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Update

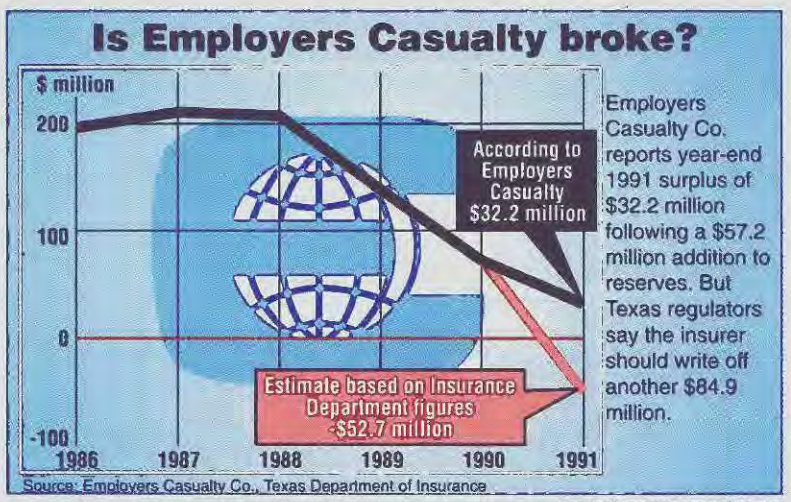
Senate pressure prompts delay of IRS non-discrimination rules

WASHINGTON—Bowing to congressional pressure, the Internal Revenue Service will give employers until Jan. 1, 1993, to comply with its massive and controversial pension non-discrimination rules.

During the one-year delay, the IRS said it would consider suggestions from employers and consultants to improve and simplify the rules.

The decision to delay the effective date came after Senate Finance Committee Chairman Lloyd Bentsen, D-Texas, re-

Continued on next page



GRAPHIC BY JOHN SMITHER

Texas regulators tell comp insurer to stop writing

By MEG FLETCHER

AUSTIN, Texas—Employers Casualty Co., ordered by Texas insurance regulators last week to stop writing new and renewal business, may be insolvent by more than $50 million.

The Texas Insurance Department expects to announce soon whether it will allow Dallas-based ECC, a major underwriter of Texas workers compensation insurance, to run off its current book of business under departmental supervision or seek some other regulatory action, said Texas Insurance Commissioner Georgia Flint.

While ECC last week announced that it had added $57.2 million to its reserves, Texas regulators contend the insurer must write off another $84.9 million, including $60 million in future liabilities owed to a nationwide pool that reinsures workers comp residual markets.

ECC's chairman admits that such a writeoff would leave ECC "technically insolvent."

"We feel that we caught them soon enough where we feel we have numerous options," said Craig Gardner, the Texas department's

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Critics say many would still lack coverage

Bush health plan called inflationary

By JERRY GEISEL

WASHINGTON—Enactment of President Bush's health care package would fall far short of ensuring universal health coverage while likely adding a new superinflationary jolt to employer health care plans, benefit experts say.

The administration contends that its package, which includes expanded tax credits and deductions to help individuals purchase health insurance, would slash the number of uninsured Americans to about 5 million from the current 35.7 million.

While benefit experts agree that tax credits and deductions to defray costs would make health insurance available to more people, they say the administration's projection of the number of people who would obtain coverage is totally unrealistic. Health insurance would remain unaffordable for a significant portion of the currently uninsured, they say.

Some advocacy groups even contend that the number of people without health insurance would continue to increase if the administration's plan were enacted.

They say that without controls on the charges levied by hospitals and physicians, health care costs will continue to spiral and put the price of insurance beyond what even more Americans can afford.

Meanwhile, benefit managers fear that enactment of the president's plan would result in cost shifting that will mean higher costs for company health plans.

They say that if the president's plan—which the administration estimates will cost $100 billion over the first five years—is funded by big cutbacks in federal pay-

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Outhwaite members agree to settlement

Surprise $200 million accord may prompt more members to sue

By GAVIN SOUTER and STACY SHAPIRO

LONDON—Disgruntled Lloyd's of London members may stampede to court in the wake of last week's surprise settlement between 987 members of underwriter Richard Outhwaite's syndicate and 81 members agencies.

Members of the Outhwaite syndicate who were not party to the landmark suit will be left out of the 116 million pound ($206.5 million) settlement and are time-barred from filing a separate action. Their plight has prompted many members of other loss-riddled syndicates to seek legal advice on how to protect their own interests.

The surge of Lloyd's members seeking to join actions against other syndicates also was prompted by another settlement last week. Members suing their agents over losses from former syndicate 553, managed by C.J.W. (Underwriting Agency) Ltd., will receive 4 million pounds ($7.1 million).

These two settlements, made within days of each other, are fueling speculation that more out-of-court settlements could follow among members with losses, underwriting agencies and Lloyd's.

At the same time, Lloyd's is coming under renewed fire in the House of Commons, where many members of Parliament are demanding an inquiry into various problems in the market (see story, page 77).

Last week's surprise settlement came in the landmark suit brought by members of the open 1982 underwriting year of syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. The settlement was reached four months after the trial began and 10 years after Mr. Outhwaite

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Line slip members allege MEWA reinsurance fraud

Reinsurers not told about true nature of business: Suit

By DOUGLAS McLEOD

NEWARK, N.J.—Seven life insurers claim they are the victims of a complex fraud in which a reinsurance pool manager and others bound them unknowingly to huge blocks of loss-plagued health insurance business while stripping off large commissions and fees.

The life insurers—members of a 1988 reinsurance pool managed by Zimmerman Line Slip Inc.—charge that ZLS conspired with a third-party administrator, a fronting insurer, a reinsurance intermediary and others to bind pool members improperly to $250 million in multiple employer welfare arrangement risks.

The MEWA business exposed the line slip members to as much as $64 million in losses, the seven life insurers allege. However, several line slip members have settled roughly half of the MEWA claims, court documents show.

ZLS and others tried to cover up the nature of the MEWA risks to generate a large flow of premiums from which they could take millions of dollars of ceding and brokerage commissions and management fees, Mutual Benefit Life Insurance Co. and six other life insurers charge in a lawsuit filed in federal court in Newark, N.J.

Some of the line slip members say they were not told that they were reinsuring MEWA business for more than a year. When they learned the nature of the business and objected, ZLS arranged to retrocede all the business to another pool, the insurers say.

However, many of the retrocessionaires in this pool turned out to be "undercapitalized offshore insurance companies" that had run into regulatory problems in the United States, the insurers charge.

Most of the retrocessionaires stopped paying claims within a year after assuming the MEWA risks. And, most of the line slip members—which say they did not retain any of the MEWA premiums—then refused to pay the ceding companies, according to the court papers.

The life insurers' complaint is one of four separate lawsuits arising from the line slip's 1988 MEWA business. The suits have been consolidated in U.S. District Court in Newark.

Several of the defendants in the various actions have filed counterclaims, cross claims and third-party claims against others, creating a staggeringly complex case in which virtually everyone connected with the 1988 line slip is

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Spotlight on Health Care Cost Control . . . Page 3

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Update

IRS delays pension rules

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ceived support from all committee members for S. 2210, legislation he proposed that would delay the rules by one year. Sen. Bentsen had hoped his bill would send a message to the IRS to delay the rules.

The promulgation of the pension non-discrimination rules has developed into a severe embarrassment for the IRS. The rules, which exceed 600 pages, were not published in final form until November, almost three years after they were due.

In addition, the rules are poorly drafted and contain many flaws, benefits experts say. For example, portions of the rules for employers that want to run non-discrimination tests for separate operating units are so complex and contain so many exceptions that many say they are virtually useless (*BI,* Dec. 9, 1991).

Chapter 11 liabilities boosted

WASHINGTON—An Internal Revenue Service ruling could make it more expensive for companies to resolve mass tort claims by filing for Chapter 11 bankruptcy protection.

The IRS has ruled in a technical advice memorandum, ruling No. 9204001, that a company may not deduct legal, accounting and consulting expenses connected with a Chapter 11 filing when the main purpose of the filing was to settle tort claims arising from the company's business. The IRS concluded that the professional expenses represent costs of reorganization that must be capitalized rather than deducted. As a result, tax liabilities for companies in Chapter 11 could be boosted.

But, experts predict the ruling will be challenged in bankruptcy courts, which have jurisdiction over tax disputes. "I can assure you that will be widely contested," said bankruptcy specialist Christopher J. Redmond of Redmond, Redmond & Nazar in Wichita, Kan.

The ruling violates a basic tenet of tax policy by treating the same professional expenses differently for a company in Chapter 11 than for a company operating normally, said David Berenson, national director of tax policy with Ernst & Young in Washington, D.C. The ruling will not "sit well with bankruptcy judges or creditors" because it will not help companies emerge from Chapter 11, he said.

Dow Corning shakeup

MIDLAND, Mich.—Battered by problems related to its silicone gel breast implants, Dow Corning Corp. last week replaced both its chairman and its chief executive officer.

Those changes were announced one day after Dow Corning, at the request of the U.S. Food and Drug Administration, released 15 scientific studies and 94 internal documents that indicated the company had for years known of safety problems with the implants.

Keith R. McKennon, previously an executive vp of Dow Chemical Co., was named chairman and CEO of Dow Corning, a joint venture of Dow and Corning Corp. As chairman, he replaces John S. Ludington, now chairman emeritus. As CEO, he replaces Lawrence A. Reed. Mr. Reed remains president and was also named chief operating officer.

Among the documents the company released are descriptions of implant rupture problems from 1971 through the 1980s and a memo suggesting that breast-massage instructions given to women by their plastic surgeons may increase the odds of an implant rupture. Dow Corning faces hundreds of product liability suits filed by women who claim leaking implants caused immune system diseases and other health problems (*BI,* Jan. 13). The documents had been under court seal as part of product liability litigation (*BI,* Dec. 23, 1991).

Dow Corning and its parent companies also face a suit seeking class-action status on behalf of a group of Corning stockholders. Corning stock dropped sharply after the FDA banned the implants (*BI,* Jan. 27).

Bush offers model tort reforms

WASHINGTON—The Bush administration wants states to ban trial testimony based on "junk science"—a term coined to describe theories that are not widely accepted—as part of its wide ranging civil justice reform agenda.

The administration's proposed model would require that all expert-witness testimony be based on "widely accepted" scientific or medical theories rather than fringe theories. For example, "expert" testimony that slips and falls can cause certain types of cancer would be banned because there is no scientific evidence to support that contention.

In addition, expert witnesses would be banned from receiving contingency fees if the side for which they are testifying prevails in court.

The model amendments would also streamline the discovery process by requiring automatic disclosure of "core," or basic, information and by requiring that parties meet in discovery-planning conferences.

Vice President Dan Quayle released the administration's "Civil Justice Reform Model State Amendments" late last week with little fanfare. The amendments are a companion to the Access to Justice Act of 1992 introduced in the House and Senate earlier this month (*BI,* Feb. 10). That legislation would, among other things, try to discourage frivolous suits by making the losers in certain civil cases pay at least part of the victor's legal fees.

5 indicted in MEWA fraud case

PHILADELPHIA—A federal grand jury has indicted the four top officers of Cabot Day Insurance Co. and an escrow agent on felony charges related to a scheme that left thousands of policyholders in at least 14 states without health insurance.

The indictment includes charges of racketeering, conspiracy to commit racketeering, theft of employee benefit funds and wire fraud.

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Errors & omissions

• The Feb. 3 issue incorrectly identified Paul G. Gaston of Spriggs & Hollingsworth in Washington, D.C., as an attorney for GAF Corp. Mr. Gaston has represented other asbestos manufacturers facing similar claims, but does not represent GAF.

Tort reform proponents see boost from Bush plan

By MICHAEL BRADFORD

Court upholds Maryland cap on pain and suffering awards. Page 76

WASHINGTON—Tort reform advocates say a little help from the White House may bring renewed interest to tort reform efforts on the state level.

Tort reform measures face tough fights in some states where legislators are also grappling with tax issues and budget problems this year, said Diane Swenson, vp of the American Tort Reform Assn. in Washington, D.C.

Among the tort reforms that ATRA will be pushing for in a whopping 41 states are measures to limit medical liability, product liability and punitive damages.

And, ATRA will be heading back to 20 state legislatures in an effort to protect tort reform gains in recent years or fight bills that would expand liability. Protecting tort reforms was ATRA's key concern—and big success—in 1991 (*BI,* Feb. 4, 1991).

But, the Bush administration's emphasis on civil justice reform is bolstering tort reform proponents' optimism that their cause will be buoyed in the eyes of legislators and the public, she said.

Republicans earlier this month introduced into Congress the Access to Justice Act of 1992, part of a larger package of tort reforms recommended by President Bush's Council on Competitiveness (*BI,* Feb. 10).

"This is the first time we've had the administration give much attention to civil justice reform," Ms. Swenson said. "That's bringing it back to the front page. There's a renewed interest in the issue."

Still, she concedes that "it will be very difficult to get the issue on the ballot in many states" because of the pressing budgetary and tax issues that are taking up legislators' time.

For example, New York "has been concerned with its budget for almost a year," she said.

Tort reform advocates plan to push for reforms in at least 41

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1918 law held to bar insurance sales in small towns

Banks stunned by ruling

By LAURA MAZZUCA

WASHINGTON—A surprising federal appeals court ruling deals the banking industry a staggering blow by essentially rendering nonexistent an exemption to federal banking law that allowed national banks to sell insurance in small towns.

The U.S. Court of Appeals for the District of Columbia concluded that Section 92 of the National Bank Act—a 1916 provision granting the right to sell insurance to national banks operating in towns with populations of less than 5,000—was repealed by Congress in 1918, even though legislation and court decisions since then have been based on the 1916 provision.

If the decision stands, it will have far-reaching implications not only for the banking and insurance industries—which continue to battle each other in courts and in Congress over the expansion of banking powers—but for the businesses that have grown to rely on bank insurance sales in small towns.

"It would be a heavy blow, not only to national but state-chartered banks," said Stephen J. Verdier, senior legislative counsel for the Independent Bankers Assn. of America, which represents small banks. "Literally thousands of banks would have to shut down their insurance operations; it could be a real problem."

Insurance lobbyists, who say that the banking industry tried to "manipulate" Section 92 to unfairly expand its reach into insurance, are hoping that the court decision will give them leverage in their battle against further banking expansions. One such expansion is the "Delaware loophole," which allows subsidiaries of banking giants Chase Manhattan Corp. and Citicorp to underwrite and sell insurance nationwide under a Delaware law. The loophole was recently upheld by the U.S. Supreme Court (*BI,* Jan. 20).

The Feb. 7 appeals court ruling will have no effect on the Supreme Court decision.

The appeals court ruling was a surprise, said a spokeswoman for the American Banking Assn., be-

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Self-referrals cost millions

Physicians inflate work comp costs, study maintains

By JUDY GREENWALD

SAN FRANCISCO—Referrals by physicians to facilities in which they have a financial interest costs California employers an estimated $356 million annually in unnecessary workers compensation medical costs, a study concludes.

These so-called physician self-referrals represent about 10% of the $3.6 billion that will be spent in California this year on workers comp medical costs, notes the study done by the San Francisco office of William M. Mercer Inc.

The study was sponsored by San Francisco-based Industrial Indemnity Insurance Co., a Crum & Forster Inc. unit. It was presented as testimony to support a bill, A.B. 189, that would prohibit most physician self-referrals in California, not just those linked to workers comp incidents.

The bill, proposed by Assemblywoman Jackie Speier, D-South San Francisco, already has been approved by the state Assembly and is pending in the Senate.

Meanwhile, the Federal Trade Commission is conducting several investigations of physician self-referrals around the country, including California.

Of particular interest are arrangements that may violate antitrust law by allowing physicians to corner the market for a service and preclude competitors from operating because they would not be able to get physician referrals, says Mark Horoschak, head of the FTC's health care division and assistant director of its bureau of competition.

While physician-owned medical service providers are not new, they are proliferating, said Mr. Horoschak. "It seems to have been a problem that's emerged in the last year or so."

Sharp marketers are bringing together physicians with medical service providers, he said. In some

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Inside

✔ If the United States ever is to adopt a universal health care system that will also rein in soaring health care costs, there will have to be more dialogue among politicians, employers, providers and others, this week's editorial says. **PAGE 8**

✔ A program in Pennsylvania that brings employers together with hospitals to share information about health care costs and services may improve quality of care, its organizers say at a recent conference. Coverage begins on **PAGE 64**

✔ Japan's 23 non-life insurers could be hit with staggering cost increases and a major capacity shortage for catastrophe reinsurance programs that renew April 1 following a record typhoon losses last year. **PAGE 71**

✔ Maryland's highest court has upheld the constitutionality of a 1986 state law that caps awards for pain and suffering in personal injury cases. **PAGE 76**

✔ The quality of reporting to shareholders in the property/casualty industry continues to deteriorate, says industry analyst Myron M. Picoult. **PAGE 79**

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Health Care Cost Control

Companies eye new approach to coverage for working dependents

By LORI BLOCK

Employers that try to eliminate health care coverage for employees' working spouses may be targeting more than costs.

Many of these employers are looking to introduce more equity into a system they deem to be unfair, benefit consultants and corporate executives say.

In particular, many employers are taking aim at other companies that drive employees to enroll in their spouses' plans by failing to provide adequate health insurance or, in some cases, by offering employees incentives to obtain coverage elsewhere.

And some employers are trying to modify benefit plans that favor employees opting for dependent coverage over single employees.

Of course, a key reason why more employers are rethinking benefits for dependents—particularly to working spouses—is the rising cost of health care. However, consultants add, it is difficult to quantify just how much employers can save by reducing benefits for dependents with access to other sources of coverage.

Companies can employ a variety of methods aimed at "encouraging" their employees' working spouses to obtain coverage elsewhere. These range from raising copayments for employees with dependent coverage to refusing coverage to a spouse if he or she can obtain coverage from his or her own employer.

"The most effective way (to contain costs) is to not cover individuals who you feel should not be provided coverage under your plan," said David Repko, a principal in Cleveland with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

"Companies only want to worry about their obligations to their employees and are concerned about being cost-shifted upon by other companies," said Rich Sinni, director of the health management practice at Buck Consultants Inc. in New York. "They want to be fair, but they don't want to be taken advantage of."

"The overall concept is, 'Can we get somebody else to pay for some of these benefits?' " says Arthur Dreschler, national practice leader for group benefits at Martin E. Segal Co. in New York.

Such an attitude is nothing new, said William Danish, a principal with Kwasha Lipton in Fort Lee, N.J. To many employers, "the best form of cost containment was to have somebody else pay for (their) employees' health care."

But what is new is that some employers are actively encouraging their workers to obtain coverage elsewhere, consultants and employers report.

Seeking coverage under a spouse's plan also is being driven by the growth of managed care programs and the prevalence of two-income households, Mr. Repko said.

While many rankle at providing coverage to another firm's employees, other employers may alter their plans

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Employers monitor lifestyles

Financial incentives for wellness gain favor

By CHRISTINE WOOLSEY

Ten or 15 years ago, benefit managers across the country generally felt that what an employee did away from work was his or her private affair.

Not anymore.

Today, employers are becoming involved in the lifestyles of their employees as a way to control skyrocketing health care costs.

Some employers are making good employee health a condition of employment. Many others are implementing plan design changes under which employees with unhealthy lifestyles pay more for their health care benefits—especially those who use tobacco, have high blood pressure or cholesterol levels, or are overweight.

Others have taken a more positive approach—awarding healthy employees for their healthy habits.

"Employers are beginning to focus more attention on prevention, rather than just on containing costs after health problems develop," said Dr. Bryan Bushick, a consultant in Minneapolis with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. "And, they've found that financial incentives can be a powerful way to motivate employees to adopt healthy lifestyles."

The good news is that employers are saving substantial amounts of money as a result of these initiatives.

The bad news is that the programs are not a cure-all. Like so many other strategies—cost shifting, utilization review, managed care—they are but another tool for benefit managers as they hasten to build a fortress against ever-increasing costs.

And, consultants and attorneys warn, there are potential legal problems associated with programs that penalize employees with unhealthy lifestyles—primarily violations of state discrimination or privacy laws (see story, page 10.)

Employers have been offering wellness programs of one kind or another to employees for decades. Early programs typically took the form of health awareness campaigns designed to teach employees and dependents how to become healthier. Exercise classes, smoking cessation programs and literature distribution were common.

Some employers even built on-site corporate fitness centers to communicate their commitment to employee health and to make it more convenient for employees to slim down or reduce stress.

In a study scheduled to be released next month, Lincolnshire, Ill.-based Hewitt Associates found that 76% of 618 employers surveyed offer at least one "health promotion activity."

Similarly, a recent survey by the Hay Group of Philadelphia found that 91% of 832 respondents have some type of program to promote employees health.

And, A. Foster Higgins & Co. Inc. of New York reported in its sixth

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10 largest general service utilization review firms

Based on total inpatient admissions reviewed in 1991

Company (ownership)	Total inpatient admissions reviewed	Full-time staff: Total	Full-time staff: Physicians	Full-time staff: RNs	Physicians on retainer
Blue Cross & Blue Shield Assn. (Not for profit)	2.4 million	1,478	130	1,324	1,000
Intracorp (CIGNA Corp.)	748,776	4,407	10	2,400	400 to 500
Private Healthcare Systems Inc. (17 insurers)	440,000	526	77	239	0
Metropolitan Life Insurance Co.-Managed Care Services Group (Mutual insurer)	400,000	525	24	403	12
HealthCare COMPARE Inc. (Publicly held)	392,440	946	30	238	4,000
AXIOM Review Inc. (Privately held)	353,000	95	2	60	115
Health Risk Management Inc. (Publicly held)	268,000	615	29	85	5,500
Conservco Inc. (Travelers Corp.)	250,000	1,700	4	850	281
Cost Care Inc. (John Hancock Mutual Life Insurance Co.)	248,000	587	54	163	8,600
Peer Review Analysis Inc. (Publicly held)	175,000	99	4	25	135

Source: *BI* survey

BI GRAPHIC BY JOHN HALL

Employers increasingly are pressuring utilization review firms to guarantee the savings their reviews are supposed to generate.

While a few vendors will accept financial penalties if they fail to meet cost containment goals, other UR firms fear such deals may compromise treatment decisions for the sake of making a profit. See story, page 28.

Meanwhile, utilization review providers continue to harmonize their efforts with managed care networks, hoping to make the UR process less cumbersome for physicians, employers and patients.

Many UR firms also are expanding the range of services they offer.

For an overview of the market and profiles of the leading UR firms, see story, page 32.

A directory of utilization review vendors begins on page 36.

Wellness incentives

Continued from previous page
annual Health Care Benefits survey that 33% of employers offered either an on-site fitness center or a financial subsidy for health club membership in 1991—up from 27% in 1990 (*BI*, Jan. 27.)

These initiatives have proved to be quite worthwhile for some employers. Golden, Colo.-based Adolph Coors Co., which implemented a comprehensive wellness program in 1981 with many fitness features, has saved an estimated $1.9 million annually by decreasing medical costs, reducing sick leave and increasing productivity, according to Lynn Gilfillan, community wellness coordinator.

Yet, according to Hewitt's survey, many employers are uncertain about whether these programs are meeting their objectives—particularly if those objectives include improved employee health and medical cost containment. Forty-one percent of responding employers say they are "not sure" their health promotion activities are effective in improving employee health or containing costs, the study found. And, 32% of respondents indicated that these activities were "slightly effective" or "not effective" in containing costs.

But the new generation of wellness programs—those that include health risk appraisals and tie them to financial incentives—may be more effective. These programs as yet are much less prevalent than their predecessors. Just 3% of respondents to the Foster Higgins survey reported offering wellness programs with financial incentives in 1991. However, 5% said they planned to start such a program this year.

Employers are "realizing that keeping their employees healthy can significantly cut health premium costs," pointed out Michael Carter, a senior vp with the Hay Group. As a result, employers are now "strengthening the typical wellness program by making it financially worthwhile for the employee to meet" the company's wellness criteria.

"It's not a matter of information. We all know what is unhealthy, but we need to (motivate) employees to change their behavior," said J. Kennerly Davis Jr., vp and corporate secretary for Dominion Resources Inc., an electrical utility holding company in Richmond, Va.

Dominion now pays its workers an extra $10 per month in pretax flexible benefits credits if they qualify as low-risk in five lifestyle-related categories.

Not only are employers embracing the idea, but many are convinced that improving employee health may be one of the last frontiers in cost control.

According to a recent survey by TPF&C, 12% of 135 large U.S. firms either offer a discount or impose a surcharge on employee contributions to life or health insurance plans based on certain behaviors. Another 6% plan to adopt such financial incentives over the next two years, and 19% said they are considering it.

Employers will continue to focus on employee health, because "health care costs are now affecting the bottom line. It's as much of an issue in the board room as other business issues," according to Sue Nelson, health benefits manager for Texas Instruments Inc. in Dallas.

Skeptics caution against thinking that wellness incentives are the eighth natural wonder.

"Health care costs will go down with these programs, but there is a limit to how far they'll go down," said Ron Mason, a consultant in TPF&C's Los Angeles office. "It will only be another tool in the toolbox, because we haven't invented the immortal employee who doesn't get sick."

The new breed of wellness incentives can take the form of awards or penalties. Typical awards include paying healthy employees—those who do not use tobacco, who exercise, wear seat belts, and have "normal" weight, blood pressure and cholesterol levels—a cash bonus, or reducing their contributions toward the employer-sponsored health plan. Employers with flexible benefit plans often give healthy employees additional flex credits to spend on other types of benefits.

Common penalties include risk-related deductibles that require unhealthy employees to pay higher deductibles depending on their health status. Other employers require unhealthy employees to contribute more toward their health insurance premiums than healthy employees pay.

Some programs are voluntary; others require employees to participate in health risk appraisals. And some target dependents and retirees as well as active workers.

"A lot of companies are talking about putting in one of these programs, but they haven't pulled the trigger yet," commented Dave Morgan, a managing consultant with Foster Higgins in Richmond, Va. "It's not as easy to do as it sounds. There really is a lot of thought that has to go into" designing a program like this, he said (see story, page 16.)

Most consultants advise employers to link incentives only to behaviors that are within the employee's control. "Safety habits, smoking and exercise might be included," Dr. Bushick said. "Employers should use caution, however, in applying incentives to health conditions that could result from an individual's genetic makeup, such as high blood pressure or high cholesterol."

"I see employers trying to isolate risk factors that really do affect health care claims," Mr. Morgan said. Data that clearly illustrates how lifestyle-related behavior can lead to increased health care costs is now becoming available, he said.

However, Mr. Morgan noted, while employers can monitor employees' weight, blood pressure and cholesterol levels through medical tests, they typically rely on the honor system when it comes to smoking and seat belt use.

There are ways to provide employees an incentive to tell the truth about their smoking status, said Hay Group's Mr. Carter. For example, if a company is going to offer non-smokers an incentive, it could publish the names of all the people who are eligible for the award. An employee who smokes—and who knows his or her co-workers are aware of his or her smoking—is more likely to answer honestly, Mr. Carter said.

Another way—albeit more draconian—to monitor employees' honesty about smoking is to closely scrutinize health care claims for any smoking-related conditions, consultants say. However, most employers say they have no plans to go that far. And new scientific information shows that some non-smokers are susceptible to ailments found in smokers, they say.

The type of approach employers take—awards vs. penalties—often depends on the company's goals and how soon it must accomplish measurable savings.

"You want to be fair on one hand, but you want to be effective on the other," Mr. Morgan said. "If a wellness program doesn't change employees' behavior, all it does is cost you money."

Conducting a cost/benefit analysis is crucial in getting most bottom line-oriented chief executive officers to buy into these types of programs, consultants say.

Continued on page 6

Seeking a glide path in the self-insured risk corridor?
ERC's flexible excess worker's compensation
is the safe alternative to winging it.



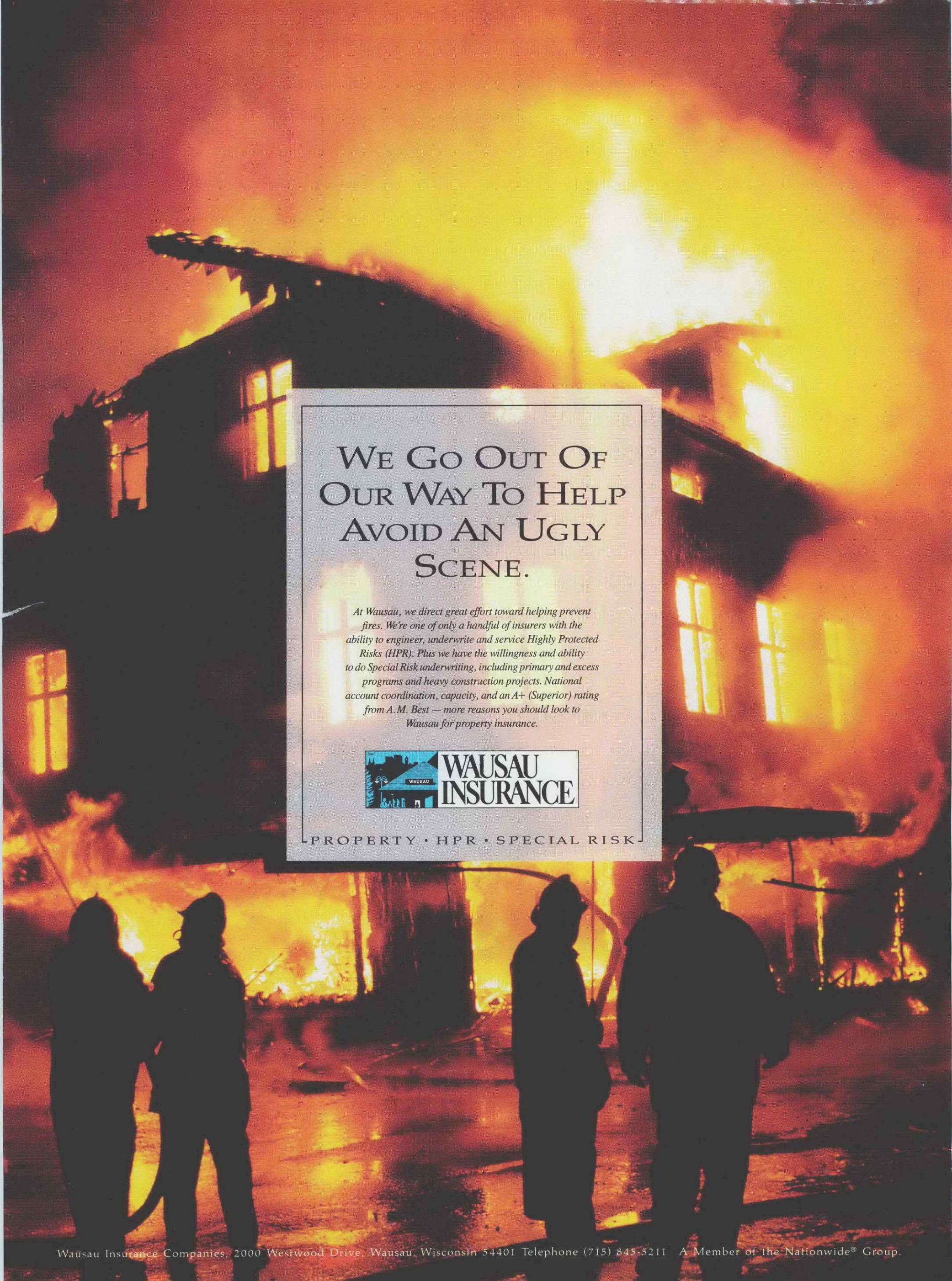
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Wellness incentives

Continued from page 4

"Unfortunately, few employers have conducted this analysis, because the methodology to do so up to now was unavailable," said Leigh Williams, a consultant with Hewitt in Lincolnshire. "Our message is (that) now it is very possible to perform cost/benefit analyses."

For example, some firms have researched how much more expensive unhealthy lifestyles can be.

Milliman & Robertson Inc. conducted a study in 1987 for Control Data Corp., a Minneapolis-based computer manufacturer, to estimate how much high-risk and low-risk people cost in terms of medical care, said Stephen D. Brink, a consulting actuary in the consultant's Brookfield, Wis., office.

Among the study's findings: People with high blood pressure are 68% more likely to incur medical claims in excess of $5,000 per year; people not wearing seat belts during an automobile accident incur 54% more hospital days; and smokers' overall health costs are 18% higher than costs for non-smokers.

In January, Control Data began charging smokers 10% more in health insurance premiums than non-smokers, according to a Control Data spokesman.

Other experts point out that, invariably, a small percentage of employees accounts for the largest percentage of health care claims in any one company.

"We have found that in any given benefit plan, 10% of participants drive 70% of claims costs," said Foster Higgins' Mr. Morgan.

Because more data is now available that shows how lifestyles relate to specific illnesses, some skeptics are mellowing, Mr. Morgan said, adding, however, that employers currently are either big proponents of these programs or doubtful about them.

However, consultants say, simply identifying where the health problems lie within a corporation is not enough. To be truly successful, employers have to change employees' behavior. That is why financial incentives are in vogue, they say.

In 1989, Phoenix-based U-Haul International Inc., whose group health indemnity program is insured through Oxford Life Insurance Co. in Phoenix, paid $18.6 million in health care expenses for its approximately 18,600 employees and dependents. A mere 392 people accounted for $7.7 million of that total, said a spokeswoman.

Faced with no choice but to cost-shift, U-Haul in 1990 began requiring tobacco users and overweight individuals to pay $5 each pay period to help offset rising health care premiums. Non-smokers and employees that fall within U-Haul's "acceptable" height and weight range still do not have to contribute any amount toward their health insurance.

"In the 1980s, we had some wellness programs, including Weight Watchers and Jazzercise classes in our conference rooms," the spokeswoman said. "But it was voluntary and no one participated. The pocketbook really wakes people up."

U-Haul's health care costs decreased 3% as of March 1991, the spokeswoman said. She noted, however, that U-Haul introduced both a preferred provider organization and utilization review along with the new wellness incentives, all three of which probably helped reduce the company's costs. The company will release another round of results this April.

Houston-based Baker Hughes Inc. spent six months pouring over its health claims data to pinpoint what types of claims and which employees were responsible for racking up the highest medical costs. The oil and gas firm found that 55% of its total claims costs fell in four categories: circulatory, digestive, musculoskeletal and respiratory.

"All of those ailments are lifestyle-related, and we found that the use of tobacco contributed to three of the four," explained Joe Vinson, director of compensation and benefits.

Using that information, Baker Hughes and Hewitt Associates designed a program implemented in 1990 that discourages tobacco use. At the same time, the company put in a wellness program that encourages healthy employees to keep up their good habits.

Baker Hughes charges tobacco users an extra $10 per month above their normal contributions for medical care. Meanwhile, the firm pays up to $50 per employee per year for employees' health checkups, which include triglyceride, cholesterol, blood pressure and height/weight tests. If the employee does not use tobacco and meets minimum norms on three of the four tests, the firm will deposit $100 in the employee's health care reimbursement account.

After the first year, Baker Hughes took in $418,000 as a result of the surcharge for tobacco users. That $418,000 more than paid for the $260,000 in wellness awards and health checkup costs, Mr. Vinson said.

Furthermore, Baker Hughes estimates it will save as much as $3 million to $5 million over the next three years as a result of preventing some of the lifestyle-related claims it identified.

"Based on our studies, employers see some fairly immediate results —typically a reduction in medical care costs—"as a result of wellness incentives, Mr. Brink noted.

But, he added, some savings—particularly those associated with smoking cessation or weight loss—take a little longer to measure.

Employers also may experience short-term savings in the form of reduced accident rates and fewer sick days, said Mr. Mason.

Because disincentives tend to produce savings right away, they often are more eagerly embraced by upper management than incentives, Mr. Carter pointed out.

Incentive approaches—those that reward healthy employees for their behavior—usually cost money. But, consultants say, those costs may be offset in the long run, because healthier employees generally need less medical care.

Some employers may think it is inappropriate to prod their workers into adopting healthy habits—or to punish workers with unhealthy habits—but more and more employers and consultants are persuaded by the concept that healthy employees will cost less.

Basking Ridge, N.J.-based property/casualty insurer Crum & Forster Inc. is among the faithful. Faced with health care cost increases averaging 20% in 1989, 1990 and 1991, the self-insured company decided to take the issue of corporate wellness seriously.

"It became clear to us that the only way to defeat (rising costs) was to make employees healthy so they would cost less," explained Vincent Sweeney, vp of corporate benefits. With the help of its consultant and health plan administrator, Crum & Forster is implementing a managed care plan that emphasizes health promotion.

Employees complete an annual health risk appraisal designed to assess their overall health. The appraisal is sent to the employee and his or her primary care physician, who then discuss how the employee can achieve better health.

"We are trying to encourage a partnership between the employee and the primary care physician and also (motivate) employees to become healthy," Mr. Sweeney explained. ■

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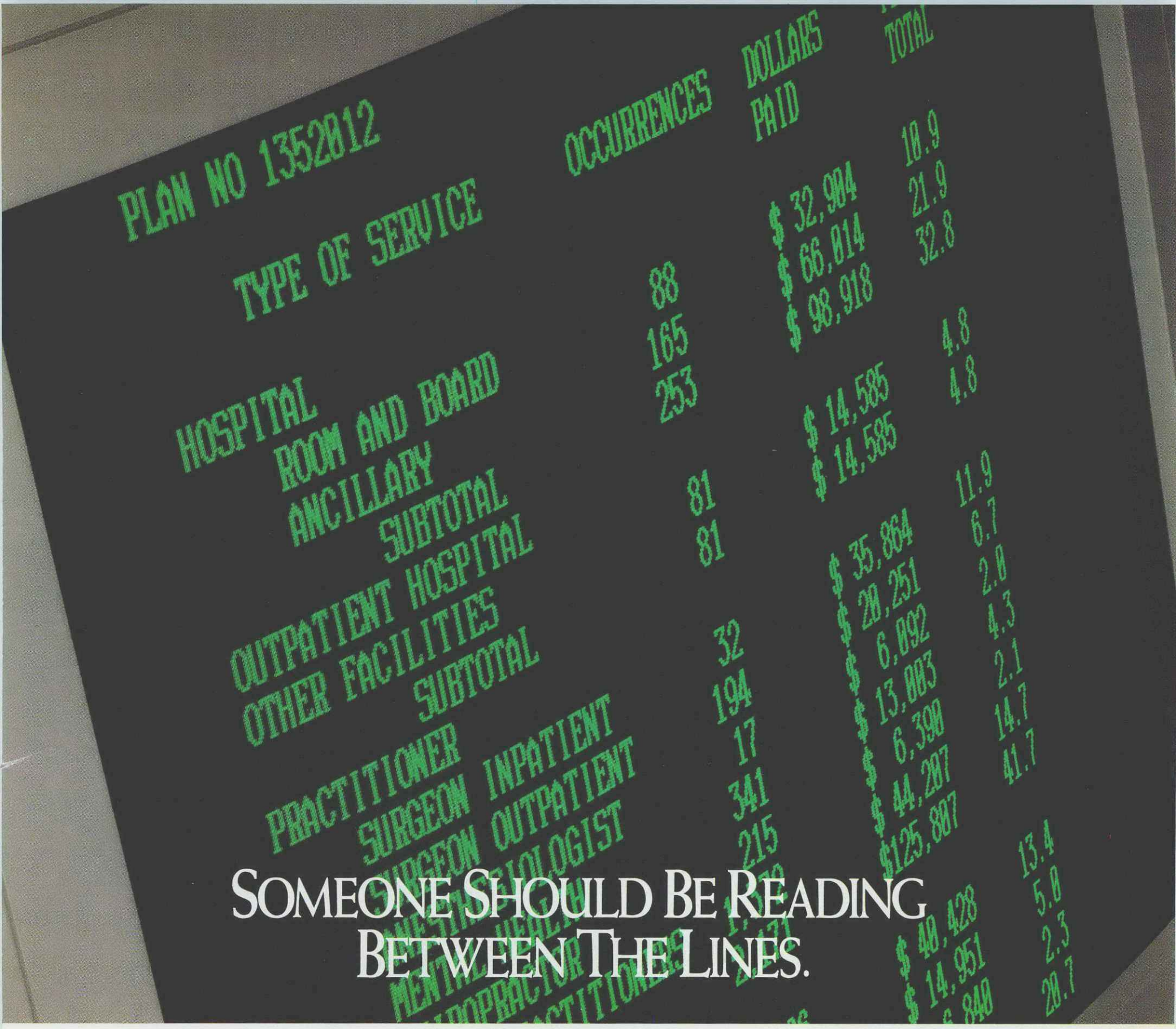
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Opinions

Where do we go from here?

IF THE UNITED STATES ever is to adopt a universal health care system that at the same time will rein in soaring health care costs, there will have to be more honesty, candor and dialogue among Republicans and Democrats, business and labor, and other interest groups.

It's difficult to take seriously any plan to improve health care access for the nation's 35.7 million uninsured, which the Bush administration's health care package purports to do, if the proposal fails to spell out how the five-year, $100 billion cost to subsidize coverage will be financed. The money has to come from somewhere. Any plan that doesn't recommend a specific funding source is simply folly.

If the package were to be funded by Medicare and Medicaid provider reimbursement cuts, as many say would likely happen, the result would be even more cost shifting by hospitals and physicians to employer-sponsored health care plans. That would make private health insurance even less affordable, possibly leading more companies to drop coverage for their employees.

This would, of course, fuel a vicious circle: As more workers lost employer-provided health insurance, even more funds would be needed to pay for the Bush proposal.

It also is hard to take seriously any plan, like the Bush administration's package, which is virtually silent on health care cost containment. Does the administration think costs will be controlled just through wishful thinking? What incentives are there in this package for providers to hold down charges or better manage their operations? There are none that we can see.

Finally, at this stage in the health care debate, it's hard to take seriously any proposal that would not guarantee coverage for all Americans. The administration says that the Bush plan would provide health care access to all but about 5 million uninsured Americans. That still is too many.

Some critics of the plan say that the program would help far fewer of the nearly 36 million uninsured, while some speculate that the number of uninsured Americans would actually rise (see story, page 1).

While the Bush proposal falls short of the mark, congressional Democrats haven't been entirely straightforward with their reform proposals, either.

Consider the "play-or-pay" approach to expanding access to health care coverage that is embraced by the Senate Democratic leadership. Under this approach, an employer would either have to offer a health care plan meeting certain federal standards or pay a tax to help fund a public plan for the uninsured. Congressional Democrats have said little about how large a public plan would be necessary under play or pay, even though some analysts suggest that the public plan could be nearly four times larger than the federal Medicare program. Is this really a good idea?

At the same time, congressional Democrats, especially in the Senate, haven't made it clear that a payroll tax would only partially cover the cost of subsidizing coverage for the uninsured. Obviously, there would have to be other new federal taxes, something that Democrats have shied away from discussing.

To the credit of Democrats, though, they at least recognize that the key to achieving universal coverage is controlling costs for all buyers of health care services. Several of the major Democratic packages would set limits on national health care spending and would prevent providers from raising charges on private payers to make up for shortfalls



from public plans.

We believe it is possible to develop a health care package that would make universal coverage a reality and still help to bring down health care cost increases to a more acceptable level.

Such a package may be based on the current health care system, it may be based on a play-or-pay format, or it might be necessary to enact a national health care system. We don't think that any of these ideas should be rejected out of hand, keeping in mind the crisis that exists in the current health care system.

We especially are appalled by leaders who castigate the health care reforms suggested by others, even though they have no realistic suggestions of their own.

However, that's what has been happening for the past four years.

How do we come up with such a reform package—especially during an election year?

We propose that a weeklong summit be held that brings together representatives of the administration, congressional leaders on both sides of the aisle, health care providers and insurers, business groups, labor unions, taxpayer groups, advocates for the uninsured and others. The meeting could be held in late June, after the primaries are over and before the national political conventions. The proceedings would be open to the public and could be televised, if not on the major networks, at least on a cable network like C-SPAN.

The purpose would be to propose different solutions to the health care crisis and then discuss them, face-to-face, with candor.

In such a format, the authors of the various proposals—be they the Bush administration, congressional Democrats or private groups—would have to demonstrate how their proposals would be financed and how they would work.

If no good proposals came out of the meeting, or if a particular side "sandbagged" during the discussion, the American people would have something to keep in mind when they go to the polls in November.

Of course, such a meeting will never happen—especially not in an election year. Our elected leaders in Washington—the only group that can make health care reform a reality—would never stand for a frank and open discussion of such an explosive topic.

But, such a meeting of the minds will have to take place at some time before the U.S. health care system can be reformed. It's better that it happens now than much, much later.

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Spotlight report

Off-duty conduct: none of employer's business?

Health savings make rules tempting, but employers risk privacy lawsuits

By CHRISTINE WOOLSEY

Employers that try to regulate employees' off-duty conduct—particularly if the conduct is legal—run the risk of being sued by employees who believe what they do on their own time is none of their employer's business.

In fact, laws recently passed in 21 states in one form or another prohibit employers from basing employment-related decisions on a worker's off-duty behavior or lifestyle.

Yet more and more employers are doing just that. They are prodding workers to eat right and lower cholesterol levels, to reduce stress and lower blood pressure levels, to exercise, lose weight and stop smoking.

Some companies offer "carrots" to healthy employees for their good health habits, while others mete out "sticks" to penalize unhealthy employees (see story, page 16).

A few companies have gone so far as to refuse to hire people who fall short of their wellness criteria.

All of this is being done in the name of health care cost containment. But, management consultants and lawyers warn, employers should definitely look before they leap into such practices, even if employers have the best of intentions.

"There is a lot of concern about how employees will react to such programs," said Stephen D. Brink, a consulting actuary with Milliman & Robertson Inc. in Brookfield, Wis. There is concern about privacy, but there also is concern about whether employers can adequately determine if someone is "high risk," he said.

Unions generally oppose programs that try to regulate worker lifestyles, said Claudia Bradbury, policy associate at the AFL-CIO in Washington, D.C.

The labor organization is "very opposed to negative incentive programs regarding health care, like penalties based on individual characteristics like blood pressure or weight," she said.

Employers that adopt such programs are "easily putting themselves in a position of screening persons for genetic problems," she said. "I think I should be able to live the way I want to, but in some cases I may not be able to lose weight or lower my cholesterol level because of genetics."

And, she said, "the fact that certain lifestyles increase or decrease health care costs has nothing to do with how many widgets (a worker) can spit out in an hour."

Critics of these programs also worry that unless they are limited by law, employers will go too far in monitoring employees off-work behavior.

"If a company determines that it has the right to ban one habit that isn't healthy, will it set a precedent for banning others? If so, where do we draw the line?" asks Mildred L. Culp, president of Executive Directions International Inc., a consulting firm in Seattle.

"In our cost-conscious era, will companies start refusing to hire or retain employees who have the least tan on their faces because of the risk of cancer?" she asks. "Will companies require employees to eat high-fiber diets for the same reason? Will they step in on the mental health side, trying to get access to information about divorces or court appearances that may directly or indirectly affect an employee's performance?"

Other observers contend these programs are an invasion of privacy.

"Employers are increasingly looking into what you are doing at home. They are asking you what you eat, how much you sleep, whether you exercise—and that's none of their business, because it's not affecting job performance," said Jonathan Anderson, a staff assistant at the American Civil Liberties Union in New York.

"As a general rule, employees do have, under the common law, a right of privacy, and that right is recognized in most states," said Jonathan Segal, a management attorney with Wolf, Block, Schorr & Solis-Cohen in Philadelphia. However, "where there is legitimate employer interest, the employees' right—under the common law—may have to give way.

"There are two principal justifications for employers' interest in off-duty conduct," Mr. Segal said. "One is cost containment. Employers are interested in removing from the workplace individuals who engage in conduct that is likely to result in increased utilization of health care. The second is safety. Off-duty conduct may affect the employee's on-duty conduct, or his behavior may pose a risk to his co-workers."

Most courts will side with employers when off-duty conduct is illegal, Mr. Segal said. But, he noted, "as you go from the realm of illegality to legality, it's much harder for the courts to decide in the employer's favor."

Some observers don't buy employers' argument that regulating employee lifestyles has become a business necessity because health care costs are careening out of control.

"Employers' economic argument is really a red herring," said Walker Merryman, a vp at the Tobacco Institute in Washington, D.C., which, along with the ACLU, has lobbied for state worker privacy laws. "Once you start down that road" of allowing employers to regulate off-duty conduct, "you have almost a limitless supply of areas of discrimination: alcohol use, red meat diets, even recreational activities like hang gliding or mountain climbing," he said.

How far employers can go in policing their workforce will probably be determined in state courts and legislatures, consultants and attorneys say.

"The one big wild card in all of this is case law," said Leigh Williams of Hewitt Associates in Lincolnshire, Ill. "There isn't any, so employers are doing the best they can by reviewing the legal issues."

Some employers have had no problems establishing fairly restrictive hiring policies mainly aimed at smokers.

In 1986, Turner Broadcasting System Inc. in Atlanta stopped hiring tobacco users. The ban was not applied to existing employees, though they are restricted from smoking outside of designated areas.

"Our internal thought process was that if we stopped hiring smokers, in 10 or 15 years we'd be smoke-free," explained William Shaw, vp of administration. The policy was not an effort to reduce health costs, but was adopted because Chairman Ted Turner wanted a smoke-free workplace, he said.

TBS employees back the policy, and no job applicants have sued, Mr. Shaw said. So far, refusing to hire tobacco users "has not been a roadblock to our growth or success as a company at all."

Other employers haven't been as lucky.

Ford Meter Box Co. is being sued

Continued on next page



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Continued from previous page
by a former employee who was dismissed for violating a company rule against all tobacco use.

Part-time clerk Janice Bone applied for a full-time position with the Wabash, Ind.-based manufacturer in 1989. The firm categorized her as a "new hire" based on her change in job status, according to Susan Tabler, a defense attorney with Ice, Miller, Donadio & Ryan in Indianapolis.

During an interview with the personnel department, Ms. Bone admitted that she smoked, but agreed to quit. Six weeks after taking the job, however, Ms. Bone failed a drug test given to all new hires. "She was fired after the test revealed she had nicotine traces in her blood," explained Ms. Tabler.

Ms. Bone sued, claiming invasion of privacy, intentional infliction of emotional distress and wrongful termination. The case comes to trial in June.

A similar lawsuit is pending against the city of North Miami, Fla.

In 1990, Arlene Kurtz applied for a clerical job with the city. After passing a written examination, she was asked to sign a document stating that she had not smoked in the last 12 months, explained her lawyer, Pam Chamberlin of Mitrani, Rynor & Gallegos in Miami. When Ms. Kurtz would not sign, the city refused to hire her.

"She is completely barred from getting a job with the city regardless of her qualifications and regardless of the fact that smoking does not affect her job performance," Ms. Chamberlin said. The city hiring policy "violates federal due process and equal protection clauses, which require employers to base hiring decisions on job requirements," she argued.

Ms. Chamberlin also characterized the policy as discriminatory because it only applies to new hires. "If (the city) were really concerned about eliminating health care costs associated with smoking, the policy should apply to all employees."

A 'significant risk' of lawsuits arises when firms try to regulate off-duty conduct, Mr. Segal says.

Another employer—the city of Athens, Ga.—considered barring employment of anyone with a high cholesterol level.

According to John O'Looney, a former president of the ACLU chapter in Athens, the city attempted to deny employment to anyone whose cholesterol level was above a certain level. Threatening litigation, the ACLU convinced Athens officials to drop the effort, Mr. O'Looney said.

When employers try to regulate off-duty conduct, they run a "significant risk" of being sued, said Mr. Segal, the management lawyer.

That risk is even higher, he said, if the "conduct" is something like high blood pressure, which can be hereditary. Employers that target these conditions may be accused of age, sex or racial discrimination, because some groups are more predisposed to certain health problems, he added.

He recommended that employers do several things to reduce the risk of lawsuits.

After identifying which factors they want to improve, employers "need to ask themselves whether their reasons for doing so are legitimate," Mr. Segal pointed out. "If their goal is related to improving health or safety, (their reasons) usually are."

Next, employers should consider whether there are less restrictive ways to reach those goals. For instance, they may decide simply to require smokers to pay more for health insurance, rather refuse to hire them.

"Get employees involved in the program; explain why you are doing it; and give them a notice period so they have some time to try to change their behavior," Mr. Segal suggested.

Employers also should be aware of state statutes that may prohibit basing employment-related decisions on employees' off-duty conduct.

Such laws are on the books in 21 states: Arizona, Colorado, Connecticut, Illinois, Indiana, Kentucky, Louisiana, Maine, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, and Virginia.

Similar bills are pending in Georgia, Michigan and New York.

Some of these laws merely prohibit employers from treating employees who are smokers differently from non-smokers, but others go further.

In Illinois, for instance, the Right to Privacy in the Workplace Act prohibits an employer from "refusing to hire or from discharging any individual or otherwise disadvantage any individual with respect to compensation, terms, conditions or privileges of employment because the individual engages in lawful activities off the premises of the employer during non-working hours."

The Americans with Disabilities Act may pose further problems when it takes effect in July for most major companies.

In general, under the ADA, employers no longer can refuse to hire workers predisposed to work-related or non-work-related injuries and illnesses. And, employers cannot exclude applicants because their conditions are likely to deteriorate in the future or because workers compensation or health insurance premiums are likely to increase once they are hired (*BI*, Jan. 27.)

Smoking is not specifically mentioned in the ADA, but some management attorneys think it may be defined as a disability.

"I think people will argue that smoking—because of the addiction to nicotine—may very well be a disability," said Michael Lotito of Jackson, Lewis, Schnitzler & Krupman in San Francisco. "Former Surgeon General (C. Everett) Koop has said that nicotine is as addictive as heroin.

"If a company has a rule that says you can't smoke at work, that's OK. But, it will be much more problematic if the company takes the position that it won't hire a smoker," Mr. Lotito said.

Two issues are raised by companies that defend such policies by citing the higher incidence of disease or greater absenteeism among smokers, he said.

First, the argument is "speculative," Mr. Lotito said. "You can't predict how smoking will impact this specific individual." Plenty of people have smoked for 40 years and are still performing their jobs well, the lawyer said.

The ADA calls for case-by-case determinations and because every individual is different, employers may run into trouble if they start to lump people into a "class," he said.

In addition, "the Equal Employment Opportunity Commission says that any increase in workers compensation or health insurance costs is no defense for the failure to hire because someone is a smoker."

The bottom line is that no employer is immune from lawsuits, attorneys and consultants say.

"Each company has to evaluate the risk of potential litigation," Mr. Lotito said. And, he noted, "under the ADA, there are so many unanswered questions that the best a lawyer can do is to help you evaluate that risk."

In addition, employers must keep in mind that "even if your program is legally correct, that wouldn't stop employees from suing," Ms. Williams noted. ■



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Linking wellness to health care costs

Hershey sweetens flex benefits for healthy workers

By CHRISTINE WOOLSEY

HERSHEY, Pa.—Hershey Foods Corp. is trying to get a handle on corporate health care costs by encouraging its workers to adopt healthy lifestyles.

The food processing giant estimates it will spend about $3,100 on health care for each of its Pennsylvania employees in 1992. And the costs are even higher for out-of-state workers, said Richard Dreyfuss, director of executive compensation and employee benefits.

And, while health promotion is not new to Hershey employees, linking employee contributions to their health status is, he said.

Hershey already offers a number of health promotion programs, including aerobics and smoking cessation classes, fitness centers, nutritional information and an employee assistance program.

"We've had a commitment to well employees and employees' well-being for years. Now, we've taken it one step further by linking employee wellness to annual health care costs," Mr. Dreyfuss explained.

"We don't view this as dictating lifestyles, we see it as an accountability issue to fellow employees and to the corporation. We are telling employees, 'What you do has consequences and now you are going to be more accountable for your behavior.' "

The company self-insures medical and dental benefits for its 10,000 U.S. employees through a flexible benefits plan.

In April 1991, Hershey introduced a pilot wellness incentive plan for about 600 salaried employees at its Hershey, Pa., headquarters. The company plans to evaluate how well the program works for these employees before expanding it to cover other workers or business units, Mr. Dreyfuss said.

In spite of utilization review and other cost containment features in its health plan, Hershey found utilization—and its health care costs—were increasing, Mr. Dreyfuss said. "We have such an open health care system that the potential for over-utilization is abundant."

The company began discussing additional strategies to curtail over-utilization. "We think healthier employees use less health care and recover faster from illnesses," he said.

An outside consultant estimated 25% to 35% of Hershey's health care costs were directly related to employees' lifestyles, Mr. Dreyfuss said. There are about 20 modifiable risk factors that can help keep medical costs in check, according to the consultant. Hershey studied the list and narrowed it down to five: smoking, seat belt use, weight, blood pressure and cholesterol levels.

"The biggest factor we left out was alcohol use—that's a tremendous cost to companies," Mr. Dreyfuss said. "But we didn't want to get into drug screening in the workplace. And, alcohol use is a gray area. Some studies say a glass of wine per day is actually therapeutic. But is two glasses a day therapeutic or is it a problem?"

Realizing that access to health promotion services is not enough to change employees' behavior, Hershey decided to introduce some incentives—and disincentives—that would encourage workers to become healthier.

To establish appropriate incentives, however, Hershey had to set goals. "We wanted to respond to inquiries from employees who felt they were subsidizing unhealthy employees' behavior."

All Hershey employees paid a flat rate of $5.50 per month toward health insurance and some healthy employees felt it was unfair to pay the same amount as those who use more services, he said.

In addition, the company wanted to create incentives that would encourage "unhealthy" employees to become healthier while at the same time encourage healthy employees to keep up the good work.

"You really have to deal with two constituencies," Mr. Dreyfuss said. "If you reward non-smokers, it doesn't mean much to the smokers and if you penalize smokers, it doesn't do much to encourage others to keep up good habits."

A third goal of the program, of course, is to reduce utilization, which should cut costs. But, he said, "we didn't do this just as a cost containment tool. Philosophically, we want healthy employees."

Hershey's consultant helped figure out how much of the company's health insurance costs were attributable to each of the five risk factors. "This is not an exact science," Mr. Dreyfuss warned.

Medical tests confirm whether employees have weight or blood pressure problems, but seat belt use, smoking and exercise information is self-reported. "You do get employees who lie," he conceded. But, "we think that it's a smaller issue than assuming everyone will tell the truth."

An estimated 22% to 27% of all U.S. workers smoke. In the Hershey pilot program, 7% of the employees admitted smoking and now Hershey collects a surcharge of $32 per month from them.

People with high blood pressure are assessed a $35 monthly surcharge, overweight people pay $32 per month.

But, Hershey reallocates that money to healthy employees in the form of a flexible benefits credit. "We wanted a revenue neutral policy," Mr. Dreyfuss explained.

Employee reactions varied. "One group felt this was inappropriate, that it was an intrusion and an invasion of privacy and they were very vocal about it," he explained. Another group, though, "thought it was about time" to make unhealthy individuals accountable for their behavior.

Mr. Dreyfuss stressed the importance of involving employees in the program design. "Our employees participated to a full extent, which is one reason we were able to optimize its acceptance by the majority of employees."

Hershey introduced the program through meetings with groups of about 25 employees. "We wanted to make sure right off that employees understood the plan." Hershey also encouraged employees to contact the personnel department if they had further questions.

