FEBRUARY 18, 1991

Business Insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $2.00 a copy; $80 a year

Update

Senate committee sets hearings on insurance industry solvency

WASHINGTON—The Senate Commerce, Science and Transportation Committee plans to hold a series of hearings on the solvency of the insurance industry.

The first hearing, scheduled for Feb. 27, will deal with the financial health of the industry and examine the causes of large insurer insolvencies over the last decade, according to a congressional source.

The committee last week was still searching for witnesses to testify at the hearing, which will be chaired by Sen. Richard H.

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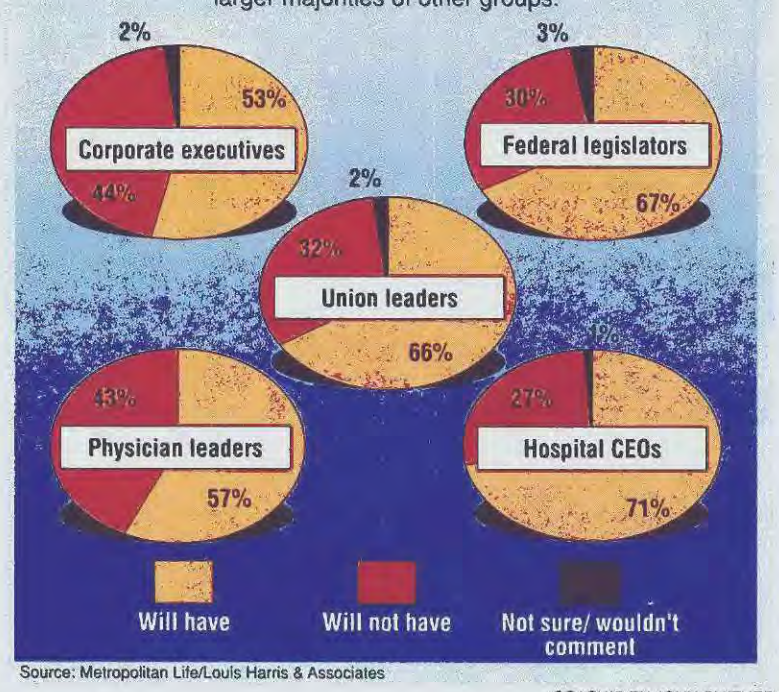
Universal health coverage likely

About half of the corporate executives polled believe all Americans someday will have some type of health insurance, compared with larger majorities of other groups.



Source: Metropolitan Life/Louis Harris & Associates

GRAPHIC BY JOHN SMITHER

Firms can abide mandate to offer health benefits

By CHRISTINE WOOLSEY

CHICAGO—Corporate executives would accept a mandate to provide basic health insurance for all full-time employees and dependents in order to heal an ailing U.S. health care system, a new survey shows.

In a sharp departure from many executives' public positions, a majority of surveyed executives said a law requiring employers to provide basic health benefits would be acceptable, as long as all parties involved in the health care system made similar concessions.

In addition, half of the corporate executives polled believe the nation will eventually enact some type of universal health care system. That figure, though, was higher for other groups surveyed—including union leaders, hospital executives and group health insurers (see chart).

The poll, "Trade-offs & Choices: Health Policy Options for the 1990s," was sponsored by Metropolitan Life Insurance Co. and conducted by Louis Harris & Associates Inc. It is based on 2,048 interviews with representatives of nine groups that have key roles as health care payers, providers, regulators, administrators or consumers.

Survey results were presented last week in Chicago.

Other parties in the health care system were also willing to make some concessions, the survey found.

Group health insurers responding to the survey, for example, said they would insure small employers, regardless of claims history, if there were a reinsurance mechanism to spread their risk.

And physician leaders of medical societies said they would accept medical practice guidelines and a fee-for-service payment system with a fixed cap.

While all sides generally recognized the need for change, "it's im-

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Risk Retention Act overhaul unveiled

Bill clarifies purchasing group rules

By JERRY GEISEL

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 a sweeping proposal unveiled last week by the Bush administration.

However, the proposal would effectively overturn a controversial 1987 court decision allowing states to set rate and policy form requirements for insurers providing 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 a purchasing group insurer.

In addition, the proposal would require that purchasing groups and risk retention groups be controlled by policyholders—not by insurers, brokers, agents or other advisers.

Finally, the proposal would increase the amount of information that purchasing groups would have to report to regulators in all states in which the group intends to operate.

Buyers welcome many of the changes. The proposal, they say, would clear up many ambiguities in the Risk Retention Act that have led to litigation and uncertainty. It would also lead to financially stronger purchasing group insurers, they say.

While regulators acknowledge that the Bush proposal would be an improvement over earlier reform measures, they still say the new proposal still is flawed. They particularly object to provisions that would bar all states from setting purchasing group rate and policy form requirements.

Observers agree that legislation bearing the Bush administration's imprimatur will speed up consideration of changes to the Risk Retention Act, which have languished in Congress.

"By definition, an administration bill means heightened attention that it would not otherwise get," said James Anderson, chairman of the government affairs committee of the National Risk Retention Assn., a Washington, D.C.-based organization representing risk retention and purchasing groups.

"It is a very positive step when an administration acknowledges the need for changes in the Risk Retention Act. Hopefully, this will add momentum to

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Home prospects rise with new ownership

By JUDY GREENWALD

MANCHESTER, N.H.—The Home Insurance Co.—and its policyholders—will clearly be better off under the management of an investor group led by a Swedish insurer than it has been under AmBase Corp.'s control, observers agree.

In fact, analysts predict The Home could flourish under the aegis of a strong, well-capitalized insurer parent (*BI*, Dec. 31, 1990).

Swedish insurer Trygg-Hansa SPP Holding AB owns 60% of Home Holdings Inc., the investment group that acquired The Home. The group changed its name last week from TVH Acquisition Corp.

AmBase shareholders approved the sale of The Home and other AmBase assets Tuesday at a special stockholders meeting, with 20.2 million shares, or 54.1% of the company's 37.3 million shares voting in favor of the sale. Only 2.2 million shares were opposed.

The meeting, held at The Home's offices in Manchester, N.H., and attended by about 25 people, lasted just 15 minutes. The sale was completed Wednesday.

AmBase Chairman and Chief Executive Officer George Scharffenberger said in an interview following the vote that the transaction will "vastly strengthen The Home. It now has a very wealthy parent.

"I just couldn't see a better owner," he added.

Home Chairman James J. Meenaghan noted that The Home's link with Trygg-Hansa will give it the opportunity to offer policyholders international expertise (see story, page 90).

Outside observers also are enthusiastic.

"I really think it's a strong positive for the policyholders and the employees of The Home Insurance Co.," commented David Wells, an analyst with Fitch Investors Service in New York. "Anything would be an improvement" to financially troubled AmBase, he said.

"Fundamentally, we think a major cloud has been removed from The Home Insurance Co.," commented Alan Levin, senior vp with Standard & Poor's Corp. in New York. Its parent company now will be focused exclusively on the insurance business "and not on a lot of diversified businesses" as was AmBase, he explained.

The acquisition "removes a lot of uncertainty," he said.

Referring to TVH's name change to Home Holdings, Mr. Levin commented "that sort of illustrates the commitment they have behind this thing."

Home Holdings is controlled by a consortium headed by Trygg-Hansa SPP Holding AB, with about 60.3% ownership, Finnish insurer Industrial Mutual Insurance Co., with 20% ownership, and International Insurance Investors, with about 10% ownership. International Insurance

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Update

Senate to study insolvencies

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Bryan, D-Nev.

The Senate hearing would follow extensive hearings on the same subject by the House Oversight and Investigations Subcommittee and a request by Sen. Donald W. Riegle Jr., D-Mich., for a Treasury Department investigation of insurance solvency issues (*BI*, Dec. 31, 1990). A Treasury Department review of the insurance industry already is underway (*BI*, Jan. 28).

Banks praise EPA liability rule

WASHINGTON—Private lenders say a revised U.S. Environmental Protection Agency rule would give them more protection from Superfund liability than an earlier draft.

The "EPA has taken out some of the things that we thought were objectionable," said Thomas J. Greco, associate general counsel at the American Bankers Assn. in Washington, D.C. For example, the agency no longer says that failing to inspect property used as collateral would mean automatic loss of the secured lender exemption.

The revised draft was sent last week to the Office of Management and Budget for approval. Like the earlier version (*BI*, Oct. 15, 1990), the new rule would let banks and other private lenders participate in a variety of business practices without incurring Superfund liability for contaminated property in which they had a secured interest.

The proposal attempts to clarify the secured lender exemption in the Comprehensive Environmental Response, Compensation and Liability—or Superfund—Act. Federal court interpretations of the exemption have varied (*BI*, Sept. 3, 1990).

The rule would allow lenders, for example, to advise troubled borrowers, restructure loans, liquidate assets or foreclose on loans without risking liability. Lenders also could require regular environmental inspections of a borrower's property or require cleanup of the property without risking liability. And, lenders that sell a property within six months of foreclosure also would be exempt from liability.

Government agencies that involuntarily acquire contaminated property also would be exempt from Superfund liability under the proposal. This would protect, for example, the Resolution Trust Corp., which takes over property from failed savings and loans.

Three arrested in fraud scheme

NORFOLK, Va.—The FBI has arrested three men for allegedly scheming to bomb a chemical storage facility and make the incident look like a terrorist act to collect $2.7 million of insurance.

The bureau says the plot was hatched by Edward Gresham of Ellicott City, Md., who was storing 2 million gallons of sodium hydrosulfide—a corrosive chemical used in metal finishing and leather tanning—in a tank he was leasing at Allied Terminals Inc. in Norfolk, Va. The facility is located within miles of several military installations.

Mr. Gresham and two accomplices plotted to use two pipe bombs to blow up the tank Mr. Gresham leased as well as another tank containing methanol, a highly explosive chemical, the FBI said. But, the bombs were discovered by a facility worker.

The FBI said an informant claims Mr. Gresham told him about the scheme to use insurance proceeds to resolve Mr. Gresham's financial problems. For example, Mr. Gresham owed Allied more than $66,000 in back payments, the FBI said.

Mr. Gresham had doubled his property insurance on the chemical to $2.7 million in December 1990 and would have collected $1 million in profits if the tank had been destroyed, the bureau said.

The coverage was written by Centennial Insurance Co., a subsidiary of Atlantic Mutual Insurance Co. The coverage was placed by Burroughs & Watson Inc. in Norfolk.

A Centennial official and Centennial's broker refused to speculate on whether damage caused by terrorism would be covered under the policy.

The FBI also arrested James Wayne Openshaw and Cecil Ross in Arizona. The two have confessed, the FBI said.

All three men are being held on charges of conspiracy, arson and wire and mail fraud. Mr. Gresham was denied bail at a bond hearing in U.S. District Court in Baltimore last week. A bond hearing for the other two men was scheduled for late last week.

Health cost sharing at Temple

PHILADELPHIA—The Temple Assn. of University Professionals agreed to a contract last week that, among other things, requires each member to pay $260 a year toward group health insurance.

Beginning in July, union members will have to pay $5 a week toward the coverage, which is written by Newark, N.J.-based Prudential Insurance Co. of America. Non-union workers and six other university unions had already agreed to pay the $260 in premiums.

TAUP members—1,100 faculty members and other academic professionals—went on strike for 29 days last fall over salary issues and the proposed health insurance payments (*BI*, Sept. 17, 1990). Union members—who have been without a contract since July 1, 1990—returned to work Oct. 3 under a court order.

On a 338-to-65 vote, union members last week approved the contract, which takes effect July 1 and expires Oct. 15, 1994. Contributions from union members could save Temple up to $1.2 million over the term of the contract.

Average base salaries are to rise about 34% over the 51-month contract. That will cost the school about $18 million, the spokesman said.

Green goes on trial tomorrow

NEW ORLEANS—Louisiana Insurance Commissioner Doug Green is scheduled to go on trial tomorrow on federal charges that he accepted bribes in return for favorable regulatory treatment of now-defunct Champion Insurance Co.

A superseding indictment filed Nov. 29 leveled numerous conspiracy, mail fraud and money laundering charges against Mr. Green. Among other things, he is charged with accepting more than $2 million in

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Shand, A&A role alleged in failure of Mutual Fire

By JOANNE WOJCIK

PHILADELPHIA—The rehabilitator of Mutual Fire, Marine & Inland Insurance Co. is suing Shand, Morahan & Co. Inc. and Alexander & Alexander Inc., charging that the companies' actions helped push Mutual Fire into insolvency.

The suit, filed Feb. 5 in Pennsylvania's Commonwealth Court, accuses Shand, Morahan, which had a managing general agent contract with Mutual Fire beginning in 1971, and A&A, Shand's former parent, of committing "detrimental actions" that contributed to Mutual Fire's financial downfall.

Philadelphia-based Mutual Fire was placed into court-ordered rehabilitation in December 1986, though it was not officially declared insolvent until February 1989. A final rehabilitation plan was approved in January 1990 (*BI*, Jan. 29, 1990).

The insurer's financial difficulties stem from defaults by limited partnerships on loans the insurer had guaranteed and from growing underwriting losses on reinsurance business it assumed (*BI*, June 30, 1986).

Mutual Fire, which ranked as the fifth-largest U.S. surplus lines insurer in 1985 based on $72.9 million in non-admitted premiums written in 1984, stopped writing treaty reinsurance in March 1986 and direct insurance in April 1986.

Mutual Fire's estimated surplus deficit is $450 million, making it the fourth-largest insurer insolvency in U.S. history.

In its lawsuit, Mutual Fire alleges that Evanston, Ill.-based Shand, Morahan and New York-based A&A, as Shand's parent during relevant periods, "have contributed to and/or deepened the insolvency of Mutual Fire."

Among other things, the suit charges that the defendants failed to:

- Set appropriate reserves for losses and loss adjustment expenses for business produced and underwritten on behalf of Mutual Fire.
- Properly manage claims made on the business written and produced on behalf of Mutual Fire.
- To disclose complete, accurate and timely information concerning business produced and underwritten on behalf of Mutual Fire.
- Conduct policy audits, which resulted in the undercollection of premiums.
- Take steps to ensure that the business produced and underwritten on behalf of Mutual Fire was ceded to financially secure reinsurers after information became known that reinsurers previously secured by Shand, Morahan on Mutual Fire's behalf were experiencing financial difficulties.
- Select and follow recommendations of "competent defense counsel" and "to take steps to substitute defense counsel and supervisory counsel for claims made on

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Appellate court deals P&G coverage setback

By STACY ADLER

CHICAGO—Procter & Gamble Co. must pay $10 million in defense and indemnity costs per policy year before it can tap liability policies written before 1979 to cover costs related to hundreds of Rely tampon lawsuits, a federal appellate court affirmed.

The 7th U.S. Circuit Court of Appeals last month upheld a federal court jury verdict that lawsuits against P&G stemming from injuries linked to Rely tampons constitute multiple occurrences, even though all the lawsuits allege bodily injury from the tampons.

As a result, Cincinnati-based P&G cannot tap a $25 million first-layer excess liability policy written by Commercial Union Insurance Co. that covers the manufacturer from July 1, 1978, to July 1, 1979, until it exhausts a $10 million annual aggregate self-insured retention, rather than a $1 million per-occurrence retention.

Had all the claims been considered one occurrence, the company could have tapped the coverage after it paid out $1 million to Rely claimants during the policy period.

About 75 to 80 Rely-related claims fell within the 1978-79 policy period, according to a Commercial Union attorney. However, to date, P&G has spent only about $5 million—or half its aggregate retention—on Rely claims that fell within the policy year, the attorney said.

Indemnity and defense costs for one Rely claim has pierced the $1 million per-occurrence retention during the 1978-79 policy year. Through a compromise agreement, Commercial Union agreed to reimburse P&G $40,000 for this claim.

While the litigation centered around the 1978-79 coverage, the ruling also affects policies written in previous years by a Commercial Union unit. American Employers Insurance Co. wrote $50 million of first-layer excess coverage above P&G's $1 million per occurrence/$10 million aggregate retention from 1972 to 1978.

Therefore, P&G cannot tap its American Employers policies until it has paid out $10 million in defense and indemnity costs for Rely claims in each year from 1972 to 1978.

To date, P&G has not pierced the $10 million aggregate retention for any of these years. However,

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Deadline near for EBIS directory

Business Insurance will publish its annual directory of employee benefit information systems in the April 1 issue.

That issue will also contain a spotlight report on trends in employee benefit plan design and administration.

There is no charge for employee benefit software companies to be included in the annual directory; however, in order to be included companies must request and return a questionnaire provided by *Business Insurance*.

If your company produces and supplies proprietary software products to corporate employee benefits personnel and you have not yet received a questionnaire, please request one by writing Karen Armaganian, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-280-3195.

The deadline for returning completed questionnaires is March 4.

Inside

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Vol.25, No."—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611.

Containing health costs

Point-of-service plans gain support despite administrative load

By JOANNE WOJCIK

Even though administrative costs for point-of-service health care plans are significantly higher than those for "plain vanilla" HMOs or indemnity plans, the managed care plans are curbing health care cost increases, consultants and insurers say.

And, some consultants predict that point-of-service plan administration eventually will cost less as the plans—the latest trend in managed care—mature.

In addition, plan administrators—usually large insurance companies—say they are making technological investments and management changes that eventually will reduce the plans' administrative burden and lead to reduced costs.

There also are some steps employers can take today to keep point-of-service administrative costs in check, consultants and insurers agree.

Under a point-of-service plan, pioneered by Southwestern Bell Corp. and Allied-Signal Corp. and offered by a growing number of employers, employees are enrolled in HMO-like networks but can opt to receive services from non-network providers at reduced benefit levels.

Claims for services rendered by network providers as well as non-network providers are administered by a single source, usually an insurer.

While approximately 10% of costs under a typical indemnity plan are attributable to administrative expenses, slightly more than 16% of point-of-service plan costs are for administration, according to Armand Bengle, principal and manager of Alexander Consulting Group Inc.'s Western regional resource center in San Francisco.

That estimate is based on a review of approximately one dozen of the consultant's employer clients with between 1,000 and 5,000 employees.

"The biggest increase in cost is for network management," Mr. Bengle said.

But, point-of-service plan network management costs can vary by plan administrator.

For example, it will cost more for an insurer to build a provider network from the ground up than it will to subcontract with already existing HMOs and preferred provider networks, Mr. Bengle explained.

As a result, "pure administrative costs may be lower for plans administered by established regional HMOs than for those administered by insurers," said Joseph W. Duva, a principal at Ernst & Young of New York.

However, large national insurers have more flexibility, the capability to assume some risk for the plan's performance and usually have data gathering systems in place that can be updated to handle both in- and out-of-network claims, Mr. Duva said.

"There are some trade-offs," he said.

In addition to higher upfront development costs, point-of-service plans also cost more to operate on an ongoing basis because more intensive utilization review and additional provider relations staff and member services staff are needed, observed Lawrence B. Leisure, a consultant in the San Francisco office of TPF&C, the benefits consulting unit of Towers, Perrin, Forster & Crosby Inc.

"These are bodies, which create more overhead," Mr. Leisure pointed out.

"Point-of-service is a great product to market, but it's a nightmare to administer," said Debbie Smith, a consultant with The Wyatt Co. in Atlanta.

If an employee visits a primary care—or "gatekeeper"—physician before consulting with another provider each time he or she seeks care, administration is similar to that for an HMO, she said.

But when an employee walks into a network provider's office without a referral from his or her primary care physician, that provider needs to know whether the service will be covered on a network basis, Ms. Smith explained.

And, if the service is not covered on an in-network basis, the provider then needs to know whether the employee has met his or her deductible, if a copayment is required or if the service being provided is covered at all by the employer's plan.

In the end, the provider usually ends up calling the claims administration office, "which is just now getting PPOs straight," Ms. Smith quipped.

Another factor contributing to point-of-service administrative costs is the need for increased employee education and communication efforts, consultants and insurers say.

"A lot of costs are incurred by employees with questions," observed Charles T. Bell, senior vp of Aetna Health Plans Inc. in Hartford, Conn., a unit of Aetna Life & Casualty Co.

Education "is very time-consuming and difficult," agreed Rich Sinni, national director of Buck Consultants Inc.'s health management practice in New York.

"Remember, you're restricting employees' access to health care," he said.

Employee education is needed before the plan is implemented, at the time plan selection is made and throughout the duration of the program "to reinforce how it works," Mr. Sinni explained.

In addition, the networks need additional provider relations staff.

"In point-of-service, most plans are customized, so benefits are paid at different rates," which creates confusion for providers who have contracts with several insurers, Mr. Sinni pointed out.

Because of all of these additional commu-

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UR programs need regular checkups

By CHRISTINE WOOLSEY

Just as a cold sufferer turns to aspirin for relief, employers are using utilization review as a common pain reliever for the chronic ache of rising health care costs.

However, employers must examine their UR programs to be sure the dosage is appropriate, benefit consultants and UR experts say.

While most UR programs produce results within a year, employers should continue to monitor their performance for several years, experts contend.

There are a variety of ways to probe the inner workings of a utilization review program. Among other things, employers can scrutinize health claims data, investigate a vendor's services and staff, and survey employees about the program.

"Historically, employers have signed an agreement with a UR company and then not done an in-depth evaluation of how (the program) is working," pointed out Paul Goldbeck, a vp and group benefits consultant with Booke & Co. in Winston-Salem, N.C. But, "employers really need to be diligent in terms of managing their medical programs."

"The kind of money that goes into those programs warrants a close look at where the dollars go. And, to the extent that vendors are involved with the money, employee benefit managers need to be sure" that UR vendors are operating efficiently, Mr. Goldbeck said.

Employers can use three different levels of scrutiny when evaluating them, said Rich Maturi, vp of managed care programs for Blue Cross & Blue Shield Assn. of Chicago.

The first level determines whether the UR program is saving money; the second level considers the extent to which the program is preventing or allowing inappropriate medical care; and the third level examines the program's operational structure, he explained.

"You don't need a master's degree in public health to figure out what your UR vendor is doing," said Scott Ziemba, a consultant with Hewitt Associates of Lincolnshire, Ill. But, he said, employers

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10 largest general service utilization review firms

Based on total inpatient admissions reviewed in 1990

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)	2.6 million	2,402	88	1,275	1,050
Intracorp (CIGNA Corp.)	819,580	4,300	30	2,000	400-500
Metropolitan Life Insurance Co.-Managed Care Services Group (Mutual company)	498,000	560	23	464	25
HealthCare COMPARE Corp. (Independent)	358,400	763	30	232	NA
Axiom Review (Privately held)	325,959	78	2	34	121
The Sunderbruch Corp. (Privately held)	250,080	317	3	147	0
Conservco Inc. (Travelers Corp.)	250,000	1,700	4	850	281
Cost Care Inc. (John Hancock Mutual Life Insurance Co.)	210,000	526	51	163	NA
Crawford & Co. - Healthcare Management Group (Independent)	159,725	1,538	9	580	0
Parkside Health Management Corp. (The Lutheran General Health Care System)	120,000	88	26	62	124

Source: *BI* survey

The utilization review industry is consolidating as services are integrated into managed care plans, executives of major UR vendors say. For an overview of the UR market, see page 25.

Point of service

Continued from previous page
nication requirements, it is costing insurers more to administer point-of-service plans than they realized it would, Mr. Sinni said.

For years, insurers had separately offered both components of a point-of-service plan—an HMO and an indemnity plan—"but they didn't realize they would have to develop more local UR, negotiate third-party contracts with providers and add people to service these accounts" if they were to merge them to form point-of-service plans, he said.

"These programs are very labor-intensive, and the policyholder pays for it," Mr. Sinni said.

Much of the higher administrative costs also result from the "elaborate, integrated claims systems" needed to process both in- and out-of-network claims, according to Mr. Sinni.

"It's a whole facet of plan operation that's foreign to most indemnity companies," said Curt Speed, a group benefits consultant with Hewitt Associates of Lincolnshire, Ill. "When you add it all up, this is far more complicated than even we consultants anticipated."

"Some carriers were taken aback by the amount of resources needed" to administer point-of-service plans, agreed Glenn Meister, a principal at A. Foster Higgins & Co. Inc. in Los Angeles. "It's a different business delivering managed care services than processing claims."

But, insurers maintain they were fully aware of the additional investment that would be required to offer the integrated programs.

"If administrative costs are higher, it's because it costs more to manage care," said Mike Gaffney, president of Travelers Health Network in Dallas, a unit of The Travelers Corp.

It is simple arithmetic: "If you add point-of-service to HMOs, expenses will go up," said Art Leland, director of national managed care programs for the Chicago-based Blue Cross & Blue Shield Assn.

"Setting up and managing networks, provider relations and education, utilization management and quality assurance" all add to the heavier administrative burden, he said.

Point-of-service is simply "a more expensive plan to implement," said Aetna's Mr. Bell.

But there's a definite payoff for the additional investment required for a company to establish a point-of-service plan, according to Travelers' Mr. Gaffney.

"The point of point-of-service is to provide better managed care, not fewer benefits," he said.

Travelers manages approximately 18 to 20 point-of-service plans nationwide.

"Substantial savings in claims dollars are achieved despite the higher administrative costs," agreed Jim Cassity, vp-Southwestern group operations for Prudential Insurance Co. of America in Houston.

Administrative costs for Prudential's point-of-service plans range from 8% to 20% of claims costs, depending on group size, plan design, level of network usage and overall utilization, according to Mr. Cassity.

Another reason point-of-service plans cost more to administer is their initial unpredictability, according to Dan Donohue, senior vp-national accounts for CIGNA Health Plans Inc. in Bloomfield, Conn.

"You want to keep as many claims dollars as you can within the network," he said. But without experience as a guide, "you can't estimate the minimum in-network usage needed to achieve savings."

But, in the aggregate, "administrative costs are relatively small when compared with medical costs," Mr. Donohue said.

Indeed, point-of-service plans have produced substantial overall savings for employers, insurers and consultants agree.

For example, an analysis of the experience of six employer groups with point-of-service plans conducted by Metropolitan Life Insurance Co. of New York showed that reduced claims by enrollees in point-of-service plans brought down aggregate claims among the employer groups by 15% on average in 1989 compared with 1988.

Reductions ranged from 9% to 21%, depending on the proportion of services that were performed by out-of-network providers, according to a Met Life spokesman.

This translates to a savings of $33.6 million on claims totaling $227.3 million for 147,000 plan members.

"This is surely welcome news and underscores the fact that utilizing well-managed networks of health care providers can indeed produce substantial savings for our customers," said John D. Moynahan Jr., executive vp in charge of Met Life's group operations. Met Life operates managed care networks in more than 65 markets.

Health care cost increases, including administration costs, under Prudential's point-of-service plans have consistently been lower than the national average for health care plans, Mr. Cassity said.

In 1988, point-of-service plan costs increased between 10% and 12%, compared with a national average exceeding 20%.

And, in both 1989 and 1990, point-of-service plan costs increased approximately 10%, according to Mr. Cassity.

"The focus of point-of-service plans has been on reducing claims costs, not so much on administration," said Foster Higgins' Mr. Meister.

Because research and development of a new managed care plan adds so much to point-of-service administrative costs, some consultants believe that first-time buyers of point-of-service plans are paying more than future buyers will, much like the early buyers of pocket calculators paid a higher price to be the first on the block with the new gadgets.

For example, while point-of-service administrative costs comprised as much as 20% of claims costs three years ago, they range from 10% to 15% today, said Buck's Mr. Sinni.

"In the next three years, we may see administrative costs come down even further, perhaps close to that of an HMO," he predicted.

"The early purchasers of managed care have probably paid more for administration, but the results have been there to justify it," said Mr. Duva, who orchestrated Allied-Signal's foray into point-of-service in 1988 (see story, page 6).

"Network development is a time-consuming process," said Hewitt's Mr. Speed. "I would expect declines (in administrative costs) as insurers become more familiar with networks and develop systems and routines."

"Certainly, there's a load for recovering some of these start-up costs," said Mr. Meister.

In addition, as employees become more familiar with point-of-service plans, there will be less need for educational support, he said.

In addition, plan administrators are developing systems to simplify plan administration, which will lead to lower administration costs.

For example, Prudential has developed a fully integrated claims-paying system called CHARTS to administer the point-of-service plan offered by its largest client, St. Louis-based Southwestern Bell Corp., Mr. Cassity noted.

The system "will significantly reduce our claims processing cost" in the long run, Mr. Cassity said.

And, Prudential is making another investment to streamline administration of its point-of-service product: The insurer is installing electronic devices in physicians' offices in five cities—Philadelphia, Los Angeles, San Francisco, and Orlando and Tampa, Fla.—as part of a pilot project to enhance communications

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GROUP HEALTH CLAIMS ARE BETTER HANDLED WHEN YOU KNOW THE PERSON WHO'S HANDLING THEM.

There's a misconception in group health coverage that by being impersonal and relying solely on computers, claims will be processed faster.

Well, it doesn't have to work that way. At Wausau, we assign one group claims administrator to each policyholder. We even send the person's photo to the company employees, so there's always a face associated with the voice on the phone.

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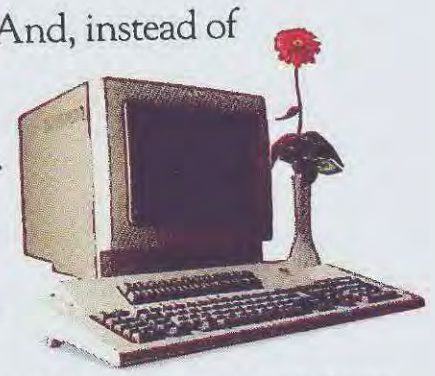
Now, personal service like this may seem unnecessary. But think about it: The claims administrators know their accounts inside and out. They handle questions efficiently. Recognize problems instantly. And understand the specific concerns of each policyholder.



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Point-of-service

Continued from page 4
between the insurer and providers.

The system, created by Health Information Technologies of Princeton, N.J., operates similarly to electronic credit card readers used by retailers to gain access to a mainframe computer via a telephone modem.

A provider runs an employee's network identification card through the card reader, which calls up a mainframe computer loaded with pertinent plan information.

"It will significantly improve our claims processing costs," which make up 52% of administrative expenses, according to Mr. Cassity.

Travelers is planning a similar experiment in on-line access with the Health Information Technologies' system.

Travelers' pilot project, dubbed "CareNet," first will focus on providers participating in Travelers' federally qualified HMOs in Sacramento, Calif., and Austin, Texas.

"Once it proves its worth," it will be expanded to include providers in Travelers' point-of-service plans, said Al Alexander, vp of information technologies for Travelers in Hartford, Conn.

Travelers is further streamlining its point-of-service administration by consolidating member services provided to networks into a single Automated Response Unit.

"This allows us to reduce the number of local service representatives by about one-half," said Mr. Gaffney.

In addition, employers can take some steps to keep administrative costs in check, which will lower their total health care bill, consultants and insurers agree.

For example, employers should:

- Keep point-of-service plan benefits as simple as possible.

"This makes communication, education and administration easier," said Aetna's Mr. Bell.

- Request a detailed accounting of claims and administration costs to let point-of-service plan administrators know that they are being watched.

"Pursue what goes into that 'all other' category," and ask why the prices of specific components have increased, advised Mary Corrigan, an associate with William M. Mercer Inc. in Los Angeles.

- Negotiate a contract that ties administrative fees to the quality of the service rendered.

"It wouldn't bother me to pay more for good service," said Ernst & Young's Mr. Duva.

- Attempt to negotiate a performance guarantee that puts the point-of-service plan administrator at some risk if annual plan cost increases exceed a specified percentage.

But such a contract should focus on total plan costs, not just on administrative costs, said Foster Higgins' Mr. Meister. "If they can reduce claims $15, I don't mind paying $2 instead of $1 in administrative costs." ■

Point-of-service pioneers examine changes in plans

By JOANNE WOJCIK

Two employers that pioneered point-of-service health care plans are pleased with the performance of their experimental managed care programs, but both are investigating possible refinements to further control health care costs.

Both the CustomCare program at Southwestern Bell Corp. and the Health Care Connection at Allied-Signal Inc. have kept the companies' health care cost increases far below the national average since they were implemented.

In addition, enrollment in both companies' plans has increased as more employees have become familiar with the plans.

"We're very pleased to find that the point-of-service option is doing what it intended to do—mitigate health care cost trends," said Milt King, district manager-benefits for St. Louis-based Southwestern Bell.

Hewitt Associates of Lincolnshire, Ill., in a recent operational analysis also gave high marks to the plan, which is administered by Prudential Insurance Co. of America in Newark, N.J.

"We were very impressed with Prudential's CHARTS claims processing system, said Curt Speed, a group benefits consultant with Hewitt. CHARTS is a fully integrated claims-paying system designed to administer Southwestern Bell's point-of-service plan.

Southwestern Bell employees and retirees can choose from three options: CustomCare, the company's self-insured indemnity plan or a traditional HMO.

Employees enrolled in CustomCare who use network providers pay only $10 per doctor's office visit and $5 per drug prescription, while most hospital, outpatient and physician services are covered at 100%.

CustomCare enrollees who use providers outside of the network pay an annual deductible of $350 per covered individual and a 20% copayment for most services.

In addition, health care obtained from non-network providers is subject to utilization review.

CustomCare covers about 51,000 employees and retirees in 13 cities.

The company's self-insured indemnity plan, also administered by Prudential, provides coverage at the same level as the non-network portion of CustomCare. Currently 24,300 employees and retirees are enrolled in the indemnity plan.

Until a year after CustomCare was implemented, the self-insured plan provided first-dollar coverage.

Employees also can select coverage from a variety of HMOs with which Southwestern Bell has contracted. However, HMO coverage usually is less comprehensive than that of CustomCare, according to Mr. King.

About 8,700 active employees and retirees are enrolled in HMOs.

Even though Southwestern Bell's total health plan costs increased significantly during the first year CustomCare was offered, plan cost increases during the second two years dropped to a level significantly below the national average, according to a study Southwestern Bell commissioned last year.

During 1987—the first year CustomCare was in effect—total health care costs jumped 26.5%, according to the study, which was conducted by Johnson & Johnson Health Management Inc. of New Brunswick, N.J.

The increase was attributed to three factors:

- A significant migration of employees from the company's self-insured first-dollar indemnity plan into health maintenance organizations in areas where Prudential had not yet established point-of-service networks. Traditional HMO plan costs were much higher than the point-of-service network costs.

Enrollment in traditional HMOs grew to 29% of employees and retirees in 1987, from 11% in 1986, according to Mr. King.

But, that percentage has since

Continued on page 10

DOES IT SEEM LIKE SOME EMPLOYEES RUN TO THE DOCTOR FOR EVERY LITTLE THING?

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*Healthweek News, Feb. 12, 1990.

NORTHWESTERN NATIONAL LIFE

Opinions

End the IRS gobbledygook

RESPONDING TO employer criticisms that its benefit regulations often are too complex, the Internal Revenue Service last year said it would try harder to make future regulations simpler and more understandable.

However, in the first major test of its self-proclaimed policy, the IRS has fallen far short of the mark.

Its new proposed regulations dealing with how employers can run various pension plan non-discrimination tests on a separate lines of business basis are anything but simple.

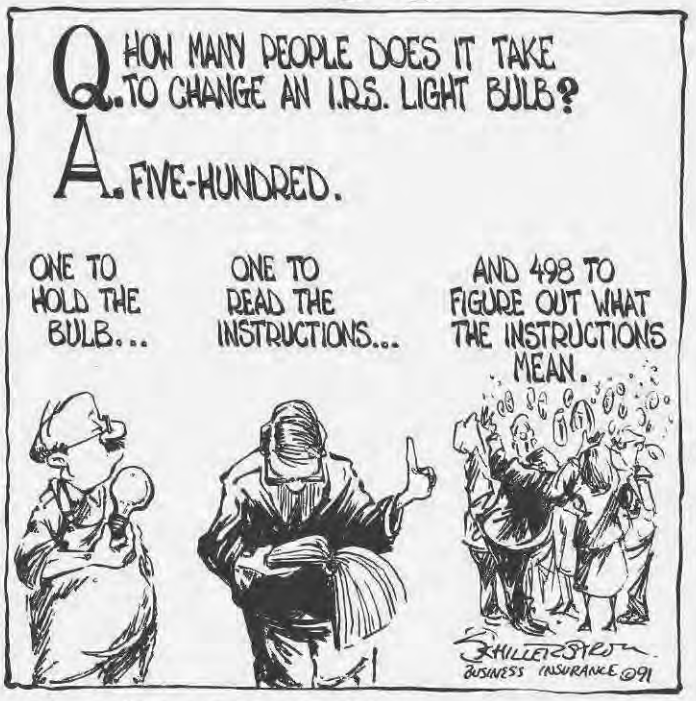
Employers with many pension plans that want to determine whether they have separate lines of business for pension non-discrimination testing purposes will have to plow through 165 pages of regulations to get answers. And then, employers must clear many different and confusing hurdles established by the IRS. These include the rules governing the size of a corporate unit or subsidiary, the percentage of tangible assets that are exclusive to that unit and the percentage of employees who exclusively work for that unit.

Some of those requirements may look good on paper, but we wonder how practical they are in the real world of business.

Unless a company forced its employees to keep time sheets, would an employer—to satisfy the IRS' separate employee workforce test—readily know whether 90% of employees who provide services to a line of business work for that operation on an exclusive basis? We think not.

Aside from their complexity, the proposed regulations contain some real practical problems. As we reported last week, the regulations are written in such a way that employers that have a large central headquarters staff as well as many lines of business would have a difficult time meeting criteria to test their pension plans on a separate lines of business basis (*BI*, Feb. 11).

In addition, the regulations, in a baffling twist, seem to bar employers from counting certain employees who are covered under a pension plan to determine whether a sufficient percentage of lower-paid employees are eligible for pension coverage.



The confusion does not end there.

For example, if 165 pages of regulations governing separate lines of business testing were not enough, employers also must weed through 300 pages of general pension non-discrimination rules that the IRS issued last year (*BI*, May 21, 1990).

We cannot help but wonder whether it really takes nearly 500 pages to provide workable pension non-discrimination rules. The IRS rules strikes us as a classic case of regulatory overkill.

Fortunately, the IRS pension non-discrimination rules are proposed, and the agency has in the past shown a willingness to modify its positions in the face of cogent and convincing employer arguments.

We hope employers do speak up. It was, after all, the voice of employers that persuaded Congress in 1989 to repeal Section 89, a much bigger case of regulatory overkill that would have affected all employers' welfare benefit plans.

Employers are entitled to fair and reasonable rules by which to operate their pension plans. If the IRS cannot offer such rules, employers will have to go to their legislators to force the IRS to provide them.

Letters

Protect America's right to private health care

To the editor: With the nation's health care costs rising above the affordable level, we tend to be looking at other countries' health care delivery systems for solutions to our problems. When our founding forefathers created our government, do you think they were looking to duplicate socialist forms of administration? Throughout my childhood education, my study of history always indicated a common theme of freedom. Our predecessors initially sailed here to obtain freedom from different forms of socialism.

Our Bill of Rights guarantees freedom of speech, freedom of religion and freedom of the press. I want the freedom to choose whether or not I offer my employees a health care plan as part of their compensation package. I want the freedom to decide what kind of health plan I want for my family. Health care is not a God-given right. If you live in America, you must earn it.

Many say it is not possible to earn access to health care because health care is unaffordable. Those people do not deserve the freedom to aspire to new financial heights. They should move to a socialist country where they can pay higher taxes so that the government will provide their care.

With all due respect to our government, its inefficiencies have proven that it cannot adequately provide care to the elderly in the form of Medicare. What makes people think the government can provide care cheaper than the insurance companies? Will the government force doctors and hospitals to charge less, thereby sacrificing quality of care and innovations in technology? Once again, move to another country if you do not want the best care possible.

Many Americans blame health care cost problems on "greedy" insurance companies and their exorbitant profits. Let's get real. You should examine health insurers' profits as a percentage of expenses and revenues for the past five years. Compare that with the average manufacturing firm. If profits were excessive, insurance companies would not be desperately attempting to find new ways to manage health care and to contain health care costs. They would not be selling their group health care divisions or declaring bankruptcy, as some health maintenance organization companies have done.

We must all work together to find new solutions to obtaining affordable health care. We could start by eliminating inefficiencies in our system. We should:

- Crack down on those committing health care fraud. It currently is looked on as "white-collar" crime with minimal punishment.
- Limit the astronomical judgments given in medical malpractice lawsuits. This will bring down the cost of malpractice insurance which, in turn, will lower physicians' fees.
- Promote more competitions among physicians in setting fees. Preferred provider organizations were a good start. HMOs seem to be the next logical step, as long as the government allows them to compete.

Mandated health care is not the answer to our problem. It is just another step toward socialized medicine. It will only contribute to the demise of the small employer by forcing him to pay premiums he cannot afford. I urge taxpayers to speak to their legislators to protect the freedom within our current health care delivery system.

Richard C. Mattingley II
Chief Financial Officer-
San Diego Branch
Ruland & Mattingley
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Published by Crain Communications Inc., Chicago

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SUBSTANCE ABUSE IN THE WORKPLACE — THE BLUE COLLAR VIEW.

One in an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **CURTIS WESSELN,** *Vice President of Wesseln Construction;* **DENNIS DELUCCIO,** *Superintendent, Wesseln Construction;* **JESS GORMAN,** *Superintendent, Wesseln Construction;* **DICK MURY,** *with Frank B. Hall Corporation, Wesseln's broker;* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company;* **LARRY EVANS,** *Manager of Safety Management, Argonaut Insurance Company.*

MODERATOR Wesseln Construction specializes in residential framing here in Southern California. Just how big is the company?

CW: We average probably 200 people. At the highest maybe 800, depending on the jobs and how busy the market is. Right now it's slow and it's getting slower due to the rise in mortgage rates.

MODERATOR How big a problem is substance abuse in your industry?

CW: We don't see it too much because when we're down in that 200 range, we're staying with our regular people, some of whom have been with us 20-25 years. If we get up above 400, then we're employing whoever we can find to man the jobs. And then it's whoever you get and you don't know until they come to work not fit to work, or they do something.

Abusers are injured 3.6 times more often.

MODERATOR Do you have any pre-screening program for drugs and alcohol?

DD: The judgement of the foreman that's hiring them. There's no rule that says if someone walks on a job you have to hire them. If the foreman looks at them and thinks "Not this guy," he just says, "No, we don't need anybody." He doesn't tell them they don't look like the kind of people we want to hire. But no, we don't have a program.

MODERATOR Do you work with a number of unions?

CW: Basically just the Carpenters Union. Each one has their own district, District 1815 out of Santa Ana, plus others in San Diego and LA.

MODERATOR Are you making any special efforts to address the problem of substance abuse in the workplace?

CW: Like Dennis just said, it's basically on judgement. There is some talk of having some type of pre-screening, but exactly what the limits are isn't clear.

MODERATOR Do you have any measurement of hours or money lost, or injuries due to accidents, related to drugs or alcohol?

CW: We're pretty low, knock on wood, compared with the industry. And most of those injuries that do happen are to the new guys during the first two or three months they're on the payroll. They step on a nail, they fall eight feet, but we don't necessarily say that it's drug related.

MODERATOR Is substance abuse a topic at contracting and builders groups? How do they address it?

CW: More as a problem in general, not something that's just a problem in our industry.

SL: The Laborers, Cement Masons, Teamsters and the Carpenters just agreed to a substance abuse program in southern California. Which is good news, because a recent study in California asked construction workers on a job site to volunteer to be tested for the presence of alcohol and drugs. 23% of those people tested positive.

MODERATOR And those were the volunteers?

SL: Right. These are people who tested positive for opiates, marijuana, barbiturates, amphetamines, PCP or alcohol. If you're not familiar, marijuana stays in your system the longest, up to three weeks. Cocaine, up to 48 hours.

MODERATOR Those are drugs. What about alcohol?

SL: If you drink 2 alcoholic beverages in an hour, you would test about .08. One of our customers is a union contractor who tested his workers in four cities: Miami, Houston, Dallas and Tulsa. Positive test rates were 28%, 40%, 44%, 53%. In Tulsa, when he wants 20 guys, he has to make a couple of calls to the hiring hall. That's because the guys know he has a full testing program, and a lot of them won't even bother to go out because they know they'll test positive.

MODERATOR You said you don't have a substance abuse program, but do you have a stated policy? Something workers sign before they can go to work for you?

CW: I don't even know if we have the legal right to do that.

SL: Oh, you have the right. In fact, if you consider substance abuse to be a health and safety issue, you have an *obligation* to provide a safe and healthful place to work. The fourth amendment only protects individuals from illegal search and seizure by the *state*. You as a private employer are legally free to institute company policy that establishes pre-employment screening, post-accident screening, and reasonable suspicion. That is your right. A memo from the National Labor Relations Board General Counsel states, "There can be no quarrel with an employer's desire to insure a drug-free workplace or a drug-free working environment. We simply conclude that on request an employer must bargain in good faith with the union about a decision to institute drug testing and the content, procedures and effects of such a program."

JG: That sounds fine, but does it work in the real world?

SL: Yes, but there are guidelines. Other union contractors that have instituted programs have started at the very top. The first one in the line was the president. And the same rules they apply to their workers they apply to the rest of management, without exception. So, aside from negotiating with the union, the only hotbed you have as an employer is random testing. That's still an issue that can get you in trouble. But frankly, pre-employment screening combined with post-accident testing and reasonable suspicion will get over 95% of the substance abusers.

National statistics show 21.6% of construction workers use illegal substances on the job. 17% use alcohol.

MODERATOR If you adopted a testing program, do you think your labor pool would dry up? Or is there an excess of labor?

DD: There's a shortage. When we have to get above that 400 mark, the quality of workmanship we get suffers. We try not to do that but when there are jobs, you have to have enough men to keep to schedule. It's probably a good idea to screen them before you hire them, but a lot of the problem is the foreman needs men to do the job and he wants them now.

MODERATOR He wants bodies.

CW: He wants qualified men. But when he calls up the hiring hall and says, "I need five guys," he needs them on that building at 7:05, not at 8:30 when they come back from some screening program.

MODERATOR What do you think the reaction would be to testing?

CW: With our core 200, I don't think we'd have a problem. With the 400, maybe not. Past that we don't care. If the statistics are right and we're only getting 70% of a good day's work out of them, then we don't want them anyway.

DD: The problem wouldn't be in testing, it would be in what do you do with these guys if they test positive? Do you say, "Whoops, you're positive, you're gone?" Or do you try to help them?

SL: The courts and society as a whole seem to be much more forgiving if an employer offers an assistance program, where the first time someone tests positive they're not thrown out on the street. It's almost always cheaper to rehabilitate someone than it is to dump him and hire someone to replace him, especially if he's a supervisor or a foreman.

CW: Image is always important, but that doesn't bring home dollars or the contracts. We try to do our best here, but if we have an assistance program, all of a sudden there's another cost that has to be recouped in the contracts. It's bad enough competing against non-union firms without raising our costs. I agree with the whole idea of helping guys, but putting it into practice is another issue.

DD: Look at it from our perspective. We employ people for a certain period of time. Say we find that someone's on alcohol or something and we get him help and dry him out. Most of the time, the job's over in a month or two and he's gone on to a job with another company that doesn't have a program and he falls back into the same habits. He may not come back to us for two or three jobs beyond that. And when he does come back, we may have to deal with, and pay for, the same problem again.

MODERATOR Does the BIA or the Contractors Union have any kind of assistance program?

CW: Not that I'm aware of.

SL: You're correct. But remember, you don't have to pay for an assistance program. All you have to do is provide access. It can be as simple as a typewritten letter that says, "Here's a list of all the assistance program providers," or "Here's the 1-800 Cocaine hotline."

JG: That sounds good, but how do you get the guy to do something?

SL: This is how one contractor does it. I quote from his employee manual. "The company recognizes that alcohol and drug abuse is an illness. It is with this philosophy that the following guidelines have been established. An employee terminated for violating a policy shall not be eligible for rehire for a period of 30 calendar days. During that period, it will be the individual's responsibility to seek rehabilitation. They will then be required to take a second test at their own expense at the company-approved laboratory which must result in a negative diagnosis." This policy is signed by the president of the company and given to every employee. Now they have a reputation as a drug and alcohol-free workplace. They just don't get the guys from the hall who are using drugs and alcohol because they know they've got to go through the screening. Their workers' compensation premiums have gone down more than 40% in one year.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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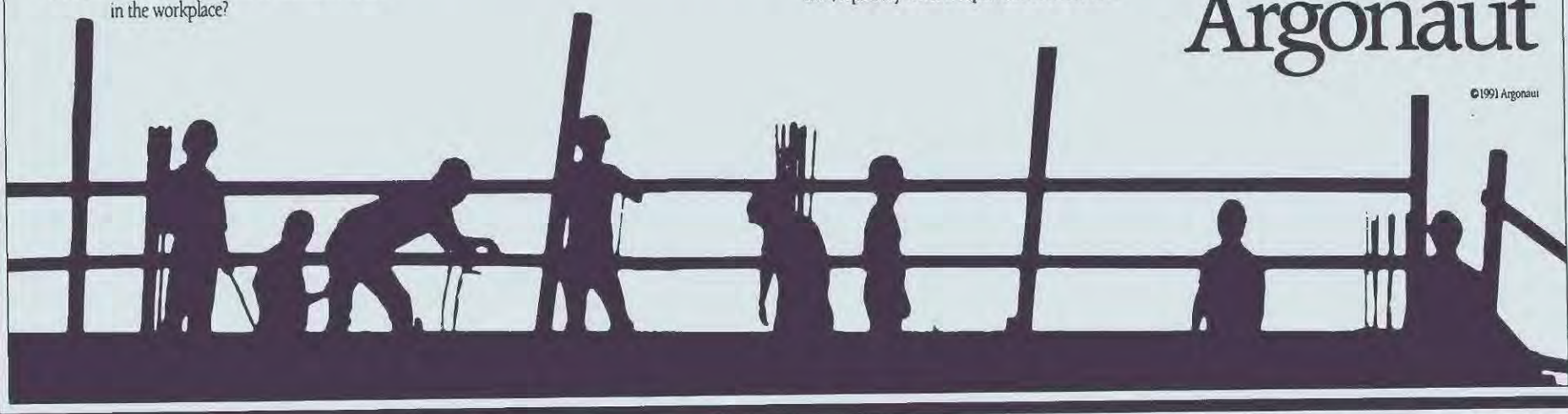

Pioneer plans

Continued from page 6
fallen to slightly more than 10%.

