

# Business Insurance

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## Monsanto not held liable for Houston pollution damage

HOUSTON—Builders and 222 homeowners are seeking a new trial after a Texas jury last week found Monsanto Co. not liable for \$595 million in damages, \$475 million of it in punitive damages, that plaintiffs sought for hazardous waste dumped near their Houston subdivision.

A Harris County court ruled the company was not liable for diminution of property values and pain and suffering allegedly caused by hazardous waste left

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## Tort plan rejected

### Ambiguity cited in ABA proposal to merge cases

By STACY ADLER

LOS ANGELES—The American Bar Assn. is not recommending that Congress approve a proposal to consolidate certain types of mass tort litigation, largely because attorneys say sloppy drafting left the proposal unduly ambiguous.

The ABA's House of Delegates, the group's policy-making arm, decided last week not to recommend a proposal that would consolidate in federal court all cases involving at least 25 claims—each seeking more than \$50,000—stemming from a single incident.

An ABA endorsement was considered important because the group represents more than half the nation's 700,000 lawyers.

While supporters said their proposal was intended to streamline litigation stemming from single events, like airplane crashes, critics said the proposal could be construed to apply to sequential events, like asbestos litigation and other product liability cases.

All sides agree that the proposal should not be applied to product liability litigation.

The proposal, which is similar to legislation currently before Congress, was introduced in lieu of an earlier plan to consolidate before a seven-judge panel all cases involving 250 or more claims, each seeking more than \$50,000, that stem from a single incident (*BI*, Aug. 14, 1989).

After an "avalanche" of critical letters, the earlier proposal was withdrawn on the opening day of the House of Delegates session at the ABA's Los Angeles convention, said Robert F. Hanley, a Denver attorney who chaired the ABA panel that drafted the original proposal. The new proposal was later presented to



The 460-member ABA House of Delegates erupted in a raucous debate over the tort proposal.

the delegates.

The withdrawal of the earlier proposal will allow the ABA to monitor debate on the legislation pending in the House of Representatives before acting, said Mr. Hanley of Morrison & Foerster.

H.R. 3406, introduced by Rep. Robert Kastenmeier, D-Wis., and pending before the House Courts subcommittee he chairs, would consolidate in federal court civil actions involving at least 25 claims—each for more than \$50,000—stemming from a single incident (see story, page 72).

The legislation would expand current law by allowing courts to determine liability in consolidated tort proceedings. Judges currently can only consolidate cases for pre-trial proceedings.

Judges also would be given greater leeway in determining which state's laws would apply to a case. For example, the judge would determine whether the laws in the state where involved parties are incorporated or based or the laws in the state where the relevant event occurred or any other states' laws are applicable.

Current restrictions on judicial discretion in selecting which state laws to use would not apply.

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## N.C. high court OKs coverage for pollution cleanup costs

By DOUGLAS McLEOD

CHARLOTTE, N.C.—For the second time in as many months, policyholders are cheering a state supreme court ruling that the costs of a government-ordered pollution cleanup constitute "damages" under a comprehensive general liability policy.

The North Carolina Supreme Court ruled earlier this month that pollution must be considered as "property damage" under a CGL policy and that government-imposed cleanup costs meet the policy definition of damages the policyholder has become "legally obligated to pay."

The court also concluded that a government administrative action requiring cleanup constitutes a "suit" under the terms of the policy, triggering insurers' duty to defend policyholders.

The Feb. 7 North Carolina decision follows a Jan. 4 ruling by the Washington Supreme Court, which similarly found that government-ordered cleanup costs are insurable damages under CGL policies issued to The Boeing Co. and

others (*BI*, Jan. 15).

The North Carolina and Washington state supreme courts are the first to rule on this coverage issue, which is also set for review by the supreme courts of California, Iowa, Massachusetts, Minnesota, New Hampshire, New Jersey and New York.

Policyholder attorneys hail the first two victories as harbingers of a trend to allow coverage of government-mandated cleanups.

"Within six weeks, we have had two state supreme courts deciding cases in policyholders' favor," said Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York.

These rulings, along with a 1989 Georgia Supreme Court ruling nullifying the CGL policy's pollution exclusion clause, "indicate a pretty substantial trend in favor of policyholders," he said. "The policyholders are finally convincing the courts that insurance policies provide the coverage the policyholders bought and paid for."

Though future state court rulings could go against policyholders, the

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## Petromark reserves called inadequate

By DOUGLAS McLEOD

NASHVILLE, Tenn.—A risk retention group writing pollution liability insurance for owners of underground petroleum storage tanks is operating under state supervision following an actuarial opinion indicating the group may be insolvent.

A review by The Wyatt Co. found that Petroleum Marketers Mutual Insurance Co., a Risk Retention Group, will need to more than triple its reserves to \$33 million from \$10 million to meet outstanding claims, Petromark officials say.

If the Wyatt study is correct, Petromark—the second-largest market for underground petroleum storage tank coverage—would see its policyholder surplus plummet from the \$9.5 million it reported at year-end 1989 to a deficit of \$10.5 million, Petromark President Scott F. Blankenship announced in a Feb. 8

letter to policyholders.

Petromark has hired the Tillinghast division of Towers, Perrin, Forster & Crosby to conduct a second actuarial review. If the Wyatt findings are confirmed, Petromark will have to raise additional capital from its policyholders or face liquidation by the Tennessee Insurance Department, Mr. Blankenship's letter says.

Because Petromark is a non-assessable mutual, additional capital contributions from policyholders would be strictly voluntary, said Max Clay, president of The Planning Corp., the Reston, Va.-based underwriting manager for Petromark.

Petromark agreed Feb. 7 to be placed under the Tennessee department's supervision. Pending results of the Tillinghast review, the group has discontinued writing new business and is offering renewal coverage only for 60-day periods.

Petromark would be only the second risk retention group formed under the federal Risk Retention Act to be declared insolvent. Rent Rite Advantage Services Inc., a Risk Retention Group, is in rehabilitation in Arizona (*BI*, Aug. 21, 1989).

Meanwhile, representatives for four associations of gasoline marketers and service station operators last week cited Petromark's problems in arguing for a delay in enforcement of the Environmental Protection Agency's financial responsibility requirements for underground storage tank owners. Those rules are due to take effect this year for owners of fewer than 100 tanks.

The EPA rules—which are being phased in from January 1989 to January 1991—require owners of underground petroleum tanks with monthly throughputs exceeding 10,000 gallons to maintain environmental impairment liability coverage with limits of \$1 million

per claim. Owners of smaller tanks must maintain EIL limits of \$500,000 per claim and \$1 million annual aggregate.

Representatives of the National Assn. of Convenience Stores, Petroleum Marketers Assn. of America, Service Station Dealers of America and Society of Independent Gasoline Marketers of America met with EPA Administrator William Reilly Tuesday to ask that the compliance deadline for the EPA rules be extended to Dec. 22, 1991.

Among other things, the trade associations cited a "tank insurance crisis" that has been exacerbated by the Petromark uncertainty and an announcement by Federated Mutual Insurance Co. of Owatonna, Minn.—the largest market for underground tank insurance—that it is phasing out coverage for tank locations in 11 states where coverage is provided by state funds.

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## Update

## Monsanto plaintiffs to try again

Continued from previous page  
at an abandoned refinery. Several owners used the so-called Brio refinery before it closed in 1982.

"The jury was just dead wrong," said Larry Doherty of Doherty, Norman & Williamson in Houston, an attorney for builders Park Avenue Homes Inc. and T.B. Campbell Inc. "The process of obtaining a new trial has been started."

Robert A. Hall of Woodard, Hall & Primm in Houston, an attorney for St. Louis-based Monsanto, explained that the chemical firm supplied chemical byproducts to the refinery, which reprocessed and "sold them on the open market."

The jury found Monsanto's activities were not "abnormally dangerous," he said.

## Health benefit tax studied

WASHINGTON—Taxing all employer-provided health care benefits as income would raise \$133 billion in federal income tax revenues over five years, the Congressional Budget Office said last week.

In its report on deficit reduction options, the CBO also said treating employer health care contributions as income would raise \$73 billion in FICA taxes from 1991 to 1995.

Taxing employees on employer health care contributions exceeding \$100 a month for individual and \$250 a month for family coverage would generate \$30 billion in new income tax revenues in 1991 to 1995 and \$17 billion in FICA tax revenues, the CBO report said.

## U.S. Perrier losses not covered

GREENWICH, Conn.—Perrier Group of America Inc., which is recalling its trademark bottled water after discovering small amounts of benzene, has no insurance to compensate it either for recall costs or for the estimated \$40 million in sales it will lose while Perrier remains off the shelves.

The company, a unit of Source Perrier S.A. of France, recalled 72 million bottles last week after discovering it contained four to 19 parts per billion of benzene, which is not considered a dangerous level of the toxic chemical.

Perrier Group expects its water, which generates \$150 million in annual sales, to be off the shelves for about three months, a spokeswoman says.

## Summer Olympics reinsurance

LONDON—Lloyd's of London broker Johnson & Higgins is placing the liability and cancellation coverage reinsurance for the 1992 Summer Olympics in Barcelona, Spain.

J&H Ltd., a subsidiary of New York-based Johnson & Higgins, was awarded the contract by Spanish insurer La Union y el Fenix Espanol Cia de Seguros Reunidos S.A. of Madrid, which is writing \$100 million of liability insurance for the games. But, La Union is retaining only 5% to 10% of the risk.

J&H Ltd. has placed \$90 million to \$95 million of liability reinsurance worldwide. The London market—led by Lloyd's of London underwriters—is writing about 40% to 50% of the coverage, and the rest is placed with continental European reinsurers, said Nuno de Brito e Cunha, joint chairman of J&H Ltd.

The Spanish insurer plans to cede most of the \$250 million in cancellation coverage it is writing for the Spanish Olympic organizing committee. J&H likely will need to tap the worldwide reinsurance market to find sufficient coverage, said Mr. de Brito e Cunha.

Property coverage for the games also will be written in the Spanish market but will not be reinsured, he said.

## Exxon captive moving to U.S.

HAMILTON, Bermuda—"Internal requirements" have forced Exxon Corp. to wind down Ancon Insurance Co., its Bermuda captive, and incorporate a captive called Ancon Insurance Co. Inc. in Vermont, Exxon says.

Ancon writes a portfolio of primarily non-U.S. property/casualty risks for Exxon affiliates, which generates more than \$100 million in annual premiums.

The move "had nothing to do with...Bermuda," said Bill Jueds, president of Exxon Insurance Services in Florham Park, N.J.

Ancon had been running off unrelated business since October 1984 when it announced it would not add to its increasingly unprofitable \$25 million book of third-party risks. Staff members were moved to New Jersey about two years ago.

A Johnson & Higgins captive management subsidiary in Bermuda will remain in charge of the Ancon runoff, Mr. Jueds said.

M&M Insurance Management Services Inc. will manage the Vermont captive.

## Insurers fault new auto rate law

HARRISBURG, Pa.—Auto insurers in Pennsylvania claim a new state law, which freezes private passenger auto insurance rates until this summer and mandates subsequent rate cuts that could exceed 22%, does not contain adequate cost-saving measures.

The law, signed by Gov. Robert P. Casey on Feb. 7, requires auto

Continued on page 78

## Errors and omissions

• Pools and trusts accounted for 5.9% of the risk financing market in 1989, not 6.9% as reported in the Jan. 29 issue. In addition, pools and trusts are predicted to account for 5% of the market in 1992, not 6% in 1990.

• Information about insurers' junk bond holdings in the Feb. 12 issue was based on Sept. 30, 1989, data, not Sept. 30, 1988.

## Employer defends choice of troubled annuity insurer

By JERRY GEISEL

WASHINGTON—Executives of a company planning to terminate an overfunded pension program are defending a now-canceled agreement to purchase annuities to guarantee benefits from a junk-bond laden insurer whose credit rating has since been lowered.

During a Senate Labor Subcommittee hearing last week, Howard Gittis, vice chairman of MacAndrews & Forbes Holdings Inc., testified that the company selected Executive Life Insurance Co. as the annuity insurer because it had the highest credit rating available and was offering the best price when the annuities contract was signed.

But, last month, Standard & Poor's Corp. lowered Executive

Life's claims paying rating to A from the AAA rating it had when MacAndrews & Forbes first agreed to purchase the annuities.

The annuities were to guarantee coverage to 6,300 employees and retirees provided by two pension plans—with \$32 million in excess assets—sponsored by Coleman Co. Inc., a Wichita, Kan., outdoor recreational equipment manufacturer MacAndrews & Forbes acquired last year.

The downgrading of Executive Life's rating came as its parent, First Executive Corp., whose junk bond holdings have a face value of \$8 billion, announced it would take a \$515 million charge against fourth-quarter earnings to reflect defaults and declines in the value of securities it holds.

New York-based MacAndrews & Forbes has since canceled its contract with Executive Life and is looking for another annuities insurer.

Coleman intends to set up two new defined benefit plans to replace the terminated plans.

It has also established a new 401(k) salary reduction plan.

The Feb. 13 Senate subcommittee hearing came amidst rising congressional concerns about the security of workers' and retirees' benefits after employers terminate overfunded pension plans.

Employers terminating overfunded pension plans are required by the Pension Benefit Guaranty Corp.—the federal agency that reviews proposed plan terminations

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## Cap on AIDS claims dropped

## Firm revises benefit policy

By MICHAEL BRADFORD

CHATSWORTH, Ga.—A Georgia carpet company says it will drop a \$10,000 cap on lifetime health care benefits for covered lives who have "voluntarily" contracted AIDS.

Following strong protests by an AIDS activist group, Galaxy Carpet Mill Inc. in Chatsworth, Ga., promised to lift by last week the cap for covered lives with acquired immune deficiency syndrome or other sexually transmitted diseases.

A nationwide call-in Jan. 25 orchestrated by New York-based AIDS Coalition To Unleash Power, or ACT UP, generated about 500 calls to the company protesting the benefit cap in its self-funded benefit plan.

The group also contends provisions in other employers' health care plans discriminate against AIDS victims, but another activist group and a labor lawyer say most employers do not support such provisions.

Galaxy told ACT UP Feb. 5 that it would strike the

cap.

"You may advise your organization that Galaxy's plan will consider all sexually transmitted diseases, including HIV, as any other illness," wrote Jack M. Pounds Jr., director of human resources, in a letter to the group. Human immunodeficiency virus, or HIV, can develop into AIDS.

The company made the decision to remove the cap after it "had an opportunity to review" the plan, he wrote.

Mr. Pounds agreed to discuss Galaxy's decision to rescind the controversial provision but later did not return repeated calls.

Before it was revised last week, the Galaxy benefit plan stated the lifetime cap on AIDS benefits would be waived only if "it is established by clear and convincing proof that the infection or disease...was involuntarily acquired"—that is, was not contracted sexually or through use of intravenous drugs

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## UR coalition promotes standards, accreditation

By CHRISTINE WOOLSEY

WASHINGTON—A newly formed coalition of leading utilization review companies is promoting voluntary standards of practice that will lead to professional accreditation for UR firms.

The creation of the Utilization Review Accreditation Commission—composed of executives of several UR firms, a trade association and an insurance company—comes on the heels of recent proposals by the American Medical Assn. to make the UR process more uniform and efficient (BI Jan. 22).

"There is a critical need for national utilization review standards that responsibly address the legitimate concerns of the provider community," said URAC Chairman Roger Taylor, who also is president of Corporate HealthCare Management, a UR subsidiary of EQUI-COR Inc. in Nashville, Tenn.

Among those concerns are the amount of time physicians say they are required to spend on the phone with UR firms, the failure of the UR industry to develop uniform practice guidelines and the intrusion of non-physician reviewers into clinical decision making.

"The formation of URAC sends a strong message to the provider community," Dr. Taylor said. "It signals the reinforced commitment of the UR industry to work with providers to ensure the appropriate utilization of health care services."

The voluntary URAC standards will apply to prospective and concurrent review of inpatient hospital admissions as well as outpatient surgical procedures, including all acute medical, surgical, obstetrical, psychiatric and chemical dependency services.

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## Inside

✓ Tougher regulations are needed to protect pension benefits guaranteed by annuities, says this week's editorial. **PAGE 8**

✓ UR firms must limit increases in physician services without interfering in the practice of medicine, says Dr. Ed Zalta of CAPP CARE Inc. in Perspectives. **PAGE 43**

✓ In Speaking Out, Mutual of Omaha's Rebecca S. Fahrlander says a Canadian-style health care system is not the answer to U.S. problems. **PAGE 44**

✓ The London insurance market will change radically in the next few years, leading insurance executives in London agree. **PAGE 71**

✓ Some members of Lloyd's of London syndicate 90 have appointed a law firm to determine if there are grounds to sue members' agencies for more than \$250 million in losses. **PAGE 72**

✓ Insurance brokerage stocks remain attractive for long-term gains, says analyst Leonard Wilson. **PAGE 79**

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# Controlling benefit costs

## Employer coalitions offer purchasing clout

By JUDY GREENWALD

A growing number of employer coalitions are forming health care purchasing networks in an effort to rein in runaway health care costs.

About 15 to 20 employer coalitions around the country have either started their own managed care networks or are in the process of doing so, and more are moving in this direction, observers say.

These networks, which resemble preferred provider organizations, negotiate provider

fees and some even offer utilization review services.

But health care coalitions offer more than purchasing clout, coalition officials say. Coalitions also stress quality services for their members more heavily than their insurer counterparts that offer similar services, they assert.

Creating health care purchasing organizations was the natural next step for coalitions after first providing members educational services and then researching which local

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## Managed care eases pain of transplant costs

By DONNA DIBLASE

As medical breakthroughs are making successful organ transplants a reality, new managed care techniques are helping employers, insurers and HMOs to control the cost and quality of these expensive procedures.

For instance, many health care payers are contracting with individual hospitals, primarily large research facilities, to provide organ transplant services to health plan enrollees.

These specialty managed care programs,

which are often called "centers of excellence," often include incentives such as increased coverage for enrollees who select network hospitals.

Insurers, health maintenance organizations and employers emphasize quality when selecting facilities for the networks—which is measured in volume, survival rates and other factors—rather than the prices negotiated with hospitals.

Emphasizing quality rather than price, employee benefits experts say, helps control

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Managed care boosts quality  
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Survey rates UR techniques  
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Retiree plans under scrutiny  
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## UR vendors push product over price

By CHRISTINE WOOLSEY

As the utilization review industry matures, UR vendors' services are evolving to include more than the traditional preadmission hospital review and length of stay determination.

As a result, vendors say, competition in the UR marketplace will increasingly focus on products and performance rather than on price.

"The marketplace is very competitive and there has been dramatic product development," said Robert Patricelli, president of Value Health Inc., the Avon, Conn.-based parent company of five specialty UR firms and the eighth-largest general service UR vendor ranked by *Business Insurance*. The rankings are based on the number of inpatient hospital admissions reviewed in 1989.

In the early 1980s, there was almost "no penetration, and now more than 70% of indemnity plans have UR techniques in place. That's incredible growth for such a young

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### 10 largest general service utilization review firms

Based on total inpatient admissions reviewed in 1989

Company (ownership)	Total inpatient admissions reviewed	Full-time staff			Physicians on retainer
		Total	Physicians	RNs	
Blue Cross & Blue Shield (Not for profit)	2.4 million	2,280	80	1,200	1,000
Intracorp (CIGNA Corp.)	692,043	4,000	20	1,612	NA
Metropolitan Life Insurance Co. Managed Care Services Group (Mutual company)	633,000	NA	25	611	24
Axiom Review Inc. (Privately held)	310,656	92	3	50	111
HealthCare Compare Inc. (Independent)	303,600	500	27	250	0
The Sunderbruch Corp. (Privately held)	235,200	302	3	140	0
Cost Care Inc. (Independent)	155,116	304	27	81	0
Value Health Inc. (Privately held)	154,600	215	10	38	54
Corporate HealthCare Management (EQUICOR Inc.)	143,252	288	9	88	27
Health Risk Management Inc. (Privately held)	83,000	315	4	61	16

Source: BI Survey

**Spotlight report**

**Transplants**

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costs in the long run.

"Quality of care is an indicator of cost-efficiency, because if things are done right the first time they don't have to be done again," said Rich Sinni, director of the health management practice at Buck Consultants Inc. in New York.

To some benefits experts, centers of excellence are a new phase in the evolution of managed care.

It "began with transplants," said Dr. Bill Mayer, a consultant with The Wyatt Co. in Washington, D.C. "But we are now seeing a broadening of this specialty contracting" to other expensive procedures like coronary bypass surgery.

"What we'll continue to see in the 1990s is quality being a major variable in managed care contracting," said Dr. Paul Frankel, national medical director of the managed care services group of

Metropolitan Life Insurance Co. in New York.

It "is the total reverse in managed care, because you actually are rewarding providers based on quality" rather than solely on price and volume, said Susan Gleeson, executive director of technology management for the Blue Cross & Blue Shield Assn. in Chicago.

The focus on quality rather than exclusively on cost is "very exciting," said Dr. Mayer.

Employers "see centers of excellence programs as the positive side of managed care. It's managed care for quality's sake instead of only for the sake of cost savings," said Lawrence B. Leisure, national health care practice leader at TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

Extensive testing, prolonged drug therapy and pre- and post-operative treatments make an organ transplant's total cost difficult to estimate, insurers and con-

sultants say.

According to a 1989 study by the Health Insurance Assn. of America, the average first-year cost of a liver transplant was \$170,000 in 1988, which a heart transplant averaged \$138,000 and a kidney transplant averaged \$51,000.

A 1989 study by Hewitt Associates of Lincolnshire, Ill., found transplant costs incurred by 976 employers through 1988 ranged from \$10,000 to \$400,000, depending upon the procedure.

Any type of organ transplant, including the 18 months of care often required after transplant surgery, can cost \$500,000, said Carol Scheele, product manager of Life-Source Network, a provider network developed by EQUICOR Inc. of Nashville Tenn.

In addition to their cost, transplants remain a very rare procedure, due in part to the limited availability of donor organs and the existence of alternative treat-

ments for some serious illnesses.

Also, transplant centers can be very selective about patients put on donor organ waiting lists.

"It's a lot of money per case, but the number of cases has been small because of the number of organs available to transplant," said Dr. Richmond Prescott, associate medical director of a physicians group that contracts with Kaiser Permanente Medical Care Program, an HMO in Oakland, Calif.

Faced with the rare transplant case, most employers turn to their insurers and HMOs to help manage, consultants say.

Transplant benefits, now provided by most employer-sponsored health care plans, commonly cover heart, liver, kidney and bone marrow transplants.

"It's usually the employer that decides what they will cover in their plan. But, when employers do offer coverage, they ask their insurer to find centers that do these

procedures most often do them well," said Mr. Sinni of Buck.

"Transplants don't happen every day, so many employers don't think about specialty contracting" and often use existing networks developed by insurers or HMOs, explained Dr. Edward Lipson, director of the managed care network unit with William M. Mercer Meidinger Hansen Inc. in San Francisco.

To better manage organ transplant cases, insurers and HMOs are increasingly using the "centers of excellence" approach, in which they attempt to evaluate quality transplant facilities by thoroughly analyzing hospital transplant data, on-site visits and consultation with outside medical specialists.

In Metropolitan Life's "Centers of Quality" program introduced last year, "selection of the facilities was driven by data on outcomes of the procedures, such as death and organ rejection rates," said Dr. Frankel. "We held off on developing a program like this until we had this outcome data."

The insurer also considered whether hospitals had support services like a specialty transplant laboratory and immunology team and whether they had performed a certain number of heart, liver, kidney or bone marrow transplants.

"Below a certain minimum volume, it is hard to have a quality program and it is hard to measure the quality of the program," said Dr. Frankel, whose network is handling six cases.

Met Life's program has 16 hospitals, but "we don't want to have a defined number of facilities in the network. This is a living program and the performance of the contracting facilities will be continually monitored," he said.

Transplant patients in the insurer's group indemnity plans are not required to use the network, but are told of the facilities through the insurer's case management program. For patients using the network, Met Life pays transportation costs and housing and transportation costs of family members.

In Met Life's managed care plans, patients receive different levels of coverage for using network and non-network facilities.

Since introducing its "Institutes of Quality" program in July 1988, Prudential Insurance Co. of America Inc. says it has saved 25% to 30% on transplant cases.

Prudential's program includes eight hospitals specializing in heart, liver or kidney transplants or a combination of the three. Between August 1988 and August 1989, the insurer managed 24 heart, 28 liver and 79 kidney transplants.

Dr. David Plocher, vp of group medical services, said selection standards for facilities in the program include: a hospital's transplant program must be at least two years old and annually perform at least 12 heart or liver transplants and at least 25 kidney transplants; physicians must be specially trained; and average survival rates for transplant patients must be at least 18 months.

"There's a great variability in the success and expertise nationwide in transplant procedures. We would prefer paying for transplants in hospitals that are good at these procedures," said Dr. Plocher.

Transplant patients in PruCare HMOs are automatically referred to the nearest network hospital. Transportation costs for the patient and a companion are covered, as are housing costs for the companion.

Under Prudential indemnity plans that adopt the program, employees are given financial incentives to use the network. Typically, surgical costs are paid at 90% or

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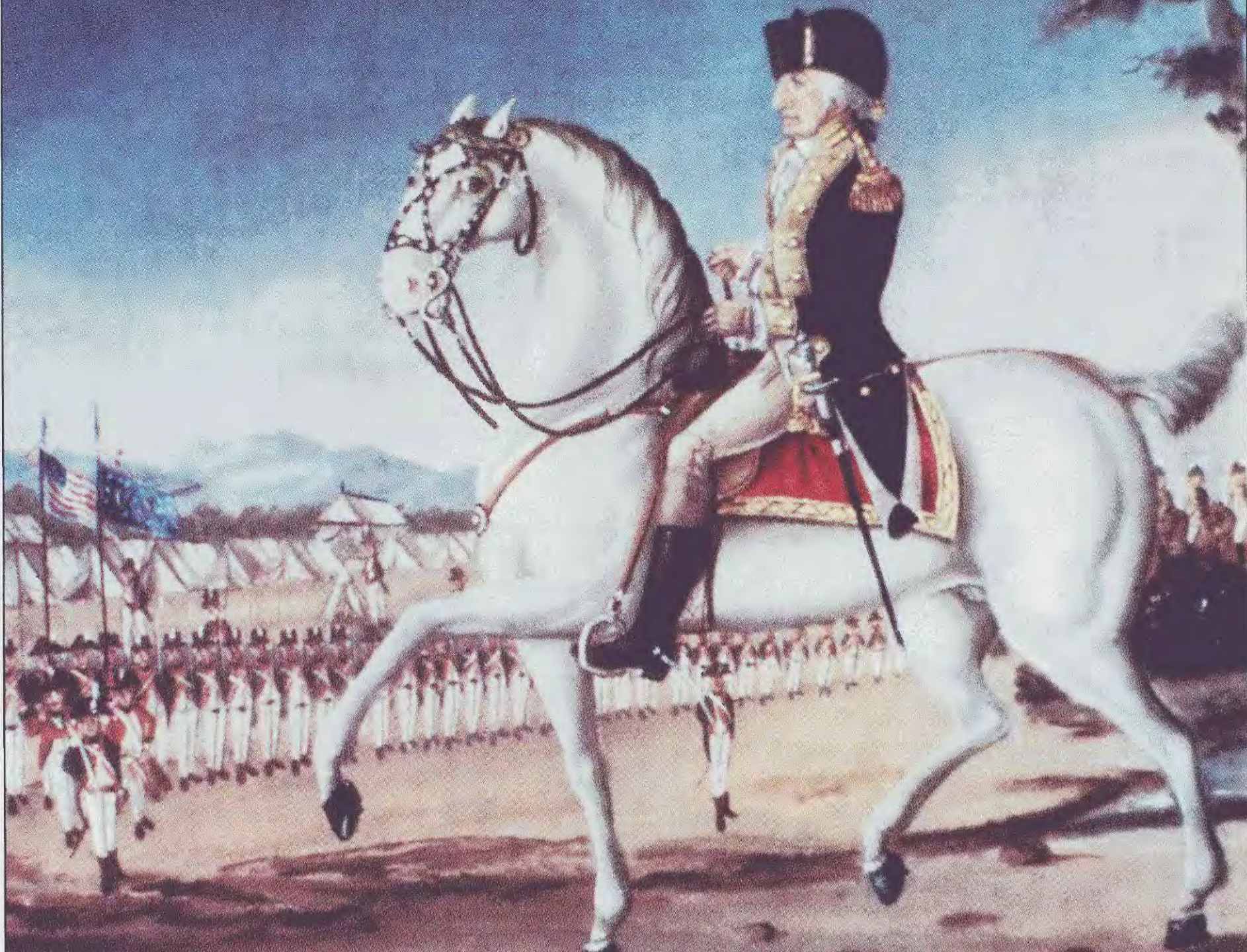
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Responsiveness. For companies like Yoder, it's one way Wausau answers the call.



## Transplants

Continued from page 4

100% if the network is used, compared with 70% or 80% for non-network care. Travel and housing expenses also are covered for network users.

Prudential plans to expand its Institutes of Quality program to include facilities specializing in other expensive procedures like coronary artery bypass surgery or some neurological procedures.

EQUICOR, which spent \$25 million on transplants in 1989, launched LifeSource Network last month to manage transplants for its indemnity, HMO and PPO plans.

The network includes 10 hospitals that specialize in at least one of these transplants: heart, heart/lung, liver, bone marrow, pancreas, kidney and kidney/pancreas.

Through LifeSource, EQUICOR hopes to "promote the use of hos-

pitals with proven track records in transplants to enhance patient outcomes while controlling costs," said Steve Richter, vp of product development.

When developing LifeSource, EQUICOR sent questionnaires to 25 hospitals. Facilities had to have five years of statistical data on their transplant procedures; allow on-site visits from EQUICOR's medical directors; and negotiate fees for transplant services, said Ms. Scheele.

Many Blue Cross & Blue Shield plans have contracted with hospitals to perform transplants since early 1986, and the BC/BS Assn. is expected to introduce a national centers of excellence program later this year.

Like other insurers, BC/BS will select hospitals based on volume of procedures, survival rates, ancillary services and other factors, said Ms. Gleeson.

"The first cut of facilities will be

made based on how they meet the quality criteria. Then, we'll negotiate on cost," she said. The Chicago-based BC/BS Assn. will negotiate "global" fees that include all services related to the transplant.

Patients will be covered only if they use network facilities. However, Ms. Gleeson notes that in BC/BS plans with transplant networks, "we're not seeing much of a case of the patient wanting to go somewhere other than the center the plan has contracted with."

In addition to insurers, a number of large HMOs also have developed transplant networks.

For example, CIGNA Healthplans Inc. manages transplants through its "Designated Specialty Facilities" program, said Dr. Michael R. Soper, national medical director for the HMO subsidiary of Philadelphia-based CIGNA Corp.

Network hospitals must perform a certain volume of transplants per year, must meet survival rate cri-

teria and must negotiate fees, though "cost is not as much an issue as things that indicate a hospital's experience," he said.

Only patients using designated facilities are covered. "For transplants, it really makes sense to send patients to special facilities," Dr. Soper said.

Twenty-five claims in 1989—mainly for bone marrow, liver and heart transplants—cost CIGNA Healthplans about \$1.5 million, he said. CIGNA Healthplans HMOs have about 1.5 million enrollees.

Kaiser Permanente contracts with Stanford University Medical Center in Palo Alto, Calif., for heart transplants and with the University of California at San Francisco Medical Center for liver transplants.

"Specialty contracting is the name of the game. Most HMOs don't have the capacity to do transplants like heart and heart/lung," said Dr. Prescott of the Per-

manente Medical Group, which provides care to Kaiser's 6.2 million members. "We also have contracts with a variety of other centers to do bone marrow transplants."

Kaiser manages much of the pre- and post-operative transplant care within its own HMO facilities and has contracted hospitals perform the actual surgery, he said.

Kaiser's Northern California HMO has authorized about two dozen liver transplants and about 10 heart transplants, Dr. Prescott said. Those patients, he said, may not all receive transplants, but they can be on organ donor waiting lists.

Costs for any of the transplants could exceed \$250,000, he said.

United Health Care Corp., which has had a centers of excellence program for transplants for about three years, has made its network available to outside HMOs, insurers and employers as a stand-alone service since October 1989, said Kirk Stapleton, director of facility contracts for the Minneapolis-based HMO.

The six network facilities in United Health Care's program met standards including: a minimum survival rates, surgeons with one year formal transplant training and two years transplant experience, and the availability of comprehensive transplant support services, Mr. Stapleton said.

In developing the network "we began to look at the fact that there are 250 hospitals doing heart transplants, but we wondered if all of them were doing these procedures well," he said.

With West Coast, East Coast and Midwestern centers, the network is near large concentrations of the HMO's 1 million members in 14 states, Mr. Stapleton said.

United Health Care authorizes an average of 50 organ transplants per 1 million members, he said.

Patients are not required to use network facilities but most do because "they know we are trying to help them make an informed decision," he said.

In addition to insurers and HMOs, two major employers have developed transplant networks.

Minneapolis-based Honeywell Inc. has covered 17 organ transplants since it began contracting with hospitals to perform organ transplants for employees and dependents under its self-insured health care plan in the early 1980s (BI, Dec. 3, 1984).

St. Louis University Medical Center in St. Louis now performs all of Honeywell's transplants, said Dr. John Burns, vp-health management for Honeywell.

The company contracts on its own for transplants because "some of the network models out there tend to be discount-based and we feel very uncomfortable with discounted health care. We buy health care based on quality because this, in the long run, is the most cost-effective," he said.

Since developing its own four-hospital transplant network three years ago, Hewlett-Packard Co. has covered only one transplant under its self-insured health plan, said Susan Moriconi, health benefits manager for the Palo Alto, Calif.-based computer firm.

Patients receive coverage only for transplants performed by network hospitals, she said. "We want to make sure we're covering the right procedures in the right places," she said.

Hewlett-Packard worked with its claims administrator, U.S. Administrators Inc., in selecting and contracting with the hospitals. Selection criteria included the volume of transplant procedures performed by the facility and the facility's success rate, she said.

Half of the company's 66,000 employees are in the indemnity plan and half are in HMOs. ■

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## Opinions

## Safeguard pension benefits

SHOULD THE REGULATORY agencies or Congress take action to improve the security of workers' and retirees' benefits when employers terminate overfunded pension plans and buy annuities to finance participants' benefits?

Absolutely.

We can well understand why annuitants' anxiety about the security of their retirement benefits is growing.

Currently, when an employer terminates an overfunded pension plan to recover the surplus assets, it must guarantee plan participants' promised benefits by purchasing annuities from a commercial insurer. However, the only federal requirement governing the insurers from which employers purchase annuities—that the insurer be licensed in at least one state—is so minimal that it provides scant comfort to pension plan participants.

The absence of tough regulatory standards opens up the market for pension plan annuities to virtually any insurer regardless of its creditworthiness or financial stability.

While employers terminating overfunded pension plans generally have selected insurers with the highest credit ratings, there is no assurance that will continue. And, if insurers—some of which have made big investments in the battered junk bond market—collapse, annuity holders might not receive their promised benefits.

If the benefits of workers and retirees covered by defined benefit pension plans are guaranteed by the federal Pension Benefit Guaranty Corp. in the event an employer's pension plan collapses, it seems only reasonable that annuitants be assured that their benefits are underwritten by commercial insurers with the highest ratings.

And, if the PBGC believes it lacks the regulatory authority to impose such a requirement, Congress should do so now through the enactment of legislation.

Requiring an employer to select a highly rated insurer when it buys annuities for employees and retirees is only one step in easing the anxieties of annuitants over the safety of their retirement benefits.

But such a requirement, by itself, means little. Indeed, anyone following the tremendous volatility in the property/casualty insurance market knows that today's top-rated insurer can become tomorrow's insolvency candidate.

As a result, further safeguards are needed to provide additional security for annuity holders.

One requirement could be to permit an employer to automatically cancel an annuity contract—without any cancellation fees—if its annuity insurer loses its top financial rating. No doubt, there are other alternatives worth considering.

But we are not ready to sign on to suggestions bandied about by several members of Congress



that the PBGC should be required to guarantee annuities of employees and retirees who were covered by overfunded pension plans that later were terminated.

Such a requirement would add tens of billions of dollars in potential liabilities that the PBGC would have to guarantee. And it undoubtedly would result in yet another increase in the termination insurance premium the PBGC charges employers with defined benefit plans.

Surely employers—especially those companies that have no intention of terminating their defined benefit plans—would object to a premium increase.

One proposal, which again is being discussed in Congress and which we firmly oppose, is to either ban reversions or require companies to give plan participants most of an overfunded plan's surplus assets—in the form of cost-of-living adjustments to their benefits—before a termination would be allowed.

That would be unfair and counterproductive.

When employers terminate overfunded pension plans, participants receive all promised benefits. To require employers to do more would, in effect, be providing retirees with an unearned gift.

Employers, faced with a prospect of not being able to recover surplus assets, would cut back on their pension contributions to the lowest level permitted under federal law.

Retirees would not receive any additional benefits, while pension plans would be much more likely to become dangerously underfunded if their investments turned sour.

Anything that weakens pension plan funding will detract from, not enhance, the safety and security of participants' benefits.

## Letters

## Utah PPO is not owned by life insurer

To the editor: The *Business Insurance* 1989-1990 Directory of HMOs and PPOs incorrectly lists Premier Medical Network

as the owner of Great West Care, a preferred provider organization serving the Salt Lake City and Ogden, Utah, area. In reality, Premier Medical Network serves as a PPO for Great West Life Assurance in Utah through a contractual agreement.

Furthermore, Premier Medical Network is a provider-sponsored PPO that contracts with multiple payers other than Great West Life Assurance, including insurance companies, self-insured employers, union trusts, multiple employer trusts, etc.

The officers reported in the directory actually are the officers of Great West Life Assurance Co.

Premier Medical Network includes seven hospital facilities and more than 400 physicians. It serves Salt Lake, Davis, Weber, Box Elder and Summit counties in Utah. Its scope of services, compensation arrangements with providers and control measures are accurately reported in the HMO/PPO directory.

**Robert Immitt**  
Executive Director  
Premier Medical Network  
Salt Lake City

Information about Premier Medical Network originally was reported to *Business Insurance* by Great West Life Assurance.

*Business Insurance* welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill., 60611.

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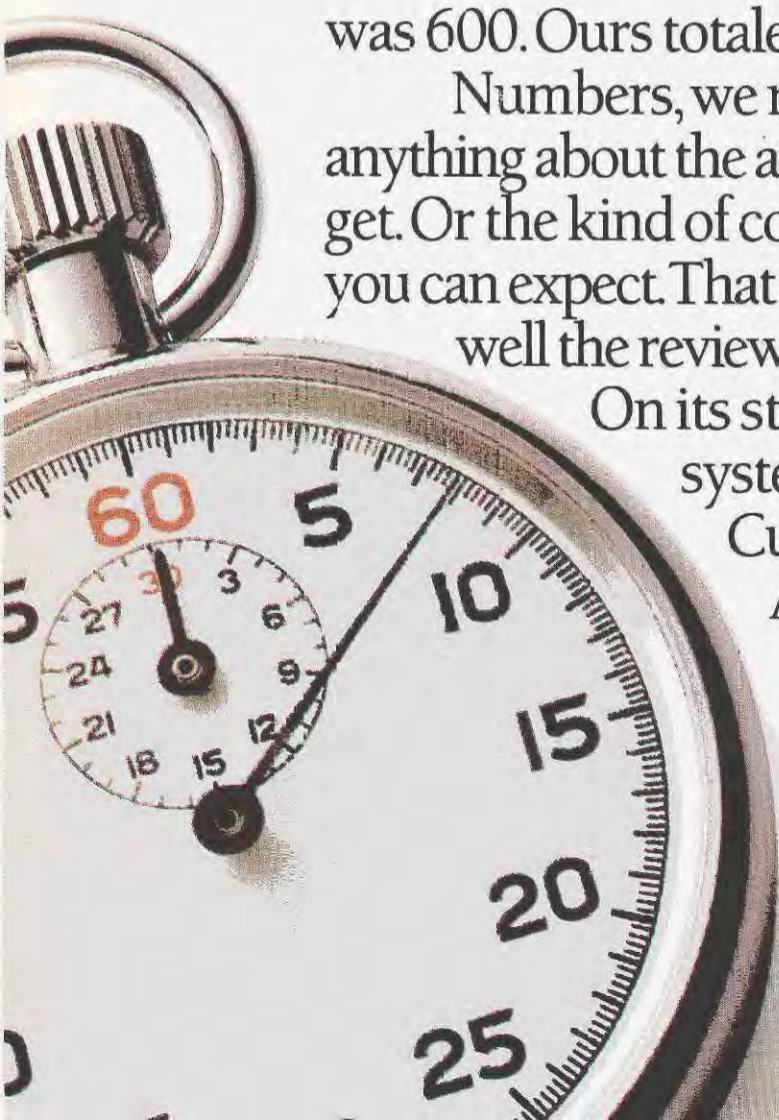
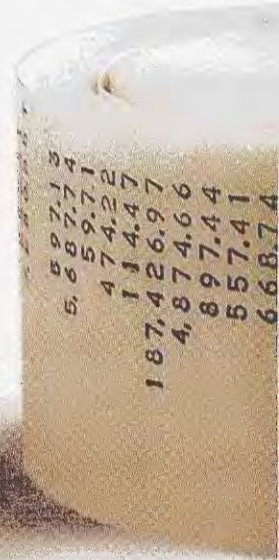
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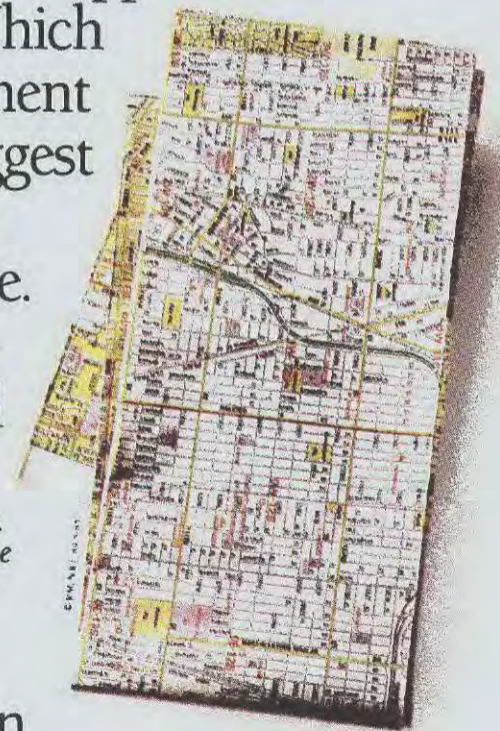
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**Spotlight report**

**UR vendors**

*Continued from page 3*  
industry," he said.

While Mr. Patricelli noted that competition among "plain-vanilla hospital review" firms still is primarily based on price, other vendors say competition in the UR industry is based on service.

For instance, in addition to expanding review services to the outpatient environment, UR firms are emphasizing the importance of case management. And some UR firms are offering employee health education and promotion programs and customized review features.

Robert J. Becker, chairman of Downers Grove, Ill.-based HealthCare COMPARE Corp., the fifth-largest UR vendor, said competition among UR firms is becoming performance-based "because employers didn't know there was a product to be bought" in the past.

In fact, one of the biggest prob-

lems UR vendors face is "the divergence in activities of UR firms. Some are good, some aren't—but all of them carry the same label. It's like saying all cars are expensive without recognizing there are Yugos and Mercedes," he said.

"Employers dealing with multiple UR firms have problems picking" the vendor best for them, said Doug Leland, vp of medical review services at Intracorp in Berwyn, Pa., a CIGNA Corp. unit and the second-largest UR vendor.

"A lot of people still approach these services as a commodity, thinking what you buy from one company is the same as any other," he said.

But, clients are slowly becoming more aware that UR firms operate differently, vendors say.

"Employers aren't just looking at price, they look at what other types of services" UR companies can offer, said Lawrence Goelman, president and chief executive offi-

cer of Ccst Care Inc. in Huntington Beach, Calif., the seventh-largest UR vendor.

While saving money still is a top priority for employers, "it's harder now to replicate initial savings with an account because you don't

ent demands by further refining inpatient review services and expanding review activity to outpatient, mental health and substance abuse procedures (BI, March 20, 1989).

"We have a good handle on

**Some UR firms 'are good, some aren't—but all of them carry the same label. It's like saying all cars are expensive without recognizing there are Yugos and Mercedes,' says Robert J. Becker of HealthCare COMPARE Corp.**

have a lot of fat to trim" since UR programs have been in place now for some time, said Maxine Lange, director of managed care programs at Blue Cross & Blue Shield Assn. in Chicago. BC/BS is the nation's largest UR vendor.

UR vendors now must meet cli-

abuses in the inpatient environment, and 50% of claim dollars come from inpatient services," Mr. Leland said. "But clearly we're just scratching the surface of the outpatient arena."

In addition to reviewing outpatient procedures, clients want UR

vendors to take a good look at mental health and substance abuse programs.

"The care (in those programs) is a significant problem and clients are requesting meaningful, professional review," Dr. Becker said.

Whether a company will choose a UR vendor based on price or performance depends on the employer, Dr. Becker said. "There are some clients with dollar signs in their eyeballs. But, others are much more sensitive to the performance" of an individual vendor.

Typically, utilization reviewers ask patients to notify the UR staff before a hospital admission. UR staff nurses or physicians review the appropriateness of proposed surgery and other medical care before and during hospitalization.

The patient is notified if proposed treatment is inconsistent with the most cost- and care-effective method of treatment.

However, clients increasingly are asking for services that are more pro-active.

Traditional preadmission certification and continued stay reviews are no longer adequate in the battle against rising health care costs, said Mr. Leland.

Instead, UR vendors should practice case management, wasting no time in identifying cases that are most likely to benefit from alternative procedures or treatment settings, he said.

"Clients are becoming more sophisticated," said Mr. Goelman. "Diagnosis and length of stay are no longer a question." Instead, employers are becoming increasingly concerned with how a UR firm manages a "medical episode."

That means focusing on medical necessity and alternative settings before, during and after a patient seeks treatment, he said.

"We'll see more emphasis on case management and case planning in traditional hospital admissions," said Paul W. Frankel, national medical director of the Managed Care Services Group of Metropolitan Life Insurance Co. in Westport, Conn., the third-largest UR vendor.

"Hospital review should include discharge planning," Dr. Frankel added.

Mr. Leland agreed: "If you are going to really manage a hospital stay aggressively, you need to be able to provide cost-effective alternatives even after the stay."

"We'll see a lot of growth in the medical case management area in the 1990s," said Roger Taylor, president of Corporate HealthCare Management, a division of EQUICOR Inc. in Nashville, Tenn., and the ninth-largest UR vendor.

Typically, up to 40% of an employer's health care dollars can be consumed by 5% of its employees, he said. "Both UR firms and employers are realizing those catastrophic cases can be managed" in a pro-active way that can result in definite savings, he said.

And, "as people become more interested in long-term care and employers modify their benefits" to cover it, post-discharge treatment will be increasingly scrutinized, Dr. Taylor predicted.

"Coordination of home health care is important because that's where most patients go," Intracorp's Mr. Leland said. But, post-discharge reviews also will include rehabilitation or skilled nursing facilities, he said.

In addition to case management, "employers—especially self-funded companies—want more emphasis on education and support" for their employees, said Joan E. Copeland, executive vp at ValuTrac, a Portland, Ore.-based UR firm.

For example, "some of our clients are asking for patient advocacy programs that teach employees to be better consumers" of  
*Continued on next page*

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Continued from previous page health care, she said.

Employers that implemented utilization review as a tool to "clamp down on benefits and save money" now want "employees to realize they do have a commitment to health," Dr. Taylor reports.

However, he said the philosophy that keeping employees healthy can help reduce a company's health care costs has not filtered through all of corporate America. "Employers are starting to see this, but it's not really a full movement."

While UR firms generally are being asked to offer more services, some clients are opting for scaled-down UR packages.

Most UR firms now have the computer and data system capabilities to pinpoint where an employer's health care dollars are being spent. As a result, some employers may find they don't need to buy a full package of UR services.

"The days of offering a standard UR program are at an end," observed Mr. Goelman. "Programs will get tailored to meet particular needs and UR services will be a function of the employer's employee base."

Dr. Taylor agreed: "We're seeing much more customization of products. UR is now tied to the experience of a particular client," he said.

For example, a bank with a high population of female employees may want its UR vendor to focus most aggressively on pre- and post-natal health care services, Mr. Goelman explained. Or, a manufacturing industry client that employs mostly older male workers may want to scrutinize cardiovascular services more closely.

And, "if you don't have much of a psych benefit, you may not need to buy high-cost, aggressive psych products," Dr. Taylor said.

Martin Kreis, senior vp of American Health Network Inc., a UR firm in Dallas, said he has seen "more requests for unbundled UR services, like precertification only."

However, Mr. Kreis cautions clients against buying individual utilization review components. "You wouldn't buy a car without a steering wheel," he said.

Following are profiles on the 10 largest general service UR firms:

### Blue Cross & Blue Shield Assn.

While the Blue Cross & Blue Shield Assn. is not traditionally recognized as a utilization review vendor, 68 of the 71 BC/BS hospital coverage plans provide benefit plan management services, including UR.