While it will take some time to measure long-term savings associated with reduced utilization, Mr. Dreyfuss said he has already noticed fewer employees smoking and increased use of the company's fitness center. And, of the 7% of workers who say they smoke, 2% have quit, a recent survey found. ■

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American International Companies

MEDICAL COST CONTAINMENT REPORT

ACCOUNT NO.	POLICY NO.	ACCOUNT NAME	POLICY NAME	POLICY PERIOD	PAYMENT PERIOD	REPORT DATE	PAGE
9999999	999999999	ABC CORPORATION	XYZ CORPORATION	1/1/90–1/1/91	8/1/90–8/31/90	9/5/90	1

REPORTING DIVISION 100 ALL DIVISIONS
REPORTING LOCATION 011 ALL LOCATIONS

OFF	CASE	CLAIMANT NAME	STATE	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	SERVICES PBA	HBR	PPO	OTHERS	GROSS SAVINGS
001	123451	S. HURCHALLA	PA	2	1,230.00	984.93	0.00	245.07	0.00	0.00	245.07
001	123452	G. KOSTURA	OH	1	225.00	183.49	0.00	0.00	31.01	10.50	41.51
001	123453	M DOHM	FL	6	2,231.58	1,751.74	258.59	0.00	221.25	0.00	479.84
001	123454	J. GREENE	TX	1	190.00	152.19	26.04	0.00	11.77	0.00	37.81
001	123455	K. MURRAY	CA	5	15,203.48	11,719.38	369.63	0.00	3,114.47	0.00	3,484.10
001	123456	J. HARRINGTON	MI	2	6,081.38	4,687.74	0.00	0.00	1,245.78	147.86	1,393.64
001	123457	A. HAYES	PA	1	3,040.69	2,343.87	0.00	73.93	622.89	0.00	696.82
001	123458	D. PSZONEK	FL	3	9,122.07	7,031.61	221.79	0.00	1,808.60	60.07	2,090.46
001	123459	C. FINN	GA	1	1,520.33	1,171.93	0.00	36.96	311.44	0.00	348.40
TOTALS FOR LOCATION 011 ALL LOCATIONS				22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTALS FOR DIVISION 100 ALL DIVISIONS				22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65

PBA: PROVIDER BILL AUDIT PPO: PREFERRED PROVIDER ORGANIZATION HBR: HOSPITAL BILL REVIEW OTHERS: OTHER TYPES OF SAVINGS
TYPES OF SAVINGS

American International Companies

MEDICAL COST CONTAINMENT SUMMARY

ACCOUNT NO.	ACCOUNT NAME	PAYMENT PERIOD	REPORT DATE	PAGE
9999999	ABC CORPORATION	8/1/90–8/31/90	9/5/90	2

	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	SERVICES PBA	HBR	PPO	OTHERS	GROSS SAVINGS
TOTAL FOR POLICY 999999 XYZ CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR ACCOUNT 999999 ABC CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR POLICY 999999 XYZ CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR ACCOUNT 999999 ABC CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR POLICY 999999 XYZ CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR ACCOUNT 999999 ABC CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65
TOTAL FOR POLICY 999999 XYZ CORPORATION	22	38,844.53	30,026.88	876.05	355.96	7,367.21	218.43	8,817.65

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Varied paths lead to common goal of wellness

Employers' dilemma: the carrot or the stick?

By CHRISTINE WOOLSEY

Employers that aggressively pursue wellness as part of their strategy to control health care costs can choose from a variety of programs.

And, while the road to implementing wellness incentives is a long one riddled with potholes—not the smallest of which is employee-relations problems—consultants and employers agree it can lead to lower health care costs.

Financial incentives for wellness can be offered regardless of an employer's current plan design, pointed out Michael Carter, a senior vp with the Hay Group in Washington, D.C. Incentives work just as well with traditional indemnity plans as they do with plans that include managed care networks, he said.

Employers with flexible benefit plans may have an easier time instituting these programs because their employees are already used to making choices, other consultants say.

A number of preliminary steps can help ensure the success of any program, consultants say. But the exact approach taken—rewarding healthy workers or penalizing unhealthy ones—often depends on how desperately the company needs to control costs.

"Which approach employers take depends on the philosophy of the company and the company's current health care situation," said Lawrence Keller III, an assistant vp and attorney with benefit consultant Miller, Mason & Dickenson Inc. in Chicago. "A company that is pressed against the wall may have to penalize employees to get the quickest action. A company that is doing well financially may be able to offer rich incentives."

When deciding which approach will work best, employers should keep in mind the level of cost that the company already has shifted to employees, suggested Dave Morgan, a managing consultant with A. Foster Higgins & Co. Inc. in Richmond, Va.

"The reward approach is much more palatable and it makes putting in a program an easier sale," noted Stephen D. Brink, a consulting actuary with Milliman & Robertson Inc. in Brookfield, Wis.

The employee-relations impact is an important consideration, noted Leigh Williams, a consultant with Hewitt Associates in Lincolnshire, Ill.

Incentives are typically viewed as positive and penalties as negative, but there are exceptions. Company finances, for instance, can affect perceptions, Ms. Williams said. "If the company is on the brink of financial disaster and there is the potential for layoffs," a penalty may be considered good if it mitigates more serious problems.

How much time an employer has to measure results also can influence decisions about which method will work best, she added. Penalizing employees—for example, by charging unhealthy workers more than healthy workers—often produces revenue which can be quickly and easily measured.

As with any other benefits change, clear communication is a key to success, consultants and employers agree.

If the program is not explained effectively, employees may react negatively, said Foster Higgins' Mr. Morgan. "Employees do not always view these programs the way they are intended. Even if you have an incentive plan with no penalties, some employees may not view it as an advocacy program if you don't explain why it's being done."

Before establishing a program, employers should follow some general rules, consultants advise.

Employers should "find out what their competitors are doing, gather information on different programs, paying attention to what works and why," Mr. Brink suggested.

Then employers must closely scrutinize their own employee and dependent populations so they can decide which lifestyle variables to focus on, like smoking, obesity, high blood pressure or cholesterol, alcohol consumption or drug use, exercise, stress levels or seat belt use.

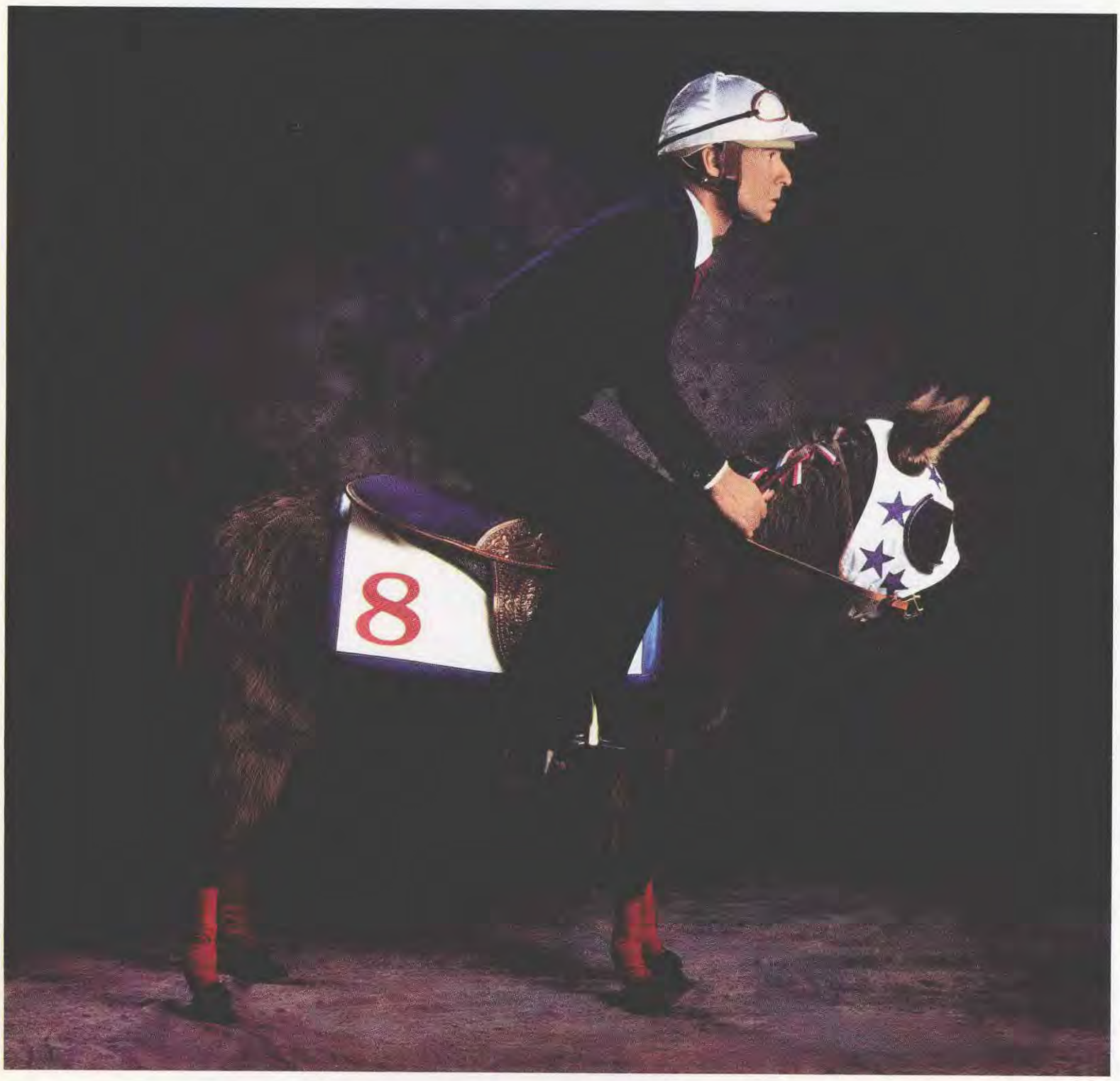
Consultants say employers interested in changing employee behavior should try to isolate factors that the employees can control. "You don't want to structure a program that targets genetic conditions that can't be controlled," Mr. Morgan said. Some experts believe cholesterol, blood pressure and even obesity can be attributed to heredity more than lifestyle.

And, employers should not automatically target employees who submit the most expensive health care claims, Hewitt's Ms. Williams stressed.

"Employers have traditionally looked at medical diagnoses and claims costs" when trying to isolate lifestyle factors they want to control, she said. For example, an employer may look at cardiac diagnoses—which typically are very expensive in terms of claims costs—and assume that is where the company's health problems lie. But depending on other variables that may not be the case, she explained.

Among other things, employers must "look at what the company

Continued on page 18



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Carrot or stick?

Continued from page 16

can expect in terms of cardiac claims based on its demographics," she said. "In a company where the average employee age is 47, a high incidence of cardiac claims may not be that surprising."

And, Ms. Williams added, employers also have to keep claims costs for certain diagnoses in perspective. "Ten million dollars in cardiac claims may sound astronomical," but it may be less than what other firms spend, she said.

Once employers identify the lifestyle-related conditions they want to target, they have to profile employees and dependents so they can determine how many are high risk in those categories, Mr. Brink of Milliman & Robertson said.

More importantly, employers must develop their own definition of "high risk," he added. For example, with smoking "does 'high risk' mean you currently smoke or that you smoked in the last year or that you live with a smoker? Many times the simpler the definition, the better," he said.

Estimating how much higher health costs are for high risk employees is a challenge for most employers. Some studies have calculated how much more expensive smokers are than non-smokers, but it is not an exact science.

That type of analysis "gets trickier when you take into account more than the employees' smoking status. There are other variables that are interrelated to smoking and health," Mr. Brink noted.

Another crucial step in the process is estimating the percentage of employees likely to change their behavior as a result of any incentives or penalties, consultants say.

"This is where the 'art' comes in. There is very little literature published on this," Mr. Brink said.

Estimating how many employees will change their habits "is still a guessing game," conceded Mr. Carter of Hay Group. "A conservative estimate is to say you'll impact 10% of lifestyle-related illnesses."

Once an employer has decided whether to use an award or penalty approach, it must also decide what type of award or penalty to use, Mr. Carter said.

Some employers favor premium differentials. Employees who fall outside the "healthy" category are assessed a surcharge or must pay additional premium contributions. Other employers reward healthy individuals with cash or flexible benefit credits.

Mr. Carter recommends basing an employee's contributions on his or her level of health. For example, smokers may be required to pay 10% more than non-smokers, and employees with high blood pressure may have to pay 5% more. Employees who both smoke and have high blood pressure may be required to pay 15% more.

Employees' contributions could be decreased when they enroll in smoking cessation or other treatment programs and may be eliminated altogether if they are successful in those programs, he said.

Mr. Carter said the amount of any penalties or awards "is a function of how much employers have to reduce health care costs."

But, he said, the amount has to be large enough to motivate employees. In penalty programs, Mr. Carter recommends that unhealthy employees be charged at least $500 per year—an amount "that is large enough for employees to take notice, yet not too prohibitive."

There is no right answer when deciding how generous incentives should be or how steep penalties should be, Ms. Williams said.

"We don't talk about financial limits, because it varies with each organization and it depends on what employees are contributing toward their health coverage today. If they are paying nothing—any amount becomes visible, regardless of its size," she said.

"A few employers have taken claims data and figured out the difference in medical costs between smokers and non-smokers or employees with high blood pressure vs. low blood pressure and then passed the difference on to unhealthy employees." However, "logistically this is a challenge and an expense, so some employers don't want to go that far."

Ms. Williams said employers also must keep in mind what types of programs will appeal enough to high-risk employees to get them to participate. "If you've got an employee that weighs 250 pounds, would that person put on a leotard and go to a company gym, or would that person be too embarrassed? You may have to take a different approach with that employee."

For example, a private exercise regime could be provided or financial incentives or penalties could be implemented, she explained. "You really want to change high risk behavior, so this is an important consideration," Ms. Williams said.

Would a 250-pound worker 'put on a leotard and go to a company gym?' asks Ms. Williams.

Finally, employers have to calculate the costs associated with implementing the program. Those costs may include employee surveys, the cost of any medical tests, staff time spent administering the tests, other administrative costs and any communications efforts.

And, employers should be sure to subtract from these costs any "soft" savings associated with ancillary benefits, like improved employee morale, increased productivity, reduced absenteeism, reduced life insurance costs and possibly reduced workers compensation costs.

Commercial group life and health insurers are just now catching on to employers' desire to regulate worker lifestyles. Consultants and employers say only a few insurers are willing or able to help employers design these programs.

Aetna Life Insurance Co. of Middletown, Conn., helped Crum & Forster Inc. design and implement its financial incentives program (see related story, page 3).

And, Health Management Corp. of Richmond, Va., is working with employers around the country who are interested in adopting risk rating. "We believe risk rating in general will do more for health promotion" than voluntary health awareness approaches, said Marcia Rowan, president of the Blue Cross & Blue Shield of Virginia subsidiary.

But, consultants say that insurers haven't been beating down employers' doors with new ideas.

"A lot of insurers have wellness packages, but they aren't as familiar with risk rating," said Foster Higgins' Mr. Morgan.

Insurers can't offer much help "because it's hard in this area to develop a uniform product for every company. These types of programs are very specific to employers' demographics or locations," explained Ron Mason, a consultant in Los Angeles with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

"Insurance companies can't make money selling these products because they can't distribute them on a mass basis," he said. "Unfortunately, the insurance industry is not designed to customize products." ■



Working spouses

Continued from page 3

out of concern about providing greater compensation to workers with dependents than to single workers.

Employers need to "ask whether it's appropriate for a single employee to have an effectively lower compensation than an employee with dependent coverage," said Mr. Dreschler.

Employers must determine whether employees with either spouses or children or both are "worth more" simply because of their family, said Thomas Grass, a consultant and the national group/flex practice leader for The Wyatt Co. in San Diego. "If the answer is not yes, than (employers) have got to wrestle with their philosophy vs. their employee relations."

However, other consultants question this line of reasoning.

Bob Eicher, a principal with A. Foster Higgins & Co. Inc. of New York, says that "from a single employee's standpoint, employers are making things more fair in some instances and less fair in other instances." For example, he noted, if an employer rewards employees whose spouses don't opt for dependent coverage, single employees still come up short because they are ineligible for such rewards.

As employers ponder who they want their plans to cover, some may try to remove working spouses from their plans, although consultants are divided over how widespread this practice will be.

"I think it's validly qualified as a trend," Mr. Dreschler said of this effort. "It's happening on a steady basis and is likely to continue."

Tom Beauregard, a health care consultant with Hewitt Associates in Rowayton, Conn., concurs. "It really relates to health care costs. It's a financial issue" that is forcing employers to consider limiting the number of dependents they provide coverage for, he said.

Thomas Donlon, managing director of the health and welfare consulting practice at Miller Mason & Dickenson in Chicago, argues that "trend" may be too strong a word for what is happening. He concedes that his firm "has seen more activity in this area than it historically has," but such efforts won't be "well-received" by employees and are unlikely to win favor with employers.

Deborah Chollet, associate director of the Center for Risk Management & Insurance Research at Georgia State University in Atlanta, also believes this practice will never dominate the benefit environment, "in part because of the administrative difficulties."

"I think you need to be smart about what you design," Wyatt's Mr. Grass advises. "It doesn't make sense to design things that are administratively impossible or that put you at a disadvantage."

Furthermore, many consultants argue that implementing such changes—regardless of the motives—will result only in short-term savings. And, they say, these changes fail to address the root problem of rising health care costs (see story, page 23).

Predicting savings is difficult because there are a myriad of factors influencing the outcome, including the change that is adopted; what class of beneficiaries is removed; how many claims were eliminated from the plan; and company demographics.

"The cost savings associated with any of these changes is highly individualized," said Mr. Repko of TPF&C.

Nevertheless, encouraging certain beneficiaries to obtain health insurance elsewhere is hardly new.

According to many consultants, employers do just that as soon as they differentiate between contribution levels for single employees and employees with dependents.

Specifically because of concern about covering dependents who could obtain coverage elsewhere, Lonza Inc., a chemical manufacturer in Fair Lawn, N.J., three years ago began requiring employees with dependent coverage to contribute to premiums.

While single employees pay nothing toward premiums, employees who opt for dependent coverage must contribute 20% of the cost.

"Our approach was to reverse the golden rule of insurance," said Dan Barbeau, director of compensation and benefits for Lonza. "We're trying to do unto others as they are doing unto us. The main thing we want to do is cover those spouses and dependents who can't get coverage elsewhere. (But) if it's possible to shift some costs away from us, we'll do it."

Mr. Barbeau could not estimate savings generated, though he noted that about 10% of the employees with dependent coverage dropped it after the change.

Buck's Mr. Sinni says companies could expect to see at least a 10% reduction in their premium costs if they increase contributions for dependent coverage.

That approach is actually the second step along a continuum of plan changes employers can make to reduce the number of dependents—particularly working spouses—in their plan, according to Hewitt's Mr. Beauregard.

The first step is when employers are aware their plan provides coverage to those who could get it elsewhere but decide to take no action, he said.

The next step for many employers would be to impose a premium surcharge on coverage, especially for working spouses of employees.

General Electric Co. has taken this step. Beginning Jan. 1, if a GE employee seeks coverage for a spouse who waived coverage elsewhere, an extra charge of up to $10 a week will be added to the cost of their dependent coverage, according to Larry G. Cook, consultant-insurance plans for Fairfield, Conn.-based GE. Dependent coverage already costs $250 more per year than single coverage.

Recognizing that some working spouses earn only supplementary wages, GE waives the surcharge if the spouse earns less than $15,000 annually; if the spouse earns between $15,000 and $20,999, the surcharge is only $5.

Mr. Cook said the company decided against a more stringent approach because it "does not want to be in a position of leaving anyone exposed."

Still, GE felt compelled to adopt such a program.

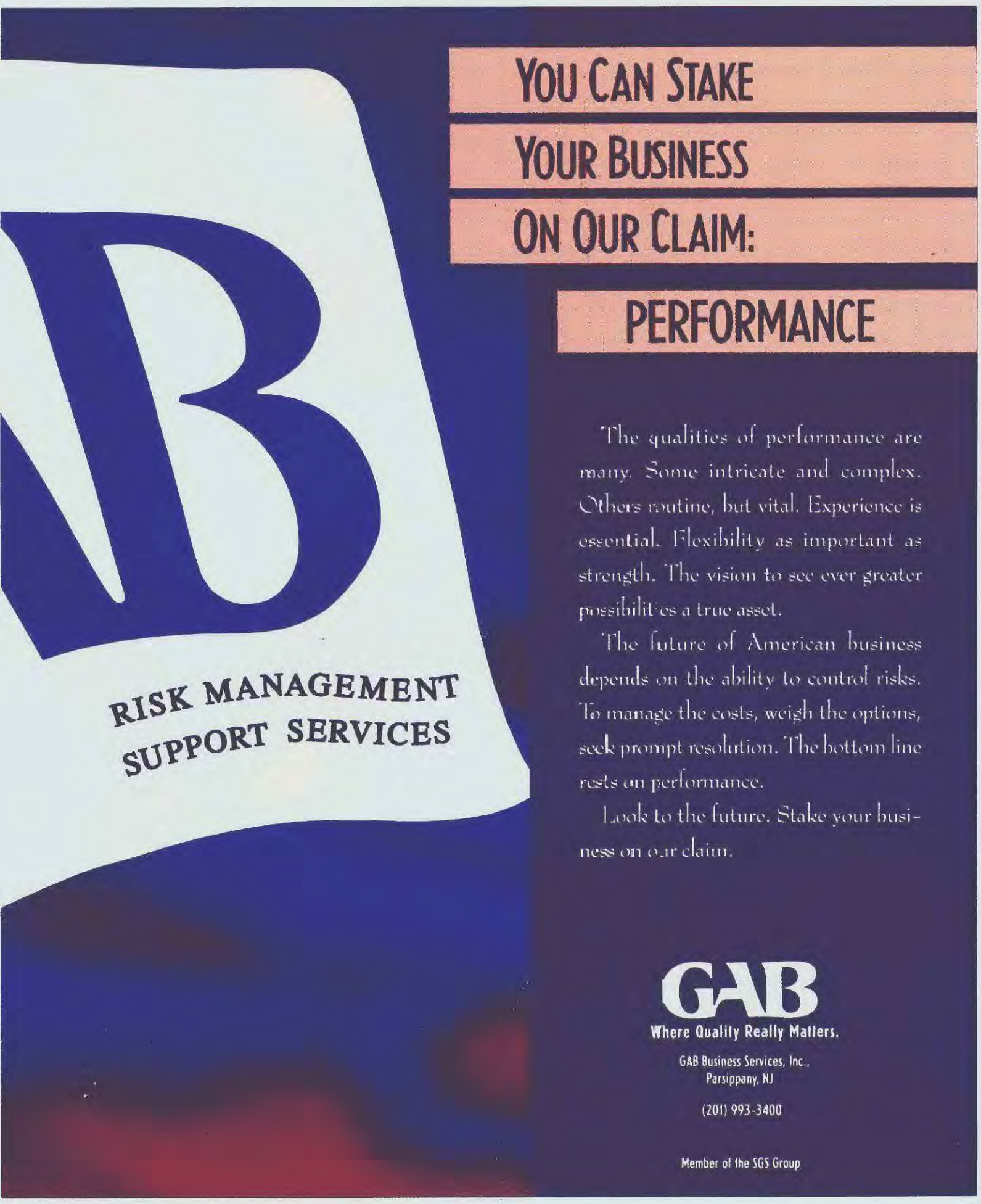
"We were aware of a number of companies that offered bonuses to their employees who dropped their coverage and enrolled in their spouses' employers' plans," Mr. Cook said.

Other employers were accomplishing a similar goal by introducing flex plans that force employees to prioritize their benefits or simply charging employees more for individual employee coverage than GE does for dependent coverage, Mr. Cook added. "Other employers are intentionally trying to shift their liabilities."

Procter & Gamble Co. also adopted a premium surcharge for coverage provided to working spouses. For about three years, P&G has tried to discourage its employees' spouses from opting for its dependent coverage by applying an $80 monthly surcharge if they have waived coverage from their own employer.

That surcharge is waived if the spouse's employer requires employees to pay 50% or more of the cost of coverage, said a spokes-

Continued on next page



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Working spouses

Continued from previous page
woman for Cincinnati-based P&G.

The final point along the continuum is outright denial of coverage when it is available elsewhere.

Just one step shy of that may be the plan introduced two decades ago by J.C. Penney Co. of Plano, Texas, which effectively ensures few spouses will be covered under its plan.

Employees' spouses can qualify for health care coverage through J.C. Penney only if the employee can prove the spouse is not the household's primary wage earner (*BI*, April 11, 1988).

Consultants agree that if an employer decides it wants to reduce its obligations to working spouses, they are most likely to adopt a plan like those at GE and P&G.

Such a plan "really isn't a penalty to employees," said Hewitt's Mr. Beauregard. "It's really GE's attempt to counteract other employers' incentive approaches."

Still, even this modest a proposal is unlikely to be widely adopted, others say.

"Enforcement is difficult," said Ms. Chollet of Georgia State. "Do you presume all spouses have a coverage option elsewhere and require the employee to prove otherwise?"

Yet employers committed to attacking this problem have still other approaches at their disposal.

For example, an employer could create multiple tiers of contributions that correspond to each employee's personal circumstances. For example, consultants say, the tiers could include a coverage option for an individual, an individual plus spouse, an individual plus spouse and children, and an individual plus spouse who waived coverage elsewhere.

Flexible benefits also provide another opportunity to encourage spouses, and even employees, to waive health care coverage (see story, page 22).

Consultants note, too, that employers are getting more sophisticated in how they coordinate benefits when more than one source of coverage is available.

Duplicate coverage arises, for example, when an employee has two jobs or when an employee opts for coverage but also is covered as a dependent under another plan.

Foster Higgins found in a survey of more than 2,400 employers that 50% said they were coordinating benefits to ensure that there is no duplication in coverage.

"Employers are willing to have a decent plan in place. What they are reluctant to do is have a plan that when coordinated with another plan would pay 100% or more," said Mr. Grass of Wyatt.

In addition, "100% coverage does nothing to discourage unnecessary utilization," and runs counter to what many employers with managed care programs, for example, are trying to accomplish, noted Segal's Mr. Dreschler.

The idea behind coordination of benefits is twofold, said Mr. Danish of Kwasha Lipton. First, it's designed "to make sure that our plan will never pay more than the employee should get," he said.

Second, if designed properly, it can designate the sequence in which benefits will be paid, ensuring that a claimant's employer always pays first, Mr. Danish said.

For example, the Putnam-Northern Westchester Health Benefits Consortium, a group of 19 New York school districts, recently changed its health plan so that if any dependents have coverage elsewhere, the other plan is tapped first for all prescription drug charges (*BI*, Jan. 20).

"I recognized that we potentially could be paying benefits that we don't have to pay," said David Stern, the consortium's risk manager. "We did not want to reduce the benefits for any of these people. We just wanted to ensure that the other plan paid its fair share."

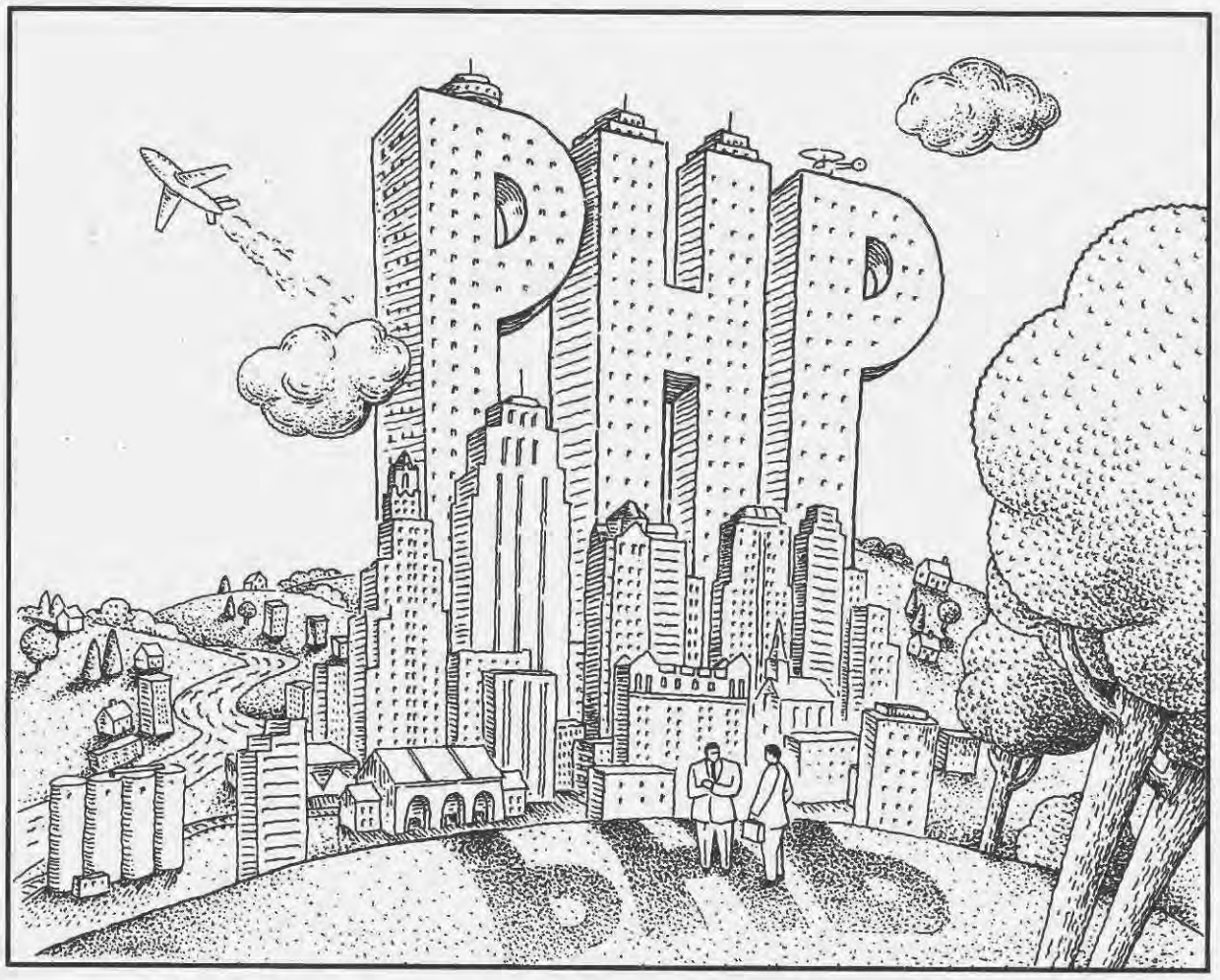
The consortium, which expects to cut drug costs 9% this way, still will pay any portion of a dependent's prescription drug charges not covered under the dependent's other plan, like coinsurance.

But making the procedure more complex may save the consortium even more money. Mr. Stern said he realizes that because of the extra work involved, "people may ignore" that repayment offer.

Benefit coordination also works for employers who want to spend less for their own employees, consultants say. For example, in auto accident claims, the employer could require that auto insurance be the primary payer.

Another form of coordination of benefits is "phantom coordination," arguably the most complex

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Working spouses

Continued from page 20

and rarest of these initiatives. This rare policy arises when an individual has waived coverage from his own employer and opted to be covered by his spouse's employer. The spouse's employer, though, refuses to be the primary payer for this individual and deems him to be covered by a "phantom plan" that must pay a certain level of benefits before its plan kicks in. As a result, the individual will incur sizable out-of-pocket expenses before the spouse's employer pays.

Hewitt's Mr. Beauregard said he knows of just one company, which he would not identify, that has adopted such a policy.

That employer explained the phantom plan to its employees so those opting for it would know what costs they would incur, he explained.

"At that point, you may be better off just saying, 'we won't cover you if coverage is available elsewhere,' " Mr. Beauregard said.

Before any employer considers altering its plan, there are several issues that must be considered.

First, charges of discrimination may be raised since the plan may be perceived to fall unfairly upon a certain class of people.

A 1988 federal appellate court ruling upholding the J.C. Penney plan's "head of household" provision, though, should give employers some assurance that such a change will not constitute discrimination, said Mr. Beauregard.

However, Foster Higgins' Mr. Eicher says employers should "forget about the potential legal problems and ask, 'Is it ethical?' "

Mr. Dreschler of Segal agreed, noting that employers also need to ask, " 'Does it fit with our corporate philosophy?' " Employers "really ought to be thinking through the question of 'what is this going to mean?' " he said, noting that employers need to consider what message they will be sending to their employees if they adopt such a policy.

Providing health care benefits "used to be a moral issue," with companies saying: " 'We owe them coverage.' Now, employers are narrowing their scope and aren't being as paternalistic," said Mr. Sinni of Buck.

Mr. Sinni insists such changes will be met with tremendous resistance by employees who will "feel that they are being shifted upon and that the company has no concern for their well-being."

To overcome this resistance, the consultants all recommend using a thorough communications campaign (see story, page 24).

Miller, Mason's Mr. Donlon also cautioned that if employers don't carefully focus these programs, they could place their employees in a precarious position.

With health care costs escalating and other pressures mounting, employees "are closer to the brink of economic disaster than ever before," he contends.

Employee privacy should also be considered. With many of these plans, employers must somehow ascertain what other coverage options their employees' spouses have, consultants say. And, they point out, in the case of a plan like Penney's, the company will need to know the salaries of employees' spouses if those spouses are to be considered for coverage.

At GE, officials are relying on the "honesty and integrity" of its employees, Mr. Cook said.

Still, many employees may be uncomfortable volunteering such information.

These programs will "put a lot of employees into the position of having to commit fraud," Mr. Eicher said. "I don't know that employers want to put their employees in that position." ■

Flex plans are incentive to drop health cover

By LORI BLOCK

Although it might not have been their intended purpose, flexible benefit plans frequently are an impetus for employees to drop out of their employer-sponsored health care plans, consultants say.

For example, an employee may obtain health insurance under his spouse's employer's plan to take advantage of flex plan incentives offered by his employer. These incentives may include a cash buyout or the application of flexible credits to other benefits in lieu of health care.

Thomas Grass, a consultant and the national group/flex practice leader with The Wyatt Co. in San Diego, said he doesn't believe many employers are trying to entice employees with cash or other benefits to get coverage elsewhere.

When it does happen, though, "it's more prevalent under (a flexible benefits plan), which provides employers with an easy tool to get that message across," he said.

William Danish, a principal with Kwasha Lipton in Fort Lee, N.J., concurs, saying this kind of cost shifting from one employer to another is most often related to flex plan incentives.

Mr. Danish said the number of flex plans that offer a catastrophic coverage-only option will increase in an attempt to meet the needs of younger workers who don't feel they need a comprehensive health plan but do want coverage for a catastrophic illness or injury.

Statistics appear to support these assertions. In a recent survey, Hewitt Associates found that 97% of the flex plans examined offered some choices in health care. Of these, 76% permit employees to waive coverage altogether.

Furthermore, of the plans that permit an employee to waive coverage, 69% provide the employee with flexible credits or cash.

Employers with such plans are not totally abdicating their responsibilities, however. Roughly two-thirds of those with a no-coverage option require employees to provide some form of proof, perhaps even a sworn statement, that they have coverage from another source.

Similarly, a survey by A. Foster Higgins & Co. Inc. found that 69% of flex plan sponsors permit employees to waive both dependent and employee coverage. The percentage of employees that waive coverage increases with more established plans. In plans that are at least 2 years old, 69% of the employers report that at least 5% of their employees waive coverage.

And, as in the Hewitt survey, Foster Higgins found that more than a quarter of the employers that permit employees to waive coverage require their employees to prove that they can obtain coverage elsewhere. Furthermore, 20% require such proof of coverage when dependents waive coverage.

Flexible benefits represent "an incentive approach" to reducing the number of participants in a plan, said Tom Beauregard, a health care consultant with Hewitt in Rowayton, Conn. They also have raised the ire of some companies that feel the health care coverage burden is being shifted to them.

Companies like Proctor & Gamble Co. and General Electric Co. have taken steps to reduce the number of spouses covered under their plans because "they are trying to combat employers that are offering such opt-outs," he said. ■



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Are employers 'dumping on one another'?

Penalties on working spouses called harmful, irrational

By LORI BLOCK

Even as more employers explore ways to exclude from their health care plans dependents who can obtain coverage elsewhere, some consultants say this cost-cutting approach is, at best, short-sighted.

Policies aimed at forcing working spouses to obtain coverage from their own employers do nothing to control underlying health care costs, these consultants argue.

They also argue:

- Adopting such a measure increases the plan's complexity, making it difficult for the benefit department to administer and for employees to understand.
- The savings from such a measure is difficult to predict and is likely to be temporary, lasting only until other employers adopt countermeasures.
- The savings that are generated only help one employer. No true savings result; costs are only shifted.

"We have plans that don't make any sense and that are designed simply to retaliate against those companies that offer a bounty," said Bob Eicher, a principal with A. Foster Higgins & Co. Inc. of New York, referring to the inducement or "bounty" that some employers offer to encourage employees to waive coverage.

Thomas Donlon, managing director of the health and welfare consulting practice of Chicago-based Miller Mason & Dickenson, an Aon Corp. unit, says such plan provisions lack any "worthwhile long-term savings" and don't merit the administrative complexity they bring to the plan.

"There's some savings involved until the employer across the street (implements retaliatory) measures and you're right back where you started," Mr. Donlon pointed out. The only difference is that now the employer has to cope with a plan that may require substantial information gathering and record keeping on top of what already exists.

"I just don't think the savings that can be realized are worth it," he said.

And, the savings that such penalties generate represent savings to just one employer; they do nothing to reduce the cost of health care overall, consultants, union leaders and other observers stress.

Mr. Eicher insists that such penalties only "reallocate who pays for what people."

"It's an example of dumping on one another, which is a good definition of America's health care system," argues William S. Hoffman, the director of the United Auto Workers' Social Security department.

While he said that the union understands why many employers feel they need such policies, "people are getting caught in the middle."

Claudia Bradbury, a policy associate with the AFL-CIO, concurs. "A large number of our members work for large firms, and many of (those employers) are self-insured with a secure benefits package," she said. These companies have a "legitimate concern" that smaller employers are taking advantage of them.

Penalizing dependents who waive other coverage is "crucial for a lot of companies, but it's completely ineffective," Ms. Bradbury explained. "Individual attempts to shift costs only have a short-term effect" on health care costs.

However, she said, programs designed to penalize only working spouses who could obtain adequate coverage elsewhere are not necessarily going to attract union opposition (see story, page 3). Programs like those adopted by General Electric Co. and Proctor & Gamble Co. "show true dedication to trying to end the cost shift" without hurting employees, she said.

But, Ms. Bradbury also stresses that "it's our notion that every employer should do its fair share."

Both management consultants and union leaders argue that no matter how well a program to induce dependents to obtain health care coverage elsewhere is designed, it doesn't aid in the search for a cure to the nation's health care woes.

'I just don't think the savings that can be realized are worth it,' says Thomas Donlon.

"It's a stop-gap measure. I think employers need to spend their resources on longer term (solutions) in concert with other employers," said Mr. Donlon.

For instance, employers should work together to ensure that payers—both employers and employees—receive high-quality, cost-effective health care. "These are the things they should be doing," he said.

Meanwhile, some observers argue that the mere fact that employers are willing to consider such measures indicates that Corporate America is reaching the height of its frustration with the U.S. health care system and is more likely to accept a federally legislated solution.

Mr. Donlon can see a time when there are legislative mandates governing which employer covers which individuals. And, Mr. Eicher questions how much longer Congress will allow tax deductions for health benefits when employers offer their employees "bounties" to waive coverage.

In a recent survey, employee benefit managers said they would support tax credits for buying health insurance and reform of both state medical malpractice and tort laws as tools to improve the health care system.

Some 77% of the 466 managers surveyed by the TPF&C division of Towers, Perrin, Forster & Crosby Inc. said they would support tax credits for individuals who purchase their own health insurance. Two-thirds would support tax credits for small businesses that purchase health coverage for their employees for the first time.

"We're building a case for some major health care financing reform," said Deborah Chollet, the associate director of the Center for Risk Management & Insurance Research at Georgia State University in Atlanta.

"The fact that (employers are) willing to go to such an extreme demonstrates what they will support legislatively," Ms. Chollet said. ■



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Firms explain grim facts behind health plan changes

By LORI BLOCK

Communication is always an important part of a benefit plan, though perhaps never more so than when employers change the ground rules for dependent coverage.

Increasingly, employers are considering ways to remove from their plans those dependents who can obtin coverage elsewhere. The most common candidates are working spouses who choose not to be covered under their own employer's plan.

Any company that tries to remove dependents from its health plans must explain all aspects of the change to employees, consultants insist.

"It comes down to (explaining) what you are doing, why you are doing it and how it's going to impact them," said Thomas Grass, a consultant and the national group/flex practice leader for The Wyatt Co. in San Diego.

Tom Beauregard, a health care consultant with Hewitt Associates in Rowayton, Conn., suggested that employers make these points: health care costs are rising; some employers have been paying less than their fair share while others have been paying more; and removing dependents from a plan may stave off the need for large future cost hikes or benefit cuts.

Employers must emphasize that they are not trying to penalize those who really need coverage, said Rich Sinni, director of the health management practice at Buck Consultants Inc. in New York. They should explain that "they are just trying to make a more equitable distribution."

Any employer considering a substantial penalty against employees whose spouses waive coverage elsewhere must outline the reason for the penalty and how it may help control costs, said Arthur Drechsler, the national practice leader for group benefits at Martin E. Segal Co. in New York.

"I don't think anything other than a straightforward approach is appropriate," he advises.

Such an approach may actually improve some employee attitudes toward health benefits, Mr. Sinni said. "Employers are hoping that they can show their employees that this will make the compensation more equitable."

In fact, this concept of equity—if it is truly an issue and cause of concern among employees—may actually give the employer an advantage, said William Danish, a principal with Kwasha Lipton in Fort Lee, N.J.

"As in any benefit change, the most important part is communicating that change," he said. "This kind of approach will actually sell better with single employees as it helps address the equity issue."

Equity may often take a backseat to savings. Still, if equity is an issue, "it makes sense to communicate that fact to employees, too," he said.

Explaining the reasons for these penalties may not be as difficult as some employers would expect. Although the penalties may appear to be a reduction in benefits, some employers have targeted them to minimize any adverse impact.

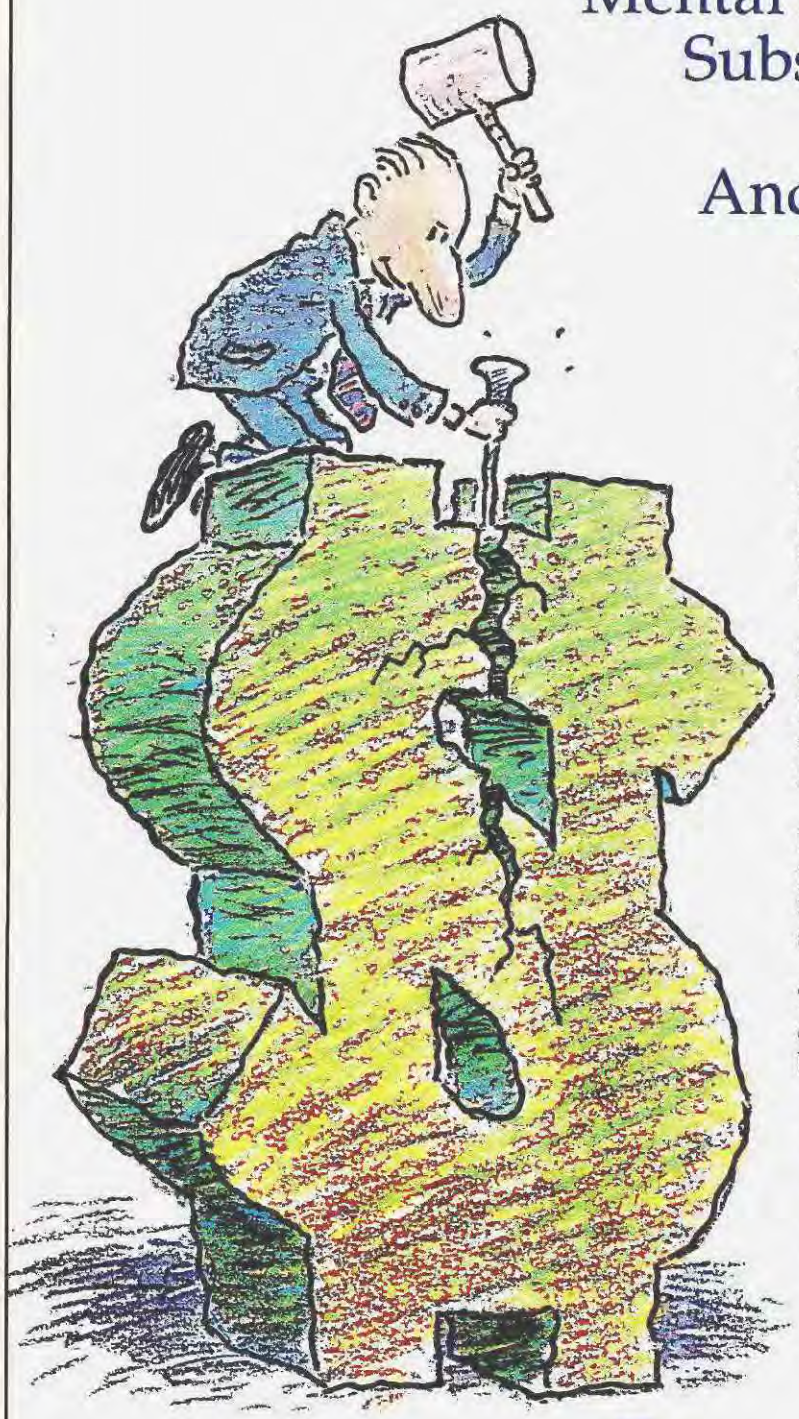
Furthermore, "employees understand that there's a rational basis for this kind of pricing," said David Repko, a principal with TPF&C in Cleveland, a division of Towers, Perrin, Forster & Crosby Inc.

This understanding means that union opposition to such changes is not as strong as one might believe, consultants say. Representatives of both the AFL-CIO and the United Auto Workers indicated that while such penalties should not be a roundabout way of cutting benefits, they understand why some companies want to shift some costs to other companies.

And, lastly, because these penalties will force employees and their spouses to evaluate how they want to structure their health care coverage, companies may be able to tell employees that they need to become part of the solution.

Says Mr. Sinni: "I think (such penalties) can make people better consumers. People haven't been good consumers of health care; instead, they assume health care is an inalienable right." ■

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Contracting with providers offers control

Direct contracts can lower health costs, but are not an option for many employers

By LOUISE KERTESZ

Some employers frustrated by unfulfilled expectations of cost savings and quality care from preferred provider networks offered by third parties are taking matters into their own hands by contracting directly with health care providers.

Through direct contracting, employers have more control over their networks, which could lead to greater savings and better care.

Many providers welcome the opportunity to directly contract with employers because it allows them to significantly improve their market share.

But, direct contracting is a viable option only for employers with enough health plan participants to support the network.

Even then, direct contracting is not a panacea for spiraling health care costs, benefits consultants warn.

There also are other weighty problems associated with direct contracting, like the cost of developing and monitoring networks. And employers that contract directly may face some liability problems they would not ordinarily face (see story, page 27).

Yet, there is continuing widespread interest in direct contracting among employers and employer coalitions.

Surveys by benefit consultant Witt Associates in 1989 and 1990 showed that many employers had negotiated direct contracts with hospitals.

"And, it's reasonable to conclude that the trend is continuing to evolve," said Allan Fine, vp and national practice director for managed care at Witt in Oak Brook, Ill.

Mr. Fine observed, though, that "just because there is interest, there is not necessarily a corresponding level of activity."

Nonetheless, many large private employers and employer coalitions, as well as public sector employers, have proven that negotiating contracts directly with hospitals and physicians can help them control costs. Two examples are the Health Care Network of Greater Milwaukee and the Utah Public Employee Group Health program (*BI*, Jan. 6; July 31, 1989).

Even some smaller employers have tried direct contracts. "We have done it for employers with as few as 300 employees in a given market," said Michael Cadger, Southeast region managed care practice leader at A. Foster Higgins & Co. Inc. in Atlanta.

Some employers are turning to direct contracting because "off-the-shelf networks" do not fit their needs, said Jeffrey Klonoff, a consultant with Hewitt Associates in Walnut Creek, Calif.

For example, network discounts are not providing some employers with sufficient savings, he said.

One big reason for that is the high fees the preferred provider organizations and insurers charge to use their networks, said Foster Higgins' Mr. Cadger. Access fees generally range from $1.50 to $2 per employee per month but can be as high as $4—and that can amount to hundreds of thousands of dollars annually for a giant corporation. Hiring people to manage a directly contracted network in-house could cost "substantially less" than those access fees, he said.

Savings that employers have realized from PPOs "have not offset access fees," asserted Leslie Weitzman, Midwest regional practice leader for health strategies at Alexander Consulting Group Inc. in Chicago.

"Employers have not actually gone out to determine the cost benefits of PPOs," she said. "They would not make other large purchases without such an analysis."

Direct contracting also is attractive to employers that want to pursue a "very strong hands-on" management strategy with their employees, Mr. Klonoff said.

Foster Higgins' Mr. Cadger agreed. "The real advantage of direct contracting is that employers get exactly what they want."

"Over time, existing PPO networks continually evolve by adding and deleting providers. Consequently, what an employer buys today may look different six months from now."

But, a direct-contracted network is "custom-designed and ensures maximum participation from employees," since employers tend to contract with providers that are most popular with their workers, Mr. Cadger said.

Direct contracting has been most successful for large employers, like Hewlett-Packard Co. in Palo Alto, Calif. Hewlett-Packard directly contracted with its first network of physicians and hospitals in 1984 in California's Santa Clara Valley.

Hewlett-Packard's health care costs have been increasing 9% to 11% for the past several years.

In 1984 "there was no other choice," given the company's specific needs in providing health care for its workers and its managed care goals, said Susan Moriconi, the company's benefits manager.

But even a large company like Hewlett-Packard found the going rough at first.

"We originally thought we would transplant this model all over the country," Ms. Moriconi said. "We thought it would be very easy.

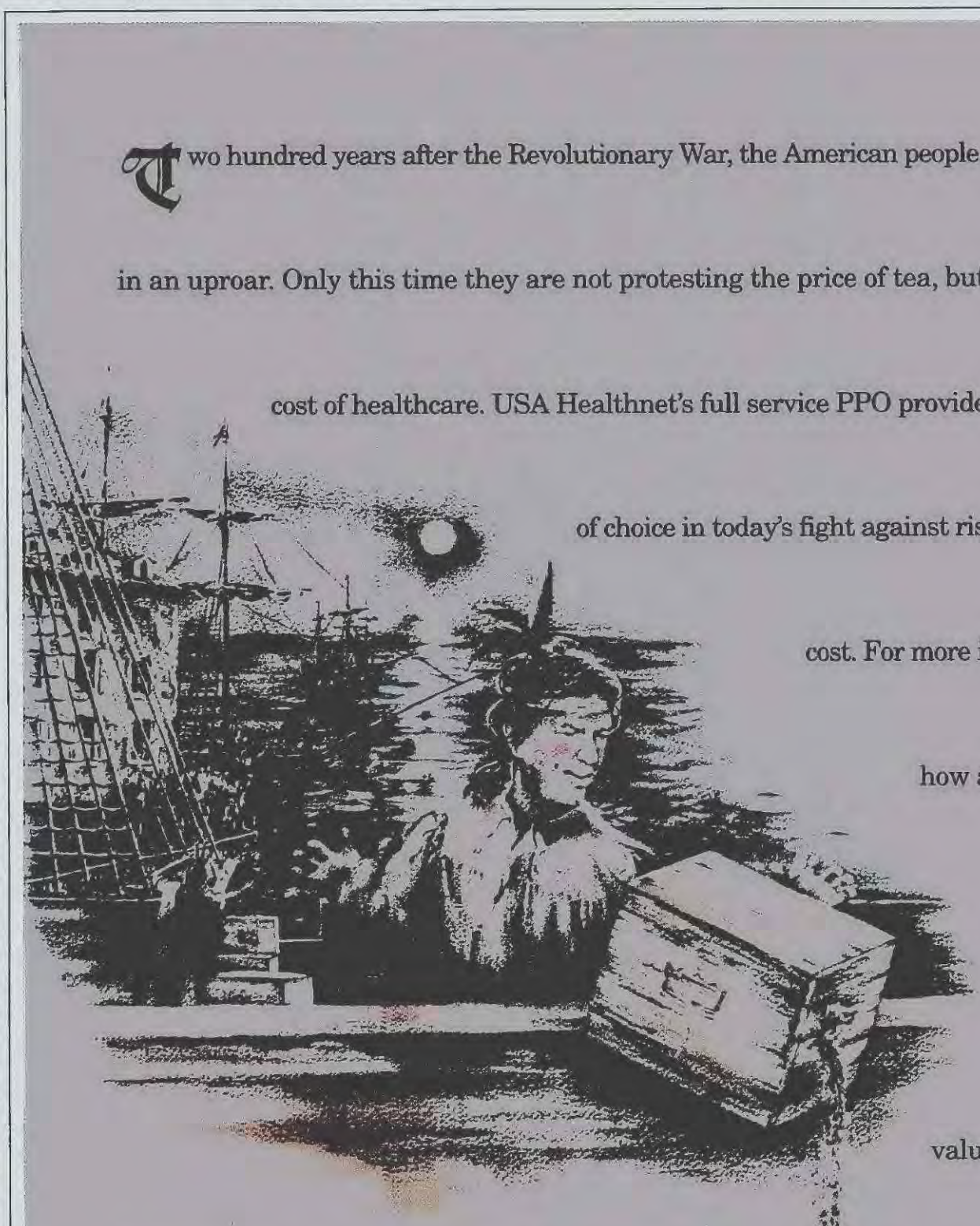
"But, we found it was very, very difficult," since physicians in some parts of the country were not as receptive to the company's managed care goals as were physicians in its California network.

Physicians in other parts of the country also required "a longer learning curve" to meet Hewlett's managed care expectations, she said. And, since 1984, "a number of good products that you can lease" have become available nationwide, Ms. Moriconi said.

As a result, the company has "decided to focus our direct contracting in areas where we have large (employee) populations," she said.

The savings generated by direct

Continued on next page



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Direct contracts

Continued from previous page
contracting "vary from place to place—from 10% to 18% on the medical-surgical side," Ms. Moriconi said.

Currently, more than one-third of Hewlett-Packard's 55,000 U.S. employees are enrolled in directly contracted medical-surgical PPOs.

Hewlett also offers leased PPO options and health maintenance organizations nationwide.

Hewitt's Mr. Klonoff warned employers considering directly contracting with providers that they must view it as "a long-term strategy" rather than a short-term cost-saving measure.

If employers look only at cost when contracting directly with providers, it could lead them to change providers in their network frequently, which could interfere with the relationships employees have established with physicians. And, that could undermine the company's managed care goals, Mr. Klonoff said.

Rather than focusing on cost, an employer coalition in Des Moines, Iowa, is directly contracting with hospitals and physicians in "a purchasing-for-quality initiative," said Dr. Bryan Bushick, a consultant in Minneapolis with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc.

Eight employers in the 55-member Health Policy Corp. of Iowa are heading up a demonstration project to directly contract with providers because of their "general dissatisfaction with the managed care products available in the market," Dr. Bushick said.

The employers experienced "frustration that they weren't really having their expectations conveyed to the providers." Particularly, employers believed they had a "lack of timely and useful data concerning health benefit expenditures."

So the employers decided to try to form "a greater partnership between payers and providers," Dr. Bushick said.

The coalition members are seeking a partnership with providers based on the principles of the so-called "total quality improvement program" that many employers have implemented to improve product quality while operating more efficiently, Dr. Bushick explained.

"Employers looking at the long term know that good quality care is cost-effective," he said.

The coalition's provider network, limited to providers in central Iowa, initially will provide only cardiovascular services, "though over time it may expand geographically and may also provide other medical services," he said.

In addition, there is "a commitment by the employers to integrate a wellness strategy," he said. In the coalition's request for proposals, "providers were asked what they can do about health promotion."

The Iowa coalition's effort shows that employers considering direct contracting do not have to look at establishing a network for all types of medical care.

Since developing and monitoring a comprehensive health care network "is a complex activity, one way an employer can be successful is to undertake a small portion of that activity" by directly contracting with specialist providers, said David Rinaldo, a TPF&C consultant in Valhalla, N.Y.

"Then, of course, they can grow the network slowly," he said.

Hewlett-Packard also has decided to key in on contracting directly for those medical services—like mental health—for which costs are rising most rapidly.

The company has directly contracted all of its mental health care PPOs in an attempt to better manage its employees' "generous" $300,000 lifetime mental health benefit, Ms. Moriconi said.

Despite its advantages, direct contracting may not be for everyone.

"Direct contracting really is not the fix-all for health care costs," Ms. Moriconi emphasized.

First, "it is very time-consuming," she said. And with resources tight in a recession, managing a directly contracted network becomes even more of a challenge, she said.

"My first choice would be that it go in the other direction," she said, explaining that "people who do this for a living" should be putting together more cost-effective provider networks and managing the health care of a client's employees.

And, direct contracting could be disastrous for employers that do not plan carefully, consultants warn.

Although 'loosely managed' networks put together primarily for discounts 'can result in some savings, they are certainly not the most effective,' says David Rinaldo. 'You don't guarantee disaster that way, but you do court it.'

For example, employers might lose their networks if their plans do not adequately encourage employees to use them.

"Some providers have come back to employers and said, 'You're not giving us enough business,' " and networks have dissolved, observed Ms. Weitzman of Alexander Consulting Group.

"I don't think, realistically, that direct contracting is a viable option in most circumstances," she said.

In addition, properly administering a directly contracted network in-house could prove too expensive for smaller employers, consultants warn. Only large employers have the staff and money to manage their networks, as well as to initiate negotiations with providers.

And, without proper administration, a directly contracted network will not provide quality, cost-effective care.

Although "loosely managed" networks that are put together primarily for discounts "can result in some savings, they are certainly not the most effective network in terms of the total experience," said TPF&C's Mr. Rinaldo.

"You don't guarantee disaster that way, but you do court it," he said.

While many employers have turned to direct contracting, it is "not a significant market issue," said Richard Maturi, senior vp-health care affairs at Blue Cross & Blue Shield Assn. in Chicago.

Given the cost of properly administering a directly contracted network, employers cannot keep up with "the sophisticated technical content of managed care" developed by insurers and established networks, Mr. Maturi said.

"It would be like us deciding to go into the auto business," he said.

Mr. Maturi also asserted that leased PPO arrangements can help employers control health costs. "Employers clearly see when we do the bids that their one-time savings and trend savings more than offset the administrative fees." ■

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Liability risk shouldn't deter direct contracts, attorney says

By LOUISE KERTESZ

Employers that contract directly with providers to establish preferred provider networks may not enjoy the protective "buffer" against liability they have when they use preferred provider organizations available from third parties.

However, that should not deter employers that have good reasons to undertake direct contracting, asserts Bill Brossman, an attorney with William M. Mercer Inc. in San Francisco.

Employers can take several steps to protect themselves against lawsuits by employees injured by network providers, as well as assure they establish a good managed care program.

No court has yet held an employer liable for the negligent acts of a directly contracted health care provider, but employers would be wise to note that courts have established liability for hospitals when their physicians' negligence has harmed patients, according to Mr. Brossman, who practices health care law.

Among the two theories of liability that have been applied to hospitals, corporate negligence is of the greatest concern to employers, he said.

Under the theory of corporate negligence, hospitals are held accountable for the negligent acts of their staff physicians because hospitals are responsible for ensuring that patients are treated by qualified and competent health care providers.

"The corporate negligence theory of hospital liability is very well established, and there are numerous court cases that have found hospitals responsible" for injuries to patients.

And, a Missouri appeals court recently applied the corporate negligence theory to health maintenance organizations, he noted. "Though the case was dismissed on the basis of an immunity statute that prevented HMOs from being sued, the court did accept an HMO member's argument that HMOs are responsible for screening physicians," he said.

Mr. Brossman therefore reasons that it is possible that a court one day will apply the corporate negligence theory against an employer that has directly contracted with providers whose subsequent negligence is responsible for an employee's injuries.

Employers therefore should take great care in establishing and monitoring their networks and document each step of the process, Mr. Brossman said.

He recommends that employers:

- Conduct a due diligence study focusing on physician credentialing and quality assurance. Hospitals should be asked how they select and monitor their staffs and how quality assurance is maintained.

Physician groups should be asked how they credential and monitor their members.

Gathering and analyzing data is the first and most important step for employers that want to contract directly with health care providers, benefit consultants agree.

"For direct contracting to be successful, data has to be developed," said Allan Fine, vp and national practice director for managed care at Witt Associates in Oak Brook, Ill., a benefit consultant.

"Employers need to ascertain where employees are going for their care," as well as analyzing utilization data, he said.

"To do it right, you need an awful lot of data," agreed consultant Jeffrey Klonoff of Hewitt Associates in Walnut Creek, Calif.

TPF&C, for example, has helped employers like the state of Utah evaluate the data they gather on providers with the help of statistical criteria known as Harrington Patterns, which measure proper treatment patterns (*BI*, Jan. 6).

The employer then should conduct site visits and meet with key hospital personnel and medical staff before the final financial terms are negotiated and a contract is executed, said Michael Cadger, Southeast region managed care practice leader at A. Foster Higgins & Co. Inc. in Atlanta.

The network's operations also should be monitored through an annual audit in which savings are quantified, problem areas are identified and quality of care is evaluated, he said.

- Obtain some contractual warranties that the hospitals and physician groups will maintain proper credentialing and monitoring procedures.

If the employer is contracting with individual physicians, credentialing and monitoring should be done by someone on the employer's staff or by an outside expert, Mr. Brossman said.

