions Inc.
6160 N. Cicero, Suite 320, Chicago, Ill. 60646; 312-282-8610

Year founded: 1984; began providing utilization review services in 1984.
Services provided: 40% of gross revenues from providing utilization review services to employers, including frequent retrospective review, hospital bill audit, quality of care review, cost and quality evaluation of HMOs and PPOs, non-acute care day review, effectiveness audits for utilization review programs; occasional outpatient psychiatric and substance abuse services, case management; 60% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Four total staff members. Three professional staff members who are registered nurses.
Clients: 25 employer clients.
1986 gross revenues: Not reported.
Charges: Per employee, 75 cents-$1.50; per case, $18-$48.
Principal officers: Joseph N. Mohr, president; Melody D. Connor, secretary.

Health Economics Corp.
1300 W. Mockingbird Lane, Dallas, Texas 75247; 214-638-6611

Year founded: 1982; began providing utilization review services in 1982.
Parent company: The Halliburton Co.
Services provided: 77% 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, analysis of practice patterns; occasional hospital bill audit, outpatient service predetermination; 23% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 62 total staff members. 26 professional staff members, including two physicians, 24 registered nurses. One professional on a retainer basis who is a physician.
Clients: 52 employer clients; 40% with fewer than 500 employees, 24% 500-999, 13% 1,000-2,499, 9% 2,500-4,999, 14% more than 5,000.
Branch offices: Houston.
1986 gross revenues: $2.1 million total, $1.6 million from utilization review services for employers.
Charges: Per employee, 60 cents-$1.52.
Principal officers: Stephen F. Coady, president/chief executive officer; Gary Lanham, national director-marketing; Felix Peppard, medical director; Rick Starkweather, vp-technical/financial services.

Health International
1840 Century Park E., Suite 670, Los Angeles, Calif. 90067; 213-551-1840

Year founded: 1979; began providing utilization review services in 1979.
Services provided: 60% 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; 40% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 13 total staff members. Professional staff members include two physicians, four registered nurses. 12,000 professionals on a retainer basis who are physicians.
Clients: 112 employer clients.
1986 gross revenues: Not reported.

Continued on page 50

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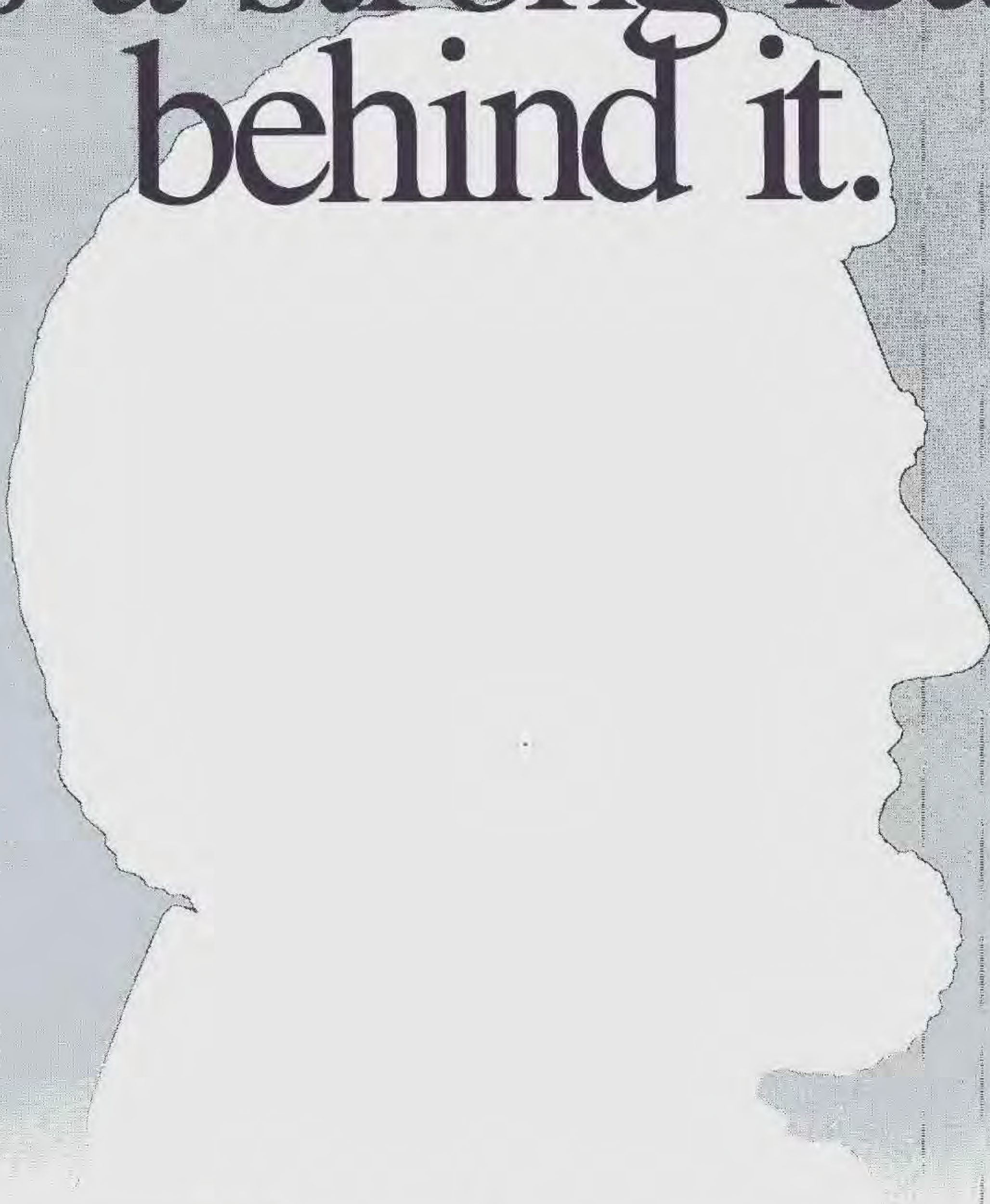

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Charges: Flat fee.

Principal officers: Donald K. Kelly, chairman/chief executive officer; Michael C. Peerboom, president/chief operating officer; Gregory S. Perez, vp-marketing.

Health Management Network

Executive Park, P.O. Box 110845, Nashville, Tenn. 37222; 615-333-3300

Year founded: 1983; began providing utilization review services in 1984.

Parent company: American Progress Corp.

Services provided: 92% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, outpatient service predetermination, case management; occasional discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services; 8% 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 professionals on a retainer basis who are physicians.

Clients: 75 employer clients; 95% with fewer than 500 employees, 3% 500-999, 1% 1,000-2,499, 1% 2,500-4,999.

1986 gross revenues: $272,000 total, $250,240 from utilization review services for employers.

Charges: Per employee per month, up to $2.25; per case, up to $60 per hour.

Principal officers: Sandi Clevenger, president/chief executive officer; Greg McNair, vp-marketing; Marion Adams, vp-administration.

Health Management Strategies International Inc.

1301 Pennsylvania Ave. N.W., Suite 800, Washington, D.C. 20004; 202-637-0246

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

Parent company: Group Hospitalization & Medical Services Inc.

Services provided: 90% 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 psychiatric and substance abuse services, alternative treatment facilities; 10% of gross revenues from other services.

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

Staff: 44 total staff members. Professional staff members include one physician, 17 registered nurses. Two professionals on a retainer basis who are physicians.

Clients: 82 employer clients; 77% with fewer than 500 employees, 11% 500-999, 5% 1,000-2,499, 4% 2,500-4,999, 3% more than 5,000.

1986 gross revenues: $2 million total, $1.8 million from utilization review services for employers.

Charges: Per employee per month, 25 cents-$1.50.

Principal officers: E. Seton Shields, president; William R. Vandervennet, senior director-finance/administration; Brian E. McCagh, senior director-marketing.

Health Related Services Inc.

301 Fifth Ave. 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 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; occasional hospital bill audit; 20% of gross revenues from other services.

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

Staff: 130 total staff members. 70 professional staff members, including one physician, 69 registered nurses. 80 professionals on a retainer basis who are physicians.

Clients: 8,000 employer clients; 10% with fewer than 500 employees, 5% 500-999, 10% 1,000-2,499, 15% 2,500-4,999, 60% more than 5,000.

Branch offices: Erie, Pa.

1986 gross revenues: $10 million total.

Charges: Per employee, $1-$2; per case, $65-$100 per hour.

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. Lancey St., Pittsfield, Maine 04967; 207-487-2829

Year founded: 1979; began providing utilization review services in 1985.

Services provided: 25% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional discharge planning, retrospective review; monthly bulletins; 75% of gross revenues from other services.

Services reviewed: Group health services, substance abuse services.

Staff: 13 total staff members. Eight professional staff members, including five registered nurses, three licensed practical nurses. Five professionals on a retainer basis who are physicians.

Clients: Not reported.

1986 gross revenues: Not reported.

Charges: Per hour, $42-$48.

Principal officers: Mary E. Orloski, president; Lynne S. Parkhurst, vp-review services.

Health Review Systems Inc.

6160 N. Cicero, Suite 320, Chicago, Ill. 60646; 312-282-8610

Year founded: 1982; began providing utilization review services in 1983.

Services provided: 60% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit; occasional outpatient psychiatric and substance abuse services, case management, quality of care review, cost and quality evaluation of HMOs and PPOs, non-acute day care review, effectiveness audits for utilization review programs; 40% of gross revenues from other services.

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

Staff: Eight total staff members. Four professional staff members who are registered nurses.

Clients: 19.2% with fewer than 500 employees, 15.3% 500-999, 26.9% 1,000-2,499, 23.1% 2,500-4,999, 15.5% more than 5,000.

1986 gross revenues: Not reported.

Charges: Per employee, 30 cents-$1.29; per case, $28.

Principal officers: Joseph N. Mohr, president; Melody D. Connor, secretary.

Health Risk Management Inc.

8000 W. 78th St., Minneapolis, Minn. 55435; 612-829-3500; 800-824-3882

Year founded: 1977; began providing utilization review services in 1984.

Services provided: 75% 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, case management, preadmission fee negotiation with doctors and hospitals; occasional review of outpatient surgery, outpatient psychiatric and substance abuse services; 25% of gross revenues from other services.

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

Staff: 160 total staff members. Professional staff members include 20 physicians, 45 registered nurses, seven licensed practical nurses, five medical records technicians. Professionals on a retainer basis include two nurses.

Clients: 75 employer clients; 1% with fewer than 500 employees, 4% 500-999, 10% 1,000-2,499, 15% 2,500-4,999, 70% more than 5,000.

Branch offices: Phoenix, Ariz.

1986 gross revenues: Not reported.

Charges: Per employee per year, $7-$38; per case, $32-$184.

Principal officers: Gary T. McIlroy, chief executive officer/chairman; Marlene Travis, chief operating officer; Al E. Gourley, executive vp-health care provider contracting; Bruce Kelley, vp-analytical services; Tim Temple, vp; Terry Booth, vp-sales.

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Continued from facing page

HealthCare COMPARE Corp.

730 Springer Drive, Lombard, Ill. 60148; 312-932-7070

Year founded: 1982; began providing utilization review services in 1984.

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, CareLine (informational telephone service), disability review.

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

Staff: Approximately 200 total staff members.

Clients: Not reported.

1986 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Robert J. Becker, chairman; James C. Smith, president.

HEALTHMARC Inc.

Opus Center, Suite 148, 9900 Bren Road E., Minnetonka, Minn. 55343; 800-328-5979, ext. 1205

Year founded: 1983; began providing utilization review services in 1974 under different ownership.

Parent company: United HealthCare Corp.

Services provided: 80% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, informational evenings and weekends, chiropractic review service, patient education; occasional hospital bill audit; 20% of gross revenues from other services.

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

Staff: 26 total staff members. 21 professional staff members who are registered nurses. 32 professionals on a retainer basis, including two physicians, 30 physician advisors.

Clients: 150 employer clients; 75% with fewer than 500 employees, 10% 500-999, 5% 1,000-2,499, 5% 2,500-4,999, 5% more than 5,000.

Branch offices: Minneapolis, Los Angeles.

1986 gross revenues: Not reported.

Charges: Per employee, $1.50-$2; per case, $80; catastrophic case management when not included in per employee fee, $100 per hour.

Principal officers: Mark Tierney; president; Kathleen Whittington, vp; Glenda Garrard, western regional director.

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Integrated Health Systems Inc.

120 Northwoods Blvd., Worthington, Ohio 43085; 614-888-2223

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

Parent company: Health Matrix Inc.

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, case management, claims audit; occasional outpatient psychiatric and substance abuse services.

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

Staff: 40 total staff members. 31 professional staff members, including one physician, three registered nurses, one licensed practical nurse. Nine physicians on a retainer basis.

Clients: 44 employer clients.

1986 gross revenues: $1.8 million, all from utilization review services for employers.

Charges: Per employee, $1.35-$1.50; per case; flat annual fee; case management, $35-$40.

Principal officers: Bradley C. Engel, president; Deborah V. Loveland, general manager.

Intracorp

Chesterbrook Corporate Center, 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: 20% 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 psychiatric and substance abuse services, case management, psychiatric precertification; 80% of gross revenues from other services.

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

Staff: 3,400 total staff members.

Clients: 9,500 employer clients.

Branch offices: Atlanta, Chicago, Philadelphia, Los Angeles, Dallas.

1986 gross revenues: Not reported.

Charges: Per employee per month, 90 cents-$1.15; per case.

Principal officers: Warren D. Fuller, president; Daniel H. Davis and Dick A. Anderson, senior vps; Katherine Perry, vp/chief financial officer.

Island Peer Review Organization

95-25 Queens Blvd., 9th Floor, Rego Park, N.Y. 11374; 718-896-7230

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

Services provided: 1.5% 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, case management; 98.5% of gross revenues from other services.

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

Staff: 130 total staff members. 72 professional staff members, including one physician, 66 registered nurses, five medical records technicians. 350 professionals on a retainer basis who are physicians.

Clients: Three employer clients; 67% with fewer than 500 employees, 33% more than 5,000.

Branch offices: Three locations in downstate New York.

Subsidiary: IPRO National Medical Review.

1986 gross revenues: $5 million total, $75,000 from utilization review services for employers.

Charges: Per capita, fee for service.

Principal officers: Thomas J. Sheehy, president of the board; Theodore O. Will, executive vp; Raphael P. Nennen, medical director.

k

Kepple & Co. Inc.

405 W. Northmoor Road, Peoria, Ill. 61614; 309-692-7330

Year founded: 1982; began providing utilization review services in 1986.

Services provided: 8% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment, 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; 92% of gross revenues from other services.

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

Staff: Three total staff members, all of whom are professionals; including two registered nurses, one medical records technician. One pro-

Continued on next page

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Continued from previous page
fessional on a retainer basis who is a physician.
Clients: 14 employer clients; 57% with fewer than 500 employees, 36% 500-999, 7% 1,000-2,499.
1986 gross revenues: $980,000 total, $77,000 from utilization review services for employers.
Charges: Per employee, $1.15-$2.50.
Principal officers: Michael D. Kepple, president; Linda P. Kepple, vp.

Managed Healthcare Resources Inc.
7930 State Line Road, Suite 214, Prairie Village, Kan. 66208; 913-341-1215

Year founded: 1986; began providing utilization review services in 1986.
Services provided: Utilization review services include concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management, drug utilization review.
Services reviewed: Group health services.
Staff: Four total staff members. Two professional staff members who are registered nurses.
Clients: Will begin offering utilization review services to employers in 1987.
1986 gross revenues: Not reported.
Charges: Per case, approximately $390; flat annual fee.
Principal officers: Gail Shafton, president/chief executive officer; Kermit Fendler, vp.

MedCost Inc.
3407 W. Wendover Ave., Greensboro, N.C. 27407; 919-299-0062

Year founded: 1983; began providing utilization review services in 1984.
Parent company: Jefferson-Pilot Life Insurance Co.
Services provided: 36% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, precertification, concurrent hospital treatment review, length of stay determination, second surgical opinion; occasional discharge planning, retrospective review, case management; 64% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 13 total staff members. Three professional staff members who are registered nurses.
Clients: Approximately 35 employer clients; 75% with fewer than 500 employees, 11% 500-999, 11% 1,000-2,499, 3% 2,500-4,999.
1986 gross revenues: Not reported.
Charges: Per employee, 75 cents-$1.10.
Principal officers: Otto W. Mueller, president; Billie J. Davis, vp.

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: 20% of gross revenues from providing utilization review services to employers, including frequent preadmission review, precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, medical peer review, paid claims analysis; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 80% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: Five total staff members who are professionals, including one physician, three registered nurses. 204 professionals on a retainer basis, including 200 physicians, two nurses.
Clients: Five employer clients; 40% with fewer than 500 employees, 20% 500-999, 20% 2,500-4,999, 20% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee per month, 35 cents-$1.50; per case, $40-$175 per hour.
Principal officers: Michael J. O'Connor, president; Andrew J. Brislen, vp; C. Larkin Flanagan, treasurer; David S. Fox, secretary.

Medical Review Corp.
40 Maple Ave., Morristown, N.J. 07960; 201-267-2233

Year founded: 1982; began providing utilization review services in 1983.
Services provided: 60% 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 psychiatric and substance abuse services, case management, stop-loss audits; 40% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 20 total staff members. 12 professional staff members, including two physicians, eight registered nurses, one licensed practical nurse, one medical records technician. 30 professionals on a retainer basis, including 28 physicians, two nurses.
Clients: 35 employer clients; 20% with fewer than 500 employees, 20% 500-999, 30% 1,000-2,499, 10% 2,500-4,999, 20% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee, $1.10-$1.75; per case, $50; per case (second surgical opinion), $175.
Principal officers: B. Marc Allen, chairman/chief executive officer; Peter Stalker III, vp; Burt Eichler, secretary.

MedTrac Inc.
2550 University Ave., Suite 240, St. Paul, Minn. 55114; 612-646-2848

Year founded: 1969; began providing utilization review services in 1969.
Parent company: Corroon & Black Corp./Foundation for Health Care Evaluation.
Services provided: 20% 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, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit, criteria development, utilization review consultation systems; 80% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 17 total staff members. 14 professional staff members, including 11 registered nurses. 700 professionals available on a retainer basis who are physicians.
Clients: 260 employer clients; 70% with fewer than 500 employees, 15% 500-999, 10% 1,000-2,499, 5% 2,500-4,999.
1986 gross revenues: Not reported.
Charges: Per employee, per case, per hour.
Principal officers: Ronald G. Cameron, president; L. Erik Norbom, vp/director-marketing; Patricia L. Hanson, vp/director-internal operations.

MedView
15565 Northland Drive, Southfield, Mich. 48075; 313-552-8800

Year founded: 1983; began providing utilization review services in 1983.
Services provided: 85% 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; occasional hospital bill audit, outpatient service predetermination, case management; informational telephone service, workers compensation medical utilization

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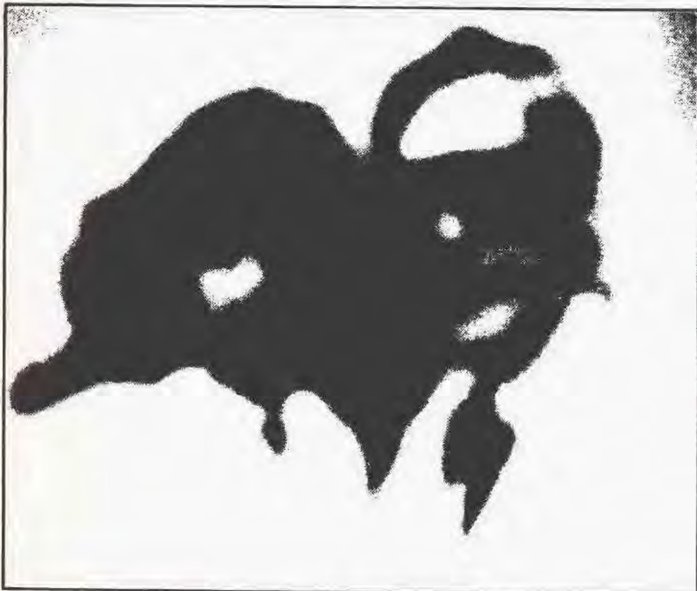

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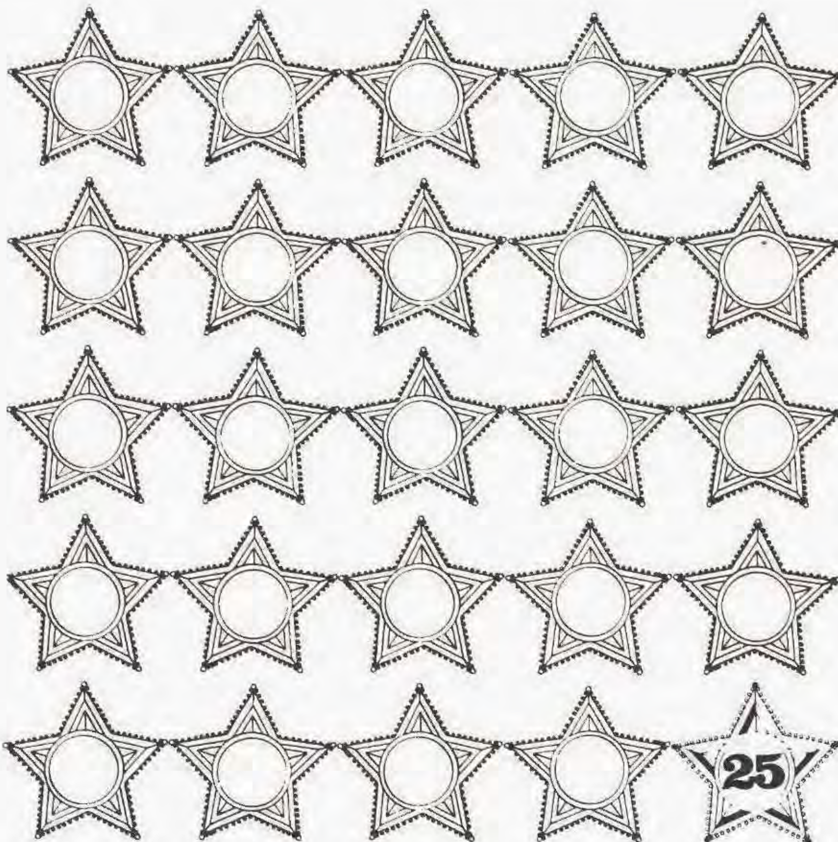

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Continued from facing page
review; 15% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 60 total staff members. 25 professional staff members, including four physicians, 20 registered nurses, one medical records technician. Nine professionals on a retainer basis, including four physicians, five nurses.
Clients: 55 employer clients; 50% with fewer than 500 employees, 13% 500-999, 20% 1,000-2,499, 7% 2,500-4,999, 10% more than 5,000.
Branch offices: Chicago, Los Angeles.
1986 gross revenues: $2.4 million from utilization review services for employers.
Charges: Per employee, 90 cents-$2; per case, $60-$85; percent of savings.
Principal officers: Robert J. Mackay, president/chief executive officer; David Segel, senior vp/chief marketing officer.

Member Service Administrators Inc.
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: 60% 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 psychiatric and substance abuse services, case management; occasional outpatient service predetermination; benefit analysis and consultation; 40% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: 40 total staff members. 40 professional staff members, including one physician, eight registered nurses, one licensed practical nurse, one medical records technician. Six professionals on a retainer basis who are physicians.
Clients: 55 employer clients; 30% with fewer than 500 employees, 30% 500-999, 30% 1,000-2,499, 5% 2,500-4,999, 5% more than 5,000.
Branch offices: Oklahoma City.
1986 gross revenues: $2.5 million total.
Charges: Per employee, 75 cents-$3; per case, $10-$70; flat annual fee, $2,500 and up; percent of savings.
Principal officers: Richard D. McCutchen, executive vp; Rocky L. Rockett, vp-operations.