These plans reported reviewing 2.4 million inpatient hospital admissions in 1989, making BC/BS the largest UR vendor ranked by *Business Insurance*.

While the majority of those reviews are conducted for Blue Cross/Blue Shield policyholders, BC/BS plans do offer utilization review services on an unbundled basis, Ms. Lange said.

While BC/BS plans now serve relatively few stand-alone UR clients, the association is marketing a new benefits management product, Custom Care-USA, as an unbundled national UR product. Custom Care-USA can be sold along with traditional health insurance programs or as a free-standing product.

"The plans are saying 'if we can't get the health business, we'll sell them this,' but we still want to get both," Ms. Lange said.

Custom Care-USA includes preadmission review, admission review, concurrent review, discharge planning, individual case management, second surgical opinion, subscriber assistance and psychiatric and substance abuse review services.

Employers can purchase the components separately or as a package and can choose to have reviews conducted centrally by one BC/BS plan or locally through several plans.

Currently, 44 employers with 285,298 lives are enrolled in Custom Care-USA, Ms. Lange said.

Each BC/BS plan must complete a 50-page application detailing its abilities to determine whether it qualifies to participate in Custom Care-USA. "This assures that all sites involved in the program meet the program's quality control standards and can deliver and service program components consistently," Ms. Lange said.

Nationwide resources and recognition help individual BC/BS plans provide high-quality UR services to clients, Ms. Lange said. "Our massive data base helps us profile providers and hospitals" to identify treatment that is unnecessary.

And, "our claims volume and membership volume is so large (health care providers) pay attention to us."

BC/BS plans reported employing 1,280 full-time professional UR staff members in 1989, including 80 physicians and 1,200 registered nurses.

In addition, BC/BS plans can access a national panel of 36,000 board-certified consultants in 30 different medical specialties who will provide second opinions.

"Some accounts are skeptical" about second opinion programs' cost effectiveness, but the service also can be used as an educational tool, she said. "Our covered lives use these physicians when they have a question" about a particular procedure.

### Intracorp

Berwyn, Pa.-based Intracorp, a CIGNA Corp. unit that is celebrating its 20th anniversary, chalked up another year of steady growth, increasing its gross revenues 12.5% to \$225 million in 1989 from \$200 million in 1988.

Fifteen percent of those revenues came from providing utilization review directly to corporate and institutional employers, while the remaining 85% was derived from UR services for insurers, managed care networks and third-party administrators.

Intracorp reviewed 692,043 inpatient admissions last year to rank as the second-largest UR vendor. In addition, the company reported servicing 13 million employee benefit lives.

Mr. Leland attributes Intracorp's steady growth to the company's "market responsiveness and a national perspective with a regional or local presence."

"One of our hallmarks has been understanding our business well enough to know we're providing value to our customers," he said.

That confidence has allowed Intracorp to move away from marketing its services on a savings-related basis and concentrate more on delivering the different types of services employers are increasingly requesting.

"We've started providing very conservative savings figures" to clients, he said. "That's hard to do with a customer market who wants to see savings," he admitted.

The company now is developing services to better serve its clients.

For example, Intracorp recently implemented its own mental health and substance abuse utilization review service. Previously, inpatient mental health and chemical dependency cases were reviewed for Intracorp's clients by the American Psychological Assn.

However, beginning in 1988, Intracorp severed its relationship with the APA. "By May 1989, we had completed building our own internal mental health component," Mr. Leland said.

Continued on page 16

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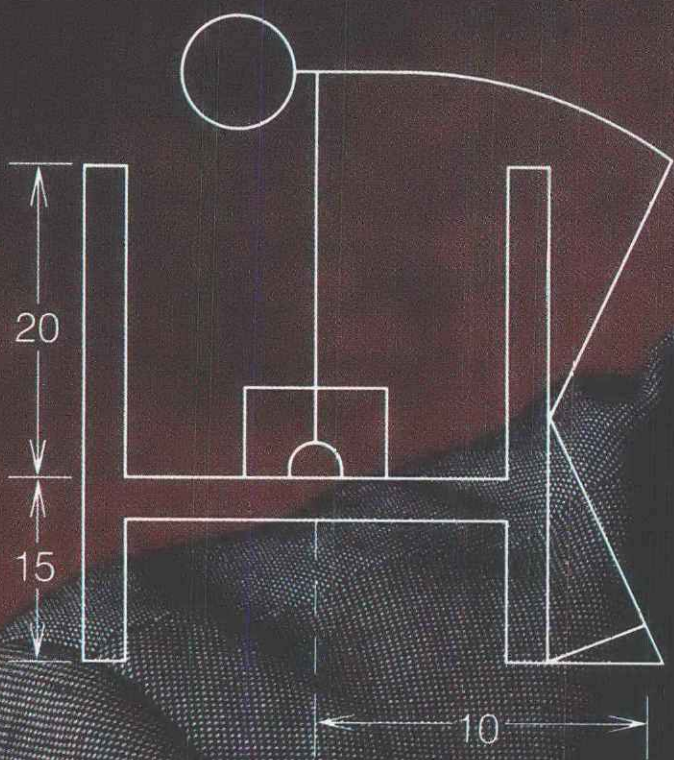
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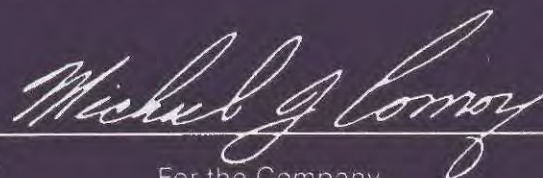
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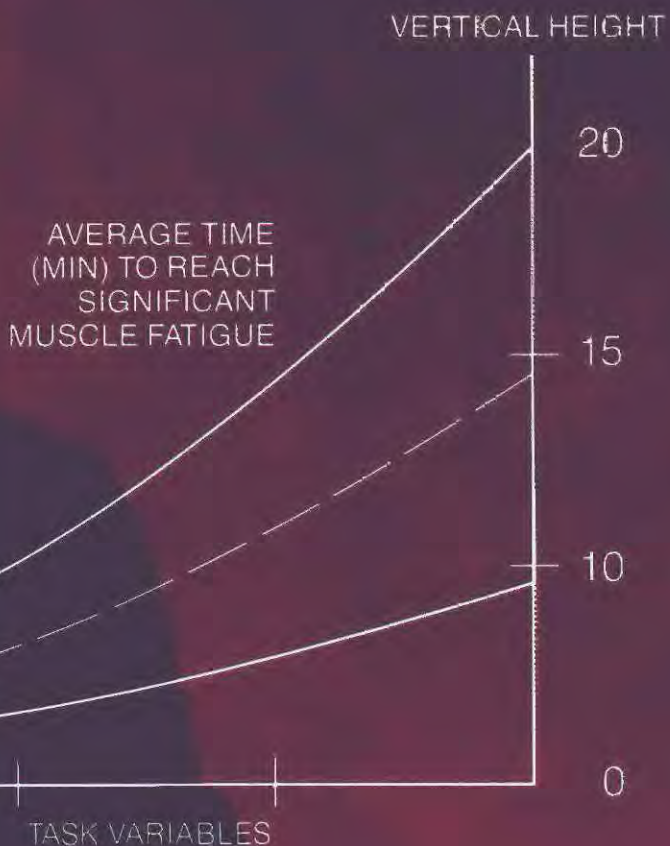
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# A N E W T E A M

## UR vendors

Continued from page 13

The company now employs 65 mental health professionals, including psychiatric registered nurses, psychologists, social workers and one psychiatrist.

Each of Intracorp's five regional service centers has a specialty unit staffed just by mental health professionals, he said.

Mr. Leland said the move to provide mental health and chemical dependency reviews is in response to the growing demands by employers that report that mental health care costs are skyrocketing.

Providing both medical and psy-

chiatric reviews is advantageous to Intracorp and its clients, he said. "There are a surprisingly high number of cases in which the patient has both mental health and medical needs. By having mental health and medical professionals in the same center who are able to link up to one system, we can better manage a case because they can share the same information."

In addition to bringing psych/substance abuse reviews in-house, Intracorp has integrated its workers compensation and accident/health marketing and distribution.

"We've been providing services for workers comp for 20 years and to the accident and health market

for six years," Mr. Leland said. Over the last 18 months, the company has merged these operations so that clients need only deal with one account manager to handle both areas of business.

"Clients used to have to deal with two companies. Now they can get all the services in one spot and deal with one person," Mr. Leland explained, noting that many clients prefer one-stop shopping.

### Metropolitan Life Insurance Co.

Metropolitan Life Insurance Co. has restructured its utilization review operations over the past year to serve its clients more efficiently,

according to Dr. Frankel.

For example, Corporate Health Strategies, formerly Met Life's principal UR affiliate, has been integrated into the company's other managed care services as the Managed Care Services Group.

The reorganization shows that Met Life is "responding to customer needs of having an integrated approach to managed care. It is a continuum, and all the elements of managed care needed to be together," Dr. Frankel explained.

"Essentially, elements of 27 companies were merged," he said. The consolidation will "improve the efficiency of our operations" by eli-

minating administrative redundancies and overhead.

Met Life's various UR services reviewed approximately 633,000 inpatient hospital admissions in 1989, making it the third-largest UR vendor.

Metropolitan's UR unit reviews group health, chiropractic, psychiatric and substance abuse services for its clients, including members of the insurer's health maintenance organization network.

Following the restructuring Met Life now is beefing up some of its products, including ambulatory services utilization reviews.

"We've built into the claims paying system the maximum expected frequencies for ambulatory services," Dr. Frankel said. Now, when a claim enters Met Life's computer system, the diagnosis of the claim and the services recommended are compared with the maximum expected frequency of such services, he explained.

In addition, "we profile doctors and keep track of every denial," Dr. Frankel said. "We keep track of all the claims sent to Metropolitan and the doctors who are found to" provide excessive services.

The company attributes all medical necessity denials to 10% of physicians account and 73% of all denials to just 1% of doctors, he said. "So, there are a few very aberrant doctors out there and a lot of very good ones."

In addition, "we profile doctors and keep track of every denial," Dr. Frankel said. "We keep track of all the claims sent to Metropolitan and the doctors who are found to" provide excessive services.

In addition to scrutinizing unnecessary treatment, Met Life UR

**'There are a few very aberrant doctors out there and a lot of very good ones,' says Dr. Paul Frankel.**

staffers will increasingly focus on underutilization of medical services.

For example, "If a child got three measles shots in a year, that's too much. But if he or she didn't receive any, that's underutilization," he said.

The company will use this data to monitor quality of providers, Dr. Frankel said.

Met Life's new Quality Management Indicator "screens every hospital admission for potential quality problems," he said.

The QMI profiles hospitals and doctors according to their frequency of quality problems so that Met Life can notify the providers or other appropriate parties and problems can be rectified, he said.

"We don't want to only profile providers, but improve their quality" as well, he said.

### AXIOM Review Inc.

Millburn, N.J.-based AXIOM Review Inc., the nation's fourth-largest UR vendor, is the product of the 1985 merger of four Professional Standards Review Organizations, which formerly provided UR-type services for the federal Medicare program, explained Vp Robert Jones.

However, AXIOM discontinued its Medicare subcontracting business last year and now is concentrating on providing UR services for Medicaid cases, private employers and insurance plans.

"We've expanded our marketing nationally and internationally," Mr. Jones explained. "Our aim is to get private employers and insurance companies" as clients.

While AXIOM primarily serves clients in New Jersey, New York


Continued on page 18



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**Spotlight report**

**UR vendors**

*Continued from page 16*  
and Pennsylvania, the company also has the capability to provide UR services to non-East Coast clients, said Dennis J. Duffy, AXIOM's president and chief executive officer.

The company provided utilization review services to 36 clients in 1989, 12 of which were corporate and institutional employer clients.

AXIOM reviewed 310,656 inpatient hospital admissions last year to rank as the fourth-largest UR firm profiled by *Business Insurance*.

About 15% of AXIOM's overall 1989 gross revenues of \$5.7 million were generated from UR services for private employers.

One of the factors that makes AXIOM unique from other UR vendors is that "the largest majority of our reviews are done on-site by registered nurses at the hospitals," said Vp Margaretta Nemets.

In addition, AXIOM places emphasis on "the type of information" furnished to an employer to allow it "to understand and better manage its benefit plans," AXIOM Vp Erwin Weiland said. "We keep on our (computer) system roughly 2½ years worth of discharge information, which includes more than length of stay and diagnosis."

This vast data base enables AXIOM to "pull out a specific employer's experience," Mr. Weiland explained. AXIOM then can profile a client's experience by location to identify any geographical trends. Or, the employer's data can be "compared to other groups of similar composition" to let a company

UR and provider network development and administration, for military dependents, he said.

While the contract already has been awarded, "it's been temporarily suspended as a result of a protest filed by the unsuccessful bidder of procurement," he said.

The company also will beef up its workers compensation UR services, Dr. Becker said. Workers compensation "is really no different than group health—it's just a matter of who the payer is."

"It's been unmonitored and has

been a victim of over-utilization and increased costs," he said.

**Sunderbruch Corp.**

West Des Moines, Iowa-based Sunderbruch Corp. is the sixth-largest UR vendor nationwide, based on 235,200 hospital admission reviews in 1989.

The privately held company also reported significant growth last year, both in terms of gross revenues earned and number of lives serviced.

Sunderbruch's revenues from UR

activities increased 26% to \$14.9 million in 1989 from \$11.8 million in 1988. Seventy percent of those revenues came from providing utilization reviews directly to corporate employers.

Employee benefit lives serviced increased 9.6% to 2.9 million in 1989 from 2.7 million in 1988. In addition, the company increased its corporate client base by 98% to 125 in 1989 from 63 in 1988.

Chief Executive Officer Richard McMaster said that ensuring quality care is more important to Sun-

derbruch than convincing clients that they will save a certain amount of money through UR.

"The most irresponsible aspect of this business is misquoting savings," he said.

"We believe that quality is the best long-term solution," said Pamela DePriest, director of marketing. "We're not here just to save you money one year to get your business."

In fact, she said, "we tell people not to measure Sunderbruch by  
*Continued on next page*



**'Reducing admissions is an important factor,' says Erwin Weiland of AXIOM.**

know if its experience is different from others in the same industry.

"Reducing admissions is an important factor," Mr. Weiland said. "And, we do indicate to clients there can be a reduction."

But, "you need to convince an employer of the long-range benefits of a UR program. If you can stabilize their health care costs in terms of premium increases, you've provided them with a real service," he said.

**HealthCare COMPARE Corp.**

Gross revenues at HealthCare COMPARE Corp. jumped 51% last year to \$31.5 million from \$20.8 million in 1988.

Those revenues include business from AFFORDABLE HealthCare Concepts, the company's preferred provider network in Sacramento, Calif.

However, the company experienced flat growth in the number of benefit lives it serviced, reporting 5 million employee benefit lives serviced in 1989, the same as the previous year.

"The growth we want per year is the growth we can manage," said Dr. Becker, HealthCare COMPARE's chairman.

The Downers Grove, Ill.-based company ranks as the fifth-largest UR vendor in the nation based on 303,600 hospital admissions reviewed in 1989.

HealthCare COMPARE receives "an average of 2,700 calls per day relating to primarily inpatient reviews," according to Dr. Becker.

Healthcare COMPARE this year expects to finalize a contract to provide services to the U.S. Department of Defense, Dr. Becker noted. Under the contract, HealthCare COMPARE would provide managed care services, including

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*Continued from previous page*  
 dollars at all. You should measure us on your rates of admissions per year. You have to look at whether you're consistently staying at an average number of admissions."  
 Employers should be wary of UR firms' promises of cost savings, Mr. McMaster said. "Managing health care is not a financial or insurance discipline. Managing health care is a discipline in itself," he asserted.  
 Mr. McMaster said the company plans to continue to refine its medical case management services.

"We emphasize the early identification of problems, and we'll put more emphasis on outpatient alternatives," he said.  
 For example, most employees admitted to the hospital for an acute psychotic episode traditionally spend the first few days in inpatient acute care units, Mr. McMaster said.  
 However, many times "ongoing treatment could be accomplished in a non-acute environment or even an outpatient program," he pointed out.

While most employer health care plans provide more coverage for inpatient than outpatient care, "a lot of our clients have been very cooperative and accepting of the alternative treatments we recommend," Ms. DePriest said.  
 "Outpatient treatment may last longer and cost more, but it may be better for (the employee) and may help avoid repeat admittance later," she said.  
 Sunderbruch operates offices in St. Louis; Chicago and Peoria, Ill.; and Lincoln, Neb.

**Cost Care Inc.**  
 Cost Care Inc.'s "boutique" personality is responsible for its success, says Mr. Goelman, president and chief operating officer of the seventh-largest UR firm.  
 "We've tailored our programs to meet client needs. So even though we offer 15 services, they are delivered differently according to clients' needs," he said.  
 In addition, each employer's account is handled by the same team of Cost Care employees, making

the process more personal. "Health care is a personal process, so we've organized into teams. We think UR has to be a very personal service," Mr. Goelman said.  
 The Huntington Beach, Calif.-based company provides UR services to corporate clients as well as members of Cost Care's managed care networks. In 1989, the firm reviewed 155,116 inpatient hospital admissions.  
 Cost Care has been reviewing inpatient hospital services since 1981 and in 1988 began reviewing outpatient services and procedures.  
 Last year, the company added two new UR components: chiropractic and imaging reviews.  
 "Chiropractic is an area that lends itself to overutilization," Mr. Goelman said.  
 Cost Care now employs a full-time chiropractor who will review cases from his particular perspective. Then, a physician reviews the case from a medical necessity standpoint, Mr. Goelman explained. "There are several physicians on our staff who will look at what (chiropractic) services are being rendered and how long they should continue."  
 The company's imaging review service consists of detailed examination of the necessity and appropriateness of high-cost imaging tests, like computerized axial tomography—or CAT—scans and magnetic resonance imaging procedures.  
 Cost Care will "look at whether the doctor who's ordering the tests has gone through all the other alternatives before resorting to using these tests," Mr. Goelman explained. Also, reviewers will investigate whether other types of technology, which may be less expensive, were considered.  
 "The goal is to make sure the patient gets the appropriate level of services. And, we want to get at the real reason behind using the new technology," he said.



**Value Health Inc.**  
 Founded in 1987, Avon, Conn.-based Value Health Inc. is the parent company of five specialty managed care firms:  
 • American PsychManagement Inc. in Arlington, Va., which offers mental health and substance abuse UR and managed care programs.  
 • Health Information Designs Inc. in Arlington, Va., a pharmaceutical UR vendor.  
 • Value Health Sciences Inc. in Santa Monica, Calif., a medical care UR firm.  
 • ValueRx Inc. in Southfield, Mich., a prescription drug plan.  
 • National Foot Care Program Inc. in Southfield, Mich., which sponsors a podiatric care preferred provider organization and offers related UR services.  
 The first three companies reviewed a total of 154,600 inpatient acute-care hospital admissions in 1989, making Value Health Inc. the eighth-largest UR vendor nationwide.  
 Value Health serviced a total of 8.1 million lives in 1989 through one or more of its subsidiaries.  
 In addition to its inpatient admission reviews, Value Health also reviewed more than 160,000 outpatient procedures last year, said Robert Patricelli, Value Health Inc.'s president.  
 He noted that outpatient review is important because simply pushing cases from inpatient into outpatient settings won't necessarily save employers any money.  
 "You have to look at the whole health care system," focusing on clinical issues, Mr. Patricelli said. "The whole UR industry has to get beyond managing the level of care and has to get into criteria-based medical necessity review."  
 Value Health is doing just that through a computerized medical necessity review program mar-

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*Continued on next page*

## UR vendors

Continued from previous page  
keted by subsidiary Value Health Sciences, Mr. Patricelli said.

The program, based on "very elaborate clinical practice standards to precertification," contains information on 35 expensive inpatient and outpatient procedures, he said. However, rather than focusing on length of stay or the setting in which treatment is delivered, the system flags cases where a procedure seems not to have been medically necessary.

"Nurses are now armed with a program that allows them to collect data from patient and doctor and let the system make a judgment," he said.

But, he explained, the system itself does not make a decision to deny a claim. Rather, it "scores" the case, and if a procedure's score indicates that it may have been unnecessary, the case will be sent to a

physician for further review.

Implemented in 1989, the program is purchased by 15 clients representing 6 million lives. Most users are large insurers, though several self-insured employers also have purchased the system, said Mr. Patricelli.

Value Health typically licenses the software to these companies and will train in-house nurses to perform the reviews, he said.

"What employers need is some way to make judgments on getting to the 20% to 40% of procedures that are not necessary," Mr. Patricelli said. "Employers see it as an add-on module to UR that permits them to challenge the medical necessity of the procedure itself."

### Corporate HealthCare Management

Corporate HealthCare Management, a subsidiary of EQUICOR Inc. in Nashville, Tenn., is the ninth-largest UR vendor based on

143,252 inpatient admissions reviewed in 1989 from a client base of approximately 6 million lives.

Corporate HealthCare Management reported 1989 gross revenues of \$23.3 million, a 33% increase from the \$17.5 million reported in

**Employers need a way to judge 'the 20% to 40% of procedures' that are unnecessary,' says Mr. Patricelli.**

1983. Ninety-one percent of the firm's 1989 gross revenues came from providing UR services directly to employers.

Among the company's recent innovations is the creation of a centralized department to review medical and mental health proce-

dures, noted Dr. Taylor, president of Corporate HealthCare Management.

"Rather than have medical and psychiatric reviews operating in separate product areas, we now have our medical leadership centralized in one department with a senior medical director, consultants and other medical directors," he explained.

In addition, "we've now completed and are installing a state-of-the-art mainframe system" that will better monitor the basis on which treatment is approved or denied.

The Integrated Referral and Authorization System, which was two years in development, "directly integrates" with claims information from EQUICOR clients and clients that purchase unbundled UR services.

The computer system "creates an authorization and claims history record that is transportable to

other systems," Dr. Taylor explained.

The company can "much better service employers" because this new system can furnish information on the patient's diagnosis and course of treatment. The record also includes the nurses or doctors talked to and "unique information on why we approved services or not," he said. Claims adjudicators that have access to the system can now pull up a full "authorization record instead of just a 'yes or no'" regarding payment, he added.

Dr. Taylor said Corporate HealthCare Management plans to develop a similar system this year for psychiatric authorizations.

In addition, Dr. Taylor said Corporate HealthCare Management has beefed up its health promotion services.

"We invested a whole lot more in the products that we made, and now we have a legitimate array of products" available to clients, including health advisory services and employer newsletters.

### Health Risk Management Inc.

Another newcomer to this year's UR rankings is Health Risk Management Inc.

HRM reviewed 83,000 hospital admissions in 1989 to rank as the 10th-largest vendor. The privately owned company services approximately 2.7 million lives, including benefit and workers compensation lives.

The Minneapolis-based vendor bases its hospital admission authorizations on a patient's diagnosis and whether the medical procedures recommended are appropriate according to that particular diagnosis, said Marlene Travis, president and chief operating officer.

"You have to look at whether a diagnosis is believable and what are the different treatment options available," she said.

In the early days of utilization review, everyone thought of UR as only encompassing preadmission review and length of stay issues, she said.

But, deciding to pay claims based on an admission's appropriateness or whether a length of stay is acceptable "ignored the medical issues."

When someone calls Health Risk Management, "we apply our own medical standards and ask them about their diagnosis and symptomatology," she said. "We discuss treatment options with practitioners and try to get them to use the most appropriate and conservative treatment."

"We also advise patients if we think (a procedure) is inappropriate and tell them to discuss it with a doctor," she said. Keeping patients informed helps them understand why a UR firm is taking the action, she added.

Whether a person should be hospitalized and the expected length of stay is less important than these medically sensitive issues, she said.

"You can't do utilization review in a cookbook way," Ms. Travis said, noting that HRM has spent the last four years developing its own medical necessity guidelines and criteria. Those guidelines do not simply authorize admissions based on widely accepted criteria that say the diagnosis automatically assures hospitalization. Rather, they focus intensely on the specific diagnosis and symptoms, she said.

Other UR professionals have accepted HRM's medical criteria as a credible tool on which to base admission and length of stay decisions, Ms. Travis said.

"I feel like we've had a best-kept secret. But now we want to take this resource and make it available to other UR firms, she said. ■

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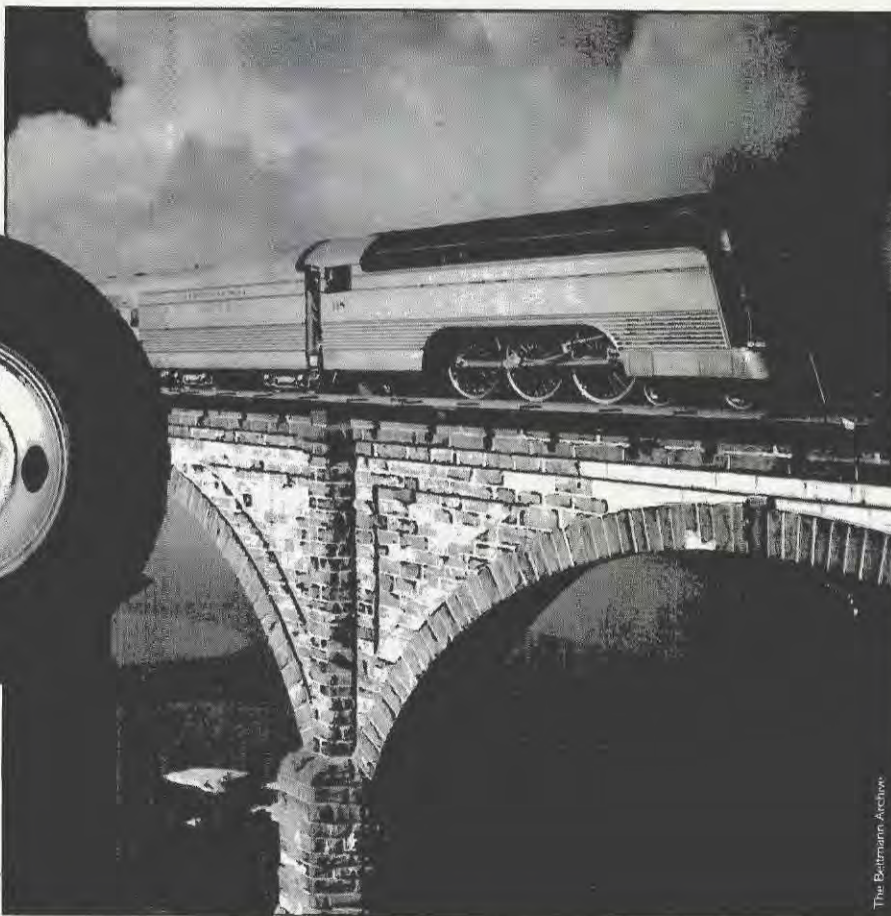
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## Employer coalitions

Continued from page 3

community providers are best, observers say.

Coalitions usually take one of two approaches: Employer-only coalitions that either exclude provider altogether or keep them in secondary roles, or broad-based coalitions that offer providers membership on equal footing with employers.

While some employer-only coalitions are developing purchasing groups, more broadly based coalitions focus more on educating members on the underlying factors that impact health care costs.

Each of the two approaches has its supporters and its critics.

Advocates of the employer-only coalitions say these groups can point to concrete savings for employers as a result of the groups' bottom-line approach, which keeps members active in the organization.

They also charge that coalitions

that have invited equal provider participation have been largely ineffective in controlling health care costs.

But the more broad-based coalitions say that the employer-only coalitions tend to foster unproductive adversarial relationships with providers, which blocks long-term solutions to soaring costs.

They also say that while employer-only groups may help their members control health care costs, the ultimate result is that providers shift these costs to other employers outside of the coalitions.

But, many observers question how effective either type of coalition has been to date (see story, page 24).

Many of the coalitions now in existence were formed eight to 10 years ago in response to Reagan administration cutbacks in health care planning agencies charged with studying the nation's health care issues, observers explained.

Their growth received additional impetus from grants from the Wash-

ington-based Robert Wood Johnson Foundation, which helps fund local community-based cost containment programs.

Also encouraging the growth of coalitions was the Dunlop Group of Six, formed in 1981, which includes executives from six national organizations: the AFL-CIO, the American Hospital Assn., the American Medical Assn., Blue Cross & Blue Shield Assn., the Business Roundtable and the Health Insurance Assn. of America.

Today, there is some type of employer health care coalition in all but eight of the 100 largest cities around the country, according to Gaylen W. Young, director of the AHA's Office of Health Coalitions and Private Sector Initiatives.

And, overall, there are now about 160 coalitions overall around the country, Ms. Young estimates.

As a result, new coalition growth has slowed, and those that are forming are appearing in smaller com-

munities.

There also has been some "skinnying down" in the number of coalitions due to consolidation. For instance, in Indianapolis, where there once were four separate coalitions, only one now exists, Ms. Young noted.

To help their members control health care costs, coalitions are starting to "get more directly involved in controlling health care costs" by using their purchasing power, said Carol Cronin, vp at the Washington Business Group on Health, which is becoming a clearinghouse of information for coalitions. The association now works closely with about 30 coalitions nationwide.

"I think what you're seeing is the verge of a possible trend," said Fran Miller, president of both the Denver-based Colorado Business Coalition for Health—whose approximately 500 employers represent 50,000 covered lives—and the coalition-associated Alliance, the fourth-largest

managed care organization in the state.

The current move toward health care purchasing networks is a natural evolution of the coalition movement, observers say.

"It has taken us a decade of experience to learn that this is the solution," said Jeanne Keller, executive director of the Vermont Employers Health Alliance in Burlington, whose members include 90 employers with 100,000 covered lives, or about 20% of the state's population.

"I look back on this decade, and say, 'We didn't really do anything, but we spent the time figuring out' what to do, Ms. Keller said. "It took us that much time to get at the idea of purchasing" health care through a network of preferred providers.

The stages involved in reaching that point included collecting and disseminating health care data; deciding what to do with the data; making the commitment to "try to make a change within the delivery system," and then proceeding to act as a purchasing agent, said John Sforza, executive director of the Florida Health Coalition in Miami, which has 40 employer members with 1.6 million covered lives.

Mr. Sforza said the Florida coalition, which also offers its own utilization review service, is now in the latest stage, "but we continue to do the other things as well," such as collecting and disseminating data.

"There is an empowerment that occurs along the way that's probably the most striking feature of this development," observed George Murphy, chairman and chief executive officer of the San Diego-based Community Care Network, a private firm that helps coalitions operate their PPO-type programs.

After years of collecting data on rising health care costs, these coalitions suddenly realize, "By golly, there's something that we can do about it," he explained.

The WBGH's Ms. Cronin said it is still too early to make an overall evaluation of coalitions' effectiveness in containing health care costs. "I think the proof will be in the pudding."

But some coalitions that offer health care purchasing networks say they have already had some positive results.

For instance, Mr. Sforza of the Florida Health Coalition said one company with 2,500 employees implemented a coalition-developed pilot purchasing project involving diagnostic tests and cut its diagnostic test bills by 35%.

And the 23 companies that participated in all of the Memphis Business Group's services, which include a PPO-type arrangement and utilization review, saw health care costs drop 22% on average per case, said Executive Director Gordon Smith.

"In our particular case, it's been very effective," said Fred Bowman, vp of finance and administration at Seessel's, a chain of seven supermarkets that is a member of the Memphis coalition.

The Buyers Health Care coalition in Nashville, Tenn., has negotiated one-year contracts for each of 10,000 health care services and procedures with about 95% of the area hospitals, said President Edwin Childs.

"We have a price down to the aspirin for each item in the hospital," he said. "We deliver an auditable cost savings to each employer on each claim."

He estimates his coalition saves its employers 15% to 20% in hospital costs.

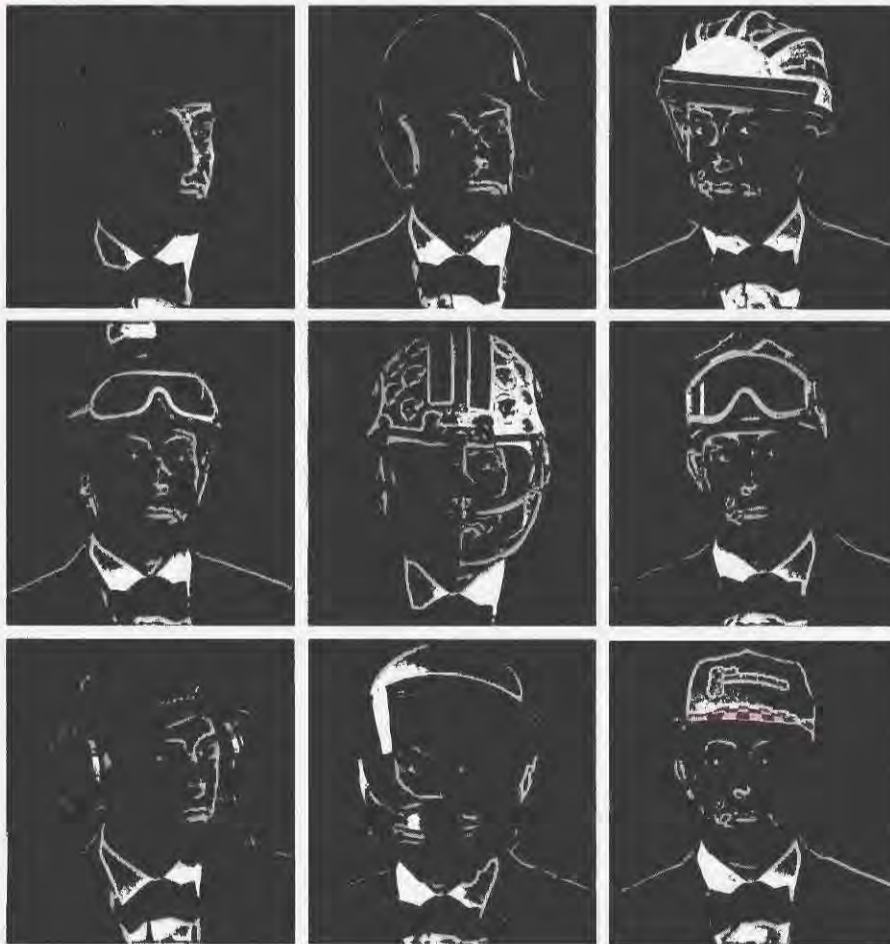
The Vermont coalition's efforts include a mail-order pharmaceutical program that can save employees 40% on maintenance drug costs, Ms. Keller said.

The coalition also is working on developing preferred provider programs for mental health, dental and vision care, she said.

Coalitions setting up purchasing arrangement stress the need to en-

Continued on page 24

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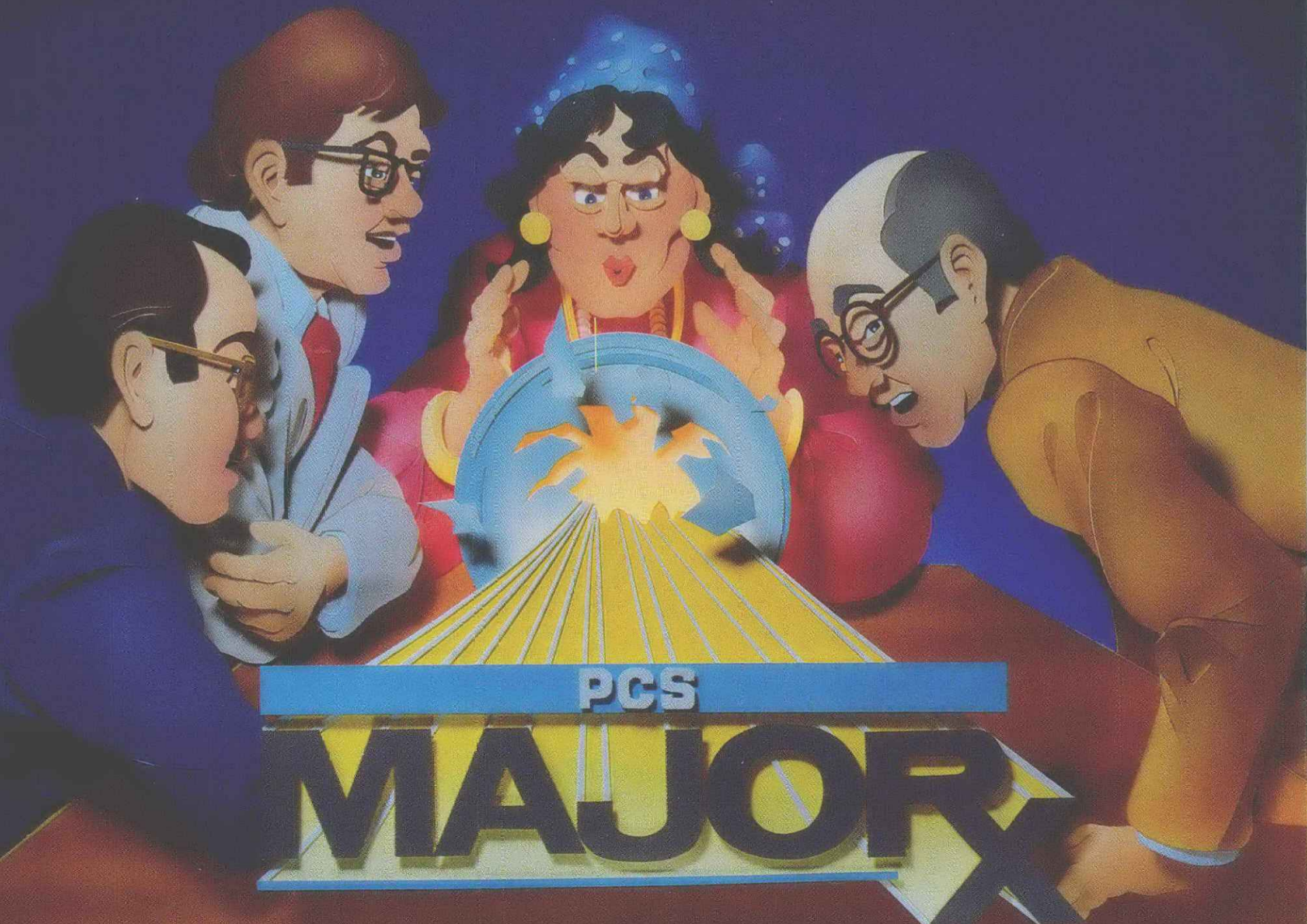
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## Coalitions

*Continued from page 22*  
sure quality services. "Quality is the No. 1 driving issue," said Colorado's Mr. Miller (see story, page 31).

But, coalitions offering health care purchasing networks will have to take pains to ensure they are establishing programs with high-quality providers to distinguish them and survive the competition from the better-capitalized insurance industry, Mr. Miller said. Otherwise, "they'll just be a blip in history," he warned.

The Colorado coalition has lined up a network of providers from which employer members can create their own preferred provider network while maintaining their own plan design, Mr. Miller explained. "We're not a PPO. We're a master network out of which you can create a PPO," he said.

"This is probably the only way we're going to deal with this issue" of soaring health care costs, agreed Chuck Ripp, director of membership development for the Midwest Business Group on Health, which has created the Employers Purchasing Institute for Quality preferred provider organization for its members in the Chicago area.

The MWBGH, whose Chicago-area employer members have about 20,000 employees, is also working with the New York-based Hartford Foundation on how to improve the quality of health care, he said.

"I think we've got the best prices in town," said Dick Wagner, project director of the Greater Milwaukee Business Group on Health, an MWBGH chapter that offers members a PPO-type network. But, "we have been very, very careful" about maintaining quality, he said.

The Milwaukee coalition, whose members have 75,000 to 90,000 employees, has checked the credentials

for each of the 1,300 physicians in its network, Mr. Wagner noted.

The Milwaukee program also is involved in the Hartford Foundation's study on improving health care quality.

"We want to be sure the quality of the providers that we have in the network is the best," said Mr. Wagner, explaining that high-quality programs lead to lower costs.

But, he noted, coalitions must work with providers to be successful. "It is really something we have to do with the providers. We can't do it by ourselves. It becomes a provider quality relationship."

"The emphasis has got to be on quality," agreed Ralph S. Pollock, chief operating officer of ValueCare Inc. in Hartford, Conn., formerly the Business Coalition on Health.

ValueCare plans to launch a preferred provider organization by January 1991 for its 17 members with 300,000 covered lives, which represents about 12% of Connecticut's population, Mr. Pollock said (*BI*, Jan. 22).

ValueCare could have set up just a discount PPO organization, Mr. Pollock said. But all that would do "is cost shift to the other employers."

Instead, he said, it is trying to "do everything differently," including being highly selective in its choice of participating physicians and focusing on educating employers about cost-effective health care.

The PPO will analyze claims data and work with an advisory board of physicians to form a network of high-quality, cost-efficient providers, according to Mr. Pollock.

"We're trying to keep all those system issues in perspective," Mr. Pollock said.

The Nashville coalition, whose members have 48,000 lives, deter-

*Continued on page 26*

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## Coalition misgivings are widespread

Employer coalitions have not been the answer to soaring health care costs that employers had hoped they would be, several observers agree.

"I frankly think that employer coalitions have had a noble cause, but I think they've been relatively, if not totally, ineffective," said Robert Siver, vp of Siver Management Consultants in St. Petersburg, Fla.

Unless a coalition can completely control the practice and pricing of medicine, "I just don't see it being that effective," said Bill Danish, a consultant with Fort Lee, N.J.-based Kwasha Lipton.

Even coalition executive directors acknowledge their groups' shortcomings.

"I would grade coalitions generally as maybe about a C-plus, I guess," said Patrick Casey, executive director of the Health Action Council of Northeast Ohio in Cleveland.

"I'm in touch with a lot of different coalitions around the United States and they vary in their effectiveness," Mr. Casey said. Coalitions, he said, can more effectively help members control health care costs by offering only employers full membership.

A November survey of 125 coalitions sponsored by the Dunlop Group of Six—which includes executives from the AFL-CIO, the American Hospital Assn., the American Medical Assn., Blue Cross & Blue Shield Assn., the Business Roundtable and the Health Insurance Assn. of America—showed that coalitions themselves appear ambivalent about their effectiveness in controlling costs.

Forty-nine responded in a neutral fashion when asked whether coalitions are effective. Twenty-two reported their groups were ineffective and only 45 said they were effective.

In light of what employers are doing on their own in health care cost management, "it's not clear that you need coalitions any more," said Helen Darling, a principal with William M. Mercer Meidinger Hansen Inc. in Stamford, Conn.

Coalitions seem "old fashioned" and "can't move as fast" as employers can individually, she said.

But Richard Ekstrom, former chairman of the Pittsburgh Business Group on Health and manager of health benefits at Westinghouse Electric Corp., believes "they've had a constructive effect."

No single factor, however, "can be singled out or measured for its effect on controlling health care costs," Mr. Ekstrom said.

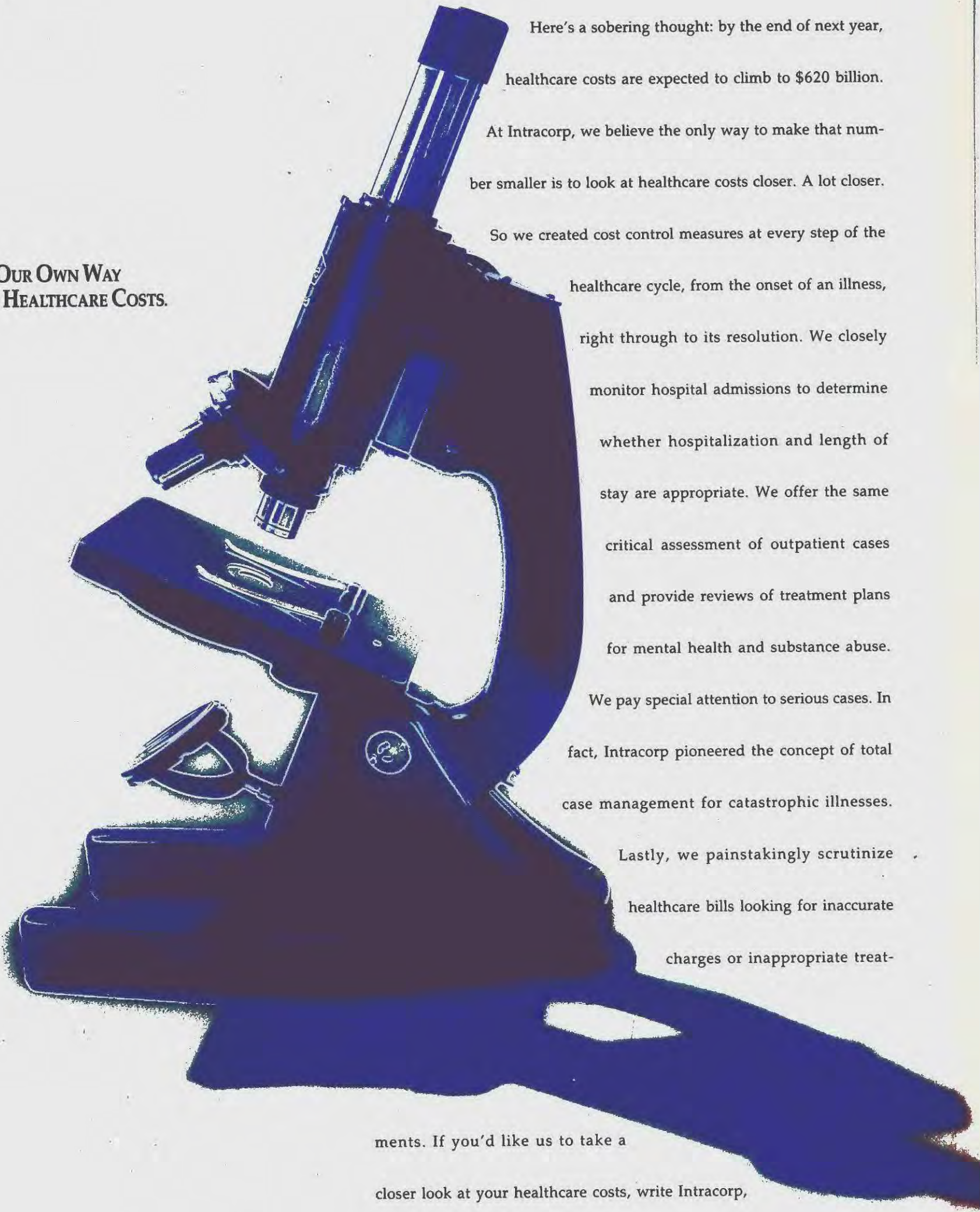
Observers say the structure of employer coalitions can impede effectiveness in controlling health care costs.

For instance, not all coalition members may follow the organization's decisions, said Richard Sinni, director of the Secaucus, N.J.-based health management practice of Buck Consultants.

"You sometimes lose some of your larger employers groups" that feel that a particular program is "not where they want to be corporately," he said.

—By Judy Greenwald

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## Spotlight report

## Coalitions

Continued from page 24

mines which hospitals are the best for particular procedures as part of its program, Mr. Childs noted. "Every hospital has some center of excellence," she said. No hospital is a "one-stop shop."

Community Care Network's Mr. Murphy predicts coalition-sponsored purchasing arrangements will continue to develop. "I'm not sure this is the last phase," he said. "I suppose this isn't the end of the process."

Some observers envision the eventual creation of a nationwide program. "We're looking to assist coalitions throughout the country," said Mr. Ripp of the MWBGH. "We see it eventually as a national type of program."

Mr. Murphy agreed that there are "perhaps some common threads" that would make some sort of national coalition feasible.

But, Mr. Murphy believes that coalitions will continue to be essentially community-based. "Our experience suggests that health care is a local issue and is more effectively dealt with in a customized, local approach," he said.

Not all employer-only coalitions, however, are moving toward establishing preferred provider networks for their members.

For instance, such an approach would not be appropriate in St. Louis, said Jim Stutz, executive director of the St. Louis Area Business Coalition.

He explained that St. Louis serves as the headquarters for several large, national companies that are "fully capable" of developing their own purchasing arrangements and do not need the coalition to do so. Indeed, there are 38 employers in the coalition with about 300,000 covered lives, or about 12% to 15% of the area's population, Mr. Stutz said.

"It's just not a demand of our employers," he said, observing that "every area is different."

Instead, employers in the St. Louis area are interested in focusing on efforts that would lead to a more competitive health care marketplace, Mr. Stutz said.

The St. Louis coalition has concentrated on collecting and analyzing claims experience data from hospitals, as well as data on financial performance. As part of an upcoming project, the coalition plans to provide information on what hospitals will be charging in the future.

However, the coalition already has helped keep health care costs down, Mr. Stutz believes.

For instance, it was active in encouraging utilization review firms to set up operations in St. Louis. And, Mr. Stutz believes, UR firms were instrumental in the 28% reduction of hospital lengths of stay in the market to 620 per 1,000 covered lives in 1988 from 862 per 1,000 in 1983.

There is no wrong or right way to approach cutting health care costs, Mr. Stutz said. "It's taking each market and looking at what the needs are."

Meanwhile, coalitions that include providers as active members feel they also can make a contribution—albeit a more indirect one—toward containing health care costs.

Jim Ring, chairman of the Minnesota Coalition on Health, which includes providers, acknowledges that the coalition's impact on controlling health care costs has been "marginal at best."