- Include a hold harmless clause in the provider contract.

The other theory of liability applied in health care cases is of less concern to employers, Mr. Brossman said.

Under the agency theory of liability, courts have held that HMOs are liable for the negligent acts of their physicians, who were acting as agents of the HMO.

Liability could potentially flow to an employer that directly contracted with providers under this theory, "but it is not a tremendous exposure," Mr. Brossman said. A court likely will not find that an employer exerts enough control over a network physician to make that physician an agent of the employer, he reasoned.

"What's important is for the employer to ensure that the independent contractor status" of the providers in a network "is reflected in all the contractual documents" and in all billing procedures, he said.

"The employer wants to distance himself to the greatest extent possible from the physician" to protect against allegations of agency liability, Mr. Brossman said.

Employers should take other steps to establish the most cost-effective network, consultants say.

For example, employers should establish utilization and cost targets for hospitals and doctors, "which will generate real savings," Mr. Cadger said.

It is important that employers "know what they are contracting for," agreed Leslie Weitzman, Midwest regional practice leader for health strategies at Alexander Consulting Group Inc. in Chicago.

For example, a hospital's discounts to an employer should be based on services the employer really needs, like baby deliveries. A 20% overall discount from a hospital that performs many high-cost services like organ transplants might not result in any savings for an employer, she explained. ■



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Employers pressure UR firms to live up to financial guarantees on cost containment

But treatment may suffer, some warn

By JOANNE WOJCIK

Employers increasingly are pressuring utilization review firms to guarantee the savings the reviews are supposed to generate.

A few vendors will accept financial penalties if they fail to meet cost containment goals. But most hesitate to put their money where their mouth is out of fear that they may appear to be compromising treatment decisions for the sake of making a profit.

Instead, most vendors are willing to guarantee the quality of their service, wagering a portion of their fees if they don't live up to promises they have made.

Offering financial guarantees to back up cost-containment promises, however, is not a new concept in health care.

For example, CIGNA Corp. agreed to a three-year cap on year-to-year increases when it set up a point-of-service plan for Allied-Signal Inc. four years ago.

Many of these highly publicized risk-sharing contracts between employers and managed care firms may have planted the idea in the minds of employers with indemnity-based programs that do not want to revamp their plans, some observers believe.

"Some UR firms may be offering financial guarantees in response to competition from point-of-service plan vendors," said John Erb, a principal consultant with A. Foster Higgins & Co. Inc. in New York.

"Up until six months ago, we didn't have any customers interested," said Dr. James Vance, chief medical officer for Conservco Inc., a Travelers Corp. subsidiary in Tampa, Fla. "But they have become much more interested in the past few months."

"A few employers are asking for financial guarantees, mostly because their consultants are saying they should," observed Dr. Ed Zalta, chairman and chief executive officer of CAPPCARE, a UR firm based in Newport Beach, Calif.

"A lot of consultants are initiating performance guarantees as a form of quality control," said Dierdre Kelley, an Atlanta-based health care consultant with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

Because UR firms—unlike managed care firms—have little control over other health plan components, like provider selection or compensation and claims payment, they are hesitant to make financial guarantees.

"Usually we won't guarantee savings if we have no control over care other than UR," said Dr. Zalta.

John D. Steifel, regional actuary for Aetna Healthplans' eastern region, agreed: "Unless you have control over claims payment, you'd be crazy to enter into one of these contracts."

Similarly, many UR firms are reluctant to make financial guarantees if a health plan does not make UR mandatory.

"The use of UR must be mandatory before we will enter into any financial guarantee contract," said Gary McIlroy, chairman and CEO of Health Risk Management Inc. in Minneapolis.

"How can you have any control over utilization if UR is not mandatory?" echoed Dr. Zalta.

Likewise, UR firms that cannot control claims payment practices will not enter into a financial guarantee contract.

"The third-party administrator can dictate the success or failure of a UR vendor," said Bill Danish, a principal consultant with Kwasha Lipton in Fort Lee, N.J.

Because many TPAs have difficulty understanding UR recommendations for payment authorization, they often overpay, Mr. McIlroy explained.

In fact, a recent audit of one TPA working for a Health Risk Management client showed it had made unauthorized claims payments totaling more than $300,000.

"We have seen this so often that we created our own claims administration group," Mr. McIlroy said.

Health Risk Management purchased Pension & Group Services Inc., a Kalamazoo, Mich.-based TPA, in 1990.

Enrollment fluctuations that make it difficult to project year-to-year utilization also deter many UR firms from entering into financial guarantee contracts, according to Nina Auger, vp-managed care delivery for Blue Shield of California in San Francisco.

"If you give a group a blanket guarantee, how do you know you'll get the same population (as the one on which the guarantee is based)?" she asked.

During open enrollment, she explained, many healthy employees in the indemnity plan may choose an HMO, or many less healthy HMO enrollees may opt for the indemnity plan.

Concerns over conflicts of interest prevent many UR firms from making financial guarantees.

"Liability experts are advising companies to move away from cost savings-based reimbursement arrangements, because it's too tempting for a personal injury attorney," said Dr. Arnold Milstein, president of National Medical Audit, a subsidiary of William M. Mercer Inc. based in San Francisco.

"A UR firm could theoretically deny every admission," agreed Foster Higgins' Mr. Erb.

If a patient can show that a potentially harmful utilization review decision was made on the basis of a financial incentive, both the UR firm and the employer can be held liable, according to Maureen Corcoran, an attorney with Pillsbury, Madison & Sutro in San Francisco who specializes in managed care liability.

"If the employer knew the contract was too good to be true and the UR firm was denying payment inappropriately," the employer may be found to be violating its fiduciary responsibility as the plan sponsor, she said.

While so far no courts have found that employers are liable for such acts, some case law does sup-

Continued on page 30

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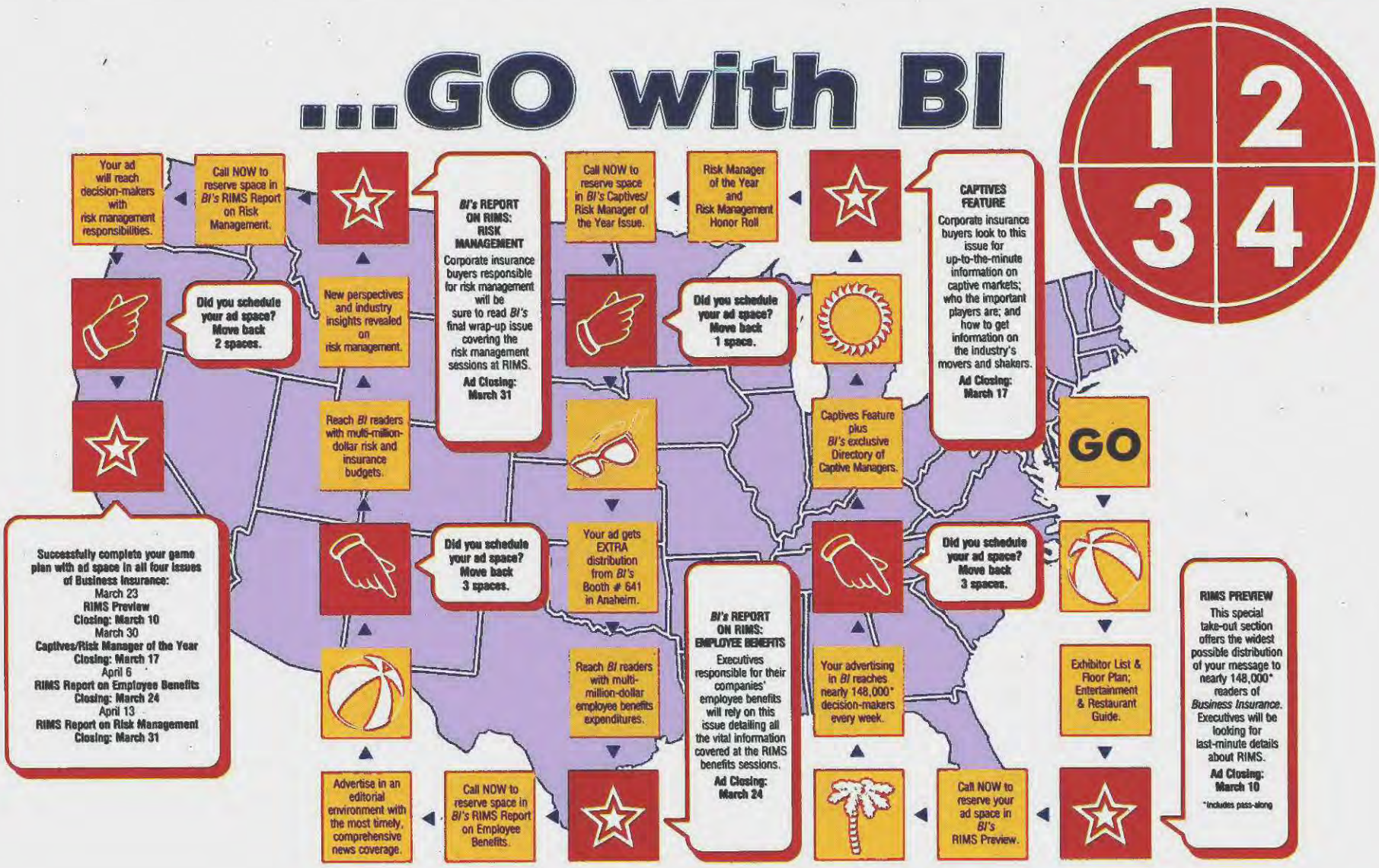
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Guarantees

Continued from page 28
port the argument, Ms. Corcoran said.

Any time a UR company says it will save a certain amount, "it's my perception that that does increase liability," observed Dr. Robert Becker, chairman of the Utilization Review Accreditation Commission in Washington, D.C.

"It is not unlikely that utilization review decisions could be based on reaching financial targets," added Dr. Becker.

If "you've got money on the line, your motives for cost-cutting decisions may be suspicious," observed Pam DePriest, director of marketing for Sunderbruch Corp., a UR firm in St. Louis. "We want our reviews to be totally objective."

"We would never have any incentive that would make it appear we would not pay a claim," asserted Alice Ward, director of risk management for Blue Shield of California.

Instead, Blue Shield will agree to identify an employer's problem areas and establish goals, said Ms. Ward.

For example, to reduce an employer's unusually high Caesarean section rate, Blue Shield will agree to launch an education campaign, mandate second surgical opinions and set up a high-risk pregnancy program, she said.

Because of this potential liability, "our legal counsel will never permit us to enter into a percentage-of-savings contract," said Health Risk Management's Mr. McIlroy. "But they will allow us to make certain guarantees," such as that savings will outpace the UR fees paid by a 2-to-1, 3-to-1 or even 4-to-1 ratio, depending on the client's past claims experience.

Aetna Healthplans is one exception to the no risk-sharing rule. It offers employers that purchase both UR and TPA services a contract in which Aetna and the employer share in any savings or claims above a target level.

For example, if the vendor and employer agree that the claims target will be set at $3,200 per year per employee, the employer will agree to pay 100% of claims that total between 95% and 105% of that amount.

If claims are between 105% and 115% of that amount, Aetna and the employer will split the amount 50-50.

Likewise, if the claims fall below the target, the vendor and employer will share equally in the savings, Mr. Steifel explained.

However, because Aetna Healthplans is technically providing insurance that it will meet a claims goal, it charges employers that contract for such financial guarantees a premium, which might amount to about 1% of claims, according to Mr. Steifel.

Despite other firms' conflict-of-interest concerns, Mr. Steifel believes that if a firm is professional, it will not make treatment decisions based on financial incentives or penalties.

"We are driven by customer service," he said. "And our customers include people who file the claims —the employees."

Furthermore, Aetna Healthplans has established a Chinese wall between UR reviewers and those involved in contract negotiations with employers.

And, even if reviewers do discover there is some financial penalty at stake if claims exceed a certain level, "they haven't got the foggiest idea how to manipulate the claims, because they're too busy working in the field," said Mr. Steifel.

Aetna Healthplans, like most UR vendors that offer financial outcome guarantees, also will voluntarily submit to outside audits to prove they are objective, Mr. Steifel added.

Travelers' Conservco also is beginning to explore offering financial guarantees, but has not yet signed any contracts, according to Mr. Vance.

Healthmarc, the UR subsidiary of United Health Care Corp., has financial guarantee contracts with about 20% of its employer clients, according to Mark Tierney, chief executive officer of the Minneapolis-based firm.

But the firm's penalties and incentives are nominal compared with those of Aetna Healthplans.

Mr. Tierney believes the penalty "shouldn't be so onerous that it would jeopardize" treatment decisions. He suggested that the penalty should be approximately 10% of UR fees.

While only a few UR firms offer financial guarantees, most are more willing to enter into service-based contracts.

"We would never want to see in a contract how much care should be approved or denied," said Kwasha Lipton's Mr. Danish. "Medicine is not an exact science. There's too much fluctuation. And even experience doesn't help because of medical advances" that add to treatment costs.

He suggests that instead of tying a financial incentive to claims volume, the contract should focus on service.

Specifically, he suggests setting service standards for things like how quickly reviewers answer the phone, what hours the vendor operates and how easy it is for nurse reviewers to access physicians.

Many employers are warming to the idea of performance guarantees as they begin to realize that if a UR vendor does everything by the book, it will achieve the most savings possible.

"If you are doing everything you've proposed, then you'll be achieving savings," said Sunderbruch's Ms. DePriest.

"Most employers don't want a 20% rebate on fees if the UR firm is

Continued on next page



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UR firm allows clients to set priorities

CYPRESS, Calif.—Recognizing that each employer has different expectations of its utilization review provider, one California review firm customizes its programs.

Not only does Cypress, Calif.-based Pacific Review Services try to meet the top 10 UR priorities identified by each of its client, but it also has tied employee compensation to how well those client company satisfaction standards are actually met.

The program was developed last year after a nationwide poll of 200 PRS clients—including self-insured employers and third-party administrators—showed little consensus about what constitutes high-quality service.

"We thought clients were most interested in saving money, but instead the answers were all over the board," recalled PRS President Vicki Merrill.

One company, in fact, actually thought the reviewing done by PRS was "too aggressive in saving money," said Ms. Merrill.

Following the survey, PRS developed a list of 30 service priorities and asked each client to select its own top 10 from the list. This enabled the UR firm to develop a set of quality standards for each company.

PRS says its employees focus their efforts on meeting these priorities.

For example, if cost containment were the No. 1 priority for Company A, UR reviewers would make treatment decisions with cost in mind. And if friendliness of UR personnel were the top priority for Company B, PRS employees would, for instance, take the time to explain a decision to that client's employees and establish a rapport with them.

To further motivate PRS employees to meet these varying priorities, executives' bonus pay and a percentage of PRS employees' merit pay now is linked to how well they score on a report card completed by each client every six months.

"It's part of our drive to get each employee involved and responsible for making decisions that will lead to the highest degree of service and customer satisfaction," Ms. Merrill explained.

Clients also are given the opportunity to change their top 10 criteria annually.

In any case, PRS will not go so far as to jeopardize quality health care to meet a client's goals, Ms. Merrill stressed.

"No top 10 (priority) will change the length of stay criteria or how to manage care," she said.

Although the survey responses varied considerably, PRS was able to assemble an overall list of the top 10 quality indicators by averaging the responses to its survey.

One company actually thought PRS was 'too aggressive in saving money,' says Vicki Merrill.

The top priorities chosen by clients in order of importance are:

- Responsiveness of personnel in answering questions and follow-through on inquiries.
- Timely phone response—answering questions and returning messages.
- Aggressive managed care services resulting in reduction of claims.
- Timeliness of PRS review decisions and determination letters.
- Patient advocacy ensuring quality of medical care.
- Timely, accurate and insightful data in reports to clients.
- Return on investment for services.
- Licensed certified professionals on staff.
- Relations with hospitals and other providers.
- Friendliness of personnel.

PRS is a subsidiary of PacifiCare Health Systems, a publicly held health maintenance organization with operations in California, Oregon, Washington, Oklahoma and Texas.

—By Joanne Wojcik

Guarantees

Continued from previous page

messing up," said Dr. Milstein of National Medical Audit. "They want out of the contract."

In about a third of the contracts being negotiated between employers and UR firms, National Medical Audit includes an incentive based on customer satisfaction: If the UR users—patients and physicians—are happy with the service, the vendor receives a small bonus from the employer—usually in the thousands of dollars.

"It's the best of both worlds," Dr. Milstein said. "There's no liability exposure, yet the employer still retains the ability to ditch the vendor" if it is not living up to expectations. "And renewal depends on good cost-savings results."

In such contractual arrangements, customer satisfaction is measured by use of a survey through which elements of performance, like timeliness, rationality of review decisions, diplomacy and persuasiveness, are measured.

For example, doctor-to-doctor and nurse-to-patient interactions are rated based on reviewers' ability to enforce rigorous—yet clinically responsible—standards in a tactful but persuasive manner, Dr. Milstein explained.

Many employers are negotiating review standards to ensure that performance is consistent with contractual obligations, according to JoAnn Fritsch, a Wyatt Co. consultant in Washington, D.C., who specializes in UR audits.

"Many UR firms are falling short of meeting their internal standards," she said. For example, some that claim they will review a case within 24 hours may actually be taking 48 or 72 hours.

Rather than being paid for providing inferior service, Ms. Fritsch suggests that UR vendors be forced to pay a penalty—for example, a percentage of their fees—if they do not meet their own internal standards at least 95% of the time.

"Everyone who has a UR contract should have performance standards with financial penalties," she said.

Service agreements also withstand the test of time, unlike financial guarantees, which must be renegotiated after a particular target has been met.

"If it's an outcome guarantee, such as reducing inpatient days per 1,000, you'll get to a point where you're no longer cutting off the fat," Ms. Fritsch said.

Setting service standards also can be used to bring small, regional UR vendors up to the performance level of the large, national firms, points out TPF&C's Ms. Kelley.

And standardizing UR procedures nationwide is "better than jumping from vendor to vendor," she observed. ■



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UR, managed care vendors join forces

By DEBORAH SHALOWITZ

Utilization review firms continue to dovetail their efforts with managed care networks, hoping to make the UR process less cumbersome for physicians, employers and patients.

Many UR firms also are expanding the range of services they offer, from adopting or expanding reviews of workers compensation-related procedures to developing more specialized health care cost containment services.

And, as UR firms expand and integrate a variety of services into their operations, many are seeking accreditation to differentiate themselves from their many competitors (see related story).

The biggest trend in utilization review has been brewing for quite some time: the intermingling of utilization review and managed care networks.

"Utilization review as a stand-alone product is not going to be effective in managing health care costs," said Rosemary Sheehan, vp and manager of UR product development for Lexington, Mass.-based Private Healthcare Systems Inc., the nation's third-largest UR vendor, according to *Business Insurance. BI*'s rankings are based on the number of inpatient hospital admissions reviewed in 1991.

"Utilization review really is not what the market is concerned about anymore," said Marlene Travis, president of Minneapolis, Minn.-based Health Risk Management Inc., the seventh-largest vendor. "People are interested in care management and want a one-stop shop where they can get care management."

"In the next generation of utilization management. . .the focus will be on managed care," agreed Mary Ellen O'Donnell, director of utilization management for Blue Cross & Blue Shield Assn. in Chicago.

One of the most important benefits of linking the UR process with a managed care network is that physicians will become more involved in developing the criteria on which reviews are based, several experts said.

As UR firms become more involved in managed care, physicians will be involved in setting medical policy, said Lottie Kurcz, vp-marketing for HealthCare COMPARE of Downers Grove, Ill., the fifth-largest UR firm.

Managed care companies need to evaluate physicians in the selection phase, so that doctors who need policing are not including in their network, said Gene Guselli, president and chief executive officer of Private Healthcare Systems. "Once you get doctors that you trust. . .get them involved in the process. Let them become part of the evolution of standards and criteria," he suggested.

"We feel that a good partnership with providers of medical care is important," noted Dr. James Vance, chief medical officer for Tampa, Fla.-based Conservco Inc., the eighth-largest UR vendor. "We're trying to be sensitive to the hassle factor" involved with utilization review, he said, by prospectively forging agreements with physicians on areas that will need to be reviewed.

Don Duford, senior vp of Berwyn, Pa.-based Intracorp, the nation's second-largest UR firm, suggested releasing review criteria to doctors so that "as long as a doctor follows it, we won't call much," thereby lowering UR costs.

When dealing with network providers, "you may delegate all or part of utilization management to that group," thereby simplifying the process, agreed Dr. Paul Bluestein, national medical director of the Westport, Conn.-based Managed Care Services Group of Metropolitan Life Insurance Co., the fourth-largest UR vendor.

Another benefit of linking utili-

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Commission gives accreditation to UR service firms

To stand out from from the abundance of companies offering UR services, many firms are seeking accreditation from the Utilization Review Accreditation Commission.

The Washington, D.C.-based group began accrediting UR vendors late last year but, as of earlier this month, had accredited only eight companies.

Of the nation's 10 largest UR firms profiled by *Business Insurance*, only Intracorp and Health Risk Management have already been accredited, according to Elizabeth Friberg, the URAC's director of accreditation. Several other firms said they are in the process of seeking accreditation.

URAC has received 54 accreditation applications since it began accepting them last July, Ms. Friberg said.

The accreditation process takes about three to four months and is conducted in three stages: an internal stage, during which the URAC staff reviews a company's 20-page application and seeks any necessary supporting documentation; an accreditation committee review stage, during which the application is reviewed by 14 health care specialists who make a recommendation about the application; and an executive committee review stage, during which a committee of four URAC directors reviews the application and considers the larger committee's recommendation.

The standards on which applications are judged include: accessibility and availability of staff; quality of staff; review procedures; appeals procedures; type of criteria used in making clinical decisions; and confidentiality policies. The criteria address prospective and concurrent review processes for inpatient review programs and outpatient surgery precertification.

Accreditations are granted for two years.

If an accreditation is not granted immediately, companies have 90 days to correct problems and can obtain another 90-day extension if requested, Ms. Friberg said. "We give people an opportunity to reach the level of compliance," she noted.

The base rate for an application is $3,500, plus an additional $1,000 per site, up to a maximum of $9,000. Companies with more than 15 sites must negotiate a fee with URAC.

—By Deborah Shalowitz

Continued from previous page
zation review with managed care is that health care becomes less costly and less confusing for employers, the experts said.

Employers save money if the health care system integrates the utilization review function into a managed care network because the system is more efficient and easier to deal with, Ms. Travis said.

"Utilization review by its nature is intrusive and it's adversarial," commented Eric Spitzer, president and CEO of Peer Review Analysis Inc. of Malden, Mass., the 10th-largest vendor. Therefore, anything UR companies can do to speed up the process is good, he said.

"At some point, either we or our competition are going to get smart enough to have a terminal in a doctor's office or hospital," so that claims can be preapproved electronically, much like credit card applications, Mr. Spitzer said.

Another area most UR firms are trying to integrate into the services they provide is workers compensation medical reviews. Many firms have instituted or expanded disability management programs.

Previously, "people weren't paying a lot of attention" to workers compensation costs, said Dennis Duffy, president and CEO of Millburn, N.J.-based AXIOM Review Inc., the sixth-largest UR vendor. However, a disability management program that involves the worker, employer, doctor and hospital can help control these costs, he stated.

Employers also are becoming "more and more interested in customized" health care UR programs, said Cathy Johnson, vp of marketing and product development for Conservco.

Many employers are becoming more sophisticated in what they seek from a UR firm, agreed Lawrence Goelman, president and chief executive officer of Huntington Beach, Calif.-based Cost Care Inc., the ninth-largest UR firm.

"I see clients along a continuum" Mr. Goelman said. Some, for instance, will prefer less extensive UR services and others will prefer very sophisticated review systems.

Some employers, like some buyers of computer software, will be satisfied with a basic package of services, while others may want continual upgrades, Mr. Goelman said. Whether an employer wants to upgrade its UR services "will be a function of corporate culture, an industry's profitability, union contracts and how intrusive the employer wants to be in the health care industry," he said.

Following are profiles of the largest general service UR vendors:

Blue Cross & Blue Shield Assn.

The Blue Cross & Blue Shield Assn. is once again the largest UR firm in the nation.

Blue Cross & Blue Shield plans combined reviewed a total of 2.4 million inpatient hospital admissions last year, down from 2.6 million in 1990.

Ms. O'Donnell said the decline was due to a decline in membership among BC/BS plans as well as a drop in the rate of admissions. The rate fell because of greater participation in managed care networks, she said.

Like many other UR firms that are affiliated with insurers, most of the reviews that the BC/BS plans conduct are bundled with other services from the insurer.

"The plans in the BC/BS association will sell unbundled utilization review to administrative-services-only accounts if requested, but they don't actively market unbundled services," she said.

The BC/BS association's main utilization review service, Custom-Care USA, is available through 27 of its 73 plans. While all plans offer some UR services, in order to offer the more comprehensive Custom-Care, a plan must first submit a detailed application and undergo an on-site evaluation of its utilization management program.

In the past year, BC/BS expanded its use of appropriateness reviews and focused reviews, she said.

An appropriateness review considers not only where a procedure should be performed, but also whether the procedure should be performed at all or in lieu of another treatment, she said. Although the company has provided the service for a few years, recently its popularity has grown, she said.

A focused review analyzes utilization data to identify problem areas, she said. Such reviews could focus on a particular provider group, a geographic region or particular procedures.

With focused reviews, "you don't review the majority of care; you focus on the care that is questionable," Ms. O'Donnell explained. "You're going to see much more of that in the future because of the potential to reduce administrative overhead."

However, focused reviews only are possible when the UR firm has access to a lot of claims data, allowing it to identify deviations from normal trends, she cautioned.

BC/BS also has expanded its case management capabilities to include disability and workers compensation case management and chronic illness case management, Ms. O'Donnell said.

Chronic illness case management seeks to manage high cost conditions, like complicated diabetes, cystic fibrosis and sickle cell anemia, she said.

BC/BS plans serviced 55.8 million employee benefit plan lives in 1991.

Intracorp

Intracorp, which is No. 2 in the *Business Insurance* rankings, is enhancing two segments of its UR business, according to Mr. Duford.

The CIGNA Corp. unit last year expanded its case management capabilities and also is broadening the scope of INFER, its artificial intelligence software for reviewers.

Intracorp, which reviewed an estimated 748,776 inpatient hospital admissions in 1991, down from 819,580 the previous year, also began managing cases over the phone last year, which enables it to manage four times as many cases as when it only conducted case management on site, Mr. Duford said. The phone system also allows the company to manage cases less expensively, he said.

Intracorp further enhanced its case management capabilities by ensuring that all case managers who work in the field have portable computers. The computers are linked to area offices, which in turn are linked to the company's headquarters. This allows all Intracorp case managers to approach cases similarly and draw upon the experience of other managers with similar situations.

Meanwhile, Intracorp last year added a mental health segment to its artificial intelligence program, INFER, which staff nurses who review claims can use to identify situations requiring case management, Mr. Duford said.

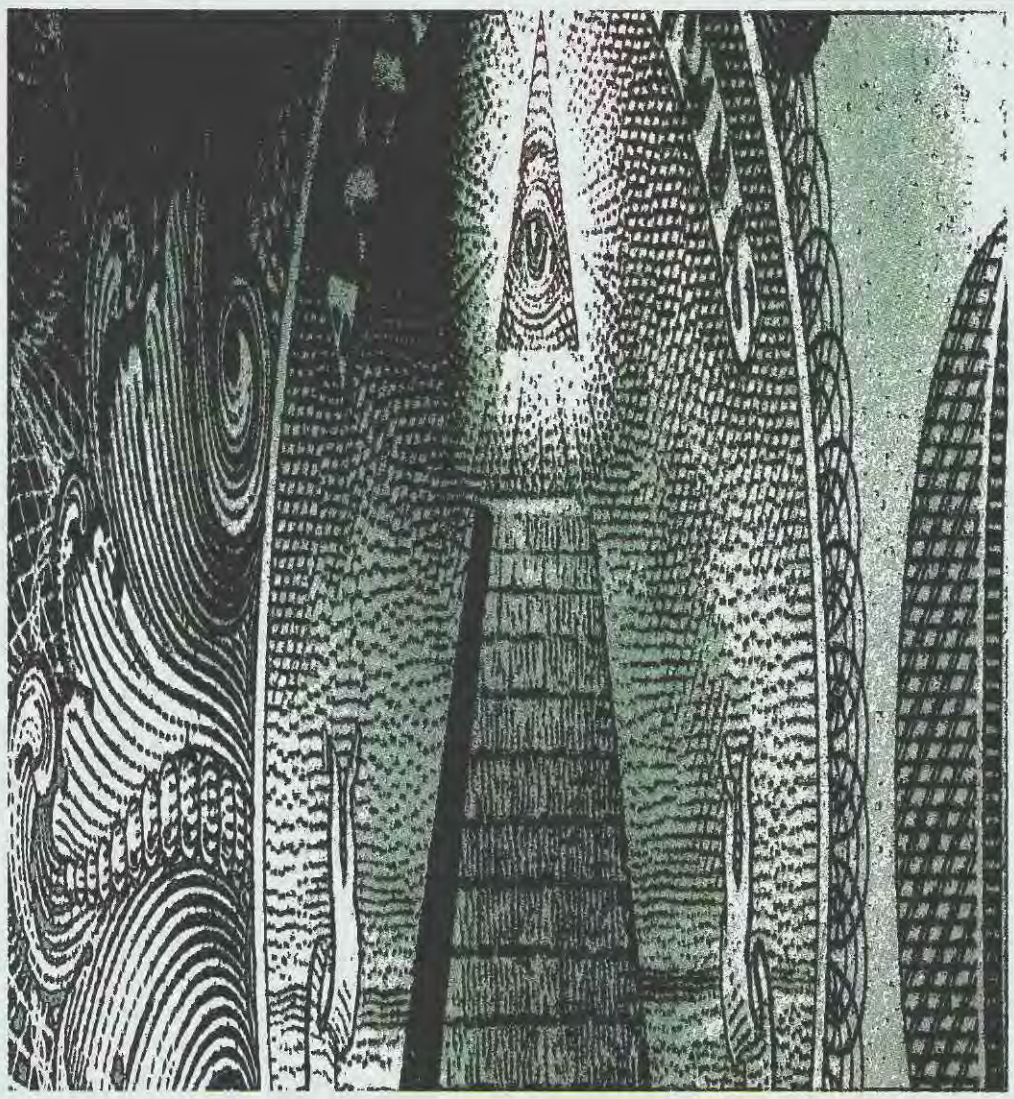
Intracorp is testing the use of INFER to also evaluate outpatient cases, he added.

Looking forward, Intracorp hopes to develop ways to better focus utilization reviews on those cases that really require management, Mr. Duford said.

"Hospital utilization has changed," he said. "That's permanent. But we need to find the situations where care rendered is outside of recommended protocols.

"We have to be smarter to pick

Continued on next page



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Top 10 UR firms

Continued from previous page
those episodes (for management) that are off track. We need to find the 10% to 20% of cases where we can change the outcome."

Intracorp also plans to focus more on educating patients about health and wellness. "We need to impact patient behavior" as well as the more traditional areas that utilization review usually focuses on, Mr. Duford said.

"We need to help patients avoid care through education and wellness," he said. "We need to have a fully integrated program to deal with the patient before they get sick, while they're sick and after."

Some 4.3% of the company's gross revenues were generated by providing UR services to employers, while 34.8% was generated by providing UR services to insurers, health maintenance organizations, preferred provider organizations or third-party administrators. The remainder was generated by other services provided by the company.

Intracorp's total gross revenues were $295.8 million in 1991, of which $115.8 million was generated by UR services.

Intracorp serviced 24.5 million employee benefit plan lives and 2.9 million workers compensation lives in 1991.

Private Healthcare Systems Inc.

Until last year, Private Healthcare Systems Inc., which is owned by 17 insurers, offered UR services only to its owner insurers and their subscribers.

Beginning in 1991, however, the company began servicing self-insured employers.

The company reviewed 440,000 inpatient hospital admissions last year, giving it the No. 3 ranking, up from 228,500 in 1990.

The lion's share of its UR business—73%—still comes from providing UR services to insurers, managed care organizations and third-party administrators, but the firm plans to put "much more emphasis and time and attention into tapping into (the self-insured employer) market," said Mr. Guselli.

The company reported that only 3% of its business was generated by providing UR services to employers. The remainder of Private Healthcare's 1991 revenues came from other services it provides.

Private Healthcare, a former partnership that recently incorporated, estimates 1991 revenues of $46 million, of which $35 million was generated by UR services.

Although the company contracts with doctors and hospitals in 42 metropolitan areas, it provides UR services from three regional offices: the Lexington, Mass., corporate headquarters; Irvine, Calif.; and Rosemont, Ill.

One of the strengths of Private Healthcare is its extensive data base, Mr. Guselli said. Each of the company's 17 insurer shareholders has contributed all of its claims data, including all interactions with physicians and hospitals.

One way the data base is used is for a quality monitoring program, Mr. Guselli said.

The quality monitoring program examines criteria such as recidivism to an inpatient setting, complications following surgery and follow-up care.

Private Healthcare's data base also allows the company to develop a profile of each physician in the database and monitor his or her medical treatments. If a particular physician is suspected of hospitalizing people unnecessarily, the computer system can be programmed to flag all of that physician's hospitalization requests.

Private Healthcare also has developed an electronic claims filing system that eventually will allow claims to be filed directly from a hospital or physician's office into the data base. The electronic claims filing system will reduce administrative confusion and make the company more efficient, Mr. Guselli noted.

Private Healthcare serviced 4.7 million employee benefit plan lives in 1991 and 200,000 workers compensation lives.

Metropolitan Life Insurance Co.

The Managed Care Services Group of Metropolitan Life Insurance Co. underwent a major organizational restructuring last year that moved the company from a highly centralized organization to one with a more local focus, according to Dr. Bluestein.

Under the new structure, the Managed Care Services Group established 10 regional headquarters: Atlanta, Boston, Chicago, Cleveland, Denver, Houston, Los Angeles, New York, Philadelphia and St. Louis.

The creation of the regional structure allows MetLife to "become more familiar with the (local) provider community," Dr. Bluestein said.

MetLife reviewed 400,000 acute care inpatient hospital admissions last year, ranking it fourth on the *Business Insurance* list, down from 498,000 in 1990.

"The focus here is much more on quality than it is on size," Dr. Bluestein commented. "We're trying to focus on better and better rather than bigger and bigger."

MetLife's UR business is twofold:

- Reviews conducted for clients that are not members of one of the company's managed care networks.
- Reviews that are conducted for members of a MetLife managed care network.

In the future, the non-network segment of the firm's UR business will decrease, while the network reviews will increase, Dr. Bluestein predicted. As that happens, the practice of utilization review will change, he said.

"As you begin to contract with doctors, the focus changes from what are the company's rules to what are the rules that will be agreed upon by the medical community," Dr. Bluestein explained.

MetLife serviced 6 million employee benefit plan lives in 1991.

HealthCare COMPARE

HealthCare COMPARE last year concentrated on expanding its PPO network, Sacramento, Calif.-based AFFORDABLE HealthCare Concepts.

In 1992, it plans to expand its utilization review and managed care services in the workers compensation arena and to offer several new services as pilot programs, Ms. Kurcz said.

HealthCare COMPARE was the fifth-largest UR vendor based on 392,440 inpatient hospital admissions reviewed last year, up from 358,400 in 1990.

To expand its workers compensation services, HealthCare COMPARE in March will merge with Occupational Urgent Care Health System Inc., a Sacramento, Calif.-based company that offers workers compensation PPOs and utilization management (*BI*, Nov. 25, 1991).

And, HealthCare COMPARE this year will begin providing UR services and PPO networks for companies that buy workers compensation insurance from Liberty Mutual Insurance Co. of Boston, Ms. Kurcz said.

The company's goal is to develop a "24-hour product" that looks at an employee's health from all perspectives, she said.

Utilization review is particularly important for this type of product because "there is some concern that there's a duplication of payments" to the group health benefits system and the workers compensation system, Ms. Kurcz said. Some estimates place duplication of payments as high as 15%, she said.

HealthCare COMPARE also plans to try out several new programs in 1992, Ms. Kurcz said.

In one pilot program, all services associated with the birth of a baby would be combined into a separate network. The specialized maternity network would provide a continuum of care from conception through "well-baby" care, involving a fertility specialist, an obstetrician/gynecologist and a pediatrician, she explained.

A company "would have more hands-on management" with such a network, Ms. Kurcz pointed out.

Other areas to which the concept could be applied to include psychiatric and chemical dependency care and transplants, she added.

HealthCare COMPARE also plans to develop national pharmacy PPO networks, based on a pilot pharmacy PPO network in Texas that the company already operates, Ms. Kurcz said.

Technological changes in the company in the last year include the development of an artificial intelligence software system that is being used to identify cases for case management, Ms. Kurcz said.

The firm generated 29% of gross revenues from providing UR services to employers, 13% from providing UR services to insurers, HMOs, PPOs or TPAs, and the remainder from other services.

Total gross revenues were $71 million in 1991, of which $30 million was generated by UR services.

HealthCare COMPARE serviced 9.45 million employee benefit plan lives in 1991.

AXIOM Review

Although AXIOM Review remains predominantly a regional UR firm, it reviewed 353,000 inpatient hospital admissions in 1991, up from 325,959 a year earlier, ranking it No. 6.

Unlike many of the national UR firms, AXIOM "tries not to do anything telephonically," Mr. Duffy said. "We try to have people there, rather than just a name on a telephone."

AXIOM nurses and sometimes physicians go to hospitals to conduct on-site reviews, he explained.

The firm primarily serves the Northeast from Delaware through Massachusetts from two offices: its Millburn, N.J., headquarters, and a new office in Farmingdale, N.Y.

AXIOM is expanding its UR services to include workers compensation reviews, because "it seems to be an area where the level of impact is large," Mr. Duffy said.

At the time that a workers compensation claim is filed, an insurance adjuster or an employer's representative notifies AXIOM and starts the review process, explained Robert Jones, senior vp and chief operating officer.

"We feel that we've got a basic product but we've got to change with the market," said Mr. Duffy. "Everybody is looking at every cost."

Along with traditional UR services, AXIOM has been conducting a lot of bill reviews in the past year, Mr. Duffy noted. "We have gotten more calls for bill review than we ever had previously."

The company offers bill review services on either a fee or a contingency basis.

AXIOM's reviews typically save clients between 20% and 40% of a bill's original charges, Mr. Duffy estimated.

Another new service is wellness program development. The company currently is working with two large employers to set up wellness programs, he said.

AXIOM generates 20% of its gross revenues from providing UR services to employers, 65% from providing UR to insurers, HMOs, PPOs or TPAs, and the remaining 15% from other services.

Total gross revenues were $8.9 million in 1991, of which $8.1 million was generated by UR services.

Health Risk Management Inc.

Health Risk Management Inc. expanded many of its services last year, including its PPO networks, claims management abilities and disability management services.

HRM now offers its PPO network in 42 states and 300 cities, Ms. Travis noted.

And, to expand its claims management capabilities, the firm recently acquired Pension & Group Services Inc., a Kalamazoo, Mich.-based TPA.

"You can't manage health care unless you can link care management with price management and those with claims management," she said. Now HRM offers "a much tighter management system."

The firm reviewed 268,000 inpatient hospital admissions last year, up sharply from 92,072 in 1990, making it No. 7 in the rankings.

In the workers compensation area, HRM has added software to increase efficiency and help keep track of differing state regulations, Ms. Travis said.

Also on the software front, a subsidiary of HRM, the International Institute for Health Care Quality, next month will begin leasing software containing 75 health care practice guidelines, Ms. Travis noted.

HRM generates 70% of its gross revenues from providing UR services to employers, 10% from providing UR to insurers, HMOs, PPOs or TPAs, and the remaining 20% from other services.

Projected gross revenues are $32 million for the year ending June 30.

The company serviced 5 million employee benefit plan lives in 1991

Continued on next page

Seldane®
(terfenadine) 60 mg Tablets

BRIEF SUMMARY
CAUTION: Federal law prohibits dispensing without prescription.

DESCRIPTION
Seldane (terfenadine) is available as tablets for oral administration. Each tablet contains 60 mg terfenadine. Tablets also contain, as inactive ingredients: corn starch, gelatin, lactose, magnesium stearate, and sodium bicarbonate.

INDICATIONS AND USAGE
Seldane is indicated for the relief of symptoms associated with seasonal allergic rhinitis such as sneezing, rhinorrhea, pruritus, and lacrimation.

CONTRAINDICATIONS
Seldane is contraindicated in patients with a known hypersensitivity to terfenadine or any of its ingredients.

PRECAUTIONS
General: Terfenadine undergoes extensive metabolism in the liver. Patients with impaired hepatic function (alcoholic cirrhosis, hepatitis), or on ketoconazole or troleandomycin therapy, or having conditions leading to QT prolongation (e.g. hypokalemia, congenital QT syndrome) may experience QT prolongation and/or ventricular tachycardia at the recommended dose. The effect of terfenadine in patients who are receiving agents which alter the QT interval is not known. These events have also occurred in patients on macrolide antibiotics, including erythromycin, but causality is unclear. The events may be related to altered metabolism of the drug, to electrolyte imbalance, or both.
Information for patients: Patients taking Seldane should receive the following information and instructions. Antihistamines are prescribed to reduce allergic symptoms. Patients should be questioned about pregnancy or lactation before starting Seldane therapy, since the drug should be used in pregnancy or lactation only if the potential benefit justifies the potential risk to fetus or baby. Patients should be instructed to take Seldane only as needed and not to exceed the prescribed dose. Patients should also be instructed to store this medication in a tightly closed container in a cool, dry place, away from heat or direct sunlight, and away from children.
Drug Interactions: Preliminary evidence exists that concurrent ketoconazole or macrolide administration significantly alters the metabolism of terfenadine. Concurrent use of Seldane with ketoconazole or troleandomycin is not recommended. Concurrent use of other macrolides should be approached with caution.
Carcinogenesis, mutagenesis, impairment of fertility: Oral doses of terfenadine, corresponding to 63 times the recommended human daily dose, in mice for 18 months or in rats for 24 months, revealed no evidence of tumorigenicity. Microbial and micronucleus test assays with terfenadine have revealed no evidence of mutagenesis.
Reproduction and fertility studies in rats showed no effects on male or female fertility at oral doses of up to 21 times the human daily dose. At 63 times the human daily dose there was a small but significant reduction in implants and at 125 times the human daily dose reduced implants and increased post-implantation losses were observed, which were judged to be secondary to maternal toxicity.
Pregnancy Category C: There was no evidence of animal teratogenicity. Reproduction studies have been performed in rats at doses 63 times and 125 times the human daily dose and have revealed decreased pup weight gain and survival when terfenadine was administered throughout pregnancy and lactation. There are no adequate and well-controlled studies in pregnant women. Seldane should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Seldane is not recommended for nursing women. The drug has caused decreased pup weight gain and survival in rats given doses 63 times and 125 times the human daily dose throughout pregnancy and lactation. Effects on pups exposed to Seldane only during lactation are not known, and there are no adequate and well-controlled studies in women during lactation.
Pediatric use: Safety and effectiveness of Seldane in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Experience from clinical studies, including both controlled and uncontrolled studies involving more than 2,400 patients who received Seldane, provides information on adverse experience incidence for periods of a few days up to six months. The usual dose in these studies was 60 mg twice daily, but in a small number of patients, the dose was as low as 20 mg twice a day, or as high as 600 mg daily.
In controlled clinical studies using the recommended dose of 60 mg b.i.d., the incidence of reported adverse effects in patients receiving Seldane was similar to that reported in patients receiving placebo. (See Table below.)
Rare reports of severe cardiovascular adverse effects have been received which include arrhythmias (ventricular tachyarrhythmia, torsades de pointes, ventricular fibrillation), hypotension, palpitations, and syncope. In controlled clinical trials in otherwise normal patients with rhinitis, at doses of 60 mg b.i.d. small increases in QTc interval were observed. Changes of this magnitude in a normal population are of doubtful clinical significance. However, in another study (N=20 patients) at 300 mg b.i.d. a mean increase in QTc of 10% (range -4% to +30%) (mean increase of 46 msec) was observed without clinical signs or symptoms.
In addition to the more frequent side effects reported in clinical trials (See Table), adverse effects have been reported at a lower incidence in clinical trials and/or spontaneously during marketing of Seldane that warrant listing as possibly associated with drug administration. These include: alopecia (hair loss or thinning), anaphylaxis, angioedema, bronchospasm, confusion, depression, galactorrhea, insomnia, menstrual disorders (including dysmenorrhea), musculoskeletal symptoms, nightmares, paresthesia, photosensitivity, seizures, sinus tachycardia, sweating, tremor, urinary frequency, and visual disturbance.
In clinical trials, several instances of mild, or in one case, moderate transaminase elevations were seen in patients receiving Seldane. Mild elevations were also seen in placebo treated patients. Marketing experiences include isolated reports of jaundice, cholestatic hepatitis, and hepatitis. In most cases available information is incomplete.

ADVERSE EVENTS REPORTED IN CLINICAL TRIALS

Adverse Event	Percent of Patients Reporting: Controlled Studies* Seldane N=781	Placebo N=665	Control N=626***	All Clinical Studies** Seldane N=2462	Placebo N=1478
Central Nervous System					
Drowsiness	9.0	8.1	18.1	8.5	8.2
Headache	6.3	7.4	3.8	15.8	11.2
Fatigue	2.9	0.9	5.8	4.5	3.0
Dizziness	1.4	1.1	1.0	1.5	1.2
Nervousness	0.9	0.2	0.6	1.7	1.0
Weakness	0.9	0.6	0.2	0.6	0.5
Appetite Increase	0.6	0.0	0.0	0.5	0.0
Gastrointestinal System					
Gastrointestinal Distress (Abdominal distress, Nausea, Vomiting, Change in Bowel habits)	4.6	3.0	2.7	7.6	5.4
Eye, Ear, Nose, and Throat					
Dry Mouth/Nose/Throat	2.3	1.8	3.5	4.8	3.1
Cough	0.9	0.2	0.5	2.5	1.7
Sore Throat	0.5	0.3	0.5	3.2	1.6
Epistaxis	0.0	0.8	0.2	0.7	0.4
Skin					
Eruption (including rash and urticaria) or itching	1.0	1.7	1.4	1.6	2.0

* Duration of treatment in "CONTROLLED STUDIES" was usually 7-14 DAYS.
** Duration of treatment in "ALL CLINICAL STUDIES" was up to 6 months.
*** CONTROL DRUGS: Chlorpheniramine (291 patients), d-Chlorpheniramine (189 patients), Clemastine (146 patients)

OVERDOSAGE
Information concerning possible overdosage and its treatment appears in Full Prescribing Information.

DOSAGE AND ADMINISTRATION
One tablet (60 mg) twice daily for adults and children 12 years and older.
Product Information as of July, 1990
MARION MERRELL DOW INC.
Prescription Products Division
Kansas City, MO 64114

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and 800,000 workers compensation lives.

Conservco Inc.

Conservco Inc. last year launched a workers compensation UR program and began offering several other new services.

The Travelers Corp. unit reviewed 250,000 inpatient hospital admissions in 1991, unchanged from 1990, making it the eighth-largest UR vendor.

Conservco began offering a workers compensation PPO last year in 36 of the 40 sites where Travelers has an employee benefit PPO network, noted Ms. Johnson. "Utilization review is a cornerstone of this network," she added.

Several red flags built into the workers compensation PPO system activate the UR component, Ms. Johnson explained.

For example, if a worker is expected to miss more than five days of work because of an injury, either the doctor or the workers compensation claims adjuster must call the UR system, she said. The doctor's proposed treatment plan then is discussed with the UR representative.

Other red flags that activate the system include a catastrophic claim and any claim needing physical therapy, she added.

Other new services that Conservco has developed include "Bright Futures," a maternity management program, and "Specialty Care Institutes," a transplant management program.

The "Bright Futures" program is designed to educate patients, identify high-risk pregnancies for case management and prevent pregnancy complications like high blood pressure and gestational diabetes, Mr. Vance said.

The program "is an intensive effort to identify as early as possible high-risk" pregnancy candidates, he said. The program "has a chance to make a significant impact on preventing premature births."

In industries that employ many women, like retailing and banking, maternity costs can be the largest component of a company's health care costs, Mr. Vance noted.

Under Conservco's "Specialty Care Institutes" program, the UR firm helps to direct people needing transplants to the 12 to 15 leading transplant institutions in the country, Ms. Johnson said.

This is "an example of how utilization review is branching out into additional hybrid uses," Ms. Johnson noted.

Conservco generated 80% of its gross revenues from providing UR services to employers, 6.5% from providing UR to insurers, HMOs, PPOs or TPAs, and the remaining 13.5% from other services.

Total gross revenues were $115 million last year, of which $35 million was generated by UR services.

Conservco serviced 4 million employee benefit plans lives in 1991 and 300,000 workers compensation lives.

Cost Care Inc.

Cost Care Inc. last year began offering several enhancements to its UR program.

Under a program called the "Dedicated Physician Review Program," a UR representative routinely talks with patients before and after certain treatments and procedures, Mr. Goelman said.

Some of the 20 procedures that trigger this personal attention include hysterectomy, tonsillectomy and ear surgery for children.

The program validates the physician's assumptions and makes sure that patients are following through with prescribed therapy and medications, Mr. Goelman noted.

Response was "very, very positive" when the program was tried out with a few companies over the past two years, he said. "There's a communications problem in the health care industry. In many cases. . .we're able to talk to patients one-on-one in English" to help them understand the procedure and needed follow-up, he said.

Cost Care, a subsidiary of John Hancock Mutual Life Insurance Co., also has expanded its activities in the short-term disability arena by becoming involved in the medical treatment of workers who do not return to work within specified time periods.

For example, if a secretary breaks his or her leg in a skiing accident, the UR representative would call the physician and discuss whether the worker could return to work more quickly if he or she had a stool to rest the broken leg on, Mr. Goelman said.

Overall, Cost Care reviewed 248,000 inpatient hospital admissions last year, making it the ninth-largest UR firm in the *Business Insurance* rankings, up from 210,000 in 1990.

Cost Care also has developed a panel of transplant specialists around the country that reviews whether a patient is a good candidate for a transplant and advises the patient about where the procedure can be done or about possible alternatives, Mr. Goelman said.

The company generated 80% of its gross revenues from providing utilization review services to employers and 20% of its gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

Cost Care last year serviced 5.25 million employee benefit plan lives and 96,000 workers compensation lives.

Peer Review Analysis Inc.

Peer Review Analysis Inc. is concentrating its UR efforts on "specialty matched physician review," a service that uses physician specialists to review the efforts of their colleagues in the same specialty.

Peer Review Analysis, which became a publicly traded company last year, performed 175,000 inpatient hospital admission reviews in 1991, making it the 10th-largest UR vendor ranked by *Business Insurance*, up from 113,000 admissions in 1990.

Most of the 135 physician consultants that Peer Review contracts with for UR services are specialists who have been with the company since 1984 and work between 15 and 20 hours per week, Mr. Spitzer noted.

"Our approach really matches up physicians by specialty to get the best result for the patient," he explained.

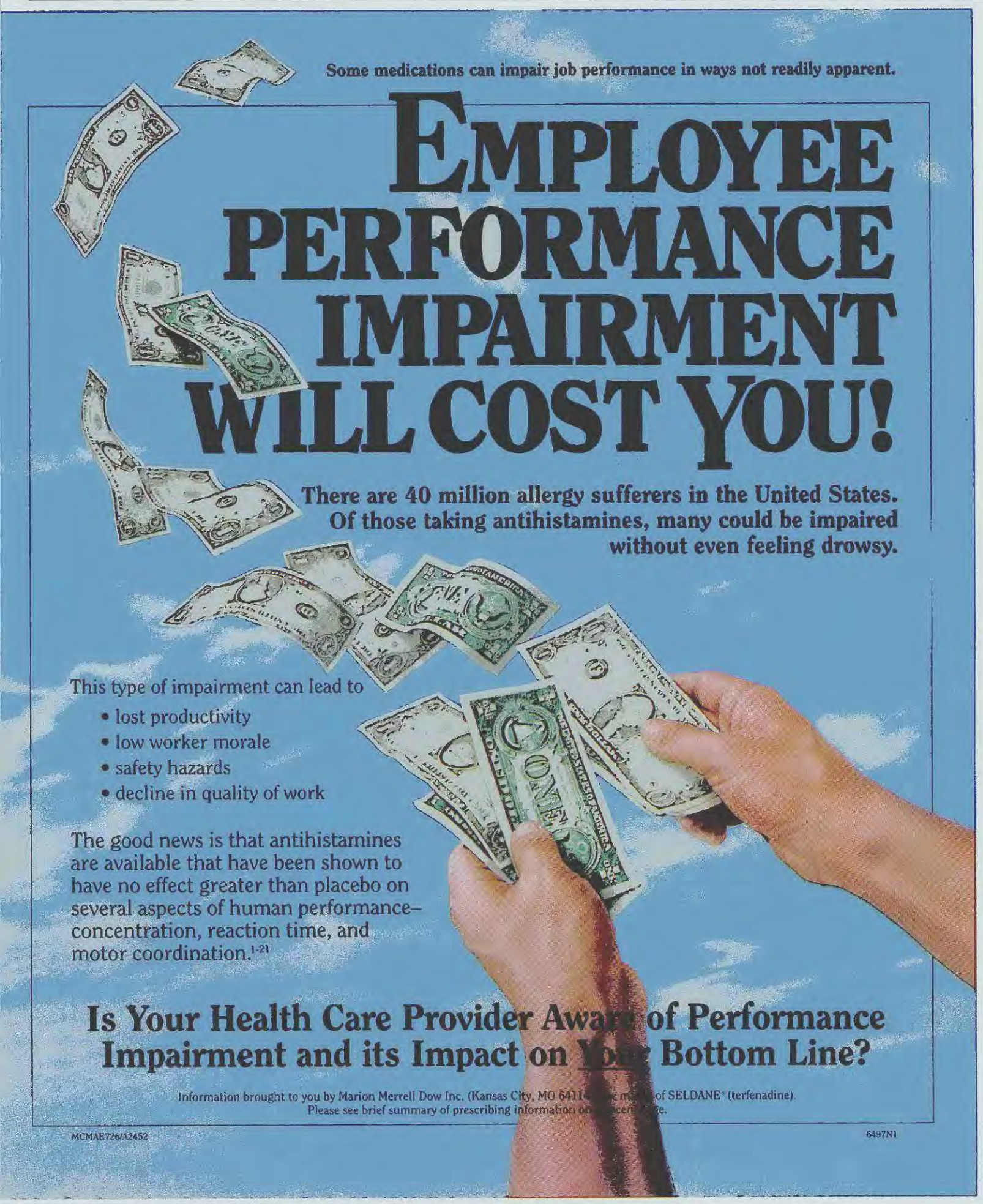
A new program begun last year provides rehabilitation review. Teams of doctors, rather than a single doctor, review a rehabilitation case, Mr. Spitzer said.

Peer Review Analysis also has developed a computer software program called AutoPREP that is licensed to clients for use by their own in-house UR managers, Mr. Spitzer said. AutoPREP asks a series of questions designed to determine whether a specific procedure and where it will be performed are appropriate for a patient's problem. AutoPREP covers about 30 common outpatient procedures and a few inpatient procedures.

Some 25% of the company's 1991 gross revenues were generated by providing UR services to employers and 75% of gross revenues were generated by UR services for insurers, HMOs, PPOs or TPAs.

Peer Review Analysis' total gross revenues in 1991 were $8.1 million, all of which were generated by UR services.

The company serviced 8 million employee benefit plan lives in 1991 and 120,000 workers compensation lives. ■



Directory of utilization review vendors

A

Action Healthcare Management Services

301 E. Bethany Home Road, Suite C-278, Phoenix, Ariz. 85012; 602-265-0681; fax: 602-265-0202

Founded: 1987.
Parent company: Cavco Industries Inc.
UR services provided to employers: 9(% of gross revenues.
UR services provided to others: 10% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service predetermination, case management.
Occasional UR services: Retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, high-risk pregnancy identification.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 14 total; nine professionals, including seven registered nurses, three licensed practical nurses. On retainer: one physician.
Clients: 85 total; 58 employer clients; 70% with fewer than 500 employees, 17% with 500 to 999 employees, 9% with 1,000 to 2,499 employees, 4% with 2,500 to 4,999 employees.
Covered lives: 65,000 employee benefit plan lives; 900 workers compensation lives.
Admissions reviewed: 2% to 3% diverted for outpatient treatment.
Charges: Per employee, $1.25 to $2.50; per hour, $75 to $95.
Principal officers: Ruth Smith, president/chief executive officer; Cori Hamilton, vp-health care services/secretary.

Admar Corp.

1551 N. Tustin Ave., Suite 300, Santa Ana, Calif. 92701; 714-953-9600; fax: 714-953-9060

Founded: 1973; began providing utilization review services in 1983.
UR services provided to employers: 35% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination.
Occasional UR services: Outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse, catastrophic cases, home health care referrals.
Staff: 170 total; 36 professionals, including 34 registered nurses, two licensed practical nurses. On retainer: four physicians.
Clients: 73 total; 16 employer clients; 20% with fewer than 500 employees, 25% with 500 to 999 employees, 31% with 1,000 to 2,499 employees, 12% with 2,500 to 4,999 employees, 12% with more than 5,000 employees.
Covered lives: 1.8 million employee benefit plan lives.
Admissions reviewed: 67,000; 10% diverted for outpatient treatment.
1991 gross revenues: $7.3 million total, $948,000 from UR services.
Charges: Per employee, $1.50; per case, $50; per hour, $90.
Principal officers: Richard Toral, president/chairman; Virginia Pascual, executive vp/boardmember; Edward Evans, vp-finance; Pamela J. Kehoe, vp-management information system; Donald C. Cummins, vp-sales and marketing.

ALTA Health Strategies Inc.

6975 Union Park Center, Sixth Floor, Salt Lake City, Utah 84047; 801-568-5500; fax: 801-568-5652

Founded: 1960; began providing utilization review services in 1987.
UR services provided to employers: 13% of gross revenues.
Frequent UR services: Preadmission certification, 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, preauthorization of services, predetermination of fees, hospital fee negotiation, high-risk and short-stay maternity programs, admission review, disability management, help line, dental utilization management, claims review, quality assurance studies, PPO steering.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, podiatric, home health hospice, extended care facility.
Staff: 188 total; 164 professionals, including one physician, 157 registered nurses, six medical records technicians. On retainer: 140 physicians.
Clients: 645 total; all employer clients; 69% with fewer than 500 employees, 12% with 500 to 999 employees, 13% with 1,000 to 2,499 employees, 3% with 2,500 to 4,999 employees, 3% with more than 5,000 employees.
Covered lives: 1.5 million employee benefit plan lives.
Admissions reviewed: 72,980; 2.4% diverted for outpatient treatment.
Branch offices: Atlanta, Milwaukee and Pittsburgh.
1991 gross revenues: $142 million total, $18 million from UR services.
Charges: Per employee.
Principal officers: Terry Nofsinger, president/chief executive officer; Jim Kenworthy, chief administrative officer; Sid Paulson and George Driesbach, executive vps; Linda Gerbig, senior vp-health care management.

American Claims Evaluation Inc.

375 N. Broadway, Jericho, N.Y. 11753; 516-938-8000; fax: 516-938-0405

Founded: 1981; began providing utilization review services in 1982.
UR services provided to employers: 30% of gross revenues.
UR services provided to others: 70% of gross revenues.
Frequent UR services: Hospital bill audit, DRG code validation.
Medical services reviewed: Group health, workers compensation/disability, hospital claims auditing.
Staff: 51 total.
Clients: 475 total; 150 employer clients.
Branch offices: Dallas, Chicago Los Angeles.
1991 gross revenues: $5.9 million total.
Principal officers: Gary German, president/chief executive officer; Gary Knauer, chief financial officer treasurer; Robert Dubester, vp-operations.

American International Healthcare Inc.

30 W. Gude Drive, Fifth Floor, Rockville, Md. 20850; 301-251-8600; fax: 301-251-2957

Founded: 1977.
Parent company: American Inter-

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national Group Inc.

UR services provided to employers: 14% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review, second surgical opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 15 total; nine professionals, including one physician, eight registered nurses. On retainer: 100 physicians.

Clients: 10 total; seven employer clients; 71% with fewer than 500 employees, 29% with more than 5,000 employees.

Covered lives: 57,000 employee benefit plan lives.

Admissions reviewed: 3,600.

Charges: Per employee, $1.70 to $4; per case, $140 to $500.