N

National Health Network
500 Sugar Mill Road, Suite 210B, Atlanta, Ga. 30338; 404-998-0328

Year founded: 1984; began providing utilization review services in 1984.
Services provided: 37% 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, second surgical opinion, hospital bill audit, case management; occasional retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services; 63% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 39 total staff members. 30 professional staff members, including two physicians, 24 registered nurses, two licensed practical nurses, two medical records technicians. 57 professionals on a retainer basis, including 38 physicians, 19 nurses.
Clients: Total clients not reported; 38% with 1,000-2,499 employees, 47% 2,500-4,999, 15% more than 5,000.
Branch offices: Orlando, Fla.; Birmingham, Ala.; Charleston, S.C.; Charlotte, N.C.
1986 gross revenues: Not reported.
Charges: Per employee, 85 cents-$3.60; per case, $17-$60; flat annual fee; percent of savings.
Principal officers: Robert Truscheit, president/founder; Shane Alexander, vp/chief executive officer.

P

PCC
828 N. Hollywood Way, Burbank, Calif. 91505; 818-843-8551

Year founded: 1968; began providing utilization review services in 1968.
Parent company: Drug Data Systems Inc.
Services provided: 45% of gross revenues from providing utilization review services to employers, including frequent retrospective review, hospital bill audit; occasional concurrent hospital treatment, length of stay determination, outpatient service predetermination, outpatient psychiatric and substance abuse services, drug early warning programs; 55% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: Not reported.
Clients: Not reported.
1986 gross revenues: Not reported.
Charges: Per case, $75 minimum.
Principal officers: Alvin Saidiner, president.

Pacific Review Services
5995 Plaza Drive, Cypress, Calif. 90630-0848; 714-220-3700

Year founded: 1983; began providing utilization review services in 1984.
Parent company: Pacificare Health Systems.
Services provided: 40% 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, second surgical opinion, outpatient service predetermination, case management; occasional retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services, concurrent home health care review, providing nursing facilities and rehabilitation centers; 60% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 76 total staff members. 30 professional staff members, including two physicians, 12 registered nurses, four medical records technicians. Professionals on a retainer basis include 45 physicians, one nurse; 3,000 physicians available for second surgical opinion.
Clients: 1,000 employer clients; 40% with fewer than 500 employees, 20% 500-999, 20% 1,000-2,499, 10% 2,500-4,999, 10% more than 5,000.
1986 gross revenues: $1.2 million from utilization review services.
Charges: Per employee, $1.25-$2; per case, $50-$275; rate reduction with percent of cost savings.
Principal officers: Terry Hartshorn, president/chief executive officer; Samuel J. Tibbitts, chairman; John Seifker, vp/chief financial officer; Alan Hoops, vp-marketing.

Peer Review Analysis Inc.
222 Third St., Cambridge, Mass. 02142; 617-354-8550

Year founded: 1984; began providing utilization review services in 1984.
Services provided: 1% 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, utilization review and quality assurance consulting; occasional hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 99% of gross revenues from other services.
Services reviewed: Group health

Continued on next page

We could write a book about the misconceptions people have about mental illness and its treatment.

Do the horrors of the past still exist in psychiatric hospitals? Or—maybe just as bad from a cost standpoint—have they become expensive "country clubs" instead?

A whole lot of misconceptions still persist about the quality of care that patients receive in today's specialty psychiatric hospitals, and especially about the costs of that care. To the individual and his family. To his employer. And to the insurer.

For instance, did you know that all member hospitals of the National Association of Private Psychiatric Hospitals are accredited by the Joint Commission on Accredidation of Hospitals? Or that most of these hospitals provide outpatient,day treatment and partial hospitalization, as well as full inpatient care?

In addition to many levels of care, these specialty hospitals offer programs tailored for children, adolescents, and adults, as well as providing chemical dependence and eating disorder programs.

Some say the cost of that special care is high. But the cost of pretending the problem doesn't exist is much greater. An illness which has been estimated as a $55 billion a year problem for industry is one you can't afford to ignore.

Right now the NAPPH has available a limited number of copies of a study which effectively analyzes the direct and indirect costs of mental health insurance coverage. If there's a chance that this data might help you to better evaluate mental illness benefits for your employees—then you owe it to your company to send for your confidential copy of this study.

There's still a whole lot of ignorance about mental illness. But you don't have to be victim of it.

We Wrote This One Instead.

It clears up a lot of misinformation about actual costs for treatment, reimbursement trends,and cost containment.

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The National Association of Private Psychiatric Hospitals
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BI 2/16

The National Association of Private Psychiatric Hospitals

Continued from previous page
services, psychiatric and substance abuse services, dental services.

Staff: 13 total staff members. Professional staff members include six physicians, five registered nurses, two medical records technicians. Professionals on a retainer basis include 20 physicians, 64 nurses.

Clients: 10 employer clients; 90% with fewer than 500 employees, 5% 1,000-2,499, 5% 2,500-4,999.

1986 gross revenues: $996,000 total, $10,000 from utilization review services for employers.

Charges: Per employee, $1.25-$2.25; per case, $50-$500; percent of savings.

Principal officers: Russell Robbins, president; Charles Smith, treasurer; Barry Manuel, chairman.

Peer Review Systems Inc.

3720-J Olentangy River Road, Columbus, Ohio 43214; 614-451-3600

Year founded: 1974; began providing utilization review services in 1974.

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.

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

Staff: 125 total staff members. Professional staff members include one physician, 75 registered nurses, eight medical records technicians. Professionals on a retainer basis include 20 physicians.

Clients: Total clients not reported; 20% with fewer than 500 employees, 25% 500-999, 20% 1,000-2,499, 20% 2,500-4,999, 15% more than 5,000.

1986 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Dudley Briggs, chairman; Robert Snow, president; Robert P. Stone, chief executive officer.

Physical Therapy Review Services

P.O. Box 64, Woodlyn, Pa. 19094; 215-874-1248

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

Services provided: 100% of gross revenues from providing utilization review 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: Nine total staff members. Eight professionals on a retainer basis who are licensed physical therapists.

Clients: Eight employer clients; 30% with fewer than 500 employees, 30% 500-999, 30% 1,000-2,499, 10% 2,500-4,999.

Charges: Flat fee per review.

Principal officers: David W. Clifton Jr., director/owner; Leslie Buksar Clifton, business manager.

Preferred Choice Health Plan Inc.

343 W. Houston, Suite 314, San Antonio, Texas 78205; 512-228-2621

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

Parent company: Santa Rosa Medical Center.

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, outpatient service predetermination, outpatient psychiatric and substance abuse services; occasional hospital bill audit, case management.

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

Staff: Five total staff members who are professionals, two registered nurses. Professionals on a retainer basis include 15 physicians.

Clients: Five employer clients; 3% with fewer than 500 employees, 10.5% 500-999, 86.5% 1,000-2,499.

1986 gross revenues: $9,059 total, all from utilization review services for employers.

Charges: Per employee, 95 cents-$1.60.

Principal officers: Hugh L. Wolff, chairman; Lori L. Hitzeman, president; Roger Pemberton, vice chairman.

PReview-Health Benefits Management of Ohio Inc.

3737 W. Sylvania Ave., P.O. Box 887, 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: 76% of gross revenues from providing utilization review services to employers, including frequent precertification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; 24% of gross revenues from other services.

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

Staff: 33 total staff members. 19 professional staff members, including three physicians.

Clients: 62 employer clients; 50% with fewer than 500 employees, 23% 500-999, 12% 1,000-2,499, 6% 2,500-4,999, 3% more than 5,000.

1986 gross revenues: $1.4 million total, $1 million from utilization review services for employers.

Charges: Annual fee per employee, $14-$22.

Principal officers: John Anderson, president/treasurer; John Newton, vice chairman; Jerome Rogers, secretary.

Pro Health Review

8060 Knue Road, Suite 228, Indianapolis, Ind. 46250; 317-841-5501

Year founded: 1985; 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, case management; occasional hospital bill audit.

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

Staff: Professional staff members include two registered nurses. Professionals on a retainer basis include one physician.

Clients: Seven employer clients; 86% with fewer than 500 employees, 14% 2,500-4,999.

1986 gross revenues: $50,000 from utilization review services for employers.

Charges: Per employee, 75 cents-$1.75.

Principal officers: Julie Phegley, executive director.

Republic-RSB Cos. Inc.

1280 Iroquois Drive, Naperville, Ill. 60566; 312-420-6800

Year founded: 1964; began providing utilization review services in 1985.

Services provided: 15% 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, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 85% of gross revenues from other services.

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

Staff: 300 total staff members, including four physicians, 125 registered nurses, one licensed practical nurse, four medical records technicians. Professionals on a retainer basis include 52 physicians, 10 nurses.

Clients: 48 employer clients; 70% with fewer than 500 employees, 5% 500-999, 5% 1,000-2,499, 10% 2,500-4,999, 10% more than 5,000.

Branch offices: Parsippany, N.J.; Atlanta; Garden Grove, Calif.; Houston.

1986 gross revenues: Not reported.

Charges: Per employee, 90 cents-$1.70.

Principal officers: Richard E. Mandel, president; Steven E. Nelson, vp-marketing/administration; Roger L. Reedy, vp-sales; William N. Werner, medical director.

RMSCO Management Services

223 W. Jackson Blvd., Chicago, Ill. 60606; 312-322-4800

Year founded: 1980; began providing utilization review services in 1983.

Parent company: Associated Agencies Inc.

Services provided: 30% 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, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, medical telephone assistance, self-audit review; occasional retrospective review; 70% of gross revenues from other services.

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

Staff: 140 total staff members. 13 professional staff members, including two licensed practical nurses, 11 medical records technicians. Two professionals on a retainer basis who are physicians.

Clients: 30 employer clients; 80% with fewer than 500 employees, 10% 500-999, 10% 1,000-2,499.

1986 gross revenues: $200,000 total, $60,000 from utilization review services for employers.

Charges: Per employee, 75 cents-$2.

Principal officers: Robert M. Schrayer, president; Irving Shainberg and Karen Vacko, executive vps; Patricia Vile, vp-RMSCO Management Services-benefits; Jim Brooks, vp-RMSCO Management Services-casualty.

Rush Contract Care

910 W. Van Buren, 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: 15% of gross revenues from providing utilization review services to employers, including frequent preadmission 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; 85% of gross revenues from other services.

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

Staff: 17 total staff members.

Clients: 460 employer clients; 98% with fewer than 500 employees, 1% 2,500-4,999, 1% more than 5,000.

1986 gross revenues: Not reported.

Charges: Per employee per month, $1.25.

Principal officers: Jerome Hahn, medical director; Gordon M. Mallett, director.

SaveCare

20520 Nordhoff St., Chatsworth, Calif. 91311; 818-407-2293

Year founded: 1984; began providing utilization review services in 1984.

Parent company: Healthwest.

Services provided: 75% 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, case management; occasional mail-order prescription drug programs, claims management; 25% 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. 40 professionals on a retainer basis who are physicians.

Clients: 63 employer clients; 80% with fewer than 500 employees, 12% 500-999, 4% 1,000-2,499, 4% 2,500-4,999.

1986 gross revenues: $210,000

Continued on facing page

Choices

Today's ever-changing healthcare marketplace is filled with choices. You know today's employees don't want yesterday's benefits. But how do you find time to investigate and create the most appropriate benefits plan for your company?

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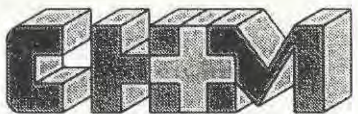

Corporate Healthcare Management 87

Showcasing today's employee benefits

Continued from facing page
from utilization review services for employers.
Charges: Per employee, $1.15-$1.50; per case, $45-$55.
Principal officers: Jerry Torgerson, executive director; Peter Mack, director-marketing/sales.

Select Faculty Care
200 Park Ave. S., New York, N.Y. 10003; 212-473-2166

Year founded: 1981; began providing utilization review services in 1981.
Services provided: 100% 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, case management.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Seven total staff members. Professional staff members include three physicians.
Clients: 17 employer clients; 5% with fewer than 500 employees, 95% more than 500.
1986 gross revenues: Not reported.
Charges: Per employee.
Principal officers: Donald Rubin, president; Roxanne Young, vp.

SelectCare Management Co. Inc.
19750 S. Vermont Ave., Suite 205, Torrance, Calif. 90502; 213-515-0770

Year founded: 1983; began providing utilization review services in 1984.
Services provided: 20% 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, case management; occasional hospital bill audit, 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: 30 professional staff members, including four registered nurses, one medical records technician. 10 professionals on a retainer basis who are physicians.
Clients: 1,200 employer clients; 90% with fewer than 500 employees, 6% 500-999, 4% 1,000-2,499.
1986 gross revenues: $1.5 million total, $300,000 from utilization review services for employers.
Charges: Per employee, 85 cents-$3.
Principal officers: John L. Miller, president.

t

TPA of America Inc. (American Benefit Plan Administrators Inc./ HealthCare Strategies Inc.)
2999 W. 6th St., Los Angeles, Calif. 90020; 213-738-1590

Year founded: 1984; began providing utilization review services in 1984.
Services provided: 5% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional precertification, outpatient psychiatric and substance abuse services; maternity education programs and case management for high-risk pregnancies and premature infants; chiropractic and podiatric case review; 95% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: 27 total staff members. 23 professional staff members, including two physicians, 18 registered nurses, three medical records technicians. Two professionals on a retainer basis who are physicians.
Clients: 25 employer clients; 8% with fewer than 500 employees, 2% 500-999, 15% 1,000-2,499, 17% 2,500-4,999, 58% more than 5,000.
Branch offices: Columbia, Md.; more than 30 affiliated companies in the U.S.
1986 gross revenues: $21.2 million total, $1.3 million from utilization review services for employers.
Charges: Per employee, $1.25-$2.25; per hour for case management, $125.
Principal officers: H.L. Auston, president; Robert J. Cardinal, senior vp-administration services; C.J. Monson, executive vp-American Benefit Plan Administrators Inc.; Janice Albert, president-HealthCare Strategies Inc.; Sam Sanbar, senior vp-division I-American Benefit Plan Administrators 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 1974.
Parent company: Crownx/Kaplan.
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.
Services reviewed: Group health services, psychiatric and substance abuse services, dental services.
Staff: 950 total staff members. 91 professional staff members, including three physicians, 86 registered nurses, two medical records technicians. 61 professionals on a retainer basis who are physicians.
Clients: 62 employer clients; 27% with 1,000-2,499 employees, 13% 2,500-4,999, 60% more than 5,000.
Branch offices: Calabasas and North Hollywood, Calif.; Pittsburgh.
1986 gross revenues: Not reported.
Charges: Per employee.
Principal officers: Samuel X. Kaplan, chairman; Millard H. Stiles Jr., president/chief executive officer; Ronald A. Bruce, executive vp/chief operating officer; Matthew W. Kaplan, executive vp-sales/marketing; James J. Larocca, executive vp/chief financial officer.

U.S. Corporate Health Management
2825 Santa Monica Blvd., Suite 210, Santa Monica, Calif. 90404; 213-453-2022

Year founded: 1979; began providing utilization review services in 1984.
Services provided: 80% 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, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 20% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 45 total staff members. 30 professional staff members, including two physicians, 16 registered nurses, one medical records technician. 145 professionals on a retainer basis, including 65 physicians, 80 nurses.
Clients: 85 employer clients; 15% with fewer than 500 employees, 5% 500-999; 20% 1,000-2,499; 25% 2,500-4,999, 35% more than 5,000.
1986 gross revenues: Not reported.
Charges: Per employee, per case.
Principal officers: Jonathan Fielding, president; Anne Marie Hammond, vp-marketing; Craig Horton, vp-operations.

Universal Managed Care
70 N. Main St., Wilkes-Barre, Pa. 18711; 717-829-6001

Year founded: 1985; began providing utilization review services in 1985.
Parent company: Blue Cross of Northeastern Pennsylvania/Ernst Health Management.
Services provided: 40% of gross revenues from providing utilization review services to employers, including frequent preadmission hospital review, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, case management; occasional retrospective review, hospital bill audit; 60% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 15 total staff members. 10 professional staff members who are registered nurses. 26 professionals on a retainer basis, including one physician, 25 nurses.
Clients: 25 employer clients; 50% with fewer than 500 employees, 20% 500-999, 10% 1,000-2,499, 10% 2,500-4,999, 10% more than 5,000.
Branch offices: Pittsburgh.
1986 gross revenues: $500,000 total, $200,000 from utilization review services for employers.
Charges: Per employee, 70 cents-$2; per hour, $55 with discount for volume.
Principal officers: Gilbert Tough, chief executive officer/chairman; Kathleen Ernst, president/chief operating officer.

v

Valutrac
1815 S.W. Marlow, Suite 110, Portland, Ore. 97225; 503-297-1338

Year founded: 1981; began providing utilization review services in 1986.
Parent company: Metrocare Inc./Lincoln National Life Insurance Co.
Services provided: 20% of gross revenues from providing utilization
Continued on next page

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Continued from previous page
review 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; outpatient supervision, patient education, weekend admission review; 80% of gross revenues from other services.

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

Staff: More than 45 total staff members. Professional staff members include 15 registered nurses. Professionals on a retainer include more than 110 physicians.

Clients: More than 150 employer clients; 60% with fewer than 500 employees, 20% 500-999, 15% 1,000-2,499, 4% 2,500-4,999, 1% more than 5,000.

Branch offices: Seattle; Grand Rapids, Mich.; Minneapolis; Philadelphia; Charlotte, N.C.; Atlantic City, N.J.; Jackson, Miss.

1986 gross revenues: Not reported.

Charges: Per employee; 85 cents-$1.50.

Principal officers: Steve Gregg, president-Metrocare Inc.; Joan E. Copeland, vp-operations; Dale White, vp-development. ■

datebook

FEB. 23-24. Financing and Structuring Association Captives and Buying Programs seminar in New York, sponsored by the Tillinghast Division of Towers, Perrin, Forster & Crosby; $50 for Basics of Captives seminar (Feb. 23); $400 for Financing and Structuring seminar (Feb. 24). Conference Director, Tillinghast/TPF&C, 72 Post Road, Darien, Conn. 06820; 203-655-9791.

FEB. 23-24. Auditing with the New CGL Program seminar in Des Moines, Iowa, sponsored by Premium Audit Advisory Service; $175 for subscribers; $200 for non-subscribers. **Also March 2-3** in Baltimore; **March 5-6** in New Brunswick, N.J.; **March 23-24** in Denver; **March 26-27** in Kansas City, Mo.; **April 2-3** in Cleveland; **May 4-5** in St. Paul, Minn.; **May 6-7** in Minneapolis; **May 11-12** in Atlanta; **July 28-29** in Worcester, Mass.; **Aug. 20-21** in Dallas; and **Sept. 29-30** in Edison, N.J. Premium Audit Advisory Service, 85 John St., New York, N.Y. 10038; 212-669-0511.

FEB. 23-27. Hazardous Materials: Handling and Disposal course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $700. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

FEB. 23-27. Modern Safety Management course in Calgary, Alberta, sponsored by the International Loss Control Institute; $695. **Also March 2-6** in Dallas, **March 16-20** in Atlanta, **March 23-27** in Pittsburgh, **April 6-10** in Boston and **April 27-May 1** in Atlanta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

FEB. 23-27. Loss Control Management course in Atlanta, sponsored by the International Loss Control Institute; $695. **Also March 23-27** in Calgary, Alberta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

FEB. 24. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance workshop in Philadelphia, sponsored by the Society of Chartered Property & Casualty Underwriters; $125 for CPCU members; $150 for non-members. Mari Jennings, Professional Services Coordinator, Society of CPCU, Kahler Hall, Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

FEB. 24. ISO Commercial General Liability Rating workshop in Blue Bell, Pa., sponsored by the Insurance Society of Philadelphia and Delaware Tech; $65 for members; $75 for non-members. **Also March 26** in Georgetown, Del.; **April 2** in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

FEB. 25. Tax Reform Seminar in East Windsor, N.J., sponsored by the Professional Insurance Agents of New Jersey; $50 for PIA members; $75 for non-members. Professional Insurance Agents of New Jersey, Education Department, 130 W. State St., Trenton, N.J. 08608; 800-424-4244.

FEB. 25-27. 1987 International Benefits Information Service Institute: An Introduction to International Employee Benefits in Brussels, Belgium; £410 or $615. Bruce F. Spencer, Charles D. Spencer Associates Inc., 222 W. Adams St., Chicago, Ill. 60606-5258; 312-236-2615. Or, Vincent J. Simone, Orchard House, 7 Little Austins Road, Farnham, Surrey, United Kingdom 0252-726416.

FEB. 26. Pollution Update—Insurance Liability and Regulations workshop in Rosemont, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters and the Chicago Chapter of CPCU; $125 for CPCU members; $150 for non-members. Julie Ann Juliana, Professional Services Coordinator, Society of CPCU, Kahler Hall, 720 Providence Road, Malvern, Pa. 19355; 215-251-2735.

FEB. 26. ISO Commercial Property Rating workshop in Georgetown, Del., sponsored by the Insurance Society of Philadelphia and Delaware Tech; $105 for members; $120 for non-members. **Also April 9** in Blue Bell, Pa.; **April 21** in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

FEB. 26-27. Maritime Conference in Newark, N.J., sponsored by the National Assn. of Marine Surveyors Inc.; $175. Frank Christiansen, Frank Christiansen Associates Inc., 1715 Highway 35, Suite 209, Middletown, N.J. 07748; 201-615-0500.

FEB. 27-MARCH 1. National Conference of Insurance Legislators seminar in Tampa, Fla.; $100 for legislators, commissioners and staff; $225 for industry advisory committee members; $350 for other industries and guests; $25 spouses. National Conference of Insurance Legislators, P.O. Box 217, Brookfield, Wis. 53005; 414-782-6669.

MARCH 2-4. 1987 Loss Control Management Development Conference in Orlando, Fla., sponsored by the Alliance of American Insurers; before Jan. 1: $170, $150 each for three or more attendees from same organization; after Jan. 1 add $20 to each category. Loss Control Department, Alliance of American Insurers, 1501 Woodfield Road, Schaumburg, Ill. 60173-4980; 312-490-8500.

MARCH 3. Questions on the New Insurance Services Office's CGL Policies? Ask the Claims Department! workshop in Austin, Texas, sponsored by the Central Texas Chapter of the Society of Chartered Property & Casualty Underwriters; $110 for CPCU members; $140 for non-members. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

MARCH 4-5. Behavioral Science as an Approach to Accident Prevention course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

MARCH 4-6. Eighth Annual Petroleum Insurance Conference in New Orleans, co-sponsored by Self-Insurance Resource Inc. and Professional Development Institute; $495; $50 for spouse activity fee. Professional Development Institute, North Texas State University, P.O. Box 13288, NT Station, Denton, Texas 76203-3288; 800-433-5676; 817-565-2483 in Texas.

MARCH 4-6. California Self-Insurers Assn.'s 57th Annual Meeting in Monterey, Calif.; $255 for members; $315 for non-members; $110 for spouses. California Self-Insurers Assn., 921 11th St., Suite 619, Sacramento, Calif. 95814; 916-442-4576.

MARCH. 4-6. Shippers National Freight Claims Council's 13th Annual Claim Conference and Claims Prevention Exhibition: Liability Changes and New Challenges in New Orleans; $295 for SNFCC; $345; less 33% for additional registrants from same organization. Shippers National Freight Claims Council Inc., 120 Main St., Box Z, Huntington, N.Y. 11743; 516-549-8984.

MARCH 5. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance workshop in San Francisco, cosponsored by the Northern California and Golden Gate chapters of the Society of Chartered Property & Casualty Underwriters; $125 for CPCU members; $150 for non-members. Julie Ann Juliana, Professional Services Coordinator, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

MARCH 5-6. Public Agency Risk Pooling seminar in Clearwater Beach, Fla., sponsored by the Public Risk & Insurance Management Assn.; $150 for PRIMA members; $250 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

MARCH 5-6. The Settlement of Liability Claims: A Workshop in Dispute Resolution for Professionals seminar in Chicago, co-sponsored by the IIT Chicago-Kent College of Law and Resolve Dispute Management Inc.; $175 prior to Feb. 16; $195 after Feb. 16. Jacqueline Jones, IIT Chicago-Kent College of Law, 77 S. Wacker Drive, Chicago, Ill. 60606; 312-567-5190.