• A high volume of elective surgeries by employees during the last year that the self-insured indemnity plan offered first-dollar coverage.

• A rise in the number of outpatient doctor visits, because employees were encouraged by the CustomCare program to establish relationships with their new primary care physicians.

In subsequent years, though, plan costs increased significantly less, the J&JHMI study found.

For example, Southwestern Bell's health care costs increased 12% in 1988, while various studies estimated that employers' health care costs rose 18% to 20% nationwide.

The telephone company's health care costs increased less than 7% in 1989, compared with a 20% to 24% increase nationwide.

Mr. King estimates that the company's health care costs increased 7% increase in 1990.

So far employee response to CustomCare has been positive he said.

"Initially, there was some apprehension but as the plan has matured, they've become very satisfied," Mr. King said.

According to the most recent employee satisfaction survey Southwestern Bell conducted, 84% rated the point-of-service plan as excellent or very good, up slightly from 82% in 1988.

In addition, enrollment in CustomCare rose to 83% of employees in 1989 from 77% in 1987, according to the J&JHMI study.

Mr. King also noted that 3,900 employees who live in areas outside of cities where network providers are available have opted to join the network, probably because their workplace is close to a CustomCare provider.

Morristown, N.J.-based Allied-Signal has not released data concerning the outcome of its 3-year-old point-of-service plan, said but Gary P. Yeaw, director of group insurance said: "It's meeting our objectives."

The plan, administered by CIGNA Health Plans Inc., has "brought the cost trend at or near single-digits," he said.

"Not only are we reducing the rate of increase (in health care costs), but also hospital days per 1,000 (employees) and length of stay," Mr. Yeaw said.

For example, hospital bed days per 1,000 employees decreased to 331 for Health Care Connection enrollees in 1989 from 334 the year before. Under the self-insured indemnity plan, there was a rate of 526 hospital bed days per 1,000 employees in 1989 and 611 in 1988.

Allied-Signal also is seeing its health care costs shift toward network providers as more employees opt to use Health Care Connection, he said.

For example, while 16% of the company's total health care costs were paid to non-network providers in 1989, only 14.8% were paid to non-network providers in 1989, according to Mr. Yeaw.

In addition, the number of high network users—those who use network providers for more than 95% of health care services—increased to 75.8% in 1989, from 74.6% in 1988, Mr. Yeaw pointed out.

"A couple of percent doesn't seem like much, but it takes a lot of work to move a couple of percent," he said.

A total of 53,700 of Allied-Signal's 74,300 domestic employees are enrolled in Health Care Connection, more than double the 35,000 that enrolled when the program was launched in March 1988.

Employees who use network providers typically receive 100% coverage, though the plan imposes a $10 deductible physician office visit and $5 deductible per drug prescription.

Those who opt out of the network must pay 20% of the cost of services above a deductible that equals 1% of their base salary for individual coverage and 3% for family coverage.

Neither of the pioneering managed care firms view their customized point-of-service plans as finished products.

"CustomCare is still evolving," according to the summary of the case study conducted by J&JHMI. "The plan will continue to be monitored in the years ahead to identify new opportunities to reduce. . .health care costs."

For example, attention is now being focused on reducing the health care costs of employees who do not have access to the network, Mr. King said.

In addition, the Hewitt analysis suggested that Prudential beef up the use of its "PruPass" utilization management program in the network setting.

The program, which Mr. Speed described as "light years ahead" of any other utilization management system currently available, was only being used in the indemnity setting.

"It needs to be moved over to the point-of-service program at this time," he said.

Prudential is studying Hewitt's recommendations.

"The input from the audit will help us continue to refine and enhance the services we provide Southwestern Bell, as well as other customers," said Rebecca Rush, vp-group marketing, Southwestern group operations for Prudential.

Allied-Signal is "gradually establishing new networks and negotiating with unions" in an effort to increase its point-of-service enrollment, Mr. Yeaw said.

"We'll probably never have 100% point-of-service enrollment. We have a lot of small, diverse businesses in rural areas, on mountain tops," he explained.

Still, "we think the program is getting better as time goes on," Mr. Yeaw said. "CIGNA is on the leading edge, but there's always room for improvement."

In addition, Allied-Signal recently negotiated an extension to its three-year "risk contract" with CIGNA, the terms of which were not released.

Under the prior agreement, CIGNA agreed to absorb cost increases that exceeded a stipulated amount in each of the program's three years (*BI*, Feb. 22, 1988).

While neither CIGNA nor Allied-Signal would disclose the specific percentage for the first two years of the program, CIGNA guaranteed that Allied-Signal's costs would not increase more than 6% to 7% in the third year (*BI*, March 19, 1990).

While CIGNA was believed to be the first health insurer to agree to such a contract for a multiyear period, Prudential also entered into a similar risk-sharing arrangement with Southwestern Bell when the telephone company established its point-of-service plan in April 1987, according to Mr. King.

Mr. King also declined to provide details of Southwestern Bell's risk contract.

While both CustomCare and Health Care Connection have succeeded in controlling the steep climb in employee health care costs, "none of these programs are the final solution," asserted former Allied-Signal Benefit Manager Joseph W. Duva, who is now a principal benefit consultant at Ernst & Young in New York.

Point-of-service plans, like other health care programs, "need to be constantly managed and audited," he said.

"If you let it ride, you'll see it get out of control," he warned. ■

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UR vendors

Continued from page 3

must have a clear objective in mind for a review program.

"Not everyone is bottom line-oriented. Some employers want to use utilization review as an educational tool for employees," he explained (see story, page 18).

Claims analysis that compares utilization before and after controls are introduced can give employers an idea of how well a firm is containing costs, consultants and UR executives agree.

"It's best to get at least a year's claims experience," said Dr. Roger Taylor, national leader of The Wyatt Co.'s health care consulting practice in Washington, D.C.

He suggested employers "look at health care cost trends and specific information like inpatient admissions per 1,000 covered lives." By using that data, companies can tell whether their employees use more or fewer services than workers at similar companies.

That data needs to be monitored year after year. "The biggest hit is in the first year" and later savings are more difficult to notice, said Dr. Taylor.

Hewitt's Mr. Ziemba warned that employers should not necessarily rely on canned UR vendor data and reports when evaluating a program. Some UR companies simply send one sheet of paper outlining the number of hospital days requested by physicians and a smaller number of days approved by the vendor. The difference is cited as "days"—and therefore dollars—"saved."

"This doesn't mean zilch," he said.

Pamela DePriest of The Sunderbruch Corp. agreed.

"Days saved does not take into account the costs of medical care received outside a hospital," explained Ms. DePriest, director of marketing at the Des Moines, Iowa, utilization review firm.

It's important to visit the review firm's offices, according to Healthmarc's Mr. Tierney. 'If you're concerned about how your employees are treated under a UR program, you are not going to see it in a document.'

An employee, for example, may be referred for outpatient services or sent home to undergo expensive drug therapy. Those costs should be factored into the "days saved" equation, she said. And administrative costs should also be subtracted to give a true picture of savings.

Some consultants caution that basing UR savings on health claims data can be misleading.

"It's probably rare that the only change made (to an employer's health care plan) was the addition of utilization management," noted Dr. Arnold Milstein, president of National Medical Audit, a William M. Mercer Inc. unit in San Francisco. NMA has audited more than 100 utilization review organizations, assessing whether they assure the appropriate delivery of health services, operate efficiently and monitor health care spending.

Employee benefit managers should consider other changes made during the period being reviewed and any changes in their employee population, Dr. Milstein said. He adds that sizable populations can include random variations in inpatient days per 1,000, so any change should be examined for its statistical significance.

Different definitions used by the UR firm and a separate claims administrator can complicate matters, experts say.

"When we do claims analysis, we spend 60% of our time understanding definitions," noted Charlene Weigel, director of information services for Intracorp, a CIGNA Corp. review unit in Berwyn, Pa.

As an example, she cites "bed days per 1,000 employees" in maternity cases. UR services offered by insurance companies typically consider them two admissions—one for the mother and one for the newborn. But many independent firms count it as only one admission, she explained.

Random audits of medical charts also can help employers determine how well a review firm is doing. Employers can do audits themselves or hire outside firms.

Dr. Milstein said employers should examine 60 to 120 cases that have gone through the utilization management process. Employers should request information, like hospital bill data, from their claims administrator and then have three independent physicians check the records to make sure the review firm is doing what it promises, he said.

Employers also can compare a sample of 10 different diagnoses and the average length of stay the firm certifies to industry averages or figures from another firm.

"You'll get a feeling of their overall intensity of review," said Mark Tierney, president of Healthmarc Inc., the UR subsidiary of United HealthCare Corp. in Minnetonka, Minn.

Those comparisons can also demonstrate how intensely a UR firm manages cases and the types of medical criteria it uses to certify lengths of stay, he said.

Employers could also gauge a UR firm's aggressiveness by asking when review nurses will check back with a patient after a hospital stay has been certified, Dr. Milstein said.

When the nurse checks back on the third day of a certified three-day hospital stay, "that's aggressive," he said. "If they check back in four or five days, you know it's a lukewarm firm. And if it's six days, you'll know it's a sham."

Evaluating UR firms with length-of-stay date is not universally approved. Intracorp's Ms. Weigel, for one, is wary of it. Review firms calculate average length of stay by dividing the number of bed days by total admissions. But that's a "dangerous number," she cautioned, because employers don't get a picture of the number of bed days and admissions.

For example, an employer with a lower average length of stay may actually have a higher number of bed days and admissions—and thus higher health care costs—than another employer with a higher average length of stay, she pointed out.

Consultants and UR executives also stress that benefit managers can help their cause by visiting the review firm.

"When people sit down with consultants and compare UR services, it all comes down to mush," Healthmarc's Mr. Tierney said. "If you're concerned about how your employees are treated under a UR program, you are not going to see it in a document."

Visiting the review firm's offices can give benefit managers an idea of how the process unfolds. "You can listen to one side of the conversation and observe how nurses handle cases," Mr. Tierney explained.

Continued on page 16

WIC

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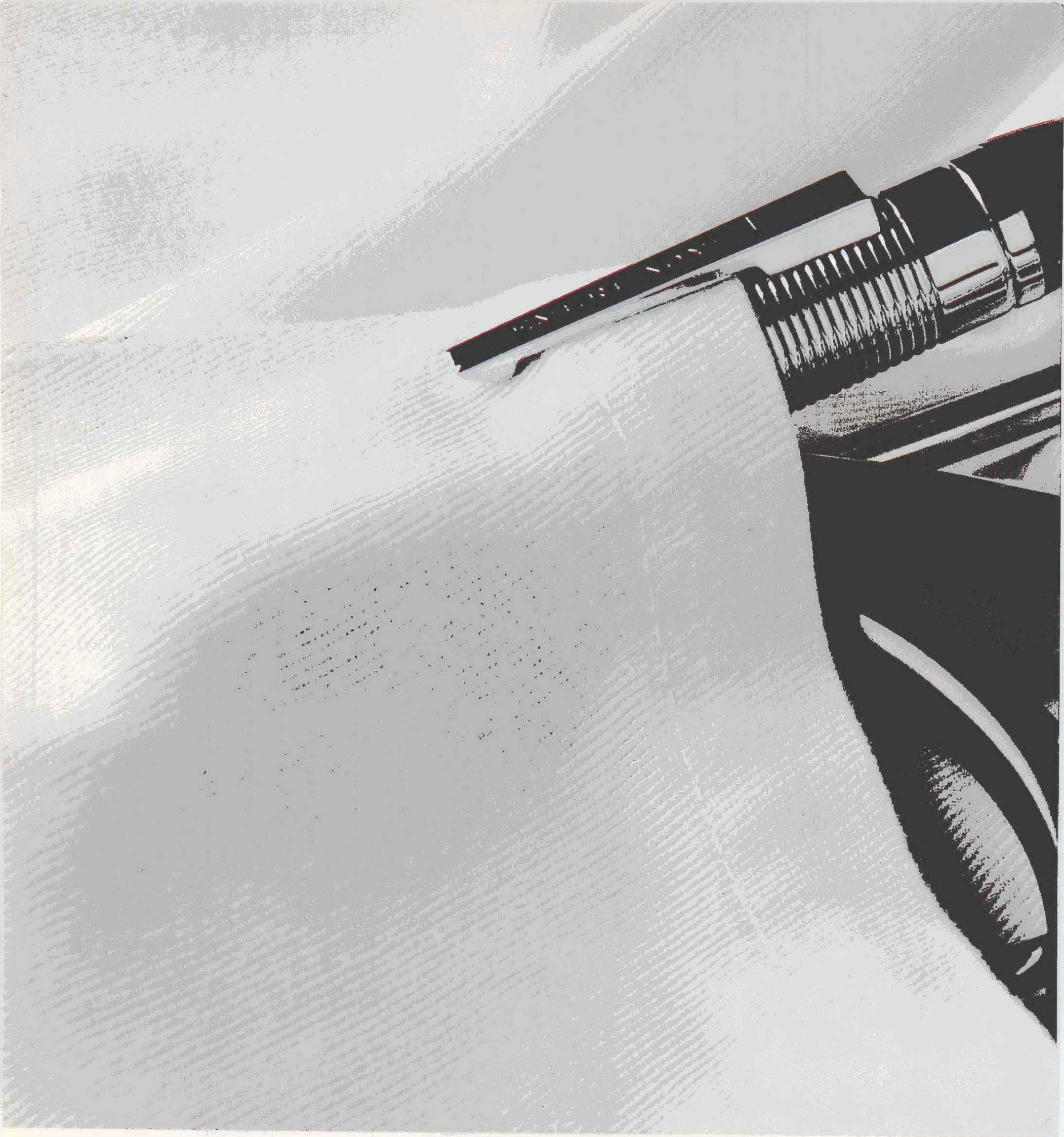

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Reviewing UR firm

Continued from page 12

On-site visits are not for everyone.

Most employee benefit managers probably don't have the time, he pointed out. "Unless its an employer with 1,000 lives or more, I don't see it happening as much."

But the more concerned benefit managers are in evaluating the company's UR program, the more likely they are to check it out personally, Mr. Tierney said.

Employee satisfaction surveys and testimonials from other customers also can shed light on a review firm's performance.

'The purpose of (UR programs) is sometimes lost. The point is to make patients better off," said Leslie Michelson, president of Value Health Sciences Inc. in Santa Monica, Calif. VHS, a subsidiary of Value Health Inc. of Avon, Conn., licenses a software program that evaluates medical necessity to insurers, HMOs and other UR vendors.

Employers do not need to survey all employees, just a sample who have been through the UR process. One thing to ask is whether employees perceive the program as merely a cost containment tool or also as a way to improve health care.

Employers also must be sure to investigate the firm's internal performance standards, pointed out Mary Lou Smith, manager of utilization management at the BC/BS Assn. Among other things, employers can ask how many days the vendor takes to notify patients and physicians of its decision and how it notifies them—in writing or by telephone.

Claims of "24-hour review" should be investigated to be sure that staff members, not recordings, are available to answer patient and provider calls, she said.

And, Ms. Smith said, the review firm's capacity to meet with providers face-to-face is important when a particular doctor isn't cooperative in releasing information needed for reviews.

'If it were true that every case gets thoroughly reviewed by a physician, I'd say it's a very inefficient program and has to be extremely costly,' says Doug Leland, vp of product development and management at Intracorp.

Employers also can learn about internal quality standards by asking about the training programs required for UR nurses and physicians on staff, she added.

Indeed, examining staff qualifications and the ratio of nurses to covered lives is an important evaluation tool, experts say.

Medical records technicians and other office personnel should only be responsible for processing demographic information. Consultants and UR executives agree that medical information should be processed by nurses.

"In general, we're finding that the best-functioning utilization management programs have one registered nurse per 10,000 lives," NMA's Dr. Milstein said.

Employers may want to check the specialty backgrounds of a firm's registered nurses, suggested Marlene Travis, president and chief operating officer of Health Risk Management Inc. in Minneapolis. "If you've got a gynecological problem, you don't want an orthopedic nurse reviewing it."

And, Dr. Milstein pointed out, attending physicians are more easily persuaded by nurses who have a background in the cases they review. "Those nurses can handle (the physician's) arguments and will be more credible because they've had experience."

In addition, he said, the UR firm should have a built-in inventory of alternative care facilities available. Nurse reviewers can more easily convince the attending physicians that inpatient care isn't necessary if they can say can the UR firm has a good relationship with a specific site for alternative care.

Consultants and UR executives agree that a review firm should employ physicians on a full-time basis to do its job properly. Some firms only use physicians who are actively practicing and others employ a "panel" of physician reviewers who often are retired.

Most firms have access to speciality physicians as well.

However, experts agree that claims of "100% physician review" are usually misleading. Most also say it is unnecessary.

"If it were true that every case gets thoroughly reviewed by a physician, I'd say it's a very inefficient program and has to be extremely costly," said Doug Leland, vp of product development and management at Intracorp.

The willingness of the reviewers to stand firm also can affect the effectiveness of the review firm, Dr. Milstein said.

"There are a lot of peace-lovers out there who will stretch criteria so they can approve the doctor's request," he said. Quality review firms value nurses and physicians who are savvy persuaders since "UR, at its core, is a persuasion process."

A UR vendor's software programs should be examined for efficiency and report-producing capabilities, experts say.

In addition, employers may want to check out the medical protocol software used to evaluate medical necessity and appropriate lengths of stay.

Medical appropriateness systems often incorporate artificial intelligence and "decision trees" that guide a nurse through a review, highlighting questions that should be asked and basing further review on the answers to those questions. Vendors using these systems often highlight the fact that such programs cut down on nurse training times and the need for physician involvement.

Yet most experts say that medical criteria systems are not the most important factor.

"It's a very useful adjunct for review but in no way is it a substitute for clinical judgment," said Wyatt's Dr. Taylor.

"Sexy software does not account in 1991 for the difference between mediocre and superior UR," agreed Dr. Milstein.

Over the next six to 12 months, experts say UR will move further away from simply assessing the necessity of a particular procedure or hospital length of stay. Instead it will focus more on issues of quality of services and patient advocacy.

"Utilization review is no longer an adequate description of the industry," Intracorp's Mr. Leland said. "We do more than manage utilization —we manage costs and provide education and health awareness," he said.

While some employers are beginning to understand that UR vendors can do more than just admit or deny a hospitalization, "I don't think the UR vendor as patient advocate is communicated to employees very well," said Dan O'Malley, a principal in Pittsburgh with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

Utilization review should be used to help educate employees because "the educated consumer will ultimately get the best-quality health care," he said. ■

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Spotlight report

UR effectiveness difficult to measure

By CHRISTINE WOOLSEY

Employers and consultants agree that utilization review can contain health care costs, but identifying which specific UR components are the most effective is difficult.

Employers are "all over the map on this," said Dr. Arnold Milstein, a managing director at William M. Mercer Inc. and president of National Medical Audit, a San Francisco-based Mercer unit specializing in health care cost control.

Some employers warn against evaluating UR programs on the basis of savings, saying their biggest benefit is teaching employees to be better health care consumers.

Which type of review benefit managers consider most effective "probably depends on. . .the anecdotes their vendor is telling them," said Dr. Milstein.

Indeed, experts agree that there is little hard data on the effectiveness of various types of programs.

If popularity is any indication of effectiveness, preauthorization, concurrent hospital review and case management stand out (see story, page 19.)

"Along with with mom and apple pie, preauthorization and concurrent review are still the staples of utilization review," said Scott Ziemba, a consultant with Hewitt Associates in Lincolnshire, Ill.

At Deere & Co. in Moline, Ill., concurrent review has produced "marked improvement," said Richard Van Bell, president of its John Deere Health Care Inc. unit. The agricultural manufacturer self-insures and self-administers its health care plans.

Since Deere began concurrent review in the late 1970s, inpatient days have fallen from about 1,200 per 1,000 to 400 to 500, depending on location, he said. Precertifying inpatient hospitalizations, begun in the mid-1980s, has also proved cost-effective, said Mr. Van Bell.

In that sense, Deere may be an exception. Consultants say precertification is rarely credited for large savings.

"Most people aren't comfortable getting down to a nuts and bolts evaluation of precertification," explained Paul Goldbeck, a vp and group benefits consultant with Booke & Co., a consulting firm in Winston-Salem, N.C.

When employers are asked what aspect of UR is most beneficial, "most say case management because that's where detailed analysis is done," Mr. Goldbeck said.

Most employers using case management say it's their most effective program, agreed Dr. Roger Taylor, national leader of health care consulting with The Wyatt Co. in Washington, D.C.

Employers, claims administrators and insurers consider case management the most effective component, according to a Self-Insurance Educational Foundation survey (*BI*, Feb. 19, 1990). Case management was given an average of 2.1 points on a three-point scale rating effectiveness, compared with 1.8 points for precertification and 1.7 for concurrent review.

And the popularity of case management is growing rapidly. In a recent Wyatt poll, 68% of employers said they had case management programs during 1990, up from 50% in 1988 (*BI*, Jan. 21).

"Large case management is the No. 1 seller," said Mark Tierney, president of Healthmarc Inc., the utilization review unit of United HealthCare Corp. of Minnetonka, Minn., noting that catastrophic cases can cost hundreds of thousands of dollars. "There is a high interest level on the part of benefit managers on large cases because those are the ones the CEO is involved with."

Second surgical opinion programs, on the other hand, are falling out of favor, experts say.

"Second surgical opinion has probably been evaluated for its impact more than any other component" of utilization review, Dr. Milstein said. "A lot of employers have had very disappointing results."

Many employers feel that mandatory second surgical opinion is a waste of time, said Healthmarc's Mr. Tierney. Indeed, in the Self-Insurance Educational Foundation poll, respondents gave it an effectiveness rating of only 1.1 points.

However, Dr. Milstein said, lack of control over who was evaluating the cases could have watered down the effectiveness of many programs. The random lists of specialists that many UR firms maintain do not "do enough to guarantee against conflicts of interest," Dr. Milstein explained. Requesting a second opinion from physicians on the same medical staff "is absurd" because their first instinct may be to agree with their peer.

"A second opinion program essentially sends the same facts to a different physician for a different opinion. If the second opinion physician (bases) his opinion on the same facts, his instinct is to confirm the first opinion," explained Leslie Michelson, president of Value Health Sciences Inc. in Santa Monica, Calif. "That doesn't get at the question of whether the procedure is the optimal choice for this patient."

Second opinion programs can be helpful when used primarily to educate patients about alternatives to surgery, experts say.

"If you use second surgical opinion as a patient advocacy and education tool," it can be effective, said Doug Leland, vp of product development and management at Intracorp of Berwyn, Pa., a CIGNA Corp. unit.

"When you look at second opinion from a flat-out cost standpoint," the results often are disappointing, said Bill Matson, manager of U.S. health and wellness programs for International Business Machines Corp. in Purchase, N.Y. 'To really understand the value, you have to take a look at what happens after a patient goes for a second opinion."

IBM, for example, recently found that 25% of all employees who were required to get a second opinion decided against surgery after that review. Mr. Matson explained, "only a small fraction didn't have surgery because the second opinion doctor said not to." Instead, most decided against surgery after learning more about the procedure and alternatives, he said.

"I think it's very important that utilization management get away from policing and move toward patient advocacy," agreed William Goss, manager of health care programs for General Electric Co. of Fairfield, Conn. "If employees take more control over their own health care, you'll find they will act in their own self-interest."

Patient advocacy and education programs could help control costs, but savings should not be their primary focus, he said. ■

UR, a 1980s innovation, is today's staple

By CHRISTINE WOOLSEY

Utilization review continues to gain in popularity with employers, according to several recent surveys.

Preadmission certification, medical case management and other programs implemented in the early-1980s—when inpatient hospitalization costs began to soar—are now commonplace among employer-sponsored health plans, the surveys found.

For example, The Wyatt Co. found that 83% of the 900 group health plans surveyed included preadmission testing. Also, 73% of plans require precertification of inpatient days, and 68% include medical case management, the survey found (*BI*, Jan. 21).

And, 30% of employers have introduced at least one of these programs since 1988, Wyatt said in "Medical Benefits for Active & Retired Employees."

A study of 1,955 employers by A. Foster Higgins & Co. Inc. concurs that utilization review programs are now a standard feature of indemnity plans.

Ninety-three percent of survey participants who responded to this question use some type of review to judge the appropriateness of services, according to the New York-based consultant's "Indemnity Plans: Cost, Design & Funding."

The study also reported on the increasing costs of group health coverage and the growing number of employers that self-fund their group health plans (*BI*, Jan. 28).

However, 64% of survey respondents said they did not know whether utilization review programs had helped control costs.

But, among employers that said they could gauge the effects of utilization review, 70% said the programs reduced costs; 3% said they increased costs; and 27% reported no effect.

A smaller study of 75 large companies found that 79% used utilization review to help control costs. Ninety-seven percent of those surveyed include preadmission certification, and 93% use both concurrent review and case management, reported TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. of New York.

Research indicates that the average hospital stay indeed has dropped over the last decade.

"There can be no doubt that hospital admission rates and the average length of confinement for specific illness have fallen dramatically since (utilization review) programs were instituted in the early 1980s, which speaks to the overall effectiveness of these programs," said John Erb, a managing consultant at Foster Higgins.

For example, data from 981 U.S. hospitals shows that the average stay declined to 5.6 days in 1989 from 6.7 in 1980, according to the Commission on Professional & Hospital Activities, a non-profit research organization in Ann Arbor, Mich.

In a 1990 study, the Blue Cross & Blue Shield Assn. found that four of seven utilization review services studied cut hospital admissions by 19.8% and inpatient days by 24.2%.

The survey used data compiled by 54 Blue Shield plans from 1980 to 1988 to examine the cost effectiveness of pre-admission certification; concurrent review; retrospective review with denial of payment; retrospective review without denial of payment; second surgical opinion; individual case management; and discharge planning.

Over that nine-year period, two combinations of utilization review services—preadmission certification combined with concurrent review and retrospective review with payment denial—"resulted in statistically significant reductions in hospital admissions, inpatient days and inpatient payments per 1,000 members," said Douglas S. Peters, senior vp for the BC/BS Assn. in Chicago.

Blue Shield plans that included all four of these programs in 1988 saved a total of nearly $53 per enrollee, he said.

However, the study did not consider the cost of administering these various programs or the cost of alternative care, Mr. Peters pointed out.

Mandatory second surgical opinion, retrospective review, case management and discharge planning programs did not statistically reduce health care utilization and benefit payments over the same nine-year period, Mr. Peters explained.

But results indicate that retrospective review and case management programs were effective in the later part of the study period, he noted.

Another BC/BS Assn. study concluded that rates of inappropriateness vary significantly by procedure and that preauthorization of surgical procedures can be a cost-effective way to evaluate the appropriateness of care.

The study covered five BC/BC plans and one BC/BS health maintenance organization for one year beginning in July 1989. Total membership was 1.5 million.

Each plan chose between seven and 18 surgical procedures to evaluate, including hysterectomies, tonsillectomies and coronary artery bypass grafts—a procedure in which new blood vessels are attached to blocked arteries to allow blood flow.

The study found that 27% of 663 tonsillectomies were inappropriate but not one of 181 coronary artery bypass grafts reviewed were deemed inappropriate.

However, "historically, the literature told us that a lot of coronary artery bypass grafts were inappropriate," said Mary Ellen O'Donnell, director of utilization management for the BC/BS Assn.

For example, a Rand Corp. study found that 32% of the artery grafts were inappropriate, "but we found that 0% were inappropriate."

The study illustrates that utilization reviewers should not always rely on historic rates of inappropriateness, Ms. O'Donnell said.

However, she cautioned that the BC/BS study reviewed only eight such cases.

In addition, one plan conducted a cost/benefit analysis and found preauthorization to be cost-effective, Ms. O'Donnell noted. A total of $103,804 spent during the six-month pilot program reaped a savings of $265,280, or $2.56 for every dollar spent on preauthorization.

Some procedures were clearly more cost-effective to preauthorize than others, according to Ms. O'Donnell. "There was not a one-to-one correlation between specific procedures' inappropriateness and their cost of review," she explained. ■

Spotlight report

State regulation of UR firms sparks debate

By CHRISTINE WOOLSEY

Increasing state regulation of utilization review companies will hamper product design and flexibility and drive up the cost of services, predict consultants, employer groups and UR executives.

Physician and hospital groups, however, say UR interferes with the delivery of health care. They are demanding new laws to prevent untrained individuals at UR firms from making medical decisions.

The controversy has spurred the creation of voluntary uniform guidelines and standards designed to monitor utilization review.

Two sets of guidelines covering concurrent review and overall administrative procedures were proposed last year by the American Medical Assn., Blue Cross & Blue Shield Assn., the American Hospital Assn., the Health Insurance Assn. of America and the American Managed Care & Review Assn. (*BI*, Jan. 22, 1990).

In addition, the Utilization Review Accreditation Commission—which represents UR firms, employers, insurers, doctors and hospitals—has developed national standards to encourage efficient and effective UR. Those standards will be used to evaluate firms seeking voluntary accreditation (*BI*, Feb. 19, 1990).

Both sets of guidelines are being distributed to UR firms for implementation, as well as to doctors and hospitals to illustrate that the industry is trying to police itself.

"The best indication of whether or not (the guidelines) are being embraced is how much legislation (regulating UR firms) is enacted this year," said Richard Petersen Jr., vp of governmental affairs and chief counsel at Intracorp, a CIGNA Corp. unit in Berwyn, Pa.

But UR firms and employers complain that state regulation tries to "micro-regulate" programs. "If a state law creates a UR product manual, specific customer needs may not be able to be met," Mr. Petersen said.

"About 34 states have considered some form of legislation that would regulate UR, but as of 1990 only 12 states have adopted" such laws, Mr. Petersen said.

Much of the legislation is aimed at independent UR firms rather than insurers, health maintenance organizations and hospitals.

Typical regulations require UR firms to submit staff information and a description of their review process and appeals procedures.

Tougher measures include requiring firms to detail the qualifications of review personnel and submit their criteria for determining the appropriateness of medical procedures.

"Physicians have the right to know the source of medical review criteria and how they were developed," said Rich Maturi, vp of managed care plans at the BC/BS Assn. in Chicago.

Prompted by that demand, some UR firms have publicized their review protocols.

For example, Preferred HealthCare of Wilton, Conn., which specializes in mental health UR, recently released the clinical protocols it uses in reviewing mental health and substance abuse treatment.

Some experts say the UR industry was forced to develop medical appropriateness criteria because doctors and hospitals had not done so.

"The medical community continues to be ineffective in establishing any medical protocols of their own, and the UR industry has been a catalyst in creating protocols," said Doug Leland, vp of product development and management at Intracorp.

However, some UR firms say they have spent enormous amounts of money determining their criteria and fear that releasing those criteria could take away their competitive advantage.

Consultants, UR executives and insurers agree that any regulations that UR firms are required to meet will mean increased overhead costs that will be passed on to employers.

"The Washington Business Group on Health and other employers are clearly concerned about the growing state efforts to regulate UR," said Mary Jane England, president of the Washington, D.C.-based employer coalition.

"When you over-regulate, it's costly. The more regulations you put in, the more costly it is to the UR companies around the country that have to fulfill requirements in each state. Employers will end up paying for it," she said.

Those employers, however, are concerned about UR quality, Ms. England said. And there is some question, she concedes, about whether all UR firms are meeting certain operating standards or are continually cutting costs to remain competitive.

"The fact that the AMA, in conjunction with the other organizations, is involved (in this issue) highlights the fact that there are problems," said Dr. John T. Kelly, director of quality assurance at the Chicago-based association.

Standardized UR "will eliminate confusion," said Kylanne Green, associate director in the managed care department of the Health Insurance Assn. of America in Washington, D.C. "And it should eliminate the hassle factor to the extent that you don't need 10 different road maps for 10 different UR companies."

UR organizations that gain the URAC stamp of approval will help employers and providers identify reputable firms, while non-accredited companies may find themselves lacking clients, she said.

"Historically, that's what has happened when accreditation has been used as a standard of excellence," Ms. Green pointed out.

"Employers are beginning to demand high-quality services, and cost savings isn't the only concern," said Mr. Petersen. "As legitimate UR companies embrace and use the guidelines as a foundation of their product and then focus on high-quality service to customers, some companies will fall out of the market."

However, others note that the guidelines represent only a minimum standard.

"Because they were endorsed by such a wide range of interest groups, the result is the very bare minimum," said Dr. Arnold Milstein, president of National Medical Audit, a San Francisco-based unit of William M. Mercer Inc. specializing in designing and evaluating health care cost containment programs for employers.

Employers recognize that the accreditation of UR companies using the URAC standards "isn't the highest standard," said the WBGH's Ms England. But "at least they are assured of an adequate standard of operation." ■

Consolidation becomes trend among UR firms

By DEBORAH SHALOWITZ

While unbundling of utilization review services was the UR industry's watchword of the '80s, consolidation seems to be the news of the '90s.

As fewer firms offer more and broader services, utilization review will be integrated into a broad range of managed health care services offered by health care companies, vendors predict. For example, the same firms will increasingly offer UR services in combination with network-based managed care services, like preferred provider and health maintenance organizations.

High entry costs and stiff competition will prevent companies from entering the field, they contend.

And technological advances will allow utilization reviews to consider a wider range of clinical factors, experts say. Firms will examine not only medical necessity but also the appropriateness of prescribed treatment.

At the same time, though, UR firms are working to reduce friction between reviewers and physicians, some vendors say.

"The industry continues to get referred to as utilization review, but it's actually much broader than utilization review," said Doug Leland, vp of product management and development for Berwyn, Pa.-based Intracorp, the second-largest general-service UR vendor ranked by *Business Insurance*. Rankings are based on the number of inpatient hospital admissions reviewed in 1990.

Utilization review really is a "comprehensive health care consulting mechanism on the front-end of the claims-paying process," Mr. Leland said.

It has broadened gradually but persistently. What began with simple preadmission certification, length of stay determination and second surgical opinions, now includes an array of services like discharge planning, retrospective review, case management, outpatient service predetermination and outpatient psychiatric review.

Utilization review firms will evolve into "well-versed managed care firms," predicted Marsha Ballard, president of Parkside Health Management Corp. of Park Ridge, Ill., the 10th-largest UR vendor.

There will be "some fallout in the next couple years as it gets more difficult to (only) do utilization review," she added.

"Free-standing utilization review is increasingly going to be performed in connection with network-based plans," predicted Robert Patricelli, president of Value Health Inc., an Avon, Conn., company that owns five specialty UR firms. Its Value Health Sciences Inc. unit in Santa Monica, Calif., sells one of the most widely used UR computer systems.

Several UR vendors say it is easier and more efficient for employers to deal with one company that has a network of service providers and reviews the services of those providers.

Using one health care management company instead of separate vendors for specialized cost control services is "not only easier, but you end up with less of a Tower of Babel effect," said James Smith, president and chief executive officer of HealthCare COMPARE Corp. of Downers Grove, Ill., the fourth-largest UR vendor.

Rosemary Sheehan, vp of utilization management for Lexington, Mass.-based Private Healthcare Systems Ltd., noted that clients have access not only to the company's utilization review services,

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UR vendors

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but also to its 42 PPO networks.

Until this year, Private Healthcare Systems, which is owned by a partnership of 17 insurers, offered UR services only for its owner insurers and their subsidiaries. As a result, even though it reviewed 228,500 inpatient hospital admissions last year, it was not ranked.

However, as of Jan. 2, the firm began offering utilization management services directly to self-insured employers and has already signed some employer contracts, according to Rich Luhr, marketing communications manager.

Utilization review is "moving to the managed care environment," said Dr. Paul Frankel, vp and national medical director of the Managed Care Services Group of Metropolitan Life Insurance Co. in Westport, Conn., the third-largest UR vendor.

One advantage is that utilization review is evolving into "working with doctors instead of in a policing mode," he pointed out.

"The medical profession is saying, 'You're driving us nuts,' " agreed Dr. James Vance, chief medical officer with Conservco Inc. in Tampa Fla., the seventh-largest vendor. "So, we as an industry have to move toward reducing the hassle factor for physicians."

One way to do so is reviewing more selectively. For example, Dr. Vance said, a UR firm should focus on coronary bypasses and other often overused procedures, as well as on doctors with poor performance records.

Another way to reduce hassles for doctors is to combine the UR function into other medical cost management techniques, pointed out Catherine Johnson, vp of marketing for Conservco.

"An industry trend is tying (utilization review) together with total medical management—provider networks, utilization management, case management and claims payout reviews," she said. "It all comes together."

"The market will move through free-standing utilization review to managed care, where utilization review is a part of a limited provider service program," agreed Richard Maturi, vp of managed care programs for Blue Cross & Blue Shield Assn. in Chicago, the largest provider of UR services ranked by *BI.*

As some firms offer one-stop shopping for managed care, firms that only offer UR services will be hard-pressed to survive, many vendors predict.

"We're going to continue to see some acquisitions and mergers," predicted Jeff Aycock, assistant vp of Crawford & Co.'s HealthCare Management Group in Atlanta. "If you want market penetration, that's one way to do it."

There will be a "decrease in the number of competitors but an increase in competitiveness," said Mr. Leland of Intracorp.

And competition, said MetLife's Dr. Frankel, "is a healthy motivator of all of us in the industry to reach a little farther, do a little better."

Dennis Duffy, president and chief executive officer of AXIOM Review in Millburn, N.J., the fifth-largest UR vendor, estimated that after a few more years of an industry shakeout, there will be some 50 to 60 independent UR companies in business, along with those UR companies owned by insurers.

Entering the field once did not require a large capital outlay. But because of increased sophistication and the field's reliance on computers, it "will be very expensive to open up a utilization review company," according to Ms. Ballard of Parkside.

"Companies can't afford to get into the business anymore," agreed Intracorp's Mr. Leland.

Running a comprehensive UR firm now requires "a big capital base," agreed Lawrence Goelman, president of Huntington Beach, Calif.-based Cost Care Inc., the eighth-largest firm.

Traditional UR has expanded in large part because of the development of advanced computer programs—sometimes using artificial intelligence—that help UR staff review a host of specific data on individual cases, vendors say. UR staff nurses or physicians then are better able to evaluate the appropriateness of certain medical procedures and treatments, they say.

One popular program—used by BC/BS, Conservco and others—is Value Health Science's Medical Review System, which uses artificial intelligence to review medical services. Value Health Science began licensing the system in May 1989.

The system is licensed on an annual basis primarily to insurers, HMOs and PPOs, according to Mr. Patricelli. Fees are about 2 cents to 12 cents per covered life per month. Value Health Sciences will train nurses on the licensee's staff to use the system for an additional fee. The system also can be sold directly to employers that will hire nurses to do the reviews.

Using artificial intelligence, the MRS system asks a series of questions about an individual's case, with each question based on the nurse's response to the previous one, explained Mr. Patricelli.

The system "tries to certify" whatever procedure is being considered, he said. When a procedure is rejected after all the questioning, the case is referred to one of Value Health Science's six physicians. They try to determine if any data was incorrectly entered or if the system failed to consider any mitigating factors, according to Mr. Patricelli.

Recommendations are based on risks and benefits to patients, not costs, he said.

Currently the MRS system covers 34 high-cost inpatient and outpatient procedures, Mr. Patricelli said. New ones are added continuously.

Hysterectomy, for example, was added to the system in 1990. The operation now has the highest denial rate of all reviewed procedures—25% to 35%—Mr. Patricelli said. Value Health Sciences plans to add chiropractic manipulation of the back this year, he added.

Another computer system that operates on a similar basis is Auto-PREP.

Like the MRS system, Auto-PREP 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, explained Eric Spitzer, president of Peer Review Analysis Inc., the Malden, Mass., company that developed the system.

If the procedure is denied, the case automatically is referred to a UR staff physician for review, he said.

However, unlike the MRS system, Auto-PREP does not rely on artificial intelligence. And, Auto-PREP covers 45 commonly performed outpatient procedures.

Peer Review Analysis is just beginning to license the software to other firms, like insurers, Mr. Spitzer said.

He predicted that Auto-PREP "will become a mainstay of our company" in the next few years. In 1990, the firm had gross revenues of $6.5 million and reviewed 113,000 inpatient hospital admissions.

Another sign that computer technology has grown very important: All the UR firms boasted of

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their improved ability to provide more, and more meaningful, utilization data.

"The utilization review industry is moving toward a greater sophistication in data reporting and analysis," commented Crawford & Co.'s Mr. Aycock. This allows self-insured employers to reserve adequate funds for health benefits and make plan adjustments for the future, he said.

Likewise, "the employer is becoming much more sophisticated and demands more details of what utilization review does and how it reports," noted Conservco's Ms. Johnson.

There is a general trend toward taking claims data and combining it with utilization review data to pinpoint problem areas and providers, pointed out Mary Ellen O'Donnell, director of utilization management for BC/BS.

Following are profiles of the largest general service UR vendors. Comparisons between the number of admissions reviewed by the firms in 1990 compared with 1989 are unavailable because most of the firms now treated childbirth admissions as one admission in 1990 as opposed to two in 1989:

Blue Cross & Blue Shield Assn.

The combined total of inpatient hospital admissions reviewed by all of the Blue Cross & Blue Shield Assn. plans—a Goliath among health insurers—remains the highest in the nation: 2.6 million reviews last year.

However, the majority of these reviews are conducted for clients that use other BC/BS services, like claims administration, acknowledged Mr. Maturi.

Nonetheless, three-quarters of the group's 73 plans perform utilization reviews on an unbundled basis, and the remaining plans might provide the service if requested, he said.

Each plan that offers BC/BS's UR service program, called Custom Care-USA, must complete a detailed application and undergo an on-site review of its utilization management program, according to Judy Wilson, director of national product sales for the BC/BS Assn. The, UR activities can be centralized for a client through one BC/BS plan or performed through many plans for a client with multiple locations, she explained.

But, during the past year, BC/BS has shifted its marketing emphasis to offering UR as part of network-based health care services from pushing Custom Care as an unbundled national UR product, Mr. Maturi said.

As a result, BC/BS has integrated its utilization review standards into the association's HMOs, point of service networks and PPOs, he said.

BC/BS has also expanded the range of UR services it provides, Ms. O'Donnell noted. For example, psychiatric and substance abuse reviews and outpatient reviews are now available throughout the country, she said.

And, BC/BS plans are expanding their case management capabilities, added Mary Lou Smith, manager of utilization management. "Case management is now getting into more areas," she said. "The process that is used in case management is a winner."

BC/BS plans use case management for chronic care cases, disability cases, high-risk maternity cases, psychiatric cases and some home health care cases, she said.

And, as part of its UR services, BC/BS also reviews the quality of service providers, Mr. Maturi noted.

"Things are beginning to come together out there," he said. Utilization review "becomes not only an activity of looking at each individual case, but also of looking at providers in your panel and quality of care."

BC/BS plans across the country serviced 30.4 million employee benefit plan lives in 1990.

Intracorp

Berwyn, Pa.-based Intracorp, a unit of CIGNA Corp., saw its UR business increase in 1990 following CIGNA's acquisition of EQUICOR Inc.

EQUICOR subsidiary Corporate Health Care Management, which in 1989 was the ninth-largest UR vendor in *BI*'s ranking (*BI*, Feb. 19, 1990), has been fully integrated into Intracorp, Mr. Leland said.

Intracorp remains the second-largest UR firm, based on 819,580 inpatient hospital admission reviewed last year.

Another noteworthy Intracorp development during 1990 is the establishment of INFER, an artificial intelligence software system that helps staff nurses who review claims to identify situations requiring medical case management, Mr. Leland said.

The 500 nurses that use INFER enter case information into the system and are asked a series of questions. Based on the answers given by the nurses, the computer recommends whether a specific case qualifies as one of the approximately 2% of reviewed hospital admissions that could benefit from case management.

INFER looks at factors other than diagnostic codes that may influence catastrophic cases, Mr. Leland said.

For example, family characteristics, previous treatments received and the number of prior hospital admissions all would be factored into INFER's recommendation, he explained.

"So far, (INFER) is working extremely well," he said. The system has "exceeded our expectations."

Mr. Leland noted that Intracorp officials had expected INFER to identify fewer cases for case management and a narrower range of problems. Instead, the system has identified more cases and a wider variety of cases that could benefit from different kinds of case management, he said.

Intracorp is expanding its computer capabilities in another area, Mr. Leland said.

Intracorp rehabilitation nurses who work in the field are now equipped with portable computers that are linked to area offices, which in turn are linked to the company's headquarters.

This allows individual nurses to approach cases similarly, Mr. Leland said. Intracorp plans to outfit its case management nurses with portable computers in the coming year, he added.

Intracorp serviced 21.5 million employee benefit plan lives and 1.8 million workers compensation lives in 1990.

Metropolitan Life Insurance Co.

1990 saw Westport, Conn.-based Managed Care Services Group of Metropolitan Life Insurance Co. expand and refine various computer and data systems.

As a utilization review company, "we're really data-driven" and "information-driven," Dr. Frankel said.

MetLife last year reviewed 498,000 inpatient hospital admissions, ranking third among the leading UR firms.

MetLife has made a "dramatic enhancement in (its) ability to profile" physicians and use the information in medical management, Dr. Frankel said.

A new software program that the company developed, called Ambulatory Utilization Review, allows the company to monitor a phys-

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UR vendors

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ician's frequency of inappropriate care and how well he or she complies with medical protocols, Dr. Frankel explained.

"As we become better and better in physician profiling, we'll be able to select better networks," he said. Then a shift from straight utilization review to quality management will occur, he said. This, in turn, will "remove some hassles of utilization review for network doctors."

And, he said, this will "lower costs and make life a lot more enjoyable for doctor and patient alike."

MetLife also has enhanced its medical case management techniques, Dr. Frankel said.

If certain diagnoses occur or a certain dollar limit is reached, the claim automatically is selected by the firm's computer system for case management review, he said.

MetLife in 1990 serviced 6 million employee benefit lives.

HealthCare COMPARE Corp.

Downers Grove, Ill.-based HealthCare COMPARE saw business grow in 1990 due to the expansion of its PPO network, AFFORDABLE HealthCare Concepts, to all states except New York, New Jersey and Maryland, according to Mr. Smith. The PPO, which is based in Sacramento, Calif., previously had been primarily a California operation.

"The PPO provides us with a unique door-opener," Mr. Smith said.

The growth in business helped boost to 358,400 the number of inpatient hospital admissions reviewed last year, making HealthCare COMPARE the fourth-largest UR vendor.

During the last year, HealthCare COMPARE has concentrated on fully integrating its utilization review activities into the PPO, Mr. Smith said.

As physician profiling improves, 'we'll be able to select better networks,' MetLife's Dr. Frankel says.

For example, when a hospital preadmission certification is done, people are reminded that if they use a network hospital, their own health care costs will be lower due to reduced deductibles and copayments, he explained. "The reminder and the redirection of a planned use of a hospital" is very effective, he said, adding that "within a few years, the PPO network use is increased."

This has been a "very dramatic activity for us," Mr. Smith stated. There is "a wonderful synergy" between utilization review and a PPO.

HealthCare COMPARE also can provide a substantial amount of data for clients because the firm generates data both from its utilization review activities and from PPO claims activity, Mr. Smith said.

HealthCare COMPARE reviews a wide range of health care services including group health services, chiropractic services, psychiatric and substance abuse services, workers compensation and disability services and home health services.

It is easier and often more appropriate for a company to use the same UR vendor for many of these services, Mr. Smith suggested.

For example, often a hospital admission for a psychiatric case really is necessary for chemical detoxification, Mr. Smith explained. And, chemical detoxification really is a medical concern, he said. However, the substance abuse stems from a psychiatric problem, he added.

Therefore, using one UR vendor can simplify a client's administrative task in dealing with this kind of situation, he said.

HealthCare COMPARE provides services to insurers, third-party administrators, direct corporate clients, federal employee plans, Taft-Hartley/union trusts and government programs such as CHAMPUS and Medicare.

In addition to its Illinois headquarters, the company has branch offices in Sacramento, Calif., and Savannah, Ga.

HealthCare COMPARE last year serviced 3.8 million employee benefit lives.

AXIOM Review Inc.

Although Millburn, N.J.-based AXIOM Review is content with a regional presence in the United States, it is setting its sights on expansion overseas.

AXIOM—which ranks as the fifth-largest UR vendor, based on 325,959 inpatient hospital admissions reviewed in 1990—concentrates its UR efforts primarily on the New York, New Jersey and Pennsylvania area, said Mr. Duffy.

"There's a good-sized market out there" of mid-sized, self-insured companies that do not want to deal with the bureaucracy of a large utilization review firm, said Vp Erwin Weiland.

"There are certainly enough companies in the Northeast with 4,000 to 6,000 employees, for example, that want a mid-sized company like us," he said. "They want the personal touch."

"Because we're local, a large majority of reviews are (conducted) on-site" at area hospitals, instead of over the telephone, Mr. Duffy noted.

While the firm concentrates on one region of the United States, it is trying to make inroads into the European market, Mr. Duffy said.

During the last year AXIOM has provided consulting services and seminars to professionals in the Netherlands and the firm hopes to expand to other European markets as well, Mr. Weiland said. AXIOM is "assisting them in the design of a quality assurance utilization review system," he said.

In the United States, AXIOM is concentrating on expanding its outpatient utilization review services, Mr. Duffy said.

Also, the firm is marketing its services to townships and cities, hoping to establish groups of self-insured government entities that jointly would purchase utilization review services, he said.

AXIOM generates 22% of its gross revenues from providing utilization review services to employers and 78% of its gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

Sunderbruch Corp.

Last year was a "reflection year" of "nice, stable growth," summed up Richard McMaster, chief executive officer of West Des Moines, Iowa-based Sunderbruch Corp.

However, he predicted that this year will see more growth for the company, which is the sixth-largest UR firm, based on 250,080 inpatient hospital admissions reviewed in 1990.

Sunderbruch will continue to be a Midwestern "regional specialty" company, he said. And, the firm expects to sign contracts with some very large Midwestern employers this year, he said.