Principal officers: Thomas Ramey, president; Alfred Discepolo, chief operating officer; Dennis Burkhart, vp.

Anthem Health Systems Inc.

5451 W. Lakeview Parkway S. Drive,
Indianapolis, Ind. 46268;
800-654-1459; fax: 317-298-6669

Founded: 1983; began providing utilization review services in 1983.

Parent company: Anthem Inc.

UR services provided to employers: 2% of gross revenues.

UR services provided to others: 55% of gross revenues.

Frequent UR services: Preadmission certification, 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 UR services: Hospital bill audit, predetermination for skilled nursing facility placement.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, medical office claims, pharmacy.

Staff: 379 total; 143 professionals, including four physicians, 130 registered nurses, three licensed practical nurses, six medical records technicians. On retainer: 50 physicians.

Clients: 75 total; 27 employer clients; 16% with fewer than 500 employees, 19% with 500 to 999 employees, 32% with 1,000 to 2,499 employees, 24% with 2,500 to 4,999 employees, 9% with more than 5,000 employees.

Covered lives: 1.2 million employee benefit plan lives.

Admissions reviewed: 116,435; 4% diverted for outpatient treatment.

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

1991 gross revenues: $22.6 million total, $12.9 from UR services.

Principal officers: Michael Bell, chief executive officer; Lisa Getzfrid, chief operating officer; Judith Fleming, chief marketing officer.

Associates for Health Care Inc.

125 N. Executive Drive, Suite 201,
Brookfield, Wis. 53005;
414-784-9007; fax: 414-784-6419

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 32.8% of gross revenues.

UR services provided to others: 5.7% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

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

Staff: 39 total; all professionals, including one physician, 10 registered nurses, two licensed practical nurses, two medical records technicians.

Clients: 372 total; 367 employer clients; 78.5% with fewer than 500 employees, 10.1% with 500 to 999 employees, 6.3% with 1,000 to 2,499 employees, 3.5% with 2,500 to 4,999 employees, 1.6% with more than 5,000 employees.

Covered lives: 174,000 employee benefit plan lives.

Admissions reviewed: 13,562; 17.8% diverted for outpatient treatment.

Continued on next page



UR listings explained

The *Business Insurance* directory of utilization review service providers lists companies that offer utilization review directly to members of employer-sponsored group health care plans.

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

The directory is an editorial service; there is no charge for companies to be included.

The listings begin with the company name and address, the **year founded**, and **parent company**, if any.

Under **UR services provided to employers,** the percentage of 1991 gross revenues generated from utilization review services to employers is noted. **UR services provided to others** lists gross revenues generated from utilization review services provided to insurance companies, HMOs, PPOs or third-party administrators.

Specific programs the company provides are described under **frequent** and **occasional UR services.**

The types of **services reviewed** (options include group health, dental, chiropractic, psychiatric and substance abuse and workers compensation/disability), and information on **staff** follows. Number and size of **clients** serviced in 1991 follow. Number of employee benefit plan lives, workers compensation lives, total admissions reviewed and percentage of proposed admissions diverted for outpatient care in 1991 are given under **covered lives**.

Locations of **branch offices** and how the company **charges** for its services are provided next.

Total **1991 gross revenues** and revenues generated from utilization review services are included when provided. Names and titles of **principal officers** complete the listings.

Information reported is based on each company's response to a *BI* questionnaire. Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.

If you would like to receive a questionnaire for next year's directory of utilization review vendors, please write Karen Armaganian, 740 N. Rush St., Chicago, Ill. 60611-2590.

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P.O. Box 306, Montpelier, Vermont 05601

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diverted for outpatient treatment.
Charges: Per employee, per case, per hour.
Principal officers: Dr. Ed Zalta, chairman/chief executive officer; Michael E. Henry, president/chief operating officer; Greg Hamblin, chief financial officer; Robert Broaddus and Roberta Holtzman, senior vps.

CareAmerica Inc.

301 E. Main St., Suite 114, Barrington, Ill. 60010; 708-382-7470; fax: 708-382-0772

Founded: 1984.
UR services provided to employers: 20% of gross revenues.
UR services provided to others: 80% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, inpatient psychiatric and substance abuse services, case management.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: 14 total.
Covered lives: 200,000 employee benefit plan lives; workers compensation lives.
Admissions reviewed: 11,000.
Principal officers: F. Jerome Coquillard.

Carenet Inc.

40 John Glenn Drive, Amherst, N.Y. 14228; 716-691-8556; fax: 716-691-8524

Founded: 1988; began providing utilization review services in 1989.
Parent company: North American Administrators Inc.
UR services provided to employers: 100% of gross revenues.
Frequent UR services: Preadmission certification, 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, prenatal risk determination program.
Occasional UR services: Outpatient service predetermination.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: Six total; including one physician, five registered nurses. On retainer: seven physicians.
Clients: 40 total; all employer clients; 25% with fewer than 500 employees, 50% with 500 to 999 employees, 25% with 1,000 to 2,499 employees.
1991 gross revenues: $700,000 total, all from UR services.
Charges: Per employee, $1 to $2; percentage of savings generated, 25%.
Principal officers: Ronald Zoeller, president; E. Timothy Danahy, executive vp; David Miller, senior vp; Charles Barger, vp; Dr. Arthur Orlick, medical director.

CarreFour

2301 Main St., Kansas City, Mo. 64141; 816-395-3106; fax: 816-395-3959

Founded: 1986; began providing utilization review services in 1987.
Parent company: Blue Cross & Blue Shield of Kansas City.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, case management.
Occasional UR services: Second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse.
Staff: 21 professionals, including two physicians, 15 registered nurses, four medical records technicians. On retainer: four physicians.
Clients: 34 total; 25 employer clients.
Covered lives: 625,000 employee benefit plan lives.
Admissions reviewed: 10,023.
Charges: Per employee; per case, $500 to $1,500; per hour, $75 to $150.
Principal officers: Gail Shafton, president.

ChiroView

1021 S. Wolfe Road, Suite 105, Sunnyvale, Calif. 94086; 408-732-1970; fax: 408-732-6668

Founded: 1984; began providing utilization review services in 1984.
UR services provided to others: 95% of gross revenues.
Frequent UR services: Retrospective review, case management, concurrent review.
Medical services reviewed: Group health, chiropractic, workers compensation/disability, physical therapy.
Staff: Five total. On retainer: 30 physicians, 15 physical therapists.
Clients: 145 total.
1991 gross revenues: $1.1 million from UR services.
Charges: Per employee, 52 cents to 75 cents; per case, $110 to $145; per hour, $125 to $175.
Principal officers: Sigmund Miller, president; Laura Levitt, administrative director; Donna Baker, director-operations; Donald C. Gable, marketing director; Richard Silver, chiropractic coordinator.

Conservco Inc.

3903 Northdale Blvd., Suite 200, Tampa, Fla. 33624; 813-960-6212; fax: 813-960-5772

Founded: 1981; began providing utilization review services in 1985.
Parent company: Travelers Corp.
Continued on next page



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John R. Coleman
Vice President
RLI Northern California
Regional Office

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RLI 9025 N. Lindbergh Drive Peoria, IL 61615
800/445-5468

Founded: 1975; began providing utilization review services in 1975.
UR services provided to employers: 20% of gross revenues.

InsurerTopics

A special editorial section sent exclusively to insurers and reinsurers

Hard times hit loss control

Cutbacks in loss efforts invite disasters in safety, morale

By MARK A. HOFMANN

Some financially strapped companies think cutting back loss control efforts is a way to regain lost economic ground in a lingering recession.

But according to insurer loss control experts, that's a losing proposition.

Loss control professionals preach that programs to prevent disasters and protect the financial health of the business are vital, even during periods of shrunken budgets and lowered expectations. Even a small loss control investment made during a recession will reduce the threat of succumbing to a catastrophe and prepare the company to seize growth opportunities when the economy turns around.

Experts point out that loss control, particularly the type that promotes the safety of a company's most valuable assets—employees—doesn't always require huge cash outlays. In fact, expenditures can be quite modest, they say.

But even so, many loss control experts say that companies are reducing these precautionary efforts.

One of the problems is that some companies view loss control as "an extra or 'nice-to-have' " but not a critical component of a business's operations, even in the most prosperous of times, said Janice Travnick loss control safety officer for Kemper National Insurance Cos. in Long Grove, Ill.

John Thomson, senior vp-global risk management for CIGNA Worldwide Inc., a unit of Philadelphia-based CIGNA Corp., shares Ms. Travnick's contention. Many unsophisticated insurance buyers consider loss control simply an unnecessary value-added service to the buyer, he said.

"I don't need loss control; that's what I buy insurance for," Mr. Thomson said he had been told by some risk managers. Companies with that philosophy, he said, aren't the kind of policyholders CIGNA pursues.

If a plant manager or an entire company hasn't embraced the idea of loss control as an integral part of its management philosophy in the best of times, the company's commitment weakens even more in a recession, said John Klovstad, assistant vp and district manager in the Dallas office of Norwood, Mass.-based Factory Mutual Engineering & Research.

"It all starts with the level of understanding they have in the first place," said Mr. Klovstad.

Kemper's Ms. Travnick agreed that the situation deteriorates during a recession. She is among those who sense a definite trend toward reducing the resources devoted to loss control, adding that this is not necessarily true of her clients.

As one indication of this trend, Ms. Travnick noted that she's received numerous calls from job safety and workplace health professionals looking for new jobs because their old jobs had been eliminated in the name of corporate cost-cutting.

Norma Sandowski, manager-technical services and assistant vp of the loss control department at Zurich-American Insurance Group in Schaumburg, Ill., also observes some indication of a cutback in loss control and safety programs. For example, Ms. Sandowski noted that recent television news reports have focused on a perceived scaling back of safety and loss control efforts. The cutbacks sometimes have tragic results, she said.

"This is the time to take the absolute opposite approach," said Kemper's Ms. Travnick.

Mike Mineo, loss control casualty service manager for Kemper National, agreed that companies should reinforce safety and loss control efforts during uncertain economic times. He noted that companies can send a devastating signal to their employees by slacking off on their workplace safety efforts.

If a company provides a strong safety and loss control program during good economic times and then starts cutting corners, it risks sending worker morale through the floor, Mr. Mineo said. Workers will draw the conclusion that their employer doesn't care about them—and will return the favor.

There are ways, however, for hard-pressed companies to make low-cost investments that maintain safety and morale, pointed out Michelle Goley, Kemper National's occupational services manager.

"People need to understand that loss control measures are not expensive," she said.



Ms. Travnick



Mr. Thomson



Mr. Klovstad



Ms. Sandowski

Two of the most effective measures are to train selected company personnel in first aid and to institute return-to-work programs so that injured workers can return to productivity more quickly, even if the jobs they're assigned to upon return aren't necessarily the ones they held before, she said.

Ms. Goley noted that a beverage distributor that instituted first-aid and return-to-work programs cut the cost of work-related injury claims by about 75% to $800 in the first year the programs were instituted, from between an average of $3,000 and $4,000 per year. Although the distributor did incur a one-time cost for outside expertise to launch the programs, the savings even in the first year far outstripped the cost of the program, she said.

"People think big costs, big investment—that isn't necessarily so," said Ms. Goley.

Zurich's Ms. Sandowski said that a recession creates additional challenges for insurance company loss control professionals.

"It's a time when we must systematically and aggressively reshape our approach to eliminating or reducing the primary causes of loss," she said. Insurers have to work in partnership with customers, which means that, first, insurers have to attract the customer's attention.

The insurer should first approach customers with quantifiable statistics, Ms. Sandowski said. The key, of course, is the effect on the bottom line, and in a recession, both customers and insurers have to be flexible, she said.

"We're stressing that there's not just one solution to the problems and opportunities in business," she said. For example, rather than target a single, general area like the frequency and severity of loss, Zurich loss control professionals might look for specific problems

Continued on next page



Insurer Topics

Hard times

Continued from previous page
that will respond immediately to an enhanced loss control effort, like a renewed effort to cut down on slip-and-fall accidents, which can be reduced through low-cost techniques.

CIGNA's Mr. Thomson said another technique in promoting loss control in a recession, particularly when confronted by a manager who questions the implementation of loss control efforts other than insurance, is to point out a simple fact of economic life.

"You never recover every dollar that you've lost," even when you're insured, said Mr. Thomson.

In addition, instituting adequate loss control measures means the cost of an insurance program will become more stable over the long run.

A company must look ahead toward the maintenance or expansion of its market share when the economic upturn occurs, Mr. Thomson said. That, for many U.S. companies, means an ever-greater commitment to international operations. And, international expansion brings up specific loss control issues, because "there's a lot less (attention to) detail" in warehousing goods overseas than there is in the United States, he said.

If goods are lost because of fire or some other catastrophe that is worsened by cheaply built storage facilities, the U.S. company is out of luck, particularly if the disaster happens on the eve of a upturn. Without the readily available goods, the market share could be lost forever, Mr. Thomson pointed out.

One of the best ways to help ensure that loss control doesn't suffer when the economy deteriorates is to make sure that loss control is included in the initial budget for a project, said Factory Mutual's Mr. Klovstad.

If you make a physical change and adequate loss control isn't budgeted into the project, "it's going to be more difficult to get it in after the budget is approved," he said.

Loss control needs to part of the conceptual stage of any project, he said. If planners are thinking about loss control as they design a new facility, they build it into the project in the most cost-effective way, he said.

Mr. Klovstad said that one of the most critical factors in maintaining a company's loss control defenses in a recession is for management to move quickly to fill holes in its employee emergency response group. These are groups in which each worker member is assigned a specific task to perform during an emergency, like contacting the fire department or shutting down a vital piece of equipment.

But as management thins out the workforce, the person assigned to perform a particular task might be laid off, said Mr. Klovstad. If the emergency team is to respond effectively, that position has to be reassigned quickly, he said.

Mr. Klovstad said that a recent Factory Mutual study of more than 3,000 industrial and commercial fires underscored the importance of maintaining an adequate emergency team. The average property damage sustained by facilities with a well-trained, formal emergency team was $190,000 during the 1980-89 period studied. The average property damage sustained by facilities without such a team was $1.35 million, according to the study.

The temptation to cut back on loss control as a means of saving money during a recession must be resisted, Mr. Klovstad said.

"It's got to be a process—a way of life." ■

Ex-cop leads Home's fraud squad

Investigative unit tracks down nationwide insurance scams

By MICHAEL BRADFORD

NEW YORK—John McNulty is still on the mean streets of New York, looking for people who take what doesn't belong to them.

But he no longer wears a cop's uniform and those aren't street hoods he's chasing. It's the insurance cheat that Mr. McNulty is after.

His beat is a great deal larger now that he's off the New York police force and supervising a new fraud investigation unit of The Home Insurance Co. With two other staffers, he covers the entire country.

It was The Home's internal investigators—those charged with tracking down fraud within the company—who convinced senior management to create the special unit to handle "external" insurance fraud.

When internal investigators came upon suspected fraud by policyholders or other outsiders, "we would handle it," recalls Evo Riguzzi, the insurer's director of corporate security. But those actions came only after the fact, he said, and "we weren't doing the program justice."

Doing the program justice was not easy. Securing the resources and actually assembling the investigative unit took about a year. One thing that slowed the effort down last year: Operation Desert Storm.

"The war got in the way. I wasn't there to push for it," he said.

Instead, Mr. Riguzzi, an Army Reservist for 20 years, was spending six months in Saudi Arabia as commander of the police brigade charged with handling Iraqi prisoners of war.

Other, more mundane factors also slowed progress.

"As with any program, you've got to be able to demonstrate that you can do it efficiently and that it will be cost-effective," he said.

Procedures and guidelines for the unit had to be written and then had to pass muster with Home lawyers, Mr. McNulty pointed out. And preliminary work had to be done in some states—like California, Massachusetts, New Jersey, and Pennsylvania—that set standards for external fraud investigation by insurance companies.

When staffing the investigative unit, Mr. Riguzzi stressed balance.

A former IRS agent in the South Bronx, Mr. Riguzzi joined The Home in 1983.

That was the same time Mr. McNulty first took up insurance investigation. His 14 years as a New York City cop ended in 1981 after he was jumped by a street gang while working undercover and beaten so badly that even extensive therapy left him medically disabled. He joined The Home as assistant security director in 1989.

Given those investigative backgrounds, Mr. Riguzzi has hired people with strong insurance backgrounds. In fact, the unit's two other fraud investigators—one stationed in Houston, the other in Brea, Calif.—were both hired from other insurers.

"Other people may have it the other way: They may be good insurance people but don't know how to bring a case," Mr. Riguzzi said.

If needed, the unit can use three other internal fraud investigators based in New York, Mr. McNulty pointed out.

"Right now, we are covering the whole country on a small scale," he said. "But we're still getting the job done."

More investigators could be added late this year or early in 1993 in Chicago and Orlando, Fla. Adding those cities would give the unit a broader regional presence and allow it to assign offices to cover particular states, he said.

The unit will expand as its workload increases, he said.

"In order to create more jobs, we have to show that there's some work there. When we come to the point where we can't handle it with what we've got, then we hope we can get more people."


Mr. McNulty

Referrals to the unit come from Home claims handlers around the country. When claims handlers suspect fraud, they are to alert their supervisors, who then decide whether to pursue their suspicions.

If they agree that a claim needs further checking, it is sent to the fraud unit where a final decision is made whether to investigate.

The claims investigated come from all lines of business and the investigative unit already has scored several successes in exposing fraudulent claims, he said.

The unit "treats every claim the same, whether it's a $1 million loss or a $10 million loss," he said.

When discovered, fraud is reported to law enforcement authorities, who then decide whether to pursue criminal charges. "If they decide to go further, we'll go the extra step" and help prosecute the crooks, said Mr. McNulty.

So far the investigators have tracked down "dead" people who appear quite healthy following claims by relatives for death benefits. The unit also has uncovered workers compensation fraud in which claimants have an acquaintance sign and cash a benefits check and then report it stolen so that a second check is issued.

Occasionally a product liability claim with a suspicious look to it will be filed against a Home policyholder, said Mr. McNulty.

"We see people who are putting in product liability claims, saying they bit into a piece of candy with glass in it," he explained.

These schemers often try this particular fraud against several companies, Mr. McNulty noted, without realizing that many different companies have product liability coverage with the same insurer.

Sometimes the perpetrators' names appear as claimants against different Home policyholders "two or three times in the same day," in such claims, he said.

While the unit is realizing success in its first months of operation, figures aren't available on the dollar amounts of fraudulent claims that have been uncovered, he said.

The potential savings to Home, however, could be substantial.

Mr. McNulty said industry figures indicate that 10% of all claims filed are potentially fraudulent.

Other insurers considering setting up an investigation unit should have no trouble finding help and advice. "You can call your neighbor in the next company and they will be more than willing to help you get up and running," said Mr. Riguzzi. "Generally speaking, when somebody is plugging away and stealing from you, they are usually stealing from several other companies at the same time."

Another source is the International Assn. of Special Investigation Units. The group of insurer investigators, based in Madison, Wis., educates insurers and the public about fraud. ■

John Deere automates loss control reports

By SARA MARLEY

NEW YORK—Loss control field representatives at John Deere Insurance Co. have traded in their dictation tapes for laptop computers.

The Moline, Ill.-based insurer has purchased an expert loss control system designed by International Management Technologies Inc. to increase productivity and improve the timeliness and quality of field reports.

The system produces risk-specific checklists that lead the field representatives through property surveys. Then the computer guides the field reps in compiling their reports, pointing out potential hazards at the client's site, as well as inconsistencies and errors in the information.

Field reps file their reports directly to the company's mainframe computer and then prints out a recommendation letter to the policyholder.

The time it takes to complete a basic report can be slashed from about two hours to less than a half-hour, said Doug Falkenburg, founder and president of New York-based IMTI. Policyholders receive recommendation letters within days, not weeks, he added.

"The best thing the system has done for us is improve the turnaround in correspondence to our insured accounts," said Glenn Williams, manager of loss control at Deere. "Our compliance level has almost doubled" since the system was installed Aug. 1.

Michael Wilson, manager of technology management for the New York-based American Insurance Services Group Inc., agrees that time saved in processing reports is more valuable then time saved producing them. "Once people get used to using (the automated system), you can improve the quality, accuracy and completeness of the reports," he said.

AISG is considering commissioning a generic loss control program from IMTI, though AISG members like Aetna Casualty & Surety Co., Fireman's Fund Insurance Cos., and Maryland Insurance Group already have automated loss control systems.

The Deere package cost $130,000, about $50,000 of which went to IMTI. In addition, Deere pays the company about $3,800 annually for support and upgrades. Within three years, the system will pay for itself, said Mr. Williams.

The cost of an IMTI system depends on the number and complexities of the coverages involved. A basic five-coverage system costs about $50,000. Costs for a single-coverage system can range from $25,000 for commercial property to $90,000 for a program to assist in complicated machinery surveys. Insurers also pay a monthly fee based on the number of users.

Because the expert system is programmed to mimic human thought processes, the computer has the ability to weigh information it's given and develop its own opinion of the risk.

"In the industry, the automated opinion of risk is very controversial," IMTI's Mr. Falkenburg said. "They don't want the machine to second guess the rep."

Different insurers have come up with different uses for the system's conclusions. Some pass them on to the underwriter along with the field representative's opinion and ask the field rep to explain the discrepancy.

"The rep can be made aware of something he might have overlooked" by using the system, Mr. Falkenburg said. Then, "he can explain why he thinks the risk is better or worse than the automated opinion."

"It can help flag some things that might be overlooked in someone's rush to get something accomplished," AISG's Mr. Wilson said.

The loss control system also can spot errors, like percentages that don't total 100 or discrepancies between insured and actual values.

Some companies use the computer's assessment in their auditing process. "They want their people and their experience to be the ones to ultimately make the decision," Mr. Falkenburg said.

However, he warns against becoming dependent on the computer and its pre-worded recommendations. "You can never get away from narrative. You can use checklists, but there will always be something exceptional, something that needs to be noted."

John Deere field representatives now use the expert system to help them file reports more easily and quickly; they currently do not use the system's expert opinion capability for underwriting purposes.

Because Deere is a direct writer, its agents handle initial information collection and surveys, including supplying photos and diagrams for the underwriters. The loss control representatives come in later on a consulting basis.

However, Mr. Williams said Deere plans to make some use of the system's automated risk analysis features once the insurer assigns weights to various risk factors.

Of the 16 employees who use the system, Mr. Williams said a few had no problems, a few had major problems and the rest fell in the middle.

However, "each and every one has told me that they never care to go back to dictating reports," he said.

Productivity dropped off slightly during the first few weeks, but has since returned to earlier levels.

"Basically the only disadvantage is that anytime you introduce a new way of doing things, the training curve takes a little time," Mr. Wilson said.

IMTI provides training and backup support to its clients. When the Deere system was first installed, Mr. Williams said he spoke to Mr. Falkenburg several times a day. Now, problems crop us less than once a week.

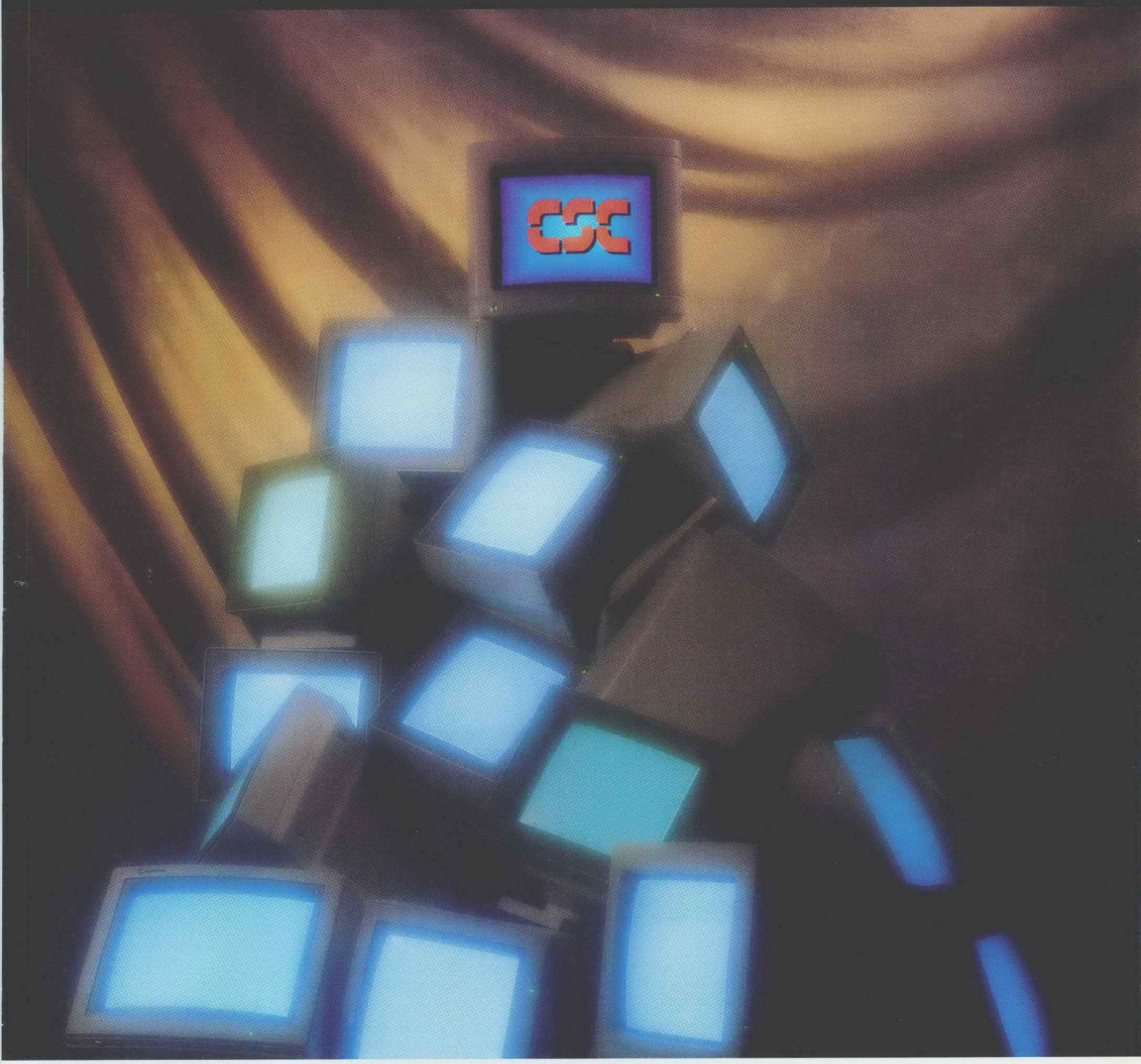
The expert system has improved other office procedures besides the handling of loss control reports and client recommendations, Mr. Williams said. With their laptop computers, field representatives can communicate with the office, with underwriters and with clients via electronic mail or fax. They also file activity reports on the computer.

Underwriters no longer need to print out loss control reports, but instead can retrieve up to three years' of reports on the company's mainframe computer.

The automation will allow John

Continued on page 40D

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Insurer Topics

John Deere

Continued from page 40B

Deere's field staff to grow without adding clerical support, he said.

IMTI has developed six loss control systems, spending between eight and 14 weeks on each.

"All systems are developed for the client's particular operations, using their forms and operation manuals," Mr. Falkenburg said. He added that some companies decide to change forms and procedures as part of the computerization.

IMTI is currently evaluating the latest "writing tablet" technology that would allow a field representative to carry the computer during the survey, saving even more time. Currently, the representative takes notes and enters them into the computer later.

A writing tablet computer would ideally weigh only two or three pounds—compared with six pounds or more for the current generation of laptops—and have sophisticated handwriting-recognition ability. Mr. Falkenburg said IMTI plans to introduce a writing tablet product during the second half of the year.

IMTI has implemented electronic cameras and electronic drawing into its system. And a desktop publishing feature eliminates the need to separately format each report.

In the future, IMTI would like to combine expert loss control systems with Microsoft Windows, a graphic-based system which allows the user to work simultaneously with more than one software application.

"It's a very exciting field because it integrates so many different technologies," Mr. Falkenburg said. ■

Just who are we supposed to serve?

Simple question clouds quality

By MARK A. HOFMANN

Before an insurer launches a program to improve quality customer service, it helps to know who the customer is.

Defining a customer is far from simple for property/casualty insurers, experts say. While one insurer may consider policyholders to be its customers, another may view the independent agents who sell its policies as its customers.

And, for some departments within insurance companies, customers may be fellow employees.

And even if the customer is identified, there's still the matter of defining "quality." Some insurers haven't given that question serious enough thought, says Peter Reid, a principal with The Corinthian Group Inc., a Lyndhurst, N.J.-based management consultant that specializes in the insurance industry.

The definition of quality "will depend precisely on who are your customers and in which particular segment of the insurance business" a company operates in, Mr. Reid said.

He added that there are two types of quality: product quality and service quality. Product quality is just what its name says, while quality service involves the timeliness and manner of delivery, he said.

"What we see in the insurance industry is 'quality' used as a marketing tool," according to Mr. Reid.

But the marketing tool often isn't backed up with the resources and employee education needed to make it more than a slogan, he said.

Mr. Reid said that his firm takes clients through a "quality process" tailored to the individual company. The process begins with a preliminary review with management of critical quality issues. This review is followed by a quality cost analysis that reviews the cost of products and services at the existing quality level. Then there is an evaluation of internal and external obstacles to providing quality service, he said.

The consultant then develops programs that help both managers and employees attain quality service goals and look at ways to meet customer expectations.

The most important step is evaluating and assessing the new strategies, Mr. Reid said. After monitoring the program's progress, the insurer will make whatever changes it deems necessary, he said.

Mr. Reid stressed that achieving quality service is not magic; it's hard work and requires attention to detail. It requires planning and standards and continuous attention.

A quality service problem sometimes can be solved with setting up a simple system, he pointed out. For example, a company can require that all telephones be ans-

Continued on page 40F

MARCH

Insurer-Agency Relations

Today's soft market continues to put unique pressures on insurers and agents. *BI's Insurer Topics* section will report on what insurers expect from their agents. Editors will examine the hows and whys insurers and agents are turning to the other to prepare for a turn in the market.

Issue: March 16
Ad Closing: March 4

APRIL

Automation: Underwriting

Are insurers making the most of their electronic data processing underwriting arsenal as they do battle against tight budgets in the soft market? *BI's Insurer Topics* section will look at how and where automation has saved insurers the most money. Editors will talk to insurers, consultants and vendors to find out what techniques represent the most cost-effective use of insurers' limited resources.

Issue: April 20
Ad Closing: April 8

MAY

Reinsurance Issues; Relations with Intermediaries

What do insurers want from their intermediaries? Are the ties that bind becoming tighter, or are accounts being shifted rapidly in the face of rising catastrophe reinsurance rates? *BI's Insurer Topics* section will look at ceding companies ... what services are they seeking, or are they turning their backs on intermediaries and embracing direct-writing reinsurers?

Issue:May 18
Ad Closing: May 5

Insurer Topics

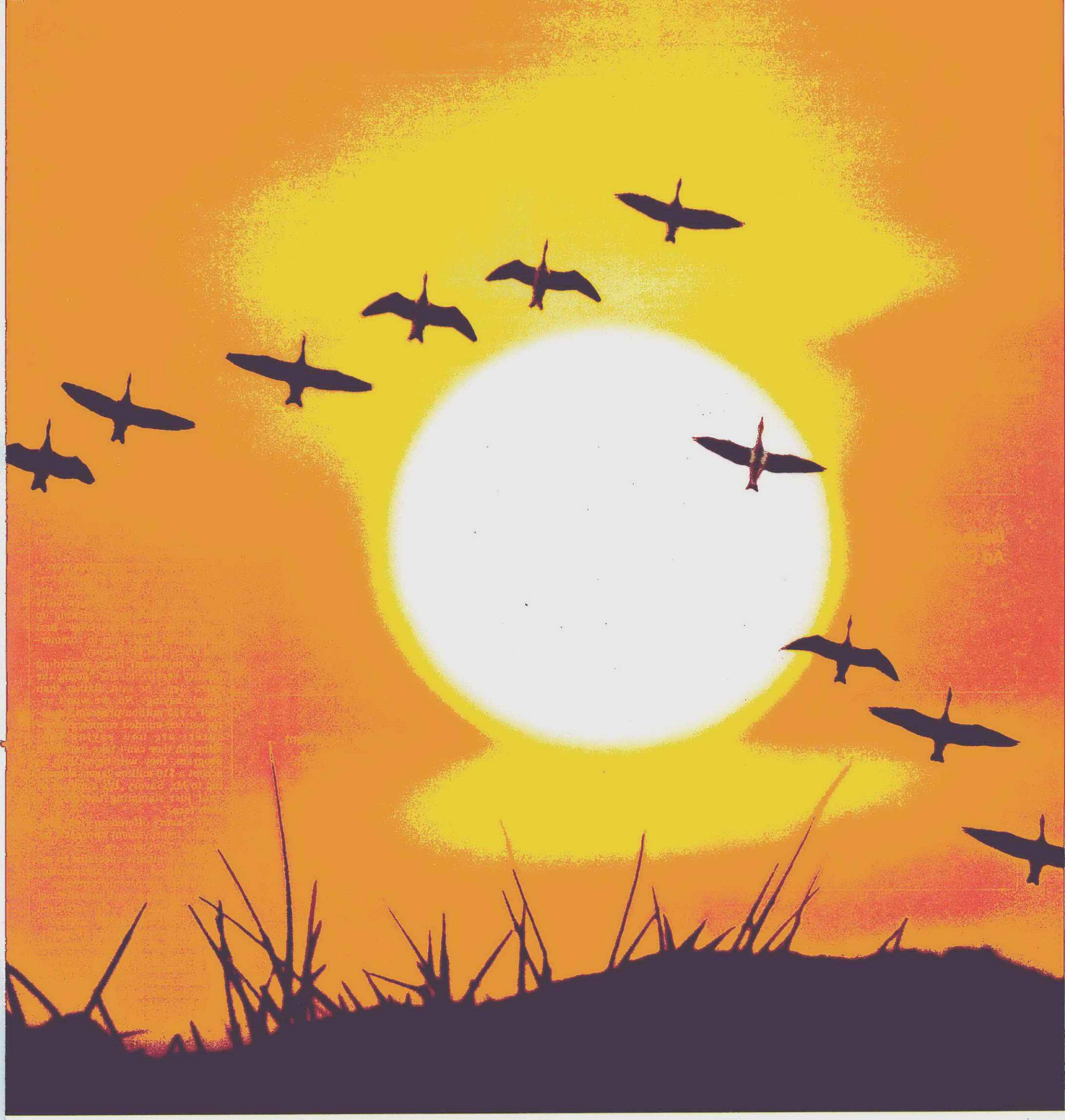
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Insurer Topics

Quality

Continued from page 40G

wered within three rings.

"It really doesn't take a lot of effort," he said.

While companies must know what their customers want to provide quality service, companies don't always make that effort, he said. They think that the mere fact that they've developed a product or service guarantees that somebody out there will buy it. That's not always the case.

Insurers can avoid this trap by doing something as simple as holding focus groups to determine what customers really want, he said.

Mr. Reid said that some large U.S. companies, notably Proctor & Gamble Co. and International Business Machines Corp., have done extremely well in providing quality service to their customers. However, he said he does not see those examples being followed by the financial services industry.

One ongoing attempt to provide quality customer service is taking place at Schaumburg, Ill.-based Zurich-American Insurance Group.

"We wanted to create an environment in which every employee always knows who the customer is" and in which employees are always looking for ways to improve, said Pam Arnold, internal consultant for Zurich-American's Continuous Improvement Program. The company currently has eight full-time employees in its Continuous Improvement Department, which oversees the program.

Zurich-American decided to bring its target marketing strategy "inside" in 1989 in an effort to be more responsive to its customers, Ms. Arnold explained.

To do so, the insurer found that it had to "knock down traditional roadblocks," Ms. Arnold said. Among those barriers was having different departments pursue different objectives, she said.



Ms. Arnold

The inaugural phase of the program, "Partners for Excellence," began with a series of workshops for several departments at a time. Ms. Arnold said that about 40% of the Schaumburg headquarters staff has completed the program. "Momentum is really building," she said.

The first phase of the program, dubbed "Diagnosis," has departments identify their customers, both external and internal, and then engage in face-to-face discussions with those customers, Ms. Arnold said. These discussions should involve the people who will actually work with each other on a daily basis, not just department heads and other managers.

In the second phase, "Direction-Setting," a team representing a department clarifies its vision of what customer service goals it wants to achieve in three to five years and defines what changes in services must occur to reach those goals, she said.

In the third stage, "Redesign," the department redesigns the process to meet customer service goals.

Ms. Arnold said that Zurich-American's Swiss managers "are very interested and very supportive" of the effort. She credited the system with enhanced productivity, greater efficiency and a clarification of responsibilities among departments.

Ms. Arnold said that the least measurable yet most important result of the program is a clear definition of the word "customer."

There's still a question as to who an insurer's customer really is, said Mark Savory, national director of Ernst & Young's insurance industry consulting services in New York.

Many insurers haven't decided whether the customer is the agent or the policyholder, he explained. This is one reason insurers have lagged behind companies in other industries in being perceived as providing quality service.

Another key reason for the perceived lag is the fact that insurance has historically been treated as a commodity, said Mr. Savory. Until fairly recently, there was not a lot of bundling and unbundling of services for customers.

That must change, he said.

"Being able to satisfy customers, even in the face of declining prices," will become increasingly important, said Mr. Savory.

Insurers have become aware of their problems, something made manifest in public opinion surveys that ranked them as little better than service stations in perceived quality service, he said.

Life insurance companies were a little ahead of their property/casualty brethren, but during the past year or so, property/casualty companies have begun picking up on the idea of quality service—first in personal lines, now in commercial lines, said Mr. Savory.

In commercial lines, providing quality service means "going the extra step," he said. Rather than simply saying, 'No, we won't accept a $25 million program,' quality service-minded commercial insurers are now saying that although they can't take the whole program, they will be willing to accept a $10 million layer, according to Mr. Savory. It's a matter of "not just slamming the door in their face."

Mr. Savory offered an eight-step quality improvement approach for insurers. The steps are:

- Hire a quality specialist to establish, direct, control and monitor the quality improvement process.
- Break down work into distinct blocks of time to help establish and conduct a quality improvement process in less than 20 weeks.
- Focus on priority improvement opportunities or problem areas.
- Dedicate a full-time core team of the company's best people to be trained and organized into three or more quality improvement teams.
- Use technical and analytical training programs to help the core team.
- Obtain management's support by having management sign off on the teams' recommendations. This will help defuse possible conflicts with departmental managers and thus make the system more efficient.
- Implement recommendations as quickly as possible.
- During implementation, use quality teams as assistants to department managers to activate approved recommendations. ■

MARCH — **Agency-Insurer Relations**

Issue: March 2
Ad Closing: February 19

As the property/casualty marketplace continues to squirm in the doldrums, are hostilities increasing between agents and their insurers? *BI's Agent/Broker Topics* section will look at the cost containment efforts put in place by insurers and how they are affecting independent agents. Editors will examine the major complaints that agents are leveling against their insurers.

APRIL — **Consulting Services**

Issue: April 6
Ad Closing: March 24

In a competitive market agents are forced to look beyond the typical placement of insurance for their revenue. *BI's Agent/Broker Topics* section will look at the alternative fee based services agents are turning to. What services are agents providing for their clients? How do agents search out these non-traditional markets? How receptive are their clients? Are agents successfully increasing their revenues by offering consulting services?

MAY — **Mergers/Acquisitions/Divestitures**

Issue: May 4
Ad Closing: April 22

Reality: there are fewer agencies today than 5 years ago; smaller agencies had trouble surviving as larger competitors gobbled them up, and in the throws of recession the numbers are dwindling still. *BI's Agent/Broker Topics* section will look at what small to medium-sized agencies can do to hang on ... merge with similar sized agencies, buy books of business handled by smaller firms, groom themselves for acquisition by a bigger operation. Editors will examine how agencies can improve their financial management in a sluggish market.

Agent/Broker Topics

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* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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IT errors and omissions

- Due to an editing error, Judith L. Stone, executive director of Advocates for Highway & Auto Safety, was identified as being affiliated with the National Safety Council in the Jan. 20 *Insurer Topics*. Ms. Stone is a former NSC federal affairs director and has been executive director of Advocates since 1989.

Insurer Topics

Law firm offers its clients alternatives to hourly bills

By LORI BLOCK

CHICAGO—Donald L. Mrozek knows that law firms once did not widely bill by the hour, even if he has no first-hand recollection of the practice.

And if Mr. Mrozek, chairman of the Chicago-based law firm Hinshaw & Culbertson, has his way, legal fees may once again be based on something other than hourly rates.

"As late as the '60s, our firm's predominant form of billing was not hourly," said Mr. Mrozek, who is spearheading a movement at the firm toward alternative billing systems. Instead, clients were charged by the case based on "the effort involved and the result achieved."

While times changed at his firm and others across the nation—they may change once again, he said.

Years ago, clients began forcing firms to itemize their billing, which led to charges that were pegged to the hours worked, Mr. Mrozek said. Once again, it is clients who are now questioning the hourly approach, he said.

As a result, Hinshaw & Culbertson, which specializes in tort defense and other cases involving insurers and their clients, has decided to turn back the clock. The law firm, which has 295 attorneys in 16 cities, has been working on a variety of alternative billing mechanisms.

One factor behind the change is an overall effort to develop quality services at reasonable prices, said Mr. Mrozek. "The second factor driving it is the difficulties we've encountered with our clients over hourly rates."

Oddly enough, Hinshaw & Culbertson has found that clients rarely take issue with the total bill, but they do take exception to "particular entries," he said. These entries include charges for time spent on phone calls, conducting research and attending legal staff meetings.

Mr. Mrozek also is concerned that hourly billing is subjective, enabling law firms to "low-ball" their hourly rate but then liberally interpret the actual time spent in service to the client.

"I think Hinshaw would agree that, on both sides, hourly billing builds distrust," observed Robert H. Abney, director-claims management services for the Chicago Hospital Risk Pooling Program, a Hinshaw & Culbertson client. The insurance pool is made up of 14 Chicago-area hospitals.

"There's no question that there's pressure on lawyers in a firm to bill," said Mr. Abney. Meanwhile, "many clients have no idea what a lawyer does when defending a case."

And, he adds, hourly billing "perhaps magnifies the concern of the clients that too much work is being done."

Interest in alternative billing increased after a report on the topic ran last year in a Chicago legal newspaper and Mr. Mrozek discussed the issue before an audience of insurance company representatives at the firm's 1991 Insurer Symposium.

About 20 of Hinshaw & Culbertson's existing clients have contacted the firm to discuss alternative billing, Mr. Mrozek said. For example, the Chicago Hospital Risk Pooling Program began discussing the idea with the firm about a month ago, Mr. Abney said.

Clients are now "the driving force" behind the move to alternative billing, said Mr. Mrozek. And that makes for a rather interesting phenomenon, he said: After insisting upon more itemization for years, clients are now willing to consider a more holistic approach to billing.

"It's come full circle," according to Mr. Mrozek.

Of course, Hinshaw is not the only firm to try alternative billing. Four years ago, a temporary American Bar Assn. task force began examining alternative billing, and other law firms have reported interest in the idea.

At Hinshaw & Culbertson, the idea has evolved into three primary approaches to billing:

- Set price plus bonus.

For clients whose definition of "results" is that their cases are resolved quickly, Hinshaw & Culbertson is devising a system in which the client, who commits to providing a certain volume of cases, agrees annually to a set fee for each case. In addition, if the case is resolved within a certain period of time, Hinshaw & Culbertson will receive a previously agreed-upon bonus.

To those who believe the hourly billing method encourages lawyers to drag out the resolution process, "this approach is turning it exactly around," said Mr. Mrozek. "We're excited about the possibilities. But, it requires good faith on both sides."

- Client teams.

Here, Hinshaw & Culbertson will assign a team of lawyers to a particular client. This team, which would include lawyers of various experience levels, may work for the client either full- or part-time.

Once the team is selected, the firm and the client will meet and discuss a fee schedule, which, assuming the team works full-time for the client, will cover the lawyers' salaries, overhead and also provide profits for the firm.

"I jokingly refer to this as the rent-a-lawyer program," Mr. Mrozek said. But in all seriousness, he stresses that such an arrangement requires the firm and the client to form a true partnership because private information, like lawyers' salaries and the firm's expenses, are discussed. "Cli-

Continued on next page

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Insurer Topics

Backers of no-fault bolstered by Rand research

By LORI BLOCK

SANTA MONICA, Calif.—A new study by the Rand Corp.'s Institute for Civil Justice confirms what many in the insurance industry have long believed: A well-designed no-fault auto insurance system can both reduce costs for consumers and better compensate people injured in auto accidents.

However, such a system will only reduce costs for consumers if realized savings from a no-fault program are earmarked for reducing auto insurance premiums, stressed Stephen J. Carroll, a senior economist with the Santa Monica, Calif.-based research organization. Policymakers, he noted, also could decide to use the savings to boost compensation to more seriously injured people who may otherwise be undercompensated.

Researchers also found that a no-fault system can save money by preventing consumers from collecting for the same accident under both auto insurance and private health insurance, including group health policies.

The findings played well with the American Insurance Assn. "We are very optimistic that this study is going to provide the documentation necessary to convince legislators and consumers across the country that well-designed no-fault auto insurance systems can save money and deliver better benefits faster to injured drivers," said David Snyder, the trade group's senior counsel.

The study explained that no-fault systems make a distinction between serious and less-serious injuries. Which category an injury falls into is determined either by a "verbal threshold," in which the type of injury dictates whether it is serious, or by a dollar amount.

Under no-fault, "seriously injured" people can pursue liability claims for all economic and non-economic losses, while the less seriously injured can recover only for economic losses, like lost wages or medical bills.

No-fault provides enhanced insurance against the policyholder's own economic losses, the study explains. Known as "personal injury protection," it covers economic losses up to a specified limit, regardless of fault.

The study was designed to test nearly all reasonable combinations of potential no-fault provisions to determine how injury costs and compensation would be altered in states that currently have a traditional tort-based system.

The examination yielded the following general conclusions:

- No-fault auto insurance can either yield substantial savings or increase costs over the traditional system, depending on the provisions adopted.
- No-fault plans reduce insurers' and claimants' transaction costs, regardless of a plan's specific provisions.
- No-fault plans match compensation more closely with any economic loss incurred by increasing the portion of economic loss that is compensated and by reducing the amount of compensation paid in excess of economic loss.
- No-fault plans generally speed up compensation, with injured individuals being paid an average of two months sooner than they would under the traditional system.

To illustrate how these effects would be achieved, the Institute for Civil Justice examined a model no-fault plan that featured a verbal threshold and a $15,000 personal injury protection limit under which only economic losses are reimbursable.

The institute developed this model based on the experiences of states that currently have a no-fault system and compared that plan's experience to a model representing experience in states where the traditional, tort-based system is used.

Under the model no-fault plan, total injury coverage costs were reduced 22%, the study found.

Specifically, an individual's average gross injury compensation would fall to $3,764 with no-fault, from $4,681 with the traditional system. Insurers' transaction costs fall to $528 under no-fault, from $793 under the traditional system.

The reduction in injury compensation is achieved by making the compensation to injured individuals more equitable, according to the study.

For example, the hypothetical no-fault plan used by the institute would reduce the number of individuals that receive more than their economic damages to less than 25% from the current system's 62%, the study said. On the other hand, the number of individuals who receive less than full compensation would be reduced to 16% from the current 27%.

No-fault systems accomplish this by ensuring that those who are less seriously injured receive less compensation, while those more seriously injured received more, Mr. Carroll said. No-fault systems more closely link compensation with the actual economic damages incurred, he explained.

Using conservative estimates, the AIA's Mr. Snyder said that "at $15,000 you're compensating 85% of the accident victims for their out-of-pocket expense."

Recognizing that at that rate some people still are left undercompensated, Mr. Snyder said that, "In all of these systems, we recommend that people be allowed to purchase additional coverage up to several hundred thousand dollars.

"I think you're really dealing with a very small percentage of uncompensated people, and the only way a system can deal with that is to provide unlimited medical coverage," he said.

Of course, no-fault systems could be designed to pay more in some instances, the study's authors pointed out. Legislators could decide they did not want to use no-fault's realized savings to reduce consumer costs by lowering auto insurance premiums and instead use the savings to raise compensation to more seriously injured people, Mr. Carroll said.

And the study does not examine other factors influencing insurance premiums, such as property damage costs, and underwriting and overhead costs.

However, Mr. Carroll said that because injury compensation costs usually amount to 40% to 60% of overall insurance costs, "reducing injury compensation costs should lead to lower premiums."

The study also examined the impact a no-fault system could have on broader insurance issues.

For example, the study examined "coordination of benefits" and found the savings would be "tremendous" if private coverage were made the primary payer in auto accidents, Mr. Carroll said.

"Most people with (access to) private health care are going to collect from private health insurance regardless of whether they collect from their auto insurance," he explained. A well-designed no-fault system can put a stop to that duplicative coverage, he said.

Furthermore, the study shows, if a no-fault plan requires people injured in an auto accident to collect medical costs from their health insurer before their auto insurer, savings in total injury coverage costs rise to 33% from 22%.

The AIA supports such an offset. "I don't think consumers, and society in general, can afford to pay twice for injuries anymore," Mr. Snyder said.

He said the study will be particularly relevant to states now considering adopting no-fault systems or modifying their current ones. These include Arizona, Connecticut, California, Colorado, Louisiana, Massachusetts, New Jersey, Rhode Island and Texas. ●

Copies of "No-Fault Automobile Insurance, A Policy Perspective" and "No-Fault Approaches to Compensating People Injured in Automobile Accidents" are available from the Rand Corp. publications department for $4 and $20, respectively. Contact: Rand Corp., Publication Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif., 90407-2138; 310-393-0411.

Legal fees

Continued from previous page

ents have been very receptive to this idea and have kept things confidential," he said.

- In-house service.

This last method evolved within the firm almost by accident when a client found itself suddenly without an in-house legal staff after one attorney left the firm and another became seriously ill. Hinshaw & Culbertson agreed to temporarily assume the firm's in-house work for a set fee. In this case the fee was based on a month's worth of legal services, but Mr. Mrozek said it could also be set on a quarterly or annual basis. Several Hinshaw & Culbertson attorneys work on the client's projects on an ongoing basis, though not on site.

He reports that the firm is performing the client's necessary "in-house" legal services at a lower cost. This program works best in areas, like workers compensation, with a large volume of predictable cases, Mr. Mrozek said. "It also works well when the client knows what they have been paying."

Discussing the various billing alternatives with clients, though, may lead to conflict.

Clients may not only be seeking to simplify the billing process and eliminate distrust, but to corral their litigation costs, commented Mr. Abney. "Obviously, if we save a dollar, the law firm loses a dollar," he said. "That makes this whole process difficult."

Regardless of which method of alternative billing is selected, Mr. Mrozek stresses that it must be built on a solid foundation of historical information so that both sides understand the expenses that go into resolving each case.

"We have made a conscientious and serious effort to keep records" of all cases, classifying them by type of case, type of client and the jurisdiction. That way we know what's required of each case," Mr. Mrozek said.

From that starting point, Hinshaw & Culbertson can examine a group of cases similar to the one it is about to tackle and estimate what it will cost to resolve the case.

As for clients, Mr. Abney said they must trust the law firm—or firms—with which they are discussing alternative billing. And, because law firms may view alternative billing as a way to build long-term relationships that also promise large volumes of work, "I would hope that this desire on their part would cause them to be forthcoming with us," Mr. Abney said.

Similarly, Mr. Mrozek said that the firm hopes that "by doing this. . .it strengthens existing relations and hopefully creates some new ones." ■

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Continued from previous page

UR services provided to employers: 80% of gross revenues.

UR services provided to others: 6.5% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, skilled nursing, home health care, focused surgical and diagnostic review.

Occasional UR services: Retrospective review, second surgical opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 1,700 total; 854 professionals, including four physicians, 850 registered nurses. On retainer: 281 physicians.

Clients: 7,600 total.

Covered lives: 4 million employee benefit plan lives; 300,000 workers compensation lives.

Admissions reviewed: 250,000, 3% diverted for outpatient treatment.

Branch offices: San Antonio, Texas; San Diego; Hartford, Conn.; Westmont, Ill.

1991 gross revenues: $115 million total, $35 million from UR services.

Principal officers: Dennis Huffman, president; Cathy Johnson, vp-marketing; Kam Shah, chief financial officer; Cathy Rayhill, vp-information systems; Pat Saronno, vp-human resources; Jim Vance, chief medical officer.

Consumer Health Network

908 Oak Tree Road, Suite C, South Plainfield, N.J. 07040; 908-754-6200; fax: 908-754-4431

Founded: 1988; began providing utilization review services in 1992.

UR services provided to employers: 25% of gross revenues.

UR services provided to others: 50% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, outpatient service predetermination.

Occasional UR services: Length of stay determination, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Six total; all professionals, including four registered nurses, two medical records technicians. On retainer: 15 physicians.

Clients: 23 total; one employer client with 2,500 to 4,999 employees.

Covered lives: 78,000 employee benefit plan lives.

Admissions reviewed: 7,000.

1991 gross revenues: $2 million; $950,000 from UR services.

Charges: Per employee, $1 to $1.65 per month; per case, $125 to $250; per hour, $70 to $275.

Principal officers: Nancy C. Romeo, president; Richard C. McDonough, chairman; J. Robert Lackey, George Reinhard, John J. O'Connor, Joseph Carabello, director-marketing.

Core Management Inc.

200 Wheeler Road, Fifth Floor, Burlington, Mass. 01803; 617-229-9400; fax: 617-229-9429

Founded: 1984.

UR services provided to employers: 30% of gross revenues.

UR services provided to others: 30% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management, maternity care, surgical/diagnostic review program.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 96 total; 65 professionals, including 20 physicians, 45 registered nurses.

Clients: 11 total; five employer clients; 14% with 1,000 to 2,499 employees, 28% with 2,500 to 4,999 employees, 58% with more than 5,000 employees.

Covered lives: 450,000 employee benefit plan lives; 8,400 workers compensation lives.

Admissions reviewed: 36,000; 2% diverted for outpatient treatment.

Branch offices: Santa Monica, Calif.

1991 gross revenues: $8.1 million total, $4.8 million from UR services.

Principal officers: George Carpenter, chairman/chief executive officer; Craig Horton, president/chief operating officer; Jim Franklin, executive vp-sales and marketing.

Corporate Care Management Inc.

70 Corporate Drive, Binghamton, N.Y. 73904; 607-724-6520; fax: 607-722-1332

Founded: 1976; began providing utilization review services in 1976.

UR services provided to employers: 93% of gross revenues.

UR services provided to others: 5% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, DRG validation, facility and physician fee negotiation, plan language consultation.

Occasional UR services: Second surgical opinion, hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, pharmacy.

Staff: 21 total; 16 professionals, including one physician, 13 registered nurses, two licensed practical nurses. On retainer: eight physicians.

Clients: 31 total; 29 employer clients; 17% with fewer than 500 employees, 17% with 500 to 999 employees, 52% with 1,000 to 2,499 employees, 4% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Covered lives: 62,000 employee benefit plan lives; 8,000 workers compensation lives.

Admissions reviewed: 9,600; 4% diverted for outpatient treatment.

Charges: Per employee, $2.50 to $3; per hour, $70 to $99.

Principal officers: Dr. John F. Spring, chairman; Patrick J. Kearse, president/chief executive officer; Barbara S. Kane, vp/chief operating officer.

Corporate Medical Management/CoMed Management Inc.

525 Metro Place N., Suite 300, Dublin, Ohio 43017; 614-766-0061; fax: 614-889-2148

Founded: 1987; began providing utilization review services in 1987.

Parent company: New York Life Insurance Co.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 89% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, medical claims review.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric

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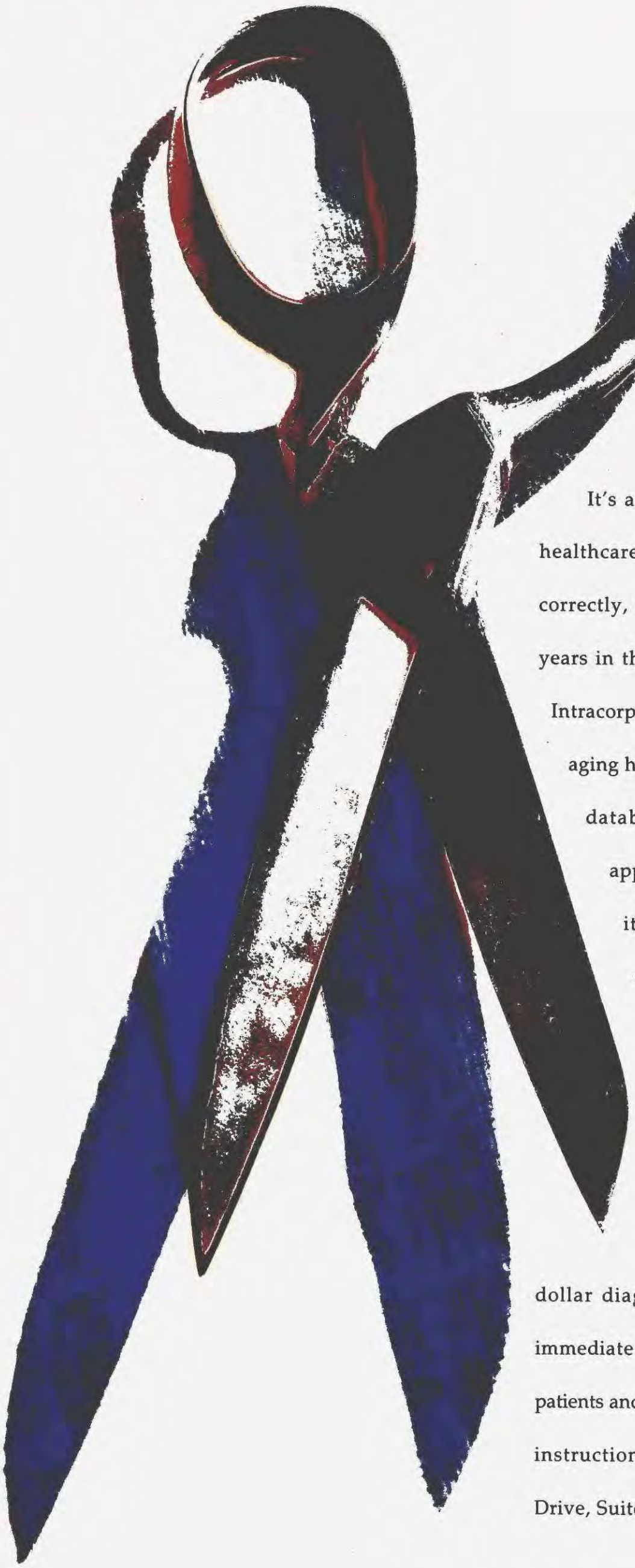


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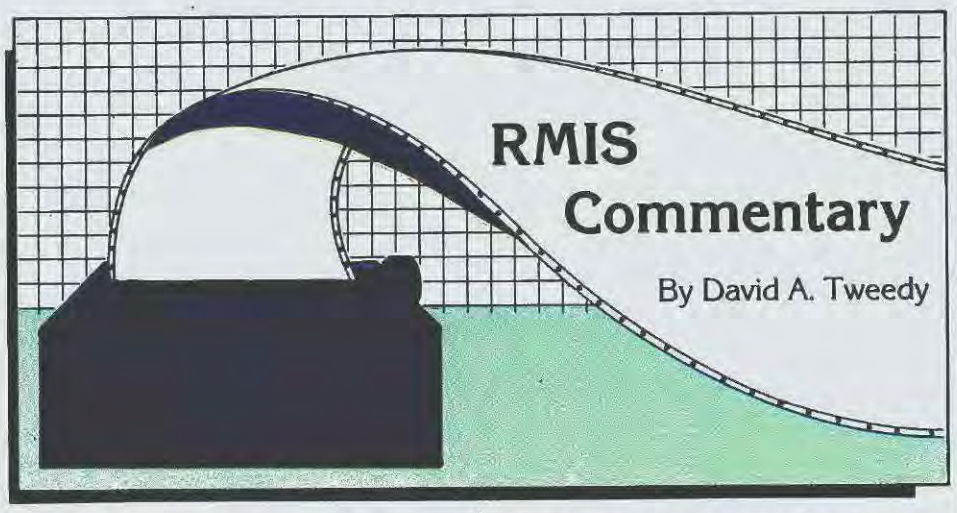
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It's a tool not many have when it comes to cutting healthcare costs. It's called experience. And when used correctly, it can bring very sharp results. With over 20 years in the industry, and over 1.5 million case reviews, Intracorp has acquired a vast pool of knowledge in managing healthcare costs and has used it to build a unique database of healthcare information. Now, we've applied that information so that employers can use it to compare their claims experience to other similar companies'. This analysis will help pave the way for improvements and adjustments to problem areas and can help to reduce overall costs. We've also used our database to develop an exclusive, state-of-the-art expert system that helps isolate those serious, high-dollar diagnoses that require more attention through immediate case management. The result: Better care for patients and lower costs for those paying the bills. For further instructions write Intracorp, Dept. 13, 1205 Westlakes Drive, Suite 300, Berwyn, PA 19312.