MARCH 5-6. Ansul Fire School in Beaumont, Texas, sponsored by Ansul Fire Protection; $450. **Also March 9-10, March 12-13, March 16-17.** Ansul Fire Protection, 1 Stanton St., Marionette, Wis. 54143-2542; 715-735-7411.

MARCH 5-6. Fourth Annual Group Risk Administrators Assn. Educational Conference in Tampa, Fla.; $150 for GRA members; $175 for non-members. Florida Group Risk Administrators Assn., P.O. Box 846, Tallahassee, Fla. 32302; 904-222-1888.

MARCH 5-7. 10th Practical Pension Planning Seminar in Kissimmee, Fla., sponsored by Corbel & Co.; $395. Brenda Chatham, Corbel & Co., P.O. Box 17548, Jacksonville, Fla. 32245-7548; 904-731-4455.

MARCH 6-7. The Creation and Implementation of Good Faith in the Property Insurance Policy: From Drafting the Forms Through Handling Claims conference in Hilton Head, S.C., sponsored by the American Bar Assn.; $350 for ABA members; $325 for ABA Tort & Insurance Practice Section members; $300 for young lawyers; $75 for law students; $375 for non-members. American Bar Assn., Division for Professional Education, Department NI 450, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

MARCH 8-11. International Benefits Conference in Orlando, Fla., sponsored by the International Foundation of Employee Benefit Plans; $605 for IFEBP members; $680 for non-members; $40 discount if received more than 60 days prior to conference. Registrations Department, International Foundation of Employee Benefits Plans, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MARCH. 9-10. Health Care Cost Containment workshop in Hilton Head, S.C., sponsored by the Health Research Institute; $495. **Also March 23-24** in Stamford, Conn.; **April 13-14** in Orlando, Fla.; **May 11-12** in Houston; **June 1-2** in Chicago; **June 22-23** in Philadelphia; **July 27-28** in Honolulu; **Aug. 17-18** in San Diego; **Sept. 14-15** in Cleveland; **Oct. 5-6** in Boston; **Oct. 26-27** in San Francisco; **Nov.9-10** in New York; and **Dec. 7-8** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 9-10. Asbestos: Regulation, Removal and Prohibition seminar in New York, sponsored by the Practising Law Institute; $390; $40 for course handbook only. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

MARCH 9-11. Third Annual International Insurance Assembly in Miami, sponsored by the Insurance Exchange of the Americas, the University of Miami, city of Miami and FIIRA; $305; $125 for accompanying person/spouse. Helen Frey, Conference Coordinator, University of Miami Conference Center, 400 S.E. Second Ave., Fourth Floor, Miami, Fla. 33131; 305-372-0140.

MARCH 9-11. Fire Detection and Suppression symposium at the Maritime Institute of Technology and Graduate Studies, Linthicum Heights, Md., sponsored by the Society of Fire Protection Engineers; $475 for SFPE members; $535 for non-members. Lisa Juliano, Society of Fire Protection Engineers. 60 Batterymarch St., Boston, Mass. 02110; 617-482-0686.

MARCH 10. Tax Law: The Tax Reform Act of 1986 workshop in Philadelphia, sponsored by the Insurance Society of Philadelphia and Delaware Tech; $105 for members; $120 for non-members. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

MARCH 10-12. Reinsurance Cycles, Regulations and Information—Past, Present and Future symposium in Chicago, sponsored by the Society of Chartered Property & Casualty Underwriters; $210 for CPCU members; $260 for non-members. Mari Jennings, Professional Services Coordinator, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

MARCH 10-12. Second Annual Western States Asbestos Abatement Conference in San Francisco, sponsored by Hall-Kimbrell Educational Services; $425. Hall-Kimbrell Educational Services, 4840 W. 15th St., P.O. Box 307, Lawrence, Kan. 66044; 800-445-0682.

MARCH 10-13. The 11th International Captive Insurance and Reinsurance Forum in Hamilton, Bermuda, sponsored by the Tillinghast Division of Towers, Perrin, Forster & Crosby; $750; $675 for additional registrants from same company; $350 for Captives in Brief seminar (March 10). Conference Director, Tillinghast/TPF&C, 722 Post Road, Darien, Conn. 06920; 203-655-9791.

MARCH 11. Risk Management Seminar in Phoenix, Ariz., sponsored by the Arizona Central Chapter of the Risk & Insurance Management Society Inc.; $60 for RIMS members; $70 for non-members. Erick Johnson, Del E. Webb Corp., 3800 N. Central Ave., P.O. Box 29040, Phoenix, Ariz. 85038; 602-264-8434.

MARCH 11. Advanced "Post Graduate" Cost Management workshop in Hilton Head, S.C., sponsored by the Health Research Institute; $250. **Also March 25** in Stamford, Conn.; **April 15** in Orlando, Fla.; **May 13** in Houston; **June 3** in Chicago; **June 24** in Philadelphia; **July 29** in Honolulu; **Aug. 19** in San Diego; **Sept. 16** in Cleveland; **Oct. 7** in Boston; **Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 29-APRIL 3. 25th Annual Risk and Employee Benefits Conference in Las Vegas, Nev., sponsored by the Risk & Insurance Management Society. Before Jan. 30: $545 for RIMS members, $595 for non-members for full week; $425 for RIMS members, $475 for non-members for partial week; $195 for one day. After Jan. 30: $595 for RIMS members, $645 for non-members for full week; $525 for RIMS members, $575 for non-members for partial week. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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MMRMA

Continued from page 1

potential claims, Mr. Waterman contends.

While MMRMA quickly tries to settle claims for which members feel they are clearly liable, the program's lawyers aggressively contest claims and lawsuits that are considered meritless, he added.

The program's largest loss to date—a $706,064 settlement of a wrongful death claim—was paid so quickly that MMRMA did not have time to notify reinsurers that its settlement offer had been accepted, Mr. Waterman said.

The settlement prompted the program's lead reinsurer, Munich Reinsurance Co., to audit MMRMA claim files to see if other potentially large losses existed, he said, adding that Munich Re was satisfied with the audit and later renewed its participation on the program.

Officials at Munich Re could not be reached to confirm their audit.

Camelback Reinsurance Underwriters Inc., underwriting manager for Imperial Casualty & Indemnity Co., audited MMRMA claim files and procedures last year and found no significant problems, a Camelback official said.

Home Reinsurance Co. also is in the process of conducting an audit, a Home Re official confirmed.

"There is always going to be some difference as to what the proper amount" should be for loss reserves, Mr. Buckless observed. "I would say overall that we have had good reserving. It's an area where you have to be constantly vigilant.

"As our loss funds and reserves have built up, we felt we could prudently retain more of the risk," he added, explaining the decision to self-insure portions of MMRMA's reinsurance layers instead of buying more commercial reinsurance.

"We kind of held our breath a little at first," said Mr. Buckless, whose county was one of MMRMA's three original members. "The concept was great, but it still had to prove itself. But we have been very happy with the results."

"I really have not heard any complaints that I can think of. It seems like they have a very good record of customer satisfaction," said Kenneth E. Beres, a consultant with The Wyatt Co. in Detroit, who has recommended the MMRMA program to several municipalities.

In answering the program's critics, Mr. Waterman pointed to the exodus from the Michigan municipal market of several commercial insurers and the insolvency of others, including Transit Casualty Co., Ideal Mutual Insurance Co. and Mission Insurance Co.

"The reason we have been successful is (that) the industry has not done its job," Mr. Waterman said. "If the industry had never had a failure, if they had taken a reasonable attitude, I probably would not be in this business.

"I don't have the best program in the world," he added. "I wish it were better. I wish my reinsurance were better, that the terms and conditions were better. (But) I think I have a better program than what else is available."

Although some consultants have questioned MMRMA's operations, Mr. Waterman traces much of the criticism of the program to independent agents, many of whom lost municipal accounts to MMRMA as the commercial insurance market tightened.

"I think the biggest reason the agents hate me is that I don't use them. We did not use the independent agency system," Mr. Waterman said.

The MMRMA program is marketed through a group of exclusive representatives known as "regional risk managers," Mr. Waterman explained.

Some agents are clearly outspoken in their attacks on program.

"If he is doing what he says he is doing, it's the second coming of Christ. It's a miracle," charged Howard B. Camden, president of Advanced Underwriters Inc., an agency based in the Detroit suburb of Farmington Hills.

However, MMRMA is not the only target of the agents' attacks in what Mr. Beres described as a "range war" in the Michigan municipal insurance market.

In a newsletter last July, the Michigan Municipal League—which sponsors its own property/casualty self-insurance pool as a competitor to MMRMA—complained that independent agents were spreading "unfounded rumors" about the financial condition of the MML pool.

Indeed, some of the agents' charges against MMRMA also are unfounded. Some rival agents, for example, questioned whether MMRMA actually had any of the commercial reinsurance it claimed to have. But several of the program's reinsurers, contacted by *Business Insurance*, confirmed their participations (see story, page 65).

The suspicions of MMRMA's critics have been fueled in part by the tight control the program's directors and managers keep on reinsurance, financial and other information.

MMRMA members are not given copies of reinsurance treaties or cover notes and must visit the offices of Governmental Risk Managers in Livonia, another Detroit suburb, if they wish to review the documents.

MMRMA's directors voted two years ago to bar the program's representatives from releasing any reinsurance information to consultants without the board's permission, according to Mr. Waterman.

The MML pool also does not give members copies of its reinsurance documents, but it will allow consultants to review the documents in the presence of their clients, according to Eugene Berrodin, MML's director of insurance services.

Richard L. Beeckman, a Saginaw-based consultant hired to review MMRMA for Washtenaw County and the city of Ann Arbor, learned how hard it could be to get information. After several requests for evidence of MMRMA's commercial reinsurance coverage, Mr. Beeckman said he was given a typewritten list of the reinsurers on plain paper on condition that he not reveal the names to anyone, including his clients.

Business Insurance encountered similar problems. During an interview at his office last year, Mr. Waterman offered another typewritten list of reinsurers as evidence of the program's current participants. But, after *Business Insurance* started contacting some of the reinsurers to confirm their participation, MMRMA's broker, Stewart Smith, instructed the reinsurers not to discuss the program and to refer questions to Mr. Waterman, reinsurers say.

Mr. Waterman later offered to allow a reporter to review reinsurance documents at Stewart Smith's New York office on the condition that none of the information be used in this story.

Over the last two years, MMRMA representatives have also distributed lists of reinsurers that contained deliberate errors ranging from simple misspellings of reinsurance company names to the inclusion of reinsurers that were not actually participating on the program, according to Mr. Waterman, who said this was done at the MMRMA board's direction.

The list Mr. Waterman showed to *Business Insurance* during the interview—which was later found to include names of reinsurers that were not writing the program—

Continued on page 60

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PROVIDENT MUTUAL
SECURITY THROUGH FINANCIAL SERVICES

MMRMA

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was one of the deliberately incorrect lists, Mr. Waterman confirmed.

The erroneous lists were not meant to deceive, Mr. Waterman said, but to track down the source of leaks about the program's operations. If a list containing a particular error were found circulating among competitors, he explained, MMRMA managers would know which member had released the list.

One member who was leaking the lists along with financial and loss information was recently identified and measures were taken against further leaks, according to Mr. Waterman, who said the member did not leave the program.

Mr. Waterman and MMRMA's directors, long beleaguered by agents' criticism of the MMRMA program, defend the tight lid on information by saying that such details could be used by rivals to damage MMRMA.

"To the outside, it may look like we are being a little protective," Mr. Buckless observed. But "there comes a point when you get tired of having to prove that what you are doing is right."

"We have been shot at from every direction it's feasible to shoot at an organization, and that has been going on since 1981," added Robert Deadman, city manager for the Detroit suburb of Farmington and an MMRMA director.

However, Mr. Beeckman said he was frustrated by his inability to get reinsurance and other information from the MMRMA's representatives.

"Continuous delays and the confusion regarding when or if certain pieces of information could be or would be provided created an atmosphere of uncertainty" about the program, concluded Mr. Beeckman in a report last November in which he advised his clients against joining the MMRMA.

Michigan Assistant Attorney General Harry Iwasko said he is also concerned by the shortage of information about the program in light of the accusations leveled against it by competitors.

MMRMA—like the MML pool—operates under a Michigan statute that exempts it from regulation by the state Insurance Bureau and that requires only the filing of an annual audited financial statement with the state Treasury Department.

"They are not only self-insured, they are self-regulating as well, and that is very scary to me," Mr. Iwasko said.

He added that he doesn't know enough about the program to assess its stability and has no way of getting the information unless it is voluntarily provided by MMRMA. He said he has never asked for such information.

"If it is being soundly run. . .and is soundly reserved, it's a gold mine," Mr. Iwasko said. "If it isn't, it's a ditch."

MMRMA members "would literally have nowhere to go" if MMRMA ran out of money to pay claims, said Mr. Beeckman, noting that MMRMA—like the competing Municipal League pool—is not covered by the state property/casualty guaranty fund, which covers claims against insolvent licensed insurers.

"They would literally be self-insured. . .and they would have to go to their constituents to raise the money," Mr. Beeckman said, explaining that municipal officials might have to raise property owners' taxes to fund such uninsured losses.

If MMRMA ran out of funds, public entities could attempt to receive assistance from the state's general fund, said Dale Larson, senior vp with Corroon & Black of Michigan Inc. If they were unable to do that, he added, MMRMA members would have to post judgment bonds funded by tax revenues to cover liability awards.

Caught between the program's boosters and its critics are city, county and township officials who have seen commercial insurance coverage dry up and are uncertain what the future will bring.

"We are a city like many others that feels like we really do not have any choice," said Karen Harlick, finance director for the city of Ferndale, another Detroit suburb and an MMRMA member.

"The insurance market in Michigan was such that we just could not afford the premiums being charged," Ms. Harlick said. "We were a city that was not in a position to decide where we would get our insurance."

Ms. Harlick said that she had "great reservations" about joining MMRMA in 1985 because of questions raised about the stability of the program by a competing agent. Nevertheless, Ferndale became an MMRMA member when the agent told city officials to prepare for a possible 400% premium increase and the elimination of police professional liability coverage, she said.

So far, she added, the city's experience with the MMRMA has been good.

But "how well they have us protected in the event of a catastrophe, I don't know," she said.

The MMRMA program

MMRMA operates under Michigan's Public Act 138, legislation originally supported by the Municipal League that provides for the formation of municipal self-insurance pools.

Governmental Risk Managers provides underwriting and risk management services, while accounting services are provided by the Southfield-based firm of Quenneville & McSweeney; claims adjusting services by Municipal Claims Service of Livonia; and legal services by the Livonia firm of Cummings, McClorey, Davis & Acho.

Reserves for MMRMA claims are initially set by Municipal Claims Service, but these reserves may be changed by attorneys at Cummings, McClorey after review of the files, according to Bernard P. McClorey, a partner with the firm.

The coverage document issued to MMRMA members, known as a "joint exercise of powers agreement," provides:

- General liability coverage, including law enforcement liability, public officials errors and omissions, medical malpractice coverage for paramedics and emergency medical service personnel and motor vehicle liability coverage.
- Property coverage for real and personal property, including extra-expense, money and securities, fidelity and surety coverages. Property reinsurance is placed to whatever limits are required excess of a member's retention of 10% of the first $100,000 of loss after a $1,000 deductible.
- Vehicle physical damage coverage with limits of $500,000 per vehicle excess of a $10,000 retention and $1 million per disaster excess of a $30,000 retention.

Unlike members of the Municipal League pool—which share risks within the pool's $500,000 retention—MMRMA members do not actually share risks.

A portion of each MMRMA member's loss contribution is reserved—and separately accounted for—to cover losses within the member's retention. No member is responsible for the losses suffered by any other member within the other member's retention.

If losses within a member's retention exhaust its "net contribution account"—which is a member's loss contribution less expenses and ceded reinsurance

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JUDGMEN

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premiums—the member must cover any shortfall in the account.

Twenty MMRMA members had negative fund balances as of last June 30, while other members had fund balances ranging from $1,529 to $430,565.

MMRMA also offers each member stop-loss reinsurance coverage to limit the losses paid within the retention in any one year.

For example, if a member's per-occurrence retention on the liability program were $50,000, MMRMA might provide stop-loss coverage attaching after the member pays $75,000 in losses in a single year.

This stop-loss coverage is also self-funded by MMRMA members, who pay an additional 5% of their total member contributions into a stop-loss fund, Mr. Waterman said.

As required by Public Act 138, MMRMA also maintains a commercially reinsured aggregate stop-loss contract with a $5 million limit of liability, attaching after exhaustion of the total funds available in MMRMA to pay claims in any one year, Mr. Waterman said. The total funds available to MMRMA to pay claims—including members' fund balances and all loss and expense reserves—amounted to $13.5 million at Dec. 31, 1986, according to Mr. Waterman.

The aggregate reinsurance is retrospectively rated so that reinsurers collect $1 in premium for every 70 cents of loss paid, he said.

(Several larger MMRMA members have retentions higher than the standard $50,000 for liability risks. In addition, several smaller entities—including townships, community mental health facilities, housing authorities and transit authorities—are part of a sub-program known as the Statewide Pool, whose members do share risks within their retention. The Statewide Pool is treated as a single member of the larger MMRMA.)

For the liability program, MMRMA then purchases reinsurance excess of members' retentions up to $10 million per occurrence. The commercial reinsurance is paid for from members' loss contributions not allocated to funding losses within each member's retention.

All MMRMA members buy the full $10 million in liability limits and nearly all purchase all of the coverages offered by MMRMA.

Member loss contributions also are used to fund the self-funded portions of MMRMA's four reinsurance layers, with MMRMA receiving payment as if it were a commercial reinsurer participating on the quota-share treaties, according to Mr. Waterman.

Several sister programs are also covered by the same reinsurance treaties—including MMRMA's self-insured participation—excess of $50,000, Mr. Waterman

Continued on next page

3 sister programs cover public entities

By DOUGLAS McLEOD

LIVONIA, Mich.—Operating alongside the Michigan Municipal Risk Management Authority are three sister programs that provide property and liability coverages to various groups of public entities.

Each of the three programs is covered by the same liability reinsurance treaties covering MMRMA excess of $50,000 per occurrence. MMRMA itself acts as a reinsurer of the three programs for the portions of the reinsurance program that MMRMA self-funds, and members of each program pay MMRMA a portion of their loss contributions as if MMRMA were a commercial reinsurer.

The three programs also use some of the same service providers as MMRMA.

As with the larger MMRMA program, loss contributions to and claims against the three sister programs are separately accounted for by member, and members do not share risk.

The three programs also use some of the same service providers as MMRMA, including Cummings, McClorey, Davis & Acho for legal services and Municipal Claims Service for claims handling services.

Each of the three programs has its own board of directors and each program prepares its own financial statements separately from MMRMA.

The three programs are:

- The Michigan Township Participating Plan, with 804 current township members and member contributions of $4.4 million for the 15 months ended June 30, 1986. MTPP, started in April 1985, offers liability coverage limits of up to $10 million per occurrence, though less than 5% of its members buy the full limit and most opt instead for a $1.5 million limit, according to David P. Kensler, program administrator for MTPP.

The first $50,000 per occurrence of MTPP members' liability coverage is reinsured by Governmental Casualty Insurance Co., a licensed Ohio insurer formed last year by Wade Waterman, president of MMRMA's management company, and others connected to the MMRMA program, according to Mr. Kensler.

MTPP members typically carry deductibles of $1,000 on police professional liability, $5,000 on employee benefit liability and $250 on errors and omissions coverages, Mr. Kensler said.

- The Michigan Community College Risk Management Authority, with 16 community college members and about $504,000 in member contributions for the year ended June 30, 1986, according to Mr. Waterman.

Member contributions will probably total $2 million this year, he added.

Members of the college program, which was established in July 1985, all purchase liability coverage limits of $10 million per occurrence, Mr. Waterman said.

Members carry retentions of $10,000 per occurrence and $30,000 annual aggregate for liability risks, according to Mr. Waterman.

Universal Re-Insurance Co. Ltd. of Bermuda writes reinsurance of $40,000 excess of $10,000 per occurrence and $500,000 excess of $30,000 annual aggregate, he said. This coverage is 100% retroceded to Cove Marine Insurance Co. Ltd., another Bermuda reinsurer owned by Mr. Waterman and others, according to Mr. Waterman.

- The Michigan Road Commission Risk Management Authority, with 10 county road commission members that produced $449,767 in loss contributions for the year ended June 30.

Members of the road commission program purchase liability limits of $5 million including a $50,000 retention, Mr. Waterman said, adding that he doesn't expect much growth in the road commission program this year. ■

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MMRMA

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said. These are the Michigan Township Participating Plan, with 804 township members; the Michigan Community College Risk Management Authority, with 16 college members; and the Michigan Road Commission Risk Management Authority, with 10 road commission members (see story, page 61).

Of the 250 MMRMA members, 25% are cities, producing 53% of the program's earned loss contributions; 24% are counties, producing 35% of contributions; 20% are townships, producing 8% of contributions; and 31% are other entities, producing 4% of contributions, according to an MMRMA newsletter.

In all, the MMRMA family of programs has about 1,080 members.

Agents report that other insurers write municipal coverages in Michigan—including International Surplus Lines Insurance Co. through Arthur J. Gallagher & Co. and Great American Surplus Lines Insurance Co.—but that MMRMA and the MML pool have the majority of municipal business in the state.

MMRMA and its sister programs have reported explosive growth in the last two years, as commercial markets for municipal liability coverage have tightened.

Loss contributions to MMRMA totaled $15.3 million—including $203,933 in reinsurance premiums paid by MMRMA's sister programs—for the fiscal year ended June 30, 1986, nearly quadruple the $3.9 million reported in 1985. Loss contributions totaled $2.9 million in 1984, $2.2 million in 1983, $1.5 million in 1982 and $541,911 in 1981, according to the program's audited financial statements.

The MMRMA financial statements do not include the results for any of the sister programs.

MMRMA anticipates more than $25 million in loss contributions in the 1987 fiscal year, and the sister programs are projecting an additional $7.5 million in contributions, the MMRMA newsletter says.

By comparison, the MML liability and property pool, with about 580 members, reported loss contributions of $14.1 million for the year ended last Dec. 31, up from $4.9 million in 1985, according to Mr. Berrodin.

The MML pool provides total liability coverage limits of $3 million, with the $2.5 million excess of $500,000 portion reinsured. The only self-funding in the MML reinsurance program is a $500,000 per-occurrence participation in the $1 million excess of $2 million layer by NLC Mutual Insurance Co., a Tennessee-based captive that reinsures municipal property/casualty insurance programs in several states, says Mr. Berrodin.

As MMRMA has grown, however, the questioning and criticism of the program by competitors and some consultants has intensified.

Increased self-funding

In his report to Washtenaw County and Ann Arbor, Mr. Beeckman cited increasing levels of self-insurance by the MMRMA as a principal reason for recommending against the program.

Mr. Waterman confirmed that since its July 1, 1986, liability reinsurance renewal, the MMRMA has self-insured:

- 14.4% of the first reinsurance layer of $450,000 excess of $50,000.
- 25% of the second layer of $500,000 excess of $500,000.
- 50% of the third layer of $4 million excess of $1 million.
- 50% of the fourth layer of $5 million excess of $5 million.

On a $10 million loss, MMRMA currently would be responsible for paying about $4.7 million excess of a member's retention.

During the previous fiscal year, MMRMA had self-funded 22% of the first layer, 15% of the third layer and 25% of the top layer, according to its audited financial statement. The year before that, all of the program's liability reinsurance was placed with U.S. and foreign reinsurers and none was self-funded, according to cover notes obtained by *Business Insurance* and subsequently confirmed by Mr. Waterman.

MMRMA also currently self-insures 50% of the first property reinsurance layer, Mr. Waterman confirmed.

Mr. Beeckman noted in the report that the self-funded portions of the MMRMA liability reinsurance program were on an occurrence basis with no aggregate and that MMRMA's policy form is "the broadest available to my knowledge."

"Without detailed loss statistics. . .it is difficult to precisely anticipate the impact of these much greater levels of assumption," the report says.