"Medical review and health management is a local matter," Mr. McMaster said. "We don't try to be everything to everyone. We are committed to a local presence."

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UR vendors

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Having a local presence allows a UR vendor to meet face to face with the doctors who are subject to the reviews, he said. Vendors "have to try to understand providers' perspectives," he added.

Sunderbruch plans to open two new offices in 1991 to serve new clients, Mr. McMaster said. He declined to specify where these locations would be except to say they would be in the Midwest.

Currently Sunderbruch has branch offices in St. Louis; Chicago and Peoria, Ill.; and Lincoln, Neb.

Mr. McMaster also noted that Sunderbruch is trying to work with employers to turn utilization review into a patient education and advocacy process.

"Business needs to educate and get a stronger buy-in from employees," he said. Workers need to know that "rather than just look at cost," utilization review "looks at the individual patient from a quality perspective."

Sunderbruch last year serviced 3.1 million employee benefit lives and 950 workers compensation lives.

Conservco Inc.

The big news last year for Tampa, Fla.-based Conservco Inc., was its acquisition by Travelers Corp. in January 1990. The combination of Conservco's expertise in workers compensation and Travelers' expertise in employee benefits makes the company unique, Ms. Johnson said.

Corporate chief financial officers in particular seem very interested in the "marriage of these two concepts," she noted.

Conservco last year reviewed 250,000 inpatient hospital admissions, earning it the No. 7 spot in the *Business Insurance* ranking of leading UR firms.

To better serve its expanded client base, Conservco last year developed several new programs, pointed out Dr. James Vance, chief medical officer.

For example, in the employee benefits area, Conservco started a program of on-site concurrent review and on-site case management, he noted.

And, the company is expanding its outpatient reviews, he added. In the employee benefits area Conservco offers outpatient reviews for substance abuse, psychiatric services, skilled nursing facilities and home health care, he said. In the workers compensation area, Conservco offers outpatient concurrent reviews of physical therapy and chiropractic services.

Conservco also is increasing the number of physicians it employs to conduct utilization reviews, Dr. Vance said. This year, in addition to its Tampa headquarters, the firm plans to have one full-time physician in each of its four branch offices: Hartford, Conn.; San Antonio; Westmont, Ill.; and San Diego.

This will allow physicians that are subject to the company's utilization reviews to talk to a peer whenever necessary, Dr. Vance said.

Conservco also plans to use its utilization review nurses to a greater degree by allowing them to serve "almost as a hot line contact," Ms. Johnson said.

For example, an employee could call a nurse through a toll-free telephone number and discuss an illness or injury that might not require hospitalization, she said. "This'll pull people into the managed care arena."

Conservco in 1990 serviced 4 million employee benefit lives and 300,000 workers comp lives.

Cost Care Inc.

The acquisition of Huntington Beach, Calif.-based Cost Care Inc. by John Hancock Mutual Life Insurance Co. last June helped boost the number of hospital admissions Cost Care reviewed in 1990 to 210,000, making it the eighth-largest UR firm.

In addition to conducting utilization reviews for all of the Boston-based insurer's managed care operations, Cost Care also took over two of John Hancock's medical review processing facilities, Mr. Goelman said.

The firm now operates medical review processing facilities in Huntington Beach, Calif.; Schaumburg, Ill.; Atlanta; and Lynnfield, Mass.; It has sales and service offices in Memphis and Chattanooga, Tenn.; Chicago; Cincinnati; and New York.

Cost Care last year also expanded some of its services, Mr. Goelman said.

The firm now will review diagnostic imaging services on an outpatient basis as well as on an inpatient basis, he said. The imaging techniques reviewed include computerized axial tomography (CAT scans) and magnetic resonance imaging (MRI) procedures.

'Business needs to educate and get a stronger buy-in from employees,' Mr. McMaster says.

And, Cost Care has expanded MaternaCall, the firm's high-risk pregnancy identification program, according to Mr. Goelman.

Also, Cost Care developed a primary care network for specific clients in Florida, Mr. Goelman said. The company now has about 12 networks throughout the country and plans to build additional ones in 1991, Mr. Goelman said. He estimated that by the end of the year, Cost Care could have as many as 38 networks operating in different sites around the country.

Although Cost Care now is owned by John Hancock, some 80% of its gross revenues come from providing UR services to self-insured employers and 20% from providing UR services to insurance companies, HMOs, PPOs or TPAs.

The firm serviced 5.3 million employee benefit plan lives in 1990.

Crawford & Co.—HealthCare Management Group

Acquisitions made in the past couple of years are starting to pay off in terms of increased UR business for Crawford & Co.'s HealthCare Management Group.

With 159,725 inpatient hospital admission reviews conducted in 1990, Crawford ranks as the ninth-largest UR vendor.

The Atlanta-based risk management consultant began providing UR services in 1980 but growth has been particularly strong in the past few years following the 1989 acquisition of Skokie, Ill.-based Efficient Health Systems and the 1988 purchase of Savannah, Ga.-based Compass Health Management, both independent utilization review firms, according to Mr. Aycock.

In addition to maintaining offices in those two locations, Crawford also has a branch office in Columbia, S.C., that primarily conducts precertification reviews for the state of South Carolina.

Also, the firm maintains 185 HealthCare Management offices throughout the United States and Canada where nurses are available for on-site reviews.

Recent growth also can be attributed to increased marketing efforts, as Crawford recently dou-

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bled the number of account representatives it employs, Mr. Aycock added.

In addition to reviewing group health, chiropractic, psychiatric and substance abuse services, Crawford also reviews a variety of home health care services, Mr. Aycock pointed out.

Crawford certifies the medical necessity of home health care nurses, equipment and therapies such as physical therapy, speech therapy and occupational therapy, Mr. Aycock said.

Crawford serviced 1.8 million employee benefit plan lives and 1.5 million workers compensation lives in 1990.

Parkside Health Management Corp.

Park Ridge, Ill.-based Parkside Health Management Corp. attributes the increase in its UR services last year to the growth of its PPO network.

"Managed care has just really exploded," Ms. Ballard said. Parkside's PPO, Chicago-based PATH Health Network, was established in 1987, she said.

Parkside reviewed 120,000 inpatient hospital admissions last year, earning it the No. 10 spot in the *Business Insurance* ranking of leading UR firms.

Despite the growth of its PPO, Parkside remains a national utilization review firm, Ms. Ballard said, with half of its gross revenues coming from providing UR services to employers, one-quarter of gross revenues from providing UR services to insurers, HMOs, PPOs or TPAs and the remaining quarter from providing other services.

Ms. Ballard attributes Parkside's success to the company's "flexibility in tailor-making our programs."

Also, "we grew up out of the provider side," she said, explaining that she is a former nurse and many of the company's officers are either nurses or physicians. The firm is owned by The Lutheran General Health Care System.

In addition to providing UR services, Parkside also has developed a personal computer-based software system called CasePlex P.C. that allows users to manipulate the data that is available from hospital and physician billing statements, Ms. Ballard noted.

To use CasePlex, an employer would send his or her claims data tape to Parkside and Parkside would send back formatted floppy disks. Users would be able to use the floppies to ask "what if" questions like how many men are submitting claims and what hospitals are being used the most.

Parkside could update the disks annually or at another interval, Ms. Ballard said.

Parkside serviced 1.6 million employee benefit plan lives in 1990. ■

Ball retiree plan piques interest of other firms

By JERRY GEISEL

MUNCIE, Ind.—An innovative program launched last month by Ball Corp. through which employees can tax-effectively fund their retiree health care benefits is attracting more than double the participants the company expected.

But, the number of participants in the program still is only a small percentage of eligible employees, according to the Muncie, Ind.-based consumer and industrial products manufacturer.

Consultants, though, note they are seeing employer interest in an element of the Ball program that allows retirees to supplement employer-provided retiree health coverage, though no employer has yet implemented a similar program.

Under the program, developed by The Wyatt Co., salaried employees hired in 1990 and later can fund their retiree health care expenses with aftertax contributions, which Ball is investing in a group annuity contract with United of Omaha Life Insurance Co. Employee contributions made this year are guaranteed to earn 8.5% interest over the next five years.

Ball will not provide retiree health care coverage to those employees.

Employees hired before 1990—who are covered by a company-sponsored retiree health care plan—can use the program to fund retiree health care benefits the company does not provide, like dental benefits, as well as to pay for uncovered medical expenses, like deductibles and coinsurance.

For employees hired before 1990, Ball provides up to $30,000 of lifetime medical benefits for an individual retiree and up to another $30,000 in coverage for the retiree's spouse.

Since the program was launched, 65 of 4,500 eligible salaried employees—including about 200 employees hired in 1990—have agreed to contribute at least 2% of their annual salary toward the program.

Most program participants are employees hired before 1990, who are making contributions to supplement health care coverages provided by Ball, company officials say. A precise breakout is not available.

And, 53 of the 65 participants are at least 40 years old: Fifteen employees are between ages 40 and 49, 32 are between 50 and 59 and six are between ages 60 and 65.

In addition, 47 participants earn annual salaries of at least $40,000. However, five participants have annual salaries of less than $19,000, while seven have annual salaries of between $20,000 and $29,999, and six earn between $30,000 and $39,999.

"Older employees are closest to retirement. They have the greatest concerns about retiree health care expenses," said William J. Miner, a Wyatt consultant in Chicago, who helped design the Ball program.

"Employees are concerned about heavy dental expenses as well as the cost of eyeglasses. They want to put money aside now to prefund those costs," said William Spievak, Ball's director of corporate compensation and benefits.

Employees also are using the program so they will have funds available when they retire to cover premiums charged under Part B of Medicare, which provides physician services. The current monthly premium is $29.90 and is expected to rise to about $45 by 1995.

While the relative number of plan participants is small, participation is much higher than expected, Mr. Spievak pointed out.

He thought only about 25 to 30 employees would sign up for the program initially.

"Given a tax-effective vehicle

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Ball program

Continued from previous page
where savings are protected and assured, employees will respond and save for retirement health care expenses," he explained.

Mr. Spievak expects that participation in the retiree health care funding program over the next five years to increase substantially to between 500 and 600 employees.

Since Ball's program was unveiled last year (*BI,* Nov. 26, 1990), Mr. Spievak said he has received about a half-dozen calls each week from benefit managers and others seeking additional information.

"At Ball, we have a program that is working. Others want to know more about it," he said.

Wyatt's Mr. Miner said he also is still receiving calls from employers about the Ball program. And, several major employers, which Mr. Miner would not identify, are seriously studying whether to adopt a Ball-type program, he said.

"Companies are searching for new ways of dealing with retiree health care costs and liabilities they will have to report under the new Financial Accounting Standard Board rules," Mr. Miner said.

The new FASB rules will require employers to recognize on their financial statements retiree health care expenses when accrued rather than paid. This change—which takes effect in 1993 for most employers—will wallop many employers' reported earnings (*BI,* Dec. 17, 1990).

"We believe this is a program every company should look at as a response to retiree medical cost problems," Mr. Miner said.

However, employers are more interested in adopting the program to enable employees to supplement retiree health care coverage rather than as a replacement for company-provided coverage, he said.

Other consultants say they also have received calls from clients about the Ball program, but they report no rush yet from clients to adopt similar programs.

"We've had many inquiries. But clients aren't ready to go in that direction yet," said Marsha Venturi, a consulting actuary with Buck Consultants Inc. in Secaucus, N.J.

Indeed, benefit consultants agree that few employers would be willing to take the dramatic step of eliminating retiree health care coverage, such as Ball has done for its new employees.

Instead, the aspect of the Ball program that will allow many future retirees to supplement employer-provided health care coverages would likely appeal to other companies, according to consultants.

"Companies want to maintain a fairly large stake in the retiree health care plan. Eliminating coverage is a very large step that may have fit Ball quite well. But that would not be true for most of our clients," said Ed Winterbauer, a managing consultant with A. Foster Higgins & Co. Inc. in Princeton, N.J.

"Among companies we have talked to, eliminating retiree health care coverage does not seem to be high on their list of priorities. There is a sense of urgency to better control retiree health care costs, but not to the extent of eliminating coverage," agreed Gary Laugharn, a consultant with Hewitt Associates of Lincolnshire, Ill.

Ball "is saying no more (retiree) health care to new employees. That is not a way that balances the needs of employers and employees. It is too one-sided," said John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J.

"Pragmatically, the program would be of more interest as a supplement—not a replacement—for employer-provided coverage," said Mr. Winterbauer.

Under the Ball program, employees make contributions to a so-called "Employees' Retiree Medical Account," in which funds earn a guaranteed interest rate. Ball keeps track of employee contributions and the pro-rata share of interest income in the accounts.

When an employee in the new program retires, he or she will submit bills to Ball for the cost of private medical insurance premiums, Medicare Part B premiums or other out-of-pocket medical expenses. Those retirees then will be reimbursed for those expenses and there will be a corresponding reduction in their account balances.

Amounts paid out of the account for health care expenses will be tax-free to retirees. IRS regulation 1.72-15 permits the tax-free use of aftertax contributions and the investment income on those contributions for health care coverage.

Employers are more interested in adopting a program like the Ball plan to enable employees to supplement retiree health care coverage, rather than as a replacement for company-provided coverage, says Wyatt's Mr. Miner.

Future retirees will not be required to use their entire account balances for health care expenses. Account balances also could be used to purchase an individual annuity. However, participants choosing this option will have to pay taxes on the full amount of each monthly annuity payment.

In addition, employees that leave Ball before retirement will have to convert their account balances into an annuity or a lump sum. These annuities or lump sums also will be subject to taxes.

If an employee dies before retirement, the account balance would be paid out to a designated beneficiary as a taxable lump sum.

While the Ball program has generated interest among other employers, benefit experts expect that employers will consider many approaches as they try to better control rising retiree health care expenses.

Another approach being considered by employers is linking company-provided retiree health care benefits to length of service. By contrast, many employers today provide the same retiree health care benefits to all employees after they have met a basic age and service requirements, like age 55 and 10 years of employment.

"While there will be many approaches taken, there will be a common theme to the approaches: Employers will be looking for ways to limit their retiree health care costs and liabilities," Hewitt's Mr. Laugharn said. ■

Directory of utilization review vendors

A

Action Healthcare Management Services Inc.

301 E. Bethany Home Road, Suite C-278, Phoenix, Ariz. 85012;
602-265-0681; fax: 602-277-3674

Year founded: 1986.

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 outpatient service predetermination, case management, high risk pregnancy management, inpatient psychiatric and substance abuse, workers compensation case management.

Occasional UR services: Hospital bill audit, outpatient psychiatric and substance abuse.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 14 professionals, including seven physicians, five registered nurses, two licensed practical nurses. On retainer: 615 physicians, 600 nurses.

Clients: 62 total; 31 employer clients.

Covered lives: 55,000 employee benefit plan lives; 1,000 workers compensation lives.

Admissions reviewed: 4,000.

Charges: Per employee, $1.20-$2.50; per hour, $85-$105.

Principal officers: Ruth Smith, president; Glenn R. Sperry, vp-corporate development/marketing and sales; Cori Hamilton, vp-health care services.

Admar Corp.

850 Town & Country Road;
Orange, Calif. 92668;
714-953-9600; fax: 714-953-9060

Year founded: 1973; began providing utilization review services in 1983.

UR services provided to employers: 38% 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, home health care, concurrent review.

Occasional UR services: Hospital bill audit, outpatient service predetermination.

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

Staff: 168 total; 26 professionals, including 25 registered nurses, one licensed practical nurse. On retainer: four physicians.

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Directory of UR firms explained

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

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

The directory is published as an editorial service; there is no charge for companies to be included.

The listings begin with the company name and address, followed by the **year founded**, the year the company began offering utilization review services (if different from the year founded) and the **parent company**, if applicable.

Under **UR services provided to employers,** the percentage of 1990 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, health maintenance organizations, preferred provider organizations or third-party claims administrators.

Specific utilization review 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** follow. Numbers of staff are provided in full-time equivalents, except for those on retainer.

Number and size of **clients** serviced in 1990 follow. Number of employee benefit plan lives and workers compensation lives serviced are given under **covered lives**. **Admissions reviewed** reports the number of total acute care inpatient hospital admissions reviewed in 1990.

Locations of U.S. and foreign **branch offices** and how the company **charges** for its services are provided next.

Total **1990 gross revenues** and revenues generated from utilization review services are included when provided by the company.

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

Information reported is based on each company's responses 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 be listed in the 1992 directory of utilization review service providers, write Karen Armaganian, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

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Clients: 52 total; 12 employer clients; 17% with fewer than 500 employees, 17% with 500-999 employees, 33% with 1,000-2,499 employees, 8% with 2,500-4,999 employees, 25% with more than 5,000 employees.

Covered lives: 829,458 employee benefit plan lives.

Admissions reviewed: 85,509.

1990 gross revenues: $10.2 million total, $4.3 million from UR services (as of Oct. 31).

Charges: Per employee, $1.35; per case, $90; per hour, $80-$100 for psychiatric and chemical dependency case management.

Principal officers: Richard Toral, president/chairman; Virginia Pascual, executive vp/board member; Edward Evans, vp-finance/chief financial officer; Pamela J. Kehoe, vp-management information system; Donald C. Cummins, vp-sales/marketing.

ALTA Health Strategies Inc.

2610 Decker Lane, Salt Lake City, Utah 84119; 801-973-7300; fax: 801-974-6829

Year 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, preauthorization, predeterminations, fee negotiations, chiropractic and podiatric review, high-risk and short-stay maternity program, geriatric case management, admission review, home health, hospice and extended care facility review, disability management, helpline, dental management.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, podriatric, home health, hospice.

Staff: 237 total; 151 professionals, including one physician, 150 registered nurses. On retainer: 86 physicians.

Clients: 647 total, all employer clients; 71% with fewer than 500 employees, 13% with 500-999 employees, 10% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 3% with more than 5,000 employees.

Covered lives: 1.8 million employee benefit plan lives.

Admissions reviewed: 75,000.

Branch offices: Atlanta; Milwaukee; Pittsburgh; Victorville, Calif.

1990 gross revenues: $131 million total, $16.9 million from UR services.

Principal officers: Terry Nofsinger, president; Jim Kenworthy, chief advisory officer; Sid Paulson, George Dreisbach, executive vps; Linda Gerbig, senior vp-managed care.

Alternative Care Management Systems Inc.

3530 Snouffer Road, Suite 100, Columbus, Ohio 43235; 614-761-0035

Year founded: 1985; began providing utilization review services in 1986.

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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, chiropractic service review, physical therapy review, skilled nursing facility, home health agency, hospice review, prescription drug utilization review.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: 12 total; 4 professionals, all registered nurses.

Clients: 34 total, all employer clients; 61% with fewer than 500 employees, 20.5% with 500-999 employees, 8.8% with 1,000-2,499 employees, 5.8% with 2,500-4,999 employees, 2.9% with more than 5,000 employees.

Covered lives: 66,325 employee benefit plan lives.

Admissions reviewed: 3,652.

1990 gross revenues: $1 million total, all from UR services.

Charges: Per employee, negotiable based upon services provided.

Principal officers: John O. Micha, president.

American Claims Evaluation Inc.

375 N. Broadway, Jericho, N.Y. 11753; 516-938-8000; fax: 516-938-0405

Year 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: 465 total; 135 employer clients.

Branch offices: Atlanta; Chicago; Dallas; Detroit; Los Angeles; New York; San Francisco.

1990 gross revenues: $4.4 million total, all from UR services.

Charges: Contingency: up to 50% of savings.

Principal officers: Gary Gelman, president/chief executive officer; Robert Lindberg, executive vp/chief operating officer; Robert Dubester, vp-operations.

American Health Network

3988 N. Central Expressway, Dallas, Texas 75204; 214-841-1137; fax: 214-823-8052

Year founded: 1983.

Parent company: Anthem Group Services Corp.

UR services provided to employers: 5% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Second surgical opinion.

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

Staff: 67 total; 66 professionals, including three physicians, 63 registered nurses.

Clients: 20 total; 10 employer clients; 70% with fewer than 500 employees, 20% with 1,000-2,499 employees, 10% with 2,500-4,999 employees.

Covered lives: 320,503 employee benefit plan lives.

Admissions reviewed: 65,718.

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

1990 gross revenues: $7.1 million total, $4.2 million from UR services.

Charges: Per employee, variable.

Principal officers: Martin R. Kreis, senior vp; Sandra A. Jung, director-central region; Linda R. Rossi, director-western region; Venessa J. Wood, director-eastern region.

American International Healthcare Inc.

30 W. Gude Drive, 5th Floor, Rockville, Md. 20850; 301-251-8600; fax: 301-251-2957

Year founded: 1977; began providing utilization review services in 1987.

Parent company: American International Group Inc.

UR services provided to employers: 17% of gross revenues.

UR services to others: 83% 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, and case management.

Occasional UR services: Retrospective review, prenatal review.

Medical services reviewed:

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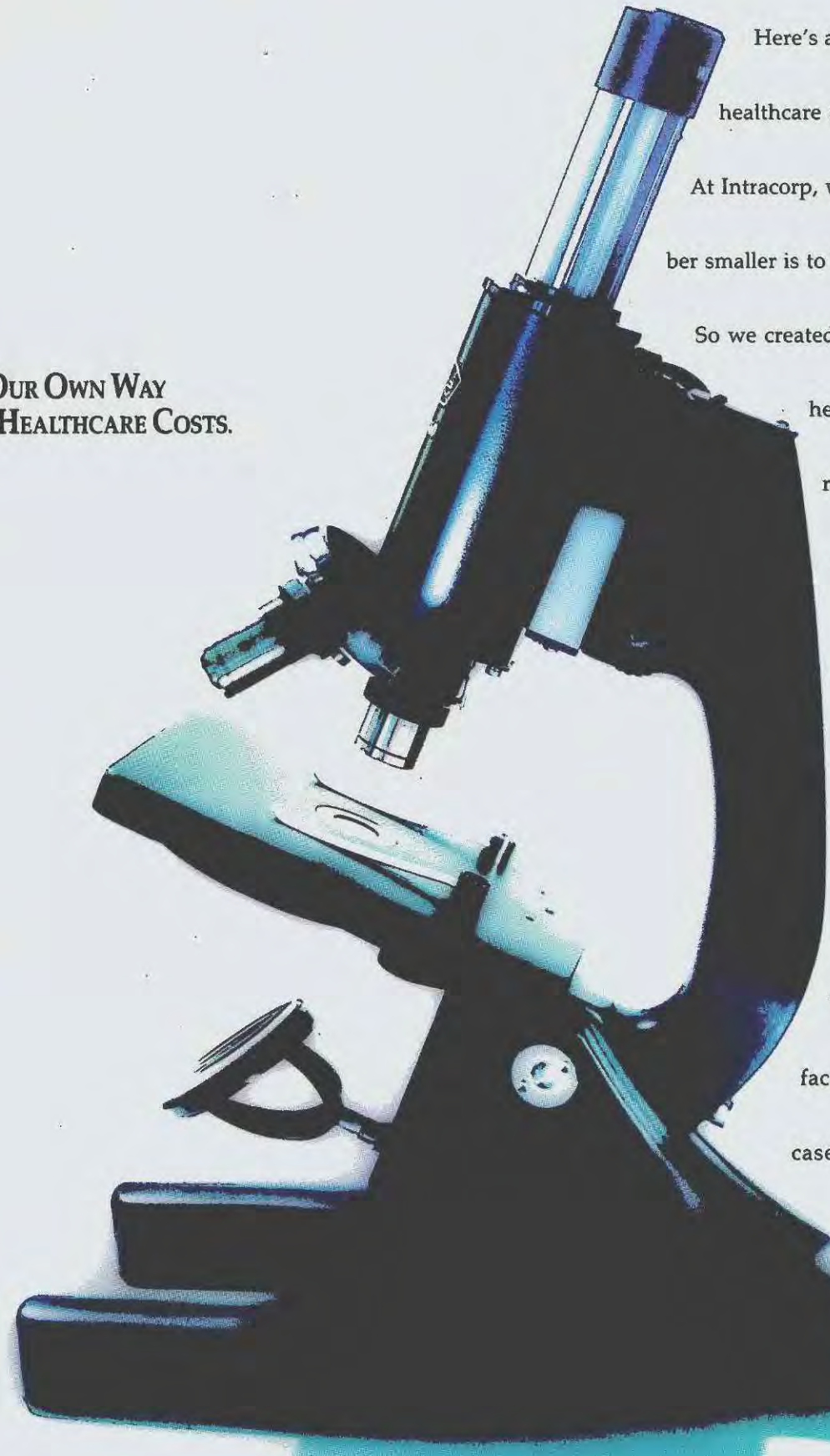
We Have Our Own Way Of Looking At Healthcare Costs.



Here's a sobering thought: by the end of next year, healthcare costs are expected to climb to $620 billion. At Intracorp, we believe the only way to make that number smaller is to look at healthcare costs closer. A lot closer.

So we created cost control measures at every step of the healthcare cycle, from the onset of an illness, right through to its resolution. We closely monitor hospital admissions to determine whether hospitalization and length of stay are appropriate. We offer the same critical assessment of outpatient cases and provide reviews of treatment plans for mental health and substance abuse.

We pay special attention to serious cases. In fact, Intracorp pioneered the concept of total case management for catastrophic illnesses.

Lastly, we painstakingly scrutinize healthcare bills looking for inaccurate charges or inappropriate treatments. If you'd like us to take a closer look at your healthcare costs, write Intracorp, Dept. I3, 1205 Westlakes Drive, Suite 300, Berwyn, PA 19312. After all, the closer we look, the better you'll look.

INTRACORP

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Group health services, chiropractic services, psychiatric and substance abuse services, workers compensation/disability.

Staff: 17 total; 10 professioals, including one physician, nine registered nurses. 16 physicians, two nurses on a retainer basis.

Clients: 22 total; all employer clients; 80% with fewer than 500 employees, 5% with 500-999 employees 5% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 56,000 employee benefit plan lives.

Admissions reviewed: 1,400.

Charges: Per employee, $1.65-$5.85; per case, $75-$500; per hour, $75-$175.

Principal officers: Thomas Ramey, president; Dr. Dwight Robertson, senior vp; Alfred Discepolc, senior vp/chief financial officer; Dennis Burkhart, vp.

American PsychManagement Inc.

1560 Wilson Blvd., Suite 1000, Arlington, Va. 22209;
703-528-2255; fax: 703-528-0623

Year founded: 1983.

Parent company: Value Health Inc.

UR services provided to employers: 21% of gross revenues.

UR services provided to others: 7% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient psychiatric and substance abuse services.

Occasional UR services: Retrospective review, outpatient service predetermination, case management.

Medical services reviewed: Psychiatric and substance abuse, workers compensation/disability.

Staff: 250 total; 50 professionals, including five physicians, 45 registered nurses. On retainer: 10 physicians, two psychologists, six M.S.W.s, eight clinicians.

Clients: 42 total; 38 employer clients; 3% with 2,500-4,999 employees, 97% with more than 5,000 employees.

Covered lives: 3.2 million employee benefit plan lives; 8,350 workers compensation lives.

Admissions reviewed: 24,400.

Branch offices: Santa Monica, Calif.

Charges: Per employee, $30/year; per case, $450.

Principal officers: Robert E. Patricelli, president (Value Health Inc.); Steven J. Shulman, president/chief executive officer; Dr. Kenneth A. Kessler, chairman.

Associated Medical Review Services

2821 Richland Ave., Metairie, La. 70002; 504-885-9365;
fax: 504-885-7861

Year founded: 1985.

UR services provided to employers: 97% 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, case management.

Medical services reviewed: Group health, workers compensation/disability.

Staff: Eight total; five professionals, including one physician, two registered nurses.

Clients: 279 total; 270 employer clients; 82% with fewer than 500 employees, 15% with 500-999 employees, 2% with 2,500-4,999 employees, 1% with more than 5,000 employees.

Covered lives: 200,000 employee benefit plan lives; 2,500 workers compensation lives.

Admissions reviewed: 80,000.

Charges: Per employee, $1.15-$1.80; per case, $35-$70; per hour, $55.

Principal officers: Katherine Belchic, president; Vincent Varisco, vp; A.J. Blanchat, secretary; Pamela Chauff, treasurer.

Associates for Health Care Inc.

125 N. Executive Drive, Suite 201, Brookfield, Wis. 53005;
800-952-8661; fax: 414-784-6419

Year founded: 1984.

UR services provided to employers: 32% of gross revenues.

UR services provided to others: 18% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, case management, post discharge review.

Occasional UR services: Length of stay determination, hospital bill audit, outpatient psychiatric and substance abuse services.

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

Staff: 34 total; 10.5 professionals, including one physician, 8.5 registered nurses, one licensed practical nurse.

Clients: 1,045 total; 1,000 employer clients; 75% with fewer than 500 employees, 22% with 500-999 employees, 1% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employ-

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ees.

Covered lives: 65,000 employee benefit plan lives.

Admissions reviewed: 15,299.

Charges: Per employee, $1.80-$2.50; per hour for large case management, $75.

Principal officers: Richard Blomquist, president/chief executive officer; Judith Grimes, vp; Robert J. Zimmermann, vp-marketing.

Assured Health Systems, Inc.

20 Mall Road, Suite 130,
Burlington, Mass. 01803;
617-273-9966; fax: 617-270-9798

Year founded: 1987.

UR services provided to employers: 8% of gross revenues.

UR services provided to others: 12% 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.

Occasional UR services: Retrospective review.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 40 total, all professionals, including four physicians, 15 registered nurses.

Clients: 34 total; 31 employer clients; 61% with fewer than 500 employees, 13% with 500-999 employees, 10% with 1,000-2,499 employees, 16% with more than 5,000 employees.

Covered lives: 800,000 employee benefit plan lives.

Admissions reviewed: 4,800.

Branch offices: Berkeley, Calif.; Boston; Denver; Portland, Ore.

1990 gross revenues: $7.9 million total, $1.6 million from UR services.

Charges: Per employee, 50 cents-$2.00; per case, $275-$500; per hour, $95-$135.

Principal officers: Dr. Ronald Geraty, president; David Zarchan, senior vp; Dr. Peter Panzarino, medical director.

August Healthcare Services Inc.

435 Ford Road, Suite 500,
Minneapolis, Minn. 55426;
612-525-4636; fax: 612-525-4492

Year founded: 1985.

Parent company: Employee Benefit Plan Inc.

UR services provided to employers: 78% of gross revenues.

UR services provided to others: 12% 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 risk management, dental utilization review.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 94 total; 43 professionals, including one physician, 38 registered nurses, four licensed practical nurses. On retainer: 90 physicians.

Clients: 1,400 total; 128 employer clients; 50% with fewer than 500 employees, 22% with 500-999 employees, 20% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 3% with more than 5,000 employees.

Covered lives: 834,672 employee benefit plan lives; 1.6 million workers compensation lives.

Branch offices: Anaheim, Calif.; Dallas; Minneapolis; Olympia, Wash.

Charges: Per employee, $1.50-$4.

Principal officers: Amir Eftekhari, chief operating officer; Dr. William M. Thompson, vp-national medical director; Steve Guyette, director-sales/marketing; Jean LaFavor, director-managed care.

AXIOM Review

33 Bleeker St., Millburn, N.J.
07041; 201-379-6300;
fax: 201-379-0490

Year founded: 1975.

UR services provided to employers: 22% of gross revenues.

UR services provided to others: 78% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, HMO evaluation, DRG analysis.

Occasional UR services: Discharge planning, 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: 57 professionals, including two physicians, 34 registered nurses, 10 licensed practical nurses, 11 medical records technicians. On retainer: 121 physicians, 11 nurses.

Clients: 69 total; 21 employer clients; 30% with fewer than 500 employees, 45% with 500-999 employees, 25% with 1,000-2,499 employees.

Admissions reviewed: 325,959.

1990 gross revenues: $6.1 million total, all from UR services.

Charges: Per employee, 30 cents-$1.90; per case, $26.50-$50; per hour, $60-$200.

Principal officers: Dennis J. Duffy, president/chief executive officer; Robert J. Jones, senior vp/chief operating officer; Margaretta Nemets, senior vp; Erwin P. Weiland, Nicole Selenko, vps; Michael E. Beams, chairman; Dr. Gilbert Melnick, vice chairman; Dr. Thomas J. Connolly Jr., secretary/treasurer.

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B

Beech Street Inc.

2 Ada, Suite 200, Irvine, Calif. 92718; 714-727-1353; fax: 714-727-1793

Year founded: 1951; began providing utilization review services in 1982.

Parent company: Mulberry Street Investments.

UR services provided to employers: 20% 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, cost containment.

Medical services reviewed: Group health services, chiropractic services, psychiatric and substance abuse services, workers compensation/disability, auto medical liability.

Staff: 189 total; 32 professionals, including three physicians, 24 registered nurses. On retainer: 15 physicians.

Clients: 74 total; 64 employer clients; 50% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Covered lives: 1.3 million employee benefit plan lives; 3 million workers compensation lives.

Admissions reviewed: 36,000.

Branch offices: Houston.

1990 gross revenues: $13 million total, $2.6 million from UR services.

Charges: Per employee, 95 cents-$1.50; per case, $85-$150; per hour, $75-$100; percentage of savings.

Principal officers: Larry J. Pyles, chief operating officer; John K. Mills, executive vp; George J. Bregante, vp-sales/marketing.

Behavioral Health Group Inc.

2693 Union Ave. Extended, Suite 101, Memphis, Tenn. 38112; 901-327-4664; fax: 901-327-4789

Year founded: 1987; began providing utilization review services in 1988.

UR services provided to employers: 1% of gross revenues.

UR services provided to others: 57% 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: Group health, psychiatric and substance abuse, nursing home preadmission screening.

Staff: 10 total; six professionals, including one physician, three registered nurses, one psychologist, one social worker.

Clients: Six total; one employer client; 100% with 1,000-2,499 employees.

Covered lives: 650,000 employee benefit plan lives.

Admissions reviewed: 2,355.

1990 gross revenues: $889,305 total, $667,755 from UR services.

Charges: Per employee, $1.50-$6.50; per case, $295-$375; per hour, negotiable.

Principal officers: Jim Rout, president/chief executive officer; Debbie Williams, controller.

Blue Cross & Blue Shield System

676 N. St. Clair, Chicago, Ill. 60611; 312-440-6000; fax: 312-440-6099

Year founded: 1929; began providing utilization review services in early 1970s.

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.

Occasional UR services: Outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: 2,402 total; 1,472 professionals, including 88 physicians, 1,275 registered nurses, 109 social workers and medical records technicians. On retainer: 1,050 physicians.

Covered lives: 30.4 million employee benefit plan lives.

Admissions reviewed: 2.6 million.

Branch offices: Locations nationwide.

Charges: Negotiated locally with accounts; per contract; per month.

Business Health Services Inc.

7311 Green Raven Drive, Suite 170, Sacramento, Calif 95822; 916-391-4155; fax: 916-391-4158

Year founded: 1985; began providing utilization review services in 1987.

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.

Medical services reviewed: Group health, workers compensation/disability.

Staff: Nine total; all professionals, including one physician, eight registered nurses. On retainer: 13 physicians, one nurse.

Clients: Eight total; one employer client; 100% with more than 5,000 employees.

Covered lives: 52,000 employee benefit plan lives; 10,500 workers compensation lives.

Admissions reviewed: 2,600.

Charges: Per employee, 30 cents-$2.50; per case, $125-$600; per hour, $75-$175.

Principal officers: Dr. E. Scott Rosenbloom, president/medical director.

C

CCM/Medical Review Services

1063 Maitland Center Commons, Suite 200, Maitland, Fla. 32751; 407-875-6931; fax: 407-875-0216

Year founded: 1979; began providing utilization review services in 1985.

Parent company: Adjusteo Inc.

UR services provided to employers: 15% 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: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 80 total; 28 professionals, including 24 registered nurses, four medical records technicians. On retainer: eight physicians.

Clients: 54 employer clients; 55% with fewer than 500 employees, 20% with 500-999 employees, 5% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Covered lives: 30,000 employee benefit plan lives, 20,000 workers compensation lives.

Admissions reviewed: 3,810.

Branch offices: Oakland, Santa Clara, Pasadena, Calif.; Hollywood, Jacksonville, Tampa, Temple Terrace, Fla.; Baton Rouge, New Orleans, La.; Braintree, Mass.; Minneapolis; Austin, Texas.

1990 gross revenues: $4.8 million total, $660,000 from UR services.

Charges: Per employee, $1-$2.50 for UR; per case, $75-$85 for case management; 2% of gross charges audited plus expenses and file set-up fee of $10.50 for audits.

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Principal officers: Grace Armstrong, senior vp/director-CCM; Sherrie Dulworth, vp/director-CCM Medical Review Services.

CMG Health Inc.

25 Crossroads Drive, Owings Mills,. Md. 21117; 301-581-5000; fax: 301-581-5007

Year founded: 1986.

UR services provided to employers: 10% 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, claims payment and processing.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 90 total; 26 professionals, including eight physicians, four registered nurses, 14 social workers.

Covered lives: 450,000 employee benefit plan lives.

Admissions reviewed: 2,500.

Branch offices: Prairie Village, Kan.; Des Moines, Iowa; Richmond, Va.; Denver.

1990 gross revenues: $7.5 million total, $3 million from UR services.

Principal officers: Alan J. Shusterman, president; Ronald Cunn, vp-medical affairs; Douglass Kay, vp-quality assurance; Lisa Shusterman, vp-clinical services; Diana Woltereck, vp-operations.

California Psych Health Plan

5750 Wilshire Blvd., Suite 490, Los Angeles, Calif. 90010; 213-965-4870; fax: 213-937-9688

Year founded: 1973; began providing utilization review services in 1978.

UR services provided to employers: 5% 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, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 22 total; four professionals, including two physicians, two registered nurses.

Clients: 70 total; 69 corporate, including 80% with fewer than 500 employees, 7% with 500-999 employees, 7% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 3% with more than 5,000 employees.

Covered lives: 250,000 employee benefit plan lives.

Admissions reviewed: 200.

1990 gross revenues: $6.8 million total, $350,000 from UR services.

Principal officers: Diana Seeb, chief executive officer; Michael Jospe, director-professional services; Robert L. Belichick, director-marketing; Julia D. Cyburt, controller.

CAPP Care Inc.

17390 Brookhurst, Suite 280, Fountain Valley, Calif. 92708; 714-963-8065; fax: 714-963-0549

Year founded: 1982; began providing utilization review services in 1984.

UR services provided to employers: 11% of gross revenues.

UR services provided to others: 83% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, case management.

Medical services reviewed: Group health, psychiatric and substance abuse, Medicare review.

Staff: 54 total; 48 professionals, including three physicians, 30 registered nurses, 15 medical records technicians. On retainer: six physicians.

Clients: 85 total, all contracted through TPAs or insurance carriers.

Covered lives: 983,000 employee benefit plan lives.

Admissions reviewed: 52,179.

Branch offices: Tucson, Ariz.; Cleveland.

Charges: Per employee, $1.30-$2; per case.

Principal officers: Dr. Ed Zalta, chairman/chief executive officer; Michael E. Henry, president/chief operating officer.

CareAmerica Inc.

301 E. Main St., Suite 114, Barrington, Ill. 60010; 708-382-7470; fax: 708-382-0772

Year 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.

Staff: 14 total.

Covered lives: 200,000 employee benefit plan lives.

Admissions reviewed: 11,000.

Principal officers: F. Jerome Coquillard.

Carenet

455 Commerce Drive, Amherst, N.Y. 14228; 716-691-8556; fax: 716-691-8524

Year founded: 1983; began providing utilization review services in 1989.

Parent company: North American Administrators Inc.

UR services provided to employers: 75% 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, hospital bill audit, outpatient service predetermination, case management.

Occasional UR services: Outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: Seven total; five professionals, including one physician, four registered nurses. On retainer: 17 physicians, one nurse on a retainer basis.

Clients: 25 total; all employer clients; 35% with fewer than 500 employees, 30% with 500-999 employees, 30% with 1,000-2,499 employees, 5% with 2,500-4,999 employees.

Covered lives: 35,000 employee benefit plan lives.

Admissions reviewed: 2,309.

1990 gross revenues: $240,000 total, $215,000 from UR services.

Charges: Per employee, $1.25-$1.50; per hour, 50 cents.

Principal officers: Ronald K. Zoeller, president; David W. Miller, senior vp; Charles W. Barger, vp; E. Timothy Danahy, executive vp.

Carrefour

2301 Main St., Kansas City, Mo. 64141; 816-395-3106; fax: 816-395-3959

Year founded: 1986; began providing utilization review services in 1987.

Parent company: Blue Cross & Blue Shield of Kansas City.

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, 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.

Staff: 15 professionals, including one physician, 13 registered nurses, one medical records technician. On retainer: three physicians.

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Clients: 34 total; 25 employer clients.

Covered lives: 210,000 employee benefit plan lives.

Admissions reviewed: 11,970.

Charges: Per employee, negotiated; per case, $500-$1,500; per hour, $75-$150.

Principal officers: Gail Shafton, president.

The Claims Network

P.O. Box 638-7170, Indianapolis, Ind. 46268; 800-638-7170; fax: 317-298-6669

Year founded: 1990; began providing utilization review services in 1986.

UR services provided to employers: 10% 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, outpatient psychiatric and substance abuse services, case management, physician bill reviews, independent evaluations, data indexing for outpatient surgical facility fees, DRG validations, surgical code bundling.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 184 total, all professionals, including four physicians, 68 registered nurses, two licensed practical nurses, four medical records technicians. On retainer: 275 physicians.

Clients: 1,200 total.

Branch offices: Salt Lake City, Centerville, Utah; Orlando, Fla.; Rutherford, Woodridge, N.J.; Los Angeles; Dallas; Hartford, Conn.; Arlington Heights, Ill.

Principal officers: Dennis SeRine, president (Medco Review Inc.); Diane Hoyle, executive vp (Medical Review Institute of America Inc.); Mike Thalasinos, president (Professional Appointment Services Inc.); Jeanita Schulten, vp-marketing & communications (Key Care Health Resources Inc.); Richard Proctor, director-marketing (Prompt Associates).

CoMed Management Inc.

525 Metro Place N., Suite 300, Dublin, Ohio 43017; 614-766-0061; fax: 614-899-2148

Year founded: 1987.

Parent company: New York Life Insurance Co.

UR services provided to employers: 20% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, AIDS management, claims data analysis, preferred provider organization.

Services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse services, workers compensation/disability, experimental organizational therapies.

Staff: 84 total; 30 professionals, including two physicians, 29 registered nurses.

Clients: 50 total; 46 employer clients; 68% with fewer than 500 employees, 13% with 500-999 employees, 8% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 320,000 employee benefit plan lives.

Principal officers: Janice Spillane, president/chief operating officer; Edward G. Wendt Jr., chief executive officer; Diane Schrimpf, Krista Ball, vps.

Comprehensive Review Technology Inc.

455 E. Mound St., Columbus, Ohio 43232; 800-338-2305; fax: 614-464-0053

Year founded: 1985; began providing utilization review services in 1984 (under the name HBG).

UR services provided to employers: 19% 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, hospital bill audit, case management, precertification for workers compensation and casualty insurers.

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, nursing home reviews.

Staff: 50 total; including 30 registered nurses. On retainer: 18 physicians, seven nurses.

Clients: 25 total; 10 employer clients; 80% with fewer than 500 employees, 9% with 500-999 employees, 8% with 1,000-2,499 employees, 2% with 2,500-4,999 employees, 1% with more than 5,000 employees.

Covered lives: 80,000 employee benefit plan lives; 70,000 workers compensation lives.

Branch offices: Fort Lauderdale, Fla.; Tulsa, Okla.; Indianapolis.

1990 gross revenues: $2 million total, $300,000 from UR services.

Charges: Per employee, $1.10-$1.60 for UR services; per audit, one-third of the savings; per hour, $75 for case management.

Principal officers: William Heiss, chairman; Dale Wood, president; John Williford, vp-operations; Al Nehr, president-finance.

Conservco Inc.

3903 Northdale Blvd., Suite 200, Tampa, Fla. 33624; 800-525-5590; fax: 813-960-5772

Year founded: 1981; began providing utilization review services in 1985.

Parent company: The Travelers Corp.

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, independent medical evaluations, skilled nursing facility, home health care, surgical diagnostic review, private duty nurse 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: 6,000 total.

Covered lives: 4 million employee benefit plan lives; 300,000 workers compensation lives.

Admissions reviewed: 250,000.

Branch offices: Hartford, Conn.; San Antonio, Texas; San Diego; Westmont, Ill.

1990 gross revenues: $108 million total, $43 million from UR services.

Charges: Per employee, $1.25-$3; per case, $110-$125.

Principal officers: Dennis Huffman, president; Jim Vance, chief medical officer.

Core Management Inc.

2825 Santa Monica Blvd., Santa Monica, Calif. 90404; 800-258-2673

Year founded: 1981; began providing utilization review services in 1984.

UR services provided to employers: 39% of gross revenues.

UR services provided to others: 52% 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, disability duration certification, workers compensation medical review.

Occasional UR services: Hospital bill audit, outpatient psychiatric and substance abuse services, case man-

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gement.

Services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, analytic consulting.

Staff: 142 total; 88 professionals, including 76 registered nurses. On retainer: six physicians.

Clients: 49 total; 35 employer clients; 3% with fewer than 500 employees, 18% with 1,000-2,499 employees, 18% with 2,500-4,999 employees, 61% with more than 5,000 employees.

Covered lives: 3.3 million employee benefit plan lives; 28,000 workers compensation lives.

Admissions reviewed: 71,000.

Branch offices: Burlington, Mass.; Schaumburg, Ill.; Laguna Hills, Calif.

1990 gross revenues: $9 million total, $8.2 million from UR services.

Charges: Per employee, $1.20-$2.15; per hour, $80-$300.

Principal officers: George Carpenter, chairman/chief executive officer; Craig Horton, president/chief operating officer; James J. Franklin, executive vp.

Corporate Care Management Inc.

70 Corporate Drive, Binghamton, N.Y. 13904; 607-724-6520; fax: 607-722-1332

Year founded: 1974.

UR services provided to employers: 95% of gross revenues.

UR services provided to others: 4% 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 verification.

Occasional UR services: Second surgical opinion, hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 15 total; 14 professionals, including one physician, 12 registered nurses, one licensed practical nurse. On retainer: one nurse.

Clients: 24 total; 23 employer clients; 4% with fewer than 500 employees, 37% with 500-999 employees, 42% with 1,000-2,499 employees, 13% with 2,500-4,999 employees, 4% with more than 5,000 employees.

1990 gross revenues: $600,000 total, $570,000 from UR services.

Charges: Per employee, $1-$2.50; per hour, $70 for non-catastrophic, $95 for catastrophic.

Principal officers: John F. Spring, chairman; Patrick J. Kearse, president.

Cost Care Inc.

1 Pacific Plaza, 7711 Center Ave., Suite 100, Huntington Beach, Calif. 92647; 714-842-4909; fax: 714-897-1633

Year founded: 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, provider networks, disability management.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 526 total; 372 professionals, including 51 physicians, 163 registered nurses, 29 licensed practical nurses, 129 medical assistants. On retainer: 8,600 physicians.

Clients: 7,000 total, all employer clients.

Covered lives: 5.25 million employee benefit plan lives.

Admissions reviewed: 210,000.

Branch offices: Atlanta; Chattanooga and Memphis, Tenn.; Chicago and Schaumburg, Ill.; Cincinnati; Lynnfield, Mass.; New York.

Principal officers: Lawrence Goelman, chief executive officer/president; Virginia Cirica, senior vp-chief operating officer; Ray Foose, vp-marketing; David Ackley, vp-chief financial officer; Vicki Schweitzer, vp-operations; Dr. Alan Greenfield, vp-medical services.

Cost Containment Administration

300 Esplanade Drive, Suite 1241, Oxnard, Calif. 93030; 805-988-1459; fax: 805-485-0663

Year founded: 1989.

UR services provided to employers: 100% 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.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 15 total.

Clients: Four total; all employer clients; 50% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 25% with more than 5,000 employees.

Covered lives: 25,000 employee benefit plan lives.

Admissions reviewed: 2,000.

Branch offices: Seal Beach, Calif.

Charges: Per employee, per case, per hour.

Principal officers: Mary M. Lacyk, president; Mary M. Abraham, chief financial officer.

Cost Management Technologies Inc.

4435 Main, Suite 810, Kansas City, Mo. 64111; 816-531-6300; fax: 816-531-3699

Year founded: 1985; began providing utilization review services in 1986.

UR services provided to employers: 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.

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

Staff: 32 total; two professionals that are registered nurses. On retainer: 36 physicians.

Branch offices: St. Louis.

Charges: Per employee, per hour.

Principal officers: Patrick A. Thompson, president; James R. Angelica, executive vp; Joseph P. Stasi, chief financial officer.

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Crawford & Co.-HealthCare Management Group

5620 Glenridge Drive N.E., Atlanta, Ga. 30302; 404-847-4565

Year 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, PPO.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, home health care.
Staff: 1,538 total; 925 professionals, including nine physicians, 580 registered nurses, 15 licensed practical nurses, eight medical records technicians.
Clients: 1,785 total; 1,485 employer clients; 4% with fewer than 500 employees, 15% with 500-999 employees, 36% with 1,000-2,499 employees, 35% with 2,500-4,999 employees, 10% with more than 5,000 employees.
Covered lives: 1.8 million employee benefit plan lives; 1.5 million workers compensation lives.
Admissions reviewed: 159,725.
Branch offices: Chicago; Savannah, Ga.; Columbia, S.C.
1990 gross revenues: $91 million total (estimated), $15.5 million from UR services.
Charges: Per employee, $1.45-$3.
Principal officers: P.A. Bollinger, executive vp; Dr. G. Berk Lynch II, J. David Tiller; John H. Potter, Jeff Aycock, vps.

D

Data Med Inc.

3860 Gregory Drive, Northbrook, Ill. 60062; 708-291-0742; fax: 708-291-9415

Year founded: 1985; began providing utilization review services in 1986.
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, retrospective review, second surgical opinion, case management, employee education.
Occasional UR services: Outpatient service predetermination, outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse.
Staff: 23 total; 18 professionals, including 10 physicians, eight registered nurses.
Clients: 95 total; 90 employer clients; 84% with fewer than 500 employees, 10% with 500-999 employees, 5% with 1,000-2,499 employees, 1% with 2,500-4,999 employees.
Covered lives: 18,000 employee benefit plan lives.
Admissions reviewed: 2,100.
Charges: Per employee, 75 cents-$2.75; per hour, $80-$105.
Principal officers: Louis R. Morgan, vp.