INTRACORP

What's hot in RMIS?

As industry matures, vendors improve, diversify systems



I WOULD LIKE to summarize the major observations found in my review of leading risk management information systems and vendors. In the December column (*BI*, Dec. 23, 1991), I outlined the parameters used to conduct the review, which was completed last month and should be available by early March.

After looking at 16 of the leading RMIS vendors, I have found the following trends:

- **Diversified services.**

The RMIS industry, as a mature one, is characterized by the majority of vendors diversifying their services and product line. Not surprisingly, almost all have something to offer in the field of medical cost containment software for workers compensation, like bill review.

Existing vendors with this capability include: Risk Sciences Group, through parent Crawford & Co.'s medical services division; Corporate Systems Ltd.; DAVID Corp.; Pyramid Services Inc.; Insurance Software Packages Inc.; California Interactive Computing Inc., through an affiliation with Medical Data Research; Travelers Corp.; American Technical Services Inc.; DORN Technology Group Inc.; and Paradigm Infosystems.

At the same time, many vendors are recognizing the opportunities in merging the group health area with the workers compensation area. This fused system—dubbed ERIS, or employee benefit and risk management information system—is an instrumental tool for third-party administrators, insurers and information system vendors to enter the market for so-called 24-hour coverage. A system blending employee benefits and property/casualty insurance has tremendous appeal to risk and benefit managers alike, who seek to reduce their overall cost of claims.

Vendors specializing in this area are: CIC, ISP and Travelers. Others, like Corporate Systems, ATS, Paradigm and Pyramid, are developing capabilities. This is another area where more vendors (especially on the benefits side) are sure to appear within the next few years.

An additional area of increasing emphasis is the underwriting function. Especially among vendors whose clientele tends to be TPAs, brokers, pools, risk retention groups, captives or associations, there is a great deal of interest in obtaining a system with not only claims management and risk management abilities, but also the ability to take that raw data and feed it into an underwriting base, which can then calculate rates and premiums. Pyramid currently is working on such a system, soon to be released. Paradigm already has one. I am told that others are working on them, as well.

The decision, of course, is whether to create a proprietary module or align with a vendor specializing in the field. Again, market demand will determine how many vendors enter this specialty. During the current soft market for most lines other than workers comp, there is not as much pressing need for a comprehensive system. Yet, inevitably, the hard market will return and, when it does, the clamoring for self-insurance vehicles will cause increased demand.

Price range for various platforms

	One user	10 users	50 or more users
Mainframe			
Start-up costs	n/a	$60,200	$61,500
Ongoing annual costs	n/a	61,500	64,800
Midrange			
Start-up costs	$48,000	$61,000	$119,000
Ongoing annual costs	6,000	23,000	35,000
PC (including local area network)			
Start-up costs	$19,000	$36,000	$64,000
Ongoing annual costs	4,000	7,000	12,000

Source: Betterley Risk Consultants Inc.

GRAPHIC BY KIMBERLY MART

- **Technological advances.**

Another element of a mature marketplace is the increased emphasis on research and development. Coincidentally, the entire computer industry has been experiencing tremendous advances in both hardware and software—from super microprocessors to innovations in graphical user interface to advances in client server architecture. CASE tools—or computer-aided simulation engineering that allows the simultaneous programming of groups of functions—imaging and electronic data interface are some of the buzzwords describing processes that are designed to make the risk management information systems more attractive, sophisticated, and easy to use and integrate.

Some of the more prevalent advances have been in the "cross-platform" solutions, according to Andy Daniels of Risk Sciences Group. Essentially, it is no longer an acceptable practice to force a client to use one of three major hardware platforms: PC, minicomputer and mainframe. Rather, through network technology, client server architecture, structure query language and a host of other technical advances, the client has the option to utilize one, two or all three platforms to solve a specific problem.

Another byproduct of the technological advancement is the quest for greater "user friendliness." Paradigm is an excellent example here. The company has chosen the Apple Macintosh environment to provide an information system. We all know the "point and click" ease of use with a Mac through the use of a mouse and the simplicity and logic of the screens, which basically lead inexperienced computer users from icon to icon, helping them build a report or analyze numbers. This is called graphical user interface and is being mimicked by Windows in the IBM environment.

Many vendors are developing, or have developed, PC products for Windows. Pyramid is one such company. Through their own proprietary systems, many other vendors are letting clients access Windows.

In many instances, the client does not even have to request changes to be made by the vendor at their location. They can simply create a report format or a screen design themselves—within limitations—to save a great deal of expense and time. The final result looks exactly the way the client wants it.

- **Increased competition.**

Another telling result of our review is the heightened competitiveness among the major vendors. This competition is no longer related to platform. I am increasingly seeing projects where Corporate Systems competes against Pyramid, Conway against DAVID, and so forth. There is definite multiplatform competition. This is because the PC vendors are able to offer products that can compete in power and speed with their mainframe/timeshare competitors on a level playing field. The question becomes ability to service, diversity of services offered, cost and stability of vendor.

In fact, we tell clients and prospects to carefully evaluate their vendor in terms of their long-term viability, the product services offered, the amount of time and expense devoted to research and development, and current client satisfaction.

Further, some vendors are increasingly reluctant to provide sensitive information on their pricing strategy. Five vendors initially refused to give me any pricing information until I promised not to reveal their cost structure, but only include it in a generic average. Another vendor specifically accused its competition of stealing ideas, product features and business practices.

I am discouraged to hear things like this. This profession must be an ethical one, and these comments, if true, are appalling.

Nevertheless, it does signify the degree of competitiveness in the industry, and the potential buyer should be aware of the opportunities presenting themselves at this time. Therefore, the upcoming Risk & Insurance Management Society conference in Anaheim, Calif., might be a great place to begin some serious consideration of products available and potential opportunities to upgrade your current system.

- **Pricing ranges.**

Although I can't provide specific prices, there is a general range for each platform (see table).

The vendors providing mainframes include: Risk Sciences Group, Travelers, Gallagher Bassett Services Inc. and Corporate Systems.

Midrange vendors are: CIC, Conway and Corporate Systems.

And PC-based systems are available from: DAVID, ATS, Dorn, ISP, Pyramid, Cantor, Anistics, Helmsman Management Services Inc., Seligman Information Systems and Travelers. ■

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.



Containers of the costs, unite!

By Donald M. Duford

As managers, strategists and partners, UR firms can reform health system

IN THIS ELECTION YEAR, health care remains one of the top issues on the national agenda. As a multitude of health care reform proposals vie to become the plan for the future, the issue of cost containment has been pushed to the forefront of public attention (see story, page 1).

The health care cost containment industry is conspicuously missing from this drama. With the nation focused on health care reform, shouldn't utilization review vendors be adding their collective voice to the debate, offering alternatives that the UR industry can provide?

Of course they should. But they haven't. They've been too busy resting on past laurels to offer a viable solution for the future.

Twenty years ago, the health care arena was vastly different. There was no debate. Employers gave 100%, employees received 100%. With no financial liability, it simply didn't occur to employees to question value.

It's hard to believe that it was only eight years ago that employers responded to swelling health care costs by the routine use of UR. Employers gave, employees received and the utilization review industry monitored.

It worked. By changing admission rates and number of bed days used, fat has been cut out of the system. But now, the UR industry needs to stop chewing the fat and focus on additional areas where we can have a broader impact on a system whose growing complexity and cost is a foremost national concern. This will require UR vendors to become partners with others who have vested interests in improving the health care system. Two groups on which an immediate and direct impact can be made are employers and employees.

By positioning ourselves as managers, educators and strategists—rather than as watchdogs over these two groups—UR vendors can help them make better health care decisions.

- **Educating employers.**

First employers must be taught to be educated information consumers. UR vendors are sitting on a mountain of information collected from the millions of admissions reviewed each year. Having information is one thing, but mining it to help deliver better health care for less money is the next crucial step. Information, when properly used, can energize the industry and positively affect patient care in several ways.

UR vendors have the capability to track trends. For example, if back problems are prevalent in a specific industry, a UR firm then can point employers toward safety measures that could reduce risks. By tracking outcomes, they can help employers identify categories of admissions and other care that are off the norm and should be investigated within their employee population.

Regional differences also come into play. In some parts of the country, procedures like hysterectomies or gall bladder operations may be far more prevalent. The ability to collect centralized information can be used to help employers focus on excesses in the system, reduce those excesses and leave what seems to be OK alone—thereby stretching their cost containment expenditures to maximum value.

- **Modifying employee behavior.**

Until now, the UR industry has done little to help employers better educate their employees about health care. Because more of the health care expense burden is shifting to employees, UR firms need to actively develop programs that focus on employees, their health and their decision making.

In an ideal world, it's not just the UR industry's responsibility to get the best care for the least amount of money—it's everyone's. UR vendors must join employers in teaching their employees to understand and manage their own health care, to become responsible consumers, to look at and evaluate options that benefit everyone involved. To do that, employees must receive the information they need to make responsible health care decisions. Easier said than done? Not necessarily.

There is always tension between the need for change and the resistance to it. When pre-admission certification was first introduced in the mid-1980s, many employers worried that employees would perceive it as intrusive and threatening. Yet, a survey published last year found that 92% of employees were satisfied with their pre-admission certification experience.

Generating participation in company health management programs, like health risk appraisals and classes on weight reduction and smoking cessation, is a challenge. Again, by focusing on employees—especially those that need support—employers can positively affect their employees' health and the company's own health care bill. A company's health care program must include the employee health management component. If not, employees receive sick care or hospital care, not health care.

Americans strive to be informed consumers, often consulting reports, magazines and the advice of experts to guide their purchases. Yet most people are singularly uninformed when it comes to medical issues. Yes, one of the first steps is for corporations to communicate information regarding programs like prenatal classes, on-site aerobics and medical screenings. But it is also incumbent upon employers to give employees information regarding alternatives to suggested care, the danger of proposed care and the cost of medical care. The trick is to have the right information available at the right time.

It would be advantageous for health care consumers to learn a little about the UR business and how it can actually help them get the care they need. For example, mental health and substance abuse therapy can be handled as effectively on an outpatient basis as inpatient—and is less expensive and disruptive. A woman who has had one Caesarean section is not necessarily a candidate for a second. Surgery is just one way of dealing with a prostate problem. Employees have a right to know, and employers—in their roles as health care purchasers and facilitators—have an opportunity to provide access to necessary information.

The entire UR process began by teaching employees that they needed to place a phone call before receiving treatment. Now, we need to expand upon the use of that important phone call. That phone call must be used to inform employees about legitimate costs for services, to help them understand medical jargon and to support them in making health care decisions. It only takes one major health crisis in a family to recognize the value of the support such services can render.

- **Where do we go from here?**

The heart of the UR business—health care costs—is a national problem affecting everyone, employers as well as the American public. No matter who becomes president or what health care system is put in place, the challenges will not entirely fade. Employers will need to become wise consumers to perpetuate reforms put in place. And the UR industry will need to shift its concerns from a narrow focus on costs to thinking and acting more on the behalf of employees before they become patients.

If the UR industry offers a true alternative, then employers won't have to resort to tailoring benefit plans to limit use. Employers can give, employees can receive—and providers can provide.

The UR industry has demonstrated that people can modify their behavior. It's the industry's turn to show that they can modify theirs. ■



Donald M. Duford is senior vp of Intracorp, a provider of health care cost control and disability management services, based in Berwyn, Pa.

Timing is not everything, subrogation ruling says

The fact that a group health care policyholder collected a settlement from a third party before signing a subrogation agreement with the plan administrator did not entitle him to retain the settlement proceeds, says an Alabama Supreme Court decision only recently reported.

Kim Sharpley was employed by Baker Industries, a division of Sonoco Products Co. Sonoco was self-insured, and its employees were covered under a group life, medical and dental policy administered by Provident Life & Accident Insurance Co.

This policy extended subrogation rights to Provident for any sums the employee received because of injury or illness caused by another person.

Legal briefs

In March 1986, Mr. Sharpley was injured in an car accident allegedly caused by a third party and was hospitalized for three months. In July, Mr. Sharpley received a $25,000 settlement from the third party's insurer.

Mr. Sharpley did not use any of these funds to pay the $15,550.15 in medical expenses he had incurred as a result of the accident. Also in July, signed a subrogation agreement from Provident. In August 1986, Provident paid Mr. Sharpley's medical expenses. When Provident became aware that Sharpley had recovered $25,000 from the third party, it tried to collect $15,550.15 from Mr. Sharpley. He refused. Provident then sued Mr. Sharpley and won in the trial court.

On appeal, Mr. Sharpley argued that he was not obligated to reimburse Provident because he had collected the settlement from the third party before he signed the subrogation agreement.

The trial court found this argument unpersuasive. The court said that equity would not allow Mr. Sharpley to be unjustly enriched by retaining all of the proceeds paid to him or on his behalf if those proceeds exceeded the amount of his loss.

Also, the court noted that the subrogation agreement that Mr. Sharpley had signed encompassed *any* reimbursement received for the accident that caused the injuries. However, the court returned the case for review of the full extent of Mr. Sharpley's accident-related loss which had not been established at trial.

•

Sharpley vs. Sonoco Products Co., Supreme Court of Alabama, Dec. 28, 1990 (*BI*/01/F.-$10).

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

Continued from page 41
and substance abuse.

Staff: 87 total; 26 professionals, including three physicians, 23 registered nurses. On retainer: 54 physicians, seven nurses.

Clients: 100% with fewer than 500 employees.

Covered lives: 180,000 employee benefit plan lives.

Admissions reviewed: 23 000; 1.7% diverted for outpatient treatment.

Charges: Per employee, per hour.

Principal officers: Janice Spillane, president/chief executive officer; Diane Schrimpf, vp-operations/PPO; Krista Ball, vp-healthcare management services; Michael Franks, director-sales and marketing.

Cost Care Inc.

1 Pacific Plaza, 7711 Center Ave., Suite 100, Huntington Beach, Calif. 92647; 714-842-4909; fax: 714-897-1633

Founded: 1981; began providing utilization review services in 1981.

Parent company: John Hancock Mutual Life Insurance Co.

UR services provided to employers: 80% of gross revenues.

UR services provided to others: 20% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, patient advocacy hot line, high-risk pregnancy management, disability management.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 587 total; 375 professionals, including 54 physicians, 163 registered nurses, 29 licensed practical nurses, 129 medical records technicians. On retainer: 8,600 physicians.

Clients: 7,000 total; all employer clients.

Covered lives: 5.3 million employee benefit plan lives; 96,000 workers compensation lives.

Admissions reviewed: 248,000; 4% diverted for outpatient treatment.

Branch offices: Schaumburg, Ill.; Atlanta; Lynnfield, Mass.; Memphis and Chattanooga, Tenn.; Chicago; Cincinnati; New York.

Principal officers: Lawrence Goelman, chief executive officer/president; Virginia Cirica, chief operating officer/senior vp; Ray Foose, vp-marketing; David Ackley, chief financial officer/vp-finance; Vicki Schweitzer, vp-operations; Dr. Alan Greenfield, vp-medical services.

Crawford & Co. HealthCare Management Group

5620 Glenridge Drive N.E., Atlanta, Ga. 30302; 404-847-4565; fax: 404-847-4028

Founded: 1941; began providing utilization review services in 1980.

UR services provided to employers: 19% of gross revenues.

UR services provided to others: 3% of gross revenues.

Frequent UR services: Preadmission certification, 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, maternity management, ambulatory review.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, home health care.

Staff: 1,692 total; 1,018 professionals, including 10 physicians, 638 registered nurses, 17 licensed practical nurses, nine medical records technicians.

Clients: 2,142 total; 1,782 employer clients; 17% with fewer than 500 employees, 28% with 500 to 999 employees, 36% with 1,000 to 2,499 employees, 15% with 2,500 to 4,999 employees, 4% with more than 5,000 employees.

Covered lives: 2 million employee benefit plan lives; 1.7 million workers compensation lives.

Admissions reviewed: 143,753; 7% diverted for outpatient treatment.

Branch offices: Chicago; Savannah, Ga.; Columbia, S.C., and 185 health care management offices nationwide and in Canada.

1991 gross revenues: $105 million total, $17 1 million from UR services.

Charges: Per employee, $1.45 to $3.

Principal officers: P.A. Bollinger, president; Dr. G. Berk Lynch II, vp; J. David Tiller, John H. Potter and Jeff Aycock, vps.

D

Data Med Inc.

650 W. Dundee Road, Northbrook, Ill. 60062; 708-291-0742; fax: 708-291-9415

Founded: 1985; began providing utilization review services in 1986.

UR services provided to employers: 90% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, 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.

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

Staff: 26 total; 18 professionals, including 10 physicians, eight registered nurses.

Clients: 83 total; 78 employer clients; 90% with fewer than 500 employees, 10% with 1,000 to 2,499 employees.

Covered lives: 18,500 employee benefit plan lives; 3,500 workers compensation lives.

Admissions reviewed: 2,800; 5% diverted for outpatient treatment.

1991 gross revenues: $285,000 total, $245,000 from UR services.

Charges: Per employee, 75 cents to $2.90; per hour, $95 to $155.

Principal officers: Louis R. Morgan, president.

E

E.M. Associates

P.O. Box 2650, Binghamton, N.Y. 13902; 607-771-0272; fax: 607-773-4407

Founded: 1987; began provicing utilization review services in 1987.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 60% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning retrospective review, second surgical opinion, hospital bill audit. case management.

Occasional UR services: Outpatient service predetermination, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, auto.

Staff: 15 total; 12 professionals, including nine registered nurses, one licensed practical nurse, two medical records technicians. On retainer: six physicians.

Clients: 30 total; three employer clients; 66% with fewer than 500 employees, 34% with 500 to 999 employees.

Covered lives: 1,000 employee benefit plan lives.

Charges: Per employee, per case, per hour.

Principal officers: Kathleen A. Ernst, president.

ETHIX Care Management

12655 S.W. Center St., Suite 180, Beaverton, Ore. 97005; 503-641-5352

Founded: 1985; began providing utilization review services in 1986.

Parent company: The ETHIX Corp.

UR services provided to employers: 30% of gross revenues.

UR services provided to others: 70% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, high risk pregnancy management, chronic care management, workers services management, fee negotiation.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, secondary Medicare.

Staff: 125 total; 83 professionals, including three physicians, 75 registered nurses, one licensed practical nurse, one medical records technician. On retainer: 50 physicians, 150 nurses.

Clients: 180 total; 100 employer clients; 70% with fewer than 500 employees, 10% with 500 to 999 employees, 2% with 1,000 to 2,499 employees, 8% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Covered lives: 1.5 million employee benefit plan lives; 12,000 workers compensation lives.

Admissions reviewed: 60,000; 7% diverted for outpatient treatment.

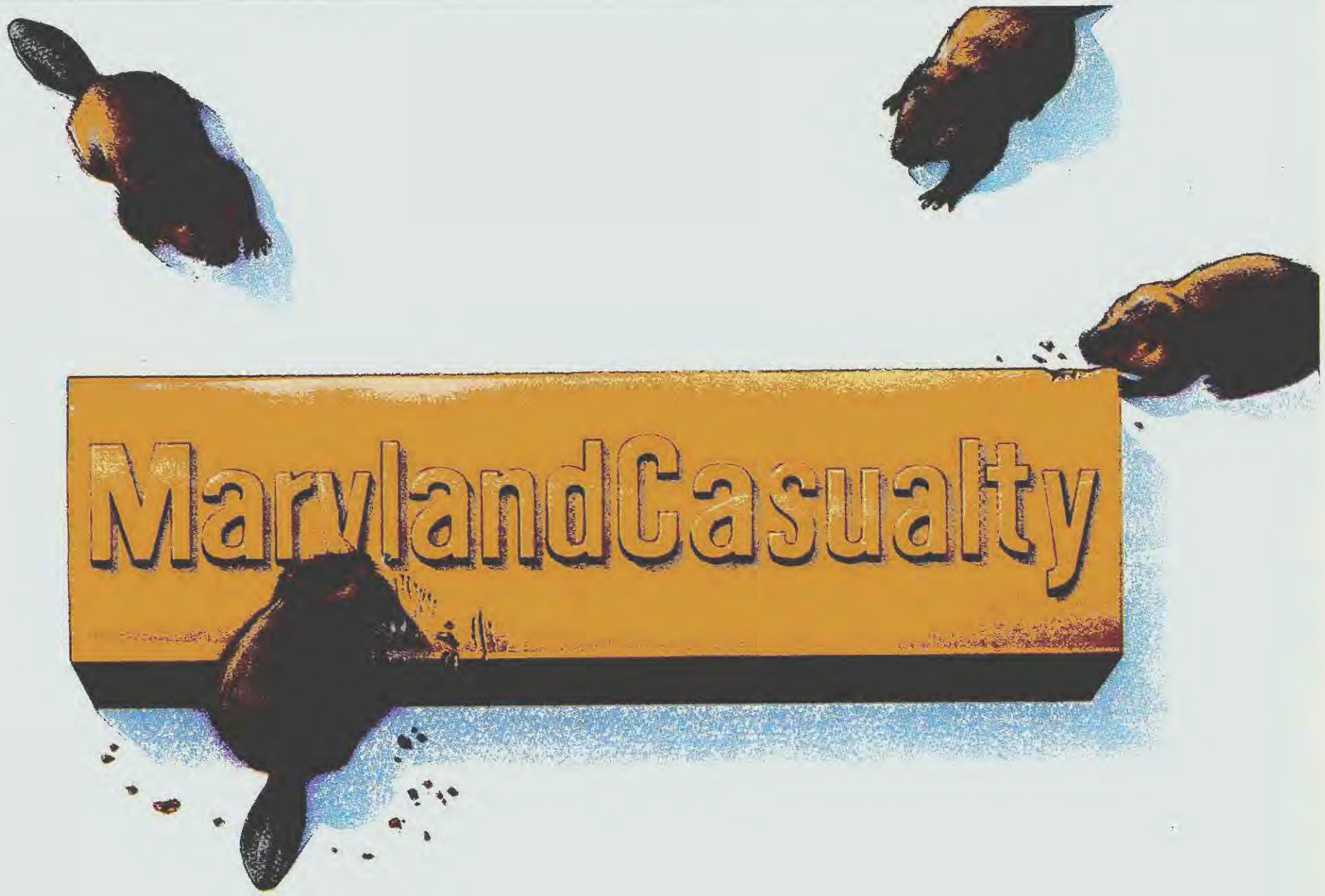
Branch offices: Portland, Ore.; Indianapolis; Dallas; Salt Lake City; Jackson, Miss.; Bolingbrook, Ill; Grand Rapids, Mich.

1991 gross revenues: $5.8 million total, all from UR services.

Charges: Per employee, $1.50 to $1.75 per month; per case, $100 to $500; per hour, $85 to $150.

Principal officers: ETHIX Care Management: Dale White, chief executive officer; Joan Copeland, president.

Continued on next page



Continued from previous page

Covered lives: 300,000 employee benefit plan lives; 137,000 workers compensation lives.

Admissions reviewed: 13% diverted for outpatient treatment.

Branch offices: Scottsdale, Ariz.

1991 gross revenues: $4 million total, all from UR services.

Charges: Per employee, $2.75; capitated fees (workers compensation case management).

Principal officers: Dr. Donald K. Kelly, chairman/chief executive officer; Suzanne D. Kelly, vice chairman/corporate secretary; Michael C. Peerboom, president/chief operating officer; David C. Dubs, vp-marketing.

Health Management Strategies International Inc.

1725 Duke St., Suite 300, Alexandria, Va. 22314; 703-706-4100 or 800-624-6472; fax: 703-706-4803

Founded: 1985; began providing utilization review services in 1985.

Parent company: Group Hospitalization & Medical Services Inc.

UR services provided to employers: 67% of gross revenues.

UR services provided to others: 31% of gross revenues.

Frequent UR services: Preadmission certification, 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, network development and management, psychiatric audit.

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

Staff: 340 total; 185 professionals, including 25 physicians, 160 registered nurses.

Clients: 264 total; 255 employer clients; 71.4% with fewer than 500 employees, 7.3% with 500 to 999 employees, 7.1% with 1,000 to 2,499 employees, 5.1% with 2,500 to 4,999 employees, 8.6% with more than 5,000 employees.

Covered lives: 11.8 million employee benefit plan lives.

Admissions reviewed: 79,400.

Branch offices: Denver.

1991 gross revenues: $24.2 million total, $23.7 million from UR services.

Charges: Per employee, per case, per hour.

Principal officers: E. Seton Shields, president; William R. Vandvennet Jr., executive vp; Allan B. Zients, senior vp/medical director; Joseph W. Avellar, vp-operations.

Health Resources Ltd.

P.O. Box 246, Pittsfield, Maine 04967; 207-487-5135; fax: 207-487-2496

Founded: 1979; began providing utilization review services in 1984.

UR services provided to employers: 85% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, 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, physician bill review.

Occasional UR services: Retrospective review.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 10 total; nine professionals, including six registered nurses, two licensed practical nurses, one medical records technicians. On retainer: one physician.

Clients: Six total; 27 employer clients; 60% with fewer than 500 employees, 25% with 500 to 999 employees, 15% with 1,000 to 2,499 employees.

Branch offices: South Portland, Maine.

Charges: Per employee, per case, per hour.

Principal officers: Myles D. Hutchins, operations manager; Debora Seneca, case management services.

Health Risk Management Inc.

8000 W. 78th St., Minneapolis, Minn. 55439; 612-829-3500 or 800-824-3882; fax: 612-829-3578

Founded: 1977; began providing utilization review services in 1984.

UR services provided to employers: 70% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, 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, point-of-service provider networks, claims administration/management, provider contracting, fee negotiation, workers compensation, premature birth prevention, disability, pharmaceutical, data analysis, chiropractic, communications, dental, diagnosis and treatment options.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, pharmaceutical.

Staff: 615 total; 127 professionals, including 29 physicians, 85 registered nurses, nine licensed practical nurses, four medical records technicians. On retainer: 5,500 physicians.

Clients: 185 total; 160 employer clients; 12% with fewer than 500 employees, 12% with 500 to 999 employees, 26% with 1,000 to 2,499 employees, 22% with 2,500 to 4,999 employees, 28% with more than 5,000 employees.

Covered lives: 5 million employee benefit plan lives; 800,000 workers compensation lives.

Admissions reviewed: 268,000; 1.9% diverted for outpatient treatment.

Branch offices: Kalamazoo, Mich.; Shrewsbury, N.J.; Chicago; Atlanta; Woodland Hills, Calif.; Philadelphia.

1991 gross revenues: $32 million total.

Charges: Per employee, per case, per hour.

Principal officers: Dr. Gary McIlroy, chief executive officer; Marlene Travis, president/chief administrative officer; Dr. John Blank, chief operating officer; Tom Clark, chief financial officer; Adele Kimpell, vp-claims; Al Pertuz, vp-operations; Ken Diamond, vp-provider relations.

Health Service Review Inc.

6730 Roosevelt, Franklin, Ohio 45005; 800-334-6468 (Ohio) or 800-334-6469; fax: 513-422-1281

Founded: 1983; began providing utilization review services in 1983.

UR services provided to employers: 98% of gross revenues.

UR services provided to others: 2% of gross revenues.

Frequent UR services: Preadmission certification, 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, DRG validation.

Medical services reviewed: Chiropractic, psychiatric and substance abuse.

Staff: 28 total; 18 professionals, all registered nurses. On retainer: 28 physicians, two nurses.

Clients: 148 total; 146 employer clients; 72% with fewer than 500 employees, 17% with 500 to 999 employees, 7% with 1,000 to 2,499 employees, 3% with 2,500 to 4,999 employees, 1% with more than 5,000 employees.

Covered lives: 213,200 employee benefit plan lives.

Admissions reviewed: 15,500; 6% diverted for outpatient treatment.

Charges: Per employee, $1.45 to $1.60; per hour, $95 (case management).

Continued on page 52

PPG's answer to the rising cost of employee benefits . . .



. . .was as clear as glass. FlexRx.

How can you reduce the cost of your employee benefits plan without actually reducing employee benefits?

Companies like PPG, the maker of glass, coatings and chemicals, have found the FlexRx maintenance prescription drug program to be part of the solution.

IMMEDIATE MEASURABLE COST REDUCTIONS

High volume, below wholesale pricing.

Our volume buying power results in prescription prices that are approximately 25% to 30% less than retail store prices.

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FlexRx has an average substitution rate approximately three times that of retail drug stores. Since generics can cost up to 70% less than brand name equivalents, the potential savings are significant.

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Management reports.

Cost control reports are provided periodically, allowing administrators to maintain tight control over prescription drug expenditures.

PROGRAM DESIGN

Program design is extremely important. The FlexRx team of experienced pharmacists and benefits managers will meet with you to determine your specific needs and objectives, and to design your program accordingly.

QUALITY SERVICE AND EDUCATION

Quality service and education are essential to the success of a prescription drug program. FlexRx provides numerous ways to educate employees regarding generic drugs, along with the various benefits they obtain by using the program. Start-up packages, posters, quarterly newsletters and employee meetings are just some of the methods we use to increase program awareness and participation.

Most importantly, FlexRx maintains an excellent proactive service approach to benefits administrators and plan participants. The customer learns quickly that FlexRx cares.

FOR MORE INFORMATION CALL:

Linda Schuetz, R.Ph., Director of Sales at 1-800-634-9704.

FlexRx®
Flexibility in a Maintenance Prescription Drug Program



The Maryland
Insurance Group

First we changed the way we work. Then we changed our name.

We have made a lot of changes here at Maryland Casualty. Changes to make us more responsive to our customers and to our independent agents.

We sharpened our focus on the commercial and personal insurance markets and created separate business organizations to meet their unique needs. We moved our insurance professionals out closer to our customers and agents so we could serve them better.

We've also focused anew on service and on excellence in everything we do.

And, now that we've changed the way we work, we're also changing our name.

As The Maryland Insurance Group, you'll find nearly 100 years of insurance expertise. But, you'll also find a brand new company. One filled with enthusiasm and energy, and strongly committed to our customers and our agents.

As our new identity indicates, we are strong and dependable. We also are bright and warm and caring. The Maryland Insurance Group. We think you'll find it's a change for the best.

Maryland Casualty Company
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Business Insurance
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IN CONJUNCTION WITH IBF CONFERENCES
P R E S E N T S

THE FIRST ANNUAL HEALTH CARE MANAGEMENT & COST CONTAINMENT CONFERENCE

Managed Care, A Changing Industry

The industry event for all employee benefit managers, human resource executives and health care providers

April 27-28, 1992
The Grand Hyatt Hotel • New York City

HEALTH CARE MANAGEMENT CONFERENCE AGENDA

MONDAY, APRIL 27

7:45 a.m. *Registration (Coffee & Danish)*

8:45 a.m. OPENING REMARKS FROM THE CHAIR
Kathryn J. McIntyre
Publisher/Editorial Director
Business Insurance

9:00 a.m. KEYNOTE ADDRESS
Eugene LeBlanc
Executive Director of Special Assignments
Ministry of Health
Government of Ontario

9:30 a.m. MANAGED CARE: A CHANGING INDUSTRY
- ▶ Current models of managed care
- ▶ Developing trends that are changing the arena of managed care
- ▶ The next generation of managed care

Charles Jacobs
President
InterQual, Inc.

Warren L. Moser
President
Advance Benefit Concepts

Roger S. Taylor, M.D.
National Leader - Health Care
The Wyatt Company

10:30 a.m. *Mid-Morning Refreshments*

11:00 a.m. INNOVATIVE APPROACHES TO CONTAIN HEALTH CARE COSTS: ASSESSING YOUR COMPANY'S PARTICULAR NEEDS
- ▶ Balancing access, quality and cost in customizing a health care program
- ▶ Designing and implementing an effective communications program to assist employees in making informed decisions

Jay Hague
Corporate Director of Benefits
Campbell Soup Company

Jim Norton
Managing Consultant
A. Foster Higgins & Co.

12:00 p.m. GOING DIRECT: PURCHASING DIRECTLY FROM THE SOURCE
- ▶ Customizing plan design
- ▶ Leasing existing networks
- ▶ Determining and evaluating cost-effectiveness
- ▶ Sharing risk with providers
- ▶ Legal liabilities

Leesa J. Key
Partner
Coopers & Lybrand

Paul McAuliffe
Director - Compensation & Benefits
Becton, Dickinson & Co.

12:45 p.m. *Luncheon for Attendees & Speakers*
Sponsored by
John Hancock Financial Services

1:30 p.m. **Luncheon Speaker:**
William E. Caulfield
Senior Vice President
Group Benefit Operations
John Hancock Financial Services

2:00 p.m. PREVENTIVE CARE: INTEGRATING PREVENTIVE CARE INTO BENEFIT PROGRAMS
- ▶ Financial incentives to promote healthy behavior
- ▶ The ingredients of a successful wellness program
- ▶ Effective communication with employees

Lynn Gilfillan
Community Wellness Development Coordinator
Coors Brewing Company

John Moses
Consultant
Hewitt Associates

Sonia Muchnick-Baku
Director, National Resource Center on Worksite Health Promotion
Washington Business Group on Health

3:00 p.m. *Mid-Afternoon Refreshments*

3:30 p.m. ***Concurrent Session A:***
THE TOP RISK MANAGEMENT ISSUE OF THE 90s: WORKERS COMPENSATION
- ▶ Applying managed care techniques to contain workers compensation costs
- ▶ The working model
- ▶ The range of services required
  - case management
  - claims management
  - utilization review

David Figurelli
Treasurer
Esstar, Inc.

Douglas Rinaldi
Risk Manager
City of Waterbury, CT

Michele Wilber
Chief Executive Officer
Healthnet Corporation

3:30 p.m. ***Concurrent Session B:***
FLEXIBLE BENEFITS: HAVE THEY PROVEN EFFECTIVE IN CONTAINING HEALTH CARE COSTS?
- ▶ Advantages and drawbacks
- ▶ Are employees using them efficiently?
- ▶ Measuring cost-effectiveness

John Hickey
Partner
Kwasha Lipton

Andrea L. Schultz
Vice President & Director - Human Resources
Educational Testing Services

HEALTH CARE MANAGEMENT CONFERENCE AGENDA

4:15 p.m. **MANAGING YOUR MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS: IMPROVING QUALITY WHILE CONTAINING COSTS**

- ▶ The Chrysler Success Story: A managed mental health/substance abuse program with returns
- ▶ Integrating MH/SA benefits with your current employee assistance program
- ▶ Scoring points with your union through quality managed MH/SA benefit plan design
- ▶ Cutting edge concepts for MH/SA benefit plan redesign

Panel Moderator:
Sara Bilik
Vice President–Marketing
Preferred Health Care

Donald Longnecker
Manager - Finance & Planning
Health Care Group Insurance
Chrysler Corporation

David McDonnell
President and Chief Executive Officer
Preferred Health Care

5:15 p.m. **COCKTAIL RECEPTION**
Sponsored by Coopers & Lybrand

TUESDAY, APRIL 28

7:30 -8:45 *Special Working Continental Breakfast*
Sponsored by Preferred Health Care

PRACTICAL STEPS FOR TAKING CONTROL OF YOUR COMPANY'S MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS
Discussion will focus on state-of-the-art how-to's you can use for:

- ▶ Cost-effective MH/SA benefit plan design
- ▶ MH/SA vendor selection, management and evaluation
- ▶ EAP integration in the new managed environment

Sara Bilik
Vice President–Marketing
Preferred Health Care

David Stone
Corporate Vice President - Marketing
Preferred Health Care

8:45 a.m. **REMARKS FROM THE CHAIR**

9:00 a.m. **HEALTH CARE REFORM: WHAT IS ON THE HORIZON?**

- ▶ The probability of systemic reform: Is national health insurance a viable option?
- ▶ Proposed bills in Congress
- ▶ Issues being addressed at the State level

Panel Moderator:
Jerry Geisel
Editor-At-Large
Business Insurance

William Custer, Ph.D.
Director of Research
Employee Benefit Research Institute

Ellen Goldstein
Director of Health Policy & Communications
Association for Private Pension & Welfare Plans

Frank McArdle
Partner and Research Consultant
Hewitt Associates

10:00 a.m. *Mid-Morning Refreshments*

10:30 a.m. **QUALITY OF CARE MANAGEMENT AND COST CONTROL:IS IT A ZERO-SUM GAME?**

- ▶ Assessing cost-effectiveness and quality of care standards of providers
- ▶ How do employers evaluate what they have purchased in the health care marketplace?
- ▶ Techniques for monitoring the quality of care of providers

Panel Moderator:
Joseph Metz
Director of Governmental Legal Services
Buck Consultants

John George
Executive Vice President
InterGroup Services Corporation

The Honorable Donna Lynne
First Deputy Commissioner
Office of Labor Relations
City of New York

11:30 a.m. **LATEST DEVELOPMENTS IN HEALTH MAINTENANCE AND PREFERRED PROVIDER ORGANIZATIONS**

- ▶ Exclusive provider organizations
- ▶ Open-ended HMOs
- ▶ Managed fee-for-service
- ▶ Utilization review

Art Drechsler
Vice President
Martin E. Segal

Larry Goelman
President and Chief Executive Officer
Cost Care, Inc.

12:15 p.m. *Luncheon for Attendees & Speakers*

1:00 p.m. **Luncheon Speaker:**
Gerry Goodrich
Deputy Commissioner of Health
State of New Jersey

1:30 p.m. ***Concurrent Session A:***
EFFICIENT AND COST-EFFECTIVE USES OF TECHNOLOGY IN MANAGING HEALTH CARE COSTS

- ▶ Evaluating the claims process
- ▶ Monitoring physician costs

Panel Moderator:
Doug Leland
Vice President
Intracorp

Jack Romeo
Director of Health Care Systems
Bethlehem Steel Corporation

David Rullo, M.D.
Medical Director
Health Payment Review

1:30 p.m. ***Concurrent Session B:***
UNDERSTANDING AND IMPLEMENTING FAS 106

- ▶ The redesign of retiree health benefits
- ▶ How to fund accrued liability
- ▶ Practical aspects of plan implementation

Lee Launer
Partner
Coopers & Lybrand

Neela K. Ranade
Vice President,
Welfare Benefits Consulting
Actuarial Sciences Associates

2:15 p.m. *Mid-Afternoon Refreshments*

2:45 p.m. **HEALTH CARE COALITIONS: COMPANIES COMING TOGETHER TO REACH COMMON GOALS**

- ▶ Defining the health care coalition
- ▶ What types of strategies are the coalitions implementing
- ▶ Advantages and drawbacks for individual companies

Debra Hubers
Director of Marketing
The Alliance

Dorothee Maynard
President
Good Neighbor Alliance

3:30 p.m. **END OF CONFERENCE**

▶ **HOW TO REGISTER:** Register for The First Annual Health Care Management & Cost Containment Conference in one of three easy ways:

1. Telephone IBF Conferences at (516) 229-2375, or
2. Fax your registration to us at (516) 229-2386, or
3. Mail your completed registration form (or a photocopy) to:
   IBF Conferences/International Business Forum
   50 Charles Lindbergh Blvd., Suite 400
   Uniondale, NY 11553-3619

▶ **FEE:** Your registration fee includes lunches, refreshments, receptions, and the conference workbook. The registration fee is $795. Early Bird registration fee is $695 if you register before March 13. You may send a check for your registration fee, charge to your American Express Card, or we will invoice you. Please make checks payable to "IBF Conferences" and print the name(s) of attendee(s) on the face of the check.

▶ **GROUP DISCOUNT:** A group discount of $100 per person off the registration fee is available for 3 or more registrants from the same company.

▶ **DATES:** April 27 & 28, 1992

▶ **VENUE:** Grand Hyatt New York
Park Avenue at Grand Central
New York, NY 10017
(212) 883-1234

▶ **CANCELLATIONS** received in writing by IBF before March 27, 1992 will receive a refund minus a $100 administrative charge. Thereafter, refunds are not available. Substitutions may be made at any time by calling IBF at (516) 229-2375.

▶ **REDUCED RATE ACCOMMODATIONS:** Please make your reservation directly with Grand Hyatt New York at (212) 883-1234. You will receive a discounted room rate if you mention the name of the conference.

▶ **TABLETOP EXHIBITORS:** There will be space set aside for tabletop exhibits for companies who target products and services to this market. To access this high-level audience, contact Kim Mascolo at IBF at (516) 229-2375.

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Please register the following individuals for **The First Annual Health Care Management & Cost Containment Conference:**

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2. Name:_____ Title: _____

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Telephone: (516) 229-2375
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Continued from page 48

Principal officers: Thomas L. Wiley, president/chairman; Donald J. Barker, Karen L. Mehl, William Stief, vps.

HealthCare COMPARE/AFFORDABLE

3200 Highland Ave., Downers Grove, Ill. 60515-1223; 708-241-7900; fax: 708-241-7856

Founded: 1982; began providing utilization review services in 1984.
UR services provided to employers: 29% of gross revenues.
UR services provided to others: 13% of gross revenues.
Frequent UR services: Preadmission certification, 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.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, home health services, high-risk pregnancy, bill audit.
Staff: 946 total; including 30 physicians, 238 registered nurses, 25 licensed practical nurses, 17 medical records technicians. On retainer: more than 4,000 physicians.
Clients: 2,785.
Covered lives: 9.5 million employee benefit plan lives.
Admissions reviewed: 392,440; 1.5% to 2% diverted for outpatient treatment.
Branch offices: Sacramento, Calif.
1991 gross revenues: $71 million total, $30 million from UR services.
Charges: Per employee, $1.45 to $3; per hour, $200.
Principal officers: James C. Smith, president/chief executive officer; John L. Krakauer, executive vp/chief operating officer; Joseph E. Whitters, vp-finance/chief financial officer; Ronald H. Galowich, executive vp/secretary/general counsel.

HealthCare Management Consulting Services

5723 Benning St., Houston, Texas 77096; 713-723-0297

Founded: 1991; began providing utilization review services in 1991.
UR services provided to others: 50% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management, consultation to HMOs, TPAs and self-insured employers.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: One total, who is a registered nurse.
Clients: Eight total.
1991 gross revenues: $60,000 total, $25,000 from UR services.
Charges: Per hour, $80 to $100.
Principal officers: Margaret Radzwill.

Healthcare Review Corp.

9200 Shelbyville Road, Suite 619, Louisville, Ky. 40222; 502-426-4888; fax: 502-429-5233

Founded: 1986; began providing utilization review services in 1986.
UR services provided to employers: 36% of gross revenues.
UR services provided to others: 62% of gross revenues.
Frequent UR services: Preadmission certification, 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, prenatal screening.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, outpatient diagnostic and surgical services.
Staff: 78 total; all professionals, including five physicians, 71 registered nurses, two licensed practical nurses. On retainer: 20 physicians.
Clients: 38 total; six employer clients; 17% with fewer than 500 employees, 17% with 2,500 to 4,999 employees, 66% with more than 5,000 employees.
Covered lives: 224,800 employee benefit plan lives; 80,000 workers compensation lives.
Admissions reviewed: 22,000; 0.7% diverted for outpatient treatment.
1991 gross revenues: $4.2 million total, all from UR services.
Charges: Per employee, 85 cents to $4; workers compensation, $60 (inpatient), $40 (outpatient).
Principal officers: James C. Rogers, president; Dr. Barbara M. Freeman, vp/medical director.

Healthmarc

9705 Data Park Drive, Minnetonka, Minn. 55343; 612-945-1205; fax: 612-945-6259

Founded: 1983; began providing utilization review services in 1983.
Parent company: United HealthCare Corp.
Frequent UR services: Preadmission certification, 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 (through United Behavioral Systems Inc.).
Occasional UR services: Hospital bill audit.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 200 total; 154 professionals, including five physicians, 140 registered nurses, two licensed practical nurses, seven medical records technicians. On retainer: 100 physicians.
Clients: 324 total.
Covered lives: 2 million employee benefit plan lives.
Admissions reviewed: 56,500.
Branch offices: Pasadena, Calif.; Charleston, W.Va.; Minneapolis.
Charges: Per employee, $1.60 to $3.30; per case, $60 to $185; per hour, $120 to $175.
Principal officers: Mark Tierney, president; John Davis, vp-operations; Deanna Rhode, director-corporate policy and administration.

HealthNetwork Inc.

1420 Kensington Road, Suite 203, Oak Brook, Ill. 60521; 708-954-2900; fax: 708-954-1518

Founded: 1985.
UR services provided to employers: 4% of gross revenues.
UR services provided to others: 36% of gross revenues.
Frequent UR services: Preadmission certification, 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 UR services: Retrospective review, hospital bill audit.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: Seven professionals, including one physician, six registered nurses. On retainer: six physicians, three nurses.
Clients: 261 total; 222 employer clients; 46% with fewer than 500 employees, 46% with 500 to 999 employees, 8% with 1,000 to 2,499 employees.
Covered lives: 64,910 employee benefit plan lives.
Admissions reviewed: 3,999; 8% diverted for outpatient treatment.
Principal officers: George C. Phillips Jr., president; Donna Wolak, vp/finance.

Healthpass

750 E. Park Drive, Harrisburg, Pa. 17111; 717-531-6950; fax: 717-531-6283

Founded: 1986; began providing utilization review services in 1986.
UR services provided to employers: 50% of gross revenues.
UR services provided to others: 25% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management.
Occasional UR services: Hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: 10 total; five professionals, including one physician, four registered nurses. On retainer: five physicians.
Clients: 15 total; all employer clients; 73.4% with fewer than 500 employees, 13.3% with 500 to 999 employees, 13.3% with more than 5,000

Continued on next page

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Products & Services Listing

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READER SERVICE

To obtain free information on the products and services advertised, turn to our post-paid Reader Service Reply Card bound in this issue, or complete the coupon below and mail to:

BUSINESS INSURANCE
Reader Service Center
650 So. Clark St., 6th Fl.
Chicago, IL 60605-1702

Business Insurance
FREE LITERATURE FOR READERS

Issue Date: FEBRUARY 17, 1992
Card Expiration: APRIL 13, 1992

All questions must be answered to process inquiries.
PLEASE CHECK ONE ITEM FOR EACH CATEGORY:

1. My organization is best described as:
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B ☐ Association
C ☐ Union
D ☐ Government
E ☐ Educational Inst
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H ☐ Ins/Reins Co
I ☐ Actry/Consit
J ☐ Attorney
K ☐ Adj/Apprs
L ☐ TPA
M ☐ Healthcare Inst
N ☐ Other _____

2. Number of employees:
1 ☐ 150 or less
2 ☐ 151 - 499
3 ☐ 500 - 999
4 ☐ 1,000 - 4,999
5 ☐ 5,000 or more
6 ☐ Unknown

3. My title is best defined as:
A ☐ Administrative Mgt
B ☐ Financial Mgt
C ☐ Risk Mgt
D ☐ Benefits Mgt
E ☐ Loss prevention Mgt
F ☐ Other _____

4. My purchasing involvement for the requested products is to:
1 ☐ recommend only
2 ☐ specify
3 ☐ approve

5. Do you now receive a personally addressed copy of Business Insurance?
A ☐ Yes
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Circle the numbers below that correspond to the companies listed on our Advertiser Index for the February 17, 1992 issue. Cards with more than 20 items circled will not be processed. This card expires April 13, 1992.

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Please print clearly

Name _____
Title _____
Company _____
Address _____
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Phone ( ) _____

Continued from previous page
employees.

Covered lives: 69,335 employee benefit plan lives.

Admissions reviewed: 5,325.

Charges: Per employee, 92 cents to $1.81; per case, per hour.

Principal officers: Gary J. Dillon, president/chief executive officer; Frank E. Lentz, vp; Dr. Joseph J. Trautlein, medical director.

HealthPro Inc.

10 Mechanic St., Worcester, Mass. 01608; 508-757-5440; fax: 508-754-6862

Founded: 1975; began providing utilization review services in 1975.

UR services provided to employers: 95% of gross revenues.

UR services provided to others: 5% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, HMO quality review.

Staff: 114 total; 95 professionals, including two physicians, seven registered nurses, one licensed practical nurse, two medical records technicians. On retainer: 60 physicians, 10 nurses.

Clients: 6% with fewer than 500 employees, 23% with 500 to 999 employees, 12% with 1,000 to 2,499 employees, 6% with 2,500 to 4,999 employees, 53% with more than 5,000 employees.

Covered lives: 2.1 million employee benefit plan lives; 10,000 workers compensation lives.

Admissions reviewed: 135,000.

Branch offices: Columbus, Ohio.

1991 gross revenues: $7.1 million total, $6.9 million from UR services.

Charges: Per employee, $1.25 to $2.50; per hour, $125 to $225.

Principal officers: Michele Stranger-Hunter, chairperson; Gary N. Lapidas, president; Barbara Ladon, vp-marketing.

The Holman Group

6900 Owensmouth Ave., Canoga Park, Calif. 91303; 818-704-1444; fax: 818-593-2529

Founded: 1979; began providing utilization review services in 1981.

UR services provided to employers: 15% of gross revenues.

UR services provided to others: 15% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse, workers compensation/disability.

Staff: 120 total; 13 professionals, including five physicians, one registered nurse, two licensed practical nurses, five medical records technicians. On retainer: 50 physicians, three nurses.

Clients: 100 total; 40 employer clients; 10% with fewer than 500 employees, 10% with 500 to 999 employees, 50% with 1,000 to 2,499 employees, 10% with 2,500 to 4,999 employees, 20% with more than 5,000 employees.

Covered lives: 600,000 employee benefit plan lives; 50 workers compensation lives.

Admissions reviewed: 25,000.

Branch offices: Las Vegas; Riverside, San Francisco, San Diego, Torrance, Downey, Covina and Pasadena, Calif.

1991 gross revenues: $7 million total, $975,000 from UR services.

Charges: Per employee, 75 cents to $3.50; per case, $160 to $450.

Principal officers: Dr. Ron Holman, president/chief executive officer; Linda Holman, vp/chief financial officer; James Buddle, chief operating officer; Marylin Kingston, senior vp; Dr. Marilynne Rosen, vp-clinical services.

I

IPRO National Medical Review

1979 Marcus Ave., Lake Success, N.Y. 11042-1002; 516-326-7767, ext. 535; fax: 516-328-2310

Founded: 1983; began providing utilization review services in 1983.

Parent company: Island Peer Review Organization.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 70% of gross revenues.

Frequent UR services: Preadmission certification, retrospective review, hospital bill audit, DRG validation, medical coding, quality of care audits, claims analysis, mental health case management, outpatient service predetermination.

Occasional UR services: Length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management, concurrent hospital treatment review.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability, outpatient.

Staff: 400 total; all professionals, including six physicians, 280 registered nurses, 25 medical records technicians. On retainer: 550 physicians.

Clients: 40 total; 10 employer cli-

Continued on next page

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ents; 20% with fewer than 500 employees, 10% with 500 to 999 employees, 20% with 1,000 to 2,499 employees, 40% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Branch offices: Albany, Syracuse, Buffalo, N.Y.

1991 gross revenues: $30 million total.

Charges: Per employee, per case, per hour.

Principal officers: Dr. Thomas J. Sheeny, president; Theodore O. Will, executive vp; Raphael P. Nenner, vp-medical affairs; Lisa A. Garrigan, vp-corporate planning and development.

Intracorp

1205 Westlakes Drive, Suite 300, Berwyn, Pa. 19312; 215-889-2600; fax: 215-889-6777

Founded: 1970; began providing utilization review services in 1984.

Parent company: CIGNA Corp.

UR services provided to employers: 4.3% of gross revenues.

UR services provided to others: 34.8% of gross revenues.

Frequent UR services: Preadmission certification, 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, DRG review, provider bill auditing.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, auto liability.

Staff: 4,407 total; all professionals, including 10 physicians, 2,400 registered nurses. On retainer: 400 to 500 physicians.

Clients: 30,032 total; 16,217 employer clients; 94% with fewer than 500 employees, 2% with 500 to 999 employees, 2% with 1,000 to 2,499 employees, 1% with 2,500 to 4,999 employees, 1% with more than 5,000 employees.

Covered lives: 24.5 million employee benefit plan lives; 2.9 million workers compensation lives.

Admissions reviewed: 748,776; 9.5% diverted for outpatient treatment.

Branch offices: Atlanta, Dallas, Chicago, Los Angeles, Philadelphia, Pittsburgh.

1991 gross revenues: $295.8 million; $115.8 million from utilization review services only.

Charges: Per employee, per case, percent of savings.

Principal officers: Warren D. Fuller, president/chief executive officer; Robert J. Ailes, senior vp/chief medical officer; Kenneth R. Ross, Richard D. Anderson, Donald M. Duford, senior vps; Kent Spafford, vp.

K

Kepple & Co. Inc.

209 W. Fifth St., Peoria, Ill. 61615; 309-673-7330; fax: 309-673-7369

Founded: 1982; began providing utilization review services in 1986.

Parent company: Proctor Healthcare Inc.

UR services provided to employers: 12% of gross revenues.

Frequent UR services: Preadmission certification, length of stay determination, discharge planning.

Occasional UR services: Concurrent hospital treatment review, retrospective review, second surgical opinion, hospital bill audit, case management.

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

Staff: Five total; all professionals, including one physician, two registered nurses, one licensed practical nurse, one medical records technician.

Clients: 44 total; 80% with fewer than 500 employees, 7% with 500 to 999 employees, 13% with 1,000 to 2,499 employees.

Covered lives: 17,321 employee benefit plan lives; 3,122 workers compensation lives.

Charges: Per employee, $1.85 to $2.45; per hour, $60 to $225.

Principal officers: Michael D. Kepple, president; Norm Laconte, chairman; Kevin Roberts, vp/secretary/treasurer.

M

MCC Managed Behavioral Care Inc.

11095 Viking Drive, Suite 350, Eden Prairie, Minn. 55344; 800-433-5768; fax: 612-943-9659

Founded: 1974; began providing utilization review services in 1974.

Parent company: CIGNA Corp.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 90% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 118 total; all professionals, including two physicians, 31 registered nurses. On retainer: two physicians.

Clients: 555 total; 498 employer clients; 14% with fewer than 500 employees, 16% with 500 to 999 employees, 21% with 1,000 to 2,499 employees, 14% with 2,500 to 4,999 employees, 35% with more than 5,000 employees.

Covered lives: 550,000 employee benefit plan lives.

Branch offices: Various locations in 42 states.

1991 gross revenues: $120 million total, $11.6 million from UR services.

Charges: Per employee, 60 cents to $1.20.

Principal officers: Terry Wills, president; Mark Johnson, vp-operations (Western division); Randy Cox, vp-operations (Eastern division); John Bartlett, vp/corporate medical director; Julian Cohen, vp-operations support.

Massachusetts Peer Review Organization

300 Bear Hill Road, Waltham, Mass. 02154; 617-890-0011; fax: 617-890-5485

Founded: 1985; began providing utilization review services in 1986.

Parent company: Massachusetts Medical Society.

UR services provided to employers: Less than 1% of gross revenues.

Frequent UR services: Concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, quality assurance, DRG and coding validation.

Medical services reviewed: Group health, workers compensation/disability.

Staff: 120 total; including three physicians, 60 registered nurses, two medical records technicians. On retainer: 200 physicians.

Clients: Three total.

Admissions reviewed: 90,000.

1991 gross revenues: $7 million total.

Charges: Per employee, per case, per hour.

Principal officers: Dr. Brenda E. Richardson, president; Dr. Guenter Spanknebel, vp; Dr. Eugene La Lancette, clerk; Dr. Irving Weissman, treasurer.

MedCost Inc.

P.O. Box 25347, 1399 Ashleybrook Lane, Suite 100, Winston-Salem, N.C. 27114; 919-760-3090; fax: 919-760-1506

Founded: 1983; began providing utilization review services in 1984.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 60% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, case management.

Occasional UR services: Discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services.

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

Staff: 22 total; including 13 registered nurses.

Clients: 35 total; 17 employer clients; 29% with fewer than 500 employees, 29% with 500 to 999 employees, 13% with 1,000 to 2,499 employees, 13% with 2,500 to 4,999 employees, 6% with more than 5,000 employees.

Covered lives: 280,000 employee benefit plan lives.

Admissions reviewed: 13,500.

Charges: Per employee, $1.10 to $2 per month; per hour, $60 to $85.

Principal officers: Otto W. Mueller, president/treasurer; Billie J. Davis, vp/secretary.

Medical Claims Review Services Inc.

7910 Woodmont Ave., Suite 700, Bethesda, Md. 20814-3015; 301-913-0002 or 800-356-2775; fax: 301-913-0028

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 5% of gross revenues.

UR services provided to others: 92% of gross revenues.

Frequent UR services: Retrospective review, outpatient service predetermination.

Occasional UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, case management.

Medical services reviewed: Dental, chiropractic, workers compensation/disability, auto.

Staff: 48 professionals, including four physicians, six registered nurses, eight medical records technicians. On retainer: 50 physicians, 15 nurses.

Clients: 570 total; 10 employer clients; 2% with 2,500 to 4,999 employees, 98% with more than 5,000 employees.

1991 gross revenues: $6 million total, $5.6 million from UR services.

Charges: Per case; per hour, $75 to $200.

Principal officers: Dr. Ronald E. Gots, chairman/chief executive officer; Thomas C. McCarthy, executive vp; John J. Madigan, vp; Dr. Alfred Taricco, medical director.

Medical Cost Management

122 S. Michigan Ave., Chicago, Ill. 60603; 312-341-0217; fax: 312-341-9283

Founded: 1986; began providing utilization review services in 1986.

UR services provided to employers: 60% of gross revenues.

UR services provided to others: 40% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management, high-risk maternity management.

Occasional UR services: Outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, podiatry.

Staff: 17 total; 13 professionals, including five physicians, six registered nurses. On retainer: 53 physicians, 45 nurses.

Clients: 200 total; 75% with fewer than 500 employees, 10% with 500 to 999 employees, 10% with 1,000 to 2,499 employees, 4% with 2,500 to 4,999 employees, 1% with more than 5,000 employees.

Charges: Per employee, per case, per hour.

Principal officers: Michael J. O'Connor, president; Dr. Andrew J. Brislen, Dr. David S. Fox, Dr. C. Larkin Flanagan and Dr. Lawrence L. Kerns, directors.

Medical Foundation Services Inc.

3625 N.W. 82nd Ave., Miami, Fla. 33166; 305-593-0404; fax: 305-477-6622

Founded: 1973; began providing utilization review services in 1973.

UR services provided to employers: 50% of gross revenues.

UR services provided to others: 25% of gross revenues.

Frequent UR services: Preadmission certification, 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 UR services: Hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and

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Continued from previous page
substance abuse, workers compensation/disability.

Staff: 39 total; including 15 physicians, 20 registered nurses, one medical records technician. On retainer: 25 physicians, five nurses.

Clients: 50 total; 20 employer clients; 70% with fewer than 500 employees, 10% with 500 to 999 employees, 5% with 1,000 to 2,499 employees, 5% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Covered lives: 100,000 employee benefit plan lives; 10,000 workers compensation lives.

Admissions reviewed: 9,000; 2% diverted for outpatient treatment.

1991 gross revenues: $2 million total, all from UR services.

Charges: Per employee, 90 cents to $2.10; per case, $75; per hour, $75.

Principal officers: Rose Strain, executive director; Richard N. Dietrich, marketing director; Carla Feilbach, director-review.

Medical Review Corp.

237 South St., Morristown, N.J. 07960; 201-267-2233; fax: 201-455-0581

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 70% of gross revenues.

UR services provided to others: 20% of gross revenues.

Frequent UR services: Preadmission certification, 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 UR services: Hospital bill audit, DRG validation, ElderLine, high-risk pregnancy assessment.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Clients: Includes 20% with fewer than 500 employees, 10% with 500 to 999 employees, 30% with 1,000 to 2,499 employees, 30% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Charges: Per employee, per case, per hour.

Principal officers: Marc Allen, chairman/chief executive officer; Judy Luray, vp-administration.

Medical Review Institute of America

670 E. 3900 S., Suite 300, Salt Lake City, Utah 84107; 800-654-2422; fax: 801-261-3189

Founded: 1982; began providing utilization review services in 1982.