Questioning MMRMA's long-term prospects, Mr. Beeckman said in an interview that, "It cannot be financially sound. . . .You cannot convince me that you could provide $10 million in occurrence coverage including police and professional liability at a 45% assumption (level) and make money when nobody else has."

Mr. Beeckman added that he thought the MMRMA concept was basically a good one, but that the program would be more fiscally sound if—among other things—liability limits were reduced and coverages were limited.

"I would like to see the program work because we just don't have an alternative here," he said. "I just wish (Mr. Waterman) would tighten it up a little."

Wyatt's Mr. Beres also said he is "concerned about the increase in share the board members have voted to take on within the authority."

"We are sort of reserving much in the way of further comment until we can muster something in the way of further information," said Mr. Beres, who in November recommended the MMRMA program to the city of Owosso.

One of MMRMA's own reinsurers also expressed doubts about the degree of self-funding.

A series of large claims, though unlikely, is still a possibility that should be funded for, and MMRMA is now self-insuring "more limits than they have a reasonable chance of funding" if such large claims develop, according to E. Lee Duncan, vp with Associated/International Insurance Co. in Los Angeles, which reinsures 2% of the top layer of the current MMRMA program.

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While member retentions and the top reinsurance layer are attractively funded for the exposure, the first three reinsurance layers are relatively thinly funded, Mr. Duncan said.

Although MMRMA might consider self-assuming 20% to 25% of each reinsurance layer, he added, "anything more than that to me is high stakes and taking a lot of risk."

The first reinsurance layer is rated on a swing plan, in which loss contributions held for member retentions can be adjusted depending on the loss experience of the first-layer reinsurers.

Reinsurers in the first layer are entitled to a minimum of 8% of earned loss contributions and a maximum of 22%, depending on their loss experience, Mr. Waterman confirmed.

Member retentions are then funded with a minimum of 27.75% of total loss contributions to a maximum of 41.75%, depending on experience of the first-layer reinsurers.

Favorable loss experience thus results in MMRMA retaining a larger share of premiums that would otherwise be ceded to reinsurers.

Reinsurers on the second layer then receive 6.25% of loss contributions, those on the third layer 14% and those on the top layer 8%, Mr. Waterman confirmed.

Mr. Duncan noted state insurance laws generally forbid regulated insurers from writing policies with net retained limits of more than 10% of their policyholder surplus. MMRMA, retaining roughly half of the $10 million limit it writes for its members, would thus have to maintain surplus of at least $50 million if it were a regulated insurance company, he said.

Using the same principle, in the fiscal year ending June 30, 1986—when it self-funded about 19.5% of its $10 million limit—MMRMA would have needed $19.5 million in surplus if it were a regulated insurer.

However, the MMRMA's "surplus"—the balance of funds in member contribution accounts after claim payments, reserves, expenses and ceded reinsurance premiums—was $3.8 million as of June 30, 1986, according to financial statements. The balance of MMRMA's reinsurance fund, intended to cover the self-insured portions of the reinsurance layers, was $455,796 as of June 30, 1986, excluding a $600,000 reserve for incurred-but-not-reported losses, according to the financial statement.

Mr. Waterman says that surplus is not a "tangible item" for MMRMA, since members cover any shortfalls in their contribution accounts for losses within their retentions. MMRMA's "surplus" is therefore the ability of members to pay losses, he emphasized.

Maintaining adequate surplus is more important for the self-insured portions of the reinsurance layers, he said, noting that there is no provision for assessing members if the reinsurance fund falls short. If the fund were exhausted, the MMRMA board might either have to raise members' loss contributions or prorate members' claims, he said.

Mr. Waterman added, however, that premiums collected to fund such self-insured losses are far in excess of what MMRMA will actually need.

The fund balance in member contribution accounts was $4.4 million as of Dec. 31, 1986, while the balance in the reinsurance fund was $1.7 million, Mr. Waterman said. The reinsurance fund is expected to total $3.4 million after additions to IBNR reserves at June 30, 1987, he added.

Mr. Waterman also said that MMRMA expects "99%" of its claims to be under $1 million.

MMRMA has been hit with only three claims in excess of member retentions in its history, according to Mr. Waterman. One was the $706,064 wrongful death claim; two other claims ranged between $100,000 and $250,000, he said.

The decision to self-insure was made because of the program's "excellent loss experience" and the increasingly short periods of time over which MMRMA's reinsurance premiums "paid back" the limits in each layer, according to Mr. Waterman.

At the reinsurance rates in effect for fiscal 1986, he said, premiums ceded for the first layer would equal the layer's $450,000 limit within 0.3 years; premiums ceded for the second $500,000 layer would equal that limit in 0.8 years; premiums ceded for the third $4 million layer would equal that limit in 3.5 years; and premium ceded for the fourth $5 million layer would equal that limit in 5.2 years.

Projected payback periods for the 1987 fiscal year are even shorter, he added.

Mr. Waterman noted the rates demanded by MMRMA's commercial reinsurers were excessive given the program's experience.

"I felt strongly, and still do, that we should have received a substantial rate reduction. They said, 'Well, we are willing not to give you a rate increase,'" he explained.

"We thought that the risk involved did not warrant the premium being asked," added Mr. Deadman, an MMRMA director. "The more of the risk we can assume and properly fund, the more we will be independent of the insurance industry."

MMRMA directors also denied agents' accusations that the program was forced to self-insure because it was unable to find adequate commercial reinsurance.

"It wasn't a matter of not being able to get reinsurance. In fact, we have reinsurers that want a little more of the action. But we had layers that were so doggone profitable that we didn't want to give them away," said Ronald Showalter, clerk and treasurer of the city of Garden City and an MMRMA director.

Mr. Waterman added that MMRMA's directors may consider a proposal to eliminate the program's remaining commercial reinsurance at the next renewal and self-fund the entire program with the support of a bond issue.

MMRMA's ability to successfully self-fund portions of the reinsurance program depends, in part, on a reliable estimation of case and IBNR loss reserves.

Reserving practices

For the 1986 fiscal year—when it collected $15.1 million in member loss contributions—MMRMA reported $1.8 million in claims and legal expenses paid net of subrogation receipts and recoveries from the reinsurance and stop-loss programs, according to an unaudited financial statement used by Mr. Beeckman in his report to Washtenaw County and Ann Arbor.

MMRMA also increased loss reserves by $1.7 million, or 11.1% of total earned member contributions of $15.1 million; increased reserves for the stop-loss program by $640,729, or 4.3% of total contributions; increased reserves for legal expenses by $462,719, or 3.1% of total contributions; and paid $570,843 in claims service fees, according to the unaudited statement.

(A 1986 financial statement audited by Arthur Andersen & Co. shows slightly smaller reserve increases: $1.4 million for losses and $447,719 for legal expenses. The audited statement also shows no

Continued on next page

J&H INFOLINE

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New Pollution Liability Facility To Be Offered.

Major corporations, frustrated by the virtual disappearance of pollution liability insurance, are applauding the upcoming formation of the NACC Risk Retention Group. The facility will provide coverage for both gradual and sudden-and-accidental environmental impairment, and for cleanup, as well. The facility will cover only investor-insureds.

Johnson & Higgins is applying to the state of Vermont for permission to form NACC under the Risk Retention Act of 1986. The act clears the way for risk retention groups to operate in any state after being chartered by the domicile state.

Limits of coverage will vary according to the capital contribution of individual investors and the total capitalization of the facility. The minimum capital contribution per investor is $1 million and the expected maximum is $10 million per investor.

In order to qualify for membership, a participant must have its proposed site(s) pass an environmental inspection. The site(s) also will be subject to subsequent inspection. NACC coverage is site-specific.

If a corporation has a high-risk profile—such as a waste disposal company has—it would not ordinarily be eligible for participation, although NACC contemplates including a broad range of businesses.

International Technology Corporation will coordinate site inspections and, in most instances, conduct them as well. Clement Associates of Washington, D.C. will act as facility underwriter. Chase Investment Bank and Brown Brothers Harriman & Co. will be investment managers. A three-firm legal defense group will be coordinated by the firm of LaRoe, Winn & Moerman. Johnson & Higgins will be the NACC manager.

A preliminary information memorandum was sent to interested corporations in mid-December and initial investor closing is expected in mid-February. The NACC facility is now open to all corporations that qualify, and to their brokers.

All interested participants should read the preliminary information memorandum before investing. For more information, call your J&H office.

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Continued from previous page
increase in reserves for the stop-loss program.)

Adding up these losses, loss adjustment expenses and reserves and comparing them to total member loss contributions of $15.1 million, Mr. Beeckman estimated MMRMA's loss ratio at 34%.

Mr. Beeckman noted in his report the difficulty of making such calculations, since MMRMA reports its results using generally accepted accounting principles rather than the statutory accounting principles an insurance company would use.

For example, total member contributions of $15.1 million include more than $4.7 million in contributions ceded to the program's reinsurers; an insurance company reporting earned premiums—on which loss ratios are based—would exclude such ceded premiums.

If reinsurance premiums were excluded from MMRMA's total loss contributions, the effect would be to increase the program's loss ratio.

In an interview, however, Mr. Waterman confirmed that a 34% loss ratio is "probably right," adding that MMRMA's own accident year loss ratio calculations for the years 1980 through 1986 showed an overall loss ratio of less than 34%.

Mr. Beeckman, however, says in the report that "it seems very unlikely that the loss and loss expense ratio can legitimately be expected to remain at this percentage. . .A 35% loss ratio on municipal exposures (of all sizes) would contrast sharply to the massive losses experienced by the insurance industry."

The report notes that the industry's loss ratios for general liability business written in Michigan were 74.5% for 1980, 81.9% for 1981, 102.7% for 1982, 82.3% for 1983 and 109.2% for 1984, according to figures compiled by A.M. Best Co. Including underwriting expenses, the industry combined ratios for these years were "far in excess of 100%," the Beeckman report says.

MMRMA reported underwriting, risk management and other expenses of $3.3 million for fiscal 1986, or 21.6% of total member contributions.

Comparing these expenses to total member contributions, Mr. Beeckman calculated the program's expense ratio at 22%, making for a combined ratio of 57.7% after dividends paid to four members totaling 1.7% of loss contributions.

"It would appear that the combined ratio is quite a bit lower than one would expect. If reserves are underrated, it could have an adverse effect upon the future," Mr. Beeckman's report says. "This is especially true if the apparent underreserving were to continue after the major reinsurance assumptions of MMRMA of new losses."

"It doesn't make any sense. He's drawing from the same communities we are," said the MML's Mr. Berrodin, noting that the MML's loss ratio for 1986 was about 50%.

"There is no reason to believe he is being more selective than we are. In fact, it's the reverse," Mr. Berrodin said.

At least one MMRMA member has complained about underreserving for claims.

Clifford Maison, deputy controller for the city of St. Clair Shores, a Detroit suburb, said that inadequate reserves were established for three claims against the city.

A 1985 wrongful death claim against St. Clair Shores that may ultimately be settled for $500,000 or more was reserved at $5,000, Mr. Maison said. The two other claims—which are not as serious and will probably be settled within the city's retention—are reserved at $5,000 and $2,000, he said.

Still other claims against the city

Continued on next page

MMRMA's reinsurance detailed

LIVONIA, Mich.—The Michigan Municipal Risk Management Authority would prefer the details of its reinsurance support were kept confidential.

However, based on interviews with the reinsurers, with Wade Waterman, president of MMRMA's management company, and with other sources, the following details of the liability reinsurance program emerged:

- The first layer—$450,000 excess of $50,000—is reinsured on a "split slip," with some reinsurers covering excess of $50,000 and others excess of $100,000, according to Mr. Waterman. Gaps created by the split slip are self-insured by MMRMA, he said.

First-layer reinsurers include Munich Reinsurance Co., with a 50% share excess of $50,000; Dorinco Reinsurance Co., a Midland, Mich.-based unit of Dow Chemical Co., with 10% excess of $100,000; and the MMRMA itself, which is self-insuring 14.4% excess of $50,000.

- Reinsurers on the second layer of $500,000 excess of $500,000 include Munich Re with 50%; MMRMA, self-insuring 25%; Universal Re-Insurance Co. Ltd., a Bermuda-based rent-a-captive facility, with 15%; and Dorinco, with 10%.
- Reinsurers on the third layer of $4 million excess of $1 million include MMRMA, self-insuring 50%; Universal Re, with 25%; Home Reinsurance Co., with 12.5%; and Aneco Reinsurance Underwriting Ltd. in Bermuda, with 6%.
- Reinsurers on the top layer of $5 million excess of $5 million include MMRMA, self-insuring 50%; Universal Re, with 35%; Home Re, with 10%; and Associated/International Insurance Co.—an affiliate of the MMRMA's broker, Stewart Smith Intermediaries Inc.—with 2%.

Other reinsurers that confirmed that they are on the program but declined to discuss details of their participations are Employers Mutual Casualty Co. of Des Moines, Iowa, through Russell Reinsurance Services of Southfield, Mich.; and Imperial Casualty & Indemnity Co. of Omaha, Neb., through Camelback Reinsurance Underwriters Inc. of Phoenix, Ariz.

Although Bermuda-based Universal Re operates rent-a-captive programs, Mr. Waterman said the reinsurer's participation does not represent further self-funding of the MMRMA's reinsurance program.

All business ceded to Universal Re is retroceded to other Universal Re clients, according to Mr. Waterman, who added that MMRMA does not in turn assume any risks from the other clients.

He added that Cove Marine Insurance Co. Ltd., a Bermuda-based insurer owned by Mr. Waterman and others, is not a retrocessionaire of Universal on this business.

Hal Forkush, president of Atlantic Security Ltd., Universal Re's management company, confirmed that the MMRMA business is ceded to other Universal Re clients.

Mr. Forkush added—and Mr. Waterman confirmed—that if a loss reserve is posted exceeding premium funds available for payments, Cove Marine could be required to post a letter of credit as security. ■

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MMRMA

Continued from previous page

carry no reserves at all, he added.

Mr. McClorey, a partner with Cummings, McClorey, MMRMA's law firm, said that St. Clair Shores is actually carrying a five-figure reserve for its retention on the death claim.

Mr. McClorey added that the reserve has been at the five-figure level since before last June 30, and that a June 30, 1986, loss run showing the reserve at $5,000 is mistaken.

"Hopefully that's true, and it's taken care of," replied Mr. Maison, adding, though, he had discussed the case with Cummings, McClorey attorneys "four or five times" since June 30 and was never told of the increase in the reserve.

Loss ratio calculations in the Beeckman report did not include the MMRMA's reserves for IBNR losses, and the question of IBNR reserve adequacy is not addressed in his report.

However, MMRMA's competitors also question the program's IBNR reserving practices.

For fiscal 1986, MMRMA increased its IBNR reserves for losses within members' retentions by $594,727 or 3.9% of total member contributions.

Incurred-but-not-reported reserve increases amounted to 3.0% of member contributions in 1985, and to 1.6% of member contributions in 1984 and 1983, according to MMRMA's audited financial statements.

As of last June 30, MMRMA's total IBNR reserves amounted to $850,830, or 3.3% of the $26.1 million in total member contributions collected since 1981, according to the financial statements.

(These percentages again are based on total member loss contributions. If ceded reinsurance premiums were deducted from the total, the IBNR reserve increases would represent a larger percentage of the net member loss contributions.)

"You couldn't get (IBNR) reserves on a shoe store that would be 4%, much less a volatile book of business like municipalities," said Michael Ormstead of Burnham & Flower Group in Kalamazoo, which lost roughly half of its township accounts to the Michigan Township Participating Plan, an MMRMA sister program. Burnham & Flower is now marketing the MML program.

The MML program set aside IBNR reserves of $1.2 million—or 25%—of its member contributions of $4.9 million in 1985, according to the pool's financial statement. For 1986, MML again set aside about 25% of total member contributions for IBNR claims, Mr. Berrodin said.

Since MMRMA started self-insuring portions of its reinsurance program in fiscal 1986, the program's audited financial statement has shown a $600,000 IBNR reserve for self-funded reinsurance claims as of last June 30.

This IBNR reserve amounted to more than half of the $1.1 million paid into the reinsurance fund for fiscal 1986, according to MMRMA's financial statement.

Mr. Waterman said that MMRMA's favorable loss experience is the result of several factors, including members' use of incident reporting procedures that alert MMRMA to potential claims; inspections and risk management training that are superior to those provided by commercial insurers; a willingness to fight nuisance claims; and recently enacted tort reforms in Michigan that limit municipal exposures.

Tort reforms signed into law in July 1986 included a provision making officers, employees and volunteers of governmental agencies immune from liability for their official acts, except where gross negligence can be shown.

The Michigan tort reform law also included a provision modifying joint and several liability so that the portion of a judgment a defendant municipality must pay is limited to its percentage of fault (*BI*, Aug. 18, 1986).

In addition, he said, MMRMA did not follow commercial insurers into the price wars that started in the early 1980s and produced the disastrous industry loss ratios against which MMRMA's are now being compared.

MMRMA set its prices in 1979 and has only increased them since that time, Mr. Waterman said, noting that the prices seem low now only because of the enormous increases being demanded by commercial insurers.

MMRMA's experience so far also indicates that IBNR reserve calculations need not necessarily assume extremely long-tail losses, he added.

"What we have found in government risks is that there is no tail, (or) very little tail," he said. "Four years will tell us most of what's out there. Our figures show that IBNR quits after four years."

Mr. Waterman conceded, however, that "it's possible that something could happen. I might not know for 15 years."

While maintaining that MMRMA's reserve levels are adequate, Mr. Waterman also noted that the adequacy of reserves is less crucial for losses within members' retentions, since members must fund any shortfall themselves.

"Whether we reserve it or not, they are still responsible," he pointed out.

The situation is different for the self-funded portions of the reinsurance program—where members cannot be assessed for any shortfall in the fund balance—and that is the reason for the higher level of IBNR reserving, Mr. Waterman added.

"We are operating more like a reinsurance company there," he said.

Continued on next page

Michigan Municipal Risk Management Authority
Statements of revenues, expenses and changes in fund balances for the years ended June 30, 1986 and 1985

	General fund	Reinsurance fund	Stop-loss fund	Total all funds 1986	Total all funds 1985
Earned loss contributions	$15,057,974	$203,933	—	$15,261,907	$3,936,694
Risk management, underwriting and other expenses:					
Risk management, underwriting, accounting and legal fees	$3,142,229	—	—	$3,142,229	$930,769
Board meeting and other expenses net	114,470	—	—	114,470	69,616
Total risk management, underwriting and other expenses	$3,256,699	—	—	$3,256,699	$1,000,385
Net contributions available for claims and related expenses	$11,801,275	$203,933	—	$12,005,208	$2,936,309
Claims and related expenses:					
Reported claims-					
Claims and legal expenses paid, net of subrogation receipts and portion covered by reinsurance	$1,810,176	$114,248	$540,985	$2,465,409	$602,448
Increase in reserves for losses	1,388,902	—	—	1,388,902	333,804
Increase in reserves for legal expenses	447,719	—	—	447,719	142,443
Increase in reserves for incurred-but-not-reported losses	594,727	600,000	—	1,194,727	120,000
Reinsurance charges	4,562,309	—	—	4,562,309	1,295,388
Claims service fees	570,843	—	—	570,843	148,442
Total claims and related expenses	$9,374,676	$714,248	$540,985	$10,629,909	$2,642,525
Excess (deficiency) of revenues over expenses	$2,426,599	($510,315)	($540,985)	$1,375,299	$293,784
Other income:					
Interest income	$853,384	$53,865	$57,865	$965,114	$369,314
Other	48,812	—	—	48,812	—
Total other income	$902,196	$53,865	$57,865	$1,013,926	$369,314
Excess (deficiency) of revenues over expenses before transfers	$3,328,795	($456,450)	($483,120)	$2,389,225	$663,098
Transfers in (out):					
Reinsurance contributions	(912,246)	912,246	—	—	—
Stop-loss contributions	(928,911)	—	928,911	—	—
Excess of revenues over expenses after transfers	$1,487,638	$455,796	$445,791	$2,389,225	$663,098
Fund balances, beginning of year	1,902,051	—	—	1,902,051	1,238,953
Dividends	(253,560)	—	—	(253,560)	—
Fund balances, end of year	$3,136,129	$455,796	$445,791	$4,037,716	$1,902,051

Source: MMRMA

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Reinsurance restrictions

Another concern raised in Mr. Beeckman's report involves the breadth of coverage actually provided by the MMRMA's commercial reinsurers.

In his report, Mr. Beeckman said that he was never shown copies of reinsurance cover notes or other evidence that reinsurance was in place as described by MMRMA representatives.

At a Sept. 2, 1986, meeting at Mr. Waterman's office, Mr. Beeckman and Ron Milligan, risk manager for Washtenaw County, were shown copies of expired reinsurance treaties originally negotiated for the program, according to the report. Mr. Beeckman had expected to be shown current treaties or cover notes, but was told that Mr. Waterman had inadvertently taken these on a business trip to Ohio.

Mr. Milligan confirmed the report's account of the meeting.

In a follow-up phone call, Mr. Waterman said that he could not provide information on the current reinsurance program without authorization from the MMRMA board, and that the board was not convinced that it was in MMRMA's best interests to provide the information, the report says.

In an interview, Mr. Waterman said that further details of the reinsurance program were not given to Mr. Beeckman because the MMRMA board had ordered him not to give any information to consultants. He also said that the "expired" treaties are continuous until canceled and are still in force.

Finally, Mr. Beeckman was given a typewritten list of the reinsurers and their percentage participations on plain white paper, but only on condition that he not reveal the information to anyone, including Washtenaw County and Ann Arbor officials, the report says.

Mr. Beeckman also received a copy of an Oct. 2, 1986, letter to Mr. Waterman from Leonard T. Corsentino, senior vp with Stewart Smith in New York.

The letter stated in part, "This is to confirm that we have placed on a reinsurance basis all of the business ceded by the captioned authority in respect to the period commencing July 1, 1986. The certificate issued by the captioned authority is $10 million."

From another source, which he would not disclose, Mr. Beeckman also received a copy of a 1985 Stewart Smith cover note for the third casualty reinsurance layer that contained a clause "excluding public officials liability and all E&O."

Mr. Beeckman wrote to Mr. Corsentino last October for an explanation of this exclusion.

"The letter provoked an outcry," according to the Beeckman report. MMRMA representatives wanted to know where he had obtained the cover note and threatened to pull their quotes for Washtenaw County and Ann Arbor, the report says.

MMRMA representatives and Mr. Corsentino never confirmed or denied the contents of the cover note, according to the report.

Mr. Waterman said that the quote for Washtenaw County issued in August expired and was not withdrawn.

Several MMRMA directors, contacted by *Business Insurance* last year before the Beeckman report was issued, said they were unaware of any exclusion of E&O coverage from the reinsurance program.

In a recent interview, however, Mr. Waterman acknowledged that one of MMRMA's reinsurers, Home Re, excludes E&O risks. Home Re is the only MMRMA reinsurer to exclude E&O risks, according to Mr. Waterman, who added that the E&O exclusion does not exclude coverage of police professional liability risks.

Mr. Waterman acknowledged that one of MMRMA's reinsurers, Home Re, excludes E&O risks.

Home Re currently has a 12.5% participation on the third casualty reinsurance layer, and a 10% participation on the fourth layer.

Some MMRMA directors now say they are not worried by the exclusion.

"That's only excess of $1 million, so that does not bother me," said Stanley Fayne, an MMRMA director and risk manager for Macomb County.

Still other reinsurance documents, however, show an additional exclusion about which

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update

RIMS PREVIEW
Issue Date: March 23
Ad Closing: March 10

The editors of *Business Insurance* are preparing a pre-conference report on the upcoming RIMS Conference in Las Vegas, Nevada. We'll provide last minute updates on the Conference agenda, exhibits and events, including info on the host city.

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MMRMA

Continued from previous page

MMRMA directors say they are unaware and which Mr. Waterman contends is not in force.

Business Insurance has obtained copies of reinsurance cover notes presented by Stewart Smith during the most recent renewal for all four casualty reinsurance layers.

Each of these cover notes contains a sunset clause "excluding claims reported later than thirty-six months after expiry on occurrence section of account."