E

E-V AccelCare

475 Metro Place N., Suite 201, Dublin, Ohio 43017; 614-764-7580; fax: 614-764-7198

Year founded: 1990; began providing utilization review services in 1991.
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, dental, psychiatric and substance abuse.
Staff: Three total.
Charges: Per employee.
Principal officers: James R. Eggert, Gary L. VanArsdale, managing partners; Gregory R. Nickell, vp-operations.

EM Associates Inc.

P.O. Box 2650, Binghamton, N.Y. 13902-2650; 607-771-0272; fax: 607-723-4407

Year founded: 1987.
UR services provided to employers: 20% 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.
Occasional UR services: Second surgical opinion.
Medical services reviewed: Group health, dental, psychiatric and substance abuse, workers compensation/disability, automobile medical.
Staff: 12 total; eight professionals. On retainer: four physicians, two nurses.
Clients: 30 total; three employer clients; 66% with fewer than 500 employees, 34% with 500-999 employees.
Charges: Per employee, per case, per hour.
Principal officers: Kathleen Ernst, president; Rebecca S. De Groff, vp.

F

Florida Psychiatric Management Inc.

1276 Minnesota Ave., Winter Park, Fla. 32789; 407-647-1781/ 800-782-2052; fax: 407-647-0668

Year founded: 1978; began providing utilization review services in 1987.
UR services provided to employers: 73% of gross revenues.
UR services provided to others: 17% 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.
Occasional UR services: Retrospective review.
Medical services reviewed: Psychiatric and substance abuse.
Staff: 26 total; 15 professionals, including three physicians, three registered nurses. On retainer: one physician.
Clients: Six total; three employer clients, all with over 5,000 employees.
Covered lives: 215,000 employee benefit plan lives.
Principal officers: Dr. Martin Lazoritz, president/chief executive officer; Dr. Robert W. Pollack, medical director; I. Paul Mandelkern, vp-administration.

Focus Healthcare Management Inc.

7101 Executive Center Drive, Suite 160, Brentwood, Tenn. 37027; 615-377-9936; fax: 615-377-6098

Year founded: 1986.
UR services provided to employers: 20% 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, outpatient psychiatric and substance abuse services, case management, fee schedule audit, usual and customary review.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability,

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physical therapy.

Staff: 150 total; 65 professionals, including four physicians, 55 registered nurses, two medical records technicians. On retainer: 100 physicians.

Clients: 300 total; 35 employer clients; 5% with fewer than 500 employees, 5% with 500-999 employees 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 50% with more than 5,000 employees

Covered lives: 50,000 employee benefit plan lives; 1.2 million workers compensation lives.

Admissions reviewed: 9,200

Branch offices: Atlanta; Birmingham, Ala.; Tampa, Fla.; Arlington, Houston, Texas; Matairie, La.; Brentwood, Knoxville, Tenn.; Charlotte, N.C.; Versailles, Ky.; Overland Park, Kan.; Malvern and Pittsburgh, Pa.; St. Louis; Brookfield, Wis.

Charges: Per employee, $1.25-$2 for group health; per hour.

Principal officers: Stryker Warren Jr., president; Stuart Goldstein, vp-clinical affairs; M. Elizabeth Hand, vp-marketing/sales; Robert W. Sturdivant, vp-network development; David S. Iskowe, executive vp.

H

HHS Inc.

833 Kenmoor, S.E., Grand Rapids, Mich. 49546; 616-956-9440; fax: 616-956-6843

Year founded: 1980; began providing utilization review services in 1986.

UR services provided to employers: 76% 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, second surgical opinion, case management.

Occasional UR services: Retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 36 total; 29 professionals, including 20 registered nurses. On retainer: two physicians.

Clients: 219 total, all employer clients; 85% with fewer than 500 employees, 6% with 500-999 employees, 7% with 1,000-2,499 employees, 2% with more than 5,000 employees.

Covered lives: 90,000 employee benefit plan lives.

1990 gross revenues: $1.6 million total, $1.2 million from UR services.

Charges: Per employee.

Principal officers: Marguerite J. Mojzak, chairperson; David G. Cuneo, president.

Health Benefit Management Inc.

3200 Red River, Suite 302, Austin, Texas 78705; 512-472-7765; fax: 512-472-2232

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

Parent company: Ronald Luke and Associates Inc.

UR services provided to employers: 2% of gross revenues.

UR services provided to others: 98% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, outpatient service predetermination, case management, medical bill audit.

Occasional UR services: Discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 107 total; 102 professionals, including one physician, 85 registered nurses, 16 medical records technicians. On retainer: 72 physicians.

Clients: 72 total; 21 employer clients.

Branch offices: San Antonio, El Paso, Houston and Dallas, Texas.

Charges: Per case, per hour; per line for medical review.

Principal officers: Ronald T. Luke, chief executive officer; Dr. Henry Hug, medical director; Margaret Small, vp.

Health Benefits Management Inc.

P.O. Box 8125, Camp Hill, Pa. 17089; 800-441-2330 (in Pennsylvania)/800-441-2333 (outside Pennsylvania); fax: 800-626-9090

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

Parent companies: Pennsylvania Blue Shield and Capital Blue Cross.

UR services provided to employers: 95% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion, outpatient service predetermination, 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.

Staff: 21 total; 18 professionals, including two physicians, 16 registered nurses. On retainer: one physician.

Clients: 267 total; 265 employer clients; 65% with fewer than 500 employees, 20% with 500-999 employees, 9% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 3% with more than 5,000 employees.

Covered lives: 800,000 employee benefit plan lives; 7,500 workers compensation lives.

Admissions reviewed: 29,000.

1990 gross revenues: $1.85 million total, $1.8 million from UR services.

Charges: Per employee, $1.10-$1.40; per hour, negotiable.

Principal officers: Jerry Boyer, vp/chief operating officer; Elizabeth Galitski, director-program administration; Susan Bunting Bianchi, director-information systems.

Health Care Directions Inc.

100 Roscommon Drive, Suite 210, Middletown, Conn. 06457; 203-635-1103; fax: 203-632-5865

Year founded: 1989.

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, retrospective review, second surgical opinion, case management.

Medical services reviewed: Group health, chiropractic, workers compensation/disability, physical therapy.

Staff: 18 total, all professionals, including 13 physicians, three registered nurses, two medical records technicians. On retainer: eight physicians, two nurses.

Clients: 14 total; two employer clients; 50% with fewer than 500 employees, 50% with 500-999 employees.

Covered lives: 43,000 employee benefit plan lives; 190,000 workers compensation lives.

Admissions reviewed: 197.

1990 gross revenues: $796,000 total, $650,000 from UR services.

Charges: Per case, $75-$600; per hour, $100-$275.

Principal officers: Dr. Edward A. Kamens, president; Bruce J. Ripley, vp; Marcia K. Petrillo, secretary/treasurer.

Health Care Evaluation Inc.

6602 N. Inglewood Ave., Suite G, Stockton, Calif. 95207; 209-951-6711; fax: 209-951-2731

Year founded: 1968.

UR services provided to employers: 59% 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, outpa-

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tient service predetermination, outpatient psychiatric and substance abuse services, case management, network of clinical laboratories, select medical claim review, skilled nursing facility utilization review programs.

Services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 69 total; 51 professionals, including three physicians, 30 registered nurses, six licensed practical nurses, 12 medical records technicians. On retainer: 190 physicians, two nurses.

Clients: 65 total; 59 employer clients; 16% with fewer than 500 employees, 11% with 500-999 employees, 38% with 1,000-2,499 employees, 16% with 2,500-4,999 employees, 19% with more than 5,000 employees.

Covered lives: 1 million employee benefit plan lives; 100,000 workers compensation lives.

Admissions reviewed: 51,480.

Branch offices: Sacramento, Fresno, San Francisco, Chico, Bakersfield and Merced, Calif.

1990 gross revenues: $3 million total, $2.9 million from UR services.

Charges: Per employee, $1.30-$2.25; per case, $46-$75; per hour, $60-$75.

Principal officers: Bernice Wahler, president; Elaine Hislop, executive director; Dr. John W. Kellar, medical director.

Health Care Service Corp.

233 N. Michigan Ave., Chicago, Ill. 60601; 312-938-6997; fax: 312-938-8070

Year founded: 1935; began providing utilization review services in 1985.

UR services provided to employers: 6% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, case management, high-risk pregnancy case management.

Occasional UR services: Retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services.

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

Staff: 132 total; 88 professionals, including five physicians, 71 registered nurses, 12 licensed practical nurses and medical records technicians. On retainer: 34 physicians, 10 nurses.

Clients: 2,535 total; all employer clients; 85% with fewer than 500 employees, 5% with 500-999 employees, 2% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 1.6 million employee benefit plan lives.

Admissions reviewed: 92,491.

Charges: Per employee, $1.40-$1.70.

Principal officers: S.M. Hickman, president/chief executive officer; B.A. Buxton, vp-health care services; G.E. Leon, director-utilization review programs.

Health Cost Consultants

1945 Old Gallows Road, Suite 350, Vienna, Va. 22180; 703-883-0217; fax: 703-790-8022

Year founded: 1983.

Parent company: Inova Health Systems.

UR services provided to employers: 37% 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, hospital bill audit, case management, diagnostic reviews.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 19 professionals, including four physicians, 10 registered nurses, one licensed practical nurse, four medical records technicians. On retainer: 126 physicians.

Clients: 21 total; seven employer clients; 3% with fewer than 500 employees, 10% with 500-999 employees, 19% with 1,000-2,499 employees, 40% with 2,500-4,999 employees, 28% with more than 5,000 employees.

Covered lives: 195,000 employee benefit plan lives; 7,000 workers compensation lives.

Admissions reviewed: 14,500.

Branch offices: Columbus, Ohio.

Charges: Per employee; per hour.

Principal officers: Debbie Scheff, president; Sally-Ann Polson, vp; Ann Meyer, director of operations.

Health Economics Corp.

1300 W. Mockingbird Lane, Dallas, Texas 75247; 214-905-4400; fax: 214-905-4412

Year founded: 1984.

Parent company: Halliburton Co.

UR services provided to employers: 19% of gross revenues.

UR services provided to others: 1% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management, prenatal management.

Occasional UR services: Retrospective review, hospital bill audit, outpatient service predetermination.

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

Staff: 34 total; 27 professionals, including one physician, 17 registered nurses, nine licensed practical nurses. On retainer: nine physicians.

Clients: 85 total; 80 employer clients; 70% with fewer than 500 employees, 5% with 500-999 employees, 16% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 8% with more than 5,000 employees.

Covered lives: 300,000 employee benefit plan lives.

Admissions reviewed: 23,000.

Charges: Per employee; per case; per hour.

Principal officers: Stephen F. Coady, president/chief executive officer; Dick Herrman, vp/general manager; James R. McPhail, vp-managed health care.

Health Information Designs Inc.

1616 N. Fort Myer Drive, Suite 1420, Arlington, Va. 22209; 703-528-2032; fax: 703-276-0040

Year founded: 1976; began providing utilization review services in 1979.

Parent company: Value Health Inc.

UR services provided to employers: 36% of gross revenues.

UR services provided to others: 18% of gross revenues.

Frequent UR services: Retrospective, therapeutic prescription drug benefit utilization review.

Medical services reviewed: Prescription drug benefits.

Staff: 48 total; 14 professionals, including two physicians, four registered nurses, four pharmacists, four medical records technicians.

Clients: 72 total; 61 employer clients; 100% with more than 5,000 employees.

Covered lives: 5.4 million employee benefit plan lives.

Principal officers: Leslie Michelson, chief operating officer; Carl M. Fink, chief operating officer; Jonathan Edelson, vp-medical director; Robert E. Patricelli, president (Value Health Inc.)

Health International Inc.

1840 Century Park E., Suite 670, Los Angeles, Calif. 90067; 213-551-1840/800-333-3760; fax: 213-277-1809

Year founded: 1985; began providing utilization review services in 1987.

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, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, claims analysis, negotiated fee programs, exclusive provider networks, high-risk maternity evaluation and case management, employee claims exception review, tertiary procedure rate negotiations and net-

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ASK A RISK MANAGER

Call-in system improves injury report procedure

Q **It seems that workers compensation issues are becoming more complex for employers. We recently received fines from a state for late reporting of employee injury claims. How does your company—which has nationwide operations—handle the claim reporting process?**

A I agree wholeheartedly with you that most states have made late reporting of workers compensation claims a priority issue. By imposing fines on employers that are guilty of the late reporting practice, officials hope to—and no doubt will—find a successful remedy. After all, it has been proven true that "hitting them in the pocketbook gets their attention."

Over the past year we have drastically changed our claim reporting procedure to achieve several management objectives. Most employers have at some point faced the reality that finding and keeping good help is an ongoing problem. In our type of business especially, employee turnover is a human resources nightmare. And, since we are in the quick service category, we naturally expect our employees to quickly and efficiently prepare a large variety of food products. The challenge is how to control labor and operating expenses without disrupting the most critical area: service to our customers.

Following an internal study conducted companywide a few years ago, we realized that our managers had too many forms and reports to prepare. Naturally, the risk management department contributed to the load with its accident and incident paperwork requirements.

The opportunity to change the accident reporting program presented itself to us in a unique manner. Although I was aware of other companies that successfully used a centralized call-in program for accident reporting and was interested in the concept, for one reason or another we were reluctant to make a change. Our restaurant managers completed the required paperwork at the store level and forwarded the information to a local claims office. We expected all of the information to be complete and reported within 48 hours. Over the years it became apparent there was room for improvement in both areas.

The opportunity for change came early in 1990 when we acquired several hundred restaurants that had used the centralized call-in accident reporting program successfully for years. To require these managers to change to a less efficient program was impractical and, in reality, a step backward. Instead, we initiated our own centralized call-in program companywide and realized several benefits:

- Reduced labor costs and other expenses at the restaurant level by eliminating the need for management to manually complete and mail accident forms.
- Significantly improved our late reporting problem. Our managers find it's more convenient to pick up the phone and report an accident.
- Provided for a smooth transition of accident reporting following the acquisition.
- Created a feeling of good will between field operations and the risk management department. The call-in program was perceived to be a positive step and a real time saver, indicating that risk management supported the field operations.
- Supported our risk control/loss prevention objectives. Risk management is able to obtain more specific information concerning the nature and cause of accidents. At the same time, the caller can receive appropriate safety advice (remember to wear safety gloves, wipe up spills immediately, etc.) which serves as positive reinforcement.

Our centralized call-in program involves reporting accidents and incidents by calling a toll-free telephone number that is answered directly by risk management staff members. Each claim is assigned an internal number for tracking purposes. The manager is responsible for completing a prompt sheet before making the call so the correct information is readily available. After the risk management department receives the information, the appropriate form is forwarded to the claims office that services the restaurant.

We require all claims to be reported within a 48-hour deadline to avoid an internal late reporting penalty. However, we will send one warning letter to a manager for a first offense before actually assessing a charge. The initial warning letter has so far proven to be effective.

There are other companies that use an outside

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A new look at wellness plans

Well-designed programs trim fat from health care tab

By Edward R. Stasica

FOR ABOUT A DECADE now, progressive companies nationwide have been taking some successful strides toward better management and cost control of their employee health benefits.

Typically, savings have been generated through such initiatives as:

- Control of inappropriate utilization of the health care system, which has quality as well as cost implications.

For example, a gall bladder unnecessarily removed is not a health benefit but, in fact, is a health risk, as well as a needless expenditure for employer and employee.

- Provider price and quality negotiation.

A hospital system that has more than one-third of its beds nationwide empty obviously affords shrewd purchasers of health care an opportunity for selective contracting with quality providers who are also cost-efficient. This contracting might be done either directly with a provider or through a preferred provider organization, employer coalition or some other mechanism.

Progress undoubtedly will continue during the 1990s on both of these—and other—fronts as more and more employers commit the resources necessary to address this major long-term management issue.

In the 1990s, however, it is not only virtually certain but economically necessary that preventive health/wellness programs will come to the fore as a significant health care cost containment tool for a variety of reasons, including:

- Economic trends.

According to the Centers for Disease Control, 50% of the leading causes of death are related to preventable lifestyle factors. Hospitalization and health care costs are analogously affected.

The cost of "health care," which in actuality is predominantly "sickness care," has been escalating at 10% to 30% per year for many employers. On the other hand, wellness program costs have been nowhere near this inflation rate. In fact, an effectively designed wellness program can achieve significant costs saving and health status improvements with an expenditure of as little as 1% to 3% of a company's current annual health benefit expenditures.

- Demographic shift of the workforce.

As our workforce ages, it becomes a user of higher-intensity health care services. As a result, the leverage for cost-saving preventive measures will increase.

It should also be noted that, as a nation, we will need our workforce to be healthy and productive up to an older age to have a competitive economy.

- Cost savings-oriented design, targeting and implementation.

The state of our collective knowledge and capability regarding wellness program design is rapidly evolving and will enable wellness programming to become much more cost-effective, as well as "health effective," in the years to come.

Wellness program design will develop in several levels, or phases, of sophistication.

A Phase I wellness program is typically based on some objective data and criteria but is to a large degree based on the subjective assessments and judgments of the wellness staff, upper management and the perceived desires of employees.

One example might be that a jogging or walking program is started because the chief executive is involved in that activity.

Or perhaps the fact that a number of heart attacks and strokes have stricken key or highly visible employees might give impetus to preventive measures in this direction. Also, subjective verbal and/or written employee surveys have been used as a prime determinant of company programs.

The programs of many companies in the 1970s and 1980s have sometimes accomplished much using such relatively non-analytical approaches but, in most cases, significant enhancement is possible through more quantitative design.

Phase II wellness programs utilize the health cost data that most employers currently possess—or should possess—to provide the basis for a much more optimally designed and targeted program.

Among the information that an employee benefit department should have from its insurer, health maintenance organization, preferred provider organization or third-party claims administrator, is:

- Health claims aggregated by diagnosis category. These should then be further sorted by: employees and dependents; active employees and retirees; executive, white-collar and blue-collar workers; and by location.
- Disability claims similarly sorted.
- Workers compensation claims.
- Demographic breakdowns (age, gender, etc.), again sorted by the various categories.
- Employees with high health care costs. (Typically 5% of an organization's employees account for 50% or more of its health care

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Call-in-system

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service to receive accident calls. I personally prefer to have the risk management department obtain the information directly from the caller because staff personnel are more familiar with the organization and know what additional relevant questions to ask. We have eliminated the need to follow up on individual claims because the required information is received and further instructions are given to the caller at the time of the initial report. I'm certain our third-party claims administrator appreciates receiving timely, complete accident information from us, as well.

If you have a risk management information system, a centralized call-in accident program can provide additional advantages. One example that immediately comes to mind is identifying accidents by location code. We operate more than 1,500 restaurants, all of which are identified by a certain code.

It is important for our data to be sorted by location code for loss allocation purposes. Before the accident report is forwarded to the adjusting company that inputs the data for us, the correct location code is entered on the report. We have likewise discovered that more specific loss control information can be collected internally rather than relying on a TPA to be the sole source of coding for us.

I recently learned of one RMIS vendor that will be marketing a workers comp software package aimed at automating the claims reporting process. As you know, each state has its individual claim form. This package would show the state form on a personal computer screen to allow for quick data entry. The form is then released to a printer and the hard copy is forwarded to the appropriate party.

Those companies that self-insure workers comp programs should remember that the opportunity to self-insure is viewed as a privilege and the administration of such a program must follow state guidelines. Benefit payments are expected to be prompt. If late reporting is a problem for the self-insured, the state administrators will not hesitate to take corrective action.

The risk manager's goal in establishing a claims administration program is to provide a means of promptly and effectively reporting accidents with the ability to collect relevant loss control data in a meaningful format. As your question suggests, claims administration will continue to be a vital area as we move forward in the 1990s. ■

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefit Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.


Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Ms. Werner's column appears on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in April.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Wellness programs

Continued from previous page
expenditures.)

- Health risk/appraisal results. (Care must be taken to select a risk appraisal instrument that will yield optimally usable design information relative to the organization's wellness goals.)

Some examples may help illustrate the use of such information in Phase II wellness program design:

✔ A major conglomerate determined through health data analysis that fitness and stress issues were prevalent for middle- and upper-level management at corporate headquarters. But, at a heavily blue-collar manufacturing site in the Middle South, the company's biggest source of health claims was respiratory ailments (and 80% of the patients smoked).

Resources were therefore expended at the company headquarters on exercise equipment and stress management programs and tapes (with high employee appreciation and participation levels). At the manufacturing site, a carefully conceived non-smoking policy was gradually implemented, and an extensive smoking cessation program was subsidized (resulting in a more than 10% reduction in smokers in its first year).

✔ A medium-sized manufacturer found that its highest health care cost area was related to childbirth (including normal and low birth weight cases). This is not an unusual situation for an employer with a substantial population of women of child-bearing age.

As a result, it implemented a number of relatively inexpensive counseling and prenatal care intervention programs. The result of targeting these claims was that the company estimated it saved hundreds of thousands of dollars in premature births in the first year of the program.

✔ A Midwestern labor-intensive employer determined that back problems were its major health-related expenditure. Department personnel were provided with an innovative back program and injury claims, as well as absenteeism, were reduced by more than 40%.

In each of the above cases, in-depth analysis of available organizational health care cost data enabled wellness program design and targeting that was extremely cost effective, an attribute that will become even more critical as top management struggles with competitive pressures and difficult economic times.

Phase III wellness programs incorporate the use of incentives to motivate employees to adopt *doable* lifestyle habits that will reduce company health costs.

This approach likely will, during the 1990s, bring to health insurance the same principles that have governed automobile and property insurance premium increases. In other words, like safe drivers and owners of fire-proof buildings, healthy employees will reap economic rewards.

There are many healthy lifestyle habits that can be tied to incentives (depending on the Phase II analysis of health care costs and program design) and dozens of ways to create equitable, progressive, "win-win" incentives that benefit both the employer and employee.

Some examples of Phase III wellness programs include:

✔ One company has eliminated insurance deductibles for pregnant employees or spouses so that there will be no barrier to obtaining good prenatal care. A side benefit is that the company becomes aware of a pregnancy in the early stages, so that personalized counseling and risk reduction approaches can be offered.

✔ Another organization offers a low-cost hospital deductible for employees who, in the case of an auto accident, were wearing a seat belt. Those not wearing a seat belt have to pay a substantially higher portion of hospitalization charges.

✔ A West Coast company reduces monthly insurance premiums for employees who undergo hypertension testing and, if at risk, can document that they are undergoing an appropriate course of treatment.

It should be mentioned that incentive programs can be extremely powerful and positive agents for cost containment and better employee health, but care must be taken that the incentives are well conceived and implemented in the context of the organization's goals. Also, the potential for unanticipated or adverse results must be cautiously minimized by sound pre-planning and thoughtful design.

As employer health care costs continue to rise at 10% to 30% annually, and employees begin paying a larger share of the premiums and deductibles, their motivation to become not only more cost-conscious health care consumers, but also to adopt "cost-effective" and "health-effective" lifestyles, will be markedly increased.

What an exciting wellness possibility! ■

Edward R. Stasica is head of Stasica Associates, an independent health care and business management consultant in Mount Prospect, Ill.

Court upholds exclusion in N.Y. pollution case

The 2nd U.S. Circuit Court of Appeals ruled that general liability insurers were not liable to defend or indemnify an insured for pollution damage that was not both "sudden and accidental."

This suit arose from a suit over disposal of a radioactive substance into the inner sewer lines, sewage treatment facility and landfill in Tonawanda, N.Y. The substance was produced by a facility owned by EAD Metallurgical Inc. In 1985, the State of New York sued EAD and the owner of the property where the facility was located in federal court alleging violations of the Comprehensive Environmental Response, Compensation and Liability Act of 1980. The landowner, in turn, sued EAD and its officers.

Legal briefs

EAD was covered under general liability policies from Aetna Casualty & Surety Co., North River Insurance Co. and American Nuclear Insurers. Aetna and North River denied any obligation to indemnify and defend. EAD then sued in federal court seeking a declaration that Aetna and North River were obligated to defend and indemnify. The trial court ruled for the insurers.

The appellate court reviewed the allegations in the underlying pollution suits against EAD and concluded that there was no question that EAD was alleged to have continuously and intentionally polluted. Thus, the court said that EAD's alleged conduct did fall within the pollution exclusions for damage which was not sudden and accidental.

In affirming the trial court, the court found that the alleged pollution, resulting from purposeful conduct, could not be considered accidental.

EAD Metallurgical Inc. v. Aetna Casualty & Surety Co., 2nd Circuit U.S. Court of Appeals, May 17, 1990 (*BI*/01/M.-$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

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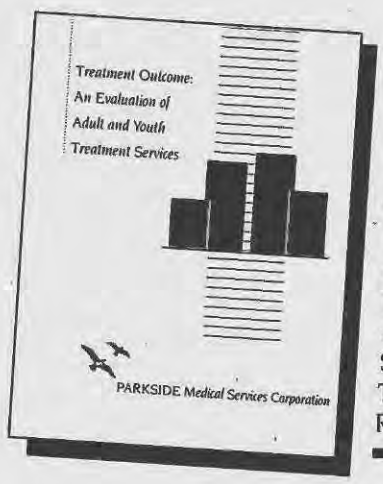

For your free copy of our Treatment Outcome Study and more on The Parkside Difference, Call: (708) 698-4744 or write to our Director of Research at Parkside Medical Services, 205 West Touhy Avenue, Park Ridge, IL 60068-5881

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works, benefit plan design consulting.

Medical services reviewed: Group health, dental, psychiatric and substance abuse, workers compensation/disability.

Staff: 39 total; 29 professionals, including three physicians, 22 registered nurses, two licensed practical nurses, two medical records technicians. On retainer: 18 physicians.

Clients: 300 total; 85% with fewer than 500 employees, 5% with 500-999 employees, 4% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 3% with more than 5,000 employees.

Covered lives: 300,000 employee benefit plan lives; 65,000 workers compensation lives.

1990 gross revenues: $3 million, all from UR services.

Charges: Per employee, $2.50 or $2 one-time set up fee.

Principal officers: Dr. Donald K. Kelly, chairman/chief executive officer; Michael C. Peerboom, president/chief operating officer; Suzanne D. Kelly, vice chairman; David C. Dubs, vp-marketing.

Health Management Services Inc.

4519 Cascade Road S.E., II-B, Grand Rapids, Mich. 49506; 616-956-6903

Year founded: 1983.

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, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: 14 total; including 10 registered nurses, two medical records technicians. On retainer: 40 physicians, one nurse.

Clients: 103 total; 80% with fewer than 500 employees, 15% with 500-999 employees, 5% with 2,500-4,999 employees.

Covered lives: 45,000 employee benefit plan lives.

Admissions reviewed: 6,000.

Charges: Per employee, 9 cents-$2.65; per case, $250-$525; per hour, $75-$150.

Principal officers: Jane E. Esenwein, president.

Health Management Strategies International Inc.

1725 Duke St., Suite 300, Alexandria, Va. 22314; 800-624-6472; fax: 703-706-4803

Year founded: 1975.

Parent company: Group Hospitalization and Medical Services Inc.

UR services provided to employers: 85% 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, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Prenatal case management, specialized mental health review, data analysis and consulting.

Medical services reviewed: Group health, psychiatric and substance abuse, prenatal case management, psychiatric drug review.

Staff: 285 total; 152 professionals, including three physicians, 129 registered nurses. On retainer: 53 physicians.

Clients: 820 total; 800 employer clients; 25% with 2,500-4,999 employees, 75% with more than 5,000 employees.

Covered lives: 10 million employee benefit plan lives.

Admissions reviewed: 74,000.

Branch offices: Denver.

1990 gross revenues: $19.6 million, all from UR services.

Charges: Per employee, per case, per hour.

Principal officers: E. Seton Shields, president; William R. Vandervennet Jr., executive vp; Dr. Alan B. Zients, senior vp/medical director.

Health Related Services Inc.

500 Wood St., Pittsburgh, Pa. 15222; 412-765-1444; fax: 412-565-3274

Year founded: 1984.

Parent company: Blue Cross of Western Pennsylvania.

UR services provided to employers: 85% 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, skilled nursing/home health review, maternity/newborn case management.

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

Staff: 75 professionals, including 10 physicians, 105 registered nurses, 60 medical records technicians. On retainer: 85 physicians.

Clients: 25,000 total; 785 employer clients; 15% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 55% with more than 5,000 employees.

Covered lives: 23 million employee benefit plan lives.

Admissions reviewed: 151,407.

Branch offices: Erie and Johnstown, Pa.

1990 gross revenues: $18.9 million total, $16.6 million from UR services.

Charges: Per employee, $1.85-$4.20; per case, $190-$275; per hour, $85.

Principal officers: Michael Graves, executive vp/chief operating officer; David P. Lyle, president; D. Patrick Flynn, vp-central operations; Nanci C. Keefe, vp-special operations.

Health Resources Ltd.

P.O. Box 246, Pittsfield, Maine 04967; 207-487-5135; fax: 207-487-2496

Year 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, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Outpatient service predetermination, preestimate and negotiation of provider charges.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: Seven professionals, including six registered nurses, one licensed practical nurse. On retainer: one physician.

Clients: 50% with fewer than 500 employees, 25% with 500-999 employees, 25% with 1,000-2,499 employees.

Branch offices: South Portland, Maine.

Charges: Per employee, per case, per hour.

Principal officers: Myles D. Hutchins, operations manager.

Health Risk Management Inc.

8000 W. 78th St., Minneapolis, Minn. 55439; 612-829-3500/ 800-824-3882; fax: 612-829-3578

Year founded: 1977; began providing utilization review services in 1984.

UR services provided to employers: 60% 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, retrospective review, second surgical opinion, hospital bill audit, outpa-

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STRAIGHT TALK

We asked Jack Williams, the new CEO of Avesis—an ancillary managed-care benefits company formerly known as National Benefit Services—to comment on issues affecting the health care industry.

Q: Health benefit costs are going through the roof! What can be done?

A: A lot of companies will tell you, "Sure, we'll help you control costs." But very few of them can actually do it. We can. We do it by offering managed care in the area of ancillary benefits—vision, dental, hearing, pharmaceutical. For instance, if you're using another third-party pharmaceutical card program and you're *really* interested in managed care, Avesis will definitely save you money.

Q: Okay, but what about the end user?

A: Employees are getting frustrated at the way their benefit costs keep going up. Any company that can offer ancillary benefits at a lower price will offset some of that dissatisfaction. That's what we do. Our limited access PPOs have lower upfront administration fees, and reduced back-end claim costs. The bottom line is *decreased benefit costs*—and everyone comes out ahead!

Q: Is that a new idea?

A: No. We started it back in 1978! But a lot of things have changed in the marketplace—and so have we. Our new name, Avesis, is reflective of these changes.

Q: What can we expect from the new Avesis in this changing marketplace?

A: Our company is more market driven and customer sensitive. Our people are more accessible, more responsive to what customers want. And we've developed products and services for the changing environment...for example, the "graying of America."

Q: What does this demographic shift mean?

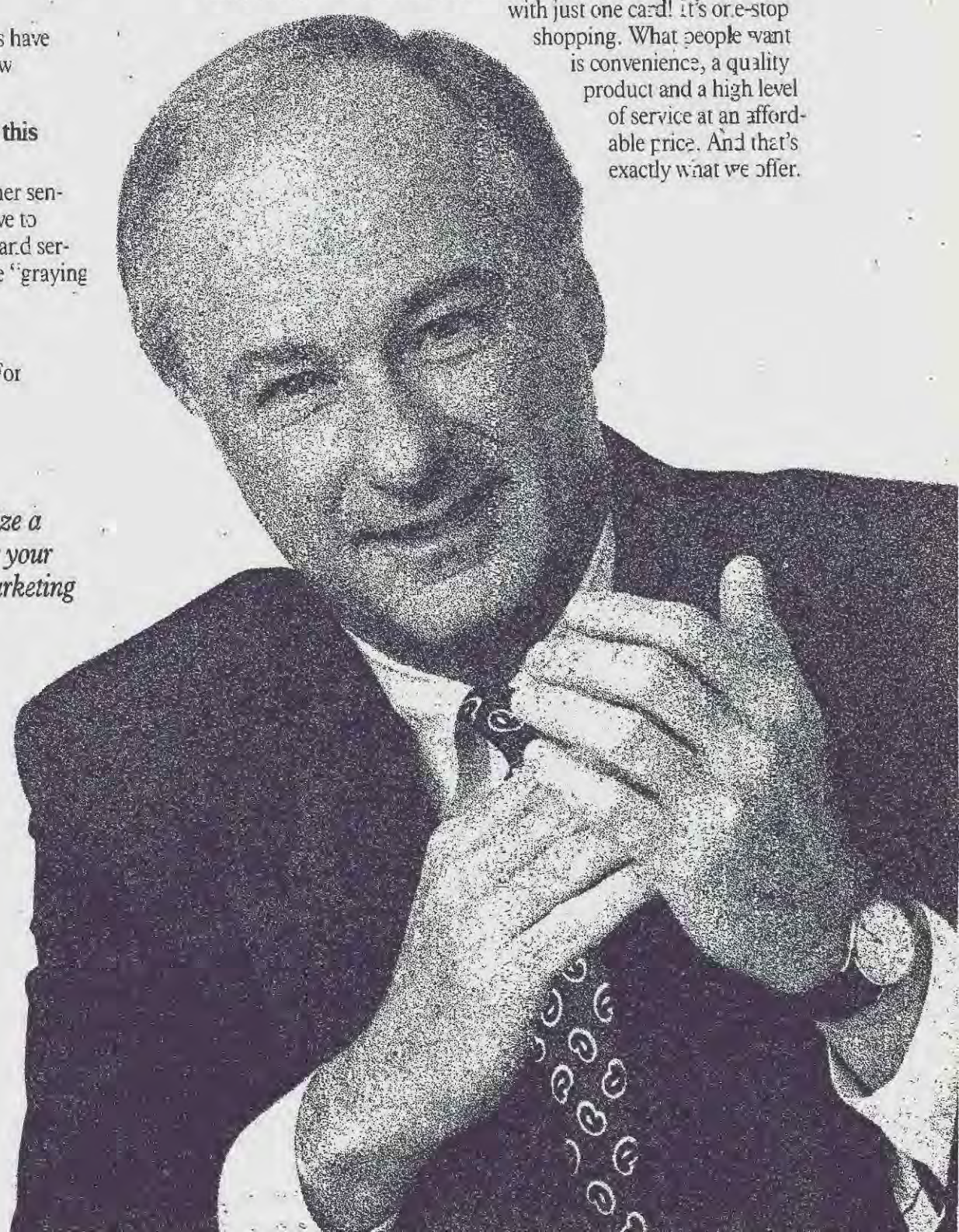
A: It means a growing need for ancillary benefits! For instance, just over 70% of the working population and 100% of persons reaching retirement age need some form of corrective vision. But fewer than 20% have vision benefits. Obviously, there's a shortfall. And if you can go to the marketplace with this benefit—at a modest cost—you've got a winner. Guaranteed!

Q: So Avesis is built around serving this need for affordable ancillary benefits?

A: Exactly. There are other companies which offer the individual components—vision, pharmacy, dental, hearing. But nobody does it all under one roof the way we do. Avesis is the only company in the U.S. that offers all these benefits on a nationwide managed care basis.

Q: And that's more convenient for your customers...

A: Precisely. You could get the individual components in different places, but Avesis offers them all...and they can be accessed with just one card! It's one-stop shopping. What people want is convenience, a quality product and a high level of service at an affordable price. And that's exactly what we offer.



For information on how Avesis can customize a managed-care ancillary benefits program for your company or clients, call Ray Drury, Chief Marketing Officer, at 1-800-522-0258.

Avēsis

INCORPORATED

4201 N. 24th Street
Phoenix, AZ 85016
602/956-7287

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tient service predetermination, outpatient psychiatric and substance abuse services, case management, premature birth prevention, claims administration, provider contracting, data analysis, fee negotiation.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, pharmaceutical.

Staff: 355 total; 112 professionals, including six physicians, 83 registered nurses, 10 licensed practical nurses, four medical records technicians. On retainer: 25 physicians.

Clients: 162 total; 155 employer clients; 9% with fewer than 500 employees, 10% with 500-999 employees, 26% with 1,000-2,499 employees, 23% with 2,500-4,999 employees, 32% with more than 5,000 employees.

Covered lives: 2 million employee benefit plan lives; 800,000 workers compensation lives.

Admissions reviewed: 92,072.

Branch offices: Shrewsbury, N.J., Chicago; Glendale, Calif.

1990 gross revenues: $17.1 million total.

Charges Per employee, per case, per hour.

Principal officers: Dr. Gary McIlroy, chief executive officer; Marlene Travis, president/chief operating officer; Tom Clark, chief financial officer; Steven Ostercamp, senior vp-sales/marketing; Al Pertuz, senior vp-operations; Kenneth Diamond, senior vp-provider development.

Health Service Review Inc.

6730 Roosevelt, Franklin, Ohio 45005; 513-422-0063; fax: 513-422-1281

Year founded: 1983.

UR services provided to employers: 92% 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, physician fee review.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 34 total; 17 professionals, all registered nurses. On retainer: 30 physicians, one nurse.

Clients: 270 total, 258 employer clients; 44% with fewer than 500 employees, 37% with 500-999 employees, 11% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 2% with more than 5,000 employees.

Covered lives: 242,200 employee benefit plan lives; 11,000 workers compensation lives.

Charges: Per employee.

Principal officers: Thomas L. Wiley, chairman; William D. Stief, president; Donald J. Barker, vp-PPO development; Karen L. Mehl, vp-quality assurance; Mary M. Hanley, vp-marketing; Thomas C. Colvin, vp-operations.

Health Services Advisory Group Inc.

301 E. Bethany Home Road, Suite B-157, Phoenix, Ariz 85012; 602-264-6382; fax: 602-241-0757

Year founded: 1982.

UR services provided to employers: 22% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Occasional UR services: Hospital bill audit, case management, medical case consultation, coding validation, drug utilization review.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 105 total, all professionals, including 51 physicians 48 registered nurses six medical records technicians. On retainer: 42 physicians.

Clients: 52 total; 47 employer clients; 58% with fewer than 500 employees, 15% with 500-999 employees, 6% with 1,000-2,499 employees, 8% with 2,500-4,999 employees, 13% with more than 5,000 employees.

Branch offices: Prescott and Tucson, Ariz.

Charges: Per employee, up to $2; per case, $10-$60; per hour, $35-$140.

Principal officers: Debra Nixon, chief executive officer; Dr. Lawrence Shapiro, president Dr. Fred Christensen, vp/treasurer.

Health Services Review Inc.

P.O. Box 530190, Birmingham, Ala. 35253; 205-858-6848; fax: 205-370-5775

Year founded: 1987; began providing utilization review services in 1984.

Parent company: Healthtrax Inc.

UR services provided to employers: 76% of gross revenues.

UR services provided to others: 6% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion outpatient service predetermination, long-term care, outpatient bill auditing.

Occasional UR services: Discharge planning, retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, psychiatric and substance abuse workers compensation/disability, long-term care.

Staff: 86 total all professionals, including one physician, 24 registered nurses, two licensed practical nurses. On retainer: 30 physicians, two nurses.

Clients: 11 total; eight employer clients; 38% with fewer than 500 employees, 25% with 500-999 employees, 13% with 2,500-4,999 employees, 25% with more than 5,000 employees.

Covered lives: 120,000 employee benefit plan lives

Admissions reviewed: 11,000.

Branch offices: Mobile, Ala.

Charges: Per employee, per case, per hour.

Principal officers: R. Craig Fulford, chief executive officer; Albert P. Finch III, executive vp.

HealthCare COMPARE Corp.

3200 Highland Ave., Downers Grove, Ill. 60515. 708-241-7900; fax: 708-719-9701

Year founded: 1982; began providing utilization review services in 1984.

UR services provided to employers: 59% of gross revenues.

UR services provided to others: 26% 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, home health services.

Staff: 763 total; including 30 physicians, 232 registered nurses, 25 licensed practical nurses, 16 medical records technicians. On retainer: 4,000 physicians.

Clients: 2,772 total.

Covered lives: 5.8 million employee benefit plan lives.

Admissions reviewed: 358,400.

Branch offices: Sacramento, Calif.; Savannah, Ga

1990 gross revenues: $42 million total, $25 million from UR services.

Charges: Per employee, $1.45-$3/month; per hour, $150.

Principal officers: James C. Smith, president/chief executive officer; John L. Krakauer, executive vp/chief operating officer; Joseph E. Whitters, chief financial officer.

Healthcare Review Corp.

9200 Shelbyville Road, Suite 215, Louisville, Ky. 40222; 502-426-4888; fax: 502-429-5233

Year founded: 1986.

UR services provided to employ-

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ers: 39% 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.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability, outpatient diagnostic and surgical services.

Staff: 83 total; 81 professionals, including three physicians, 76 registered nurses, two licensed practical nurses. On retainer: two physicians.

Clients: 32 total; eight employer clients; 12.5% with fewer than 500 employees, 25% with 500-999 employees, 12.5 % with 2,500-4,999 employees, 50% with more than 5,000 employees.

Covered lives: 218,900 employee benefit plan lives.

Admissions reviewed: 12,275.

1990 gross revenues: $2.3 million total, all from UR services.

Charges: Per employee, 75 cents-$4. Case management, $150 per hour for physician adviser, $50 per hour for nurse reviewer.

Principal officers: James C. Rogers, president; Dr. Barbara M. Freeman, vp/medical director.

Healthcare Strategies Inc.

9841 Broken Land Parkway, Suite 105, Columbia, Md. 21046; 301-381-5430; fax: 301-290-9721

Year founded: 1984.

Parent company: TPA of America.

UR services provided to employers: 94% 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, podiatric review, proactive wellness, focused maternity.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 45 total; 20 professionals, including six physicians, 10 registered nurses, four medical records technicians. On retainer: two physicians, four nurses.

Clients: 85 total; 70 employer clients; 5% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 55% with 2,500-4,999 employees, 20% with more than 5,000 employees.

Covered lives: 516,000 employee benefit plan lives; 180 workers compensation lives.

Admissions reviewed: 114,000.

1990 gross revenues: $2.3 million total, $2.1 million from UR services.

Charges: Per employee, $1.25-$2.60; per case, $225; per hour, $115-$125.

Principal officers: TPA of America—Tom Greene III, chairman; Elliot Weir, chief operating officer. Healthcare Strategies Inc.—Janice K. Albert, president; William P. Keenan, vp.

Healthchoice

1405 S. Orange Ave., Orlando, Fla. 32806; 407-237-6306; fax: 407-425-8545

Year founded: 1985; began providing utilization review services in 1988.

Parent company: Orlando Regional Medical Center.

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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Occasional UR services: Discharge planning, retrospective review, case management.

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

Staff: One physician, three registered nurses.

Clients: 18 total; 67% with fewer than 500 employees, 6% with 500-999 employees, 6% with 1,000-2,499 employees, 8% with 2,500-4,999 employees, 13% with more than 5,000 employees.

Covered lives: 111,000 employee benefit plan lives.

Admissions reviewed: 1,524.

Charges: Per employee.

Principal officers: Stephan J. Harr, vp; Nancy J. Smith, chief operating officer.

Healthmarc

5601 Smetana Drive, 4th Floor, P.O. Box 1459, Minnetonka, Minn. 55343; 612-936-1205; fax: 612-936-5991

Year founded: 1983.

Parent company: United Health Care Corp.

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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, outpatient service case management, magnetic resonance imagery, outpatient back program and patient advocacy programs.

Occasional UR services: Retrospective review and hospital bill audit.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 200 total; 91 professionals, including five physicians, 80 registered nurses, six medical records technicians. On retainer: 30 physicians.

Clients: 400 total; 380 employer clients; 70% with fewer than 500 employees, 8% with 500-999 employees, 7% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 11% with more than 5,000 employees.

Covered lives: 2.3 million employee benefit plan and workers compensation lives.

Branch offices: Pasadena, Calif.; Charleston, W.Va.

Charges: Per employee, $1.40 and up; per case, $60 and up; per hour, $100-$120.

Principal officers: Mark Tierney, president; John Davids, vp; Kathy McClurken, director-marketing; Steven Spruth, vp-workers compensation.

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HealthNetwork Inc.

1420 Kensington Road, Suite 203, Oak Brook, Il. 60521-2106; 708-954-2900; fax: 708-954-15[illegible]

Year founded: 1985.
Parent company: West Suburban Hospital, Little Co. of Mary Hospital, Illinois Masonic Medical Center, Mercy Hospital.
UR services provided to employers: 5% 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, 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, workers compensation/disability.
Staff: Seven total; six professionals, including one physician, five registered nurses. On retainer: five physicians, seven nurses.
Clients: 35 total.
Covered lives: 50,000 employee benefit plan lives.
Admissions reviewed: 5,233.
Principal officers: George C. Phillips Jr., president; Donna Wolak, vp-finance.

Healthpass Inc.

905 Governor Road, Suite 301, Hershey, Pa. 17033-2306; 717-531-6950; fax: 717-531-6283

Year founded: 1986.
Parent company: The Corp. for Penn State.
UR services provided to employers: 46.8% of gross revenues.
UR services provided to others: 26.6% 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: 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: 10 total; five professionals, including one physician, four registered nurses.
Clients: Six total; all employer clients; 33.3% with fewer than 500 employees, 16.7% with 500-999 employees, 16.7% with 2,500-4,999 employees, 33.3% with more than 5,000 employees.
Covered lives: 75,000 employee benefit plan lives.
Admissions reviewed: 5,264.
Charges: Per employee, 92 cents-$1.50; per case, $30 or negotiable.
Principal officers: Gary J. Dillon, president/chief executive officer.

HealthPro Inc.

10 Mechanic St., Worcester, Mass. 01608; 508-757-5440; fax: 508-754-6862

Year founded: 1975; began providing utilization review services in 1976.
UR services provided to employers: 80% 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, case management, claims data analysis.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.
Staff: 101 total; 90 professionals, including two physicians, 60 registered nurses, two medical records technicians. On retainer: 50 physicians.
Clients: 20% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 70% with more than 5,000 employees.
Covered lives: 1.9 million employee benefit plan lives.
Admissions reviewed: 68,500.
Branch offices: Columbus, Ohio.
1990 gross revenues: $6 million total, $5.9 million from UR services.
Charges: Per employee, $1.25-$2.25; per hour, $125-175.
Principal officers: Gary N. Lapidas, executive vp/chief executive officer; Barbara Ladon, vp-marketing/development; Michele Stranger-Hunter, president.

The Holman Group

6900 Owensmouth Ave., Canoga Park, Calif. 91308; 818-704-1444; fax: 818-593-2529

Year 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: 70 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 500-999 employees, 60% with 1,000-2,499 employees,

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How Well Are You Controlling Your Benefits Costs?

If you're like most companies, your employee benefits costs are continuing to soar.

Corroon & Black can bring those costs under control. We've proven that over and over again in our work with companies throughout the U.S. and overseas, including many Fortune 500 companies.

Corroon & Black is the United States half of Willis Corroon plc, the world's fourth largest broker. Together, we're developing leading-edge risk management and benefits programs for the 1990s.

We do business in over 100 U.S. cities, and with our growing network of C&B Consulting Group offices, we deliver a level of expertise, combined with personal service, that would be tough for any broker to match.

Take This Simple Test:

To see if your company is getting the most effective help in coping with rising benefits costs, take a moment to answer these 7 questions.

Yes ❑ **No** ❑ We have a current evaluation of our company's present and projected benefits costs.

Yes ❑ **No** ❑ We have a working program in place to manage health and medical claims.

Yes ❑ **No** ❑ Our benefit and compensation plans are subject to the same sort of budget review as all corporate capital and operating budgets.

Yes ❑ **No** ❑ Our benefits broker/consultant keeps us abreast of state and federal regulatory changes, with timely advice and recommendations.

Yes ❑ **No** ❑ Our broker periodically evaluates world insurance markets to identify the best possible coverages.

Yes ❑ **No** ❑ Self-insured benefits programs have been thoroughly evaluated.

Yes ❑ **No** ❑ Our benefit programs are designed to fit with our long-term corporate strategy.

If you would like to discuss your employee benefits in more detail, call us. We can help by reviewing your costs and discussing any aspect of your benefits program. Call Tom Ucko at (800) 242-2495.

CORROON & BLACK
A WILLIS CORROON COMPANY

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10% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Covered lives: 500,000 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.

1990 gross revenues: $6.5 million total, $975,000 from UR services.

Charges: Per employee, 75 cents-$3.50; per case, $160-$450.

Principal officers: Dr. Ron Holman, president/chief executive officer; Linda Holman, vp/chief financial officer; Marylin Kingston, senior vp; Dr. Marilynne Rosen, vp-clinical services.

I

IPRO National Medical Review

95-25 Queens Blvd., 10th Floor, Rego Park, N.Y. 11374; 718-896-7230; fax: 718-997-1641

Year founded: 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, outpatient service predetermination, DRG validation, medical coding, quality of care audits.

Occasional UR services: Concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability, physician office (outpatient).

Staff: 400 total; 311 professionals, including six physicians, 280 registered nurses, 25 medical records technicians. On retainer: 550 physicians, 30 nurses.

Clients: 40 total; 10 employer clients; 20% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 40% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Branch offices: Albany, Syracuse, Lake Success, Rochester and Buffalo, N.Y.

Charges: Per employee, per case, per hour.

Principal officers: Theodore O. Will, executive vp.

Independent Dental Consultants

301 N. Harrison St., Suite B173, Princeton, N.J. 08540; 609-243-9494

Year founded: 1988.

UR services provided to employers: 25% of gross revenues.

UR services provided to others: 25% of gross revenues.

Frequent UR services: Preadmission certification, outpatient service predetermination.

Occasional UR service: Retrospective review, second surgical opinion.

Medical services reviewed: Dental.