UR services provided to employers: 8% of gross revenues.

UR services provided to others: 90% of gross revenues.

Frequent UR services: Length of stay determination, retrospective review, surgery coding/charges review, office medicine overutilization and fee determination, disability determinations, outpatient service predetermination.

Occasional UR services: Preadmission certification, concurrent hospital treatment review, second surgical opinion.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, physical therapy, podiatry, rehabilitation, drugs.

Staff: 50 total; including three physicians, one registered nurse, 26 medical records technicians. On retainer: 300 physicians.

Clients: 675 total; 25 employer clients; 25% with 1,000 to 2,499 employees, 25% with 2,500 to 4,999 employees, 50% with more than 5,000 employees.

Charges: Hourly rate per case.

Principal officers: William Low, president; Diane Hoyle, executive vp; Dr. Robert Maddock, medical director.

Medical Review Systems Inc.

1040 Crown Pointe Parkway, Suite 930, Atlanta, Ga. 30338; 404-551-4440; fax: 404-551-4441

Founded: 1990; began providing utilization review services in 1990.

UR services provided to employers: 70% of gross revenues.

UR services provided to others: 20% of gross revenues.

Frequent UR services: Length of stay determination, retrospective review, repatriation.

Occasional UR services: Concurrent hospital treatment review, discharge planning, hospital bill audit, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 18 professionals, including four registered nurses, six medical records technicians. On retainer: two physicians, three nurses.

Clients: 37 total; 30 employer clients; 10% with fewer than 500 employees, 30% with 500 to 999 employees, 30% with 1,000 to 2,499 employees, 20% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Principal officers: Scott Smith, chairman; Tom Bartlett, president; Ed Jones, executive vp.

Medicus Resource Management

Sixth and Spruce streets, West Reading, Pa. 19611; 215-372-8044; fax: 215-378-0112

Founded: 1985; began providing utilization review services in 1988.

UR services provided to employers: 85% of gross revenues.

UR services provided to others: 15% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, maternity.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: One physician, three registered nurses.

Clients: 31 total; 30 employer clients; 67.8% with fewer than 500 employees, 22.6% with 500 to 999 employees, 6.4% with 1,000 to 2,499 employees, 3.2% with 2,500 to 4,999 employees.

Covered lives: 15,200 employee benefit plan lives.

Admissions reviewed: 2,800.

Charges: Per employee, $1.70 to $2.10.

Principal officers: Edward J. Wargo, president; C. Harold Cohn, medical director; Linda Kloap-Price, director-utilization review services.

MEDIQ Review Services Inc.

12000 J Commerce Parkway, Mount Laurel, N.J. 08054; 609-231-7400 or 800-525-4088; fax: 609-231-7401

Founded: 1986; began providing utilization review services in 1986.

Parent company: MEDIQ Inc.

UR services provided to employers: 5% of gross revenues.

UR services provided to others: 95% of gross revenues.

Frequent UR services: Retrospective review, outpatient psychiatric services.

Medical services reviewed: Group health, dental, chiropractic, workers compensation/disability, podiatric, physical therapy, independent examination.

Staff: 40 total; eight professionals, including six physicians, two registered nurses. On retainer: 2,000 physicians.

Clients: 700 total.

Branch offices: Pittsburgh; Tampa, Fla.

Charges: Per case and per hour.

Principal officers: Barbara Gutstadt, president/chief executive officer.

MedServices Management

Rose Tree Corporate Center II, 1400 N. Providence Road, Suite 4020, Media, Pa. 19063; 215-892-8050; fax: 215-892-8066

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 40% of gross revenues.

UR services provided to others: 60% of gross revenues.

Frequent UR services: Preadmission certification, 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, DRG validation, medical information healthline.

Continued on next page

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Spotlight report

Continued from previous page

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 20 total.

Clients: 65 total.

1991 gross revenues: $1.5 million total.

Principal officers: Robert D. Bauer, chief executive officer; Mary Kay Dunne, vp; Kevin E. O'Brien, marketing director.

MedTrac Inc.

P.O. Box 290429, Nashville, Tenn. 37229-0429; 615-367-9707; fax: 615-399-1718

Founded: 1969; began providing utilization review services in 1969.

Parent company: Willis Corroon P.L.C.

UR services provided to employers: 50% of gross revenues.

UR services provided to others: 50% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, auto liability.

Staff: 40 total; 38 professionals, including two physicians, 36 registered nurses. On retainer: 100 physicians, two nurses.

Clients: 372 total; 358 employer clients; 10% with fewer than 500 employees, 20% with 500 to 999 employees, 30% with 1,000 to 2,499 employees, 30% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Covered lives: 270,000 employee benefit plan lives; 18,000 workers compensation lives.

Admissions reviewed: 24,312.

Branch offices: Minneapolis; Atlanta; Detroit; Wichita, Kan.

1991 gross revenues: $3 million total, all from UR services.

Charges: Per employee, 90 cents to $1.70; per case, $250 to $850; per hour, $60 to $200.

Principal officers: Terry Warren, president/chief executive officer; John Lanier, vp-operations; Rick Bullert, regional sales manager.

Med-Valu

P.O. Box 335, Dublin, Ohio 43017; 614-764-2282; fax: 614-766-0004

Founded: 1987; began providing utilization review services in 1987.

UR services provided to employers: 35% of gross revenues.

UR services provided to others: 55% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Occasional UR services: Second surgical opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, physician office utilization review.

Staff: 30 professionals, including physicians and registered nurses. On retainer: 15 professionals, including physicians.

Clients: 14 total; four employer clients; 10% with fewer than 500 employees, 10% with 500 to 999 employees, 40% with 2,500 to 4,999 employees, 40% with more than 5,000 employees.

Covered lives: 95,000 employee benefit plan lives.

Branch offices: Oklahoma City.

Charges: Per employee, 70 cents; per case, $62.

Principal officers: Michael Linde, president; Mary Ellen O'Grady, vp-sales; Frank D. Anzelmo, vp-systems.

MedView Services Inc.

32991 Hamilton Court, Farmington Hills, Mich. 48334; 313-488-5260; fax: 313-488-5261

Founded: 1984; began providing utilization review services in 1984.

Parent company: Pharmacy Management Services Inc.

UR services provided to employers: 6% of gross revenues.

UR services provided to others: 11% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review.

Occasional UR services: Second surgical opinion, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, auto medical.

Staff: 12 total; 10 professionals, including two physicians, eight registered nurses. On retainer: one physician.

Clients: 16 total; 14 employer clients; 63% with fewer than 500 employees, 25% with 1,000 to 2,499 employees, 12% with more than 5,000 employees.

Covered lives: 28,000 employee benefit plan lives; 500,000 workers compensation lives.

Charges: Per employee, 75 cents to $3.25; per case, $100 to $185; per hour, $60 to $125.

Principal officers: Robert H. Marks, president; Debra Cerre-Ruedisili, vp/chief operating officer; Polly Jantzen, vp-client relations; Gerald L. Page, vp-finance.

MedWatch Inc.

101 Sunnytown Road, Suite 212, Casselberry, Fla. 32707; 407-331-1500; fax: 407-260-5682

Founded: 1988; began providing utilization review services in 1988.

UR services provided to others: 100% of gross revenues.

Frequent UR services: Preadmission certification, 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 UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Seven total, all professionals, including seven registered nurses. On retainer: 24 physicians.

Clients: 50 total.

Covered lives: 80,000 employee benefit plan lives; 3,000 workers compensation lives.

Admissions reviewed: 4,000; 24% diverted for outpatient treatment.

Charges: Precertification/continued stay, $1.20 to $1.60; workers compensation, $130; medical case management, $55.

Principal officers: Lynn Jennings, Bill Laurie, Jean Newman.

Memphis Business Group on Health

2675 Union Extended, Memphis, Tenn. 38112; 901-323-1808; fax: 901-458-0709

Founded: 1985; began providing utilization review services in 1987.

UR services provided to employers: 66% of gross revenues.

Frequent UR services: Preadmission certification, 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, healthy lifestyles program, prenatal case management.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 10 total; all professionals, including one physician, eight registered nurses, one licensed practical nurse.

Clients: 30 total; all employer clients; 59% with fewer than 500 employees, 15% with 500 to 999 employees, 15% with 1,000 to 2,499 employees, 7% with 2,500 to 4,999 employees, 4% with more than 5,000 employees.

Covered lives: 88,750 employee benefit plan lives; 6,200 workers compensation lives.

Admissions reviewed: 6,710.

1991 gross revenues: $810,455 total, $53,176 from UR services.

Principal officers: Donna Miller, chief executive officer; Bonnie McKever, president; Bob Ellis, vp; Linda Lucas, secretary; Westelle Florez, treasurer.

The Mental Health Programs Corp.

2203 N. Lois Ave., Suite 1100, Tampa, Fla. 33607; 813-876-5036; fax: 813-872-8666

Founded: 1986; began providing utilization review services in 1986.

UR services provided to employers: 1% of gross revenues.

UR services provided to others: 84% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Psychiatric and substance abuse, workers compensation/disability.

Staff: Seven total; including three physicians, three registered nurses, one medical records technician.

Clients: 23 total; two employer clients; 50% with 2,500 to 4,999 employees, 50% with more than 5,000 employees.

Covered lives: 1.2 million employee benefit plan lives; 10,000 workers compensation lives.

Admissions reviewed: 40% diverted for outpatient treatment.

Charges: Per employee, 20 cents to 40 cents; per case, $200 to $400; per hour.

Principal officers: Dr. Walter E. Afield, chief executive officer/medical director; Aleida De Los Rios, director-operations.

Metropolitan Life Insurance Co./Managed Care Services Group

276 Post Road W., Westport, Conn. 06880; 203-454-6100; fax: 203-454-6110

Founded: 1881; began providing utilization review services in 1984.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, Healthy Pregnancy program.

Occasional UR services: Retrospective review, second surgical opinion.

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

Staff: 525 total; 514 professionals, including 24 physicians, 403 registered nurses, 87 medical records technicians. On retainer: 12 physicians.

Clients: 5,350 employer clients.

Covered lives: 6 million employee benefit plan lives.

Admissions reviewed: 400,000.

Branch offices: Phoenix; Denver; Miami, Maitland, Fla.; Lisle, Schaumburg, Ill.; Utica, Kingston, N.Y.; Tulsa, Okla.; Norwalk, Conn.; Long Beach, Orange, Calif.; Marietta, Ga.; Cincinnati, Dayton, Ohio; Houston, Irving, Texas; Pittsburgh; Chesterfield, Mo.

Charges: Per employee per month, 31 cents to $8.95; per hour, $115 to $205.

Principal officers: Robert Schwartz, chief executive officer; John D. Moynahan, executive vp; Robert Chernow, senior vp; Dr. Paul Bluestein, national medical director; Bob Byrne, vp-operations.

MultiPlan Inc./Donald Rubin Inc.

17 W. 17th St., New York, N.Y. 10003; 212-727-9700; fax: 212-627-6396

Founded: 1971; began providing utilization review services in 1971.

UR services provided to employers: 10% of gross revenues.

Continued on next page

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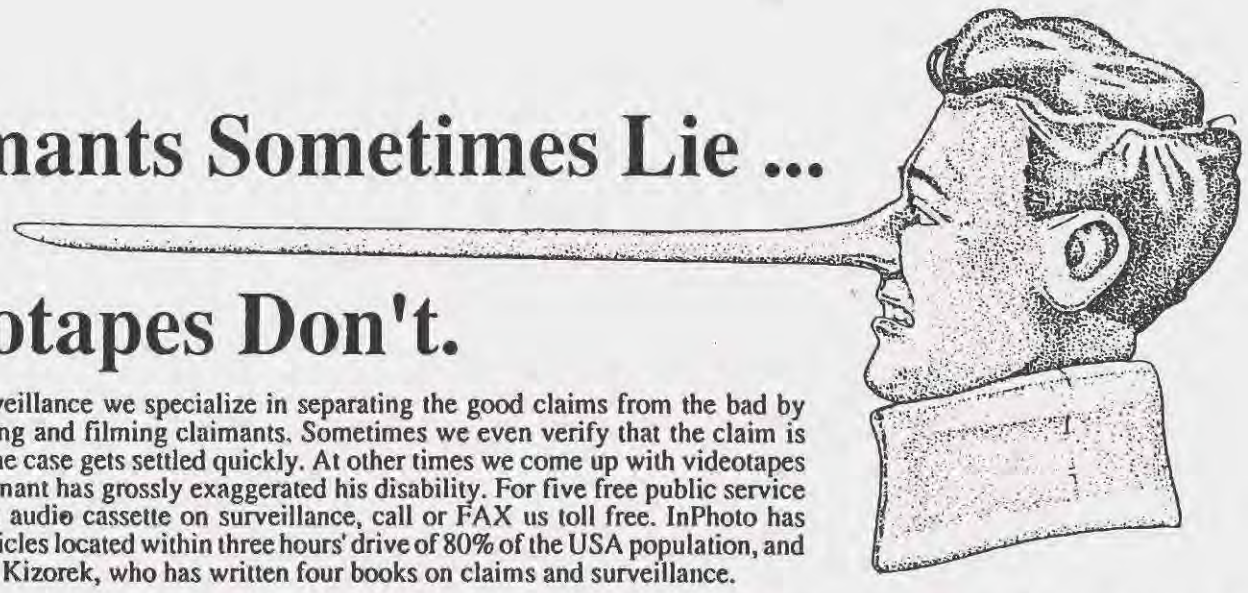
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Continued from previous page

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management.

Staff: 30 total.

Clients: 200 total.

Covered lives: 750,000 employee benefit plan lives.

Charges: Per employee, per case, percentage of savings.

Principal officers: Donald Rubin, president; Roxanne Young and Edward Gluckmann, vps; Edward Rothstein, marketing director.

Mutual of Omaha Insurance Co.

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-342-7600

Founded: 1909; began providing utilization review services in 1985.

Frequent UR services: Preadmission certification, 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 UR services: Hospital bill audit, home health care, skilled nursing, hospice, durable medical equipment.

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

Staff: 118 total; 68 professionals, including two physicians, 63 registered nurses. On retainer: 28 physicians.

Clients: 10,576 total; all employer clients; 81% with fewer than 500 employees, 8% with 500 to 999 employees, 7% with 1,000 to 2,499 employees, 2% with 2,500 to 4,999 employees, 2% with more than 5,000 employees.

Covered lives: 1.1 million employee benefit plan lives.

Admissions reviewed: 57,586.

1991 gross revenues: $6.2 million from UR services.

Charges: Per employee, $1.47 to $3.51.

Principal officers: Thomas J. Skutt, chairman/chief executive officer; John W. Weekly, president/chief operating officer (Mutual of Omaha).

N

NHA Review Services Inc.

770 S. Post Oak Lane, Suite 445, Houston, Texas 77056; 713-439-0123; fax: 713-439-7529

Founded: 1988; began providing utilization review services in 1988.

Parent company: National Healthcare Alliance Inc.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 80% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, case management, occupational case management.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Six total; all professionals, including three registered nurses, one licensed practical nurse, two medical records technicians. On retainer: 14 physicians, one nurse.

Clients: 13 total; three employer clients; 85% with fewer than 500 employees, 15% with 1,000 to 2,499 employees.

Covered lives: 86,920 employee benefit plan lives.

Admissions reviewed: 5,680; 15% diverted for outpatient treatment.

1991 gross revenues: $538,000 total, all from UR services.

Charges: Per employee, $1.25 to $1.50.

Principal officers: Robert Woolfolk, chief executive officer; Melvin Thorne, chief operating officer; Lanis McKinney, vp.

National Case Management/CIAS

300 Esplanade Drive, Suite 1240, Oxnard, Calif. 93030; 805-983-2242; fax: 805-485-0663

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 90% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management, high-risk pregnancy management.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 17 total; 14 professionals, including one physician, 12 registered nurses, one medical records technician. On retainer: five physicians, two nurses.

Clients: Eight total; five employer clients; 20% with fewer than 500 employees, 20% with 500 to 999 employees, 20% with 1,000 to 2,499 employees, 20% with 2,500 to 4,999 employees, 20% with more than 5,000 employees.

Covered lives: 50,000 employee benefit plan lives; 20,000 workers compensation lives.

Admissions reviewed: 3,500; 10% diverted for outpatient treatment.

Branch offices: Seal Beach, Calif.

Charges: Per employee, 95 cents to $3.50; per case, $150 to $3,500; per hour, $85 to $150.

Principal officers: Mary Lacyk, president; Mary Abraham, vp-finance; Elizabeth Ciaccio, executive vp; Michael Hanosh, system supervisor; Dr. William Sonnenberg, medical director.

National Health Services Inc./CareReview

10909 W. Greenfield Ave., Milwaukee, Wis. 53214; 414-778-5151 or 800-558-4353; fax: 414-778-5144

Founded: 1984; began providing utilization review services in 1984.

Parent company: Pioneer Financial Services Inc. of Rockford, Ill.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 75% of gross revenues.

Frequent UR services: Preadmission certification, 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, expert opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, individual health, long-term care, home health care.

Staff: 43 total; 11 professionals, including two physicians, nine registered nurses. On retainer: 33 physicians, 47 nurses.

Clients: 68 total; seven employer clients; 53% with fewer than 500 employees, 23% with 500 to 999 employees, 8% with 1,000 to 2,499 employees, 8% with 2,500 to 4,999 employees.

Covered lives: 1.4 million employee benefit plan lives.

1991 gross revenues: $2.3 million total, $2 million from UR services.

Charges: Per employee, $1 to $1.74; per case, $99; per hour, $85 to $160.

Principal officers: Anthony J. Pino, chief executive officer; Kristie L. Jorgenson, vp-operations; Dr. Robert C. Porter, medical director.

O

Occupational Health Services Inc.

125 E. Sir Francis Drake Blvd., Larkspur, Calif. 94960; 415-461-8100; fax: 415-925-9728

Founded: 1974; began providing utilization review services in 1987.

UR services provided to employers: 5% of gross revenues.

UR services provided to others: 1% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital

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treatment review, discharge planning, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Length of stay determination, retrospective review, hospital bill audit, outpatient service predetermination.

Medical services reviewed: Psychiatric and substance abuse, employee assistance program.

Staff: 275 total.

Clients: 400 total; including 15% with fewer than 500 employees, 35% with 500 to 999 employees, 20% with 1,000 to 2,499 employees, 20% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Admissions reviewed: 20% diverted for outpatient treatment.

1991 gross revenues: $14.5 million total.

Charges: Per employee, $1.25 to $8.45.

Principal officers: Robert G. Temer, chief executive officer.

OPTIONS Health Care Cost Containment

400 Penn Center Blvd., Suite 741, Pittsburgh, Pa. 15235; 412-824-7686; fax: 412-824-1571

Founded: 1981; began providing utilization review services in 1984.

UR services provided to employers: 50% of gross revenues.

UR services provided to others: 50% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management.

Medical services reviewed: Chiropractic, workers compensation/disability.

Staff: 12 total, all professionals, including seven registered nurses. On retainer: 100 physicians.

Clients: 15 total; all employer clients; 10% with 500 to 999 employees, 45% with 1,000 to 2,499 employees, 30% with 2,500 to 4,999 employees, 15% with more than 5,000 employees.

Covered lives: 2,000 workers compensation lives.

Admissions reviewed: 20% diverted for outpatient treatment.

Charges: Per hour, $59 for registered nurse, $200 for medical doctor.

Principal officers: Joseph M. McCabe, president (McCabe & Scarlata Inc.); Antonia L. Scarlata, secretary/treasurer (McCabe & Scarlata Inc.).

P

PCC/Drug Data Systems Inc.

828 N. Hollywood Way, Burbank, Calif. 91505; 818-843-8551; fax: 818-843-1079

Founded: 1969.

Frequent UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability, pharmacy bill review.

Charges: Fee basis.

Principal officers: Dr. Alvin Saidiner, president.

Pacific Review Services

5995 Plaza Drive, Cypress, Calif. 90630-5028; 800-223-4276 or 714-220-3700; fax: 714-220-3743

Founded: 1983; began providing utilization review services in 1983.

Parent company: Pacificare Health Systems.

UR services provided to employers: 28% of gross revenues.

UR services provided to others: 35% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, high-risk pregnancy assessment/management, skilled nursing facility/rehabilitation/home health precertification, concurrent review.

Occasional UR services: Hospital bill audit, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 71 total; 48 professionals, including two physicians, 29 registered nurses, four licensed practical nurses. On retainer: 42 physicians, five nurses.

Clients: 99 total; 78 employer clients; 9% with fewer than 500 employees, 8% with 500 to 999 employees, 24% with 1,000 to 2,499 employees, 23% with 2,500 to 4,999 employees, 36% with more than 5,000 employees.

Covered lives: 435,591 employee benefit plan lives; 2,523 workers compensation lives.

Admissions reviewed: 31,292; 8% diverted for outpatient treatment.

1991 gross revenues: $5.3 million total, $3.3 million from UR services.

Charges: Per employee, $1.30 to $3; per case, $175 to $400; per hour, $115.

Principal officers: Vicki Merrill, president.

PAR 3 Utilization Review Services Inc.

1772 Platte St., Denver, Colo. 80202; 303-433-6898; fax: 303-433-7696

Founded: 1987; began providing utilization review services in 1987.

UR services provided to employers: 75% of gross revenues.

UR services provided to others: 20% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, peer review, mental health review.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, auto.

Staff: 31 total; all professionals, including five physicians, 15 registered nurses, two licensed practical nurses, nine medical records technicians. On retainer: 93 physicians, 18 nurses.

Clients: 405 total; 100 employer clients; 85% with fewer than 500 employees, 5% with 500 to 999 employees, 3% with 1,000 to 2,499 employees, 2% with 2,500 to 4,999 employees, 5% with more than 5,000 employees.

Covered lives: 160,000 employee benefit plan lives; 20,000 workers compensation lives.

Admissions reviewed: 17,000; 15% diverted for outpatient treatment.

Charges: Per employee, 25 cents to $1.85; per case, $70 to $90.

Principal officers: Dr. Jim Riopelle, president/chief executive officer; Kimberly Sutphin, executive vp/chief operating officer; Dr. Henry Roth, chairman/medical director; Dr. Howard Entin, vp/medical director.

Parkside Health Management Corp.

205 W. Touhy Ave., Suite 200, Park Ridge, Ill. 60068; 708-698-4848; fax: 708-698-4804

Founded: 1980; began providing utilization review services in 1980.

Parent company: Lutheran General Health Care System & Evangelical Health System.

UR services provided to employers: 50% of gross revenues.

UR services provided to others: 25% of gross revenues.

Frequent UR services: Preadmission certification, 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, high-risk maternity screening, surgical case review.

Occasional UR services: Hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, podiatry.

Staff: 114 total; all professionals, including nine physicians, 105 registered nurses. On retainer: 10 physicians, 14 nurses.

Clients: 400 total; 348 employer clients.

Covered lives: 1 million employee benefit plan lives.

Admissions reviewed: 30,000.

Branch offices: Cleveland.

Charges: Per employee, $1 to $2.85; per case, $50 to $150; per hour, $115 to $225.

Principal officers: Michael S. McCarthy, chief executive officer; Jennifer L. Cline, president/chief operating officer; Jay Gore, Dr. Walter A. Hollinger and Steven R. Tiwald, vps.

Pathway Review Systems

40600 Ann Arbor Road, Suite 200, Plymouth, Mich. 48170-4495; 313-459-2997; fax: 313-454-7301

Founded: 1989; began providing utilization review services in 1990.

Parent company: Michigan Peer Review Organization.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 85% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, disability management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Seven total; all professionals, including six registered nurses, one medical records technician. On retainer: 500 physicians.

Clients: Four total; two employer clients; 25% with fewer than 500 employees, 25% with 500 to 999 employees, 10% with 1,000 to 2,499 employees, 25% with 2,500 to 4,999 employees, 15% with more than 5,000 employees.

Covered lives: 30,000 employee benefit plan lives.

Admissions reviewed: 2,747; 1.5% diverted for outpatient treatment.

1991 gross revenues: $395,193 total, $394,000 from UR services.

Charges: Per employee per month, $1.25 to $1.70; per case, $28; per hour,

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$60 to $125.

Principal officers: Dr. Richard E. Burney, chairman; Bettye Elkins, vice chairman; Gary Horvat, president; Gary Guetschow, treasurer; Sara Daniel, director-program services.

Peer Review Analysis Inc.

380 Pleasant St., Malden, Mass. 02148; 617-322-6400; fax: 617-322-7726

Founded: 1984; began providing utilization review services in 1984.

UR services provided to employers: 25% of gross revenues.

UR services provided to others: 75% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, case management, specialty physician review.

Occasional UR services: Second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, property and casualty auto, physical rehabilitation physician-team review.

Staff: 99 total; 30 professionals, including four physicians, 25 registered nurses, one medical records technician. On retainer: 135 physicians.

Clients: 95 total; 21 employer clients; 9.5% with fewer than 500 employees, 9.5% with 500 to 999 employees, 14.3% with 1,000 to 2,499 employees, 28.5% with 2,500 to 4,999 employees, 38.7% with more than 5,000 employees.

Covered lives: 8 million employee benefit plan lives; 120,000 workers compensation lives.

Admissions reviewed: 175,000; 15% diverted for outpatient treatment.

1991 gross revenues: $8.1 million total, all from UR services.

Charges: Per employee per month, $1.60 to $2.15; per case, $75 to $100; per hour, $75 to $150.

Principal officers: Dr. Barry Manuel, chairman; Eric Spitzer, president/chief executive officer; Russell Robbins, vice chairman; William Nixon, treasurer/chief financial officer; Dr. John Sandson, secretary; Dr. Arthur Ellison, medical director.

Pharmaceutical Horizons Inc.

6821 Alloway St. W., Worthington, Ohio 43085; 614-785-9437; fax: 614-885-1171

Founded: 1989; began providing utilization review services in 1989.

UR services provided to others: 95% of gross revenues.

Frequent UR services: Retrospective review, patient specific drug therapy evaluation, home infusion therapy evaluation.

Medical services reviewed: Prescription drug, cost and utilization evaluation.

Staff: One professional.

Clients: 10 total.

Covered lives: 385,000 employee benefit plan lives.

1991 gross revenues: $100,000 total, all from UR services.

Charges: Per hour, $75 to $125.

Principal officers: Allan F. Zaenger, president; Michael C. Deminski, vp.

Physical Therapy Review Services Inc.

P.O. Box 69, Woodlyn, Pa. 19094
100 Diplomat Drive, Ambassador I Building, Lester, Pa. 19113; 800-388-7877; fax: 215-521-6893

Founded: 1986.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 80% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, retrospective review, outpatient service predetermination, case management.

Medical services reviewed: Group health, workers compensation/disability, physical therapy and rehabilitation.

Staff: Eight professionals, all physical therapists. On retainer: 80 physical therapists.

Clients: 300 total; 30 employer clients.

Charges: Per case, $205 to $220; per hour, $70 to $150.

Principal officers: David W. Clifton Jr., president/chief executive officer; Susan Michlowitz, vp/director.

The Precertification Center

P.O. Box 898125, Camp Hill, Pa. 17089; 717-232-0946; fax: 800-626-9090

Founded: 1985; began providing utilization review services in 1985.

Parent company: Pennsylvania Blue Shield/Capital Blue Cross.

UR services provided to employers: 94% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion, outpatient service predetermination, short-term disability certification.

Occasional UR services: Discharge planning, retrospective review, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, maternity disability.

Staff: 25 total; including two physicians, 16 registered nurses. On retainer: one physician.

Clients: 286 total; all employer clients; 64% with fewer than 500 employees, 21% with 500 to 999 employees, 7% with 1,000 to 2,499 employees, 5% with 2,500 to 4,999 employees, 3% with more than 5,000 employees.

Covered lives: 220,000 employee benefit plan lives.

Admissions reviewed: 25,000.

1991 gross revenues: $2.1 million total, all from UR services.

Charges: Per employee per month, 85 cents to $1.40; introductory rates negotiable.

Principal officers: Jerry Boyer, vp/chief operating officer; Elizabeth Galitski, director-program administration; Susan Bunting Bianchi, director-information systems.

Prest & Associates Inc.

2304 Wimbledon Way, Las Vegas, Nev. 89107; 702-258-6384; fax: 702-258-4669

Founded: 1988; began providing utilization review services in 1988.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 70% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse.

Staff: Two total; both professionals, including one physician, one psychologist. On retainer: four physicians.

Clients: One total, who is an employer client with fewer than 500 employees.

Covered lives: 230,000 employee benefit plan lives.

Admissions reviewed: 400; 40% diverted for outpatient treatment.

Charges: Per case, $60 to $75; per hour, $100 to $150, $125 plus expenses for psychiatric consultation.

Principal officers: Dr. James Richard Prest, chairman; Susan R. Prest, president/chief executive officer.

Private Healthcare Systems Inc.

20 Maguire Road, Lexington, Mass. 02173; 617-861-5500; fax: 617-862-3458

Founded: 1985; began providing utilization review services in 1985.

UR services provided to employers: 3% of gross revenues.

UR services provided to others: 73% of gross revenues.

Frequent UR services: Preadmission certification, 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, medical necessity review, integrated mental health program.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 526 total; all professionals, including 77 physicians, 239 registered nurses.

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Clients: 18 total; two employer clients; 100% with more than 5,000 employees.

Covered lives: 4.7 million employee benefit plan lives; 200,000 workers compensation lives.

Admissions reviewed: 440,000; 1% diverted for outpatient treatment.

Branch offices: Irvine, Calif., and Rosemont, Ill.

1991 gross revenues: $46 million total, $35 million from UR services.

Principal officers: Gene Guselli, general manager; Donna Goldin, executive vp-strategic development; Dr. N. Stephen Ober, vp/corporate medical director; Michael A. Euele, assistant vp-client services.

Professional Review Organization for Washington

10700 Meridian Ave. N., Suite 100, Seattle, Wash. 98133; 206-364-9700; fax: 206-368-2419

Founded: 1975; began providing utilization review services in 1975.

UR services provided to employers: 90% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, case management, durable medical equipment review, physical therapy review, medical claims consultation.

Occasional UR services: Second surgical opinion.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 117 total; 61 professionals, including four physicians, 36 registered nurses, four licensed practical nurses, 23 medical records technicians. On retainer: 140 physicians.

Clients: 51 total; 10 employer clients; 20% with fewer than 500 employees, 20% with 1,000 to 2,499 employees, 40% with 2,500 to 4,999 employees, 20% with more than 5,000 employees.

Covered lives: 1 million employee benefit plan lives; 10,000 workers compensation lives.

Admissions reviewed: 54,200; 1% to 3% diverted for outpatient treatment.

Branch offices: Anchorage, Alaska, and Boise, Idaho.

1991 gross revenues: $6.9 million total, all from UR services.

Principal officers: John W. Daise, chief executive officer; Dr. Herbert M. Hilgers, chairman; Dr. John C. Peterson III, director-medical affairs; Rick Sheppard, director-information services; Michael B. Garrett, director-utilization management/marketing.

Professional Reviews Inc.

P.O. Box 2548, Lilburn, Ga. 30226
455 Beaver Run Road, Suite 107, Lilburn, Ga. 30247; 404-923-9705; fax: 404-381-1266

Founded: 1988; began providing utilization review services in 1988.

UR services provided to employers: 30% of gross revenues.

UR services provided to others: 70% of gross revenues.

Frequent UR services: Retrospective review, prospective chiropractic reviews.

Medical services reviewed: Chiropractic.

Staff: 18 total; nine professionals, all physicians.

Clients: 500 total.

Admissions reviewed: 11,500 chiropractic.

Branch offices: Tampa, Fla.

Charges: Per case, $145.

Principal officers: Dr. James A. Pritchard, president; John J. Kelly, vp.

Progressive Health Management Inc.

781 Northwest Blvd., Columbus, Ohio 43212; 614-421-3222; fax: 614-421-3223

Founded: 1985; began providing utilization review services in 1988.

UR services provided to employers: 2% of gross revenues.

UR services provided to others: 14% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service predetermination, case management.

Occasional UR services: Retrospective review, second surgical opinion.

Medical services reviewed: Group health, chiropractic, workers compensation/disability.

Staff: 15 total; all professionals who are registered nurses. On retainer: 19 physicians, 35 nurses.

Clients: 200 employer clients; 60% with fewer than 500 employees, 20% with 500 to 999 employees, 10% with 1,000 to 2,499 employees, 5% with 2,500 to 4,999 employees, 5% with more than 5,000 employees.

Covered lives: 20,000 employee benefit plan lives; 1,000 workers compensation lives.

Admissions reviewed: 4,200; 3% to 5% diverted for outpatient treatment.

1991 gross revenues: $1.8 million total, $300,000 from UR services.

Charges: Per employee, $1.25 to $1.60; per hour, $75.

Principal officers: Dale Wood, chief executive officer/director; Jerry Jacoby, secretary; William Heiss, consultant; Mike Larson, treasurer; Arnold Bowman and Mike Magid, directors; Michael Reidelbach, president.

Provident Life & Accident

1 Fountain Square, Chattanooga, Tenn. 37402; 615-755-1156; fax: 615-755-1750

Founded: 1887; began providing utilization review services in 1983.

UR services provided to employers: 74% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management.

Occasional UR services: Hospital bill audit.

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

Staff: 124 total; 111 professionals, including six physicians, 97 registered nurses, eight licensed practical nurses. On retainer: 137 physicians.

Clients: 1,465 total; 1,450 employer clients; 90.7% with fewer than 500 employees, 2.1% with 500 to 999 employees, 2.3% with 1,000 to 2,499 employees, 1.7% with 2,500 to 4,999 employees, 3.2% with more than 5,000 employees.

Covered lives: 1.6 million employee benefit plan lives.

Admissions reviewed: 115,555.

Principal officers: Dr. Stephen A. George, vp-managed care/chief medical officer; Dr. Warren Tingley, vp-managed care/senior medical director; Dianne Lury, vp-medical review services; John Blake, vp-medical delivery systems.

PsychCare Connections Inc.

7346 N. Monticello, Skokie, Ill. 60076; 708-679-2575; fax: 708-679-1274

Founded: 1986; began providing utilization review services in 1990.

UR services provided to others: 100% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Discharge planning, retrospective review, hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse.

Staff: Two total. On retainer: three physicians, two nurses.

Clients: Two total.

Covered lives: 34,000 employee benefit plan lives.

Admissions reviewed: 280; 10% to 15% diverted for outpatient treatment.

Charges: Per employee, 62 cents to 75 cents; per case per month, $300 to $385; per hour, $225 to $275.

Principal officers: Dolores Kapral, president; Judith Lieberman, vp-marketing; Dr. Ronald L. Kirshner, medical director; Rosalie Kirshner, vp-provider relations.

Psychology Systems Inc.

615 S. Main St., Milpitas, Calif. 95035; 408-263-8046; fax: 408-942-0264

Founded: 1979.

UR services provided to employers: 10% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Psychiatric and substance abuse.

Staff: Six total; five professionals, including one registered nurses, one licensed practical nurse. On retainer: one physician.

Clients: 402 total; all employer clients, including 45% with fewer than 500 employees, 35% with 500 to 999 employees, 12% with 1,000 to 2,499 employees, 7% with 2,500 to 4,999 employees, 1% with more than 5,000 employees.

Covered lives: 215,000 employee benefit plan lives.

Admissions reviewed: 300; 30% diverted for outpatient treatment.

Branch offices: Vallejo, Calif.

1991 gross revenues: $400,000 from UR services.

Charges: Per employee, 35 cents to $1.

Principal officers: John C. Brady II, president; Richard Falls, senior vp-marketing; James B. Wallace, vp/director-managed care; Howard Hilderbrand, finance director; Karen Bello, business manager.

Q

Quality Health Services Inc.

633 W. Germantown Pike, Plymouth Meeting, Pa. 19462; 215-941-9561; fax: 215-941-9772

Founded: 1983; began providing utilization review services in 1983.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 80% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, physician fee negotiation, DRG validation.

Occasional UR services: Hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 43 total; including one physician, 13 registered nurses, one licensed practical nurse, one medical records technician. On retainer: 46 physicians, one nurse.

Clients: 38 total; 10 employer clients; 20% with fewer than 500 employees, 10% with 500 to 999 employees, 30% with 1,000 to 2,499 employees, 30% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.

Covered lives: 155,000 employee benefit plan lives.

Admissions reviewed: 9,500; 3% to 5% diverted for outpatient treatment.

Branch offices: Newtown, Pa.; New York.

Charges: Per employee, $1.70 to $2.45; per hour, $85 to $145.

Principal officers: Robert Scherzer, chief executive officer; Roger Hiser, chairman; Barbara Nammar, director-operations; Stephen Cohen and Cheryl Richter, vp-sales; Beth Leach, vp-workers compensation.

Quality Managed Care Inc.

8717 W. 110th, Suite 270, Building 14, Overland Park, Kan. 66210; 913-345-1784; fax: 913-345-1804

Founded: 1988; began providing utilization review services in 1988.

Parent company: Lifetime Corp.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 80% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management, vocational counseling, high-risk pregnancy management.

Occasional UR services: Retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services.

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Continued from previous page

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 30 total; 19 professionals who are registered nurses. On retainer: one physician.

Clients: 12 total; five employer clients; 80% with fewer than 500 employees, 10% with 500 to 999 employees, 5% with 1,000 to 2,499 employees, 5% with more than 5,000 employees.

Covered lives: 28,000 employee benefit plan lives; 2,000 workers compensation lives.

Admissions reviewed: 2,750; 2% diverted for outpatient treatment.

Branch offices: Wichita, Kan.; Denver; Chicago.

Charges: Per employee, per hour.

Principal officers: Herbert D. Maxwell Jr., vp/general manager.

The Queen's Health Care Plan Inc.

2 Waterfront Plaza, Suite 200, 500 Ala Moana Blvd., Honolulu, Hawaii 96813; 808-522-7500; fax: 808-522-7561

Founded: 1985; began providing utilization review services in 1985.

Parent company: The Queen's Health Systems.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 40% of gross revenues.

Frequent UR services: Preadmission certification, 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 UR services: Hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 25 total; 15 professionals, including three physicians, 12 registered nurses.

Clients: 274 total; four employer clients; 95% with fewer than 500 employees, 4% with 500 to 999 employees, 1% with 2,500 to 4,999 employees.

Covered lives: 150,000 employee benefit plan lives.

Branch offices: Lihue, Kauai.

1991 gross revenues: $6 million total, $650,000 from UR services.

Charges: Per employee, $1.40 to $2.

Principal officers: Richard M. Jackson, executive vp/chief executive officer; Harry A. Baut, chief financial officer; James M. Kroft, director-commercial operations; Rhoda Wan Dee, director-utilization management/quality assurance.

R

RMSCO Management Services Inc.

651 W. Washington Blvd., Chicago, Ill. 60661-2193; 312-707-9000; fax: 312-559-3559

Founded: 1981; began providing utilization review services in 1981.

UR services provided to employers: 100% of gross revenues.

Frequent UR services: Preadmission certification, 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.

Occasional UR services: Retrospective review.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: Six total; five professionals, including three registered nurses, one licensed practical nurse, one medical records technician. On retainer: one physician.

Clients: 51 total; all employer clients; 50% with fewer than 500 employees, 30% with 500 to 999 employees, 20% with 1,000 to 2,499 employees.

Covered lives: 42,172 employee benefit plan lives.

Admissions reviewed: 1,338; 7% diverted for outpatient treatment.

1991 gross revenues: $1.9 million total, $300,000 from UR services.

Charges: Per employee, $1.50 to $1.75.

Principal officers: Robert M. Schrayer, chairman; Karen Z. Vacko, president; Thomas J. Schaffler.

Rehabilitation Advisors Inc.

445 Wymore Road, Suite 220, Winter Park, Fla. 32789; 407-629-1110; fax: 407-629-4221

Founded: 1981; began providing utilization review services in 1981.

UR services provided to employers: 5% of gross revenues.

UR services provided to others: 5% of gross revenues.

Frequent UR services: Concurrent hospital treatment review, discharge planning, retrospective review, case management.

Occasional UR services: Outpatient service predetermination.

Medical services reviewed: Group health, workers compensation/disability, auto liability.

Staff: 15 total; 13 professionals, including three registered nurses.

Clients: 182 total.

Covered lives: 318 workers compensation lives.

Charges: Per employee, per hour.

Principal officers: Betty Reid, president; Richard J. Laur, marketing director; Suzanne Funk, counselor/account representative.

Rush-Presbyterian/St. Luke's Health Plans Inc.

33 E. Congress Parkway, Chicago, Ill. 60605; 800-851-2118; fax: 312-347-4500

Founded: Began providing utilization review services in 1984.

Parent company: Rush-Presbyterian/St. Luke's Medical Center.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

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

Staff: Includes one physician, eight registered nurses, one medical records technician.

S

Sanus Preferred

7601 Ora Glen Drive, Greenbelt, Md. 20770; 301-441-1600; fax: 301-441-3559

Founded: 1986; began providing utilization review services in 1987.

Parent company: Sanus Corp. Health Systems.

UR services provided to employers: 52% of gross revenues.

UR services provided to others: 48% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination.

Occasional UR services: Retrospective review.

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

Staff: 16 total; 17 professionals, including one physician, 14 registered nurses, two licensed practical nurses.

Clients: Four total; one employer client with 1,000 to 2,499 employees.

Admissions reviewed: 350.

1991 gross revenues: $57,000 total.

Charges: Per employee, $1.93 to $3.50; per case, $50.

Principal officers: Joseph T. Lynaugh, president; Jeff D. Emerson, vp; Robert J. Kent, secretary; Theodore Waltman, treasurer.

Second Opinion Consultants Inc.

P.O. Box 621, Millwood, N.Y. 10546; 914-747-2187 or 800-446-4606; fax: 914-747-2137

Founded: 1983; began providing utilization review services in 1983.

UR services provided to employers: 100% of gross revenues.

Frequent UR services: Second surgical opinion, hospital bill audit, prospective diagnostic test screening.

Medical services reviewed: Group health, chiropractic.

Staff: 15 total; 12 professionals, including two registered nurses, four li-

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Continued from previous page
censed practical nurses, six medical records technicians. On retainer: one physician.

Clients: 15 total; 12 employer clients; 50% with 500 to 999 employees, 50% with 1,000 to 2,499 employees.

Covered lives: 10,000 employee benefit plan lives.

Charges: Per case, $155 to $170.

Principal officers: Dr. Madelon L. Finkel, president/chief executive officer; David J. Finkel, chief financial officer; Dr. Norman Mazza, medical director.

Spectrum Review Services Inc.

P.O. Box 672711, Houston, Texas 77267-2711; 713-444-2194 or 800-258-5055; fax: 713-580-5270

Founded: 1990; began providing utilization review services in 1991.

UR services provided to others: 100% of gross revenues.

Frequent UR services: Preadmission certification, 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.

Occasional UR services: Retrospective review.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Six total; three professionals, including one registered nurse. On retainer: 30 physicians.

Clients: Nine total; all employer clients 5% with fewer than 500 employees, 80% with 1,000 to 2,499 employees, 15% with 2,500 to 4,999 employees.

Covered lives: 25,000 employee benefit plan lives.

Admissions reviewed: 1,500; 5% diverted for outpatient treatment.

Charges: Per employee, $1.20 to $1.27 per month; per case, $100 to $150.

Principal officers: Frank J. Berrier Jr., president/chief executive officer; Karen L. Mesa, vp; Dr. Vergil C. Pebley, medical director/vp; Ernest C. Munshower, treasurer/vp.

Stillwell & Associates

P.O. Box 80053, Indianapolis, Ind. 46280-0053; 317-283-1714; fax: 317-283-2622

Founded: 1989; began providing utilization review services in 1991.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, high-risk maternity, rehabilitation, fee negotiation, claims data analysis.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, long-term care, travel and repatriation, tertiary review, patient advocacy, specialty review.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 29 total; 25 professionals, including two physicians, 17 registered nurses. On retainer: three physicians, 62 nurses.

Charges: Per employee, per case, per hour.

Principal officers: P.J. Stillwell, president/chief operating officer; Dr. L.M. Clark, vp.

The Sunderbruch Corp.

6000 Westown Parkway, Suite 305E, West Des Moines, Iowa 50265-7771; 515-224-6426; fax: 515-224-1002

Founded: 1971; began providing utilization review services in 1975.

UR services provided to employers: 54% of gross revenues.

UR services provided to others: 34% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: High-risk pregnancy.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, physician office care, home health care, skilled nursing facility, intensive care facility, hospice.

Staff: 322 total; 175 professionals, including three physicians, 150 registered nurses, 11 licensed practical nurses, 11 medical records technicians.

Clients: 206 total; 177 employer clients; 55% with fewer than 500 employees, 18% with 500 to 999 employees, 14% with 1,000 to 2,499 employees, 6% with 2,500 to 4,999 employees, 7% with more than 5,000 employees.

Covered lives: 1.5 million employee benefit plan lives; 75,000 workers compensation lives.

Admissions reviewed: 120,000; 5% diverted for outpatient treatment.

Branch offices: St. Louis; Chicago and Peoria, Ill.; Lincoln, Neb.

1991 gross revenues: $20 million total.

Charges: Per employee, $1.35 to $1.85; per case; per hour, $75 to $150.

Principal officers: Fred Ferree, executive vp; Kathy Fliehler, vp; Pamela DePriest, national marketing director.

T

TAO Inc.

1901 Market St., 32nd Floor, P.O. Box 15988, Philadelphia, Pa. 19103; 215-241-4600; fax: 215-241-4766

Founded: 1985; began providing utilization review services in 1985.

Parent company: Independence Blue Cross.

UR services provided to others: 91% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management.

Occasional UR services: Outpatient service predetermination, outpatient psychiatric and substance abuse services.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 40 total; all professionals, including three physicians, 12 registered nurses. On retainer: five physicians.

Clients: Nine total.

Covered lives: 2.3 million employee benefit plan lives; 1,250 workers compensation lives.

Admissions reviewed: 8,569; 5.4% diverted for outpatient treatment.

1991 gross revenues: $4 million total, $3.7 million from UR services.

Charges: Per employee, 20 cents to 70 cents per month; per case, $250 to $400; per hour, $100.

Principal officers: Dr. Anthony F. Panzetta, president/chief executive officer; Barry Davis, executive vp/chief operating officer; Frank Erdlen, senior vp-planning/development; Peter Stanton, senior vp-sales/marketing.

U

Ullicare

111 Massachusetts Ave. N.W., Washington, D.C. 20001; 202-682-7911; fax: 202-682-4911

Founded: 1984; began providing utilization review services in 1984.

Parent company: Union Labor Life Insurance Co.

UR services provided to employers: 90% of gross revenues.

UR services provided to others: 10% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management.

Occasional UR services: Outpatient service predetermination, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, podiatric.

Staff: 31 total; 16.5 professionals, including 13.5 registered nurses, three licensed practical nurses. On retainer: one physician.

Clients: 95 total; 90 employer clients; 63% with fewer than 500 employees, 16% with 500 to 999 employees, 11% with 1,000 to 2,499 employees, 9% with 2,500 to 4,999 employees, 1% with more than 5,000 employees.

Covered lives: 217,500 employee benefit plan lives.

Admissions reviewed: 8,100; 5% diverted for outpatient treatment.

1991 gross revenues: $836,000 total, $752,400 from UR services.

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Charges: Per employee, $1.50 to $1.65; per case, $90; per hour, $90 to $150; claims review, $50 per hour; hospital review, $25 case review plus 25% savings

Principal officers: Robert Georgine, chairman/chief executive officer; John Gentleman, president; Charles Sormani, senior vp-insurance; Jim Hibbitts, vp-group; Barton Bracken, assistant vp-managed care.

Unipsych Systems Inc.

7951 S.W. Sixth St., Suite 100, Plantation, Fla. 33324; 305-474-8727; fax: 305-474-1351

Founded: 1986.
Parent company: Unipsych Corp.
UR services provided to employers: 25% of gross revenues.
UR services provided to others: 25% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second psychiatric opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.
Medical services reviewed: Psychiatric and substance abuse, workers compensation/disability.
Staff: 17 total; including two physicians. On retainer: 42 physicians.
Clients: 15 total; 10 employer clients; 10% with fewer than 500 employees, 40% with 500 to 999 employees, 30% with 1,000 to 2,499 employees, 10% with 2,500 to 4,999 employees, 10% with more than 5,000 employees.
Covered lives: 100,000 employee benefit plan lives.
Branch offices: Offices throughout Florida.
1991 gross revenues: $2.5 million total.
Charges: Per employee, per case, per hour.
Principal officers: Dr. Leo Bradman, chairman; Ronald Harshman, president/chief executive officer; Dr. Ernest Cohen, psychiatric director; James Kaplan, director-finance; Laurel Patterson, administrator.

Universal Managed Care Inc.

70 N. Main St., Wilkes-Barre, Pa. 18711; 800-346-6149 or 800-752-1919 (Pennsylvania); fax: 212-821-1327

Founded: 1985; began providing utilization review services in 1986.
Parent company: Blue Cross of Northeastern Pennsylvania.
UR services provided to employers: 9% of gross revenues.
UR services provided to others: 87% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, case management.
Occasional UR services: Outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: 33 registered nurses, two licensed practical nurses.
Clients: 27 total; 25 employer clients; 68% with fewer than 500 employees, 20% with 500 to 999 employees, 12% with 1,000 to 2,499 employees.
Admissions reviewed: 21,550; 2% diverted for outpatient treatment.
1991 gross revenues: $2.2 million total, $2.1 million from UR services.
Charges: Per hour, $58 to $75.
Principal officers: Tom Warp, Dr. Joe Ichter, Andrea Vasil, Yvonne Bozinski and Deborah Stepanski.

Utilization Management Systems Inc.

224 S. 108th Ave., Suite 8, Omaha, Neb. 68154; 402-330-6112; fax: 402-330-5004

Founded: 1986; began providing utilization review services in 1986.
UR services provided to employers: 25% of gross revenues.
UR services provided to others: 50% of gross revenues.
Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, outpatient service predetermination.
Occasional UR services: Length of stay determination, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management.
Medical services reviewed: Group health.
Staff: 12 total; including four registered nurses. On retainer: 15 physicians.
Clients: 23 total; one employer client with 1,000 to 2,499 employees.
Covered lives: 78,400 employee benefit plan lives.
Admissions reviewed: 7,800.
1991 gross revenues: $954,000 total.
Charges: Per employee or per review.
Principal officers: Ron Chaffin, president/chief executive officer; Dr. John R. Kirchner, chairman.

V

Value Health Inc.

22 Waterville Road, Avon, Conn. 06001; 203-677-4101; fax: 203-677-1752

Continued on next page

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BI

Continued from previous page

Founded: 1987; began providing utilization review services in 1987.

UR services provided to employers: 7% of gross revenues.

UR services provided to others: 3% of gross revenues.

Frequent UR services: Preadmission certification, outpatient psychiatric and substance abuse services, drug utilization review.

Medical services reviewed: Psychiatric and substance abuse, drug utilization, high-cost surgical procedures.

Staff: 590 total; 131 professionals, including 13 physicians, 83 registered nurses, three medical records technicians. On retainer: 60 physicians.

Clients: 321 total; 270 employer clients; 27% with fewer than 500 employees, 25% with 500 to 999 employees, 12% with 1,000 to 2,499 employees, 18% with 2,500 to 4,999 employees, 20% with more than 5,000 employees.

Covered lives: 18 million employee benefit plan lives.

Admissions reviewed: 275,000; 40% diverted for outpatient treatment.

Branch offices: American Psych-Management and Health Information Designs in Arlington, Va.; Value Health Sciences in Santa Monica, Calif.

1991 gross revenues: $143 million total, $14.3 million from UR services.

Principal officers: Robert E. Patricelli, president/chief executive officer; William J. McBride, executive vp; Steven J. Shulman, senior vp.

W

Workers Compensation/Casualty Services

9705 Data Park Drive, Route 6230, Minnetonka, Minn. 55343; 612-945-6101; fax: 612-945-6261

Founded: 1985; began providing utilization review services in 1985.

Parent company: United HealthCare Corp.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management, rehabilitation therapies, disability management.

Occasional UR services: Retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services.

Medical services reviewed: Workers compensation/disability.

Staff: 17 total; 14 registered nurses. On retainer: two nurses.

Clients: 36 total.

Covered lives: 3 million workers compensation lives.

Admissions reviewed: 4,400.

Branch offices: Minneapolis; Pasadena, Calif.

Principal officers: T. Stevens Spruth, president; Glenda Garrard, vp; Michael Larson, director-sales/marketing; Jillene Moore, operations manager.

The following information was received too late to be included in alphabetical order:

HealthCare Strategies Inc.

9841 Brokenland Parkway, Suite 105, Columbia, Md. 21046; 410-381-5430; fax: 410-290-9721

Founded: 1984; began providing utilization review services in 1984.

Parent company: TPA of America.

UR services provided to employers: 52.8% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management, managed prenatal care.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 44 total; 16 professionals, including 13 registered nurses.

Clients: 60 total; 62% with fewer than 500 employees, 12% with 500 to 999 employees, 12% with 1,000 to 2,499 employees, 7% with 2,500 to 4,999 employees, 7% with more than 5,000 employees.

Admissions reviewed: 14,000.

1991 gross revenues: $3.1 million total, $1.6 million from UR services.

Charges: Per employee, $1.25 to $1.52; per case, $250 to $275; per hour. $115 to $125.

Principal officers: Janice K. Albert, president; William P. Keenan, vp; Karen Schofield, comptroller; Jennifer Schroyer, operations manager.

Rx Management Inc.

2160 Highland Ave., Birmingham, Ala. 35205; 205-939-4709; fax: 205-939-4713

Founded: 1991.

Parent company: Complete Health Services Inc.

UR services provided to employers: 15% of gross revenues.

UR services provided to others: 80% of gross revenues.

Frequent UR services: Retrospective review, pharmacy benefit management.

Medical services reviewed: Pharmacy health services.

Staff: 15 total; all professionals.

Clients: 12 total; 10% with 1,000 to 2,499 employees, 10% with 2,500 to 4,999 employees, 80% with more than 5,000 employees.

Covered lives: 325,000 employee benefit plan lives.

Principal officers: David K. Morris, president. ■

Hospitals, employers share health care cost data

By SARA MARLEY

CHICAGO—A program in Pennsylvania that brings employers together with hospitals to share information about health care costs and services is embarking on a new phase that may improve quality of care, its organizers say.

The Private Sector Initiatives program, which was established five years ago by the Hospital Assn. of Pennsylvania in Harrisburg, Pa., provides participants in regional "Buy Right Councils" with information on hospital costs, average lengths of stay, mortality rates and patient satisfaction.

As the program's sponsor, HAP provides data processing and administrative support.

The second phase of the program will include greater involvement by physicians and the addition of employer-provided data, said Kenneth A. Rethmeier, vp of research and education services for the hospital association.

The Buy Right Councils will also explore improving quality rather than simply reporting costs. "We want to redirect from short-term symptomatic solutions to long-term systemic changes," he said.

"Managed quality will result in managed cost. By controlling the variation of care, you will control cost," Mr. Rethmeier said during a January seminar in Chicago titled "A Comprehensive Look at Reducing Healthcare Costs." The seminar was sponsored by the International Quality & Productivity Center, an Upper Montclair, N.J.-based conference organizer.

The health care information generated by the program is gathered on a quarterly basis from 33 HAP-member hospitals and distributed annually to employers in the state that pay $5,000 to $10,000 per year to participate in the program.

Twenty to 25 companies belong to the councils, including some of the state's largest employers, like Aluminum Co. of America and USX Corp., both in Pittsburgh, and Consolidated Rail Corp. and Scott Paper Co., both in Philadelphia.

Another 20 firms, including Pittsburgh-based Westinghouse Electric Corp. and USAir Inc., which operates in Pennsylvania but is headquartered in Arlington, Va., are considering joining, program organizers say.

In the next phase of the program, physicians will be included in discussions with employers, as will labor, insurance companies and employee representatives, Mr. Rethmeier said.

The most significant improvement will be the addition of company-provided information like claims experience and environmental and workplace risk factors, he said.

With the additional information to be exchanged during the second phase, the councils also can address specific company and regional needs and be more purchaser-specific, targeting populations and diagnoses. One company requested that the reports include data on mental health and drug and alcohol abuse treatments.

Mr. Rethmeier said the Buy Right program has flourished despite traditional sources of conflict between health care providers and consumers. Hospitals are concerned about additional government regulation, challenges to their tax-exempt status and financing problems, he said. Insurers and businesses worry about cost shifting and increases in their share of the health care burden, while physicians want reasonable and timely payment. Patients want the highest quality of care regardless of cost, he added.

Under the Buy Right program, expectations are clarified and common goals are stressed.

"Hospitals get the opportunity to sit down with the major employers in their area. They can protect their market share" by stressing their services and proving that costs are competitive, Mr. Rethmeier said. "For businesses, it means a better understanding of the complexities of the health care system."

Companies, like individuals, have found the cost of health care arbitrary at times.

"It is our belief that an understanding of quality and price is based on consumer education," Mr. Rethmeier said.

Buy Right data is not available to the public, although some companies distribute the reports internally to employees.

"We feel confidentiality lends credence and value to the system," Mr. Rethmeier said. "Our CEOs are still learning that health care is a public issue. My guess is that at some point (the program) will expand."

The reports do not include statistics that would skew the portrait of overall hospital performance, like including long-term cancer patients in the average length of stay calculations.

In the future, Mr. Rethmeier said he would separate reports for such cases and for other exceptions like teaching hospitals. ■

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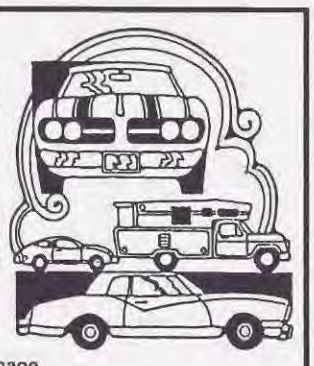
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Flex benefits and point-of-service plans

Combination cuts costs: Monsanto official

By CHRISTINE WOOLSEY

CHICAGO—The combination of flexible benefits and point-of-service managed care can be an excellent cost containment tool when implemented properly, says a corporate employee benefits manager.

Monsanto Co. has seen its health care cost trends drop substantially since 1990 when it integrated flexible benefits with a point-of-service managed care network for about 1,800 employees, said A. Robert Lahr, employee benefit manager.

"Overall, we moved from an 18% health care cost trend to a 0% health care cost trend because of flexible benefits and managed care," Mr. Lahr said during a session of a conference sponsored last month by the International Quality & Productivity Center, an Upper Montclair, N.J.-based company that conducts executive education seminars and conferences.

Mr. Lahr traced the steps taken by Monsanto from 1985 through January 1992 to better manage health care costs and, at the same time, responsibly address the changing needs of its business units and employees.

The St. Louis-based chemical concern employs about 41,000 workers worldwide and its 1990 net sales worldwide were $9 billion. The decentralized firm operates six business units: Monsanto Co., Monsanto Chemical Co., Monsanto Agricultural Co., Fisher Controls International Inc., G.D. Searle Co. and The NutraSweet Co.

While the cost control programs discussed at the seminar apply only to Monsanto Co.'s 1,800 salaried workers, similar programs cover salaried workers at other Monsanto units and some union employees, Mr. Lahr noted.

Before this new approach, the self-insured company offered its employees group medical benefits with health maintenance organization options, a dental plan, employee and dependent life insurance, disability benefits, a defined benefit and a defined contribution plan, an individual retirement account and a stock purchase plan, among other things.

"Prior to 1986, our health care costs per employee were increasing on a double-digit basis," Mr. Lahr said. So the company changed its plan to encourage "greater health care consumerism" and the use of "more appropriate health care settings," he said.

In 1986, employees for the first time were required to contribute toward health care premiums. Those with family coverage were required to put $10 per month toward health insurance premiums. That figure has steadily increased to $31 this year, he said.

That same year, Monsanto also increased deductibles and introduced preadmission certification and concurrent review, substance abuse treatment limits, a prescription drug card, hospital bill audit incentives and mandatory second surgical opinions. And, the company introduced hospice care, home health care, skilled nursing care, preferred provider networks and large—case management.

The changes had an immediate effect. "Our cost per employee trend line was flat in 1986 and 1987," said Mr. Lahr.

In 1988 and 1989, however, health care costs per employee began increasing 16% to 18% again. "That's when we started plans to introduce point-of-service managed care and flexible benefits."

Rising costs were not the only reason that flexible benefits appealed to Monsanto in the late 1980s. "Because we are a fairly decentralized company with a diverse workforce, we decided that the 'one-benefit-plan-fits-all' design wouldn't fit well within Monsanto in the future," Mr. Lahr said.