"The impact is not immediate. It is clearly the long range that we're dealing with," said Mr. Ring, who is also vp-human resources at Control Data Corp. in Minneapolis.

But, he said, the coalition does enable providers as well as employers to gain a "far better sense of recognition of where we have common ground."

It also has been "without a doubt, extremely effective" in helping employers develop health care plan designs and policy statements, Mr. Ring

said.

"We already have multiple organizations that do what these purchasing groups do," said Patricia Drury, executive director of the Minnesota coalition.

The health care system's problems cannot be unilaterally solved, Ms. Drury said. "No one party can get it done."

Compromise and agreement among all parties is necessary, and "an effective coalition can effect these compromises," she said.

And while there is the risk that coalitions could eventually become stalemated, "it doesn't have to," Ms. Drury asserted.

What the Minneapolis coalition is setting out to do by involving all elements of the health care network is harder than the employer-only approach, and it can be more painful, "but when it works, it's more effective," Ms. Drury said.

The New York Business Group on Health, which has close to 300 mem-

bers from New York, New Jersey and Connecticut, includes providers in its membership for two reasons, according to Dr. Leon Warshaw, executive director of the coalition:

- The health care industry is one of the major industries in the tri-state area and "they have the same concerns banks and manufacturing companies have" about rising health care costs.

- And, even though one of its members is the city of New York with 1.3 million covered lives, the coalition currently does not have the necessary clout in the New York metropolitan area market to create an effective purchasing organization. "We have to rely on persuasion," he said.

Nevertheless, Dr. Warshaw believes that the coalition has played a useful role in educating its members about how to use health care cost effectively and about other cost-saving approaches as well as dealing with the issues of plan design.

The coalition also has tackled—

through its educational programs—such issues as prenatal care, alcohol or chemical dependency, anxiety and depression within the workforce and acquired immune deficiency syndrome.

However, it would be "impossible" to attempt to quantify health care cost savings as a result of these programs, Dr. Warshaw said.

In Detroit, the 130-member Greater Detroit Area Health Council, which includes providers as members, addresses the underlying issues in health care, said Executive Director Symond Gottlieb.

Those issues include reducing excess capacity in hospitals and variations in medical practices as well as obtaining a better consensus in such areas of concern as AIDS.

The council just finished a major report on how to implement an integrated regional health care delivery system in the Detroit area. The report detailed the essential characteristics of such a system and "how

you get there," Mr. Gottlieb said.

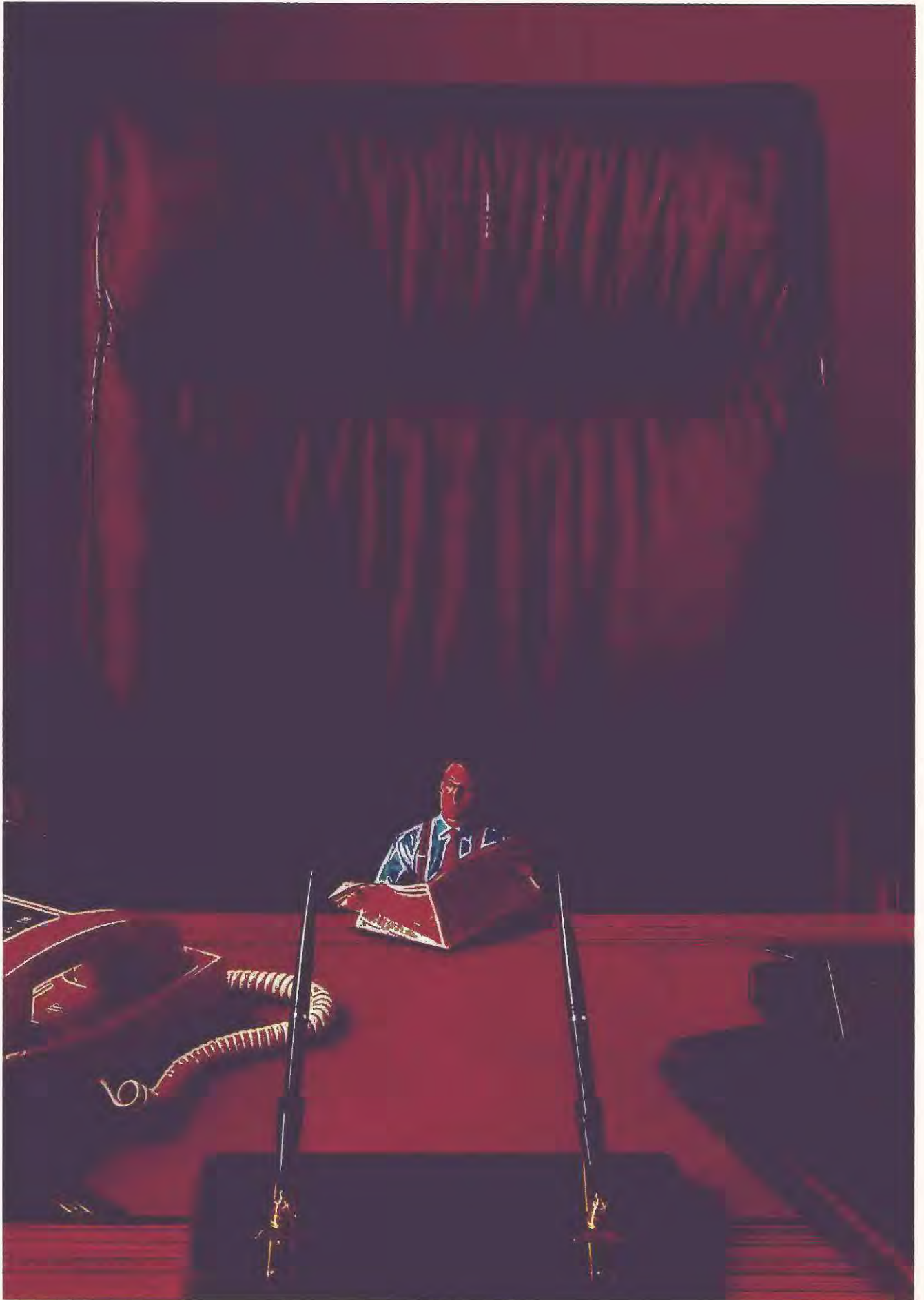
Unlike other coalitions, however, it does not seek legislative help often. "We don't think you solve the problems by legislation," he said.

The Detroit coalition is "the best forum we have now, it seems," said Harold Armstrong, general director of health care cost analysis at General Motors Corp. It is an effective listening post that permits all sides to hear others' perspectives "undiluted by a bunch of people in between," such as consultants.

Mr. Armstrong acknowledges that there are times when "philosophical gridlock" develops.

But at other times, the coalition leads to frank, open discussion from different perspectives on what it takes to effect change. And while it may not lead to precise cost savings, it does help in the "global sense," Mr. Armstrong said.

"It does a lot, and we think it's capable of doing a lot more," he asserted. ■



# Mental health benefits revised

## Advocates of 'carving out' see savings, better quality

By STACY ADLER

By dividing mental health benefits from group medical plans, employers hope to conquer skyrocketing mental health care costs.

Employers that separate group medical and mental health benefits can then focus on reducing mental health care costs, realizing savings of 10% to 40% while improving quality of care, mental health care experts say.

"Among Fortune 500 companies, at least half have gone to a stand-alone mental health care benefit in the last five years," said Dr. Kenneth Kessler, chairman of Ameri-

can PsychManagement Inc., a specialized utilization review firm in Arlington, Va.

Requests by both large and small companies to separate mental health care benefits from medical benefits have increased 300% in two years, said David J. McDonnell, president and chief executive officer of Preferred Health Care Ltd., a psychiatric UR firm in Wilton, Conn.

"For those employers whose psychiatric costs are more than 15% of total health care costs, this benefit deserves to be looked at separately," said Laura Fineberg, a consultant for Hewitt Associates in

Lincolnshire, Ill.

"Employers—particularly large employers—are going to stand-alone programs," agreed John Brady, president of Psychology Systems, a specialized utilization review firm in Milpitas, Calif. "Most of our clients now want a complete carve-out."

Potential savings are one obvious reason for the switch.

Psychiatric and substance abuse costs can be cut 10% to 40% by managing the benefit separately, said Joan Pearson, a consultant with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc. in Seattle.

"A 25% to 20% savings in the first full year of operation is not unreasonable to expect," said Mr. McDonnell. "Savings can be as high as 40%."

Carefully designed programs can save some employers 50% on mental health care costs, said John Bartlett, vp and corporate medical director of MCC Cos., a UR unit of CIGNA Corp. in Minneapolis.

After one large West Coast company's mental health care expenses under its group health care plan rose 25% in one year, the company decided to carve out the benefit, said Dr. Kessler. As a result, mental health care costs dropped 35%,

for a \$3 million savings.

Advocates say carving out mental health benefits can also improve the quality of care by ensuring that those covered get the most appropriate treatment.

"Employers can drive both cost effectiveness and quality of care by carving out the psychiatric and substance abuse benefit," said MCC's Mr. Bartlett.

By making sure employees receive appropriate mental health and substance abuse care, employers reduce the relapse rate, said Ms. Fineberg of Hewitt. "Ultimately, high quality of care is going to result in cost savings."

While carving out mental health care benefits can help employers reduce costs and improve quality of care, the process is not without its difficulties, experts warn.

Employers that decide to carve-out the mental health care benefit face communication and administrative challenges, they say.

Explaining a separate mental health care plan "can be quite complicated," said Ms. Pearson of TPF&C.

Consultants emphasize conveying a sense of caring to employees. Highland, Mich.-based Chrysler Corp., for example, calls its mental health care program "Help Line."

A carve-out also presents administrative difficulties, experts say.

"Administratively, the employer is forced to deal with two groups (of providers and utilization re-

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**'Most of our clients now want a complete carve-out,' says John Brady of Psychology Systems.**

view firms)," said Mr. McDonnell of Preferred Healthcare.

But employers often realize that, with the savings generated by a carve-out, they can afford to hire another employee to handle administration, said Mr. Kessler of American PsychManagement.

After carving out mental health benefits, an employer can best contain costs and improve care by hiring specialized psychiatric utilization review firms, changing plan design and creating a preferred provider network of mental health professionals, say consultants and specialized UR firms.

In fact, mental health care cost management has become a thriving industry.

Traditional UR programs are not effective in managing the costs of psychiatric and substance abuse benefits, according to consultants.

"The medical/surgical benefit and the psychiatric benefit are two different benefits and cannot be treated the same," said Donna DeHart, vp-marketing for TAO Inc. in Philadelphia, a psychiatric UR firm.

"You need a different type of nurse and a different type of professional to properly manage psychiatric costs," said Barbara Adachi, senior manager of health care benefits consulting with Deloitte & Touche in San Francisco.

Specialty UR firms focus on matching the employees' needs with a wide array of treatment options, including:

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## Mental benefits

Continued from previous page programs.

• Transitional residential treatment programs.

- Outpatient care.
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Experts note that inpatient care—which can account for 70% of total mental health care costs—is the most expensive, but often not the most appropriate, type of care.

“The literature shows that outpatient treatment is appropriate for 60% to 70% of those needing substance abuse treatment,” said Ms. Pearson.

Redesigning mental health benefit plans to encourage employees to seek alternatives to costly inpatient care also can produce cost savings, experts say.

“Plan design is often the first area of change,” said Ms. Pearson. Many employers’ mental health

plans either don’t cover outpatient treatment for certain types of illness or require employees to pay more for outpatient treatment, she explained.

And many have “flawed benefit incentives” that make inpatient treatment less expensive for employees than outpatient care, added MCC’s Mr. Bartlett.

Removing disincentives to outpatient treatment is the key to plan redesign, said Ms. Adachi.

Consultants and UR firms caution, however, that “benefit redesign” should not be a euphemism for “benefit reduction.”

Employers should alter plans to encourage less-expensive forms of treatment, not to cut back benefits, said Mr. McDonnell of Preferred Healthcare.

Cutting mental health care benefits to reduce costs is “throwing out the baby with the bath water,” said Mr. Kessler of American PsychManagement.

In addition to hiring specialty firms or redesigning benefits, employers attempting to manage the costs of mental health care frequently turn to psychiatric preferred provider organizations.

In addition to providing their services at a discount, psychiatric PPO providers usually agree to hold down expenses with certain cost containment techniques, such as case management.

When selecting a PPO it is important that employers choose a network of providers that practice approaches to care that are cost-effective, said Mr. Bartlett.

Employers should also “pick a psychiatric PPO that shares their treatment approach,” he said. ■

## Psychiatric costs rising at large firms

Controlling psychiatric costs is more of a problem for large employers than for small firms, according to a study scheduled to be released this fall.

For companies with more than 5,000 employees, per-employee psychiatric and substance abuse costs soared 47% to \$297 last year, from \$202 in 1988, according to the preliminary results of an A. Foster Higgins & Co. Inc. study.

In comparison, costs for employers with fewer than 5,000 employees declined slightly, to \$215 in 1989 from \$218 a year earlier, the study found.

Still, “for the average employer 15% to 25% of total health care costs is for mental health care,” said Laura Fineberg, a Hewitt Associates consultant in Lincolnshire, Ill.

“These costs are going up faster than any other component of the medical plan,” said Joan Pearson, a consultant with Towers, Perrin, Forster & Crosby Inc. in Seattle.

Per-employee costs for psychiatric and substance abuse benefits increased 18% to \$244 in 1989, from \$207 in 1988, according to the study.

Foster Higgins also found that self-insured employers do not control mental health costs as well as their insured counterparts. Costs rose 26% between 1988 and 1989 for self-insured mental health plans, compared with 17% for insured plans, the survey found.

Among factors contributing to the high cost of mental health care are extended hospital stays and increased hospitalization of adolescents.

Average inpatient hospital stays for mental health care are 20.5 to 21.5 days, or nearly four times longer than the average 5.6 to 6.1 day stay for general medical care or surgery, according to Barbara Adachi, senior manager of health care benefits consulting with Deloitte & Touche in San Francisco.

Mental health care costs can be “especially problematical if the employer has a large number of adolescents in the insured population,” said Ms. Fineberg of Hewitt.

Much of the increase in mental health care for adolescents—hospital admissions increased 450% from 1984 to 1987—can be attributed to increased advertising by hospitals, she explained.

Teen-agers are being inappropriately hospitalized for behavioral, rather than true psychiatric problems, charges John Brady, president of Psychology Systems, a specialized utilization review firm in Milpitas, Calif.

“People are being convinced that adolescents need expensive care,” agreed TPF&C’s Ms. Pearson.

—By Stacy Adler

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# Firms separating mental health benefits

By STACY ADLER

General Motors Corp.'s mental health care costs were "out of control" in 1983. Employees were overutilizing psychiatric and substance abuse benefits, and many were seeking emergency mental health care with no oversight, a company study found.

Several years later, GTE Corp. found mental health costs rising at double the rate of medical costs at its California subsidiary. Mental health care, in fact, consumed more than 25 cents of every dollar the company spent on employee health care.

To address the problem, both companies recently have "carved out" mental health benefits from their group benefits programs and redesigned their mental health care plans.

"The first thing we did was separate out the substance abuse benefit," said Beach Hall, assistant director of health care benefits for General Motors in Detroit. GM's goal was to stop the "revolving door" caused by patients that suffered a high rate of relapse.

GM also added precertification review and concurrent review of all second-time substance abuse treatments.

In 1987, the company began requiring a treatment plan for all employees prior to discharge from a detoxification treatment center and instituted stiff financial penalties for any employees found leaving treatment without medical approval.

The results, said Mr. Hall, were terrific. "In terms of substance abuse, we were treating the same number of people at a lower cost," he said.

Substance abuse care costs were cut 17% between 1987 and 1988. A year later, substance abuse care costs rose at less than the rate of inflation, he said.

GTE Corp.'s first step toward reducing mental health care expenses at its California operations was to redesign its benefit plan to encourage use of less expensive types of care, said Bruce Taylor, former manager of employee insurance for the Stamford, Conn.-based company.

The phone company's traditional benefit plan paid 100% of the cost of inpatient psychiatric and substance abuse treatment, but only about 50% of the costs for outpa-

tient treatment.

The current plan at GTE California covers both inpatient and outpatient psychiatric and substance abuse care at 100% if the employee has treatment pre-approved by GTE's employee assistance staff or by its new psychiatric UR firm, Preferred Healthcare of Wilton, Conn.

However, employees who do not have treatment reviewed in advance are covered for only 80% of inpatient costs and 50% of outpa-

tient costs.

GTE also instituted a new communications campaign entitled "Who Cares?" The message of that program was "GTE cares."

"The results of the program were that in 1987 and 1988 we were able to treat more employees and more dependants," said Mr. Taylor. In 1986, prior to the changes, GTE treated 2,823 claimants for psychiatric illnesses. In 1987, after the changes, the company treated 3,044. The number fell to 2,956,

however, when the workforce was cut in 1988.

But, even though more employees and dependents were received mental health treatment, the company lowered costs for psychiatric and substance abuse treatment by 25% in 1987 and 5% the following year, said Mr. Taylor.

"We expect to see similar results for 1989," said Mr. Taylor. "Preliminary indications are that we will see another 5% to 10% decrease in costs." ■

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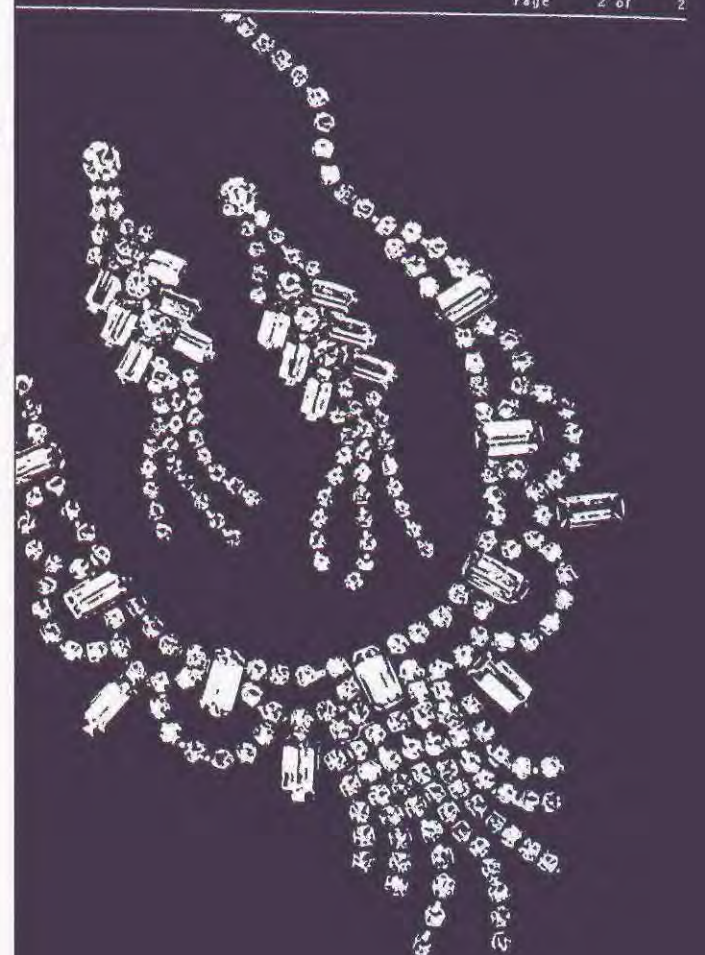
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# Managed care may improve quality

By LINDA J. COLLINS

## Scrutiny identifies best providers

Managed care techniques and other tools used to control health care costs generally are improving the quality of health care patients receive, health care experts say.

Managed care programs, like health maintenance organizations and preferred provider networks, attempt to identify high-quality, cost-efficient providers, which better guarantees that employees and dependents receive the best care avail-

able, cost-containment experts explain.

In addition, utilization review can serve as a "double check" on the courses of treatment prescribed by physicians.

But, while managed care programs generally have improved the quality of care, rewarding doctors for their cost efficiency could cause some less

reputable physicians to cut corners in an attempt to impress employers and insurers, one physician contends.

And many doctors complain that the morass of red tape created by non-standardized UR procedures forces physicians to spend time on administrative matters that could be spent treating patients.

The dramatic rise in health care costs during the late 1970s and most of the 1980s forced employers and group health insurers to control these costs. While the tools have generally been effective in holding down cost increases, they have not detracted from the overall quality of care, consultants said.

And, preserving quality care is on

top of employers' lists as they enter the '90s, they added.

In the 1980s, "a lot more interest was focused on cost control at the corporate level," explained Tony Gajda, chairman of the health care consulting practice group of William M. Mercer Meidinger Hansen Inc. in New York.

"Toward the close of the 1980s, more attention was paid to quality," as employers, insurers and consultants were better able to evaluate the effectiveness of those programs, Mr. Gajda added.

"We view the quality of care and appropriateness of care to be the two key issues for employers and providers in the next 24 months," said Larry Goelman, president and chief executive officer of Cost Care Inc., a UR firm based in Huntington Beach, Calif.

"There is a large increase in the number of employers now looking for second generation utilization review (that is) care-effective as well as cost-effective," Mr. Goelman said.

In the last few years, employers have become increasingly concerned about the quality of care their employees receive, agreed Barbara Hammer, group benefits consultant with Hewitt Associates in Rowayton, Conn.

"Employers are now trying to reach a better understanding of who are the providers, who are the more efficient providers and what are the outcomes of their treatments. Cost containment has made employers more sensitive to the quality of care," said Ms. Hammer.

For example, many employers now examine how provider networks select their physicians to ensure that the money they spend on health care is being used as effectively as possible, she said.

Among the criteria being examined are the success of various treatments and the number of repeated admissions to a hospital for the same or a related illness or injury, Ms. Hammer explained, adding that such examination is essential.

"When employers seek to control costs, and limit their employees' access to free choice of providers, they have to look at the quality issue. I don't think anyone wants to have a program where an employee loses a limb or a life to save (the employer) dollars," she stressed.

Although many doctors resisted the changes brought about by cost containment programs, these programs improve the quality of care, said Dr. Robert J. Becker, chairman of Healthcare COMPARE Corp., a UR firm in Downers Grove, Ill.

"I think there has been some sentinel effect of cost control in making physicians objectively think about their treatment plan," Dr. Becker observed.

For example, UR programs have forced physicians to demonstrate that their patients are receiving care "at an appropriate site" and that they are using a treatment plan that can be justified "to another physician with whom they have no personal, financial, constituency or referral relationship," he explained.

Health care cost control efforts have "focused rational attention on how to judiciously utilize limited health care dollars and resources," said Sheila Leatherman, vp of research and development for United HealthCare Corp. in Minneapolis, an HMO and health care cost management firm.

This has limited the use of unnecessary medical procedures that can "expose patients to unnecessary risks," she noted.

"Conversely, there is also attention now on correcting underutilization of services, which may mean such things as creating better access to care for pregnant women in

Continued on next page

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## Quality of care

*Continued from previous page*  
the first trimester, and ensuring that older women receive mammographies for breast cancer and diabetics receive regular eye exams to detect retinopathy," Ms. Leatherman explained.

Another way that managed care providers can improve the quality of care they deliver is to direct them to the right type of physician or the best treatment plan, said Eli Glick, a physical therapist with Phycare Physical Therapy in suburban Philadelphia.

Because "there are so many different types of treatments and philosophies of care, it is often difficult for a patient to pick the right one. Cost containment firms can help refer them to the appropriate people," Mr. Glick observed.

John C. Erb, a managing consultant with A. Foster Higgins & Co. in New York, agreed that managed

care programs "may have slightly improved the quality of care" because "people are directed to the right types of care instead of being left adrift to fend for themselves with no handbook, no map or no chart to the medical care system."

Historically, many people have relied solely on referrals from neighbors or friends in selecting physicians, he said.

"In the managed care area, the physicians have been screened and typically are specialists or board-certified," Mr. Erb added.

But while employers are taking a greater role in selecting health care providers, patients also must learn to be more accountable for their actions and become more actively involved in their health care to receive quality care, said Phycare's Mr. Glick.

"With more outpatient services being provided, people now have to have a better understanding of and control over the decisions they are making," agreed Greg Riedi, senior vp of Intracorp, a UR firm in Berwyn, Pa.

A greater effort needs to be made "by everybody within the health care arena to educate consumers and involve them more in the process," Mr. Riedi said.

Indeed, "the responsibility for helping individual patients learn how to access care correctly falls on the provider, employer and health plans," said Dr. K. James Ehlen, chairman and chief executive officer of Physician's Health Plan of Minnesota, a Minneapolis HMO affiliated with United HealthCare.

While United HealthCare's Ms. Leatherman feels that in the long run cost control efforts have improved the quality of care patients receive, she acknowledges that some early cost control efforts might have been misguided.

For example, she said that the installation of across-the-board employee copayments or deductibles may have "inhibited employees' access to health care."

One way to avoid this problem would be for employers to eliminate copayment requirements for such areas as prenatal doctor visits, Ms. Leatherman suggested.

"You want to encourage pregnant women to receive prenatal care," she explained.

And, while second surgical opinion requirements are "still very effective" in eliminating some unnecessary procedures, they have been less successful when they are applied across-the-board, Intracorp's Mr. Riedi said (*BI*, Feb. 20, 1989).

In fact, Blue Cross & Blue Shield Assn. recently revised its second surgical opinion procedures, said Susan Gleeson, director of BC/BS' Center for Quality Healthcare in Chicago.

"In areas where there has been a high degree of concurrence between first and second surgical opinions, the second surgical opinion requirement has been eliminated. And, we have also instituted waiver requirements for some procedures where the need for surgery is absolutely indicated," Ms. Gleeson explained.

In addition to ensuring that patients get necessary medical attention as promptly as possible, "this has made these programs a lot more cost-effective," she added, noting that the average second surgical opinion costs about \$100.

Cost Care's Mr. Goelman also pointed out that the basic approach that a UR firm takes can affect the quality of care a patient receives.

There are two types of UR, Mr. Goelman explained:

- The statistical model, which relies on the patient's age, sex and medical diagnosis to determine whether a medical procedure is justified.

- The clinical model, which examines the patient's own medical history as well as the medical procedure the doctor proposes.

When UR decisions are based  
*Continued on next page*

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Continued from previous page  
solely on statistics, "they can't document and validate the quality of care being provided. The clinical model is the only way to deal with the quality issue and improve patient outcomes," Mr. Goelman said, adding that an increasing number of UR firms are now using the clinical model instead of the statistical model.

A physician also cautioned that when HMOs and PPOs offer doctors financial incentives for keeping costs down and limiting patient referrals, the quality of patient care could be jeopardized.

While most physicians will always perform the necessary tests and studies their patients need or refer them to the appropriate specialists, less reputable doctors seeking contracts with employers or PPOs may take shortcuts to prove that they are a cost-efficient provider, contends the chief of neurosurgery for a major Eastern hospital.

"I don't think patients should be discouraged from seeking medical advice or physicians should be rewarded for not doing some things," he stressed.

The neurosurgeon also said treatment decisions should be made based on where the best service is available, "not where they offer the best price."

In addition, doctors complain that the sometimes excessive amount of time they are required to spend to comply with non-uniform UR requirements means less time spent with their patients, which hurts the quality of care provided.

"The lack of consistency or uniformity in the processes that various review organizations require—the information requested and the steps physicians have to comply with—is creating "an extraordinary administrative burden" for physicians and their staffs, said Dr. John Kelly, director of quality assurance for the American Medical Assn. in Chicago.

"This lack of uniformity can be extremely frustrating to physicians at a time when they are trying to provide necessary services to their patients," he said.

To address this problem, "efforts are now under way by over 25 different physician organizations to develop parameters for use by physicians in performing a number of different medical and surgical procedures involving the entire spectrum of medical care," Dr. Kelly explained.

For example, the 435-member AMA House of Delegates adopted an "Initiative on Medical Review" last December with four main goals: to streamline and reduce duplication in the review process; to assure that UR is performed by physicians; to remove the secrecy from established medical review guidelines; and to promote uniformity and consistency across reviewing entities (BI, Jan. 22).

In addition, a task force of managed care providers also are working to develop voluntary national UR standards (see story, page 2).

The task force will also "establish a separate corporation for the purpose of credentialing managed care companies," HealthCare COM-PARE's Dr. Becker said.

However, the accreditation program "will probably not be in place until January 1991, because it will take a while to develop it and get organizational support," he added.

But, by establishing UR standards and developing an accreditation program for managed care companies, the task force expects to realize two goals, according to Dr. Becker:

- To show that UR companies "must be accountable" for their actions.

- To act as a "statement by UR companies that we really want to work with providers."

While Physician Health Plan's Dr. Ehlen agreed that "a certain amount of duplication and confusion is being created by different review organizations requiring different procedures,"

he pointed out that those organizations would probably be more willing to comply with standards developed on a local or regional basis.

"Initially, these efforts may need to be locally driven, and state or county medical associations are going to be important in facilitating these efforts," Dr. Ehlen said.

The Chicago-based Midwest Business Group on Health began one such local effort last year in Kingsport, Tenn., said Barbara Kavalew, the MBGH's director of research.

"Employers are looking at ways of working with providers to provide quality health care in their community," Ms. Kavalew noted.

With the help of MBGH, the chief

executive officers of the three major hospitals in Kingsport and a representative group of employers and physicians established a working group of 14 people to improve the quality of care in the community.

The working group in August went through 2½ days of training on the theory of quality improvement, taught by representatives from Harvard Health Plan in Cambridge, Mass., and Nashville, Tenn.-based Hospital Corp. of America, Ms. Kavalew said.

The working group, which now meets every other week, then set up teams of additional people representing employers, hospitals and pro-

viders to examine four separate areas:

- A way to improve the effectiveness of the UR process.
- Outpatient alternatives to lower the the number of patients readmitted to hospitals with chronic respiratory diseases.
- The discharge of some patients from hospitals to nursing homes.
- The increasing problem of teenage smoking.

Those teams are now undergoing 64 hours of training at a local technical institute, she said.

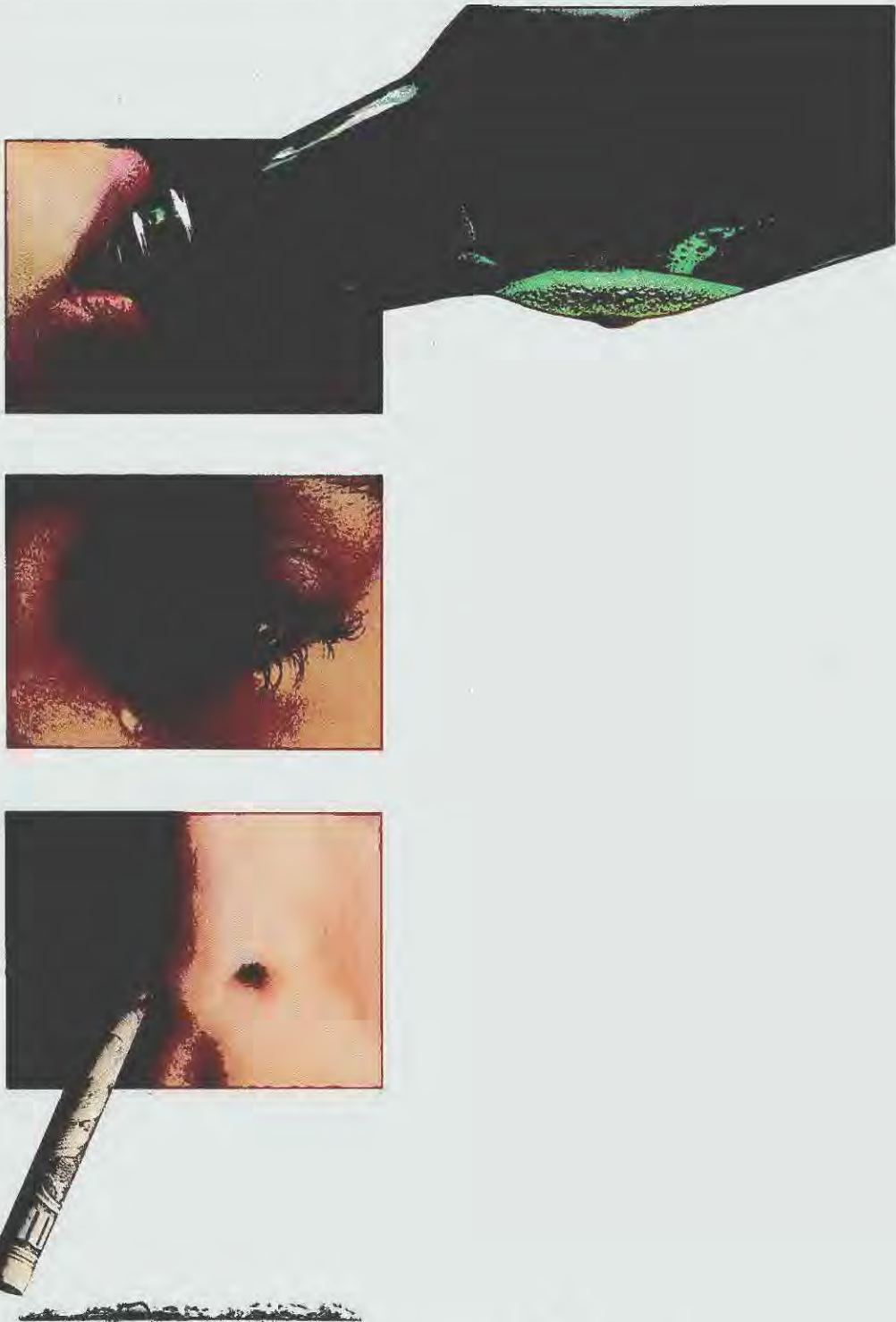
"They will come up with proposed changes, and those changes will be evaluated. Then, more teams will be chartered," Ms. Kavalew explained.

"It is anticipated that this will reduce costs down the road, but the goal is to improve the quality of health care," she said.

A similar effort will begin in Chicago next month, she added.

While the MBGH received a two-year grant from the John A. Hartford Foundation in New York to spearhead its efforts, Ms. Kavalew stressed that "resources in the community will make sure this effort is sustained" after the grant runs out.

In addition, "we're looking at different communities and ways to communicate this to other groups for more widespread implementation," she added.



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# Directory of utilization review vendors

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### Action Health Care Inc.

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

**Year founded:** 1987.

**Parent company:** Cavco Industries.

**Services provided:** 90% of gross revenues from providing utilization review services to employers, including 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, on-site concurrent treatment review, on-site large case management, on-site psychiatric and substance abuse case management; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 11 total; seven professionals, including five registered nurses, two licensed practical nurses. One physician and 300 nurses on a retainer basis.

**Clients:** 65 total clients; 64 employer clients; 81% with fewer than 500 employees, 12% with 500-999 employees, 6% with 1,000-2,499 employees, 1% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 42,000 employee benefit plan lives; 700 workers compensation lives.

**Charges:** Per employee, \$1-\$3; per case, \$75-\$95 per hour; percent of billed charges, 9%.

**Principal officers:** Ruth Smith, president; David K. Stewart, executive vp.

### ALTA Health Strategies Inc.

2610 Decker Lane, Salt Lake City, Utah 84119; 801-973-7300

**Year founded:** 1960; began providing utilization review services in 1987.

**Services provided:** 11.3% of gross revenues from providing utilization review services to employers, including frequent 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, behavioral precertification and case management, inpatient and outpatient chiropractic care, podiatric precertification, disability management, quality assurance; 88.7% of gross revenues from other services.

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

**Staff:** 200 total; professionals include 170 registered nurses. 40 physicians on a retainer basis.

**Clients:** 610 total clients, all employers; 60% with fewer than 500 employees, 16% with 500-999 employees, 6% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 8% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 550,000 employee benefit plan lives; 60,000 total admissions reviewed.

**Branch offices:** Calabasas and Victorville, Calif.; Pittsburgh.

**1989 gross revenues:** \$110 million total, \$12.5 million from utilization review services.

**Principal officers:** W. Terry Nofsinger, president/chief executive officer; Lane A. Summerhays, senior vp-finance; Linda Gerbig, senior vp-health care management.

### Alternative Care Management Systems Inc.

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

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

1986.

**Services provided:** 100% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination; other services include skilled nursing facilities, hospice care, home health care, chiropractic care, prescription drugs.

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

**Staff:** 12 total; five professionals who are registered nurses. 13 professionals on a retainer basis.

**Clients:** 29 total clients; 13 employer clients; 58.6% with fewer than 500 employees, 24% with 500-999

employees, 7% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 3.4% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 67,000 employee benefit plan lives; 3,173 total admissions reviewed.

**1989 gross revenues:** \$840,000 total, all from utilization review services.

**Charges:** Per employee, per case, per hour.

**Principal officers:** John O. Michael, president.

### American Health Network Inc.

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

**Year founded:** 1983.

**Parent company:** American General Group Services Corp.

**Services provided:** 4% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 71% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

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

**Staff:** 55 total; all professionals, including three physicians, 52 regis-

tered nurses.

**Clients:** 1,359 total clients; 428 employer clients; 60% with fewer than 500 employees, 30% with 500-999 employees, 6% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 1% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 372,093 employee benefit plan lives; 82,926 total admissions reviewed.

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

**1989 gross revenues:** \$7.3 million total, \$5.5 million from utilization review services.

**Principal officers:** Howard L. Korn, president/chief executive officer; Henry A. Arnold, senior vp/chief marketing officer; Martin R. Kreis, senior vp-managed care.

*Continued on next page*



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### Alternative Care Management Systems Inc.

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

## Guide to directory of UR vendors

The annual *Business Insurance* directory of utilization review service providers lists companies that offer utilization review 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 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 the **services provided** heading, the percentage of 1989 gross revenues generated from utilization review services to employers

is noted, followed by specific utilization review programs the company provides.

Also listed is the percentage of 1989 revenues generated from providing utilization review services to insurers, PPOs, HMOs and third-party administrators as well as the percentage generated from other services.

The types of **services reviewed** (including group health services, dental services, chiropractic services, psychiatric and substance abuse services and workers compensation/disability services) 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 1989 follow. Number of employee benefit plan lives, workers compensation lives and total admissions reviewed in 1989 are given under the **covered lives/reviewed admissions** heading. Admissions reviewed may include inpatient, outpatient and ambulatory service reviews.

Locations of U.S. and foreign **branch offices** and methods by which the company **charges** for its services are provided.

**Total 1989 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.

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

The directory is published as an editorial service; there is no charge for companies to be included. If you would like to be listed in the 1991 directory of utilization review service providers, please write Sara Harty, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

### Continued from previous page American International Health & Rehabilitation Services Inc.

50 S. Clinton St., East Orange,  
N.J. 07018; 201-414-2700

**Year founded:** 1986.

**Parent company:** American International Group Inc.

**Services provided:** Utilization review services offered to employers include frequent discharge planning, case management, provider bill audit, durable and non-durable medical equipment coordination, independent medical evaluations; occasional concurrent hospital treatment review, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination; 95.8% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 4.2% of gross revenues from providing other services.

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

**Staff:** 359 total; including one physician, 167 registered nurses. 53 professionals on a retainer basis.

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

**Covered lives/reviewed admissions:** 30,000 employee benefit plan lives; 7,211 workers compensation lives.

**1989 gross revenues:** More than \$20 million total.

**Charges:** Per case.

**Principal officers:** Ralph L. Rousseau, chief operating officer.

### American PsychManagement Inc.

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

**Year founded:** 1983.

**Parent company:** Value Health Inc.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, outpatient psychiatric and substance abuse services; occasional discharge planning, retrospective review, outpatient service predetermination, case management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 120 total.

**Clients:** 38 total clients; 30 employer clients; 3% 2,500-4,999 employees, 97% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1.1 million employee benefit plan lives; 7,586 workers compensation lives.

**1989 gross revenues:** \$10.3 million total.

**Charges:** Per employee, per case.

**Principal officers:** Kenneth A. Kessler, chairman; Saul Honigstein, president/chief executive officer; Robert A. Patricelli, president-Value Health Inc.

### Associated Medical Review Services Inc.

2821 Richland Ave., Metairie, La.  
70002; 800-366-2475

**Year founded:** 1985.

**Services provided:** 92% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; occasional retrospective review, second surgical opinion, hospital bill audit; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 3% of gross revenues from providing other services.

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

**Staff:** Five professionals; four professionals on a retainer basis.

**Clients:** 158 total clients; 10% with fewer than 500 employees, 75% with

Continued on next page



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safety program. And made some suggestions about what it should include. And how to follow up on them.

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*Continued from previous page*  
500-999 employees, 10% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 2% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 137,500 employee benefit plan lives; 6,000 workers compensation lives; 68,000 total admissions reviewed.

**Charges:** Per employee, 90 cents-\$2.25; per case, \$35-\$220.

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

### Associates for Health Care Inc.

150 N. Sunnyslope Road,  
Brookfield, Wis. 53005;  
414-784-9007; 800-952-8661

**Year founded:** 1984.

**Services provided:** 45% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, discharge planning, retro-

spective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, post-discharge review; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 50% of gross revenues from providing other services.

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

**Staff:** 25 total; 10 professionals, including nine registered nurses, one licensed practical nurse. One physician on a retainer basis.

**Clients:** 280 total clients; 35 employer clients; 94% with fewer than 500 employees, 2% with 500-999 employees, 3% with 1,000-2,499 employees, 1% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 150,000 employee benefit plan lives.

**Charges:** Per employee, \$1.80-\$2; per case for bill audits, \$50.

**Principal officers:** Richard L. Bloomquist, president; Judy Grimes,

vp; Robert T. Zimmermann, director-marketing.

### Assn. for Organizational & Human Development

7346 N. Monticello, Skokie, Ill.  
60076; 708-679-2575

**Year founded:** 1986; began providing utilization review services in 1987.

**Services provided:** Utilization review services offered to employers include frequent 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 hospital bill audit, large case review management; 95% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** Two total; both professionals, including one physician, one psychologist. Eight physicians, two nurses on a retainer basis.

**Clients:** Three total clients.

**Covered lives/reviewed admissions:** 1,500 total admissions reviewed.

**Principal officers:** Dr. Ronald L. Kirschner, president.

### Assured Health Systems Inc.

20 Mall Road, Suite 130  
Burlington, Mass. 01803;  
617-273-9966

**Year founded:** Reorganized in 1989; began providing utilization review services in 1987.

**Services provided:** 8% of gross revenues from providing utilization review services to employers, including 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, employee assistance programs; 17% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 75% of gross revenues from providing other services.

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

**Staff:** 45 total; professionals include one physician, seven registered nurses. Also, 37 EAP professionals on staff, 310 on a retainer basis.

**Clients:** 218 total clients; 212 employer clients; 5% with fewer than 500 employees, 25% with 500-999 employees, 30% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 10% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 400,000 employee benefit plan lives; 20,000 workers compensation lives; approximately 6,000 total admissions reviewed.

**Branch offices:** Chicago; Boston; New York; Washington D.C.; Atlanta; Denver; Dallas; Los Angeles; San Francisco; Cleveland and Springfield, Ohio.

**1989 gross revenues:** \$7 million total; \$1.75 million from utilization review services.

**Charges:** Per employee per month, \$1-\$8; per case, \$100 to \$2,000; flat annual fee, \$6,000-\$60,000; per employee per year for employee assistance programs, \$24-\$60.

**Principal officers:** Dr. Ronald Geraty, president; David Zarchan, senior vp; Keith Dixon, vp-marketing; Dr. Peter Panzarino, medical director.

### August International Corp.

1 City Blvd. W., Suite 1000,  
Orange, Calif. 92668;  
714-938-2600

**Year founded:** 1985.

**Services provided:** 35% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service pre-

*Continued on next page*

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Continued from previous page  
determination, outpatient psychiatric and substance abuse services, case management, data reporting and analysis, employee education; 6% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 59% of gross revenues from providing other services.

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

**Staff:** 250 total; professionals include three physicians, 32 registered nurses, two licensed practical nurses, 60 physicians on a retainer basis.

**Clients:** 44 total clients; 42 employer clients; 10% with fewer than 500 employees, 30% with 500-999 employees, 25% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 15% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 166,000 employee benefit plan lives; 1.5 million workers compensation lives; 35,713 total admissions reviewed.

**Branch offices:** Olympia, Wash.; Dallas.

**Charges:** Per employee, per case; 2%-3% of total bill for bill audits.

**Principal officers:** Michael Lewis, president; Dr. William Thompson, national medical director; Nancy Casey, vp-managed care; Charles Cressman, vp-sales.

**AXIOM Review Inc.**

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

**Year founded:** 1975.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, HMO evaluation; occasional discharge planning, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 85% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 92 total; 81 professionals, including three physicians, 50 registered nurses, three licensed practical nurses, 25 medical records technicians. 111 physicians, five nurses on a retainer basis.

**Clients:** 36 total clients; 12 employer clients; 40% with fewer than 500 employees, 60% with 500-999 employees.

**Covered lives/reviewed admissions:** 310,656 total admissions reviewed.

**1989 gross revenues:** \$5.7 million total.

**Charges:** Per employee per month, \$1.50-\$6.50; per case, \$4.50-\$26.

**Principal officers:** Dennis J. Duffy, president/chief executive officer; Robert Jones, Margaretta Nemets, Erwin Weiland and Nicole Selenko, vps; Dr. Edgar V. Santoro, chairman; Dr. Gilbert Melnick, vice chairman; Dr. Thomas J. Connolly, secretary/treasurer.

**B**

**Beech Street Inc.**

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

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

**Services provided:** Utilization review services offered to employers include frequent 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 retrospective review.

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

**Staff:** 43 total; 32 professionals, including two physicians, 26 registered nurses. Four physicians on a retainer basis.

**Clients:** 293 total 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/reviewed admissions:** 859,834 employee benefit plan lives; 940,166 workers compensation lives; 27,386 total admissions reviewed.

**Branch offices:** Houston.

**Charges:** Per employee, 95 cents-\$1.50; per case, \$80-\$150.

**Principal officers:** Ronald Ooley, president/chief executive officer; Larry J. Pyles, chief operating officer; John K. Mills, senior vp.

**Behavioral Health Group Inc.**

2693 Union Ave. Extended, Suite 101, Memphis, Tenn. 38122; 901-327-4664

**Year founded:** 1987; began pro-

viding utilization review services in 1988.

**Services provided:** Utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 92% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs, TPAs or government-funded insurance programs; 8% of gross revenues from providing other services.

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

**Staff:** Eight total; six professionals, including two physicians, three registered nurses, one licensed practical nurse. One physician and one nurse on a retainer basis.

**Clients:** Five total clients; one employer client with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 250,000 employee benefit plan lives; 2,650 total admissions reviewed.

**1989 gross revenues:** \$414,425 total; \$380,410 from providing utilization review services.

**Charges:** Per case, \$295-\$350.

**Principal officers:** Jim Rout, president; Debbie Bateman, controller.

**Blue Cross & Blue Shield of Georgia Inc.**

2357 Warm Springs Road, Columbus, Ga. 31908; 404-571-5731

**Year founded:** 1947; began providing utilization review services in 1982.

**Parent company:** Blue Cross & Blue Shield Assn.

**Services provided:** Gross revenues from utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occa-

Continued on next page

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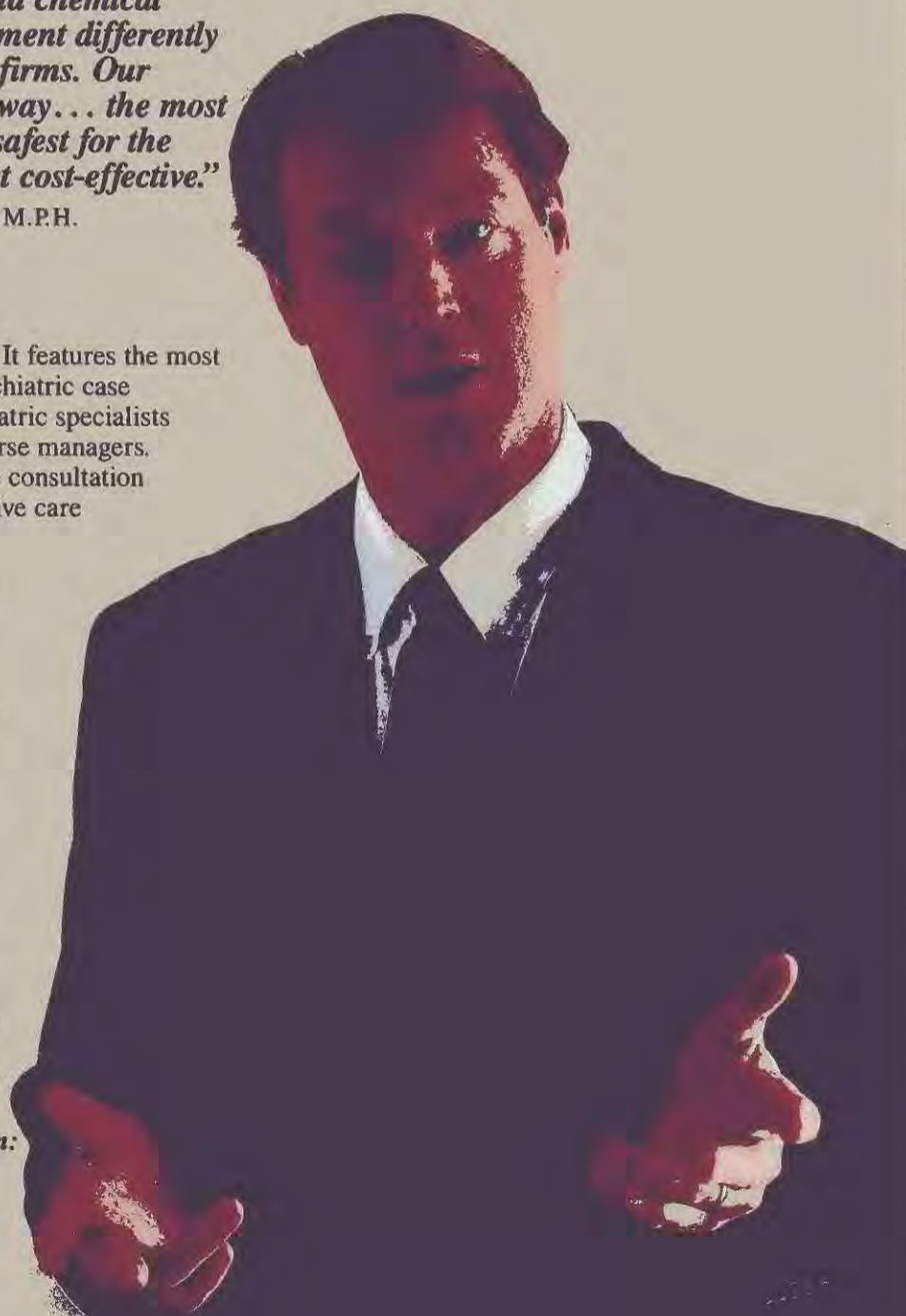
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LAWRENCE W. OSBORN, M.D., M.P.H.  
• B.A., Amherst College  
• M.D., Cornell University Medical School  
• M.P.H., Harvard School Of Public Health  
• Board certification in Psychiatry  
• Board eligible in Occupational Health  
• Former N.E. Regional Medical Officer and Assistant Administrator, U.S. Healthcare Financing Administration

**Spotlight report***Continued from previous page*

sional retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; other services include inpatient psychiatric services, inpatient and outpatient reviews.