Mr. Duncan of Associated/International confirmed that the sunset provision was a part of the fourth-layer conditions he agreed to and that its inclusion played a major role in his decision to participate on the program.

"It was a critical factor for me, I'll tell you that," he said.

Mr. Duncan also said that he believes the sunset provision in the cover notes initially submitted on the first three layers was not removed.

Mr. Waterman and Bernard McClorey denied any conflict of interest, Mr. Waterman noting that Cove Marine was never used as a direct reinsurer on the programs.

"The terms and conditions are basically Munich Re's, the lead reinsurer's," he said.

Business Insurance could not confirm with other reinsurers the inclusion of the sunset clause in other layers.

MMRMA directors—including Mr. Buckless and Mr. Deadman, members of the board's insurance committee, which oversees reinsurance placements—said in recent interviews that they knew nothing about a sunset provision in the program.

Mr. Waterman said that Munich Re had requested a sunset clause at the last renewal and that its inclusion is still a subject of negotiation.

"We will certainly resist it," Mr. Waterman said. "If it means that I lose the Munich over this, I will lose the Munich over this."

Mr. Waterman insisted, however, that no sunset provision has been added to MMRMA's commercial reinsurance coverage.

"I do not have a sunset clause," he said. "I have not agreed to any modification of the treaties."

A sunset clause may have been included in the Stewart Smith cover notes because "that's what (the reinsurers) wanted," Mr. Waterman said, explaining that the reinsurers may have signed onto the program hoping to hammer out an agreement on a sunset clause at a later date.

He added, though, that he has never signed or approved any such change in the the liability treaties' terms and that the reinsurers have never sent him any proposed endorsements to the treaties for his signature.

"If they wish to send them to me, we will take it under advisement," Mr. Waterman said.

Mr. Duncan noted that the Stewart Smith cover notes include a provision that wording of coverage conditions is "to be agreed by underwriters."

Conceivably, he said, Munich Re could back off of its demand for the sunset clause, which would mean that Associated/International and other reinsurers above Munich Re would also be without the clause.

He added, however, that MMRMA reinsurance proposal was presented to him with a sunset clause and that "I was led to believe that they had just not agreed to the final wording."

The Stewart Smith cover notes for all four liability reinsurance layers also show several other limitations, including:

- A 48-month commutation clause, which would give reinsurers the option of seeking commutation of MMRMA losses after four years.

The clause is marked, "to be agreed by underwriters" in all four cover notes.

- Coverage of medical malpractice exposures on a claims-made basis with a 12-month discovery period and no retroactive period if previous coverage was on an occurrence basis or if no coverage existed.
- Coverage of water utilities, sewer facilities and swimming pools on a claims-made basis with a 12-month discovery period.
- The exclusion of coverage for prisons, punitive damages and pollution exposures.

Mr. Waterman also denied that the MMRMA treaties include a commutation clause or any provision for claims-made coverage of any risk. He also noted that MMRMA itself excludes coverage of prisons and pollution risks.

Along with the scarcity of information about reinsurance coverage, MMRMA's critics also complain about discrepancies in MMRMA representatives' descriptions of the the program.

"If you listen to six of their representatives explain how the program is run. . .you get six totally different answers," said Mr. Ormstead of Burnham & Flower.

For example, in an Aug. 20, 1986, letter to Mr. Beeckman, Donald P. Althoff, an MMRMA salesman, said that each of the program's members is responsible for any portion of a claim that becomes uncollectible because of the insolvency of an MMRMA reinsurer, "the same as if one of their previous private sector carriers were to become insolvent."

In an interview, however, Mr. Waterman said that such uncollectable losses would not come out of members' pockets but would be paid by MMRMA as a whole out of stop-loss or other internal funds.

Mr. Waterman conceded that there were some discrepancies in Mr. Althoff's description of the program to Mr. Beeckman, adding "those discrepancies are regrettable. I'm sorry they occurred."

MMRMA competitors also complain that the program's representatives issue premium quotations—frequently but not always lower than the competitors'—without carefully underwriting the risk.

MMRMA has quoted on some governmental units without asking for such basic underwriting data as the number of vehicles operated by the entity, according to Corroon & Black's Mr. Larson.

"They have written on price and price alone, because they can beat our price any time they want to," said Mr. Ormstead. "They don't ask about losses and they write anything."

"Wade (Waterman) is taking everybody around," said Mr. Beeckman.

Mr. Waterman denies any lack of selectivity in his underwriting, saying that the MMRMA declines to even issue quotes on about 25% of the risks it reviews because the exposures are too severe.

He added that the MMRMA is able to issue quotes quickly in many cases because the program's underwriters have been building underwriting files on various municipalities over a period of months or years, and already have much of the underwriting data they need. ■

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Bermuda underwriter acted as MMRMA retrocessionaire

By DOUGLAS McLEOD

LIVONIA, Mich.—At various times since 1984, Bermuda-based Cove Marine Insurance Co. Ltd. has acted as a retrocessionaire of the Michigan Municipal Risk Management Authority and three of its sister programs.

According to a list of shareholders in Bermuda, Cove's shareholders include:

- Wade Waterman, president of Governmental Risk Managers Inc., the MMRMA's management company, and Joseph Waterman, Wade Waterman's brother.
- David Chamberlain, vp with Governmental Risk Managers.
- Paul Quenneville, a partner with Quenneville & McSweeney P.C. of Southfield, Mich., certified public accountants for the MMRMA.
- Owen J. Cummings, Bernard P. McClorey, Gerald C. Davis and Ronald G. Acho, partners with the Livonia law firm of Cummings, McClorey, Davis & Acho P.C., which provides legal services to the MMRMA.
- W.B. Revenaugh Jr. of Utica, Mich., and Robert E. Barnes of Livonia, individual investors who are not connected with MMRMA, according to Mr. Waterman.

Each of these individuals holds 119 Cove Marine shares, according to the share register. Two other individuals hold three shares apiece: Leonard T. Corsentino, senior vp of Stewart Smith Intermediaries Inc. in New York, MMRMA's reinsurance broker; and Daniel L. McClorey, Bernard McClorey's brother.

Four other Bermuda residents hold one share apiece, according to the register.

At various times since July 1, 1984, Cove Marine has served as a retrocessionaire behind Great Global Assurance Co. of Scottsdale, Ariz., on the MMRMA program, the Michigan Road Commission Risk Management Authority, the Michigan Township Participating Plan and the Michigan Community College Risk Management Authority, according to Mr. Waterman.

Great Global was placed in rehabilitation last year (*BI*, Aug. 18, 1986).

As of July 1, 1984, Great Global reinsured the MMRMA and the road commission program on a portion of each of three layers of a property reinsurance program that provided total limits up to $2 million excess of MMRMA members' retentions, according to reinsurance documents. Great Global also had a piece of a $5 million excess aggregate reinsurance agreement covering property risks.

Starting in April 1985, Great Global also reinsured the first $50,000 per occurrence on the MTPP's liability program, according to Mr. Waterman. Also as of July 1, 1985, Great Global reinsured $40,000 excess of $10,000 per occurrence and $500,000 excess of $30,000 annual aggregate for the community college plan's liability program, he said.

Great Global had initially planned to retain 100% of the risk on these programs, according to Mr. Waterman. However, in July 1985, Great Global was under pressure from state regulators to reduce its net premium-to-surplus ratio, and told the MMRMA that it wanted to cede 50% of the business to reduce its retained writings, Mr. Waterman said.

Great Global later decided that it wanted to cede 100% of the risk, he said.

Great Global then ceded the business retroactively to North Star Hospital Mutual Insurance Ltd., a Bermuda-based hospital group captive managed by Polaris International Insurance Managers Ltd., a Great Global affiliate. North Star also did not want to retain the business, so it was ceded again to Cove Marine, Mr. Waterman explained.

The retrocessions to North Star and then to Cove were retroactive to July 1, 1984, on the MMRMA property business, he said.

The retrocessions on MTPP and college plan business were retroactive to July 1, 1985, according to Mr. Waterman, who added that on the MTPP program, a third retrocessionaire, Universal Re-Insurance Co. Ltd., was added retroactively to replace North Star.

"What a tangled web that was,"

Continued on next page

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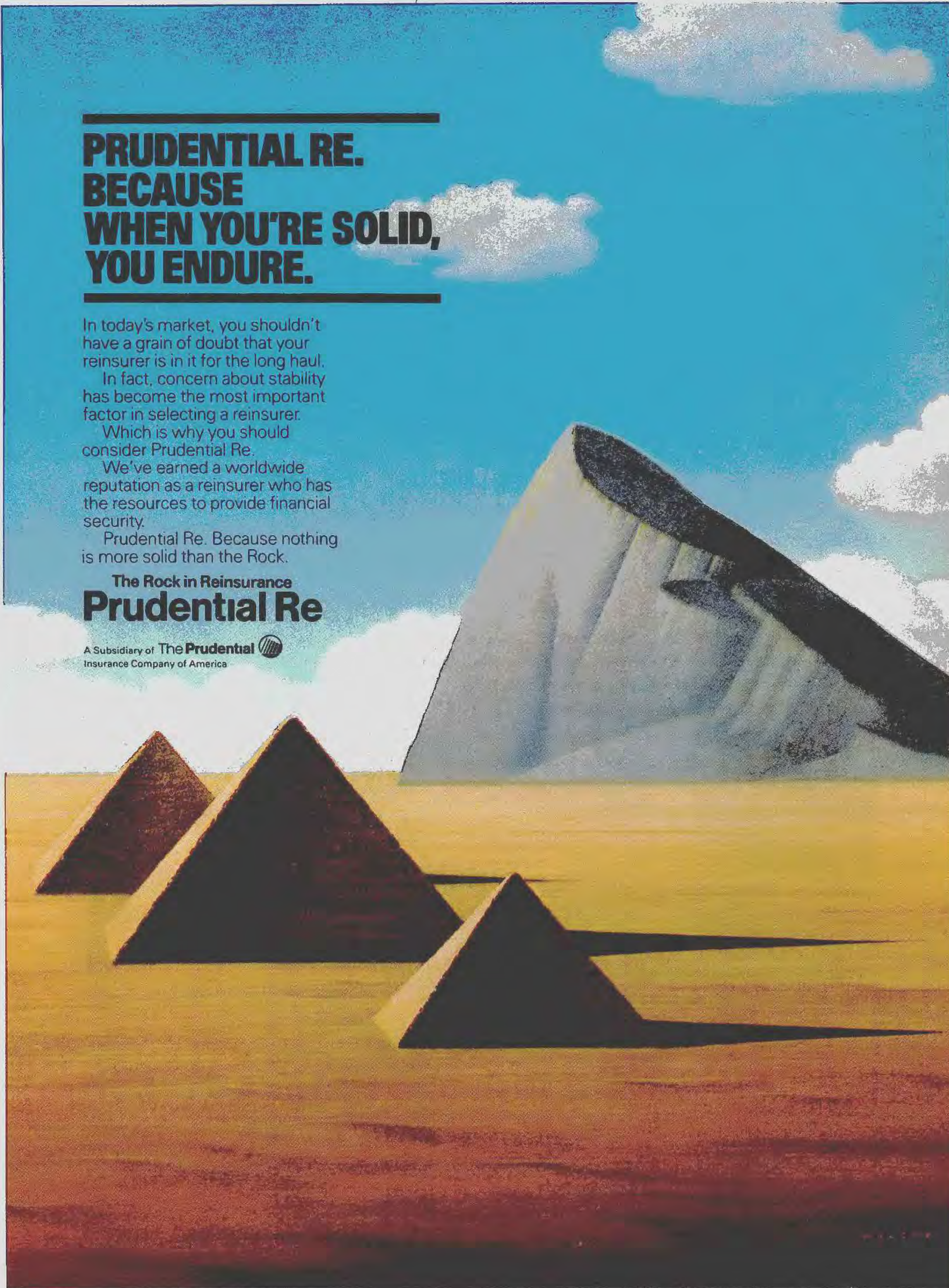

MMRMA retrocessionaire

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Mr. Waterman observed.

With the July 1985 property reinsurance renewal, the MMRMA self-insured some portions of the risks that had been reinsured by Great Global, and found other reinsurers to assume the rest, he said, adding that Cove Marine ceased functioning as a retrocessionaire.

At the July 1, 1986, renewal, MTPP replaced Great Global —and the retrocessions to North Star, Universal Re and Cove Marine—with Governmental Casualty Insurance Co., an Ohio insurer formed last year by Mr. Waterman and others connected with MMRMA to write municipal liability insurance.

The portions of the community college program originally placed with Great Global were reinsured as of July 1, 1986 by Universal Re, which continues to cede 100% of the college risks it writes to Cove, Mr. Waterman said.

In all, about $1.2 million in premiums were ceded to Cove Marine for MMRMA and the related programs, according to Mr. Waterman, who said Cove collects $1 in premiums for each 70 cents in losses paid and refunds excess profits to the members of the programs.

Excess profits refunds on all the programs have totaled between $400,000 and $500,000, he said.

Mr. Waterman added that Cove Marine was never intended to be used as a reinsurer of MMRMA or its sister programs, but instead was set up to write association insurance programs in other states.

Mr. Waterman and Bernard McClorey denied any conflict of interest, Mr. Waterman noting that Cove Marine was never used as a direct reinsurer on the programs.

Cove was used on the MMRMA programs, he said, only as a retroactive stop-gap measure, and was replaced by other reinsurers or by self-insurance as soon as possible.

"When we got backed into it, which was always after the fact, we took steps to eliminate it, not that I don't think the risk is good," he said.

However, several MMRMA directors contacted by *Business Insurance* said they were unaware of the retrocessions to Cove Marine.

The MMRMA board had reviewed the possible use of Cove to replace Fremont Indemnity Co. on portions of the property insurance program in 1983, but decided against it, according to Gerald Buckless, an MMRMA director and county representative for Livingston County.

"I don't think the board really seriously considered that," Mr. Buckless said. "Personally, I don't think it would have looked right if we had used (Cove)."

When informed of the retrocessions, however, Mr. Buckless said, "I really don't think that they have probably done anything wrong."

Mr. Waterman also said that he "doubted" that the directors of the MTPP program knew of the retrocessions to Cove Marine, but that the directors of the community college program were informed of the retrocessions.

However, two directors of the community college program said in interviews they weren't familiar with Cove Marine.

"I don't believe they are one of our reinsurers," said Anthony Jarson, vice chancellor for administrative services for Oakland Community College in Bloomfield Hills, adding that he would have no way of knowing if Cove were a retrocessionaire.

The name Cove Marine "does not sound familiar," said Timothy Bennett, dean of business affairs and treasurer for Monroe County Community College in Monroe. "It doesn't ring a bell."

Mr. Waterman and Bernard McClorey denied any conflict of interest, Mr. Waterman noting that the Bermuda company was never used as a direct reinsurer on the programs.

Mr. Corsentino of Stewart Smith also denied any conflict of interest, explaining that he became a Cove shareholder as a favor to the other owners, who for tax reasons wanted to limit their individual shareholdings to less than 10% of the reinsurer's outstanding stock. ■

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Panel tackles task of PPO credentialing

A new credentialing process for preferred provider organizations could alleviate employers' confusion in selecting a PPO.

"There's a sense among the purchasing community of what an HMO is, but there's a lot of confusion over what a PPO is," said Peter Boland, president of Berkeley, Calif.-based Boland Healthcare Consultants.

Mr. Boland also is the chairman of a new committee of the American Assn. of Preferred Provider Organizations in Alexandria, Va. The committee's task is to develop a voluntary credentialing function for PPOs.

"Realizing there are many variations of PPOs, the charge of the AAPPO is to give the purchaser a better frame of reference as to what you're really getting when you select a PPO," he said. "And, this set of standards will set goals for providers and sponsors of PPO programs."

The task force will develop eligibility criteria for PPO credentialing in categories such as:

- Provider selection.
- Reimbursement systems.
- Benefit design.
- Range and access to preferred providers and services.
- Utilization review protocols.
- Quality assurance guidelines.
- Case management and discharge planning.
- Reporting systems for purchasers, or employers.
- Provider reporting systems.
- Management.
- Financial solvency.
- Employee/patient education systems.

"While a line can be drawn to the early HMOs and the federal HMO law and federal qualification of HMOs, the credentialing is an AAPPO stamp of approval. This is not regulatory," Mr. Boland said.

The task force includes representatives from PPOs, hospitals, insurers, employers and management consultants, Mr. Boland said.

The AAPPO plans to have the credentialing function available to its member PPOs by late spring, he said.

The credentialing function "at least provides uniformity of the definition of PPOs," said Laird Miller, chief executive officer of Minneapolis-based health care consultant Health Systems Management Inc., and a member of the AAPPO committee.

"There are very few employers or purchasers that will be able to evaluate a PPO on their own, so there is a need for standards that we can rely on," Mr. Miller said. ■

St. Paul establishing unit in London

By CAROLYN ALDRED and STACY SHAPIRO

london

LONDON—The St. Paul Cos. Inc. is establishing its first independent non-U.S. underwriting operation in London.

Last week, the St. Paul, Minn.-based insurance holding company assumed total underwriting control of The St. Paul Fire & Marine Insurance Co. (U.K.) Ltd.

St. Paul (U.K.) will write predominantly non-marine reinsurance, of which 60% will be derived from U.S. risks, said James P. White, chairman and chief executive of the London company and senior vp of the corporate reinsurance division of St. Paul Fire & Marine Insurance Co.

The London operation is headed by chief underwriter Christopher Bone.

The company actually has existed for six years—until 1985 under the name of Mercury Reinsurance Co. (U.K.) Ltd.—under the management of English & American P.L.C. But St. Paul now will assume direct control of the underwriting operation, while E&A will continue to be involved in the management, secretarial and accounting functions of St. Paul (U.K.).

Net premium volume for St. Paul (U.K.) in 1986 totaled 26 million pounds ($39.5 million at year-end exchange rates).

The company has a capital base of 10 million pounds ($14.8 million).

The St. Paul Cos. considers London and New York to be the two world centers for reinsurance, which is why the group chose London for its first international office, Mr. White said.

"This is a commitment by St. Paul Cos. to have a firm position in the London marketplace," Robert J. Haugh, chairman of the holding company. "It rounds out our entire portfolio, giving us the ability to see (reinsurance) business through all the different windows."

St. Paul Cos. owns 26% of Lloyd's broker Minet Holdings P.L.C. and 25% of another London insurer, St. Kathryn Insurance Co. P.L.C. Both of these holdings are considered strictly investments, said Douglas W. Leatherdale, executive vp of St. Paul Cos.

Even though Minet still faces potential lawsuits from the troubles of its ex-subsidiary, PCW Underwriting Agencies Ltd., Mr. Leatherdale said: "We are very comfortable with our investment in Minet. We have no plans to increase or decrease it. Minet's financial results. . .have been highly gratifying, which is a tribute to its management team."

St. Paul (U.K.) is a natural progression from the sale of St. Paul Cos.' stake in AFIA to CIGNA Corp. in Philadelphia, Mr. Haugh said. "AFIA was a means to get involved in international business. . . (But) we have no intention at the moment to be everywhere in the world as we did in the passive presence with AFIA."

Mr. Haugh said St. Paul Cos. plans to open other foreign branches, but he does not know where yet. There are no current plans to write direct U.K. business, he said.

St. Paul Cos. also reported 1986 operating income of $154 million, up from $42 million in 1985 and an operating loss of $195 million in 1984, said Mr. Leatherdale. Written premiums rose 14.5% to $2.6 billion from $2.2 billion in 1985.

The group's improved performance is due to the substantial changes St. Paul Cos. has made in its commercial insurance division and rate hikes in its surplus lines division, according to Mr. Haugh.

"There is a substantial improvement in the quality of the way we do business," he said.

PCW settlement

Lloyd's of London hopes to announce a settlement "within weeks" with the members of syndicates formerly managed by PCW Underwriting Agencies Ltd., according to Lloyd's Chief Executive Alan Lord.

Mr. Lord said settlement talks "were making progress and the matter was now in the hands of the lawyers."

The final details of a settlement currently are being negotiated between lawyers for the parties involved in the PCW affair, and Lloyd's expects to make an offer to PCW members soon, he said.

PCW members have refused to pay underwriting losses totaling 235 million pounds ($357.2 million) and are threatening to file lawsuits against Lloyd's, Minet Holdings P.L.C.—PCW's parent—and 36 other defendants if a settlement is not reached (*BI*, Nov. 17, 1986).

Lloyd's is anxious to reach a solution before June 30—one year to the day that Lloyd's set aside 235 million pounds from its Central Fund to allow members of former PCW syndicates to pass Lloyd's solvency tests.

If a settlement is not reached by June 30, this money either will be returned to the Central Fund or will be reallocated.

Meanwhile, the cost of implementing the 70 recommendations made by the Neill report, a government inquiry into self-regulation at Lloyd's, may cost the Corp. of Lloyd's 2 million pounds ($3 million) annually, according to Mr. Lord.

Already, Lloyd's expects to spend about 12 million pounds ($18.2 million) in operating costs during 1987, Mr. Lord added.

Dewey Warren

William E. Thompson, president of Landmark National Corp. of Oklahoma City, is no longer the single largest shareholder of Lloyd's of London broker Dewey Warren & Co. Ltd.

Mr. Thompson's 14.6% interest in Dewey Warren, purchased late last month, has been topped by Bell Group International Ltd., which is owned by Australian businessman Robert Holmes a Court.

On Feb. 9, Bell acquired 42% of Dewey Warren by purchasing 5 million shares for 3 million pounds ($4.6 million). Bell already held 191,000 shares of the Lloyd's broker.

Under London Stock Exchange rules, Bell normally would have had to at least offer to buy all of the shares of Dewey Warren once it acquired more than 30% of the company.

However, the exchange's Panel on Takeovers and Mergers has agreed to waive this requirement if Dewey Warren shareholders approve the purchase.

Shareholders are expected to vote by the end of this month.

Bell is a British-based company engaged in theater ownership, property, film and television production and distribution, with a net worth in excess of 200 million pounds ($304 million).

Although it owns no other insurance broker, Bell owns U.K.-based Bryanston Insurance Co. Ltd.

Dewey Warren also is offering its shareholders the chance to purchase four new shares of stock for every five shares they own, in an attempt to raise an additional 2 million pounds ($3.04 million). Through this stock sale and the Bell stock purchase, Dewey Warren plans to increase its capital base by 5 million pounds ($7.6 million).

Dewey Warren stock was selling last week for 87 pence ($1.32) per share.

In the wake of the Bell purchase, Dewey Warren Chairman P. Brenan and Director C.J. Baker will resign and Bell will appoint a new chairman, an executive director and two additional non-executive directors.

Dewey Warren has been looking for a strong majority shareholder because it of poor results and an exodus of key managers, according to the broker's financial adviser, Phillips & Drew Corporate Finance.

Hogg subsidiary

Lloyd's of London broker Hogg Robinson Group P.L.C. is furthering its U.S. expansion by forming a New York-based reinsurance intermediary.

The intermediary, HRG Intermediaries Inc., was formed through the acquisition of New York-based John Gilbert Intermediaries Inc., a privately held firm, from its president and chief executive, John Gilbert.

There was no exchange of cash, but under terms of the agreement Mr. Gilbert will be chief executive of HRG, with a set salary and bonuses based on the profitability of the new company, according to John Beer, managing director of Hogg Robinson Group's non-marine treaty reinsurance division.

Most of John Gilbert Intermediaries' staff and existing business also will be transferred to HRG Intermediaries, Mr. Beer said.

"The capitalization and financial base of the new company has not been formalized yet, although we expect brokerage" revenues of about $1 million in the first year of operation," said Mr. Beer.

The company will concentrate mainly on placing reinsurance for U.S. insurers through contacts established by John Gilbert and Republic Hogg Robinson Inc., Hogg Robinson's U.S. retail brokerage subsidiary.

"U.S. treaty reinsurance is too big a market for us to ignore, and it was an area we felt we had neglected until now," said Mr. Beer.

Last month, the Hogg Robinosn also bought Michigan-based Globe Agency Inc., a retail insurance agency, for $7 million. It was the company's fifth U.S. acquisition in 15 months (*BI*, Feb. 2).