Staff: Six total; three professionals, including two physicians, one registered nurse. On retainer: two physicians, one nurse.

Charges: Per case, $15-$25; per hour, $75-$150.

Principal officers: Dr. Kenneth O'Connor, president.

Integrated Behavioral Health

30011 Ivy Glenn Drive, Suite 218, South Laguna, Calif. 92677; 714-495-9019; fax: 714-495-7245

Year founded: 1989; began providing utilization review services in 1991.

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.

Occasional UR services: Hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse, workers compensation/disability, behavioral health and medical services.

Staff: Five total; including two physicians, two registered nurses, one medical records technicians On retainer: seven physicians.

Clients: 20 total; 13 employer clients; 46% with fewer than 500 employees, 15% with 500-999 employees, 8% with 1,000-2,499 employees, 8% with 2,500-4,999 employees, 23% with more than 5,000 employees.

Charges: Per employee, per case, per hour.

Principal officers: Samuel L. Mayhugh, president/chief executive officer.

Integrated Benefit Services

1630 S. Sixth St., Springfield, Ill. 62730; 217-522-3736; fax: 217-522-8338

Year founded: 1989; began providing utilization review services in 1990.

Parent company: Casper, Barthoff & Miller, Inc.; VHA Great Rivers.

UR services provided to employers: 10% 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.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: Two total, including one registered nurse, one licensed practical nurse. On retainer: one physician.

Clients: Seven total, all employer clients: 50% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees.

Covered lives: 6,800 employee benefit plan lives.

Admissions reviewed: 2,000.

Charges: Per employee.

Principal officers: Ronald Krause, chairman; John G. Miller, president.

Integrated Psych Care

5330 Heatherdowns, Suite 100, Toledo, Ohio 43614; 419-865-2444; fax: 419-865-2342

Year founded: 1987.

UR services provided to employers: 15% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 14 total; eight professionals, including two physicians, six registered nurses.

Clients: Eight total; one employer client; 100% with fewer than 500 employees.

Covered lives: 100,000 employee benefit plan lives.

Admissions reviewed: 500.

1990 gross revenues: $2.5 million total, $250,000 from UR services

Charges: Per employee, 30 cents-$1.75; per case, $350-$400.

Principal officers: Jacquelyn Ayers, president; James King, secretary/treasurer.

Intracorp

1205 Westlakes Drive, Suite 300, Berwyn, Pa. 19343; 215-889-2500; fax: 215-889-2990

Year founded: 1970; began providing utilization review services in 1984.

Parent company: CIGNA Corp.

UR services provided to employers: 11% 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, retrospective review, second surgical

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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.

Staff: 4,300 total; 2,030 professionals, including 30 physicians, 2,000 registered nurses. On retainer: 450 physicians.

Clients: 25,000 total; 3,000 employer clients; 70% with fewer than 500 employees, 11% with 500-999 employees, 9% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 6% with more than 5,000 employees.

Covered lives: 21.5 million employee benefit plan lives; 1.8 million workers compensation lives.

Admissions reviewed: 819,580.

Branch offices: Atlanta, Dallas, Chicago, Los Angeles, Philadelphia, Pittsburgh.

1990 gross revenues: $285.6 million total, all from UR services.

Charges: Per employee, per case, percent of savings for some auditing.

Principal officers: Warren D. Fuller, president/chief executive officer; Dr. Robert J. Ailes, senior vp/chief medical director; Richard A. Anderson, executive vp-operations; Gregory J. Riedi, senior vp-marketing, Katherine S. Perry, senior vp/chief financial officer; Douglas A. Leland, vp-product management & development; Donald M. Duford, senior vp-sales; Claire Annechini, vp-systems; Arthur D. Beebe, vp-human resources.

K

Kepple & Co. Inc.

209 W. Fifth St., Peoria, Ill. 61605; 309-673-7330; fax: 309-673-7369

Year founded: 1982; began providing utilization review services in 1986.

Parent company: Proctor Community Hospital.

UR services provided to employers: 13% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, case management.

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

Staff: Six total; all professionals, including one physician, three registered nurses, one licensed practical nurse, one medical records technician.

Clients: 39 total; 80% with fewer than 500 employees, 5% with 500-999 employees, 15% with 1,000-2,499 employees.

Covered lives: 16,500 employee benefit plan lives.

Admissions reviewed: 3,200.

1990 gross revenues: $3 million total, $377,000 from UR services.

Charges: Per employee, $1.75-$3; per hour, $60 (RN)-$225 (physician).

Principal officers: Michael D. Kepple, president; Norm Laconte, chairman; Kevin Roberts, vp/secretary/treasurer.

Key Care Health Resource Inc.

5451 W. Lakeview Parkway S. Drive, Indianapolis, Ind. 46268; 800-367-4207/317-298-6600; fax: 317-298-6669

Year founded: 1986; began providing utilization review services in 1987.

Parent company: Associated Insurance Cos. Inc.

UR services provided to employers: 69% of gross revenues.

UR services provided to others: 17% 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, prenatal care coordination, cardiovascular risk assessment, health promotion/consulting services.

Occasional UR services: Second surgical opinion.

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

Staff: 110 total; all professionals, including one physician, 61 registered nurses, two licensed practical nurses. On retainer: 50 physicians.

Clients: 40 total; 32% with fewer than 500 employees, 26% with 500-999 employees, 27% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 1 million employee benefit plan lives.

1990 gross revenues: $6.4 million total, $5.5 million from UR services.

Charges: Per employee, 35 cents-$1.85; per case, $500-$3,000; per hour.

Principal officers: Richard C. Huber Jr.

L

Lincoln National Administrative Services Corp.

1300 S. Clinton, Fort Wayne, Ind. 46801; 800-248-0811; fax: 219-455-4394

Year founded: 1905.

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: 125 on average total.

Clients: 80 total.

Covered lives: 306,511 employee benefit plan lives.

Admissions reviewed: 40,000.

Branch offices: Frederick, Md.; Chicago; Colorado Springs, Colo.; Fort Scott, Kan., Pleasanton, Calif.

Principal officers: John Cole, executive vp/chief executive officer; Steve Goldstone, senior vp-marketing group general manager-Western; Kevin Hickey, senior vp-marketing group manager-Eastern.

M

MCC Cos. Inc./PsychPACER

5353 Wayzata Blvd., Suite 500, Minneapolis, Minn. 55416; 800-722-3763; fax: 612-943-9846

Year founded: 1986.

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, outpatient psychiatric and substance abuse review, case management.

Occasional UR services: Retrospective review.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 11 total; all professionals who are registered nurses. On retainer: two physicians.

Clients: 18 total; four employer clients; 25% with fewer than 500 employees, 25% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 25% with more than 5,000 employees.

Admissions reviewed: 2,500.

1990 gross revenues: $80 million total, $590,000 from UR services.

Charges: Per employee, $60; per case, $300; per hour, $90.

Managed Care Administrators

12651 High Bluff Drive, Suite 200, San Diego, Calif. 92130-2023; 619-259-1933; fax: 619-792-7068

Year founded: 1988.

UR services provided to employers: 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.

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

Staff: Seven total; five professionals, including five registered nurses. On retainer: two physicians.

Clients: 80 total; all employer clients; 65% with fewer than 500 employees, 20% with 500-999 employees, 10% with 1,000-2,499 employees, 5% with 2,500-4,999 employees.

Covered lives: 70,000 employee benefit plan lives.

Charges: Per employee, $1.25-$1.50.

Principal officers: Raymond E. Hughes, chief executive officer/chairman; Edward M. Bosanac, president/chief operating officer.

Massachusetts Peer Review Organization

300 Bear Hill Road, Waltham Mass. 02154; 617-890-0011; fax: 617-890-5485

Year founded: 1985; began providing utilization review services in 1986.

Parent company: Massachusetts Medical Society.

UR services provided to others: 100% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, quality of care review, DRG validation.

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

Staff: 116 total; 85 professionals, including three physicians, 60 registered nurses, three medical records technicians. On retainer: 150 physicians.

Clients: Three total.

Covered lives: 800,000 employee benefit plan lives.

Admissions reviewed: 70,000.

Branch offices: East Longmeadow, Mass.

1990 gross revenues: $7 million total, all from UR services.

Charges: Per employee, per case, per hour

Principal officers: Dr. Brenda E. Richardson, president; Dr. Guenter Spanknebel, vp; Dr. Eugene V. Lancette, clerk; Dr. Irving Weissman, treasurer.

MedCost Inc.

2150 Country Club Road, Suite 160, Winston-Salem, N.C. 27104; 919-721-1844; fax: 919-721-0543

Year founded: 1983; began providing utilization review services in 1984.

UR services provided to employers: 10% of gross revenues.

UR services provided to others: 65% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, case management, prenatal education.

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: 20 total; nine registered nurses.

Clients: 43 total; 23 employer clients; 57% with fewer than 500 employees, 13% with 500-999 employees, 17% with 1,000-2,499 employees, 9% with 2,500-4,999 employees, 4% with more than 5,000 employees.

Covered lives: 170,000 employee benefit plan lives.

Admissions reviewed: 12,000.

Charges: Per employee, $1-$2; per hour $60-$85.

Principal officers: Otto W. Mueller, president; Billie J. Davis, vp.

Medical Claims Review Services Inc.

7910 Woodmont Ave., Suite 700, Bethesda, Md. 20814-3015; 301-913-0002/800-356-2775; fax: 301-913-0028

Year founded: 1984.

UR services provided to employers: 3% of gross revenues.

UR services provided to others: 92% of gross revenues.

Frequent UR services: Retrospective review, retrospective lost time analysis, automobile medical coverage, retrospective limited review.

Occasional UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, case management.

Medical services reviewed: Dental, chiropractic, workers compensation/disability.

Staff: 40 total; 27 professionals, including four physicians, five registered nurses, one licensed practical nurse, eight medical records technicians. On retainer: 50 physicians, 20 nurses.

Clients: 590 total; 10 employer clients; 100% with more than 5,000 employees.

Covered lives: 10,000 workers compensation lives.

Admissions reviewed: 400.

1990 gross revenues: $3.2 million total, $3 million from UR services.

Charges: Per employee, 50 cents-$1.75; per hour, $75-$200; flat rate per type of service, $75-$495.

Principal officers: Dr. Ronald E. Gots, chairman; George S. Attridge, president; Thomas C. McCarthy and Dr. Ignacio Rodriguez, executive vps; John J. Madigan, vp.

Medical Cost Management

122 S. Michigan Ave., Suite 1200, Chicago, Ill. 60603; 312-341-0217; fax: 312-341-9283

Year founded: 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, high risk maternity management, 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, podiatry.

Staff: 16 total; 12 professionals, including four physicians, six registered nurses. On retainer: 40 physicians, 45 nurses.

Clients: 180 total; 108 employer clients; 75% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 1% with more than 5,000 employees.

Charges: Per employee, per hour.

Principal officers: Michael J. O'Connor, president; Dr. Andrew J. Brislen, Dr. David S. Fox and Dr. C. Larkin Flanagan, directors.

Medical Foundation Services Inc.

3625 N.W. 82nd Ave., Suite 211, Miami, Fla. 33166; 305-593-0404; fax: 305-477-6622

Year founded: 1973.

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, 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.

Staff: 40 total; 30 professionals. On retainer: 10 professionals.

Clients: 250 total; 25 employer clients; 50% with fewer than 500 employees, 20% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Covered lives: 125,000 employee benefit plan lives; 25,000 workers compensation lives.

Admissions reviewed: 17,000.

1990 gross revenues: $7.5 million total, all from UR services.

Charges: Per employee, $1.10-

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$1.90.

Principal officers: Rose Strain, executive director; Richard N. Dietrich, director-marketing; Carla Feilbach, director-review.

Medical Review Corp.

237 South St., Morristown, N.J. 07960; 201-267-2233; fax: 201-455-0581

Year founded: 1982; began providing utilization review services in 1984.

UR services provided to employers: 65% 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, physical therapy review, rehabilitation, aggregate claim audit, DRG validation.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Clients: 10% with fewer than 500 employees, 20% with 500 to 999 employees, 40% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Charges: Per employee, per case, per hour, percentage of savings.

Principal officers: Marc Allen, chairman.

Medical Review Institute of America

P.O. Box 2670, Salt Lake City, Utah 84110-2670

Year founded: 1982.

UR services provided to employers: 9% of gross revenues.

UR services provided to others: 90% of gross revenues.

Frequent UR services: Preadmission certification, length of stay determination, retrospective review, outpatient service predetermination, dental and oral surgery review, surgical code bundling, usual and customary fee determination.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 42 total; four professionals, including three physicians, one registered nurse. On retainer: 200 physicians.

Clients: 550 total; 50 employer clients; 25% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 50% with more than 5,000 employees.

Admissions reviewed: 27,600.

Charges: Per case, $60-$250, based on an hourly rate.

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; 404-395-9117; fax: 404-395-9138

Year founded: 1990; began providing utilization review services in 1991.

Frequent UR services: Length of stay determination, retrospective review, hospital bill audit.

Medical services reviewed: Group health.

Staff: Five total. On retainer: two physicians.

Principal officers: Scott Smith, president; Steve Smith, vp; Edward D. Jones III, secretary/treasurer.

Medicus Resource Management

Sixth and Spruce Streets, West Reading, Pa. 19611; 215-372-8044; fax: 215-378-0112

Year founded: 1989.

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, outpatient psychiatric and substance abuse services, case management, maternity care, inpatient/outpatient claims review.

Occasional UR services: Retrospective review, second surgical opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: 23 total; four professionals, including one physician, three registered nurses. On retainer: 16 physicians, three nurses.

Clients: 112 total; 110 employer clients; 94% with fewer than 500 employees, 4.5% with 500-999 employees, 1.5% with 2,500-4,999 employees.

Covered lives: 22,000 employee benefit plan lives.

Admissions reviewed: 1,500.

1990 gross revenues: $175,000 total, all from UR services.

Charges: Per employee, $1.50-$1.90.

Principal officers: Edward J. Wargo, president; Dr. C. Harold Cohn, medical director; Linda Kloap, utilization review supervisor.

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MEDIQ Review Services Inc.

600 Cramer Building, Route 38, Mount Holly, N.J. 08060; 609-267-3838; fax: 609-267-2448

Year founded: 1986.
Parent company: MEDIQ Inc.
UR services provided to others: 90% of gross revenues.
Frequent UR services: Retrospective review, independent examinations, case management, integrated physician review, automated hospital and provider bill review.
Occasional UR services: Chiropractic certification, hospital bill audit, outpatient service predetermination.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability, podiatric, osteopathic.
Staff: 50 total; all professionals, including 13 physicians, one registered nurse, 36 medical records technicians.
Clients: 600 total.
Branch offices: Offices in California, Florida, Pennsylvania, New Jersey.
Principal officers: Barbara Gutstadt, president/chief executive officer; Jeff Behrend, senior vp.

Med-Services Management Co.

1 Bala Ave., Suite 4C, Bala Cynwyd, Pa. 19004; 215-667-5155; fax: 215-667-0839

Year founded: 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 review/validation, medical information hot line.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 20 total.
Clients: 65 total.
1990 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.

1300 Godward St. N.E., Suite 3000, Minneapolis, Minn. 55413; 612-379-4145/800-289-3610; fax: 612-379-0608

Year founded: 1969.
Parent company: Willis Corroon P.L.C.
UR services provided to employers: 50% 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, outpatient psychiatric and substance abuse services, case management, fraud and abuse detection.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 34 total; 21 professionals, all registered nurses. On retainer: 200 physicians.
Clients: 305 total.
Covered lives: 218,334 employee benefit plan lives.
Admissions reviewed: 27,700.
Branch offices: Atlanta; Nashville, Tenn.
Charges: Per employee, $1.25-$1.70; per case, $95-$165; per hour, $65-$160.
Principal officers: Ronald G. Cameron, president/chief executive officer.

MED-VALU Inc.

650 Shawan Falls Drive, Suite 210, Dublin, Ohio 43017; 614-764-2282; fax: 614-766-0004

Year founded: 1987.
UR services provided to employers: 70% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services.
Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, claims audit for medical necessity.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 24 total; all professionals, including four physicians, 20 registered nurses. On retainer: four physicians.
Clients: 15 total; seven employer clients; 100% with more than 5,000 employees.
Covered lives: 400,000 employee benefit plan lives; 1,000 workers

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compensation lives.

Admissions reviewed: 28,100.

Branch offices: Norristown, Pa.; Oklahoma City; Cleveland.

1990 gross revenues: $1.5 million total, $1.4 million from UR services.

Charges: Per employee, 70 cents-$1.20 per month; per case, $53-$60.

Principal officers: Michael Linde, president; Mary Ellen O'Grady, vp-marketing; Frank Anzelmo, vp-systems.

Medview

30057 Orchard Lake Road, Suite 200, Farmington Hills, Mich. 48334; 313-851-0700; fax: 313-851-2561

Year founded: 1983; began providing utilization review services in 1984.

UR services provided to employers: 8.3% of gross revenues.

UR services provided to others: 37.3% 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, prepayment review of other selected outpatient procedures.

Medical services reviewed: Group health, dental, psychiatric and substance abuse, workers compensation/disability.

Staff: 112 total; 32 professionals, including physicians and registered nurses. On retainer: three physicians.

Clients: 31 total; 22 employer clients; 36.5% with fewer than 500 employees, 13.6% with 500-999 employees, 31.8% with 1,000-2,499 employees, 13.6% with 2,500-4,999 employees, 4.5% with more than 5,000 employees.

Covered lives: 127,159 employee benefit plan lives; 2 million workers compensation lives.

Admissions reviewed: 6,516.

Branch offices: Chicago; Houston; Los Angeles.

1990 gross revenues: $8 million total, $3.6 million from UR services.

Charges: Per employee, $1.50-$2; per case, $150; per hour, $40-$75.

Principal officers: Robert J. Mackey, president; Dr. David S. Segel, senior vp; Debra J. Cerre, vp/chief operating officer (COMPPRO); Polly Jantzen, vp/chief operating officer (MEDPRO).

Medwatch Inc.

101 Sunnytown Road, Suite 208, Casselberry, Fla. 32707; 407-331-1500; fax: 407-260-5682

Year founded: 1988.

UR services provided to employers: 55% of gross revenues.

UR services provided to others: 45% 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, psychiatric and substance abuse, workers compensation/disability.

Staff: 10 total; including seven registered nurses.

Clients: 22 total; 21 employer clients; 85% with fewer than 500 employees, 10% with 500-999 employees, 5% with 1,000-2,499 employees.

Covered lives: 28,000 employee benefit plan lives; 3,000 workers compensation lives.

Admissions reviewed: 4,000.

Charges: Per employee, $1.15-$1.40; per hour, $50-$60.

Principal officers: Lynn Jennings, president.

Memphis Business Group on Health

2714 Union Extended, Suite 200, Memphis, Tenn. 38112; 901-323-1808; fax: 901-458-0709

Year founded: 1985; began providing utilization review services in 1987.

UR services provided to employers: 68% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning second surgical opinion, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review, hospital bill audit. outpatient service predetermination.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 13 total; nine professionals, including one physician, five registered nurses. On retainer: three professionals.

Clients: 27 employer clients; 59% with fewer than 500 employees, 15% with 500-999 employees, 15% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 4% with more than 5,000 employees.

Covered lives: 79,115 employee benefit plan lives; 5,284 workers compensation lives.

Admissions reviewed: 5,463.

1990 gross revenues: $725,000 total, $493,000 from UR services.

Charges: Per employee, $1.85/month; per case, $70.

Principal officers: Fred Bowman, president; Linda Lucus, vp; Mary Ann Camp, 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

Year founded: 1986.

UR services provided to employers: 5% 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, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Hospital bill audit.

Medical services reviewed: Psy-

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chiatric and substance abuse, workers compensation/disability.

Staff: 18 total; eight professionals, including three physicians, four registered nurses, one licensed practical nurse.

Clients: 40 total; two employer clients; 100% with 1,000-2,499 employees.

Covered lives: 1.2 million employee benefit plan lives.

Admissions reviewed: 5,000.

Charges: Per employee, 10 cents-50 cents per month; per case, $250-$450; per hour, $100-$200.

Principal officers: Dr. Walter E. Afield, chief executive officer/medical director; Jim Kent, executive vp/chief operating officer.

Metropolitan Life Insurance Co.

276 Post Road W., Westport, Conn. 06880; 203-454-6100; fax: 203-454-6110

Year 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, pregnancy program.

Occasional UR services: Retrospective review, second surgical opinion.

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

Staff: 560 total; 528 professionals, including 23 physicians, 464 registered nurses, 41 medical records technicians. On retainer: 25 physicians.

Clients: 5,350 employer clients.

Covered lives: 6 million employee benefit plan lives.

Admissions reviewed: 498,000.

Branch offices: Chesterfield, Mo.; Cincinnati and Dayton, Ohio; Denver; Houston and Irving, Texas; Kingston and Utica, N.Y.; Lisle and Schaumburg, Ill.; Long Beach and Orange, Calif.; Maitland and Miami, Fla.; Norwalk, Conn.; Phoenix; Tulsa, Okla.; Marietta, Ga.; Pittsburgh.

Charges: Per employee, 31 cents-$10.50 per month; per hour, $110-$195.

Principal officers: Robert Schwartz, chief executive officer; John D. Moynahan, executive vp; Robert Chernow, senior vp-managed care services group; Paul Frankel, national medical director.

MultiPlan Inc./ Donald Rubin Inc.

17 W. 17th St., New York, N.Y. 10011-5510; 212-727-9700; fax: 212-627-6396

Year founded: 1971.

UR services provided to employers: 30% 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, DRG validation.

Staff: 17 total.

Clients: 100 total; 20% with fewer than 500 employees, 5% with 500-999 employees, 20% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 30% with more than 5,000 employees.

Covered lives: 500,000 employee benefit plan lives.

Admissions reviewed: 10,000.

Charges: Per employee, per case, percentage of savings.

Principal officers: Donald Rubin, president; Roxanne Young, Edward Gluckmann, vps; Edward Rothstein, marketing director.

Mutual of Omaha Insurance Co./United of Omaha Life Insurance Co.

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-342-7600

Year 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 psychiatric and substance abuse services, case management.

Occasional UR services: Hospital bill audit, outpatient surgery precertification.

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

Staff: 79 total; 61 professionals, including six physicians, 55 registered nurses. On retainer: nine physicians.

Clients: 7,271 total; 82% with fewer than 500 employees, 9% with 500-999 employees, 7% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees.

Covered lives: 268,206 employee benefit plan lives.

Admissions reviewed: 47,307.

1990 gross revenues: $1.8 billion total.

Charges: Per employee, $1.20-$1.50; per case, $400-$500.

Principal officers: Thomas J. Skutt, chairman/chief executive officer; John W. Weekly, president/chief operating officer (Mutual of Omaha).

N

NHA Review Services

770 S. Post Oak Lane, Suite 445, Houston, Texas 77056; 713-439-0123; fax: 713-439-7529

Year founded: 1989.

Parent company: National HealthCare Alliance Inc.

UR services provided to employers: 10% 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.

Occasional UR services: Hospital bill audit, outpatient psychiatric and substance abuse services, case management.

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

Staff: Six total; five professionals that are registered nurses. On retainer: 10 physicians, five nurses.

Clients: 12 total; four employer clients; 25% with fewer than 500 employees, 25% with 500-999 employees, 50% with 1,000-2,499 employees.

Covered lives: 94,000 employee benefit plan lives.

Charges: Per employee, $1.30-$2; per hour, $75-$175.

Principal officers: Francis L. Browning, president; Dr. John M. Baird, vp-medical director.

National Health Services Inc./CareReview

10909 W. Greenfield Ave., Milwaukee, Wis. 53214; 414-778-5151; fax: 414-778-5144

Year founded: 1984.

Parent company: Pioneer Financial Services Inc.

UR services provided to employers: 20% of gross revenues.

UR services provided to others: 72% 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, inpatient psychiatric/alcohol/drug certification, long-term care, home health care case management.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, individual health.

Staff: 40 total; 10 professionals, including two physicians, eight registered nurses. On retainer: 25 physicians, 15-25 nurses.

Clients: 63 total; 13 employer clients; 53% with fewer than 500 employees, 23% with 500-999 employees, 8% with 1,000-2,499 employees, 8% with 2,500-4,999 employees.

Covered lives: 751,303 employee benefit plan lives.

Branch offices: Anderson, Ind.

1990 gross revenues: $2.1 million total, $1.9 million from UR services.

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Charges: Per employee, $1.30-$2.50; per case, $89-$250; per hour, negotiated; hourly rate plus expenses and other negotiated rates.

Principal officers: Mark W. Williams, president; Donald L. White, vp.

O

Occupational Health Services Inc.

125 E. Sir Francis Drake Blvd., Larkspur, Calif. 94939-1860, 415-461-8100/800-327-7526; fax: 415-925-9728

Year founded: 1974; began providing utilization review services in 1987.

UR services provided to employers: 15% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Retrospective review, hospital bill audit, outpatient service predetermination.

Medical services reviewed: Psychiatric and substance abuse, employee assistance programs.

Staff: 215 total; 15 professionals, including one physician, two registered nurses. On retainer: two physicians.

Clients: 400 total, all employer clients; 15% with fewer than 500 employees, 35% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Admissions reviewed: 300.

1990 gross revenues: $11.5 million total, $1.5 million from UR services.

Charges: Per employee, 45 cents-$1.25.

Principal officers: Robert G. Temer, chief executive officer; Julian Zuhlke, vp-finance.

Options-Health Care Cost Containment

741 Penn Center Blvd., Pittsburgh, Pa. 15235; 412-824-7678; fax: 412-824-1571

Year founded: 1981; began providing utilization review services in 1984.

UR services provided to employers: 60% 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, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management.

Occasional UR services: Discharge planning.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 40 total, including one physician, 20 registered nurses. On retainer: 60 physicians.

Clients: 30 total, all employer clients; 10% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 40% with more than 5,000 employees.

Covered lives: 1,500 workers compensation lives.

Principal officers: Joseph M. McCabe, president; Antonia L. Scarlata, secretary/treasurer.

P

PCC/Drug Data Systems Inc.

828 N. Hollywood Way, Burbank, Calif. 91505; 818-843-8551; fax: 818-843-1079

Year 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; 800-223-4276/ 714-220-3700; fax: 714-220-3743

Year founded: 1983.

Parent company: Pacificare Health Systems Inc.

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, 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, high-risk pregnancy screening and management, home health rehabilitation/ placement review, disability review and management.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/ disability.

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Staff: 80 total; 50 professionals, including one physician, 36 registered nurses, two licensed practical nurses. On retainer: six physicians, five nurses.

Clients: 132 total; 74 employer clients; 38% with fewer than 500 employees, 15% with 500-999 employees, 28% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 9% with more than 5,000 employees.

Covered lives: 625,265 employee benefit plan lives.

Admissions reviewed: 38,618.

Charges: Per employee, $1.30-$3.70; per hour, $100.

Principal officers: Pacific Health Systems Inc.—Terry Hartshorn, chairman; Wayne Lowell, chief financial officer; Alan Hoops, secretary/chief operating officer. Pacific Review Services—Vicki Merrill, president.

PAR 3 Utilization Review Services Inc.

7000 N. Broadway, Suite 105, Denver, Colo. 80221; 303-426-8280; fax: 303-650-1668

Year founded: 1987.

UR services provided to employers: 40% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, PPO peer review.

Occasional UR services: Retrospective review, second surgical opinion.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: 26 total; all professionals, including three physicians, seven registered nurses, one licensed practical nurse, four medical records technicians. On retainer: 71 physicians, 18 nurses.

Clients: 358 total; 22 employer clients; 85% with fewer than 500 employees, 6% with 500-999 employees, 2% with 1,000-2,499 employees, 2% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 87,000 employee benefit plan lives.

Charges: Per employee, 25 cents-$1.65; per case $100-$250; per hour, $35-$120.

Principal officers: Kimberly A. Sutphin, president/chief operating officer; Dr. Howard Entin, vp/director of behavioral medicine; Dr. Henry Roth, vp/medical director; Mabel Lachappell and Harry Auston, vps-finance.

Parkside Health Management Corp.

205 W. Touhy Ave., Park Ridge, Ill. 60068; 708-698-4848; fax: 708-698-4804

Year founded: 1980.

Parent company: The Lutheran General Health Care 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, preferred transplant network, medical information help line, PPO network.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 88 professionals, including 26 physicians, 62 registered nurses. On retainer: 124 physicians, six nurses.

Clients: 400 total.

Covered lives: 1.6 million employee benefit plan lives.

Admissions reviewed: 120,000.

Branch offices: Chicago; Cleveland.

Charges: Per employee, $1-$2.85; per case, $50-$125; per hour, $100-$110; hourly management fees.

Principal officers: Marsha Ballard, president; Jennifer Cline, Stephen Tiwald, Lee Green and Walter Hollinger, vps; Les Preuss, assistant treasurer.

Pathway Review Systems

40500 Ann Arbor Road, Plymouth, Mich. 48170; 313-459-2997; fax: 313-459-484[illegible]

Year founded: 1989; began providing utilization review services in 1984.

Parent company: Michigan Peer Review Organization.

UR services provided to employers: 5% 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, case management, surgical preauthorization.

Occasional UR services: Retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination.

Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.

Staff: Eight total, all professionals, including seven registered nurses, one medical records technician.

Clients: Three total; one employer client; 100% with 2,500-4,999 employees.

Covered lives: 5,000 employee benefit plan lives; 3,000 workers compensation lives.

Admissions reviewed: 3,500.

1990 gross revenues: $250,000 total, all from UR services.

Charges: Per employee, 90 cents-$1.15; per case, $26.25; per hour, $54-$125.

Principal officers: Gary Horvat, president/chief executive officer; Sara Daniel, director-program services.

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Peer Review Analysis Inc.

380 Pleasant St., Malden, Mass. 02148; 617-322-6400; fax: 617-322-7726

Year 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, independent physician review.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 87 total; 39 professionals, including six physicians, 30 registered nurses, three medical records technicians. On retainer: 90 physicians.
Clients: 81 total; 15 employer clients; 13.5% with fewer than 500 employees, 13.5% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 33% with more than 5,000 employees.
Covered lives: 6 million employee benefit plan lives; 50,000 workers compensation lives.
Admissions reviewed: 113,000.
1990 gross revenues: $6.5 million total, all from UR services.
Charges: Per employee, $1.15-$2.15 per month; per case, $65-$90; per hour, $75 (registered nurse)-$150 (physician); $65 per referral for independent physician review.
Principal officers: Dr. Barry Manuel, chairman; Russell Robbins, vice chairman; Eric Spitzer, president.

Physical Therapy Review Services Inc.

P.O. Box 69, Woodlyn, Pa. 19094; 800-388-7877; fax: 215-521-6893

Year founded: 1986.
UR services provided to employers: 15% 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, retrospective review, second surgical opinion, case management.
Medical services reviewed: Group health, physical therapy.
Staff: Seven physical therapists. On retainer: 65 physical therapists.
Clients: 315 total; 35 employer clients.
Charges: Per employee, negotiable; per case, $180-$230 for claims review; per hour, $150 for consultation; separate fee for medical testing only.
Principal officers: David W. Clifton Jr., president/chief executive officer; Susan L. Michlovitz, vp/director-operations; Leslie Buksar Clifton, controller.

Prairie States Enterprises Inc.

500 N. Clark St., Chicago, Ill. 60610; 312-464-1888; fax: 312-464-0097

Year founded: 1990.
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 service predetermination, outpatient psychiatric and substance abuse services, case management, short- and long-term disability review, treatment options program.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.
Principal officers: Felicia Wilhelm, Kenneth Krispin, principals.

Preferred Care of the Carolinas Inc.

P.O. Box 12500, Charlotte, N.C. 28220; 704-554-8731; fax: 704-554-1076

Year founded: 1989; began providing utilization review services in 1982.
Parent company: Brunson & Brunson Inc.
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, outpatient service predetermination, case management.
Occasional UR services: Hospital bill audit, outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse.
Staff: 11 total; eight professionals that are registered nurses. On retainer: one physician, two nurses.
Clients: Four total; two employer clients; 50% with 1,000-2,499 employees, 50% with more than 5,000 employees.
Covered lives: 117,273 employee benefit plan lives.
Admissions reviewed: 8,250.
Charges: Per employee.
Principal officers: James Fred

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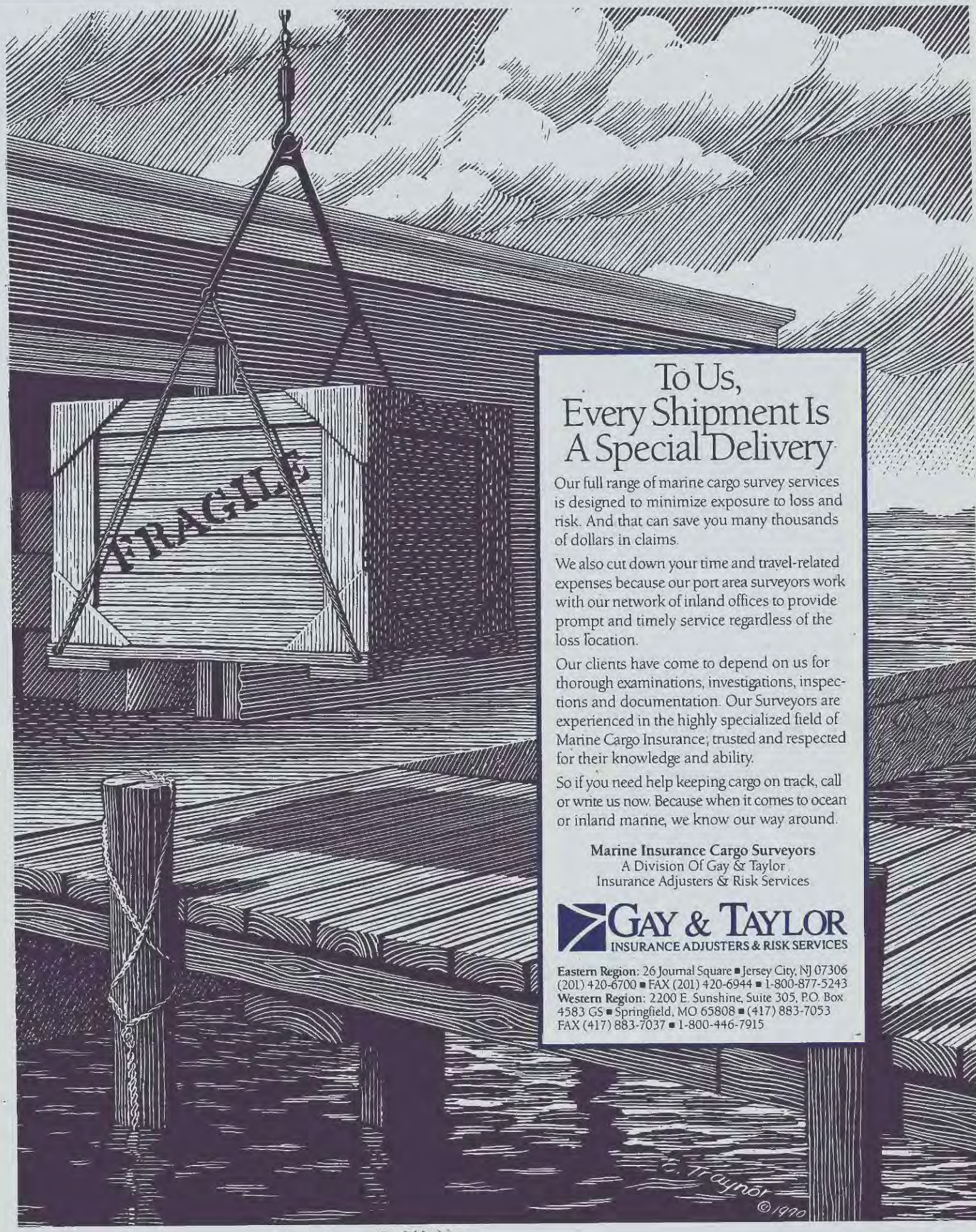

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Brunson Jr., James F. Brunson III, co-presidents.

Private Healthcare Systems Ltd.

20 Maguire Road, Suite 101, Lexington, Mass. 02173; 617-861-5500; fax: 617-862-3458

Year founded: 1985.
UR services provided to employers: 0% of gross revenues in 1990; is available in 1991.
UR services provided to others: 74% 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, medical necessity determination, psychiatric/chemical dependency review.
Occasional UR services: Outpatient service predetermination.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: 550 total; 295 professionals, including 45 physicians, 250 registered nurses.
Clients: 19 total.
Covered lives: 3.4 million employee benefit plan lives; 75,000 workers compensation lives.
Admissions reviewed: 228,500.
Branch offices: Irvine, Calif.; Rosemont, Ill.
1990 gross revenues: $29.1 million total, $21.5 million from UR services.
Charges: Per employee per month.
Principal officers: Gene Guselli, general manager; Donna Goldin, executive vp-product development; Jeffrey L. Kraines, medical director.

Professional Review Organization for Washington

10700 Meridian Ave. N., Suite 100, Seattle, Wash. 98133; 206-364-9700; fax: 206-368-2419

Year founded: 1975.
UR services provided to employers: 99% of gross revenues.
UR services provided to others: 1% 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: Second surgical opinion, outpatient psychiatric and substance abuse services, physical therapy review, medical claims consultation, disability claim review.
Medical services reviewed: Group health, psychiatric and substance abuse, workers compensation/disability.
Staff: 127 total; 57 professionals, including one physician, 35 registered nurses, three licensed practical nurses, 18 medical records technicians. On retainer: 200 physicians.
Clients: 45 total; two employer clients; 7% with fewer than 500 employees, 9% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 79% with more than 5,000 employees.
Covered lives: 1 million employee benefit plan lives; 10,000 workers compensation lives.
Admissions reviewed: 42,215.
Branch offices: Anchorage, Ala.; Boise, Idaho.
1990 gross revenues: $6.3 million total, all from UR services.
Principal officers: Dr. Herbert M. Hilgers, chairman; John W. Daise, chief executive officer; Dr. John C. Peterson III, director-medical affairs; Rick Sheppard, director-operations/data services; Michael B. Garrett, director-marketing/professional services.

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

Year founded: 1988.
UR services provided to employers: 30% of gross revenues.
UR services provided to others: 70% of gross revenues.
Frequent UR services: Prospective chiropractic reviews.
Occasional UR services: Retrospective review.
Medical services reviewed: Chiropractic.
Staff: 18 total; nine professionals that are physicians.
Clients: 500 total.
Admissions reviewed: 11,000 chiropractic.
Branch offices: Tampa, Fla.
Charges: Per case, $135.
Principal officers: James A. Pritchard, president; Dr. James A. Pritchard, director; John J. Kelly, vp.

Psychology Systems Inc.

615 S. Main St., Milpitas, Calif. 95035; 408-262-8046; fax: 408-942-0264

Year founded: 1979; began providing utilization review services in 1986.
UR services provided to employers: 10% of gross revenues.
Frequent UR services: Preadmission certification, discharge planning, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, aftercare follow up.
Occasional UR services: Concur-

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InsurerTopics

A special editorial section sent exclusively tc insurers and reinsurers

Getting serious about fraud

Insurers press for tough laws

By MARK A. HOFMANN

Horse thieves often received an invitation to a necktie party in the Old West.

But modern-day counterparts of horse thieves—car thieves—can get off with a sentence suspended by the court rather than a court sentence of suspension by the neck.

While they're not trying to bring vigilante justice back, insurers are acting to toughen the laws dealing with car theft—and other property crimes that can involve insurance fraud.

But doing so means overcoming apathy and a perception that insurance-related fraud isn't a serious crime, say advocates of a tougher approach. They admit that anti-theft and anti-fraud groups on both the state and national level have registered mixed success.

And, some experts warn, with regional economies mired in recession, the temptation to try pulling a fast one on the insurance company may increase.

Even before the economic downturn, insurance-related crime was costing consumers a considerable amount. According to Federal Bureau of Investigation figures cited in the Insurance Information Institute's "1991 Property/Casualty Fact Book," the value of motor vehicles stolen nationwide in 1989—the last year for which figures are available—totaled more than $8 billion.

Arson, though apparently declining slightly, also remains a major consideration. According to the III, the number of fires known or suspected to be deliberately set declined about 2.5% between 1988 and 1989. Despite the decline, such fires still caused an estimated $1.56 billion in damage in 1989, according to Rick Gilman, executive director of the New York-based Insurance Committee for Arson Control.

Lack of understanding between public and private concerns impedes efforts to combat arson, Mr. Gilman said. Insurers are sometimes reluctant to share information with governmental bodies for fear they will be sued if the information turns out to be false, he said. Likewise, some governmental bodies don't want to share information with insurers.

The same types of problems exist on the automotive front, pointed out John Bernstein, assistant general counsel for State Farm Mutual Automobile Insurance Co. in Bloomington, Ill.

Even some industry allies on tort reform and no-fault auto legislation consider anti-fraud laws at best a yawn, he said. And after such laws are passed, bureaucracies remain reluctant to change time-honored ways of doing things—such as how they handle titles for vehicles—he said.

Mr. Bernstein is a member of the Coalition to Reduce Auto Fraud and Theft. CRAFT was founded 10 years ago by representatives of State Farm, the Schaumburg, Ill.-based Alliance of American Insurers, the Washington, D.C.-based American Insurance Assn., the Des Plaines, Ill.-based National Assn. of Independent Insurers and the Palos Hills, Ill.-based National Automobile Theft Bureau. Although it has no permanent office or staff, the coalition has developed nine model state auto theft laws.

Chairman William R. Schroeder, who is also vp-claims for the Alliance, stressed that CRAFT is a task force, with its membership shifting from time to time.

Model laws are subject to constant review and evaluation, he said. After initially considering about 15 model laws, CRAFT pared the number down to nine to better focus its efforts. A 10th, dealing with towing and garaging, is being considered, Mr. Schroeder said.

CRAFT's model laws are the:

- Motor Vehicle Chop Shop, Stolen and Altered Property Act, which would make people owning, operating or conducting chop shops—in which stolen autos are reduced to parts for resale—subject to felony charges. It would also provide for the forfeiture of equipment and tools and provide treble damages to people "aggrieved by a chop-shop operation."
- Salvage Certificate and Junk Vehicle Act, which would require the surrender to the state department of motor vehicles of the title to a junked car to "terminate the title chain of a vehicle in junked condition and, most importantly, to establish a paper trail to detect and prevent fraud and theft."
- Vehicle Owner Fraud Act, which would subject to felony prosecution people who knowingly make a false report or claim regarding the theft, destruction, damage or conversion of a vehicle, vehicle part or vehicle contents. The act would also make it a felony to illegally obtain evidence of ownership of a vehicle by making a false report or application to a governmental body such as a department of motor vehicles.
- Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting Immunity Act, which would provide limited immunity from lawsuits to public agencies and insurers that exchange information obtained during fraud or theft investigations.
- Certificate of Title as Evidence Act, which would allow the introduction of a certificate of title as evidence of ownership and unauthorized use or possession in criminal cases involving vehicles. The act would also allow the preservation of a witness present in court when a continuance is granted, thus eliminating the need for the witness to appear at every court proceeding. The act seeks to stop the practice of having cases dismissed after the owners of stolen vehicles, tired of repeatedly showing up in court only to have the case continued at the defense's request, finally decide not to appear.
- Inspection and Cancellation of Titles for Exported Vehicles Act, which would require the submission of the title of any vehicle leaving the country permanently for cancellation by the appropriate authority. Initial failure to comply would be a misdemeanor, and any subsequent failure would be a felony.
- Insurance Fraud Act, which would make all forms of insurance fraud, including false statements—both oral and written—a felony.
- False Police Reports Act, which would make it a misdemeanor on the first conviction and a felony on the second conviction for any person to knowingly make or assist in making a false report of theft, destruction, damage or conversion of any property to a law enforcement agency or department of motor vehicles.
- Uniform Act for the Return of Stolen Property Retained as Evidence, which provides a method for the release of property being held as evidence in a criminal proceeding. Under the act, a prosecutor, upon receiving a request for the release of property, provides notice to the defendant so that the defendant can arrange for photographs or other evidence to be used in lieu of the actual property during a trial.

The laws are far from universally adopted, said Gary Turner, the material damage manager with Kemper National Insurance Cos. in Long Grove, Ill. The reason, he said, is not that lawmakers are listening to people who profit from insurance-related crime.

"It's not so much opposition as lack of interest. It's not a sexy crime. It's not a sexy issue," said Mr. Turner, who has worked with CRAFT for years.

Mr. Turner added that because each state has its own legal code, "the action has to come from the states" if insurance-related crime is to be cut back.

Yet lack of interest can easily impede state efforts. For example, less than a month ago, Massachusetts officials announced the formation of the Insurance Fraud Bureau of Massachusetts.

More than two years ago, the bill to create the Boston-based bureau was introduced in the state legislature. It authorized the creation of a fraud bureau with representatives of both the insurance industry and the state government on its board. Insurance companies were to foot the bill.

"We don't know of anybody who was against it," said Daniel J. Johnston, president of the Boston-based Automobile Insurers Bureau of Massachusetts and executive director of the new fraud bureau. Mr. Johnston said the state had a body called the Fraudulent Claims Board during the 1970s, but the body was later disbanded because it was deemed ineffective.

The idea arose that a fraud bureau combining private and public efforts might prove more effective, Mr. Johnston said. The initial catch was that no other state in the nation had such a unit. A considerable amount of negotiating was needed to make the fraud bureau acceptable to both public entities and insurers.

But even after the details were ironed out, there was no legislative urgency in authorizing the board, he said. Lawmakers in the Bay

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Anti-fraud efforts

Continued from previous page

State, like their counterparts in many other states, were preoccupied with taxation, state services and revenue shortfalls, he said.

John Mooney, chairman of the new fraud bureau and chief executive officer of Arbella Mutual Insurance Co. in Quincy, Mass., said that potentially fraudulent bodily injury claims will be receiving a considerable amount of attention by the new bureau.

He noted that Massachusetts raised its no-fault tort threshold to $2,000 from $500 a few years ago, so that claims of $2,000 or less stayed out of litigation. But instead of reducing the size of bodily injury claims for ailments like soft tissue injuries, the average claim amount increased. "It seems like the $2,000 has become a very aggressive target of abuse," he said.

One reason people are tempted to commit such fraud, said Mr. Mooney, is a feeling that they're entitled to recover everything they've paid in auto insurance premiums over the years. Some people don't view cheating the insurer as a crime, he said.

A local approach can be critical, he said. If local officials believe reducing fraud will lower their constituents' premiums, they'll be more willing to commit resources to anti-fraud efforts.

"Yesterday's medical bills are your insurance bills tomorrow. Yesterday's accident is your cost tomorrow," he said. "People have to realize that their neighbors are contributing to the high cost of insurance."

John G. Eager, claims counsel for the NAII, also praised local approaches. He said that the NAII analyzed the increase in the incidence of car theft in six states from 1985 to 1989 using figures drawn from member companies and the NATB. The national increase was 41.9%, he said. But for Florida, the increase was 70.9%; for California, 68.4%; New York, 60.5%; and for Texas, 51.7%. Illinois remained virtually stable at 3.9% and in Michigan, the incidence of auto theft decreased by 10.9%, Mr. Eager said.

Mr. Eager said Michigan's experience was particularly interesting. During the mid-1980s the state had the highest incidence of auto theft in the country and showed no signs of slowing down. However, in 1986, the state established the Michigan Automobile Theft Prevention Authority, which is funded by a $1 assessment on insurers for each car insured in the state. The money goes toward law enforcement and community anti-theft programs, he said.

According to NATB's analysis of the FBI's "Uniform Crime Reports" for 1989, Michigan had the nation's eight-highest theft rate.

Mr. Eager said Michigan's approach drew interest in Illinois, where a similar group was approved by the Legislature last year. The new group, the Illinois Anti-Car Theft Committee, consists of law enforcement personnel, business representatives and insurers, he said.

"State efforts are in some respects more focused" than national efforts, he said. Mr. Eager added that state efforts should follow a three-prong strategy:

- First, an effort should be made to tailor CRAFT model legislation to state specifics.
- Second, car theft prevention committees—representing a broad range of interested groups like law enforcement and consumers—should be formed to push for the enactment of anti-theft laws.
- Third, insurers should make every effort to get policyholder input on how to combat theft. "You actually get the community tied into the effort," he said.

Local police can also be crucial, said Tim Goggin, superintendent of the special investigative unit at Nationwide Mutual Insurance Co. in Columbus, Ohio. How an insurer presents a case of potential fraud to local authorities plays a critical role in whether the case is prosecuted, he said.

If an insurer representative simply brings in a stack of documents that don't make sense to laymen and don't present a particularly coherent case, the papers will gather dust, said Mr. Goggin, a former investigator for the prosecutor's offices of Lake and Athens counties in Ohio.

On the other hand, if the investigator "puts together a good case that's well-delivered and that's cogent," there's a considerably greater chance that a prosecutor will take action. A good case, Mr. Goggin said, will pierce the "fog index," the mythical index which determines whether or not a jury will be able to understand the evidence.

Recruiting former law enforcement professionals as investigators often gives insurers an edge, said Mr. Goggin. This is particularly true if the investigator is assigned to the same region where he or she had been an officer. Such people will know how to approach local authorities; they may still be considered part of the "fraternity."

Jay Williams, director of the special investigation unit at CNA Financial Corp. in Chicago, noted that tip-off to potential fraud can come from outside the organization rather than through internal investigation.

"We do get calls," Mr. Williams

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Insurer Topics

Anti-fraud efforts

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said.

Some calls come from agents, some from policyholders. Most frequently, however, they come anonymously from parties to a scheme to defraud the company, like an employee of a chop shop. He said the callers seldom have the noblest of intentions. "It can be envy or revenge."

Mr. Williams stressed the importance of explaining the impact of fraud. CNA has mailed premium stuffers dealing with fraud to policyholders and aired radio commercials emphasizing that ultimately everyone pays for fraud.

"A lot of people who'd never shoplift won't hesitate to pad a claim," he said.

But experts stress that fraud often goes well beyond adding a few dollars here and there.