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

**Staff:** 1,531 total; professionals include four physicians, 90 registered nurses, 10 licensed practical nurses, six medical records technicians.

**Clients:** 5,000 total clients.  
**Covered lives/reviewed admissions:** 500,000 employee benefit plan lives; 38,575 total admissions reviewed.

**Branch offices:** Atlanta.  
**1989 gross revenues:** \$675.8 million total.

**Charges:** Per employee, 95 cents-\$1.50; per case for case management, \$55-\$75.

**Principal officers:** Tom Kinser, chief executive officer; Jerry Juneau, senior executive vp; Bill Normark,

executive vp.

**Blue Cross & Blue Shield  
United of Wisconsin/  
The Advantage Program**

401 W. Michigan St., Milwaukee, Wis. 53201; 414-226-9915

**Year founded:** 1986.

**Services provided:** Gross revenues from utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occasional retrospective review, outpatient psychiatric and substance abuse services; other services include home health care pre-authorization.

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

**Staff:** 26 total; 23 professionals, including one physician, 22 registered nurses. Three physicians on a retainer basis.

**Clients:** 280 total clients; all em-

ployer clients; 89% with fewer than 500 employees; 5% with 500-999 employees, 4% with 1000-2,499, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 209,520 employee benefit plan lives; 12,384 total admissions reviewed.

**Charges:** Per employee per month, \$1.50; per case, \$87; per review, \$28.

**Principal officers:** Thomas Hefty, president/chief executive officer; Thomas Gazzana, vp-health management.

**Business Health Services**

7311 Greenhaven Drive, Suite 170, Sacramento, Calif. 95831; 916-391-4155

**Year founded:** 1985; began providing utilization review services in 1987.

**Services provided:** Services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical

opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services; occasional retrospective review, case management; 80% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

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

**Staff:** Seven total; all professionals, including one physician, six registered nurses. 23 physicians hired on a retainer basis.

**Clients:** 10 total clients.  
**Covered lives/reviewed admissions:** 65,000 employee benefit plan lives; 10,000 workers compensation lives; 4,000 total admissions reviewed.

**Charges:** Per employer, 75 cents-\$1.85.

**Principal officers:** E. Scott Robinson, president/medical director.

**C**

**CMG Health**

25 Crossroads Drive, Suite 140, Owings Mills, Md. 21117; 301-581-5000

**Year founded:** 1986, began providing utilization review services in 1987.

**Services provided:** Services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 100% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 60 total.

**Covered lives/reviewed admissions:** 350,000 employee benefit plan lives.

**Branch offices:** Kansas City, Mo.; Des Moines, Iowa.

**Principal officers:** Alan J. Shusterman, president; Dr. Ronald Cann, vp-medical affairs; Dr. Douglas Kay, vp-quality assurance; Lisa R. Shusterman, vp-clinical affairs; Diana Wolterreck, vp-operations; Charles Rhode, vp-marketing.

**California Psychological  
Health Plan**

3600 Wilshire Blvd., Suite 900, Los Angeles, Calif. 90010; 800-331-3016; 213-381-6285

**Year founded:** 1974.

**Services provided:** 18% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient psychiatric and substance abuse services, case management; occasional retrospective review; 2% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 80% of gross revenues from providing other services.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 23 total; two professionals. 20 professionals on a retainer basis.

**Clients:** 31 total clients; 30 employer clients; 35% with fewer than 500 employees, 10% with 500-999 employees, 15% with 1,000-2,499 employees, 25% with 2,500-4,999 employees, 15% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 235,000 employee benefit plan lives; 24,000 total admissions reviewed.

**1989 gross revenues:** Approximately \$5 million total, \$900,000 from utilization review services.

**Charges:** Per employee, 75 cents-\$2.25.

*Continued on next page*



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*Continued from previous page*  
**Principal officers:** Dr. Diana Seeb, chief operating officer; Robert L. Belichick, director-marketing.

**CAPP Care Inc.**

17390 Brookhurst, Suite 280,  
 Fountain Valley, Calif. 92708;  
 714-963-8065

**Year founded:** 1982; began providing utilization review services in 1984.

**Services provided:** 11% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination; occasional retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management; 83% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 6% of gross revenues from providing other services.

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

**Staff:** 150 total; professionals include five physicians, 34 registered nurses, one licensed practical nurse, 21 medical processors. Eight physicians on a retainer basis.

**Clients:** 45 total clients; 17 employer clients; 10% with fewer than 500 employees, 20% with 500-999 employees, 20% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 20% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 775,810 employee benefit plan lives; 92,921 total admissions reviewed.

**Charges:** Per employee, \$1.30-\$1.85.

**Principal officers:** E. Zalta, chairman/chief executive officer; M.E. Henry, president/chief operating officer.

**CareAmerica Inc.**

301 E. Main St., Suite 114,  
 Barrington, Ill. 60010;  
 708-382-7470

**Year founded:** 1984.

**Services provided:** 100% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, inpatient psychiatric and substance abuse services, case management.

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

**Staff:** 12 total.

**Clients:** 1% with fewer than 500 employees, 4% with 500-999 employees, 10% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 55% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 150,000 employee benefit plan lives; 9,000 total admissions reviewed.

**Charges:** Per employee; per case; flat annual fee.

**Principal officers:** F. Jerome Coquillard, president.

**CarreFour**

2301 Main St., Kansas City, Mo.  
 64141; 816-395-3106

**Year founded:** 1986; began providing utilization review services in 1987.

**Parent company:** Blue Cross & Blue Shield of Kansas City.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, case management; occasional second surgical opinion, outpatient service predetermination; 80% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

**Services reviewed:** Group health services.

**Staff:** 10 professionals, including eight registered nurses, two medical records technicians. One physician on a retainer basis.

**Clients:** 32 total clients, 27 employer clients.

**Covered lives/reviewed admissions:** 200,000 employee benefit plan lives; 1,067 total admissions reviewed.

**Charges:** Per employee; per case; by the hour, \$75.

**Principal officers:** Gail Shafon, president.

**Coast Medical Review Inc.**

12235 Beach Blvd., Suite 9,  
 Stanton, Calif. 90680;  
 714-895-3044

**Year founded:** 1981.

**Services provided:** 80% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, hospital bill audit; occasional discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

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

**Staff:** 10 total; professionals include one physician, one registered nurse, two medical records technicians. 88 physicians, 28 nurses on a retainer basis.

**Clients:** 98 total clients; 82 employer clients; 8% with fewer than 500 employees, 8% with 500-999 employees, 28% with 1,000-2,499 employees, 33% with 2,500-4,999 employees, 23% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 40,000 employee benefit plan lives; 460 total admissions reviewed.

**Branch offices:** Stockton, Calif.; Dallas; Tempe, Ariz.; Inverness, Fla.; New York.

**Charges:** Per employee, \$1.50-\$3; per case, 20%-25% of savings; per hour for case management, \$200 and 25% of savings; bill audits, \$20.

**Principal officers:** Larry Gallant, president.

**CoMed Management Inc.**

525 Metro Place N., Suite 300,  
 Dublin, Ohio 43017; 614-766-0061

**Year founded:** 1987.

**Parent company:** New York Life Insurance Co.

**Services provided:** 20% of gross revenues from providing utilization review services to employers, including frequent 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 outpatient service predetermination; 60% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, long-term care, disability.

**Staff:** 75 total; 30 professionals, including one physician, 29 registered nurses. One physician, two nurses, 43 consultants on a retainer basis.

**Clients:** 50 total clients; 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/reviewed admissions:** 820,000 employee benefit plan lives; 36,000 total admissions reviewed.

**Principal officers:** Janice Spillane, president/chief operating officer; Edward G. Wendt Jr., chief executive officer; Diane Schrimpf, vp-operations; Krista Ball, vp-health care management services.

**Comprehensive Managed Care**

4130 Salisbury Road, Suite 1250,  
 Jacksonville, Fla. 32216;  
 904-281-0529; 800-262-0529

**Year founded:** 1989.

**Services provided:** 50% of gross

*Continued on page 46*

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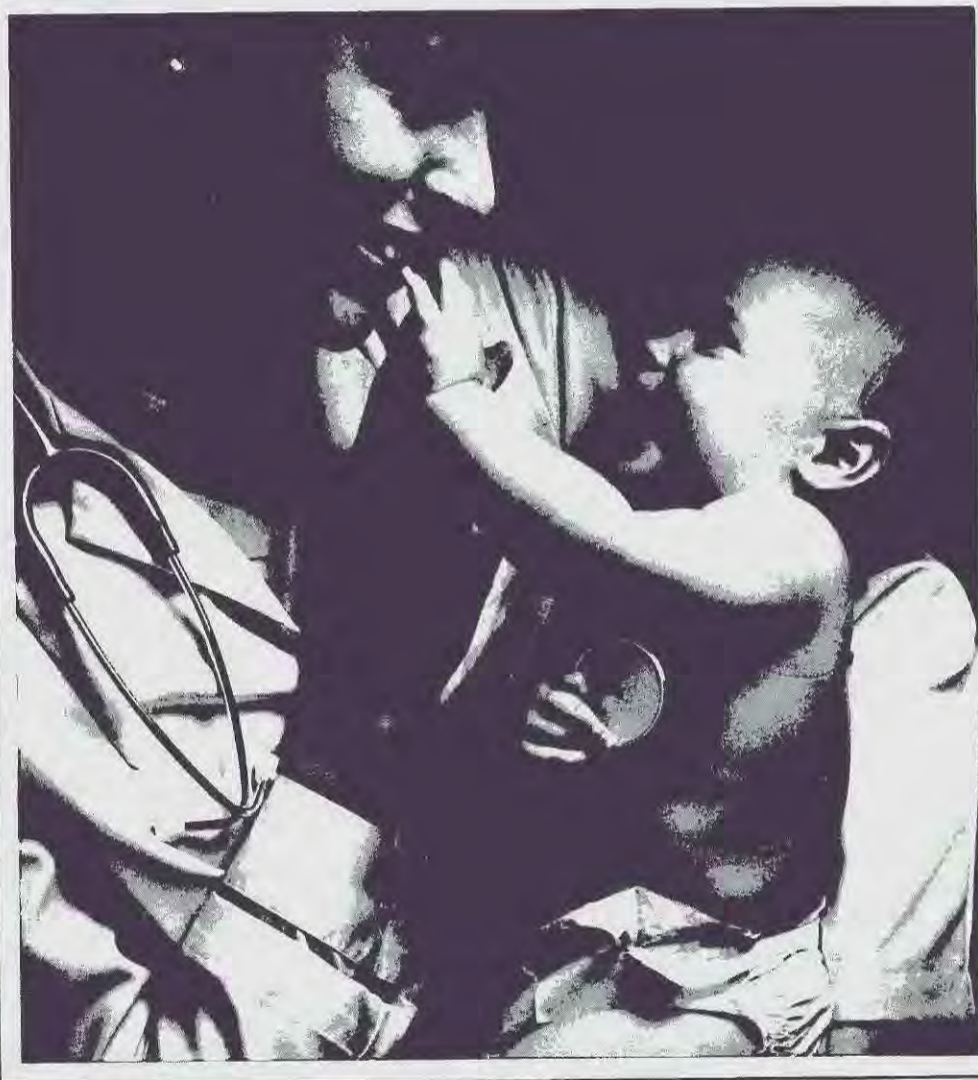
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# Managed care nemesis

By Edward Zalta

**D**URING THE PAST DECADE, several methods have evolved to expand health care management services in an attempt to control the increases in the volume and intensity of physician services.

Managed care programs have reduced admissions to hospitals and days of care per 1,000 lives. And many managed care organizations report frequency reductions of 20% to 40% in their admission rates when compared to the non-managed care sector. Avoidance of unnecessary hospitalizations, channeling to ambulatory surgery centers, reduction of medically unnecessary stays and a greater responsiveness on the part of the physician community are primarily responsible for these reductions.

However, while many of these lowered admission rates have led to cost savings in an inpatient care setting, increases in the physician service component of the health care dollar have continued an upward spiral. Often, inpatient savings have been completely offset by increases in the physician services sector.

The challenge now facing all utilization management firms is inventing the best and most cost-effective method of managing the physician cost escalation without interfering in the practice of medicine or adversely impacting quality. The task is made even more difficult when one considers that the most often cited reason for excessive testing is defensive medicine.

This cost escalation is defined as the increase in volume providing more services than appropriate for the patient's presenting symptoms or diagnosis and an increase in the level of services as defined by the Current Procedural Terminology. Examples of volume increases are: increased frequency of visits; increased use of diagnostic modalities such as X-rays, laboratory tests, electrocardiograms (ECGs), holter monitors (which are portable electrocardiogram monitors); and excessive prescribing of modalities such as physical therapy modalities.

Examples of intensity increases are: misuse of new patient codes for an illness or different place of service; redefining routine office visits as comprehensive or extended; and redefining referrals as consultations.

The methods presently employed to curb these increases in physician services can best be described as:

• **Precertification of ambulatory services.**

While many utilization review firms provide for the precertification of inpatient care and outpatient surgeries, some have offered to include diagnostic testing such as ECGs and magnetic resonance imaging (MRI), or even for a series of encounters that may exceed a certain dollar figure. Should the attending physician conclude that such a diagnostic test or procedure is medically indicated, the patient is responsible for initiating precertification before the service is performed or risk incurring a financial penalty.

Extending utilization review to ambulatory services—exclusive of ambulatory surgery—cannot control the upward spiral in the volume and intensity of physician services for several reasons:

✓ The cost of providing the review will often exceed contemplated savings. As an example, an unrealistic reduction of 50% in the frequency of ECGs during 1989 for one major employer would have saved \$360,000 (there were 16,000 ECGs at an average cost of \$45 each). The cost of administering such a program, though, could exceed \$1 million (16,000 precertifications at approximately \$65 each), for a savings-to-cost ratio of 1-to-2.8. Stated differently, it would have cost the employer \$2.80 for every dollar saved for ECGs in 1989 if a reduction of 50% were achieved by review. When the

## Admissions down, but doctor use up

inherent cost of office visits is added, the savings-to-cost ratio would be a ridiculous 1-to-4.

✓ Denials of requests for precertification of ambulatory services would be few, as physicians cannot always justify the ordering of any diagnostic test or procedure based on the unknown or the potential for any given symptom or symptom complex.

✓ Physician resistance to this very obtrusive review will be counterproductive to other, more reasonable and cost-effective reviews.

✓ Liability for the employer/payer and the UR firm in the case of denials would be increased as the courts could perceive this as interference in the practice of medicine. A plaintiffs' attorney would have little difficulty in getting a parade of "experts" to testify that had the patient had the ECG or MRI, the subsequent condition could have been prevented or ameliorated.

✓ The noise level in the claims offices will increase in direct proportion to the number of ambulatory services selected for precertification.

✓ The erroneous assumption is made that the attending physician will in most instances have decided on a working diagnosis.

Precertification of ambulatory services at best can address only a few of the problems of volume and none of the problems of intensity.

• **Gatekeeper/primary care physician.**

This method has several variations depending on the responsibilities assigned to the gatekeeper. Some plans limit the responsibilities to precertification of inpatient care. Others expand the duties of the primary care physician to include authorization of referrals and diagnostic testing. Another variant is to impose risk sharing or capitation. The basic assumption is that the gatekeeper is capable of controlling access to medical resources, facilities and consultants.

Certainly the primary care physician is in the best position to know the family and social situation, as well as the total health, of the individual. On the other hand, the training of the primary care physician, whether a family practitioner or internist, is often not sophisticated enough to be of help when the consulting physician is involved in evaluation and management. A peer group specialist will often be the only one able to accurately evaluate the recommendations that are given by the specialist.

In a fee-for-service setting, the primary care physician may be totally inappropriate because there is little or no incentive to save the payer any funds. Conversely, if the primary care physician is capitated or otherwise placed at risk, the patient becomes concerned that the physician will withhold necessary tests or services because the costs of such services directly or indirectly come out of the physician's pocket. The potential for denial of needed tests or evaluations is inherent when the economic interests of the physician becomes predominant.

The primary care physician has the least amount of training to be an effective liability-proof gatekeeper. Although well-versed in the broad range of primary care disciplines, superficial knowledge of many medical areas and little knowledge of community resources make them ill-equipped to deal with the specific in-depth problems that afflict their patients. The internist is more equipped to handle the medical problems but less well-equipped to handle surgical situations, gynecological or neurological problems.

The primary care physician is perhaps better equipped to handle precertification for inpatient

admission than referrals or approval of ambulatory resources, but even here he or she lacks the practice guidelines and automation so necessary in today's UR arena.

The gatekeeper concept puts many in a no-win position. Some patients are upset because they "lose their doctor." Specialists may be upset because of the loss of patients and the poor health of patients sent to them. And gatekeepers become upset when they, too, suffer economic constraints, the pressures of this economic balancing act and the hostility of secondary providers.

Attempts to pierce the corporate shield by malpractice plaintiffs' attorneys has occurred in the gatekeeper model. Now the "deep pocket" of the employer, payer or UR firm is under attack with allegations that the "at risk" provisions restricted the ordering or performing of needed medical services. Court decisions or congressional and state statutes could end all gatekeeper programs since the disclosure requirements that may be required by these bodies, when and if imposed, will have a chilling effect on public enrollment in such plans.

As with precertification of ambulatory services, few mechanisms exist other than placing the physician at risk in the gatekeeper model to control the volume of physician services, and no mechanisms exists to control the intensity.

• **Risk sharing.**

By making providers financially responsible for excess costs and eligible to share in any profits, payers hoped that providers would become more cost-effective by becoming their own gatekeeper. Providers, in turn, hoped to gain a significant piece of the premiums. Both payers and providers were wrong because, unfortunately, the profession as a whole has failed this test.

Many in the profession seem to have adopted a "get mine while the getting is good" philosophy, thus ensuring losses and not profits for the majority.

The disadvantages cited in the gatekeeper method when the responsibilities are expanded to include risk sharing are as valid here as the criticism that risk sharing does little to control the intensity of services.

• **Pre-claims review for appropriateness.**

In this approach, ambulatory service codes are matched against diagnostic-specific tables to determine appropriateness. Considerable agreement can be reached as to what is or isn't appropriate for the more common diagnoses. If the diagnosis is a fractured rib, then the charge for an MRI is inappropriate. But is it? Every physician can cite examples where the ordering of a particular ambulatory service was not only appropriate but necessary to prevent a non-meritorious malpractice claim.

In addition to the above, there are other drawbacks to reviewing individual claims for appropriateness of ambulatory services:

✓ Presumption is made that the physician knows the diagnosis. That's not necessarily true. Physicians order diagnostic tests based on what they don't know and then test to validate their presumptive diagnoses, as well as for defensive medical purposes.

✓ Presumption is made that the diagnoses were coded correctly or that co-morbidity, if present, was also coded. Again, that's not necessarily true. Physicians and their office personnel have had limited experience and no expertise with the coding of medical conditions.

Additionally, most payer systems do not capture complete or multiple codes for medical conditions even if they were correctly encoded by physician office personnel.

✓ The noise level in the claims office and the reverberations from providers when they are wrongfully accused of ordering inappropriate testing will significantly increase. Such allegations

*Continued on next page*

# Canadian system not a panacea

By Rebecca S. Fahrlander

IS THE U.S. health care system really in need of fundamental changes, as reported by a majority of respondents to a recent Harris survey? And is a Canadian-style health care system, which recently has been so widely touted, really the answer to U.S. health care problems? I contend that the answer to both questions is no.

It is true that all is not well with American health care. For many years, the cost of health care has been rising at a rate that exceeds the Consumer Price Index. The medical care component of the CPI rose 8.5% between December 1988 and December 1989, while the overall CPI rose 4.6% during the same period. Employers and consumers alike have become concerned with these increases and the difficulty in containing costs.

Much has been made recently of the fact that health care represents 11.5% of the U.S. gross national product, compared with 8.6% of the Canadian GNP. In the United States, this is projected to rise to 15% by the year 2000. However, when asked if 15% of the GNP is too much to pay for health care, 61% of Americans said no, a recent survey found. And, while current cost increases are clearly undesirable, the average annual per-household expenditure for health care in 1987 was \$1,135, representing about 4% of average pretax income.

Surveys have consistently shown that most Americans are satisfied with their physicians and with their group health care plans. About 87% of Americans are insured, and 13% are uninsured. For the majority of Americans who are insured, the health care system is working. Certainly the needs of the 13% who are uninsured

must be addressed.

Many recent discussions on how to resolve the problems of uninsured individuals have focused on Canada's national health system. The Canadian system has been promulgated by various groups as a model for the United States to emulate. But is it?

The Canadian provinces each operate public health plans that cover hospital and physician care for residents. However, additional benefits, such as prescription drugs, vary among the provinces. About 40% of the revenue for the provincial plans comes from federal government grants, with the provincial governments funding the rest of the plan costs. Methods of provincial funding vary and may include premiums, sales taxes or payroll taxes in addition to general revenues.

The Canadian system is based on freedom of choice of physicians. Doctors generally are reimbursed on a fee-for-service basis, and physician payment schedules are negotiated between the provincial territorial authority and the organization representing physicians. Hospital administrators negotiate with provincial authorities for their budgets.

However, this system has not eliminated concerns about health care costs.

Although Canada's per capita expenditures for health care are lower than ours, government officials are becoming increasingly concerned about the system's apparent inability to control increasing costs. The existing funding system has not provided sufficient incentives for consumers and providers to seek and

## Speaking out

provide the most cost-effective treatment. The system also has been characterized by higher levels of inpatient treatment than in the United States. In Ontario, for example, the Ontario Health Insurance Plan's expenditures grew at an annual average rate of 15.5% from 1981 to 1987.

Most provinces have gone beyond the original intent of the health insurance system, which was to provide only basic necessary medical care. As benefits have been added to the programs, costs have risen accordingly. Approximately one-third of the average provincial budget is allocated to its health care program. By 2011, taxation levels are expected to have increased 2.5 times to keep the Canadian program in operation. Indeed, in Ontario, the premier's Council on Health Strategy noted that if recent cost increases continue, the ability of the provincial government to support other social programs may be threatened.

The system in Canada also is characterized by access and quality problems of its own. Although theoretically no one is without access to health care, that access may be slower than is desirable. Waiting lists for various types of surgery and tests are common and often lengthy. As many as 1,000 people have been on waiting lists for heart surgery in Toronto hospitals. The waiting list for coronary bypass surgery is six to eight months. The result is that rationing of care occurs, although theoretically it is spread more randomly across the various socioeconomic classes rather than being limited to lower income uninsureds, as in the United States.

Quality and access problems are also represented by lower levels of research and technology. Compared to the United States, for example, Canada has one-sixth the number of lithotriptors per capita. Lithotriptors use shock waves to break up small stones, such as kidney stones.

Canada's health care system has addressed the issues of universal access and cost shifting, but this has been accompanied by waiting lists for many procedures and tests and poor access to some medical technology.

In the United States, we basically have a sound health care system that provides high quality care to a majority of the population. We need to address the problem of the uninsured and we need to contain costs in some areas. However, a Canadian-type health care system is not the best alternative. While it would address the issue of universal access, it would also "fix" many components of the U.S. system that are not broken. It would, I believe, result in higher costs—through taxation—to most Americans and slower access to many forms of care.

Other alternatives, such as expanded state risk pools and Medicaid, should be examined. These alternatives, unlike national health care systems, would preserve and expand on the private/public partnership that has served our nation well. ■



Rebecca S. Fahrlander, Ph.D., is supervisor of group market research for Mutual of Omaha Insurance Co. in Omaha, Neb.

## UR methods

Continued from previous page  
imply malpractice or can jeopardize a physician's right to practice. These are serious allegations and are difficult to substantiate by review of individual claims.

Pre-claims review for appropriateness addresses some of the problems of volume increases but none of the problems of intensity increases.

### • Aggregating claims data.

This method compares a provider's frequency of use of ambulatory services and office visit codes to other providers in the same specialty. Thus, it is provider-specific and independent of diagnoses, yielding a physician profile and indicating the cost-effectiveness of the provider.

A prerequisite for the review of physician services using aggregated claims data is the establishment of specialty-specific standards for the frequency of use of office visit codes and ambulatory services, as well as a data base of all physicians and their specialties. Once these standards and their standard deviations are established and validated, then the aggregated data review will yield significant results in the identification of aberrant physician practice behavior when compared to the norm.

This method readily identifies providers who unbundle laboratory panel tests, upcode their office visits, treat every encounter as a consultation, require their patients to have an excessive number of X-rays, use injections in lieu of oral medications, fit every patient with a holter monitor, do routine ECGs on every visit or any other excessive physician services.

Once identified, and if members of a contracting network, they are asked to examine the appropriateness of use for the specific service in each identified instance. Through this education approach, most providers modify their practice behavior, at least for the participating organization, as only a few are detected as continuing the excessive use of such services on subsequent reviews. Those whose office personnel resist modification or feel that they will not be identified a second time, are usually dropped from the network.

Non-members of a contracting network who exceed the standards are flagged as overutilizers of services. The records are retained for future reference.

This automated method of controlling the escalation in the volume and intensity of physician services is far superior to all others. It serves as a selection methodology for identifying cost-effective providers; does not increase the noise level in claims offices; has not been subject to legal challenge; is not dependent on accurate coding or co-morbidity; is not subject to rationalization of individual treatment of a particular symptom complex; is very cost-effective, relying almost exclusively on computer review; and, in contrast to all of the other methods, controls both the volume and intensity of physician services.

The review of aggregated claims is combined with computer review of claims for aberrant billing practices. Together, the programs readily identify physician offices whose practice behavior not only is not cost effective, but whose office personnel engage in

billing practices that are, at best, non-conforming to Current Practice Terminology guidelines established by the profession and, at worst, fraudulent.

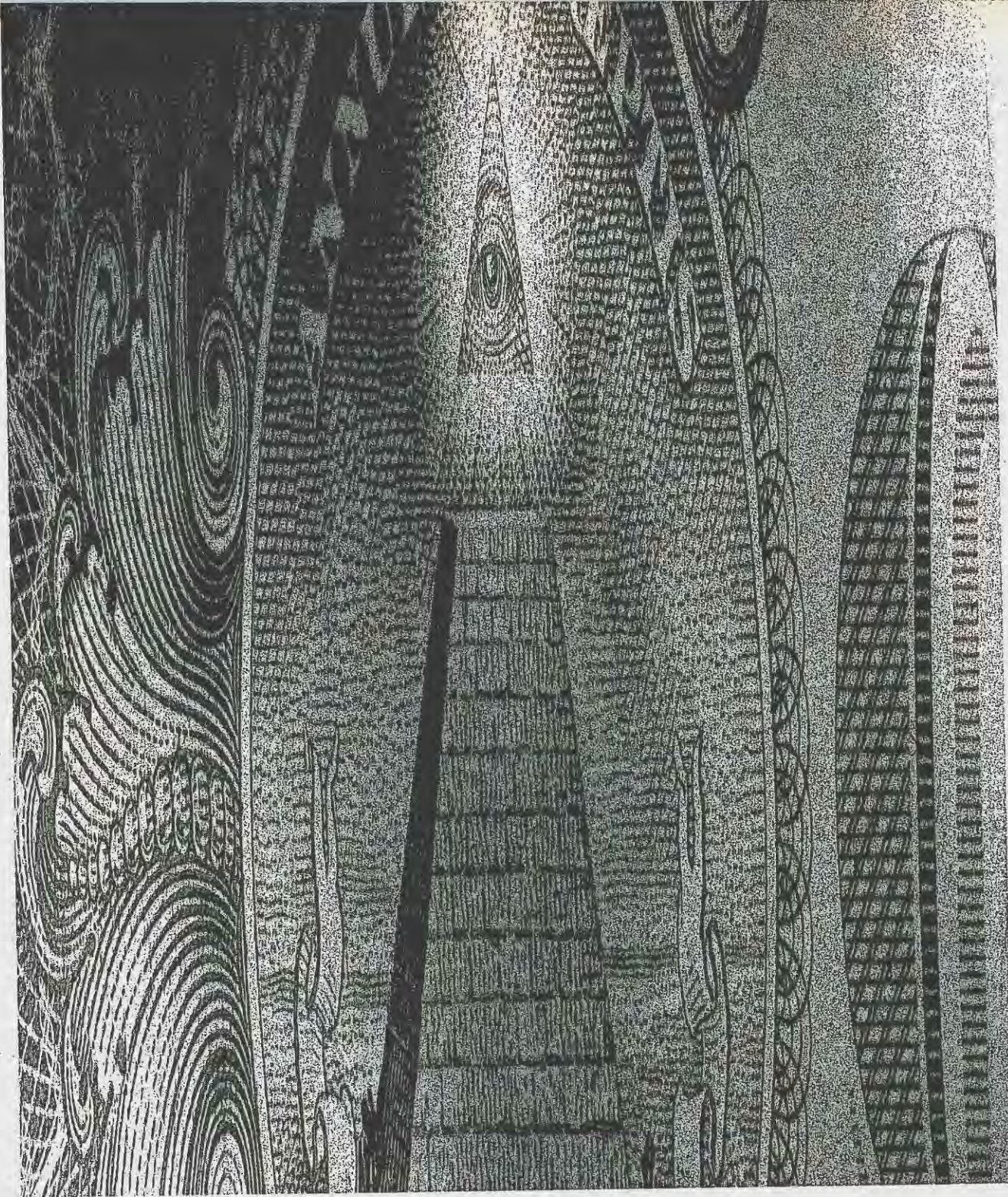
In every geographic area where sufficient claims data has been reviewed, the number of physician offices identified as billing for excessive physician services and aberrant billing practices ranges from 30% to 35%.

One method of measuring the savings from a review of aggregated claims data is to compare the differences in the cost per encounter after adjusting for any difference in the frequency of patient visits. During 1989, the savings were found to be 26% when the cost per encounter in the managed sector was compared to the cost per encounter in the non-managed sector. The savings-to-cost ratio was estimated to be 10-to-1.

Of all the methods devised to control the volume and intensity of physician services, the review of aggregated claims data appears to be the least obtrusive, least subject to challenge, most effective and most cost-effective. ■



Dr. Edward Zalta is chairman and chief executive officer of CAPP Care Inc. in Fountain Valley, Calif.



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**Spotlight report**

*Continued from page 39*  
revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion, hospital bill audit; 25% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 12 total; professionals include three physicians, four registered nurses, two psychologists.

**Branch offices:** Athens, Ga.; Columbia, S.C.

**Charges:** Per employee; per case; by the hour.

**Principal officers:** William B. Johns, president.

### Comprehensive Review Technology Inc.

455 E. Mound St., Columbus, Ohio 43232; 614-464-9481

**Year founded:** 1985.

**Services provided:** 60% of gross revenues from providing utilization review services to employers, including frequent 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 audits, pharmacy review; 40% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 50 total; 31 professionals, including one physician, 30 registered nurses. Eight physicians on a retainer basis.

**Clients:** 84 employer clients; 64% with fewer than 500 employees, 6% with 500-999 employees, 7% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 16% with more than 5,000 employees.

**Charges:** Per employee, 25 cents-\$1.50; per case, \$100-\$175; by the hour, \$50-\$85; percent of savings for audits.

**Principal officers:** William R. Heiss, chief executive officer/president; John R. Williford, director-operations; Jim E. Houston, director-finance/administration; Dean Conley, director-marketing/research.

### ConServCo Inc.

3903 Northdale Blvd., Suite 200, Tampa, Fla. 33624; 800-525-5590

**Year founded:** 1981; began providing utilization review services in 1985.

**Parent company:** The Travelers Insurance Co.

**Services provided:** 38% of gross revenues from providing utilization review services to employers, including frequent 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 retrospective review, second surgical opinion, independent medical evaluations; 62% of gross revenues from providing other services.

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

**Staff:** 1,600 total; professionals include 850 physicians.

**Clients:** 1,400 total clients.

**Covered lives/reviewed admissions:** 3.5 million employee benefit plan lives; 200,000 workers compensation lives.

**Branch offices:** Tampa, Fla.; San Diego and San Mateo, Calif.; Boston; Oak Brook, Ill.

**1989 gross revenues:** \$90 million total, \$34 million from utilization review services.

**Charges:** Per employee, \$1.45.

**Principal officers:** Dennis L. Huffman, president; Larry Mattingly, chief executive officer; Jack DeMum-

brum, vp-planning/development; Catherine Johnson, vp-marketing; Tim Rooney, vp-sales; Terry Oetting, vp-operations.

### Corporate Care Management Inc.

32 Broad Ave., Binghamton, N.Y. 13904; 607-724-6520; 800-541-7403

**Year founded:** 1973; began providing utilization review services in 1974.

**Services provided:** 98% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective re-

view, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit; 1.5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 0.5% of gross revenues from providing other services.

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

**Staff:** 14 total; 11 professionals, including nine registered nurses, two licensed practical nurses. One physician on a retainer basis.

**Clients:** 14 total clients; 13 employer clients; 23% with fewer than

500 employees, 8% with 500-999 employees, 1% with 1,000-2,499 employees, 13% with 2,500-4,999 employees, 15% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 32,375 employee benefit plan lives; 15,000 workers compensation lives; 5,000 total admissions reviewed.

**Charges:** Per employee, 80 cents-\$2.40; per case per hour, \$60.

**Principal officers:** Dr. John F. Spring and Patrick J. Kearse.

### Corporate HealthCare Management

1801 West End Ave., P.O. Box 1-15, Nashville, Tenn. 37702-1115; 615-320-7608

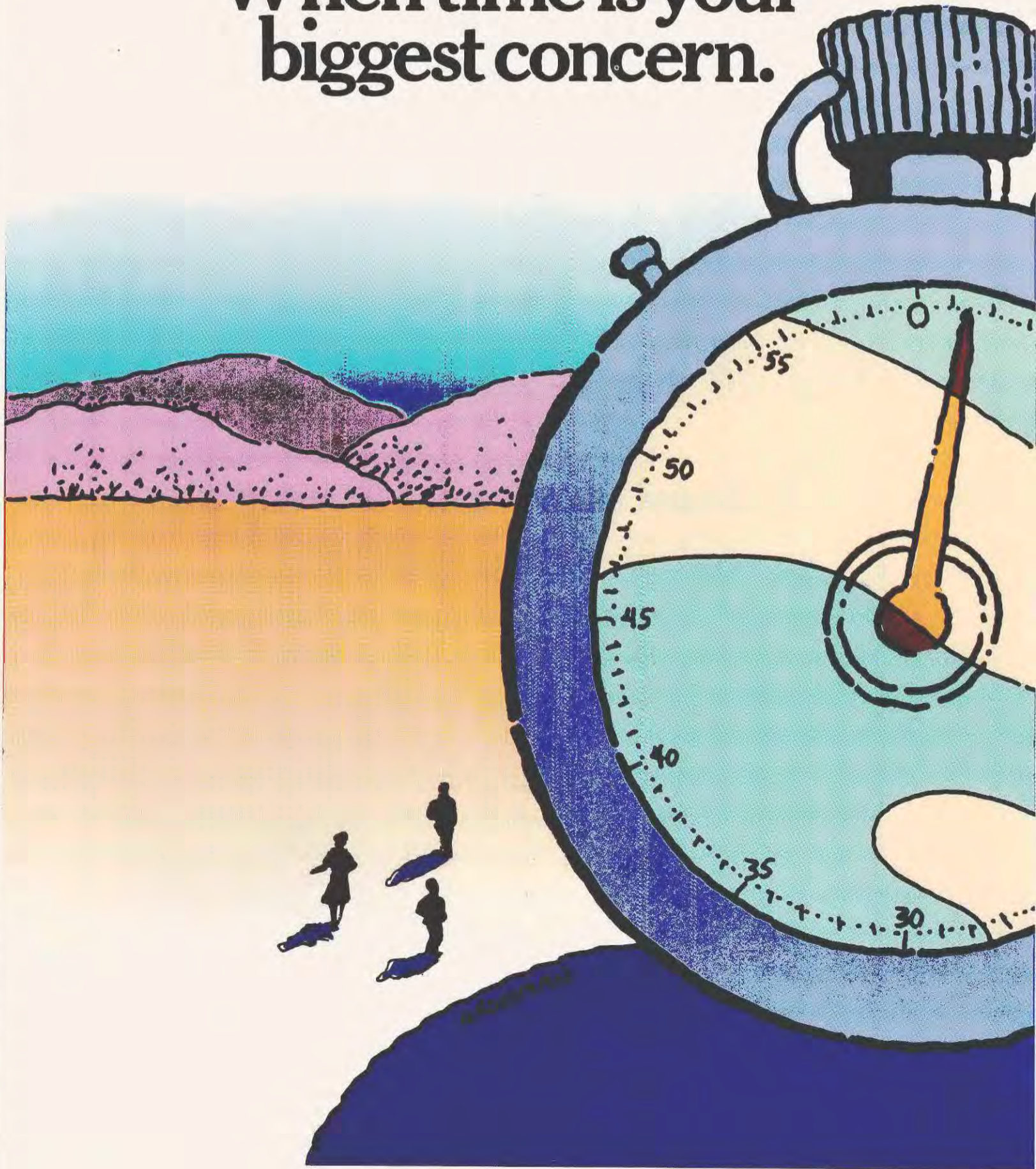
**Year founded:** 1983.

**Parent company:** EQUICOR Inc.

**Services provided:** 91% of gross revenues from providing utilization review services to employers, including frequent 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, health advisory services and health promotion programs; occasional retrospective review; 6.2% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 2.8% of gross revenues from providing other services.

*Continued on next page*

# When time is your biggest concern.



Continued from previous page

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

**Staff:** 288 total; 97 professionals, including nine physicians, 88 registered nurses, 27 physicians on a retainer basis.

**Clients:** 1,034 total clients; 1,020 employer clients; 59% with fewer than 500 employees, 6% with 500-999 employees, 10% with 1,000-2,499 employees, 17% with 2,500-4,999 employees, 8% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 6 million employee benefit plan lives; 143,252 total admissions reviewed.

**Branch offices:** Brea, Calif.; Pitts-

burgh.

**1989 gross revenues:** \$24 million total, \$23.3 from utilization review services.

**Charges:** Per employee; per case.

**Principal officers:** Dr. Roger Taylor, president-Corporate HealthCare Management/senior vp-EQUICOR Inc.

#### Cost Care Inc.

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

**Year founded:** 1981.

**Services provided:** 80% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination,

discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, high-risk maternity identification and management; 20% of gross revenues from providing utilization review services to HMOs, PPOs or TPAs.

**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, podiatric services.

**Staff:** 304 total; 170 professionals, including 27 physicians, 81 registered nurses, 19 licensed practical nurses, 10 medical records technicians.

**Clients:** 6,800 total clients, all employer clients.

**Covered lives/reviewed admissions:** 3 million employee benefit plan lives; 230,000 workers compensation lives; 155,116 total admissions reviewed.

**Branch offices:** New York; Memphis and Chattanooga, Tenn.; Chicago; Cincinnati.

**Principal officers:** Lawrence Goelman, president/chief executive officer; Ray Foose, vp-marketing; Virginia Cirica, senior vp-operations.

#### Cost Containment Management

12481 Telecom Drive, Temple Terrace, Florida 33637; 813-978-9711

**Year founded:** 1979; began providing utilization review services in

1985.

**Parent company:** Adjustco Inc.

**Services provided:** 50% of revenues from providing utilization services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 85 total; professionals include 29 registered nurses, three medical records technicians. Eight physicians on a retainer basis.

**Clients:** 22 total clients.

**Covered lives/reviewed admissions:** 30,000 employee benefit plan lives; 20,000 workers compensation lives; 4,551 total admissions reviewed.

**Branch offices:** Birmingham, Ala.; Pasadena, Santa Clara and Oakland, Calif.; Hollywood, Jacksonville, Temple Terrace and Tampa, Fla.; Braintree, Mass.; Farmington Hills, Mich.; Minneapolis; Atlanta; Baton Rouge and New Orleans, La.; Austin, Texas.

**1989 gross revenues:** \$4.9 million total.

**Charges:** Per employee, 90 cents-\$2.10; \$65-\$75 per hour for case management; percent of savings or percent of charges for retrospective review.

**Principal officers:** John Addeo, chief executive officer; Arthur M. Yoss, chief operating officer; Anthony G. Todd, chief financial officer; Grace Armstrong, senior vp; David B. Crosby, vp-sales.

#### Cost Management Technologies Inc.

4435 Main, Suite 810, Kansas City, Mo. 64111; 816-531-6300

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

**Services provided:** 32% of gross revenues from providing utilization review services to employers, including frequent 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; 68% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 35 total; four professionals who are registered nurses. 36 physicians on a retainer basis.

**Branch offices:** St. Louis.

**Charges:** Per employee, per case.  
**Principal officers:** Patrick A. Thompson, president; Scott K. Johnson, managing principal; John L. Laird, vp.

#### Crawford & Co.-HealthCare Management Group

5620 Glenridge Drive, P.O. Box 5047, Atlanta, Ga. 30302; 404-256-0830

**Year founded:** 1941; began providing utilization review services in 1980.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent 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, employee assistance programs, medical fee negotiation; 2% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 83% of gross revenues from providing other services.

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

**Staff:** 1,200 total; 710 professionals, including five physicians, 400 registered nurses, 12 licensed

Continued on next page

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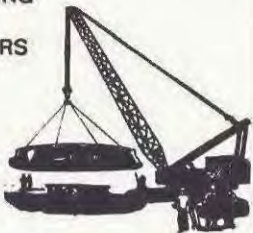
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**Elaine Garner**

Continued from previous page  
practical nurses, eight medical records technicians, 10 physicians and one nurse on a retainer basis.

**Clients:** 1,525 total clients; 1,215 employer clients; 7% with fewer than 500 employees, 17% with 500-999 employees, 40% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 6% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1.5 million employee benefit plan lives; 775,000 workers compensation lives; 85,680 total admissions reviewed.

**Branch offices:** Savannah, Ga.; Chicago; Columbia, S.C.; 185 health care management offices in the United States and Canada.

**1989 gross revenues:** \$71 million total, \$12.2 million from utilization review services.

**Charges:** Per employee per month, \$1-\$3.

**Principal officers:** P.A. Bollinger, executive vp; G.W. Billiard and Dr. G. Berk Lynch II, vps; Jeff V. Aycock, assistant vp.

## D

### Data Med Inc.

650 W. Dundee Road, Northbrook, Ill. 60062; 708-291-0742

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

**Services provided:** 90% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management, employer education; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 40 total; 22 professionals, including 11 physicians, eight registered nurses, three medical records technicians. Five physicians, four nurses on a retainer basis.

**Clients:** 85 total clients; 70 employer clients; 80% with fewer than 500 employees, 12% with 500-999 employees, 8% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 32,850 employee benefit plan lives; 2,450 total admissions reviewed.

**Charges:** Per employee, 50 cents-\$2.30.

**Principal officers:** Louis R. Morgan, vp.

## E

### EM Associates Inc.

P.O. Box 2650, 168 Water St., Binghamton, N.Y. 13902; 607-771-0272

**Year founded:** 1987.

**Services provided:** 10% of gross revenues from providing utilization review services to employers, including frequent 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 preadmission certification, second surgical opinion; 90% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 12 total; eight professionals. Two physicians and three nurses on a retainer basis.

**Clients:** 26 total clients; two employer clients; 100% with fewer than 500 employees.

**Charges:** Per employee, per case, by the hour.

**Principal officers:** Kathleen A. Ernst, president; Rebecca S. De Groff, vp.

### Empire State Medical Foundation Inc.

420 Lakeville Road, Lake Success, N.Y. 11042; 516-437-8134

**Year founded:** 1984.

**Services provided:** 5% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional concurrent hospital treatment review, length of stay determination, outpatient service predetermination, outpatient psychiatric and substance abuse services, quality assurance surveys and assessments, home health care review, utilization data analysis, recoding and validation of diagnostic related groups; 95% of gross revenues from providing utilization review services to insurance companies.

Continued on next page

## MEDICAL UNDERWRITERS INCORPORATED NAMES O'BRIEN SENIOR VP

Medical Reinsurance Underwriters Incorporated is pleased to announce the appointment of Robert K. O'Brien as Senior Vice President.

Bob is deep in experience: 32 years with State Mutual of America; Vice President, in Group Insurance for the past 14 years. Needless to say, he adds considerable Medical Underwriting expertise to MRU's already extensive capabilities.

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*(Physician Developed Criteria)*

Continued from previous page  
ance companies, HMOs, PPOs or TPAs.

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

**Staff:** 210 total; 130 professionals, including 10 physicians, 105 registered nurses, 15 medical records technicians.

**Clients:** Five total clients; two employer clients, both with more than 5,000 employees.

**Covered lives/reviewed admissions:** 500 total admissions reviewed.

**Branch offices:** New York and Syracuse, N.Y.

**1989 gross revenues:** \$17.1 million total.

**Charges:** Per case, \$10-\$60.

**Principal officers:** Dr. James Flanagan, president; Dr. Richard Eberle, vp-medical affairs; William Egan, executive vp.

## F

### FHC Options Inc.

240 Corporate Blvd., Norfolk, Va. 23502; 804-459-5300

**Year founded:** 1986.

**Parent company:** First Hospital Corp.

**Services provided:** 2% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 98% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 138 total; 29 professionals, including four clinicians, 23 clinical nurses, two medical records technicians. Six physicians, eight clinicians on a retainer basis.

**Clients:** 17 total clients; 12 employer clients; 8% with fewer than 500 employees, 2% with 500-999 employees, 90% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 400,000 employee benefit plan lives; 4,760 total admissions reviewed.

**Branch offices:** Shippensburg, Ambler, Centre Hall, Clarion and Wilkes-Barre, Pa.; St. Augustine and Pineland, Fla.; Milwaukee; Cidra, Puerto Rico; Vallejo, Calif.; Portsmouth, Virginia Beach and Richmond, Va.; Brentwood, Tenn.

**1989 gross revenues:** \$35 million total.

**Charges:** Per employee per month.  
**Principal officers:** Ronald I. Dozoretz, chairman-First Hospital Corp.; Richard C. Peters, president; Daniel T. Gallagher, vp/chief operating officer.

### Family Health Plan

12655 S.W. Center, Suite 180, Beaverton, Ore. 97005; 503-641-5352

**Year founded:** 1985; began providing utilization review services in 1987.

**Parent company:** MetroCare Inc.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent 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, chronic care management, continued stay determination, denial and appeal procedures, outpatient second surgical opinion, claims review; occasional retrospective review; 40% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

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

**Staff:** 12 total; six professionals, including one physician, five registered nurses. Six professionals on a retainer basis.

**Clients:** 2,537 total clients; 30 em-

ployer clients; 96% with fewer than 500 employees, 4% with 500-999 employees.

**Covered lives/reviewed admissions:** 21,169 employee benefit plan lives; 2,245 total admissions reviewed.

**Branch offices:** Grand Rapids and Troy, Mich.; Charlotte, N.C.; Bellevue, Wash.; Bloomington, Minn.; King of Prussia, Pa.; Linwood, N.J.

**1989 gross revenues:** \$485,520 total, \$242,760 from utilization review services.

**Charges:** Per employee, \$1.50-\$3.50; per hour per case, \$65-\$75.

**Principal officers:** Steve Gregg, president/chief executive officer.

### FOCUS Healthcare Management Inc.

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

**Year founded:** 1986.

**Services provided:** 0.9% of gross revenues from providing utilization review services to employers, including frequent preadmission certifica-

tion, 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, rehabilitation; 39.48% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 59.62% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, physical therapy services.