BBC settlement

The British Broadcasting Corp. is not filing a claim under its general liability insurance policy for compensation the BBC paid to the family of a man killed while rehearsing a stunt scheduled for a live television broadcast.

Graham Leslie, insurance manager for the BBC, said that no claim would be filed with the company's insurers because the BBC wished to keep the matter private. However, he said the incident "would be covered under the company's general liability coverage" if the BBC had decided to file a claim.

An official coroner's inquest last month returned a verdict of accidental death in the death of Michael Lush, who fell last November while practicing a stunt for the "Noel Edmonds Late, Late Breakfast Show," an entertainment program that had been broadcast live on Saturday evenings throughout Britain.

The program has since been canceled (*BI*, Dec. 1, 1986).

A spokesman for the BBC said the television network made a compensation offer to Mr. Lush's family on the day of the verdict, and the offer was accepted. The spokesman refused to disclose the amount of the settlement, saying it "is confidential between the corporation and the relatives of Mr. Lush."

However, sources say the BBC paid 100,000 pounds ($152,000) in compensation.

Both Mr. Leslie and the BBC's broker, Sedgwick Group P.L.C., refused to comment on the BBC's general liability insurance coverage, but sources in the London market estimate that the BBC has 5 million to 10 million pounds ($7.6 million to $15.2 million) in coverage.

Mr. Leslie admitted last December that the BBC's insurers had expressed concern about the stunts performed by members of the public on the "Late, Late Breakfast Show."

Bowring results

Lloyd's of London broker C.T. Bowring & Co. Ltd., a subsidiary of Marsh & McLennan Cos. Inc., has reported a 17.5% increase in pretax profits for 1986 to 55.6 million pounds ($84.5 million).

The profits, up from 47.3 million pounds ($71.9 million) in 1985, were earned from operating revenues of 159.2 million pounds ($242 million), up 16.3% from 136.9 million pounds ($208 million) in 1985.

Comings & goings

Paul Dawson appointed managing director of Jardine Credit Insurance Ltd., a unit of Jardine Insurance Brokers Group. Mr. Dawson was formerly with Credit Management Consultants, which manages credit insurance business for Stewart Wrightson P.L.C.

Sedgwick Group P.L.C. appointed **Rob White-Cooper** as a director of the company. Mr. White-Cooper is chairman of Sedgwick U.K. Ltd., the subsidiary responsible for providing insurance brokerage and risk management services within the United Kingdom.

The British Insurance Brokers Assn., a U.K. trade association, appointed **Gordon Polson** secretary and director of administration. Mr. Polson will be assisted by **Peter Atkinson** as deputy secretary.

David Hough, secretary of the Lloyd's Insurance Brokers Committee, has also been named director of London Market International, a subcommittee of BIBA.

Geraldine Wright joined the Lloyd's insurance Brokers Committee as deputy secretary of LIBC.

Peter Robinson appointed managing director of Glanvill Enthoven North America Ltd. in London. Previously, Mr. Robinson was with Jardine Emett & Chandler Inc. in San Francisco. ■

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Health care legislation

Continued from page 1

out-of-pocket expenses for covered services would not exceed about $1,500.

In the Senate, Finance Committee Chairman Lloyd Bentsen, D-Texas, is developing his own proposal, while a packet of Republicans—including Sens. David Durenberger, R-Minn., and Robert Dole, R-Kan.—are working on a so-called Republican alternative.

In addition, President Reagan last week announced that he will propose legislation that would place a $2,000 annual limit on a beneficiary's out-of-pocket costs for Medicare-covered services.

This limit was first recommended in a report issued in November by Health and Human Services Secretary Otis Bowen (*BI*, Dec. 1, 1986).

In part, this surge of congressional interest in enacting catastrophic health care legislation is fueled by political reasons.

"Expanding Medicare is an easy target for the Democrats to make their mark" now that they control both the Senate and House, observes James Weil, a vp with Metropolitan Life Insurance Co. in New York.

"Here is an opportunity to do something positive for older people who wield considerable political clout," added Frank McArdle, educational director of the Employee Benefit Research Institute, a Washington-based benefits think tank.

Congressional interest in expanding the Medicare program also has increased because of growing concern over whether Medicare—after years of cutbacks—really protects the elderly from big health care bills.

"Old folks are scared out of their wits about health care costs," said Stuart J. Brahs, executive director of the Assn. of the Private Pension & Welfare Plans in Washington.

There is good reason for that concern. Congressionally approved increases in Medicare deductibles and coinsurance requirements have boosted what retirees must pay out of pocket for lengthy hospital stays.

For example, the maximum out-of-pocket expense a beneficiary must pay for basic hospital expenses during a 120-day hospital stay is now $12,220, compared with a maximum of $2,914 in 1977.

"We have almost accepted the fact that Medicare will be expanded," said Edward J. Davey, a vp with Johnson & Higgins in New York.

While the final shape of a catastrophic health care bill for Medicare beneficiaries is far from certain, it is clear that employers have a big stake in the debate's outcome.

On the positive side, if Medicare were expanded, it could take some financial pressure off employer-provided supplemental Medicare plans, experts say. Many employer-sponsored retiree health care plans are integrated with Medicare so that the employer plan picks up some of the costs that Medicare does not pay.

"To the extent Medicare picks up catastrophic expenses that might otherwise been paid by the employer plan, there could be a savings to employer plans," said William J. Arnone, a benefit consultant with Buck Consultants Inc. in Los Angeles.

But, catastrophic health care legislation for the elderly may be a precursor to other health care actions by Congress, some of which would hurt employers.

For example, Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., is preparing legislation that would require every employer to provide a health insurance plan (*BI*, Feb. 9).

The Kennedy proposal, likely to be introduced within the next few weeks, would set minimum federal standards for employer-provided plans, including a $2,000 annual limit on out-of-pocket expenses for covered services. Under a current outline of the proposal now being circulated, a beneficiary's share of the premium could not exceed 20%.

Small employers would be able to buy coverage from special pools in their geographic areas. Pool coverage would be underwritten by insurers that win government contracts after competitive bidding.

While enactment of the Kennedy proposal in the near future is not considered likely, passage of an expanded Medicare program would give a boost to proposals to expand health care coverage for active employees, observers say.

There is also concern on whether employers may have to pick up some of the costs of an expanded Medicare program.

For example, under the Bowen proposal, the cost of capping Medicare-covered services at $2,000 a year would mean a $4.92 increase in the monthly premium that beneficiaries pay under Medicare Part B, which covers physician services. The current Part B monthly premium is $17.90.

But experts, noting that the government has consistently underestimated the cost of Medicare through much of the federal program's 22-year history, question if the $4.92 hike really would cover the costs of expanding the Medicare program.

"I would view with some skepticism whether $4.92 is adequate," said Mr. Arnone. So far, HHS has not provided documentation on assumptions it used in coming up with the $4.92 figure.

If the proposed increase does not cover expanded Medicare costs or if Congress refuses to raise the premium in future years to pay for increased costs, some fear that employers would be forced to make up the difference.

"There would be a great reluctance on the part of Congress to raise the premium in future years to meet the increased costs of expanded catastrophic coverage. Instead, Congress would be likely to require employers to pay the additional cost," said James Klein, manager of pensions and employee benefits at the U.S. Chamber of Commerce in Washington.

There also are concerns that some of the new proposals to expand Medicare could ultimately lead to taxing employer-provided health care benefits.

For example, the Stark-Gradison proposal would pay for an expanded Medicare program by taxing beneficiaries on a portion of the actuarial value of the Medicare benefits they receive. However, under this approach, many beneficiaries still would not be taxed because their taxable income—even by counting the value of the Medicare package as income—still would not put them over the threshold that triggers the payment of federal income taxes.

This financing structure is fairer than the Bowen approach, since the elderly poor might not be able to afford the $4.92 monthly premium increase, said Rep. Stark.

"If we go that (the Bowen) way, we risk denying coverage to those who need it the most," Rep. Stark recently said before a meeting of the American Hospital Assn. in Washington.

But others say that if the elderly are taxed on their Medicare benefits, it could lead to new congressional attempts to tax employees on employer-provided health care coverage.

"I can already hear the argument. If retirees are taxed on their benefits, then employees should be taxed on their benefits, too," said James Dorsch, Washington counsel for the Health Insurance Assn. of America, an industry trade group.

There are some encouraging developments for employers in Congress' drive to expand health care coverage.

Sen. Kennedy—who observers say formerly paid scant attention to the views of business groups—has made a point of having his staffers meet with employer organizations to obtain their input in drafting his health care proposal.

In addition, there appears to be greater congressional recognition that a proposal—narrowly defeated during the last session—requiring states to establish employer-subsidized pools to provide coverage for high-risk uninsured individuals needs redrafting. Under that proposal, if premiums paid by participants to cover expenses were insufficient—as would have been almost certain—employers would have been assessed to make up the difference.

Employers argued that the pool concept was unfair to companies that already offer health care coverage to employees. In effect, those companies would pay for health care twice—once for their own employees and once for those receiving coverage from the pools.

Those complaints are being heard in Congress. For example, Rep. Stark, while not yet dropping the pool concept, recognizes that the proposal "has to go back to the drawing board," said William Vaughan, an administrative assistant to Rep. Stark. ■

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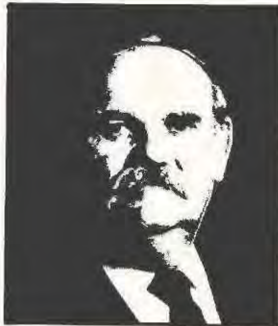

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around the states

Dramshop reform bill vetoed by N.J. governor

TRENTON, N.J.—In conditionally vetoing a bill designed to protect tavern owners from lawsuits stemming from drunken patrons' actions, New Jersey Gov. Thomas H. Kean said he felt the measure would go too far in protecting tavern owners.

Gov. Kean called for a "more comprehensive and balanced approach."

Under the vetoed bill's provisions, passengers injured while in the cars of drunken drivers would not have been permitted to file lawsuits against the tavern where the drivers were served, explained a spokesman for the New Jersey Insurance Department.

However, under the vetoed bill, tavern owners still could have been sued if they served visibly intoxicated patrons who then injured third parties, the spokesman said.

"I advocate the enactment of reasonable modifications to our civil justice system rather than the total elimination of certain injured parties' rights to institute a civil action" when a tavern owner violates state regulations by serving visibly intoxicated adults, the governor said through a spokesman.

The spokesman said Gov. Kean felt the bill did not provide a definitive statement about "to whom and under what circumstances" a liquor license holder could be liable. The spokesman also noted that despite Gov. Kean's opposition to the bill, the governor still opposes the concept of joint and several liability in liquor liability cases, believing a defendant should be obliged to pay only an amount commensurate with his liability.

Municipality liable

ROBBINS, Ill.—In a ruling that has drained the bank accounts of Robbins, Ill., a federal court says the municipality—not two former officials—is liable for $575,000 in damages stemming from a suit filed by a discharged police officer.

Robbins' bank accounts, seized late last month under order of the 7th U.S. Circuit Court of Appeals in Chicago, do not cover the amount of the award, and the southwest Chicago suburb of about 8,000 residents was uninsured for the loss. As a result, municipal employees were laid off because the village no longer could afford to pay their wages.

In the case, Samuel Coleman, a former Robbins police officer, alleged his civil rights had been violated when he was fired after reporting to the village board about municipal corruption.

A lower court in 1984 found that former Mayor Marion Smith and former Police Chief Gordon Frierson were liable for the award. However, both former officials appealed the original ruling, claiming they were acting in their official capacities. The appellate court ruled the village was liable for the award.

Still unresolved is whether Mr. Smith and Mr. Frierson could be forced to pay part of the judgment themselves, if the village is unable to pay it all.

Robbins already has paid about $140,000 in other expenses, including Mr. Coleman's lost wages and his attorney's fees.

The village could recover some of its losses in the case if it is successful in its plans to sue Aldus Mitchell, its former attorney.

However, Mr. Smith and Mr. Frierson now are seeking at least $2 million in damages in a joint suit filed against the village, Mr. Mitchell and his previous law partners, according to Hal Kessler, an attorney with Kessler & Ex in Chicago, who represents Mr. Frierson.

The suit names the village for allowing Mr. Mitchell to represent the pair and Mr. Mitchell for providing inadequate representation, according to Mark Sterk, an attorney with Odelson & Sterk, which began representing the village in 1985.

Despite the layoffs, some municipal employees were at their jobs last week, although they may never be paid for the time worked. ■

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Outhwaite

Continued from page 2

Hughman Ltd. estimate that the refusal to pay claims on asbestos losses may cost the syndicates 6.8 million pounds ($10.8 million) out of a total of 45.5 million pounds ($69.2 million) in asbestos claims.

As a result, Stewart & Hughman has postponed its plan to go public this spring.

"It was a very material fact that had a distinct bearing on our offer for sale, and we felt we could not proceed with the (offering)," said Peter Stilwell, a director of Stewart & Hughman.

Also, syndicates managed by Philip N. Christie & Co. Ltd. have filed a lawsuit in British High Court alleging that the Outhwaite syndicates owe them at least $627,094 on a $5 million runoff reinsurance policy with an $800,000 deductible.

Other syndicates—including those managed by Anton Underwriting Agencies Ltd.—also are worried the Outhwaite syndicates will not pay asbestos losses.

In anticipation of an increasing number of asbestos claims coming into the market, the Council of Lloyd's is monitoring the disputes with the Outhwaite syndicates and is "gathering information with a view to resolving the situation," said a Lloyd's spokesman.

Sources speculate that at the time the Outhwaite syndicates wrote the runoff policies, the syndicates—and perhaps even the entire Lloyd's market—may have underestimated the size of potential asbestos claims and how quickly they could be settled.

For example, one Lloyd's source who requested anonymity said that the Outhwaite syndicates agreed to pay runoff claims for one syndicate once its claims reached nearly four times the amount of claims reported in 1981—the year the runoff reinsurance covering years prior to 1978 was placed with the Outhwaite syndicates.

However, the claims are now expected to be six times greater than they were in 1981, said the source.

In addition, marine syndicate 418, managed by Merrett Underwriting Agency Management Ltd., said in 1985 it was caught off guard by the severity of asbestos losses.

The syndicate reported an underwriting loss of up to 17 million pounds ($21.8 million) for the 1982 underwriting year, which closed in 1985. Merrett attributed that loss to runoff reinsurance it wrote for insurance companies and other Lloyd's syndicates prior to 1976.

It was the first time Lloyd's largest marine syndicate reported an underwriting loss in 25 years (*BI*, April 22, 1985).

"The claims deterioration is phenomenal," said one Lloyd's source. "Some in the market support the view that the claims facility caught him (Mr. Outhwaite) out."

The Outhwaite agency first reported in 1985 that losses on runoff polices might be severe for the 1982 underwriting year.

According to the Outhwaite agency's 1985 report for the 1982 underwriting year, Outhwaite syndicates faced at least 127.1 million pounds ($193.2 million at current exchange rates) in outstanding losses from runoff reinsurance policies. Including other losses and incurred-but-not-reported losses, the syndicates reported total losses of 201 million pounds ($305.5 million).

According to the report, however, reinsurance purchased by the Outhwaite syndicates is expected to cover 125 million pounds ($190 million) of the outstanding asbestos runoff policy losses.

This "series of special reinsurance policies"—which are what are known as "time and distance" policies—pay out lump-sum amounts on specified dates ending in 2006.

The actual amount this reinsurance will pay, however, is based on the amount of claims estimated in the original insurance policies that were ceded to the runoff reinsurance contracts, not the ultimate claims eventually received by the Outhwaite syndicates.

In addition, while claims are now being presented to the Outhwaite syndicates, much of the reinsurance proceeds will not be collected until years from now.

Outhwaite has reserved for the remaining 75.9 million pounds of losses for the 1982 accounting year, the report said.

Because of the severity of the losses, Mr. Outhwaite has kept the 1982 underwriting year open so that any losses under these contracts will be paid from the 1982 account.

"We remain confident that the reserves together with our reinsurance are adequate to cover liabilities," said Outhwaite Chairman Maurice Hussey in the report.

Mr. Outhwaite says he has refused to pay some asbestos losses incurred by syndicates managed by three underwriting agencies because they stemmed from long-tail liability insurance policies not taken into account at the time the runoff reinsurance was placed by the syndicates.

"As a result of the inquiries made during the last 18 months, we are obliged to question the basis on which certain of these policies were placed," said Mr. Hussey in the letter to members.

The policies are few in number, but "the sums involved are considerable and may attract publicity," said Mr. Hussey.

Although the Stewart & Hughman agency would not give details of its accounts and how the Outhwaite syndicates' refusal to pay claims affects its syndicates, members of these syndicates determined from a letter to them from the agency's chairman, Brian Stewart, that the Outhwaite syndicates' refusal to pay claims may cost the syndicates 6.8 million pounds ($10.3 million).

In the Jan. 21 letter, Mr. Stewart said that there was "uncertainty" of payment on runoff policies covering all of the liabilities of marine syndicate 17/16/18 and non-marine syndicate 15.

Mr. Stilwell confirmed that the disputed policies had been placed with the Outhwaite syndicates.

One runoff policy for syndicate 17/16/18 was placed in the autumn of 1981 by Lloyd's broker Winchester Bowring Ltd. At least one claim was made under the policy in December 1986, but the Outhwaite agency asked for "details. . . supplied when quotations for the policy were obtained."

"This naturally must raise in our minds some doubts as to the intentions of the underwriter regarding not only this claim, but also future claims and their collectibility," said Mr. Stewart.

If claims are not paid, syndicate 17/16/18 will just "break even" in 1984, Mr. Stewart said in the letter.

For the year 1984, syndicate 17/16/18 had a premium income capacity of 28.9 million pounds ($43.9 million). Members of the syndicate say the syndicate was expected to write 80% of its premium income capacity, or 23.1 million pounds ($35.1 million), and make an 8% profit, or 1.8 million pounds ($2.7 million), before Mr. Outhwaite questioned the runoff reinsurance.

However, if the syndicate only breaks even, as Mr. Stewart expects, it will cost the syndicate the 1.8 million pounds in expected profits, according to the members.

The Outhwaite syndicates' refusal to pay claims could also affect non-marine syndicate 15, managed by Stewart & Hughman.

Syndicate 15 had purchased two layers of runoff reinsurance. The first layer is written by an unnamed insurer, which has paid claims "as and when requested," said Mr. Stewart. The second layer, however, has no aggregate limit and is written by the Outhwaite syndicates, said Mr. Stewart, who fears Mr. Outhwaite will not pay potential claims because he is refusing to pay claims on the other syndicates' coverage.

Mr. Stewart said that if Mr. Outhwaite refuses to pay the claims, then "a substantial loss would be incurred, which we estimate could amount to 40% of premium limit allocations."

Members of Stewart & Hughman syndicates say that syndicate 15 had a premium income limit in 1984 of 20.9 million pounds ($31.8 million). The syndicate was expected to write 80% of its premium income limit, or 16.7 million pounds ($25.4 million), and produce a 10%, or 1.7 million-pound, loss before the dispute with the Outhwaite syndicates.

But if syndicate 15 suffers a 40% loss, as expected, it will cost the syndicate a total of 6.8 million pounds ($10.3 million), or 5 million pounds ($7.6 million) more than anticipated.

Despite the possibility that the Outhwaite syndicates may eventually pay the claims, Mr. Stewart told Stewart & Hughman syndicate members that "as a result of this uncertainty, the 1984 underwriting accounts of both syndicates (15 and 17/16/18) would have to be kept open so that any subsequent recoveries would be credited to the names who have borne the losses." ■

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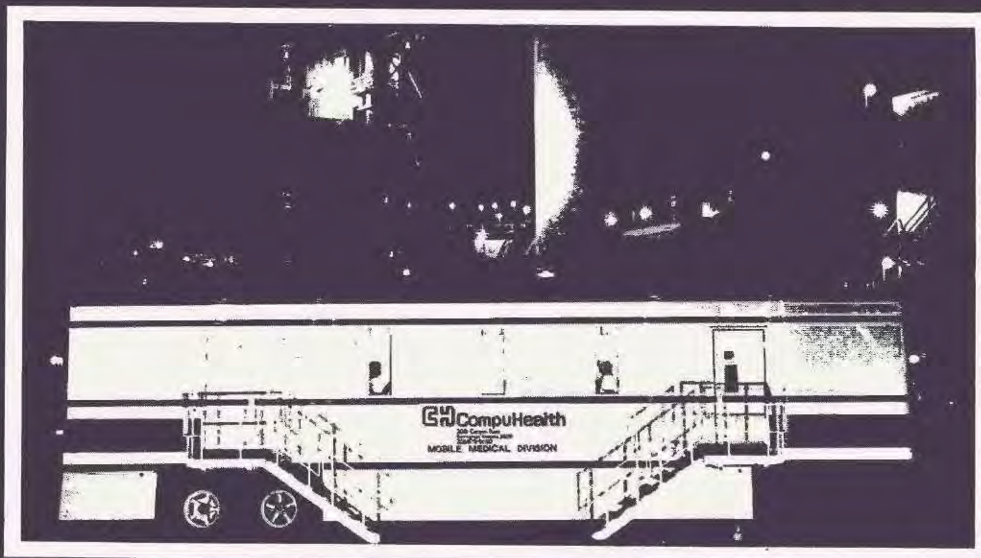

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Circulation Breakdown*

Commercial Consumers

Administrative:

CEO's Presidents and Owners 2,426
Vice-presidents, General Managers and Other Administrative Personnel 3,136

Financial:

Chief Financial Officers and Vice-presidents of Finance 2,683
Secretaries, Treasurers, controllers and other Financial Personnel 4,888

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 8,144

Sub-total 21,277

Associations 506
Government, Unions and Educational Institutions 1,400

Commercial Consumers

Sub-total 23,183

Insurance Agents and Brokers 11,009
Insurance Companies 7,111
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 5,560
Others Allied to the Field 1,442
TOTAL 49,294

* Source Business/Occupational breakdown of qualified circulation, November 24, 1986 issue, as submitted to BPA for December 1986 BPA Publisher's Statement.

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Newman named Buffalo Re chairman

Steven H. Newman has been named chairman and chief executive officer of Buffalo Reinsurance Co. in Woodland Hills, Calif., a subsidiary of Continental Corp. Mr. Newman succeeds **Edward J. Jamison Jr.**, who remains as president.

Mr. Newman previously was president of The Home Insurance Co. in New York, which he joined in 1982 as executive vp responsible for underwriting, claims, legal, reinsurance and risk management functions. Before joining The Home, Mr. Newman was a vp with American International Group Inc.

In addition, **Greg D. Ewald** appointed vp in the Chicago office of Buffalo Re. Mr. Ewald joined the company in 1979 after working at Travelers Insurance Co.

Other reinsurance changes:

Martin R. Brady Jr. and **Richard M. Young** both named vps-bond marketing and underwriting from assistant vps at North American Reinsurance Corp. in New York. Before joining North American Re in 1981, Mr. Brady was a vp at Alexander & Alexander. Mr. Young previously was an associate manager at the Philadelphia branch of Fidelity & Deposit Co.

At NWNL Reinsurance Co. in Minneapolis, **Robert Drag** and **James Giordono** appointed vps-treaty underwriting and **George Foulkes** appointed vp-claims. Mr. Drag joined NWNL Re in 1981 and has served on the company's marketing and systems users committees. Mr. Foulkes joined NWNL Re in 1983. Mr. Giordano joined the company in 1981 after working at American Reinsurance Co.

Frank Buccafusco appointed vpat Andrew Edwards Facultative Intermediaries Inc. in Dallas. Prior to joining Andrew Edwards Mr. Buccafusco was president of Pro Re Inc. of New York.

comings & goings: industry

Insurers

James M. Wilson appointed vp and manager of the Pacific region for Harbor Insurance Co. in Los Angeles and its subsidiary, Pacific Insurance Co. Mr. Wilson was formerly casualty manager for MTS Insurance Services in Los Angeles.

Robert W. Waeger promoted to senior vp-claims at PHICO Insurance Co. in Mechanicsburg, Pa.