Mr. Bernstein said relatively long-term car loans on relatively cheap vehicles may prompt owners to report vehicles stolen when in fact they've disposed of them themselves. "You get to the point where you owe more on the car than it's worth, so you 'sell' it to the insurance company," he said.

Vehicle arson appears to be on the rise, said Mr. Gilman. The crime is doubly difficult to detect. First, there generally isn't enough left of the car to determine whether fire accelerants were used. Second, many fire and police departments don't classify possible cases of vehicle arson as such—they count them with routine accident statistics, he said.

NAII's Mr. Eager said thieves are always looking for low-risk, high-profit ventures: Car theft fits the bill. Even when thieves or perpetrators of insurance fraud are caught, they know that if their crimes are not a high priority offense to local authorities, they have a very good chance of escaping jail, he said. And even when such criminals are sentenced to jail time, some states will allow them to walk away because the prisons are already overcrowded and the space that exists is reserved for violent criminals, he said.

"I think there's a perception that insurance companies are a fountain of cash," Mr. Bernstein said. One way to dry up that fountain is to enact and enforce strict laws, he said.

"You can get at the actual thief, but you very often can't get at the guy who hired him. There are a lot of people who benefit from auto theft who may not be subject to felony law," he said. "You've got to get strict penalties." ■

SIU casebooks tell tall-but-true tales of insurance fraud

By MARK A. HOFMANN

Insurance company special investigative units lack the glamor of Sherlock Holmes' Baker Street Irregulars, but some of the tales in SIU casebooks bear repeating.

As Jay Williams, head of Chicago-based CNA Financial Corp.'s SIU points out, "There is no limit to the way insurance fraud can be perpetrated."

In many cases, the fraud is as simple as using used parts to repair a damaged auto and submitting a bill for new parts, Mr. Williams said. But occasionally the fraud gets much more involved, he said.

As an example of the lengths to which some people will go to obtain insurance money by fraud, Mr. Williams told of a policyholder who submitted a claim for vandalized commercial property. The policyholder—the building's owner—said that all of its bathroom fixtures had been smashed.

But the policyholder said he'd accept $100,000 or CNA's "best offer," which seemed somewhat suspicious, Mr. Williams said.

CNA's suspicions grew when the policyholder also offered to buy the claim representative dinner for two at a nice restaurant to expedite the payment, he said.

As if that were not suspicious enough, a CNA investigator who tried examine the vandalized property found an empty lot. Mr. Williams told the local claims representative to find out who had ordered the building demolished. It turned out that the owner had obtained a demolition order three weeks before filing the claim. It also turned out that the building, contrary to the owner's insistence that it had been a viable commercial concern, had been abandoned several years earlier.

CNA denied the claim and referred the matter to the local law enforcement agency.

Tim Goggin, superintendent of the SIU at Columbus, Ohio-based Nationwide Mutual Insurance Cos., said unusual scams are not confined to commercial claims. In fact, one of the strangest cases his office has faced recently took place in Atlanta.

An anonymous caller contacted the local Nationwide office and offered to direct investigators to a policyholder's stolen car—for a fee. The caller wanted $10,000, which was considerably less than the car was worth, Mr. Goggin said.

The investigator told the caller that the company didn't pay rewards for such information. A few days later, the caller offered to provide the same information for a lower price. Once again, the Nationwide investigator rebuffed him. The caller kept calling and kept lowering the price.

Finally, the investigator offered to meet the caller's most recent offer, which was $3,500, Mr. Goggin said. The investigator, however, had no intention of paying a cent to the caller. In fact, the investigator, a former Atlanta-area police officer, contacted old acquaintances still in law enforcement, who expressed considerable interest in the mysterious caller.

Following the caller's instructions, the investigator placed a bag supposedly containing the cash in a bus shelter at a shopping mall. The bag really contained pieces of blank paper. Once the drop was made, the investigator telephoned the caller, who told him where to find the missing car. The car was recovered in perfect shape.

Meanwhile, the mysterious caller went to pick up the cash. Once he picked up the bag, the police immediately attempted to arrest him. The caller tried to get away and managed to cause significant damage to cars in the parking lot in the effort, Mr. Goggin said.

In a final twist, the car driven by the caller turned out to be another stolen vehicle that might have been intended as the bait for another scam, Mr. Goggin said. ■

Insurer Topics

Investigator follows hot trail on life fraud

By MARK A. HOFMANN

FORT WAYNE, Ind.—The trail led deep into the jungles of Bolivia, where a U.S. insurance company investigator examined a charred campsite, finding evidence that a policyholder's alleged death had in fact never occurred.

The bogus death is just one example of a growing problem of life insurance fraud, says John Hitzeman, director of life reinsurance claims for Lincoln National Life Reinsurance Co. in Fort Wayne, Ind., a unit of Lincoln National Corp.

Economic hard times, which never seem to end in some parts of the world, have made such fraud particularly attractive, Mr. Hitzeman said.

The Bolivian case involved a U.S. citizen who traveled to the jungle on a hunting trip. The man supposedly died when the hut in which he was sleeping burned. The charred remains of a corpse were sent back to the United States, where they were immediately cremated.

The man's "widow" then filed a claim with Lincoln National. Mr. Hitzeman declined to comment on the face value of that policy.

However, the claim didn't seem right, Mr. Hitzeman said. The fact that the man had died outside the country and that the body had been cremated immediately upon return to the United States before anyone could examine it raised warning flags for Lincoln National's life insurance death claim experts, he said.

Mr. Hitzeman said that another possible indicator of life insurance fraud is a claim made by survivors of an allegedly dead policyholder covered by numerous small policies, particularly when the policies are issued by many different companies.

Investigating the verity of such claims can be extremely difficult, Mr. Hitzeman said.

For large claims, particularly those totaling $1 million or more, an insurer wants to use an investigator whom it knows and trusts implicitly, he said. But getting that person to the site of an alleged death is expensive. And, once there, the investigator must contend with cultural and legal differences, Mr. Hitzeman said.

In the case of the "dead hunter," Lincoln National's investigator, accompanied by an agent from the Federal Bureau of Investigation, flew to Bolivia. There the investigator had to hire a translator and a guide. The four-man team arranged a flight into the country's interior.

When they reached an area with no airstrips, the team rented a truck and plunged even farther into the jungle. When they ran out of road, they hiked the remaining few miles to the campsite.

There wasn't much left, but the investigator was able to determine that the hut had been destroyed two days before the hunter allegedly arrived in the country. Local authorities who had issued the death certificate hinted that they'd be willing to rescind the certificate for a fee.

The investigator returned to the United States, presented his case and, according to Mr. Hitzeman, the matter was "settled favorably," despite the threats of the allegedly dead man's wife to sue the insurer.

A few years later, the "widow" was convicted of murdering her second husband. Her first husband—who had supposedly died in Bolivia—was sighted several times in Florida, Mr. Hitzeman said.

Mr. Hitzeman said he does not know of any cases in which the perpetrators of life insurance fraud were prosecuted. "Who are you going to prosecute? The widow? The children?" he asked.

In fact, the purpose of reviewing claims is to validate them, not deny them, Mr. Hitzeman stressed.

"We're not out to find fraud. We like to prove that a claim is valid. If you take a positive approach, the bad ones fall out," he said.

Mr. Hitzeman said that despite the company's commitment to detecting fraud, the problem is growing rather than receding. Some of the perpetrators are extremely sophisticated, he said.

He added that there have even been cases in which terrorists have turned to life insurance fraud to finance their activities, although he would not elaborate. ■

IEF slates workshop in California

INDIANAPOLIS—The Insurance Education Foundation plans to expand its efforts this year by holding three—rather than two—insurance education workshops for high school teachers.

The new workshop will be held July 22-Aug. 2 at California State University in Sacramento.

"California State University at Sacramento offers the high quality of insurance programs that we seek to host the workshop," said Nancy Coleman, executive director of the IEF. "Additionally, the location offers a geographical balance that will enable more teachers on the West Coast to attend."

The other workshops will be held June 17-28 at the Insurance Center at Drake University in Des Moines, Iowa, and July 8-19 at The College of Insurance in New York.

About 40 teachers are expected to attend each workshop. Those who complete the two-week course receive three hours of graduate credit.

The purpose of the program is to teach high school teachers about how insurance works so they can present the subject more effectively in their classrooms. The IEF was founded by the National Assn. of Mutual Insurance Companies as part of an effort to make insurance education more widespread at the high school level (*IT*, Aug. 21, 1989).

For further information on the IEF and its programs, contact Nancy Coleman, Executive Director, Insurance Education Foundation, P.O. Box 68700, Indianapolis, Ind., 46268; 317-875-5250.

Insurer Topics

Health care provider fraud on the rise

By MARK A. HOFMANN

HARTFORD, Conn.—Although insurance fraud is probably as old as insurance itself, the nature of fraud is always changing.

For example, when Hartford, Conn.-based Aetna Life & Casualty Co. began a formal health care fraud investigative unit in 1982, roughly 75% of the fraud was perpetrated by policyholders and 25% by health care providers, according to Jim Garcia, director of the insurer's health insurance tracking unit, which investigates claim discrepancies that may involve fraud.

But due to the insurer's increased vigilance of policyholder fraud, the percentages have flip-flopped over the past three years: Now three-quarters of the health insurance fraud detected by Aetna is perpetrated by providers, Mr. Garcia said.

And, health insurance fraud perpetrated by providers still is on the rise, he said. "We really feel it's increasing, because of the economics, which provide more of a motivation to beat the system."

However, Mr. Garcia noted that in response to overbilling by providers, "payers are taking a lot closer look at the benefits that are paid. They're looking at what's reasonable and customary, they're looking at utilization of services."

Provider fraud is much more sophisticated than most types of health insurance fraud committed by policyholders, and investigators have to look for an entirely different set of possible warning flags, he said.

Learning how to read those flags is critical, said Mr. Garcia, who oversees a 68-person investigative unit spread across the country. The ability to read the warning flags gives investigators a chance to concentrate their efforts on the most suspicious cases and helps insurers recover of millions of dollars, he said.


Mr. Garcia

In 1990, for example, Aetna uncovered $19.1 million in actual fraudulent claims, he said. That represented an increase of about 18% over the amount of fraud detected in 1989, he said.

However, Mr. Garcia pointed out that that figure might be somewhat misleading. Uncovering that $19.1 million in direct fraud resulted in a savings of more than $165 million in "preventable loss," which is a projection of how much money a particular fraud would cost the insurer over a year's time if it had not been detected, he said.

Policyholder fraud cases often are obvious, according to Mr. Garcia. For example, duplicitous policyholders often physically alter documents with white-out and write-overs, which investigators can easily detect, he said.

In other cases, perpetrators use the wrong medical terminology in their efforts to inflate benefits, he said.

But as health insurers looked beyond policyholders' attempts to inflate their benefits and began taking a closer look at what they were actually paying for, they discovered a previously unrecognized amount of provider fraud, Mr. Garcia said.

Mr. Garcia stressed that the percentage of providers attempting to commit fraud is very small, but he added that even a relative handful of miscreants can rack up a very large amount of money before they are identified.

A series of flags helps investigators uncover potential provider fraud, Mr. Garcia said.

"What I call our No. 1 flag—and it's not particularly a fraudulent activity—is where (providers) waive the copayment," he said. Patients are told that the provider will take the insurance payment alone as payment in full, so the patient has no incentive to examine the explanation of benefits, he said.

The unscrupulous providers then pad the insurance claim to obtain money for services never provided.

Another flag is "overutilization of services," Mr. Garcia said. Providers who are always "billing for a high amount of services" may come under scrutiny, he said.

Investigators' suspicions also are raised when a provider always bills for accidents rather than routine matters, Mr. Garcia said.

For example, he noted that odd causes for the accidents that run up bills of $8,000 or $10,000—such as tripping over a hose or a crack in the sidewalk—arouse suspicions.

In addition, unusually high numbers of claims for non-emergency services provided on Sundays or holidays, when providers typically do not have office hours, also raise suspicions.

Mr. Garcia said that the suspected fraudulent activity that is easiest to prove is billing for services that never occurred, provided that the insurer has assistance from policyholders.

The patient sometimes will notify the insurer when a discrepancy appears on a provider bill, he said.

But the first person the patient usually goes to after spotting a discrepancy is the provider, Mr. Garcia said. If the provider says, "Don't worry, we'll take care of it," the matter usually ends there, he said.

Mr. Garcia said insurers must teach policyholders an important lesson: "Your explanation of benefits is like your bank reconciliation." The message should be, "If the numbers don't mesh, don't shrug it off," he said.

Aetna established a toll-free hot line about two years ago to encourage policyholders to report discrepancies to the insurer.

Mr. Garcia noted that that the insurer has been "very careful about using the word 'fraud' " in regard to the hot line because a discrepancy is no proof of fraud. It is not called a fraud hot line, because fraud has to be proved in court, he said.

If Aetna uncovers a pattern of discrepancies, the insurer notifies the proper authorities, he said.

Investigators also must be extremely careful about how they go about their job to avoid exposing themselves to lawsuits, Mr. Garcia warned.

"It's not fraud until it's proven," Mr. Garcia said. "For it to be an actual fraud, it must be proven in the courts. To use that terminology opens the insurer to charges of false allegations or defamation of character," he said.

Any person suspected of fraud should be given the benefit of the doubt, or the insurer could find itself in court, Mr. Garcia said.

Insurers must be careful to avoid looking as if they are out to indiscriminately accuse health care providers of fraud, he said. "Insurers need the cooperation of providers, and for us to be successful to contain health care costs, we need the health care providers to assist in that program."

Providers must have confidence that insurers are only searching for facts, he said.

"A lot of the medical community may view aggressive anti-fraud activity as doctor-bashing or a witch hunt," Mr. Garcia said. "There's a large sensitivity level in handling this type of activity."

Insurers also must take pains to convince prosecutors that health insurance fraud is a serious crime, he said. In many jurisdictions, insurance fraud of any sort is a low-

Continued on next page

Continued from previous page
priority matter, according to Mr. Garcia.

Part of the problem is that some prosecutors look at fraud as a crime against insurance companies, not consumers, even though consumers ultimately pay for fraud through increased premiums, he said.

Mr. Garcia has developed a five-step plan to combat fraud. The steps are:

- Making all parties—insurers, providers, policyholders and prosecutors—aware that fraud is a problem because it drives up the cost of insurance.

Insurers must adopt the attitude that success in detecting and fighting fraud will improve the quality of insurance while making it more affordable, he said. They must communicate this to their policyholders and encourage them to report billing discrepancies.

In addition, health care providers must be made aware what constitutes fraud, Mr. Garcia said. He said that Aetna has worked with Yale University in New Haven, Conn., and medical trade associations to study the incidence and patterns of health care fraud.

- Determining what resources are available to fight fraud. Upper management support for anti-fraud efforts is essential, he said.
- Identifying the possible fraud. This is best done through gathering information through claims audits and encouraging policyholders to provide information on discrepancies, he said. In the future, insurers will become even more effective at detecting fraud through automated tools such as expert systems, Mr. Garcia said.

Expert systems use programs developed by duplicating the thought process of experts in a given field, like claims examiners. The experts are subjected to an involved interviewing process, in which they explain every aspect of their decision-making processes. Programmers then translate this expertise into a computer program, which generally serves as a first cut in processing claims. The expert system, which is a form of artificial intelligence, identifies non-routine material for closer examination by human experts.

- improving the ability to investigate. Many insurance company special investigative units recruit investigators almost exclusively from law enforcement backgrounds, but Mr. Garcia places a greater emphasis on claims handling experience in recruiting investigators for Aetna. A claims professional can learn investigative skills, he said.
- Prosecuting the case.

Some insurance companies will present a provider suspected of fraud with evidence of the fraud, accept restitution and let the matter drop, Mr. Garcia said. "But if you don't have a penalty, you haven't stopped the activity," he said.

Mr. Garcia recommended that appropriate law enforcement agencies and state licensing boards be notified when the evidence of possible fraud warrants.

Mr. Garcia was one of the founders of the National Health Care Anti-Fraud Assn., a Washington, D.C.-based organization of health insurers and government agencies that swaps information on detecting and preventing fraud (*IT*, Sept. 18, 1989).

He said that even though the association cannot lobby at either the state or federal legislative levels because it has governmental entities as members, it provides a valuable service by giving anti-fraud professionals a chance to network.

"As an individual company, you can't make a dent. It's got to be a joint effort," he said. ■

Detectives keep pace with con artists

By MARK A. HOFMANN

WESTPORT, Conn.—Insurers now are far more concerned about detecting and preventing fraud than in 1971, when a group of property/casualty companies formed the Insurance Crime Prevention Institute.

In fact, "the level of fraud awareness within the industry is at an all-time high," said Wendall C. Harness, who next month retires as director of the Westport, Conn.-based ICPI after having served as its director since 1983.

And law enforcement professionals' willingness to prosecute insurance crimes is also much higher than it was when the ICPI was founded two decades ago, he said. On a scale of one to 10, the probability that a good fraud case would be prosecuted was about four in the early 1970s, Mr. Harness said. Now, that probability is seven to eight on the same scale, he added.


Mr. Harness

According to Mr. Harness, the ICPI acts as "an interface" between insurers and law enforcement agencies. In addition to assisting in fraud investigations by compiling information that is provided to law enforcement, the ICPI conducts training programs for member insurance companies. Some 440 insurers, representing 65 parent organizations, currently belong to the organization.

Mr. Harness said that several factors have played a key role in changing public attitudes about insurance fraud. Education about fraud and awareness of its costs are two major factors, he said.

"Insurance fraud is the second most pervasive crime in the United States, second only to income tax evasion," Mr. Harness said, estimating that . property/casualty insurance fraud alone costs about $17 billion per year.

He pointed out that insurance fraud cuts across class and economic lines. The perpetrators range from financially hard-pressed automobile owners looking for quick money to well-organized rings of doctors, lawyers and others who stage auto accidents to defraud insurers.

And, Mr. Harness thinks that fraud may become even more pervasive in the near future as economic hard times hit various parts of the country. "People will do things that they wouldn't do with a pocketful of money," he said.

For example, during the gasoline crisis of the 1970s, people began "divesting themselves of gas-guzzling lead sleds" and attempted to collect insurance money by claiming that the cars had been stolen or vandalized, he said.

But he emphasized that corrupt

Continued on next page

Insurer Topics

Australian state cracks down on auto fraud

By MARK A. HOFMANN

SYDNEY, Australia—Even though Australia and the United States are a hemisphere apart, they share a good deal in common: a language, a democratic government, a taste for lager beer—and a serious auto insurance fraud problem.

Faced with an avalanche of fraudulent auto insurance claims and a dismal record of successful prosecutions of insurance fraud, the Government Insurance Office of New South Wales in Sydney in 1988 initiated an unprecedented fraud crackdown.

Since then, the GIO—the government-owned insurance facility that is the sole insurer of motor vehicles in Australia's most populous state—has saved about $30 million Australian ($23.4 million) that would otherwise be lost to fraud, said Charles Hodges, manager of the GIO's special claims unit.

The successful effort combined government commitment to reducing fraud, publicity and the creation of a series of warning flags to pinpoint fraud. As a result, the GIO—which had won five only insurance fraud cases before 1988—has had more than 370 court victories since the aggressive anti-fraud campaign began, he said.

The anti-fraud campaign has not run into any significant opposition, he noted. In fact, the only people who seem to be against it are those who profit from fraud, he quipped.

Mr. Hodges, a retired police superintendent, said the effort began with convincing the government of New South Wales that auto insurance fraud was a serious problem that required a serious answer.

Part of the answer was to assign three police investigators to the GIO to check out questionable claims, he said. Another part of the answer was more vigorous prosecution that viewed insurance fraud as a serious offense.

The GIO developed a series of possible markers that could indicate fraud. According to Mr. Hodges, these flags included accidents that occurred late at night on quiet streets, cars containing several people in which the driver was the only person uninjured and attempts by the injured to recover $100,000 Australian ($78,000), the maximum recovery permitted under New South Wales law.

Many of the fraud rings centered around specific immigrant communities, which Mr. Hodges declined to identify. The fact that questionable claims appeared to be concentrated among certain communities provided the investigators with more flags: the use of certain translators that seemed to pop up in repeated cases involving non-English-speaking immigrants; the use of certain medical providers in auto injury cases; and the fact the all of the victims—who claimed not to know each other—had come from the same village in another country.

The GIO has saved about $23.4 million that would otherwise be lost to fraud, says Mr. Hodges.

Mr. Hodges stressed that his unit does not pursue cases that have a likelihood of legitimacy—or that even contain a "shade of gray." The GIO has not been accused of impropriety, he said. But when a case of suspected fraud is fairly straightforward, the GIO pursues it vigorously.

Assembling a sound case is not easy, he noted. "It's very difficult to investigate an accident that never occurred in the first place."

"We aggressively went after claimants," explained Richard Gilley, the GIO's marketing and development manager. The GIO would obtain film of supposedly immobile accident victims running from television cameras and then publicize those cases in the media. "When a case was decided in our favor, we aggressively sought legal costs," he added.

While Messrs. Hodges and Gilley point out that the GIO has saved about $30 million Australian ($23.4 million) in direct fraud costs since it began its crackdown, the indirect savings may be much higher. The high visibility of the campaign probably has discouraged the filing of additional fraudulent claims, they say.

"We're trying to make everybody aware that it is the community that pays" for insurance fraud, Mr. Gilley said, adding that it is a message New South Wales motorists appear to be receiving loud and clear. By publicizing the GIO's success in tracking and prosecuting insurance fraud, "we let people who were lodging fraudulent claims know the consequences of their being caught." ■

Fraud prosecutions

Continued from previous page

professionals, organized fraud rings and repeat offenders operate regardless of economic conditions.

Mr. Harness stressed that no matter what the source of the fraud, insurers are serious about detecting and prosecuting it.

"What we've seen is a very, very aggressive effort to combat fraud," he said. The number of possible fraud cases referred to the ICPI by member insurers testifies to this emphasis, he said: Last year, the ICPI received nearly 10,000 referrals, an increase of about 30% from 1989.

"The industry does not want to be an easy touch," Mr. Harness said. Insurers have a responsibility to their policyholders to root out fraud, because that's who ultimately makes up the difference, he noted. To pass on fraud costs is "a no-win situation," he added, leading to further consumer discontent with the industry.

Vigorous prosecution of fraud is the key to curbing its incidence, he said. He cautioned, however, that "the real issue is not so much incarceration" as making the perpetrator answer for the crime. The possibility of losing a license to practice law or medicine may deter some corrupt professionals, he said. Long probations and court-ordered restitution also can have a deterrent effect, he said.

"We've got to take the money out of the crime," Mr. Harness said.

Looking back over his time with the ICPI, Mr. Harness observed that now there is "outstanding cooperation" between the private and public sectors in fighting insurance fraud. Mr. Harness himself came to the ICPI from the public sector, having been a special agent in criminal and counterintelligence investigations for the U.S. Air Force for more than a decade before joining the infant ICPI as an agent in charge of investigations in four Northwestern states—Oregon, Washington, Idaho and Montana.

"Before that, all I knew about insurance was that if I didn't pay my premiums, they'd take my insurance away," he said with a chuckle.

A successor for Mr. Harness, who retires on March 8, has not yet been chosen. ■

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rent hospital treatment review, length of stay determination, retrospective review.

Medical services reviewed: Psychiatric and substance abuse.

Staff: Five physicians, one registered nurse, one licensed practical nurse.

Clients: 23 total.

Covered lives: 17,001 employee benefit plan lives.

Admissions reviewed: 75.

Branch offices: Mare Island, Calif.

1990 gross revenues: $3 million total, $300,000 from UR services.

Charges: Per employee, 63 cents-$3.

Principal officers: John C. Brady II, president; James B. Wallace, vp/director-managed care; Richard D. Falls, vp-marketing.

Q

Quality Health Services Inc.

633 W. Germantown Pike, Plymouth Meeting, Pa. 19462; 215-941-9561; fax: 215-941-9772

Year founded: 1983.

UR services provided to employers: 28% of gross revenues.

UR services provided to others: 72% 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, surgical fee negotiation, DRG validation.

Occasional UR services: Retrospective review.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse.

Staff: 42 total; including one physician, 14 registered nurses, two medical records technicians. On retainer: 44 physicians, three nurses.

Clients: 35 total; 18 employer clients; 16% with fewer than 500 employees, 28% with 500-999 employees, 22% with 1,000-2,499 employees, 22% with 2,500-4,999 employees, 12% with more than 5,000 employees.

Covered lives: 300,000 employee benefit plan lives.

Admissions reviewed: 26,000.

Charges: Per employee, $1.65-$2.45; per hour, $75-$135.

Principal officers: Roger Hiser, chairman; Robert Scherzer, president/chief executive officer; Barbara Nammar, director-operations; Michael Stevens, controller; Stephen Cohen, vp-sales.

Quality Managed Care Inc.

11050 Roe Blvd., Suite 202, Overland Park, Kan. 66211; 800-888-6722; fax: 913-345-1784

Year founded: 1989.

Parent company: Network Health Services Inc.

UR services provided to employers: 10% 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.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 12 professionals, including eight registered nurses. On retainer: 18 physicians, four nurses.

Clients: 302 total; 295 employer clients; 93% with fewer than 500 employees, 3% with 500-999 employees, 2% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees.

Covered lives: 300,000 employee benefit plan lives; 10,100 workers compensation lives.

Admissions reviewed: 2,900.

Branch offices: Wichita, Kan.

Charges: Per employee, $1-$2.10; per case, $100-$125; for case management, $85-$95 per hour.

Principal officers: Timothy Sullivan, president; John R. Coleman, vp/chief operating officer.

The Queen's Health Care Plan Inc.

Two Waterfront Plaza, 500 Ala Moana Blvd., Suite 200, Honolulu, Hawaii 96813; 808-522-7500; fax: 808-522-7561

Year founded: 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, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 19 total; 11 professionals, including two physicians, nine registered nurses.

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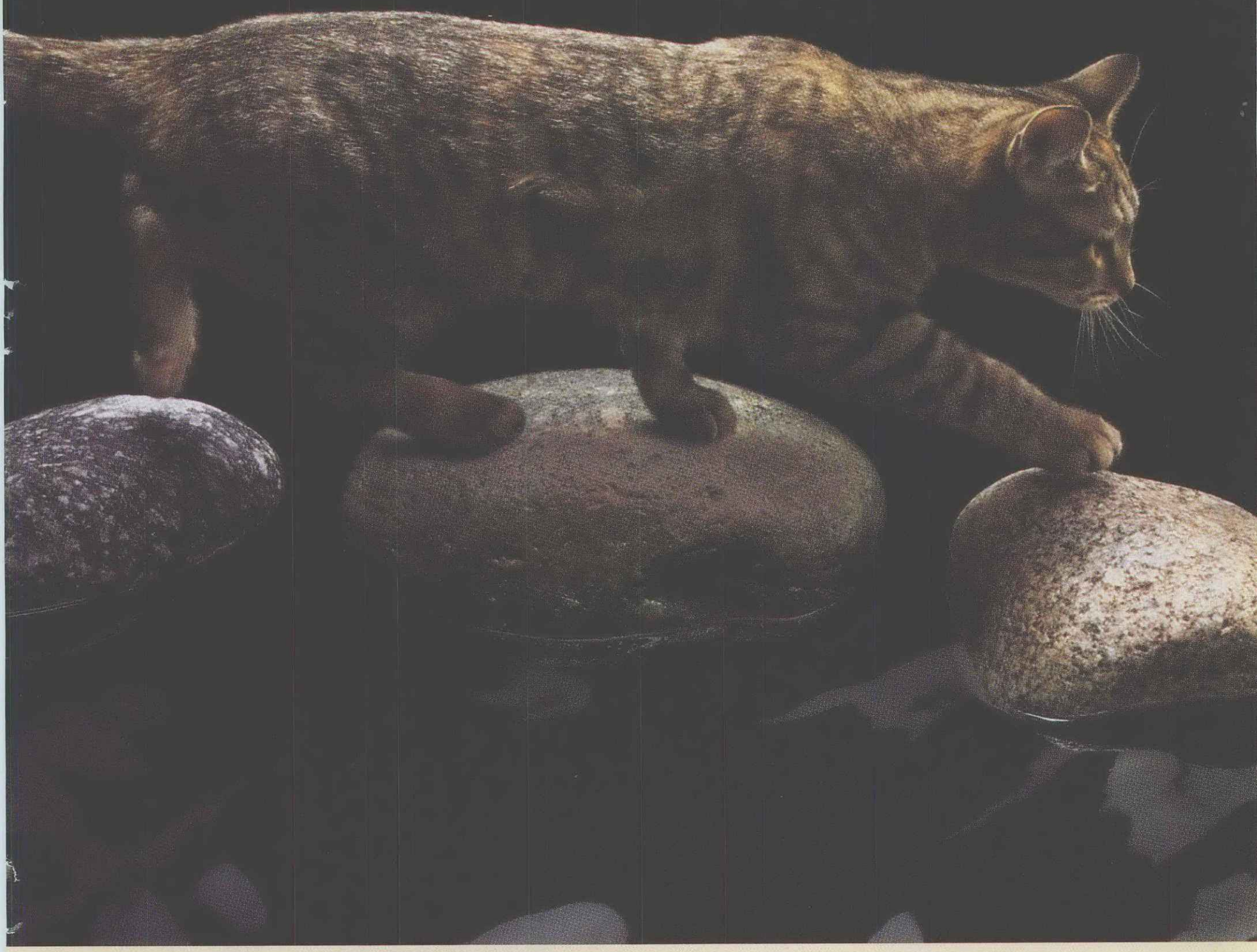

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ERIC GROUP, INC.

Solutions to Environmental Risk

Continued from page 74

Clients: 268 total; 260 employer clients; 96.54% with fewer than 500 employees, 0.77% with 500-999 employees, 0.77% with 1,000-2,499 employees, 0.77% with 2,500-4,999 employees, 1.15% with more than 5,000 employees.
Covered lives: 130,000 employee benefit plan lives.
Branch offices: Kauai, Hawaii.
1990 gross revenues: $4 million total.
Charges: Per employee, $1.40-$2.
Principal officers: James M. Kroft, acting chief executive officer; Rhoda Wan Dee, director.

R

RMSCO Management Services Inc.

651 W. Washington Blvd., Chicago, Ill. 60606; 312-707-9000; fax: 312-559-3559

Year founded: 1981; began providing utilization review services in 1982.
UR services provided to employers: 25% 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.
Staff: Four total; three professionals, including two registered nurses, one licensed practical nurse. On retainer: one physician.
Clients: 52 total, all employer clients; 50% with fewer than 500 employees, 30% with 500-999 employees, 20% with 1,000-2,499 employees.
Covered lives: 51,489 employee benefit plan lives.
1990 gross revenues: $1.5 million total.
Charges: Per employee.
Principal officers: Robert M. Schrayer, president; Karen Z. Vacko, executive vp; Max R. Schrayer III, senior vp.

Republic-RSB Cos. Inc.

1717 Park St., Naperville, Ill. 60566-7088; 708-420-6800; fax: 708-420-9178

Year founded: 1964; began providing utilization review services in 1983.
Parent company: HCX Acquisitions Inc.
UR services provided to employers: 7% of gross revenues.
UR services provided to others: 16% 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, independent medical exams.
Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 460 total; 210 professionals, including six physicians, 196 registered nurses, eight medical records technicians. On retainer: six physicians.
Clients: 5,000 total; 513 employer clients; 9% with fewer than 500 employees, 22% with 500-999 employees, 12% with 1,000-2,499 employees, 17% with 2,500-4,999 employees, 40% with more than 5,000 employees.
Covered lives: 5 million employee benefit plan lives.
Admissions reviewed: 48,836.
Branch offices: Atlanta; Houston; Los Angeles; San Francisco; Dallas; St. Louis; Boston; Sparta, N.J.
1990 gross revenues: $27 million total, $6 million from UR services.
Charges: Per employee, $1.60-$2.10; per case, $95-$125; per hour, $70-$90.
Principal officers: Thomas J. Garvey, president; Robert E. Gant, senior vp-audits division; John W. Dugan, senior vp-sales; Lou D'Andrilli, vp-account management; Sharon F. O'Shea, senior vp-managed care; Grae Baxter, vp-human resources; Donald E. Hernley, vp/chief financial officer; Virginia G. McDonald, vp-managed care services; Barbara B. Dickson, vp/counsel; Dr. Henry Feffer, director-medical research.

Rush Contract Care

33 E. Congress Parkway, Chicago, Ill. 60605; 312-347-0947; fax: 312-347-4500

Year founded: 1984.
Parent company: Rush Presbyterian St. Lukes Medical Center.
UR services provided to employers: 23% 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, outpatient service predetermination, case management.
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: Nine total; all professionals, including one physician, eight registered nurses.
Clients: 43 total.
Covered lives: 103,000 employee benefit plan lives.
Admissions reviewed: 6,600.
1990 gross revenues: $1.9 million total.
Charges: Per employee, $1.85-$2.10; per hour, $85-$150.
Principal officers: Truman Osmond, president/chief operating officer (Rush Health Plans); James Gilmartin, vp-product development (Rush Contract Care); Dr. Patricia McCreary, medical director.

S

Sanus Preferred Services

7601 Ora Glen Drive, Greenbelt, Md. 20770; 301-982-0098; fax: 301-441-3559

Year founded: 1987.
Parent company: Sanus Corp. Health Systems.
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 service predetermination, outpatient psychiatric and substance abuse services, case management.
Medical services reviewed: Group health, psychiatric and substance abuse.
Staff: 16 total; including 16 registered nurses.
Clients: Eight total, all employer clients; 80% with fewer than 500 employees, 20% with 500-999 employees.
Admissions reviewed: 375.
1990 gross revenues: $50,000 total.
Charges: Per employee, per case.
Principal officers: Joseph T. Lynaugh, president; Jeff D. Emerson, vp.

Second Opinion Consultants Inc.

P.O. Box 621, Millwood, N.J. 10546; 800-446-4606/ 914-747-2187; fax: 914-747-2137

Year founded: 1983; began providing utilization review services in 1984.
UR services provided to employers: 20% of gross revenues.
UR services provided to others: 80% of gross revenues.
Frequent UR services: Second surgical opinion, chiropractic review, diagnostic review.
Occasional UR services: Preadmission certification, length of stay determination, retrospective review, hospital bill audit.
Medical services reviewed: Group health, chiropractic, workers compensation/disability, diagnostic testing.
Staff: 15 total; 12 professionals, including two registered nurses, four licensed practical nurses, six medical records technicians. On retainer: one physician.
Clients: 3,000 total; 15 employer clients; 10% with 1,000-2,499 employees, 40% with 2,500-4,999 employees, 50% with more than 5,000 employees.
Covered lives: 15,000 employee benefit plan lives.
Charges: Per case, $155-$170.
Principal officers: Dr. Madelon Lubin Finkel, president/chief executive officer; David J. Finkel, treasurer; Dr. Norman Mazza, medical director.

The Sunderbruch Corp.

3737 Woodland Ave., West Des Moines, Iowa 50265; 515-224-6426; fax: 515-224-1002

Year founded: 1971; began providing utilization review services in 1975.
UR services provided to employers: 70% of gross revenues.
UR services provided to others: 30% 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: Home health care review, hospice care review, skilled nursing facility review, high-risk pregnancy, ambulatory case management.
Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.
Staff: 317 total; 172 professionals, including three physicians, 147 registered nurses, 12 licensed practical nurses, 11 medical records technicians.
Clients: 201 total; 175 employer clients; 68% with fewer than 500 employees, 15% with 500-999 employees, 8% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 4% with more than 5,000 employees.
Covered lives: 3.1 million employee benefit plan lives; 950 workers compensation lives.
Admissions reviewed: 250,080.
Branch offices: St. Louis; Chicago and Peoria, Ill.; Lincoln, Neb.
1990 gross revenues: $17 million total.
Charges: Per employee, $1.30-$1.70; per case.
Principal officers: Rick McMaster, chief executive officer; Rebecca Hemann, vp; Pamela DePriest, director-marketing.

T

TAO Inc.

1901 Market St., 32nd Floor, Philadelphia, Pa. 19103; 800-344-1255; fax: 215-241-4766

Year founded: 1985.
Parent company: Independence Blue Cross.
UR services provided to employers: 6% of gross revenues.
UR services provided to others: 92% 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: 42 total; 19 professionals, including three physicians, 15 registered nurses, one medical records technician. On retainer: one physician.
Clients: Seven total; one employer clients; 100% with more than 5,000 employees.
Covered lives: 2.3 million employee benefit plan lives.
Admissions reviewed: 10,500.
1990 gross revenues: $3.7 million total, $3.6 million from UR services.
Charges: Per employee, per case.
Principal officers: Dr. Anthony Panzetta, president/chief executive officer; Barry Davis, vp/chief operating officer; Donna E. DeHart, vp-sales/marketing.

U

Ullicare

111 Massachusetts Ave. N.W., Washington D.C. 20001; 800-848-9200

Year founded: 1984; began providing utilization review services in 1985.
Parent company: Ullico 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, case management, claim analysis review.
Occasional UR services: Outpatient service predetermination, outpatient psychiatric and substance abuse services.
Medical services reviewed: Group health, psychiatric and substance abuse.
Staff: 18 total, all professionals, including one physician, 14 registered nurses, three licensed practical nurses. On retainer: five physicians.
Clients: 90 total, all employer clients; 63% with fewer than 500 employees, 13% with 500-999 employees, 14% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 3%

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Continued from previous page
with more than 5,000 employees.

Covered lives: 90,000 employee benefit plan lives.

Admissions reviewed: 10,500.

1990 gross revenues: $1 million total, all from UR services.

Charges: Per employee, $1.50/month; per hour, $75.

Principal officers: Bob Georgine, chairman/chief executive officer; Jim Hibbitts, vp-group; Bart Bracken, asst. vp-managed care; Jim Luce, executive vp/chief operating officer.

UniPsych Systems Inc.

7951 S.W. 6th St., Suite 100, North Miami Beach, Fla. 33162; 305-474-8727; fax: 305-474-1351

Year founded: 1986.

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 psych 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: 16 total; five professionals, including two physicians, three medical records technicians. On retainer: 18 physicians, 21 psychologists.

Clients: 14 total; six employer clients; 10% with fewer than 500 employees, 30% with 500-999 employees, 30% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 10% with more than 5,000 employees.

Covered lives: 100,000 employee benefit plan lives.

Admissions reviewed: 226.

Branch offices: Throughout Florida.

Charges: Per employee.

Principal officers: Dr. Leo Bradman, chairman; Ronald C. Harshman, president/chief executive officer.

United Behavioral Systems Inc.

3600 W. 80th St., Suite 210, Minneapolis, Minn. 55431; 800-433-0519; fax: 612-830-3122

Year founded: 1985.

Parent company: United HealthCare Corp.

UR services provided to employers: 10% 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, client management information system reporting, benefits consultation, referral to network providers.

Occasional UR services: Retrospective review, hospital bill audit.

Medical services reviewed: Psychiatric and substance abuse.

Staff: 17 total; all professionals, including five physicians, nine registered nurses, two medical records technicians. On retainer: six physicians.

Clients: 31 total; nine employer clients.

Covered lives: 1.7 million employee benefit plan lives.

Admissions reviewed: 3,500.

Charges: Per employee, per case, per hour.

Principal officers: Jack Newstrom, president/chief executive officer; Deborah Trout, director-utilization review/network programs.

Utilization Management Program

200 ATC, 1575 Northside Dr., Suite 250; Atlanta, Ga. 30318-4208; 404-350-4301; fax: extension 185

Year founded: 1985.

Parent company: Atlanta HealthCare Alliance.

UR services provided to employers: 66% of gross revenues.

UR services provided to others: 34% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, case management.

Occasional UR services: Retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 13 total; 11 professionals, including one physician, 10 registered nurses. On retainer: two physicians.

Clients: 17 total; 35% with fewer than 500 employees, 12% with 500-999 employees, 12% with 1,000-2,499 employees, 29% with 2,500-4,999 employees, 12% with more than 5,000 employees.

Covered lives: 125,000 employee benefit plan lives.

Admissions reviewed: 15,000.

1990 gross revenues: $891,675 total, $627,829 from UR services.

Charges: Per employee, 95 cents-$1.25; per case, $120-$175; per hour, $35-$75.

Principal officers: S. Walker McCune, executive vp; Jody Hunter, vp; Karen B. Rothschild, program manager.

Utilization Management Systems Inc.

224 S. 108th Ave., Suite 8, Omaha, Neb. 68154; 402-330-6112; fax: 402-330-5004

Year founded: 1984.

UR services provided to employers: 2% of gross revenues.

UR services provided to others: 50% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, discharge planning, retrospective review, hospital bill audit, case management, inpatient/outpatient procedure preauthorization, physician ambulatory care audit, employee education seminars, benefit plan and cost containment consulting.

Occasional UR services: Second surgical opinion.

Medical services reviewed: Group health, psychiatric and substance abuse, individual health services, physician outpatient services.

Staff: 19 total; eight professionals, including two physicians, six registered nurses. On retainer: 16 physicians.

Clients: 18 total; one employer client; 100% with 500-999 employees.

Covered lives: 95,000 employee benefit plan lives.

Admissions reviewed: 3,934.

1990 gross revenues: $1 million total, $512,266 from UR services.

Charges: Per employee, 90 cents-$1.65; physician ambulatory care audit, 5 cents per record.

Principal officers: Dr. John R. Kirchner, chairman of the board/medical director; Ron Chaffin, president/chief operating officer; Harvey Ford, chief executive officer; Alan Parsow, corporate treasurer; Cynthia Collins, corporate secretary.

V

Value Health Sciences Inc.

1448 15th St., Suite 202, Santa Monica, Calif. 90404; 213-394-2212; fax: 213-451-8511

Year founded: 1988; began providing utilization review services in 1989.

Parent company: Value Health Inc.

UR services provided to others: 87% of gross revenues.

Frequent UR services: Preadmission certification, retrospective review.

Medical services reviewed: Group health.

Staff: 42 total; eight professionals, including six physicians, one registered nurse, one medical records technician. On retainer: 21 physicians.

Clients: 30 total; 100% with more than 5,000 employees.

Covered lives: 7.5 million employee benefit plan lives.

Admissions reviewed: 193,590.

Charges: Per employee, 25 cents/month.

Principal officers: Leslie D. Michelson, president; Jacqueline Kosecoff, executive vp; Dr. Mark R. Chassin, senior vp; Dr. Robert Dubois, vp; Robert E. Patricelli, president (Value Health Inc.)

Valutrac

12655 S.W. Center, Suite 180, Beaverton, Ore. 97005; 800-843-9616/503-641-5352; fax: 503-643-9943

Year founded: 1986.

Parent company: Ethix Corp.

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 service predetermination, outpatient psychiatric and substance abuse services, case management, special delivery maternity management hospital fee negotiation, specialty options program case pricing; PPO.

Medical services reviewed: Group health, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 260 total; 103 professionals, including 12 physicians, 90 registered nurses, one medical records technician. On retainer: 120 physicians.

Clients: 4,276 total; 4,164 employer clients; 60% with fewer than 500 employees, 20% with 500-999 employees, 10% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees.

Covered lives: 1 million employee benefit plan lives.

Branch offices: Charlotte, N.C.; Dallas; Detroit, Grand Rapids, Mich.; Indianapolis; Linwood, N.J.; Minneapolis; Philadelphia; Portland, Ore., Salt Lake City; San Antonio; Seattle.

1990 gross revenues: $5.5 million total, all from UR services.

Charges: Per employee, $1-$2; per case, $100-$350; per hour, $85-$150.

Principal officers: Stephen Gregg, chief executive officer; Peter Linder, president (Ethix Corp.); Joan E. Copeland, president (ValuTrac).

W

Western Medical Review

23840 Hawthorne Blvd., Torrance, Calif. 90505; 213-378-2248; fax: 213-378-1739

Year founded: 1977.

Parent company: San Diego Health Care Alliance.

UR services provided to employers: 100% of gross revenues.

Frequent UR services: Preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, outpatient service predetermination, case management.

Occasional UR services: Discharge planning, hospital bill audit, outpatient psychiatric and substance abuse services.

Medical services reviewed: Group health, dental, chiropractic, psychiatric and substance abuse, workers compensation/disability.

Staff: 55 total; 45 professionals, including one physician, 35 registered nurses, four licensed practical nurses, five medical records technicians. On retainer: 50 physicians, two nurses.

Clients: 500 total; all employer clients.

Covered lives: 350,000 employee benefit plan lives; 2 million workers compensation lives.

Admissions reviewed: 54,243.

Branch offices: San Diego.

1990 gross revenues: $3 million.

Charges: Per employee, $1.15-$2.50.

Principal officers: Victoria Nishioka, operations manager.

Workers Compensation/ Casualty Services

5601 Smetana Drive, P.O. Box 1587, Minneapolis, Minn. 55440; 612-936-5907; fax: 612-936-5991

Year founded: 1985.

Parent company: United HealthCare 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, medical back care review, cumulative trauma disorder review, chiropractic service review, MRI and CT scan review.

Medical services reviewed: Workers compensation/disability.

Staff: 21 total; eight professionals that are registered nurses. On retainer: two physicians.

Clients: 20 total; 11 employer clients; 10% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 70% with more than 5,000 employees.

Covered lives: 1.2 million workers compensation lives.

Branch offices: Pasadena, Calif.

Principal officers: Steve Spruth, president; Glenda Garrard, vp; Mike Larson, director-sales/marketing. ■

Firms drop HMOs to increase bargaining power

By MICHAEL SCHACHNER

Ever searching for ways to chop away at rising health care costs, employers increasingly are giving many of their HMOs the ax.

Many employers are reducing the number of health maintenance organizations they offer to workers to create better bargaining leverage with remaining HMOs.

Cutting back on HMO contracts also simplifies administration and trims costs, say employee benefit managers and HMO executives.

In addition, one major employer implemented a self-insured managed care plan and eliminated 10 of the 12 HMOs it had offered to prevent adverse selection in the new plan.

But employers also have other reasons to cut back.

And, experts stress that employers must consider a variety of factors—including many that are more important than premiums—in considering reducing the number of HMO choices they offer.

In its soon-to-be-released "1990 HMO Industry Study," the Group Health Assn. of America, an industry trade group based in Washington, D.C., reports that 67% of 330 responding HMOs are feeling heavy or moderate pressure from employers that want to reduce the number of HMOs they offer.

"Employers are certainly looking at the number of HMOs they offer," agreed Rik Lindahl, director of quality client services for consultant KPMG Peat Marwick in Dallas.

The move by employers to cancel contracts with many of the HMOs they have worked with for several years signals the end of what one benefit consultant called a "social movement" and a "purchasing oversight."

"HMOs in the early 1980s through about 1985 grew onto benefit programs without employers scrutinizing them and seeing what they had to offer," said Gino Nalli, a consultant in the Washington, D.C., office of The Wyatt Co.

"Consolidation is a definite trend where good HMOs will survive and prosper, while weak players will get pruned," he said.

However, industry experts are quick to point out that HMO enrollment nationwide increased an estimated 10% in 1990.

The GHAA says a random survey of 44 HMOs with 11.8 million enrollees found that enrollment increased 6.8% in 1990, up from a 6.4% rise in 1989.

In addition, market penetration by HMOs is significantly higher than statewide studies indicate, with HMO market penetration in the nation's 27 largest metropolitan areas ranging from 46% of the population in San Francisco to 10% in the Pittsburgh metropolitan area, according to another GHAA study (*BI*, Jan. 21).

The high number of HMO contracts offered by many employers can be traced in part to the Health Maintenance Organization Act of 1973, which required employers with 25 or more employees in a given area to maintain at least one contract each in that area with two types of federally qualified HMOs: a group-staffed HMO and an independent practice association HMO.

However, that requirement will be eliminated in 1995 under the 1988 amendments to the act (*BI*, Aug. 22, 1988).

The HMO Act, though, is not the major reason that some employers have contracted with a large number of HMOs, according to benefit consultants.

Wyatt's Mr. Nalli said the HMO Act is only responsible for a small percentage of the total number of HMOs offered by employers. He said that once employers complied with the mandate, they had free reign to contract with as many or as few additional HMOs as they desired.

Observers insist that the large number of HMOs offered by many employers is mostly the result of employers trying to offer employees as many health care coverage options a possible.

Employers, though, now are trying to better manage limited health care resources by offering only cost-effective HMOs, experts say.

By reducing the number of HMOs they offer, employers can gain some leverage in negotiating premiums by increasing enrollment in remaining HMOs, which in turn leads to better pricing with those HMOs, health care experts say.

"Employers are going with the vendors that offer them the best deal," said Erling Hansen, general counsel with the GHAA.

"Consolidation allows employers to strike better deals with surviving HMOs," said Tom Billet, a principal with New York-based employee benefits consultant A. Foster Higgins & Co.

"Employers are trying to get the best handle possible on managing the health care delivery system," said Chip Sharkey, senior vp-employee benefits with CIGNA Corp. in Hartford, Conn.

"Control is hampered by fragmentation, and bargaining leverage is diluted when operations are spread out," Mr. Sharkey said.

"Companies these days are looking for no more than two or three HMOs in any given area, and they often want a national vendor or two. With this type of arrangement they can often get away from more expensive community rates and push for experience rating," he explained.

"Because HMOs have traditionally attracted a better-than-average risk, employers can demand experience-based rating and service accountability from the remaining HMOs," said Michael Thompson, vp-marketing of the group national account operations of Prudential Insurance Co. of America of Roseland, N.J.

For example, American Telephone & Telegraph Co. Inc. of New York is reducing the number of HMOs with which it contracts to establish a national network that will facilitate better pricing, explained Kitty Holness, district manager in charge of benefits planning and analysis.

Ms. Holness admitted that AT&T, which signed contracts with about 300 different HMOs throughout the 1980s, was too acquiescent in designing the HMO portion of its health care program.

"We were too passive. We viewed HMOs as an alternative care system and thought we should offer as many as possible," Ms. Holness said, referring to how AT&T got to the point of offering 300 different HMOs, some of which had only a couple of enrollees.

But last year AT&T dropped about 40 HMOs across the country after conducting regional examinations that uncovered low enrollment, high premiums and too much competition within certain areas.

The communications giant plans on cutting loose many more HMOs over the next couple of years, Ms. Holness said.