**Staff:** 75 total; 27 professionals, including two physicians, 25 registered nurses, five medical records technicians. 20 physicians on a retainer basis.

**Clients:** 125 total clients.

**Covered lives/reviewed admissions:** 115,000 employee benefit plan lives; 10,426 total admissions reviewed.

**Charges:** Per employee for group health services, \$1.35-\$1.65; by the

hour for workers compensation services, \$60.

**Principal officers:** Stryker Warren Jr., president/chief executive officer; David S. Iskove, executive vp/chief operating officer; Stuart R. Goldstein, vp-clinical affairs.

## H

### John Hancock Managed Health Care

John Hancock Place, P.O. Box 111, Boston, Mass. 02117; 617-572-6000

**Year founded:** 1862; began providing utilization review services in 1983.

**Parent company:** John Hancock Financial Services.

**Services provided:** Utilization review services include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospi-

tal bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, home health care and skilled review, review of rehabilitation facilities.

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

**Staff:** 145 total.

**Covered lives/reviewed admissions:** 525,000 employee benefit plan lives; 70,000 total admissions reviewed.

**Branch offices:** Chicago, Dallas, San Francisco.

**Principal officers:** E. James Morton, chairman/chief executive officer; Stephen I. Brown, president/chief operating officer.

### Health Administration Services Inc.

12600 Northborough, Suite 300, Houston, Texas 77067; 713-873-8682

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

Continued on next page



## Are You Losing Your Grip on Mental Health Costs and Services?

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Houston, TX 77056  
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**Spotlight report**

Continued from previous page 1985.

**Services provided:** 17% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination, medical appeals review, surgical fee review, home health care; 1% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 82% of gross revenues from providing other services.

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

**Staff:** 47 total; eight professionals, including four registered nurses, one licensed practical nurse, one medical records technician.

**Clients:** 19 total clients; 16 employer clients; 21% with fewer than 500 employees, 5% with 500-999 employees, 37% with 1,000-2,499 employees, 32% with 2,500-4,999 employees, 5% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 40,000 employee benefit plan lives; 4,750 total admissions reviewed.

**Charges:** Per employee, \$1.55-\$2.50; by the case; by the hour.

**Principal officers:** Stephen Gauen and Richard Hillyer

**Health Care Directions Inc.**

100 Roscommon Drive,  
Middletown, Conn. 06457;  
203-635-1103

**Year founded:** 1989.

**Services provided:** 7% of gross revenues from providing utilization review services to employers; 93% of gross revenues from providing other services.

**Services reviewed:** Chiropractic services, workers compensation/disability, podiatric services.

**Staff:** Four total; all professionals, including one physician. Five physicians, three nurses on a retainer basis.

**Clients:** Seven total clients; two employer clients, both with fewer than 500 employees.

**1989 gross revenues:** \$70,000 total, \$5,000 from utilization review services.

**Charges:** Per case, \$75-\$500; per hour, \$100 and up.

**Principal officers:** Dr. Edward A. Kamens, president; Bruce Ripley, vp; Marcia K. Petrillo, secretary/treasurer.

**Health Care Evaluation Inc.**

6602 N. Inglewood Ave. Suite G,  
Stockton, Calif. 95207;  
209-951-6711

**Year founded:** 1968.

**Services provided:** 60% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospi-

tal bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, medical claims review, skilled nursing facility review, mental health and chemical dependency care management; 36% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 4% of gross revenues from providing other services.

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

**Staff:** 70 total; 45 professionals, including 31 registered nurses, six licensed practical nurses, eight medical records technicians. 150 physicians, six nurses on a retainer basis.

**Clients:** 72 total clients; 70 employer clients; 20% with fewer than 500 employees, 11% with 500-999 employees, 37% with 1,000-2,499 employees, 14% with 2,500-4,999 employees, 18% with more than 5,000 employees.

**Covered lives/reviewed admis-**

**sions:** 1.2 million employee benefit plan lives; 51,473 total admissions reviewed.

**Branch offices:** Sacramento, Fresno, East Bay, Chico, Merced and Bakersfield, Calif.

**1989 gross revenues:** \$2.5 million total; \$2.4 million from utilization review services.

**Charges:** Per employee, \$1.30-\$2.50; per case, \$38-\$75.

**Principal officers:** Bernice Wahler, president; Elaine Hislop, executive director; Dr. John W. Kellar, medical director.

**Health Care Services Corp.**

233 N. Michigan Ave., Chicago, Ill.  
60601; 312-938-8330

**Year founded:** 1937; began providing utilization review services in 1975.

**Services provided:** 2% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, outpatient service predetermination, high-risk pregnancy case management; 98% of gross revenues from providing other services.

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

**Staff:** 107 total; 79 professionals, including four physicians, 75 registered nurses. 28 physicians on a retainer basis.

**Clients:** 2,000 total clients; 1,800 employer clients; 80% with fewer than 500 employees, 2% with 500-999 employees, 2% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 11% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1.6 million employee benefit plan lives; 74,000 total admissions reviewed.

**Charges:** Flat annual fee, percent of premium.

**Principal officers:** Brad Buxton, vp; Grace Leen, director; S. Martin Hickman, president.

**Health Cost Consultants**

1945 Old Gallows Road, Vienna,  
Va. 22180; 703-883-0217

**Year founded:** 1983.

**Parent company:** Inova Health Systems.

**Services provided:** 20% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, case management; occasional retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services; inpatient psychiatric and substance abuse services, high-risk pregnancy identification and management; 78% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 2% of gross revenues from providing other services.

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

**Staff:** 20 total; all professionals, including two physicians, 12 registered nurses, three medical records technicians. 105 physicians on a retainer basis.

**Clients:** 11 total clients; 1% with fewer than 500 employees, 99% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 101,522 employee benefit plan lives.

**Charges:** Per employee, 90 cents-\$1.25.

**Principal officers:** Debbie Scheff, president; Dr. Lou Pugsley, vp-medical affairs; Sally-Ann Polson, vp-marketing.

**Health Economics Corp.**

1300 W. Mockingbird Lane, Dallas,  
Texas 75247; 214-905-4400

**Year founded:** 1984.

**Parent company:** Halliburton Co.  
**Services provided:** 20% of gross revenues from providing utilization review services to employers, includ-

Continued on next page

# MANAGING HEALTH CARE COSTS

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1610 Arden Way, Suite 165  
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Continued from previous page  
ing frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, prenatal monitoring; occasional hospital bill audit; 4% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 76% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, workers compensation/disability, prenatal services.

**Staff:** 44 total; 37 professionals, including one physician, 30 registered nurses, six licensed practical nurses. Seven physicians on a retainer basis.

**Clients:** 88 total clients; 84 employer clients; 58% with fewer than 500 employees, 15% with 500-999 employees, 16% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 8% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 400,000 employee benefit plan lives; 300 workers compensation lives; 8,500 total admissions reviewed.

**Charges:** Per employee, per case, flat annual fee.

**Principal officers:** Stephen F. Coady, president/chief executive officer; James R. McPhail, vp-managed health care; Herbert D. Maxwell Jr., vp-sales/marketing.

### Health Information Designs Inc.

1616 N. Fort Meyer Drive, Suite 1420, Arlington, Va. 22209; 703-528-2032

**Year founded:** 1976; began providing utilization review services in 1979.

**Parent company:** Value Health Inc.

**Services provided:** 69% of gross revenues from providing utilization review services to employers, including frequent retrospective review, prescription drug utilization review; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 26% of gross revenues from providing other services.

**Services reviewed:** Prescription drug benefits.

**Staff:** 45 total; 18 professionals, including one physician, one registered nurse, two medical records technicians. One physician on a retainer basis.

**Clients:** 65 total clients; 57 employer clients; 100% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 5.3 million employee benefit plan lives.

**1989 gross revenues:** \$2.7 million total, \$2 million from utilization review services.

**Charges:** Per employee, \$1-\$1.50.

**Principal officers:** Carl M. Fink, chief executive officer; Dr. Judith K. Jones, senior vp/medical director; Robert A. Patricelli, president-Value Health Inc.

### Health International Inc.

1840 Century Park E., Suite 670, Los Angeles, Calif. 90067; 800-333-3760; 213-551-1840

**Year founded:** 1985; began providing utilization review services in 1987.

**Services provided:** 80% of gross revenues from providing utilization review services to employers, including 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 analysis; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 30 total; 22 professionals, including three physicians, 15 registered nurses, two licensed practical nurses, two medical records technicians. 18 physicians on a retainer basis.

**Clients:** 251 total clients; 83% with

fewer than 500 employees, 6% with 500-999 employees, 5% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 2% with more than 5,000 employees.

**Charges:** Per employee, \$2.

**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.

5181 Cascade Road S.E., Grand Rapids, Mich. 49506; 616-956-6903

**Year founded:** 1983.

**Services provided:** 75% of gross revenues from providing utilization review services to employers, including frequent 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 man-

agement, maternity review, home health care review; occasional retrospective review, hospital bill audit; 25% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 26 total; 16 professionals, including one physician, 14 registered nurses, one licensed practical nurse. 20 physicians, two nurses on a consulting basis.

**Clients:** 180 total clients; 170 employer clients; 90% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 50,000 employee benefit plan lives; 12,750 total admissions reviewed.

**Charges:** Per employee, 90 cents-\$2.50; per case, \$150-\$350; by the hour, \$75-\$200.

**Principal officers:** Jane E. McCreary, president.

### Health Management Strategies International Inc.

1725 Duke St., Suite 300, Alexandria, Va. 22314; 703-706-4100

**Year founded:** 1985.

**Parent company:** Group Hospitalization & Medical Services Inc.

**Services provided:** 75% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services, case management, health data consulting; occasional second surgical opinion, outpatient service predetermination; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance

abuse services.

**Staff:** 190 total; 95 professionals, including five physicians, 90 registered nurses. 40 physicians on a retainer basis.

**Clients:** 15 total clients; two employer clients; both with more than 5,000 employees.

**Covered lives/reviewed admissions:** 10 million employee benefit plan lives; 25,000 total admissions reviewed.

**Charges:** Per employee, \$1-\$2; per case, \$150-\$250.

**Principal officers:** E. Seton Shields, president; William R. Vandervennet Jr., executive vp; Daniel J. Klein, senior vp-marketing; Dr. Alan B. Zients, senior vp/medical director.

### Health Related Services Inc.

500 Wood St., Pittsburgh, Pa. 15222; 412-765-1444

**Year founded:** 1984; began providing utilization review services in 1985.

**Parent company:** Blue Cross of  
*Continued on next page*

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**Spotlight report**

Continued from previous page  
Western Pennsylvania.

**Services provided:** 85% of gross revenues from providing utilization review services to employers, including frequent 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 and home health care review, psychiatric case management, maternity and infant case management; 15% of gross revenues from providing other services.

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

**Staff:** 251 total; 166 professionals, including nine physicians, 127 registered nurses, 30 medical records technicians. 85 physicians on a retainer basis.

**Clients:** 14,028 total clients; 690 employer clients; 15% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 em-

ployees, 15% with 2,500-4,999 employees, 55% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 2.1 million employee benefit plan lives; 135,357 total admissions reviewed.

**Branch offices:** Erie and Johnstown, Pa.

**1989 gross revenues:** \$17.7 million total, \$15 million from utilization review services.

**Charges:** Per employee, \$1.85-\$3.89; per case, \$85-\$190 plus expenses.

**Principal officers:** David P. Lyle, president; D. Patrick Flynn, vp-central operations; David M. O'Brien, vp-regional operations; Nanci C. Keefe, vp-government operations/special programs.

**Health Resources Ltd.**

P.O. Box 246, 3 N. Lancey St.,  
Pittsfield, Maine 04967;  
207-487-5135

**Year founded:** 1979; began pro-

viding utilization review services in 1985.

**Services provided:** 75% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion or waiver, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, patient education and advocacy programs; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

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

**Staff:** Eight total; seven professionals, including six registered nurses, one licensed practical nurse. One physician on a retainer basis.

**Charges:** By the hour, \$46-\$52.

**Principal officers:** Mary E. Orloski, president.

**Health Risk Management Inc.**

8000 W. 78th St., Minneapolis,  
Minn. 55435; 612-829-3500;  
800-824-3882

**Year founded:** 1977; began providing utilization review services in 1984.

**Services provided:** 70% of gross revenues from providing utilization review services to employers, including frequent 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; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services, workers compensa-

tion/disability, pharmaceutical services.

**Staff:** 315 total; 80 professionals, including four physicians, 61 registered nurses, 11 licensed practical nurses, four medical records technicians. 16 physicians, three nurses on a retainer basis.

**Clients:** 155 total clients; 150 employer clients; 5% with 500-999 employees, 10% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 55% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1.9 million employee benefit plan lives; 800,000 workers compensation lives; 83,000 total admissions reviewed.

**Branch offices:** Shrewsbury, N.J.; Glendale, Calif.

**Charges:** Per employee, per case, flat annual fee.

**Principal officers:** Gary McIlroy, chief executive officer; Marlene Travis, president/chief operating officer; Steven Osterkamp, senior vp-sales/marketing; Al Pertuz, senior vp-operations; Ken Diamond, senior vp-provider development.

**Health Services Review Inc.**

P.O. Box 530190, Birmingham,  
Ala. 35253; 205-868-6848;  
800-288-4292

**Year founded:** 1987; began providing utilization review services in 1984.

**Parent company:** Healthtrax.

**Services provided:** 63% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination, long term care review, on-site reviews, outpatient surgery review; 7% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 30% of gross revenues from providing other services.

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

**Staff:** 35 total; professionals include one physician, 30 registered nurses, three licensed practical nurses, one medical record technician. 35 physicians on a retainer basis.

**Clients:** 49 total clients; 27 employer clients; 74% with 500-999 employees, 11% with 1,000-2,499 employees, 8% with 2,500-4,999 employees, 7% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 270,832 employee benefit plan lives; 6,175 workers compensation lives; 24,390 total admissions reviewed.

**Branch offices:** Mobile, Ala.

**Charges:** Per employee, per case.

**Principal officers:** Vernon E. Duke, president; Harriet Hughes, vp-operations; Brenda Glusman, vp-marketing/public relations.

**Health Service Review Inc.**

6730 Roosevelt, Franklin, Ohio  
45005; 513-422-0063

**Year founded:** 1983.

**Services provided:** 97% of gross revenues from providing utilization review services to employers, including frequent 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, short and long term disability case management; occasional retrospective review; 3% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, podiatric services.

**Staff:** 29 total; professionals include 12 registered nurses. 31 physicians, two nurses on a retainer basis.

**Clients:** 200 total clients; 190 employer clients; 40% with fewer than 500 employees, 39% with 500-999 employees, 13% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 2% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 200,000 employee benefit plan

Continued on next page

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After all, the only suit you want your client to be in is hanging in the closet.



Continued from previous page  
lives; 13,400 total admissions reviewed.

**Charges:** Per employee, \$1.45-\$3; per case, \$85-\$150.

**Principal officers:** William D. Stief, president; Thomas L. Wiley, chairman; 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

**Year founded:** 1982.

**Services provided:** 18% of gross revenues from providing utilization review services to employers, including frequent 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 hospital bill audit, case management and consulting; 1% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 81% of gross revenues from providing other services.

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

**Staff:** 89 total; 47 professionals, including two physicians, 40 registered nurses, five medical records technicians.

**Clients:** 39 total clients; 31 employer clients; 87% with fewer than 500 employees, 1% with 500-999 employees, 1% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 10% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 17,500 employee benefit plan lives; 3,600 workers compensation lives.

**Charges:** Per employee, per case.

**Principal officers:** Debra Nixon, chief executive officer; Lawrence Shapiro, president; Fred Christensen, treasurer; Marshall Block, vp; Ed Goldstein, secretary.

**HealthCare COMPARE**

3200 Highland Ave., Downers Grove, Ill. 60515; 708-719-9000

**Year founded:** 1982; began providing utilization review services in 1984.

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

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

**Staff:** 500 total; 347 professionals, including 27 physicians, 250 registered nurses, 30 licensed practical nurses, 40 medical records technicians.

**Clients:** 12,000 total.

**Covered lives/reviewed admissions:** 303,600 total admissions reviewed.

**Branch offices:** Sacramento, Calif.; Savannah, Ga.

**1989 gross revenues:** \$31.5 million total.

**Charges:** Per employee based on number of employees.

**Principal officers:** Dr. Robert J. Becker, chairman; James C. Smith, president/chief executive officer; John L. Krakauer, executive vp/chief operating officer; Ronald H. Galowich, executive vp/secretary/general counsel; Joseph E. Whitters, vp-finance/chief financial officer.

**Healthcare Review Corp.**

9200 Shelbyville Road, Suite 215, Louisville, Ky. 40222; 502-426-4888

**Year founded:** 1986.

**Services provided:** 65% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective re-

view, second surgical opinion, outpatient service predetermination, case management; occasional outpatient psychiatric and substance abuse services, ambulatory surgery review, nursing home care review; 13% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 22% of gross revenues from providing utilization review services to hospitals and nursing homes.

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

**Staff:** 18 total; 11 professionals, including three physicians, seven registered nurses, one licensed practical nurse. One physician, six nurses on a retainer basis.

**Clients:** 47 total clients; eight employer clients; 50% with fewer than 500 employees, 12.5% with 500-999 employees, 12.5% with 2,500-4,999 employees, 25% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 130,000 employee benefit plan  
*Continued on next page*

# Does Your Benefits Program Benefit Your Bottom Line?

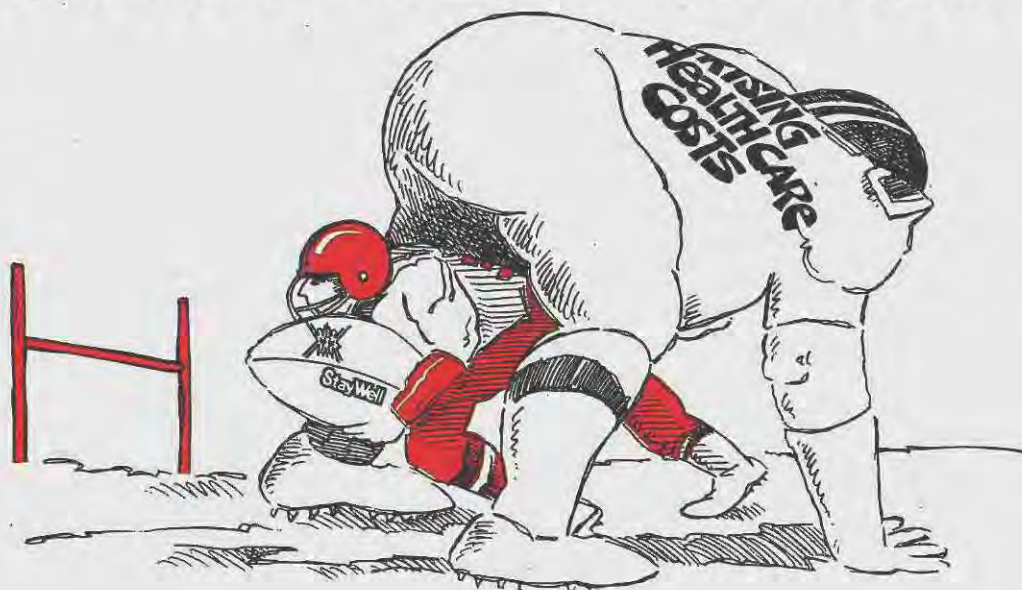
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Continued from previous page  
lives; 8,801 total admissions reviewed.

**1989 gross revenues:** \$1.1 million total.

**Charges:** Per employee, 75 cents-\$4; by the hour for case management, \$50-\$150.

**Principal officers:** James C. Rogers, president; Dr. Barbara Freeman, medical director/vp.

#### HealthCare Strategies Inc.

9841 Brokenland Parkway, Suite 105, Columbia, Md. 21046; 301-381-5430

**Year founded:** 1984.

**Parent company:** TPA of America Inc.

**Services provided:** 85% of gross revenues from providing utilization review services to employers, including frequent 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, prospective ambulatory review, maternity review; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

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

**Staff:** 45 total; 20 professionals, including six physicians, nine registered nurses, two medical records technicians. Three physicians on a retainer basis.

**Clients:** 81 total clients; 67 employer clients; 5% with fewer than 500 employees, 10% with 500-999 employees, 55% with 1,000-2,499 employees, 20% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 410,000 employee benefit plan lives; 100 workers compensation lives; 73,000 total admissions reviewed.

**1989 gross revenues:** \$1.9 million total, \$1.8 million from utilization review services.

**Charges:** Per employee, \$125-\$260; per case for maternity review, \$225; large case management, \$115-\$125.

**Principal officers:** Tom Greene III, chairman-TPA of America Inc.; Elliot Weir, chief operating officer-TPA of America Inc.; Janice K. Albert, president; William P. Keenan, vp.

#### Healthmarc Inc.

P.O. Box 1459, Minneapolis, Minn. 55440; 612-936-1205

**Year founded:** 1983.

**Parent company:** United Health-Care Corp.

**Services provided:** 70% of revenues from providing utilization review services to employers, including frequent 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 hospital bill audit, high-risk pregnancy screening and management, skilled nursing facility review; 30% of revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 111 total; 73 professionals, including two physicians, 70 registered nurses, six medical records technicians. Eight physicians on a retainer basis.

**Clients:** 375 total clients; 323 employer clients.

**Branch offices:** Pasadena, Calif.

**Principal officers:** Mark Tierney, president; Carol Hampton, vp-operations; Glenda Garrard, vp-workers compensation; Dr. Fred Mosley, medical director.

#### HealthNetwork Inc.

1420 Kensington Road, Suite 203, Oak Brook, Ill. 60521; 708-954-2900; 800-345-7848

**Year founded:** 1985.

**Services provided:** 5% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, ambulatory review; occasional retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 15% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 80% of gross revenues from providing other services.

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

**Staff:** Five total; four professionals, including one physician, three registered nurses. One nurse on a retainer basis.

**Clients:** 130 total clients; 30 employer clients; 95% with fewer than 500 employees, 2% with 500-999 employees, 2% with 1,000-2,499 employees, 1% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 35,000 employee benefit plan lives; 2,100 total admissions reviewed.

**Charges:** Per employee per month, \$1.80-\$2.25; \$65-\$200 per hour for large case management; \$22 per \$1,000 for hospital bill audits.

**Principal officers:** George C. Phillips Jr., president/chief executive officer; Donna Wolak, vp-finance/ chief financial officer.

#### Healthpass PPA

905 Governor Road, Suite 301, Hershey, Pa. 17033-2306; 717-531-6950

**Year founded:** 1986.

**Parent company:** Healthpass Inc.

**Services provided:** 55% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, case management; occasional second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 38% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 7% of gross revenues from other services.

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

**Staff:** 10 total; professionals include one physician, four registered nurses.

**Clients:** Six total clients, all employer clients; 33.3% with fewer than 500 employees, 16.7% with 500-999 employees, 16.7% with 1,000-2,499 employees, 33.3% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 75,000 employee benefit plan lives; 5,700 total admissions reviewed.

**1989 gross revenues:** \$400,000 total, \$372,000 from utilization review services.

**Charges:** Per employee, 92 cents-\$1.50; per case, \$30 and up.

**Principal officers:** Gary J. Dillon, vp-Healthpass Inc./director-Healthpass PPA.

#### HealthPro Inc.

10 Mechanic St., Worcester, Mass. 01608; 508-757-5440

**Year founded:** 1975; began providing utilization review services in 1976.

**Parent company:** HealthPro Inc.

**Services provided:** 90% of gross revenues from providing utilization review services to employers, including frequent 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, quality review, quality assurance assessment, pre-surgical screening; 10% of gross revenues from providing other services.

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

**Staff:** 90 total; 75 professionals, including one physician, 50 registered nurses, five medical records

Continued on next page

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Continued from previous page  
technicians. 50 physicians on a retainer basis.

**Clients:** 10% with 2,500-4,999 employees, 90% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 50,000 total admissions reviewed.

**Branch offices:** Columbus, Ohio.  
**1989 gross revenues:** \$3.5 million total.

**Charges:** Per employee, \$1.25-\$1.75; per case per hour, \$125.

**Principal officers:** Michele Stranger-Hunter, president; Gary N. Lapidus, executive vp/chief executive vp; Barbara Ladon, vp/director-marketing.

#### The Holman Group

6900 Owensmouth Ave., Canoga Park, Calif. 91303; 818-704-1444

**Year founded:** 1979; began providing utilization review services in 1981.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 15% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 70% of gross revenues from providing other services.

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

**Staff:** 70 total; professionals include five physicians, one registered nurse, two licensed practical nurses, five medical records technicians. 50 physicians, three nurses on a retainer basis.

**Clients:** 100 total clients; 40 employer clients; 10% with fewer than 500 employees, 10% with 500-999 employees, 60% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 500,000 employee benefit plan lives; 50 workers compensation lives; 25,000 total admissions reviewed.

**Branch offices:** Las Vegas, Nev.; Riverside, San Francisco, San Diego, Torrance, Downey and Pasadena, Calif.; Phoenix, Ariz.

**1989 gross revenues:** \$5 million total, \$1.5 million from utilization review 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.

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, Rochester and Buffalo, N.Y.

**1989 gross revenues:** \$30 million total, including parent company revenues.

**Charges:** Per employee, per case, flat annual fee.

**Principal officers:** Theodore O. Will, executive vp.

#### Independent Dental Consultants

301 N. Harrison St., Suite B173, Princeton, N.J. 08540; 201-286-9210

**Year founded:** 1987.

**Services provided:** 25% of gross revenues from providing utilization review services to employers, including retrospective review, outpatient service predetermination, alternative benefit reviews, claims review; 50% of gross revenues from providing utilization review services to insurance

companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

**Services reviewed:** Dental services.

**Staff:** Six total; all professionals, including five physicians, one registered nurse.

**Charges:** Per case, \$13-\$16; percent of savings, 25%.

**Principal officers:** Dr. Kenneth O'Connor, president.

#### Integrated Psych Care Inc.

5330 Heatherdowns Blvd., Suite 100, Toledo, Ohio 43614; 419-865-2444

**Year founded:** 1986; began providing utilization review services in 1987.

**Services provided:** Utilization review services offered to employers include frequent 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; 25% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 75% of gross revenues from providing other services.

**Services reviewed:** Psychiatric and substance abuse services.

**Staff:** 10 total; professionals include two physicians, eight registered nurses.

**Clients:** Three total clients.

**Covered lives/reviewed admissions:** 100,000 employee benefit plan lives; 580 total admissions reviewed.

**1989 gross revenues:** \$2.5 million total, \$600,000 from utilization review services.

**Charges:** Per employee, 63 cents-\$1; per case, \$250-\$350; per enrollee per month, 30 cents-50 cents.

**Principal officers:** Jacquelyn T. Ayers, president; James King, secretary/treasurer.

#### Intracorp

1205 Westlakes Drive, Suite 300, Berwyn, Pa. 19312; 215-889-2600

**Year founded:** 1970.

**Parent company:** CIGNA Corp.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; DRG review, provider bill audits; 85% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 4,000 total; all professionals, including 20 physicians, 1,612 registered nurses.

**Covered lives/reviewed admissions:** 13 million employee benefit plan lives; 135,000 workers compensation lives; 692,043 total admissions reviewed.

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## HYATT LEGAL PLANS

#### IPRO National Medical Review

95-25 Queens Blvd., 10th Floor, Rego Park, N.Y. 11374; 718-896-7230

**Year founded:** 1983.

**Parent company:** Island Peer Review Organization.

**Services provided:** 20% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, retrospective review, hospital bill audit, outpatient service predetermination; occasional concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient psychiatric and substance abuse services, case management; DRG validation, medical coding audits; 70% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

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

**Staff:** 350 total; 250 professionals, including five physicians, 200 registered nurses, 20 medical records technicians; 550 physicians, 30 nurses on a retainer basis.

**Clients:** 40 total clients; 10 employer clients; 20% with fewer than

Continued from previous page

**Branch offices:** Main offices in Atlanta, Dallas, Chicago, Los Angeles and Philadelphia; 115 additional offices in the United States, Canada and Australia.

**1989 gross revenues:** \$225 million total.

**Charges:** Per employee, per case, percent of savings.

**Principal officers:** Warren D. Fuller, president/chief executive officer; Richard A. Anderson, executive vp-operations; Gregory J. Riedi, senior vp/director-marketing; Katherine S. Perry, senior vp/financial officer; Donald M. Duford, senior vp/sales; Claire Annechin, vp-information systems; Fred B. Pluckhorn, vp-human resources.

**K**

**Kepple & Co. Inc.**

20 W. Fifth St., Peoria, Ill. 61602; 309-673-7330

**Year founded:** 1982; began providing utilization review services in 1986.

**Parent company:** Procter Healthcare Inc.

**Services provided:** 13% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning; occasional retrospective review, second surgical opinion, hospital bill audit, case management; 87% of gross revenues from providing other services.

**Staff:** Six total; professionals include one physician, four registered nurses, one medical records technician.

**Clients:** 37 total clients, all employer clients; 86% with fewer than 500 employees, 8% with 500-999 employees, 6% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 12,000 employee benefit plan lives; 2,200 total admissions reviewed.

**1989 gross revenues:** \$2.3 million total, \$281,569 from utilization review services.

**Charges:** Per employee, \$1.85-\$2.95.

**Principal officers:** Michael D. Kepple, president; Norm Laconte, chairman; Kevin Roberts, vp/secretary/treasurer.

**Key Care Health Resources**

5587 W. 73rd St., Indianapolis, Ind. 46268; 317-298-6600; 800-367-4207

**Year founded:** 1986; began providing utilization review services in 1987.

**Parent company:** The Associated Group.

**Services provided:** 51% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, medical case management, psychiatric and substance abuse case

management, health promotion and wellness programs, prenatal care coordination, information and referral for senior citizens; occasional retrospective review, outpatient psychiatric and substance abuse services; 13% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 36% of gross revenues from providing other services.

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

**Staff:** 120 total; 105 professionals, including four physicians, 63 registered nurses, one licensed practical nurse; 52 physicians on a retainer basis.

**Clients:** 35 total clients; 32% with fewer than 500 employees, 26% with 500-999 employees, 27% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1 million employee benefit plan lives; 65,500 total admissions reviewed.

**Charges:** Per employee, 35 cents-

\$3.96; per case, \$500-\$3,000; percent of savings.

**Principal officers:** Richard Huber, chairman.

**M**

**MCC Cos. Inc./ PsychPACER Inc.**

1401 W. 76th St., Minneapolis, Minn. 55423; 612-861-9500.

**Year founded:** 1974; began providing utilization review services in 1986.

**Parent company:** CIGNA Corp.

**Services provided:** 1% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit; 2% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 97% of gross revenues from providing other services.

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

**Staff:** Nine total; all professionals, including seven registered nurses. Three physicians on a retainer basis.

**Clients:** 16 total clients; three employer clients; 25% with 500-999 employees, 75% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 350,000 employee benefit plan lives; 2,500 total admissions reviewed.

**1989 gross revenues:** \$37.7 million total, \$1 million from utilization review services.

**Charges:** Per employee per month, 25 cents-55 cents; per case, \$90-\$100 per hour.

**Principal officers:** Terry Wills, president; Julian Cohen, vp-operations support; Mark Tidgewell, finance officer; Joe Strahn and Randy Cox, vps-operations.

**Managed Care Administrators**

12651 High Bluff Drive, San Diego, Calif. 92129; 619-259-1933

**Year founded:** 1988.

**Services provided:** Utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; occasional hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 95% of gross revenues from providing other services.

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

**Staff:** Five total; five professionals, including one physician, three registered nurses, one licensed practical nurse; 15 physicians on a retainer basis.

**Clients:** 70 total clients; 50% with fewer than 500 employees, 30% with 500-999 employees, 20% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 53,000 employee benefit plan lives.

**Charges:** Per employee, \$1.25-\$1.75.

**Principal officers:** Raymond E. Hughes, chairman/chief executive officer; Dr. Edward M. Bosanac, president/chief operating office.

**Managed Care Consultants**

1321 S. Maryland Parkway, Las Vegas, Nev. 89104; 702-384-0800

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

**Services provided:** 20% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service pre-

Continued on next page



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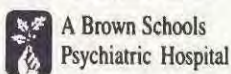
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*Continued from previous page*  
determination, outpatient psychiatric and substance abuse services, case management; 60% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

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

**Staff:** Nine total; four professionals, including three registered nurses, one medical records technician; one physician, one nurse on a retainer basis.

**Clients:** Seven total clients; 60% with fewer than 500 employees, 40% with 500-999 employees.

**Covered lives/reviewed admissions:** 25,000 employee benefit plan lives; 1,775 total admissions reviewed.

**Branch offices:** Reno, Nev.

**Charges:** Per employee.

**Principal officers:** Joe Lawrence, president; Gerald W. Kring, vp.

### Massachusetts Peer Review Organization

300 Bear Hill Road, Box 9007,  
Waltham, Mass. 02254-9007;  
617-890-0011

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

**Parent company:** Massachusetts Medical Society.

**Services provided:** 1% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, ambulatory surgery review, level of care determination for Medicare, quality assurance; occasional second surgical opinion, outpatient psychiatric and substance abuse services; 99% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 135 total; 97 professionals, including three physicians, 65 registered nurses, 11 licensed practical nurses; 210 physicians on a retainer basis.

**Clients:** Three total clients.

**Covered lives/reviewed admissions:** 800,000 employee benefit plan lives, 65,000 total admissions reviewed.

**Branch offices:** West Springfield and Middleboro, Mass.

**1989 gross revenues:** \$6.3 million total.

**Charges:** Per employee, per case, flat annual fee.

**Principal officers:** Dr. Brenda E. Richardson; Dr. Guenter Spanknebel, vp; Dr. Irving Weissman, treasurer; Dr. Eugene LaLancette, clerk.

### Medical Claims Review Services

7910 Woodmont Ave., Suite 700,  
Bethesda, Md. 20814;  
301-913-0002; 800-356-2775

**Year founded:** 1984.

**Services provided:** 5% of gross revenues from providing utilization review services to employers, including frequent retrospective review; occasional concurrent hospital treatment review, length of stay determination, second surgical opinion, hospital bill audit, outpatient service predetermination, case management, retrospective lost time analysis; 92% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 3% of gross revenues from providing other services.

**Services reviewed:** Dental services, chiropractic services, workers compensation/disability.

**Staff:** 31 total; 26 professionals, including four physicians, five registered nurses, seven medical records technicians; 50 physicians, 15 nurses on a retainer basis.

**Clients:** 556 total clients; 10 employer clients; 100% with more than 5,000 employees.

**1989 gross revenues:** \$2.7 million total, \$2.6 million from utilization review services.

**Principal officers:** Dr. Ronald E. Gots, chairman; George Attridge, president; Thomas C. McCarthy and

Dr. Ignatio Rodriguez, executive vps; John J. Madigan, vp.

### Medical Cost Management Corp.

122 S. Michigan Ave., Suite 1200;  
Chicago, Ill. 60603; 312-341-0217

**Year founded:** 1986.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 15% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 35% of gross revenues from providing other services.

**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services, workers' compensa-

tion/disability, podiatric services.

**Staff:** 15 total; professionals include four physicians, four registered nurses, one licensed practical nurse; 350 physicians, 45 nurses on a retainer basis.

**Clients:** 140 total clients; 75 employer clients; 75% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 5% with 2,500-4,999 employees.

**Charges:** Per employee, 80 cents-\$1.45.

**Principal officers:** Michael J. O'Connor, president; Dr. Andrew J. Brislen, vp; Dr. David S. Fox, secretary; Dr. C. Larkin Flanagan, treasurer.

### Medical Foundation Services Inc.

3625 N.W. 82nd Ave., Suite 211,  
Miami, Fla. 33166; 305-593-0404

**Year founded:** 1973.

**Services provided:** 70% of gross revenues from providing utilization review services to employers, includ-

ing frequent 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; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

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

**Staff:** 50 total; 40 professionals, including two physicians, 20 registered nurses, 10 licensed practical nurses, eight medical records technicians. Seven physicians, three nurses on a retainer basis.

**Clients:** 250 total clients; 200 employer clients; 50% with fewer than 500 employees, 25% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 em-

ployees, 5% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 150,000 employee benefit plan lives; 50,000 workers compensation lives; 20,800 total admissions reviewed.

**1989 gross revenues:** \$2 million total, \$1.6 million from utilization review services.

**Charges:** Per employee, \$1-\$1.35; per case, \$50-\$75; retrospective review, \$55 per hour.

**Principal officers:** John Sforza, executive director; Lois Osman, operations director; Richard N. Dietrich, marketing director.

### Medical Review Corp.

237 South St., Morristown, N.J.  
07960; 201-267-2233

**Year founded:** 1982; began providing utilization review services in 1984.

**Services provided:** 40% of gross revenues from providing utilization review services to employers, includ-

*Continued on next page*

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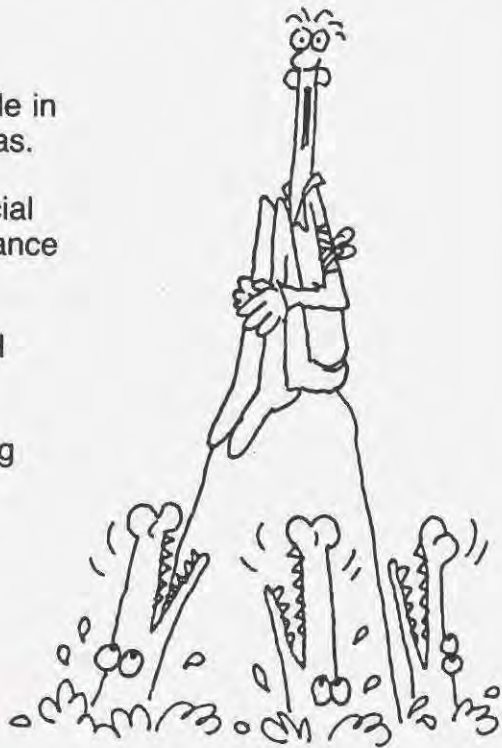
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*Continued from previous page*  
 ing frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, hospital bill audit, skilled nursing, rehabilitation, DRG validation, aggregate audits; 40% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

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

**Clients:** 15% with fewer than 500 employees, 20% with 500-999 employees, 30% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 15% with more than 5,000 employees.

**Charges:** Per employee, per case, percent of savings.

**Principal officers:** Marc Allen, chief executive officer.

**Medical Review Institute of America**

570 E., 3900 S., Suite 300, Salt Lake City, Utah 84107;  
 300-654-2422

**Year founded:** 1982.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent length of stay determination, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, outpatient medical claims review, outpatient surgical facility review; 80% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, home health care, pharmaceutical services, durable medical equipment.

**Staff:** 30 total.

**Clients:** 605 total clients; 25 employer clients; 25% with 1,000-2,499 employees, 50% with 2,500-4,999 employees, 25% with more than 5,000 employees.

**Charges:** Per hour.

**Principal officers:** Bill Low, president; Dr. Robert Maddock, medical director; Diane Hoyle, executive vp/general manager.

**Medicus Resource Management**

Sixth and Spruce Streets, Reading, Pa. 19601; 215-372-8417

**Year founded:** 1989.

**Parent company:** Berkshire Health Plan.

**Services provided:** 100% of gross revenues from providing utilization review services to employers, including 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, return to work programs.

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

**Staff:** Four total; professionals include one physician, two registered nurses; five physicians, three nurses on a retainer basis.

**Clients:** 19 total clients; 17 employer clients; 70.5% with fewer than 500 employees, 23.5% with 500-999 employees, 6% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 7,500 employee benefit plan lives.

**1989 gross revenues:** \$45,000 total.

**Charges:** Per employee, \$1.40-\$1.80.

**Principal officers:** Edward J. Wargo, president; C. Harold Cohn, medical director; Linda Kloep, utilization review supervisor.

**MedCost Inc.**

2150 Country Club Road, Suite 160, Winston-Salem, N.C. 27104;  
 919-721-1844

**Year founded:** 1983; began providing utilization review services in 1984.

**Services provided:** 14% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occasional retrospective review; 55% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 31% of gross revenues from providing other services.

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

**Staff:** 16 total; professionals include six registered nurses; one physician, one nurse on a retainer basis.

**Clients:** 20 total clients; eight em-

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employer clients; 37% with fewer than 500 employees, 50% with 500-999 employees, 13% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 150,382 employee benefit plan lives; 7,987 total admissions reviewed.

**Branch offices:** Charleston, S.C.  
**Charges:** Per employee, \$1.10-\$1.45; by the hour for case management, \$55-\$70.

**Principal officers:** Otto W. Mueller, president; Billie J. Davis, vp.

### MedReview

114 Fifth Ave., New York, N.Y. 10011; 212-691-4300

**Year founded:** 1974.

**Parent company:** New York County Health Services Review Organization.

**Services provided:** 70% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, DRG validation, claims review, data analysis; occasional second surgical opinion, outpatient psychiatric and substance abuse services, case management; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, home health care, podiatry services.

**Staff:** 79 total; 44 professionals, including 14 physicians, 20 registered nurses, 10 medical records technicians, 25 physicians, 10 nurses on a retainer basis.

**Clients:** 31 total clients; 20 employer clients; 45% with fewer than 500 employees, 13% with 500-999 employees, 3% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 36% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 63,300 total admissions reviewed.

**1989 gross revenues:** \$4 million total, \$3.5 million from utilization review services.

**Charges:** Per case, \$35-\$500; contingency fees.

**Principal officers:** Dr. Albert F. Keegan, chairman; Dr. Albert Schwartz, vice chairman; Dr. Richard Bonforte, secretary; Dr. Lowell E. Bellin, treasurer.

### Med-Services

#### Management Co.

One Bala Ave., Suite 4-C, Bala Cynwyd, Pa. 19004; 215-667-5155

**Year founded:** 1984.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent 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, DRG review and validation; occasional case management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 20 total.

**Clients:** 60 total clients.

**1989 gross revenues:** \$1.5 million total.

**Principal officers:** Robert D. Bauer, chief executive officer; Mary Kay Dunne, vp; Kevin O'Brien, marketing director.

### MedTrac Inc.

1300 Godward St. N.E., Suite 3000, Minneapolis, Minn. 55413; 612-379-4145; 800-866-8181

**Year founded:** 1969.

**Parent company:** Corroon & Black Corp. and The Foundation for Health Care Education.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent preadmission certification,

tion, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 41 total; 26 professionals who are registered nurses; 700 physicians on retainer.

**Clients:** 500 total clients.

**Covered lives/reviewed admissions:** 250,000 employee benefit plan lives; 20,000 workers compensation lives; 30,000 total admissions reviewed.

**Branch offices:** Atlanta; Nashville, Tenn.

**Charges:** Per employee, 90 cents-\$1.65; per case, \$65-\$100; by the hour, \$65-\$130.

**Principal officers:** Ronald G. Cameron, president/chief executive officer; Elizabeth A. Bothreau, vp/director-admissions; Patricia L. Hanson, vp/director-research/development/quality control.

### MED-VALU by MHC

650 Shawan Falls Drive, Dublin, Ohio 43017; 800-447-3459

**Year founded:** 1987.

**Services provided:** 40% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services; occasional retrospective review, second surgical opinion, case management; prospective physicians utilization review; 40% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 20% of gross revenues from providing other services.

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

**Staff:** 25 total; all professionals, including two physicians, 23 registered nurses; five physicians on a retainer basis.

**Clients:** 25 total clients; eight employer clients; 5% with fewer than 500 employees, 25% with 500-999 employees, 25% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 15% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 182,000 employee benefit plan lives; 8,000 workers compensation lives; 31,000 total admissions reviewed.

**Branch offices:** Berea and Cleveland, Ohio; Norristown, Pa.

**1989 gross revenues:** \$1.1 million total, \$800,000 from utilization review services.

**Charges:** Per employee, \$1-\$1.25; per nurse per month, \$7,000 for 10,000 insureds and dependents.

**Principal officers:** Michael Linde, president; Mary Ellen O'Grady, vp-

sales; Frank Anzelmo, vp-systems.

### MedWatch Inc.

101 Sunnytown Road, Suite 201, Casselberry, Fla. 32707; 407-331-1500

**Year founded:** 1988.

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

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

**Staff:** Five total; all registered

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issue: February 19 — Reader Service  
 closing: February 6  
 editorial feature: Benefits: Health Care Cost Control — Directory: Utilization Review Providers  
 demographic section: Insurer Topics: Forging Coalitions

issue: February 26  
 closing: February 13

issue: March 5  
 closing: February 20  
 demographic section: Agent/Broker Topics: Agency-Insurer Relations/Errors & Omissions

issue: March 12 — Reader Service Bonus Distribution: International Captive & Reinsurance Forum  
 closing: February 27  
 editorial feature: Risk Management Services — Directory: Risk Management Consultants

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Continued from previous page  
 nurses; one physician, one nurse on a retainer basis.

**Clients:** 10 total clients; two employer clients; 60% with fewer than 500 employees, 20% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 15,000 employee benefit plan lives; 3,000 workers compensation lives; 1,000 total admissions reviewed.

**1989 gross revenues:** \$200,000 total.

**Charges:** Per employee per month, \$1-\$1.50.

**Principal officers:** Lynn Jennings, president; William Laurie, secretary.

### Metropolitan Life Insurance Co.-Managed Care Services Group

276 Post Road W., Westport, Conn. 06880; 203-454-6100

**Year founded:** 1881; began providing utilization review services in 1984.

**Parent company:** Metropolitan Life Insurance Co.

**Services provided:** Utilization review services include frequent 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, ambulatory review, prenatal program.

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

**Staff:** 25 physicians, 611 registered nurses, 24 physicians on retainer.

**Covered lives/reviewed admissions:** 633,000 total admissions reviewed.

**Charges:** Per employee per month, 28 cents-\$1.82.

**Principal officers:** Robert Chernow, vp-Managed Care Services Group, Dr. Paul Frankel, national medical director.

### MultiPlan Inc./Donald Rubin Inc.

200 Park Ave. S., Room 911, New York, N.Y. 10003; 212-477-3880

**Year founded:** 1971.

**Services provided:** 30% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management, DRG validation; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 60% of gross revenues from providing other services.

**Staff:** 17 total.

**Clients:** More than 100 total clients; 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/reviewed admissions:** 500,000 employee benefit plan lives; 10,000 total admissions reviewed.

**Charges:** Per employee, per case, percent of savings.

**Principal officers:** Donald Rubin, president; Roxanne Young and Edward Gluckmann, vps; Edward Rothstein, marketing director.

### Mutual of Omaha Insurance Co./United of Omaha

Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-342-7600

**Year founded:** 1909; began providing utilization review services in 1985.

**Services provided:** Utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, case management; occasional hospital bill audit.

**Services reviewed:** Group health services.

**Staff:** 59 total; professionals include three physicians, 42 registered

nurses, 12 physicians on retainer.

**Clients:** 7,873 total clients; 80% with fewer than 500 employees, 10% with 500-999 employees, 7% with 1,000-2,499 employees, 2% with 2,500-4,999 employees, 1% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 252,905 employee benefit plan lives; 20,000 total admissions reviewed.

**1989 gross revenues:** \$1.7 million total.

**Charges:** Per employee, \$1.20-\$1.40.

**Principal officers:** Thomas J. Skutt, chairman; John W. Weekly, president-Mutual of Omaha Insurance Co.; William J. Netzler, president-United of Omaha Insurance Co.

## N

### NHA Review Services Inc.

770 S. Post Oak Lane, Suite 445, Houston, Texas 77056; 713-439-1222; 800-950-7528

**Year founded:** 1989.

**Parent company:** National Health Care Alliance Inc.

**Services provided:** 75% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion; occasional retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 25% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** Four professionals, including one physician, two registered nurses, one licensed practical nurse.

**Clients:** Five total clients.

**Covered lives/reviewed admissions:** 76,000 employee benefit plan lives.

**1989 gross revenues:** \$98,000 total.

**Charges:** Per employee, \$1.50-\$1.80.

**Principal officers:** Francis L. Browning, chairman/chief executive officer/president; Frank J. Berrier Jr., vp.

### National Chiropractic Review Service

600 Cramer Building, Route 38, Mount Holly, N.J. 08060; 609-267-3838

**Year founded:** 1986.

**Services provided:** 5% of gross revenues from providing utilization review services to employers, including retrospective review, chiropractic review, independent chiropractic exams, third-party review, thermography review, disability evaluations; 85% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

**Services reviewed:** Chiropractic services.

**Staff:** 70 total; 15 professionals, including 14 physicians, one registered nurse; 900 chiropractic physicians on a retainer basis.

**Clients:** 600 total clients.

**Branch offices:** Santa Ana Heights, Calif.; Tampa, Fla.; Baltimore, Chicago.

**Principal officers:** Dr. B. Lawrence Wolther, president; Barbara J. Gutstadt, executive vp/chief operating officer; Dr. Jeff Behrend, vp-clinical director.