Changing demographics meant Monsanto's workforce was no longer made up of "traditional employees," he said. "The traditional employee situation 15 years ago consisted of an employee who was the primary wage earner, a nonworking spouse, two kids and a dog," he said in a follow-up interview. And that scenario didn't vary much from employee to employee.

"Today, we have a wide diversity of ages and family (structures). There are more single employees because people aren't marrying as early in life. There are more single parents. And, employees are retiring earlier than in the past.

"The whole myriad of personal situations employees have suggests that a single benefit structure just doesn't fit everyone as well."

Employers considering flexible benefits and managed care should conduct studies to ascertain how valuable those programs can be, Mr. Lahr suggested.

Before implementing a flex plan for its 1,800 corporate staff, Monsanto conducted some internal studies to see how flexible benefits and point-of-service plans were working for its other business units.

The firm found that plans without flexible benefits or a point-of-service managed care network experienced annual health care cost trend increases in the high teens and low 20s, Mr. Lahr said. Meanwhile, 15% to 16% annual health care cost trends plagued plans with flexible benefits but no managed care.

Plans with flexible benefits and a point-of-service network, however, experienced little or no annual increases, he said.

Employees were surveyed before the plan was changed. "Our studies indicated that employees were willing to trade off certain benefits for others," said Mr. Lahr.

Employee focus groups helped the company design the plan, he added. The employees' input made Monsanto feel more comfortable with its design decisions because "we were right on target with what employees were seeking," he said.

Surveys conducted after introducing flexible benefits helped measure employees' satisfaction. "We found that 80% of employees changed their health plan as a result of flex, which indicated to us that there was something else they needed." And, 80% of employees surveyed also said their health care plan improved with the introduction of flexible benefits.

What worked for Monsanto may not work for every company, Mr. Lahr cautioned. "You really have to do your homework and do some mathematical modeling to see how it'll work for you." ■

Backers of health reform have varied levels of trust in the government: Exec

By SARA MARLEY

CHICAGO—Health care reform rests on the level of trust that business, consumers and providers will place in the government, says a General Motors Corp. benefits executive.

Kevin D. Anderson, director of employee benefits and legislative analysis for the Detroit-based automaker, divided various health care reform proposals into three groups.

Those favoring a national health care system place their complete trust in the government, he said; backers of "play-or-pay" proposals place some trust in the government; and those who favor market-based reforms place no trust in the government.

"Someone will pay to expand the system," Mr. Anderson said at a seminar last month sponsored by the International Quality and Productivity Center, an executive education firm in Upper Montclair, N.J. "There is no magic solution. Health care reform will take hard work and will occur over a period of time."

With 1.8 million covered lives, General Motors is the largest nongovernment purchaser of health care in the nation. With health care costs rising an average of 13% annually since 1965, the company's health care tab exceeded $3 billion in 1991, Mr. Anderson said.

He faulted both the Bush administration and the Democratic leadership for lacking comprehensive health care policies. And, while he predicted that health care will be a major campaign issue, he doubted that any solutions will come out of this year's election.

Legislative reform must address cost containment, not just increased access, because continually increasing costs make the health care system even more inaccessible, according to the GM executive.

The single-payer reform proposal, under which the federal government would provide health care for everyone, would resolve the problems of access and cost shifting from insurance company to employer to employee, according to Mr. Anderson.

However, businesses fear they will be called on to foot the bill to expand access, he said. Businesses also are leery of making the government solely responsible for keeping health care costs down, he added.

The single-payer plan also raises questions about exactly who would be covered and whether it would include visitors and people living in the country illegally.

Under the "play-or-pay" proposals, every business would be required to provide a basic health plan or pay a payroll tax.

The problems with such an approach lie in deciding just what benefits to require and how to administer the "pay" option, Mr. Anderson said.

Any reform calls for groups with conflicting goals to compromise, Mr. Anderson said. Hospitals and physicians are looking for a fair price; employers want cost containment; unions want a government solution; and states do not want any additional federally mandated programs to deplete their budgets.

"Everyone sees the need for change, but thinks the solution should not hurt them disproportionately," according to Mr. Anderson. "All the players will be somewhat adversely impacted (in order to achieve) a long-range solution." ■

Conference on health costs draws 50

CHICAGO—Nearly 50 benefits professionals attended "Reducing Healthcare Costs," a two-day conference held here Jan. 16-17.

The conference, sponsored by The International Quality & Productivity Center, an Upper Montclair, N.J.-based company that conducts executive education seminars and conferences, featured sessions on health plan designs and strategies that can help employers control rising costs.

About a dozen speakers discussed public and private initiatives to address the health care crisis and cost containment approaches like flexible benefits, wellness programs and managed care.

The Chicago-based Midwest Business Group on Health, an employer coalition, endorsed the meeting.

The conference is scheduled to be repeated May 11-12 in Washington, D.C. For more information contact: Donna McKenna, International Quality & Productivity Center, The Livery Building, 209 Cooper Ave., Suite 5D, Upper Montclair, N.J. 07043; 800-882-8684.

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Self-referrals

Continued from page 2

cases, these marketers are in the business of selling equipment like magnetic resonance imaging equipment, he said. Rather than seeking non-physician investors, these marketers are getting physicians directly involved.

"Clearly, we're seeing places where this type of activity seems to be accelerating," agreed an Industrial Indemnity spokesman. The Los Angeles area in particular "seems to have more of this than any other place in the state," he said.

Federal Medicare and Medicaid self-referral regulations took effect last July. They require that self-referring physicians account for no more than than 40% of the investors in health care entities, and that no more than 40% of revenues be obtained from those with any financial interest in such an enterprise, according to a spokeswoman for the Department of Health and Human Services' Office of Inspector General.

The Mercer study is still in preliminary form, though its conclusions will remain the same when it is finished, according to its authors, Gregory Johnson, a Mercer principal, and Alex Swedlow, a Mercer consultant.

The study used a medical bill data base from Industrial Indemnity, a major workers comp insurer in California, to examine 6,581 workers comp claims from 1990 and 1991 for physician self-referrals to physical therapy, diagnostic imaging and psychiatric services facilities.

Various methods were used to verify that physicians owned clinical facilities.

The study looked at 1,257 musculoskeletal injury cases. In cases where an injured worker received initial treatment from a provider with an ownership interest in a physical therapy clinic, the worker received a referral for physical therapy services 66% of the time. When there was no ownership interest, that figure was only 32%.

Physician ownership "more than doubles the likelihood of a physical therapy referral," the study concludes.

Physical therapy services account for an estimated $575 million per year in California workers comp costs, of which about $233 million goes toward services "delivered for economic rather than clinical reasons," the authors contend.

In addition, the study found that 78% of the 864 referrals for diagnostic imaging procedures—like MRI and computerized axial tomography procedures—in 1990 and 1991 involved cases of physician ownership.

An independent pre-certification review program involving more than 800 diagnostic imaging cases found this procedure had no clinical value 32% of the time, the study reported.

The study estimates that $234 million is spent annually for workers comp-related imaging procedures in California at facilities owned by physicians. Therefore, $74 million, or 32%, is spent "for referral-for-profit rather than clinical need," says the study.

Examining psychiatric testing and evaluation, the study noted that workers comp stress claims cost California employers an estimated $250 million in outpatient psychiatric services, including treatment, testing and evaluation reports.

Looking at 4,460 California stress claims, the survey found that just 17% of all psychiatric service costs are for actual therapy, with the remaining 83% spent on evaluation reports and testing.

The study also found that 70% of 362 claims studied included self-referrals from one psychiatric facility to one or more other facilities.

Furthermore, claims from such facilities were 28% more expensive than were claims incurred at facilities with independent ownership, the study said.

"By extrapolating this trend to the entire population of California stress claims, we estimate that $175 million per year of these costs are influenced by referral-for-profit among psychiatric facilities," according to the study. "Within that total, California employers pay an additional $49 million" in overcharges, or 28% of the total.

Eliminating unnecessary expenses in physical therapy, diagnostic imaging and psychiatric testing would reduce California employers' workers comp insurance premiums 3% annually, says the study.

"Other medical services—such as diagnostic laboratories, medical equipment and outpatient surgery centers, which are often characterized by referral for profit—are not included in this study and would drive costs up even further," the study says.

"Since workers compensation costs account for less than 5% of all California medical costs, the total impact of physician ownership and investment on the California economy is several billion dollars each year."

Mr. Johnson, the study's co-author, said that physician self-referral is a particular problem in workers compensation, because unlike group health insurance claims, employees pay no deductibles or copayments and, thus, have little incentive to resist doctors' recommendations and limit medical costs.

Physician self-referral can serve as "sort of the manufacturing process for a fraudulent claim" because the physician can aid an injured employee who wants to avoid returning to work, Mr. Johnson said.

He said that the only example comparable to physician self-referral is college professors who require their students to buy textbooks they themselves wrote. There is "no other professional society that can do that," Mr. Johnson said.

The bill now pending in the California Senate, which has the support of the American Insurance Assn. and John Garamendi, the state insurance commissioner, would prohibit any physician self-referrals unless "there is no alternative provider or facility available and to delay or forego the needed health care would pose an immediate health risk to the patient."

Violations would be a misdemeanor punishable by a fine of up to $10,000, with violators also referred to the Medical Board of California for disciplinary action.

•

Copies of the study can be obtained for free by contacting Gregory Johnson, William M. Mercer Inc., P.O. Box 7440, San Francisco, Calif. 94120; 415-627-5457.

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Purchasing group reform proposed

By JERRY GEISEL and MARK A. HOFMANN

Washington

WASHINGTON—A risk purchasing group insurer generally would have to meet the same capital and surplus requirements as admitted insurers in every state in which it provides coverage under legislation introduced this month.

However, the bill would overturn a 1987 court decision allowing states to set rate and policy form requirements for insurers that provide coverage to purchasing groups.

Instead, only one state—the state a purchasing group declares as its principal place of business—could regulate the policy forms or rates used by the insurer.

The bill, S. 2219, introduced by Sen. Robert Kasten, R-Wis., also would require that purchasing groups and risk retention groups be controlled by policyholders—not by insurers, brokers, agents or other advisers.

The Kasten bill is virtually identical to a proposal advanced by the Bush administration last year (*BI*, Feb. 18, 1991). Supporters say it will help clear up ambiguous provisions in the Risk Retention Act, the federal law that allows employers to band together to form risk retention and purchasing groups.

The Kasten bill "provides Congress with a vehicle by which they can more clearly define the exemption of Risk Retention Act entities from multistate regulation and clarify the requirements that groups must meet to operate under the (act)," said Fred Souk, counsel for the National Risk Retention Assn., a Washington, D.C.-based trade group. The NRRA represents risk retention and purchasing groups as well as firms providing services to the groups.

The Kasten bill currently does not have any co-sponsors.

Medical malpractice

States that have adopted no-fault medical malpractice programs to resolve certain birth-injury claims use these programs far less frequently than their proponents had predicted, says a General Accounting Office study on litigation alternatives.

However, health maintenance organizations that mandate arbitration be used to settle claim disputes say the alternative is saving time and money, the study shows.

"Medical Malpractice: Alternatives to Litigation" examined among other things statutory no-fault claims resolution programs for infants with neurological injuries. The Virginia Birth-Related Neurological Injury Compensation Act took effect Jan. 1, 1988, and the Florida Birth-Related Neurological Injury Compensation Act went into effect exactly one year later.

"When the programs were first implemented, program officials in both states expected about 40 claims to be filed under each program annually. The actual number has been much lower," writes Janet L. Shikles, director-health financing and policy issues for the GAO.

"As of October 1991, 21 claims had been filed—two in Virginia and 19 in Florida. One Virginia claim was determined to be ineligible, and a decision is pending on the second. Twelve of the Florida claims were determined to be eligible, with initial payments totaling about $1.5 million," says the study.

The study gave three reasons for the low volume of no-fault claims:

- The programs are aimed at a very small, narrowly defined group of claimants.
- Lawyers may be waiting to see if the laws pass constitutional tests before filing claims.

The Virginia Supreme Court has upheld the constitutionality of that state's law, while a suit challenging the Florida law is pending in the state Supreme Court, the GAO study said.

- The time between injury and the filing of a claim usually takes several years, because of the types of injuries covered by the laws.

But the GAO report credits the no-fault programs with some success. For example, one unnamed malpractice insurer resumed offering malpractice insurance for Virginia obstetricians after the law was enacted, the report said.

The GAO study also examined the success of two HMOs in mandating that claims disputes be subject to arbitration.

Oakland, Calif.-based Kaiser Permanente Medical Care Program and Ross-Loos Medical Group of Glendale, Calif., require that subscribers arbitrate claims arising from their health care plans in several states, the study notes.

"We requested details on the HMOs' claims experience, but HMO officials did not provide the data. However, HMO officials indicated that a majority of the claims filed for arbitration are either closed without payment or settled before a hearing is held," says the report.

"For their enrollment of 1 million beneficiaries, Ross-Loos officials estimated an average of 50 malpractice claims are filed each year. On average, the officials estimated, between 6 and 12 claims are resolved annually by arbitration hearings, and decisions generally favor health care providers," the study said.

"Between 1985 and 1989, Kaiser officials indicated 5.5 million Kaiser enrollees covered by mandatory arbitration filed about 3,890 claims, an average of about 778 annually. About 440 of these claims were resolved by arbitration hearings, and decisions favored health care providers about 48% of the time," says the report.

Other litigation alternatives for malpractice claims the report examined included some little-used state malpractice arbitration programs and a new program for resolving certain malpractice claims in Maine, which went into effect only last month.

Copies of the report, "Medical Malpractice: Alternatives to Litigation" (GAO/HRD-92-28), may be obtained from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; 202-275-6241. The first copy is free; additional copies cost $2 each, with a check payable to the Superintendent of Documents. A 25% discount applies to orders of 100 or more sent to the same address. ■

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MARCH

MARCH 2-3. Eastern Claims Conference in New York City, sponsored by the ECC; $130 for both days; smaller packages are available. Eastern Claims Conference, P.O. Box 6030, Parsippany, N.J. 07054-0591; 212-907-8521.

MARCH 2-4. Environmental Regulation Course in Beverly Hills, Calif., and Nashville, Tenn., sponsored by Executive Enterprises Inc.; $1,045. **Also March 9-11** in Philadelphia and Washington, D.C.; **March 16-18** in Las Vegas; **March 23-25** in Atlanta; **March 30-April 1** in Chicago; **April 6-8** in Virginia Beach, Va.; **April 7-9** in Detroit; **April 13-15** in Boston; **April 27-29** in St. Louis; Minneapolis; and Anchorage, Alaska. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 3. Workers Compensation-Issues into the 90s seminar in Lancaster, Pa., sponsored by the Society of Chartered Property & Casualty Underwriters and the Pennsylvania Dutch chapter; $119 for society members; $129 for non-members. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

MARCH 3. Pay for Performance seminar in Seattle, sponsored by the Society of Chartered Property & Casualty Underwriters and the Agency Administration Section; $125 for section members; $145 for society members; $165 for non-members. Mari Stambaugh, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2741.

MARCH 3-4. Seminars on the Management of Risk in Engineering in Liverpool, England, sponsored by the Geneva Association; no charge. Association de Geneve, 18, Chemin Rieu, 1208 Geneva, Switzerland; 022-47-09-38.

MARCH 4-5. Lender Liability and Environmental Due Diligence in Business and Real Estate Transactions in Washington, D.C., sponsored by RTM Communications Inc.; $700. RTM Communications, 1020 N. Fairfax St., No. 201, Alexandria, Va. 22314; 800-966-7475.

MARCH 4-5. The European Environmental Regulation Conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 4-6. Self-Insurance Institute of America Inc.'s Sixth Annual Legislative Conference in Washington, D.C., sponsored by the SIIA; $295 for members; $225 for additional registrants from the same firm; $595 for non-members. SIIA, P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

MARCH 5. Small Business Solutions Workshop in Springfield, sponsored by the Illinois Chamber of Commerce; $135 for members; $195 for non-members. **Also March 12** in Chicago. The Illinois Chamber, 20 N. Wacker Drive, Suite 1960, Chicago, Ill. 60606-3083; 800-621-4220; 312-372-7373.

MARCH 5. Reviewing Possible Gaps in Umbrella/Excess/CGL Coverage seminar in Fort Wayne, Ind., sponsored by the Society of Chartered Property & Casualty Underwriters and the Northern Indiana Chapter; $90 for society members; $105 for non-members. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2735.

MARCH 5-6. National Health Care System Reform at the Company, Local and State Level conference in Rosemont, Ill., co-sponsored by the Midwest Business Group on Health, Marion Merrill Dow and The Upjohn Co.; $475 for MBGH members; $585 for non-members. MBGH, 8303 W. Higgins Road, Suite 200, Chicago, Ill. 60631; 312-380-9090.

MARCH 5-6. WCRI Annual Issues & Research Conference in Cambridge, Mass., sponsored by the Workers Compensation Research Institute; $195 for WCRI members; $395 for non-members. WCRI, 245 First St., Suite 1402, Cambridge. Mass. 02142; 617-494-1240.

MARCH 5-7. Annual Symposium on Environmental, Hazardous Waste and Toxic Tort Litigation in New Orleans, sponsored by the Defense Research Institute; $410 for DRI members; $460 for non-members; some discounts available. DRI, Damages Seminar, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MARCH 5-7. Insurance Coverage Litigation seminar in Tucson, Ariz., sponsored by the American Bar Assn. Section of Litigation; $225 for ABA members; $250 for non-members. Beverly Henderson, ABA Insurance Coverage Litigation Meeting, 750 N. Lake Shore Drive, Chicago, Ill. 60611.

MARCH 7-8. Americans with Disabilities Act: A New Training Course in Atlanta, sponsored by the American College of Occupational and Environmental Medicine; $350 for ACOEM members; $450 for non-members; $175 for ACOEM student members; $225 for student non-members. **Also May 2-3** in Washington, D.C. ACOEM, 55 Seegers Road, Arlington Heights, Ill. 60005; 708-228-6850.

MARCH 9-10. Documenting Your Environmental Program: Preparing for and Surviving a Regulatory Inspection conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,090. **Also April 6-7** in Los Angeles. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 9-11. Accident Investigation seminar in Washington, D.C., sponsored by Loss Control Management Services; $855 for members; $950 for non-members. **Also April 7-9** in Cleveland. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 9-13. Modern Safety Management seminar in Denver, sponsored by Loss Control Management Services; $990 for members; $1,100 for non-members. **Also March 23-27** in Los Angeles and Atlanta. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 9-13. Risk Management seminar in Atlanta, sponsored by Loss Control Management Services; $1,080 for members; $1,200 for non-members. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 10. Pay for Performance seminar in Nashville, Tenn., sponsored by the Society of Chartered Property & Casualty Underwriters and Agency Administration Section; $125 for section members; $145 for society members; $165 for non-members. Mari Stambaugh, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2775.

MARCH 10. Human Resource Management System seminar in New York City, sponsored by Genesys Software Systems Inc.; no charge. **Also March 12** in Hartford, Conn.; **March 18** in Dallas; **March 19** in New Orleans. Jayna Smith, 508-685-5400, ext. 3080.

MARCH 10. Executive Briefing seminar in New York City, sponsored by Genesys Software Systems Inc.; no charge. **Also March 12** in Hartford, Conn.; **March 18** in Dallas; **March 19** in New Orleans. Jayna Smith, 508-685-5400, ext. 3080.

MARCH 10-11. Reasoning Reinsurance seminar in Dallas, sponsored by University of Dallas' Graduate School of Management; $675. Professor Bruce Evans, Executive Director, University of Dallas, Reinsurance Management Institute, Irving, Texas 75062; 214-721-5360; or Carla Aslakson, seminar coordinator, 214-721-5299.

MARCH 10-13. The 16th Annual Bermuda Insurance and Reinsurance Forum in Hamilton, Bermuda, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; $900; $800 for additional registrants from the same company. Eileen Callahan, Conference Director, Towers Perrin, 100 Summit Lake Drive, Valhalla, N.Y. 10595; 914-745-4611.

MARCH 11. Americans with Disabilities Act: Understanding it and Complying with its Intent seminar in Los Angeles, sponsored by NATLSCO; $100. **Also March 13** in San Francisco. NATLSCO, Michele Arger, 1 Kemper Drive, Long Grove, Ill. 60049; 800-323-9585.

MARCH 29-APRIL 3. 30th Annual Risk Management and Employee Benefits Conference in Anaheim, Calif., sponsored by the Risk & Insurance Management Society Inc. $695 for RIMS members; $795 for non-members. Partial week and one-day registration allowed. Risk & Insurance Management Society, Conference Department-Registration, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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Bank insurance sales

Continued from page 2

cause neither side had asked for a ruling on whether or not the statute existed.

The appellate decision was a response to a suit filed last year by insurance trade associations against the U.S. Comptroller of the Currency. The suit challenged the comptroller's 1986 ruling that expanded Section 92 by allowing national banks or their branches operating under the small-town exemption to sell insurance outside a small town.

The appellate court's decision, which goes beyond the insurance industry's goal and not only forbids such expanded powers but essentially declares the exemption itself non-existent, also came as a shock to the insurance industry.

"Clearly this is the biggest legal victory we've ever seen," said Robert Rusbuldt, vp of government affairs for the Independent Insurance Agents of America, a co-plaintiff in the original suit. "But the decision went further than we believed it would."

The court's "strict constructionist" interpretation of the issue is a reversal of earlier years, when the federal judicial system focused more on interpretation and patterns of practice than the "letter of the law," said Patricia A. Borowski, chairwoman of the Alliance for Separation of Banking & Insurance, a coalition of insurance trade groups. Ms. Borowski also is vp of government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va., one of the insurance associations that brought the suit.

In a lengthy opinion by U.S. Circuit Judge James L. Buckley, the court raised the question of whether Congress actually intended to repeal Section 92 in 1918, when it revised the Bank Act, or whether it was inadvertently omitted from the revised act and that 75 years of subsequent interpretations never addressed the issue of whether or not the exemption existed.

The court concluded that "to reinstate a law that, intentionally or unintentionally, Congress has stricken from the statute books" is "one for Congress to correct, not the courts," and remanded the case to the district court.

Lobbyists from both sides are closely watching the comptroller's office, which may seek a stay pending a request for rehearing and possibly seek review from the U.S. Supreme Court, said a spokesman for the Office of the Comptroller of the Currency. The comptroller has 45 days from the date of the court decision to take action.

Until then, banks operating under the small-town exemption probably will continue to pursue "business as usual," said Mr. Verdier of the Independent Bankers Assn. ■

FEBRUARY CLOSINGS

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Business Insurance
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MEWA fraud suit

Continued from page 1

suing, being sued or both.

Three defendants—including Zimmerman & Co. Inc., an intermediary that produced business for the line slip—filed motions last year seeking to compel the 1988 line slip members to arbitrate the dispute. However, U.S. District Judge Alfred J. Lechner Jr. last month denied the motion, and the parties are preparing to litigate.

Zimmerman & Co. is appealing the ruling to the 3rd U.S. Circuit Court of Appeals, according to its attorney, Peter C. Harvey of Riker, Danzig, Sherer, Hyland & Perretti in Morristown, N.J.

Mr. Harvey denied any wrongdoing by ZLS, Zimmerman & Co. or George G. Zimmerman, who headed both firms. "It's pretty evident that all of the (line slip) members knew this business was being written," Mr. Harvey said of the MEWA business. "These allegations are baseless." But, he added, "it's cheaper to pay lawyers than to pay the claims."

Mendham, N.J.-based ZLS, now known as Hartford Line Slip Inc., managed calendar-year reinsurance pools that assumed a variety of accident and health risks from numerous ceding insurers.

Hartford Line Slip is unrelated to ITT Hartford Group Inc.

Business was ceded to ZLS pools through intermediary Zimmerman & Co., also based in Mendham.

The six other members of the 1988 ZLS line slip that are plaintiffs in the Mutual Benefit action are Beneficial Life Insurance Co., General American Life Insurance Co., Manufacturers Life Insurance Co. (USA), New York Life Insurance Co., Oxford Life Insurance Co. and Standard Insurance Co.

The other members of the 1988 line slip were Security Benefit Life Insurance Co., Transamerica Occidental Life Insurance Co., Integrated Resources Life Insurance Co., Provident Mutual Life Insurance Co., Business Men's Assurance Co. of America and State Mutual Life Insurance Co.

ZLS was a relatively small operation until it began writing MEWA business, court papers say: Gross premiums ceded to ZLS members totaled $14 million in 1986 and $29 million in 1987. But, volume exploded in 1988, when ZLS assumed $250 million in MEWA premiums for 1988 participants, according to one lawsuit against the pool manager. ZLS also assumed $41 million in non-MEWA business for 1988 line slip members.

ZLS accepted MEWA business for the 1988 line slip from six ceding insurers or groups, according to the Mutual Benefit complaint.

The ceding companies included All American Life Insurance Co.; Bradford National Life Insurance Co. and affiliate Lamar Life Insurance Co.; United Companies Life Insurance Co.; and United Olympic Life Insurance Co. and affiliate Bankers Security Life Insurance Society, the complaint says.

In addition, 1988 ZLS pool members Integrated Resources and Provident Mutual separately ceded MEWA business to the pool.

The United Olympic/Bankers Security MEWA business exposed the pool to the biggest potential losses, accounting for more than $34 million of the total $64 million in projected line slip liabilities, the Mutual Benefit complaint charges.

The All American business is expected to produce $22 million in line slip losses, and business ceded under the other four contracts accounts for $8 million of losses, the complaint says.

However, United Olympic/Bankers Security settled with nine of the 13 ZLS pool members in February 1991, and Bradford/Lamar agreed to settle its MEWA claims against the pool in November 1990, court papers show. Lawyers involved in the case declined to provide settlement details.

USLICO Corp., parent of United Olympic and Bankers Security, announced this month that it will incur a $6.9 million aftertax loss in the fourth-quarter of 1991 because of the MEWA business.

All American, meanwhile, has not settled or collected on MEWA claims from 11 of the 13 line slip members, which led the ceding company to fire the first shot in what has become a dizzyingly complex legal battle.

All American filed a declaratory judgment action in April 1991 against the 11 line slip members that have refused to pay claims. The suit seeks to recover $4.9 million in unpaid cash calls against line slip members, along with an order that the ZLS reinsurance is binding. Even though it has not collected reinsurance payments from most of the line slip members, All American is paying MEWA claims, one source said.

On the heels of the All American suit came three other complaints: A lawsuit filed by Security Benefit, the Mutual Benefit action and a suit filed by United Olympic/Bankers Security, all of which have since been consolidated in federal court in Newark.

The most explosive of these may be the Mutual Benefit suit, which levels federal racketeering charges against several companies and individuals involved in the MEWA business.

The suit was filed in May 1991, two months before Mutual Benefit was seized by New Jersey regulators to avert its collapse after thousands of policyholders demanded to cash in their policies or transfer funds (*BI*, July 22, 1991).

The latest amended Mutual Benefit complaint, filed in December, names:

- Zimmerman & Co. and Mr. Zimmerman.
- Consultants & Administrators Inc., a third-party administrator in Delaware, Ohio, and two of its officers and owners: President Paul J. Bargnesi and Vp-Marketing Samuel C. Corey. C&A managed some of the MEWA programs reinsured by the 1988 line slip, court papers show.
- William J. Flynn and Wm. J. Flynn & Associates Inc., a Mendham, N.J., agency. Flynn & Associates both produced MEWA business for C&A and assisted in arranging reinsurance of MEWA risks with the 1988 line slip, the complaint alleges. The complaint also charges that Mr. Zimmerman delegated authority to Flynn & Associates to act as the line slip's representative on "virtually all matters" relating to the MEWA business.
- All American.
- Business Men's Assurance, a 1988 line slip member that owned 30% of ZLS and Zimmerman & Co. between 1986 and 1990, according to the complaint.

The Mutual Benefit complaint charges that the defendants conspired to bind 1988 line slip members to huge blocks of MEWA business to generate commissions and fees for themselves, knowing that ZLS was not authorized to write MEWA risks and that the business would generate massive losses.

Many of the MEWA risks were unprofitable "takeover" blocks that Zimmerman & Co., Flynn & Associates, C&A and other TPAs arranged to transfer to All American and United Olympic/Bankers Security from other direct insurers that were desperate to get rid of the business, the complaint charges.

The MEWA risks—many of them ceded to the 1988 line slip between 1988 and 1990 under addenda to ZLS reinsurance agreements—included programs covering associations of real estate agents, certified public accountants, pharmacists, Christian ministers and credit unions, the lawsuit says.

Mr. Zimmerman and Mr. Flynn repeatedly misrepresented the scope of the MEWA business and its profitability, the suit alleges.

When two line slip reinsurers, Business Men's Assurance and State Mutual Life, found out about the business, Mr. Zimmerman "secretly" arranged to retrocede their participations to USCAP Insurance Co. Ltd., a Zimmerman & Co. subsidiary in Tortola, British West Indies, the suit says.

Other line slip reinsurers learned of the MEWA business in September 1989—though Mr. Zimmerman still "significantly misrepresented" its scope—and they objected, the suit says.

To avert cancellation of the business, Mr. Zimmerman persuaded the line slip members instead to retrocede their MEWA risks to another pool managed by Managed Medical Benefit Risk Corp., the suit says. MMBRC was formed by Mr. Flynn and Mr. Zimmerman, but Mr. Zimmerman concealed his ownership interest, the suit alleges.

Mr. Zimmerman also failed to provide line slip members with pertinent information about MMBRC and its subscribers, many of which turned out to be "undercapitalized, offshore insurance companies that had encountered regulatory difficulties" in the United States, the complaint charges.

The suit does not identify the MMBRC retrocessionaires, but they are named in other pleadings filed in the consolidated case. They include:

- Savoy Reinsurance Co. Ltd. of the Turks & Caicos. Illinois and California regulators issued warnings against Savoy Re in 1989, after finding that its assets included a $50 million certificate issued by an insolvent Texas trust company and purportedly backed by gold and platinum ore in a New Mexico slag pile (*BI*, June 19, 1989).
- Winston Hill Assurance Co. Ltd. of the Turks & Caicos. California regulators warned brokers against the company last year, and a Missouri court ordered it to stop writing business in the state (*BI*, Jan. 1, 1991; April 22, 1991).

Winston Hill reported $58.3 million in assets in a 1988 quarterly financial statement, including $28.7 million in certificates of deposit with a bank identified only as Dresner Bank and $28.3 million in gold securities held by Gulf Union Bank in Nassau, Bahamas.

- Hanover Guaranty Insurance Co. Ltd. of the Turks & Caicos, which was barred by regulators in California and Texas in 1990 (*BI*, April 16, 1990).

Hanover reported $48.6 million in assets in a 1989 financial statement, including a $46 million claim to mineral deposits in Lincoln County, Ore.

- Old American Insurance Co. Ltd., one of a group of Turks & Caicos insurers formerly operated by Alan A. Teale.

Mr. Teale, who formerly was president of the defunct Insurance Exchange of the Americas, was a target of a Senate insurance fraud investigation last year (*BI*, July 1, 1991; July 25, 1988).

- Oxford Indemnity Insurance Co. of Casper, Wyo., which was ordered into liquidation in December 1989.

The complaint charges that Mr. Zimmerman falsely told line slip members that the non-U.S. retrocessionaires would each be required to post a $1 million letter of credit and that MMBRC would retain 97.5% of the MEWA premiums to pay claims.

The suit does not say how much money the retrocessionaires received, but lawyers involved in the case estimated that $13 million to $14 million was held by MMBRC to pay claims, and that an additional $2 million was actually passed along to the retrocessionaires.

The MMBRC retrocessionaires stopped paying claims in 1990 after MMBRC claim reserves ran out, leaving the 1988 line slip reinsurers potentially on the hook for the remaining MEWA liabilities, court documents say.

The lawsuit charges that All American participated in the alleged conspiracy to generate ceding commissions and life insurance business linked to the MEWA risks. Business Men's Assurance allegedly participated to generate profits for ZLS and Zimmerman & Co., of which it was part owner, the suit charges.

In addition to federal and state racketeering and fraud charges, the complaint charges Mr. Zimmerman with breach of fiduciary duty and all the defendants with interfering with the line slip members' fiduciary relationship with Mr. Zimmerman.

Several defendants—including Mr. Zimmerman, Zimmerman & Co., Mr. Flynn and Flynn & Associates—have filed answers denying the charges, raising several defenses and asserting cross claims against other defendants for indemnification in case they are found liable.

C&A and its two officers have moved to dismiss the complaint on the grounds that it fails to state a claim against them, according to their lawyer, Mark F. Hughes Jr. of Robinson, St. John & Wayne in Newark, N.J.

All American and Business Men's Assurance are also expected to file motions to dismiss the suit, arguing among other things that federal Racketeer Influenced and Corrupt Organizations act claims against insurers are barred by the McCarran-Ferguson Act.

Hugh P. Francis, an attorney for Mr. Flynn and Flynn & Associates, denied any wrongdoing by his clients. He also denied that line slip members were kept in the dark about the MEWA business. "For them to say at this late date that they had no knowledge the pool was writing (MEWA risks) is suspect," said Mr. Francis, of Francis & Berry in Morristown, N.J. He added that ZLS accounting statements separately reported the risks.

He also claimed that MMBRC provided ZLS with financial statements for the retrocessionaires. "If there were any objections to the companies, the opportunity was there to raise them," he said.

However, Mr. Francis said he does not know whether ZLS passed the financial statements along to the line slip members.

Meanwhile, Security Benefit, another line slip member, has filed suit against All American; United Olympic/Bankers Security; C&A; Mr. Flynn and Flynn & Associates; Mr. Zimmerman and Zimmerman & Co.; and Business Men's Assurance.

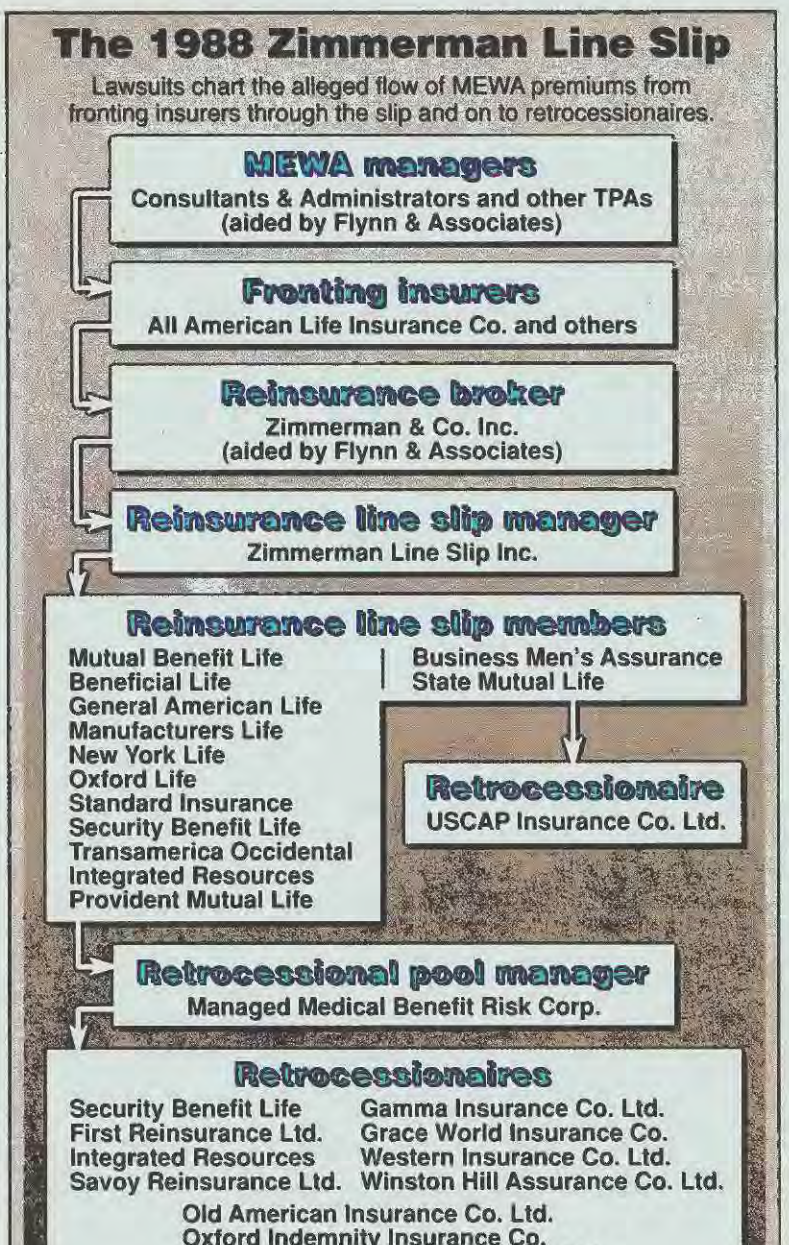
Like the Mutual Benefit action, Security Benefit's suit charges the defendants with conspiring to write MEWA business to benefit themselves, knowing it violated the ZLS management agreement and that the business was unprofitable.

Security Benefit also charges that misrepresentations by Mr. Zimmerman and Mr. Flynn led it to agree to act as a retrocessionaire in the MMBRC pool. Security Benefit took a 5% share of the line slip's MEWA retrocessions.

Separately, in the fourth action in the consolidated case, United Olympic/Bankers Security has filed a complaint against Transamerica Occidental, one of the 1988 line slip reinsurers that did not settle the ceding companies' MEWA claims. United Olympic/Bankers Security alleges breach of contract and bad faith and seeks to recover $938,000 in cash calls for claim payments.

These two complaints also have generated denials by the defendants and a welter of cross claims and counterclaims.

Lawyers say massive discovery proceedings are continuing. ■



GRAPHIC BY JOHN HALL

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Business Insurance
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Bush health plan

Continued from page 1

ments to hospitals and doctors who treat Medicare and Medicaid patients, providers will jack up charges for those covered by employer plans.

"Employers that provide coverage today could potentially and significantly be cost-shifted if Medicare and Medicaid reimbursements are held down," said Dr. Jacque Sokolov, vp and medical director for Southern California Edison Co. in Rosemead, Calif.

However, other elements of the administration package are being applauded. Employers and insurers welcome provisions to pre-empt state benefit requirements as well as restrictions on managed care.

Also, there is support for proposals that would make it easier for small employers to band together to purchase health insurance or to self-fund coverage on a group basis.

Others, while not taking a direct position on the package, are encouraged that the administration has at last staked out a position.

"I've never seen health care become part of the national political debate. That is very gratifying to (those) who have been grappling with thorny health care issues for years," said Cathy Corse Wooster, benefits planning manager at Barnett Banks Inc. in Jacksonville, Fla.

And some experts say the Bush plan is only a first effort so it should not be judged too harshly.

"This is only the first of what will likely be an evolving proposal," said Joseph W. Duva, a partner with Ernst & Young in New York.

Neither the Bush package nor those advanced by Democrats in Congress have any chance of being passed this session, observers say.

The differences in approach are too great to bridge anytime soon. Democrats have proposed the creation of a Canadian-style national health insurance program or a requirement that employers either offer a health plan or pay a new payroll tax.

"There is no consensus on the approach that should be taken," said Chip Kerby, a principal with William M. Mercer Inc. in Washington, D.C.

Still, some reforms—what some observers describe as tinkering around the edges—could be enacted. These reforms could include, for example, barring employers from excluding from coverage new employees who have pre-existing medical conditions and previously were covered under another health plan. Most small employers now have such exclusions, while many large ones also exclude pre-existing medical conditions for a limited period of time.

"It will be tough for members of Congress to say, 'I won't support an incremental change because I want to hold out for something even better,' " said Frank McArdle, a Hewitt Associates consultant in Washington, D.C.

The centerpiece of the Bush package—new tax credits and deductions to help the poor and middle class buy health insurance—is drawing the most criticism as wholly inadequate to assure universal coverage.

The credit also could take the form of a certificate which would be transferred to an insurer to purchase coverage. The credit could not be used for other purposes or taken as cash.

The maximum amount of the credit or deduction would be $1,250 for a single person, $2,500 for married couples and $3,750 for families of three or more.

Individuals with incomes below the federal poverty level would receive the maximum tax credits. Those earning more than the federal poverty level would receive a smaller tax credit, with the credit decreasing to 10% of the maximum for those with income equal to 150% of the federal poverty level.

The poverty level is set at about $7,000 for individuals and about $14,000 for families of four.

Those with income exceeding 150% of the poverty level generally would receive a tax deduction for their health insurance expenses.

No tax deductions or credits would be available to individuals with income of more than $50,000, couples with income exceeding $65,000 or families of three or more with income exceeding $80,000.

Of the 35.7 million uninsured Americans, 10 million are below the federal poverty level. Another 6 million or so people below the federal poverty level either purchase individual health insurance or are covered by an employer plan, says the Employee Benefit Research Institute, a think tank in Washington, D.C.

These individuals and their families would be able to make full use of the tax credit, and many would be able to obtain insurance.

"It seems reasonable to believe that many of these folks would use (the tax credit), since coverage essentially would be free, especially if states subsidize" the difference between the amount of insurance the credit would buy and the actual cost of coverage, said EBRI Research Director Bill Custer.

But Mr. Custer questioned whether the partial tax credits available to people above the poverty level—the so-called working poor—as well as the tax deductions for middle class, would be enough to make coverage affordable for those groups.

"The administration is kidding itself if it thinks the credits and deductions would achieve universal or near universal coverage," said Karen Ignagni, director of the department of employee benefits for the AFL-CIO in Washington, D.C.

If millions of people remain uninsured, hospitals will cost shift to employer plans to recover expenses incurred on uncompensated care.

"The cost shift to pay for the uninsured will not go away," said Roger Taylor, a consultant and national leader for health care at The Wyatt Co. in Washington, D.C.

And if the administration pays for the tax credits and deductions through cutbacks in Medicare and Medicaid reimbursement, providers will shift even more costs to employers, experts say.

"The more Medicaid and Medicare is squeezed, the bigger the cost shift will be to businesses and individuals," said Ron Pollack, executive director of Families USA, a health care advocacy group in Washington, D.C.

There is nothing to prevent that from happening, because the administration did not include any provisions to restrain provider charges.

With more cost shifting, the cost of health insurance will become even less affordable, said Mr. Pollack.

At the same time, if health care costs continue to rise at double-digit rates, the value of the credit and deductions will quickly erode. The maximum amount of the credit and tax deductible expenses would be tied to inflation. But many observers expect that it would be indexed to overall increases in the Consumer Price Index, not its medical care component.

"The affordability gap" will increase, and by the end of the decade, more people—even with tax credits and tax deductions—may be uninsured than today, Mr. Pollack said, adding that annual family health care costs could rise to $14,000 by the year 2000, compared with the current $6,500.

Meanwhile, benefit experts say parts of the Bush plan would make insurance more available to small employers and encourage use of managed care.

For example, under the package, small employers that band together and buy policies from insurers on a group basis through new "Health Insurance Networks" would be exempt from state laws requiring policies to offer certain benefits. Such laws can add roughly 2% to 10% to the cost of coverage, experts say.

In addition, the package would pre-empt state managed care regulations. ■

INTERNATIONAL

Lloyd's underwriters protest BCCI pact

By GAVIN SOUTER

LONDON—Lloyd's of London underwriters may appeal a U.S. District Court ruling restricting their claims to U.S. assets of the liquidated Bank of Credit & Commerce International.

The underwriters argue that the plea agreement approved last month is illegal and fails to reward them for what they say is their crucial role in exposing illegal BCCI activities. The scandal-plagued bank collapsed amid allegations of widespread fraud in July 1991.

Under the agreement, BCCI will plead guilty to racketeering and fraud charges and agree to cooperate with federal authorities. The bank will also forfeit its $550 million in U.S. assets. Half that amount—$275 million—would be used to support two banks formerly owned by BCCI, First American Bankshares Inc., based in Washington, D.C., and Independence Bank of Encino, Calif.

The other half would be given over to the liquidators of BCCI.

U.S. government lawyers argue that this arrangement is the most equitable way to handle the numerous claims on BCCI's assets. Those claims far outstrip the bank's actual assets.

The agreement was approved Jan. 24 by Judge Joyce Hens Green of the District of Columbia.

The underwriters' involvement with the bank dates back five years.

In 1987, Munther Bilbeisi, a Jordanian coffee trader, made a claim on a policy underwritten in Lloyd's, led by syndicates managed by Sturge Holdings P.L.C. The underwriters sued in Florida, charging that the claim was fraudulent

The underwriters say that the BCCI plea agreement is illegal and fails to reward them properly.

and that BCCI aided the fraud by issuing fraudulent letters of credit and cashiers checks (*BI*, July 29, 1991).

The underwriters late last year won their fraud suit against Mr. Bilbeisi, but not before running up legal bills of $9 million (*BI*, Dec. 9, 1991). They say that the plea agreement will hinder their efforts to recover those costs.

The underwriters challenge the plea agreement on two grounds:

- The U.S. government is settling for only a fraction of what it should be seeking.
- The underwriters led the investigations which exposed the illegal activities of BCCI and therefore should be allowed to retrieve their costs from the assets.

"The plea agreement requires a disposition of forfeited assets, which is not authorized by statute and is in violation of the Department of Justice's own regulations," the underwriters state in a court memorandum. Justice Department rules require that the money in an asset forfeiture fund must be made available to the victims of a crime, the underwriters said.

Under the department's regulations, court papers show, the priority of payments is: the expenses of seizure and forfeiture of the property; the recognized net equity of lienholders; and the recognized claims of victims of the related criminal activity.

The Racketeer Influenced and Corrupt Organizations Act entitles victims of crimes to petition the Department of Justice for remission or mitigation of the forfeiture, which is not provided for in the plea agreement, court papers say.

Not all the bank's recoverable U.S. assets are included in the plea agreement. Court papers say it omits the liquidators' U.S. claims against those who defrauded the bank and those that owe it money.

"The provisional liquidators lack either the authority or willingness to recover monies owed to BCCI in the United States. It is uncontroverted that they have not sued any of the perpetrators of the fraud against BCCI," the Lloyd's underwriters charge.

Those perpetrators include people associated with the bank who

Continued on next page

Senegal air crash coverage unclear

LONDON—Mystery surrounds the insurance coverage—or possible lack of it—for a chartered plane that crashed in Senegal last week, killing 31 of the 59 people on board and injuring 15 others.

The plane, carrying mainly French citizens, was on a 45-minute pre-dawn flight from Dakar, Senegal, to a resort owned by Club Mediterranee S.A. in Cap Skirring, Senegal. Its pilot reportedly mistook a hotel's lights for the airport runway and crash landed.

The Convair CV 640 was owned by Gambcrest Enterprises Ltd. Hull and liability coverage for the Gambian company was at one time placed in London by Needler Heath Kingsworth Ltd.

But many French and London aviation underwriters say they believe that Gambcrest's coverage portfolio—including $1 million in coverage for the plane—was canceled recently due to non-payment of premiums. A spokesman for Needler Heath said the company had "no insurance in force on the aircraft," though the broker had "some involvement with the aircraft" in the past. He said he didn't know of any insurance in force at the time of the crash.

London and French sources also believe that the airline Air Senegal had leased the aircraft from Gambcrest. But Air Senegal's hull and liability insurance—placed in the Senegalese market—will probably not pay for the loss. Underwriters for the airline were not notified the plane was being leased from Gambcrest, sources say.

A spokeswoman for French tour operator Club Med in Paris, which chartered the Air Senegal flight, said compensation to the victims will be paid by Union des Assurances de Paris. She did not elaborate. A spokeswoman for UAP in Paris would not reveal any details.

French aviation underwriters say that Club Med's general liability coverage is more likely to pay such compensation than any aviation-type coverage, though general liability coverage would not cover the loss of the aircraft.

—By Stacy Shapiro

Japanese reinsurance renewals

Costs to skyrocket after typhoon loss

By STACY SHAPIRO

LONDON—Japan's 23 non-life insurers could be hit with staggering cost increases and a major capacity shortage for catastrophe reinsurance programs that renew April 1 following a record $5 billion typhoon loss last year.

Already, London reinsurers want to charge 20 to 65 times the price they charged last year for Japanese property catastrophe reinsurance.

One reason for this huge increase is that Japanese insurers are seeking vastly higher limits. When Typhoon 19 hit last year, Japanese insurers had a total of $1.4 billion in catastrophe reinsurance; now they want as much as $5 billion, London underwriters say.

Negotiations still are under way and much can change before March 31, when the current programs expire, executives say. If the insurers find that the prices are just too high, they may retain more risk and buy less reinsurance.

Japan's property tariff rating structure will probably keep insurers from passing on reinsurance price hikes for at least a year.

The Japanese reinsurance renewal season "is a very unusual situation and a very delicate matter," said Hady Wakefield, chairman of C.T. Bowring & Co. Reinsurance Ltd. in London. Bowring is the reinsurance broker for Nippon Fire & Marine Insurance Co. Ltd., Toa Fire & Marine Reinsurance Co. Ltd. and Fuji Fire & Marine Insurance Co. Ltd., all of Tokyo.

Continued on next page



BI GRAPHIC BY JOHN HALL

Bank sale may end voting dispute

By WILLIAM PITT

LONDON—Continental European insurance giants AMG Aachener & Munchener Beteiligungs A.G. and Assurances Generales de France Group may be close to solving their long-running and often bitter dispute over the French company's voting rights at AMB.

For the time being, the French are still talking tough. A senior official at AGF, who asked to remain anonymous, said that the company is considering suing AMB's management in the German courts over its refusal to register the 25% stake AGF has acquired in the German company. Registration of the shares, which AGF began acquiring in 1990, would grant AGF voting rights equivalent to its stake.

Although AGF holds non-voting shares, a 25% stake constitutes a blocking minority under German law, provided the shares are registered. But Aachen, Germany-based AMB said the insurer's bylaws give its board the right to decide whether to register the shares.

However, Peter Matthiesen, a director of AMB, indicated that a solution may be at hand. He explained that AGF suggested last month that it might be able to help AMB find a buyer for part of Bank fuer Gemeinwirtschaft, acquired by AMB in 1987, whose losses have been a drain to the German insurer.

The proposed buyer was Credit Lyonnais, the state-owned French bank. AGF's assistance in this proposal could prompt AMB to register its shares.

Early last week, AMB was still awaiting an offer, but Mr. Matthiesen confirmed that if Credit Lyonnais comes forward, "it will be helpful—especially in the direction of registering (AGF's) shares."

BfG has been a millstone around AMB's neck ever since the insurer acquired control of the bank through a deal with the then-West German trade union movement. The bank was a major lender to Co Op A.G., a supermarket chain that collapsed in 1989. More recently, a deterioration of BfG's loans to Eastern European nations have necessitated further capital injections.

Stock market analysts have repeatedly stressed the healthy quality of AMB's core insurance business, but have lamented that this is not reflected in the share price because of the cloud of uncertainty that has hung over BfG.

Tim Dawson, European insurance analyst at Merrill Lynch in London, last month warned that the "immediate key to higher reported earnings (at AMB) is recovery at BfG." He said this was uncertain because of "the risks in BfG's portfolio given exposure to Eastern Europe and a slowing West German economy."

AGF has stayed away from the "bancassurance" alliances so warmly embraced by other French insurers. But AMB's core insurance business appeals to AGF because Germany is the one major European market where AGF has made little progress in recent years.

AGF has boosted its volume of business derived from outside France by a series of acquisitions in recent years. As a state-owned company, it is barred from trading as a direct insurer in most of the United States, so its foreign expansion has been focused on the European Community.

In 1990, more than one-third of AGF's premiums originated outside France; more than 80% of this non-French business came from other E.C. member states.

However, Germany, Europe's biggest national insurance market, has proved a very hard nut for AGF to crack—as it has for other French insurers. If AGF were able to consolidate its stake in AMB, it would achieve exposure to the German market through what analysts agree is a fundamentally healthy insurer, which is growing fast on the life insurance side.

AGF also has suggested to AMB that a merger between its own reinsurance operations and AMB's might make sense. AGF Reassurances merged last year with another French reinsurer, Societe Anonyme Francaise de Reassurances, based in Paris, but the resulting entity is still much smaller than the giants of European reinsurance. And Aachen Reinsurance Co., AMB's reinsurance subsidiary, is dwarfed by the big German reinsurers like Munich Re and Cologne Re.

"A reinsurance merger would make sense," argued Mr. Dawson at Merrill Lynch. He doubted that AGF would otherwise seek to interfere much in the running of AMB, because it has expressed confidence in the German company's management.

"In the near term—that is, in one, two or three years—what AGF wants to do is consolidate its shareholding," he said. "That would give it a nice return on its investment, because AMB's figures when restated according to French accounting standards look good. There would be an immediate boost to (AGF's) net asset value."

All now hinges on Credit Lyonnais' potential offer to AMB for a stake in the BfG bank. A spokesman for Credit Lyonnais said last week that the bank was "studying the dossier" on BfG, but declined to comment on when, or if, an offer would be made. ■

INTERNATIONAL

BCCI settlement

Continued from previous page

withdrew their funds just before the bank collapsed or borrowed money from the bank, court papers say.

Rather than pursuing those people, the underwriters charge, the liquidators have spent more than $2 million a week since the seizure of BCCI trying to prevent creditors from asserting their claims.

Court papers indicate that in December 1990, the "problem loans" owed BCCI totaled $4.1 billion. That figure comes from Price Waterhouse, the bank's auditors, which also estimates the total amount taken out of the bank fraudulently at $16 billion.

Consequently, the plea agreement "lets the real criminals off the hook," court papers say.

"A $550 million settlement of a $16 billion bank fraud committed against a bank that laundered more than $90 billion in drug money and supported billions more in other forms of tax, customs and insurance fraud, itself borders on the fraudulent " the underwriters allege.

They also took issue with the Justice Department's argument that rather than sue in U.S. courts, the Lloyd's underwriters should sue in Luxembourg, where the bank was incorporated, and the Cayman Islands, where it had extensive operations.

Denying them access to U.S. courts protects the criminals at the expense of the victims, the underwriters claim. "Both Luxembourg and the Cayman Islands have extensive bank secrecy legislation. That legislation will protect the identity of borrowers from BCCI and its customers."

Also, neither jurisdiction allows pretrial discovery to the extent that U.S. courts allow. Broad discovery rules are necessary for any action to recover funds, the underwriters say in their appeal memorandum.

Yet the Lloyd's underwriters contend it was they who financed the civil discovery that provided the information leading to some of the U.S. government's indictments of BCCI.

And this should give them higher priority for compensation, the underwriters argue.

The underwriters' case is strengthened by the inactivity of the U.S. government when the underwriters discovered Mr. Bilbeisi's coffee smuggling in 1983, they charge in court papers.

While Mr. Bilbeisi was smuggling coffee, BCCI transferred "millions of dollars" on his behalf to its offices in Panama City, the underwriters charge. They contend those funds may have been paid as "some form of collateral or security for activities involving" an associate of Panamanian President Manuel Noriega.

"The government was aware of the very coffee smuggling scheme directed by Munther Bilbeisi through BCCI since June 22, 1983, when it decided to do nothing, perhaps because of the connection between Bilbeisi and the government's then-client, Manuel Noriega," the underwriters allege. The statement referred to reports that Gen. Noriega, now being tried in Miami on drug trafficking charges, was once an agent of the U.S. government.

Consequently, the U.S. government's failure to investigate Mr. Bilbeisi and BCCI, after Sturge notified it of the transactions, permitted the bank to perpetuate fraud for so long, the underwriters charge.

The U.S. government, however, successfully argued that the plea agreement is "in the best interest of the worldwide depositors and creditors" of BCCI.

Foreign parties with civil claims against BCCI should not be given preference in claims on bank assets, the government argued.

"There is no constitutional, legal, or equitable reason why these claimants have the right to lay claim to a pool of assets in the U.S. to the exclusion of similarly situated victims worldwide," U.S. attorneys argued. "In essence, the objections to the plea agreement come principally from parties who are unhappy that funds will be forfeited which they had hoped to obtain for themselves." ■

Japanese insurers

Continued from previous page

All but one Japanese non-life insurer exhausted their catastrophe reinsurance programs when Typhoon 19 hit in September, he said. And the typhoon did not even hit portions of Japan with the highest property values, Mr. Wakefield said.

Now that the Japanese insurers are alert to potential windstorm losses, they are re-examining their reinsurance programs, he said.

The insurers want to buy catastrophe reinsurance limits up to the level of their Typhoon 19 loss, "whatever their loss was," added another London broker. But high rates are making that impossible, so "they'll pay for what they can afford," the broker said.

Besides, the capacity isn't available for the limits the Japanese insurers seek, the broker said.

An enormous amount of work has gone into the Japanese reinsurance renewals in the past four months, said Roger Elliott, chairman of Willis Corroon P.L.C., who is personally involved in placing Tokio Marine & Fire Insurance Co. Ltd.'s reinsurance.

Although the Tokio program may soon be completed, Mr. Elliott would not reveal details. Willis Corroon is also the broker for Mitsui Marine & Fire Insurance Co. Ltd., which also is expected to complete renewals shortly.

Generally, Mr. Elliott said, the Japanese insurers "will buy more cover and pay more for it."

A spokesman for Tokio in Tokyo would not comment on its renewals. A spokesman for Mitsui in Tokyo also would not comment on its reinsurance renewals, though he said that reinsurance costs are expected to be four to 10 times more than last year.

Much of the sensitivity pervading current renewals is attributable to Typhoon 19, the fourth most powerful typhoon on record in Japan and the most devastating since the 1950s.

On Sept. 27-28, the typhoon swept across the country, hitting Nagasaki, Hiroshima, Toyama, Hokkaido and other cities with winds up to 150 mph (*BI*, Dec. 2, 1991; Oct. 7, 1991).

Total insured losses for the 23 insurers and two reinsurers in the Marine & Fire Insurance Assn. of Japan Inc. amounted to 484.3 billion yen ($3.8 billion at current exchange rates). Of that total, 86.2% was from property or "fire" policies; 5.5% was from auto policies; 4.3% was from accident policies; and 3.8% was from hull and cargo policies.

In addition, Zenkyoren—the National Mutual Insurance Federation of Agricultural Cooperatives, the insurance division of the Agricultural Cooperation Society of Japan—reported another 145 billion yen ($1.14 billion) in losses from Typhoon 19, London underwriters say.

Until last year, underwriters say, the worst typhoon year was 1990, when Japanese losses totaled only 36 billion yen ($264 million at year-end 1990 exchange rates).

Japanese insurers retained much of the Typhoon 19 loss. Altogether, the insurers bought only about $1.4 billion in catastrophe reinsurance during April 1 renewals last year.

The insurers are expected to tap catastrophe reserves and take out bank loans to cover the claims from the typhoon by the time they report their year-end results on March 31. Altogether, the insurers are expected to use up to 140 billion yen ($1.1 billion at current exchange rates), or 40% of total catastrophe reserves, to meet typhoon claims (*BI*, Jan. 27).

Since much of the losses will be paid out of their catastrophe reserves, it is unlikely that Typhoon 19 will dramatically affect the insurers' income statements for the year ending March 31, said Shelly Harris, vp for Standard & Poor's Corp. in New York. Overall, the insurers' net income will be flat or slightly down from the previous year, while surplus will remain strong, she added.

The typhoon losses probably will not prompt S&P to downgrade any of the nine Japanese insurers it tracks, said Bob Mebus, managing director of insurance rating service for S&P in New York. Eight of those insurers are rated triple-A.

But the financial strength of the non-life insurance sector in Japan is not what it once was, said Mr. Mebus. With auto insurance setbacks in Japan, an uncertain legislative climate, slumping asset values and Typhoon 19 losses, "some of the luster has come off," he said.

Meanwhile, there is a "big gap" this renewal season between the significantly higher rates that Japanese insurers are being asked to pay and what they may be willing to pay, Mr. Mebus said. He said he wouldn't be surprised if the ceding insurers increase their net retentions rather than pay higher premiums.

Japanese insurers could recoup higher reinsurance costs only by increasing premiums on property policies, he added. But that's easier said than done. Any such changes would have to be approved by the Ministry of Finance, and "that's very political," said Mr. Mebus.

Since 1985, Japanese property insurance policies have covered windstorm losses for free, though policyholders must pay extra for earthquake coverage.

Generally, Mr. Elliott says, the Japanese insurers 'will buy more cover and pay more for it.'

The policy pays "first-yen" losses from windstorms as long as the damage exceeds 200,000 yen ($1,568). If the damages do not reach that level, the insurer pays nothing. This policy mechanism is called a "franchise" rather than a deductible, since the policy will pay everything if losses exceed the set amount.