"Our goal now is to develop a better nationwide partnership that ensures the best premiums. The best way to do that is to have a large number of people enrolled in one HMO. Lives ensure leverage for negotiations. You don't have much leverage when only two or three employees are enrolled in an HMO," she said.

On a smaller scale, the Potomac Electric & Power Co. of Washington, D.C., has trimmed to four from seven the number of HMOs it offers its workforce of more than 5,000, said Bill Wolverton, manager-industrial relations.

PEPCO discontinued the three HMO contracts to improve its negotiating status with remaining HMOs, Mr. Wolverton said. "With fewer HMOs, we can negotiate better. When you have a concentrated workforce to offer, you can get away from community rating and develop a tailored plan based on experience."

Two of PEPCO's HMOs are open-ended products that allow employees willing to pay deductibles and co-payments to go outside the network for care (*BI*, Jan. 8, 1990), while the other two are traditional HMOs.

Reducing HMO offerings also leads to simplified administration, experts said.

"Employers want to improve efficiency and manage health care costs in a given location. That is why they're consolidating HMO offerings," said Tim Borchert, a consultant with Hewitt Associates of Lincolnshire, Ill.

"Many companies are realizing that for some time now they have offered five or six HMOs in one area. Now, they're evaluating that redundancy and finding out that administration costs may be too high and enrollment in certain HMOs is too low to justify keeping them," Mr. Borchert said.

"Cutting down leads to improved management of transaction and administrative costs, which translates into a savings of time and hard dollars," Peat Marwick's Mr. Lindahl said.

Typical administration costs range from 7% to 10% of the total cost of an HMO contract, he said.

By consolidating, employers can "trim a percentage point here and a percentage point there on administrative costs. For large employers with a lot of HMO contracts, this adds up," he said.

"If employers can set up a national or single account system, they can pay one bill rather than 10 or 20; they can interact with one account representative; and they can likely negotiate a better price," Foster Hig-

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gins' Mr. Billet summed up.

Other employers are hoping to contain their health care costs in other ways besides negotiating lower premiums with HMOs after cutting back on the number of choices they offer workers.

For example, San Francisco-based Wells Fargo Bank N.A. this year dropped 10 of its 12 existing HMO contracts in an effort to encourage employees to opt for its new self-insured managed care plan, which replaced the bank's self-insured indemnity plan (*BI*, April 16, 1990).

Wells Fargo reduced the number of HMOs it was offering to eliminate the adverse selection process that it feared would carry over from its defunct indemnity plan to its new managed care plan, according to Martha Clark, vp and manager of employee benefits and compensation.

"Before, almost all of our healthy, younger employees that used a relatively low amount of health care services were in HMOs, but the company's costs were still very high. Why pay $2,200 to an HMO for a person that utilizes just a couple hundred dollars of health care services over the course of a year? Those are the people we want in our self-insured plan," she said.

The bank still offers most of its 15,000 workers in California access to Oakland-based Kaiser Permanente Medical Care Program, and about 1,000 employees living in areas not serviced by Kaiser have access to The Health Plan of America, which is based in Orange, according to Ms. Clark.

To Wells Fargo's surprise, about 65% of its employees who had been enrolled in discontinued HMOs chose to enroll in the managed care plan, Ms. Clark said. The bank had hoped that about 50% would opt for the new plan with the other half remaining in the two remaining HMOs.

And, other employers are finding other reasons to reduce the number of HMOs they offer.

General Motors Corp. has canceled contracts with five HMOs that no longer were cost-effective and would have required additional employee contributions to have been maintained, according to Beach Hall, GM's director of health care plans (*BI*, Oct. 29, 1990).

Detroit-based GM over the past few years has reduced the number of HMOs it offers to 112 from more than 130, according to Mr. Hall.

GM a few years ago reduced HMO offerings in several regions where it had contracts with different HMOs, Mr. Hall noted.

"In those areas we let enrollment do the talking and eliminated some HMOs where enrollment wasn't satisfactory. It saved some administrative costs, but for a company of our size that was hardly a bulk cost. What's one gray hair?" he said.

But, GM has added two new HMOs.

"Sure, we're looking to eliminate HMOs that become so cost-ineffective that it makes no sense to offer them, but we're not actively dropping HMOs as part of any corporate policy," Mr. Hall said.

"If HMOs are convenient and cost-effective, we'll keep them and we're even looking for additional HMOs in areas where we have people but no current HMO arrangements," he said.

Employers that are considering scaling down their HMO offerings must look at an array of factors, but the order of importance of these factors may vary among employers, benefits consultants say.

For example, Foster Higgins' Mr. Billet said that while cost-containment is the ultimate goal, price itself does not have to be an employer's first consideration.

"I think employers should first find out which HMOs have the ability to serve multiple areas. The logic is that if an employer can offer one HMO in five places, it's a better arrangement than contracting with many different HMOs," because of administrative costs and leverage, Mr. Billet said.

He said service then should be analyzed, with an emphasis placed on utilization control effectiveness, case management capabilities and the quality of physicians and specialists with whom the HMO contracts.

Only then should price be considered, he said.

Mr. Lindahl of Peat Marwick recommended that employers base decisions mostly on the quality of care offered through the HMO, though he warned that quality may be hard to assess because most quality models are based on patient outcome results and not on the quality of care during an illness.

"But, price is still a major issue," Mr. Lindahl said. "Maybe it shouldn't be, but it's clearly a matter."

He suggested that employers look at an HMO's pricing track record and attempt to determine future premium hikes.

"Premium performance is one factor all HMOs should be judged on," said Marshall V. Rozzi, an executive vp with Blue Bell, Pa.-based U.S. Healthcare Inc., an HMO with operations in six northeastern states.

"Many HMOs have incurred losses in order to keep pricing down. Eventually, that will have to change. A good benefits manager can foresee cases like this, and it may be beneficial to drop that HMO now before it raises its rates."

Employers also should not overlook how popular an HMO is among employees when considering a reduction in HMO offerings, urged Wyatt's Mr. Nalli.

"Popularity is big. You ought not to kill a plan with high employee enrollment. After looking at enrollment, you can examine price, reputation and the HMO's (overall) track record," he said.

For example, Ms. Clark of Wells Fargo said the bank experienced some employee backlash when it announced that all but two HMOs were being eliminated and that employees had only one HMO option.

"The reaction was very negative at first. There's definitely some pain and agony involved with establishing a new employee/doctor relationship," she said.

As employers have embarked on a campaign to diminish the number of HMOs they offer, HMOs are finding that they no longer can expect to retain business without adding value to the contract.

HMOs wishing to survive have been forced to improve the quality of care they provide, agree in some cases to offer experience rating instead of community rating, and develop national account abilities for multistate employers, experts say.

For HMOs, the trend among employers to reduce the number of HMO they will offer workers means that the contracts of HMOs with a large market share, pricing flexibility and financial stability will be renewed, and those HMOs even may thrive, according to HMO executives.

Weaker regional HMOs either will be acquired by larger HMOs or go out of business, HMO officials say.

"HMOs with existing market share and solid management information service capabilities will benefit, while smaller HMOs without these strengths could fall by the wayside," said Prudential's Mr. Thompson.

"To compete, HMOs must first and foremost provide quality medical care management," said Mark Hanrahan, director of sales and marketing for Aetna Health Plans in Dallas, the managed care unit of Hartford, Conn.-based Aetna Life & Casualty Co.

U.S. Healthcare's Mr. Rozzi summed up what employers and HMOs are coming to grips with: "Not all HMOs are created equal. That's true of everything. If an HMO has a poor premium history and poor market penetration, it isn't likely to be retained. Conversely, if we as HMOs have done our jobs, we'll be there." ■

Doctors study health quality, not cost control

By SARA J. HARTY

Physicians and medical students need to learn more about managed care and other health care cost containment techniques, employee benefit experts say.

However, practicing physicians and medical students aren't necessarily interested in utilization review and other cost control tools, preferring to concentrate on quality management.

That may soon change. Some suggest that physicians will grow more amenable to cost control as the health care environment changes.

In the past, the "short supply items were physicians and hospital beds. Now they are patients and dollars," said Bob Coburn, a managing consultant with A. Foster Higgins & Co. Inc. in Washington, D.C.

The need for physicians to learn more about cost containment is "overwhelming and has been for at least the last 25 years," argues James B. Couch, vp-quality management for Travelers Corp. in Hartford, Conn.

"There is no question that physicians need to get involved in managing health care costs," said Roger S. Taylor, national leader of The Wyatt Co.'s health care consulting practice in Washington, D.C.

Physicians are becoming more aware of cost problems, but there is "not an active effort on (their) part to find out about" cost containment, said Michael J. Martin, a principal with William M. Mercer Inc. in San Francisco.

Dr. Martin said that one basic problem with the U.S. health care system is that the "incentives are backwards." Physicians "don't have a vested interest" in controlling costs, he said.

National medical organizations do offer seminars on cost containment and utilization review. But most physicians don't want to take time out of their schedules to attend unless they are interested in moving into administration themselves, said Robert J. Ailes, senior vp/chief medical officer at Intracorp, a UR firm in Berwyn, Pa.

Medical professionals say cost containment is less important than improving care. Better quality, they say, will naturally moderate costs.

One indication of the new focus on quality is the decision by the Venice, Fla.-based American College of Utilization Review Physicians, an organization established in 1973 to promote UR education, to change its name to the American College of Medical Quality (*BI*, Feb. 19, 1989).

"Cost containment and quality assurance have to go hand-in-hand," said Martin D. Keller, professor of preventive and internal medicine at Ohio State University in Columbus.

While cost containment is not an acknowledged medical specialty, quality assurance is and "has imbedded in it certain aspects of cost containment," Dr. Keller said.

Cost containment and UR "are very important from a payer's perspective, but from a provider's perspective and, I suspect, a patient's perspective," quality is more important, said Peter Goldschmidt, president of the World Development Group, a health care consulting firm in Bethesda, Md.

Providers aren't the only ones stressing quality. Federal Express Corp. has a contract with a private hospital in Memphis, Tenn., that places equal weight on cost and quality.

"You don't necessarily want people to go to the lowest-cost provider," said Steve Priddy, vp of personnel administration at Federal Express.

As national medical organizations address quality and cost issues, they are emphasizing the development of practice parameters.

These parameters help physicians determine what course of care is the best to follow given specific circumstances, which increases efficiency and, according to providers, controls costs.

An "enormous amount of information" published in the AMA journal helps guide clinical practice, said John T. Kelly, director of quality assurance at the AMA.

"There is a concerted effort to provide advice and the mechanisms to improve clinical decision making," said Dr. Kelly.

And a task force at the American Academy of Family Physicians has developed parameters for specific conditions, said John A. Swanson, director of health care services with the Kansas City, Mo., organization.

The AAFP also sponsors courses that teach members how to develop practice parameters. And, the academy sponsors an annual administrative interchange for family physicians in managed health care and national meetings for all members that include sessions in clinical policies and quality management.

Though they still stress quality, some doctors are being forced to become more directly interested in controlling costs, say some UR firms.

"If physicians want to be a part of the marketplace and maintain their volume (of business) they must get involved" in cost containment, said Dr. Ailes.

Doctors know that "if they aren't interested in cost-effective care," employers, patients and review companies will be, said Gary T. McIlroy, chief executive officer at Health Risk Management Inc., a UR firm in Minneapolis.

"Physicians at all levels are keenly aware of the extent to which medical practice is subject to scrutiny," agreed the AMA's Dr. Kelly.

Federal Express' Mr. Priddy noted that all groups involved in the health care system—physicians, hospitals, employers and labor groups—must jointly discuss rising health care costs.

"No one group in isolation can solve this problem," said Mr. Priddy.

Federal Express recently participated in the Tennessee Healthcare Exchange Group, a consortium bringing physicians, employers, labor groups and hospitals together in different parts of the state to discuss cost, quality and other health care issues.

The group came up with priorities including:

- The lack of measurable and visible quality standards.
- The high amount of unreimbursed cost shifting.
- The lack of a consolidated national health care reform plan.
- A litigious system that is driving up malpractice costs. ■

Include UR in medical studies: Experts

By SARA J. HARTY

Should medical students be given a larger dose of health care cost containment philosophy and methodology?

"With few exceptions, the medical schools in this country are 20 years behind in preparing students for the realities of practicing" medicine, said James B. Couch, vp-quality management for Travelers Corp. in Hartford, Conn.

"I'd like to see first-year medical students learning about the financial impact of their decision making," Dr. Couch said.

One idea is incorporating topics like utilization review into the general medical school and residency curriculum in a way that it could eventually lead to a specialty, said Gary T. McIlroy, chief executive officer of Health Risk Management Inc. in Minneapolis.

At the American College of Medical Quality, a group of doctors is working toward that as a goal, he said.

Some educators say that medical schools try not to leave students in the dark about costs.

"The effort is first of all to make medical students aware of what the costs of things are, so that they recognize there is an economic cost," said Martin D. Keller, professor of preventive and internal medicine at Ohio State University in Columbus.

Medical schools, however, should always stress quality over cost, he said.

For example, students are taught "what will the alternative be if you don't run a test? It may be more costly in the long run," Mr. Keller explained.

In some way, quality assurance and cost containment have been injected into nearly all schools, he said.

However, they are "a product of the '80s" and are not yet very well developed in medical school curriculums, he said.

Only a few medical schools offer relevant courses.

Since 1981, medical students at Pennsylvania State University in Hershey, have been required to take a course in quality and accountability, said Joseph J. Trautlein, co-director of the school's Physicians Fellowship Program (see related story).

Medical students' training should include quality and cost issues, says Mr. Ziegenfuss.

But at Northwestern University in Chicago, little of the medical school curriculum touches explicitly upon utilization review and quality assurance, said Eve Veis, curriculum coordinator.

A class for second-year students, "Community Medicine," does include a segment on health insurance and medical quality, according to Ms. Veis.

Dr. Couch teaches a class on cost-effective clinical decision making to resident physicians at the University of Connecticut Health Center.

Computers are used to break "complex decisions into components so that the students can see the clinical as well as financial" aspects, he said.

He has taught the class to fourth-year medical students and to residents at three other institutions, but said that when he left those schools, the class was discontinued.

The medical school curriculum is not coming along too quickly, agreed James T. Ziegenfuss, associate professor of management and health care systems at Penn State and co-director of the fellowship program.

In their primary training, students should be introduced to quality and cost issues, said Mr. Ziegenfuss.

But in-depth training is more appropriate once a doctor "has substantial clinical experience to build on to understand the complexities of patient care and organizational structure," he said.

He said doctors and students must examine the entire health care delivery system—including information systems and providers' financial resources—when investigating quality and cost issues, rather than examining only individual physician behavior.

"This is very different from saying there's a quality assurance or utilization review problem, let's find the nurse or doctor causing the problem" and remove them, he explained.

Utilization review may be working its way into residency programs as well.

Because utilization review is "something that is going to be part of medicine for the foreseeable future, there are attempts to include it in the training of residents," said Robert Vanecko, associate dean for graduate medical education at Northwestern.

Dr. Vanecko mentioned seminars and conferences that relate to utilization review, as well as an effort by hospitals to include residents and young physicians on hospital committees that handle utilization review and quality assurance. ■

Programs help doctors learn more about UR

Two programs give doctors an opportunity to learn about quality assurance and utilization review so that they can incorporate them in their practices or in their role as hospital administrators.

Parkside Health Management Corp., a UR vendor in Park Ridge, Ill., is offering a new program that gives physicians an opportunity to learn about UR and other cost containment techniques while still maintaining their own practice.

The program is geared toward general internists or family practitioners in their first two to five years of practice, said Walter A. Hollinger, vp-medical affairs and chief medical officer at Parkside.

The Parkside program is rare in that it is sponsored by a business rather than a health care provider, said Dr. Hollinger. The program offers "a perspective, a look at the way health care dollars are expended," he explained. The physicians involved in the program will ask "questions they've never asked before. They do take it back to their practices," he said.

Program participants work through a set of rotations, are assigned readings that relate clinical practice to utilization review and write a research paper addressing a specific topic.

Work related to the program takes four to eight hours per week.

Parkside is currently sponsoring one fellow. Dr. Hollinger said expansion will probably be limited to two or possibly three fellows per year.

Three physicians have completed another UR and quality assurance fellowship program at the Pennsylvania State University Medical College in Hershey.

Participants in the program gain a sense of the theories and concepts involved in quality improvement and quality assurance. They learn about the different kinds of resources—computers and information systems—that support quality management, and they learn to apply concepts of efficiency, said James T. Ziegenfuss, co-director of the Fellowship Program in Quality Assurance and Utilization Review.

"Upon completion of the program, the fellows will be proficient enough in business areas to speak the language and operate in a corporation or hospital where everyone else has (business) degrees," said Joseph J. Trautlein, co-director of the program.

This program was originally funded by the American Board of Quality Assurance & Utilization Review Physicians, an organization that certifies physicians in quality assurance and utilization review. It is currently sponsored by Penn State, University Hospital and the Veteran's Administration.

This program is for physicians who are "evolving into administrators," explained Dr. Trautlein. "Nothing in the standard medical curriculum prepares" physicians for more administrative functions, he said.

Unlike the Parkside program, fellows at Penn State participate in the program full-time and do not maintain a private practice. Dr. Trautlein explained that the program combines "didactic teaching and. . .on-the-job training." Participants work with various hospital administrators during the day and take classes at night. The program takes a minimum of one year to complete.

—By Sara J. Harty

Insurer seeks Superfund reforms

By COLLEEN JOHNSON

CHICAGO—Business and insurers must press Congress for a more equitable method of paying for hazardous waste cleanups, or many companies and insurers may face severe financial hardship, an insurer executive says.

"Congress and other public policy decision-makers must examine the cost of addressing our environmental problems and make the cost-benefit analysis tests for environmental issues that have been sorely lacking for more than a decade," said Peter A. Lefkin, vp of government and industry affairs for Fireman's Fund Insurance Cos. of Novato, Calif.

Mr. Lefkin and other speakers at the 1991 Harold H. Hines Jr. Memorial Symposium in Chicago criticized the effectiveness of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, better known as Superfund.

Mr. Lefkin was one of three speakers who discussed environmental issues faced by employers in the 1990s at the Feb. 7 symposium presented in memory of Mr. Hines, a former president and chief executive officer of Rollins Burdick Hunter Co. who died in 1984.

The symposium, which attracted 260 people, was co-sponsored by the Insurance School of Chicago and the Chicago and Northeastern Illinois chapters of the Risk & Insurance Management Society Inc.

"The first couple of years of Superfund were absolutely abysmal," Mr. Lefkin said. But when Congress reauthorized the program in 1986, it used administrators for the U.S. Environmental Protection Agency as "scapegoats" for the problems instead of correcting defects, he maintained.

Both Mr. Lefkin and Jan Paul Acton, regulatory policies program director for the Rand Corp. in Santa Monica, Calif., noted that the Superfund program has had little success in actually cleaning up sites.

Among the 1,200 sites on a priority list, the EPA has declared that only about 30 have been cleaned, Mr. Acton said.

The delay stems from litigation and uncertainty over cleanup procedures, Mr. Acton said.

According to Mr. Acton, the EPA has estimated the cost of Superfund cleanups at $30 million per site. But that figure, he adds, might be too high.

Noting that the Superfund act was extended for another four years last year, Mr. Lefkin said the time could be used by those affected by Superfund to lobby Congress for changes, Mr. Lefkin said.

He noted that the act does not just affect large insurers. Also hit by Superfund are small businesses, municipalities and banks, which are watching the impact of court rulings on lender liability, he said.

The U.S. Supreme Court recently declined to review a ruling by the 11th U.S. Circuit Court of Appeals that a lender with "the capacity to influence the corporation's treatment of hazardous waste" could be held liable under Superfund (*BI*, Jan. 21).

The 9th Circuit has also interpreted the Superfund secured lender exemption. It ruled last August that a municipal entity that issued revenue bonds to a firm to promote industrial development was not liable for the company's cleanup costs because the municipal entity was not involved in managing the firm (*BI*, Sept. 3, 1990).

The threat Superfund could pose to insurer solvency might encourage Congress to look at revising the law, Mr. Lefkin said.

An incentive for firms to be environmentally conscious is the 'risk of losing business, because the public is going to pressure you to change the way you do business if they perceive an environmental threat,' Ms. Hockman says.

At a House Banking Subcommittee hearing last fall, Crum & Forster Inc. "presented written testimony stating that if a majority of courts decide cleanup costs are covered under CGL policies, the resulting exposure could bankrupt every major liability insurer in the country," Mr. Lefkin said.

But Crum & Forster also testified that if "cases are decided in favor of insurance companies, then thousands of U.S. businesses would confront huge retroactive liabilities and could be forced to close," Mr. Lefkin said.

Noting that legislation proposing enhanced federal regulation of insurer solvency is likely, Mr. Lefkin said such a law could be beneficial because the federal government "spawned the Superfund leviathan and would be forced to accept some responsibility for its financial consequences."

"I think Congress is getting the message" that something needs to be done with Superfund, he said.

Mr. Lefkin cited a proposal by American International Group Inc. Chairman Maurice R. Greenberg—supported by Fireman's Fund—that a 2% tax be imposed on commercial insurance premiums, with an equivalent assessment on self-insurers, to fund the cleanup of pollution resulting from past waste disposal (*BI*, March 6, 1989).

Meanwhile, the Justice Department has reported that 1990 was a record year for environmental enforcement, said Deborah C. Hockman, assistant director-laboratory operations for Geneva, Ill.-based WMI-Environmental Monitoring Laboratories Inc., a subsidiary of Waste Management Inc.

An incentive for firms to be environmentally conscious is the "risk of losing business, because the public is going to pressure you to change the way you do business if they perceive an environmental threat," Ms. Hockman said.

"I think business will change because they believe it is the right thing to do," she said.

However, Mr. Lefkin observed that economic worries might dampen some environmentalists' concerns. "When a guy is worrying about his job, I think his environmental commitment might lessen," he said.

On another environmental matter, Mr. Lefkin said that businesses also should be aware that the cost of removing asbestos from buildings could be very high.

The EPA has estimated that removing asbestos from buildings nationwide could cost more than $51 billion, he said.

But asbestos removal contractors say the total could hit $250 billion, while the Building Owners & Managers Assn. estimates removal costs could hit $4 trillion, according to Mr. Lefkin. ■

INTERNATIONAL

London court freezes Aneco assets

By ROGER SCOTTON

HAMILTON, Bermuda—A London High Court judge has frozen up to $430,000 in assets belonging to Bermuda-based Aneco Reinsurance Underwriting Ltd., the captive reinsurer that stopped underwriting last year.

The order, known as a "mareva injunction," was issued Feb. 8 and applies to Aneco assets held in England, Wales and Bermuda.

Justice Waller expressly called for the order to be served on Aneco in Bermuda and on the U.K. home of Mark Hardy, who controls Aneco's parent, Forum Re Group Ltd.

Mr. Hardy said he will contest the injunction.

The injunction was granted following a petition filed by Aneco creditor American Professional Assurance Ltd., a Cayman-based captive owned by a group of anesthesiologists. APAL alleged that unless the court acted, Aneco would take steps to remove its assets from APAL's reach.

APAL argued that Aneco, Bermuda's leading captive reinsurer until it stopped underwriting last September (*BI*, Sept. 17, 1990; Sept. 10, 1990), is refusing to pay claims under certain reinsurance contracts with APAL.

The captive claims that it has strong grounds for concern about Forum Re Group's financial condition. It points to—among other things—developments surrounding the controversial liquidation of a Forum subsidiary, Focus Insurance Ltd., whose winding up was recently ordered to be placed in the hands of court-appointed, rather than privately appointed, liquidators (*BI*, Feb. 11).

Last month, court-appointed Focus liquidator David E.W. Lines alleged in an affidavit filed in Bermuda Supreme Court that a "very substantial proportion" of Focus assets were transferred to an unlicensed Turks & Caicos reinsurer owned by Mr. Hardy the same day that Focus placed itself into voluntary liquidation (*BI*, Jan. 28).

APAL alleges that Aneco's assets are in danger of being removed or otherwise dissipated to block the legitimate claims of creditors.

Its petition says there is no trust fund or escrow account against which it can enforce its claims against Aneco and that it had no choice but to seek a mareva injunction. APAL also said that it believes Aneco has insufficient assets in London to cover its claims and that the injunction should cover Aneco assets in Bermuda.

APAL, which reinsures the U.S.-based Anesthesiologist Professional Assurance Trust and the Tennessee-based Anesthesiologists Professional Assurance Co. Risk Retention Group and which has ceded business to both Aneco and Forum, argues that the London High Court has the jurisdiction to grant the injunction against Aneco.

The Cayman captive argues that since Mr. Hardy, Forum's chairman, lives in Sudbury, Suffolk, in England and since he controls Aneco, Aneco's central management is effectively located wherever Mr. Hardy is. Regardless of management work carried out in Bermuda, APAL contends that it is Mr. Hardy who makes all decisions concerning Aneco.

However, Mr. Hardy said last week that he would vigorously contest the injunction and seek its dismissal.

The action is without merit, he said, adding that he strongly rejected APAL's claim that it is owed funds by Aneco. He said that in event of a dispute, adequate remedies are available to APAL, not the least of which is the arbitration clause in the contracts between the two companies.

Mr. Hardy suggested that alternative remedies have been ignored because APAL is unlikely to succeed against Aneco.

"As far as I'm concerned, this move against Aneco involved blatant misuse of a mareva injunction to further a commercial dispute," Mr. Hardy said. ■

$875 million capacity for terrorism line slip

By GAVIN SOUTER

LONDON—Energy brokers have set up a line slip at Lloyd's of London with $875 million to cover offshore and onshore oil installations against terrorist attack under Lloyd's new malicious damage and sabotage policy.

The facility coincides with a sharp decrease in marine and aviation hull and liability war risk rates as London underwriters grow more confident with continued claims of allied air and naval superiority in the Persian Gulf.

WAR in the GULF

The energy line slip was set up by the five London master energy line slip brokers: C.T. Bowring & Co. Ltd., Willis Corroon P.L.C., Bain Clarkson Ltd., Sedgwick Group P.L.C. and Jenner Fenton Slade Ltd.

Onshore capacity of $700 million is combined with offshore capacity of $175 million. The slip is placed solely at Lloyd's where it is led by underwriters Stephen Merrett and Richard Youell.

Lloyd's previous malicious damage and sabotage policy excluded terrorist attacks—directly or indirectly linked with war—on land risks and fixed off-shore rigs. The new policy covers all terrorist acts, including damage caused by Iraqi sympathizers (*BI*, Feb. 11).

Precise premium rates will not be known until the coverage is purchased. But rates quoted for of-shore North Sea installations are around 0.125% of the insured value, said Philip Hallett, executive director in Bowring's energy department.

Clients are demanding the coverage, Mr. Hallett said. "They are used to having it and they will want to go on having it."

The capacity generated should meet most clients' requirements, Mr. Hallett said.

Rates for coverage vary considerably depending on the risk, said Jonathan Marland, deputy chairman of Lloyd Thompson Ltd. "The cover-

Continued on next page

Peru's insurance industry

Open market to be proposed

By MARIA KIELMAS

LONDON—Peruvian insurers and government officials are drafting an insurance law that is expected to denationalize the industry.

Talks between the two groups follow the December repeal of a 1987 law that nationalized Peru's insurers, banks and credit institutions (*BI*, Oct. 5, 1987).

"The new law is being prepared through discussions by a committee including representatives from insurance companies and the Banking and Insurance Superintendency," said Manuel Portugal, general manager of the Assn. of Peruvian Insurance Companies. The new insurance law will be included in a measure covering the entire financial services sector, he added.

"We want to demonopolize the insurance industry and open up the market in the same way as Chile, Colombia and Mexico," he said.

In October 1987, then-President Alan Garcia approved the controversial law nationalizing 17 insurers, 10 banks and six finance companies.

Strong opposition—including employee strikes, street demonstrations, court rulings that the proposal was unconstitutional and clashes between legislators in both chambers of the National Assembly—failed to block the law.

Photo by Peter Miller/Image Bank

Peru's insurers hope a proposed law will help attract foreigners to more than Machu Picchu.

Rather than enact outright nationalization, the law limited private shareholder ownership to a total value of 40 taxation units, or about $6,000. President Garcia said the law was designed to widen the spread of share ownership among the public and workers, instead of concentrating financial power in the hands of a few families.

Expropriation was prompted by "national interest" and the "emergency situation affecting economic activity," according to the law.

After the law was enacted, the government-appointed "intervention committees" to run the companies in place of existing senior management and boards of directors. But the law was not enforced during the remainder of President Garcia's presidency, said Caridad de la Puente Wiese, operations manager of Lima-based Cia. de Seguros Condor.

Shortly after Peruvian police used force to take over several private banks in 1987, the government announced it would refrain from enforcing the law by force and instead would let the courts decide the matter (*BI*, Nov. 9, 1987).

"Although some banks were intervened temporarily, the situation returned to an apparent normality in 1988," Ms. de la Puente said. "Nevertheless, the nationalization law remained in force and one was afraid of it being enforced at any moment.'

When Alberto Fujimori was elected president in October last year. he promised to repeal that law and to adopt a more open economic policy. The law was repealed on Dec. 25.

But the situation of insurers in

Continued on page 85

Pension income worldwide

Multinationals face maze of standards: Study

By PAUL D. WINSTON

Private, employer-provided pension benefits make up a greater percentage of retirement income in Australia than in 19 other countries, a recent survey shows.

Most retirement benefits in Australia come from private pensions. In other countries government-provided termination indemnities and social security programs provide a large share of retirement income.

In fact, in five of the 20 nations surveyed—France, Singapore, Sweden, Taiwan and Venezuela—workers typically receive all their retirement benefits from some type of government-mandated program, according to "Retirement Income Throughout the World," a recent survey by TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

For example, Swedish retirement benefits are composed entirely of government social security payments and compulsory employer plans, the survey shows.

And in Venezuela, termination indemnities—a lump sum paid to retiring workers—comprise the largest portion of retirement benefits.

The TPF&C survey examined retirement income patterns in 20 countries for four classes of employees: factory workers, salaried employees, middle managers and executives.

It also reported the average percentage of a worker's final earnings that are replaced by retirement benefits and how much of these benefits are comprised by: a termination indemnity; social security and other compulsory pension plans; and private, company-sponsored pensions.

"Multinational companies face an astounding number of retirement income variables around the globe," said the study's author, Wolfgang Glage, a TPF&C vp in Stamford, Conn.

This variety poses particular challenges for multinationals, he said, because "without a doubt the vast majority of multinational companies centrally coordinate and control retirement benefits."

And U.S. multinationals, which are required by the Financial Accounting Standards Board to estimate their pension liabilities, face particular hurdles in managing their diverse pension exposures, Mr. Glage observed.

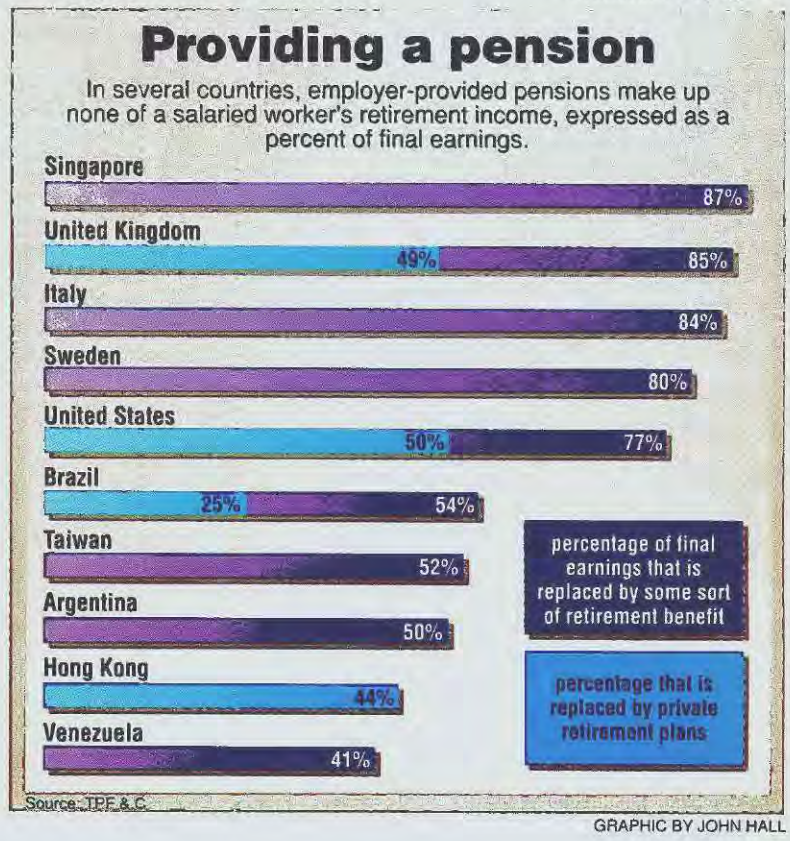
"Retirement plans are a significant long-term expense. Companies must be aware of these exposures so there are no surprises down the road," he said.

According to the study, the five nations where the highest percentage of factory workers' final earnings are replaced are:

- Spain, where 91% are replaced, all by social security benefits.

Private pensions integrated with

Continued on next page



GRAPHIC BY JOHN HALL

Pension benefits

Continued from previous page
the government benefits are available only to middle- to upper-level workers, the study says.

- Singapore, 87%, all by the government's Central Provident Fund. The study notes, however, that private plans are beginning to emerge for senior executives.
- Sweden, 85%, all by a combination of the government social security system and a compulsory pension system.
- United States, 84%. Forty percent is replaced by Social Security and 44% by private pensions.
- Australia, 83%. Twenty percent is replaced by social security old age pensions and 63% by private pensions.

Private plans typically pay benefits in a lump sum, the study notes.

Among salaried employees, the top five nations are:

- Singapore, where 87% of final earnings are replaced at retirement, all by the social security system.
- United Kingdom, 85%. Thirty-six percent of final earnings are replaced by the social security system and 49% by private pensions.
- Italy, 84%. Eighteen percent of final earnings are replaced by a termination indemnity and 66% by the social security system.
- Sweden, 80%, all by social security and compulsory benefits.
- United States, 77%. Twenty-seven percent of final earnings are replaced by Social Security and 50% by private pensions.

Middle managers recovered less of their final earnings at retirement, the survey found.

"An important fact underscored by the study is that company retirement benefits and social security replace a smaller percentage of an upper-income individual's compensation, compared with that of a lower-paid worker," Mr. Glage said.

The five nations with the highest retirement benefits for middle managers were:

- Italy, 84%. Eighteen percent of final earnings are replaced by a termination indemnity, 65% by the social security system and 1% by private pensions.
- Sweden, 79%, all by social security and compulsory benefits.
- United Kingdom, 73%. Twenty-three percent of final earnings are replaced by a government pension and 50% by private pensions.
- Switzerland, 72%. Fifteen percent of final earnings are replaced by social security benefits and 57% by private pensions.
- Australia, 70%, all by private pensions.

Low-paid employees have a higher percentage of income replaced than do higher-paid workers.

Executives, because of their relatively higher earnings, recovered the lowest percentage of their final pay at retirement, the study shows. The top five nations were:

- Italy, 75%. Twenty-one percent of final earnings are replaced by a termination indemnity, 52% by social security and 2% by private pensions.
- Sweden, 75%, all by social security and compulsory benefits.
- Australia, 74%, all by private pensions.
- United Kingdom, 72%. Twelve percent of final earnings are replaced by social security and 60% by private pensions.
- Spain, 70%. Twenty-seven percent of final earnings are replaced by social security benefits and 43% by private pensions.

The nations with the lowest benefits for factory workers and the percentage of final earnings replaced by retirement benefits are: Hong Kong, 36%; Argentina, 50%; Venezuela, 51%; Taiwan, 60%; and Germany, 64%.

For salaried employees, the countries with the lowest percentages of income replaced by retirement benefits are: Venezuela, 41%; Hong Kong, 44%; Argentina, 50%; Taiwan, 52%; and Brazil, 54%.

For middle managers, the countries with the lowest percentage of income replaced are: Venezuela, 36%; Taiwan, 37%; Argentina, 41%; Hong Kong, 48%; and Japan, 50%.

And, for executives, the countries with the lowest percentage of income replaced are: Singapore, 29%; Taiwan, 33%; Venezuela, 34%; Japan, 40%; and Mexico, 46%.

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For a free copy of "Retirement Income Throughout the World," contact Loretta Marotta, TPF&C, 17th Floor, 245 Park Ave., New York, N.Y. 10167-0128.

War rates

Continued from previous page
age is being requested from a wide variety of clients ranging from chemical plants to hotels."

Meanwhile, marine and aviation hull and liability war risk rates continued to drop in the London market as underwriters were reassured by reports of the allied military supremacy.

"In some cases marine hull rates have come down by as much as two thirds," said David Lentaigne, managing director of the marine division of Alexander Howden Reinsurance Brokers Ltd.

"It is a reflection of the extra security which now exists with the elimination of the Iraqi navy and most of its air force," he added.

Marine hull war risk rates for vessels visiting Ras Tanura in Saudi Arabia have fallen to 0.625% of insured value from 1.5% in a week, Mr. Lentaigne said. And rates are down to between 0.25% and 0.3125% from 0.375% for Kharg Island off Iran, and to between 0.25% and 0.3125% from 0.5% for vessels visiting Israel.

Marine and aviation cargo war risk rates also dropped last week. The joint Lloyd's/Institute of London Underwriters war risk rating committee met Wednesday for the first time in more than a week and a half to set new marketwide rates.

The following cargo war risk rates were changed:

- Iranian Gulf ports, places and offshore islands north of 27 degrees 30 minutes north latitude. Marine cargo war risk rates were cut to 0.25% of insured value from 0.75%.
- Gulf ports and places south of 27 degrees 30 minutes north latitude and west of 52 degrees east longitude. Marine cargo war risk rates were cut to 0.5% from 1%.
- Qatar and Bahrain ports and places. Marine rates were cut to 0.5% from 1%, and aviation rates to 0.125% from 0.25%.
- Saudi Arabian Red Sea ports including Jeddah. Marine rates were cut to 0.1% from 0.125%. Aviation rates for Jeddah were cut to 0.075% from 0.125%.
- Israeli Mediterranean and Red Sea ports. Marine rates were cut to 0.2% from 0.25%.
- Jordan. Marine rates were cut to 0.2% from 0.25%, and aviation rates were cut to 0.15% from 0.25%.
- Turkey. Aviation rates were cut to 0.025% from 0.05%. ■

INTERNATIONAL

U.S. reinsurance rates to climb: Underwriter

LONDON—U.S. ceding companies should brace themselves for a huge increase in reinsurance rates as early as the middle of this year, according to a leading Lloyd's of London reinsurance underwriter.

Already, British insurers this year have paid whopping increases to renew reinsurance programs, noted Dennis Purkiss, underwriter for subsyndicates of syndicate 418, managed by Merrett Underwriting Agency Management Ltd.

"We expect a big surge of rates" for U.S. cedants as early as the middle of the year and no later than the end of the year, said Mr. Purkiss.

LONDON

At the moment, increases for U.S. ceding companies are only a fraction of those for British companies renewing their reinsurance programs, he said. This will change, he added.

The London reinsurance market hardened during January renewals for British and European ceding companies, primarily due to huge catastrophe losses from January and February 1990 windstorms in Europe (*BI*, Jan. 7).

Catastrophe losses have also hammered the London excess-of-loss reinsurance market. Catastrophe losses "spiral" around the London market as LMX underwriters continually pass portions of a risk to each other. The Piper Alpha North Sea oil platform disaster in 1988, for example, cost insurers $1.2 billion, Mr. Purkiss said, but loss advices to Lloyd's underwriters through LMX coverages have now reached $9 billion.

During the January renewals, however, there was a "massive" contraction in the non-marine LMX market. Many London underwriters were forced to stop writing reinsurance for ceding companies until their own retrocessions could be put together (*BI*, Jan. 7).

"We've finally seen the collapse of the spiral market" in non-marine business, said Mr. Purkiss. He stopped underwriting retrocessional non-marine LMX business two years ago but continues to reinsure London, U.S. and other ceding companies.

While the "pressure" on the reinsurance market "must have an effect on the direct market,"Mr. Purkiss said he doesn't know how long it will take U.S. ceding companies to pass rate increases on to corporate policyholders.

—By Stacy Shapiro

U.K. winter storms

British insurers last week were waiting for a flood of claims to commence, following severe storms earlier this month throughout the nation.

Claims ranging from burst pipes to auto crashes will inevitably follow the harsh weather that left many parts of the country under at least a foot of snow, insurers say.

But until the snow thaws, underwriters will be unable to judge the severity of losses, they say.

"It very difficult to judge what the effect will be, because as far as snow is concerned, although it causes a lot of disruption, it does not do a lot of damage. You have to wait until the thaw to see the burst pipes and flooding," said a spokesman for the Assn. of British Insurers.

Claims should be substantially lower than the claims from the windstorms that battered Britain in January and February 1990, he said. In the past 10 years, severe cold in January and February has cost insurers between 200 million and 300 million pounds ($398 million to $597 million). Storms have cost 1 billion to 2 billion pounds ($2 billion to $3.9 billion), he said.

John Wetherell, chairman of Lloyd's of London's Non-marine Assn., said: "I think that there will be some fairly severe claims because there has been a lot of snow covering a lot of the country."

—By Gavin Souter

Peruvian insurance

Continued from page 83

Peru remains unchanged, said Ms. de la Puente Wiese. The state reinsurer, Lima-based Reaseguradora Peruana S.A., is the only company authorized to cede reinsurance abroad, and state direct insurer Popular y Porvenir Compania de Seguros is the sole insurer of government companies and property.

Insurers are hoping that the new law will be in place by April and that they will be able to negotiate contracts directly with multinational clients and captives without government restrictions, she said.

"It's also possible that foreign brokers and reinsurers will come into the (Peruvian) market," said Ms. de la Puente Wiese. "We are optimistic about our future now that there has been a slight upturn in the economy."

Gross premium volume in the Peruvian market totals about $250 million, according to Mr. Portugal. Of this, slightly more than $50 million is ceded abroad as reinsurance, he said.

Mr. Portugal acknowledges that potential foreign investors in Peru could be put off by the country's domestic security situation and risk of terrorism. Much of the country remains politically unstable as security forces fight ultra-leftist terrorist groups.

Terrorism coverage in Peru, which is available in fire insurance policies, is producing considerable losses for insurers. "The results are not very good," Mr. Portugal said.

The Persian Gulf war also has had an effect on terrorism. In an apparent protest against the coalition forces in the Middle East, terrorists recently attacked foreign-owned interests in Lima, including the U.S. Embassy and a Kentucky Fried Chicken restaurant.

Insured losses totaled $150,000, said Mr. Portugal, noting that the losses were paid by the domestic market. ■

Rely litigation

Continued from page 2

American Employers has agreed to pay P&G $5,500 for individual claims that have exceeded the $1 million per-occurrence retention.

A P&G spokesman would not comment on the 7th Circuit ruling. P&G lawyers only would say that no decision has been made on whether to appeal.

P&G removed Rely tampons from the market in September 1980 after being hit with hundreds of lawsuits by victims of toxic shock syndrome, which several studies have linked to use of high-absorbency tampons like Rely.

Since then, more than 1,000 lawsuits suits have alleged the tampons caused injury or death. P&G had spent more than $80 million to defend and settle these suits as of June 30, 1987, the most recent date for which figures are available.

Before last month's appellate court ruling, P&G had resolved coverage disputes with two other liability insurers: Northbrook Excess & Surplus Insurance Co., a unit of Allstate Insurance Co.; and First State Insurance Co., a Hartford Insurance Group unit.

Northbrook was P&G's first-layer excess liability insurer from July 1, 1979, through June 30, 1981. Northbrook wrote $25 million in limits excess of P&G's retention of $1 million per occurrence/$10 million aggregate. The retention includes defense costs.

The Northbrook policy is an indemnity policy, which means P&G retains control over the defense of any lawsuits and Northbrook agrees to reimburse it for its costs as defined by the policy.

A vast majority of the Rely claims fell under the Northbrook coverage, attorneys say. First State provided $25 million in coverage

More than 1,000 lawsuits suits have alleged the Rely tampons caused injury or death.

excess of Northbrook's layer in 1980-81. The First State policy follows form with Northbrook's.

P&G's second-layer excess coverage in 1979-80 was written by Pine Top Insurance Co. of Chicago, which has been ordered liquidated in Illinois (*BI*, June 30, 1986). Pine Top, though, resolved its dispute with P&G.

The litigation stems from a lawsuit Northbrook filed against P&G in 1983, also naming Commercial Union as a defendant.

P&G then filed a counterclaim against Northbrook, Commercial Union and American Employers.

First State and Pine Top later intervened in the litigation.

P&G filed virtually identical litigation in 1985 in a Cincinnati court. However, the Chicago litigation decided all issues in the Cincinnati case.

In a victory for insurers, a U.S. District Court jury in Chicago ruled in March 1989 that the Rely lawsuits constituted multiple occurrences.

After the trial court judge issued a final ruling based on the jury's verdict, both P&G and Northbrook agreed not to appeal those portions of the decision that effect their relationship, explained Northbrook attorney David Spector of Mayer, Brown & Platt in Chicago.

As of June 30, 1987, Northbrook had paid P&G $40.7 million. However, the insurer contested more than $20 million in defense-related costs, some of which it had paid. Northbrook also contested P&G's interpretation of its retentions.

The jury found that $9.3 million in defense-related costs were not insured. But, the jury also found that $12 million in defense-related costs were insured. The net result of these rulings, taking into account funds already paid by the insurers, is that Northbrook owed P&G $2.3 million.

In addition to the agreement between Northbook and P&G, First State also settled its dispute with the manufacturer. Terms were not disclosed.

P&G, however, did appeal the portion of the decision that affects the Commercial Union and American Employer's policies.

In affirming the 1989 jury verdict, the 7th Circuit reviewed the jury instructions given by the lower court judge.

Continued on next page

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Continued from previous page

The judge told the jury: "The issue for your decision is not whether there were contracts but, rather, what meaning the parties intended by the terms of the contracts. You must decide from a consideration of all the facts and circumstances in evidence what various insurance policies mean with respect to the terms used. You must decide what parties mutually intended when they entered into the contracts."

In its appeal, P&G argued that the judge erred by not telling jurors that vague or ambiguous policy terms must be construed in favor of the policyholder.

This rule of insurance policy interpretation, known as contra proferentum, is based on the notion that insurers have vastly superior bargaining power and that the average policyholder has little if anything to do with policy drafting. Citing this rule, most courts hold that ambiguous language should be construed against the insurance company.

However, in this case, the district court jury and the appellate court agreed that P&G was not a typical policyholder.

Both courts agreed that because the company had a substantial say in the drafting of its liability policies it was not entitled to special rules of policy construction.

"The record clearly established that P&G was a co-drafter of the Commercial (Union) policy and not simply a party given a take-it-or-leave-it option," the 7th Circuit found.

The court went on to note that "significant portions of policy's language were customized at P&G insistence."

Therefore, the trial court judge did not err by not instructing the jury that all ambiguous terms must be construed in favor of P&G, the appellate court found.

"More and more insureds are actively negotiating terms of coverage, so there should not be a presumption that all insurance contracts" should be interpreted in favor of the policyholder, said Commercial Union co-counsel Shaun McParland Baldwin of Tressler, Soderstrom, Maloney & Priess in Chicago.

"This is a significant victory for insurers," she said.

Another important message for insurers in this case is that they can successfully take complex coverage questions to a jury, said Commercial Union co-counsel Christopher M. Bechhold of Thompson, Hine & Flory in Cincinnati.

"This shows that a jury can reach a proper resolution when faced with a complex coverage question," he said.

The ruling may motivate more insurers to take coverage disputes with policyholders to a jury, he said.

P&G had requested the jury trial.

The 7th Circuit also upheld the trial judge's ruling to award Commercial Union $90,000 of expenses, which included costs for photocopying, photos, charts and graphs.

Because Commercial Union owes P&G $40,000 for costs that exceed the $1 million per-occurrence retention and P&G owes the insurer $90,000 for court-awarded costs, the net result is that P&G owes Commercial Union $50,000.

In addition, the appellate court ordered the trial judge to reconsider his decision that the costs P&G incurred to prepare a data base were covered by the Commercial Union policy.

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Northbrook Excess & Surplus Insurance Co. vs. Procter & Gamble Co. et al. vs. Commercial Union Insurance Co. and American Employers Insurance Co.; U.S. Court of Appeals for the 7th Circuit, No. 89-2506 and No. 89-3128.

MetLife survey

Continued from page 1

portant to understand the stakeholder' positions on key issues and identify areas of possible compromise," said John D. Moynahan Jr., executive vp in charge of MetLife's group insurance department. Those stakeholders are "in a position to effect change and are whom we will ultimately rely on to improve the American health care system."

So far, however, "people have been speaking from embedded positions and extremes," he said. "Not a whole lot of progress is made that way.

"To move discussion and debate forward toward consensus and action. . .most stakeholders in our current system will almost certainly have to settle for less than they insist upon today," Mr. Moynahan said.

Respondents were asked whether they would make specific tradeoffs "if it were part of a program where each group would make some concessions" to reach a consensus.

"The willingness of respondents to accept compromises and tradeoffs must be interpreted in that context," Mr. Moynihan stressed.

Corporate America appears willing to make several trade-offs to improve the health care system.

For example, if all parties in the health care system made some compromises, 72% of the executives said they would accept a law requiring employers to provide a basic health plan for all full-time employees and their dependents. About one-third said such a law would be totally acceptable; about 40% said it would be somewhat acceptable.

In addition, 69% of the executives said that a law requiring all employers to offer the same level of coverage would be acceptable if other groups made trade-offs. Eighteen percent said it would be totally acceptable, while 51% said it would be somewhat acceptable.

Basing commercial group health insurance premiums on community rating rather than experience rating would be acceptable to 61% of corporate executives. More striking is that 52% of large employers—those with 10,000 or more employees—find community rating acceptable, Mr. Moynahan said.

Sixty-two percent of surveyed executives said they would accept a law requiring employers to provide health insurance to retirees younger than 65, who are not yet eligible for Medicare. The proposal, though, is much more acceptable to larger employers, many of whom already provide such coverage, than to smaller companies.