### National Health Services Inc.

10909 W. Greenfield Ave., Milwaukee, Wis. 53241; 414-778-5151

**Year founded:** 1984.

**Parent company:** Pioneer Financial Services.

**Services provided:** 25% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, case management.

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agement, inpatient psychiatric and substance abuse services, pharmaceutical services; occasional second surgical opinion, outpatient psychiatric and substance abuse services; 58% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 17% of gross revenues from other services.

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

**Staff:** 35 total; 24 professionals, including 17 physicians, seven registered nurses. Two physicians, approximately 15 nurses on a retainer basis.

**Covered lives/reviewed admissions:** 707,077 employee benefit plan lives.

**Branch offices:** Anderson, Ind.  
**1989 gross revenues:** \$1.8 million total, \$1.5 million from utilization review services.

**Charges:** Per employee, \$1-\$2.20; per case; time and expense.

**Principal officers:** Mark W. Williams, president; Donald L. White, executive vp.

\$40-\$50; per case, \$100-\$250; per employee per month, 80 cents-\$1.

**Principal officers:** Joseph M. McCabe, president; Antonia L. Scarlata, secretary/treasurer.



**PCC/Drug Data Systems Inc.**

828 Hollywood Way, Burbank, Calif. 91505; 818-843-8551

**Year founded:** 1969.

**Services provided:** 10% of gross revenues from providing utilization review services to employers, including review of hospital and pharmacy charges; 90% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Covered lives/reviewed admissions:** Five million workers compensation lives.

**Charges:** Fee for service.  
**Principal officers:** Dr. Alvin Sainer.

**Pacific Peer Review Inc.**

6230 Claremont Ave., Oakland, Calif. 94618; 415-547-7841

**Year founded:** 1983.

**Services provided:** 60% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 40% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 18 total; 11 professionals, including one physician, eight regis-

tered nurses, one licensed practical nurse. 30 physicians, eight nurses on a retainer basis.

**Clients:** 311 total clients; 309 employer clients; 2% with fewer than 500 employees, 15% with 500-999 employees, 30% with 1,000-2,499 employees, 43% with 2,500-4,999 employees, 10% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 400,000 employee benefit plan lives; 100,000 workers compensation lives.

**Charges:** Per employee, per case, by the hour for consulting.

**Principal officers:** Dr. Thomas Forde, president; Margaret M. Kelly, executive director.

**Pacific Review Services (PRS)**

5995 Plaza Drive, Cypress, Calif. 90630; 800-223-4276

**Year founded:** 1983; began providing utilization review services in 1984.

**Parent company:** Pacificare Health Systems.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent 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, home health care, skilled nursing and rehabilitation review, maternity management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Group health services, psychiatric and substance abuse services, workers compensation/disability, maternity, ambulatory.

**Staff:** 63 total; 32 professionals, including two physicians, 28 registered nurses, one licensed practical nurse, one medical records technician; 43 physicians, three nurses on a retainer basis.

**Clients:** 101 total clients; 42 em-

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**Occupational Healthcare Management Services**

700 Broadway, Suite 1132, Denver, Colo. 80273; 303-831-3064

**Year founded:** 1989.  
**Parent company:** Rocky Mountain Health Care Corp.

**Services provided:** 30% of gross revenues from providing utilization review services to employers, including frequent 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 outpatient psychiatric and substance abuse services; 30% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 40% of gross revenues from providing other services.

**Services reviewed:** Workers compensation/disability.

**Staff:** 12 total; professionals include one physician, four registered nurses, two medical records technicians.

**Clients:** Five total clients; four employer clients; 25% with 500-999 employees, 25% with 1,000-2,499 employees, 50% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 7,250 workers compensation lives.

**Charges:** Per hour, flat fee, percent of savings, percent of premium.

**Principal officers:** Jerry Robinson, president; Randy Herndon, vp.

**Options-Health Care Cost Containment**

400 Penn Center Blvd., Suite 741, Pittsburgh, Pa. 15235; 412-824-7686

**Year founded:** 1984.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient psychiatric and substance abuse services; 10% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 75% of gross revenues from providing other services.

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

**Staff:** 25 total; 11 professionals, including one physician, 10 registered nurses. 15 physicians on a retainer basis.

**Clients:** 30 total clients; 10 employer clients; 25% with 500-999 employees, 50% with 1,000-2,499 employees, 25% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 2,000 workers compensation lives.

**Charges:** Per employee per hour,



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 ployer clients; 46% with fewer than 500 employees, 25% with 500-999 employees, 22% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 2% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 507,460 employee benefit plan lives; 48,100 total admissions reviewed.

**Charges:** Per employee, \$1.30-\$3.95; per case, \$100.

**Principal officers:** Vicki Merrill, president.

### Par 3 Utilization Review Services Inc.

7000 N. Broadway, Suite 105, Denver, Colo. 80221; 303-426-8280

**Year founded:** 1987.

**Services provided:** 95% of gross revenues from providing utilization review services to employers, including frequent 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, on-site concurrent review; occasional second surgical opinion, hospital bill audit; 5% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, workers compensation/disability, podiatric services.

**Staff:** 11 total; six professionals, including two physicians, two registered nurses, two medical records technicians; 65 physicians, 18 nurses, two social workers, 30 medical records technicians on a retainer basis.

**Clients:** 347 total clients; 92% with fewer than 500 employees, 4% with 500-999 employees, 2% with 1,000-2,499 employees, 2% with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 18,000 employee benefit plan lives.

**Charges:** Per employee, 25 cents-\$1.45; per case, \$100-\$250; by the hour.

**Principal officers:** Mabel La-Chappell, president; Kimberly Sutphin, vp/director-operations; Dr. Howard Entin, vp/director-behavioral medicine; Dr. Henry Roth, vp/medical director; Harry Auston, vp-finance.

### Parkside Health Management Corp.

205 W. Touhy Ave., Park Ridge, Ill. 60068; 800-843-1978

**Year founded:** 1980.

**Parent company:** Lutheran General Health Care Services.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, high-risk pregnancy; 25% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

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

**Staff:** 200 total.

**Clients:** 294 total clients; 279 employer clients.

**Covered lives/reviewed admissions:** 1.25 million employee benefit plan lives; 300,000 workers compensation lives; 68,000 total admissions reviewed.

**Branch offices:** Cleveland, Atlanta.

**1989 gross revenues:** \$11 million total, \$8 million from utilization review services.

**Charges:** Per employee, \$1-\$2.85; per case, \$50-\$125; hourly management fees.

**Principal officers:** Marsha Ballard, president; Jennifer Cline, vp-managed care; Jim Dunlavy, vp-sales/marketing.

### Pathway Review Systems

40500 Ann Arbor Road, Suite 200, Plymouth, Mich. 48170; 313-459-2997

**Year founded:** 1989.

**Parent company:** Michigan Peer Review Organization.

**Services provided:** 1990 projections: 20% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion, case management; occasional discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 70% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, optometric services.

**Staff:** Eight total; all professionals, including six registered nurses, two medical records technicians.

**Clients:** 15 total clients; one employer client with 2,500-4,999 employees.

**Covered lives/reviewed admissions:** 1990 projections: 35,000 employee benefit plan lives; 12,000 workers compensation lives.

**1989 gross revenues:** 1990 projections: \$350,000 total, \$315,000 from utilization review services.

**Charges:** Per employee per month, 80 cents; per case for presurgical review, \$25; per hour for consulting, \$110.

**Principal officers:** Gary G. Horvat, president.

### Peer Review Analysis Inc.

380 Pleasant St., Malden, Mass. 02148; 617-322-6400

**Year founded:** 1984.

**Services provided:** 7% of gross revenues from providing utilization review services to employers, including frequent 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; 93% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 54 total; professionals include five physicians, 20 registered nurses, one medical records technician. 80 physicians on a retainer basis.

**Clients:** 41 total clients; 10 employer clients; 30% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 30% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 4.6 million employee benefit plan lives; 20,000 workers compensation lives; 50,000 total admissions reviewed.

**Branch offices:** Honolulu.

**1989 gross revenues:** \$4.4 million total.

**Charges:** Per employee, \$1.40-\$2; per case, \$65-\$80; by the hour, \$125.

**Principal officers:** Dr. Barry Manuel, chairman; Russell Robbins, vice chairman; Eric R. Spitzer, president; Charles Smith, treasurer.

### Physical Therapy Review Services

100 Diplomat Drive, Airport Bus Center, Ambassador One, Bay One, Lester, Pa. 19113; P.O. Box 69, Woodlyn, Pa. 19094; 215-874-1248; 800-388-7877

**Year founded:** 1986.

**Services provided:** 10% of gross revenues from providing utilization review services to employers, including frequent discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient physical therapy review; occasional preadmission certification, concurrent hospital treatment review, length of stay determination, hospital bill audit; 85% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing

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other services.

**Services reviewed:** Group health services, workers compensation/disability, physical therapy.

**Staff:** Five total; all physical therapists; 60 physical therapists on a retainer basis.

**Clients:** 200 total clients; 30 employer clients.

**1989 gross revenues:** \$500,000 total.

**Charges:** Per case, \$144-\$750.

**Principal officers:** David W. Clifton Jr., president/chief executive officer; Susan L. Michlovitz, vp/director; Leslie B. Clifton, business manager.

**The Precertification Center**

Box 898125, Camp Hill, Pa.  
17089-8125; 717-232-2946

**Year founded:** 1985.

**Parent company:** Capital Blue Cross and Pennsylvania Blue Shield.

**Services provided:** 90% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, pre-procedure certification, disability certification; occasional retrospective review, case management; 5% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 5% of gross revenues from providing other services.

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

**Staff:** 28 total; 18 professionals, including two physicians, 16 registered nurses. One physician on a retainer basis.

**Clients:** 227 total clients; 224 employer clients; 62% with fewer than 500 employees, 20% with 500-999 employees, 11% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 3% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 750,000 employee benefit plan lives; 5,000 disability lives; 39,000 total admissions reviewed.

**1989 gross revenues:** \$2 million total, \$1.9 million from utilization review services.

**Charges:** Per employee per month, 95 cents-\$1.40; by the hour.

**Principal officers:** Jerry Boyer, vp/chief operating officer; Elizabeth R. Galitaki, director-program administration; Susan Bunting Bianchi, director-information systems.

**Preferred Care Review Services**

3000 Charlotetown Center,  
Charlotte, N.C. 28204;  
704-339-0339

**Year founded:** 1975.

**Parent company:** Metolina Medical Foundation Inc.

**Services provided:** 70% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; occasional retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, physical rehabilitation; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 10% of gross revenues from providing other services.

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

**Staff:** 18 total; 11 professionals, including one physician, eight registered nurses, one medical records technician; 52 physicians, one nurse on a retainer basis.

**Clients:** Seven total clients; four employer clients; 25% with fewer than 500 employees, 25% with 1,000-2,499 employees, 50% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 79,000 employee benefit plan lives; 6,400 total admissions reviewed.

**Charges:** Per employee per month, 80 cents-95 cents.

**Principal officers:** Dr. Richard Kevelman, president; Dan Carrigan,

executive vp; Dr. Dewey Dorsett, secretary.

**Pro Health Review**

8060 Knue Road, Suite 228,  
Indianapolis, Ind. 46250;  
317-841-5501

**Year founded:** 1985.

**Services provided:** 50% of gross revenues from providing utilization review services to employers, including 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; 50% of gross revenues from providing other services.

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

**Staff:** 12 total; five professionals, including two physicians, three registered nurses.

**Clients:** Five total clients; all employer clients; 5% with fewer than 500 employees, 1% with 2,500-4,999

employees.

**Covered lives/reviewed admissions:** 15,000 employee benefit plan lives.

**Professional Review Organization for Washington**

10700 Meridian Ave. N., Suite 300,  
Seattle, Wash. 98133-9008;  
206-364-9700

**Year founded:** 1975.

**Services provided:** 99% of gross revenues from providing utilization review services to employers, including frequent 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 consultation service; 1% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Group health

services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability, physical therapy.

**Staff:** 66 total; all professionals, including one physician, 45 registered nurses, one licensed practical nurse, 19 medical records technicians; 140 physicians on a consulting basis.

**Clients:** 36 total clients; 21 employer clients; 4% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 81% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 1 million employee benefit plan lives; 10,000 workers compensation lives; 45,433 total admissions reviewed.

**Branch offices:** Anchorage, Alaska; Boise, Idaho.

**1989 gross revenues:** \$6 million total.

**Principal officers:** John W. Daise, chief executive officer; Dr. J.C. Peterson III, director-medical affairs; Dr. Herbert M. Hilgers, chairman; Michael B. Garrett, director-market-

ing/professional services; Rick Shepard, director-operations/data services.

**Psychology Systems Inc.**

615 S. Main St., Milpitas, Calif.  
95035; 408-263-8046

**Year founded:** 1980; began providing utilization review services in 1981.

**Services provided:** 5% of gross revenues from providing utilization review services to employers, insurance companies, HMOs, PPOs or TPAs; including frequent 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 second surgical opinion; 95% of gross revenues from providing other services.

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

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**Staff:** 18 total.  
**Clients:** 400 total clients; 20% with fewer than 500 employees, 20% 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/reviewed admissions:** 100 workers compensation lives; 200 total admissions reviewed.

**Branch offices:** Sacramento, Calif.

**1989 gross revenues:** \$4 million total, \$100,000 from utilization review services.

**Charges:** Per employee, approximately \$5.

**Principal officers:** Dr. John C. Brady II, president; Dr. Ronald Wykstra, treasurer; Dr. M. Bowman, secretary.

## Q

### Quality Care Review Inc.

100 Roscommon Drive, Middletown, Conn. 06457; 203-632-2008

**Year founded:** 1988.

**Services provided:** 35% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, case management; occasional discharge planning, hospital bill audit; 65% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 18 total; professionals include two physicians, 14 registered nurses, one medical records technician. 20 physicians on a retainer basis.

**Clients:** Three total clients; two employer clients; 50% with fewer than 500 employees, 50% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 2,000 employee benefit plan lives; 68,000 workers compensation lives; 1,500 total admissions reviewed.

**1989 gross revenues:** \$300,000 total.

**Charges:** Per employee, \$1.50-\$2; per case, \$250-\$1000.

**Principal officers:** Dr. Edward A. Kamens, president; Marcia K. Petrillo, executive vp.

### Quality Health Services Inc.

633 Germantown Pike, Plymouth Meeting, Pa. 19462-1032; 215-941-9561

**Year founded:** 1983.

**Services provided:** 10% of gross revenues from providing utilization review services to employers, including frequent 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, DRG review, physician fee negotiation, site of care review, home health care and skilled nursing; occasional hospital bill audit, retrospective DRG review, psychiatric case management, managed mental health programs; 88% of gross revenues from providing utilization review services to insurance companies,

HMOs, PPOs or TPAs; 2% of gross revenues from providing other services.

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

**Staff:** 35 total; 12 professionals, including one physician, 10 registered nurses, one medical records technician. 35 physicians, six nurses on a retainer basis.

**Clients:** 30 total clients; 25 employer clients; 30% with fewer than 500 employees, 16% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 14% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 101,000 employee benefit plan lives; 18,000 total admissions reviewed.

**1989 gross revenues:** \$2 million total, \$1.97 million from utilization review services.

**Charges:** Per employee per month, \$1.65-\$2.25; by the hour for case management and other services.

**Principal officers:** Roger Hiser, chairman; Robert M. Scherzer, president/chief executive officer; Dr. Jan Lipes, medical director; Sharon Cohen, chief operating officer; Barbara Nammar, utilization review director.

### Quality Managed Care Inc.

11050 Roe Blvd., Suite 202, Overland Park, Kan. 66211; 800-888-6775

**Year founded:** 1989.

**Parent company:** American Nursing Resources Inc.

**Services provided:** 20% of gross revenues from providing utilization review services to employers, including frequent 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 hospital bill audit; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 60% of gross revenues from providing other services.

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

**Staff:** 12 total; six professionals, all registered nurses; 17 physicians, eight nurses on a retainer basis.

**Clients:** 116 total clients; 110 employer clients; 97% with fewer than 500 employees, 1% with 500-999 employees, 1% with 1,000-2,499 employees, 1% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 210,000 employee benefit plan lives; 10,100 workers compensation lives; 2,100 total admissions reviewed.

**Branch offices:** Wichita, Kan.

**Charges:** Per employee, \$1-\$2.10; per case, \$100-\$125.

**Principal officers:** Dr. John Dayani, president/chief executive officer; Dr. John R. Coleman, vp/chief operating officer.

## R

### RMSCO Management Services Inc.

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

**Year founded:** 1981; began providing utilization review services in 1982.

**Services provided:** 25% of gross revenues from providing utilization review services to employers, including frequent 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 retrospective review; 75% of gross revenues from providing other services.

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

**Staff:** Three total; all professionals, including one physician, two registered nurses. One physician on a retainer basis.

**Clients:** 44 total clients, all employer clients; 52% with fewer than

500 employees, 30% with 500-999 employees, 18% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 46,439 employee benefit plan lives.

**1989 gross revenues:** \$1.2 million total.

**Charges:** Per employee.

**Principal officers:** Robert M. Schrayner, president; Karen Z. Vacko, executive vp; Max R. Schrayner III and Richard A. Freeman, senior vps.

### Republic-RSB Cos. Inc.

1717 Park St., P.O. Box 3088, Naperville, Ill. 60566-7088; 708-420-6800

**Year founded:** 1964; began providing utilization review services in 1983.

**Parent company:** HCX Acquisitions Inc.

**Services provided:** 7% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, DRG validation audits, rehabilitation management, provider bill review; 16% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 77% of gross revenues from providing other services.

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

**Staff:** 460 total; 210 professionals, including six physicians, 196 registered nurses, eight medical records technicians; six physicians on a retainer basis.

**Clients:** 5,000 total clients; 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/reviewed admissions:** 5.4 million employee benefit plan lives; 56,393 total admissions reviewed.

**Branch offices:** Atlanta; Houston; Los Angeles; Sparta, N.J.

**1989 gross revenues:** \$25.6 million total, \$6 million from utilization review services.

**Charges:** Per employer, \$1.10-\$1.90; per case, \$95-\$125.

**Principal officers:** Richard E. Mandel, president; Robert Gant, senior vp; Deanna Sirtaut, vp-audit operations; Barbara A. Graham, vp-marketing; John W. Dugan, vp-sales; Grae Baxter, vp-human resources; Donald Hernley, chief financial officer.

### Rush Contract Care

33 E. Congress, Suite 710, Chicago, Ill. 60605; 312-347-0947

**Year founded:** 1985.

**Parent company:** Rush Presbyterian St. Luke's Medical Center.

**Services provided:** 15% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management; occasional retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services; 51% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 34% of gross revenues from providing other services.

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

**Staff:** 33 total; 24 professionals, including four physicians, seven registered nurses, 13 medical records technicians.

**Clients:** 15 total clients; 98% with fewer than 500 employees, 1% with 1,000-2,499 employees.

**Covered lives/reviewed admissions:** 125,000 employee benefit plan lives.

**1989 gross revenues:** \$1.4 million total, \$840,000 from utilization review services.

Continued on next page

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Continued from previous page

**Charges:** Per employee per month, \$2.75-\$3.00.**Principal officers:** Dr. Jerome Hahn, president.

S

**Sagamore Health Network**11555 N. Meridian St., Suite 400,  
Carmel, Ind. 46032; 317-573-2900**Year founded:** 1985.**Services provided:** Utilization review services offered to employers include frequent 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 hospital bill audit.**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services.**Staff:** 44 total; professionals include two physicians, five registered nurses, two licensed practical nurses.**Covered lives/reviewed admissions:** 170,000 employee benefit plan lives.**Branch offices:** South Bend and East Chicago, Ind.**Charges:** Per employee.**Principal officers:** Barry J. Sullivan, president; Lee Welton, senior vp-finance; Keith Starling, vp-operations.**Sanus Preferred Services**6611 Kenilworth Ave., Suite 300,  
Riverdale, Md. 20737;  
301-927-4300**Year founded:** 1987.**Parent company:** Sanus Corp. Health Systems.**Services provided:** 100% of gross revenues from providing utilization review services to employers, including frequent 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.**Services reviewed:** Group health services, psychiatric and substance abuse services.**Staff:** 12 total; all registered nurses.**Clients:** 12 total clients, all employer clients; 80% with fewer than 500 employees, 20% with 500-999 employees.**Covered lives/reviewed admissions:** 350 total admissions reviewed.**1989 gross revenues:** \$98,000 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.Y.  
10546; 800-446-4606;  
800-446-4626 in New York**Year founded:** 1983.**Services provided:** 100% of gross revenues from providing utilization review services to employers, including frequent second surgical opinion; occasional preadmission certification, length of stay determination, hospital bill audit, outpatient service predetermination, case management, claims review, fee negotiation, prospective review of diagnostic testing.**Services reviewed:** Group health services, chiropractic services, workers compensation/disability.**Staff:** 18 total; all professionals, including one physician, four registered nurses, five licensed practical nurses, six medical records technicians.**Covered lives/reviewed admissions:** 15,000 total admissions reviewed.**Charges:** Per case, \$155-\$160; per employee; flat fee.**Principal officers:** Dr. Madelon Lubin Finkel, president/chief executive officer; David J. Finkel, chief financial officer.**The Sunderbruch Corp.**3737 Woodland Ave., Suite 622,  
West Des Moines, Iowa 50265;  
515-224-6426**Year founded:** 1975.**Services provided:** 70% of gross revenues from providing utilization review services to employers, including frequent 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 hospital bill audit, case management, home health care review, hospice review; 30% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services, workers compensation/disability.**Staff:** 302 total; 164 professionals, including three physicians, 140 registered nurses, 11 licensed practical nurses, 10 medical records technicians.**Clients:** 138 total clients; 125 employer clients; 58% with fewer than 500 employees, 10% with 500-999

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**Spotlight report**

Continued from previous page employees, 14% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 11% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 2.9 million employee benefit plan lives; 600 workers compensation lives; 235,200 total admissions reviewed.

**Branch offices:** St. Louis; Peoria and Chicago, Ill.; Lincoln, Neb.

**1989 gross revenues:** \$14.9 million total.

**Charges:** Per employee, \$1.25-\$1.65; per case.

**Principal officers:** Richard McMaster, chief executive officer; Rebecca A. Hemann, vp; Pamela S. DePriest, director-marketing; James A. Roberts, director-operational programs.

**T**

**TAO Inc.**

1901 Market St., 32nd Floor, Philadelphia, Pa. 19103; 800-344-1255

**Year founded:** 1985.

**Parent company:** Independence Blue Cross.

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**Services provided:** 5% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, case management; occasional retrospective review, outpatient psychiatric and substance abuse services; 92% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 3% of gross revenues from providing other services.

**Services reviewed:** Group health services, dental services, chiropractic services, workers compensation/disability.

**Staff:** 43 total; 25 professionals, including four physicians, 15 registered nurses, one medical records technician.

**Clients:** Three total clients.  
**Covered lives/reviewed admissions:** 2.3 million employee benefit plan lives; 10,860 total admissions reviewed.

**1989 gross revenues:** \$3.8 million total, \$3.7 million from utilization review services.

**Charges:** Per employee; per case, \$200-\$400.

**Principal officers:** Dr. Anthony F. Panzetta, president/chief executive officer; Barry Davis, vp/chief operating officer; Donna E. DeHart, vp-marketing.

**U**

**Ullicare**

111 Massachusetts Ave. N.W., Washington, D.C. 20001; 800-848-9200

**Year founded:** 1984; began pro-

viding utilization review services in 1985.

**Parent company:** Union Labor Life Insurance Co.

**Services provided:** 100% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services.

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

**Staff:** 20 total; all professionals, including one physician, 16 registered nurses, two licensed practical nurses, on medical records technician; five physicians on a retainer basis.

**Clients:** 75 total clients, all 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/reviewed admissions:** 90,000 employee benefit plan lives; 12,000 total admissions reviewed.

**1989 gross revenues:** \$1 million total.

**Charges:** Per employee per month, \$1.50; per case, \$75-\$150; flat annual fee.

**Principal officers:** Daniel E. O'Sullivan, president/chief executive officer; James W. Luce, executive vp; James R. Hibbitts, vp-Union Labor Life Insurance Co.

**UniPsych Systems Inc.**

1590 N.E. 162nd St., North Miami Beach, Fla. 33162; 305-944-9237

**Year founded:** 1986.

**Services provided:** Utilization review services offered to employers include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second psychiatric opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 50% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 50% of gross revenues from providing other services.

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

**Staff:** 16 total; five professionals, including two physicians, one registered nurse, two medical records technicians, 14 physicians, one nurse, 16 psychologists on a retainer basis.

**Clients:** Four total clients.  
**Covered lives/reviewed admissions:** 70,000 employee benefit plan lives; 200 total admissions reviewed.

**1989 gross revenues:** \$1.5 million total.

**Charges:** Per employee.  
**Principal officers:** Dr. Leo H. 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

**Year founded:** 1985.

**Parent company:** United Health Care Corp.

**Services provided:** 2% of gross revenues from providing utilization review services to employers, including frequent 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 hospital bill audit; 2% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 96% of gross revenues from providing other services.

**Services reviewed:** Psychiatric and substance abuse services.  
**Staff:** 14 total; six professionals, including one physician, two registered nurses, one medical records technician, two psychologists. Six physicians, two nurses on a retainer basis.

**Clients:** Eight total clients; four employer clients; 10% with fewer than 500 employees, 50% with 500-999 employees, 25% with 1,000-2,499 employees, 15% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 300,000 employee benefit plan lives; more than 2,000 total admissions reviewed.

**Branch offices:** Omaha, Neb.  
**1989 gross revenues:** \$11.5 million total, \$230,000 from utilization review services to employers.

**Charges:** Per employee, 30 cents-60 cents; per case, \$300-\$500; per covered life, 18 cents-30 cents.

**Principal officers:** Jack Newstrom, president/chief executive officer; Dr. Charles Sherman, operations director.

**Utilization Management Program**

Suite 250, 200 ATC, 1575 Northside Drive, Atlanta, Ga. 30318-4208; 404-350-4301

**Year founded:** 1985.

**Parent company:** Atlanta Healthcare Alliance.

**Services provided:** 66% of gross revenues from providing utilization review services to employers, including frequent 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 hospital bill audit; 34% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

**Services reviewed:** Group health

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

**Staff:** 13 total; 11 professionals, including one physician, 10 registered nurses. One physician on a retainer basis.

**Clients:** 14 total clients; nine employer clients; 22% with fewer than 500 employees, 44% with 1,000-2,499 employees, 11% with 2,500-4,999 employees, 23% with more than 5,000 employees.

**Covered lives/reviewed admissions:** 120,520 employee benefit plan lives; 15,600 total admissions reviewed.

**1989 gross revenues:** \$682,436 total.

**Charges:** Per employee, 90 cents-\$1.25; per hour, \$35-\$75.

**Principal officers:** S. Walker McCune, executive vp; Jody A. Hunter, vp; Karen B. Rothschild, program manager.

**V**

**Value Health Sciences Inc.**

1448 15th St., Suite 202, Santa Monica, Calif. 90404; 213-394-2212

**Year founded:** 1988; began providing utilization review services in 1989.

**Parent company:** Value Health Inc.

**Services provided:** 8% of gross revenues from providing utilization review services to employers, including preadmission certification, retrospective review; 67% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs; 25% of gross revenues from providing other services.

**Services reviewed:** Group health services.

**Staff:** 21 total; five professionals, including three physicians, one registered nurse, one medical records technician; 15 professionals on a retainer basis.

**Clients:** 13 total clients; all with more than 5,000 employees.

**Covered lives/reviewed admissions:** 6 million employee benefit plan lives; 15,000 total admissions reviewed.

**Charges:** Per employee per month, 10 cents-15 cents; per case, \$65-\$80.

**Principal officers:** Leslie D. Michelson, president; Jacqueline Kosecoff, executive vp; Dr. Mark R. Chassin, senior vp; Dr. Robert Dubois, vp; Robert A. Patricelli, president-Value Health Inc.

**VALUTRAC**

P.O. Box 219095, Portland, Ore. 97225; 503-641-5352

**Year founded:** 1986.

**Parent company:** Metrocare National Inc.

**Services provided:** 80% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, high-risk pregnancy screening, skilled nursing review, chronic care review; 20% of gross revenues from providing utilization review services to insurance companies, HMOs, PPOs or TPAs.

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

**Staff:** 122 total; 84 professionals, including eight physicians, 76 registered nurses; 128 physicians on a retainer basis.

**Clients:** More than 3,500 total clients; 1,500 employer clients; 60% with fewer than 500 employees, 15% with 500-999 employees, 15% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 5% with more than 5,000 employees.

**Covered lives/reviewed admissions:** More than 1 million employee benefit plan lives; 80,000 total admissions reviewed.

**Branch offices:** Seattle; Detroit and Grand Rapids, Mich.; Pleasanton, Calif.; Dallas; Jackson, Miss.; Charlotte, N.C.; Indianapolis; Peoria, Ill.; Minneapolis; Philadelphia; Salt Lake City; Orlando, Fla.

**1989 gross revenues:** \$3.5 million

Continued on next page

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**Spotlight report**

**UR components**

*Continued from previous page with visiting nurses.*

"Medical case management works because it focuses on the individual case," said Gregory J. Riedi, an Intracorp senior vp. "It is an emphasis on the individual case, a personal face-to-face approach."

Under a hospital precertification program, rated the second most effective, an employee's physician typically must explain an employee medical problem to an employer's insurer or UR company to reach

trolling costs, were judged the least effective part of UR programs. Respondents said they had a slight impact on plan costs.

These programs may, in part, be victims of high expectations, Mr. Riedi said. And they may also have not succeeded because they were not well-focused, he added.

The low score for outpatient utilization review—1.4 points, or modestly effective—may be misleading, he said.

That score may reflect the relative newness of outpatient utilization review and a lack of data rather than ineffectiveness, he said.

Asked to rate the effectiveness of cost control measures in general, respondents said increased cost sharing, such as raising employee premium contributions, had the most impact—with an average score of 1.7 points.

Utilization review was given 1.5 points on average; restricting coverage for mental health and substance abuse, 1.3 points; and reducing benefits—such as through raising deductibles and coinsurance requirements—1.3 points.

The use of health maintenance organizations was rated the least effective in controlling health care costs with an average score of 0.5.

By contrast, a broader survey by benefit consultant Hewitt Associates found employers were almost evenly divided on whether HMO or indemnity plan costs were rising faster (BI, Feb. 5).

Most survey respondents—56%—reported that they or their clients have implemented some type of managed care approach, such as offering a preferred provider organization, case management, utilization review or precertification.

In addition, 36% said they or their clients have raised deduct-

ibles, coinsurance or employee premium contributions; 19% said they or their clients redesigned medical plans; 13% reduced benefits; and 8% added flexible benefit plans.

Medical price inflation—doctors and hospitals charging more for

their services—was rated the biggest contributing factor in rising medical care costs with a score of 2.4 on average.

Other factors cited include: outpatient surgical claims, an average score of 2.1 points; and large cata-

strophic medical claims, 2.0 points.

Copies of "Health Care Cost Containment Report" are available for \$25 from the Self-Insurance Educational Foundation, P.O. Box 15466, Santa Ana, Calif. 92705;

**Second opinion programs may be a victim of inflated expectations, says Gregory J. Riedi.**

agreement on hospitalization and the length of stay. Generally, employers will reimburse hospital charges for a certified admission at a higher level than they will for a non-certified admission.

Precertification promotes "better decision making because you know what is going to happen" and can plan for it, according to Mr. Riedi.

Under concurrent review, rated the third most effective part of utilization review, physician and hospital services are monitored as they are delivered.

It tells the medical community that "management of health care does not go away after precertification," Mr. Riedi said.

Second surgical opinions, once heavily promoted as a key to con-

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**Issue of February 19**

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# Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

## New friends

### Despite recent feud, insurers embrace consumer groups

By MARK A. HOFMANN

"We must all hang together, or assuredly we shall hang separately."

—Benjamin Franklin upon signing the Declaration of Independence

Heeding Ben Franklin's advice, property/casualty insurers have a long history of banding together to promote the well-being of their industry.

Through groups like the Alliance of American Insurers, the American Insurance Assn., the National Assn. of Independent Insurers and the National Assn. of Mutual Insurance Companies, property/casualty insurers have lobbied for favorable regulatory changes, promoted employee education and attempted to win public support on public policy questions.

But the November 1988 passage of Proposition 103 by California voters, which reflected the public's often-negative perception of property/casualty insurers, and the threat of similar measures in other states are leading companies to form new alliances.

In one case, insurers are extending their hands to their traditional foes: national consumer groups.

The Washington, D.C.-based Advocates for Highway & Auto Safety, which was formed in September, is the culmination of more than a year of meetings aimed at finding common ground between insurers and consumer advocates, pointed out Robert E. Vagley, president of the American Insurance Assn. in Washington.

"At first, there was some early anxiety and concern about working with each other," said Mr. Vagley. "There was a tremendous amount of broken glass on the floor."

"It was difficult. It was a time when consumer groups, including the Consumer Federation of America and Public Citizen, were on the offensive against the (property/casualty) industry," said Steve Brobeck, executive director of the Washington, D.C.-based Consumer Federation of America and a member of the Advocates' board.

Efforts were nearly scuttled after the release of a report last May by Public Citizen, the CFA and the National Insurance Consumer Organization that questioned the efficiency of auto insurers, called for repeal of the McCarran-Ferguson Act and was otherwise critical of insurers, he said.

Among the non-insurance industry groups on the Advocates' board are the CFA, an umbrella organization of consumer groups; Public Citizen, a consumer research group founded by Ralph Nader; the Trauma Foundation at San Francisco General Hospital, a research group involved in injury prevention issues; and the Police Foundation, a law enforcement research group.

Despite fundamental differences, many saw the coalition as a natural.

As the AIA was meeting with consumer leaders, Gerald L. Maatman, president of the Long Grove Ill.-

based Kemper Group's national insurance companies, was thinking about forming a broad-based coalition to deal with the root problems of high auto insurance prices.

In a September 1988 speech, Mr. Maatman called on insurers, consumers, law enforcement, safety experts and others to jointly tackle auto safety problems (BI, Oct. 10, 1988).

Mr. Maatman, whose companies belong to the Alliance rather than the AIA, said he was unaware that the AIA was proceeding along a parallel track when he made that speech. However, soon Kemper, the AIA, the Alliance and consumer groups were trying to hammer out a common agenda.

"You start not in recognition that you have differences, but in recognition that you have agreement," said Franklin W. Nutter, president of the Schaumburg, Ill.-based Alliance.

"You just don't go out and build a coalition," said AIA's Mr. Vagley. All members of a coalition have to have what he calls "a vital interest" that is addressed by the group.

In the case of Advocates, the vital interest is highway safety—pure and simple, he said. Issues like the repeal of McCarran-Ferguson—a move favored by consumer groups and opposed by insurers—would have no place on the agenda, Mr. Vagley said.

Advocate's structure represents a careful balancing of the interests of two often-antagonistic camps.

For instance, each insurance industry member of the Advocates board must be matched by a public board member, noted Judith Lee Stone, executive director of the Advocates. Insurers, however, provide virtually all the funding.

Ms. Stone, a former director of federal affairs for the National Safety Council in Chicago and executive director of the National Assn. of Governors' Highway Safety Representatives, noted that Advocates' agenda includes:

- Extending all federal motor vehicle safety standards, like rules requiring automatic restraints, to multipurpose vehicles and light trucks.
- Reauthorization of the National Highway Traffic Safety Administration. The Senate approved reauthorization, but a bill has not been introduced in the House.
- Preserving price competition for automobile replacement parts.
- Reinstating the requirement—dropped in 1982—that auto bumpers must be able to withstand a 5-mph crash.

Both Ms. Stone and Mr. Maatman stressed that the group also would be working with local and state organizations to promote more stringent auto safety laws. For example, Ms. Stone will be visiting several cities and state legislatures in the immediate future to introduce and publicize Advocates.

While Advocates does not have the money to establish formal state affiliates, it will work with local consumer organizations and other auto safety groups like Mothers Against Drunk Driving.

"What I am most excited about is

accomplishing things at the state level," said Mr. Maatman. Advocates currently is choosing which states will be targeted for legislative efforts, he said.

Such efforts, which would vary from state to state, will include toughening mandatory seat-belt use laws; enacting more stringent laws on drunk driving and driving under the influence of drugs, including reducing the blood alcohol content required for a driver to be legally intoxicated to 0.08% from 0.1%; and enacting mandatory motorcycle helmet laws.

Some insurers fear that any contact with consumer organizations could be used against them by those

groups and have declined to participate in the Advocates campaign, Mr. Maatman noted.

"The basic concern is, 'you can't trust consumer advocates,'" agreed the AIA's Mr. Vagley. "But nobody's letting their guard down. We're always cautious, but I'm not worried we're letting our guard down," he said.

Both Mr. Vagley and Mr. Nutter said members of their associations support Advocates.

However, the National Assn. of Independent Insurers in Des Plaines, Ill., has not joined the effort. Lowell R. Beck, president of NAII said that while his organization's board has nothing against Advocates and

wishes its supporters nothing but the best, NAII members feel that they will accomplish more by working independently of the organization on local, rather than national, projects (IT, Jan. 15).

Although the entire insurance industry may not be ready to work with Advocates, Kemper's Mr. Maatman said that within a year or so "the proof will be in the pudding" that insurers can work with national consumer groups without being cast in a negative light.

"We're going to have to show by example," he said.

"Just because they're critics doesn't mean you shouldn't work with them," Mr. Nutter added. ■



Insurer Topics

# III's new campaigns mark 'change in direction': Moore

By MARK A. HOFMANN

NEW YORK—Video news releases sent to television stations nationwide and regional consumer education efforts with agents and consumer groups will highlight the Insurance Information Institute communications efforts in 1990.

The consumer campaign represents a "a change of tactical direction" after lower-than-expected contributions forced the property/casualty trade group to drastically scale back a national public relations program, noted III President Mechlin D. Moore (BI, Jan 15).

An integral part of the new approach is the video news release, which is designed to use television to get industry positions to the public. The releases will contain the same type of consumer-oriented information the III provides to newspapers and magazines in press releases, Mr. Moore explained.

The video releases reflect the group's mission "to improve public understanding of property/casualty insurance," he said.

Mr. Moore praises the video news service as one of the III's greatest achievements.

"It's the most effective way we have devised yet to meet the needs of television stations across the country for accurate and up-to-date information on the insurance industry's viewpoint. It will certainly enable us to reach a much wider audience," he said.

From the III's Washington, D.C., offices, the video news bureau began operations last March with the production of a videotape of the National Conference on Automobile Insurance Issues. The video facility will make film clips available to television stations, in addition to the formal releases, he said.

Its first video release featured a debate between consumer advocate Ralph Nader and Robert W. Pike, senior vp, secretary and general counsel of Northbrook, Ill.-based Allstate Insurance Co.

Others promoted the insurance industry's response to Hurricane Hugo and the California earthquake.

These tapes appeared on television in Tampa, Fla., the Raleigh/Durham, N.C., metropolitan area and Charlotte, N.C., which sustained hundreds of millions of dollars of damage as a result of Hurricane Hugo.

The bureau produced about a half-dozen formal video releases last year, and Mr. Moore expects 10 to 12 in 1990.

III releases were run by about 40 local stations last year, he said. Rejected by stations in the largest markets, like New York and Chicago, at least one release was aired in Detroit, Milwaukee, Buffalo, N.Y., and Greensboro, N.C.

Mr. Moore rejects the common criticism that an entertainment orientation makes all video news releases less credible than their more news-oriented print counterparts.

"If our press releases have credi-

bility and are used widely, why shouldn't our video press releases be the same thing?" he asked.

Institute representatives also will visit newspaper editorial boards this year.

Much of the III's consumer relations effort will be targeted by regions this year.

One example: a Richmond, Va., pilot project aimed at helping consumers understand auto insurance costs.

An III task force—including the Consumer Federation of America, the National Assn. for the Advancement of Colored People and other groups—joined local agents and insurers to provide consumer tips, such as increasing deductibles, that could lower auto insurance costs.

It was, he said, "quite a comprehensive program. The most promising aspect was it was a joint effort with local consumer organizations."

Mr. Moore says "a version" will likely be implemented in other communities in 1990, but stresses that other programs will not be modeled exactly after the Richmond pilot. Instead, the III hopes to work with local groups depending upon conditions of specific areas, he said.

III's advertising also will be highly targeted this year.

"We've decided to target our efforts to key states"—including Arizona, Colorado, Georgia, Pennsylvania and Texas—where insurers believe personal auto insurance will be high on the legislative agenda, he said.

Unlike the 1989 campaign, this year's effort will not include television, but probably will be "primarily print with the probability of some radio," Mr. Moore said.

The institute also has thrown its limited resources behind the National Insurance Consumer Helpline, a toll-free telephone service fielding general insurance questions (IT, Jan. 15).

"I see the Helpline as a major priority for 1990," Mr. Moore said.

The helpline will replace the institute's own consumer hot line, which is being phased out over about a year.

Because the III also informs industry figures about social trends that could affect insurance, the institute maintains an electronic research data base and issues periodic executive news letters for the use of insurers, Mr. Moore said.

"We want to tell the outside world about the insurance industry and tell the insurance industry about the outside world," Mr. Moore said.

The institute, founded in 1959, is supported by property/casualty insurance companies.

In addition to its New York and Washington offices, the III and its affiliated Western Insurance Information Service have offices in Atlanta; Austin, Texas; Beaverton, Ore.; Boston; Chicago; Denver; Overland Park, Kan.; Seattle; and Tustin, Calif.

The Insurance Information Institute is located at 110 William St., New York, N.Y. 10038; 212-669-9200.

## AIA's mission

Continued from page 68B  
AIA's most significant achievements of recent years, he said.

Those six chief areas of concern aside, "heaven knows we'll have our share of firefights," he said.

The AIA's members write about \$56 billion in annual premiums, or about 28% of total U.S. property/casualty premium volume. Much of its members' business is concentrated in commercial lines.

# Health insurer group to continue fighting mandated benefits

By MARK A. HOFMANN

WASHINGTON—The Health Insurance Assn. of America is pursuing its mission to its members by fighting state-imposed benefit mandates.

At the same time, the HIAA is confronting the problems of long-term care, preserving a market for managed care products and attempting to tackle the problems posed by Americans without health insurance.

The association also works with other trade groups on matters of joint interest, notably the National Insurance Consumer Helpline, which is "exceeding our forecasts of use," said Carl J. Schramm, president of the Washington, D.C.-based trade group.

Last year's efforts to block new benefit mandates in Georgia, Mississippi and Nebraska were "very successful," Mr. Schramm boasted.

The association argues that state-mandated benefit laws, which require health insurance policies to cover specific types of treatment, like mental health care, force up the price of health insurance and add to the ranks of the uninsured because small employers often drop their plans when forced to offer expensive mandated benefits.

On the other hand, larger employers that self-fund their health care plans are exempt from such state mandates under U.S. law.

Meanwhile, as the debate increases over how to assure that all Americans have access to the health care system, the HIAA is continuing its efforts to develop what Mr. Schramm calls a "pro-active" position on the problems of the uninsured.

The association wants:

- All citizens below the federal poverty line to be covered by Medicaid. Today, only about 40% of those below the poverty line are covered by Medicaid, compared with about 70% in the late 1970s. The American Medical Assn., American Hospital Assn. and various consumer groups support the HIAA's position.

- Insurers to be permitted to sell no frills health insurance policies without state-mandated benefits, which would allow more people to afford health insurance.

- All states to adopt high-risk insurance pools for the medically uninsurable and to reform regulation of small-group insurance.

The reforms for coverage provided to small businesses the group seeks include, among other things: that employers with fewer than 25 employees purchasing health insurance will not be denied coverage even if one or more of the employees might otherwise be uninsurable; that neither the group nor an individual in the group may be denied coverage because the group's or individual's health deteriorates; and assure that no single group would pay more than 150% of the average cost of similar groups for basic group health coverage.

- Small employers that are not incorporated to be able to deduct 100% of their health care premiums, the same deduction to which large employers currently are entitled.

The association also has testified before the Pepper Commission, named after late Florida Rep. Claude Pepper and chaired by Sen. John D. Rockefeller IV, D-W.Va., which is investigating how to provide access to health care for all Americans and examining the problems of long-term care. A report is expected this spring.

The HIAA also has provided information to the Quadrennial Council on Social Security, which is considering the future of the Medicare system and is expected to issue its recommendations sometime in 1990.

The HIAA, along with the American Council of Life Insurance, the Insurance Information Institute and several other property/casualty insurance trade groups, have banded together to sponsor the National Insurance Consumer Helpline, a toll-free telephone service that answers questions and takes complaints about all types of insurance.

Mr. Schramm could not say how many calls the service received in its first month, only that response has exceeded expectations. Health care was the single largest area of interest with the most common question being "How do I get health insurance?"

The HIAA was founded in 1956 "to represent member companies that write health, accident and disability insurance before Congress and the state legislatures, and before the executive branches and regulatory agencies on matters of policy, legislation and regulation," Mr. Schramm said.

Its 350 member companies vary greatly in size and write an estimated 85% of the total U.S. commercial health insurance premium volume.

The association employs 130 workers at offices in New York, Chicago and Los Angeles and its Washington, D.C., headquarters.

Mr. Schramm joined the HIAA in 1987 after serving as director of the Johns Hopkins Center for Hospital Finance and Management in Baltimore.

The Health Insurance Assn. of America is located at 1025 Connecticut Ave. N.W., Suite 1200, Washington, D.C., 20036; 202-223-7780.



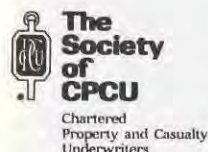
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# Despite setbacks, ISO looks to retain role

By MARK A. HOFMANN

NEW YORK—The Insurance Services Office Inc. will continue to play a significant role in the property/casualty insurance industry, despite undergoing major changes in the past year, says ISO President Fred R. Marcon.

"If the ground opened up and swallowed ISO," another organization would be formed within a few weeks to provide the same sorts of products and services, he said.

"If we didn't do it, each individual insurer would have to do it. This information allows them to make better decisions," Mr. Marcon said.

"ISO is in the business to provide information—information that will aid insurers. There is nothing magical in what we do," said the head of the New York-based group.

But, there have been significant changes in those information services and in ISO's makeup in the past year.

With an eye toward dampening congressional enthusiasm for altering insurers' federal antitrust exemptions, ISO announced last spring that it no longer would provide fully developed advisory rates beginning this year and instead issue advisory prospective loss costs from which insurers will develop their own final rates (*BI*, April 10, 1989).

Advisory prospective loss costs are estimates of insurers' future loss payments, including costs such as claims handling and legal defense. Advisory rates include prospective loss costs and provisions for insurers' marketing and overhead expenses, and underwriting profit and contingencies.

"ISO has been evolving over time. It is a step in our continuing evolution, but this is a major step," Mr. Marcon said.

Other changes at ISO include:

- Opening the ISO board up to non-industry members. Christopher DeMuth, president of the American Enterprise Institute for Public Policy, became the organization's first public board member in January.

- Turning all decision-making authority concerning ISO advisory data over to ISO staff members to quell any charges of insurer control of the process. "There is no insurer involvement in that process" now, Mr. Marcon said.

"I personally take a great deal of pride" in the transfer of responsibilities, he said.

- Trimming its number of insurer committees and putting ISO staff members in charge of the surviving committees.

Mr. Marcon also asserted that ISO helps consumers because "the information ISO provides through its economies of scale" lead to lower-cost products.

Its impact on insurer-consumer relations aside, ISO is not a lobbying organization, Mr. Marcon said.

"Advocacy and legislative change is not its bag," he said.

ISO says it tries to remain neutral but was dragged into the political arena two years ago when it was named as a defendant in an antitrust suit brought by a group of state attorneys general (*BI*, March 28, 1988).

A federal judge in San Francisco dismissed the suit last year (*BI*, Sept. 25, 1989).

However, insurers "didn't win," Mr. Marcon says, and "we will continue to be involved in a protracted lawsuit." The attorneys general are appealing the dismissal and a similar suit against many of the same defendants filed by the Texas attorney general in state court is still active (*BI*, Oct. 30, 1989).

"I believe it's sad when the judicial process can be manipulated" for political reasons, Mr. Marcon said.

Defendants claim the actions were

brought to further political careers of prosecutors, a charge which prosecutors deny.

Repeating his assessment of the situation at the annual Joint Industry Conference sponsored by ISO, the Insurance Information Institute and the American Insurance Assn. last month, Mr. Marcon called the suits "extraordinarily expensive and wasteful" (*BI*, Jan. 15).

He predicts that ISO will perse-

vere. "Our biggest challenge is to be masters of our own destiny."

About 1,500 insurers use at least one of ISO's products, which include rating information, recommended policy language and model policy forms.

The organization does not provide workers compensation insurance, life or health insurance-related services.

Any U.S. property/casualty insurer can participate in ISO. ISO partici-

pants write roughly 80% of the nation's total commercial property/casualty premium and about 35% of U.S. personal lines property/casualty insurance premium.

Members write commercial liability insurance more than any other line, followed by commercial property insurance.

The organization has seven field offices and is funded by the fees insurers pay for services and products

as well insurer assessments.

But ISO's staff of 2,700 is less than half of the 5,700 it had when the organization was formed by the 1970 consolidation of several rating and statistical organizations.