Any rate change also would be based on the last 30 years of claims experience for windstorms, many sources add, which could dilute Typhoon 19's effects.

Although insurers may begin negotiations with the Ministry of Finance to change the rating system in light of Typhoon 19, no change is likely for at least a year, they add.

The Mitsui spokesman said "there is no discussion to introduce a new type of insurance or to change the existing (tariff) system. . . . .We have no intention of changing the rate for fire insurance so far, but if there is another big typhoon or hurricane this year, we may have to change the rate."

More likely than attempting to raise insurance rates, the Japanese insurers will buy the catastrophe reinsurance they can afford and retain "vast amounts" of windstorm risk, says a London broker.

Some insurers have been asked to pay 12% of their total net income for their reinsurance programs this year, though the insurers will probably spend less than 5% of net income on reinsurance, he said.

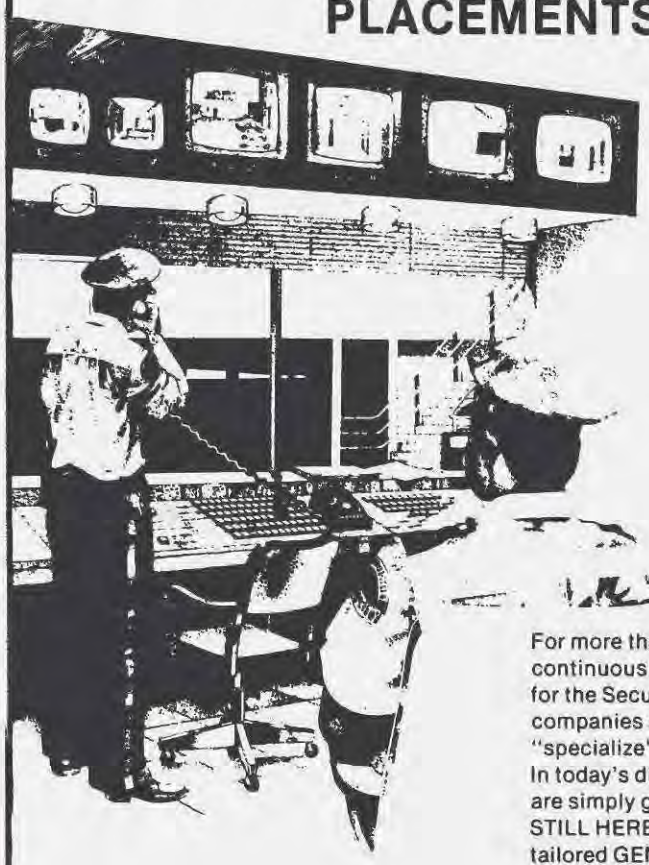
Paying the reinsurance premium could still be less expensive than retaining the risk through the catastrophe reserves, since contributions to reserves exceeding 2% of total net income are taxed at a 52% rate, he said.

The Japanese insurers also might examine various ways to structure their reinsurance programs to reduce cost, sources say. This would include co-reinsuring of various layers of the program; splitting windstorm and earthquake exposures into separate reinsurance programs; and increasing deductibles.

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Judith Rawnsley in Tokyo contributed to this story.

A BRIEF MESSAGE ABOUT INSURANCE PLACEMENTS FOR



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Tort reform

Continued from page 2

states this year, up from 28 states in 1991, ATRA says in its "State Tort Reform Outlook for 1992" report.

ATRA targets the following states for reform: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin and Virginia.

The group also targets the District of Columbia.

ATRA points out that its current outlook and agenda do not take into account changes that could come about as a result of the Bush administration's initiatives.

Besides the measure introduced in Congress, the administration is offering a model tort reform package for states to consider (see update, page 2).

Medical malpractice liability reforms are a key issue in 1992, with tort reform advocates pushing for malpractice reform legislation in 22 states and the District of Columbia.

ATRA sees a push for medical liability reforms in Arkansas, California, Colorado, Delaware, Florida, Georgia, Iowa, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Utah, Vermont, Washington, West Virginia and Wisconsin.

In Georgia, the Georgia Liability Fairness Coalition is leading a renewed effort to reform medical malpractice laws, ATRA says.

Among other goals, the coalition this year is pushing for passage of a bill that would update the definition of a professional standard of care provision in medical malpractice law. It wants to redefine that standard as "that level of care, skill and treatment practiced by reasonably prudent health care practitioners nationally in the same specialty and under similar circumstances."

The legislation also would reform the state's collateral source rule so juries could hear evidence that injured plaintiffs have received or are eligible for other relief, like workers compensation coverage.

On the East Coast, reform legislation pending in New York is designed to lower liability insurance premiums for obstetricians and gynecologists by establishing a no-fault compensation system for infants born with neurological impairments.

Product liability reforms also continue to be high on tort reform advocates' agendas. Legislators are reviewing product liability bills in Hawaii, Iowa, Mississippi, New Hampshire, New York, Oklahoma and Pennsylvania, ATRA says.

For example, the Iowa Alliance for Liability Reform has put together a legislative package that would, among other things:

- Grant limited immunity to manufacturers when a plaintiff misuses or fails to properly maintain a product.
- Create a so-called "affirmative defense" when a product is "altered, modified or changed in a way by a third party so that it contributed to the alleged injury."
- Prohibit juries from hearing evidence of subsequent design changes in the manufacture of a product.
- Limit a plaintiff's cause of action to negligence against a manufacturer for alleged design defects, failure to warn and failure to guard from defects.

The Iowa reform package also calls for a $200,000 cap on non-economic damages; restrictions on punitive damage awards; and development of alternative dispute resolution systems.

In Pennsylvania, the Pennsylvania Task Force on Product Liability intends to revisit efforts to pass product liability reform legislation that was approved by the House last year but fell short in the Senate.

"This year, the task force is keeping the product liability reform issue in the spotlight," ATRA reports.

On another major front, tort reform advocates this year are pushing proposals to limit punitive damages in Alabama, Florida, Maryland, Mississippi, Missouri, Oklahoma and Wisconsin.

The U.S. Supreme Court last year refused to set specific limits on juries' ability to award punitive damages, but did say the juries must be properly instructed and judges must review punitive awards by juries (*BI*, March 11, 1991).

In Florida, the Florida Defense Lawyers Assn. and Project Civil Reform Inc. are working for passage of a measure that would abolish vicarious liability for punitive damages, except in cases of an employer's gross negligence or those in which corporate officers are involved. Vicarious liability occurs when a company is held liable for the acts of someone who works on behalf of the company but is not employed by the company.

In Maryland, a bill would limit punitive damages to four times compensatory damages, while another bill would establish specific criteria for awarding punitive damages.

ATRA also is backing legislation that would control attorneys' fees in Alaska, Illinois, Indiana, Michigan and Washington.

Legislators in four states are expected to consider reform of joint and several liability laws this year. Those states are Florida, Minnesota, Nebraska and Rhode Island.

ATRA also expects reform efforts to encourage alternative dispute resolutions in Colorado, Georgia, Iowa, Utah, Vermont and Washington.

And, in Colorado and the District of Columbia, legislation is expected to codify immunity for the good-faith actions of volunteers for non-profit and certain other groups.

Defending already enacted tort reforms also will be a key concern this year, according to ATRA.

This year, defensive efforts to protect earlier tort reform victories will be needed in 12 states: California, Colorado, Florida, Indiana, Kansas, Kentucky, Louisiana, Maine, Nebraska, New York, Wisconsin and Virginia.

In these states, "opposition legislation, which would either repeal previous tort reforms or expand liability," is expected in the areas of prejudgment interest, product liability and punitive damages, according to ATRA's 1992 State Tort Reform Outlook.

California is cited as a particularly important battleground.

ATRA warns that potential challenges to California's 1975 Medical Injury Compensation Reform Act "pose one of the most serious threats in the country to tort reform in general."

MICRA, hailed by tort reform advocates as "the ultimate tort reform," among other things limits non-economic damages to $250,000, establishes a sliding scale for attorneys' fees and allows periodic payments of damages.

The law has "withstood constitutional challenges on the state and national levels and has had a dramatic impact on the frequency and severity of claims," ATRA said. "Some experts claim liability costs would be 50% higher without MICRA."

However, a showdown is brewing over MICRA.

In 1987, the California Trial Lawyers Assn. attempted to change MICRA's sliding scale for contingency fees, ATRA said.

A legislative battle that ensued eventually led to compromises contained in a 1987 law known as the "California Accord." The trial bar won a 5% increase in the upper end of the fee scale, but the law contains so-called "inherent risk" provisions that prohibit product liability lawsuits stemming from products that

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ISSUE	CLOSING*	1992 MEETING/CONFERENCE	LOCATION
Mar 9	Feb 25	International Captive & Reinsurance Forum	Bermuda
Mar 30	Mar 17	Risk & Insurance Management Society	Anaheim
Mar 30	Mar 17	National Managed Care Congress	Washington, DC
May 4	Apr 22	National Association of Insurance Brokers	Pebble Beach
May 18	May 5	Public Risk Management Association	Anaheim
Jun 29	Jun 16	Society for Human Resource Management	Las Vegas
Jul 6	Jun 24	National Association of Insurance Commissioners	Washington, DC
Aug 17	Aug 4	American Risk & Insurance Association	Washington, DC
Aug 31	Aug 18	Monte Carlo Rendez-Vous de Septembre	Monte Carlo
Sep 7	Aug 25	Self-Insurance Institute of America	New Orleans
Sep 14	Sep 2	Independent Insurance Agents of America	New Orleans
Sep 21	Sep 8	Nat'l Assoc. of Professional Surplus Lines Offices	Chicago
Sep 21	Sep 8	RIMS Singapore	Singapore
Oct 5	Sep 22	Nat'l Assoc. of Casualty & Surety Agents & Executives	Greenbrier, WV
Oct 12	Sep 30	Chartered Property & Casualty Underwriters	San Francisco
Oct 26	Oct 13	National Association of Independent Insurers	Orlando
Oct 26	Oct 13	Baden-Baden Conference	Baden-Baden, W. Germany
Nov 9	Oct 27	National Association of Professional Insurance Agents	Orlando
Dec 7	Nov 23	National Association of Insurance Commissioners	Atlanta

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Tort reforms

Continued from page 73

are inherently unsafe, like alcohol, cigarettes and foods high in cholesterol.

Trial lawyers and reform groups in 1987 agreed to a five-year moratorium on efforts to further change MICRA, ATRA points out.

However, it says, "the truce ends Dec. 31, 1992. Both sides have begun to prepare for the fight ahead."

State tort reform coalitions also are on guard in 12 states against so-called "protective order" legislation, which would limit the ability of parties settling a suit to keep the settlement terms sealed.

Those states are: California, Connecticut, Hawaii, Illinois, Kansas, Louisiana, Minnesota, New Hampshire, New Jersey, South Dakota, Wisconsin, and Massachusetts.

While ATRA has not taken a position on protective order legislation, many state coalitions are concerned that opening settlement records could encourage additional lawsuits.

But, protective order reform proponents contend that settlement terms should be a matter of public record.

Last year, ATRA and state tort reform coalitions repelled efforts to rescind tort reform laws or prevented passage of legislation that would have expanded liability in 29 states.

Among the blocked proposals were bills that would have expanded punitive damage awards in Louisiana, Maine and Maryland.

In addition, in Kansas and Oregon, bills that called for stricter product liability were defeated.

State tort reform coalitions in several states also were successful in defeating protective order reform legislation.

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Free copies of the ATRA's "State Tort Reform Outlook for 1992" can be obtained by contacting Anne Allen at ATRA, 1212 New York Ave. N.W., Suite 515, Washington, D.C. 20005; 202-682-1163.

Maryland court upholds limit on court awards for pain and suffering

By MICHAEL SCHACHNER

BALTIMORE—Maryland's highest court has upheld the constitutionality of a 1986 state law that caps awards for pain and suffering in personal injury cases.

The 5-2 ruling by the Maryland Court of Appeals marked only the second time a state high court has upheld a cap on pain and suffering awards.

Capping the awards at $350,000 does not violate the constitutional right to equal protection under the law, because the statute authorizing the cap "represents the type of economic regulation" required to control the tort liability system, the court ruled.

Lawyers for the plaintiff, an auto accident victim who was awarded $510,000 in non-economic damages, argued that the cap created an unconstitutional double standard.

Severely injured victims could not be fully compensated for their pain and suffering, the attorneys said, while the less severely injured could be.

That argument was rejected by the court. Writing for the majority, Judge John Eldridge said that if there is a rational reason for a law, it will be upheld as constitutional despite the fact that people are treated unequally.

The rational reason for the pain and suffering cap was to control damage awards to keep liability insurance available and affordable, the court said.

The ruling means that a pain and suffering award will be reduced to $350,000 for Sarah Murphy, now 62. She suffered serious neck and shoulder injuries in a 1987 highway collision with a tractor trailer that was owned by Port East Transfer Inc. of Baltimore.

The Feb. 7 ruling affirms a 1990 ruling in which the Maryland Special Court of Appeals lowered the original award.

An award of $287,000 to cover medical and other expenses was unaffected by the ruling.

The state's high court also vacated a $1 million punitive damage award against the trucking firm, ruling that the accident was caused only by ordinary negligence and not gross negligence.

Only one other state high court—in Kansas—has upheld the constitutionality of caps on pain and suffering awards.

Robert O'Brien of Niles, Barton & Wilmer in Baltimore, which represented the trucking firm, said Maryland's appellate courts have appropriately viewed the caps as "reasonable attempts to control the problem surrounding tort liability."

Also praising the ruling was the American Tort Reform Assn., a business-backed lobbying group in Washington, D.C.

"Needless to say, we're delighted. While caps may not be the only solution to controlling the tort system, they have been effective in the states where they exist," said ATRA President Martin Connor.

Six other states—Alaska, Colorado, Hawaii, Idaho, Minnesota and Oregon—have capped pain and suffering jury awards since 1986, according to ATRA. Courts in those states have not definitively ruled on whether the caps are constitutional.

Courts in Florida, New Hampshire and Washington have struck down such caps on the basis that they violate equal protection guarantees, according to ATRA.

George White, an attorney with White, Mindel, Clarke & Foard in Towson, Md., which represented Ms. Murphy, called the ruling "unfair," but said he would not ask the U.S. Supreme Court to review the ruling.

•

Murphy vs. Edmonds, et al., Court of Appeals of Maryland, 99 Sept. term 1990.

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Outhwaite

Continued from page 1

underwrote the 32 disastrous runoff reinsurance contracts on which the trial centered.

Settlement talks began late last year between Peter Nutting, chairman of the Outhwaite 1982 Names Assn., and Stephen Merrett, the representative for the defendants' E&O insurers, third parties say.

Lloyd's executives, including the chairman, "played no part in the negotiations," said Mr. Nutting.

Trial observers speculate that the case was settled because the defendants were concerned that London High Court Justice Saville might rule in favor of the plaintiffs. That would have set a legal precedent for other members litigating with members agencies over losses.

"In litigation, there is always the possibility of settlement," Mr. Nutting said. "It's hard to put a finger on any one (reason). . . .Litigation is extremely unpredictable."

Under the terms of the settlement, "no liability is admitted by anybody," Mr. Nutting said.

The 627 members of the 1982 Outhwaite syndicate who did not join the legal action will receive none of the settlement proceeds.

These members had an opportunity to join the members' action group as late as last June and did not do so, so are not party to the settlement, said John Heynes, a representative for the members agencies.

Of the 116 million pound settlement, approximately 61 million pounds ($108.6 million) will partly cover cash calls that have already been paid by the members; 19 million pounds ($33.8 million) is for interest on the cash calls; and 34 million pounds ($60.5 million) is for estimated future losses. Another 2 million pounds ($3.6 million) will pay for the bulk of the members' legal costs, said Mr. Nutting.

Each plaintiff will receive an amount equal to approximately 450% of the premium he or she underwrote in 1982, he said.

However, the settlement does not end the prospects for additional losses on the open 1982 year of syndicate 317/661. Including existing losses and estimates of future loss experience, the syndicate faced $481.8 million in losses as of the beginning of 1991, Outhwaite records show.

The losses came mainly from the 32 runoff reinsurance contracts Mr. Outhwaite wrote, which covered exposures to U.S. asbestos losses.

Total cash calls collected on all 1,600 members as of the end of 1991, total 181.5 million pounds ($339.4 million at appropriate exchange rates), Outhwaite records show. A further cash call of 13.1 million pounds ($23.3 million) is expected this year or next year, with the calls totaling 200.4 million pounds ($356.7 million). So far, only 5.8 million pounds ($10.3 million) of the past cash calls has not been collected, the records show.

The settlement will be put before a committee of the Outhwaite 1982 Names Assn. at a March 4 meeting, Mr. Nutting said. If the committee rejects the settlement, the trial will resume before Justice Saville.

However, "I have little doubt the plaintiffs will approve the settlement," Mr. Nutting said. "It's a good settlement for us."

The settlement does not absolve members from paying cash calls as the 1982 year of account deteriorates as expected, Mr. Nutting said. The account is expected to remain open, he said.

And Mr. Outhwaite is expected to remain as underwriter of the syndicate and run off the 1982 account, Mr. Heynes noted.

The Outhwaite 1982 Names Assn. is attempting to organize a limited stop-loss policy to further reduce the members' losses, the premium for which will be paid out of the settlement, Mr. Nutting said.

Meanwhile, the settlement will be partially paid by Lloyd's underwriters, since much of the members agencies' E&O coverage is traditionally placed in the market.

Mr. Nutting admits that when he gets his settlement check, he probably will have to pay out on behalf of other syndicates of which he is a member.

Mr. Merrett could not say how much of the E&O settlement would be paid by Lloyd's syndicates. The loss will be spread over many syndicates in different underwriting years, he said.

The Outhwaite trial was expected to continue until Easter. If the case against the members agencies had been successful, the members agencies were expected to sue R.H.M. Outhwaite (Underwriting Agencies) Ltd. to recoup their losses.

In the landmark trial, Anthony Boswood, the trial lawyer for the members, said, "Never in the commercial history of the City of London has so much money been lost by the single-handed negligence of one man" (*BI*, Oct. 14, 1991).

Over the course of the four-month trial, major figures in the London insurance market took the stand.

Mr. Outhwaite entered the witness box and robustly defended his decision to underwrite the runoff policies. In sometimes heated exchanges with Mr. Boswood, Mr. Outhwaite repeatedly said he wrote the contracts because he thought they would produce a profit for syndicate members (*BI*, Nov. 4, 1991).

Mr. Outhwaite argued that at the time the contracts were written, neither he nor the rest of the insurance industry could have foreseen the magnitude and speed with which asbestos losses would hit insurers.

Experts testifying for the plaintiffs countered that Mr. Outhwaite should have realized at the time that the contracts might produce large losses (*BI*, Nov. 25, 1991).

Richard Hazell, deputy chairman of Lloyd's, was called to testify for the defense. While he said the runoff contracts were written before the extent of the asbestos problem was clear, Mr. Hazell later admitted that Mr. Outhwaite and other underwriters—including himself—had used "unsound methodologies" to calculate potential asbestos liabilities in 1981 and 1982 (*BI*, Feb. 3).

Following Mr. Hazell's testimony, the court adjourned earlier this month for a week, citing "administrative reasons." Then, last Tuesday, both sides announced they had settled.

Mr. Merrett said it was just "coincidence" that the trial was suspended and later settled after Mr. Hazell testified.

Following the settlement, members associations and lawyers representing disgruntled members were flooded with inquiries from members seeking to join other court actions and associations.

"The telephones and fax machines haven't stopped ringing and I've had a sack full of mail," said Michael Freeman, senior partner at Michael Freeman & Co., a London law firm representing members.

Mr. Freeman has advised members of troubled syndicates to seek a court injunction to prevent drawdowns on their Lloyd's funds if other members refuse to make cash calls (*BI*, Feb. 3).

Many of the members now seeking to join the rush to obtain court injunctions were spurred into action when they saw that the Outhwaite members who did not sue would not receive any compensation under the terms of the settlement.

Lawyers say that under the Limitation Act of 1980, the Outhwaite members who did not join the original action will be time-barred from bringing a separate court action.

And the E&O insurers are unlikely to make any payments to the non-litigating members, Mr. Freeman said.

Executives at the Assn. of Lloyd's Members said they lent a sympathetic ear to the many non-litigating Outhwaite members who called when the settlement was announced.

"Some have contacted us and said that they paid on time out of loyalty to their agents and that loyalty deserves some compensation," said Roger Pascall, administrative director at the ALM.

Also, many of the non-litigating members were working members who were encouraged by their employers not to sue, he said.

The estimated 30 million pounds ($53.4 million) that would be needed to compensate the non-litigating members could be drawn from Lloyd's Central Fund, suggested ALM Chairman Mark Farrer. But, "I would only favor this solution if it was absolutely certain that you could then draw a line in the sand and ensure that a dispute like this would not happen again," he said.

Ultimately, Lloyd's should implement an arbitration and mediation system to make litigation between members and agents unnecessary, Mr. Farrer said.

Inquires and fees for joining the litigation were clogging the mail box at D.J. Freeman, another London law firm representing members, said partner David Tiplady.

Mr. Tiplady represents members in the Pulbrook 334 Names Assn., the Pulbrook 90 Names Assn. and the Poland Names Assn., which represents members of syndicates 105 and 108. All four syndicates have suffered large losses.

The Poland Names Assn. alone added 50 new members within a day of the Outhwaite announcement, Mr. Tiplady said.

Inevitably, more members will turn to litigation to recoup their losses, he said. "It was naive of the E&O underwriters to settle Outhwaite" because the case was not unique.

Although the Outhwaite settlement will not set any legally binding precedent, it will encourage members involved in other litigation to continue fighting their cases, Mr. Tiplady said.

Also, some members of the E&O syndicates that will finance the Outhwaite settlement may now consider suing their agents for negligence in settling, he speculated.

One day before the Outhwaite settlement was announced, members of the Warrilow 1984 Names Assn. reported that they had reached a settlement with C.J.W. (Underwriting Agencies) Ltd.

The 685 members were suing the agency for negligence after suffering losses of around 270% of their underwriting capacity on syndicate 553.

The members agreed on a settlement worth 4 million pounds ($7.1 million), said Warrilow Names Assn. Chairman Tom Benyon.

Total losses on syndicate 553 are estimated at more than 80 million pounds ($142.4 million). The case was due to go to trial in April.

The two settlements may have been made under pressure from the Lloyd's Council and Lloyd's officials, Mr. Benyon said.

"Lloyd's wants to clear the decks and encourage settlements wherever it can get them," he said.

Another major dispute over members losses that will be heard soon in the London High Court involves members of syndicates formerly managed by Oakeley Vaughan Underwriting Ltd. who are suing the Corporation of Lloyd's.

Lloyd's is now appealing a 1991 court decision that granted the members a full trial. Lloyd's maintains that the dispute could be settled at a preliminary hearing. The appeal will be heard by the House of Lords by mid-April.

Neither Lloyd's nor any of the Oakely Vaughan members' representatives would comment in the wake of the Outhwaite settlement.

Other existing and former managing agents that managed syndicates where members action groups have been formed include: Rose Thompson Young (Underwriting) Ltd.; Feltrim Underwriting Agencies Ltd.; Gooda Walker Ltd.; Merrett Underwriting Agency Management Ltd.; Mackinnon Hayter Ltd.; Cuthbert Heath Underwriting Ltd.; and R.A.F. Macmillan & Co. Ltd. ■

Politicians attack Lloyd's practices

By GAVIN SOUTER

LONDON—British politicians on both sides of the political divide are joining forces to attack Lloyd's of London.

The regulatory structure of Lloyd's and the credibility of individual underwriters were subjected to a political onslaught last week by an extraordinary alliance between left-wing Labor members of Parliament and wealthy Conservative MPs who have lost money at Lloyd's.

Lloyd's vigorously denied allegations raised by politicians of a "structural rottenness" in market regulation and that working members have profited at the expense of non-working members.

Lloyd's Chairman David Coleridge called the allegations an "unwarranted slur."

The political furor also fueled calls from Labor members for independent regulation at Lloyd's.

The storm began last Tuesday when Mr. Coleridge and Lloyd's Chief Executive Alan Lord addressed a meeting of Conservative MPs, several of whom are Lloyd's members.

At the meeting, Conservative MPs distributed detailed documents alleging malpractice at Lloyd's.

Those documents were leaked the next day to two left-wing Labor MPs, Brian Sedgemore and Dennis Skinner, and to Labor MP Marjorie Mowlam, who serves as the party's spokeswoman for City affairs.

Later that day, Messrs. Skinner and Sedgemore introduced motions in Parliament based on the documents alleging poor practices at Lloyd's and preferential treatment of working members, and called for an inquiry into Lloyd's.

"This House notes with alarm that Mr. David Coleridge. . .who reputedly earns 800,000 pounds ($1.4 million at current exchange rates) plus profits, was accused at a meeting with Tory honorable members of not being on the side of the primacy of the interests of the names at Lloyd's," the motion read.

The motion also singled out some underwriters in the market.

For example, it said that Brian Smith, underwriter of syndicate 45, managed by Bankside Syndicates Ltd., had a personal underwriting result of 213,422 pounds ($411,904 at appropriate exchange rates) for 1988 when the average external members "had a substantial loss and 6,000 mostly external members have had calls from Lloyd's of over 90,000 pounds ($159,300)."

Also singled out in the motion was Terry Green, underwriter of syndicate 321, managed by Gresham Underwriting Agencies Ltd., who is known as "Time Bomb Terry," according to the motion. The underwriter paid himself 353,220 pounds ($681,714 at year-end 1990 rates) in 1990 and is having to make advanced calls of 26 million pounds ($46.1 million) for the syndicate's 1989 and 1990 years, the motion said. Syndicate 321 was placed into runoff at the end of 1991.

The motions also alleged that working members were placed on profitable "insider" syndicates at the expense of non-working members.

More than 60% of the capacity for many of these so-called insider syndicates was supplied by working members, whereas the average syndicate capacity supplied by working members is 12%, the motions said.

The motions contend that the insider syndicates and their underwriting agents are: syndicate 45, managed by Bankside Syndicates Ltd.; syndicate 138, R.F. Bailey (Underwriting Agencies) Ltd.; syndicate 179, Anton Underwriting Agencies Ltd.; syndicate 183, Martin Ashley Underwriting Agencies Ltd.; syndicate 372, Claremount Underwriting Agency Ltd.; syndicate 431, Wren Underwriting Agencies Ltd.; syndicate 960, R.W. Sturge & Co.; syndicate 990, Morgan, Fentiman & Barber; syndicate 994, B.P.D. Kellett & Co. Ltd.; and syndicate 1028, Wellington Underwriting Agencies Ltd.

The motions called for an inquiry by the secretary of state for trade and industry. Labor MP Mowlam also called for an investigation in a letter to John Redwood, the minister for corporate affairs.

"The serious nature of these statements merits, in my view, an independent internal investigation of the present practice of the underwriting business, rather than the existing investigation into particular syndicates," she said referring to the document distributed to Tory MPs and Lloyd's loss reviews.

Ms. Mowlam later said Lloyd's should be independently regulated rather than self-regulated.

Mr. Redwood also received a delegation of aggrieved Lloyd's members seeking an investigation.

Led by Conservative MPs Paul Marland and David Tredinnick, the delegation was told by Mr. Redwood that they had three options: They could seek discussions with Lloyd's; if that failed, they could take legal action; and if they had any evidence of fraud, they could supply it to the Serious Fraud Office.

MPs and Lloyd's executives are to meet today to discuss reform proposal released by a Lloyd's the task force last month. Lloyd's said the meeting was set before the political storm last week.

Both Mr. Marland, a former member of Lloyd's, and Mr. Tredinnick, a current member, reportedly lost money on syndicates formerly managed by Gooda Walker Ltd.

About 60 MPs, all Conservatives, are members of Lloyd's.

Lloyd's fiercely denied the allegations in the motions and in the document distributed to Conservative MPs.

"I consider that this package of motions is irresponsible and dangerous. The facts are very different to this catalogue of unsubstantiated allegations, which represent a quite unwarranted slur on the worldwide reputation of Lloyd's and are harmful to the many thousands of policyholders who rely upon Lloyd's for their insurance protection," Mr. Coleridge said.

He defended Lloyd's internal regulation and denied allegations that working members benefit at the expense of external members.

"The fact is that in two of the last three completed (years of account), external members have enjoyed a higher return than working members," Mr. Coleridge said.

An inquiry is not needed and would not be helpful, he claimed.

Also taking issue with the charge that working members benefit at the expense of external members was Brian Kellett, chairman of B.F.D. Kellett & Co. Ltd., manager of syndicate 994, which was named in the Labor motions.

Mr. Kellett denied that 60% of the syndicate's capacity was provided by working members. He would not give the actual figure, though, saying only that it was "substantially lower."

He added that all of the external members his agency manages were placed on syndicate 944, yet five working members were not. Kellet & Co. manages 120 members.

"It is simply not true that we tell members agent who they should and who they should not put on the syndicate," Mr. Kellett said. ■

Texas insurer

Continued from page 1

associate commissioner for financial programs.

Other options, according to Mr. Gardner, include selling off assets, including the proposed sale of a solvent life insurer subsidiary; finding a buyer for the company as a whole; placing it into conservatorship; or placing it into receivership, which could lead to liquidation.

ECC's financial problems were caused in part by the unpredictability of the Texas marketplace for both general liability and workers comp insurance in the late 1980s. Insurers lost $582 million on Texas workers comp insurance alone in 1989 (*BI*, May 20, 1991).

"I'm not aware of any carrier writing our kind of business in Texas that made any money from 1985 on," said Ernest L. Proud Jr., ECC's chairman, president and chief executive officer.

The action against ECC is not expected to create workers comp capacity problems for Texas employers because Texas workers comp insurance capacity is expanding in light of recent reforms.

"The mutual intent of the department and Employers Casualty is to wind down affairs in an orderly fashion," Mr. Proud said.

If ECC's $650 million in assets "are managed correctly, a draw on the Texas Property & Casualty Insurance Guaranty Fund may be averted or minimized," Ms. Flint said.

If it is necessary to liquidate ECC, guaranty funds nationwide would pay policyholders' claims up to statutory coverage limits. ECC, a direct-writing insurer, was licensed in all states except New Jersey, but it wrote more than 80% of its 1990 business in Texas.

Regulators say they have been working with ECC during the past 18 months to reduce the company's premium volume. ECC's net premium to surplus ratio stood at 4.3-to-1 at year-end 1990 and 3.2-to-1 at year-end 1989. The company's net written premiums dropped to $143 million in 1991 from $311.6 million in 1990, $446.5 million in 1989 and $481 million in 1988.

In addition, ECC over the past two years changed its top management, strengthened loss reserves, discounted claim reserves with regulatory approval, downsized its non-Texas operations and increased the liquidity of its investments.

Regulators seized ECC last week after both the department and actuary Milliman & Robertson Inc., hired by the company at regulators' request, determined ECC's loss reserves were deficient by as much as $63 million.

ECC agreed to add $57.2 million to its reserves as of Dec. 31 in response to the audit. Mr. Proud that said about $40 million of that addition is related to general liability business written prior to 1990, while the remainder is related to pre-1990 workers comp policies.

According to ECC, the $57.2 million charge lowered its policyholder surplus to $32.2 million at year-end 1991 from $72.3 million a year earlier. Surplus stood at $138.9 million at year-end 1989 and $209.4 million at year-end 1988 (see chart, page 1).

ECC already had added $100.6 million to prior-year reserves during the second quarter of 1990.

However, despite the nearly $160 million in additions to reserves in less than two years, Texas regulators contend that ECC should write off another $84.9 million. That would reduce ECC's surplus to a negative $52.7 million, based on $702.7 million in liabilities and $650 million in assets, according to an estimate calculated from ECC's preliminary year-end 1991 figures.

Among other things, the department is insisting that ECC immediately record a $60 million liability for future losses in states other than Texas that is owed to the National Workers' Compensation Reinsurance Pool.

"The national pool is a huge problem for work comp insurers," Mr. Proud said. He contends that ECC should not be forced to record assessments to the pool as a liability until they are actually due. "The company has been recording these assessments as they are levied and paid, which for 1991 totaled $9.2 million," he said in his letter to stockholders.

However, Mr. Gardner said the department plans to stick with its conservative approach and demand that future amounts owed to the pool be recognized immediately.

The National Council on Compensation Insurance, which administers the pool, agrees that insurers should book as a liability their share of the pool's incurred losses, said Judy Gillam, an NCCI actuary in Boca Raton, Fla. "I would assume that it is rare that a carrier wouldn't consider the incurred liability."

Pool assessments are becoming an increasingly large factor in workers comp insurers' finances as the size of the residual market nationwide balloons and losses multiply (*BI*, Sept. 16, 1991). The board of directors of the national pool last year boosted the pool's own reserves by $1.4 billion, or 15% (*BI*, April 15, 1991).

In addition to the dispute over assessments owed to the national pool, the Texas department also is contesting how ECC accounts for retrospectively rated premiums as well as the valuation of ECC's corporate headquarters in Dallas, which also formerly housed Texas Employers Insurance Assn.

TEIA, a mutual insurer that was placed in conservatorship in April 1990, shared management with ECC (*BI*, March 12, 1990).

While TEIA's demise was not directly responsible for ECC's problems, it placed "heavy pressure" on ECC because it faced higher operating costs after TEIA stopped underwriting, Mr. Proud explained.

The consent order between ECC and the Texas department allows ECC to continue to seek capital, perhaps in the form of a buyout, though it has been unsuccessful in seeking capital during 1991, Mr. Proud said.

However, the order prevents ECC from disposing or transferring assets without regulators' approval.

ECC stock, which is publicly traded on the over-the-counter market, closed at 50 cents per share on Thursday, down from a 52-week high of $4.50.

The consent order also calls for department regulators to choose a supervisory team to oversee and control the company's operations.

It is "highly unlikely" that current ECC executives will be asked to participate on the team, regulators say.

Regulators initially intended to allow ECC to follow normal business procedures, which require that existing policyholders be notified by mail 90 days prior to the expiration of their policies that the policies would not be renewed. However, the department now is deciding whether a special notice to policyholders would be helpful, Ms. Flint said.

ECC's financial problems "didn't come as a total surprise," said Theo van Eeten, executive vp of the Professional Insurance Agents of Texas in Austin.

A.M. Best Co. lowered its rating for ECC and its affiliates to a C in 1990 from C-plus in 1989 and A in 1988. ECC alone received a Bq rating in 1991 from Standard & Poor's Corp. under its qualified solvency rating system.

Regulators began insisting that ECC reduce its premium volume over the past 18 months, with net written premiums steadily falling to $143 million last year from $481 million in 1988.

ECC's book of business now consists primarily of commercial risks like workers comp and general liability. Seventy percent of its current premium volume is composed of workers comp, 14% "other liability," 11% auto liability, 4% auto/property damage and 1% all other.

At the Texas department's direction, ECC "significantly" reduced its writing of automobile and homeowners' coverage last year. However, it still has more than 11,000 policies assigned to it by the Texas Automobile Insurance Plan, the state's auto insurance assigned risk plan.

In addition, ECC provided workers comp insurance coverage to 3,671 policyholders assigned to it by the Texas Workers' Compensation Insurance Facility, the workers comp assigned risk plan.

And, through a special voluntary market program, ECC and its affiliates wrote workers comp coverage for 5,735 businesses with up to $5,000 in annual premium.

Regulators are consulting with executives of the workers comp and auto residual market plans on how to provide policyholders with uninterrupted coverage.

Large commercial policyholders should be able to find other insurers to write workers comp insurance to replace policies written by ECC, several observers noted.

Some agents are hoping that the state's new competitive state workers comp fund could pick up a substantial part of ECC's business, the PIA's Mr. van Eeten said.

And, commercial insurers may be more willing to write workers comp coverage in the traditionally troubled Texas market.

"In the past two months, I've seen more carriers saying they are willing to write workers compensation—for risks with at least $500,000 in annual premium—than in the past four years," said Bill Henry, president of McQueary & Henry Inc., an independent agency in Dallas.

Mr. Henry, who resigned as an ECC official nine years ago to open his agency, said he thinks "maybe the state acted a little bit prematurely" in seizing ECC.

"I think the state board was under tremendous pressure because of recent insolvencies, and it wanted to make sure that ECC did not get out of hand," he said.

ECC "is one company that had significant problems for more than a few reasons," said Michael Lewis, senior insurance analyst with Dean Witter Reynolds Inc. in New York.

ECC problems reflect the difficult operating environment in the workers compensation market, Mr. Lewis noted.

ECC's financial problems also are indicative of an industry that still has too much capital available, Mr. Lewis said. "One way to alleviate that is to drive companies out" of the marketplace, he noted.

"ECC's problems are part of the fallout from Texas Employers and workers compensation problems generally," said Steven Cataldo, president of the Dallas/Fort Worth Chapter of the Risk & Insurance Management Society Inc.

In related action, regulators in Texas and Oklahoma were reviewing the financial condition of other ECC-affiliated companies, many of which were members of reinsurance pooling arrangements with ECC.

Specifically, Texas regulators were concerned about the financial status of Employers of Texas Lloyd's Inc. and Employers Indemnity Co.

Employers National Life Insurance Co., a Texas-based life insurer, is solvent and likely will be sold soon, regulators said.

Oklahoma regulators last week suspended Employers Casualty Corp. and Employers National Insurance Corp., two Oklahoma-domiciled ECC affiliates.

In addition, the Delaware Insurance Department placed Employers National Insurance Co. under supervision last spring after realizing that the parent company was in "deep trouble," said Catherine Mulholland, the department's director of company regulation. The regulators wanted to protect Employers National, which is "very solid," from any chance that ECC might try to draw on the Delaware affiliate's assets, she said. ■

Update

5 indicted in MEWA fraud case

Continued from page 2

From October 1988 to August 1990, Cabot Day and its marketing vehicle, Equity Med-Kare Plan Trust of Denver, allegedly sold bogus health insurance policies through multiple employer welfare arrangements. The two entities "fraudulently obtained $5.72 million in premiums from hundreds of employer groups providing medical benefits to thousands of employees and their dependents and paid only $894,940 in insurance claims," the U.S. Attorney's office in Philadelphia said.

Authorities also charge that Cabot Day is not licensed in any state. Cabot Day, which operates out of Denver, is domiciled in the British Virgin Islands. But, Cabot Day President J. William Vanderveer has said the insurer was not required to be licensed because it reinsured coverage that self-funded MEWAs sold to employers (*BI*, April, 23, 1990).

The four indicted officials are Mr. Vanderveer, Frank L. O'Bryan, Robert M. Munroe and Neil E. Smith. They and escrow agent Fred M. Dellorfano Jr. pleaded not guilty during arraignment last week and posted bail, said Assistant U.S. Attorney Andrea G. Foulkes. A March 16 trial date was set.

N.Y. court rules on dropdowns

ALBANY, N.Y.—An excess insurer does not have to drop down and provide coverage when an underlying insurer becomes insolvent, the New York Court of Appeals has ruled.

The decision marks the first time the state's highest court has decided this issue and is consistent with a majority of other state and federal rulings, said attorney Sheila Birnbaum of Skadden, Arps, Slate, Meagher & Flom in New York, who represented New York-based Home Insurance Co. in the case.

The coverage dispute stemmed from a 1985 fire in a Queens, N.Y., apartment complex that led to a $24 million claim against the owner of the building, Ambassador Associates Inc.

Ambassador had $1 million in primary liability insurance from Public Service Mutual Insurance Co. in New York, a $10 million first-layer excess policy from insolvent Mission Insurance Co. and a $15 million second-layer excess policy from Home.

Ambassador sought a declaration that because Mission is insolvent, Home should drop down and pay claims.

Affirming the lower court decision without comment, the New York Court of Appeals ruled 4-3 that Home does not have to drop down.

Writing for the dissent, Judge Vito J. Titone said the ruling "serves only to encourage excess insurers to draft policies which fail to inform policyholders in clear and unequivocal language that they—and not the excess insurer—bear the risk of an underlying carrier going insolvent."

E&O insurers to pay

NEW YORK—Insurance will cover part of a $77.5 million settlement in a securities fraud case involving accountants and investment advisers to Wedtech Corp., a failed defense contractor.

Sources confirmed that most of the $77.5 million was assessed against KPMG Peat Marwick, as successor to accounting firm Main Hurdman; accountant Deloitte & Touche, as successor to Touche Ross; and the securities firm Bear, Stearns & Co.

The settlement was reached late last month shortly before the trial date in U.S. District Court in New York. Terms were not released.

Wedtech shareholders and bondholders charged that the accountants and advisers knew or should have known about the fraud that contributed to the demise of New York-based Wedtech.

"It can be said that insurance will pay in part," said Samuel Sporn, a lawyer for the plaintiffs with Schoengold & Sporn of New York. He could not say how much insurance the 29 defendants had.

At KPMG Peat Marwick, a spokesman said most of its portion of the settlement would be covered by a professional liability policy written for Main Hurdman by syndicates at Lloyd's of London. Neither Bear, Stearns nor Deloitte & Touche would comment.

Big Six accountants now generally self-insure $6 million to $10 million per claim/$20 million to $30 million aggregate of their professional liability exposures (*BI*, Oct. 8, 1990).

Briefly noted

California Insurance Commissioner John Garamendi is proposing a $34 billion **24-hour universal health care plan** for the state that would be financed with an employer payroll tax of 6.75% on average and a 1% tax on employees' wages. The plan, under which Californians would receive health care benefits comparable to those now offered by most HMOs, could save $1 billion in workers comp health care costs annually and reduce auto insurance premiums by 15%, Mr. Garamendi said. . . .Employee leasing firm **Action Staffing Inc.** of Tampa, which offers a self-insurance fund to its clients, is insolvent by $5 million, according to the Florida Insurance Department. The self-funded health care plan, which operates in 33 states, has around 6,000 unpaid claims. . . .A massive storm system caused at least **$5 million of insured property damage** to portions of Southern California, Texas and possibly other areas on Feb. 9-11, reports the American Insurance Services Group. . . .Moody's Investors Service Inc. has lowered the financial strength rating of members of the U.S.-based **Royal Indemnity Co.** intercompany reinsurance pool by one notch to A3 from A2. It also lowered the rating of parent Royal Insurance (UK) Ltd. by two notches to A3 from A1. . . .Standard & Poor's Corp. has assigned double-A claims-paying ability ratings to Centre Reinsurance (Bermuda) Ltd., three related Centre Re entities and Zurich International (Bermuda) Ltd., which write **finite risk reinsurance and insurance**. . . .Under the federal **Military Claims Act**, the U.S. Air Force is required to pay claims arising from the crash earlier this month of a Kentucky Air National Guard plane in Indiana. . . .Constance Foster will resign as **Pennsylvania insurance commissioner** March 1 to join law firm Saul, Ewing, Remick & Saul in Harrisburg. . . .A San Francisco judge last week overturned a city ordinance regulating **workplace use of video display terminals** (*BI*, Dec. 17, 1990). She ruled that state law pre-empts local regulation of occupational safety and health. The ordinance would have required employers to provide adjustable work stations, breaks and safety education beginning in 1993.

Taking an ostrich's view

Reports to shareholders fail to acknowledge problems

By MYRON M. PICOULT

Special to Business Insurance

THE QUALITY OF reporting to shareholders in the property/casualty industry continues to deteriorate. In short, the quality is abominable.

In general, after reading annual and interim reports, one would not know that this is an industry with problems. The acknowledgment and discussion of pertinent issues and structural problems is vaguely noted in comments that reference "difficult operating environments."

These reports are missing counterattacks on the industry's critics, where appropriate. Likewise, nowhere is there to be found any substantive reaffirmation of the industry's financial strengths and its right to make a fair and reasonable return.

The 1989 property/casualty insurers' annual reports were chock full of hopeful comments about the prospects for a turn in commercial pricing. The 1990 annual reports were noticeably non-committal about the timing, and in particular, they did not address why insurance company managements were so far off the mark in their prognostications from a year ago.

Subsequent interim reports continue to note the poor pricing environment, but they provide few specifics about how managements are coping with the problem or why it is taking so long for the industry to regain its pricing sanity.

Some insights into new and renewal pricing as well as retention ratios on major lines of business would provide a better sense of management approaches, good or bad. We find it fascinating that so many insurers are lopping off deficiently priced business, yet no one else seems to be picking it up. It is as if managements are stating that ". . .we only acquire adequately priced underreserved business."

Likewise, the problems surrounding the private passenger automobile insurance and workers compensation insurance lines (as well as their respective residual market facilities) are given short shrift except for comments about the withdrawal from various geographic locations. It would be useful to have greater candor about the past profit performance of the lines involved, the costs associated with the withdrawal and the time frame involved.

A surprising number of annual reports do not explain the federal government's interest in regulating the insurance industry, the consequences of repeal of the McCarran-Ferguson Act and management positions on those issues. Likewise, the impact on various companies of the new rules by the National Assn. of Insurance Commissioners governing slow-paying reinsurance recoverables and new bond categories never surfaced in annual reports.

It will be interesting to see what commentary surfaces in the current crop of annual reports about the advent of risk-based capital and current capital allocation methods. How do insurance companies know if they are making or losing money on a by-line basis if they aren't even attempting to allocate their statutory capital and surplus accurately?

In general, after reading insurance companies' annual and interim reports, one would not know that this is an industry with problems.

Succinct commentary about reserve developments, especially on an accident year basis, remains merely a hope. Straightforward insights into the implications of shrinking cash flows and declining interest rates also have been missing. Much is made of niches, specialties and multiniches. Unfortunately, an explanation as to why this has not affected return on equity got lost in the shuffle.

Companies haven't yet recognized that their annual and interim reports are report cards. Successes, failures and supporting data should be included.

The Securities and Exchange Commission is looking into the disclosure of some 15 insurance companies (some of which apparently have property/casualty operations), suggesting that that agency also feels something is amiss. At this juncture, there is no "federal net" to protect policyholders, although there are various state guaranty pools. To date, the insurance industry has covered its own needs. However, questions are being raised about the ability of the state guaranty funds to cover what they're supposed to cover. Perhaps it is time to revamp the guaranty funds in terms of what lines should be covered and what the minimum aggregate capital requirements of the participants should be.

The accounting and nomenclature in the property/casualty industry is at best obtuse to most investors. More annual reports must include glossaries and simple descriptions of various ratios, what they are meant to show and how the ratios compare to various industry standards.

The lack of credible discussion on substantive industry issues does little to enhance the industry's poor image. The bottom line is that the industry's corporate reporting continues to slip.

The omissions are material, and it is difficult not to assume that many insurance company managements are dodging hard questions.

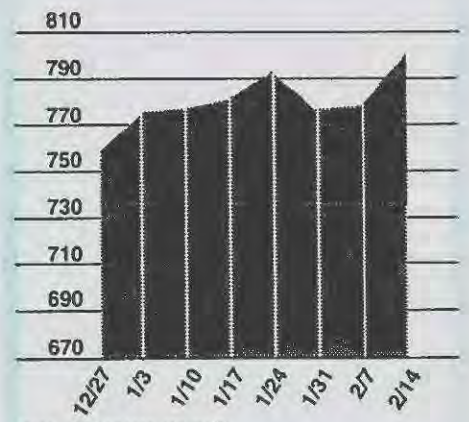
One can only speculate about their motives. It could be a misreading of the severity of their company's financial health, or it could be a delaying tactic hoping for a turnaround in the insurance industry.

In any event, the public's faith in financial institutions has been markedly diminished by the problems in the banking and savings and loan industries, and recent sizable life insurance company insolvencies. Nonetheless, the insurance industry must do a better job of disclosure. ■



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BI Insurance Index



Base = 100 on Dec. 29, 1978

Source: Nordby International Inc.

Insurance industry stocks jumped last week as the *Business Insurance* Index rose 24.0 points to 801.9 on Feb. 14 from 777.9 on Feb. 7. Advancing issues were led by Statesman Group Inc., up 14.0%; Navigators Group, up 13.2%; and Safeguard Health Enterprise, up 12.8%. Declining issues followed Belvedere Corp., down 12.5%; Sierra Health Services, down 12.1%; and Tokio Marine & Fire, down 9.8%. The most active issue for the period was U.S. Healthcare, with 3.4 million shares traded. The *BI* Index was up 1.5%; the New York Stock Exchange Composite was up 0.2%; the Standard & Poor's 500 was up 0.3%; and the Dow Jones 30 Industrials was up 0.6%.

British Issues

Feb. 13 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	437	N/M	30.7	7.0	451-	-433
Genl Accident	412	N/M	35.7	8.7	430—	-412
Gdn Royal Exch	120	N/M	15.9	13.2	128-	-120
Royal	236	N/M	34.7	14.7	236—	-220
Sun Alliance	273	N/M	18.7	6.8	280—	-269
Brokers						
Bradstock	166	18.7	6.3	3.8	166—	-164
CE Heath	447	15.7	34.5	7.7	450—	-447
Hogg Group	176	10.5	10.7	6.1	179—	-176
JIB Group	190	15.8	10.0	5.3	192—	-190
Lloyd Thompson	244	9.8	6.0	2.4	245—	-243
Lowndes Lmbrt	335	16.6	15.3	4.6	335-	-334
PWS Holdings	68	7.4	5.3	7.8	68—	-68
Sedgwick Grp	207	19.6	16.0	7.7	214—	-207
Steel Brrl Jones	300	15.9	16.3	5.4	303—	-300
Willis Corroon	242	12.7	17.6	7.3	242—	-239

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

FEBRUARY 10, 1992 THROUGH FEBRUARY 14, 1992

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	21.50	-1.15	4.88	27.50	18.00	673	1.00	4.65	20	9.77	2.20
Gallagher Arthur J. & Co.	NYS	23.88	-1.55	6.70	28.38	19.00	14	0.64	2.68	18	5.88	4.06
Frank B. Hall	NYS	3.75	0.00	-11.76	5.50	3.13	66	0.00	0.00	-6	-5.24	-0.72
Hilb, Rogal & Hamilton	OTC	13.00	-3.70	-1.89	17.50	11.25	36	0.40	3.08	22	3.56	3.65
Marsh & McLennan	NYS	75.75	-2.26	-6.91	87.25	70.00	575	2.60	3.43	18	14.77	5.13
Poe & Associates	OTC	13.50	4.85	12.50	13.50	6.50	3	0.32	2.37	15	2.52	5.36
BROKERS	AVERAGE		-0.6	0.6					2.3	13		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	35.50	2.16	16.39	35.75	23.50	244	0.32	0.90	15	23.89	1.49
Berkshire Hathaway Inc.	NYS	8750.00	0.46	-3.31	8750.00	238.28	1	0.00	0.00	-37	4612.00	1.90
ITT (Hartford Group)	NYS	60.00	2.13	3.90	63.00	50.00	1306	1.84	3.07	9	64.01	0.94
Sears (Allstate)	NYS	44.00	1.73	16.17	45.13	30.25	3130	2.00	4.55	13	37.38	1.18
CONGLOMERATES	AVERAGE		1.6	8.3					2.1	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	68.88	-1.96	-1.61	71.75	54.75	5	2.30	3.34	7	N/A	N/A
Aetna Life & Casualty	NYS	46.13	7.27	4.83	49.13	31.88	1619	2.76	5.98	9	64.23	0.72
Allied Group Inc.	OTC	19.25	0.00	13.24	21.50	13.25	1115	0.56	2.91	7	11.50	1.67
American General	NYS	41.13	-0.60	-7.58	45.63	36.00	479	2.08	5.06	10	37.14	1.11
American Indemnity/Fin'l	OTC	7.00	1.82	47.37	9.25	4.50	4	0.08	1.14	6	12.93	0.54
American International	NYS	89.00	-0.97	-9.53	102.00	78.63	1453	0.48	0.54	12	45.34	1.96
Aon Corp.	NYS	43.00	3.30	8.52	43.25	33.50	186	1.60	3.72	12	18.50	2.32
Argonaut Group	OTC	27.50	10.00	15.79	33.38	21.75	395	0.68	2.47	9	48.26	0.57
AVEMCO Corp.	NYS	27.63	8.87	10.50	27.63	18.50	85	0.40	1.45	21	9.55	2.89
Baldwin & Lyons Inc.	OTC	26.75	0.94	3.88	27.50	21.00	4	0.28	1.05	7	24.29	1.10
Belvedere Corp.	ASE	4.38	-12.50	34.62	5.38	2.63	33	0.04	0.91	13	7.65	0.57
Chandler Insurance	OTC	4.13	3.13	26.92	4.75	2.13	7	0.00	0.00	-2	5.95	0.69
Chubb Corp.	NYS	66.75	-1.66	-13.31	78.00	60.75	1413	1.48	2.22	11	35.19	1.90
CIGNA Corp.	NYS	54.50	0.23	-10.84	61.75	41.25	751	3.04	5.58	11	73.15	0.75
CNA Financial Corp.	NYS	80.50	-2.87	-17.86	104.50	75.50	110	0.00	0.00	12	70.23	1.15
Continental Corp.	NYS	27.75	0.91	0.45	30.50	23.25	482	2.60	9.37	12	37.83	0.73
EXEL Ltd.	NYS	34.75	-5.44	-7.33	40.25	27.38	269	0.90	2.59	7	N/A	N/A
Fund American Corp.	NYS	69.00	2.60	-1.25	70.25	57.25	100	0.68	0.99	18	36.11	1.91
Fremont General Corp.	OTC	22.75	-4.21	-6.67	26.00	15.50	219	1.00	4.40	6	19.13	1.19
Frontier Insurance Group	NYS	30.13	9.05	11.57	30.13	18.19	74	0.00	0.00	12	11.20	2.69
Gainsco Inc.	ASE	14.50	1.75	3.57	14.88	5.75	60	0.04	0.28	18	3.37	4.30
General RE Corp.	NYS	95.13	-0.52	-6.63	104.75	85.00	533	1.68	1.77	13	37.50	2.54
Guaranty National Corp.	NYS	14.88	-4.80	2.59	17.00	12.63	64	0.48	3.23	11	N/A	N/A
Hanover Insurance Co.	OTC	38.00	2.70	6.29	42.75	27.13	31	0.44	1.16	16	37.44	1.01
Harleysville Group	OTC	20.75	-1.19	-2.35	23.25	16.75	89	0.64	3.06	10	22.99	0.90
Hartford Steam Boiler	NYS	48.63	-0.77	-15.43	63.75	47.25	187	2.00	4.11	14	17.05	2.85
Kemper Corp.	NYS	35.25	-6.00	-7.54	46.13	28.50	790	0.92	2.61	8	34.20	1.03
Lawrence Insurance Group	ASE	10.13	-1.22	-8.99	11.13	6.75	1	0.48	4.74	16	4.71	2.15
Liberty Corp.	NYS	22.75	11.66	2.82	23.75	19.50	68	0.48	2.11	12	23.86	0.95
Lincoln National	NYS	56.88	1.11	3.88	61.00	45.38	313	2.92	5.13	10	45.16	1.26
Markel Corp.	OTC	26.50	1.92	20.45	28.00	13.75	10	0.00	0.00	12	3.22	8.23
Mutual Risk Mgmt. Ltd.	NYS	36.00	1.77	2.49	37.50	17.00	104	0.12	0.33	31	-	-
NAC Re Corp.	OTC	29.00	-4.13	-7.94	33.00	21.75	218	0.16	0.55	13	18.90	1.53
Navigators Group	OTC	47.00	13.25	14.63	47.00	26.00	34	0.00	0.00	25	13.52	3.48
Nobel Insurance LTD	OTC	4.88	0.00	21.88	5.25	3.00	31	0.00	0.00	6	7.76	0.63
NWNL Companies	NYS	30.13	-4.37	-3.21	36.50	18.63	252	1.40	4.65	8	42.73	0.71
Ohio Casualty Corp.	OTC	55.13	-0.68	11.36	58.00	40.00	149	2.48	4.50	9	36.38	1.52
Old Republic Int'l	NYS	39.00	0.00	9.86	40.50	23.63	142	0.72	1.85	8	33.09	1.18
Orion Capital Corp.	NYS	32.25	-2.27	1.98	34.00	18.75	53	0.92	2.85	9	20.42	1.58
Phoenix RE Corp.	OTC	10.50	-2.33	0.00	11.50	8.50	76	0.20	1.90	15	13.30	0.79
Provident Life	OTC	22.00	-4.35	-5.38	24.50	16.75	353	1.00	4.55	9	25.88	0.85
Re Capital Corp.	ASE	13.75	-1.79	-4.35	18.63	13.50	25	0.20	1.45	11	15.05	0.91
Reliance Group Holdings	NYS	4.50	0.00	9.09	7.13	3.50	63	0.32	7.11	3	5.61	0.80
RLI Insurance Corp.	NYS	19.75	0.00	19.70	19.88	11.88	13	0.48	2.43	9	14.41	1.37
St. Paul Companies	NYS	72.63	2.83	-0.34	75.75	57.13	354	2.60	3.58	8	52.00	1.40
SAFECO Corp.	OTC	48.25	4.04	-1.03	50.00	35.50	788	1.48	3.07	12	31.50	1.53
SCOR U.S. Corp.	NYS	18.25	-2.67	18.70	18.88	11.63	25	0.24	1.32	11	11.19	1.63
Seibels Bruce Group	OTC	4.75	-9.52	-13.64	8.88	4.38	128	0.36	7.58	-2	7.35	0.65
Selective Ins. Group	OTC	18.50	1.37	10.45	19.00	13.75	123	1.04	5.62	9	18.91	0.98
Statesman Group Inc.	OTC	6.13	13.95	6.52	6.88	2.13	747	0.00	0.00	19	2.48	2.47
Tokio Marine & Fire	OTC	43.75	-9.79	-15.05	55.25	40.50	1	0.00	0.00	-	70.93	0.62
Torchmark Corp.	NYS	57.13	3.86	-1.30	61.50	46.50	262	1.60	2.80	12	16.70	3.42
Transamerica	NYS	42.13	3.69	5.64	42.63	31.25	692	2.00	4.75	17	36.56	1.15
Transatlantic Holdings	NYS	37.63	-0.66	-3.22	39.63	29.00	55	0.24	0.64	12	18.38	2.05
Traveler's Corp.	NYS	22.13	1.72	2.31	25.38	17.25	1200	1.60	7.23	6	41.44	0.53
Trenwick Group Inc.	OTC	30.25	0.00	6.14	30.75	23.00	103	0.72	2.38	11	21.71	1.39
United Fire & Casualty	OTC	47.50	1.06	5.56	58.00	38.50	1	1.32	2.78	10	35.39	1.34
USF&G Corp.	NYS	9.75	5.41	34.48	12.50	5.63	2534	0.20	2.05	-4	11.96	0.82
UNUM Corp.	NYS	73.88	-3.43	-8.80	81.25	55.00	435	1.04	1.41	12	37.25	1.98
USLIFE Corp.	NYS	44.25	1.43	-7.57	47.88	33.38	46	1.64	3.71	10	60.34	0.73
Unitrin	OTC	34.50	0.00	-3.50	41.50	31.00	212	1.00	2.90	13	30.70	1.12
USLICO Corp.	NYS	18.75	-3.23	1.35	21.00	17.00	36	1.00	5.33	-89	29.44	0.64
Washington National	NYS	17.50	0.00	10.24	19.25	13.13	61	1.08	6.17	-8	26.86	0.65
Zenith National Ins.	NYS	15.75	-3.08	-6.67	18.50	13.75	145	1.00	6.35	7	13.14	1.20
INSURERS/REINSURERS	AVERAGE		0.4	3.3					3.2	9.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	16.63	-0.75	16.67	29.75	9.88	1446	0.00	0.00	15	5.44	3.06
HMO America Inc.	OTC	22.88	-1.61	36.57	24.88	7.50	909	0.00	0.00	24	0.61	37.50
Pacificare Health Sys.	OTC	58.50	2.63	48.10	61.50	21.38	1536	0.00	0.00	23	6.55	8.93
Safeguard Health Enter.	OTC	12.13	12.79	29.33	12.13	4.63	393	0.00	0.00	21	3.53	3.43
Sierra Health Services	ASE	23.63	-12.09	27.70	29.50	12.38	588	0.00	0.00	13	1.78	13.27
United Healthcare Corp.	NYS	88.50	2.91	18.79	93.00	29.38	747	0.06	0.07	43	3.76	23.54
United Medical Corp.	ASE	7.25	-6.45	3.57	10.88	5.88	7	0.20	2.76	12	8.79	0.82
U.S. Healthcare	OTC	53.25	+1.62	28.31	57.75	21.25	3424	0.44	0.83	26	3.38	15.75
HMOs	AVERAGE		-0.5	26.1					0.5	22		
ALL COMPANIES	AVERAGE		0.2	9.6					2.7	11		

System design: Nordby International Inc.

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