A majority of corporate executives remain opposed to a mandate that employers also provide basic health benefits to part-time employees. Only 44% said this was acceptable.

And executives overwhelmingly oppose a national health insurance system.

Seventy-four percent said they would be willing to introduce aggressively managed health care plans to avoid such a program. And if private initiatives fail to contain costs within five year, only a slender majority—53%—say they would support a national health care program.

The majority of labor union leaders surveyed—72%—also would accept a standard employer-provided health plan for all employers and employees, the survey found. And, 76% would not oppose being required to belong to managed care plans like health maintenance organizations.

However, 62% of union leaders would not accept higher deductibles and co-payments, and 74% would not accept a cap on the amount of employer-provided health care benefits that are tax-free to their members, the survey found.

Seventy-four percent of union leaders say they would be willing to work with management to contain costs if savings would be used to raise wages and improve competitiveness to save jobs, the survey reported.

Major group health insurers also appear willing to make concessions, particularly concerning the coverage of traditionally poor risks, the study found.

Ninety-four percent said they would be willing to participate in a reinsurance mechanism to spread excess health costs for small employers.

Such a mechanism, Mr. Moynahan explained, could function as a quasi-public corporation funded by the contributions of group health insurers based on their market share and by risk charges tacked onto health plan premiums.

If there were such a reinsurance mechanism, 89% of group health insurers surveyed would accept being required to renew small employers' group coverage, regardless of claims experience, the survey noted. And, 63% said that with such a mechanism they would be willing to give up some underwriting practices for small groups, like excluding coverage for pre-existing conditions.

The survey noted that two proposals were overwhelmingly unacceptable to group health insurers: government regulation of group health rates for small employers, opposed by 79%; and functioning solely as administrators of a federally sponsored health plan, opposed by 74%.

The physician leaders of medical societies are somewhat willing to compromise, the survey found, noting that four out of 10 proposals were acceptable to at least 55%.

Those proposals included having somewhat lower fees for specialists; basing compensation on a fee-for-service basis, but according to a fixed budget with an expenditure cap; being required to generally follow practice guidelines on how to treat different conditions; and requiring patients to obtain the prior approval of a primary care physician in order to see specialists for non-emergency care.

In addition, a majority of physician leaders said they would be willing to accept a 10% reduction in fees or net income in return for: a substantial reduction in paperwork, acceptable to 89%; malpractice reforms that put limits on punitive damages and damages for pain and suffering, acceptable to 88%; and an increase in autonomy, including less utilization review and regulation, acceptable to 81%.

Many physician leaders rejected some other changes in compensation. Two-thirds opposed being compensated only on a capitated basis; 63% opposed a uniform, national fee schedule for specific services; and 58% opposed being compensated partly on some measure of patient satisfaction.

Three proposals garnered the support of more than 60% of the hospital chief executive officers surveyed: closing more underused hospitals, imposing tougher restraints on capital expenditures and being required to treat all patients.

According to the survey, there is some consensus among the various groups about the need for change in the health care system and about the types of change likely in the next 10 years. But those groups also agree that any changes should be introduced incrementally.

Satisfaction with the current system ran highest among physician leaders; nearly one-third—31%—said they were satisfied. Most critical were union leaders, with 70% in favor of completely rebuilding the system.

Twelve percent of the corporate executives surveyed were satisfied with the current health care system, 63% said it needs fundamental changes and 25% favored a complete rebuilding.

Areas where majorities of respondents in all categories agreed were:

- The U.S. health care system will provide universal coverage at some time in the future.

Seventy-six percent of group health insurers foresee universal coverage in the future, compared with 71% of hospital CEOs, 66% of union leaders, 57% of physician leaders and 53% of corporate executives.

Expectations did differ somewhat among executives at large and small companies, the survey found. For example, 79% of executives at companies with more than 10,000 employees expect to see universal health insurance in the future, compared with only 38% of those at companies with 25 or fewer workers.

- A universal health insurance system should be adopted, even if it means an increase in taxes.

Different organizations have made a variety of proposals to cover the nation's uninsured. All would require higher taxes, Mr. Moynahan said.

However, the possibility of higher taxes is not a barrier to health care reform, he said. "The man on the street would probably

Continued on next page

Risk Retention Act

Continued from page 1

the effort," said James McIntyre, Washington counsel to the Risk & Insurance Management Society Inc., and a partner with the McNair Law Firm in Washington, D.C.

"Administration backing does not assure success, but it is a powerful force," said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers in Washington, D.C.

The administration said the legislation drafted by Commerce Department staffers Ted Barrett and Jane Molloy is needed to strengthen buyers' ability to utilize the law.

"Everyone—businesses, daycare centers, doctors, nurses, truckers, ranchers, architects and volunteers—needs affordable, effective liability insurance," said Commerce Secretary Robert A. Mosbacher.

"President Bush and I believe amendments will help make commercial and professional liability insurance more readily available to these people who need it," he said.

The original Risk Retention Act, passed in 1981 to facilitate alternatives to commercial product liability insurance, was a response to the hard market of the mid- and late 1970s. It created two special entities, risk retention groups—or special multiple-owner captives—and purchasing groups, a way that buyers could band together to buy insurance as a group.

The law superseded many state regulations. For example, risk retention groups licensed in one state can operate nationally without meeting other states' capital and surplus requirements.

While the 1981 law allowed risk retention and purchasing groups to write only product liability and completed operations coverages, Congress amended the law in 1986 to allow risk retention and purchasing groups to write almost all types of commercial liability insurance except workers compensation. Since then, many policyholders have tapped the alternative risk financing vehicles.

Roughly 70 risk retention and several hundred risk purchasing groups have been organized. They cover policyholders as diverse as nurse midwives, medical equipment manufacturers and educational institutions.

"The Risk Retention Act has been a wonderful vehicle," said Jon Harkavy, general counsel of Vermont Insurance Management, a Montpelier, Vt.-based captive management company. "It has facilitated the formation of many alternative risk financing vehicles, something that would not have been possible without the act," said Mr. Harkavy, who lobbied for the 1986 amendments while RIMS' director of government affairs.

But there also has been a dark side to the Risk Retention Act.

State regulators say the act has made it too easy for unscrupulous entrepreneurs to set up thinly capitalized insurers to write coverage for purchasing groups organized by the insurers. Later, regulators charge, the insurer can go broke because it lacked sufficient capital and surplus or charged rock-bottom premiums.

Bush administration officials say new financial standards for purchasing group insurers are an attempt to curb those abuses. Under the legislation, in order for a purchasing group insurer to write business in a certain state, it must be admitted in at least one state and meet these standards:

- Have the capital and surplus that the state requires of admitted insurers writing the same type and amount of business.
- "Retain risk net of reinsurance less than the maximum permitted admitted insurers" in the state.
- Maintain a premium-to-surplus ratio no greater than 3-to-1.
- Maintain minimum capital and surplus of $3 million in its principal place of business. A purchasing group designates its principal place of business, where it must maintain an office and have members.

Alternatively, a purchasing group insurer could write coverages if it met either of these standards:

- The insurer is domiciled in a state certified by the National Assn. of Insurance Commissioners as meeting its regulatory standards, which only Florida and New York have met.
- The insurer is based outside the country and is listed on the most recent NAIC's Non-Admitted Insurers Quarterly Listing or was approved since the last listing was published.

To maintain a listing, an alien insurer must, among other things, keep a trust fund of at least $2.5 million at a Federal Reserve Board member bank and capital and surplus of at least $6 million. The capital requirement will be $15 million in 1992.

By contrast, the current Risk Retention Act does not set specific capital and surplus requirement on purchasing group insurers. However, in several decisions, federal courts have ruled that a state can require a purchasing group insurer to be licensed in a state before it can write coverage for policyholders in that state (*BI*, Aug. 13, 1990; July 24, 1989).

Business groups and others say they support tougher solvency standards for purchasing groups.

"We recognize the need for greater safety and soundness of purchasing group insurers," said Mr. McIntyre, RIMS' Washington counsel.

"Solvency standards for purchasing group insurers are a good idea. They help assure that an insurer will be around when it is time to pay claims," said Beth Kravetz, a Washington, D.C., attorney who has worked with purchasing groups.

But some observers say that the administration's solvency standards may be too tough. Some worry that small, specialized but healthy purchasing group insurers may not be able to meet capitalization and solvency standards in every state.

"Some states have arbitrary high capital and surplus requirements. Those requirements might be too high for a specialized purchasing group insurer that writes high-volume, but low-risk coverages," said Ms. Kravetz.

Some also say the 3-to-1 premium to surplus requirement is not carefully drafted and needs revision. They note that it is not clear what would happen to current policyholders if a purchasing group insurer exceeded the 3-to-1 ratio.

Instead, they say the legislation should be redrafted so that a purchasing group insurer should be barred from taking on new business until its premium-to-surplus ratio is reduced to 3 to 1.

Regulators, meanwhile, welcome tougher solvency rules. But they add that purchasing group insurers should be required to be licensed in a state before operating there.

"The bill would prevent states from requiring that an out-of-state purchasing group (insurer) have a license to operate in that state and would thus restrict the state's ability to protect consumers from abusive market practices and insolvency," said NAIC President and North Carolina Insurance Commissioner James Long.

Regulators also strongly object to a provision in the bill that would make clear that generally only the state that a purchasing group declares as its principal of business could regulate policy forms and rates.

This provision would effectively overturn a 1987 federal court decision in New York, later upheld on appeal, that the Risk Retention Act does not pre-empt a purchasing group insurer from state rate and form requirements (*BI*, Oct. 5, 1987).

Regulators say rate and form requirements are vital to consumer protection.

"Our policy filing requirements are there for a purpose: to protect the consumers, who, in many cases, are not sophisticated buyers," said Miriam Boggio, deputy superintendent at the New York Department of Insurance.

But purchasing group insurers say multiple state filing requirements drive up coverage costs and make it difficult to launch a nationwide purchasing group.

"This is a very costly and extreme administrative burden," said Carol Newman, vp and general counsel with Chicago Insurance Co., a unit of Fireman's Fund Insurance Co. that writes coverage for more than a dozen purchasing groups.

Other observers say state rate and form requirements do little to protect consumers and only add administrative costs.

The Bush administration proposal also would require risk retention and purchasing groups to be controlled by its members. The legislation defines control as when members "retain the power to direct the affairs of the group and to enter at arms length into transactions with insurers and other suppliers of goods and services." This provision is clearly aimed at individuals who set up insurance companies to write purchasing group business, then themselves organize purchasing groups and solicit policyholders.

The Commerce Department's Mr. Barrett describes such activity as an abuse of the Risk Retention Act and not what legislators intended.

Regulators strongly support the policyholder control provision.

"Control by policyholders is a very good and important thing. There are too many groups not controlled by members. They are just a tool of the insurer," said Beth Stuchel, chairman of the NAIC's risk retention working group and deputy Iowa insurance commissioner.

Business groups say they support the concept of control, but believe the legislative requirements may be too vague.

"We have no disagreement with the concept of control, but we are wondering how 'arms length' would be interpreted. There seems to be a lot of ambiguity," said NRRA President David Bossman.

The Bush administration bill also contains these provisions:

- A licensed agent in the state in which the purchasing group has its principal place of business could act as an agent on behalf of the group in all other states, whether or not the agent is licensed in other states.
- Risk retention groups could be domiciled in Puerto Rico. The current law is not clear on whether Puerto Rico is considered a state for domiciliary purposes.
- States could not require risk retention groups to participate in joint underwriting authorities. A JUA is designed to provide insurance to those who cannot obtain it in the voluntary market and is funded by assessments on all insurers writing in the state.
- Risk retention groups could not be required to submit to more than one financial examination during a calendar year unless ordered to do so by a federal court.
- A purchasing group, which intends to do business in any state, would be required to provide regulators with the address, telephone number and domicile of the insurer writing coverage for the group.

The purchasing group would also have to identify its principals or officers and identify and provide the address of the organization managing the group.

- Only a risk retention group's domiciliary state could require the group to submit to an examination to determine if its members are engaged in similar businesses or activities as required under the act. ■

Mutual Fire

Continued from page 2

policies produced and underwritten on behalf of Mutual Fire" after it was learned that the performance of the previously selected counsel was inadequate.

As a result of these and other activities, the defendants allowed "Mutual Fire to continue to write business and thereby incur additional liabilities, causing the dissipation of Mutual Fire's assets and otherwise causing Mutual Fire and all its creditors, including all its policyholders, severe damage," the suit charges.

While the suit does not specify damages sought from Shand, Morahan and A&A, it estimates that they are "in excess of several hundred million dollars."

The suit also seeks punitive damages because the "failure to act in the best interests of Mutual Fire was wantonly committed and in reckless disregard of the rights of and financial consequences to Mutual Fire and all its creditors, including all its policyholders."

According to the complaint, Shand, Morahan was responsible under its underwriting management agreement with Mutual Fire for producing and underwriting business on the insurer's behalf, maintaining and furnishing financial reports to the insurer and placing reinsurance.

Shand, Morahan underwrote professional liability insurance—primarily medical malpractice coverage—on behalf of Mutual Fire.

Under its reinsurance binding authority contracts with Mutual Fire, Shand, Morahan was responsible for binding Mutual Fire as a reinsurer, handling claims and maintaining financial reports, the lawsuit alleges.

The suit does not specify what percentage of Mutual Fire's business was generated by Shand, Morahan, nor the reinsurers that have been labeled as not "financially secure."

However, a spokesman for the rehabilitator said approximately 25% of Mutual Fire's business was generated by Shand, Morahan, mostly in casualty lines. And, though he could not identify the insurers, he said Mutual Fire now has $4 million in unrecoverable reinsurance.

An attorney for Shand, Morahan rejected the charges. "Mutual Fire's problems were not due to any conduct or practice of Shand. Rather, in its dealings with Mutual Fire, Shand has acted responsibly and in good faith," said Joseph Donley of Kittredge, Donley, Elson, Fullem & Embick in Philadelphia.

"Furthermore, Shand has provided assistance to both the rehabilitator and Mutual Fire above and beyond that which was required by the terms and conditions of the underwriting management agreement between Mutual Fire and Shand," he added.

"The complaint is lengthy, but not very specific," Mr. Donley also noted.

While Mr. Donley could not provide an estimate of the percentage of business Shand, Morahan generated for Mutual Fire, he said "it wasn't very much" and was not enough to have driven the insurer into insolvency.

Shand, Morahan officials said in 1986 that Mutual Fire had not been a "major market" for Shand during the previous two or three years (*BI*, Aug. 11, 1986).

Gregg W. MacKuse, an attorney with Miller, Alfano & Raspanti in Philadelphia representing Mutual Fire in the litigation, did not know how much business Shand, Morahan generated on behalf of his client.

Attorneys for Shand, Morahan and A&A said they still are studying the complaint and have not yet decided whether to file a motion seeking its dismissal or to file an answer.

"We haven't decided how to respond," said Mr. Donley.

Regardless of the type of response selected, "we don't think there's any merit," said A&A attorney Michael J. Murphy of New York-based Lord Day & Lord, Barrett Smith.

The defendants have 20 days in which to file a response.

A&A sold Shand, Morahan to an investor group in 1987 (*BI*, Jan. 11, 1988). ■

MetLife survey

Continued from previous page

say no to taxes, but there is a growing sense of reality" among the leadership groups that reform will require tax increases, he said.

Among the groups, 92% of union leaders said everyone should have health insurance, even if that means an increase in taxes, compared with 90% of group health insurers, 82% of physician leaders, 80% of hospital CEOs and 67% of corporate executives.

- Among a number of ways to pay for improvements, the two most acceptable are "sin taxes" and higher insurance premiums for people with unhealthy lifestyles.

Raising cigarette and liquor liquor taxes is acceptable to 100% of group health insurers, 95% of physician leaders, 93% of hospital CEOs, 92% of union leaders and 86% of corporate executives.

Requiring people with unhealthy lifestyles, like those who smoke or use alcohol excessively, to pay higher insurance premiums is similarly acceptable, although union leader support falls to 68%.

Raising income taxes was not as highly endorsed, though a majority of all groups still said it would be acceptable.

Eighty-four percent of union leaders said higher income taxes would be acceptable, compared with 82% of physician leaders, 76% of hospital CEOs, and 71% of group health insurers and 57% of corporate executives.

- The health care system of the future should involve both the public and the private sectors.

All group health insurers supported such a mixed system, compared with 97% of both hospital CEOs and physicians leaders, 95% of corporate executives and 90% of union leaders.

Most respondents, though, strongly believed that employer-based plans should continue to provide the bulk of health insurance.

Ninety-five percent of group health insurers supported employer-based health insurance, compared with 85% of physician leaders, 80% of hospital CEOs and 69% of corporate respondents.

Only 50% of union leaders, though, support employers continuing such a large role in the U.S. health care system.

- Any expanded role for the government should include only setting rules for the private sector, not managing or administering health care programs.

Ninety-percent of group health insurers endorsed a rulemaking role, compared with 64% of corporate executives, 63% of hospital CEOs, 61% of physician leaders. Again, union leaders were split, with only 50% supporting a rulemaking role.

In fact, majorities of all groups surveyed, except union leaders, said that a comprehensive, government-run program funded by taxes would result in higher costs and reduced quality of care.

Mr. Moynahan said the failures of government-run programs like Medicaid and Medicare may be driving those negative attitudes.

"If there is a failure of the current system, in my view it lies more on the government side. Private employers have done a wonderful job and now they are under strain," said Mr. Moynahan. "We've sort of had a test drive of the government (through Medicare) and I wouldn't want to buy that car."

Paraphrasing a comment made by a federal official, Mr. Moynihan quipped that many people believe a government-run system "would have all the compassion of the IRS, all the efficiency of the post office and the prices paid by the Pentagon."

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Home prospects

Continued from page 1

is a Bermuda limited partnership and an affiliate of financial reinsurer Centre Reinsurance (Barbados) Ltd.

Other owners are Alexander and Gustav Vik, with 3.33% each, investment banking firm Donaldson, Lufkin & Jenrette Capital Corp., with a 1.66% share and Enskilda Securities, a Scandinavian investment bank, with 1.33% (*BI*, Dec. 31, 1990).

Home Holdings is buying The Home for about $541 million in cash, including a final $29 million dividend paid by The Home to AmBase.

In addition, Home Holdings agreed to assume about $102 million of AmBase's senior public debt and about $117 million of its subordinated public debt. Home Holdings also agreed to make up to $48 million of cash available to AmBase to meet specified obligations.

For the nine months ended Sept. 30, The Home and its subsidiaries posted a $130 million loss, compared with a $125 million profit for the comparable period. Most of the loss stemmed from realized capital losses on The Home's junk bond portfolio.

The acquisition has already received a positive response from rating agencies. Last week, S&P affirmed The Home's BBB– claims paying ability rating and removed it from its CreditWatch list.

In addition, Moody's Investors Service placed both The Home and AmBase ratings under review for possible upgrade. The Home's cumulative preferred stock has a "b3" rating and its intercompany pool members have Ba2 ratings for insurance financial strength (*BI*, Dec. 24, 1990).

Diane Monteith, an S&P analyst, said that the Home acquisition is "aggressively leveraged," with about 80% of the total capital being debt and 20% equity. "That's an important issue from a ratings standpoint."

However, The Home will pay a significantly smaller dividend to well-capitalized Trygg-Hansa and the other investors than it did to AmBase, which will bolster The Home's capital, said Ms. Monteith.

She noted that very few dividends were collected by AmBase from The Home in 1990 because AmBase was trying to bolster the insurer's capital base to sell it.

But in 1989, The Home paid AmBase a dividend totaling $131.2 million, or 86% of its $152.5 million in consolidated statutory net income. In 1988, The Home paid AmBase a dividend of $101.5 million, or 93% of its $109.1 million in net income.

In contrast, The Home is expected to pay Home Holdings a dividend closer to 60% of its net income, said Ms. Monteith.

"That 30% difference will build up the capital" of The Home, Ms. Monteith said.

In addition, The Home has been improving the quality of the assets in its investment portfolio and that will continue under Home Holdings, which should make its capital base stronger, she said.

As of Sept. 30, according to a Form 10-Q filed with the Securities and Exchange Commission, The Home and its subsidiaries owned $110 million in junk bonds that have been classified as investments held for sale. Their amortized cost at the time was $150 million.

In addition, The Home and its subsidiaries had loaned $43 million to Drexel Burnham Lambert Group Inc., which had filed for bankruptcy last February.

Another factor that will aid The Home is the excess-of-loss reinsurance program it has arranged with a syndicate of reinsurers, including Centre Reinsurance (Barbados) Ltd. "That should prevent any negative development from occurring," Ms. Monteith said.

The contract is structured so that the attachment point is negotiable each year, she said. "That is very positive and that should give the investment community and the insurance community confidence about (The Home's) reserves."

Mr. Levin called Trygg-Hansa a strong, conservative company, adding that S&P expects it will run The Home with its current management "in a responsible way."

Current Home management has done a lot to reposition the insurer "and has given it unique strengths and competitiveness," Mr. Levin said. Now, he said, "they'll be able to finally implement their strategy."

Marvin Shulman, Moody's senior analyst, commented: "I think there would have been more serious concerns had the deal not gone through."

Moody's Ba2 rating for members of The Home's intercompany pool had been under review for possible downgrade, Mr. Shulman noted. Now, it could be upgraded. "At least the perception, anyway, is Trygg-Hansa is a stronger credit than AmBase."

Douglas D. Moat, chairman of the New York-based financial consultant Manhattan Group and a former Home executive vp, said The Home has "always been limited by a non-insurance management group whose motivations have been very different" from that of an insurance company. The company has suffered from a "lack of intelligent management capability," he said.

It also has been very difficult for The Home "to attract and retain terribly competent insurance people over the years" and the acquisition "may well create an opportunity" to do so, Mr. Moat said.

Trygg-Hansa's capital base also should enhance The Home's marketplace capability, Mr. Moat said. Pointing to the dividends The Home paid to AmBase, he noted, "that obviously is a limitation on your capital base in terms of your ability to expand."

"Clearly, the policyholders should be better off with Trygg- Hansa," commented Peter Porrino, a partner with Ernst & Young in New York, which conducted due diligence on the acquisition on behalf of Home Holdings.

"I think you have people who know insurance, and I also think that European insurance companies on average are more prudent in terms of financial management than American companies," Fitch's Mr. Wells said. "I think that's a positive, and I really think just getting all that nonsense behind them. . .is a positive," he said, referring to AmBase's financial problems.

Just having a strong parent will help The Home become more competitive, commented John Bailey, who heads Coopers & Lybrand's national insurance practice in Hartford, Conn.

Charles Ronson, an analyst with Baird, Patrick in New York, called Trygg-Hansa "solid people. They're big, long-term players." He added: "It can only be up from here."

AmBase, he alleged, "took a company that needed careful nursing back to health and used it as a source of funds to invest in every half-witted idea that came along."

Less enthusiastic, though, was Joyce Culbert, an analyst with Firemark in Morristown, N.J. "To the extent that the buyer strengthens the reserves, it would be good. Otherwise, it wouldn't matter."

She added, however, that "probably management has moved to stronger hands."

Last week's sale closes yet another chapter in the insurer's 138-year history.

The Home was a unit of City Investing Co. from 1968 until 1985. City Investing, whose shareholders voted to liquidate the company in 1984, could not find a buyer for The Home, which was subsequently spun off to the shareholders under a parent company named The Home Group Inc.

The parent company's name was changed to AmBase Corp. in May 1989 to reflect other businesses—including Carteret Bancorp Inc., a savings and loan, and Gruntal Financial Corp., a securities broker—acquired in an ill-fated attempt to become a financial services firm.

AmBase retains ownership of Carteret following the sale of The Home. Home Holdings purchased Gruntal along with The Home.

Meanwhile, the federal Office of Thrift Supervision, which supervises Carteret, filed a notice of charges against 19 AmBase officers and directors, plus former President Marshall Manley, regarding severance payments awarded to Mr. Manley and AmBase officers (*BI*, Feb. 4).

The OTS last week issued a temporary cease and desist order demanding that the payments be put into an escrow account by Feb. 25. It also ordered AmBase to nullify its forgiveness of the $4 million debt incurred by Mr. Manley.

The OTS also filed suit in federal court in Newark against five AmBase officers and directors and Mr. Manley in connection with the severance payments. Among other items, it seeks a preliminary injunction prohibiting the officers and Mr. Manley from disposing of any funds.

An AmBase spokesman said Friday that company officers had not seen the complaint. ■

Update

Green goes on trial tomorrow

Continued from page 2

campaign contributions from Champion's owners in return for various regulatory favors (*BI*, Dec. 10, 1990; June 11, 1990).

The trial, before U.S. District Judge George Arceneaux Jr., is expected to take about a month.

Mr. Green faces separate state criminal charges related to Champion.

Meanwhile, Mr. Green last week appointed Hunter O. Wagner Jr. as deputy commissioner and chief of staff, replacing Thomas E. Bentley Jr., who resigned. Mr. Bentley was indicted recently for allegedly perjuring himself during the grand jury investigation of Mr. Green (*BI*, Feb. 4).

Bill would hike PBGC payments

WASHINGTON—The Pension Benefit Guaranty Corp. could be saddled with an additional $400 million to $500 million of payments under a bill that calls for partially compensating retirees whose pension plans collapsed before the PBGC began to guarantee vested benefits in 1974.

Under the Pension Restoration Act of 1991, introduced as S. 351 in the Senate and H.R. 824 in the House, retirees whose pension plans collapsed before the PBGC was established would receive an annual benefit of $75 for each year they worked for a company and were covered under its pension plan. Widows and widowers would receive 50% of a retiree's benefit.

To qualify for the special benefit, a retiree must have met all of a plan's requirements for benefits, such as age and years of service. Retirees whose plans collapsed before Sept. 1, 1974, would be eligible.

The Pension Losers Committee, a grass-roots organization backing the bill, says the legislation would benefit 46,000 individuals.

The PBGC warns, though, that enactment of the measure could lead to another increase in the termination insurance premiums it charges employers with defined benefit plans.

The PBGC later this month is expected to report that its deficit has increased sharply to about $1 8 billion from just over $1 billion.

Oil spill plaintiffs plan appeal

ANCHORAGE, Alaska—Fish processors, boat charterers, sport fishermen and other groups and individuals plan to appeal a federal judge's ruling that they cannot seek damages from Exxon Corp. for the March 1989 Valdez oil spill because the spill did not harm them physically.

The ruling by U.S. District Court Judge H. Russel Holland in Anchorage contradicts a more than 10-year-old decision by the 9th U.S. Circuit Court of Appeals in Anchorage that permitted commercial fishermen to press litigation in such cases, said Lloyd Miller, a plaintiffs' attorney with Sonosky, Chambers, Sachse & Miller in Anchorage.

Mr. Miller is preparing to appeal the ruling to the 9th Circuit.

In his ruling, Judge Holland cited a 1927 maritime law that prohibits a plaintiff from recovering future economic losses when a defendant's negligence does not result in physical harm.

But, the judge said plaintiffs could seek redress from the state and from a $100 million fund established by the Trans-Alaska Pipeline Authorization Act to cover damages resulting from any spills involving Alaskan pipeline oil. The fund is financed by a levy on oil pumped through the pipeline.

More than 170 lawsuits related to the oil spill are pending in state and federal courts in Alaska, according to an Exxon spokesman.

However, it is uncertain how many of those suits are affected by the Feb. 8 decision.

Neither the decision nor the appeal are expected to affect negotiations to settle federal criminal charges and civil litigation brought by Alaska Gov. Walter J. Hickel, a spokeswoman for the governor said.

Briefly noted

Texas Gov. Ann Richards has appointed Claire Korioth as chairman of the **Texas State Board of Insurance**, replacing James Saxton, who remains a board member. Gov. Richards has threatened to place the State Board in conservatorship if Mr. Saxton and Richard Reynolds, the other board member, do not resign. Both have refused to step down (*BI*, Feb. 11). . . .A state judge in Omaha, Neb., has granted **Alexander & Alexander Inc.**'s request for a temporary injunction forbidding 11 former A&A employees from soliciting business on behalf of their new employer, Frank B. Hall & Co. Inc. (*BI*, Dec. 24, 1990). A hearing in connection with A&A's request for a permanent injunction has not yet been scheduled. . . .Florida Insurance Commissioner Tom Gallagher has written to House Oversight and Investigations Subcommittee Chairman John D. Dingell, D-Mich., asking that Congress grant states the power to regulate **self-funded multiple employer welfare arrangements**.

Home chairman says insurer 'out from under'

By JUDY GREENWALD

NEW YORK—The Home Insurance Co.'s acquisition by a group led by Swedish insurer Trygg-Hansa SPP Holding AB will enable it to offer international expertise, says James J. Meenaghan, chairman, president and chief executive officer of The Home.

The acquisition gives the insurer "an international window that we haven't had," he said last week.

Mr. Meenaghan said he plans to meet soon with his counterparts at Trygg-Hansa and at Finnish insurer Industrial Mutual Insurance Co., another partner in the group that bought The Home, to develop plans to expand in Europe.

"This will be of undoubted benefit to our policyholders in the U.S," he said. Conversely, he added, Trygg-Hansa policyholders will now have a U.S. outlet as well.

But while The Home certainly will benefit from having a parent with about $40 billion in assets, it does not plan any essential strategic changes. It will still focus on large, complex corporate risks with a heavy emphasis on quality underwriting, said Mr. Meenaghan, who described The Home as financially solid despite the travails of its former parent, AmBase Corp.

The Trygg-Hansa deal was a relief to Home management, he noted. It was predicted that if debt-ridden AmBase could not sell the insurer, it would file for bankruptcy, and "my strong feeling was if they went into Chapter 11, The Home was going to go with them," he said.

"The Home's credibility with the people we depend on for our business, the brokers and agents, would have been destroyed," said Mr. Meenaghan, who said he was grateful to agents and brokers for sticking with the insurer during the uncertain year between the time AmBase said it planned to sell The Home and the deal's consummation.

"It's been a cliff-hanger," he said, though he stressed it was not because of any problems at The Home.

Mr. Meenaghan notes a certain irony. Founded in 1853, the insurer managed to endure two world wars, a depression and numerous catastrophes, but "damned well almost didn't survive AmBase."

Now, "we're out from under," Mr. Meenaghan said. "I think our prospects looking forward are very good."

No essential changes are planned. The insurer, he said, will stick to a strategy introduced since his arrival in 1986. At its center are: strong underwriting; quality staff; a focus on large corporate risks; fair and sensible pricing; and controlling expenses.

The strategy has been successful, he said. Home posted a 108.7% combined ratio in 1990, compared with A.M. Best Co.'s estimated industrywide 109.6%.

There also will be no change in the insurer's management, Mr. Meenaghan said, noting he has negotiated "a contract with (the new owners) I'm very comfortable with."

Despite Trygg-Hansa's financial strength, The Home has no immediate plans to boost its premium volume, he said. Given the soft market, "I'm not expecting to see us writing tons of business now."

But on a longer-term basis, Trygg-Hansa's capital base "is very reassuring" because it will allow expansion when appropriate. "It would not have been possible with AmBase," he said.

There also are no immediate plans to boost reserves or surplus, Mr. Meenaghan said. "We're in very good financial condition." ■

Insurers blast Prop. 103 proposal

By LOUISE KERTESZ

LOS ANGELES—Proposed regulations for implementing the insurance "charge" rollback provisions of Proposition 103 in California are a recycled version of previously rejected regulations that actually would tighten the state's insurance market, insurers charge.

The proposed regulations, though, are not set in stone, pledges California Insurance Commissioner John Garamendi.

In a heated public hearing last week on the regulations proposed by Mr. Garamendi last month, insurers contended that the regulations would defeat the purpose of Proposition 103 by, among other things, driving some insurers out of California and stifling competition.

The emphatic objections to the new regulations were in response to Mr. Garamendi's opening statement in which he welcomed suggestions on how to "turbo-charge" the implementation of Proposition 103.

However, Mr. Garamendi also said he would consider modifying the proposed regulations.

"This hearing is not a mere formality. I am genuinely interested in the views of the public, and I fully intend to take them into account. The regulations I adopt next month may well differ from those I proposed in January," he said.

The hearing last week was the first in a series Mr. Garamendi said he would hold on his proposed regulations.

A day after Mr. Garamendi was sworn in last month as the state's first elected insurance commissioner, he set aside the Proposition 103 implementation regulations adopted by his predecessor, Roxani Gillespie. Mr. Garamendi scheduled public hearings as well as a timetable for written comments in an attempt to adopt new rules by March 15 (*BI*, Jan. 14).

But insurer representatives at last week's hearing said they don't plan to file written comments until the March 15 deadline. Since they would be filing detailed objections to the regulations, March 15 would not be the final hearing unless Mr. Garamendi disregards their objections.

If the commissioner modifies the regulations substantially, another hearing must be held.

Mr. Garamendi's proposed regulations, designed to establish an allowable rate of return for ratemaking purposes, would preclude insurers from charging consumers for overhead expenses exceeding the industry average.

The proposed regulations also state that Insurance Department actuaries will provide "independent, unbiased projections" of future loss costs that squeeze "the excess from bloated estimates" by insurers.

In addition, when determining return on equity, the proposed rules call for taking into account the investment income on insurer capital not used to write insurance in California, which has been dubbed "surplus surplus."

The new regulations establish a two-pronged hearing process for ironing out disputes between insurers and the department: "Generic" hearings would be held to make basic industrywide factual determinations, like forecasting loss cost trends for a given line of coverage. "Company-specific" hearings would resolve disputes over how regulations apply to an individual company.

In a summary of her testimony at the hearing, Judith Mintel, associate general counsel for State Farm Mutual Automobile Insurance Co. of Bloomington, Ill., said Ms. Gillespie already rejected the regulations Mr. Garamendi proposed. The regulations were authored by former California Attorney General John Van de Kamp, she said.

As attorney general, Mr. Van de Kamp criticized Ms. Gillespie's methods of implementing Proposition 103 (*BI*, June 18, 1990).

Frederic Woocher, a former member of Mr. Van de Kamp's staff who now represents the Insurance Department in legal matters, confirmed in an interview that Mr. Van de Kamp, with the assistance of his staff and Insurance Department actuary Robert Hunter, authored the regulations Ms. Gillespie rejected.

Mr. Hunter was the department's lead witness in last week's hearing.

Mr. Garamendi's proposed regulations are "quite similar" to and "based upon" the regulations Mr. Van de Kamp proposed, with "some changes" and "technical modifications," Mr. Woocher said.

Michael Miller, an actuarial consultant with Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc. in Bloomington, Ill., who was the lead witness for Allstate Insurance Co. at the hearing, said that the proposed regulations do not embody "the intent of Proposition 103."

The regulations "display a misunderstanding of the insurance marketplace," and "technical errors" and "conceptual failings" would make the regulations "impossible to comply with," Mr. Miller said.

"Nothing in Proposition 103 gives the commissioner the centralized control and micromanagement" that the new regulations give him, Mr. Miller said.

In addition, "use of industry-average data will result in excessive rates for some insurers and inadequate rates for others," he said.

The result would be that insurance would be unavailable to many consumers, he said.

Ms. Mintel, State Farm's counsel, said the new regulations would create "a bureaucratic maze" because they would require collecting industrywide data on 12 different components of rates, she said. The result would be that decisions on insurance "charge" rollbacks called for by Proposition 103 could be delayed by as long as two years.

At a continuation of the hearing the next day in San Francisco, Thomas Conneely, president of the Assn. of California Insurance Companies, said the new regulations would not encourage insurers to cut costs.

In addition, the regulations would penalize insurers that were low-cost oriented and discourage companies from entering the market, said Mr. Conneely, who also represented the American Insurance Assn.

The regulations "would damage specialty lines," declared Sherman A. Sitrin, vp and associate general counsel-domestic companies for New York-based American International Group Inc., at the Los Angeles hearing.

Specialty lines are "a fragile market" in which insurers must have "flexibility" and be able "to respond quickly" to events and the needs of policyholders. But the new regulations, with their "generic norms," would make that impossible, Mr. Sitrin said. That would result in "the contraction or disappearance of these markets in California."

The new regulations are "designed for private passenger auto" coverage and have "no reasonable application to specialized lines" of commercial coverage, like political risk insurance, Mr. Sitrin noted.

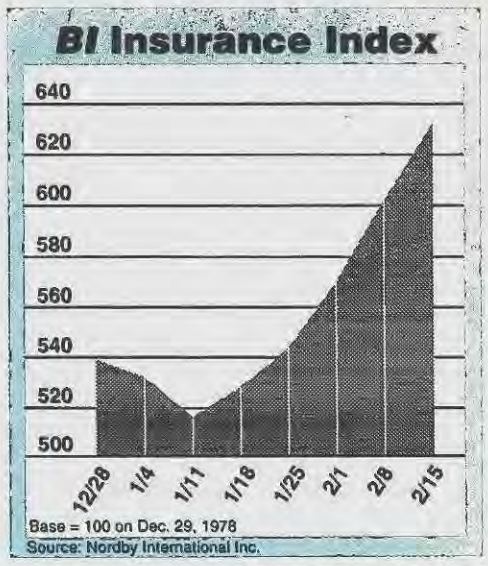
Mr. Garamendi then broke into Mr. Sitrin's testimony and asked: "Political risk? Can I send you my home address?"

Mr. Garamendi asked Mr. Sitrin to provide a list of those risks for which generic norms might be applicable.

In defending Mr. Garamendi's proposal, Mr. Hunter said that the regulations would "streamline the administrative process." Mr. Hunter called Ms. Gillespie's regulations "unwieldy" and Mr. Garamendi's proposal "state-of-the-art."

The old regulations also would have allowed companies "excessive profits," Mr. Hunter said.

Harvey Rosenfield, author of Proposition 103 and director of the insurance consumer advocacy group Voter Revolt, applauded Mr. Garamendi's regulations, saying that Ms. Gillespie's regulations would have "clearly eviscerated Proposition 103." ■



Insurance industry stocks continued to soar last week as the *Business Insurance* Index jumped 30.6 points to 630.7 on Feb. 15, from 600.1 on Feb. 8. Advancing issues for the week were led by AmBase Corp., up 37.6% (see story, page 1); FHP International, up 27.8%; and United Healthcare Corp., up 18.7%. Declining issues followed Hilb, Rogal & Hamilton Corp., down 4.4%; Chandler Insurance Co., down 3.8%; and Washington National Corp., also down 3.8%. The most active issue for the week was Sears, Roebuck & Co. (Allstate), with 6 million shares traded. The *BI* Index was up 5.1%; the Dow Jones 30 Industrials were up 3.7%; the Standard & Poor's 500 climbed 2.7%; and the New York Stock Exchange Composite gained 2.65%.

British Issues

Feb. 14 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	507	23.2	28.7	5.7	507—	493
Genl Accident	523	15.8	33.4	6.4	524—	515
Gdn Royal Exch	209	18.2	15.3	7.3	209—	199
Royal	428	22.7	34.0	7.9	433—	418
Sun Alliance	364	12.9	16.7	4.6	366—	356
Brokers						
Bradstock	274	15.5	12.0	4.4	274—	254
CE Heath	464	13.4	34.5	7.4	464—	459
Hogg Group	178	11.6	9.7	5.4	178—	173
Lloyd Thompson	317	21.2	10.0	3.1	317—	305
PWS Holdings	93	11.2	4.7	5.0	93—	83
Sedgwick Grp	237	17.6	16.0	6.7	243—	234
Steel Brnt Jones	268	15.9	14.7	5.5	268—	259
Willis Corroon	284	21.0	16.0	5.6	284—	279

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

FEBRUARY 11, 1991 THROUGH FEBRUARY 15, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.63	-0.47	15.14	28.88	16.13	481	1.00	3.76	20	9.18	2.90
Gallagher Arthur J. & Co.	NYS	24.50	1.03	5.38	25.00	19.75	126	0.64	2.61	18	5.33	4.60
Frank B. Hall	NYS	3.38	-0.15	-6.90	4.25	2.00	75	0.00	0.00	-7	-2.80	-1.21
Hilb, Rogal & Hamilton	OTC	13.63	-4.39	-7.63	16.50	11.25	214	0.36	2.64	18	4.60	2.96
Marsh & McLennan	NYS	78.88	1.77	1.12	82.00	59.75	798	2.60	3.30	19	10.56	7.47
Poe & Associates	OTC	9.75	2.63	21.88	13.00	7.75	5	0.40	4.10	9	1.93	5.05
BROKERS	AVERAGE		0.1	4.1					2.3	11		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	43.50	7.06	16.00	44.75	28.50	121	0.44	1.01	12	25.06	1.74
Berkshire Hathaway Inc.	NYS	7700.00	1.32	15.36	8900.00	5675.00	1	0.00	0.00	24	2869.00	2.68
ITT (Hartford Group)	NYS	58.00	4.98	20.83	60.88	40.25	1868	1.72	2.97	8	56.33	1.03
Sears (Allstate)	NYS	33.50	12.61	32.02	41.88	22.00	5970	2.00	5.97	13	37.75	0.89
CONGLOMERATES	AVERAGE		6.5	21.1					2.5	14		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	48.75	7.43	25.00	54.38	29.00	2193	2.76	5.66	9	58.11	0.84
Ambase Corp.	NYS	0.69	37.60	119.81	9.63	0.16	2122	0.00	0.00	0	29.08	0.02
American General	NYS	36.38	-1.02	18.29	50.63	23.50	1556	2.00	5.50	8	34.68	1.05
American Heritage	NYS	23.25	3.33	10.71	24.50	19.63	5	1.00	4.30	11	22.60	1.03
American Indemnity/Fin'l	OTC	6.25	-2.04	92.31	7.25	2.75	4	0.08	1.28	-19	17.38	0.36
American International	NYS	89.63	2.57	16.59	92.25	57.00	3377	0.44	0.49	13	41.92	2.14
Aon Corp.	NYS	36.75	6.52	5.76	41.38	26.75	699	1.52	4.14	10	19.62	1.87
Argonaut Group	OTC	75.00	3.98	17.19	78.00	53.00	20	1.60	2.13	8	36.83	2.04
AVEMCO Corp.	NYS	28.00	2.26	10.89	30.13	21.13	34	0.44	1.57	18	9.52	2.94
Baldwin & Lyons Inc.	OTC	21.25	6.89	13.33	21.88	17.00	42	0.28	1.32	8	20.80	1.02
Belvedere Corp.	ASE	2.88	4.55	15.00	5.38	1.75	7	0.04	1.39	-4	8.03	0.36
Chandler Insurance	OTC	3.38	-3.57	-50.91	10.00	2.75	115	0.00	0.00	2	9.53	0.35
Chubb Corp.	NYS	69.00	8.66	27.19	69.00	34.63	2093	1.32	1.91	11	55.49	1.24
CIGNA Corp.	NYS	49.63	5.29	21.41	55.50	33.25	1114	3.04	6.13	11	66.64	0.74
CNA Financial Corp.	NYS	88.00	11.39	28.23	84.00	49.50	208	0.00	0.00	16	54.87	1.60
Continental Corp.	NYS	30.50	8.93	22.61	31.38	15.75	777	2.60	8.52	11	41.36	0.74
Durham Corp.	OTC	26.50	6.51	-5.36	34.00	23.00	21	0.92	3.47	13	26.32	1.01
Fund American Corp.	NYS	58.25	5.43	12.29	57.88	29.50	625	0.68	1.17	24	32.74	1.78
Fremont General Corp.	OTC	16.00	0.00	10.34	21.13	10.13	164	0.80	5.00	4	19.09	0.84
Frontier Insurance Group	NYS	21.00	-1.18	10.53	33.00	15.38	35	0.00	0.00	9	7.29	2.88
General RE Corp.	NYS	99.38	6.28	6.85	99.38	69.00	1443	1.52	1.53	14	29.04	3.42
Hanover Insurance Co.	OTC	29.00	-2.52	9.43	31.00	21.00	35	0.44	1.52	13	32.03	0.91
Harleysville Group	OTC	26.50	4.95	15.85	26.50	13.50	20	0.64	2.42	8	18.94	1.40
Hartford Steam Boiler	NYS	57.13	5.53	17.18	62.13	43.50	156	1.80	3.15	15	18.94	3.02
Kansas City Life Ins.	OTC	32.00	0.00	3.64	36.50	30.00	14	1.20	3.75	8	39.22	0.82
Kemper Corp.	NYS	33.00	11.37	38.95	43.13	17.13	869	0.92	2.79	127	29.97	1.10
Lawrence Insurance Group	ASE	6.88	3.70	-1.79	9.13	6.38	8	0.36	5.24	11	4.40	1.56
Liberty Corp.	NYS	47.50	3.26	15.50	50.25	39.00	34	0.92	1.94	16	31.82	1.49
Lincoln National	NYS	50.50	0.00	17.44	56.50	30.75	441	2.72	5.39	10	49.19	1.03
NAC Re Corp.	OTC	37.25	0.00	12.88	38.25	25.50	215	0.20	0.54	16	22.81	1.63
Navigators Group	OTC	40.00	3.90	22.14	39.00	24.75	7	0.00	0.00	15	15.22	2.63
Nobel Insurance LTD.	OTC	3.06	2.10	2.10	3.75	1.88	200	0.00	0.00	-	7.76	0.39
NWNL Companies	NYS	27.50	18.28	62.96	34.50	11.75	1063	1.32	4.80	6	37.50	0.73
Ohio Casualty Corp.	OTC	45.50	1.11	10.98	50.75	26.75	150	2.32	5.10	10	33.30	1.37
Old Republic Int'l	NYS	28.63	0.86	25.14	28.75	19.00	147	0.76	2.66	6	30.70	0.93
Orion Capital Corp.	NYS	21.38	1.16	22.14	23.00	13.00	95	0.92	4.30	6	19.72	1.08
Phoenix RE Corp.	OTC	9.38	4.17	20.97	12.50	5.00	22	0.20	2.13	117	12.99	0.72
Protective Life Corp.	OTC	16.50	6.45	10.92	16.75	10.25	99	0.76	4.61	9	14.54	1.13
Provident Life	OTC	21.00	1.20	20.00	26.25	12.00	1041	0.92	4.38	5	23.24	0.90
Re Capital Corp.	ASE	15.25	9.87	18.45	15.13	11.75	55	0.00	0.00	11	14.43	1.06
RLI Insurance Corp.	NYS	14.63	4.46	0.86	14.88	9.50	100	0.44	3.01	7	12.42	1.18
St. Paul Companies	OTC	68.00	0.37	8.37	68.75	47.00	2157	2.60	3.82	8	43.47	1.56
SAFECO Corp.	OTC	39.13	-2.19	19.01	40.50	25.13	1016	1.36	3.48	9	24.87	1.57
SCOR U.S. Corp.	NYS	15.25	12.96	23.23	14.25	8.38	67	0.20	1.31	13	10.61	1.44
Seibels Bruce Group	OTC	6.50	0.00	52.94	11.75	4.25	24	0.36	5.54	-1	13.75	0.47
Selective Ins. Group	OTC	15.75	1.61	18.87	19.00	12.50	46	1.04	6.60	6	15.72	1.00
Statesman Group Inc.	OTC	2.53	3.73	61.93	2.88	1.25	222	0.00	0.00	4	4.19	0.60
Tokio Marine & Fire	OTC	54.88	-0.23	16.14	66.50	34.50	114	0.26	0.47	33	70.93	0.77
Torchmark Corp.	NYS	55.00	1.14	12.53	55.25	38.00	381	1.40	2.55	13	13.23	4.16
Transamerica	NYS	35.13	5.47	10.73	41.00	23.25	894	1.96	5.43	11	34.63	1.04
Travelers Corp.	NYS	21.25	3.01	27.82	34.88	11.50	1483	1.60	7.53	-11	44.85	0.47
Trenwick Group Inc.	OTC	25.75	0.00	11.35	26.25	16.25	98	0.48	1.86	10	16.91	1.52
United Fire & Casualty	OTC	39.50	2.60	12.46	39.50	28.75	6	1.32	3.34	9	22.56	1.75
USF&G Corp.	NYS	12.00	9.09	60.00	30.13	7.00	3095	1.00	8.33	8	22.87	0.52
UNUM Corp.	NYS	60.00	2.56	28.69	63.00	32.13	773	0.80	1.33	11	31.20	1.92
USLIFE Corp.	NYS	35.75	1.05	27.68	41.75	23.25	148	1.48	4.14	9	54.34	0.66
Unitrin	OTC	36.00	3.60	17.07	36.50	24.50	211	0.80	2.22	15	33.99	1.06
Washington National	NYS	13.50	-3.57	24.14	25.75	9.38	25	1.08	8.00	56	32.90	0.41
USLICO Corp.	NYS	20.38	5.84	28.35	23.00	14.75	73	1.00	4.91	8	27.73	0.73
Zenith National Ins.	NYS	15.50	5.08	13.76	18.13	9.88	157	1.00	6.45	-30	13.81	1.12
INSURERS/REINSURERS	AVERAGE		4.4	21.9					3.3	13.5		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	23.00	27.78	50.82	21.38	9.75	2146	0.00	0.00	19	3.54	6.50
HMO America Inc.	OTC	8.13	-0.06	25.00	8.50	4.25	325	0.00	0.00	11	1.12	7.25
Pacificare Health Sys.	OTC	22.75	13.75	40.00	26.00	12.00	1017	0.00	0.00	16	6.35	3.58
Safeguard Health Enter.	OTC	4.75	0.00	0.00	7.63	4.00	6	0.00	0.00	11	2.99	1.59
Sierra Health Services	ASE	20.75	16.05	50.91	21.25	5.50	563	0.00	0.00	61	0.62	33.47
United Healthcare Corp.	OTC	32.50	18.70	39.78	33.13	9.00	2482	0.12	0.37	33	0.34	95.59
United Medical Corp.	ASE	9.13	7.35	14.06	11.38	6.63	13	0.20	2.19	13	5.70	1.60
U.S. Healthcare	OTC	40.75	7.95	38.72	41.25	10.13	2693	0.36	0.88	25	3.07	13.27
HMOs	AVERAGE		11.4	32.4					0.4	24		
ALL COMPANIES	AVERAGE		4.7	20.8					2.8	14		

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