Mr. Marcon does not expect further staff reductions.

*The Insurance Services Office, Inc., is located at 175 Water St., New York, NY 10038; 212-487-5000.*

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- Faculty, Albany Medical College

# NAII to continue to focus on state issues

By MARK A. HOFMANN

DES PLAINES, Ill.—The National Assn. of Independent Insurers will continue to build coalitions with citizens' groups on the state level, rather than joining with national consumer groups to form broad-based campaigns.

Among the group's top priorities in 1990 are promoting member interests in statehouses and fighting to preserve state regulation of insurance.

These goals were overshadowed last year after a bitter controversy surrounding statements made by a former NAII official.

The group's senior vp and general counsel, John B. Crosby, re-

signed last October amid a barrage of criticism over his publicly likening some consumer activists to Adolf Hitler (*BI*, Oct. 2, 1989).

Those statements—"which did not represent good judgment"—were quickly disavowed and cost the association no members, says NAII President Lowell R. Beck.

Having put that controversy behind it, the NAII is now again stressing its lobbying efforts, he said.

The association last year lobbied and testified before state legislators to block the introduction of what it calls punitive, Proposition 103-like laws.

"Many critics were talking about a Proposition 103 tidal wave

sweeping the country," Mr. Beck said. "But I don't think the industry did panic. It didn't fall in and give in to unreasonable proposals around the country."

Mr. Beck admits the trade group lost some battles. For example, Maryland banned competitive rating and Nevada and South Carolina ordered rate rollbacks for personal automobile insurance.

But given the gloomy outlook in early 1989, "I consider it an ac-

complishment that the insurance industry came through that year still intact," he said.

Mr. Beck stressed that the NAII prefers to work with local or state groups on matters of public policy rather than with national consumer organizations.

That position was reflected in its decision not to merge with the Alliance of American last year (*BI*, May 1, 1989).

In addition, the association decided not to join either the Advocates for Highway and Auto Safety, a recently formed consumer/insurer coalition (see story, page 68A), or the National Insurance Consumer Helpline, a telephone hot line sponsored by prop-

erty/casualty, life and health insurers.

While Mr. Beck praises both groups' efforts, he points out that retaining the NAII's local orientation is in its members' best interests (*IT*, Jan. 15).

In addition to working with local consumer groups on no-fault insurance and other issues, the NAII has also worked with local business and ethnic organizations on topics like mandatory seat belt laws and the availability of insurance in the inner cities, said Mr. Beck.

"We want to put out money, our effort and our time with those people in the states where we can make a difference," he said, citing California, Arizona and Pennsylvania as states in which auto insurance is a particularly hot topic.

That grassroots approach also is reflected in the association's "Step-by-Step Policyholder Communications Program," a year-old program that provides members with monthly packets of camera-ready printed materials on safety and insurance industry issues (*IT*, Dec. 12, 1988).

Member companies use the materials as they see fit—reprinting them verbatim, excerpting them in company newsletters or magazines, excerpting material for premium stuffers or using them as the basis for local newspaper op-ed pieces, he said.

The NAII's 560 member companies reported a premium volume for of \$43.8 billion in 1988, the last year for which figures are available, or about 23% of the U.S.



Mr. Beck

*April*

## Compensation & Incentives

Agency principals are becoming innovative when it comes to luring new producers to their firms as well as for retaining their current employees. *BI* will review these innovations, look at compensation and the employee benefits most often offered to producers.

Issue: April 2  
Ad Closing: March 20

*May*

## Advertising/Sales Promotion IMS Conference Report

What strategies are used by successful agencies to promote their firms? Returning from the recent Insurance Marketing Services Conference, *BI* will report on how agents can improve their marketing and advertising efforts to generate more business.

Issue: May 7  
Ad Closing: April 24

*June*

## Niche Marketing

Want to increase your business? You've got to find that niche that sets you apart from your competition. *BI* will look at how niche marketing works for agents and brokers, how they can specialize by type of coverage they offer as well as by targeting their clients demographically or by nature of business.

Issue: June 4  
Ad Closing: May 22

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*Agent/Broker Topics*

**In 1989, insurers  
didn't 'give in to  
unreasonable  
proposals,' says  
Lowell R. Beck.**

property/casualty insurance industry's total volume. Members—ranging in size from Allstate Insurance Co., the nation's second-largest property/casualty insurer, to small regional and specialty companies—write 15% of the commercial premium volume and 32% of the personal lines market, including 35% of personal auto premium volume.

"We are a culture that has just about everything," said Mr. Beck.

Some NAII members write only commercial insurance while others stress personal lines. Some rely on independent agents for distribution while others are direct writers.

Membership is open to both stock and mutual property/casualty insurers. The association was founded in 1945 with 39 members to represent companies that were independent of rating bureaus.

The NAII now has a staff of 168, including employees of its Independent Statistical Service subsidiary. In addition to its headquarters in Des Plaines, Ill., the NAII operates a federal affairs office in Washington, D.C., and regional offices in Atlanta, Annapolis, Md., and Sacramento, Calif.

Before joining the NAII, Mr. Beck was an official with the American Bar Assn. and Common Cause, a Washington, D.C.-based citizen action group.

The National Assn. of Independent Insurers is located at 2600 River Road, Des Plaines, Ill. 60018; 708-297-7800.

# 95-year-old NAMIC picks up the pace

By MARK A. HOFMANN

INDIANAPOLIS—Although more insurance companies belong to the National Assn. of Mutual Insurance Companies than to the other major industry groups, 95-year-old NAMIC has maintained a relatively low profile in recent years.

But passage of Proposition 103 in California, legislative assaults on the McCarran-Ferguson Act and other disruptions of the property/casualty insurance industry have propelled the Indianapolis-based group and its members into "taking a much more active role in industry affairs," said President Larry Forrester.

"The industry has changed significantly and our members don't have much choice other than to take an active role," he explained.

This new activism is manifested in the creation of the Insurance Education Foundation (*IT*, Aug. 23, 1989) and a greater emphasis on intra-industry cooperative efforts such as the collection of money for victims of Hurricane Hugo and the California earthquake, said Mr. Forrester.

One reason NAMIC often has been overshadowed by other property/casualty insurance associations is the nature of its membership: Although such giants as Bloomington, Ill.-based State Farm Mutual Insurance Co. belong to the group, the bulk of NAMIC's 1,285 members are small or mid-sized companies. In fact, 800 members are farm mutuals, some of which write coverage in very small territories, Mr. Forrester

pointed out.

Although most members tend to underwrite personal lines insurance, some target Main Street commercial accounts, while others handle large commercial accounts, he said. NAMIC members wrote \$52 billion in property/casualty premiums last year, or more than a quarter of the total U.S. property/casualty volume.

However, Mr. Forrester pointed out that "there's a fairly significant overlap" in the membership between NAMIC and the National Assn. of Independent Insurers and the Alliance of American Insurers.

Initially founded for mutual companies, NAMIC changed its bylaws in the early 1970s to extend membership to stock companies. "It makes for a unique blend," Mr. Forrester said.

Even with the overlap, the association has a definite role to play, especially for smaller companies, he said. "There's a tremendous number of companies that aren't represented in the other associations."

NAMIC itself maintains only its Indianapolis office, but related insurance associations in more than 30 states lobby local and state officials, said Mr. Forrester. The 50 staffers at NAMIC headquarters provide member services such as technical seminars, educational materials, and legislative and regulatory background materials for member companies.

Education has received a great deal of attention from the association in recent months, most notably through the Insurance Education Foundation, he said. Creation of the foundation stemmed from the concerns of former NAMIC Chairman James L.

Osborne, who also is chairman of Oregon Mutual Insurance Co. in McMinnville, Ore.

Even before the November 1988 passage of Proposition 103, Mr. Osborne stressed that the industry's image was so poor that insurers could not afford to simply let it continue to deteriorate, Mr. Forrester said.

To help improve the industry's image, the foundation's education efforts are focused on high school students, whose first brush with the insurance industry usually comes along with their driver's licenses. That initial relationship, which generally involves high automobile insurance premiums, is not a pleasant one, Mr. Forrester

pointed out.

The "Choice-Chance-Control" program designed by the NAMIC task force on public relations and

**Members are 'taking a much more active role in industry affairs,' says Larry Forrester.**

education teaches students about the nature of risk, Mr. Forrester said. NAMIC members, which purchase the kits for distribution in

schools, handed out more than 2,800 last year, he said.

The association's commitment to education extends to its members, as well. Last year, more than 1,200 people attended NAMIC technical seminars on "all aspects of insurance company management," including loss control, underwriting and accounting, according to Mr. Forrester.

The organization also has acted as a clearinghouse for property/casualty companies' relief efforts in the wake of Hurricane Hugo and the October California earthquake, Mr. Forrester said. NAMIC recently presented checks for \$26,000 to the Greater Charleston (S.C.) Relief Fund and for more

than \$10,000 to the American Red Cross for California relief, he said.

NAMIC membership is open to all property/casualty insurance companies. Dues, which range from \$315 to \$3,500, are determined by a company's net written premiums.

NAMIC was founded by farm mutual companies in 1895. Mr. Forrester, who holds a degree in industrial management from Purdue University, has been with NAMIC since 1970.

The National Assn. of Mutual Insurance Companies is located at 3707 Woodview Trace, P.O. Box 68700, Indianapolis, Ind. 46268; 317-875-5250.

## Excellence



Mr. Forrester



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# RAA seeking common ground with insurers

By MARK A. HOFMANN

WASHINGTON—Created after a disagreement with primary insurers over a proposed federal riot reinsurance program more than 20 years ago, the Reinsurance Assn. of America, ironically, now cooperates more closely with primary insurers than with any other trade groups, says its president.

While the relationship was initially sticky, reinsurers and primary insurers now cooperate more than ever, said Andre Maisonpierre, president of the Washington, D.C.-based trade group.

The RAA "doesn't do anything with other reinsurance groups," but cooperates with primary insurance trade associations with "common regulatory and legislative" concerns, said Mr. Maisonpierre, who joined the group in 1984 after more than two decades as an official with the Alliance of American Insurers.

As an example, he cites reinsurers' work with the property/casualty insurance industry's Earthquake Project, a proposal under which the federal government would reinsure earthquake coverage written by private insurers.

Ironically, the RAA's genesis was in another proposed federal reinsurance project. In 1969, reinsurers feared increasing federal regulation and formed a lobbying group to block a proposed federal riot reinsurance act supported by some primary insurers, Mr. Maisonpierre said.

Although the RAA's chief function today is representing "its members before state and federal regulatory and legislative bodies," Mr. Maisonpierre says the job involves more than just lobbying. It also involves clearing up a lingering case of mistaken identity, he said.

To many regulators and lawmakers "reinsurance and insurance is one and the same," said Mr. Maisonpierre, adding that "we have really gone out of our way to meet with state regulators and their staffs" to increase awareness of the reinsurance industry.

Representing the interests of 31 RAA members means working closely with the National Assn. of Insurance Commissioners, Mr.

**The RAA 'doesn't do anything with other reinsurance groups,' but cooperates with primary insurance trade associations with 'common regulatory and legislative' concerns, says Mr. Maisonpierre.**

Maisonpierre noted.

The RAA recently has tried to "clean up annual statements" to identify reinsurers who "make a practice of being late" in paying ceding companies' claims, he said.

Under a new rule approved by the NAIC that applies to insurers' 1989 annual statements, insurers with undisputed reinsurance balances that are 90 or more days overdue will be hit with a penalty to be assessed against their surplus (BI, Nov. 6, 1989).

"We think this will bring about some real discipline," Mr. Maisonpierre said.

To be eligible for RAA membership, a company must:

- Be a professional reinsurer. While some RAA members write direct insurance, reinsurance represents at least 90% of the business of most members, Mr. Maisonpierre said.

- Be domiciled in the United States. Foreign-owned companies can join the association, but reinsurers owned by foreign governments are ineligible.

- Maintain minimum capital and surplus of \$75 million.
- Be licensed in California, New York and at least 23 other states.

- Maintain at least a B rating from A.M. Best Co.

Among the nation's largest reinsurers, only Kemper Reinsurance Co. is not an RAA member.

U.S. reinsurers write about 75% of the reinsurance purchased by U.S. ceding companies, and RAA members write at least 80% of that amount, said Mr. Maisonpierre.

One major RAA aim is what it calls providing a level playing field for U.S. reinsurers, he said. The trade association lobbies Congress to change tax treaties exempting some foreign reinsurers—including French, Italian and British companies—from federal excise taxes. And the RAA advocates raising the current 1% excise tax on premiums paid to most foreign reinsurers to 4%.

The RAA achieved a major victory last year when a federal judge dismissed massive antitrust litigation filed by 19 state attorneys general against insurance industry defendants, including the RAA (BI, Sept. 25, 1988). However, the RAA remains a defendant in a similar antitrust suit filed by the Texas attorney general in a state court. That suit still is pending.

Mr. Maisonpierre plans to retire as the RAA's president within the next few months. He will be succeeded by Jack Blaine, who is now executive vp.

The RAA has six professional staffers in its Washington, D.C., office.

The Reinsurance Assn. of America is located at 1819 L St. N.W., Washington, D.C., 20036; 202-293-3335

# 6% believe padding claims is OK

By MARK A. HOFMANN

OAK BROOK, Ill.—A small but rapidly increasing portion of the general public believes that padding an insurance claim to cover the cost of the premiums they pay is "all right," according to a recently released study conducted by the All-Industry Research Advisory Council.

And, a growing number of Americans also think that the incidence of false claims for several types of coverage, including personal automobile and health insurance, is "very common," according to the Oak Brook, Ill.-based group's "Public Attitude Monitor 1989."

The percentage of respondents who think that false claims are "rare" for those types of insurance has been dropping steadily since the question was first included in the AIRAC's public opinion survey in 1978, the survey's authors note.

The survey also examined consumers' feelings about the impact of attorneys' advertising on litigation and insurance costs.

The report found that 6% of 1,484 respondents "strongly agreed" that padding insurance claims to recover premiums already paid was acceptable, up significantly from 2% of respondents in 1983 and 1% in 1981.

Twenty-two percent of the respondents to last year's survey "strongly disagree" with the practice, unchanged from 1983, but down slightly from 27% in 1981.

In addition to gauging the acceptability of padding claims, the survey asked respondents to indicate in which of seven lines of insurance they thought false claims were most prevalent:

- 42% thought that false automobile claims were "very common" in 1989, up from 39% in 1983.
- 35% thought false malpractice claims were very common last year, nearly double the 18% of respondents in 1983.
- 29% thought false workers compensation claims were

very common in 1989, up from 24% six years earlier.

- 25% thought false disability claims were very common, down from 28% in 1983.
- 24% thought false fire insurance claims were "very common," down from 31% in 1983.
- 19% thought false claims for health insurance were very common, up from 15% in 1983.
- 17% thought false homeowners claims were very common, up from 16% in 1983.

In addition, AIRAC found that most consumers who have seen advertising by lawyers think such advertising is increasing the number of lawsuits and the cost of automobile insurance. According to the report, 72% of the respondents had seen or heard attorney advertisements, while 25% had not and 4% weren't sure.

Of those who had seen or heard advertisements, 41% said they were more likely to consult an attorney if they were injured in an auto accident than if they had not been exposed to the ads; 18% said they were less likely to consult an attorney; and the remainder said the ads either made no difference or could not answer.

Of those who had seen attorneys' advertisement, 73% thought that such advertising had increased the number of liability claims and lawsuits; 17% reported that the ads had no effect; 9% either did not know or did not answer; and only 1% thought the ads led to a reduction in claims and lawsuits.

In addition, 64% of the respondents familiar with the ads said that attorney advertising had increased the cost of automobile insurance; 23% said the advertising had no effect; only 1% thought the ads had cut the cost of coverage; and the remainder did not know or did not answer.

Single copies of "Public Attitude Monitor 1989" are available at no charge from the All-Industry Research Advisory Council, 1200 Harger Road, Suite 310, Oak Brook, Ill. 60521; 708-572-1177. Additional copies are \$4 postpaid.



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## Business Insurance

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# Companies revamp retiree health plans to hold down costs

By MICHAEL SCHACHNER

Strapped with mounting retiree health care costs and facing stringent accounting proposals, many employers are revamping their post-retirement medical plans to make them more cost-effective.

Some employers are asking retirees to shoulder a greater share of their health care expenditures, while others are teaching their retirees to become better health care consumers.

And, a few companies are dropping their retiree health care plans entirely.

Unfortunately, the method that has worked best for trimming active employees' health care costs—managed care—is not widely used for retiree plans, mainly because it is hard to integrate managed care programs with Medicare, benefits experts say.

Employers with retiree health care plans are being hit with the double-edged sword of skyrocketing health care costs and proposed accounting rules promulgated by the Financial Accounting Standards Board, benefits experts point out.

And, employers' hopes for some relief from growing retiree health care costs were dashed with last year's repeal of the 1988 Medicare Catastrophic Act, which would have significantly expanded Medicare benefits. To the extent that Medicare would have paid more, employer plans that were coordinated with Medicare would have automatically paid less (*BI*, Nov. 27, 1989).

Under the FASB proposals, which could take effect as early as Dec. 15, 1991, employers will be forced to abandon their current "pay-as-you-go" accounting practices and accrue as an expense against corporate earnings all retiree health care liabilities from the date an employee is hired until the employee is eligible for post-employment health care coverage (*BI*, Feb. 20, 1989).

Some employers can expect the new FASB proposals to trim their pretax profits by 20% or more, according to recent studies (*BI*, Dec. 4, 1989; June 19, 1989).

"There's a growing awareness that the total amount reflecting post-retirement benefits that companies will have to put on financial statements is a big number," said Patricia Wilson, a principal in the Philadelphia office of benefit consultant A. Foster Higgins & Co. Inc.

"To a large extent, today's focus is being shifted from current costs to FASB and the future," said Bill Danish, a consultant with Fort Lee, N.J.-based Kwasha Lipton.

"FASB is bad news for retirees" because it will force employers to curtail retiree medical coverage, according to Steve Ferruggia, director of Buck Consultants Inc.'s group actuarial practice in Secaucus, N.J.

"Benefit managers have commonly examined every nickel and dime spent on active employees, but retirees have sort of been treated like water under the bridge," he added.

Bud Martinez, employee benefits manager for Security Pacific Corp., a Los Angeles-based bank holding company, agreed: "By and large, with a few exceptions, employers have been more concerned with their largest group of employees, which would be actives. But now, they're looking at retirees as consumers and as an expense."

Most employers are turning to cost shifting in their battle with growing retiree health care costs, consultants say.

"They can reduce the overall benefit level, reduce the lifetime maximum a retiree can receive, reduce the cost of the provider by looking into

managed care or offer less benefits to retirees with fewer years of service prior to retirement," said Mr. Ferruggia. "Employees must simply make retirees pay more of the total cost."

"Cost shifting is going on, especially among smaller companies," observed David Brenneman, vp and chairman of the health and welfare practice committee of East Orange, N.J.-based Noble Lowndes, an international employee benefits consultant. "We are seeing the disappearance of first-dollar medical coverage" for retirees, he added.

Kwasha Lipton's Mr. Danish  
*Continued on next page*

1989/1990

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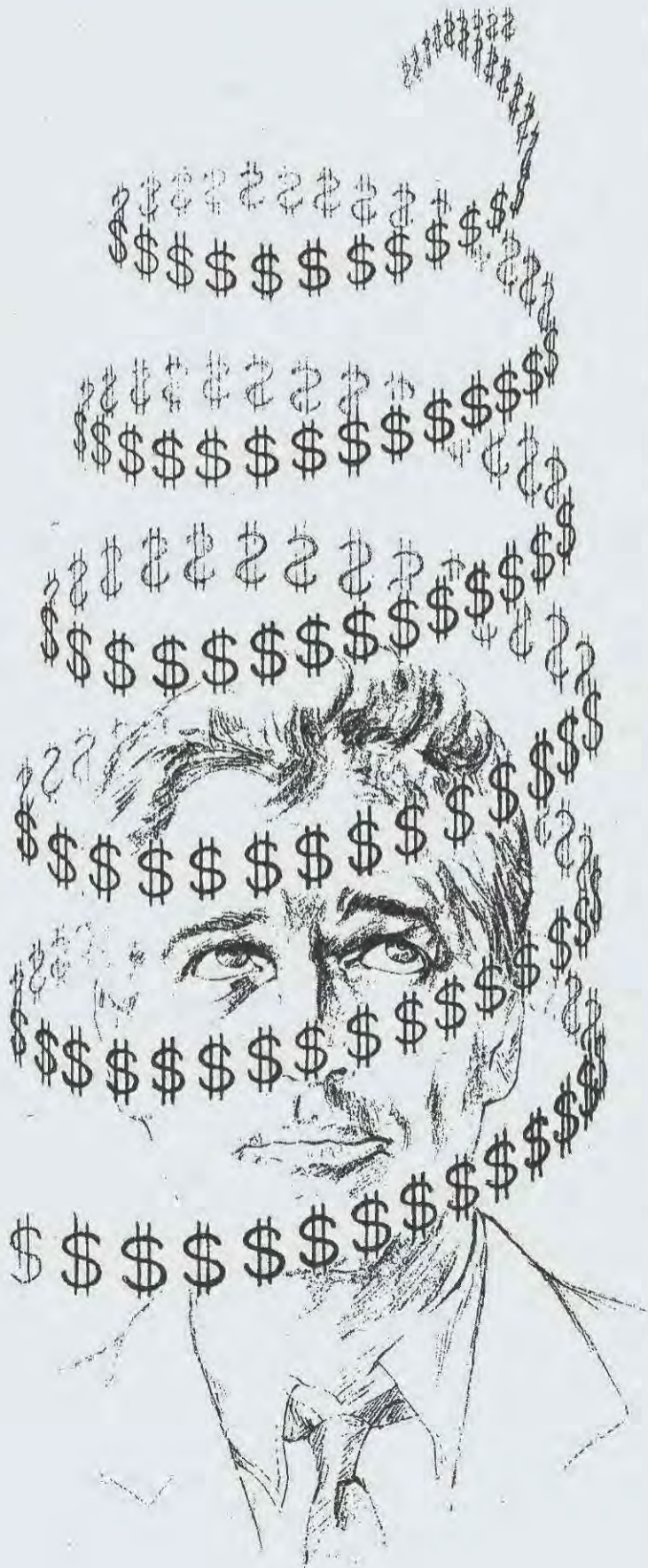
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*Continued on next page*

## Retiree benefits

Continued from previous page  
agreed: "Employers are mostly changing the level of benefits they offer by increasing coinsurance and deductibles. Employers are also seeking more contributions from (retirees), especially for spousal coverage."

"We're seeing your traditional plan tinkering," said Gary Laugharn, a consultant with Hewitt Associates in Lincolnshire, Ill. "Employers are instituting higher out-of-pocket maximums and raising the amount retirees must contribute."

New York-based ITT Corp. increased retiree contributions to its post-retirement health care plan last year when it redesigned its medical plan for 25,000 active employees and 4,700 retirees, said Anne Celfo Silverman, employee benefits manager.

Ms. Silverman explained that ITT requires that retirees with 10 years of service pay 50% of the premium under ITT's self-insured retiree health care plan. She said employees contribute 2% less for each additional year of service, up to a maximum of 25 years, after which the retiree pays 20% of the premium no matter how long they have been with ITT.

Retirees with fewer than 10 years of experience are not eligible for retiree health care benefits.

Prior to the plan change, eligible retirees contributed a flat \$10 per month for individual coverage and between \$18 and \$40 per month for family coverage.

"We felt a service-related formula was a more equitable approach to providing retirement medical benefits," Ms. Silverman explained.

In addition to raising premium contributions, ITT now requires retirees to pay 10% of hospitalization costs up to an out-of-pocket maximum of \$1,200 for single retirees and \$2,400 for retirees with families.

Previously, hospitalization had been paid in full, with out-of-pocket major medical expenses capped at \$1,000 for individuals. There was no expense cap for families.

Retired employees continue to pay a \$200 individual/\$400 family de-

ductible for major medical coverage.

Ms. Silverman estimated the plan design change will reduce the company's FASB liability by 24%.

In an effort to cushion the blow of cost-shifting to retirees and to give employers further control over costs, some employers are instituting post-retirement flexible benefit plans, which give retirees more benefit options.

Security Pacific Corp. began offering its retirees a flexible benefit program in 1989 to better manage potential FASB liabilities, explained Mr. Martinez.

Tom Grass, a consultant in the Los Angeles office of The Wyatt Co., who helped design Security Pacific's retiree flex plan, explained the plan "helps from a FASB standpoint because future retirees will receive a set number of credits, depending on their years of service. Thus, FASB liabilities are at least capped."

In addition, the flex plan enables Security Pacific to increase retiree deductibles and require retiree co-payments for the first time.

"The last two to three years health care costs were rising by 18% to 20% per year, which is a little higher than current trends. And, without Medicare for retirees, it would have been worse," Mr. Martinez said, explaining the need for the flex plan.

Prior to the introduction of the flex plan, retirees paid a \$100 per person deductible for medical care, with all expenses above the deductible paid by Security Pacific.

However, under the flex program retirees can choose from four deductible levels: \$100; \$250; \$450; and \$1,050. Retirees who select any deductible other than the \$100 level receive subsidized long-term care coverage at a cost as low as \$15 per month, depending on age. In addition, a retiree also can receive subsidized long-term care benefits if he enrolls in an HMO option or opts out of medical coverage, Mr. Grass said.

Also, under the new plan, employees who retire after Jan. 1, 1991, will be required to pay 20% of medical costs above their selected deductible, he said.

The flex plan gives retirees enough

credits to purchase the same life insurance benefit they had prior to the implementation of new program. Employees can select a lower life insurance benefit and receive additional credits, though they are not allowed to increase their life insurance benefit.

Mr. Grass said the flex plan also contains brand new vision and dental benefits that, if selected by the retiree, are paid in full by the retiree.

In addition, any non-used credits can be converted to cash, which is placed in a health care savings account to pay for expenses, like deductibles, that are not covered by the plan.

Many consultants now advocate flexible benefit programs for retirees because they have proved to be a successful cost-containment measure for active employee health care costs.

"They serve precisely the same role as they do for actives. A flexible benefits plan is one way to avoid duplicating coverage provided by a spouse's program," points out Noble Lowndes' Mr. Brenneman. Through flex plans, "retirees can be induced to choose cost-effective options—for example, an HMO that specializes in geriatric medical care, even though those are few at the present time."

Mr. Brenneman also pointed out that in exchange for the flex plan, employers can cap retirees' benefits rather than assuming an open-ended obligation for retiree health care.

Other employers have turned to even more innovative plans to control retiree health care costs.

For instance, at least one employer is asking active employers to pay now for the health care benefits they receive after they retire.

American Airlines Inc. in January began charging more than half of its active employees a monthly fee to prefund their retiree medical benefits (BI, Dec. 5, 1989).

Hewitt's Mr. Laugharn thinks asking employees to pay now for benefits they receive later is one way of teaching workers to appreciate how much their employer spends on health care.

Indeed, educating both active employees and retirees about the cost of

their benefits makes them more selective about the health care services they seek, pointed out Wyatt's Mr. Grass.

"For long-range savings, I really believe education can make a difference. There's a big problem when an employee racks up a \$1 million medical bill without realizing that there was probably alternative delivery systems that could have been less expensive," he said.

"More progressive firms are educating employees about how medical benefits fit into the whole scheme of things within the corporation. They're trying to teach them to be smart health care consumers," Mr. Grass said.

For some employers, however, the only answer to skyrocketing retiree health care costs has been to avoid offering the benefit entirely.

In fact, a recent survey by the U.S. General Accounting Office found that most employers feel they have the right to modify or terminate retiree health care benefits if the cost becomes unmanageable (BI, Feb. 20, 1989).

And, "some employers are flat-out terminating retiree medical plans for those over age 65," said Kwasha Lip-ton's Mr. Danish. "They choose instead to leave them for Medicare and other individual products. This eliminates the twin hit of FASB and current costs."

But eliminating post-retirement health care benefits for future retirees usually requires a trade-off, consultants point out.

Employers can't simply eliminate post-retirement benefits without offering those who will be affected some sort of a peace offering, usually in the form of additional compensation in other areas, Mr. Danish said.

"They pass it off by offering bigger pension benefits or higher base salaries. Active employees sometimes feel that a retiree medical benefit is a promise in a booklet which isn't as good as something tangible," he said.

While managed care techniques have proved effective in controlling health care costs for active employees, managed care programs are rarely used as a cost-containment

tool in post-retirement plans, consultants say.

For example, many employers don't offer managed care options as "Medigap" policies to retirees who are eligible for Medicare because it's very difficult to integrate managed care program with government-sponsored benefits, Mr. Danish explained.

In addition, while managed care programs tend to focus more on outpatient care and reducing lengths of hospital stays, Medicare is more of a hospitalization insurance program, he said.

"From a secondary payer's standpoint, precertification and other managed care techniques are hard to enforce," Mr. Danish said.

Furthermore, HMOs rarely accept Medicare-eligible retirees because of poor past experience, he said.

HMOs traditionally charge employers or individual retirees any amount remaining after receiving reimbursement from Medicare. However, when retirees realized that for a small amount extra they could receive a much wider array of health care services through HMOs than through Medicare, they abandoned Medicare.

"Retirees found that they could bail out of Medicare and get better benefits, and the HMOs took a bath on this deal," Mr. Danish said.

The flood of older patients requiring more lengthy and intensive services caused HMOs to lose money, he said.

In addition, employers are reticent to enroll retirees in HMOs because they have found out that the portion of the HMO premium they must pay is often more costly than indemnity plan premiums, he said.

Despite the limitations imposed by Medicare, "managed care for retirees is the wave of the not-too-distant future," predicts Noble Lowndes' Mr. Brenneman.

"Managed care organizations will be learning to care for the aged. They're going to school right now on that issue because Baby Boomers will be reaching age 65 in the next century. However, the expertise isn't there today, though it's developing," he said.

## Insider trading

**Alexander & Alexander Services Inc.:** John A. Bogardus Jr., director, disposed of by gift 240 shares of common stock at an unreported price per share on Dec. 8 and now indirectly and directly holds 98,500 shares.

A&A stock was trading at \$26.50 per share on Feb. 9.

**Berkshire Hathaway Inc.:** Malcolm G. Chace, director, indirectly disposed of by gift 105 shares of

common stock at an unreported price per share on Dec. 31 and now directly and indirectly holds 2,266 shares.

Berkshire stock was trading at \$7.650 per share on Feb. 9.

**Hilb, Rogal & Hamilton Co.:** Robert H. Hilb, president, disposed of by gift 800 shares of common stock at an unreported price on Dec. 23 and now directly holds 250,800 shares.

David W. Hamilton, director, disposed of by gift 1,900 shares of com-

mon stock at an unreported price on Dec. 21 and now directly holds 42,830 shares.

Alvin Rogal, vp, disposed of by gift 5,600 shares of common stock at an unreported price on Dec. 11 and now directly holds 217,600 shares.

Hilb, Rogal & Hamilton stock was trading at \$15.13 per share on Feb. 9.

**Marsh & McLennan Cos. Inc.:** Robert Clements, director, disposed of by gift 100 shares of common stock at an unreported price per share on Dec. 11 and now directly and in-

directly holds 42,301 shares.

John M. Regan, director, disposed of by gift 7,800 shares of common stock at an unreported price per share on Dec. 14 and now directly and indirectly holds 164,838 shares.

Adele S. Simmons, director, disposed of by gift 1,111 shares of common stock at an unreported price per share on Nov. 21. Ms. Simmons indirectly acquired by gift 1,111 shares that same day at an unreported price per share and now directly and indirectly holds 160,299 shares.

M&M stock was trading at \$76.38 per share on Feb. 9.

**Poe & Associates Inc.:** William F. Poe, chairman, exercised an option for 33,750 shares of common stock at \$4.68 per share on Jan. 2 and now directly and indirectly holds 1,082,121 shares.

V.C. Jordan, president, disposed of by gift 1,020 shares of common stock at an unreported price on Dec. 19 and now directly holds 183,973 shares.

Poe & Associates stock was trading at \$11.75 per share on Feb. 9.

**SAFECO Corp.:** Roger Eigsti, president, exercised an option for 4,800 shares of common stock at \$14.34 per share on Jan. 2 and now directly holds 25,082 shares.

SAFECO stock was trading at \$37.38 per share on Feb. 9.

**Travelers Corp.:** Ann D. McLaughlin, director, purchased 100 shares of common stock at \$38.25 per share on Dec. 7 and now directly holds 100 shares.

Travelers stock was trading at \$33.00 per share on Feb. 9.

**USF&G Corp.:** Jack Mosely, chairman, disposed of by gift 1,000 shares of common stock at \$29.25 per share on Dec. 27 and now directly holds 19,706 shares.

Paul J. Scheel, officer and director, disposed of by gift 278 shares of common stock at \$29.75 per share on Dec. 15 and now directly holds 33,255 shares.

USF&G stock was trading at \$29 per share on Feb. 9.

Insider Trading, prepared by Invest/Net Group Inc. of Miami from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers.

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# Changes sweep London market: Execs

By CAROLYN ALDRED

LONDON—The London insurance market will change radically in the next few years, leading insurance executives in London agree.

In separate speeches, three senior market executives recently outlined several examples of such changes.

"When we look back in 10 years' time, I wonder whether we will recognize some of the ways we do business now," said Lloyd's of London Chairman Murray Lawrence.

"No one is going to disagree that changes are going to happen," said Dennis Mahoney, chairman and chief executive of Alexander Howden Ltd., in a speech on computer networks used to transact business.

The question is not whether the market is going to change, but how to deal with it, he said.

Despite the market's "frustration, fear and foreboding," computer trading is inevitable, Mr. Mahoney added.

Meanwhile, one of the most tangible signs of change in London is the proposed London Underwriting Centre, which will house up to 100 insurance and reinsurance companies in one building, said Victor Blake, chairman and chief executive of CNA Reinsurance Co. of London Ltd.

"I don't see the LUC as the most important element of all the current initiatives. It is, however, the most eye-catching," he said.

The executives spoke in a series of lectures hosted by the Insurance Institute of London.

A recent controversial decision to eliminate Lloyd's traditional market structure by allowing syndicates to write all types of risks is just one of a series of changes that will allow Lloyd's to participate in a more competitive and turbulent world insurance market, Mr. Lawrence predicted.

"Virtually all aspects of Lloyd's business are being reviewed (to) improve efficiency and cost-effectiveness," he said.

Lifting the barriers that currently divide Lloyd's into four separate markets—non-marine, marine, aviation and motor insurance—has raised concern among Lloyd's underwriters and members who fear the market becoming more competitive and losing its specialist skills (BI, Jan. 8).

However, Lloyd's underwriting associations for each market will remain intact and will have a role in monitoring the business written, Mr. Lawrence said. Members "should be confident in their members' agents and managing agents," he said in response to a question from a "worried" Lloyd's member.

"We should not have restrictive practices in our market," he said.

The new system will be an improvement over the "charade at the moment of somebody being on a marine syndicate which is underwriting one ship," Mr. Lawrence said, referring to the way marine syndicates manage to write non-marine risks by ingeniously classifying them as marine business.

Other future changes in the market will include the way Lloyd's attracts business, he predicted.

"Traditionally brokers had sole right to place business at Lloyd's... on a wholesale role rather than a retail role," Mr. Lawrence said. Formerly there was "very little need by Lloyd's to sell Lloyd's; (this was) done by the broking force."

Now, as brokers have become large, international companies, "the selling role of Lloyd's has to be done more by underwriters and

this must have an effect on the size and depth of the management in managing agents," he said.

Mr. Lawrence predicted that both managing and members' agents will increase in size and decrease in number during the 1990s.

Meanwhile, "the length of the chain (between policyholder and

must continue to thrive since insurance represents a large part of Britain's foreign trade.

"Should the role of London as an insurance center be jeopardized, it would have a material effect on Britain's income" and economy, he said.

However, there are many areas

**The question is not whether the market is going to change, but how to deal with it, says Alexander Howden's Dennis Mahoney. Despite the market's 'frustration, fear and foreboding,' computer trading is inevitable, he adds.**

underwriter) is no longer necessary or conducive to encouraging business into the market," he noted.

Lloyd's underwriters must "get closer to the retail brokers," he said, noting that underwriters already are attempting to generate more business directly from Europe, including U.K. regions outside London.

Increased use of computer networks linking brokers, underwriters and policyholders will undoubtedly reduce the number of people in the chain, pointed out Howden's Mr. Mahoney.

Brokers and underwriters increasingly will have to "add value" to justify their involvement in transactions, he said.

If a broker currently adds only an administrative value, that broker no longer needs to be included, as administrative functions can be done "far more cost-effectively by a machine," he pointed out.

Meanwhile, underwriters should consider rewarding brokers to encourage them to bring new business into the market, said Mr. Mahoney.

A "broker acting in a wholesale role is undervalued. Brokers acting in the traditional area of business are finding it very difficult to make any money," he said.

As a result, brokers "find themselves in the situation where underwriters are demanding that they bring more business into London and the brokers say they can't make money on it," he said.

Meanwhile, "as syndicates get larger, they are more likely to take 100% of the risk, which is contrary to the market as we know it today," said Mr. Mahoney.

CNA Re's Mr. Blake agreed: "Traditional methods of doing business can only survive if they continue to add value and if the cost of the system is affordable."

The creation of the London Underwriting Centre will allow London to maintain some of the traditional face-to-face negotiation between brokers and underwriters in a way the market can afford, he argued.

"We must have a vision of the future and shape the market to that vision," Mr. Blake said.

"Those of us in the various market bodies see a future in which identity, individualism and continuity are still important to our customers. We see the desirability of retaining the face-to-face negotiation between broker and underwriters, but it is in jeopardy if we use it wastefully."

The LUC, due to open in 1992, "is a simple plan in that our aim is to provide a user-friendly building designed to ease the shoe-leather problem of brokers getting around the market," he said.

"This aim is totally compatible with all the other initiatives under way to streamline procedures," he added.

In his speech, Mr. Lawrence noted that the London market

that impact London's viability as a financial center over which the insurance industry has little control, Mr. Lawrence noted.

For example, poor infrastructure in London will continue to handicap companies unless improvements are made, he said.

"The conditions of travel to and from work are horrendous. How long are people going to put up with that," asked Mr. Lawrence. "Government is going to have to take steps in that area."

On a wider front, the European Community should harmonize tax policy and other rules among member nations if European insurers are to compete "on a level playing field," he noted.

And, at home, Lloyd's must continue to encourage its members to invest in the marketplace, Mr. Lawrence said.

"In the last two to three years, a lot of publicity has been given to the numbers of names resigning," Mr. Lawrence said, explaining that 4,000 Lloyd's members have resigned in the past two years while only 1,300 new names have joined.

However, "what matters is the capacity of the names and their commitment," he said, pointing out that 8,000 to 9,000 members have increased their underwriting capacity in the past two years.

As a result, Lloyd's capacity has remained almost constant at 10.8 billion pounds (\$18.4 billion), Mr. Lawrence noted.

However, the "acid test will be" attempts to increase Lloyd's capacity as the market hardens, Mr. Lawrence noted, adding that he is "optimistic" that capacity will increase.

And, he predicted that the hardening of the market is not far

away.

"In the last few years we have been unable to use all our capacity" because of soft rates and a weak dollar, he noted.

However, the recent soft "market cycle has seen major losses in the last year (and the) market turn must come soon," he said.

"In addition to adverse underwriting results, the new tax regime for insurance companies (in the United States) will begin to bite in 1990," Mr. Lawrence said.

As a result, "there is an opportunity for considerable increase in Lloyd's business over the next five years," he added.

Nevertheless, insurance and reinsurance cycles will continue unabated with higher peaks and lower troughs, Mr. Lawrence predicted.

Mr. Mahoney, though, suggested that future hard markets will be short-lived.

"We are not immune from the rest of the business world. Capital moves so quickly these days," he said, pointing out that as "rates do harden, capital will flood back in."

The hard market of 1985 and 1986 "lasted a very short time and the hard market next time won't last long," said Mr. Mahoney. ■

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## ABA proposal

Continued from page 1

In essence, the ABA was voting on the Kastenmeier bill, the major difference being there were far fewer details in the proposal before the ABA than in the legislation pending in Congress.

For instance, the ABA proposal neither defined the term "single event or occurrence" nor set out guidelines for federal judges in choosing which state's laws to apply to consolidated cases.

A raucous debate ensued in the House of Delegates.

Some delegates and outside experts argued that "single event or occurrence" could be applied to product liability actions.

"Single event or occurrence is not defined in the proposal. It could be the design of a product," said Walter Beckham Jr. of Podhurst, Orseck, Josefsberg, Eaton, Meadow, Olin & Perwin in Miami.

Plaintiffs' attorneys, it was suggested, would argue that the design of a dangerous product was the single event, even if resulting injuries occurred over many years.

"The statute is broadly drafted and could be read to include product liability claims," agreed Stephen M. Shapiro of Mayer, Brown & Platt in Chicago. "This is a solution that creates many more problems than it solves."

Use of the phrase "single event or occurrence," would generate a "windfall" for insurance companies, another critic suggested.

Insurers could argue that if a prod-

uct liability action is one occurrence for the purpose of judicial consolidation, it is one occurrence for the purpose of insurance coverage, he said. Using this reasoning, defendants in consolidated product liability actions could only tap one year's coverage to pay for hundreds of product liability claims, the critic said.

The absence of guidelines for judges choosing between laws of different states also worried some delegates. Relevant law can vary greatly between the states, with some restricting punitive damage awards or barring joint and several liability.

"The sweeping choice-of-law provisions fails to come to grips with constitutional limitations" on the choice-of-law rules, Mr. Shapiro said.

Expansive choice of law rules are a "subterfuge to create a federal common law," charged Robert L. Chiesa of Wadleigh, Starr, Peters, Dunn & Chiesa in Manchester, N.H.

"The statute is broad, general and not well-defined," agreed Anthony Palermo of Harter, Secrest & Emery in Rochester, N.Y.

A representative of the National Conference of Trial Judges argued that such drastic reform was unnecessary.

"Our judges handle cases in the thousands without problems or delay," said Hilda Gage, a Oakland County Circuit Court judge in Pontiac, Mich. "Nothing suggests the need for the extraordinary relief."

However, proponents of the ABA proposal claimed there is a great need for reform.

"There is not a state that we

haven't heard a cry for improvement in our law so that wrongs can be righted more expeditiously," said Eugene Thomas of Moffatt, Thomas, Barrett, Rock & Fields in Boise, Idaho. "People have repeatedly called out for a reduction in the cost and time of litigation."

Mr. Thomas argued that the proposal was not meant to include product liability actions.

"It does not make sense to risk inconsistent results just because people are from different states," argued N. Lee Cooper of Maynard, Cooper, Frierson & Gale in Birmingham, Ala., who also supported the proposal. "We need a single means to adjudicate these cases."

The bar association's Tort and Insurance Practice Section also supported the proposal.

It "would not eliminate multiple lawsuits—it would simply consolidate proceedings for a determination of liability," said T. Richard Kennedy, who represents the section before the House of Delegates.

"It simply does not make sense to try multiple lawsuits on whether and airplane was properly maintained before it crashed," said Mr. Kennedy of Werner, Kennedy & French in New York. "This proposal would avoid waste and inefficiency in our court system."

Despite the rejection of the proposal by ABA delegates, the issue is far from dead.

Many members suggest the original proposal will be introduced for a third time to the House of Delegates at the ABA's annual meeting in August. ■

## Tort reform group wary of consolidation bill

By ADRIENNE C. LOCKE

WASHINGTON—Some insurance trade groups and other traditional advocates of tort reform tepidly support a mass tort consolidation proposal now before Congress, though they fear the measure could ultimately be applied to product liability cases.

"The consensus seems to be that there would be support for the bill if it was clear that it would be limited to cases involving single incidents, such as a plane crash or hotel fire, and not extended to" product liability litigation, said Martin Connor, president of the American Tort Reform Assn. in Washington, D.C.

A spokesman for the bill's sponsor—Rep. Robert Kastenmeier, D.-Wis.—said the bill's intent is to consolidate mass injury litigation evolving from single incidents and would not include product liability cases.

Mr. Connor noted that judicial consolidation would not be feasible for product liability cases. Unlike disasters like plane crashes, specific facts can vary from plaintiff to plaintiff in product liability cases, even when several plaintiffs are allegedly injured by the same product.

Despite its fears, ATRA has not yet taken a formal position on the bill.

However, the ambiguity in the legislation could spell trouble in court, other observers fear.

"If it doesn't say it, then I don't trust it, because it's the way that it is written—and not its intent—that will be applied," said Tom O'Day, associate vp at the Alliance of American Insurers in Washington, D.C.

Liberty Mashigian, an attorney with Crowell & Moring in Washington, D.C., says the bill "should not apply to product liability cases, and every indication we have gotten is that it is meant to apply to those cases evolving from mass disasters."

Business groups and some attorneys also complain of the bill's provisions for allowing federal judges greater authority in consolidating tort cases and deciding which state's laws to apply to them.

The Alliance fears that business could be forced to give up advantages it may have in filing cases separately in different states.

"We are not looking for the expansion of plaintiffs' rights. We are looking for a something that would more balance the system we have today, which we think is out of balance and driving our defense costs up astronomically," said Mr. O'Day, whose trade group is looking at the proposal "cautiously."

Objections to the choice of law aspect, said Mr. Connor of ATRA, could be reduced if the bill were limited to single-event cases in which jurisdiction would often be the state where the incident occurred.

H.R. 3406 is now pending before a subcommittee chaired by Rep. Kastenmeier.

The bill would expand diversity jurisdiction, which allows federal courts to hear litigation involving parties from different states. Under current rules, if any one plaintiff and any one defendant are from the same state, federal courts cannot hear the litigation unless there is a federal question involved.

The Kastenmeier bill would create "minimal diversity" jurisdiction, which would empower federal courts to hear cases involving 25 or more claims, each seeking more than \$50,000 that stem from a single incident if one party is a citizen of one state and any adverse party is a citizen of another.

A court presiding over such a consolidated action would have the power to determine liability and award damages. Current law allows federal courts to consolidate some mass tort claims for pre-trial proceedings only.

Under the bill, once a federal judge determines liability, he or she could either determine damages in the consolidated action or remand the case to a state court for the determination.

### SPOTLIGHT REPORT

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## Pulbrook members hire law firm to plot course

LONDON—A group of Lloyd's of London members of syndicate 90 in 1982 have appointed a law firm to determine if there are grounds to sue members' agencies for more than \$250 million in losses.

About 80 of the 478 members of the syndicate, managed by Pulbrook Underwriting Management Ltd., agreed to each contribute 250 pounds (\$425) toward the cost of an investigation by law firm D.J. Freeman & Co. of alleged negligence of their members' agencies and syndicate mismanagement.

Syndicate 90 members have already paid a cash call of 22.3 million pounds (\$37.9 million) and face a further call this year of 28.7 million pounds (\$48.7 million).

"A name with a line of 50,000 pounds (\$85,000) on the syndicate has already had to pay over 50,000 pounds and now must pay a further 67,000 pounds (\$113,900)," said a memo from syndicate 90 members.

The new cash call follows a settlement last November of a runoff

reinsurance dispute with syndicate 317/661, managed by RHM Outhwaite (Underwriting Agencies) Ltd. (BI, Nov. 13, 1989).

Under the settlement, Outhwaite will pay syndicate 90 about \$64 million now and may be required to pay another \$37.5 million later (BI, Feb. 12). In exchange, the syndicate is no longer responsible for paying unlimited losses.

Patrick Browne, a member of a steering committee of syndicate 90 members, said the law firm will study, among other things:

- Why 47 members were accepted by syndicate 90 in 1982 even though Pulbrook was aware of underwriting problems.

- Why syndicate members weren't told about problems before 1982.

- Whether the reinsurance-to-close premium in 1981 was sufficient to pay the losses.

- Whether there was "inadequate disclosure" by the members' and managing agencies.

—By Stacy Shapiro

## Cleanup coverage

Continued from page 1

combined impact of the North Carolina and Washington decisions will be "very persuasive" in cases before other state supreme courts, said William Greaney of Covington & Burling in Washington, D.C., which represented several companies as friends of the court in the North Carolina case.

Mr. Greaney also noted that the North Carolina Supreme Court effectively rendered inapplicable a contrary 4th U.S. Circuit Court of Appeals decision in 1987 that the costs of responding to a government cleanup order are not insurable (*BI*, July 27, 1987).

Federal courts in North Carolina, which is part of the 4th Circuit, now can no longer follow the U.S. appellate court's ruling, though federal courts elsewhere in the 4th Circuit may still follow it, he noted.

But lawyers for insurers do not believe that the North Carolina and Washington rulings will influence other state courts greatly.

"Obviously, every decision of a high court is important," said Stephen Cohen of McElroy, Deutsch & Mulvaney in Morristown, N.J. But "I do not think it takes on any greater importance than the federal decisions that (North Carolina) declined to follow."

Future state court rulings on pollution coverage issues "will go both ways," Mr. Cohen added. "We've got a long, long way to go before there is a clear trend."

"We don't think it will have a sizeable impact," said another insurer attorney.

The latest case decides the "damages" issue under North Carolina law, but each state supreme court will have to apply its own state's law and reach its own conclusions on whether government-mandated cleanup costs constitute "damages," the lawyer said.