Regis Insurance Co. in Wayne, Pa., promoted **Kenneth R. Cowper** to vp of property underwriting. He previously served as senior underwriting manager.

Frank C. Taylor joined Westchester Fire Insurance Co., a Crum & Forster unit in Basking Ridge, as senior vp. In addition, **Richard E. Rice** elected vp for casualty underwriting at Westchester and **David R. Stokey** elected vp to oversee the Durham, N.C. office.

John Bushyager appointed resident vp and manager of Transamerica Insurance Group's regional office in Worthington, Ohio. He replaces **Cliff Maiden**, who is retiring.

Judith L. Stauber named head of UNUM Life Insurance Co. newly created LTD reinsurance risk management department in Portland, Maine. She is a vp.

James H. Baum named vp and group actuary of American Heritage Life Insurance Co. in Jacksonville, Fla. He was previously senior director of finance at Capital Blue Cross in Allentown, Pa.

Agents/Brokers

Thomas A. Watson promoted to assistant regional director of Corroon & Black Corp.'s Pacific Northwest Region. Mr. Watson, also a senior vp of C&B's Pacific Northwest Region, most recently was assistant manager of C&B's Alaska operations.

Richard A. Riley promoted to director of the Pacific Region of Corroon & Black's Brokerage and Services group. Mr. Riley, who joined C&B in 1974, replaces **Paul C. Carter** who retired but will remain with the Pacific Southwest Region as a consultant.

J. Ronald Ellis promoted to executive vp and chief operating officer of Corroon & Black of Nashville Inc. Mr. Ellis, who joined C&B in 1972, most recently was senior vp-major accounts.

James Y. Paulding appointed president of Alexander & Alexander of Japan Inc. in Tokyo. He had been senior vp of parent Alexander & Alexander Services Inc.

John R. Genovese promoted to senior vp of Rollins Burdick Hunter of Southern California Inc.

At Rollins Burdick Hunter of Missouri **Louis O. Gys** named executive vp and **Carroll J. "Cid" Keane Sr.** named executive vp. And, at Rollins Burdick Hunter of Michigan Inc. **Jim Kenyon** promoted to vp.

Michael J. Petrasek been named vp of Liberty Insurance Agency Inc. in Pittsburgh.

Robert P. Salmon named vp of Alpha Aviation Insurance in Hasbrouck Heights, N.J., following its acquisition of Edward L. Salmon Agency of Wall Township, N.J.

At Seattle-based Parker, Smith & Freck Inc. **Peter Hammett** promoted to vp from account executive.

Cary M. Shaich promoted to vp at Towle Agency Inc. in Minneapolis.

Alfred Sarina promoted to senior vp and **James Griffith** promoted to vp-underwriting/marketing at Giddings, Corby, Hynes Inc. in Modesto, Calif.

At Harding-Conley-Drawert-Tinch Insurance Agency Inc. in San Antonio, Texas, **Maryanna Christensen** promoted to vp. She joined the agency in 1980 as an underwriting manager.

Anthony V. Petrucci and **Richolson (Rick) Salembier** named vps in the casualty department of New York-based broker Johnson & Higgins. Mr. Petrucci previously was director of risk management at SCM Corp. Mr. Salembier was an account executive with a major New York insurance broker for nine years.

In the New York International Department at J&H; **Steve Caddy** and **Denis Pasternak** named vps.

H. Smith McGehee named managing director in charge of the newly expanded St. Louis office of broker Marsh & McLennan Inc.

Patricia J. Evans named vp at Rocky Mountain Insurance Brokers in Denver.

HMOs/PPOs

Gwynne R. Winsberg has been named a vp and director of EfficientCare Network, a Chicago-based preferred provider organization subsidiary of Efficient Health Systems Inc. of Skokie, Ill. Ms. Winsberg, formerly associate dean of the Loyola University-Stritch School of Medicine, also served in the U.S. Department of Health and Human Services in Washington.

Other suppliers

Promotions at third-party administrator Hewitt, Coleman & Associates in Greenville, S.C., include: **Willard L. Quinn** named senior vp of operations; **Roy O. Darby** appointed vp of employee benefits; and **James A. Connor** appointed vp of South Carolina operations.

James P. Kennedy named director-group services (Midwest) for Buck Consultants Inc. in Chicago. Mr. Kennedy formerly was a consulting principal for A.S. Hansen Inc. in Chicago.

Robert M. O'Keefe promoted to a principal in the Detroit office of William M. Mercer-Meidinger Inc. Previously, Mr. O'Keefe was an associate for the consulting firm.

At J.H. Albert International Insurance Advisors Inc. in Needham, Mass.: **Stewart T. Cowart**, **James W. Evans Jr.**, and **Alfred H. Nagelberg** appointed vps and principal consultants. Mr. Cowart and Mr. Nagelberg joined the company in 1980; Mr. Evans joined the company in 1981. ■

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Proposition 51

Continued from page 2

cally incorrect" the 1st District Court's reliance on the word "shall" in the language of the initiative as an indicator of intended futurity.

The 2nd District Court explained that in legislative proposals, the word "shall" is normally understood to be a term of compulsion rather than futurity.

"In our view, the legislative intent was for the statute to take effect immediately and to apply to as many cases as feasible," the 2nd District Court said.

The court noted that while there is a presumption against retroactive application of a statute, "legislative intent overrides the presumption against retroactivity, and remedial statutes are to be broadly construed to effectuate their remedial purpose."

Acknowledging that legislative intent is difficult to determine when the "legislators" were, in reality, millions of voters acting without legislative committee reports on the proposed law, the court nonetheless found that the statutory language of Proposition 51 demonstrates "a legislative wish to cut back on personal injury recoveries against defendants not primarily to blame for plaintiffs' injuries; to reduce the financial burden of injury claims on those defendants and on their liability insurers; and to confer a financial benefit on the public at large" through lower insurance premiums and local taxes.

The 2nd District Court also said the 1st District Court's analysis that an insurance industry profit windfall would result from the retroactive application of Proposition 51 is inaccurate.

"Insurance premiums are regulated by free-market forces, and carriers' loss experiences undoubtedly influence their future premium levels by affecting the minimum future profit levels at which they are willing to operate," the court wrote.

The court also rejected arguments that Proposition 51 must be applied prospectively because to do otherwise would result in an unconstitutional abrogation of vested rights.

"An injured person's expectancy of a tort recovery is an inchoate, unliquidated claim contingent on his or her ability to persuade a trier of fact of the merits of the claim," the count said. "Such an expectancy falls short of being a vested right."

The appellate court rejected as "frivolous" the arguments of attorneys representing Evangelatos claiming that Proposition 51 is void because the ballot summary prepared by the state attorney general was "false and misleading" by stating that "approval of this measure would result in substantial savings to state and local governments."

The court noted the statement was based on a legislative analyst's estimate of the measure's fiscal impact on state and local governments—an estimate required by California law.

The court also rejected the plaintiff's arguments that the initiative is vague and discriminates against poor tort victims by creating insurmountable economic barriers to tort litigation. The plaintiff's attorneys argued that because the initiative would lead to lower court awards and, as a result, lower contingency fees for trial lawyers, attorneys would be hesitant to represent clients who could not afford to make up that difference in other fees.

The court said that such a challenge to Proposition 51 "lacks merit," and the reduction in incentives for attorneys to represent injured plaintiffs because of the initiative is "likewise not unconstitutional."

Some attorneys who supported the Russell decision previously had said the high court's refusal last fall to review that ruling was an indication of support for Russell.

But the 2nd District Court of Appeal noted, in its opinion, that the Supreme Court's denial of review in Russell is not a binding precedent.

The 18-page opinion was written for the court by Justice Lynn D. Compton, who was joined by Justices Lester William Roth and Donald N. Gates.

The Evangelatos case involved a Los Angeles man who was blinded at age 18 while mixing chemicals for homemade firecrackers. The plaintiff sued the chemical manufacturer, distributors and retailer for unspecified economic and noneconomic damages.

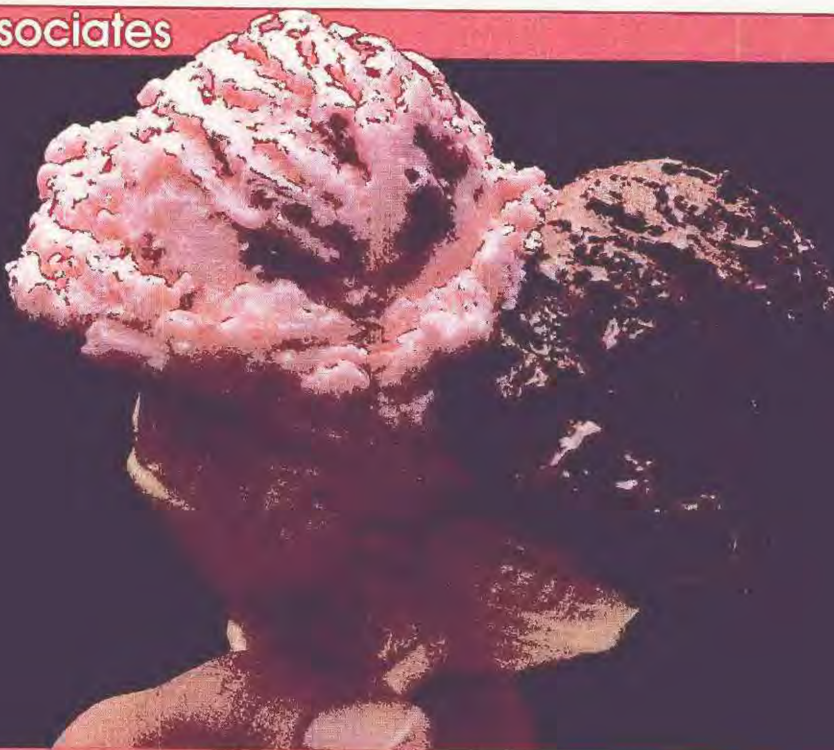
As expected, defense attorneys immediately hailed the 2nd District's decision, while plaintiffs' attorneys said they hope the ruling will be overturned by the Supreme Court.

The decision will cause "chaos" in the California trial courts because it conflicts with the Russell decision, said Deborah Mitzenmocher, with the firm of Magana, Cathcart, McCarthy & Pierry, which represented Mr. Evangelatos.

While Ms. Mitzenmocher and other plaintiffs' attorneys said they do not know how the Supreme Court will rule, defense attorneys say that if the vacancies on the court are filled as expected, the court likely will become very conservative (*BI*, Dec. 15, 1986).

"And the 2nd District Court of Appeal's opinion is the more conservative opinion," pointed out Jonathan M. Gordon, with McCutchen, Black, Verleger & Shea. Mr. Gordon filed a friend-of-the-court brief in the Evangelatos case on behalf of one of the original defendants who was dismissed by the trial court.

Mr. Gordon said he expects the Supreme Court to delay deciding the case until after the three vacancies on the court are filled and he is confident the court will uphold the 2nd District Court's ruling. ■



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IEA syndicates

Continued from page 1

much as $4 million each, according to Bill Godwin, assistant director of company regulation for the Florida department.

Mr. Godwin added that the insolvency figures—developed by RLI Corp., which owns Syndicate One and 80% of Daum Management—represent a "worst case" scenario and that the insolvencies may not be that large.

Syndicate Four still has surplus of about $600,000, but it is considered impaired since the syndicate has less than the $1 million in surplus required of exchange syndicates, Mr. Godwin said.

A fifth syndicate—Hispano American Insurance Syndicate Ltd., which was placed in court-supervised rehabilitation earlier this month—may be insolvent by as much as $3 million, he added.

IEA and Insurance Department officials are examining seven to 12 reinsurance treaties underwritten by the five impaired syndicates in an attempt to gauge the extent of the losses and their impact on other IEA syndicates that participated on the same treaties.

Sources say the biggest problems stem from two blocks of business:

- A book of long-haul trucking risks ceded to the exchange by Forum Insurance Co. of Schaumburg, Ill., and produced by Will Darrah & Associates, a managing general agency in Myrtle Beach, S.C.

Underwriters at Lloyd's of London, which also reinsured Forum on the Will Darrah book, have reported huge losses on the business (*BI*, Dec. 29, 1986).

- A book of taxicab risks ceded to the exchange from Cadillac Insurance Co. of Detroit.

Exchange sources charge that business on some of these treaties was handled improperly by managing general agents, and IEA President Nicholas Cross said that the exchange is seeking recision on some of the treaties and loss commutations on others.

A Forum official said Forum has not discussed recision or commutation of its treaty.

Additional exchange syndicates that participated on these and other treaties that are now under examination include AIB Syndicate Inc., B.G.H. Syndicate Inc. and W.F. Poe Syndicate Inc. All three syndicates are among the IEA's 10 largest based on 1985 gross premiums (*BI*, Sept. 1, 1986).

The problem treaties now being examined do not include business ceded by Omaha Indemnity Co. to RAM Syndicate Inc. and Administrative Management Services Syndicate Ltd. Omaha Indemnity sued the two syndicates and others last year and is currently arbitrating disputes with Royal American Managers, its former managing general agent and owner of RAM Syndicate (*BI*, April 28, 1986).

Although Mr. Cross and other exchange officials are optimistic that the IEA's current problems can be overcome, they also express concerns about the potential impact of syndicate insolvencies on the exchange's $13 million guaranty fund.

If the insolvent syndicates' losses are as large as projected in the worst-case scenarios and are found to be covered by the guaranty fund, the fund could be exhausted. This, in turn, would have a "ripple effect" on the remaining exchange syndicates, each of which includes its $500,000 deposit with the guaranty fund as part of its capital and surplus.

Mr. Cross noted that "$500,000 would not be enough to cause the insolvency of an otherwise unimpaired syndicate." He added, however, that "if the syndicate were borderline, the effect would be to cause their impairment."

"The ripple effect in the guaranty fund is clearly a cause of concern to us and is one reason we want to address the problem reinsurance treaties head-on," Mr. Cross said.

The exchange's governors and general membership last year approved an amendment to the IEA constitution that would have absolved individual syndicates of certain guaranty fund liabilities for insolvencies caused by business written before the syndicates joined the exchange, he said.

However, the Insurance Department vetoed the amendment.

The IEA recently approved a similar amendment applying only to syndicates joining the IEA after the amendment's approval, rather than to all syndicates.

The Insurance Department is currently reviewing the proposal.

Exchange officials last year expressed concern that potential losses from the Omaha Indemnity business also could exhaust the guaranty fund, which prompted the IEA to attempt to limit the liability of new syndicates to attract new capital to the exchange.

The department is considering another proposed amendment that would limit guaranty fund liability in a single insolvency to 25% of the total in the fund at the date of the insolvency, Mr. Godwin said.

Leon County Circuit Judge William L. Gary issued show-cause orders against syndicates One, Two, Three and Four on Feb. 6. The syndicates are expected to respond at a hearing set for March 19.

While RLI has estimated the insolvencies of syndicates One, Two and Three at a maximum of $4 million each, the individual investors who own syndicates Two and Four have hired their own actuary to review the syndicates' financial condition, said Claude Lilly, an insurance professor at Florida State University who is acting as a consultant to the syndicates.

Syndicate Three—also owned by individual investors—has tentatively agreed to share the cost of the study, Mr. Lilly said. Since Syndicate Three shared proportionally in the business written by Daum Management, the results of the study could easily be applied to Syndicate Three, he explained.

Syndicates Two, Three and Four will decide after the study is completed whether to contest the rehabilitation proceeding, he said.

He added the study may show the syndicates are not as broke as RLI's figures indicate. However, if they are shown to be in a "precarious position," the syndicates will work with the department "to try to solve this problem."

Syndicate Two was the IEA's eighth-largest syndicate in 1985, with gross premiums of $6.7 million—all of which was retained on a net basis—and net income of $228,000. Syndicate One was the ninth-largest, with 1985 gross premiums of $6.4 million, net premiums of $6.3 million and a net loss of $543,000.

Syndicate Three reported 1985 gross premiums of just under $3.3 million—all retained net—and net income of $209,205. Syndicate Four reported 1985 gross premiums of $1.9 million—nearly all retained net—and a net loss of $266,444.

As reported, Hispano American—owned by Ocaso S.A., a large Spanish company—was ordered into rehabilitation by the IEA board but subsequently asked the Insurance Department to petition for a court-supervised rehabilitation. A Leon County Circuit judge ordered Hispano American into rehabilitation earlier this month.

Hispano American, which stopped underwriting in 1985, was the exchange's fourth-largest syndicate that year, with gross premiums of $11.5 million, net premiums of $11.1 million and a net loss of $854,000.

Meanwhile, IEA officials have developed a computer model for projecting potential losses to several syndicates on 11 or 12 reinsurance treaties, some of which involve large volumes of claims and others which do not, according to Mr. Cross.

Results of the exchange's study of the treaties will be compared to the figures produced for the Daum Management syndicates by RLI and by the actuary working for syndicates Two, Three and Four, Mr. Cross said.

All of the results will be reviewed at a meeting of the IEA board scheduled for Wednesday, he added.

One of the problem treaties covered the Will Darrah business ceded through Forum, according to several sources, one of whom guessed that losses on the Forum treaty may equal those on three or four of the other problem treaties combined. The exchange reported a total of $1.4 million in reinsurance payable to Forum on paid and unpaid losses and unearned premiums for 1985, according to its annual statement. Forum, on the other hand, reported $4.7 million in unearned premiums and reinsurance recoverable from the exchange for the same period, according to figures published by A.M. Best Co.

One source familiar with the Forum business said that premiums actually written under the treaty exceeded by nearly 250% the volume agreed to when the risk was submitted to the exchange syndicates. Premiums written by Forum on the program totaled roughly $40 million, while the anticipated volume reported to exchange syndicates when the treaty was submitted was about $17 million, the source said, adding that exchange syndicates took about 45% of the risk.

Another problem treaty covered Chicago and California taxi business ceded by Cadillac Insurance Co., sources report. The exchange reported $487,427 in unearned premiums and reinsurance payable to Cadillac at year-end 1985, while Cadillac reported $4.4 million recoverable from the exchange for the same period.

Exchange syndicates—charging that Cadillac's MGA improperly expanded the taxi program to include California risks—are currently in arbitration with the insurer over their participation on the treaty, according to Michael Griffiths, vp of Global Underwriting Management Inc.

Sources report that other problem treaties targeted by exchange officials include:

- Puerto Rican auto risks ceded by Dependable Insurance Co. of Jacksonville, Fla. The exchange reported $582,174 in unearned premiums and reinsurance payable to Dependable at year-end 1985, while Dependable reported $4.6 million in reinsurance recoverable from the IEA, according to Dependable Executive Vp J. Lloyd West.

This business was ceded to AIB Syndicate, B.G.H. Syndicate, Hispano American, Administrative Management Services, RAM Syndicate and syndicates One, Two and Three, Mr. West said.

- Auto risks ceded by International Bankers Insurance Co. of Coral Gables, Fla. The exchange reported $2 million in unearned premiums and reinsurance payable to International Bankers in 1985, while International Bankers reported $8.3 million recoverable for the same period, according to A.M. Best figures.

- Business ceded by Protective Casualty Insurance Co. of Baton Rouge, La.; Angelina Casualty Co. of Lufkin, Texas; and Union American Insurance Co. of Coral Gables.

Sources say that problems with the Protective Casualty, Angelina and Union American treaties are relatively minor.

Poe Syndicate—which participated on the Cadillac, International Bankers, Protective Casualty and Union American treaties—is among the syndicates being examined, according to James Cordle, president of Citadel Management Corp., the syndicate's manager.

Mr. Cordle added that Poe Syndicate, the IEA's second-largest in 1985, will survive the problem treaties "even in a worst case scenario" and even if it loses its $500,000 guaranty fund deposit.

B.G.H., which sources say also is under examination, was on the Forum and Cadillac treaties, Mr. Griffiths confirmed. B.G.H. was the IEA's fifth-largest syndicate in 1985.

Sources say that AIB Syndicate, the exchange's seventh-largest in 1985, is also being examined, though AIB officials could not be reached for comment.

Mr. Cross said that discussions with ceding insurers about recision or commutation of reinsurance treaties are "moving ahead very quickly."

"We have entered into discussions already with one or two of the ceding companies," Mr. Cross said. "We believe we have good grounds for recision of some of these contracts and commutation of others."

A recision cancels a reinsurance contract from inception. Under a commutation, the IEA would be relieved of further responsibility under the contracts for a one-time lump sum payment.

While expressing confidence the IEA can weather this latest storm, exchange officials acknowledged this latest blow to the market. "The impact is tremendous, no doubt about that. But I think there are healthy syndicates here," Mr. Cordle said. "I think the exchange will survive. But it's certainly a very unpleasant development, and it took many of us by surprise." ■

update

X.L. writing E&O coverage

Continued from page 2

bankers and other professionals, but excluding doctors.

X.L. has named the Chicago Underwriting Group Inc., an affiliate of Old Republic International Corp., to act as "underwriting consultant" for its directors and officers and professional liability business, said Mr. Sinnott. Final underwriting approval, however, remains with X.L.

Trenwick Services Ltd., a subsidiary of Westport, Conn.-based Trenwick Group Inc., remains X.L.'s underwriting consultant on its excess liability business, said Mr. Sinnott (*BI*, June 30, 1986).

X.L. provides excess liability and professional liability coverage limits of $75 million excess of at least $25 million, and various D&O limits excess of $20 million.

Pension proposals expected

WASHINGTON—The Reagan administration this week is expected to propose sweeping pension legislation that would allow employers to withdraw excess assets from overfunded defined benefit plans without terminating the plans.

Under the proposal, employers would be allowed to recapture assets in excess of about 125% of plan liabilities, sources say.

In addition, the proposal is expected to give favorable tax treatment to pension plan reversions that are used to prefund retiree health benefits. Such reversions would not be subject to excise taxes or current income taxes as long as they were transferred to a trust-type arrangement. Limits would be placed on the maximum reversion that could used to prefund retiree health benefits.

The legislation also will propose beefing up current minimum funding standards for pension plans, sources say.

Another administration proposal—to base the termination insurance premiums employers pay the Pension Benefit Guaranty Corp. on the financial condition of their pension plans—continues to be fine-tuned and will be introduced separately from the other pension proposals (*BI*, Dec. 29, 1986).

Eastern agrees to pay fine

MIAMI—The possibility of litigation prompted Eastern Air Lines Inc. last week to agree to pay a $9.5 million fine—the largest civil penalty ever imposed against an airline by the Federal Aviation Administration.

The FAA levied the fine almost a year ago after it found more than 78,000 violations of maintenance and safety regulations in a special audit.

"Though we had valid and satisfactory answers to the majority of the FAA's concerns, the proposed civil penalty and possible litigation were clouding both Eastern's outstanding safety record and Eastern's substantial maintenance improvements," said Phil Bakes, Eastern's president and chief executive officer in a statement.

According to the agreement reached last week, Eastern will pay $1 million immediately and $8.5 million more by 1990. In turn, the FAA has agreed not to seek any further civil penalties for any incidents that have occurred prior to the settlement.

Briefly noted

Kaiser Steel Corp., which last month canceled health benefits for 5,300 retirees and 1,000 active employees, filed for reorganization under Chapter 11 of the Federal Bankruptcy Act. A Kaiser Steel spokeswoman said discussions are continuing with the Pension Benefits Guaranty Corp. on the possible termination of the company's defined benefit pension plan, which is underfunded by $241 million (*BI*, Feb. 9). . . .**Lloyd's of London** says it's attempting to negotiate a settlement with Lloyd's U.S., a Texas underwriter that Lloyd's of London is suing for using a "confusingly similar" name (*BI*, Dec. 1, 1986). . . .The **Oklahoma Supreme Court** has upheld a July 1986 ruling that rejected an average 25.9% workers compensation insurance rate hike approved in 1985. The court ruled insurers failed to deliver sufficient information to justify the rate increase and said they had to prove current rates were unreasonably low and would endanger insurer solvency or restrict competition (*BI*, Aug. 4, 1986).

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Kaiser defense costs

Continued from page 2

As a result of the decision, Kaiser's excess insurers will have to reimburse Truck for at least $2.7 million in defense costs and another $1 million in interest from June 1983, when the trial court decision was reached, attorneys in the case say.