In addition, the North Carolina Supreme Court only addressed the "damages" issue. The case must now be sent back to the trial court to dispose of many other coverage issues, including the applicability of the policies' pollution and owned-property exclusions and the question of how coverage would be triggered.

The North Carolina court ruled in a suit brought by C.D. Spangler Construction Co. and Durham Life Insurance Co. to recover cleanup and defense costs from St. Paul Fire & Marine Insurance Co., Travelers Indemnity Co. and other insurers.

A predecessor company of Durham Life owned property near Charlotte that was leased to Spangler beginning in 1967. Spangler then sublet part of the property to Dynatech Industries, which opened a chromium plating plant there in 1973.

Much of Dynatech's plant was destroyed in a 1974 fire that resulted in a spill of 1,250 pounds of chromic acid onto the property. In 1985 and 1986, state environmental authorities ordered Durham Life, Spangler and Dynatech to clean up the site and collect contaminated groundwater.

To date, Spangler has paid about \$600,000 toward cleanup efforts and is the only one of the three companies that have contributed to the cleanup, lawyers involved in the case say.

In December 1986, Spangler sued St. Paul—its CGL insurer from 1982 to 1985—for a ruling that the insurer must defend and indemnify it for losses related to the cleanup orders.

Spangler also named Dynatech and Durham Life in the suit, and Durham Life filed cross-claims against St. Paul—its CGL insurer from 1970 to 1985—and Travelers, its insurer in 1985 and 1986.

St. Paul and Travelers denied any coverage for cleanup and defense costs and asked the North Carolina Superior Court for Mecklenburg County for summary judgment dismissing the claims.

In January 1988, the trial court granted summary judgment for the insurers, concluding that cleanup

costs do not constitute damages under policy terms and that cleanup orders are not "suits" triggering insurers' duty to defend.

Spangler and Durham Life appealed to the state Court of Appeals, but the insurers succeeded in having the case reviewed directly by the state Supreme Court.

But, the Supreme Court reversed the trial court's findings.

Among other things, the court found that government-ordered cleanups represent "property damage" under CGL policies.

"The state's interest in protecting its natural resources is a form of property right. Thus, it follows that injury to these resources constitutes 'property damage' within the meaning of the policies," the court wrote. Costs incurred by Spangler and Durham Life in complying with cleanup orders also represent "sums which the insured (has) become legally obligated to pay as damages."

In reaching this conclusion, the court explicitly rejected the reason-

ing of two rulings by the 4th and 8th U.S. Circuit Courts of Appeals that the term "damages" refers only to legal damages and not to government-mandated cleanup costs.

The North Carolina Supreme Court said that "better reasoned" state court rulings have found coverage for policyholders under four theories. Under these theories, the term "damages" would include the cost of government-ordered cleanups because:

- The orders are a form of "legal coercion."

- A "reasonable business person" buying CGL coverage would expect such cleanup costs to be covered unless the policy specifically excludes such costs from the definition of "damages."

- It makes little difference whether the state orders a property owner to clean up pollution or performs the cleanup itself and sues the property owner to recover the costs.

- Any property damage to a third party under the terms of a policy automatically means that costs asso-

ciated with remedying that injury are "damages."

In this argument, the North Carolina court cited the Washington court's ruling in the Boeing case.

All of these theories have merit, the Supreme Court wrote. But it added that it was basing its decision on the fact that the CGL policies did not clearly limit the definition of "damages" to payments to third parties who have a legal claim for damages.

"If the insurer intended that 'damages' have only this meaning, it should have so indicated in the policy. The insured would then have understood that cleanup costs incurred pursuant to government mandate were not covered and would have been able to enter into other insuring arrangements," the court wrote.

Since the policies lacked a clear technical definition of damages, the court adopted a broad dictionary definition that includes any monetary compensation for "detriment or injury sustained."

The state Supreme Court also adopted plain language interpretations of policy terms in finding that the insurers have a duty to defend Spangler and Durham Life.

Because of the lack of a clear definition of "suit" in policy language stating that insurers "have the right and duty to defend any suit against the insured seeking damages," the court adopted the broad dictionary definition of "suit" as "the attempt to gain an end by legal process."

Under this definition, state cleanup orders could be considered "legal process," giving rise to the insurers' duty to defend, the court ruled.

St. Paul and Travelers have not decided whether to ask the North Carolina court to reconsider its ruling or petition the U.S. Supreme Court for review, attorneys say.

*C.D. Spangler Construction Co. vs. Industrial Crankshaft & Engineering Co. Inc., dba Dynatech Industries, et al, Supreme Court of North Carolina, No. 128PA88.*

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### Business Insurance

## Circulation Breakdown\*

### Commercial Consumers

**Administrative:**  
CEO's Presidents and Owners . . . . . 2,659  
Vice-Presidents, General Managers and Other Administrative Personnel . . . . . 4,006

**Financial:**  
Chief Financial Officers and Vice-presidents of Finance . . . . . 2,795  
Secretaries, Treasurers, controllers and other Financial Personnel . . . . . 3,842

**Risk/Employee Benefits:**  
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations . . . . . 10,719  
Sub-total . . . . . 24,021

Associations . . . . . 554  
Government, Unions and Educational Institutions . . . . . 1,417  
Commercial Consumers  
Sub-total . . . . . 25,992

Insurance Agents and Brokers . . . . . 10,515  
Insurance Companies . . . . . 7,673  
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators . . . . . 3,800  
Others Allied to the Field . . . . . 2,771  
TOTAL . . . . . 50,751

\* Source Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

## AIDS coverage

Continued from page 2

The Galaxy plan did not indicate how it would determine if a disease was involuntarily acquired.

According to ACT UP, Galaxy did not establish lifetime benefit caps for plan members with other illnesses.

"Their policy was clearly discriminatory regarding AIDS," said Anthony Bennett, a member of the group's insurance committee. "We don't believe there should be any limitations placed on AIDS that are not on any other illnesses."

In a Feb. 6 letter to ACT UP, Galaxy's third-party administrator said it supported the group in its "fight for fair play."

Allied Benefit Systems Inc. "recognizes that HIV can affect anyone. People who suffer from this disease are entitled to the same quality care as anyone else would be for any other medical problem," wrote Laurence Wilneff, president of the Chicago-based TPA. "As spokesman for my company, I feel that any limitation that would restrict individuals from receiving the same benefit structure for HIV is prejudicial and unfair."

Mr. Wilneff was not available for further comment. Mitchell Wilneff, an Allied vp, would not discuss Galaxy's health care plan, citing a Village Voice article that sparked the Galaxy protest, which he said misrepresented Allied's role in the controversy.

Allied is "not an insurance company nor do we establish the benefit structure of employers' plans," said Laurence Wilneff in his letter to the activist group.

ACT UP claims that other employers' health care plans discriminate against AIDS victims, but Mr. Bennett would neither identify other companies nor say whether further protests are planned.

Galaxy was not the first target of ACT UP protests.

In only two years, the group has attained notoriety through protests at the New York Stock Exchange, an international AIDS conference and St. Patrick's Cathedral in New York.

In 1988, ACT UP joined a protest over Circle K Corp.'s plans to exclude coverage for "personal lifestyle" claims, such as AIDS-related claims or those from drug abuse. The Phoenix, Ariz.-based convenience store chain eventually

dropped the provision from its self-insured plan (BI, Aug. 15, 1988).

While discriminatory provisions in insured health care plans are rare, these types of provisions "may be more prevalent in self-insured plans that aren't subject to the same regulations" state laws prescribe, said Gary Stein, policy director of Citizens Commission on AIDS, an activist group in New York.

Self-funded benefit plans are regulated by the federal Employee Retirement Income Security Act of 1974, which does not prevent an employer from restricting benefits for people with AIDS.

But a labor and employment law specialist says it is unlikely that many employers' health care plans discriminate against AIDS victims.

"Very, very, very few lawsuits" charge discrimination against AIDS patients, which suggests few companies actually have discriminatory health care plans, pointed out Frank Cronin of Jackson, Lewis, Schnitzler & Krupman, a Los Angeles law firm.

Among the few suits of this type that have been filed is a case pending in U.S. District Court in Hous-

ton.

An employee of Houston-based H&H Music Co. is charging the company conspired with its health insurer, General Accident Life Insurance Co., to deny him nearly \$1 million in health care benefits by switching H&H employees from a group medical plan underwritten by the insurer to a self-insured plan administered by the insurer. The self-insured plan limits lifetime benefits for AIDS-related treatments to \$5,000. Texas law does not allow insured plans to contain this type of limitation (BI, Nov. 27, 1989).

Mr. Cronin also asserts that it is rare for employers to fire employees who contract AIDS.

His firm last year surveyed 1,000 employers, most of which had employees with AIDS, "and none of them had fired anyone because of it," he said.

In general, employers "are not taking an aggressive attitude" toward employees with AIDS, Mr. Cronin said.

Instead, he said, employers are saying: "We have the benefits in place, they're entitled to them and they are using them."

Few employers are interested in

capping health care benefits for covered lives with AIDS, because those costs can be controlled through case management, said Gerard Dewolf, senior consultant with William M. Mercer Meidinger Hansen Inc. in Los Angeles.

Last year, he said, a large employer asked whether it should cap health care benefits for covered lives with AIDS.

"We strongly advised against it," and the employer followed the advice, Mr. Dewolf said.

Approximately 400 employers have endorsed a "bill of rights" calling for non-discriminatory company policies against employees with AIDS, which was drafted by the Citizens Commission on AIDS, Mr. Stein noted.

Among other things under the bill of rights, employers agree not to screen employees or job applicants for AIDS.

The bill of rights also calls for more AIDS education in the workplace.

International Business Machines Corp., American Telephone & Telegraph Co., ITT Corp. and Johnson & Johnson Products Inc. are among the employers that have endorsed the principles.

# Mergers on Europe's horizon: Analyst

By CAROLYN ALDRED

## London

LONDON—The future looks very bleak for many insurance companies, particularly commercial insurers, in Europe, according to a British stock analyst.

"The 1990s will be a very testing decade for insurance companies," said Simon Rudolph of Morgan Stanley International in London.

"By the end, Continental Europe will probably be dominated by a small number of well-capitalized insurers, each with a dominant position in its domestic market and a significant presence in a number of other major markets as well," he predicted.

"The overall number of players in each country will have undoubtedly shrunk, for there are simply too many insurers writing business," Mr. Rudolph said last month at conferences sponsored by Morgan Stanley in London and Edinburgh.

To survive "an insurer will need to have a rock-solid balance sheet, or specialist knowledge of a partic-

ular geographical or product market," he said. "The death knell has sounded for the medium-sized, 'plain vanilla' companies which try to be all things to all men without having the necessary capital and expertise."

Although "many insurers are entering the new decade outwardly positive about 1992 and the liberalized market" in Europe, "I do not believe that many companies have fully thought out their intended strategies," he said.

As a result, "they will not necessarily play to their strengths and many of those strategies will end in tears," he warned.

The market for commercial risks "is due to be fully liberalized by the middle of this year," said Mr. Rudolph, referring to the Second Non-Life Insurance Directive, which is scheduled to be adopted throughout the European Community by July (BI, May 16, 1988).

"Insurers will hope that the free market does not result in increased competition," he noted.

However, "the market is already ultracompetitive. Both insurers and reinsurers acknowledge that premium rates are too low, and yet there is absolutely no sign that European rates will rise in the foreseeable future," Mr. Rudolph said.

"There will be no change in the outlook for commercial insurance risks until the structural problem of oversupply is sorted out," he said.

However, Mr. Rudolph added, even if the number of insurers and reinsurers in Europe is reduced by mergers, acquisitions and insolvencies, "it is unlikely that premium rates will be raised significantly."

One reason for continued low rates will be an increase in the use of alternative financing mecha-

nisms by European buyers, he predicted.

"Clients are becoming increasingly sophisticated... and they are beginning to ask if they would not be better off retaining more of the risk themselves," Mr. Rudolph noted.

With U.S. clients increasingly turning to the alternative market, "I see no reason why the use of the alternative market should not also increase in Europe," he said.

As a result, the future for European insurance companies "looks bleak for all but the best, and even they will struggle," Mr. Rudolph concluded.

## Fuji name change

Fuji Fire & Marine Insurance Co. Ltd. of Tokyo is changing the name of its British subsidiary as part of a plan to strengthen its international business.

Fuji Fire & Marine Insurance Co. (U.K.) Ltd. is being renamed Fuji International Insurance Co. Ltd. in

the "latest step in Fuji's long-term development strategy (of) expansion of business in the London and other international markets," the company announced this month.

Fuji International recently increased its share capital to 40 million pounds from 10 million pounds (\$67.5 million to \$16.9 million).

## Soviet visit

In a first for Lloyd's of London, Chairman Murray Lawrence will visit the Soviet Union in May at the invitation of the state-owned insurance company Ingosstrakh.

The trip will be more of an introduction to Ingosstrakh personnel than a search for insurance business, according to a spokesman from Lloyd's.

While Mr. Lawrence will be the first chairman to visit the Soviet Union while in office, one predecessor, Julius Angerstein, was born in St. Petersburg, Russia—now Leningrad—in 1735.

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## Pension reversions

Continued from page 2

—to purchase annuities from an insurance company to replace benefits promised to participants.

But, the PBGC requires only that an annuity insurer be licensed in at least one state.

The previous lack of congressional concern about the stability of annuity insurers may be because no one is aware of any insolvencies of insurers that sold annuities to an employer that terminated an overfunded pension plan.

But with some life insurers holding a big stake in the deteriorating junk bond market, there are congressional worries that workers and retirees' annuity benefits could be threatened if junk bond problems lead to a rash of insurer insolvencies.

Congressional concern has been exacerbated by the PBGC's announcement earlier this month that the agency will not guarantee ben-

efits if an overfunded plan is terminated and its annuity insurer collapses.

In addition, while 44 states do have life and health insurance guaranty funds, it is not clear how many of those funds would protect group annuity benefits in the event of an insurer insolvency.

And California, the nation's most populous state, does not offer any guaranty fund protection for life and health insurance policyholders.

In the wake of that concern about the security of annuity benefits, Sen. Nancy Kassebaum, R-Kan., this month introduced S. 2069, a bill that would impose an 18-month moratorium on pension reversions to give her time to propose legislation that would set tougher standards for insurers seeking to sell annuities to employers terminating overfunded pension plans (BI, Feb. 12).

Mr. Gittis told the Senate subcommittee that MacAndrews &

Forbes considered annuity bids only from insurers rated AAA by S&P and A- from A.M. Best Co. And, those bids were reviewed by Lincolnshire, Ill.-based Hewitt Associates, Coleman's pension adviser.

"We had the best pension counsel," Mr. Gittis testified. "We chose the highest-rated insurer. What more could we have done?"

The downgrading of Executive Life's rating was not foreseen at the time an annuity contract was signed, Coleman President Larry Jones told the subcommittee.

As soon as Executive Life lost its AAA rating from S&P, MacAndrews & Forbes moved to cancel the annuity contract, Mr. Gittis said. The contract was canceled last week, and MacAndrews & Forbes will review annuity proposals from AAA-rated insurers, he said.

During an occasionally heated exchange, Mr. Gittis rejected suggestions by Sen. Howard Metzen-

baum, D-Ohio, that MacAndrews & Forbes signed an annuity contract with Executive Life because the insurer owns several hundred million dollars in bonds issued by MacAndrews & Forbes units, most notably Revlon Group Inc.

Mr. Gittis said most of Executive Life's purchase of Revlon debt was made in the aftermarket rather than at the time the debt was issued.

No business relationship with First Executive influenced MacAndrews & Forbes' initial decision to select the insurer to provide annuities for Coleman pension plan participants, he said.

Executive Life was selected because the insurer made the best bid, had the highest credit rating and offered good administrative services, Mr. Gittis said.

Mr. Gittis also challenged Sen. Metzenbaum's assertion that MacAndrews & Forbes acquires companies for their rich pension funds.

In 11 recent MacAndrews & Forbes acquisitions, Mr. Gittis said, it has terminated the overfunded pension programs of only two companies. However, he did not say how many of the acquired companies had overfunded plans.

And, in the Coleman case, MacAndrews & Forbes—a holding company controlled by New York financier Ronald Perelman—was one of several firms asked to bid when the company announced it was up for sale, he said.

Coleman's \$32 million pension surplus, an amount that will be substantially reduced after taxes are paid, was not a factor in MacAndrews & Forbes' decision to buy Coleman, a \$740 million transaction, Mr. Gittis said.

Indeed, Coleman's Mr. Jones noted that Sheldon Coleman, a member of the Coleman family, first suggested terminating the pension plan in an effort to take the company private in early 1989.

"His plan would have replaced the existing defined benefit plans with an ESOP," Mr. Jones recounted. "This was well in advance of any dealings between the company and MacAndrews & Forbes."

Mr. Gittis said the pension reversion will be used to modernize Coleman Co.'s Wichita, Kan., plant and to fund company contributions to the new 401(k) plan.

While MacAndrews & Forbes executives promise that workers and retirees will receive annuity benefits from an insurer with the highest S&P rating when the company eventually terminates the two Coleman plans, there has been fallout from the Executive Life contract in Kansas and on Capitol Hill.

"The stress on employees has been real," acknowledged Mr. Jones, Coleman's president.

Indeed, Wayne Osterhout, a 26-year Coleman employee who lost his job last year following the company's acquisition by MacAndrews & Forbes, told the subcommittee of his anxiety over the safety of his retirement benefits.

"How would you like to be 60 years old, out of a job and worry that the money is not there? When I get to be 65, I want the money to be there. . . . The money wasn't safe. . . . It wasn't guaranteed," he testified.

Sen. Robert Dole, R-Kan., said Congress is responsible for protecting retirees' benefits.

"We want to be sure a triple-A insurer is used" when an employer buys annuities after terminating an overfunded pension plan, said Senate Minority Leader Dole.

Sen. Metzenbaum agreed that congressional consideration of higher standards for annuity insurers is in order.

More importantly, he argued, Congress must separately consider whether to allow employers to recover reversions from terminated pension plans, he said.

Sen. Metzenbaum, a leading proponent of restricting pension asset reversions, used last week's hearing as a pulpit to deliver a sermon, often repetitive, on how pension terminations and reversions hurt retirees.

He said that when a company terminates a pension plan and replaces it with annuities, retirees lose any chance of cost-of-living adjustments in their benefits.

"Is it right to terminate a plan and take away any kind of a COLA for retirees? Are you being fair (to retirees) when you terminate," Sen. Metzenbaum asked MacAndrews & Forbes' Mr. Gittis.

Whether employers should give retirees cost-of-living adjustments before terminating a pension plan is something for Congress to address, Mr. Gittis replied.

In the meantime, individual companies will decide whether to provide COLAs, he said.

The COLA issue is a good question, Sen. Dole said. "But it is not the law."

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**PLUS INTERNATIONAL ASSOCIATES**

# Petromark

Continued from page 1  
Federated also discontinued tank coverage in three other states where state funds will not coordinate coverage with commercial insurers.

A recent survey by three of the trade groups found 60% of the country's independent gasoline marketers do not have the EPA-mandated coverage, with most saying they cannot afford it.

While 37 states have adopted some form of state trust fund to provide the required coverage, only five state funds have so far been approved by the EPA for meeting financial responsibility requirements, the trade groups said (BI, Nov. 20, 1989).

Petromark, which started underwriting in February 1988, has 1,100 policyholders operating a total of 12,000 retail gas stations, according to Mr. Clay.

The risk retention group offered optional policy limits of \$500,000 per claim/\$1 million annual aggregate, \$1 million per claim/\$1 million aggregate or \$1 million per claim/\$2 million aggregate.

Gross written premium volume amounted to \$16.5 million for Petromark last year, making it the second-largest market for underground tank coverage behind Federated, which generated roughly \$30 million in premiums.

In his Feb. 8 letter to policyholders, Mr. Blankenship reported that Petromark's board of directors was "shocked" when it learned Wyatt recommended a threefold increase in reserves as of year-end 1989.

The reason for the reaction, Mr. Blankenship said, "the board had no previous indication that a fi-

**Directors were 'shocked' by the proposal to triple reserves, says Scott F. Blankenship.**

financial reserve increase anywhere near the magnitude now recommended by Wyatt would be needed."

Wyatt had recommended only minor reserve increases in quarterly reviews of reserve levels over two years, according to Mr. Clay. In addition, Wyatt regularly examined the group's premium levels and recommended five rate increases over two years, which Petromark implemented, he said.

Petromark's board has not received what it considers a satisfactory explanation for Wyatt's "abrupt turn-about," which "appears to lie in some loss development trends Wyatt now believes will emerge," according to Mr. Blankenship's letter.

Wyatt has refused to answer questions from Petromark officials about why it changed its position on reserve levels, Mr. Clay said. "It's absolutely incredible."

A Wyatt spokesman said it is "inaccurate" to say the consulting firm has refused to answer Petromark's questions. However, he declined to comment further, citing client confidentiality.

Tillinghast's review of the risk retention group is expected to be finished by mid-March, Mr. Clay said.

Meanwhile, Petromark has agreed not to accept any new members without prior approval of the Tennessee department, and will offer only 60-day renewals for members with anniversary dates after Feb. 7.

Petromark has increased its rates for the 60-day renewal coverage over 1989 rate levels in accordance with a recent Wyatt recommendation, according to Mr. Blankenship's letter.

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## UR standards

Continued from page 2

Dr. Taylor said URAC wants to implement the voluntary UR standards on a limited basis by July 1, 1990.

URAC will evaluate and perhaps modify the standards and implementation procedures at the end of this year.

And, Dr. Taylor said he anticipates a fully operational accreditation commission by January 1991. The commission would be governed by a new board "that would represent a minority of UR organizations with the majority representing the provider and user communities."

To receive accreditation, a UR firm must:

- Submit a written description and flow chart of its review process.

Such documents should include name, address, phone numbers, key contact persons and business hours, as well as information on review policies, prices, staff qualifications and appeal procedures.

- Limit requests for information to only specific data, including:

- ✓ Patient/policyholder data, like name of insurer or health care plan.

- ✓ Attending physician data, such as name, phone number and degree or area of specialization.

- ✓ Clinical information, including primary and secondary diagnoses; prescribed treatment and procedures; and whether a second opinion is required or was waived.

- ✓ Information about the resources of the treating facility, such as whether it is a hospital or clinic, and names of pertinent staff other than the attending physician.

- Notify the hospital, attending physician or enrollee/patient—as dictated by the health plan—of the reviewer's decision within two days of receiving all necessary information. Results of concurrent reviews must be conveyed within one day.

- Establish an appeals process if coverage is denied. URAC emphasizes that the course of treatment is the decision of the physician and whether a treatment is covered is the domain of the claims administrator.

- Ensure confidentiality of patient-specific information, sharing data only with those agencies that have the authority to see the information, such as the claims administrator. Release forms should be modified, if needed, to clarify the provider's right to release medical information to UR firm.

- Require that, at a minimum, a registered nurse or physician must review all cases where the potential not to certify a procedure exists. All staff should be properly qualified and trained, and supported by medically credible criteria and procedures. Nurses

and physicians conducting reviews must be licensed.

- Provide free access to staff from 8:30 a.m. to 4:30 p.m. in the provider's local time zone, each normal business day. UR firms also must conduct their reviews and communications during providers' normal business hours, unless mutually otherwise agreed.

In developing its standards, URAC has incorporated some guidelines jointly developed by the AMA, the Health Insurance Assn. of America and the Blue Cross & Blue Shield Assn.

Although not a part of the standards, URAC also makes several recommendations to providers to ensure an effective and efficient review process.

For example, URAC suggests that providers designate key staff members to interact with UR firms who are available during reasonable hours; familiarize themselves with information required by UR firms; allow for on-site reviews; and establish a mechanism to receive referrals from UR firms that raised questions of deficient care.

URAC also seeks to create a clearinghouse of UR interface information, which would provide licensed health care providers, at cost, a short summary of each accredited UR organization.

In addition to addressing provider concerns, URAC hopes the standards and accreditation will minimize the need for state regulation of review practices.

For example, URAC notes that several states have passed legislation specifically addressing the UR industry, while other states are considering such legislation.

For example, Maine has passed legislation that requires UR firms to give results of their review within two working days after first notification of a case. However, Dr. Taylor says that limit may not allow enough time to gather necessary information.

The Georgia Legislature is considering legislation, H.D. 1813, that would require that reviews only be conducted by specialists practicing in the state.

And a Florida bill would require UR firms to be available by phone 24 hours a day, seven days a week. While that may seem like a good measure, Dr. Taylor notes that most UR firms do not require immediate notification for emergency admissions.

Creating voluntary UR standards would be more effective than legislated or mandated standards, URAC executives say.

"The problem is having so many different states looking at different ways of regulating. That's driving up the cost of doing business and impeding cost-containment strategies," Dr. Taylor said.

Mandated rules and regulations "would stall innovation and growth of the industry," said Robert Becker, a URAC board member and chairman of HealthCare

COMPARE Corp., a UR vendor in Downers Grove, Ill. "The industry is young enough that if it's regulated by legislation, it could limit the creativity" of cost containment techniques.

Instead, "accountability through voluntary standards is the way to approach this," Dr. Becker said.

"This effort is in concert with the thinking of the Institute of Medicine," an affiliate of the National Academy of Sciences that, in a study completed in 1989, "concluded that regulation isn't the appropriate mechanism" to help the industry work most efficiently, Dr. Becker said.

Dr. Taylor also noted that state regulation of UR practices would have a limited impact, because self-insured medical benefits are exempt from state regulation under the Employee Retirement Income Security Act. As a result, "a majority of hospital admissions wouldn't fall under the purview of state regulations," he said.

UR executives say they expect positive reaction to the URAC guidelines. And, they don't expect a major shakeout to hit the UR industry when URAC's voluntary standards are finalized.

"I don't see that the standards will put people out of business. They're really a minimum set of how we think we should operate in this business," Dr. Taylor said.

"The majority of firms want to comply and want to be accredited," said Mark Williams, a URAC board member and president of National Health Services Inc., a UR firm in Milwaukee. These companies realize that "in the medical world, you have to be willing to expose yourself to professional guidelines," Mr. Williams said.

Whether a large number of companies will find themselves without business if they don't voluntarily comply and register with URAC "depends on how the guidelines will be used," Dr. Becker said.

"If the purchasers of UR say they'll only use a UR firm credentialed by URAC, that could result in compliance. Or if state regulators say an organization must be credentialed by URAC in order to be credentialed in the state, that may ensure compliance," he said.

URAC is offering copies of its standards and seeks input from interested parties, including health-care providers, legislators, regulators, insurers and other utilization review providers.

In addition, the group will hold a meeting March 8 in Washington, D.C., to which all UR companies are invited to discuss the evolution of URAC and its guidelines.

For a copy of the URAC guidelines and further information about the March 8 "UR Summit", contact Susan Tate, American Managed Care & Review Assn., 1227 25th St. N.W., Suite 610, Washington, D.C. 20037; 202-728-0506.

## Update

### Pennsylvania OKs auto rate law

Continued from page 2

insurance rates be frozen from Dec. 1, 1989, through June 30. Afterward, rates must be cut 10% if drivers make no coverage changes.

However, a Pennsylvania Insurance Department spokeswoman explained that the rollbacks could be greater if drivers lower first-party medical coverage to a new minimum level of \$5,000 and waive wage-loss coverage, funeral benefits and uninsured motorists protection under their policies (BI, Nov. 20, 1989).

In addition, drivers can obtain another 12% rate rollback if they select optional no-fault coverage, under which policyholders waive the right to pursue pain and suffering damages except in cases involving disabling or disfiguring injuries or death.

But, the law caps the amount of medical costs insurers must pay at 110% of Medicare's payment schedule, and it requires insurers to implement Insurance Department-approved anti-fraud plans.

Also, after auto insurers implement the rate rollbacks, they will be permitted to impose gradual rate increases for one year.

Auto insurers and the National Assn. of Independent Insurers said last week they do not feel that the medical cap and the fraud-prevention programs will reduce costs enough to offset the rate reductions.

"The elective no-fault provision would not produce the cost savings that are needed to support the mandated rate freeze and rollback," remarked a spokeswoman for Allstate Insurance Co. in Northbrook, Ill., the fourth-largest private auto insurer in Pennsylvania.

"We are hard-pressed to find the cost-saving measures spelled out," said Pat McNally, vp and general counsel for the NAI in Des Plaines, Ill.

### Indian Airlines crash insured

LONDON—Indian Airlines has up to 8 billion Indian rupees (\$472.6 million) in liability insurance to respond to claims stemming from the crash of an Airbus jetliner in India last Wednesday that killed 92 of the 146 people on board.

The hull was insured for \$50 million.

Hull and liability coverage is written by the General Insurance Corp. of India and reinsured in the world market, led by Lloyd's of London's Ariel syndicate, London sources confirm. Joint brokers for the insurance and reinsurance for Indian Airlines are J.B. Boda in Bombay, and Willis Faber P.L.C. and Bowring Aviation Ltd., both in London.

Reports say the Indian government also has pledged 500,000 rupees (\$29,535) each to the families of crash victims.

The Indian Airlines Airbus A320, en route from Bombay, caught fire and crashed minutes before it was scheduled to land at Bangalore airport. The cause of the crash was not known late last week, though reports speculate that a vulture may have been sucked into the engine.

The jetliner is manufactured by Airbus Industrie, a European consortium, in Toulouse, France. The company's \$1 billion of product liability coverage is placed by leading broker Faugere & Juthau in Paris and following broker Sedgwick Group P.L.C. in London and led by aviation insurer CAMAT in Paris.

### Briefly noted

Lawyers for four **Mutual Fire, Marine & Inland Insurance Co.** policyholders have asked a federal judge to enjoin efforts by Mutual Fire's rehabilitator to hold the lawyers in contempt of court for pursuing a policyholders' class-action lawsuit against Mutual Fire's former auditor, Peat Marwick Main & Co. Mutual Fire's rehabilitator maintains that only it has standing to pursue litigation against Peat Marwick (BI, Sept. 4, 1989). . . State and private plaintiffs in the **insurance industry antitrust litigation** are scheduled to present their appeal briefs May 11 to the 9th U.S. Circuit Court of Appeals in San Francisco. The massive litigation was dismissed by U.S. District Court Judge William Schwarzer last year (BI, Sept. 25, 1989). . . **John F. Sullivan**, founder of reinsurance intermediary John F. Sullivan Co., died last week at age 78. . . Of 21 **asbestos property damage trials** held to date, defendants won 12 and plaintiffs prevailed in nine, according to the National Journal of Asbestos-in-Buildings Litigation. Eight of the trials are being appealed, while a new trial has been ordered in another case.

# Travelers realigns core business groups

Travelers Corp. has restructured operations to focus on its two main lines of business—commercial property/casualty insurance and employee benefits—rather than along distribution lines.

As part of the realignment it named three vice chairmen and two presidents of major operating units.

The realignment reflects the recognition that the "one-stop shopping" concept that was popular industry-wide several years ago was ineffective and that Travelers should concentrate on its strong core businesses instead, said Joseph T. Brophy, who was named president of Travelers' Managed Care and Employee Benefits Operations, a new position.

Mr. Brophy, who was previously senior vp of the Travelers employee

## Markets

benefits department, noted that as part of the realignment, Travelers' National Accounts Group will be dissolved. That group had handled commercial property/casualty insurance, employee benefits and pensions for large national accounts.

Under the new structure, those three areas will now be the responsibility of three different officials:

- Commercial property/casualty activities will be headed by Charles J. Clarke, who has been named president of Travelers Commercial Lines Property-Casualty Operations. Mr. Clarke formerly was senior vp for the National Accounts Group.

- Employee benefits will be headed by Mr. Brophy.

- Pension services will be headed by Richard J. Shima, formerly executive vp, who was elected vice chairman and chief investment officer.

Mr. Brophy noted that corporations generally divide up responsibility for commercial property/casualty insurance, employee benefits and pensions among their risk managers, employee benefits managers and pensions officers, respectively.

Because these areas were divided among different client company officials, "there really wasn't a lot of synergy" created in putting all these

product lines together into one National Accounts Group, he said.

In addition to the National Accounts Division, Travelers also is dissolving the Agency Marketing Group, which handled commercial property/casualty insurance for smaller corporations. That business will be Mr. Clarke's responsibility as well.

In addition, Richard H. Booth, formerly senior vp in the Agency Marketing Group, was elected vice chairman and chief insurance officer. And, Thomas O. Thorsen, who was an executive vp, was elected vice chairman and chief finance officer.

Meanwhile Travelers reported \$455 million in net income in 1989, up 727.3% from \$55 million in 1988, when Travelers added \$415 million to its real estate reserves (BI, Aug. 29,

1988). Last year's results also reflect a \$77 million aftertax charge in connection with the realignment.

Gloria Vogel, associate director at Bear, Stearns & Co., said the realignment "should make (Travelers) a much better organization. . . It just shows the desire of corporate management to continue to focus on key businesses, and to bring in people who they think are able to develop those business opportunities."

Less enthusiastic was Vita Marino, vp at Firemark in Morristown, N.J., who described the realignment as "sort of a non-event." Travelers has made a number of structural changes over the years, she said. "I don't think there'll be any significant bottom-line impact."

—By Judy Greenwald

# Insurance brokers promise attractive long-term gains

By LEONARD M. WILSON  
Special to Business Insurance

TOTAL RETURN IS A concept that is frequently used to guide investment decisions. Simply stated, total return from a stock is the sum of the average annual growth rate plus the dividend yield. For example, the Standard & Poor's index provides prospective growth of roughly 7% annually along with a current dividend yield of 3% for a 10% total return.

Total investor return from insurance brokerage stocks seems a particularly timely subject, given the apparent emerging shift in commercial property/casualty insurance pricing. Can brokers in the 1990s live up to the past record as vehicles for above-average returns?

This inquiry starts with premium growth, ultimately the determinant of commissions. Insurance markets may shift from soft to hard, but there is an underlying growth in premiums over a full cycle that has consistently correlated with growth in the gross national product.

Nominal GNP growth is a function of real economic gains and inflation. Most observers believe that the U.S. economy can expand at 3% annually. The inflation rate is anybody's guess. The only sure thing is that insurance premiums are effectively indexed to inflation through its effect on insurable values. We think that the 1990s will be marked by less, rather than more, inflation. Consequently, for this analysis, we extrapolate 3% annual inflation or a 6% nominal rate of GNP expansion.

For the past 20 years, commercial premiums have risen modestly, rather than faster than the GNP. This is true whether the starting point is in the trough or the peak of insurance cycles. The broadening concept of what constitutes an insurable loss has driven this more rapid growth in premiums. Given a continued swing to self-insurance and possible subtle changes in the magnitude of liabil-

ity awards, commercial premiums may only match GNP's 6% rate of growth in this decade.

Progress in brokerage commissions need not be limited by GNP growth, though. The alphabet brokers have, over the years, displayed a well-developed ability to gain market share. Increased market penetration reflects client mergers, increased buyer sophistication and greater activity on the part of foreign firms in the United States. No one can be certain of the alphabet brokers' market share. We put it at about 35% of total commercial commissions, but it could be higher.

If the leading brokers can gain a single percentage point of market share annually, commissions might rise about 9% on average,

**The total return on the typical brokerage stock amounts to 13% to 16%, the sum of the estimated growth rate and dividend yield.**

3% more than the underlying 6% annual advance in premiums, excluding acquisitions. This prospect is quite consistent with market share gains of the past two decades.

International insurance brokerage has become more important to the public brokers in the 1980s. Marsh & McLennan Cos. and Alexander & Alexander Services Inc. are among the public brokers that have become global enterprises, as has Fred S. James & Co. through its parent Sedgwick Group P.L.C. The other public brokers also have a thrust toward the international scene. We believe that foreign brokerage commissions can rise 9% to 10% in the 1990s. In foreign insurance brokerage, market share gains may not be a material factor.

Overall, commissions could grow at approximately 9% annually in the 1990s. The actual rate of gain will vary from year to year depending upon the phase of the under-

writing cycle.

Investment income would normally be expected to track the growth of insurance premiums, but if we are right about a lower rate of inflation, then we must also reckon with lower short-term interest rates. As a result, investment income could grow at a percentage point or more slowly than premiums.

Benefits consulting, a segment of increasing interest to each of the public brokers, has expanded rapidly in recent years. We believe a combination of intrinsic growth coupled with market share improvement could propel benefits consulting at 12% to 15% annually through most of the 1990s.

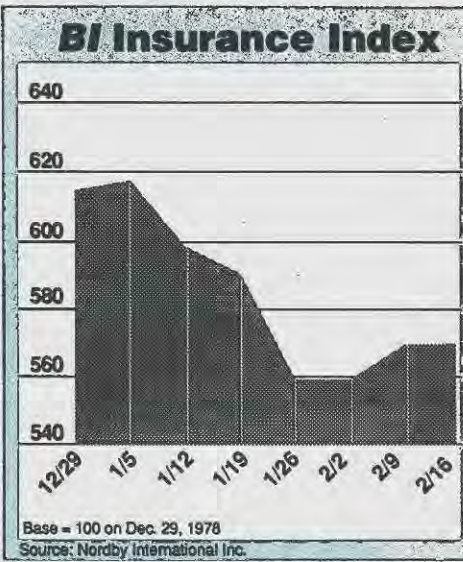
Based on these projections, top-line and earnings growth for the typical public broker might run around 10% to 12% annually. Few industries can claim an expansion potential almost twice the rate of nominal GNP growth.

Productivity gains could allow earnings growth to surpass our estimate. Headcount conceivably might rise at a slower pace than the physical workload. But for this analysis, we have decided to exclude the possibility of margin expansion in the interests of leaving a cushion for our projections.

Total return to the investor also must take account of dividends. Assuming a 50% dividend payout ratio, well within the reach of the public brokers at normal levels of profitability, a dividend yield of 3% to 4% seems plausible. The total return, then, on the typical brokerage stock amounts to 13% to 16%, the sum of the estimated growth rate and dividend yield.

Even with a generous dividend payout ratio, the public brokers will have some cash left over for acquisitions, share buybacks or investment in certificates of deposit. Judicious use of free cash could add a couple of percentage points to the total return.

Clearly, if our analysis has validity, then insurance brokerage remains one of the more attractive industry sectors for long-term gains. Risks to this positive outlook include the possibility of chronic excess underwriting capital and prolonged soft markets and the inability of the leading brokers to gain market share in the future.



Insurance industry stocks fell last week, as the Business Insurance Index dropped a slight 1.0 points to 569.8 on Feb. 16, from 569.9 on Feb. 9. Advancing issues were led by Frontier Insurance Group, up 10.3%; Provident Life Insurance Co., up 8.9%; and Continental Corp., up 6.0%. Decliners followed Seibels Bruce Group, down 8.2%; CNA Financial Corp., down 7.5%; and SA-FECO Corp., down 6.7%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 2.8 million shares traded. The BI Index lost 0.02% for the week; the Dow Jones 30 Industrial fell 0.5%; the New York Stock Exchange Composite lost 0.4%; while the Standard & Poor's 500 gained 0.4%.

## British Issues

Feb. 15 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Comm Union	504	29.0	29.0	5.8	504-492
Genl Accident	1135	17.1	68.0	6.0	1138-1127
Gdn Royal Exch	244	20.3	15.3	6.3	244-234
Royal	510	30.0	34.0	6.7	510-500
Sun Alliance	315	11.6	17.0	5.4	315-308
<b>Brokers</b>					
Bradstock	239	16.8	10.0	4.2	239-235
CE Heath	537	15.1	34.5	6.4	537-530
Hogg Robinson	170	11.9	9.7	5.6	170-170
Lloyd Thompson	273	18.2	9.3	3.4	273-273
PWS Holdings	65	10.2	3.3	5.1	65-65
Sedgwick Grp	284	21.0	16.0	5.6	285-281
Steel Bri Jones	286	17.9	15.3	5.4	287-286
Willis Faber	262	18.5	15.3	5.9	264-262

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

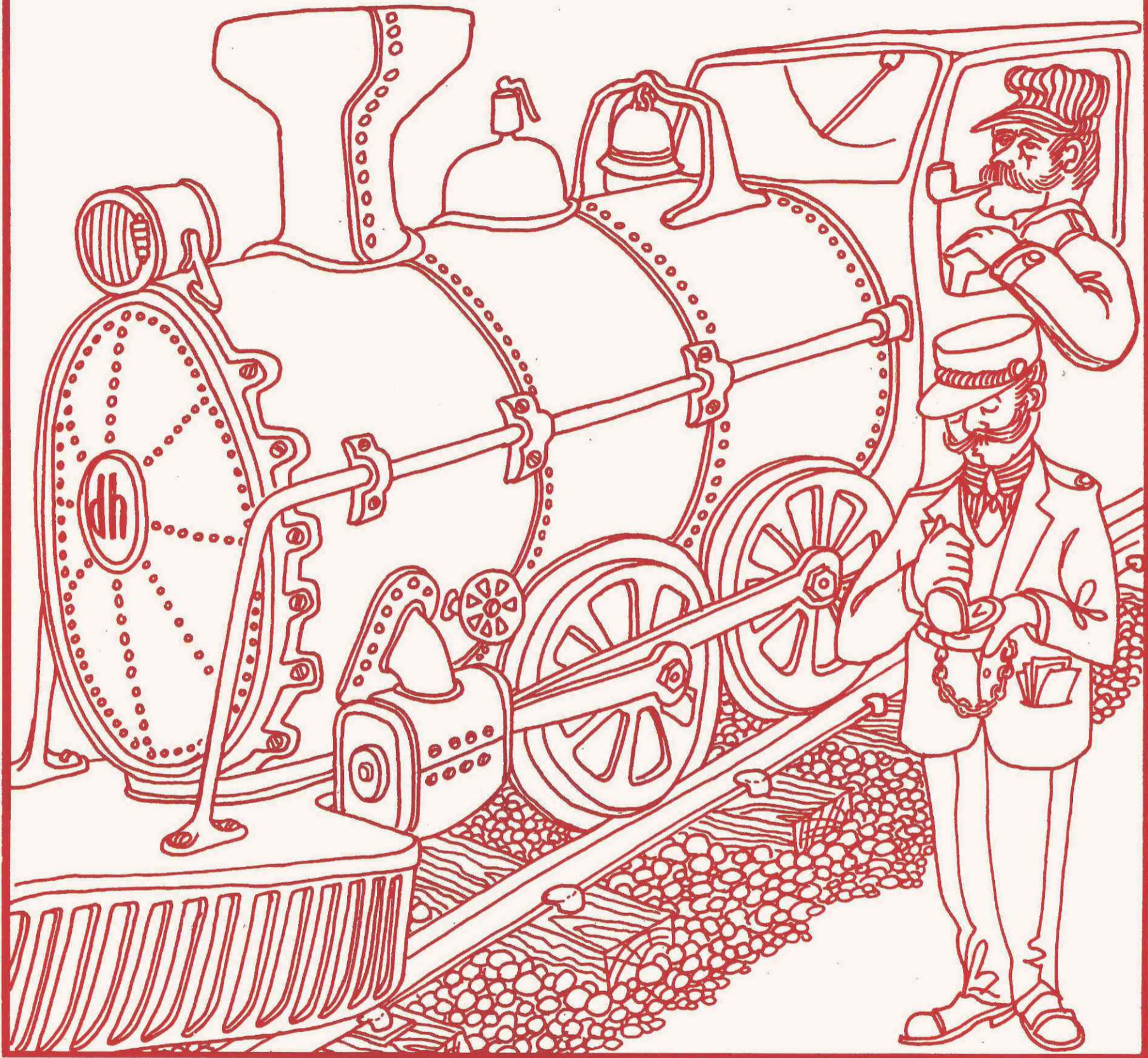
## BI Industry Stock Report

FEBRUARY 12, 1990 THROUGH FEBRUARY 16, 1990

		Weekly		Year to Date		Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Weekly		Year to Date		Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			
		Price	% change	% change	% change	High	Low							High	Low	High	Low											
<b>BROKERS</b>																												
Alexander & Alexander	NYS	26.38	-3.65	-16.27	34.00	23.13	721	1.00	3.79	16	9.18	2.87																
Carroon & Black	NYS	34.63	2.97	-9.48	41.00	31.00	90	1.24	3.58	16	12.73	2.72																
Gallagher Arthur J. & Co.	NYS	23.25	3.91	-6.06	26.50	17.63	13	0.52	2.24	16	5.33	4.36																
Frank B. Hall	NYS	2.75	0.00	-8.33	4.63	2.50	55	0.00	0.00	-1	-2.80	-0.98																
Hibb, Rogal & Hamilton	OTC	15.50	0.81	-16.78	20.63	11.00	104	0.28	1.81	17	4.60	3.37																
Marsh & McLennan	NYS	77.25	0.98	-0.96	89.75	57.50	385	2.48	3.21	19	10.56	7.32																
Roe & Associates	OTC	12.25	0.00	-7.55	12.75	8.00	10	0.40	3.27	15	1.89	6.48																
BROKERS AVERAGE																												
0.7																												
-9.3																												
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>																												
Berkley W.R. Corp.	OTC	36.50	1.39	-12.31	46.50	29.25	114	0.40	1.10	8	25.06	1.46																
Berkshire Hathaway Inc.	NYS	7550.00	-5.03	-12.46	8900.00	4625.00	1	0.00	0.00	-27	2869.00	2.63																
ITT (Hartford Group)	NYS	53.13	0.71	-11.27	64.50	51.00	1370	1.60	3.01	8	56.33	0.94																
Sears (Allstate)	NYS	40.13	2.88	3.55	48.13	36.50	2845	2.00	4.98	10	37.75	1.06																
CONGLOMERATES AVERAGE																												
0.0																												
-8.1																												
<b>INSURERS/REINSURERS</b>																												
Aetna Life & Casualty	NYS	51.25	3.54	-11.64	62.50	48.50	918	2.76	5.39	9	58.11	0.88																
AmBase Corp.	NYS	8.38	-4.29	-33.66	16.38	7.38	639	0.20	2.39	3	29.08	0.29																
American General	NYS	28.63	-0.43	-12.60	38.50	28.13	1111	1.56	5.45	9	34.68	0.83																
American Heritage	NYS	32.50	-0.76	14.04	32.75	25.75	7	1.12	3.45	13	22.60	1.44																
American Indemnity/Finl	OTC	6.75	-3.57	-15.63	13.00	6.75	13	0.56	8.30	-2	17.38	0.39																
American International	NYS	96.00	2.26	-9.00	112.00	69.38	1152	0.48	0.50	12	41.92	2.39																
Aon Corp.	OTC	37.88	1.34	-10.62	43.25	28.25	145	1.40	3.70	11	19.62	1.93																
Argonaut Group	OTC	67.00	1.90	-2.72	71.50	51.25	20	1.60	2.39	8	36.83	1.82																
AVEMCO Corp.	NYS	24.25	-2.02	-0.51	27.50	20.38	12	0.40	1.65	16	9.52	2.55																
Baldwin & Lyons Inc.	OTC	20.13	-3.01	-6.40	24.00	15.50	32	0.28	1.39	6	20.80	0.97																
Belvedere Corp.	ASE	4.88	2.63	-11.36	6.50	4.25	12	0.04	0.82	15	8.03	0.61																
Chandler Insurance	OTC	9.38	-5.06	-20.21	13.25	7.00	64	0.00	0.00	5	9.53	0.98																
Chubb Corp.	NYS	96.63	2.38	0.78	99.50	63.50	752	2.32	2.40	10	55.49	1.74																
CIGNA Corp.	NYS	48.38	3.20	-19.71	66.75	45.25	1636	2.96	6.12	11	66.84	0.73																
CNA Financial Corp.	NYS	78.13	-7.54	-21.88	108.75	57.88	138	0.00	0.00	8	54.87	1.42																
Continental Corp.	NYS	28.63	6.02	-8.76	38.63	25.75	716	2.60	9.08	10	41.36	0.69																
Durham Corp.	OTC	31.75	-0.78	3.25	34.75	29.00	55	0.92	2.90	16	26.32	1.21																
Fireman's Fund	NYS	31.75	2.42	-9.93	40.75	30.00	834	0.68	2.14	47	32.74	0.97																
Fremont General Corp.	OTC	20.13	3.21	0.00	22.50	13.38	316	0.80	3.98	9	19.09	1.05																
Frontier Insurance Group	NYS	18.75	10.29	1.35	21.75	11.38	45	0.00	0.00	8	7.29	2.57																
General RE Corp.	NYS	87.63	2.19	-2.64	96.25	60.00	586	1.52	1.73	14	29.04	3.02																
Hanover Insurance Co.	OTC	29.50	4.89	-3.28	33.00	25.75	71	0.44	1.49	6	32.03	0.92																
Hartleysville Group	OTC	26.00	2.46	-5.45	28.75	19.00	26	0.60	2.31	9	18.94	1.37																
Hartford Steam Boiler	OTC	54.00	2.86	-0.46	59.25	38.50	183	1.60	2.96	14	18.94	2.85																
Kansas City Life Ins.	OTC	35.50	0.00	-1.05	36.00	33.25	1	1.12	3.15	10	39.22	0.91																
Kemper Corp.	NYS	35.00	-6.35	-25.93	51.88	29.50	527	0.92	2.63	8	29.97	1.17																
Lawrence Insurance Group	ASE	6.88																										

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