Truck also is liable for a portion of Kaiser's defense costs.

However, one factor still unresolved is how one of Kaiser's excess insurers, Pine Top Insurance Co., will respond to the ruling. Pine Top was placed in liquidation last month in Illinois and may not be able to pay what it owes.

One attorney involved in the litigation said he is not certain whether the California guaranty fund would pay Pine Top's portion of the defense costs.

Attorneys for the insurers are currently discussing how reimbursement will be apportioned among the excess insurers.

Although the appellate court ruling primarily concerns a dispute between Kaiser's primary and excess insurers, it is also beneficial to Kaiser, which had an agreement with Truck that might have permitted Truck to seek reimbursement from Kaiser for a portion of the defense costs it had paid, said Kaiser attorney James T. Hendrick.

"It is a very good result for Kaiser Cement," said Mr. Hendrick, with the San Francisco firm of Thelen, Marrin, Johnson & Bridges. "It was very much in Kaiser's self-interest to be aligned with Truck and to have the case on defense costs issues come out as it did."

The court's opinion, however, will not be published in the official reports of the state's court opinions and therefore cannot be cited in future cases.

The litigation between the insurers stems from more than 100 claims filed against Kaiser following a May 1980 incident in which Kaiser sold crushed limestone rock that had been mixed inadvertently with kiln brick. The mixture caused flaws in the cement of about 130 construction projects in the San Francisco area.

So far, insurers have paid out approximately $61 million on behalf of Kaiser. The only major claim remaining is one brought by Alameda County for blemishes that appeared during the construction of a jail.

At the time of the incident, Kaiser had $500,000 in primary liability coverage underwritten by Truck over a $50,000 per-occurrence deductible.

Kaiser also had $100 million in excess liability insurance. Insurers participating in this coverage included:

- Transcontinental, a unit of CNA Financial Corp., which wrote a $10 million per-occurrence and aggregate layer excess of $500,000.
- Northbrook Excess & Surplus Insurance Co., an Allstate Insurance Group unit, which wrote a $15 million layer excess of $10.5 million.
- Lexington Insurance Co., an affiliate of American International Group Inc., which wrote $20 million of a $25 million excess of $25.5 million layer.
- American Excess Insurance Co., a unit of American Re-Insurance Co., which wrote the remaining $5 million of that layer.
- Allianz Underwriters Inc., which wrote a $15 million quota-share policy, part of a $25 million excess of $50.5 million layer.
- Pine Top, which wrote the remaining $10 million in that layer on a quota-share basis.
- Fireman's Fund Insurance Cos., which wrote a $25 million layer excess of $75.5 million.

Kaiser also purchased an additional $50 million in back-dated liability coverage from the London market to supplement its existing coverage if the loss ultimately exceeded $100 million.

The major dispute before the court was whether and to what extent Kaiser's excess insurers had to share defense costs with Truck.

According to the opinion, Truck exhausted its limits on Oct. 17, 1980, and although it notified the excess insurers, none agreed to pay the defense costs. As a result, Truck continued to pay for the investigation and defense of the claims.

Truck sued the insurers in October 1980. In March 1983, the trial court, relying on the the 1976 California 2nd District Court of Appeal ruling in *Aetna Casualty & Surety Co. vs. Certain Underwriters*, found that all of the insurers except Fireman's Fund, whose layer was not likely to be pierced, were required to share defense costs on a pro rata basis (*BI*, March 28, 1983).

Except for Transcontinental, whose policy provided that defense costs are included within policy limits, the other excess insurers appealed the decision contending that they did not owe Truck defense costs.

In addition, Truck appealed, contending it was entitled to prejudgment interest from the excess insurers.

The appellate court affirmed the trial court decision that the excess insurers owed Truck defense costs, in part relying on the *Aetna vs. Certain Underwriters* decision.

It first rejected Northbrook's argument that because of the "following form wording" in its policy, its obligation to contribute to defense expenses were contained within its policy limits, just like the immediately underlying Transcontinental policy.

The court focused instead on language in the Northbrook policy, that provided the insurer would pay defense costs without limitation.

"The Northbrook policy does not provide that it follows all terms and conditions of the Transcontinental policy without exception," the court said. "Rather it provides that it does so 'except as otherwise provided herein.' Thus, under Paragraph 1 of the policy, Northbrook expressly undertook to pay defense expenses without limitation."

If Northbrook intended defense costs to be included within policy limits, it could have expressly said so, the court added.

The court also rejected arguments by Lexington and American Excess that they had no duty to pay any defense expenses paid by Truck or that if they did, the trial court erred in the manner in which they would be apportioned.

Lexington and American Excess relied on language in their policies stating they were not obliged to "assume charge" of the settlement or defense of any claim or suit brought against the policyholder.

But the court found that the insurers were confusing the obligation to actively "assume charge" of a settlement or defense with the obligation to pay defense costs.

"A provision relieving an insurer of the duty to actively assume charge of settlement or defense of claims does not necessarily relieve it of the duty to contribute to defense expenses," the court said.

The court also rejected other arguments by Lexington and American Excess, including a claim that Truck should bear all of the defense expenses because the cost per dollar of the coverage written by Truck was 15 to 30 times that of the excess insurers.

The court noted that policyholders pay for two kinds of liability coverage at different rates when they purchase primary and excess insurance.

Premiums for primary insurance supports more localized claims adjustment facilities than those of the excess insurer and takes into account costs of defense, including legal fees, which the primary insurer normally provides, the court said, while the excess insurer is less frequently confronted with loss possibilities.

"Since this is so, we do not find it inequitable to require contribution to defense costs from excess insurers who provide coverage at a lower per-dollar rate than the primary insurer," the court said.

The court also found that it was not premature to apportion defense costs among the insurers, even though claims were still being paid at the time of judgment.

"We deem it far more equitable to require apportionment of defense costs subject to reallocation as additional claims are paid, as the trial court did here, than to require Truck to bear the burden of all defense expenses until all claims have been adjusted."

On various procedural grounds, the court dismissed appeals of Allianz, Pine Top and Transcontinental. It also ruled that Truck was not entitled to prejudgment interest from the excess insurers.

An attorney for Truck praised the opinion, although noting that it is not a major departure from the lower-court ruling.

"We're glad to have the trial court affirmed," said Stephen A. McFeely, with the Oakland, Calif. firm of Crosby, Beafey, Roach & May.

Robert Schiff, an attorney for Northbrook with the San Francisco firm of Fisher & Hurst, expressed disappointment with the decision, but also said it would not have much impact because it cannot be cited as precedent.

Attorneys for American Excess, Lexington, Allianz, Pine Top and Transcontinental were unavailable for comment. ■

More firms buy coverage for outside directors

NEW YORK—More companies are providing directors and officers liability insurance for their outside corporate directors, but the average limits purchased has decreased, a survey says.

And, many outside directors received double-digit pay hikes in 1986, at least partly in response to increasing legal pressures, according to the annual directors compensation survey conducted by The Conference Board in New York.

According to the survey, 88% of the 928 companies surveyed provided D&O coverage in 1986 for their outside directors, up from 85% in 1985.

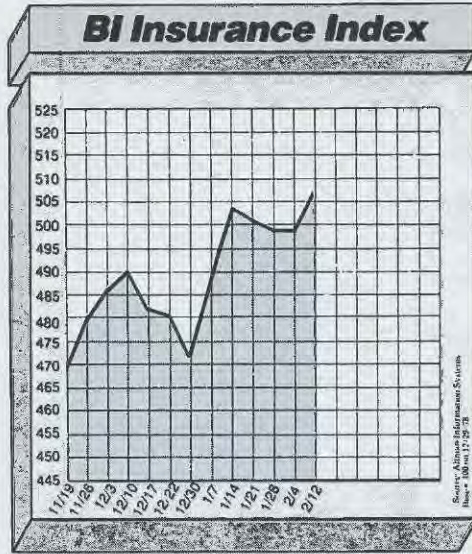
But, The Conference Board says, "There have been widespread declines in the dollar limits of coverage protecting board members against personal loss."

The survey also showed that 41% of the companies gave their outside directors pay increases during 1986. Median annual pay rose 15% among financial companies and 11% for manufacturing concerns; in both cases, this was up dramatically from the small increases seen last year. Directors in non-financial firms saw a 5% pay increase during 1986.

In addition, the survey showed that many companies also increased benefits for their outside directors.

"Corporate managements are very much aware that their directors are shouldering increased responsibility in a risky legal environment," says Jeremy Bacon, The Conference Board's specialist in directorship practices. ■

BI Insurance Index



Insurance industry stocks rebounded last week as the *Business Insurance* stock index jumped 8.3 points to 506.9 on Feb. 12 from 498.6 on Feb. 4. The index had fallen 0.1 points the previous week. Thirty-seven issues rose during the trading period, while 16 declined and 10 stocks remained unchanged. The largest increases were reported by: Frank B. Hall & Co. Inc., up 14.1%; Aneco Reinsurance Co. Ltd., up 13.6%; Kansas City Life Insurance Co., up 7.5%; USF&G Corp., up 6.8%; and The Home Group Inc. and Torchmark Corp., both up 6.5%. The largest declines during the period were reported by: USLIFE Corp., down 6.7%; American General Corp., down 4.3%; Old Republic International Corp., down 4.1%; Fremont General Corp., down 3.9%; and Zenith National Insurance Co., down 3.1%. The *Business Insurance* stock index outperformed the three major market averages during the trading period. The *BI* index rose 1.7%, while the New York Stock Exchange composite fell 1.1%, the Standard and Poor's 500 average fell 1.4% and the Dow Jones 30 Industrials fell 1.2%.

British Issues

Feb. 10	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Companies					
Comml Union	321	18.3	18.3	5.7	330—306
Genl Accident	909	15.1	37.7	4.1	926—878
Gdn Royal Exch	858	14.1	46.5	5.4	880—824
Royal	939	9.9	42.2	4.5	958—895
Sun Alliance	719	16.0	29.5	4.1	740—695
Brokers					
CE Heath	435	12.4	34.5	7.9	444—435
Hogg Robinson	377	14.0	16.2	4.3	377—369
JH Minet	277	12.3	12.0	4.3	279—269
Sedg Grp	308	14.7	16.9	5.5	315—308
Stew Wrightson	495	16.8	19.0	3.8	496—490
Willis Faber	452	16.1	15.5	3.4	463—452

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Competition will dampen spurt in brokers' profits

By LEONARD M. WILSON

Special to Business Insurance

THE COMMERCIAL property/casualty industry now seems to be on the threshold of a new phase. Most of the price increases are in place. Competition is returning to the marketplace—perhaps gingerly—but all the signs of change are there.

Insurance brokers have enjoyed a substantial return to profitability over the past two years because of sharply rising premium rates. But as the competition returns to the industry, the ability of brokers to maintain or expand their profit margins will become more difficult.

Mr. Wilson

Profit margins hit their trough in 1984. For most brokers, spreads have recovered markedly since then and, indeed, profitability is almost where it was in the 1970s.

The improvement, though, has been uneven. Marsh & McLennan Cos. Inc., Corroon & Black Corp. and Arthur J. Gallagher & Co. have experienced a pronounced snap back, while profits at Alexander & Alexander Services Inc. and Frank B. Hall & Co. Inc. have lagged.

From 1984 to 1986, Marsh & McLennan's pretax profit margin increased to 28% from 22%; Corroon & Black posted a rise to 22% from 16%; and Gallagher's margin jumped to 22% from 13%. Over the same period, revenues for these three companies expanded between 60% to 80%.

On the other hand, while Alexander & Alexander's profit margins have almost doubled, they may not exceed 15% in 1986. Frank B. Hall is still suffering from problems that have impeded any recovery in the broker's profits.

The ability to raise aggregate margins is a function of incremental profit margins. We define incremental profitability as the increase in pretax profits divided by the increase in revenues over the same period. For example, Marsh & McLennan revenues increased $705 million from 1984 to 1986, while pretax earnings advanced about $269 million. This performance provided incremental pretax profit margins of 38%.

This substantial growth in revenues for insurance brokers was spurred by the jump in prices for commercial insurance. Top-line growth was sufficiently pronounced as to outstrip materially the expansion in expenses.

With a likely tapering off in rate increases, revenue growth inevitably must slow down. Admittedly, additional business may be written with the greater availability of capacity, but insurance brokers must contend with a narrowing of the gap between the growth in revenues and the growth in costs. As a consequence, the impetus to increase profit margins will lose its momentum.

In this new, less hospitable environment, it is uncertain whether profit margins can be maintained for the more prosperous public brokers and whether the laggards can make up for the lost time and still lift their margins.

In our view, expense control is the dominant factor for profit margins in a period of more enhanced competition. An insurance broker's imbedded expense growth is a function of expansion in the book of business, the general inflation rate and programs to upgrade staff.

A typical public broker can be expected to increase headcount at an annual pace of 4% to 5% to service a larger account base. The inflation rate for 1987 and beyond is likely to run at roughly 3%. Upgrade activity probably can add 3% to 5%.

Thus, we calculate basic cost increases at 10% to 13%, with some deviation from that range depending upon management initiative.

If a broker wants to remain competitive, we doubt that the rise in expenses can be held to much less than that range. Therefore, to maintain profit margins, revenue growth has to be in a range of 10% to 13% as well.

Of course, mix of business and diversification can influence results, and activities that are not susceptible to premium rate competition can give a broker a cushion.

In 1987, we suspect that revenues will outpace expenses since premium rates, on balance, may be a modestly positive contributor. Beyond 1987, there is a high probability that premium rates will have a negative impact on revenue growth. When that occurs, brokers may have difficulty sustaining more than a 10% annual growth in commissions. Incremental profit margins could be negative rather than positive.

Profit margins for public brokers may expand slightly in 1987, but there is not much left in terms of further expansion potential.

Therefore, we have concluded that profit margins for public brokers may expand slightly in 1987, but there is not much remaining in terms of further expansion potential. That general conclusion should be qualified to the extent that a broker with laggard profitability takes remedial steps to restrain or cut expenses.

Our comments have dealt with pretax margins. The Tax Reform Act of 1986 will significantly lower the tax liabilities of the public insurance brokers. Therefore, aftertax margins, not usually a benchmark that we apply, will rise. Higher aftertax profits will further serve to inhibit an increase in pretax margins. Moreover, the equilibrium rate of return to an insurance broker will be elevated by the decreased tax liability, some of which may gradually be passed on to the client through higher service levels.

Some contacts within the insurance brokerage industry have suggested that the present level of profit margins cannot be sustained if the industry enters a period of slower top-line growth and premium rate competition.

As we view it, the test of that thesis will come in 1988. Unless there is a return to irresponsible price competition, brokers have a reasonable shot at holding on to their present level of profitability.

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

Self Insurer Services

Self Insurers Services & Underwriters Inc., has offered an initial 3 million shares of common stock to the public at a purchase price of $10 a unit. Each unit contains 10 shares.

The Sarasota, Fla-based company manages self-insurance funds for industry groups and provides consulting, administrative and management services to existing self-insurance funds.

"The capital (raised) from the stock offering will allow us to aggressively market self-insurance to the 60% of Florida companies who by law are required to have workers' compensation insurance, but are not taking advantage of the lower net costs that a self-insurance program offers," said SISU President Robert Kallio.

Wellshire Securities Inc. is managing the offering.

General Re

Stamford, Conn.-based General Re. Corp. reported that operating income for 1986 increased 76.1% to $279.1 million from $158.5 million in 1985.

Net income for 1986 more than doubled to $328.7 million from $135.8.

The combined ratio for the domestic property and casualty companies was 103.3% in 1986, compared with 110.8% in 1985.

Worldwide net written premiums in 1986 increased 45.9% to $2.9 billion in 1986 from $1.97 billion in 1985.

Aftertax underwriting losses totaled $103.4 million in 1986.

Arthur J. Gallagher

Arthur J. Gallagher & Co. of Rolling Meadows, Ill., increased its quarterly dividend on common stock to 10 cents a share from 5 cents a share, as a result of improved earnings, announced Robert E. Gallagher, president and chief executive officer. ■

BI Industry Stock Report

February 12, 1987 2/5/87 thru 2/12/87

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	26.50	4.6	407.1	1.00	3.5	26.50	27.13	779.5
Baldwin & Lyons Inc	OTC	19.00	-9.5	15.4	0.20	1.1	21.00	19.00*	0.2
Corroon & Black Corp	NYSE	32.25	4.9	14.6	0.65	2.0	32.25	31.63	880.5
Gallagher Arthur J & Co	OTC	26.75	5.9	19.1	0.40	1.5	27.25	25.50	179.7
Hall Frank B & Co Inc	NYSE	18.25	14.1	0.0	0.00	0.0	16.75	16.00	590.4
Marsh & Mclennan Cos Inc	NYSE	64.75	3.0	19.6	1.90	2.9	65.25	64.50	1,622.2
Poe & Assoc Inc	OTC	12.50	2.0	15.8	0.40	3.2	12.50	12.25	2.3
AGENTS/BROKERS	AVERAGE			20.4		2.5			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	16.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	8.38	3.1	0.0	0.00	0.0	8.38	7.50	1,358.7
Berkley W R Corp	OTC	29.00	5.5	16.0	0.24	0.8	29.00	28.25	1,081.8
Berkshire Hathaway Inc Del	OTC	3100.00	0.3	179.8	0.00	0.0	3110.00*	3095.00	1.7
CIGNA Corp	NYSE	60.63	1.0	0.0	2.60	4.3	61.50	59.63	1,574.1
CNA Finl Corp (CNA)	NYSE	56.50	2.7	14.2	0.00	0.0	57.50	55.00	377.0
General Re Corp	NYSE	59.50	3.3	21.7	1.00	1.7	60.88	58.00	1,591.9
ITT (Hartford Group)	NYSE	60.75	2.1	25.0	1.00	1.6	62.00*	59.63	4,149.2
Sears Roebuck & Co. (Allstate)	NYSE	47.25	1.9	13.1	2.00	4.2	47.25	45.50	5,391.6
Transamerica Corp (Occidental)	NYSE	34.50	-4.2	9.7	1.76	5.1	35.25	34.50	1,637.7
CONGLOMERATES/HOLDING COS.	AVERAGE			88.8		3.2			
Insurers									
Aetna Life & Cas Co	NYSE	61.25	1.2	10.7	2.64	4.3	62.63	61.25	2,111.6
American General Corp	NYSE	39.25	-4.3	10.9	1.25	3.2	41.00	39.25	3,155.8
Amern Heritage Life Invt Co	NYSE	43.00	3.0	14.9	1.32	3.1	43.50	42.00	4.6
American Indty Finl Corp	OTC	18.25	-2.7	0.0	1.12	6.1	18.75	18.25	11.2
American Intl Group Inc	NYSE	66.25	-0.7	18.9	0.25	0.4	66.88	66.00	2,264.6
Aneco Reins Ltd	OTC	3.13	13.6	0.0	0.00	0.0	3.13	2.75	348.5
Avemco Corp	NYSE	36.13	3.2	16.0	0.50	1.4	36.13*	35.38	63.1
Business Mens Assurn Co Amer	OTC	28.75	3.6	0.0	1.10	3.8	28.75	28.00	64.0
Chubb Corp	NYSE	64.63	1.8	11.5	1.68	2.6	65.50	64.00	1,071.6
Combined Intl Corp	NYSE	57.75	-0.9	10.8	2.24	3.9	59.00	57.75	369.2
Continental Corp	NYSE	49.00	3.2	233.3	2.60	5.3	49.25	47.50	1,312.3
Crown Life Ins Co	OTC	345.00	-2.8	11.9	6.40	1.9	360.00	345.00	0.3
Durham Corp	OTC	42.50	0.0	13.0	1.36	3.2	43.00	42.50	1.9
Farmers Group Inc	OTC	46.00	5.7	15.3	1.20	2.6	46.00	44.50	1,027.8
Fairmont Finl Inc	AMEX	18.13	-2.7	14.5	0.00	0.0	18.25	18.13	586.6
Fireman Fd Corp	NYSE	36.88	-0.3	15.7	0.30	0.8	37.75	36.50	1,498.3
Fremont Gen Corp	OTC	18.63	-3.9	0.0	0.48	2.6	18.88	18.25	347.0
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	700.00	700.00	0.0
Home Group Inc	AMEX	20.63	6.5	33.3	0.00	0.0	20.63	19.63	629.0
Hanover Ins Co	OTC	70.25	0.7	14.9	0.56	0.8	70.25*	69.50	71.0
Harleysville Group Inc	OTC	16.13	3.2	10.3	0.32	2.0	16.13	15.25	180.7
Hartford Steam Boiler Insptn	OTC	61.00	4.3	14.3	1.60	2.6	61.00*	59.75	207.6
Kans City Life Ins	OTC	28.50	7.5	11.0	0.96	3.4	28.50	27.50	44.6
Kemper Corp	OTC	33.50	-0.7	13.3	0.60	1.8	35.00	33.50	1,320.8
Liberty Corp S C	NYSE	37.00	-2.0	10.6	0.72	1.9	38.50	37.00	27.9
Lincoln Natl Corp Ind	NYSE	49.50	-1.7	11.4	2.16	4.4	49.75	49.50	729.0
Mission Ins Group Inc	PAC	.69	0.0	0.0	0.00	0.0	4.38	.69	9.9
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	28.00	0.0	0.0	0.00	0.0	28.50	28.00	230.9
Nobel Ins Ltd	OTC	17.00	-2.9	12.8	0.37	2.2	18.00	17.00	63.5
Northwestern Natl Life Ins	OTC	32.00	4.1	10.7	0.86	2.7	32.00	30.25	616.4
Ohio Cas Corp	OTC	43.00	1.2	14.2	1.50	3.5	43.50	43.00	423.0
Old Rep Intl Corp	OTC	31.88	-4.1	12.4	0.78	2.4	33.13	31.75	289.2
Orion Cap Corp	NYSE	28.88	3.1	0.0	0.76	2.6	28.88	28.50	50.0
Protective Corp	OTC	19.88	-3.0	10.9	0.70	3.5	20.00	19.50	170.4
Provident Life & Acc Ins Co	OTC	26.13	0.5	12.2	0.84	3.2	26.38	26.00	596.4
St Paul Cos Inc	OTC	48.25	5.5	14.0	1.76	3.6	49.50	47.25	1,978.6
SAFECO Corp	OTC	57.25	2.2	11.9	1.70	3.0	57.50	56.75	424.8
Scor U S Corp	OTC	13.00	0.0	26.0	0.00	0.0	13.00	13.00	299.1
Seibels Bruce Group Inc	OTC	16.50	3.1	0.0	0.80	4.8	16.88	16.00	73.0
Selective Ins Group Inc	OTC	22.75	3.4	10.5	0.92	4.0	23.50	22.00	159.4
Statesman Group Inc	OTC	4.88	2.6	0.0	0.05	1.0	4.88	4.63	166.1
Tokio Marine & Fire Ins Co	OTC	68.88	-2.3	77.4	0.17	0.2	68.88	68.88	6.7
Torchmark Corp	NYSE	28.88	6.5	10.6	1.20	4.2	29.50	28.25	1,315.1
Travelers Corp	NYSE	50.38	3.6	11.3	2.28	4.5	50.75	49.00	1,486.8
Trenwick Group Inc	OTC	18.00	0.0	138.5	0.00	0.0	18.13	18.00	25.7
United Fire & Cas Co	OTC	31.00	5.1	14.6	0.80	2.6	31.00	30.00	12.8
United States Fid & Gty Co	NYSE	45.25	6.8	12.5	2.32	5.1	45.25	43.25	2,403.7
Unum Corp	NYSE	30.13	0.8	8.9	0.40	1.3	30.13	29.63	913.4
Uslife Corp	NYSE	43.63	-6.7	11.3	1.20	2.8	45.75	43.63	212.1
Washington Natl Corp	NYSE	30.50	0.0	13.9	1.08	3.5	30.88	30.25	69.0
Zenith Natl Ins Corp	OTC	23.75	-3.1	26.6	0.80	3.4	25.25	23.75	251.2
INSURANCE COMPANIES	AVERAGE			13.8		2.5			

System design: Altman Information Systems

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